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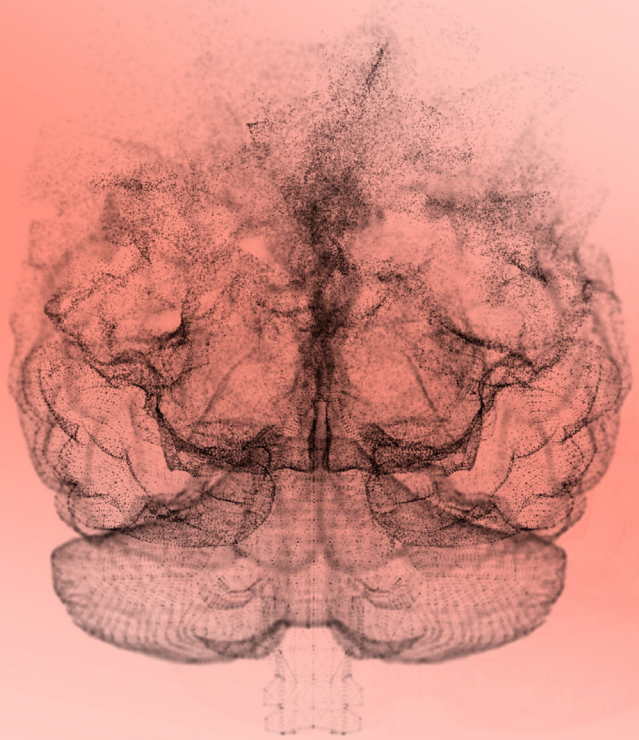

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Guest Editorial

Daniel Grose

Welcome to the first issue of the Future Leaders Communiqué for 2021. Like most people, I am glad to see the back of 2020, a year simply described by many as unprecedented. The pandemic raised the community's awareness of the important role of all health care professionals like never before. Yet the recent stress placed on our health care system has brought to our attention many cracks, some old and some new, that are in need of addressing. One of these 'cracks' is the difficulty people have in seeking mental health care. The case described in this issue highlights a system in need of repair. On an individual level, we learn from this unfortunate case as many of the themes that emerge are often found in coroners' inquiries; namely miscommunication and discontinuity in the system, leading to failures in provision of patient care.

In this issue, we share the story of Ms MT, a talented young illustrator with a bright future who entered a period of her life where she struggled with her mental health. Unlike many, Ms MT took the initiative to seek help and did so on multiple occasions. However, none of her interactions with several different medical practitioners achieved the support or clinical care needed. Instead, the coroner described her experiences as being "lost in a labyrinth of miscommunication and redirection" which ultimately ended with her suicide. An outcome the coroner found to be preventable.

The interim report from Victoria's Royal Commission into Mental Health (established in February 2019) echoes a number of themes from this case. Themes around the current system's complexity, difficulties in navigating access to mental health services, the increasing use of emergency departments as entry points of care, the under-appreciation of the importance of families and carers, and a model of care that focuses on crises rather than on prevention. The Royal Commission's report also highlighted the need to improve the mental health training of all junior doctors.

Despite the growing prevalence of mental health issues, junior doctors often lack the confidence and skill set when dealing with patients with mental health concerns. Being able to confidently complete a thorough risk assessment often takes years of experience and refinement. I thank Associate Professor Jonathon Knott, an emergency physician, and Dr Evan Symons, a psychiatrist, for sharing their tips and advice for junior doctors when faced with similar situations as described in this case.

We are very fortunate to have the support of Ms MT's family. Ms MT was a talented artist and we are grateful for the opportunity to include some of her commercially published illustrations in this issue. I encourage you to take a moment to appreciate these remarkable pieces of artwork and the underlying narrative that each portrays.

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FEEDBACK

The editorial team is keen to receive feedback about this communication especially in relation to changes in practice. Please contact us at:
flc@thecommuniques.com

Guest Editorial (continued)

Junior doctors are particularly vulnerable to their own mental health demons. Over the previous twelve months we have dealt with a whole new set of challenges including working well outside of our comfort zone, bearing the brunt of a significantly increased workload, and having our professional pathway turned upside down with delayed exams and altered career progression. This is in addition to the pre-existing stressors of a demanding career. I encourage you to be brave. Be brave enough to speak up, whether it be to a family member or close friend. Be brave to seek help from the myriad of mental health resources available, as listed at the end of this case précis. Be brave enough to overcome the setbacks. Don't suffer in silence. Be brave.

