Ashburn Hall Charitable Trust
District Health Board (now Te Whatu Ora)

A Report by the
Deputy Health and Disability Commissioner

(Case 18HDC02016)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a woman by a psychiatric hospital (the facility) and a district health board (DHB) (now Te Whatu Ora) in 2018, when she transferred from the facility to community mental health services at the DHB.

2. The woman has a complex mental health history. Since August 2013, she has had numerous mental health inpatient admissions at the DHB. On 5 July 2016, the woman was admitted to the facility for treatment. Planning for her discharge began in early 2018.

3. On 27 June 2018, following a family meeting with the facility, the plan was for the woman to be discharged to her home town on 21 September 2018.

4. On 5 September 2018, a multi-disciplinary team meeting at the facility assessed the woman as able to be managed as an outpatient when she returned to her home town. On the same day, the woman's psychiatrist telephoned the DHB's mental health contact centre (the single point of entry service) regarding a referral for ongoing follow-up.

5. On 13 September 2018, the facility emailed a referral letter to the contact centre. The letter included referral to the DHB "for wrap around support" as the woman transitioned back into the community, together with the name of the woman's ACC-funded clinical psychologist and information on therapy, physical health, and medication. Further supporting documentation was emailed to the DHB on 14 September 2018.

6. On 17 September 2018, the referral was discussed at a DHB intake meeting and was triaged as non-urgent, as the woman was still an inpatient at the facility. The DHB did not acknowledge receipt of the referral or clarify with the facility the level or nature of support needed by the woman.

7. On 21 September 2018, the woman was discharged from the facility after having resided there for almost two and a half years, and her care was transferred to the DHB. The discharge letter from the facility was sent to the contact centre on 14 November 2018.

8. In the weeks following the woman's discharge from the facility to community mental health services at the DHB, she presented to the DHB in crisis on several occasions, and was admitted to the mental health recovery unit on 6 October 2018.

Findings

9. The Deputy Commissioner considered that the facility's discharge planning and handover of the woman's ongoing care to the DHB was inadequate, and adversely affected the quality and continuity of services the woman received.

10. The Deputy Commissioner found the facility in breach of Right 4(5) of the Code. The Deputy Commissioner was critical that the inadequate discharge planning and handover meant there was a lack of clarity around the woman's needs and expectations at a time of increased vulnerability.

11. The Deputy Commissioner considered that the DHB could have been more proactive in following up the referral and in making enquiries to ascertain what kind of support the woman needed, despite the short time frame.

12. The Deputy Commissioner was also critical of the DHB's management of the woman on two of her crisis presentations, on 3 and 4 October 2018. Specifically, the Deputy Commissioner found that a duty clinician should have talked to the Emergency Department doctor on the woman's behalf on 3 October 2018, and on 4 October 2018 the woman should have been reassessed by a mental health clinician following her return to the Emergency Department.

13. While the Deputy Commissioner was critical of the DHB's follow-up of the referral, the lack of support provided on 3 October 2018, and the lack of assessment on 4 October 2018, these omissions were not considered to amount to a breach of the Code due to mitigating circumstances.

Recommendations

14. The Deputy Commissioner recommended that the facility provide a formal written apology to the woman; consider ways to engage all accepting services and consumer and family/supports in a pre-discharge teleconference to discuss medication and identify risks and early warning signs, coping strategies, patient expectations, long-term goals, strengths, and whānau/community supports; ensure that a complete discharge summary is available at the time of or prior to discharge, detailing what has been agreed in the pre-discharge meeting, including the specifics of community management and available supports and resources; and consider holding a post-discharge review meeting with the consumer, whānau, the referring team, and all receiving services (including ACC where relevant) to improve communication and coordination of services.

15. The Deputy Commissioner recommended that Te Whatu Ora provide a formal written apology to the woman; consider holding a post-discharge review meeting with the woman, whānau, the referring team, and all receiving services (including ACC where relevant) to improve communication and coordination of services; review the practice of assigning a transfer of care from another mental health service as a low priority, to allow for prioritising early engagement for consumers with likely high mental health needs; and ensure that service-wide care plans include other relevant services, including the Emergency Department, and are available to both the contact centre and the Emergency Department.

Complaint and investigation

16. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided by the district health board (DHB) (now Te Whatu Ora)[1] and Ashburn Hall Charitable Trust. The following issues were identified for investigation:

- *Whether the DHB provided Ms A with an appropriate standard of care in 2018.*
- *Whether Ashburn Hall Charitable Trust provided Ms A with an appropriate discharge and transfer of care between September and November 2018 (inclusive).*

17. This report is the opinion of Dr Vanessa Caldwell, and is made in accordance with the power delegated to her by the Commissioner.

18. The parties directly involved in the investigation were:

Ms A	Consumer/complainant
DHB	Provider/district health board
The facility	Provider/community and psychiatric hospital

19. Further information was received from:

Ms A's father	
Ms B	Care manager/occupational therapist (the DHB)
RN C	Registered nurse (the DHB)
Dr D	Psychiatry registrar (the DHB)
Dr E	Consultant psychiatrist (the DHB)
ACC	

20. Also mentioned in this report:

RN F	Registered nurse
Dr G	Psychiatrist

21. Independent expert advice was obtained from a consultant psychiatrist, Dr Paul Vroegop (Appendix A).

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand. All references to the DHB in this report now refer to Te Whatu Ora.

Information gathered during investigation

Introduction

22. This report concerns the care provided to Ms A by mental health services at a community and psychiatric hospital (the facility) and a DHB in 2018. In particular, it examines the adequacy of handover and coordination of her ongoing care by the facility following her discharge to the community after an admission of almost two and a half years, and the care provided by the community mental health services at the DHB when she presented in crisis several times in the weeks following her discharge back to the community.

Background

23. Ms A, aged in her twenties at the time of events (2018), has a complex history of post traumatic stress disorder (PTSD), depression, and significant self-harm and attempts at suicide.[2]

24. Ms A first presented to mental health services in August 2012, and has had numerous mental health inpatient admissions at the DHB since August 2013. In late June 2016, a "Whole Service Response Plan" (WSR plan) was developed by the DHB, outlining how to respond to Ms A's presentations and behaviour (discussed further below).

25. In 2016, Ms A was referred to the facility and was admitted there on 5 July 2016. Following 20 months of treatment, in March 2018 she was transferred to an associated independent living hostel, where she continued to receive treatment from the facility. Ms A said that she learned to seek help at the facility when she needed it, and had 24/7 support available.

Planning discharge and return to her home town — early to mid-2018

26. In early 2018, the initial discharge plan was for Ms A to discharge from the facility in July 2018 into the local community, and efforts to arrange study and volunteer work occurred in the following months. However, on 27 June 2018 there was a family meeting with the facility, and Ms A decided that she would return to her home town. In response to the provisional opinion, Ms A told HDC that she did not want to stay in the area and that she always wanted to be discharged to her home town. At that meeting, a discharge date was set for 21 September 2018.

27. The facility told HDC that during the family meeting, staff spoke of their concerns for Ms A psychologically in returning home. It was agreed that Ms A would have some leave with her parents, and meet with her GP and her new ACC-funded psychologist in August 2018.

28. On her return, Ms A reported that the leave had been successful and she had met her GP and ACC-funded psychologist. On 17 August 2018, the facility anticipated a relatively smooth transition back to the community in her home town. It was considered that she could be managed as an outpatient with the support of her ACC psychologist and GP, and that referral to her local DHB mental health service was probably not necessary.

[2] Due to traumatic events in her early teens.

Episode on 23 August 2018

29. Towards the end of August, Ms A became concerned about becoming unwell on her upcoming permanent return to her home town. An episode of serious self-harm on 23 August 2018 required surgical intervention. Ms A told HDC that the reason she self-harmed was not specifically related to her upcoming discharge, and that it was "much more complex" than that. The facility told HDC that because of Ms A's deterioration within a few weeks of her discharge date, there was some initial uncertainty as to whether she would require an inpatient transfer to her home town or could be managed by a Community Mental Health Team (CMHT).

30. The facility told HDC that after this event, Ms A appeared to settle quickly on the inpatient unit at the facility, and was not considered to be at high risk of relapse.

31. The facility stated:

> "[Staff had] regular close contact with the GP and ACC, who we knew were going to be involved in [Ms A's] ongoing follow-up of her mental and physical health needs. We would have certainly welcomed the opportunity to have a similar level of involvement with a Community Mental Health Team. I appreciate there were some timing difficulties with regard to having such a teleconference prior to [Ms A's] discharge, as her discharge plans changed quite quickly in the lead-up to her discharge."

32. In response to the provisional opinion, Ms A stated that she disagreed that her plans changed quickly. She said that she had decided prior to August 2018 that she would be "going home and that was always the plan". She told HDC that as far as she was aware, apart from the discharge summary, her GP never had contact with the facility, and neither did ACC. Ms A said that she recalled having to sign a "release form" several weeks after her discharge so that the DHB could obtain more information from the facility.

5 September 2018 — the facility's initial contact with the contact centre

33. On 5 September 2018, a multi-disciplinary team (MDT) meeting at the facility assessed Ms A as able to be managed as an outpatient when she eventually returned to her home town. Accordingly, later on 5 September 2018, Ms A's psychiatrist telephoned the contact centre (24/7 telephone contact centre for the mental health service responsible for screening all general enquiries and referrals received) regarding a referral for ongoing follow-up.

Referral and transfer of care to DHB — September 2018

13 September 2018 — referral to DHB

34. On Thursday 13 September 2018, the facility emailed a referral letter to the contact centre. The letter included referral to the DHB "for wrap around support by a MDT as she transitions back to the community", together with the name of Ms A's ACC-funded clinical psychologist and information on therapy, physical health, and medication, and noted that Ms A had "a

very supportive [ACC-funded] team". Further supporting documentation was emailed to the DHB on Friday 14 September 2018.[3]

17 September 2018 — discussion at DHB intake meeting

35. The referral was discussed at an intake meeting on Monday 17 September 2018. The contact centre referral tracking form noted: "TOC.[4] To check EHR[5] for previous team. Currently in the facility. D/c[6] on 21/9/18 — to check details then." A triage response number[7] of "4" — non-urgent — was assigned. The DHB told HDC that this was because Ms A was still an inpatient at the facility. A non-urgent referral requires face-to-face contact between a clinician and the consumer within 14 days of triage.

