

I have worked for a decade in the public mental health system as a psychiatrist.

I work in both rural and city community mental health settings.

I work within complex and busy and often high risk team environments.

I have a previous career in the military as an engineer. This is relevant in regards to the concept I wish to articulate. There are many problems within the mental health system I could highlight, and offer my ideas of potential solutions, but I wish to simply highlight what I believe to be, from talking to thousands of people over the years, a fundamental problem in the mental health system – encompassing the public and private components of the mental health system.

In engineering, in the design of a system, a fundamental element of safety and improvement is 'feedback'. An input goes into a 'box' and an outcome is produced, but where a feedback loop re-enters the 'box' with the input, producing a better output. The 'box' is the mental health system. The input is the mental illness (and the person living with the mental illness) and the output is what occurs after 'treatment' - the goal of someone 'better' or more specifically with the alleviation of mental illness symptoms.

Within the mental health system, decisions and actions are made thousands of times every day across New South Wales where the decision maker does not see the outcome of their decision, does not receive feedback from their decision, and with the final layer being where the decision maker does not have any accountability for their decision.

The decision could be to involuntarily admit somebody or not, to diagnose, to prescribe, to treat, to call someone or not, to document something or not. There are a large number of types of decisions and actions.

Examples are numerous and exist throughout the system but I will describe a few examples very briefly with regards to psychiatry.

In training, psychiatry trainees in all their rotations of training make hundreds of decisions a month where they do not see the outcomes, or receive feedback, or have accountability for their decisions. This is where the fundamental problems begin.

When people are admitted into hospital, they are assessed, receive some form of treatment and are discharged, and from the point of discharge, it is rare that the members of the treating team are made aware of the outcomes beyond discharge, or receive feedback about their decisions, or are accountable.

'Centres of expertise' or experts are all providing diagnostic services and management advice. It is very difficult to know how an organisation can become a centre of expertise or an individual become an experts when they do not see the outcomes of their actions, do not receive feedback, and are not accountable.

Subspecialty areas such as forensics or adolescent services write long reports or provide extensive treatment, where once the patient leaves that service or that assessment process, the clinician does not see the outcome, or receive feedback or have accountability.

Core exam elements are where psychiatry trainees talk with examiners about a treatment plan – what it would look like - but are never examined on actually providing treatment.

The vast array of people with personality disorders and maladaptive traits and those with anxiety disorders seek treatment from psychiatrists, where most psychiatrists never receive the appropriate and intensive training that is required to treat personality disorders or anxiety disorders. When there is dis-engagement, or where there is a death well beyond the time that person sought and then disengaged from treatment (as the treatment was not effective due to the psychiatrist not being trained appropriately), that psychiatrist never sees the outcome, or receives feedback, or is accountable.

When a coroners court assesses various steps and potential errors that may have led to a death, there are many people who played key roles in what may have led to a negative trajectory, who are not aware of the outcome, do not receive feedback and are not accountable.

There are many examples across the world in healthcare where outcomes do become known, where meaningful feedback is received and utilised and where clinicians have greater accountability. These processes are win-win processes. The clinician has the chance to develop as a clinician (to learn from mistakes as one example), and the user of the mental health system receives care that will always improve as time progresses, and where outcome awareness, feedback and accountability provide an improved level of care.

Without fundamental features of awareness of outcome, the seeking and provision of feedback and accountability for the outcome, the clinicians within the system will not learn or develop, and the system remains broken. No system can operate effectively without such fundamental principles.