To: Community Affairs References Committee

Re: Inquiry into Suicide in Australia

I write as a psychiatrist in private practice working in the field of general adult psychiatry.

My concern is that, while educating the public, police, emergency department staff, general practitioners etc is clearly important, the crucial point is what happens after a person is identified as being suicidal. There is nothing to be gained in identifying those who are suicidal when you are not able to offer them treatment. For those identified as being at high risk of suicide, treatment starts with the provision of a safe, secure environment, which usually means hospitalisation. If there are no beds available - which is frequently the case - safe treatment can't be offered. It would be like trying to treat an appendicitis without admitting the patient for surgery, or trying to treat a person having a heart attack at home rather than in a coronary care unit. The suicidal patient's care is thus compromised from the outset. And this failing is due not to clinical factors (such as a lack of training), but to funding/administrative failures outside the clinician's control.

What then happens - in real life - when no psychiatric beds are available is that community treatment is the only option left, but this can involve taking a punt on the person's life (as I had to do back in my days as a registrar e.g calling 10 hospitals at 3am to find there were no psychiatric beds left in Sydney, and having to send my patient off into the night, hoping he'd call the community team in the morning for follow-up). This is dangerous for those most in need of help: many persons who commit suicide have attended a mental health service, GP or emergency department in the preceding week. And even when a person gets a bed, is often not for long enough: patients are often discharged before they are substantially better, so as to make way for the next person who is in the emergency department. Undertreatment due to such bed pressures may be one reason why the suicide rate for those recently discharged is unacceptably high.

What is critical for the Community Affairs References Committee to understand is that the contribution of bed unavailability to suicide will not show up in the current psychiatric literature. Why? Because it is not studied. Studies usually focus on clinical risk factors e.g. age, sex, symptom severity, diagnosis, co-morbid alcohol and/or substance abuse, previous suicide attempts, evidence of planning and/or intent etc. They don't ask whether there were no beds that day, and how this may have affected the patient's management. (Try getting a hospital administrator to agree to that kind of study!) If the Committee were to meekly conclude "there is no evidence to link bed availability to suicide", this would be to ignore the core clinical issue compromising the care of those who are suicidal. Please don't confuse an absence of academic studies with the absence of a link between bed availability and suicide. The experiential knowledge of clinicians working at the so-called "coalface" should not be dismissed as merely anecdotal; it is conveying something important about how the health system isn't working. Until formal studies get commissioned, the experiential knowledge of clinicians in the health system is what the Committee will have to work with if it is to come up with meaningful recommendations that don't just sound grand on paper but which actually work in practice to improve the care of those who are suicidal.

Yours sincerely

Dr Alan Garrity (MBBS BA FRANZCP)