This is the story of how my son [redacted] died. Slipping through the cracks in an inadequate mental health system that is overloaded, overworked, under resourced and has antiquated belief systems that blame the mentally ill and those with addictions.

[redacted]'s life had being going well. He was a hard working young man, and he loved his job as a truck driver. He had saved his money and achieved his goal of buying his own home. He became engaged to his girlfriend and they had plans to marry. He had type 1 diabetes, but he managed it well, and he was physically fit and healthy. He loved going to the gym, and body building was one of his passions.

His life changed when he lost his licence for 4 years for drink driving, which caused him to lose his job. Suddenly unemployed and without the ability to drive, he began to experience frequent anxiety and depression. He did find other employment, but he soon resigned as his depression and anxiety had become too severe. Unemployed again, and with his mental health continuing to decline, he began to self medicate with alcohol.

Around this time, his relationship with his fiancée broke down and the wedding was cancelled. This was very hard for him; he slipped further into depression and his drinking began to escalate even more. It was at this point that I became worried for his safety, as he was unable to manage his diabetes when he was drunk. I began to check on him daily.

We tried to get my son to attend the local drug and alcohol services but as he had no licence he really struggled to get to the appointments. There is no such thing as an outreach worker for adult males in the drug and alcohol sector in our area. Once a person misses appointments they deemed "not ready to change" and their name goes to the bottom of the waiting list. At this point [redacted]'s depression was extremely severe, and there began to be no time when he was sober.

It became impossible to get help for [redacted]. If he was drunk we couldn't get him to his appointments, and the services wouldn't see him anyway. As he wasn't engaged with public drug and alcohol services, we couldn't get him onto a waiting list for a public rehab or detox. Additionally, the waiting period for a public rehab was over six months long, which contributed to [redacted]'s lack of motivation to stay sober for the initial appointment. In fact, we all feared that in six months it would be too late.

In our current health system there is no way to help people who are deeply depressed AND on substances. The responsibility then falls directly onto the family and loved ones, and in [redacted]'s case we felt completely powerless to help. Our family is not wealthy and we all work full time, which affected our ability to be constantly available and to assist financially. As his carer I took as much time off work as I felt able to without putting my own job at risk.

We began to look for private detox and rehab centres. We were desperate to find a reputable and affordable private rehab. We managed to scrape together $10,000 for [redacted] to spend 28 days at the [redacted] Clinic. He was grateful for the opportunity to finally receive treatment, but after arriving at the facility in [redacted], he realised that his time there would be even more challenging than he expected.

Many of the other patients were court mandated to be there, as they had previously been incarcerated, and there were numerous physical altercations between these patients. [redacted] didn't feel safe. He also felt very isolated from his loved ones as he was only allowed to make phone calls on Sundays. He wanted to leave, but he pushed himself to stay in order to give himself the best chance at achieving recovery.

Despite rehab being a profoundly negative experience for him, he made it to the end of his 28 days. Following his return home, he managed to stay sober for 10 months. Disappointingly, [redacted] provided no follow up or aftercare. It is possible that if there had been some ongoing support, [redacted]'s eventual relapse could have been avoided.

After rehab he was able to find full time employment and things finally seemed to be looking up. [redacted] was happy, but he knew he had to be proactive and remain vigilant in order to avoid relapsing. He wanted to put some support systems into place while he was well enough to do so, so that in the event he became unwell again he would have someone to turn to for help.

He phoned the [redacted] intake line and put in a request for a psychosocial support worker. Unfortunately he did not receive a reply until 8 months had past. But by this point [redacted] was overconfident in his recovery and felt he no longer needed the support; he declined to connect with the service. This was obviously [redacted]'s mistake, but the fact remains that if he had received a reply earlier, he almost certainly would have engaged with the support worker. Having that extra support would have been invaluable given what was to come.

