2019 Submission - Royal Commission into Victoria's Mental Health System

SUB.0002.0015.0034

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
N/A

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?
N/A

What is already working well and what can be done better to prevent suicide?
I have a lot to say for this question. Please see my attached document.

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.
Please see my attached document.

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
Please see my attached document.

What are the needs of family members and carers and what can be done better to support them?
"Please see my attached document for further thoughts on this. 1. Recognition that being a parent or carer of a person with a mental illness can be traumatic, frightening, stressful, isolating, and can disrupt ones ability to keep working, thus being financially draining. 2. Parents carers, need to be included in the treatment discussions with mental health professionals and given credit as the important part of the team that they are. Too often the health professionals health just with my son and left us out of the picture. 3. Parents/carers need to be given written information as to where they can access help, eg the Carer Gateway website etc. They also need to be given written information on their loved one's diagnosis and treatment plan. This needs to happen after the first contact, not months down the track as in our case. 4. Psychological services/counselling etc are expensive. We needed to access these for ourselves as a result of our traumatic experiences with our son's severe mental ill health. Even with the Medicare rebate, my out of pocket expenses for a 1hr psychologist appointment is in excess of $100. The 10 annual sessions provided for under the Medicare scheme are inadequate and will soon run out. Our out of pocket expenses will increase after that as the rebate we get through our private health insurance is even less. Lots of people could not afford this. Psychology services and counselling should not have an annual limit on the, just as going to the GP for a medical issue does not have an annual limit. The Medicare rebate also needs to increase so that there is a smaller gap to pay. Accessing a

psychologist should be something available to all, not just those who can afford it. This inequity increases the burden of mental health problems on disadvantaged communities. 5. The Psychiatric Triage line (1300 721 927) - does not work in a crisis. The seems to go through to a call centre and you get asked a lot of questions and at the end they just say to call 000. In a true crisis situation, it just wastes precious minutes. 6. Why is there not a CAT team service for adolescents? In a crisis our only options are calling 000, or, if less serious and we are able, go to ED. Arriving at ED is not a good solution with an acutely mentally ill patient as it is unsafe, there is nowhere safe to wait and the environment is not conducive to reducing anxiety or distress. "

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
N/A

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?
N/A

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
"See the attached document. 1. Better coordination between providers of adolescent mental health services. eg better integration between inpatient and outpatient care 2. Ability to continue care with a private psychiatrist even as an inpatient or as an outpatient under the care of CYMHS 3. Smoother pathways to re-admission to the inpatient unit. 4. All inpatients and their carers/parents ALWAYS be provided with a written document on discharge outlining the diagnostic assessment, treatment strategies, medication regime, relevant phone numbers, and crisis plans. 5. All inpatients especially those having attempted suicide receive close and active follow-up, eg within 24hrs of discharge. 6. All inpatients who have been or are suicidal or who represent a danger to others should be able to remain as an inpatient until such time as they are more stable and safe to be in the community. 7. Parents/carers should ALWAYS be asked (i) how they are, (ii) what they need and (iii) given both verbal and written information addressing their needs or how and where to access help. 8. Adolescents should have access to CAT teams for acute crisis management. 9. There should be greater incentives/subsidies for private psychiatric hospitals to expand their services to include under-18s. "

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
N/A

Is there anything else you would like to share with the Royal Commission?
N/A

OUR EXPERIENCE AS PARENTS OF A 15-16YR OLD SON WITH SEVERE MENTAL ILLNESS:

