Quality improvement themes from coronial recommendations received by the Chief Psychiatrist in 2011

health

Chief Psychiatrist information

Purpose

The Chief Psychiatrist has compiled this summary of themes emerging from coronial recommendations made during 2011 for mental health services. It is designed to help inform quality improvement activities in mental health and to assist services to focus on key areas for practice improvement.

Background

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 2008. 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. The Chief Psychiatrist publishes regular summaries of coronial findings for the mental health sector. These summaries draw together the key clinical practice and standard issues for a given period and highlight areas for ongoing quality improvement. Services are encouraged to review their local practices and procedures and implement action plans to address the issues identified.

Management of inpatients

A 39-year-old man committed suicide in an inpatient unit by hanging from an ensuite door. He had an extensive history of substance abuse, mental health issues and multiple suicide attempts. Largely because of his denial of any current suicidal ideation it was determined that the patient would be managed in the low dependency unit. A search of the deceased's room by staff after the death located a syringe that appeared to contain blood and a metal spoon that was blackened at the base. Samples taken from the deceased at autopsy showed the presence of moderate levels of Oxycodone.

Coroner's recommendations

1. A reappraisal of the criteria for admission to the low dependency unit for those persons found to be at risk of self harm.
2. Clearer protocols for the searching of patients on admission or return from leave.
3. Engineering and procedural investigation and change to eliminate, as far as possible, the means of self-harm being available to those at risk.
4. Changes to the handover procedures between nursing shifts and a coordination of observation rounds and handovers.
5. Education of clinical staff to identify and, if possible, resolve inconsistencies between patient history and test results, for example urine drug screening.

Chief Psychiatrist's comments

We support these recommendations. We recognise that determination of level of observation and placement in a unit are complex decisions, especially where there is longstanding risk of self harm. It may be appropriate to have in place protocols to guide more intensive observation or specialling of patients in the open ward. The Chief Psychiatrist is developing a guideline to assist services in the conduct of searches of patients and their property.

Discharge and transfer of patient care

Discharge planning and adequate transfer of care from one service to another following inpatient care was the theme of recommendations made following the suicide of a 30-year-old single mother of a three-year-old boy. The comments made by the Coroner provide some background to the case and the basis for the recommendations.

Coroner's comments

1. It is clear from the evidence that there had been attempts made by public mental health services to engage with the deceased and to provide her with appropriate mental health treatment and support. However, it is also apparent that the clinical decision making was constrained by the multiplicity of teams involved in the care and the lack of appropriate mental health beds being available to patients in crisis.

2. The seriousness of the client's clinical condition was not readily apparent and not able to be fully assessed within the limited time frames available for diagnosis and observation in the community. The diagnosis suffered from the absence of an examination by a psychiatrist at any stage in the process and by the lack of co-ordinated and complete diagnostic information being available to the assessing clinicians. The multiplicity of mental health services and division of responsibility between areas and consequent handover from one service to another adds to the complexity of care delivery and the potential for accurate or complete information about a patient to be overlooked.
3. I am satisfied that there was a failure to integrate all of the clinical information which was available in relation to the deceased, which may have enabled a proper and accurate diagnosis of her mental health status and in particular her risk of self harm. There was a lack of inquiry of the GP and the psychologist in relation to clinical history and lack of follow up of either.
4. It does not appear that the deceased was assessed by a psychiatrist at any time during any of her admissions or during the period in which care was provided by the mental health team. It would seem that an assessment by a specialist psychiatric clinician ought to be an appropriate and necessary step before a decision is made that a patient is to be safely discharged into the community, particularly when they are to be at home without a responsible adult being present.
5. There was no notification made to the father of the three-year-old child or to child protection services as to any protective concerns after the first attempt by overdose, nor at any time until after the final act, which resulted in the client's hospitalisation and ultimate death.
6. The client was at home with the child without anyone present to directly provide care or supervision. The child was received back into her care in a context where the mother had just one day previously taken an overdose. The child was on the premises and in the presence of the mother when she ingested the poison, which ultimately took her life. It is unacceptable that a child should be placed in the circumstance that this child was placed. There is no evidence that any consideration was made of the protective interests of the child. The only consideration made in relation to the child was to his value in contributing to the safety of the mother. The priority and assessment was misguided and had the potential to result in serious harm to the child.

Coroner's recommendations

1. Review of mental health practices in relation to the transfer of management of patients as between the regional mental health services with a view to ensuring provision of accurate and current health status information.
2. Review the level of supervision and follow up care required to be put in place prior to a mental health patient being discharged to community care.
3. Review the process and appropriateness of telephone assessments being undertaken by CAT teams of a mental health patient in the absence of prior direct contact with the assessor and that self reporting of 'well being' not be regarded as a reliable measure of safety in this context.
4. Review mental health service practices in relation to the discharge and supervision of mentally ill persons, where they have care and responsibility for children under the age of 16 years and ensure that adequate supervisory mechanisms, including appropriate protective notifications are in place.