36. On Tuesday 18 September 2018, Ms A's ACC-funded case manager telephoned the contact centre to check the progress of the referral, and mistakenly was told that it had not been received. The case manager informed the facility about this by email. The DHB apologised for the error, and the clinician (who could not recall why they said that the referral had not been received) has reviewed their practice.

37. The facility receptionist telephoned the contact centre the next day (Wednesday 19 September 2018) to check that the referral had been received.

21 September 2018 — discharge from facility

38. On Friday 21 September 2018, Ms A was discharged from the facility after an admission of almost two and a half years, and her care was transferred to the DHB. She told HDC that she returned to her home town feeling hopeful, and had started in employment. Ms A's understanding was that she could call on the DHB community team for support when needed. Ms A said that it is really important that she can access support when needed. She stated: "[W]hen I start to go off the rails, I can be helped. If it is left too long, then there is little that anyone can do to help me."

39. The facility told HDC that the expectation was that the community mental health team at the DHB would conduct a thorough assessment of Ms A as soon as she entered that service. The facility was not aware of which clinicians Ms A was referred to at the DHB, as contact was through the contact centre. The facility said that this was a significant barrier to it contacting the community team at the DHB, as there is no direct contact with the clinicians to whom they are referring a person. This also meant that it was not possible to be involved in a pre-discharge conference with the receiving team. The facility referred to the difficulties of single point of entry services, with "subsequent delays in allocation to services".

40. The facility commented that it did not receive information from the DHB about the processing of the referral, or any written acknowledgment that the referral had been

[3] Including a risk management plan, a psychiatrist admission note, and a discharge summary from a hospital Gynaecology Department.
[4] Transfer of care.
[5] Electronic health record.
[6] Discharge.
[7] Triage response numbers are: 1 — Emergency, 2 — Urgent, 3 — Acute, 4 — Non-urgent, 5 — Coordinator solution, 6 — Other agency referral, 7 — Inconclusive contact.

received, and was not aware of the timeframe in which clinical information was passed on within the DHB. The facility said that it did not receive information on which CMHT and/or clinicians the referral had been passed on to, and there was no contact from the CMHT to which Ms A was referred.

Contact by contact centre and transfer of care to CMHT

41. On Saturday 22 September 2018, a contact centre clinician, RN C, telephoned Ms A and checked her information (including her address), and her care was transferred by the contact centre to CMHT.

42. On Monday 24 September 2018, CMHT received the referral from the contact centre. Also on this day, the facility sent a discharge summary form to the contact centre, Ms A's GP, and the ACC-funded case manager and psychiatrist, which included her current diagnosis, medications, and points of immediate concern.

43. The facility accepted that it did not provide detail on the nature of ongoing follow-up and what would be required from the CMHT. However, the facility noted that the role of Ms A's GP, ACC-funded psychologist, and the CMHT seemed relatively straightforward. The facility said that it is difficult to be more specific, as this is dependent on the level of resource, expertise, and experience available within the specific CMHT. Its expectation was that the CMHT would assess Ms A and "put in place what they considered was appropriate and necessary with regard to her clinical needs at that time and their available resources".

44. The timing of the discharge summary was in line with the facility's policy (sent within seven working days of discharge). However, the actual discharge letter from the facility (different to the discharge summary form) was not sent to the contact centre until 14 November 2018. The facility acknowledged that this was not in line with its policy (as the discharge letter should have been sent within seven working days of Ms A's discharge on 21 September 2018) and was an oversight on its part, but stated that it contained essentially the same information that had been sent previously in the referral letter dated 13 September 2018.

45. The 14 November 2018 discharge letter was addressed to Ms A's referring clinical team (the Child and Adolescent Mental Health Service, for which she no longer met the age criteria), rather than the clinicians who were involved in her ongoing care.

DHB care

Initial contact with CMHT

46. The referral from the facility was sent to the contact centre (the single point of entry for the DHB's mental health services) on Thursday and Friday 13/14 September, triaged as non-urgent, and assessed by the contact centre MDT on Monday 17 September, and confirmation of address was sought on Saturday 22 September (the day after Ms A's move).

47. As noted above, the referral was received by CMHT on Monday 24 September, and therefore no clinical team had been identified before Ms A's discharge, and no appointments had been set up.

25 September 2018 — face-to-face meeting at CMHT office

48. On Tuesday 25 September 2018, Ms A telephoned CMHT in distress (having travelled past a location of previous trauma) and spoke to duty clinician RN F, and accepted the offer to meet with RN F in person.

49. Ms A had a face-to-face meeting at the CMHT office later on 25 September, the day after CMHT had received her referral and eight days after her referral had been triaged by the contact centre on 17 September. The electronic note shows a discussion of what had helped previously, Ms A's risks and protective factors, and a plan to meet her family. The duty clinician undertook a mindful body scan exercise with Ms A and provided "validation and ventilation", and noted that she had her first session with her ACC-funded therapist that morning. Ms A recalled being told that she would be allocated a care manager with the team and could contact the rostered duty person at CMHT or the Crisis Resolution Service (CRS).

50. On 26 September 2018, the ACC-funded case manager telephoned the contact centre for contact details, and was given CMHT's telephone number.

26 September 2018 — discussion at CMHT meeting

51. Occupational therapist Ms B,[8] who a few days later became Ms A's care manager at CMHT, told HDC that the next day, Wednesday 26 September 2018, Ms A was discussed at a morning CMHT meeting (two days after the referral was received at that service, nine days after her referral was triaged on 17 September, and five days after her arrival in her home town). Ms A's referral and current issues were discussed, and it was noted that CRS might need to be called if an intensive response was required, and that a "pragmatic and practical approach [was to] be taken, as the facility said they had done, in relation to self-harm events, with [Ms A] taking responsibility in the community as soon as possible".

27 September 2018 — ACC contact by CMHT

52. On 27 September 2018, the CMHT team leader telephoned Ms A's ACC-funded psychologist, and on 28 September the team leader reported at the morning meeting that Ms A had been allocated a large package of care by ACC, and the role of CMHT in her care was unclear.

1 October 2018 — CMHT contact of Ms A

53. A follow-up call was made to Ms A on 1 October 2018 by the CMHT duty clinician (RN F). Ms A reported "doing alright" and was advised that the plan was to allocate a care manager, with duty support available if needed.

2 October 2018 — contact of Ms A by Ms B

54. On 2 October 2018 (seven working days after referral to the CMHT), Ms B was allocated as the DHB care manager and Dr E as Ms A's psychiatrist. Ms B telephoned Ms A to make an initial appointment for 10am on 4 October 2018 to discuss her needs and a wellness plan. Ms B told HDC that she was "acutely aware … that this would be a tricky time for [Ms A]",

[8] Ms B is trained in health services management, cognitive behaviour therapy, and eye movement desensitisation reprocessing.

and that it was important to establish rapport and trust with Ms A while also helping her "successfully transition towards independence".

Events of 3–6 October 2018

First ED presentation — 3 October 2018

55. At around 7pm on 3 October 2018, Ms A presented to the Emergency Department (ED) at the public hospital for physical health problems.

56. At 9.30pm, Ms A telephoned the contact centre while in ED. She reported having thoughts of hurting herself, and was encouraged to talk to the ED doctor first. The DHB said that it is standard practice between ED and the contact centre for a physical health triage to occur before mental health input.

57. At 11.45pm, the ED doctor telephoned the contact centre with concerns about Ms A. The ED doctor considered that Ms A was not safe to go home, and she was admitted to the ED observation unit overnight, with a plan for her to be contacted by CMHT in the morning.

4 October 2018

58. On 4 October 2018, Ms A's admission to the ED the previous evening was discussed at the CMHT team meeting, and the plan was for Ms B to attend the ED observation unit to see Ms A. Dr E told HDC that he and Ms B reviewed the available information, including the referral letter from the facility and the WSR plan. Dr E said that a pragmatic approach taken at the facility regarding taking responsibility "was consistent with the general approach outline in the 2016 [WSR plan]", although he acknowledged that the plan was "out of date".

59. At 9.30am, Ms A first met her care manager, Ms B, at the ED observation unit. The electronic note documents a discussion with Ms A until about 11am, while they waited for a prescription. The note indicates that Ms A was medically cleared to leave, and was "keen to leave hospital". The note states: "[C]onversing well, appears alert although sometimes closing eyes. No stated [suicidal ideation] and appears sufficiently future orientated. Therefore [discharged] from ED." In response to the provisional opinion, Ms A said that she was not asked about suicidal ideation.

60. At 11am, Ms B transported Ms A to a relative's house where she was staying, and during the trip Ms A disclosed that she had harmed herself at 6.30pm on 3 October 2018 before going to ED, and she had not informed ED staff of this. Ms B then consulted with Dr E and the ED and was advised that, given the length of time in ED observation, no further action was required. Ms B informed Ms A of this advice.

61. Ms A told HDC that she informed Ms B about the self-harm only because she was frustrated and felt unheard by her. Ms A recalled telling Ms B that she needed support and "was really struggling … and didn't feel particularly safe", and "was told that [she] could have a scheduled appointment 4 days later". Ms A stated: "As a result of that I did not know what to do."

62. From the electronic note entered by Ms B at about midday, the plan was to establish regular weekly follow-ups with Ms B, and for ACC to establish a care team meeting. The note

documented that Ms A was seeing her ACC-funded therapist weekly, and that the WSR plan from 2016 was to "be entered into [the system][9] until a more up to date plan [was] in place". Ms B added another note explaining that Ms A had recently returned from the facility "after being in treatment there for 2 years [and] this is why no recent plans are in place".

63. Ms B told HDC that she located the WSR plan that morning in paper records, and discussed it and other documents with Dr E. She commented that the WSR plan was not used for decision-making at that time but provided important background information. She noted that they had also not been provided with an updated service plan by the facility.

Second ED presentation

64. Ms B missed a telephone call from Ms A at 12.45pm, and returned the call at 2pm. In response to the provisional opinion, Ms A said that she was trying to get support and telephoned Ms B before she self-harmed. She said that "unfortunately, [she] was not coping with so much change and felt unheard and wasn't able to wait for the return phone call". Ms A had self-harmed and presented to ED at around 1pm. Ms B advised Ms A to get medical attention, and documented that this approach was in line with the WSR plan "to independently seek treatment for self injuries". Ms A could then decide whether to continue with her plans for the day or return home.

65. At 2.56pm, an ED nurse telephoned the contact centre to advise that Ms A had been treated for cuts to her arm. The contact centre contacted Ms B, who confirmed that the plan from that morning still stood (see paragraph 62), and that "CMHT [would] not be attending ED to assess". The ED was informed of this, and Ms B did not attend to assess Ms A.