Our son, now 16yrs, was diagnosed with Autism Spectrum Disorder, specifically Aspergers Syndrome in 2018.
He experienced bullying at school during 2017 and as a result, changed schools at the start of 2018. had some brief issues with mental ill health early in 2018 and at times during 2018. Throughout last year, was mostly managed as an outpatient by a private psychiatrist, Dr . Dr saw every 1-4 weeks throughout late 2017 and all of 2018. He is an amazing doctor, genuinely caring and he also included my husband and myself in appointments if and when was needed. Over this time we all developed a very good relationship with Dr and he was even available to be called out of hours if the need arose, which was fortunately infrequent but nevertheless extremely reassuring.
suddenly and inexplicably became suicidal in mid January this year. He was diagnosed at that time as having Obsessive Compulsive Disorder, which was exacerbating to his underlying anxiety. He was started on sertraline, an SSRI antidepressant.
In mid February this year, things suddenly deteriorated when instead of riding his bike to school one morning, rode to the train line with the intention of committing suicide. was rescued by police and ambulance and admitted to the Adolescent Inpatient Unit (AIPU) at . dramatic deterioration lead to Dr electing to hand case over to Child and Youth Mental Health Service (CYMHS), due to genuine concern for welfare and in the hope that a different psychiatrist may have more success. medication was also stopped that day, in case it was increasing his suicide risk – a rare but serious side effect of SSRI's in adolescents.
referral to CYMHS was accepted, however did not have his first appointment with his new CYMHS psychiatrist until 4 ½ weeks after he tried to commit suicide on the train tracks that day. During this period of time was dangerously unstable and without access to any ongoing psychiatric treatment. During this time we needed to ring 000 on five separate occasions due to either suicidal behaviour or behaviour that was endangering to himself or the family (for example lighting a fire in his bedroom). During this time, had two periods of admission to the
For these weeks, was trapped in a diagnostic and therapeutic no-man's land. As an inpatient at the AIPU, his psychiatric care was in the jurisdiction of the psychiatrists who work at the AIPU. However, the AIPU psychiatrists' focus is on discharging patients

as early as possible (we were told the average stay length was three days). With such a short stay, the AIPU psychiatrists feel that their role does not require provision of any diagnostic assessment, nor does it require making decisions about treatment interventions. Conversely, the CYMHS [redacted] outpatient service prefers not to deal with AIPU inpatients as they are regarded as being under the AIPU's jurisdiction.

In effect, this meant that because [redacted] was sick enough to be an inpatient, he had no access to his CYMHS psychiatrist Dr [redacted]. Because [redacted] was sick enough to be an inpatient he did not receive a proper psychiatric assessment. Without a proper assessment he therefore did not receive any treatment plan. This gap in the adolescent mental health system is highlighted by the fact that there was no recognition that [redacted] was suffering any mental illness, nor was there any realisation that [redacted] required medication. This *Catch-22* did not change until a near-miss suicide attempt on 4th April. This was six weeks after [redacted] was accepted into CYMHS. During these six weeks we had needed to call 000 for police/ambulance on six separate occasions. During these six weeks [redacted] had also had another serious suicide attempt where he took an overdose of 83 paracetamol tablets.

On 24th April, over thirteen weeks since [redacted] first admission to the AIPU in January, we were finally provided with a written document entitled "Mental Health Safety Plan" (MHSP). This plan outlined [redacted] background, current diagnosis, medication regime, strategies for managing symptoms at home as well as pathways to readmission to the AIPU, if needed. The purpose of this document is to provide caregivers with vital phone numbers and checklists of things to do if a crisis occurs. It also remains on the Eastern Health electronic records, so that it can be accessed and used if and when [redacted] presents to an Eastern Health emergency department.

[redacted] and I asked why we had not been provided with a MHSP earlier. The AIPU consultant psychiatrist admitted that in hindsight it should have been, but that they were reluctant to issue one too soon in case it wasn't needed and they also wanted to avoid needing further updates, as numerous updates of the MHSP can apparently be confusing to medical personnel reading the document.

Having the MHSP has been beneficial, as it has helped smooth the way through ED and facilitated continuity and communication amongst mental health professionals dealing with [redacted]

Regarding readmission to the AIPU, these are either emergency admissions resulting from a crisis such as a suicide attempt, or they are requested, respite admissions, with the latter being designed to provide a circuit-breaker before a crisis occurs.

The pathways to these admissions are three:

i) if in business hours, we call [redacted] CYMHS, request [redacted] be assessed that day with a view to AIPU admission
ii) if out of hours, we go to [redacted] Emergency Department, for [redacted] to be assessed with a view to requesting readmission to the AIPU
iii) if a crisis occurs and there is immediate danger, call 000, where [redacted] is transported to [redacted] Emergency Department for assessment.

