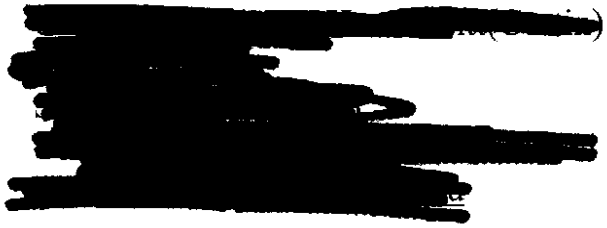
Background:
I am a member of the Council of Official Visitors in Western Australia. We are appointed by the state Minister for Health. We represent the interests of involuntary patients and also inspect public mental health facilities including hostels. I was motivated to apply for this part time position having lost my daughter to suicide at the age of 22 in 1995.



<u>Under the terms of reference there are just two sections I wish to comment on:</u>

1. **Reference B/ ...lack of resources and barriers to progress..**

On the first occasion my daughter made an unsuccessful attempt to take her life, she was committed to Royal Perth Hospital as an involuntary patient. During the three weeks she was there she saw a psychiatrist on a one-on-one basis only twice and for just 8 minutes on each occasion. However, her medical records show that she had 'psychiatric intervention' whilst she was at the hospital on a 48 hour cycle. However, these 'interventions' related to the presence on the ward of duty psychiatrists and not to any individual psychiatric therapy for my daughter. She asked to see a psychologist but this was never achieved. She was a public patient. Her anger and attitude got worse.

On leaving the hospital her behaviour and mood fluctuated with her illness. She smoked and drank some alcohol but took no other drugs. Attempts were made unsuccessfully for her to receive more intensive psychiatric or psychological intervention – as a public patient. She ultimately agreed to see

a psychiatrist as a private patient. She did not have private insurance. The fees were met by myself. The private psychiatrist was inundated with patients all demanding more time. My daughter became frustrated as, once again, she couldn't access professional help when needed. She tried another private psychiatrist with the same result.

2. **Reference H/ ..role of primary health care in prevention...**

In the final phase of her illness my daughter started to visit GP after GP seeking prescriptions for specific anti-depressants and other drugs to help her sleep. If a GP didn't provide her with the prescription she sought she went and found another who was more compliant. Ultimately, she had a collection of drugs that enabled her to commit suicide.

There are two issues arising out of these scenarios:
1/ Sustained access to psychiatric and psychological counselling on a one-to-one basis is rare in the public sector due to costs and workforce shortages. Consequently, drugs are the chosen treatment method. If health professionals had more professional support it is likely that treatment protocols would change to the extent that the current reliance on drugs would probably diminish. You only have to compare therapies undertaken in private psychiatric units to see the difference.

2/ When my daughter set out to deliberately acquire the drugs she required to commit suicide, she went, what is described as, "doctor shopping". It shouldn't be too difficult to provide computerised monitoring to prevent or restrain this, especially in pharmacies where computers are already installed. In the longer term, as more GPs come on-line, a similar monitoring system could be introduced. Meanwhile, the College of GPs and the Divisions of General Practice should be educating their members to be more vigilant.