Submission No 30

INQUIRY INTO EQUITY, ACCESSIBILITY AND APPROPRIATE DELIVERY OF OUTPATIENT AND COMMUNITY MENTAL HEALTH CARE IN NEW SOUTH WALES

Name: Name suppressed

Date Received: 22 August 2023

My partner was referred to Ryde community mental health following their time as an inpatient at Blacktown hospital mental health unit for psychosis. From my limited interactions with Ryde community mental health, and from my observations of Ben's interactions, I do not believe they are effectively meeting duty of care for the patients referred to them. None of Ben's support people were provided with any information on how to help them or avoid future episodes, information was often lost, forgotten, or not shared between relevant staff members, appointments were often rescheduled and extremely rarely face to face, and the level of contact kept with Ben was not enough to keep a realistic understanding of how they were living with their condition. Ben was not provided support to find a psychologist or any therapies, they were not given information or choice about the medications they were prescribed while in hospital, and complaints about side effects (including lethargy and depression symptoms) and requests to taper off the medication were never taken seriously by treating doctors.

Ben took their own life in April 2023, they had had a telehealth appointment with a new doctor at Ryde community health in the days leading up to the incident. I am in no way claiming the doctor is responsible for their death, but I believe their death could have been avoided were they and their carers provided with more support and information, and had their treating professionals been more invested in Ben's case.