

Southland District Health Board

**A Report by the
Health and Disability Commissioner**

(Case 07HDC14286)



Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A	Consumer
Ms B	Complainant/Mr A's sister
Dr C	Provider/Psychiatrist
Dr D	Consultant psychiatrist
Mrs E	Mr A's sister
Ms F	Southland DHB Community Forensic Nurse
Dr G	Otago DHB Mental Health Services and Intellectual Disabilities Clinical Director
Southland District Health Board	Provider
Otago District Health Board	Provider

Complaint

On 13 August 2007, the Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided to her brother, Mr A, by Southland District Health Board. Mr A supports this complaint. The following issue was investigated:

- *The appropriateness of care provided to Mr A by Southland District Health Board from June to July 2007.*

An investigation was commenced on 25 March 2008.

Information reviewed

Information was received from: Southland District Health Board (Southland DHB), Otago District Health Board (Otago DHB), Dr C and Ms B.

Independent expert advice was obtained from a general and forensic psychiatrist, Dr Peter Miller, and is attached as **Appendix 1**. Southland DHB was invited to respond to Dr Miller's report. Dr Miller provided additional advice (attached as **Appendix 2**) in response to Southland DHB's response to his initial report.

Overview

Mr A, who was 40 years old in 2007, is a long-term client of mental health services. He has a primary diagnosis of paranoid schizophrenia and polydrug abuse. Mr A is documented as being non-compliant with medications and treatment, and as having limited insight into his condition. Because of this, Mr A's treatment has tended to be provided under the compulsory treatment order sections of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

On 26 June 2007, Mr A was detained by the Police while seeking admission to Southland DHB's acute mental health unit. Consultant psychiatrist Dr C had conducted a brief assessment of Mr A before the Police intervention. Dr C reported that he observed no evidence of schizophrenia and assessed his behaviour that day as likely due to antisocial and drug-seeking behaviour.

On 24 July 2007, Mr A was admitted to Otago District Health Board Regional Forensic Psychiatry Services at Wakari Hospital. On 9 August 2007, Mr A underwent a mental state examination by consultant psychiatrist Dr D. Dr D determined that Mr A was suffering from paranoid schizophrenia.

Dr D and Mr A's sister, Ms B, a psychiatric nurse, expressed their concern regarding Dr C's assessment, and the management of Mr A by clinicians at Southland DHB in June 2007. Ms B is concerned that the overall care Southland DHB provided to Mr A was inconsistent, and that staff did not maintain sufficient liaison with the family.

Information gathered

Background

Mr A is itinerant and has received psychiatric care and treatment from a number of district health boards, mostly in the South Island and lower North Island. Mr A began to experience psychotic symptoms from age 15 onwards. His first admission for acute mental health care was to Wakari Hospital in Dunedin in 1997, when he was first diagnosed with schizophrenia. He has maintained contact with, and often resides with, his extended family, in particular family living in Invercargill. Consequently Mr A has had frequent contact with Southland DHB's mental health services.

The family has been concerned for some time about the treatment and care Southland DHB mental health services provided to Mr A. The Southland DHB mental health clinicians consider that Mr A's "intimidating, challenging and threatening" behaviour is related to his substance abuse and drug-seeking behaviour. The clinicians believe that inpatient treatment for Mr A is "counter-therapeutic" and likely to increase the potential for aggression toward staff.

Ms B has expressed her concerns in writing to Southland DHB. Southland DHB staff have met with the family to discuss their concerns and continue to keep in contact with the family about Mr A.

June to July 2007 — contact with Southland DHB mental health services

On 20 June 2007, Mr A contacted Southland Hospital to advise them that he was back living in Invercargill. Mr A said that he had not taken any medication for six months and became irritable when told there would be a delay while the mental health emergency team contacted Otago DHB to retrieve information about his medication. He demanded to be admitted to acute care. Southland Hospital mental health services alerted the Director of Area Mental Health Services (DAMHS), Otago and requested documentation on Mr A's most recent compulsory treatment order and current medication regime.

On the morning of 26 June 2007, Dr C was the locum consultant psychiatrist at Invercargill Hospital outpatient/community clinic.¹ Dr C was advised that it was likely that Mr A would present at the hospital that day seeking treatment. He briefly reviewed Mr A's clinical records.

When Mr A arrived at the hospital, Dr C agreed to see him. Mr A was aggressive, abusive and threatening, and demanded medication. He stated that he would damage property if he was not admitted immediately into acute care. Mr A threatened to "smash" the staff and Dr C. Dr C terminated the assessment and requested Police assistance. When Mr A was arrested, one of the Police officers was injured and Mr A was pepper sprayed. Dr C contacted the clinical director to inform him of the incident.

Dr C stated that the Police contacted him later that day to ask him to prepare a statement. Before doing so, Dr C reviewed Mr A's file and called Wakari Hospital to obtain information about his last admission. Dr C wanted to know why Wakari Hospital had discharged Mr A with a fortnightly prescription of haloperidol decanoate 25mg. Dr C spoke to a female nurse who did not know Mr A well. Mr A's primary nurse was not on duty and his consultant psychiatrist was on leave. Dr C asked the nurse to fax him Mr A's notes. The nurse took a message for the psychiatrist to call Dr C, but the psychiatrist did not return the call.

However, Dr C received a faxed copy of Mr A's Wakari Hospital notes, which he reviewed. He wrote a brief summary headed, "Statement for the Invercargill Police", which detailed the events of 26 June when Mr A presented at East Invercargill

¹ At the time of these events, Dr C was providing a locum service for Southland DHB. It comprised an outpatient/community clinic from 8.30am to 5pm at the mental health services' building at Southland Hospital, and occasional emergency assessments. During that time, Southland DHB provided Dr C access to weekly peer review meetings, which other consultant psychiatrists from the service attended. Dr C stated, "Throughout the [time] I worked there I felt supported and well treated by the management and clinical staff at Southland DHB. ... The work load, whilst intensive at times, was within what I consider to be reasonable for an experienced specialist psychiatrist."

Community Mental Health Clinic. Dr C noted that Mr A was “verbally aggressive and threatening” towards the clinic staff and the Police and had to be pepper sprayed in order to subdue him. Dr C did not offer an opinion about a diagnosis for Mr A. In the clinical notes for that day, Dr C noted that Mr A was “not forthcoming” regarding his symptoms.

