PO Box 745 Indooroopilly QLD 4068 AUSTRALIA Ph 1300 662 173 or +61 7 3378 26
Email info@pacificsolutions.com.au Web www.pacifictranscription.com.au

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MEDICO-LEGAL SOCIETY OF NSW INC.

SCIENTIFIC MEETING

WEDNESDAY, 11 NOVEMBER 2015 AT 6.15 P.M.

THE TOPIC: ARE CATASTROPHES IN MENTAL HEALTH FORESEEBLE?

SPEAKERS: DR MATTHEW LARGE
DR PEGGY DWYER

Transcript prepared by Karen Russell

QUESTION TIME:

DR MICHAEL DIAMOND: We will now open the meeting to questions from the audience. Can I remind you to identify yourselves so our stenographer can document who asked the question. Could you also state your name, discipline, and to whom you are addressing the question. With no further ado, I will open to the floor.

MR JULIAN WALTER, Medico-Legal advisor, MDA National: Out of the data that you looked at, for the in-patients who are given leave, can you get a sense of what their rate of suicide is on leave compared to what it is in the hospital?

DR MATTHEW LARGE: Yes, about a third of in-patient suicides occur among patients who are on approved leave and about a third of patients who are on unapproved leave. I am doing some work on this question at the moment but it seems to be about one third.

MR JULIAN WALTER: The actual risk itself, is it thought to be a lower risk once you leave hospital on temporary leave or a higher risk?

DR MATTHEW LARGE: I am doing a study of this at this very moment and I think it is the same. I do not believe it changes much. Once you are discharged, the rate of suicide appears to go up a little bit for a while, but not much - a 20 per cent increase. However we are talking about very high rates of suicide. We are talking about the difference between the Australia Square building and the MLC building. It does not really matter.

DR MICHAEL DIAMOND: Just before we go on Matthew, there were questions put to you by Dr Dwyer which I do not want to overlook because I believe there is much to be addressed. So could we address those questions and then I will return to the floor.

DR MATTHEW LARGE: "Are the risk assessment tools still helpful and appropriate?" The short answer to that is in my view they are not. There are National Institute of Clinical Excellence (NICE) guidelines, for example, in the United Kingdom, which have quite explicitly said that suicide risk assessment instruments should not be used in clinical decision making. The reason for that is we do not have any low risk patients. They just do not exist. If you had an instrument that artificially reassures you

that the patient is low risk and do not treat them or do not offer them treatment, then you can get into a big problem.

There are two sides to this. One side is the problem of over-treatment of people whom we falsely classify as high risk where we have a long shot bias. We think we know what is going to happen. But the other side is the problem of being falsely reassured about the safety of the patients. This applies at least among in-patients and also some patients in emergency departments. I did not run this argument here this evening but the data is very similar. The difference between the general community and the natural class of patients is enormous, but the difference within the class of patients is quite modest in comparison.

We do not have tools for identifying low risk patients. Perhaps we should try to develop some, so that we can just shunt off a whole group of people who are not going to kill themselves out of emergency departments. However I am not sure that that is particularly good medicine either.

I am in no doubt that when you do a risk assessment, and I said this earlier, that you can identify a group of people who are statistically more likely to suicide. I am happy to accept that that information does apply to members of that class. That is a big argument in risk assessment, but a totally empty argument. However what I am not convinced of is if there is anything logical you can do on the basis of that assessment to determine whether or not the person should have treatment.

If you think about Antony Waterlow, for about 10 years the psychiatrist was right, he did not kill anybody. So a much better judgment should have been was he sick? Was he able to weigh up the risks and benefits of his treatment? Was that process thought about? Was there any other way of providing treatment for him other than shutting him in hospital? If you think of it in those terms, there are lots of duties that are placed on doctors, in fact probably more duties that could be interrogated by courts.

DR PEGGY DWYER: Like what?

DR MATTHEW LARGEL: Like whether you would consider the patient’s ability to make rational decisions about their treatment, and that is the standard of involuntary care

in the rest of medicine. You do not have a Cardio Vascular Health Act with special provisions for diabetics. We do not send fat smokers off to camps just because of their risk of coronary events. When I mention this to endocrinologists, they are very excited about this prospect. But we do not do that because people are generally capacitous. My personal view is it is the most unfair provision in law that we have a different standard for involuntary care of mentally ill people.

I think that lawyers "crawling over this bill" is great. I would love to see more lawyers in psychiatric wards. I do not believe we should be detaining patients without lawyers. I certainly do not believe we should be detaining patients for two weeks without there being some legal judgment about whether they should be in hospital. We do not do that for people who steal a packet of Twisties from the supermarket. We allow them either to be released or to see a magistrate within 24 hours. On the other hand we seem to happily let people hang around in hospital for two weeks before they have any legal redress.