66. Ms B told HDC that she "did not feel there was any immediate risk to [Ms A]". Ms B said that she was following a more pragmatic approach, suggested by the facility, allowing Ms A to demonstrate self-responsibility, and was confident that ED staff could contact her or a CMHT duty worker or the contact centre for advice if needed.

67. Ms B also noted that Ms A had an appointment scheduled with the psychiatrist, Dr E, on 8 October 2018, with the ACC-funded care manager on 9 October, and with Ms B on 11 October, and that Ms A was aware of these appointments.

68. Ms A told HDC that she was trying to get mental health help and was being told that under a "plan" she could have an appointment on 8 October 2018 (four days away).

69. Ms B told HDC that Ms A had plans to stay with her parents, and to return to work on 5 October, and that "it made sense for her to be seen by the psychiatrist the very next business day for CMHT on Monday 8 October 2018".

70. Ms B said that her decision-making was guided by the principle of supporting people who resort to non-suicidal self-injury (NSSI) as a response to overwhelming emotions, and that responding in a reactive fashion can unwittingly reinforce the perception that an NSSI can

[9] Ms B added another note saying that she was unable to enter the WSR plan on the system as "scanned documents can not be copied in".

elicit a caring response from others. The DHB supported Ms B's response, saying that her decision was informed by her training and expertise, her understanding of the approach to treatment, and "widely accepted principles for supporting individuals who are susceptible to resorting to NSSI in response to unpleasant emotions".

71. In response to the provisional opinion and as outlined above, Ms A stated that she called to ask for help and was trying to get support before harming herself.

Evening of 4 October 2018

72. At around 6.45pm, ED telephoned the contact centre as Ms A was asking to speak to a contact centre clinician.

73. A contact centre clinician telephoned Ms A. The electronic note indicates that Ms A said that "she [was] not coping at all", that Ms B had dropped her at home that morning "but didn't ask a single question about how she felt", and that she had wanted to tell Ms B about the self harm the night before "but [Ms B] changed the subject".

74. However, as outlined above, Ms A had in fact told Ms B about the self-harm, and Ms B had followed up with ED about this (see paragraph 60). Ms B also told HDC that she had asked Ms A how she was feeling as part of assessing her mental state that morning.

75. The contact centre clinician's electronic note indicated that Ms A:

- said she had a treatment plan (the WSR plan) before she went to the facility but "that plan is not that relevant";
- "wants help, says if she goes home she will kill herself"; and
- "requesting to see CRS [DHB] team".

76. The CRS team was telephoned and informed. At around 7.10pm, ED telephoned the contact centre again and asked whether Ms A needed a "watch".[10] The call was transferred to CRS.

Self-discharge from ED and return to ED

77. The DHB's clinical notes indicate that a "watch" was put in place, but Ms A left (self-discharged) ED at approximately 9pm. She left a suicide note and harmed herself. ED alerted the Police, and Ms A telephoned an ambulance for herself at 9.35pm and she was returned to ED.

78. Ms A told HDC that she asked for mental health help again, which "was not provided to [her]".

[10] A patient "watch" entails specific staff members observing, recording, and managing specific behaviour at regular intervals, where a patient meets criteria such as risk of self-harm, risk to others, and suicide risk. The frequency of observations and type of monitoring is tailored to the patient.

79. At 10.40pm, Ms A was reviewed by an ED registrar. The plan was for "IVL[11] and bloods, paracetamol level at 4 hours (0130), ED [Observation Unit] with watch".

5–6 October 2018

80. At 3am, it was noted that Ms A was due to start treatment for the self-harm, and Ms B was emailed about Ms A being in ED.

81. Ms B reviewed Ms A at 10am on 5 October 2018. The notes indicate that Ms A engaged well, and that she was having a "speed wobble" with all of the adjustments of moving from the facility. Ms B documented that Ms A asked about respite care, but had plans for the weekend, so did not want to pursue this. The plan was for follow-up at the scheduled appointments on 8 October with Dr E and 11 October with Ms B.

82. Ms A said that she did not pursue respite care because she was told by Ms B that she did not need it, which she recalled left her feeling completely dismissed.

83. In the afternoon (from approximately 3pm), Ms A refused further medical treatment for her self-harm. The ED registrar contacted the contact centre requesting contact with CMHT.

84. Ms B telephoned Ms A and spoke with her for 30 minutes. Ms B was unable to persuade Ms A to continue treatment. Ms B recommended to the ED registrar that Ms A be directed to use distraction to soothe herself and to be responsible for decisions about treatment (while being encouraged to complete the treatment for the self-harm).

85. Ms A continued to refuse treatment and voiced suicidal ideas, so the ED registrar sought further advice from the CRS psychiatry registrar, Dr D, who liaised with the on-call consultant psychiatrist. Dr D and the consultant psychiatrist supported Ms B's plan to encourage Ms A to take responsibility, and this was communicated to the ED registrar along with education and advice.

86. Dr D said that Ms A's presentation had not changed significantly since Ms B's plan (following her discussion with Ms A around 3pm), and the consultant psychiatrist had discussed with him the importance of maintaining consistency as a service.

87. In response to the provisional opinion, Ms A told HDC that she is unsure how the psychiatrists knew that her presentation had not changed significantly as they did not assess her and did not know her from previous contact.

88. At 5.08pm, Ms A's ACC-funded case manager telephoned the contact centre saying that Ms A's mother had contacted her expressing concerns that her daughter was refusing medical treatment and might leave ED. The contact centre's advice to the case manager was to encourage Ms A's mother to telephone the contact centre directly, so that they could facilitate her expressing her concerns to CRS.

[11] Intravenous liquids (fluids injected into a vein).

89. At 5.29pm, Ms A's father telephoned the contact centre requesting a mental health assessment for his daughter as she wanted to leave ED and was at risk of self-harm. A voice message was left for CRS by the contact centre.

Second self-discharge from ED

90. Ms A told HDC that she had not had any mental health support. She stated: "I was spinning out of control and there was a huge problem for me." At 5.30pm, Ms A left ED (self-discharged), and when contacted by her family, expressed a plan to harm herself further. Ms A's family then contacted the Police.

91. Ms A was found by her father, who restrained her until the Police arrived. She was then taken back to ED by the Police around 7.13pm under section 109 of the Mental Health (Compulsory Care and Treatment) Act 1992. In response to the provisional opinion, Ms A told HDC that the contact centre refused to assess her at this point, "forcing the police to start the Mental Health Act to force an assessment to happen".

92. On 6 October 2018, Ms A was placed under section 11 of the Mental Health Act and transferred to the mental health recovery unit at the public hospital.[12] During this admission, Ms A became subject to a compulsory treatment order under the Mental Health (Compulsory Care and Treatment) Act 1992.

Further care

93. Ms A was discharged to respite care on 6 November 2018 and continued to receive care from the DHB.

94. On 12 November 2018, Ms B took Ms A to a GP appointment, and afterwards Ms A asked to collect her sensory box[13] from her parents' home, so Ms B took her there. Ms A was not living there at the time, and her parents were not present.

95. Ms A's parents questioned why Ms A had been allowed to enter the house unannounced and unattended. Ms B told HDC that the use of the box was in line with the treatment plan, and that Ms A had telephoned her mother and left a message so that she would know why the security camera had been triggered. Ms B said that she allowed Ms A to enter the house alone as she was regulated in her mood, and Ms B wanted to show trust.

96. Ms A was discharged from respite care on 11 December 2018.

Further information

The Whole Service Response plan

97. As outlined above, Ms A's WSR plan was referred to in the clinical notes for her presentations to the DHB in October 2018.

98. The WSR plan was developed in late June 2016 to respond to Ms A's chronic risk behaviours, and was made when she was under the Child and Adolescent Mental Health Service. Ms A

[12] The mental health recovery unit at the public hospital.
[13] A tool to help with emotional regulation.

returned to her home town in 2018 to the adult services, and she commented that the plan was over two years old, and had no current information about her. She told HDC:

> "I should have been treated as new to the service and my symptoms treated accordingly due to my change in age, circumstances, and the huge amount of therapy which I had undertaken over the past 2½ years."

99. The WSR plan stated:

> "If there is a change to [Ms A's] established pattern of chronic risk behaviour, there will be a reassessment for the presence of acute risk. Acute risk will signal the need for an increased level of intervention to prevent harm."

100. The DHB told HDC that there was an intention to develop a new plan, but "as [Ms A] presented in crisis very soon after being allocated a care manager, there had not been an opportunity to begin developing a fresh plan". The DHB stated that therefore, the WSR plan was used to guide responses on 4 and 5 October 2018, along with information provided by the facility, and clinical assessments of Ms A.

101. Dr E stated:

> "[The WSR plan was] not an exclusive guiding document for the decisions made … [It] was used to provide relevant background information, along with available correspondence from the facility. Importantly, clinical decision-making was based on [Ms B's] clinical experience and assessment of [Ms A] at the time. That is to say, decisions made by the team regarding her care were all informed by understanding of her previous history, presenting difficulties, and best-practice principles for the treatment of emotional dysregulation and NSSI."

102. As noted above, the WSR plan was stored as a paper file, and was not able to be loaded into the electronic system (see paragraph 63), and therefore it was not available to the contact centre staff at the time of events.

Ms A

103. Ms A told HDC that events left her "not trusting whether [CMHT] really had [her] best interests at heart, and whether an incident similar to the one that occurred would happen again if [she] asked for help". She said that this has stopped her asking for help proactively. Both Ms A and her parents told HDC that they made the complaint to HDC so that the situation does not happen again to her or anyone else.

104. Ms A believes that she was not given mental health support at the time of events because of a DHB plan that was "some years old" and "completely outdated and wrong for [her] clear needs [at the time]". She said that she felt that DHB staff did not listen to her or to other people seeking help for her.

105. Ms A stated: "I asked for help early, and it was never my desire to end up in hospital."

The facility

106. The facility acknowledged that as the referring team they hold some responsibility to follow up their referrals, and said that this is something to which they will pay greater attention in the future. It commented that a pre-discharge conference with the referring team, all receiving services, and consumer and family/supports would have been ideal, and is the facility's usual practice. The facility said that there was a family meeting with Ms A's father on the day before her discharge, which could have included the DHB, but at that time clinicians had not been allocated to Ms A.

Responses to provisional opinion

Ms A

107. Ms A was given an opportunity to respond to the "information gathered" section of the provisional opinion. Where appropriate, changes have been made to this section in response to her comments.