Chief Psychiatrist's comments

Recommendation 1

There are legal requirements that have to be fulfilled under the Mental Health Act 1986 when involuntary patients are transferred from one service to another. The legal requirements also include the necessary transfer of clinical information. The Chief Psychiatrist has issued a guideline on 'Information sharing between AMHS and PDRSS' (CPG100401), which outlines the principles of information sharing between services. There is also a program management circular 'Accessing services across regions and areas' (PMC99123), which contains further information for services. It is also good practice to provide information to other relevant service providers including the client's general practitioner.

Recommendation 2

The Chief Psychiatrist endorses this recommendation. The Chief Psychiatrist has issued a guideline on 'Discharge planning guidelines' (CPG02081), which addresses the issues raised in this recommendation. There is also a program management circular 'Discharge planning and the development of protocols between AMHS and GPs' (PMC05051).

Chief Psychiatrist's comments (continued)

Recommendation 3

The Chief Psychiatrist agrees that telephone assessments do not replace face-to-face contact when assessing a person. If the telephone assessment by triage indicates the need for CATT assessment, this should be face-to-face. The department has two program management circulars which relate to this topic: 'Mental health triage' (PMC03101) and 'Mental health responses in emergency departments' (PMC080201). In addition, the department has released a document on 'Working with the suicidal person. Clinical practice guidelines for emergency departments and mental health services', which outlines the principles for assessing suicidal patients.

Recommendation 4

We have been working closely with Child Protection in relation to vulnerable children. The Chief Psychiatrist has recently released a circular to provide guidance to mental health services on implementing priority service access for infants, children and young people placed in out-of-home care (CPG1107016). The thrust of this recommendation, however, is directed to services' responsibility to consider whether a mentally ill patient is well enough to resume parenting responsibilities; and whether appropriate supports for the children and parents are in place.

Risk Assessment

S. was aged 34 and on a community treatment order when she died. Her three children lived with their father. She had been distressed about the custody of her children following a recent Children's Court hearing. After threatening to hang herself, the police were called and arranged for her to be taken to hospital for a psychiatric assessment. A few hours later she was sent home from the hospital. Two days later she was found hanging by her partner.

Coroner's recommendations

1. To improve the safety of patients with mental health issues who are in crisis, the mental health service should review the current guidelines for patients who present to the organisation's emergency departments to:
   - comply with the Department of Health 2010 guideline on Working with the suicidal person. Clinical practice guidelines for emergency departments and mental health services. Particular emphasis should be given to ensuring that the assessment of patient risk of self-harm and completion of a mental state examination are identified and clearly articulated; and
   - develop clear guidelines for the timely review by community mental health services for patients who have undergone assessment and are consequently discharged.
2. To improve the safety and engagement of the patient, and to mitigate the risk of clinical deterioration, the mental health service should review current guidelines regarding how best to support a case managed patient on a community treatment order when there are custody issues pertaining to the patient.

Chief Psychiatrist's comments

The Chief Psychiatrist supports these recommendations.

Trans-cultural issues

The Coroner raised issues and made a number of recommendations about the assessment of patients from culturally and linguistically diverse (CALD) backgrounds following the suicide by hanging of a 40-year-old man of Lebanese descent. The Coroner felt that the pre-requisite of assessed imminent and significant risk that the person may cause serious harm to himself when a decision is made about involuntary treatment may be difficult to accurately assess in patients who have different cultural and language backgrounds, who have little insight into their condition or who otherwise seek to avoid treatment.

Coroner's recommendations

1. The Psychiatry Unit should take into account patients' reasons for seeking discharge, personal and cultural background and prior admissions when they determine whether or not to discharge them from an involuntary treatment order without a community treatment order.
2. That the Chief Psychiatrist encourage allocation of mental health clinicians with relevant language and cultural backgrounds to assist in accurately assessing chronic and acute risk of serious self-harm.
3. That the Minister for Mental Health create more positions for community mental health clinicians with an emphasis on recruiting clinicians from multicultural backgrounds.

Chief Psychiatrist's comments

These recommendations have implications for the allocation of funding and workforce. We support culturally sensitive practice and the use of interpreters when indicated.

Referrals by general practitioners and across catchment areas

Following the suicide of a 47-year-old single female by overdose of prescribed Risperidone, the Coroner made a number of comments connected with the death. The patient had a history of several psychotic episodes, depression, hypertension, gastro-oesophageal reflux disorder and hyperlipidaemia. Her GP had great difficulty in accessing urgent psychiatric assessment and this was complicated by the fact that the client had moved residence recently and the previous mental health service would not see her on that account.