For option (iii) above, over these last few months, we have needed to call 000 sixteen times. In every case, the police acted professionally and sensitively. On 4th April when [redacted] ran off at [redacted] and was eventually rescued from the path of an oncoming train, [redacted] owes his life to the fact that the police response was so rapid, urgent and ultimately effective. I have nothing but admiration and gratitude for the way they dealt with [redacted] and with the whole family in what has often been very traumatic times. All the paramedics we have dealt with in these circumstances have also been amazing. Unfortunately for options (i) and (ii) above, our experiences have been much more mixed. On Wednesday 8th May, we called [redacted] CYMHS around 11am to request an urgent assessment of [redacted] that day as he had taken himself off medications and his behaviour was very concerning to us. We felt he might have been showing signs of early psychosis. We called and left a message with the receptionist and then came in at 2pm for what had been a previously scheduled routine appointment. Unfortunately, when we arrived it became clear that our message had not been passed on and they were not expecting an urgent assessment request. [redacted] and I spoke with a psychiatrist and a psychologist who were both on duty at the time. We repeatedly asked that [redacted] who was in the waiting room, be assessed, as he required admission to the AIPU. The psychiatrist on duty was unable to help us. He attempted to fob us off, saying that [redacted] had an appointment the following day with Dr [redacted] and we should come back then. We said that this was too long away and we were concerned that we would have a crisis requiring yet another 000 call before then. That afternoon we were at [redacted] CYMHS for approximately 45 minutes unsuccessfully trying to get [redacted] seen and assessed. In the end it became clear that they were either unable or unwilling to help us, and that our only option was to go to the Emergency Department. We left CYMHS and took [redacted] to [redacted] ED. After over an hour waiting in the waiting room, [redacted] became so anxious that he was no longer able to stay and wanted to be brought home, which we did. Several hours later, [redacted] got a very large knife from the kitchen drawer and attempted to hurt himself. My husband tried to take the knife away from [redacted] and a very dangerous struggle over the knife ensued. My 13-year-old son and myself witnessed this. As neither my younger son nor myself had seen what happened at the start, but instead came in to see [redacted] and [redacted] wrestling

over a knife, it was not clear at the time if had the knife because he wanted to hurt himself or because he was attacking my husband. Fortunately, my husband disarmed and police arrived relatively quickly and was taken to ED and later admitted to the AIPU. The events of this day highlight what could have been a catastrophic failure of Mental Health Safety Plan. It resulted in further trauma to the whole family and an unnecessary escalation which would have been prevented had been admitted earlier that day as requested. At worst, it could have resulted in a serious injury and possibly suicide.

The following day, and I met with those in charge at CYMHS as well as psychiatrist, Dr . We were given the opportunity to voice our complaint about their failure to assess and admit as per his plan. and I do not feel we were given a satisfactory explanation as to why this failure occurred. Dr , who is the head of CYMHS said that it resulted from the receptionist not correctly passing on the message, and that they were unable to deal with emergency reassessment requests at such short notice. Dr also said that an assessment could not be done unless there was a whole hour available and that it was preferable for no assessment to be done rather than one done in an abbreviated time-frame.

We have also had mixed experiences with going to the Emergency Department. Even with MHSP in hand, is still subjected to waiting in the triage line, then waiting in the waiting room prior to be being seen by the psychiatric triage nurse then the psychiatric doctor on call. This can take several hours. For a patient on the Autism Spectrum, in need of urgent psychiatric care due to peracute and potentially life-threatening anxiety episodes, the ED waiting room is not an appropriate place to be. It is unsecured, thus it is unsafe, and for a person with ASD in mental health crisis, it is overstimulating. The prospect of a frustrating, stressful and uncertainly lengthy wait unfortunately creates an incentive for to precipitate a crisis in order to fast-track himself through the waiting room. This is obviously risky, traumatic and subverts the triage system, upon which an overstretched health system is reliant. From an outsider's perspective, it is difficult to understand why cannot simply call the AIPU if needing an admission, and go directly there. The AIPU has at least one psychiatrist either in the building or on call 24/7. If arrived at the AIPU, he could be placed somewhere safe and then assessed by the psychiatrist on duty or on-call (who also covers the ED) prior to admission. I have asked why this cannot be done. I have been told that this is "just the way we do it" and that a patient always requires assessment before admission. When it was pointed out that could still be assessed prior to admission, but that assessment would take place in the AIPU, rather than CYMHS

or the ED, the response was a shrug of the shoulders and again, that "this was the way it needed to be".