108. Ms A said that she wanted "to make it clear on behalf of [her] family that the amount of times [her] parents attempted to get [her] support is hugely [under-represented] in this document".

The facility

109. The facility was given an opportunity to respond to the relevant sections of the provisional opinion. Where appropriate, the facility's comments have been incorporated into this opinion.

110. The facility told HDC:

> "[The facility] wishes to acknowledge that [Ms A] was a complex young person who, four years ago, had a discharge from us that was tumultuous. This started to manifest itself three weeks before discharge even though we had been planning the discharge for quite some time prior. She was well known to [the DHB] services who had expertly kept her alive and well prior to coming to us. We had had two and a half years of some very tumultuous times with her leading to a more quiescent time in terms of her borderline personality and complex post-traumatic structures. We saw a reactivation of this just prior to her leaving."

111. The facility said that it and the DHB services were involved in an evolving situation. It said that in this case, it was very difficult to follow up on the referral as it had no individual with whom to follow up.

112. The facility apologised that the reference to "wrap around services by the MDT" was perceived to be too vague, but said that Ms A had greater than usual support on discharge and that on assuming care, the receiving service makes its own decisions as to the care to be provided. The facility said that in situations where there is limited possibility for pre-discharge contact between treating teams, there is the possibility of post-discharge contact. It said that if in crisis and receiving teams need more information, the facility is "very open to telephone calls and Zoom conferences".

113. The facility said that it suspects it did not receive a telephone call from the receiving clinicians as they were managing well. The facility stated that the acute management of a person in a "borderline crisis situation" is not unfamiliar work for a public mental health service, and the service did not contact the facility, nor did they request further information or help from the facility.

114. The facility said that it was made aware of Ms A's DHB clinician only on 8 October 2018, upon receiving a signed consent for the release of her clinical material. It stated that the first time it had telephone contact with the DHB service was on 23 May 2019, when they discussed the type of therapy Ms A was having, which appeared to be contributing to her unstable presentation.

115. The facility told HDC that a longer time frame to plan the discharge occurs "in an ideal world" and in a routine discharge, but in this case, it was trying to hold Ms A to her discharge date, which suited Ms A and her family and which Ms A was determined to meet, and there were no grounds to detain her under the Mental Health Act. It said that in retrospect, Ms A's discharge transition once in her home town was even more complicated than it anticipated or knew about.

116. The facility told HDC that once a patient has been accepted into the care of another service, the facility, as a tertiary service, no longer dictates any terms of treatment, and public services do not enter into shared care arrangements with the facility.

117. The facility said that it is aware in general terms of what public mental health services can provide, but the specifics of the disciplines involved as case managers, and the frequency of contact with services, need to be negotiated after an initial assessment. The facility stated that it can make recommendations, but it cannot do more than this. It said that Ms A had come to the facility from a public service where she had been well known, and that she and her family were used to dealing with public mental health services.

118. The facility said that in its view, the inability to communicate directly with the clinicians who had taken over Ms A's care, the triaging of Ms A's case as non-urgent and therefore deferring immediate follow-up with her, coupled with the absence of any communication from the clinicians seeking any further information, should be given greater weight.

Te Whatu Ora

119. Te Whatu Ora was given an opportunity to respond to the relevant sections of the provisional opinion and had no further comments.

Opinion: Introduction

120. When Ms A returned to her home town in September 2018, after two and a half years at the facility, she returned to family and employment but also to the location of previous trauma. The transfer was a time of increased vulnerability for Ms A. Below I consider whether she was provided with services with reasonable care and skill, and whether there was reasonable co-operation between the facility and the DHB on transfer of care to ensure quality and continuity of services.

121. At this point, I endorse the advice provided by my independent advisor, consultant psychiatrist Dr Paul Vroegop:

> "[T]he complex interplay of services and clinicians, and lack of clear communications, likely contributed to [Ms A's] distress and sense that she and her whānau were not being heard; but … this complexity should not be a reason for not addressing these systemic issues."

Opinion: Ashburn Hall Charitable Trust — breach

Discharge planning — breach

122. The referral letter from the facility to the DHB sent on 13 September was "for wrap around support by a MDT as [Ms A] transitions back to the community". However, further detail was not provided. My independent advisor, Dr Vroegop, said that the accepted standard of care in transfers of care from one service to another often seems to be limited to a written referral with recommendations, without explicitly discussing these with the client and whānau. He is critical that the referral did not detail what this meant for Ms A, and who would provide this (including the role of the ACC-funded psychologist). There was a lack of any clearly agreed methods for communicating Ms A's needs and coordination of services between Ms A, her parents, CMHT, and her ACC-funded therapist.

123. I note that the facility has apologised that the reference to "wrap around services by the MDT" was perceived as too vague, but said that Ms A had greater than usual support on discharge and that on assuming care, the receiving service makes its own decisions as to the care to be provided.

124. I also note that, as the facility has emphasised, while Ms A had a pre-existing history with the DHB's mental health services, she had not been seen by them for two and a half years. During this time, she had aged out of the adolescent service and moved into adult mental health service care. She had recently been discharged into the community after a long admission at psychiatric residential supported care, although she had been on the inpatient unit at the facility since the episode of self-harm in August 2018.

125. Dr Vroegop noted that it was not clear who would provide psychotherapy on discharge, or what support Ms A would receive from her ACC-funded team. There was no exploration by the facility of what the DHB could provide, and therefore no detail on what Ms A could realistically expect from the DHB. There was no updated care plan available for Ms A, her family, or the DHB clinicians.

126. Dr Vroegop advised that overall, this lack of clarity around needs and expectations was a moderate departure from accepted practice, given the complexity of Ms A's needs, her identified challenges in returning to her home town, and how well her treating team at the facility knew her. Dr Vroegop stated:

> "The impact of this was significant, as it appears there was a clear mismatch between [Ms A] and her parents' expectations, which added to their distress at her not receiving the care they expected."

127. I note that the decision to return to her home town on 21 September 2018 was made in June 2018 at a family meeting with the facility. Initially it was considered that Ms A could be managed as an outpatient with the support of her ACC psychologist and GP, without a referral to the DHB mental health services. This changed following an episode of self-harm on 23 August 2018, after which a transfer of Ms A to the DHB as an inpatient was considered. At an MDT meeting on 5 September, it was decided that Ms A would require a transfer to the DHB mental health services "for wrap around support by a MDT as she transitions back to the community". The facility had been in contact with Ms A's GP and ACC psychologist in her home town preparing for her transfer. However, the introduction of the DHB as a provider was late in the discharge planning and, as the facility acknowledged, "there were some timing difficulties with regard to having such a teleconference prior to [Ms A's] discharge, as her discharge plans changed quite quickly in the lead-up to her discharge".

128. Dr Vroegop acknowledged that the responsibility for supports and discharge planning was a collective one involving the facility, Ms A's ACC-funded providers, and the DHB. However, he advised that there was no follow-up by the facility to ensure that the recommendations in the referral letter could or would be followed by the DHB, and he identified this as a mild departure from the accepted standard of care.

129. The facility acknowledged that it holds some responsibility to follow up referrals, and has reflected on improvements in this area (see the "changes made" section below). It commented that a pre-discharge conference with the referring team, all receiving services, and consumer and family/supports would have been ideal, and is the facility's usual practice (see paragraph 106).

130. The facility also commented that a significant barrier to contacting the community mental health team at the DHB was the single point of entry contact centre, as the facility no longer makes direct contact with the clinicians to whom they are referring a patient. This also meant that it was not possible to be involved in a pre-discharge conference with the receiving team. The facility also expected that the community mental health team at the DHB would conduct a thorough assessment of Ms A as soon as she entered that service.

131. I note that Ms A and her parents want reassurance that this situation will not happen again and, with this in mind, I have made recommendations around holding a pre-discharge teleconference, ensuring that a complete discharge summary is available, and considering holding a post-discharge review meeting (see paragraph 183).

Conclusion

132. I acknowledge the facility's comments in the above paragraphs, and appreciate the difficulties they had from the lack of understanding of the DHB resources. However, in my view, the facility should have been more proactive in its transfer of care, especially noting that the single point of entry to the DHB has been a feature of that service for several years. I also note that whilst the initial telephone call was made to the contact centre on 5 September, the actual referral was not sent to the DHB until 13 September — only six working days prior to Ms A's discharge from the facility on 21 September.

133. In my view, this was not adequate time to allow the facility and the DHB to work together to establish the wrap-around support that Ms A required. I consider that the facility should have sent the referral to the contact centre with adequate time to prepare, and should have provided the DHB clinicians with sufficient handover, whether in the form of more detail in the referral, more extensive discharge information, a pre-discharge meeting, and/or an updated care plan, so that Ms A could understand what the receiving services could do for her, and those services could understand Ms A's needs. With the shorter time frame, and the lack of detail in the referral, I consider that the facility should have proactively followed up with the DHB to ensure that there was adequate co-operation and communication between the services.

134. I also accept Dr Vroegop's advice that the lack of clarity in the referral from the facility to the DHB affected the quality of the transfer of care for Ms A. This lack of clarity was partly driven by the timing issues discussed above — as without sufficient time to work with the DHB, it would be difficult to provide the necessary detail with which to update Ms A's care plan and service-wide crisis plan. I also believe there was an opportunity for further inclusion of Ms A and her family to clarify expectations.

135. Ms A had complex mental health needs and this was not a routine discharge. Given the prolonged treatment Ms A had received from the facility, the facility was in the best position to understand her situation and had the most up-to-date information about her condition, needs and expectations. In my view, the facility had a responsibility to ensure that the receiving service had more detailed and up-to-date information about Ms A. In this case, her specific needs were not discussed with the treating team or detailed clearly, and were not conveyed to Ms A and her whānau clearly.

136. I am concerned that the facility did not communicate adequately with the DHB to manage Ms A's risk. I acknowledge that the single point of entry system made communication more difficult, but I do not accept that the facility was unable to contact an individual clinician as it did not know who the individual clinician was. This was information that could easily have been obtained by way of a telephone call.

137. In my opinion, as the referring service who held the most recent information about Ms A, ultimately responsibility for providing adequate information and communication in the initial stage of the transition rests with the facility. I do not accept the fact that if the receiving service had required further information it could have contacted the facility — as the facility emphasised — lessens the facility's responsibility to provide the relevant information.