In November 2017 [redacted] was working as a manager in [redacted]. His depression and anxiety suddenly returned, and without any professional support systems in place, he once again turned to alcohol to self medicate. He soon became so unwell he had to resign from his job. Now unemployed again and with his 10 months of recovery gone, he spiralled deeper and deeper into depression.

He went to the GP and tried multiple antidepressants, but none of them helped, and he began to feel hopeless about ever getting better. He told me that he wished he was dead. By this time he was drinking heavily again. He was aware of the dangers associated with drinking to excess with his diabetes, but he often drank to the point of unconsciousness anyway. It seemed like he wanted to kill himself with alcohol.

Eventually there were no days when he was sober, and no space for him to make positive decisions for his future. Ambulances, called by myself or another family member, were frequently at his house. Over the course of a few months he was admitted to [redacted] Hospital about 15 times because his diabetes had gotten dangerously out of control while he was drunk or unconscious.

It seemed like the hospital staff did not understand how [redacted]'s dual illnesses - diabetes and alcoholism - posed a serious risk to his life. Each disease can be fatal on its own, but in combination they are a ticking time bomb. It was imperative that his alcoholism be brought under control; unfortunately he received no help in this regard from the hospital.

Each time [redacted] was admitted to [redacted] Hospital, staff advised him to engage with the local drug and alcohol service [redacted], but they never completed any referrals on his behalf, and they never conducted any follow up with him after he was discharged. The prevailing attitude from the medical staff seemed to be that since it was his choice to continue to drink, he had to be the one to get himself better. But at this point he was unable to help himself. He wanted to get better, but he just couldn't take the steps to make that happen.

Out of all the times [redacted] was at the hospital, he was only seen by the drug and alcohol team once or twice, despite always being drunk when he arrived. He was also not provided with any assistance regarding his other mental health issues, even though his depression and anxiety were the main driving forces behind his alcoholism.

He was never kept at the hospital longer than the barest minimum required for his diabetes to stabilise, and whenever he discharged himself he would stop at the pub or bottle shop on the way

home. It is possible that if the hospital had kept him for an extra day or two, and given him some real assistance with his alcoholism, depression and anxiety, that he would have been in a healthier and more productive mindset when he did finally leave.

I was usually at the hospital with [redacted] as his carer / mother to sit by his bed and support him as best I could, but sometimes I had to leave to go to work, or to go home to eat or sleep. The hospital always promised to let me know when he was discharged. This would have enabled me to pick him up and make sure he got home safely without stopping on the way to buy alcohol. Despite their promises however, I was never called, and time and time again he was simply discharged and sent on his way, and he was usually dangerously drunk again within the hour.

Another time when he was admitted to [redacted] hospital, I sat with him for four hours and talked him into staying to speak to the mental health and the drug and alcohol teams, who would not see him until he was sober. His blood alcohol level was very high and his diabetes was once again out of control; I thought the hospital would keep him overnight. Feeling exhausted I had to go home to sleep. Once again, I requested to be notified if he wanted to leave. Shortly after I left, [redacted] became distressed and discharged himself. Again, the hospital did not notify me and I only found out when I went to sit with him at the hospital the next morning.

With his life at risk on a daily basis, we managed to get some money together to send him to another rehab – [redacted] – this time on the Mornington Peninsula. We explained to the staff the urgency and high risk situation that [redacted] was in. [redacted] promised to give [redacted] extra time and support as they appeared sympathetic to our concerns. These promises were not kept, and they advertised therapeutic interventions and living conditions that were not delivered. Additionally, they seemed to be very inexperienced in dealing with clients with complex needs.

As with [redacted], many of the other patients at [redacted] were there as a result of a court order. [redacted] spent much of his time being driven around with the other patients as they were taken to various appointments to fulfil their bail conditions. Despite having paid thousands of dollars to be there, [redacted] was not even provided with a proper room or a bed, as the facility had taken on too many patients and there wasn't sufficient space for everyone.