With permission to include images from p18-19 of *Small Things* by Mel Tregonning (Allen & Unwin, 2016)

Editorial

by Dr Brendan Morrissey

We are very pleased to publish this edition, the first Future Leaders Communiqué of 2021. This edition is unique. The case we examine is that of the coroner's inquest into the death of Melanie Tregonning; a talented illustrator whose suicide was preceded by a series of miscommunications and system failures from the health care community as she repeatedly sought assistance with a mental health emergency.

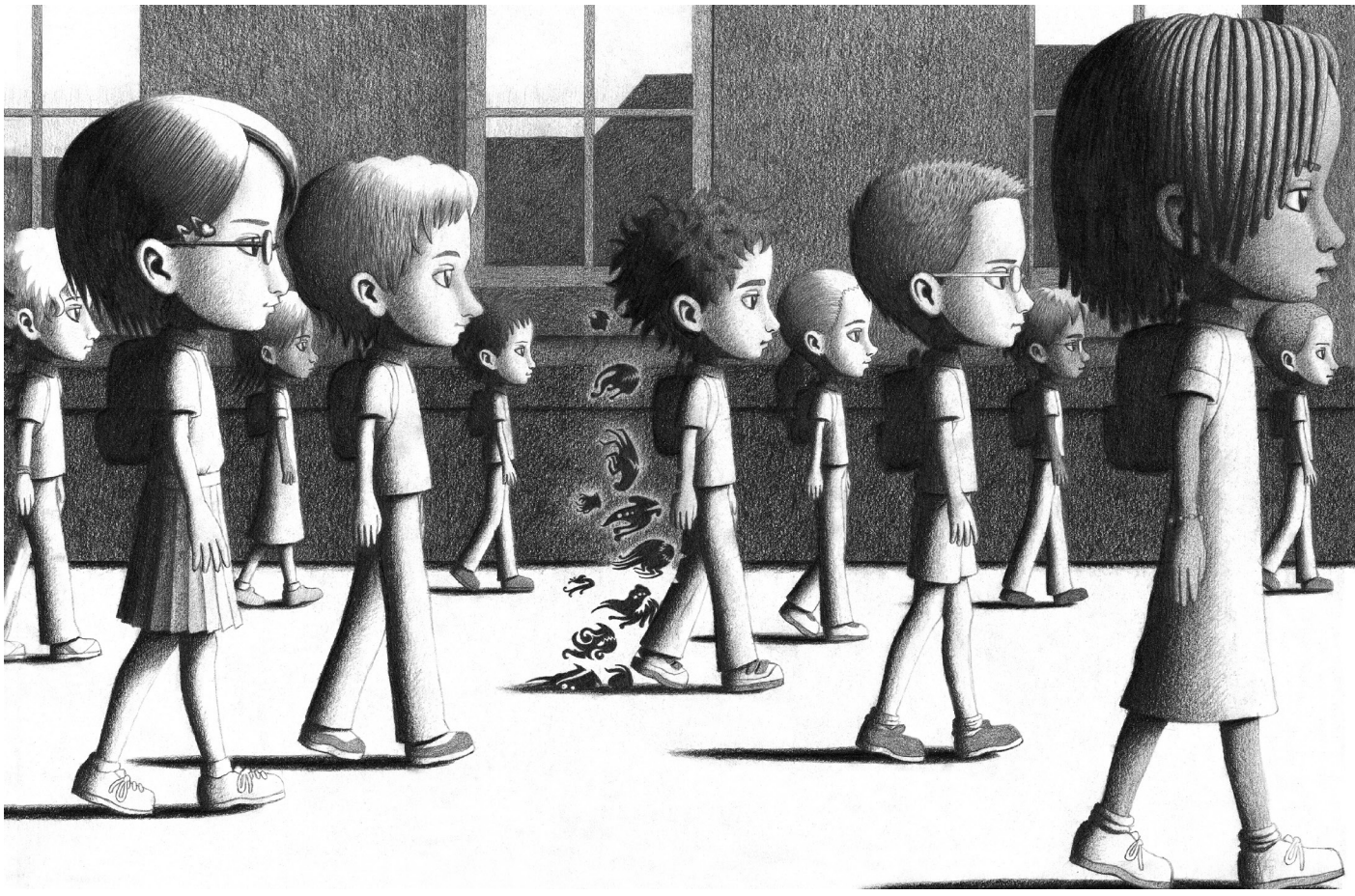
Our standard practice at the Future Leaders Communiqué is to anonymise the personal details of any patients involved in the coroner's cases we review. We have not done that in this instance. This is not a decision we make lightly and only proceeded with the family's express consent. We want this edition to reflect on what we as healthcare clinicians can learn from the coroner's inquest into Melanie Tregonning's death, and also to mourn what we have lost. Melanie Tregonning was a gifted artist with a bright future. A sample of her work is included in this edition with the permission of her family and publisher Allen & Unwin, to whom we are very grateful. Melanie's artwork is unique and engaging. Her graphic novel, Small Things, tells the story of a little boy who feels alone with the worries he has inside, but who learns that help is always close by. It is available to access via her website, http://meltregonning.com.au/