138. It is well known that the transition of care for mental health patients is a critical point and a period of risk because of the distress it can cause patients. Ms A was transitioning from a stable environment to a new care team and a new location. In the circumstances, the facility should have been more proactive and communicative with the receiving service and should have provided more detailed information about Ms A's needs. In a previous case,[14] HDC highlighted the importance of coordination of care in a mental health setting, and stated:

> "Effective coordination of care is vital in a forensic mental health setting where a vulnerable person with complex mental health needs is receiving care from multiple providers at the same time, and, often, transitioning between providers."

139. In my view, regardless of the extent, if any, to which the handover of care affected Ms A's deterioration, I consider that the transition of care was inadequate. Given that Ms A was a vulnerable patient with complex mental health needs, greater care should have been exercised to manage her risk.

140. In conclusion, I am of the view that the facility had the most in-depth and recent information on Ms A, and should have taken more responsibility for her transfer to the DHB. This meant being proactive in the transfer of care, such as providing a more comprehensive referral, or organising a pre-discharge conference with the receiving team. I also believe that this would have provided an opportunity for Ms A and her family and the DHB to clarify expectations. I accept Dr Vroegop's advice that the lack of clarity around needs and expectations from the facility to the DHB was a moderate departure from accepted standards. Accordingly, I find that Ashburn Hall Charitable Trust breached Right 4(5) of the Code of Health and Disability Services Consumers' Rights (the Code) for failing to ensure quality and continuity of services.[15]

Timely provision of discharge information — adverse comment

141. The initial telephone contact with the contact centre occurred on 5 September 2018, and the referral letter was sent on 13 September 2018 (with additional documentation sent the following day).

142. The facility sent the discharge summary form to the contact centre, Ms A's GP, and the ACC-funded case manager and psychiatrist on the following Monday, 24 September 2018.

[14] 18HDC01605.

[15] Right 4(5) states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."

However, the final discharge letter was not sent until seven weeks later, on 14 November 2018, and was addressed to the wrong service at the DHB.

143. The facility has acknowledged that the final discharge letter should have been sent within seven working days of discharge on 21 September 2018, and my independent advisor has described this as "extremely delayed", although commented that "as there was little or no additional information, this is unlikely to have affected [Ms A's] care". Similarly, in response to the provisional opinion, the facility emphasised that the information in the letter was "essentially the same".

144. I acknowledge that on this occasion the delay in sending the final discharge letter was unlikely to have affected Ms A's care, but I am of the view that without having had the opportunity to brief the receiving community team, the only information the DHB had to process this referral prior to Ms A's arrival was the referral form itself, which contained insufficient information to establish the wrap-around service requested. This is an area for improvement for the facility, as it is important to provide discharge information in a timely way to ensure continuity of care between providers.

Opinion: DHB — adverse comment

Transfer of care from facility — adverse comment

145. Dr Vroegop advised that the responsibility for supports and discharge planning was a collective one involving the facility, Ms A's ACC-funded providers, and the DHB. The decision to transfer care to the DHB was made by the facility late in the discharge planning, and I have discussed this in the opinion section above.

146. Dr Vroegop did not identify a departure from accepted practice for the referral and allocation process at the DHB. However, he advised:

> "[I]deally a clinical treating team could have been identified prior to her discharge and appointments set up. This would have ensured an earlier identification of [Ms A's] needs and expectations of the service, and processes for involving her parents and her ACC psychology team."

147. I agree that prior establishment of a clinical team would have been beneficial; however, considering the time restraints, I am not critical that this did not occur.

148. However, I do consider that the DHB's contact centre had a responsibility, upon receiving the referral on 13 September in the knowledge that Ms A would be transferring a week later, to be more proactive in making enquiries to ascertain what kind of support Ms A needed. In my view, whilst perhaps vague, the requirement for "wrap around support" suggested that a significant level of care might be needed for Ms A; however, in the intake meeting four days later, the DHB categorised the referral as "non-urgent", and did not intend to check

details until the day of Ms A's discharge. I am critical that the DHB did not consider that anything more urgent needed to be done.

149. I also note that the facility has stated that it was not aware of which clinicians Ms A would be referred to at the DHB, as contact was through the contact centre, and there was no direct contact with the clinicians to whom the facility was referring Ms A's care.

150. The DHB would have been aware of this limitation in its single point of contact system. I am critical that despite this known limitation, and the short time between receiving the referral and Ms A's planned discharge, no effort was made to acknowledge receipt of the referral, nor clarify with the facility the level or nature of support needed by Ms A, in the days before (or after) her transfer of care. This would have removed any perceived barrier to contact and enabled the facility and the DHB to provide better continuity of care.

Management of Ms A on 4 October 2018 — adverse comment

151. Ms A stayed in the ED observation unit overnight on 3–4 October 2018 after reporting having thoughts of hurting herself. She was discussed at the CMHT meeting on the morning of 4 October, and Dr E and care manager Ms B reviewed the referral letter from the facility and the WSR plan from 2016 (see paragraph 58).

152. Ms B then visited Ms A in the ED, which was their first meeting. As described by Dr Vroegop, this occurred in "less than ideal circumstances" (see paragraph 59). Dr Vroegop commented that this became a factor in the care provision, as "from this point onwards [Ms B] would be seen by other clinicians within [the DHB mental health service] as the clinician who best understood [Ms A] and her needs, and had primary responsibility for managing her care".

153. Ms A was discharged from ED. When she disclosed that she had harmed herself the previous day, Ms B appropriately followed up on this with ED (see paragraph 60). Ms A has described that she "was really struggling … and didn't feel particularly safe", and "was told that [she] could have a scheduled appointment 4 days later". She stated: "As a result of that I did not know what to do." She later self-harmed and returned to ED (see paragraph 64).

154. Ms B returned a telephone call from Ms A and advised her to get medical attention. Ms B documented that this approach was in line with the WSR plan "to independently seek treatment for self injuries". An appointment was in place to see Dr E on 8 October 2018. Ms B commented that she "did not feel there was any immediate risk to [Ms A]", and so did not assess her in person. I note that the DHB supported Ms B's response, stating that her decision was informed by her training and expertise, her understanding of the approach to treatment, and "widely accepted principles for supporting individuals who are susceptible to resorting to NSSI in response to unpleasant emotions" (see paragraph 70).

155. By the evening, Ms A was saying that "she [was] not coping at all" and she "want[ed] help", that "if she [went] home she [would] kill herself", and that the WSR plan was "not that relevant", and "requesting to see [the] CRS [DHB] team". The CRS team was informed, and ED put a "watch" in place (see paragraphs 72 to 76). Ms A later left ED and harmed herself (see paragraphs 77 to 79).

156. I acknowledge Ms A's comment that it is really important that she can access support when needed because "when [she] start[s] to go off the rails, [she] can be helped [but if] it is left too long, then there is little that anyone can do to help [her]".

157. Dr Vroegop advised that the initial assessment by Ms B in the morning was reasonable. He noted that the mental health clinicians involved felt that her behaviour was consistent with her history of emotional dysregulation, and that therapeutic principles around not reinforcing unhelpful responses to overwhelming distress (reinforced by Ms A's 2016 WSR plan) supported this approach.

158. However, Dr Vroegop considered that Ms A should have been reassessed by a mental health clinician following her return to ED that afternoon, "given that she was demonstrating a significant escalation in risk and was essentially new to the service, and that her care manager had only met her relatively briefly that morning". He identified this as a moderate departure from the accepted standard of care, and advised:

> "I believe that [Ms A's] mental state, current (rather than historical) risk, and management plan should have been reassessed and discussed within the clinical team, in the context of a vulnerable person transitioning to living in the community after a prolonged residential stay."

159. I have considered Dr Vroegop's view and that of Ms B and the DHB. I have also taken into account that Ms B and Dr E did discuss the care and considered the WSR plan alongside the information from the facility, and applied their expertise to the situation.

160. I am of the opinion that considering the fact that Ms A's WSR plan was a couple of years old and had been made when she was an adolescent (and she had moved to the adult mental health service), Ms B should have undertaken an assessment when Ms A re-presented to the ED.

161. However, I consider there to have been multiple mitigating factors, including Dr Vroegop's comment:

> "[DHB staff may] well have been placed in a position where they had limited time to develop a therapeutic relationship with [Ms A] and her whānau, and seemingly no opportunity for the whole treating team (including Psychiatrist and ACC Psychologist, as well as care manager) to develop a collaborative care plan with [Ms A] and her whānau."

162. Dr Vroegop also noted further factors that made decision-making difficult, including a lack of collaborative handover of care with the facility, an internal DHB handover from the contact centre to the treating team, and Ms A's relatively quick mental health deterioration. In these circumstances, the new team had to respond before Ms A had had an opportunity to develop a collaborative approach to her treatment (including realistic expectations of care and building a degree of trust). I also acknowledge the circumstances in which Ms B and DHB staff were placed (in particular that these events occurred within two weeks of Ms A's discharge from the facility).

163. Accordingly, whilst I consider that an assessment should have taken place at that opportunity, the team was working consistently to a previously agreed plan (with another team), and were making efforts to keep Ms A out of hospital. Ms A told HDC that this was her preference. She said: "I asked for help early, and it was never my desire to end up in hospital." Therefore, while I am concerned that an assessment did not occur, I do not consider that this omission amounts to a breach of the Code.

Crisis presentation on 3 October 2018 — adverse comment

164. On 3 October 2018, Ms A presented to ED with physical health issues, and in the evening telephoned the contact centre having thoughts of hurting herself. The duty clinician encouraged her to talk to the ED doctor first. I note the DHB's comment that it is standard practice for a physical health triage to occur in ED before the contact centre is contacted for mental health input.

165. However, in Dr Vroegop's opinion, Ms A was taking responsibility by telephoning the contact centre, and he is mildly critical that the duty clinician did not talk to the ED doctor on her behalf. Dr Vroegop advised that "[the contact centre's] duty clinician should have talked to the Emergency Department doctor and/or arranged for a mental health assessment on receipt of [Ms A's] phone call, rather than asking [Ms A] herself to do so". I accept this advice.

Whole Service Response plan — other comment

166. The WSR plan was developed by the DHB in late June 2016. Dr Vroegop advised that it was not reasonable to rely on the plan at Ms A's October 2018 presentations, as it was over two years old. He said that accepted practice is to revise such a plan "at least every 3 months, or with any change in status" to reflect changes in mental illness, risk patterns, coping strategies, and supports. He noted that the plan had been developed when Ms A had been under Child & Adolescent Mental Health Services with long periods of inpatient care.

