Submission
No 90

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

Name: Name suppressed

Date Received: 5 September 2023

Partially
Confidential

Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales

<u>Terms of Reference being addressed:</u>

(a) equity of access to outpatient mental health services (b) navigation of outpatient and community mental health services from the perspectives of patients and carers (c) capacity of State and other community mental health services, including in rural, regional and remote New South Wales (d) integration between physical and mental health services, and between mental health services and providers (e) appropriate and efficient allocation of mental health care workers, including psychiatrists, nurses, psychologists, GPs, counsellors, social workers, allied health professionals and peer workers

Thank you for the opportunity to share our story with you. We want to contribute to improving the experience for mental health patients and their families, and to help reduce the suicide rate in young men in rural areas.

On August 2022, our son died by suicide after a 5-month battle with severe depression. He was 38 years old, a loving father of children, strong, confident and ran a successful plumbing business. had no prior history of mental illness. He became very unwell, very quickly and desperately needed help. And so did we.

was being seen by the Mudgee Community Mental Health Team (Western NSW Local Health District) prior to his death. The care provided was inadequate and NSW Health and WNSWLHD Suicide Management policies were not followed.

These are our main areas of concern:

1. Model of Care:

*The current model of care promotes 'siloed' practice with minimal communication with the GP and other providers outside the Mudgee Community Mental Health Team.

*Individual clinicians are making decisions without consulting senior clinicians or requesting medical review, families are not listened to, and assessments are not done adequately.

*The treatment plan is not clear. Care is reactive in nature, uncoordinated and inadequate.

2. Inadequate communication with wider care team and sharing of information, clinical decisions made in isolation:

* 7 days after had been discharged from Dudley Private Hospital (Orange) after attempting to electrocute himself, there is an entry in the Mudgee Community Mental Health (MCMH) team medical records stating that was for 'likely discharge' from MCMH. There is no evidence of review or consultation with other members of the care team. Clinicians were making decisions in isolation. was in fact getting worse at this point and needed more intense care, not discharge. NSW Health Policy states that the month after being discharged from hospital is a high-risk period for suicide or deterioration.

*Care was led by – it was left up to him to contact health care providers. Several entries in the notes state that had significant cognitive dysfunction secondary to his severe depression. He was too unwell to make these decisions and needed guidance from his care team. At no point did MCMH facilitate attendance at the private psychologist and there was no communication between the public and private services.

* When we requested a case conference with GP and the others in his care team, it was refused and the response was 'we run a medical model, visiting psychiatrist reviews medication, we don't do case conferencing'.

*We were told that it would be a breach of confidentiality to communicate with the private psychologist and could not happen' – this is documented in the notes. How can a patient be adequately treated when the key care providers are not communicating?

*One phone call, one email and a referral letter from the GP after attempted suicide and was admitted to Bloomfield Hospital (Orange) was the only communication between Mudgee Community Health Team and GP. The GP referral letter stated that both the GP and the Private psychologist were concerned about his suicide risk, however, this was not communicated prior to attempting suicide. Another example of care providers not communicating or providing adequate care.

* The care provided during a consult on the 8/22 highlighted the major issues. was very unwell and had been threatening suicide throughout the day and attended a consultation with MCMH Team. The assessment was inadequate, suicide risk policies were not followed and no collateral information was sought from the family (who were known by the clinician to be sitting in the waiting room). There was no medical officer review during the consultation despite worsening of symptoms and no medication review. was offered voluntary admission but should have been scheduled under the Mental Health Act due to high suicide risk. Individual clinicians made decisions in isolation and the management plan not shared with the family.

During this consult, admitted to using anabolic steroids. This was not further investigated or communicated to a medical officer as a possible cause for mood disorder. Research supports the link between Anabolic Steroid withdrawal and depression/ suicidal ideation. We are concerned that this was a contributing factor in death and believe it should be routinely assessed for in patients with mood disorders/ suicide risk.

was extremely unwell that day and continued to deteriorate. There was no review by the on-call psychiatrist and no follow-up when he didn't show for the Friday appointment scheduled for 8/22. took his life on the 8/22 – five days after this missed opportunity to change the outcome.

3. Family concerns not listened to:

Two examples from the WNSWLHD Medical records supporting this:

*Multiple calls from different people all voicing serious concerns with no escalation or review of the treatment plan.

* On one occasion when sister called the MCMH Team expressing concerns about active suicidal ideation with a definite plan and timeline, she requested that the case worker contact and review him. She was told that the case worker had spoken to yesterday (Tuesday) and would not be contacting him again until the Friday, even though she had informed the case worker that had told her that he planned to kill himself on the Thursday.

* As primary carers we were not included in or adequately informed about the plan of care. We were not given the opportunity to enhance care and assessment by providing collateral information about his mental state and events occurring in his life. We were not supported to care for our very unwell, rapidly deteriorating son.

4. Assumptions/ labels and lack of investigating the reason behind Depression/ Suicide:

* Early on when became unwell, it was implied that had a borderline personality disorder. What the clinicians didn't understand is that behaviour was completely out of character and not how he would usually react to stressful events. We felt that symptoms were not being taken seriously because he had been given this "label" and it was thought he was just attention seeking and playing us. The clinicians didn't seem to want to find out why had become so unwell and the reason behind his suicidal ideation. In addition, we felt that outside information (community/ social) was influencing the clinicians' thoughts.

We were told that 'Community Mental Health was not the place for – but where is the place for a very depressed very suicidal person?

We have been fortunate to have met with the Chief Executive of WNSWLHD and the director of Mental Health and have asked them to consider the following suggestions for improvement:

1. **The existing Community Mental Health model of care be reviewed and the principles underpinning the state-wide NSW Health Integrated Care Framework and particularly WNSWLHD Planned Care for Better Health Program, be embedded into routine clinical practice. This aligns with the Towards Zero Suicide by 2023 strategy.**

2. **The Mudgee Community Mental Health team be considered as a priority site to adopt an integrated model of care as guided by the NSW Health Strategic Framework for Integrating Care and be supported by the WNSWLHD Planned Care for Better Health team to achieve this.**

3. **WNSWLHD consider employing psychologists and/or counsellors to work as part of the Mental Health Team to facilitate communication and clinical governance of psychology services.**

4. **Anabolic Steroids (AAS) be included in the Mental Health assessment/ suicide risk assessment and staff be made aware of the link between AAS and depression.**

We have been told that the Community Mental Health Services are currently under review with plans to introduce a more integrated model of care. We are grateful for the time and resources invested into this recommendation but also want to ensure that the changes occur and are sustained into the future. These changes are essential to improving the experience of future patients, supporting clinicians and reducing the risk of further serious adverse events.

The suicide rate of young men in rural NSW is a horrifying statistic and we do not want any other family to go through this experience.

We thank you for this opportunity and for conducting the Inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales.

We are willing to give evidence in the enquiry and for our names and information to be published.