We would like to thank Melanie's family for not only allowing us to include a number of Melanie's works of art, but also for sharing their own reflections on the circumstances leading to Melanie's tragic death. We are grateful to her sister, Violet, for her contribution to this edition. Mental health reform, including timely access to appropriate mental health support for all members of the community, is one of the greatest challenges currently facing our healthcare system. It is important to appreciate the bravery of advocates such as Violet - those who have been deeply affected by deficiencies in our system and speak up to evoke change. It is incumbent upon us as clinicians to heed her reflections, to better inform our practice and prevent similar errors in future.

Our expert commentaries for this edition are kindly provided by Associate Professor Jonathan Knott, Director of Emergency Research at Melbourne Health and Clinical Sub-Dean for Emergency Medicine at University of Melbourne, and Dr Evan Symons, Unit Head of Consultation-Liaison and Emergency Psychiatry at Alfred Health, Melbourne. Associate Professor Knott lends his expertise by describing some actions all clinicians can take to mitigate the risk of error in assessing and managing patients presenting with mental health issues. Dr Symons shares his tips to junior doctors in identifying, supporting and caring for those patients presenting acutely suicidal.

Editorial (continued)

This edition has been made possible by the passion, insightfulness and persistence of our guest editor, Dr Daniel Grose. Daniel is currently an Advanced Trainee in General Medicine at St Vincent's Hospital Melbourne. He is an aspiring General Physician and Geriatrician, with an enthusiastic interest in the biopsychosocial model of health and disease. Daniel has put huge thought and effort into curating this edition, and we hope that it will act as a valuable resource on this important topic for our future leaders for some time to come.



With permission to include images from p10-11 of *Small Things* by Mel Tregonning (Allen & Unwin, 2016)

Guest Commentary

by Violet Tregonning

First of all, I'd like to thank you for taking the time to read this article. I take your interest to mean you understand the importance of Mental Health and will hopefully place it at the forefront of your practice. Mental health is complicated and hard to treat, the textbooks will only teach you so much. My sister Mel was not a textbook example of a suicidal patient. Mel presented well, was composed, had meaningful work which she was passionate about and no history of mental illness.

It was stated at the time of the inquest that Mel was sent home to the safety of the family unit. Just because my sister had a supportive family to go home with, did not mean she was safe. We were completely unequipped to handle Mel's illness alone. We believe Mel should have been assessed directly by a senior doctor and admitted to hospital that night. The resident medical officer tried to be assertive and asked for Mel to be reviewed however, he was told to be confident in his own assessment. He was clearly not confident to do so. I would urge all junior doctors to trust your gut instinct and demand an assessment from the specialist when required.

Mel's sudden mental health breakdown and lack of treatment is an absolute catastrophe that has caused irreparable damage to my family. What is most devastating is that we sought help from the professionals who could have helped. Mel had been bounced from the hospital to general practitioner to hospital all to no avail.

Mel left this earth feeling defeated and that no one could help. My children will grow-up not knowing the love and creative influence of their Aunty as I did. The world will never see what other incredible work Mel could have produced. As our future doctors I hope that you will be the ones to fix this broken system of Mental Health so that people like Mel are not left behind.

Case - Inquest into the death of Melanie Tregonning "Who Cares?"

Case Number 499/2014 WA
Author **Daniel Grose,**
BSc, MD
Medical Registrar,
St Vincent's Hospital Melbourne

i. Clinical Summary

Ms MT was a 31 year old talented illustrator who lived with 5-alpha-reductase deficiency, a genetic condition that affects physical sexual development. For Ms MT, this condition did not appear to have a significant impact on her childhood. Her symptoms were thought to be relatively mild and stable with hormone therapy. Ms MT was described as a very intelligent, independent yet reserved individual who was supported by her family and artistic friends.