Dr C wrote a further statement, dated 27 June, headed “To whom it may concern”. In that statement Dr C noted that he had briefly assessed Mr A on 26 June and viewed his psychiatric notes “in this service”. Dr C stated:

“From my brief interaction with him yesterday, I could not elicit any symptoms or signs in the category of a schizophrenic disorder. On review of the notes I am not convinced that this is his main diagnosis, but there is plenty of evidence of an antisocial personality. Further reinforcing my opinion, is his medication on discharge from Wakari Hospital in Dunedin. The medication he was discharged on, Haloperidol Decanoate 25mg every two weeks is far below the therapeutic dose used to treat psychotic disorders like schizophrenia. It is also of note that [Mr A] is a poly substance user and those substances themselves can lead to brief psychotic episodes that might mimic the symptoms of schizophrenia if not assessed on a longitudinal basis.”

Dr C has since clarified that he did not think that Mr A did *not* suffer from schizophrenia. Rather, his “impression, shared with other clinicians, was that Mr A’s main problem was antisocial personality”.

On 28 June, while in Police custody, Mr A was reassessed by a forensic nurse and a nurse from the Southland Mental Health Emergency Team (SMHET). Both nurses knew Mr A from previous contacts. They found him to be irritable but logical in conversation and not delusional. He was not reporting any auditory or visual hallucinations. Consistent with Dr C’s observation a few days earlier, the nurses found no evidence that he was suffering from mental illness at that assessment.

Mr A appeared in the Invercargill Court and was bailed with the conditions that he was not to consume alcohol or drugs or to go onto Southland DHB property unless in an emergency situation. He went to stay with another of his sisters, Mrs E.

Ms F, Southland DHB Community Forensic Nurse, arranged for Mr A to be reviewed by a forensic psychiatrist on 6 July. However, when the Southland DHB mental health staff attempted to contact Mr A to offer him transport to that appointment, they were unable to locate him. Mr A did not keep the appointment.

Mrs E was notified of these developments by the community mental health team leader. She advised that Mr A was at her home, and was calm and rational.² Mrs E reported that he was continuing to use drugs and was unlikely to report to the Police station that day, even though it was a condition of his bail.

Half an hour later, Mrs E telephoned the team leader and said that Mr A was upset that she had been contacted by the hospital. He was agitated but Mrs E believed there was no risk. She said she would contact the emergency team if necessary over the weekend. Mr A did not attend further appointments or meet his Police bail requirements and became increasingly agitated.

July 2007 — Compulsory treatment at Wakari Hospital

On 11 July, the Otago Director of Area Mental Health Services made an application to the Southland District Court for a warrant under section 113A of the Mental Health (Compulsory Assessment and Treatment) Act 1992 to detain and treat Mr A. However, before this could be acted on, Southland DHB mental health services received a call on 12 July from the Otago DHB forensic services to advise that Mr A was in Dunedin and in Police custody. The Police were concerned about Mr A's mental state and organised a medical examination.

On 16 July, Otago DHB's Regional Forensic Psychiatry Services consultant psychiatrist, Dr D, interviewed Mr A at Dunedin Prison. Dr D determined that Mr A has a "chronic and relapsing mental illness ... best described as paranoid schizophrenia". Dr D contacted Ms B, who described her frustration in being unable to obtain treatment for her brother.

On 24 July, Mr A was admitted to Ward 9B, Wakari Hospital, and remained an inpatient for five weeks. During this time, Mr A was placed under a compulsory treatment order (CTO).

On 28 July, the Court Liaison Nurse asked Ms F to assess Mr A, who had been "recently released from Ward 9B Wakari Hospital". Ms F noted that the conditions of Mr A's bail were that he was to have no contact with Dr C and not to go to Southland DHB unless in an emergency. Ms F noted that, at the time of her assessment, Mr A was not displaying any evidence of delusional content in his conversation and "no evidence of overt psychotic symptomology". He did not appear "anxious, paranoid or responding to any auditory/visual hallucinations". Ms F noted her plan to advise the Court of her findings that Mr A appeared fit to plead and had no evidence of mental illness.

² Dr C subsequently commented on Mrs E's impression of her brother at that time, that he was calm and rational although he continued to use drugs. Dr C stated, "A schizophrenic disorder that remains in remission for such a lengthy period without treatment, particularly in stressful circumstances, is extremely uncommon. Mr A had not had any treatment since leaving Wakari Hospital and only showed psychotic symptoms at a later stage." Dr C believes that these symptoms confirm his earlier assessment.

August 2007 assessment

On 9 August 2007, Dr D assessed Mr A's fitness to stand trial. Dr D reviewed Mr A's available clinical records and Police history. Dr D noted that Mr A believed his recent mental health problems were because he had discontinued his medication. He provided Dr D with an overview of his spiritual beliefs and said that the voices from the spiritual world he could hear were intrusive but "intense, exciting and exhilarating" and caused him to converse or shout in response to them. Dr D stated: "There is strong evidence to suggest that [Mr A] was psychotic at the time of his presentation to Southland Hospital."³

Dr D noted that Mr A had only partial insight into his mental health condition. He appeared unable to understand that some of his perceptions and experiences were abnormal. Mr A accepted that medication reduced his audio hallucinations and was, therefore, willing to continue to take medication.

Dr D paid particular attention to Mr A's long-term history of chronic and relapsing mental health, and considered Mr A's manifestations of irritability and increasing aggression as symptomatic of untreated mental illness. In Dr D's view, at the time of Mr A's presentation at Invercargill Hospital he was manifesting significant symptoms of psychosis associated with untreated schizophrenia, characterised by delusions, auditory hallucinations (which had been noted during his admission to Wakari Hospital earlier in the year), compounded by marijuana use. Dr D's primary diagnosis was paranoid schizophrenia, of such severity that Mr A was unable to care for himself and, untreated, posed a serious threat to others including his family and caregivers. Dr D recommended that Mr A continue to receive treatment at Wakari Hospital under a CTO, with a view to eventual discharge into community care.

Discharge from Wakari Hospital

In August 2007, Mr A was discharged to boarding house accommodation under a CTO. Currently Mr A lives in Dunedin, and is under the care of Otago DHB's mental health services. He has had no further contact with Southland DHB's mental health services.

Southland DHB response

Keeping family informed

Southland DHB advised that there was frequent contact with the family when Mr A was assessed and treated by the mental health service. The family member identified in the clinical records, and by Mr A himself, as the contact person was his sister, Mrs E. She was the person Southland DHB mental health services contacted as required. The mental health team also has contact with the complainant, Ms B, although less frequently.

³ Dr C subsequently commented that Dr D's opinion of Mr A based on his August 2007 assessment was a "retrospective view" and is "at odds with the opinions of three experienced health professionals, at least two of whom knew Mr A, and a family member".

Risk of harm

Southland DHB advised that its mental health services did not underestimate Mr A's potential to seriously harm someone. Southland DHB accepts Ms B's view that when her brother is unwell and under the influence of illicit substances, he poses a risk. However, the DHB noted that Mr A is not always unwell, and that because of his itinerant lifestyle, Southland DHB is only intermittently involved in his care.