167. The DHB told HDC that the WSR plan, information provided by the facility, and clinical assessments of Ms A were all used on 4 and 5 October to guide care, and there was an intention to develop a new plan, but Ms A presented in crisis before this could be done. Dr E said that the WSR plan was "not an exclusive guiding document for the decisions made [but] was used to provide relevant background information, along with available correspondence from the facility" and assessments of Ms A and "best-practice principles for the treatment of emotional dysregulation and NSSI".

168. Dr Vroegop acknowledged that although the care provided at these presentations appeared to be broadly consistent with the WSR plan, the plan was not used by clinicians as an exclusive guiding document for the decisions made, and the impression given to Ms A and her family that the plan was relied on more heavily overstated its use. Dr Vroegop advised that the use of the WSR plan was a mild departure from accepted standards. He also advised:

> "While the WSRP should have ideally been rapidly updated in collaboration with [Ms A] and her inpatient treating team at the facility on discharge, I appreciate that there was practically insufficient time to develop a sufficient therapeutic relationship to do this following her initial assessment by [DHB] Mental Health."

169. I accept that ideally the plan should have been updated, but am of the view that the DHB did not have sufficient time in which to do this. I accept that DHB staff intended to revise the WSR plan, and that appropriately it was not solely relied on to guide decision-making. I have proposed recommendations to improve transfers of care and service-wide care planning to address this issue.

Referral and allocation — other comment

170. The facility telephoned the contact centre regarding Ms A's referral on 5 September 2018 and sent the referral letter on 13 September 2018, a week before Ms A's arrival in her home town on 21 September 2018. The referral was triaged on 17 September as non-urgent, as Ms A had not been discharged from the facility at this point. She was allocated a case manager on 2 October 2018.

171. My advisor commented:

> "[I]deally a clinical treating team could have been identified prior to her discharge and appointments set up. This would have ensured an earlier identification of [Ms A's] needs and expectations of the service, and processes for involving her parents and her ACC psychology team."

172. However, as outlined above, the treating team was established within the expected timeframes of a non-urgent referral. Dr Vroegop has not identified this as a departure of care, but more an area for improvement. This is addressed in the recommendations section.

173. I also note that on 18 September 2018 Ms A's ACC-funded case manager telephoned the contact centre to check the progress of the referral and was mistakenly told that it had not been received. The DHB has apologised for this oversight, and the clinician has reviewed their practice, which is appropriate.

12 November 2018 communication — no breach

174. On 12 November 2018, Ms B took Ms A to her parents' home to collect an item without prior communication with family, and allowed her into the house unattended. Ms A's family questioned this decision. Dr Vroegop advised that there was no departure from accepted standards, as this "was part of a considered management plan explicitly involving [Ms A], with her consent, taking increasing self-responsibility for her risk". Dr Vroegop said that communication with Ms A's family would have been good clinical practice, and I note that Ms A telephoned her mother and left a message.

Changes made since events

DHB

175. The DHB has developed a Whānau/Family Participation Policy and Framework for involving family.

176. Four full-time ED Liaison Nurse positions have been established to provide rapid triage and initial mental health assessment in ED and to facilitate a person's access to the mental health service. This occurred from 2019 at the DHB ED.

177. A number of additional psychiatrists have also been employed.

The facility

178. The facility said that it is ensuring that the psychiatrists "learn to negotiate the national services in terms of discharge and expectations from services that are receiving people".

179. The facility has reflected on the discharge processes, policies, and procedures, and has considered developing transitional follow-up processes after discharge. It said that in cases of routine discharge, it has made efforts, when possible, to notify services well ahead of discharge, and teleconferences occur with receiving teams, although in cases of a "crisis discharge" this is not always possible. Its administration team checks that referral emails have been received at the time they are sent.

180. The facility said that if a person comes to the facility from a different region and has shared care with the local mental health services and ACC, it will ensure that quarterly reports are sent to clinicians from the region from which the person has come.

181. The facility told HDC that it is having further discussions with regional co-ordinators (who co-ordinate referrals to the facility under the Ministry of Health contract) if there are additional requirements in terms of discharge.

Recommendations

182. In light of the changes already made (as noted above), I recommend that Te Whatu Ora:

a) Provide a formal written apology to Ms A for the deficiencies of care identified in this report. The apology should be sent to HDC within three weeks of the date of this opinion, for forwarding to Ms A.

b) Consider holding a post-discharge review meeting with the consumer, whānau, the referring team, and all receiving services (including ACC where relevant) to improve communication and coordination of services.

c) Review the practice of assigning a transfer of care from another mental health service as a low priority, to allow for prioritising early engagement for consumers with likely high mental health needs.

d) Ensure that service-wide care plans include other relevant services, including ED response, and are available to both the contact centre and the ED.

e) Report back to HDC on points (b) to (d) above within three months of the date of this opinion.

183. In light of the changes already made (as noted above), I recommend that the facility:

a) Provide a formal written apology to Ms A for the deficiencies of care identified in this report. The apology should be sent to HDC within three weeks of the date of this opinion, for forwarding to Ms A.

b) Consider ways to engage all accepting services and consumer and family/supports in a pre-discharge teleconference to discuss medication and identify strengths and whānau/ community supports, risks and early warning signs, coping strategies, patient expectations, and long-term goals.

c) Ensure that a complete discharge summary is available for the consumer, their family/ whānau, and receiving teams and clinicians, at the time of or prior to discharge, detailing what has been agreed in the pre-discharge meeting, including the specifics of community management and available supports and resources.

d) Consider holding a post-discharge review meeting with the consumer, whānau, the referring team, and all receiving services (including ACC where relevant) to improve communication and coordination of services.

e) Report back to HDC on points (b) to (d) above within three months of the date of this opinion.

Follow-up actions

184. A copy of this report with details identifying the parties removed, except the Ashburn Hall Charitable Trust and the expert who advised on this case, will be sent to ACC, the Director of Mental Health and Addiction Services, the Mental Health and Wellbeing Commission, and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following expert advice was obtained from consultant psychiatrist Dr Paul Vroegop:

"Independent Report for the Health and Disability Commissioner

File Number C18HDC02016

CONFIDENTIAL

14 July 2020

My name is Dr Paul Vroegop, and I have been asked to provide advice to the Health and Disability Commissioner (HDC) on case number C18HDC02016 involving the care provided by [the DHB] and [the facility] to [Ms A] in 2018. In doing so, I am abiding by the Commissioner's Guidelines for Independent Advisors (March 2019), which I have read. I do not believe that I have any personal or professional conflict of interest in relation to this case.

I am a specialist Child and Adolescent, Adult and Consultation-Liaison Psychiatrist and Pain Medicine Physician. My specialist qualifications are MBChB (Auckland 1995), FRANZCP (2004), Advanced Training Certificate in Child and Adolescent Psychiatry (2006), Advanced Training Certificate in Consultation-Liaison Psychiatry (2009) and FFPMANZCA (2015). I have worked as a specialist Child and Adolescent and Adult Psychiatrist in both community and hospital (consultation-liaison psychiatry) settings in New Zealand, and currently work predominantly in Counties Manukau Health in Auckland.

The Commissioner provided the information on which I have relied in compiling this report:

1. Letter of complaint dated 29 October 2018.
2. [The facility's] response dated 8 August 2019.
3. Clinical records from [the facility] covering the relevant period.
4. [The DHB's] response dated 3 December 2018.
5. Clinical records from [the DHB] covering the relevant period, and including the Whole Service Response Plan dated 23 June 2016.
6. Further information received from [Ms A's] parents 3 February 2019.
7. Feedback from [Ms A] on [the DHB's] response dated 10 March 2019.
8. [DHB] updated care plan 1 November 2018 and relevant progress note for 12 November 2018.
9. [DHB's] Occupational Therapist Role Description (undated)

I also discussed, in de-identified format, some aspects of this case with my RANZCP Peer Review Group (number …) of which I am a member, particularly the standard practices operating in public adult mental health services, and the normal expectations around transfers within and between such services and other private psychiatric providers. I also reviewed the Ministry of Health documentation on the recovery approach to mental illness (Ministry of Health website 2020).

I have been asked to advise whether I consider the care provided to [Ms A] by [the facility] and [the DHB] were reasonable in the circumstances, and why. In particular, I have been asked to comment on:

[Facility]:

1. Whether the information supplied by [the facility] to other providers, prior to and upon [Ms A's] discharge, was sufficient and timely.
2. Whether the supports put in place by [the facility] for [Ms A] post-discharge were appropriate.
3. Any other matters you consider warrant comment about [the facility].

([DHB]):

4. Whether the care provided by [the DHB] during 21 September 2018–3 October 2018 was appropriate and timely.
5. Whether the treatment provided by [the DHB] on 4 and 5 October 2018 was adequate/appropriate.
6. Whether it was reasonable to use the 2016 Whole Service Response Plan to guide treatment during the period post [Ms A's] discharge from [the facility].
    a) If it was reasonable, please also advise:
        i. Whether the care provided from 21 September 2018–5 October 2018 was consistent with the plan.
        ii. Whether her presentation, particularly on 4 and 5 October 2018, suggested more acute risk or deviation from usual patterns.
7. The level of communication with [Ms A's] family.
8. The family's concerns about the care provided to [Ms A] on 12 November 2018.
9. Any other matters you consider warrant comment about [the DHB].

For each question, I have been asked to advise:

a) What is the standard of care/accepted practice?

b) If there has been a departure from the standard of care or accepted practice, how significant (mild, moderate, or severe) a departure do you consider this to be?

c) How would it be viewed by your peers?

d) Recommendations for improvement that may help to prevent a similar occurrence in future.

Brief Summary:

[Ms A] is a (as of June 2020) [woman in her twenties] with a history of involvement with mental health providers since [her early teens]. She was first seen by [the DHB's] Child & Adolescent Mental Health Service (CAMHS) with the development of depressed mood, suicidal ideation, non suicidal self injury (NSSI) and oppositional behaviour, and significant PTSD (Post Traumatic Stress Disorder) symptoms. … She underwent individual and group psychotherapy (Dialectical Behaviour Therapy — DBT), had trials of multiple medications, and spent prolonged periods of this time in hospital (around 2.5 years) in [the DHB's Adolescent Inpatient Mental Health Unit].

Following referral from her CAMHS Psychiatrist and Therapist, [Ms A] was admitted to [the facility] on 5 July 2016. She was described by her psychiatrist at [the facility] [Dr G] as making good use of the residential therapeutic programme, and was transferred to [the] associated independent living hostel in mid-March 2018 while continuing to attend [the facility's] day programme and managing her own medications.

