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Topic: Disadvantaged Youth and Suicide

Program Transcript

My mobile is starting to make me nervous. It often bears bad news. For a decade, I've provided GP services at a health clinic for homeless young people. Sadly, many are no longer alive. Now and then, I get a call to let me know. Last week, a death in a park. Last month, a suicide.

The suicide caused some reflection on my part. The 24-year-old was a troubled woman. I saw her 19 times over a two year period. She strode out of our final consultation, angry that I wouldn't prescribe strong sleeping tablets. She threatened to do something that would shock me. We both knew what she meant. Luckily for my own stress levels, this episode took place months before her actual suicide. The clinic's nurse was less fortunate, having much more recently experienced a similar interaction over a different issue.

My patient had rapid, severe mood swings and a tendency to self-harm. She met the criteria for borderline personality disorder. There is increasing evidence that, rather than a wicked soul, dysfunction of the brain's limbic system underlies this condition. This dysfunction is often associated with past emotional trauma. Among my female patients, a history of childhood sexual abuse is common.

This already disturbed young woman had problems dealing with the murder of a friend and I sought psychiatric help for her.

She told me that the community mental health service said she didn't have a mental illness. She was also assessed at a public hospital psychiatric unit and apparently told that she didn't need a psychiatrist. None of this surprised me, and I'm not blaming the clinicians who assessed her. Like most health care problems, the fault does not lie with individuals. They were merely following their training and, of course, to a degree restrained by the resources allocated to the public system. There was certainly nothing unique about the failure to achieve psychiatric support for this woman and I have been down this same path many times with many patients in many locations.

Prosperity and pleasantness are common casualties of severe mental illness. One would hope that psychiatrists, of all people, could accept this but like most doctors, psychiatrists rarely show enthusiasm for, or understanding of, patients who are neither cashed up nor personable.

In a rural area, the local psychiatrist once refused my referral of an actively suicidal patient with major depression. She was drinking and he didn't see drinkers - but could a psychotic depressive live in a rural Aboriginal community without drinking?

I once heard a professor of psychiatry state that chronic mental patients taken against their will to hospital should pay their ambulance bill if they were not covered. His apparent rationale was that anybody in chronic ill-health would be mad not to ensure that they had ambulance cover.

Earlier this year, I discovered a psychiatrist was charging a patient of mine weekly consultation gap fees of up to one quarter of her income. On top of this, she was charged non-attendance fees for missed appointments. And, naturally, she was missing appointments - because she couldn't afford to pay for them.

A few days ago, my phone rang again. It was just another day at the office. One of my patients had deliberately splashed metho on her arm and set it on fire. The clinic nurse and myself discussed whether or not to send her to hospital with a note: "Dear Doctor, this woman set her arm on fire. Is it possible she has a psychiatric illness?"

One can usually find a specialist physician or surgeon to follow up difficult cases, offering whatever support they can. As a GP, I find it frustrating when psychiatrists will not do likewise. It appears that psychiatry operates in a comfort zone that conveniently defines the most troublesome and least lucrative cases as outside their concern. I often diagnose a life-threatening personality disorder but can't arrange any specialist support.

Too many young people deliberately kill themselves. Over the years, a dozen or more of the statistics have been my patients. Being poor, smelly, irritable or homeless should not be a death sentence. It's time we cut the crap about the tragedy of youth suicide and ensured a service actually gets provided for people who desperately need it.