

**Support for mental health consumer in the community
(08HDC05072, 28 July 2009)**

Mental health support service ~ District health board ~ Compulsory treatment ~ Community support ~ Coordination of community support and mental health services ~ Rights 4(1), 4(5)

The parents of a 37-year-old man with a long history of mental illness (schizoaffective disorder and mixed personality disorder) complained about the care he received. The man was subject to an indefinite compulsory treatment order, but was granted conditional leave for treatment in the community. He lived in shared residential homes, administered by a mental health support service, for two years, after which he moved into his own flat. The goal was to trial independent living for three months with intensive support from the mental health support service, in preparation for his eventual return to where his parents lived.

During the period the man lived alone, the district health board funded the mental health support service to visit him daily to assist with household chores. He was also monitored regularly by a case manager from the DHB's community mental health team. The case manager was responsible for managing the man's clinical care along with other members of the DHB mental health team. His parents visited him regularly.

During a morning visit, the man informed a support worker that he had the flu and refused to attend any outing. The support worker advised the case manager of this, but the man received no other visits that day. When the man's parents visited the next day, they found him dead in his flat. A post-mortem examination revealed that he died from an acute bacterial infection.

It was held that although it was appropriate for the mental health support service to take into account the client's wishes and to reduce the visits accordingly, the service failed to communicate this clearly to the funding authority. By not communicating adequately with DHB staff, not managing the reduction in visits appropriately, and failing to have an adequate record-keeping system, the service failed to provide services with reasonable care and did not co-operate with other providers to ensure a quality service, breaching Rights 4(1) and 4(5).

Although the psychiatric monitoring, assessment and management of the man was satisfactory, there were various gaps in the care that the DHB provided. They included the lack of integration between primary and secondary care and the lack of service co-ordination at a higher level. The DHB therefore breached Rights 4(1) and 4(5).

This case highlights the importance of good communication between community support and mental health services in tracking the actual support being provided to a mental health consumer, and his general health needs.