Other issues we have encountered have been to do with the competency of [redacted] psychiatric care.
The psychiatrist that [redacted] was assigned by CYMHS, Dr [redacted], is a registrar. This means that he has not completed his training as a psychiatrist. In addition, Dr [redacted] is on a short-term placement at CYMHS and will be leaving in early August, approximately four months after starting to see [redacted] After several weeks under CYMHS' care, and after several re-admissions and multiple 000 emergencies, it was clear that [redacted] case management was not going to be straight-forward. In light of this, [redacted] and I requested that [redacted] psychiatric care be transferred to someone with more experience and also someone who could continue [redacted] care beyond the first four months. This request was refused on the basis that no-one else was available. We were reassured that Dr [redacted] would be actively supervised, however his supervisor, Dr [redacted] later said that he oversaw the care of 120 patients across three days a week. It is difficult to imagine that Dr [redacted] is receiving any useful "supervision" if his supervisor is spread so thin.

[redacted] had been seeing a private psychiatrist, Dr [redacted], from Dec 2017 until Feb 2019. Dr [redacted] knew [redacted] and us well. Dr [redacted] was willing to continue to work with [redacted] us when [redacted] was referred to the CYMHS service. We felt that having Dr [redacted] continued input this was highly desirable as [redacted] autism made him difficult to get to know and more difficult to communicate with than a neurotypical patient may be. CYMHS (specifically Dr [redacted], the psychiatrist in charge of [redacted] CYMHS) did not allow this and advised Dr [redacted] and us that it was his "strong recommendation" that [redacted] be completely under the care of CYMHS. He said that the CYMHS "team approach" would provide far better care for [redacted] than could be provided by a psychiatrist in private practice. We never experienced any "team". For weeks we received nothing at all. When appointments started with Dr [redacted] they were only once a week and they excluded us, [redacted] parents, so we had no way of knowing how things were going, nor any way of communicating our perspective to Dr [redacted]. The net result meant that at his sickest and most vulnerable time, [redacted] had his trusted, familiar and highly competent psychiatrist taken away from him, had no ongoing psychiatrist for over four weeks, then went into the care of a temporary psychiatrist-in-training, who seems effectively unsupervised and has no experience with suicidal teens on the autism spectrum.

During the period of January 18th until June 8th, ██████ has had ten separate admissions to the AIPU. The average time period between discharge and a crisis requiring a call to 000 has been 5.7 days, with a range of 0 days to 17 days.
Despite repeated suicidal behaviour at home such as going to the train line, threatening to run away to go to the train line, taking a panadol overdose, attempts to hang himself, etc, the psychiatrist in charge of the AIPU, Dr ██████, has repeatedly pushed for discharge typically within approximately three days of admission. If ██████ had been allowed to stay at the AIPU until such time as he had been properly assessed by his psychiatrist, ██████, and had an appropriate treatment plan formulated and commenced, then many of these re-admissions could have been avoided. At times we had grave fears for ██████ life given that the AIPU was unwilling to help keep ██████ safe until he was less of a suicide risk. Due to our despair at ██████ continually being discharged before he was ready, I went in search of a private psychiatric hospital that could take ██████ I discovered that there is only one private psychiatric hospital for adolescents in Melbourne. This is ██████ Clinic. I contacted them and told them about ██████ and about our grave concerns for his safely in light of his suicide attempts and repeated early discharges from the ██████ AIPU. The person I spoke to was sympathetic, however they told me that ██████ was "too sick" for them and said that ██████ Clinic would perhaps be a better option for us once ██████ became more stable.
Whilst ██████ was at his sickest, in the weeks following his paracetamol overdose and subsequent self-harming episodes in the AIPU, ██████ told his psychiatrist, Dr ██████, that he had decided to "play along and seem ok" so that he'd be discharged, so that he'd then be free to commit suicide. Dr ██████ did not inform ██████ and I of this. Nor did Dr ██████ communicate this verbally to Dr ██████, who was at the time, pressuring ██████ and I to consent to discharging ██████ Dr ██████ had apparently only put this in his written notes, which Dr ██████ admitted to not having read. The combined effect of Dr ██████'s poor communication of information of potential life-and-death importance, together with Dr ██████'s eagerness to discharge ██████ as the earliest opportunity could have resulted in ██████ death.