[Ms A] was discharged on 21 September 2018, after spending nearly 2.5 years in [the facility]. She described returning to [her home town] with hope for the future, feeling much better than she had been for some years, but still in need of support.

She understood that [the DHB's] community mental health team was advised by [the facility] of her discharge, in order that she could be supported when needed; she noted that this was really important, 'because when I start to go off the rails, I can be helped. If it is left too long, then there is little that anyone can do to help me.'

A week prior to her discharge, on 13 September 2018 [the contact centre], which is the first point of contact/referral team for [the DHB's mental health service], received a faxed referral for [Ms A] from [the facility]. On 22 September, the day following her discharge, a [contact centre] clinician made telephone contact to ascertain [Ms A's] address in [her home town], and transfer responsibility for mental health follow-up to the appropriate … Community Mental Health Team ([CMHT]). 3 days later, on 25 September, [Ms A] made contact with [CMHT], and was told she would be allocated a care manager with the team. This was done on 2 October, when her new care manager made contact by telephone and planned an initial appointment for 4 October.

[Ms A] saw her [CMHT] care manager on 4 October, though in [the public hospital] Emergency Department where she had presented the previous day for physical health concerns, while admitting to having [harmed herself] the day beforehand. Later that day she returned to the Emergency Department for treatment having self-harmed, then left Emergency Department and [harmed herself again] before returning the next morning. Later that day (5 October) in Emergency Department she refused further medical treatment for her [self-harm]; after a discussion with her care manager, and

further liaison between the Emergency Department doctor and the on-call psychiatry registrar and psychiatrist, [Ms A] was encouraged to continue with medical treatment. She then absconded from the ED, and after contacting her father expressing a plan to further harm herself, she was found by the Police and agreed to a brief voluntary admission to [the] inpatient Mental Health Unit, where she was subsequently sectioned under the Mental Health Act and remained for some period as a compulsory patient.

[Ms A] felt she had consistently expressed that she needed support, since she first made contact with [CMHT] on 25 September and on almost every interaction with the mental health team following that, and felt she was 'fobbed off'. She expressed in her letter of complaint that her increase in suicidal ideation and self-harm was related to her not receiving timely help. She also took issue with a number of inaccuracies raised around clinical contacts with [the DHB] in their response to the HDC complaint. Lastly [Ms A's] parents also provided pertinent information regarding this period of care, alleging the [DHB] mental health services were dismissive and unresponsive to [Ms A's] needs, did not adequately assess her, and appeared guided by a significantly out of date management plan.

Issues raised:

1. Whether the information supplied by [the facility] to other providers, prior to and upon [Ms A's] discharge, was sufficient and timely.

Initial phone contact was made by [the facility] to [the DHB] MHS ([contact centre]) on 5 September 2018 to ascertain which [DHB] service she would need to be referred to, and on 12 September a discharge letter from [Dr G] was emailed to [the contact centre]. This stated, under 'recommendations on discharge', that [Ms A] would be referred to [the DHB] MHS 'for wrap around support by a MDT as she transitions back to the community', and noted that she had a very supportive team at ACC and that her clinical psychologist would be her lead ACC provider in supporting her once she returned to [her home town].

On 24 September 2018 a handwritten discharge note was sent to [the contact centre], [Ms A's] GP and her ACC case manager. The final discharge summary from [the facility] to [the DHB] MHS was sent on 14th November to [a] Child and Adolescent Psychiatrist and [Ms A's] initial referrer to [the facility] in 2016 (this was essentially a copy of the discharge letter from 12 September).

a) What is the standard of care/accepted practice?

The initial discharge summary 1 week prior to discharge was timely, though the final discharge summary was extremely delayed (7 weeks post discharge) and directed not to her current team, but her referring doctor from two years previously, which was not appropriate. However as there was little or no additional information, this is unlikely to have affected [Ms A's] care.

A more significant issue with the discharge information was the assertion that she would need 'wrap around support by an MDT [multidisciplinary team]', without

detailing either what that might mean for [Ms A], exactly who would provide this (given that it was noted she was engaged with and had support from her ACC Psychologist), and what she could realistically expect from [the DHB's] MHS. There does not appear to have been a documented effort by [the facility] to explore what [the DHB's] MHS could actually provide, given that 'support' is a rather nebulous concept.

The impact of this was significant, as it appears there was a clear mismatch between [Ms A] and her parents' expectations, which added to their distress at her not receiving the care they expected.

b) If there has been a departure from the standard of care or accepted practice, how significant (mild, moderate, or severe) a departure do you consider this to be?

I consider this to be a moderate departure from accepted practice, given the complexity of [Ms A's] needs, her identified challenges in moving back to [her home town], and how well her treating team at [the facility] knew her.

c) How would it be viewed by your peers?

With a degree of frustration, due to the predictability of patient care suffering significantly when transferred from one service to another, exacerbated by a lack of clarity around needs and expectations.

d) Recommendations for improvement that may help to prevent a similar occurrence in future.

- A minimum of a pre-discharge teleconference with referrer ([the facility]) team, all accepting services, and patient and family/supports, that includes:
  - Discussion of patient's formulation
  - Identification of strengths and whānau/community supports
  - Identification of risks and early warning signs
  - Identification of coping strategies, and what resources are required for these
  - Expectations of patient and services involved
  - Discussion of long term goals
- Complete discharge summary being available for both the patient, their family/whānau and receiving teams and clinicians, detailing what has been agreed in the pre-discharge meeting, including the specifics of community management and available supports and resources.

2. Whether the supports put in place by [the facility] for [Ms A] post discharge were appropriate.

As above (1), there was a recommendation made around the focus of her psychotherapy on discharge, though it was not clear who would be providing this therapy, or what support she would receive from her ACC team. I note that [Ms A] had pointed out that when at [the facility] she had access to '24/7 support available if I needed it' and I suspect she understood that was what she would receive from [DHB mental health] services once in [her home town].

It cannot be said that [the facility] put supports in place, as there was no follow-up to ensure that the recommendations could or would be followed. There was no suggestion of any transitional follow-up from [the facility], nor any comment on [Ms A's] previous community mental health Whole Service Response Plan from 2016 (ie whether aspects of this could still be useful for [Ms A], or whether this had no relevance 2.5 years later).

a) What is the standard of care/accepted practice?

Sadly the accepted standard of care in transfers of care from one service to another often seems to be limited to a written referral with recommendations, without explicitly discussing these with the client and whānau, though good clinical practice in complex situations such as this one should entail a more detailed face to face or telephone handover, with a clear discussion with patient and whānau around what they could expect from the receiving service.

b) If there has been a departure from the standard of care or accepted practice, how significant (mild, moderate, or severe) a departure do you consider this to be?

Mild–moderate departure from accepted practice. A referral was completed (the initial one in a timely manner), but as noted in (1) above the specifics of [Ms A's] needs from [the DHB] MHS were not discussed with the treating team, clearly detailed or clearly conveyed to the patient and her whānau. I recognise that the changing decisions taken by [Ms A] were one factor in making this less straightforward, however these occurred over several months prior to discharge:

- The role of the ACC funded psychotherapist, and [Ms A's] engagement with this therapist
- The family dynamics alluded to in the Transfer of Care summary that impacted on [Ms A's] mental health were not clearly spelt out, and may have indicated that her relationships with her parents were a source of stress rather than a significant component of her supports. It was therefore unclear to the accepting [mental health service] team as to how much involvement [Ms A] was willing for her parents to have in her mental health care.
- The lack of any clearly agreed methods for communicating [Ms A's] needs and coordination of services between [Ms A], her parents, CMHT and her ACC therapist
- The expectations [Ms A] and her parents could reasonably have of [DHB] community mental health services

c) How would it be viewed by your peers?

As above, I suspect with frustration.

d) Recommendations for improvement that may help to prevent a similar occurrence in future.

See 1(d) above. In addition, a post discharge review meeting with the client, whānau, their [team at the facility] and the receiving MH services could ameliorate any initial difficulties with communication and coordination.

3. Any other matters you consider warrant comment about [the facility].

No.

4. Whether the care provided by [the DHB] during 21 September 2018–3 October 2018 was appropriate and timely.

On 22 September, the day following her discharge, a [contact centre] clinician made telephone contact to ascertain [Ms A's] address in [her home town], and transfer responsibility for MH follow-up to the appropriate … Community Mental Health Team ([CMHT]). 3 days later, on 25 September separately [the contact centre] received a handwritten discharge summary from [the facility] and [Ms A] made contact with [CMHT], and was told she would be allocated a care manager with the team. This was done on 2 October, when her new care manager made contact by telephone and planned an initial appointment for 4 October.

Referral and allocation (21–25 September): Given that [Ms A's] referral to [the mental health service] was received prior to her discharge from [the facility], ideally a clinical treating team could have been identified prior to her discharge and appointments set up. This would have ensured an earlier identification of [Ms A's] needs and expectations of the service, and processes for involving her parents and her ACC psychology team. I reiterate that [Ms A] had pointed out that when at [the facility] she had access to '24/7 support available if I needed it' and I suspect she understood that was what she would receive from [mental health] services in [her home town].

The 'single point of entry' to all [mental health] services is [the contact centre]; while this ensures referrals are directed to the correct Mental Health team, it means there was no direct contact between the referrer ([the facility]) and the receiving team ([CMHT]) clinicians. It also appears that because she had not yet been discharged, the referral was allocated as low priority and there was no referral received to [CMHT] until after [Ms A] was actually residing in [her home town] (22–24th September); whether this was specifically because the [contact centre] clinician was confused about where she would be living as asserted (which the referral documents do not support) or whether this is informal [mental health service] policy (because people do not always move when and where they initially intend) is not clear.

Crisis presentations (25 September–3 October): The documentation provided by [CMHT] of the encounter where [Ms A] went into the office seeking help was initially reflective of her experience; she states she called asking for support as she was distressed and felt she wasn't coping … and [was] experiencing triggering memories; she spoke to duty clinician CMHN [RN F], and then was offered an immediate

appointment and came in to see him face to face. According to the notes her distress was validated, she had seen her ACC therapist that morning for the first time, and they agreed on a safety/coping plan together. She recalls being told she would be allocated a regular case worker and that this was someone who was experienced in DBT, but that in the meantime she could contact the duty clinician if she needed to. The following Monday (1 October) [RN F] called [Ms A] back to reiterate she would be allocated a care manager, and she reported she was doing ok.