The diagnosis of paranoid schizophrenia is clearly documented throughout Mr A's clinical file by a number of mental health professionals. Symptoms of schizophrenia are noted to be of variable intensity, which fluctuate between obvious psychosis and reports of no or minimal evidence of these symptoms.

Otago DHB Mental Health Services and Intellectual Disabilities Clinical Director Dr G advised that when Mr A was discharged from Wakari Hospital on 7 March 2007 and failed to attend follow-up, Wakari Hospital staff tried to locate him by liaising with the Southland and Otago mental health services, his probation officer and his family. In addition, a Director of Area Mental Health Services national network alert was posted.

The opinion of the Southland DHB's mental health services clinicians is that when Mr A is under the influence of illicit substances and not necessarily displaying acute signs of mental disorder, he poses a risk to the physical safety of others. He also exhibits antisocial personality traits. The combination of dual diagnosis and antisocial personality traits creates a risk profile and there are times when it is appropriate to involve other agencies, such as the Police, in managing Mr A.

Failure to treat

Southland DHB regrets that the family considers that its mental health services staff has sometimes failed to treat Mr A. The clinical notes indicate ongoing and consistent dialogue with Mr A's family, especially Mrs E. Despite Mr A indicating at times that he does not want his family involved in his treatment, staff continue to make and maintain contact with his family. Southland DHB has attempted to provide an appropriate level of service in response to both Mr A's needs and the family's concerns. As an example, when Mr A presented to Southland DHB's mental health services in 2007, he was assessed by the outpatient psychiatrist, the community mental health team coordinator, a registered nurse, the forensic nurse and the SMHET nurse (who knew Mr A from previous contacts with the service). The results of these assessments were consistent in that they did not find Mr A mentally unwell.

When the forensic psychiatrist reviewed Mr A's file, it was considered that Mr A needed to be admitted, and arrangements were made to obtain a bed, although this was unsuccessful at the time owing to bed shortage.

Response to expert advice

Southland DHB accepts that there should be more consistency between Southland DHB mental health services and Otago DHB mental health services in the approach to

Mr A's care: "We do believe that this is an issue that the family has appropriately raised regarding lack of coordination between the two DHBs and access to relevant and timely information." This has been acknowledged to Ms B, via her brother's case manager, with a reassurance that Southland DHB mental health services will address the inconsistencies.

Although Mr A has not presented to Southland DHB mental health services since July 2007, changes have been made. Southland DHB intends to ensure consistent approaches are taken by both DHBs in relation to Mr A's future presentations. The SMHET manager has been tasked with:

- gaining current information about Mr A to hold as reference
- obtaining a copy of the Otago DHB case manager's care plan for Mr A in order to take this into account when Southland DHB devises a care plan for Mr A
- formulating a care plan for Mr A should he represent to Southland DHB
- taking into account, when developing the care plan, the developing diagnostic picture and presenting signs and symptoms when Mr A becomes unwell.

Memorandum of Understanding

A Memorandum of Understanding (MOU) between Southland DHB mental health services and Otago DHB mental health services has been formulated (attached as **Appendix 3**). The first MOU was approved in April 2005. A revised version is now in place, having been updated and signed in October 2008.

The MOU's Statement of Intent is that "both services are cooperating to ensure that clients receive safe and effective care delivered in a seamless manner". Regular meetings have been commenced to improve co-ordination between the two mental health services.

Otago DHB response

Otago DHB Clinical Director of Mental Health and Intellectual Disability Services Dr G has reviewed volume three of Mr A's Otago DHB psychiatric file, which covers the time of these events, and discussed his case with a psychiatric registrar and the Director of Area Mental Health Services, (Otago). It appears that in March 2007, the Otago DHB mental health team in Ward 9B considered that Mr A presented with two clinical problems, schizophrenia and an antisocial personality disorder. His schizophrenia was reasonably well treated, but the main concern was his personality disorder.

Dr G advised that antisocial personality disorder is rarely helped by inpatient treatment, which can be counterproductive. However, plans to discharge Mr A were hampered by his itinerant lifestyle. When Mr A was discharged he was unable to be located for follow-up review and treatment, although a number of steps were taken. An alert was placed on the national network of Director of Area Mental Health

Services, to the effect that the whereabouts of a patient, subject to a CTO, was unknown.

Dr G noted Dr Miller's concern regarding the adequacy of discharge planning for Mr A, specifically the quality of communication between Otago DHB and Southland DHB. Dr G advised that it is the usual practice of Otago DHB mental health services to pay careful attention to discharge planning in cases such as Mr A's. When they discharge a patient to reside in an area serviced by another DHB, Otago DHB would:

- liaise with that DHB's mental health service to ensure follow-up is in place
- in cases of complex presentations, undertake extensive liaison such as teleconferencing, or face-to-face meetings.

Dr G commented that when Mr A was discharged from Ward 9B, it was not his intention to live in Southland, therefore extensive liaison with Southland DHB was not indicated at that time. When Mr A failed to attend arranged follow-up by Emergency Psychiatric Services, contact was made with Southland DHB, via the Director Area of Mental Health Services' office, to check if Mr A was in the area.

Dr G stated that if Mr A had presented to Southland DHB mental health services, he has no doubt there would have been liaison between Otago and Southland. He said that this case "exemplifies some of the problems inherent in providing treatment to patients who have antisocial personality traits, and adopt itinerant lifestyles".

Responses to provisional opinion

Dr C

Dr C's barrister submitted:

"The purpose of [Mr A's] visit in [Dr C's] opinion was to demand that he be given drugs of addiction with an accompanying threat of physical violence against those who did not accede to his request. That, and the review of his medical notes including the notes faxed by Wakari Hospital as requested, convinced [Dr C] that his primary diagnosis was antisocial personality disorder. [Dr C] did not exclude schizophrenia. In '*Quick reference to the Diagnostic Criteria from DSM-IV-TR*' of the American Psychiatric Association page 5 under the heading '*Principal diagnosis/reason for visit*' it is recorded '*It is often difficult (and somewhat arbitrary) to determine which diagnosis is the principal diagnosis or the reason for the visit, especially in situations of 'dual diagnosis*'.

It is acknowledged in the provisional opinion that in the March 2007 discharge summary from Wakari Hospital it is stated that [Mr A's] behaviour was a result of his personality not illness. The suggestion that the subsequent treatment that [Mr A] received was due to [Dr C's] diagnosis impression cannot be sustained."