There were other issues with [redacted] too. While driving patients to various appointments, one particular staff member would frequently park the transport van outside a pub, and would leave all the patients alone for 20 minutes to go inside and place bets on horses. It cannot be overstated how inappropriate it is for staff to be openly gambling in front of people trying to recover from addiction, especially since some of the patients at [redacted] had been problem gamblers.

Another staff member frequently complained to patients – including [redacted] – about the rehab and its owner. This, along with all the other issues led to [redacted] feeling disillusioned with the entire rehab program. My son left [redacted] and in no time began drinking again. He felt even more depressed than before, having spent the last of his money on "treatment" that did not help him at all. He felt he had been taken advantage of. I tried to contact [redacted] numerous times after [redacted] left, to discuss the ongoing support they had promised to provide him, and they never even returned my calls.

We had to give up on [redacted], and unfortunately, by this point we had no more money to try a different rehab. I called the [redacted] Triage so many times I lost count, asking for assistance for my son. Most of the time, they simply did not listen to me, and other times they did ridiculous things such as calling the police on [redacted].

A huge issue for my son was that he lived in [redacted]. The [redacted] downs area lies on the boundary between [redacted] and [redacted]. Every time [redacted] was taken by ambulance to hospital he would be taken to the nearest hospital which is [redacted]. But the boundary for mental health services was slightly different, which meant that if he required mental health services – as he often did – he would be required to attend [redacted]. It just wasn't practical for him to get to [redacted], and in regards to his mental health, [redacted] slipped between the cracks of both services.

Only on one occasion did [redacted] refer [redacted] for mental health support from [redacted]. To make use of the referral he had to go to [redacted] which is almost impossible to get to using public transport. The boundary for alcohol and drug services are the same as for mental health, which made it equally difficult for [redacted] to access these.

At one point my son told me he just wanted to die. He said he wanted to go to sleep and not wake up. I phoned the [redacted] Triage. I spoke to a very un-empathetic nurse who cut me off while I was speaking and informed me that my son would need to show that he could help himself before they would be able to do anything. She asked me what I expected Triage to do. I quietly said that I would like someone to help him.

I explained that I would like someone to come and see him or perhaps review his medication. I wanted to explain that he was not able to help himself, and that he wants to die. The nurse appeared not to hear me, and simply reiterated that he needs to help himself and go to the GP. I hung up. I wrote a complaint to [redacted] about the treatment we had received, and while I received an apology (see attachment), it didn't help [redacted] in any way.

I was in constant fear for my son's life; I would do anything to save him, but I had already explored and exhausted so many options. Desperate now, I wrote to the health minister [redacted] pleading for help. Months later I received a generic reply from [redacted] office spruiking all the programs we had already tried (see attachment). It was obvious that my letter and concerns were not taken seriously.

One day I tried to talk to my son's GP to tell him what was happening and to ask for assistance. I had been to this GP with [redacted] many times. The receptionist refused to allow me to speak to the GP and instead put me through to the practice nurse. The nurse refused to pass on my message about my fears for my son's life, and refused to even provide me with the GP's email address. The nurse was so rude and uncommunicative I literally cried with frustration. I was told I had to make an appointment to attend the surgery and an appointment was not available until the following week.

Having not received any consistent professional support, [redacted]'s condition continued to deteriorate. I once again phoned [redacted] Triage for assistance. My concerns for my son's life were very real. I was advised by Triage to call the police and have my son sectioned. Being desperate for assistance I followed their advise. The police attended and we called an ambulance. I requested this time he be taken to [redacted] Hospital. The Hospital immediately began an assessment of [redacted]'s mental health; this time they did not wait for him to sober up.

They completed their assessment and suggested that he stay for a while. [redacted] agreed. My daughter and I stayed with him until midnight as there were no beds in the mental health ward. We left the hospital at midnight. The hospital called me the next morning advising me that my son had absconded from the hospital, and that as they were concerned about his mental health they had contacted the police to have him returned. The police located [redacted] and called an ambulance to take him back to the hospital.

