Care of patient with an intellectual disability and mental health issues (10HDC00396, 18 June 2012)

District health board ~ Mental health services ~ Needs assessment agency ~ Disability support service ~ Multi-agency involvement ~ Mental Illness ~ Self-harm ~ Right 4(1)

This case relates to the care provided to a woman who had an intellectual impairment and lived at home with her parents with the support of a community support agency. The woman frequently contacted emergency services declaring that she intended to kill herself because she did not want to continue living with her parents. The community agency was attempting to find her an alternative residence.

For the three years prior to her death, the woman came to the attention of the police and the public hospital on numerous occasions because she had self harmed or was picked up wandering at night. She had been seen on many occasions by the DHB's Crisis Assessment and Treatment Team (CATT) and the Emergency Department (ED). On each occasion, the woman was assessed as not having a mental illness and as being at low risk of self-harm. Her behaviour was attributed to her intellectual impairment and her desire to find alternative accommodation.

Early in the last year of her life, the woman, who had previously lodged claims with ACC, reported another incident. The community agency supported her in making a further ACC claim so that she could receive counselling. ACC arranged for the woman to be assessed by a clinical psychologist, who recommended a referral for counselling for the woman to be made "via the psych services contract" due to the need for specialist intervention. The psychologist recommended that there would be a need to work outside counselling with community agencies, and the GP, to effect referral to the dual diagnosis team.

ACC obtained a psychiatric report which identified that the woman had several Axis 1 disorders, the major diagnosis being Panic Disorder. The psychiatrist did not agree with previous opinions that the underlying cause of the woman's erratic behaviour was her intellectual disability. These reports were not provided to the DHB.

Over the next two months, the woman presented frequently to CATT. On two occasions she self-harmed, and the community agency found her respite care for several days.

At this time, the woman again came to the attention of CATT and the police when she reported taking an overdose. She was assessed at the ED and arrangements were made to take her home to her parents, but the woman left before arrangements could be finalised.

Two days later, the police found the woman wandering. She was assessed by CATT at the police station and cleared for release. The woman was returned home by the police, but immediately ran away. Sadly, two days later, the woman's body was found.

The DHB acknowledged that diagnostic overshadowing (the tendency of clinicians to overlook mental health symptoms in a person with an intellectual disability) was a possible feature in this case which, together with the mental health service's differing

levels of expertise in identifying mental health issues in people with an intellectual disability, resulted in the service failing to adequately assess the woman and appropriately refer her to a dual diagnosis team.

It was held that the DHB failed to identify a lead provider, recognise the differing levels of expertise of its staff, provide appropriate dual diagnosis guidance to its CATT staff and thus ensure a referral to the dual diagnosis consult-liaison team. These failures resulted in the woman not being provided with services with reasonable care and skill. Therefore the DHB breached Right 4(1).