Southland DHB

Southland DHB acknowledged that various events and actions relating to Mr A's care could have been done better, and that this may have contributed to a more positive outcome for Mr A and his family. The Southland DHB mental health service had attempted to follow up and obtain information from the Otago DHB service although, when the issues are viewed with hindsight, they were "not assertive enough". However, a number of events occurred that were not directly attributable to one individual or service, contributing to what Dr Miller described as a "cascade" effect. The Southland DHB mental health service persisted in maintaining contact with Mr A's sister, Mrs E, at the time of these events, although Mr A was unhappy that they do so. Southland DHB advised that Mr A, "to this day identifies [Mrs E] as his family contact for the Southland DHB mental health services".

These events have been "carefully reflected on", and Southland DHB has been "diligent and thorough in applying effort and attention to learning from this situation and ensuring that [they] have systems in place to minimise a similar situation occurring, not only for Mr A, but for other patients and families who access services in more than one District Health Board area". The actions taken by Southland DHB as a result are:

- a shared management plan is being developed for Mr A with Southland DHB and Otago DHB holding a copy of this plan
- the Memorandum of Understanding between Southland DHB and Otago DHB mental health services has been updated. It clearly sets out the expectations and requirements of both services to provide continuity of care when a patient moves between both services
- Southland DHB mental health service is continuing to endeavour to develop a closer working relationship with the Otago service through formal regional meetings involving the Divisional Manager, Clinical Director, Associate Director of Nursing, Service Manager and Director of Area Mental Health Services.

Southland DHB is willing to meet with Mr A's family and provide an apology.

Ms B

Ms B advised, “It has been a relief to my family and I that there has been a finding that the care Southland DHB provided to our brother in June/July fell below an acceptable standard.” Ms B stated:

“In later years I have had no faith in the SDHB MHS’s ability to manage my brother effectively and as a result did not encourage a great level of collaboration when [Mr A] was discharged from Wakari. What I sought from the ODHB was that they would respond to family concerns regardless of whether [Mr A] was in Southland or Otago.”

Ms B stated that when her brother was receiving services from Otago DHB mental health services there was significant family involvement, and they were frequently consulted and listened to. Discharge occurred with significant family involvement because he often went back to Dunedin.

Ms B said that based on her knowledge and experience as a mental health professional, her brother does not have an antisocial personality disorder:

“Whilst I have no problems with the behaviours which he displays when mentally unwell, being described as antisocial, I think it is important that he is not described as having an ‘antisocial personality disorder’ as his history prior to 15 does not indicate this. ... One of the issues I have always had difficulty getting the SDHB’s MHS to understand is that agitated, aggressive drug-seeking behaviour is a symptom of [Mr A] being mentally unwell. ... It has always felt to me that I cannot get them to understand that whilst he has taken illicit drugs for many years there is a clear difference between his drug taking behaviours and his drug seeking/demanding behaviours, with the latter being an early warning sign. I am pleased that this has finally been acknowledged and will be crystal clear to the SDHB MHS staff in the future.”

Code of Health and Disability Services Consumers' Rights

The following rights are applicable to this complaint:

RIGHT 4

Right to Services of an Appropriate Standard

(1) *Every consumer has the right to have services provided with reasonable care and skill.*

...

(5) *Every consumer has the right to co-operation among providers to ensure quality and continuity of services.*

Opinion: Breach — Southland District Health Board

1. Southland DHB owed Mr A a duty of care under Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code). A specific duty of care is the duty to co-operate with other providers to ensure continuity of care, under Right 4(5) of the Code. Overall, I consider that the care Southland DHB provided to Mr A in June/July 2007 fell below an acceptable standard.
2. In mental health services it is especially important to maintain good continuity of care, particularly where a patient poses a risk of harm to himself or others. Mr A's diagnosis had been identified by Otago DHB mental health services some years prior to these events. His antisocial behaviour was well recognised, and his family had expressed concern that when he was untreated and using drugs and alcohol, he was at risk of harming them and others. Mr A was known to be itinerant and this complicated the continuity of his care.
3. When Mr A was placed on bail, he failed to meet the conditions of his bail and, despite exhibiting concerning symptoms, there was limited follow-up by Southland DHB. By the time positive action was taken on 11 July and a warrant to detain and treat was applied for, he had left Invercargill. There is no evidence that there was any meaningful communication with his family, or that other district health boards that had been involved in his care were notified or an alert placed on the national mental health services network. This lack of follow-up action was clearly inappropriate.
4. It is evident from the Wakari Hospital discharge summary that little consideration was given to the possibility of Mr A breaching his bail conditions and what action to take if he failed to appear for treatment. The risks were not highlighted and no

plan was put in place to notify other centres where he had been treated. However, Dr G advised that when Mr A failed to attend follow-up, efforts were made to locate him by liaising with the Southland and Otago mental health services, his probation officer and family. In addition, a DAMHS national network alert was posted. The need to obtain accurate information at this time was important, because while Mr A's symptoms were uncontrolled he remained a possible risk to others.

5. Dr Miller advised that the care provided to Mr A fell below an acceptable standard in June and July 2007, when Southland DHB clinicians ignored the primary illness of schizophrenia, and failed to use follow-up meetings to determine whether they were correct in their decisions. The root causes were mistaking Mr A's irritable, aggressive conduct for wilful, drug-induced, anti-social behaviour; the lack of frequent, meaningful communication with his family; and the failure to consider the possibility of better patient co-operation through alternative antipsychotic medication. Dr Miller noted that the accuracy and thoroughness of the assessment by the first clinician can often influence the approach of succeeding clinicians, who may erroneously accept the initial conclusions.
6. Consultation with family who care for a mental health consumer is also important to ensure that providers have all available information in assessing and treating the consumer.⁴ The family members knew that Mr A's irritable and threatening behaviour was a sign of his relapse. In my view, if the family had been contacted they would have informed Southland DHB of the warning signs. Dr Miller stated that "a carefully constructed longitudinal history, with analysis of the various modes of presentation, responses to treatment, and the role of drugs, would have been extremely helpful to staff". This information could have been obtained from the family and would have helped in the treatment of Mr A.
7. I am concerned that there was a lack of coordination between Southland DHB and Otago DHB, and a failure to share relevant information. The failure to ensure important information was passed to the relevant services in a timely fashion could have had serious consequences, had Mr A's symptoms remained untreated.
8. I conclude that Southland District Health Board breached Rights 4(1) and 4(5) of the Code.
9. It is difficult to pass judgement on the level of care Dr C provided to Mr A on 26 June 2007. He had limited access to information about Mr A and was faced with a frightening situation. My independent expert, Dr Miller, advised that Dr C acted appropriately in concluding the consultation and in summoning Police assistance.