I am not trying to get lawyers out of psychiatric care at all. In fact, I suspect that there are some pretty bad hospitals around, and the law needs to find a way into that somehow.

DR MICHAEL DIAMOND: Can I open up discussion to the floor.

DR JONATHAN PHILLIPS: Your phrase "universal standard of care" was wonderfully anti-chromatic Matthew. It seems to me that sort of one size fits all. As a clinician I guess I worry about that. I wondered whether you might expand a little on that particular phrase and what you thought of the standard and what you believe the standard ought to be?

DR MATTHEW LARGE: I am working on it. I work in an emergency department five mornings a week and see lots of patients presenting with suicidal tendencies and suicidal ideation. I believe that all of those patients should be thoroughly assessed in a sympathetic and respectful way with the doctor or the nurse controlling their feelings about the patient, being very nice and trying to understand the predicament that the patient is in. If they believe there is a mental disorder, they should discuss with the patient what options are available. Every patient should have some sort of plan, in the event

of becoming unsafe. You should work that through with every single patient.

I do not believe you should be putting into hospital, people who are capable of making decisions about things. The alternative is for you, as the psychiatrist, to make a judgment about whether the patient is high risk or low risk and then subject the patient to that decision. I believe that is disastrous. It alienates patients from decision making. It leads us to view patients as a sort of source of statistical knowledge rather than people with autonomy and decision making processes.

With respect to particular sorts of treatments, there are standards of treatment for schizophrenia. Patients who have a deteriorating social setting, hallucinations and delusions should have anti-psychotic treatment. Waterlow had no doses of anti-psychotics - not a single dose. So he should have been treated, in my view, because he was very sick and could not make decisions. That could have happened quite early and certainly would have prevented what happened.

For a treated patient with schizophrenia, their rate of homicide is very similar to that of an ordinary person walking down the street in Louisiana. Your average person in Louisiana is more likely to kill someone than is your average patient with treated schizophrenia. It is not reasonable for us to expect who is going to kill someone on the streets of Louisiana and it is not reasonable for us to expect to know which of our patients are going to kill someone else.

It is reasonable for us as doctors to assess a patient’s symptoms, to reach a diagnosis, to explain that diagnosis to the patient or to their competent relatives, to make a decision about their ability to weigh the risks and benefits of treatment and to make a decision about whether they are able to competently refuse. That is just ordinary standard medicine. It is much more akin to what doctors in other disciplines do. When we see a patient who suffers from high blood pressure, smokes and has high cholesterol, we do not shut them up in “fat camp”. We have a discussion with them about stopping smoking and about cholesterol lowering agents. In fact I was talking to Seena Fazel in Oxford last week and he is trying to develop a framing and risk calculator for suicide. Suicide is statistically less predictable than heart attacks. The risk factors for suicide have less

statistical power than the risk factors for vascular events.

MS LOUISE HAZELTON, Legal: I want to ask a question in relation to the actual facility itself. What role does it play in patient suicides in your opinion? For example, if you are in a rubber room compared to a facility that is more open? I would have thought that an in-patient facility should be safe and on one level. However I have come across ones that are multiple storeys and have had jumping attempts. I thought that was quite obvious.

DR MATTHEW LARGE: Many years ago I wrote a paper called Jumping from the General Hospital in which we described all the people that had jumped out of Royal Prince Alfred Hospital over a 15 year period. That paper has bee cited as the reason for not putting balconies on new hospitals. Accordingly I feel somewhat directly responsible for preventing patients from having fresh air and sunlight.

To answer your question, when a patient walks into our psychiatric emergency care unit they get marched through electronically locked doors that buzz and make a clanking noise. There is a big sign that says Emergency Psychiatric Unit. It is hugely frightening. It resembles that scene where Sarah Connor gets locked up in the Terminator. We need to do something different to that. Patients often kill themselves because they feel they have no other option. You do not kill yourself for no reason. You kill yourself because you cannot think of anything else that is better than your current situation. Our hospitals close down the opportunities that people face. I believe we can do much better, architecturally, with trying to design hospitals that unfold in a way that increases possibilities for not very well patients.

I do not really know to what extent the architecture makes some difference. Removing hanging points has been a somewhat effective, but in my view, somewhat disappointing measure. Hanging is pretty much the only way that people kill themselves within psychiatric hospitals and people can hang themselves with all sorts of things and do so. Something that worries me is in the community patients can do a whole lot of things, most of which are not very lethal. So they can take benzodiazepines or paracetamol, and other things for which there is a remediable action. Yet we shut them up in a psychiatric hospital where all they can do is hang themselves. This is much more lethal. That extends to patients who are absent without leave as well. They know

that we are going to be looking for them, so they have to do something quickly and railway tracks, bridges and cliffs are quick.

DR DAVID JOHNSON: It is amazing to me that the major independent risk factor for suicide in psychiatric hospitals was depression. Is there any information which would suggest that treatment of patients with depression would be better done in non-psychiatric public or private hospitals?

