PERSON-CENTRED CARE IN A SILOED HEALTH SYSTEM: COMPLEXITY OF MENTAL HEALTH

KEYWORDS

Palliative care and mental health, advocacy, relationship, pathway

EXECUTIVE SUMMARY

Accessing timely public mental health care for palliative care patients can be difficult. Professional relationships and pathways may allow better access for patients whose complex physical and psychiatric symptoms interplay, and whose medication regimen is beyond the scope of their General Practitioner. What happens when the most distressing thing for a patient is not palliative symptoms but mental health? A recent case is discussed where direct advocacy to involve the GP and community mental health led to a mixed outcome for patient and their carers.

INTRODUCTION

YEAR CASE STUDY WAS IMPLEMENTED

2026 to 2026

The specific issue being addressed

Managing complex mental health in a community palliative care service can be difficult especially for people with limited financial and social supports. A 62 year woman with End Stage Kidney Disease (ESKD) linked to a specialist community palliative care service was referred to the psychologist for low mood and existential distress. She lives alone with NDIS support 4 hours per day, 5 days per week. She has an extensive psychiatric history (set herself alight in her 20s, OCD, chronic suicidal ideation), largely managed pharmacologically. A recent hospital admission for failing kidney function led to rationalising of her medication and subsequent escalation in OCD symptoms.

Approach developed to address this issue

A comprehensive assessment included reviewing electronic medical records, meeting this lady and consulting with her NDIS support workers for collaborative information. The primary concern was the significant increase in her OCD behaviours impacting both her and the carers' lives.

Summary of activities and their implementation.

Psychological assessment revealed significant emotional and existential distress and impact on functioning and burden on carers. This client spent many hours a day listmaking, doing laundry, consulting grocery catalogues, rechecking, rewriting, sending messages to care staff, ruminating about existential despair affecting her sleep and relationship with carers. Engagement of GP and Palliative Care medical team who felt complexity beyond their scope of expertise. Consult to inpatient Consult Psychiatry for advice. Referral and advocacy on patients behalf to community mental health for public psychiatric review.

Summary of outcomes and measurable impacts of the activities

Inpatient Consult liaison team able to review notes from previous admission and give advice on best medication to reintroduce for OCD behaviours. GP started this lady on a base dose of medication but wanted expertise to manage psychiatric presentation ongoing. Referral to community mental health by Staff Specialist. Discharged

initially by Community mental health team due to nil acuity of risk. Ongoing advocacy by Palliative care psychologist and medical officer to access public psychiatric review for client.

The extent to which the activity is scalable and ease of adoption by other services / organisations.
Relationships between relevant staff of services – palliative care and community mental health in this instance – is crucial and pathways for ease of access for public health patients who do not have the resources to access private psychiatry is needed. Personal relationships between staff of services are important in building rapport and efficiency in optimising wholistic person-based care in an often 'specialities only' health system.

Important lessons learnt and critical success factors
With the addition of psychology into specialist palliative care, referrals of acute mental health conditions will increase. Vulnerable people who cannot access timely psychiatric or psychological input due to limited resources need to be supported even if the most distressing symptoms are not palliative care focused. A shared care approach is therefore essential. Existing relationship with specialised Consult Liaison teams helped with efficient responses to queries. Establishment of documented pathways and relationships between the palliative care team and Community Mental Health is vital. To enable this, clear referral pathways and a structured triage process are needed. This should outline appropriate referrals to palliative care psychology and include an "out-of-scope" component to redirect patients to external services when required, ensuring safe and appropriate use of resources.

Other comments/information
When a patient, or their family, is facing significant emotional, social, or existential distress due to a progressive, life-limiting, or terminal illness, referrals to a Palliative Care Psychologist are appropriate. Establishment of a clinical relationship is vital to the success of this support. Those people connected to palliative care temporarily for symptom control may not be best supported by referral to the palliative care psychologist and other options should be considered first.