⁴ In the context of compulsory assessment and treatment, section 7A(2) of the Mental Health (Compulsory Assessment and Treatment) Act 1992 states: "A practitioner must consult the family or whanau of the proposed patient or patient." This provision underscores the value of family involvement in caring for mental health consumers (subject to the consumer's agreement).

Dr C was in the difficult position of being a short-term contract locum and not having the advantage of being part of the established multidisciplinary team. However, Dr Miller was critical of Dr C's "very limited" attempt to obtain clinical information from Wakari Hospital. Dr Miller noted that the Wakari Hospital discharge summary would have been available to Dr C and could have been sent by facsimile or email if he had requested it. The need to obtain accurate clinical information was urgent and someone would have been able to provide this information, even if not until the next day.

10. I agree with my advisor that Dr C should have sought further clinical information from Wakari Hospital. Dr C did in fact obtain and read Mr A's Wakari Hospital records which were faxed on 26 June. It is unclear whether the discharge summary would have assisted Dr C to reconsider his opinion. Mr A had reported to Wakari Hospital staff that he was experiencing visual and auditory hallucinations, and he was discharged on fortnightly prescriptions of haloperidol 25mg. Dr C considered that this was far below the therapeutic dose used to treat psychotic disorders such as schizophrenia. He believed that this supported his view that Mr A's presentation was attributable to an antisocial personality disorder, not schizophrenia. Furthermore, while Mr A was in custody, he was reassessed on 28 June by two experienced mental health staff who knew him. They were also of the opinion that there was no evidence that he was suffering from mental illness at that time. This is consistent with Dr C's assessment a few days earlier.
11. As a result of this complaint and my expert's advice, Southland DHB has introduced a number of measures to address the identified inconsistencies in Mr A's treatment and care should he re-present at Invercargill Hospital. These measures include closer liaison with Mr A's Otago DHB case manager, and utilising the information gathered by both DHBs in a more co-ordinated manner.
12. A Memorandum of Understanding between Otago DHB and Southland DHB mental health services was in place at the time of these events. The intent of the Memorandum is that Otago DHB and Southland DHB mental health services cooperate to ensure that clients receive safe and effective care that is delivered in a seamless manner. The Memorandum was reviewed and updated in October 2008.

Other comment — Otago DHB

Dr Miller noted that aspects of the care provided by Otago DHB mental health services to Mr A are open to question. In his view, Wakari Hospital's "less than optimal discharge process" in March 2007 had a "cascade effect" on Mr A's subsequent care, in that certain attitudes and treatments were perpetuated by Southland DHB mental health services.

Dr Miller stated that it does not seem that any major review of Mr A's treatment was undertaken by Wakari Hospital early in 2007, such as conferring with the Invercargill Hospital services, although it must have been apparent that he would return there at some point.

Dr Miller advised that the mental health teams from Otago DHB and Southland DHB both seem to have made decisions that were not based on a thorough longitudinal assessment, file reviews, face-to-face meetings with the family, and discussion with each other. This resulted in a less assertive approach to treatment, discharge and follow-up than was warranted. It was not until the forensic report of August 2007 that a comprehensive report was prepared. A more rigorous assessment could have been conducted some years earlier, and would have clarified the diagnosis.

Dr Miller was critical of the lack of liaison that occurred as part of the discharge planning process. In considering Mr A's itinerant history and his family connections, staff at Wakari Hospital would have been prudent to have liaised with staff at Southland DHB and provided them with clear information concerning Mr A's current care plan.

Dr Miller would have expected to see in the discharge summary, evidence of meaningful discussions with the family, and a plan to address the likelihood of Mr A defaulting from follow-up. The risk issues, such as the consequences of medication non-adherence, were not highlighted. It would have been helpful for other centres where Mr A had presented for treatment to be notified.

Dr Miller stressed the importance of Otago DHB and Southland DHB using this case and his comments as an opportunity for learning.

Recommendations

I recommend that Southland DHB:

- apologise for its breach of the Code. A written apology should be sent to HDC for forwarding to Mr A's family
 - offer to meet Mr A and his family to discuss any outstanding concerns.
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Follow-up actions

- A copy of this report will be sent to the Director of Mental Health.
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- A copy of this report, with details identifying the parties removed except Southland DHB and Invercargill Hospital, Otago DHB and Wakari Hospital, and my expert, Dr Miller, will be sent to the Mental Health Commission, the Mental Health Foundation, and the Schizophrenia Fellowship, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix 1 — Independent advice from psychiatrist Peter Miller

The following preliminary expert advice was obtained from Dr Peter Miller MBChB; FRANZCP; General and Forensic Psychiatrist:

“Nature of Complaint:

The complaint is by the sister of [Mr A] (hereafter called ‘the patient’), [Ms B], and essentially alleges that clinicians employed by Southland DHB, on several occasions between 2003 and 2007, failed to make an accurate assessment of the patient’s mental state; failed to meaningfully engage his family; and failed to acknowledge the degree of risk he posed to others.

Psychiatric History of [Mr A] (‘the patient’):

I will not traverse this in detail; it is well described in the report by [Dr D] dated 13 August. In brief, the patient has suffered from schizophrenia since his early 20s, or as early as 20 years of age, but a definitive diagnosis was not made until he was in hospital in Dunedin in 1997/8.

His illness has been characterised by delusions, hallucinations, and complicated by multiple substance abuse, treatment refusal, itinerant behaviour and at times violence, making the delivery of consistent treatment extremely difficult. He had admissions to hospitals in [five regions].

During periods when he was accepting treatment, usually by long-acting injections of medication, offending was much reduced or absent.

His use of alcohol, cannabis and other drugs preceded the development of his illness as did his offending. As is usual for persons with schizophrenia, his insight (his appreciation that his mental state is abnormal, producing distress and disability, and is helped by medication) is limited at best and absent at worst.

Analysis

1. Difficulties in management intrinsic to the patient’s clinical presentation:

The patient displayed anti-social and multiple drug using behaviour from adolescence prior to reporting symptoms of psychosis which may have been responsible for psychotic symptoms, or for enhancing them at times. It is likely he met criteria for ‘conduct disorder’.

It is not unusual for the diagnosis of schizophrenia to be delayed in people presenting in this manner, sometimes for some years.

His itinerant behaviour made a comprehensive knowledge of the various modes of presentation of his illness by clinical staff, together with frequent changes of staff, meant that an 'institutional' knowledge base was not well-established.

The patient's self-presentation in June 2007 'demanding' admission was an unusual presentation; more usually, such patients are brought unwillingly to hospital. However, with hindsight, the patient was correct ... he did need treatment.