DR MATTHEW LARGE: The suicide rate among general hospital patients is astonishingly low and is declining. When I wrote that paper, Jumping from the General Hospital, one in 100,000 admissions at general hospitals resulted in a suicide. In most recent American data the figure has been one in a million admissions resulting in a suicide. Part of the reason is people are not in hospital for long enough to commit suicide. However I believe if you could do more mainstreaming and regarding psychiatric disorders as more like ordinary medical disorders and making it a less stigmatising experience, that would be very good.

A lot of patients do express the preference to be treated in a private hospital. I believe learning to listen to patients a lot more about what they want to do has got to be the starting point. Most patients are mentally competent. Indeed the vast majority of patients are mentally competent. It is in fact only some schizophrenic patients, drug affected patients and patients with very severe depression or mania who are not competent. I think something like 70 per cent of the patients I see in the emergency department are competent from the first minute that I am seeing them.

DR MICHAEL DIAMOND: First of all Dr Dwyer, have you had satisfactory answers to your questions?

DR PEGGY DWYER: There is only the thing that is raised in general discussions with my colleagues about replacing risk factors. I agree there is a general acceptance that it is very difficult to predict risk and you cannot always do it. However the people conducting assessments are not just very experienced psychiatrists. They are often nurses in regional areas without a lot of support. A list of factors to look out for, for example, a history of self-harm, a history of psychiatric illness in the family, and an idea for the method that you would use is useful. It seems to me to be, as a matter of common

sense, a useful tool for them. I guess the issue is then that it might not be appropriate if the result of that method is low risk assessment. You do not need to go on to criticise somebody for that, if they explain the reasons why they were conducting the assessment in the way they did. Do you think that that a check list is helpful to practitioners in any way?

DR MATTHEW LARGE: I believe if someone presents with a psychiatric problem, pretty much whatever they say, they have a very high risk of suicide. We should know all of that information about them. We should take a comprehensive history from them. When a patient tells you that they are feeling really terrible and feel like killing themselves, you should do something about that. However I do not necessarily think that that should be interpreted as a statement of their future conduct.

I believe we should talk to patients more. I also believe we should talk more with each other. I do worry that we send junior people out to the frontline with a check list. Inevitably they will have a suicide in their first couple of years and most of them will never work in mental health again. They filled in the check list, better or worse, but even the very best check list can lead to a suicide.

I say two other things about it. We have this enormous reliance on what the patient says immediately but we have not really thought very much about the game theory of that. My experience is that a lot of patients who say they are suicidal want to be admitted and we should take good notice of them. However a lot of patients who say they are not suicidal do not want to be admitted and we should take good notice of them also. Moreover we should not necessarily think that we have made a forecast. In fact, among patients with mood disorders, suicidal ideation is unrelated to suicide. Patients with depression and suicidal ideation are no less or more likely to kill themselves than patients with depression and no suicidal ideation. I have published that in a meta-analysis in Acta Psychiatrica Scandinavica this year.

I am not sure if that answers your question. But we should be very careful in our dealings with patients and very sympathetic. We should try to help them go away feeling a bit better about themselves. We should allow them to make decisions as far as possible. In fact,

I go a little bit further. There are some patients who are chronically incapacitous to manage their affairs. Once patients are chronically incapacitous to manage their affairs, some of them I believe should be allowed to make incapacitous decisions because that is after all their life.

DR MICHAEL DIAMOND: Perhaps I might make a comment and close the meeting after that. It seems that we run a mental health service and provide psychiatric involvement to patients, that is very much predicated by the issue of suicidality or not. Hence people end up in hospital on that basis quite frequently and that decision is the central decision that is made about whether or not they should stay in hospital. These decisions are often made by very junior people and there is a kind of reductionist view that relies on the check lists. I agree with Matthew that they are not of great value because they are not applied particularly well. They do not reflect the sort of engagement that Matthew is talking about. What Matthew is saying is that superficial assessments are quite harmful and less than useful while a much more developed communication and a much deeper consideration of the issues that have been presented, and interpreting those issues, is a much better way to interact with people who are suicidal. They are quite different approaches.

DR MATTHEW LARGE: There was a study recently describing a single question suicide risk assessment to be used in general hospitals, which is: Are you suicidal or not? I wrote a letter to the Journal, which was published, saying I thought this was absurd, dismissive, ridiculous, humiliating, unethical and revolting. Surprisingly, the authors were a bit upset with me.

DR MICHAEL DIAMOND: I must bring the meeting to a close. In doing so I must thank both speakers for providing us with such excellent presentations, such thought provoking issues and highlighting the fact that there are no answers to complex questions. We can continue to try and address these issues with intelligence and consideration, and hopefully continue to improve what we do in our respective fields of medicine and law. I ask the audience to join me in thanking you both very much.

MEETING CONCLUDED