Coroner's comments

1. Whatever may have been the referral processes, it appears that the general practitioner experienced difficulty in locating an immediate response mental health assessment and treatment option for the patient.
2. This criterion for determining whether a person receives treatment from a service, relying as it does, not on their history of receiving service, or indeed absent any factors relating to the convenience of the patient, but rather map driven geographical boundaries, militates against the provision of quality care and may be a disincentive to mental health patients to engage with services.
3. In this case the patient expressed her desire to attend a service she had previously attended with clinicians with whom she was familiar. She expressed reluctance to attend at a 'new' location. It would seem apparent that some consistency of service provision for a mental health patient would be a useful treatment tool and may have engaged the patient in the process — although no conclusion may be reasonably drawn that it would have prevented the death.
4. Mental health patients are not infrequently transient or homeless, often as a result of behaviours arising from their mental illness. In this case, a referral issue arose because of the patient's residential address change. For the mental health service provision to be dependent upon residential address would, given these factors, seem to be counter-productive.
5. It was acknowledged in the statement from the health service, that the GP was seeking immediate assessment. Notwithstanding this, there was no immediate clinical team available to see the patient and it was proposed that assessment would take place six days later. Whilst this no doubt arises as a result of the resources available to public mental health services, the intervention of a GP in referring a person for 'immediate assessment' would suggest that the matter requires more urgent assistance than six days into the future.

Coroner's recommendations

That the Secretary, Department of Health, review mental health service practices in relation to the patient's residential address being the determinant of the location of care. In particular in relation to patients with prior attendance history at an area mental health service.

That the Secretary, Department of Health, review the manner in which referrals by general practitioners to public mental health services are made and prioritised or triaged, to ensure that GPs, as frontline mental health providers, have access to appropriate levels of support and assistance when making referrals.

Chief Psychiatrist's comments

Recommendation 1

The department has embarked on a process to review the current configuration of services across geographical areas and develop a plan for change. This will help to create more integrated services and ensure that more Victorians are able to receive support from the services closest to where they reside. The plan is to actively engage service providers and consumers in the review.

Recommendation 2

The Chief Psychiatrist accepts the principle that GPs as frontline mental health service providers should have access to appropriate levels of support and assistance when making referrals.

Services for patients with dual diagnosis or personality disorders

The Coroner made the following comments and recommendations following a suicide by hanging of a 30-year-old man with substance use disorder, anti-social personality disorder and more recently with depression and anxiety. The deceased had multiple admissions to various mental health services in Victoria and NSW. It is apparent from the medical records that he had a consistent history of discharge from inpatient mental health units after minimal admission periods, where medical issues such as toxicity of overdose were addressed. There was little or no follow up for drug and alcohol issues and discharge was effected as soon as he was assessed as not being at immediate risk of self harm. It also appears that the diagnosis of anti-social personality disorder meant that he was not regarded by mental health services as mentally ill and hence intensive public mental health services were not available.

Family members provided evidence that they had struggled to obtain assistance from the mental health and drug and alcohol services systems, which they had experienced as 'divided' in terms of the treatment options made available.

Coroner's comments

1. One of the issues which arose in this proceeding is the inability of health services, including mental health and drug dependency services, to detain persons with substance abuse disorders. Whilst there is provision under the Alcoholics and Drug Dependent Persons Act (sections 11, 12) to detain a person for treatment, (including a voluntary admission for a minimum of three months), the evidence is that these provisions are rarely used and that there are no facilities available in which such persons might be detained.
2. Evidence was given that since the introduction of the Mental Health Act 1986 and the consequent closure of public mental health institutions, there has been a lack of long term inpatient beds available to treat mental health patients. Given the complexity and long-term nature of care needed by dual diagnosis patients, the lack of long-term inpatient facilities and the lack of inpatient longer stay detoxification facilities such as those contemplated under the Alcoholics and Drug Dependent Persons Act, militates against the provision of this care.

Coroner's recommendations

1. That the public health authorities work towards the development and provision of integrated dual diagnosis services for those with mental illness (including personality disorders) and substance dependency and that those services be made available to those being treated in both the public and private mental health systems.
2. That the provision of mental health services to persons diagnosed with personality disorder be reviewed to ensure that a consistent approach to the characterisation and classification of personality disorder as a mental illness is adopted by public mental health services in Victoria.
3. That the effectiveness of the operation of the Alcoholics and Drug Dependent Persons Act 1968 be enhanced by the provision of long term inpatient involuntary and voluntary treatment beds for persons with alcohol and drug dependency.
4. That a review be undertaken of the operation of the Alcoholics and Drug Dependent Persons Act 1968 to ascertain its effectiveness in enabling the detention and enforced treatment of persons unable to function in the community as a result of alcoholism and/or drug dependency.

Chief Psychiatrist's comments

The former Department of Human Services undertook an extensive review of the above mentioned act in 2005. As a result the 'Severe substance dependence treatment act 2010' has been enacted. This includes, in section 8, provisions for the detention and treatment of persons who meet the criteria. It should be noted that current policy and practice do not support long-term secure involuntary treatment for severe substance dependence.

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