

Submission
No 88

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

Name: Amelia Klein
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Partially
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Submission to the Inquiry into Equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales

My name is Amelia Klein. I am a community lawyer and have lived experience of significant mental health issues, including a brief inpatient stay in a mental health unit at Blacktown Hospital in 2017. I will only address some of the terms of reference in this submission. I am willing to give evidence at a hearing.

This inquiry is most relevant to me not because of my experience as a patient, but as a contact under a crisis plan and loved one of a patient. [redacted] was in the treatment of a community health service when they took their own life in May 2023. I was aware that [redacted] had been diagnosed with Bipolar Disorder. They had been discharged after involuntary stays in mental health units on three occasions in 2022, with the final discharge happening in December 2022.

[redacted] nominated me as an emergency contact and informal carer in a document that was created when they were in the mental health unit in December 2022, and I attended the mental health inquiry in December 2022 where [redacted] involuntary stay was extended for a period of six weeks. After that decision (while not strictly in the scope of this inquiry), [redacted] was then quite quickly discharged within 10 days, including overnight and day leave being granted within that time. The inconsistency of this decision making and the lack of communication would come to characterise my experiences and, as much as I am aware, [redacted] experiences, with the community mental health team.

Immediately following [redacted] being discharged from hospital, I was with them when they had the initial contact with the CMH team at home. This was prior to Christmas 2022 and [redacted] intended to travel to the upper Hunter for the opportunity to recuperate after the stressful inpatient experience. I recall that there was no opposition to [redacted] spending time, but they were advised that there would be no contact until the new year. I recall that I was concerned at that time given there had been such concern about [redacted] wellbeing only about a week before to the point where they had been required to stay in hospital involuntarily for their own safety. I knew, however, that [redacted] was going to be with people that cared for them, so I asked them to promise me that they would let those they were with know if they had any concerns about their safety.

Over the next six months, [redacted] continued to have some contact with Community Mental Health. The Community Mental Health team was in charge of their medication and they were still actively being treated by the CMH Team up until their death; their last appointment was a week before their death. It was clear to me that the CMH team was not funded to do the work to keep all of their patients safe and happy. Contact was incredibly sporadic; I recall that if [redacted] was not able to take a call at the time that the CMH team made it because of their work or other commitments, it could be a week before there would be any follow up contact. I have very real concerns that there is not sufficient capacity for CMH services and there is not sufficient

allocation of resources. I am concerned that this lack of capacity and resources contributed to death. I do not in any way blame individual workers or the team as a whole; it appeared to me that they were working within a system where they were stretched thin and providing everything they could manage.

The appointment themselves seemed to be quite infrequent, and was frustrated by the lack of engagement as to issues that their medication was causing. had been a bright and energetic person prior to their medication for Bipolar Disorder, which had caused a blunting of their emotions, energy and enjoyment of life's experiences. I encouraged to talk about their concerns with the doctors and treating professionals, because I was concerned about safety primarily, but also wanted them to have their concerns heard and, if appropriate, alternatives explored. There seemed to be little engagement with the idea that the medication was causing concerns, and that had previously reduced their own medication due to side effects. While I encouraged them to listen to the CMH team as professionals, it was clear that there was significant frustration and in retrospect, I am concerned that simply stopped raising the concerns because they didn't seem to be taken seriously.

The large majority of appointments with the CMH team were via telehealth. had a telehealth appointment with a new doctor in the CMH team in the week before their death. I have seen the importance of telehealth and online services, but I do have concerns that face to face appointments being replaced by telehealth options when face to face is a practical option increases the risks to patients. I think every day about the what ifs when it comes to life and their death which came too early, and one of the major ones is if a doctor had seen them face to face and been able to see the warning signs better.

I never received any information or guidance from the CMH team, and I do not believe that any of the nominated designated carers were provided with information as to the risks or concerns. I was not given any guidance or information about concerns in terms of the depressive cycle. While I have had some training in dealing with people who are acutely suicidal, I did not personally see such warning signs with , and I had not been given any resources, education or information in terms of when to escalate. I was also not given any resources in relation to support I could access as a carer. I was not made aware of any of the services where I could refer for more support, other than inpatient treatment in the case of a crisis.

I would like to once again emphasise that I do not blame the members of the CMH Team for death. The system that they exist within is one which makes it incredibly difficult to provide holistic and wrap around care. In my professional experience, I have seen CMH teams provide assistance and support to people who are chronically mentally ill and reliant upon the disability support pension. However, there is clearly a gap in being able to provide services to those who fall in the middle in terms of ability to maintain some level of employment and ability to manage their needs. I can only ask that the Committee make recommendations to fund and support the teams doing this difficult work, given that lives literally depend on it.

If I can provide any more information, I am available via email or telephone provided with this submission, or willing to attend a hearing to provide further evidence.

Amelia Klein