I wish that they had acted with such urgency during [redacted]'s many previous hospital visits. Unfortunately however, they only seemed to understand the seriousness of his condition after I lodged a written complaint. In all our other dealings with both [redacted] and [redacted] Hospital I was very unsatisfied with the quality of care provided.

Back at [redacted] Hospital, [redacted] was sectioned for a further 24 hours. Then he was moved to [redacted] Hospital as there were no longer any beds available at [redacted]. I was not informed that he was being transferred. He stayed at [redacted] Hospital for a few days. Upon his discharge he was not linked with any [redacted] mental health or drug and alcohol services for follow up.

After leaving the hospital [redacted] continued to drink off and on. He engaged with the [redacted] Care Program, a community program funded via [redacted]. He was seen by a mental health nurse fortnightly but once again he was not allowed to attend appointments unless he was completely sober. This acted as a significant barrier to his recovery, because as well as missing multiple appointments, he was never seen by the nurses when he was at his worst. When he was sober he appeared to be quite well and have good insight into his issues. He could convince others that he was aware of the risks he was taking when he was drinking, and that he was actively trying to minimise these risks.

One weekend I went away. As usual, I spoke to my son on the phone daily. He told me he was going to work over the weekend and that he needed to stay sober for a job he was doing. He had seen his GP and obtained some Valium, and he planned to stay sober by withdrawing from alcohol with the assistance of Valium. On my return I had tried to call him but there was no answer. As he had worked at night I tried not to worry too much. On the Monday I went to check on him and found him dead. The coroners finding was that he had died of Ketoacidosis; he had stopped caring for his diabetes. He had alcohol and Valium in his system. I will never be sure if he stopped managing his diabetes on purpose or if he simply lost track of time due to the substances he was using.

The mental health system failed my son. He was overdosing on alcohol in much the same manner that people overdose on other drugs in order to kill themselves. He had been doing this for a long time. My son's needs were complex. He required specialist support and care; he required mental health and hospital staff to be proactive and to do more than the minimum; he required follow up. He understood the judgmental attitudes of those around him, particularly from the professionals who were treating him. He saw how he was blamed for his own illness. How can anyone recover in an environment that does not provide adequate empathy and support. Intensive support could have saved my son's life. Someone to follow up. Someone to understand that it is not a matter of choice to have a mental illness, to drink alcohol. Who would choose to live like that. No one listened or took his risk seriously.

For my beautiful son [redacted].

Suggestions to Improve the System.

- Assertive, Intensive treatment programs for those at risk. Suicide, Mental Health, Drugs and Alcohol and physical Health.
- Updated training and research to better understand addiction in relationship to mental health. Removing old fashioned idea that someone must want help. Some people are incapable of making this choice they will die before they are able to choose.
- Priority for those with complex needs.
- Accreditation of Private Rehab programs and education standards for workers and operators.
- Emergency Departments, Psychiatric Triage and CATT teams need to be better resourced so that they have time to listen to the individuals needs.
- Services need more education around the stigma and how to best be non-judgment and how to use empathy for those with mental health and addiction issues.
- Better communication between services and holistic treatments.
- Mental Health and Drug and Alcohol services need to be better resourced to avoid long waits for service.
- Mental Health and Drug and Alcohol services need to be Co located and work collaboratively recognising risk and optimising communication between services. Providing a more wholistic approach and recognising risk.
- Flexible services and flexible boundaries for those living on the fringes. Eg. [redacted].

- More psychosocial outreach services and support workers.
- More public rehabilitation centres. Providing services to suit the needs of each individual. Such as new research into modern ideas and not the AA 12 step model which can be a concept that people find difficult and doesn't suit everybody's beliefs.
- Extra specialist doctors in Mental Health and Drug and Alcohol.
- Carers to have access to GPs and be allowed to give vital information and work collaboratively. With family inclusive practice.
- After hours services to allow people to continue to work and still receive support. The stresses of returning to work are often triggers for Mental Health/Alcohol and drugs.
- More accessible support for carers.