1. Comments on some care episodes:

Beginning in October 1998, doubts were expressed about his primary diagnosis of schizophrenia, despite abundant evidence of the disorder being present, and possibly since 1987.

February 2004:

The patient was admitted with police assistance after family reported they were scared of him and described clear psychotic symptoms. He was described by nursing staff as 'unkempt, prominent body odour, deluded; grimacing'. However he was discharged two days later with the psychiatrist stating he did not have psychotic symptoms.

A carefully constructed longitudinal history, with analysis of the various modes of presentation, responses to treatment, and the role of drugs, would have been extremely helpful to staff, but is not evident in the documents I have seen until the report of August 2007 by [Dr D].

Statements are noted in his file referring to his drug and alcohol use as being 'primary' with 'no signs of psychosis' even though he had not been taking medication for some time. Such a statement can not be made with any certainty until a drug and alcohol-free period of some days has occurred, which can only take place in a locked ward using the Mental Health Act.

Threatening and other aggressive behaviour seems to have been usually ascribed to an 'anti-social personality' or to drug /alcohol use of both without consideration of uncontrolled illness being at least a component of his behaviour. In fact, irritability and threatening behaviour seem to be cardinal signs of a relapse of schizophrenia in this man, which was well-known to his family.

Incident of 26 June 2007:

The patient self-presented to the Invercargill mental health services demanding admission, and displayed significantly threatening behaviour, especially to the assessing psychiatrist who did not know him.

This psychiatrist in my view acted appropriately in summoning police assistance. It was a frightening experience for him and other staff.

However, despite stating he had read the patients files, [Dr C] **stated that schizophrenia was not likely to be the diagnosis.** He does not mention whether he contacted the Wakari Hospital psychiatrist who treated him in early 2007 and who was not in doubt about his diagnosis.

Follow-up in prison after the patient's arrest appears to have not taken cognisance of the possibility of relapse of schizophrenia, which was long-established as being chronic; he was known to have not been on medication for 3 months and it was not until 4 weeks later that he was transferred to the Wakari hospital and there found to be in relapse of his schizophrenia.

I also note his management in Ward 9b Wakari Hospital in early 2007. It does not appear that any major review of his treatment was undertaken including conferences with the Invercargill services, although it must have been almost certain that he would return there at some point.

Conclusions:

1. In my view the patient's care fell below an acceptable standard in June/July 2007 and to a lesser degree, in early 2004. On both occasions psychiatrists unwisely ignored the primary illness of schizophrenia which by then was not a tentative diagnosis or at least they failed to use follow-up meetings to determine if they were correct in their decisions.

Root causes were:

- a) Failure to accept the nature of the patient's presentations, mistaking aggressive, irritable conduct for wilful, drug-induced, anti-social behaviour;
- b) Lack of meaningful and/or frequent enough communication with family by a number of teams over some years.
- c) Failure to consider the possibility of better co-operation of the patient with new anti-psychotics, which include a depot preparation and oral medications. The patient was constantly defaulting from follow-up from his long-standing depot injections, possibly because he didn't like the

side-effects of his medication, so in his case depot preparations were not a great advantage over orals.

- d) In my view it is not only the Southland DHB which did not treat the patient optimally but the Wakari hospital mental health team should have initiated a video/teleconference or some liaison with Southland in March 2007, prior to his discharge, to review treatments.

Limitations on this report:

I would normally, in the course of an inquiry, circulate a draft of this report to the mental health teams of Southland and Otago for their comment. It is possible that some important steps were taken of which I am unaware.”

Appendix 2 — Further advice from psychiatrist Peter Miller

Further expert advice was obtained from Dr Miller.

“In response to your letter to me dated 30 April 2008 I have read the responses to my comments outlined in my report of 3 March 2008.

My comments are as follows:

1. Southland response from [the] General Manager.

[The General Manager] has taken steps to address many of my concerns; some others are more matters of opinion rather than fact. In particular, improved liaison with Otago Mental Health Services regarding [Mr A] to adopt shared care plans which are accurate, up to date and consistent is an important step.

The memorandum of understanding underpins this contact and, while a good document, may need to be more widely disseminated.

Regular meetings and other forms of communication between Southland DHB and Otago DHB mental health services are reported to have commenced and hopefully can be sustained.

Family contact: The service has acknowledged the importance of family contact but it is important to note that family members can have different views about risk and symptoms; their opinion can be misleading, and information from family is only one part of an assessment eg: the team’s unwise acceptance of assurances from sister [Mrs E] in the face of contrary evidence.

Forensic Community Team: I note the involvement of this team following [Mr A’s] arrest. They faced the difficulty of [Mr A] being able, for short periods, to conceal the extent of his disturbance. Their early discussions with [their psychiatrist] lead to him recognising that [Mr A] required admission to hospital for fuller assessment which sadly was not able to be actioned sooner.

Response from [Dr C], Psychiatrist

[Dr C] was in the difficult position of being a locum, and part-time, so he did not have the advantage of being ‘embedded’ in an established multi-disciplinary team. He said he had no further contact with [Mr A] following the incident following which [Mr A] was arrested.

However I consider his response to reflect a very limited attempt on his part to obtain clinical information from Wakari Hospital. A discharge summary would have been available and could have been faxed or e-mailed if he had requested it; the need to obtain accurate clinical information was urgent, and

someone would have been able to provide this information, even if it was the next day.

[Mr A] was bailed and so may have remained a risk to others with uncontrolled symptoms of his illness.

The accuracy and thoroughness of the assessment of the first clinician to see a patient can often influence the approach of succeeding clinicians who may erroneously accept the initial conclusions.

Otago DHB response ([Dr G], Psychiatrist and Clinical Director)

[Dr G] has reviewed [Mr A's] records, and noted diagnoses of Schizophrenia and 'Anti-social Personality Disorder', though the discharge summary states 'Anti-social features', which is different.

The Southland team accepted the statement in the March 2007 discharge summary which stated that his anti-social behaviour was a result of his personality not illness, which must be open to question; ie: to what degree was his anti-social behaviour related to poorly controlled schizophrenia? Which his sister believes, and the long periods without court appearances would support this view.

[Mr A] was discharged on 7 March 2007 to 'no fixed abode', with the 'expectation' that he would find accommodation in Dunedin and self-present for follow-up. This is despite the statement from [the] Judge, at his judicial hearing on 21 February 2007, that 'community follow up would be important particularly given what [a psychiatrist] describes as multiple risk factors'.

In the event he did not appear and on 30 March was discharged from follow-up, although was still subject to a compulsory treatment order.