We also have concerns about the use of seclusion, forced sedation, physical restraint and the Intensive Care Area (ICA).
██████ was kept in isolation, the Intensive Care Area ("ICA"), from Monday 1st April until Friday 5th April. This was during his readmission immediately following his paracetamol overdose. He was placed in this area as he had allegedly make a sexually inappropriate comment to two other female inpatients during his most recent admission and the AIPU doctors felt that ██████ was a potential threat to other inpatients. This was

despite the allegations being unproven and [redacted] having never previously behaved inappropriately towards another patient. The ICA room has no furniture other than a makeshift bed, which is really just a thick, plastic covered mattress on the floor. Minimal personal items are permitted. There is no furniture in the room other than the bed. There is little natural light. There is no human contact other than a nurse that sits in an adjacent room. In the immediate aftermath of [redacted] overdose, he was emotionally unstable, highly anxious and depressed. On the Tuesday he told me that the previous night his anxiety and distress had caused him to bang his head against the wall so much so that his head had started to bleed and he required restraint and sedation. The AIPU staff never informed myself o[redacted] that this happened. Two nights later, a similar episode occurred, except this time, [redacted] was so distressed he needed to be placed in physical restraints in the seclusion room (no light, no people, no furniture) and again forcibly sedated. On Tuesday, Wednesday night and Thursday morning I pleaded with the AIPU doctors to let [redacted] out of the ICA as it seemed to be progressively worsening his mental state. I said that keeping him in these living conditions was cruel to anybody let alone someone as vulnerable and fragile as a [redacted] I also said that they were violating [redacted] human rights and that his treatment was inhumane. The doctor's response was that being in the ICA was deemed a necessary safety to other patients and his being there was being reviewed daily. On the Thursday (4th April), I took [redacted] from the AIPU across to [redacted] CYMHS for an appointment with Dr [redacted]. After leaving the appointment, [redacted] ran off from me. I tried to follow but soon lost him. I alerted the police and the staff at [redacted] Train Station, [redacted] was found about 90 minutes later near Surrey Hills Station on the train line. A Metro Trains employee pulled [redacted] out of the path of an oncoming express train, which was reportedly travelling too fast to stop in time. The police at the scene later told me that this person saved [redacted] life that day. [redacted] later told me that he ran off because he could not face going back into the ICA. The following day [redacted] was transitioned out of the ICA and the following Monday, [redacted] was finally started on two medications, which resulted in [redacted] stabilising about two weeks later. It is frightening that it took a near-miss suicide for the doctors at the AIPU and his treating psychiatrist, Dr[redacted], to finally take [redacted] condition seriously. If it were not for the police's rapid response and the Metro Trains employee's heroism that day [redacted] may not be alive today.

Another concern is there has been no support offered to John and myself or [redacted] younger brother. There has been no recognition from the hospital or CYMHS that this has been an extraordinarily stressful and traumatic time for all of the family. Never once has any of the staff at the AIPU or at CYMHS asked us how we were coping. There was also a

period where [redacted] was becoming violent at home and we were at times feeling unsafe and property damage was occurring. There was never any recognition from staff that it was not acceptable to expect anyone, even if they are the parents, to be or feel unsafe at home.

The first acknowledgement that carers may require support came during a discharge meeting on 21st May, four months after [redacted] first became unwell. We were handed a sheet of paper that had some key information for carers on it, such as the Carer Gateway website and hotline. Admittedly CYMHS has provided [redacted] and myself with a psychologist, who sees us weekly. However, we were disappointed to discover that the psychologist was there *to help us help* [redacted] (parenting skills etc), rather than actually help us process and deal with the enormity of what had been happening [redacted], our younger son has been completely ignored by those at the AIPU and CYMHS, despite the fact that he has witnessed many traumatic events. For example he has been the one who has needed to call 000 on more than one occasion, and he was also first on the scene when [redacted] tried to hang himself in his bedroom on 28th May. Fortunately [redacted]' school has a good Wellbeing program and several staff continue to regularly check-in with [redacted] and give him the opportunity to talk.

