Annexure C

10/09/2023

To Board CHHC/MNCLHD

I would like to again advocate for support of patient's experiencing mental ill-health and the primary care physicians who treat them.

I am not sure if the board members are aware of the 4 youth suicides over the last month or so. Steve Sawtell's oldest son is probably known as he is a prominent member of the community and his wife a local high school teacher, but the homeless indigenous single mother of 3 known to me, another 19 year old boy, and 17 year old indigenous girl from Macksville will be less known.

Death by suicide has gone from 10th cause of death in the **under 14s** in 2015 to the 4th cause of death in the **under 14s** in 2021 (ABS) and suicide remains the leading cause of death 14-44 year olds, killing twice as many than next cause which is motor vehicle accidents.

As a GP working predominantly in complex mental health space there are still many challenges for us. Examples from my last 2 weeks of work include lack of communication and support from LHD managing a first presentation of psychosis in the community, lack of capacity for child and adolescent psychiatrist to continue prescribing medications commenced in Kamala in patient admission on highly traumatized 17 year old, usual yo yo between mental health and drug and alcohol in response to unsuccessfully trying to get a mental health rehab admission for patient in 50s with psychosis and relapse of weekend ICE use and carer burn out. I have requested in writing x 3 and phone x 2 for the CHHC policy on managing first presentation psychosis without a response.

I would like to pose the following questions to the board members:

1 How can the board members be assured that the mental health needs of the local population are known and have been adequately assessed?

2 Does the method used to assess local mental health needs include assessment of years of potential life lost? Does it include a measurement of morbidity and complex grief of family and friends who lose a loved one to suicide, or any assessment of psychological impact of staff members affected by such losses?

3 How does the board know that the LHD is working productively with others in the same space for example NGOs, DCJ, Justice Health and PHN to ensure that those presenting with mental health conditions or psychological distress receive coordinated and appropriate care in the community when not accepted into hospital led interventions and care (eg are referrals happening to Wesley after care service for all those who present with attempted suicide? Does the emergency department or ACS make referrals to the iam program for all youth under 25 who present with suicidal thinking who are not admitted? Do all patients and their carers receive support to contact head to health service. Do hospital psychiatrists provide detailed letters for patients outlining diagnosis and treatment responses for those with complex mental health needs who would benefit from NDIS support workers)

4. Given that the Mid north coast has higher than state and national average death by suicide rates how can the board be assured that the district is receiving the appropriate amount of funding to

meet the local communities needs regarding treatment for mental health challenges, and that the funding is being directed to those with the greatest need?

5 How does the board know if related parts of the hospital: particularly dental care, sexual health, sexual assault and drug and alcohol services are communicating well with each other to ensure that patients engaged in their services are having holistic care that addresses these common facets that contribute to increased risk of death by suicide?

6 Does the board consider that local mental health services provided by the LHD are coordinated to meet the needs of local patients experiencing mental ill health, local GPs, local NGOs working in this space and the families of those who support patients with complex mental health needs?

Yours sincerely and hopefully

Dr Nicola Holmes