In the months leading up to her death, Ms MT had decided to take leave from her job as an illustrator to focus on completing her own graphic novel. Although there was no prior history of mental health concerns, it was during this time that her family noted a worrying change in her mental state with low mood, poor sleep and disinterest in her usual hobbies.

One day Ms MT decided to seek help and attended the emergency department (ED) of a private hospital with the intention of being reviewed by her long-standing and trusted endocrinologist.

However, after speaking with an ED nurse, Ms MT reported that she felt better and left, indicating that her plan was to return home. Ms MT subsequently went to a nearby beach with a plan to suicide but was interrupted by a fortuitous phone call from her father.

The next day, Ms MT's parents became increasingly concerned with her withdrawn and irrational mental state and sought urgent review with the endocrinologist. On review, the endocrinologist agreed with her parents' concerns of depression and suicide risk.

The endocrinologist advised that Ms MT be reviewed by her general practitioner (GP) to organise a Mental Health Care Plan for psychological support. This was arranged later the same day, but the earliest available appointment with a psychologist was almost a week away. Over the course of this same day, Ms MT became increasingly distressed as she realised her attempts at seeking help were not fruitful.

Later that day, Ms MT's obvious despair prompted her parents to return her to their local medical clinic. Ms MT was seen by another GP, Dr V, who was immediately alarmed by Ms MT's active suicidal ideation. Ms MT accepted the offer of seeking urgent psychiatric assessment at a nearby public hospital. Dr V organised for an ambulance transfer to the hospital and alerted an emergency medicine physician at the hospital with a verbal handover of Ms MT's expected arrival and high-risk mental state.

At the ED, Ms MT was seen by a relieving resident medical officer, Dr K, who described a calm woman with suicidal ideation. Dr K concluded that Ms MT was at risk of suicide and at risk of absconding. Consequently, Dr K attempted to contact the psychiatry liaison nurse (PLN), as per usual protocol.

After several attempts to contact the PLN without a reply, Dr K was later informed that there was no PLN on duty at that time. Dr K proceeded to contact the psychiatric duty medical officer, Dr D. Dr D was a psychiatry registrar working in a busy after-hours role as the primary psychiatry contact for the hospital. Dr D initially dismissed the referral, instructing Dr K to discuss the case with the PLN, unaware there was no one on duty.

Following multiple conversations between Dr K and Dr D, a decision was made to discharge Ms MT with outpatient follow-up. This was based on Dr D's impression that Ms MT was at a low suicide risk. Dr K was hesitant about this proposed plan and reportedly communicated that he didn't have the appropriate skills to make a complete psychiatric assessment.

Meanwhile, Ms MT became increasingly anxious while awaiting a psychiatric assessment. In part, this was exacerbated by the ED environment, as a patient in the bed next to her was audibly distressed due to excruciating pain.

Dr K explained the management plan to Ms MT. Ms MT was instructed upon discharge from the ED to immediately present to the hospital's specialist psychiatric facility to submit a referral. Dr K was under the impression that this process would result in Ms MT undergoing a psychiatric assessment on arrival.

Ms MT arrived at the facility but did not have the appropriate referral documentation. The mental health clinical nurse specialist, Nurse M, also informed Ms MT that she lived outside the facility's catchment area. Understandably, Ms MT felt frustrated. The nurse was unaware of the circumstances leading to this presentation and gave Ms MT a choice. The nurse could complete an assessment or Ms MT could present to an appropriate facility in her catchment area. Ms MT told the nurse she would present to the

'Both the GP and ambulance staff had made thorough notes relating to Ms MT but none of these were available to Dr K at the time of review.'

appropriate psychiatric facility the next day and left to return home with her father.

Ms MT was found dead early the next morning. There were no suspicious circumstances.

ii. Pathology

The autopsy examination confirmed evidence of wounds consistent with a self-inflicted injury. Toxicology analysis concluded a therapeutic level of venlafaxine. There was no record that Ms MT had ever been prescribed this antidepressant. Given the circumstances, the coroner concluded the manner of Ms MT's death was by way of suicide.

iii. Investigation

Ms MT's sister requested the coroner consider holding an inquest given her belief that the mental health service failed her sister. The subsequent inquest focused on the communication problems between health professionals and the psychiatry assessment process. There were two key instances where errors occurred in the transfer of information.

The first instance was from the GP and ambulance staff to the ED.