What I did not find evidence of in this discharge summary were:

- (a) 'Meaningful' discussions with family ie: face-to-face, with discussions of medication alternatives, especially as [Mr A] had shown that he did not like depot medications and they were easily evaded by absconding, so they in themselves, were unlikely to improve compliance. If a patient prefers a particular drug, whether by long-acting injection or oral, and feels better on it, possibly because of loss of side-effects from the original drug, adherence is often improved.
- (b) The likelihood of him defaulting from follow-up and what to do if he failed to appear for treatment.
- (c) Risk issues were not highlighted, or specified, or linked to medication adherence, though a statement 'extensive forensic history' is in the

report.

- (d) Of lesser import but potentially helpful would have been notifying other centres where he had been treated previously, of his AWOL status from the Mental Health Act ie: Nelson, Christchurch, Invercargill, though this would not necessarily have enabled him to be located before significant relapse, but would have been available to Southland services where, in the event, he did present.

Conclusions & Recommendations:

I stated in my report dated 3 March 2008, that I considered that the care of [Mr A] by the Southland DHB fell below an acceptable standard in mid-2007, and to a lesser extent in early 2004, I still hold to that opinion.

Aspects of care by the Otago DHB mental health services also are open to question.

Both teams seem to have made decisions which were not based on a thorough longitudinal assessment, file reviews, face to face meetings with family, and discussions with each other, which permitted a less assertive approach to treatment, discharge and follow-up than was warranted.

Indeed, despite 10 years of illness, it was not until the forensic report of August 2007, that such a comprehensive report was prepared.

It is evident from this report that the less than optimal discharge process from the Otago services in March 2007 had a 'cascade' effect on subsequent care in that certain attitudes and treatments were perpetuated by Southland.

Indeed, a more rigorous assessment could well have been conducted some years ago which may at least have clarified the diagnosis, which should not really have been in doubt since 1998.

Some of my conclusions are obviously arrived at with the 'wisdom of hindsight' and I don't wish to be too critical of individuals or teams and I would re-iterate that a meeting with staff may have modified some aspect of this report, but I hope these comments can be seen as a learning opportunity."

Appendix 3 — Text



MEMORANDUM OF UNDERSTANDING

between

**OTAGO DISTRICT HEALTH BOARD
PROVIDER ARM
MENTAL HEALTH SERVICES**

and

**SOUTHLAND DISTRICT HEALTH BOARD
PROVIDER ARM
MENTAL HEALTH SERVICES**

MEMORANDUM OF UNDERSTANDING
(Whakaaturanga o te Ngakau Mohio)

Memorandum of Understanding – Otago and Southland DHB Provider Arm Mental Health Services
October 2008

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Memorandum of Understanding
between Southland District Health Board Provider Arm Mental Health
Services and Otago District Health Board Provider Arm Mental Health Service

Recognising that

Southland and Otago Services have separate missions

AND acknowledging that each party brings to its respective task, valuable expertise and resources

AND acknowledging full cooperation and collaboration between both parties at all levels as essential to ensure the coordinated, effective and efficient delivery of services to meet the needs of our mutual clients and their families and whanau.

1. OBJECTIVE

Southland and Otago DHB Provider Arm Mental Health Services are committed to working together to ensure that consumers and their families receive safe and effective care delivered in a seamless manner.

This document clarifies communication between the two services relating to the interface between the crisis, general adult inpatient and community services.

While not specifically covering specialist services this Memorandum also applies to any specialist service referral or presentation where uncertainty about referral point exists, or emergency psychiatric intervention may be required. Maori Mental Health Team referrals/presentations are included in this Memorandum. Forensic Consumers are not covered by this document and the Service Provision Framework (SPF) developed between the two District Health Boards should be referred to for this client group.

Where an interface between the two DHBs occurs and it is not specifically defined (for example, CAFS and AOD Services) in this document, the expectation is that the spirit and principles of this memorandum will be applied.

2. SERVICE OVERVIEW

SOUTHLAND DHB PROVIDER ARM MENTAL HEALTH SERVICES

Southland District Health Board Mental Health Service aims to deliver a mainly community based specialist secondary mental health service to the Southland District which covers Invercargill City and surrounds, Western Southland, the Wakatipu Basin, Gore and districts and Stewart Island.

Services

Service delivery is based on consumer need and effective coordination of the continuum of care between providers, consumers and their family/ whanau or caregivers. All services are planned and delivered in partnership and consultation with Tangata Whenua to reflect the characteristics and needs of the population in the Southland DHB district.

The range of provided services include:

- Southland Mental Health Emergency Team (SMHET)
- Adult Community Mental Health Services (including Community Mental Health, Forensic Services, Intellectual Disability Dual Diagnosis and Maternal Mental Health)
- Maori Mental Health Services, Te Korowai Hou Ora
- Child and Adolescent and Family Services
- Services for Older Persons, Mental Health Advisers
- General Hospital Liaison Psychiatry
- Acute Mental Health Inpatient, Inpatient Intensive Care
- Alcohol and Drug, Methadone, Mental Health Day Activity Centres
- Crisis Respite Care and Primary Mental Health
- Mental Health Needs Assessment / Service Co ordination
- Consumer and Family Advisory Services, including Youth Advisor

OTAGO DHB PROVIDER ARM MENTAL HEALTH SERVICES

Otago DHB Provider Arm Mental Health Service aims to deliver a range of specialist secondary mental health services to the Otago region including the Greater Dunedin City, Waitaki, Central Otago, South Otago and associated districts.

Services

The range of services provided by Otago include:

- Community Mental Health Services (CMHT) including teams in Dunedin, Oamaru, Balclutha and Clyde.
- Mental Health Needs Assessment and Service Co-ordination (NASC) Service
- Emergency Psychiatric Service (EPS)
- Day Programmes and Outpatient Groups
- Child and Adolescent Family Services
- Youth Specialty Services
- Community Alcohol and Drug Service (including methadone programmes)

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- Early Intervention Service
- Consult Liaison Service
- Crisis Respite
- Mental Health of Older People – inpatient, day hospital and community services
- Forensic Services – including medium secure inpatient, prison and community liaison
- Intellectual Disability Service, including Dual Diagnosis – secure inpatient and community based services
- Te Oranga Tonu Tanga – Maori Mental Health Service
- Acute Inpatient Unit
- Intensive Care Inpatient Unit
- Rehabilitation Inpatient Unit
- Level III Residential Unit
- Consumer and Family Advisory Services

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3. INTRODUCTION

The following matters are agreed in principle between Otago DHB and Southland DHB Mental Health Services to give guidance and direction when consumers of one service present in crisis to the other service or are referred to each other's services.

Responsibilities

3.1 Crisis presentations

Current Southland consumer presenting to Otago services

During business hours the Otago service should contact the Clinical Coordinator, Invercargill Community Mental Health Team or the Duty Person for the Gore and Wakatipu Community Mental Health Teams for consumers residing in their areas.

