

**Communication between DHBs in relation to
mental health care of itinerant patient
(07HDC14286, 27 February 2009)**

District health board ~ Psychiatrist ~ Mental health services ~ Itinerant patient ~ Communication ~ Schizophrenia ~ Drug abuse ~ Follow-up ~ Continuity ~ Rights 4(1), 4(5)

The family of a 40-year-old man complained about the care he received from Southland District Health Board (DHB). The man was a long-term client of mental health services, and had a primary diagnosis of paranoid schizophrenia and polydrug abuse. He was documented as being non-compliant with medications and treatment, and having limited insight into his condition. He lived an itinerant lifestyle and received psychiatric care and treatment from a number of district health boards.

The man presented to the Southland DHB acute mental health unit seeking admission. The consultant psychiatrist conducted a brief assessment of the man, who then became violent towards the consultant, resulting in the Police being called and the man being detained. The psychiatrist reported that when he assessed the man, he observed no evidence of schizophrenia and assessed his behaviour that day as likely due to antisocial and drug-seeking behaviour.

The man was assessed by two other mental health professionals two days later on the order of the court, and their opinion about his presentation was similar to that of the consultant psychiatrist. A month later the man came to the attention of the Dunedin police again and was admitted to Otago DHB's Regional Forensic Psychiatry Service. A week later, he underwent a mental state examination by a different consultant psychiatrist, who determined that the man was suffering from paranoid schizophrenia.

It was held that Southland DHB breached Right 4(1) by not conducting an accurate and thorough assessment of the man, which then influenced future handling of his care by other providers within the DHB. Consultation with his family did not occur, which meant that signs of relapse were missed or treated as drug-induced anti-social behaviour, instead of his primary illness of schizophrenia.

Furthermore, continuity between providers coming into contact with the man was also poor. Failure to use follow-up meetings to verify previous decisions, the DHB's lack of coordination around his care, and the failure to share relevant information with Otago DHB resulted in a breach of Right 4(5).