Both the GP and ambulance staff had made thorough notes relating to Ms MT but none of these were available to Dr K at the time of review. The inquest heard evidence that Dr V wrote a brief referral letter following a phone call to the ED, as she was informed during her call that all the relevant information had been recorded. Dr V explained that she was under the impression that she was talking to a consultant psychiatrist rather than an emergency physician. Furthermore, the ambulance record, which contained important information about Ms MT's mental state, was not available. This led to Dr K lacking key details of the circumstances of her presentation, which would have prompted a higher degree of caution.

The second miscommunication occurred between Dr K and Dr D.

Dr K was under the impression that Ms MT was to go the psychiatric facility for a comprehensive assessment. This was supported by his contemporaneous notes.

Dr D gave evidence that he was not directly requested to review Ms MT. He also denied being aware of a number of key details from her presentation. This included her earlier presentations to three other health professionals and the circumstances of her ambulance transfer to the ED for urgent psychiatric assessment as requested by her GP.

'Nurse M, an experienced mental health nurse, also admitted she was not aware of the many red flags in Ms MT's case.'

Dr D stated that his decision not to review Ms MT in the ED would have been different if he had known these facts.

Nurse M, an experienced mental health nurse, also admitted she was not aware of the many red flags in Ms MT's case. Nurse M emphasised that if a PLN was available, the usual process of a review in the ED would have occurred and Ms MT would not have been referred to the psychiatric facility.

The inquest sought an expert opinion from an experienced consultant psychiatrist who suggested that Ms MT likely had a depressive disorder and required a comprehensive psychiatric assessment with a clear formulation of a management plan. In his opinion the endocrinologist, the GP, and Dr K performed appropriate mental health assessments for their level of training, but the transfer of information was poor.

He went on to suggest that the lack of communication of essential information including warning flags was not uncommon. He concluded that Ms MT's death was probably preventable given the multitude of opportunities for intervention.

The circumstances surrounding Ms MT's therapeutic level of an antidepressant remain unanswered.

iv. Coroner's Findings

The coroner concluded that there were a number of instances where important information was not communicated which was compounded by a number of system failures relating to communication, and the protocol for mental health emergencies. However, the coroner found that there were sufficient indications to prompt a more thorough psychiatric assessment than what was performed.

This led the coroner to consider an adverse finding in relation to Dr D's conduct. In summary, it was the communication deficiencies, system failures and inadequate psychiatric assessment that resulted in Ms MT not accessing the help she needed.

The key recommendation from this inquest highlighted the need for an appropriate therapeutic environment for patients presenting with mental health emergencies, such as a mental health observation area embedded in an ED, which is accompanied by appropriately trained staff.

v. Author's Comments

Ms MT was a young woman in despair. Yet she had the desire and willingness to seek help.

'Despite self-initiating multiple attempts to seek the help she needed, Ms MT became "lost in a labyrinth of miscommunication and redirection" at a time when she was vulnerable.

There were obvious red flags in this case including:

- a previous suicide plan;
- multiple engagements with health professionals including an ambulance transfer for psychiatric review;
- an overt change in her mental state with withdrawal from her usual activities; and,
- living with a chronic physical illness.

Despite self-initiating multiple attempts to seek the help she needed, Ms MT became "lost in a labyrinth of miscommunication and redirection" at a time when she was vulnerable. Ms MT had interactions with a total of four medical practitioners in addition to the many other health care professionals that were directly or indirectly involved in her care. Sadly, this did not stop the tragic outcome.

As a junior doctor, we must remember the fundamentally essential skill of effective communication.

The ISBAR ('Introduction - Situation - Background - Assessment - Recommendation/ Request') format provides a framework that assists in clarifying information transfer and ensuring our request is understood. If there is a discrepancy between our request and the response, then a graded assertiveness approach should be considered to ensure our patients are not the subject of poor communication.

Additionally, the nature of the junior medical workforce often results in working in unfamiliar positions in new environments. Appropriate orientation and familiarisation with hospital-specific policies and procedures is crucial.

On a systems level, there is increasing recognition of the need to have facilities that are conducive to best practice care. There is a growing amount of research into the best way to embed mental health teams into EDs and have appropriate spaces for managing acute mental health presentations.

vi. Further Reading

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vii. Keywords

Mental health, psychiatric assessment, communication, emergency department, depression, suicide

The system is broken!