SUMMARY OF ISSUES WE HAVE ENCOUNTERED WITH THE ADOLESCENT MENTAL HEALTH SYSTEM:

1. <u>Lack of coordination between elements of the adolescent mental health provision</u>

- Poor communication and lack of crossover, at least initially, with psychiatric care for as an inpatient versus an outpatient. This resulted in a long initial gap where was not receiving ongoing care, and therefore experiencing a delay in diagnosis and starting treatment. This delay lead to a worsening of condition and could have resulted in his death on 4th April.
- Inability of CYMHS to allow to continue seeing his long-term psychiatrist. long-term private psychiatrist, Dr was willing and able to liaise and work together with CYMHS. Continuing to see Dr would have improved care and may have minimised further deterioration. Being able to continue with Dr would also have provided and myself with a feeling that we were being supported, as we initially had no support whatsoever from CYMHS nor the staff at the AIPU.
- The re-admission procedures on Mental Health Safety Plan are cumbersome and poorly coordinated. We had been told by the AIPU that we could request assessment for admission by going to CYMHS during business hours. Based on this, should not have been turned away from CYMHS on 8th May. CYMHS' refusal to make a triage assessment of that day could have resulted in a fatal outcome.
- Why does a mental health patient seeking a *non-emergent* admission, need to go to the Emergency Department for triage/waiting and then assessment? Both the AIPU and the ED are covered out-of-hours by the psychiatrist on call. Why cannot pre-hospital assessment occur at the AIPU? The present system increases strain on the ED department with a patient that is technically not presenting with an emergency.
- Why does a mental health patient seeking a *crisis admission*, have to go to ED? This is not an appropriate environment for someone in a mental health crisis and may in fact precipitate an escalation of symptoms. Is there a way that the ED could accommodate waiting mental health patients in a safer and more sensitive way?
- A Mental Health Safety Plan should be provided for <u>every</u> patient discharged from the AIPU. In our case, this should have been 24th January, not 24th April.

2. **Reliance on early discharges from the [redacted]**

No doubt the demand for inpatient beds exceeds supply and this pressure drives the motivation for doctors at the AIPU to discharge patients as early as possible. However, in [redacted] case, his repeated early discharges, especially in the early weeks of his illness, no doubt contributed to a worsening of his condition and put his life at risk. It could be argued that allowing him to stay in hospital longer, until such time as it was clear he would remain well in the community and not require re-admission, would have lead to fewer hospital days overall.
We also felt at times that [redacted] life was at risk if he was discharged, and during another period we felt unsafe with him home. These concerns were largely ignored and not taken seriously by those at CYMHS and the AIPU. In fact, we were told by one of the AIPU psychiatrists that they often discharge patients that are still suicidal.
At least in the [redacted] region, there appears to be a lack of provision for those with a severe mental illness requiring a period of time in hospital long enough to assess, diagnose and stabilise their condition.

3. **Lack of alternative inpatient services in Victoria**

Those in the 16-24 years age group have the highest prevalence of mental illness compared to any other age group of Australians. The services currently available for under-18s does not reflect this.

4. **Lack of support for family members**

In our experience, the doctors at the AIPU and at CYMHS seem to have little recognition of the emotional and financial toll of caring for a mentally unwell loved one. Without a functional family and able carers, patients like [redacted] could become homeless, could end up in the criminal justice system, suffer worsening mental health or commit suicide. Our family was fortunate in that one parent was able to take long-service leave during this time to facilitate caring for [redacted] and all that that encompassed. As parents, we were also able to be strong advocates for [redacted] throughout this process. Many families would not have the resources that we have had, though, and through our experience it is easy to see why there is such a strong link between mental ill health, homelessness, unemployment

and those ending up in the criminal justice system. Victorians deserve a mental health system that works for all of us, including those in disadvantage.

5. **Inability to change to a different psychiatrist**

Registrars working under supervision should in fact be supervised. If there are concerns that the patient's needs are complex enough that they are beyond the registrar's experience and capability, then a patient should be able to change to someone with an appropriate level of expertise and also someone who is not on a short-term placement.
Carers and parents should be given the opportunity to speak with the psychiatrist about their perspectives on the patient's progress at home. We were not always given this opportunity. We were often only given very minimal information about [redacted] degree of safety risk.

Dr [redacted] ([redacted] mother)
Mr [redacted] ([redacted] father)
9th June 2019