After hours the Otago Service should contact the Southland Mental Health Emergency Team (SMHET) - contact through Southland Hospital, Invercargill.

Current Otago consumer presenting to Southland Services

During business hours the Southland Service should contact the Emergency Psychiatric Service (contact through Dunedin Hospital), which will identify the appropriate Community Mental Health Team for ongoing liaison.

After hours the Southland Service should contact the Emergency Psychiatric Service (contact through Dunedin Hospital)

Process

If the consumer is not a current patient of the services, then both services will liaise regarding the best clinical management for that individual person.

- Communication should be initially by phone and followed up promptly with supporting documentation.
- Where the consumer is to be escorted back to their usual service rather than admitted to an inpatient area, the services will meet halfway to facilitate the transfer, wherever possible.
- Requests for assessments of persons in Police custody at the Queenstown Police Station will be managed as follows:

When individuals from outside the Wakatipu basin are brought to the holding cells at the Queenstown Police Station by the Central Otago police, requests for psychiatric assessment are to be directed to the Central Otago Mental Health Service, rather than the WCMHT or SMHET. This is consistent with the Memorandum of Understanding between the Queenstown Police and the Southland District Health Board Mental Health Service.

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3.2 Community referral

Southland consumer relocating to Otago

Referral is made to the Emergency Psychiatric Service who will refer on to the appropriate sector/district team. Referral documentation will include the current recovery plan.

Otago consumer relocating to Southland

Referral is sent to Clinical Coordinator, Invercargill Community Mental Health Team. Referral documentation will include the current treatment plan.

The referral will be sent in a timely manner allowing communication between services before relocation occurs. This includes consumers relocating for limited term visits and planned respite as well as permanent residence. All relevant information (such as management plan, risk assessment, relapse prevention plan and care team details) will accompany the referral.

The relocation of the consumer will not occur until the referral is formally accepted by the service the referral is made to. When the patient is subject to the Mental Health Act, the referring DAMHS will also make a referral to the accepting DAMHS. The relocation of the patient will not occur until the receiving DAMHS has accepted the patient.

The DAMHS ensure that each DHB end dates the ACTS on the same day of transfer.

3.3 Inpatient referral between Southland DHB Mental Health Inpatient Unit and Otago DHB Inpatient Units

Once the need for referral to an inpatient bed in the other region is identified, a referral is made to the unit identified. In Southland this would be the Mental Health Inpatient Unit based in Invercargill. In Otago this would be Ward 9B, *Otago to complete.*

This referral is actioned at a number of levels:

- Consultant Psychiatrist/ Responsible Clinician to Consultant Psychiatrist/ Responsible Clinician
- Unit Manager/Charge Nurse Manager to Unit Manager/Charge Nurse Manager
- DAMHS to DAMHS

Contact Details

Clinical Nurse Manager / Clinical Coordinator,
Inpatient Mental Health Unit,
Southland Hospital
Invercargill Phone 03 214 5786

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Charge Nurse Manager
 Ward 9B
 Wakari Hospital
 Dunedin
 Phone 03 476 6002

Acting DAMHS,
 Southland DHB
 Contact via Southland Hospital Switchboard

**Consultant Psychiatrist/ Responsible Clinician to Consultant Psychiatrist/
 Responsible Clinician**

The transferring consultant psychiatrist/responsible clinician makes the first contact to the appropriate consultant in the receiving service. Once the referral is accepted medical handover occurs between relevant medical teams, consultant to consultant

Unit Manager/Charge Nurse Manager to Unit Manager/Charge Nurse Manager

Once the referral is accepted the respective Unit Manager/Charge Nurse Manager or their designates will liaise to ensure all aspects of the transfer are arranged safely and effectively.

DAMHS to DAMHS

When consumers being transferred are subject to the Mental Health Act, the DAMHS are responsible for referring and accepting patients into their respective areas and ensuring that all requirements of the Mental Health Act are complied with.

3.4 Current Patient of either Southland or Otago that moves between the two services

A small number of patients move between the two services. When these patients are identified a joint management plan is to be developed to ensure a smooth delivery of service in which ever region the patient presents. This plan must include, but is not limited to, the name of the current key worker, responsible clinician, current treatment plan, risk management plan and relapse prevention (crisis) plan. Responsibility for development and updating of the plan rests with the designated key worker currently working with the patient and the crisis team (SMHET or EPS) in the other region

4. SERVICE LINKAGES

A number of agreed contact points interact together to support and maintain smooth service delivery. These are usually roles that have similar roles in each organisation.

4.1 Additional Collaboration

- Invitations to meetings and forums of mutual interest
- Sharing of education and information materials
- Pooling of resources, experience and a shared enthusiasm in pursuit of innovation and planning
- Celebration of successes
- Regular meetings to discuss and progress joint initiatives, issues

4.2 Sharing of Information

It is agreed that, within the framework of the Privacy Act, upon formal request, information will be shared between Otago DHB and Southland DHB Mental Health Services for the safety, health and wellbeing of our mutual clients.

4.3 Confidentiality

All parties shall ensure that its employees comply with all statutory and ethical provisions relating to the non disclosure of medical and personal information as well as confidentiality of client records.

4.4 Resolution of Disputes

In the event of arising conflict and / or other problems between Otago DHB and Southland DHB MHS, a meeting would be called to include individuals involved plus the Southland DHB Service Manager and Otago DHB Service Manager, to discuss and find solutions to the conflict or problem.

If during the term of the agreement, there are any disputes that have not been resolved by discussion between the parties, the authorised representatives agree to meet within 10 working days of receiving written notice to resolve the issue. In the event that any dispute is not capable of resolution following such negotiations the parties agree to submit the matter to their respective Senior Managers: in the case of Southland DHB the Divisional Manager, Mental Health and in the case of Otago DHB, the Group Manager, Mental Health & Community Services.

5. AMENDMENT VARIATION

The parties agree that these understandings may be amended or varied by mutual agreement between parties. Such variations should be raised and addressed through the Otago DHB Service Manager(s) and the Southland DHB Mental Health Service Manager.

6. TERM OF AGREEMENT

This Memorandum will be reviewed annually.

Review of the Memorandum can occur at any time by mutual agreement.

Either party may terminate this Memorandum by providing three months written notice, or sooner by mutual agreement.

By signing this partnership agreement both parties declare and agree to the preceding.

For Southland District Health Board:

Divisional Manager
Mental Health Services
Southland District Health Board

Date:

For Otago District Health Board:

Group Manager
Mental Health & Community Services
Otago District Health Board

Date:

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