Quality improvement themes from coronial recommendations received by the Chief Psychiatrist in 2008

Chief Psychiatrist Information

Purpose

This information is a summary of themes from the coronial recommendations over the 2008 calendar year. It is intended to inform quality improvement activities and assist services to focus on key practice improvement areas.

Introduction

Under the provisions of the *Mental Health Act 1986*, mental health services are required to notify the Chief Psychiatrist of the death of any patient that is a reportable death within the meaning of the *Coroner's Act 1985*. The Chief Psychiatrist registers an interest with the coroner regarding the findings arising from any coronial inquest or inquiry into these deaths. The Chief Psychiatrist is in a unique position to review these findings and to identify emerging themes across the service system. Currently the Chief Psychiatrist publishes regular summaries of coronial findings for the mental health sector – these summaries draw together the key clinical practice and standards issues for a given period and highlight areas for ongoing quality improvement action. Services are encouraged to review their local practices and procedures and implement action plans to address the issues identified.

Community Treatment Orders

There have been a number of Coroner's recommendations in 2008 regarding the management of patients on a Community Treatment Order (CTO) following their discharge from Acute Inpatient Units.

1. Following the death of a 35 year old female on a CTO after suffering multiple injuries sustained following a train accident, the coroner recommended that there should be a review of protocols and procedures to ensure that community-based case managers and the Crisis Assessment Teams are involved in the planning and management of patients' return to community treatment.

Chief Psychiatrist's comments

This recommendation from the coroner is perfectly reasonable and should be part of any discharge planning procedure for any patient including a patient on a CTO and is in keeping with the *Chief Psychiatrist's Discharge Planning Guideline CPG 02081.*

2. Following the death of a 39 year old man who committed suicide by a gunshot wound to his head, the coroner recommended an improvement of policies and procedures regarding the support of persons on Community Treatment Orders and their families including education and referral to additional external supports such as mental health social supports agencies and/or counselling. He made following further comments in his recommendation:

- Discharge planning procedures and documentation to identify family and/or support persons. Discuss whether patients would be willing to give informed consent for clinicians to liaise with identified family/carers. Consider the capacity of family/carers to provide the level of support required. Identify education and support needs of family/carers.
- Referral protocols should be established between Mental Health Services and support agencies. Ideally there should be a referral process that involves the support service following up directly with the family after the referral is made. This would ensure that contact is actually made.
- Case Management guidelines should require case managers to assess whether or not additional avenues for patient support and education are required in addition to case management. Case managers should work with other agencies that may in some circumstances be more conducive to providing the required support and education in addition to that provided through case management.

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Chief Psychiatrist's comments

This is another perfectly reasonable recommendation by the coroner and is in keeping with the *Chief Psychiatrist's Discharge Planning Guideline CPG 02081.*

3. In relation to the above case the coroner further recommended that pharmacies should be able to advise mental health services when CTO patients have failed to collect prescribed medication, a possible indication that patients are being non-compliant.

Chief Psychiatrist's comments

This is a good idea but difficult to enforce as the patient on a CTO can access different pharmacies. If it can be made a condition of the CTO that the patient does go to a particular pharmacy, then the pharmacy can report to the Mental Health Service concerned.

4. A further recommendation following on from the above was that Mental Health Services arrange blood samples for testing of serum levels are collected from CTO patients while they attend their psychiatric clinics, rather than requiring patients to attend separate pathology clinics when supervision is more problematic.

Chief Psychiatrist's comments

This recommendation is worth considering for individual patients when such a service may make a difference in monitoring serum levels of medication, their compliance and side effects.

5. Yet another recommendation to do with the same case was that, given the propensity for CTO patients suffering from chronic schizophrenia to be released home following short psychiatric stays, DHS examines this issue with the object of providing CAT and other teams with appropriate guidelines as to whether and in what circumstances a home search for prescription drugs may be legally possible. Such ability would equip CAT and other teams to more effectively manage chronically ill patients who are to be given early discharge than is currently the case.

Chief Psychiatrist's comments

The Chief Psychiatrist does not support this recommendation as it would be a breach of the patient's freedom and human rights.

Services are referred to the *Chief Psychiatrist's Community Treatment Guideline (CPG 01111)* and *Discharge Planning Guideline (CPG 02081)* which would be useful in relation to the above recommendations from the Coroner.

Chief Psychiatrist

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