A/ Professor Jonathan Knott
PhD, MclinEd, FACEM
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Clinical Sub-Dean for Emergency Medicine, University of Melbourne

The case of Ms MT exemplifies the challenges that people with a mental illness face when trying to access acute health support. At the very best of times our health system is complex and often impenetrable for those trying to access care. Unsurprisingly, for those with additional challenges such as mental illness, complex psycho-social circumstances or acute illness, it is even harder to seek the care required. Tragically this has been recognised for many years, is the subject of a Royal Commission into Victoria's Mental Health System and is raised regularly by practitioners, organisations, and speciality Colleges.

Ms MT had a supportive family and a general Practitioner (GP) who recognised the seriousness of her illness and not only directed her to the best available urgent assessment but also contacted the Emergency Department (ED) directly to flag the need for urgent assessment. Many of those struggling in our system are doing it alone and are unwilling or unable to use the normal referral pathways.

'Also, the whole system is set up for failure, there is fragmentation of care between GPs and hospitals, within hospitals, and within the mental health system.'

Even for Ms MT, by the time she arrived at the public hospital ED, she had been seen in a private hospital by various staff, including the specialist who knew her well, and the initial GP. There were multiple potential opportunities to intervene and provide the care she was seeking and needed.

EDs are currently the best place for a person in Ms MT's circumstances but these settings are far from ideal. Medical, nursing and mental health staff are mostly working at levels well over-capacity, the environment is not conducive to the distressed individuals who require calm and time to settle, and communications may be misplaced during the patient's journey. All these elements were present when Ms MT presented to hospital.

Also, the whole system is set up for failure, there is fragmentation of care between GPs and hospitals, within hospitals, and within the mental health system. Pre-hospital communication is conducted via a phone call to an ED doctor who is unlikely to be the carer for Ms MT. Written referrals are still faxed from GP to ED, a system that is both insecure and unable to ascertain the communication was received. Ambulance notes are prepared electronically but then printed out rather than linked to the patient record.

Within the ED, multiple assessments at triage, by secondary nurses and medical staff, social workers and mental health staff risk miscommunication at every step. At any point where the risk to someone like Ms MT is downplayed, they are likely to be discharged. Finally, the Victorian Mental Health system is funded and managed by geographic area, that is, based on where that person lives. As with Ms MT, being in the "wrong" area means being redirected, potentially to a service with no clinical or health record of Ms MT and therefore, no basis to prioritise her care.

'No other patient group is so severely discriminated against due to lack of resourcing.'

The intensive nature of mental health patients arriving in EDs can mean that a voluntary presentation may flag a person as lower risk than those brought in against their will. Mental illness is dynamic by nature and any opportunity to remove a person from the queue waiting for beds will result in discharge to community care. After prolonged waits for assessments and possible hospital admission, patients may be willing to leave despite this being against their best interests. Although all ED care is expected to be concluded within 4-hours of arrival, patients with severe mental illness who require admission may have extremely long waits to access hospital inpatient beds. ED stays over three days awaiting a ward bed still occur. No other patient group is so severely discriminated against due to lack of resourcing. Sadly, the case of Ms MT is recognisable to anyone with experience working at the coalface of our health care system. There are proposals to prevent this happening, but all will require major system changes.

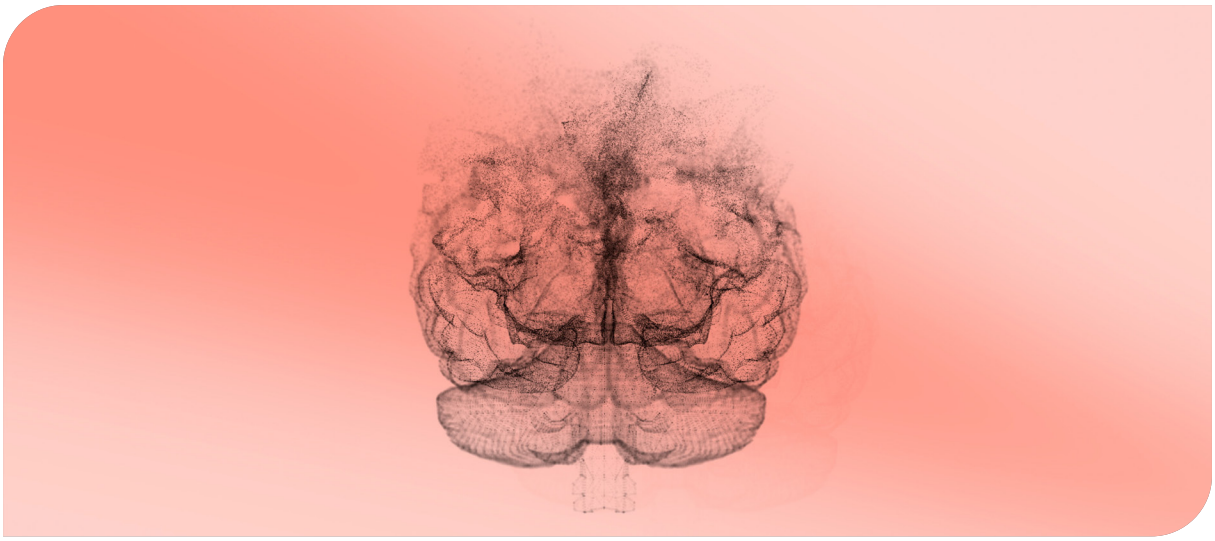
In the short term, several steps can be taken to avoid tragedy.

