Annexure A

PO BOX 1175

Coffs Harbour

NSW 2450

6/2/2019

To Sara Shaugnessy,

Clinical director for mental health services,

Coffs Harbour Health Campus.

Dear Sara ,

Overall, I would like to share there is much improved communication and collaboration between YAF and Headspace, but still lacking a bit between hospital and Headspace.

A couple of incidents last week I thought I would report to you.

I saw a patient MRN xxxx, who is 22 and has complex PTSD from an abusive childhood and multiple foster placements, possible ADHD and polydrug use. He came to see me after a hiatus in attendance (he is notoriously difficult to get to attend from our and your perspectives). He came asking if I could organize for him to go back into jail. He was released in September and was feeling unsafe in the community. He had auditory and visual hallucinations. I suggested trying to organize a mental health rehab admission for him as there were no acute safety concerns but his response was, he had tried that and jail felt a lot safer and calmer. Not sure what his inpatient and/or rehab experiences were, but sad that he did not want to engage back with services designed to help someone with his symptoms. I also note his discharge (included copy for you) states no further involvement from psychiatry as had drug use. This seems a classic case of patient's with comorbidity falling through the cracks and lack of acknowledgment from mental health services that his drug use is entwined with significant mental health issues, complex PTSD and possibly untreated ADD.

The other issue I had last week is more concerning.

I have been caring for an indigenous 23-year-old woman xxxx since she was 14 and know her well. She has a complex trauma background, mother died of an overdose about 5 years ago. Significant abuse and neglect from her father and uncle she lived with most of her life. Domestically violent partners who have been in and out of jail, poly substance use, overwhelming grief: attended 23 funerals in 5 years(including close friend just after signing a lease together and suicide of childhood friend), homeless living mostly in her car for last 5 months, prolapsed cervical disc following a fall, multiple dental abscesses over the last 6 months as well as oral thrush, upper dentures due to full extraction secondary to neglect of dental care as a child, low weight due to stress, poor nutrition and lack of food (not eating disorder) BMI of 14.2 at 34.6kg.

Her father died unexpectedly 3/1/2019. This was traumatic and she both witnessed his death and the emergency services responses. Prior to this she had a few brief presentations and admissions since October 2018 to medical ward with dental pain and thrush, cervical neck pain and dehydration and malnutrition. After the death of her father she imploded and presented to Mclean and Yamba and was finally admitted to Coffs following a seizure on the 30/1/2019.

She was cleared medically for discharge on the 5/2/2019. She told me she had a normal MRI and was cleared to drive? I requested she be considered for mental health rehab to give her stable accommodation, work out some supported accommodation, improve her weight and nutrition, access hospital dentists, all in a coordinated way over the next couple of months. I discussed with the medical registrar this would need to be suggested gently. I left messages on Patricks phone regarding my suggestions for mental health rehab. (later was informed by patient that she refuses to see Patrick following a traumatic interaction on the day of her father's death)

Instead she was scheduled which was extremely traumatizing for her. She has had schedules and hospital admissions in the past which have all been extremely negative experiences for her. When I phoned to speak to the psychiatrist who scheduled her I spoke with Dr Anwar. He informed me she needed to be in hospital until her BMI was 17. (of note this patient has had a BMI consistently under 17 since July 2017 apart from a brief period of 6 months when on olanzepine for troubling PTSD hallucinations) He could not explain how she had been discharged on so many occasions over the last 5 months with BMIs in 14s and 15s. It seems confusing and inconsistent to me. I found Dr Anwar's manner abrupt, disrespectful and dismissive when I spoke to him. He was adamant that the patient had an eating disorder based on her weight alone. His attitude made me extremely frustrated. He was unaware of the patient's weight on the day of scheduling her. I was left feeling that he was not interested in the best outcome for the patient but in ticking the necessary risk boxes.

Following my conversation with Dr Anwar (and without further assessment) she was "unscheduled" and allowed to go home. It was clear that the responsibility for following up her weight and bloods was mine and I accepted that.

The act of scheduling someone is a very serious legal decision and I am disappointed that my patient had such a traumatic experience which in the end seemed totally unnecessary. These kind of experiences are what prevent patients seeing the hospital services as potentially helpful around times of high risk.

Could you let me know if there a hospital policy regarding BMIs at which mental health patients must be scheduled on BMI alone? In the past I have had trouble getting mental health to admit with BMI of 13.5.

I am disappointed that no one from mental health contacted me prior to assessing the patient or prior to scheduling her given my intense involvement over the last few months.

I feel in her case if Headspace team had of been consulted and included in the collaborative discharge planning then another traumatizing experience may have been avoided for an extremely traumatized patient.

Could you let me know if the mental health services in the hospital have had "trauma informed care" training?

I also note that in her discharge summary which will have been uploaded to my health record as a permanent medical record it states that

"*Patient initially refused to stay in hospital and schedule was written. Patient later approached team and said she had agreed to stay in hospital voluntarily*"

This is incorrect and unclear, the patient never agreed to a mental health admission and has been severely traumatized by admissions in the past. This line should read:

"Patient was voluntary admitted to the medical ward. After 5 day admission under medical team and cleared from a medical perspective she was scheduled by the mental health team, and then unscheduled and discharged into the care of the GP."

The line "*unable to be admitted to mental health ward as patients with BMI < 17 are restricted from being admitted*" should instead read

"unable to be admitted to mental health rehabilitation ward ……."

Are patients with eating disorders not managed on the mental health ward with BMI < 17?

I wonder if this discharge summary could be amended and reuploaded.

Could rehab please consider her for admission as her BMI is chronically below 17 and is not due to eating disorder.

I believe if this young woman does not get supportive, trauma informed, psychiatric treatment at this intense time of high risk in her life, then her suiciding is a likely option in the next 6-12 months.

I do not believe that she fits the "early intervention" model of Headspace, but as she has formed strong attachment and relationships with us I am willing and expect to be involved in her ongoing care. An additional case management model would seem suitable for her, but again there needs to be trauma informed clinicians who can actively engage her.

Thank you for looking into the above cases.

Yours

Dr Nicola Holmes