- Listen to the patient and record the issues of concern they raise. Irrespective of how senior you are, make a note of any concerns you have for this person's welfare.
- Seek collaborative history, from the GP, family, the ambulance or police notes, and from previous presentations. We trust our patients to provide accurate histories. However, for some people, this is not always possible or reliable.
- Each health care worker needs to take on some of the responsibility for mitigating risk. Ultimately it may be that it is the consultant psychiatrist who determines if a need for admission will occur, but everyone prior to that person can evaluate the risk to the patient to the best of their ability and advocate for the best available care.
- Junior staff should escalate to more senior staff in their department if they feel that a poor decision is being made by someone else. This is especially so if it is done by anyone who has not personally seen and assessed the patient.

Sadly, it is an accepted fact that people with mental illness are discriminated against. Does any other patient population presenting with a life-threatening condition, such as suicidality, get sent away to organise follow-up themselves? We admit patients to hospital for chest pain and neurological abnormalities with a far lower risk of mortality or morbidity than someone like Ms MT. The question that needs to be asked is why did she fail to get the care that she needed? If it is about a lack of resources, a lack of training, the low priority that mental illness receives, why is it that this has been acknowledged for many years yet remains unaddressed?

Resources:

Royal Commission into Victoria's Mental Health System interim report https://rcvmhs.vic.gov.au/interim-report



Care of the acutely suicidal patient

Dr Evan Symons,
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Alfred Health, Melbourne

In recent years, giant strides have been taken in Australia in raising awareness of the symptoms, signs and impacts of common mental illnesses. Though still problematic, stigma associated with mental health problems has declined considerably. Suicide was something of a taboo topic for many years, but no longer. Federal and state governments have prioritised development and evaluation of evidence-based suicide prevention programs and set ambitious targets to meet.

Reflecting greater community awareness, there is ample evidence of increased help-seeking behaviour by individuals. Telephone calls to non-government organisation helplines are growing, as are patients with mental health crises presenting to emergency departments across the country.

'Whilst distressed patients are increasingly likely to reach out for assistance, as health professionals we need to focus on seizing those opportunities.'

Sadly though, suicide remains the number one cause of death for Australians aged between 15 and 44 years. Several models predict increasing suicide rates, associated with the COVID-19 pandemic and all of its sequelae. Access to specialist care is inconsistent across the country, often expensive and difficult to navigate.

Despite those barriers, the majority of people who end their lives have seen a health professional in the weeks preceding their death, though not necessarily for identified mental health issues. Whilst distressed patients are increasingly likely to reach out for assistance, as health professionals we need to focus on seizing those opportunities.

For doctors in all settings, it is important to be on the look-out for signs and symptoms of depressive illness, which is highly prevalent among treatment-seeking adults. Misuse of alcohol and/or other drugs is also an important driver of suicidality. If a patient is distressed or presents with depressive symptoms, it is appropriate to ask about suicidal thoughts, planning and access to lethal means (such as firearms). Patients often do not volunteer these thoughts without prompting and asking these questions does not increase risk.

Having established that a patient is experiencing acute suicidal thinking, it is important to recognise that this constitutes a psychiatric emergency, arguably the mental health equivalent of acute severe chest pain. Hospital admission is often indicated, if not intensive community outreach. Decision-making in this regard is dependent on careful consideration of risks.

Assessment of suicide risk is a challenging task. Contemporary literature suggests that "tick-box" style risk stratification tools are not particularly helpful with respect to identifying individual

'A shared understanding of the serious risk posed by the acutely suicidal patient, and an agreed approach to their care, can help to ensure that opportunities to intervene are not missed.'

patients who are at imminent risk of ending their lives. Such tools can, however, support non-expert clinicians in exploring important risk factors, which might otherwise be missed. Meaningful suicide risk assessment and initial safety planning cannot really occur without development of a thorough understanding of the individual ("diagnostic formulation"). This should encompass biological and psychosocial vulnerabilities, as well as protective factors. This generally requires face-to-face review by a well-trained clinician. If barriers exist in this regard, it is appropriate for junior doctors to escalate their concerns.

Whilst in the tragic case of Ms MT, the coroner appropriately identified miscommunication between health professionals as a contributing factor, communication with significant others/carers is also a key component of care for this patient group.

Carers are typically an invaluable source of information with respect to events preceding the patient's presentation and provide critical guidance with respect to risk assessment and disposition.

The coroner also commented on the "need for an appropriate therapeutic environment" for this patient group in hospital emergency departments, as well as provision of "appropriately trained staff". These are excellent recommendations. Additionally, in order to optimise care of this patient group, there is a need for hospital emergency and mental health staff to develop collaborative working relationships over time. A shared understanding of the serious risk posed by the acutely suicidal patient, and an agreed approach to their care, can help to ensure that opportunities to intervene are not missed.

Finally, the role of assertive discharge planning from the emergency department or psychiatric inpatient unit is critical. Available community services vary between regions and models of care are changing during the pandemic. That said, it is generally appropriate for patients who have presented to hospital with acute suicidal thinking, to be followed up post-discharge by a crisis mental health team, with capacity for daily contact over the first few days. In many jurisdictions, new teams are being created to provide outreach support to these patients over a more extended period. One example is the development of "Hope teams" in Victoria, which can remain involved with vulnerable patients for up to three months. Early evaluation of these programs appears promising.

In summary, suicide remains a tragic, enormously impactful, and unacceptably frequent occurrence in this country. Whilst government leadership and changing community attitudes are encouraging, every doctor has an important role to play in identification and support of those at risk. Key messages for junior medical staff include:

1. Assessment of the acutely suicidal patient should include discussion with significant others/carers wherever possible. Consideration of suicide risk is a complex task, requiring integration of this collateral history with features of history and mental state examination. Specialist input is highly recommended.
2. When in doubt escalate to senior staff.
3. Discharge to the community should generally only occur following linkage with proactive mental health specialist support.

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Get Help

If you or anyone you know needs help these support services are available to individuals:

- *Lifeline Australia* telephone counselling at 13 11 14 (24 hours)
- *Suicide Call Back Service* on 1300 659 467 (24 hours) or visit www.suicidecallbackservice.org.au.
- *SANE* Helpline - Talk to a mental health professional at 1800 187 263 (10am-10pm AEST) or visit www.sane.org/services/help-centre.
- *Beyond Blue* on 1300 22 46 36 or visit beyondblue.org.au.
- *Doctors for Doctors* visit www.drs4drs.com.au.
- *MensLine Australia* on 1300 789 978
- Guide to staying alive: https://www.sane.org/mental-health-and-illness/facts-and-guides/guide-to-staying-alive.
- Resources for discussing suicide: http://www.conversationsmatter.com.au/

Comments From Our Peers

"Clear clinical communication is important, especially in the context of dysfunctional, fragmented and complicated systems. This may require you to have to go out of your way to ensure the right information is communicated and received by the other party."

"In my experience often, young doctors will cherry pick away from mental health patients due to inexperience or a heart sink mentality. But like all areas of medicine the more patients you see to develop mental state examination and risk assessment skills the more comfortable you become."

"In patients presenting with mental health concerns, their family, friends and community are invaluable in putting their experiences into context and assisting with risk assessment. This case reminds me of the importance of reaching out and listening to a patient's support networks."

"I wonder if Ms MT was able to be assessed by an appropriately skilled clinician whether her story would be different."

"Escalate patients that you feel may be being mismanaged to more senior staff, no matter how difficult it may seem."

"Considering the concept of "information transfer" as a source of failure requires each doctor to individually take responsibility for the continuation of their patients' care. Whether this is a phone call, fax, email or physically entrusting the patient to take a hardcopy document with them, it is important to remember the responsibility to the patient continues even after they have left your care."

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