The following day she phoned [the contact centre] duty phone from ED, where she was having treatment for a physical health issue, expressing distress and suicidal thoughts; she was advised to speak to the Emergency Department doctor about this. She did so and the Emergency Department doctor phoned [the contact centre] expressing concern about [Ms A's] mental state and arranged for her to stay overnight in Emergency Department and be reviewed in the morning.

a) What is the standard of care/accepted practice?

Referral and allocation: New referrals to specialist Mental Health Services are generally allocated an appropriate care manager/key worker to coordinate their mental health treatment, and if unallocated will be seen by a 'duty clinician'.

Crisis presentation: Ideally a person expressing suicidal idea, particularly presenting with a number of risk factors and a significant history of self-harm and suicide attempts such as [Ms A], should be assessed by a mental health clinician as soon as practicably possible. However when in an observed, contained environment such as an Emergency Department it is variably accepted practice to delay a crisis assessment overnight, often so that a clinician who knows the person, as well as family and other supports, can be present.

b) If there has been a departure from the standard of care or accepted practice, how significant (mild, moderate, or severe) a departure do you consider this to be?

Referral and allocation: No departure from accepted practice.

Crisis presentation: Mild departure from accepted practice; the [contact centre] duty clinician should have talked to the Emergency Department doctor and/or arranged for a mental health assessment on receipt of [Ms A's] phone call, rather than asking [Ms A] herself to do so. I cannot comment on whether this was influenced by [Ms A's] 2016 management plan (and by phoning [the contact centre] she was clearly taking responsibility for communicating her distress). **No departure** from accepted practice; the delay in face to face mental health assessment until the next morning (as above).

c) How would it be viewed by your peers?

No significant departure from usual practice.

d) Recommendations for improvement that may help to prevent a similar occurrence in future.

The practice of assigning a transfer of care from another mental health service a low priority could be reviewed, particularly for people with likely high mental health needs. By prioritising early engagement, and ensuring realistic expectations of care, for this high risk group, it would be less likely for people to present in crisis.

5. Whether the treatment provided by [the DHB] on 4 and 5 October 2018 was adequate/appropriate.

[Ms A] recalled her first meeting with her new care manager [Ms B] on the morning of 4 October as she drove her to her grandmother's place from the Emergency Department where she had presented for physical health concerns, where she felt her requests for support were ignored and she was told she would have an appointment in 4 days' time on Monday 8 October. She stated this perceived lack of support led to her becoming even more distressed, and several hours later she inflicted serious self-harm and self presented to the Emergency Department. Again when seen there, she felt she did not receive the mental health help that she needed; in response she left Emergency Department and [harmed herself] before returning. While receiving treatment for this, she was told that the [mental health service] had refused to provide any assessment or treatment until her next planned appointment. [Ms A] then absconded with the intent to complete suicide, before being found by her father and the Police, returned to hospital and admitted to [the] inpatient Mental Health Unit, where she was subsequently sectioned under the Mental Health Act.

[DHB] notes record an assessment by [Ms B] in Emergency Department, following which she drove [Ms A] back to her grandmother's. During this drive [Ms A] divulged she had [harmed herself] prior to attending Emergency Department the previous day. After telephone consultation with the Emergency Department doctor and psychiatrist no further medical or mental health treatment was recommended, no change to immediate management was suggested, and weekly follow-ups were planned. [Ms B] also noted that as no more recent management plan was available, the 2016 service wide management plan would be uploaded to [Ms A's] records.

Shortly afterwards [Ms A] presented to Emergency Department [having harmed herself] and the Emergency Department triage nurse contacted [the contact centre] who after discussion with Ms B, advised that [Ms A's] 2016 management plan 'stood' and that no [CMHT] clinician would attend Emergency Department to assess her mental state.

a) What is the standard of care/accepted practice?

In the circumstances of a client with a significant history of mental health difficulties and high risks, and especially if not well known to the service, a thorough risk assessment and consultation is the accepted standard of care. This was the first time [Ms A] and her newly allocated care manager had met, under what must be acknowledged as less than ideal circumstances. This became an added factor in [Ms A's] mental health care provision, given that from this point onwards [Ms B] (Occupational Therapist) would be seen by other clinicians within [the mental health service] as the clinician who best understood [Ms A] and her needs, and had primary responsibility for

managing her care. The [DHB's] Role Description for Occupational Therapists notes: *'The Occupational Therapy role within the team is one of care manager that focuses on assessment, treatment and goal setting with the clients. Treatment plans are developed in partnership with the client and their family. The role also involves ongoing treatment, monitoring, and discharge planning.'*

b) If there has been a departure from the standard of care or accepted practice, how significant (mild, moderate, or severe) a departure do you consider this to be?

Moderate–Severe. [Ms A] should have been reassessed at this point, given that she was demonstrating a significant escalation in risk and was essentially new to the service, and that her care manager had only met her relatively briefly that morning. It is not entirely clear to what extent this was a collective treating team decision from the records provided.

c) How would it be viewed by your peers?

Seriously. After the contact from the ED, I believe that [Ms A's] mental state, current (rather than historical) risk, and management plan should have been reassessed and discussed within the clinical team, in the context of a vulnerable person transitioning to living in the community after a prolonged residential stay.

d) Recommendations for improvement that may help to prevent a similar occurrence in future.

Guidelines should include that a person presenting with significant self-harm and distress in an Emergency Department setting should be reassessed by a mental health clinician. If a client is well known to a mental health team, has a current up to date mental health assessment and management plan, their presentation is part of a usual pattern of responding to distress, and there is thoughtful consideration of any changes in risk, it may be reasonable for them not to be reassessed; however this decision should be discussed with other clinicians in the treating team who know the person well, and taken as a team.

6. Whether it was reasonable to use the 2016 Whole Service Response Plan to guide treatment during the period post [Ms A's] discharge from [the facility].

a) If it was reasonable, please also advise:

i. Whether the care provided from 21 September 2018–5 October 2018 was consistent with the plan.

ii. Whether her presentation, particularly on 4 and 5 October 2018, suggested more acute risk or deviation from usual patterns.

No, this was not reasonable given that over 2 years had elapsed and [Ms A] had not been resident in the community during this time.

b) What is the standard of care/accepted practice?

Accepted practice is that a Whole Service Response plan, such as [Ms A's] 2016 one, should be collaboratively revised on a regular (at least every 3 months, or with any change in status such as from inpatient to outpatient treatment).

c) If there has been a departure from the standard of care or accepted practice, how significant (mild, moderate, or severe) a departure do you consider this to be?

Moderate–severe departure from accepted practice.

d) How would it be viewed by your peers?

It does not make clinical sense to utilise a 2.5 year old management plan. [Ms A's] plan was developed during a time when she was under Child & Adolescent MH Services and had recurrent, severe self-harm and suicide risk to the point where she was in Adolescent MH inpatient care for prolonged periods.

e) Recommendations for improvement that may help to prevent a similar occurrence in future.

Whole Service Response plans should not be used if they have not been updated within the last 3 months to reflect changes in mental illness, risk patterns, coping strategies and supports.

7. The level of communication with [Ms A's] family.

I am assuming, from the documentation provided, that the lack of communication [Ms A's] parents refer to in their letter relates to the events of 12 November; specifically that [Ms A] was taken to their home without prior communication or discussion with them and allowed into the house unattended, and also that they were not aware of where the respite care facility [Ms A] was staying at, and that staff at the respite facility did not appear to be aware of [Ms A's] next of kin or risk behaviours, neither of which I am able to comment on given the information provided.

Prior to this point there was two-way communication between [Ms A's] parents and MH clinicians, and it appears the concern raised by her parents was that their views were not taken seriously, rather than that there was no communication.

a) What is the standard of care/accepted practice?

I could not find reference to a specific standard of care, however accepted practice would be that communication with whānau prior to a visit home would be expected, unless there were clearly documented risks in doing so.

b) If there has been a departure from the standard of care or accepted practice, how significant (mild, moderate, or severe) a departure do you consider this to be?

Mild departure from accepted practice (around communication on 12 November). No departure from accepted practice (level of communication with [Ms A's] family generally).

c) How would it be viewed by your peers?

I believe this would be viewed as a mild departure from accepted practice.

d) Recommendations for improvement that may help to prevent a similar occurrence in future.

Possibly providing training for staff on engaging and working with whānau and supports of services users, providing clear messages to service users and whānau around confidentiality, sharing of information and the limitations to this based on the service users and whānau wishes, and appropriate documentation of the same.

8. The family's concerns about the care provided to [Ms A] on 12 November 2018.

a) What is the standard of care/accepted practice?

See 7 (a) above.

b) If there has been a departure from the standard of care or accepted practice, how significant (mild, moderate, or severe) a departure do you consider this to be?

See 7 (b) above.

c) How would it be viewed by your peers?

See 7 (c) above.

d) Recommendations for improvement that may help to prevent a similar occurrence in future.

See 7 (d) above.

9. Any other matters you consider warrant comment about [the DHB mental health service]/[the DHB].

I appreciate that the mental health clinicians concerned, especially [Ms B] as [Ms A's] care manager, may well have been placed in a position where they had limited time to develop a therapeutic relationship with [Ms A] and her whānau, and seemingly no opportunity for the whole treating team (including Psychiatrist and ACC Psychologist, as well as care manager) to develop a collaborative care plan with [Ms A] and her whānau.

This was likely due to multiple factors as detailed above; lack of a collaborative handover of care from [the facility], the 'internal' handover of her referral from [the contact centre] to [Ms A's] eventual treating team and the perceived uncertainty of her discharge address, and the relatively quick deterioration in [Ms A's] mental health. This meant [Ms A's] new clinical team met her 'on the back foot', without the chance for her to develop a collaborative approach to her treatment, including realistic expectations and a degree of trust in their care.

Lastly, though I am unable to comment on this, I wonder whether caseloads and time allocated to new as well as existing service clients may have also influenced these factors.

Summary:

In summary, I would like to comment that I believe [Ms A's] mental health care was suboptimal in several ways, and the complex interplay of services and clinicians, and lack of clear communications, likely contributed to her distress and sense that she and her whānau were not being heard; but that this complexity should not be a reason for not addressing these systemic issues. The most disappointing outcome of her experience is that she did not experience a sense that many of the health practitioners involved cared for her.

The roles of [Ms A's] ACC funded Sensitive Claims psychologist and team, who were identified as a critical component of her psychological care on her return to [her home town], were not clarified or detailed in the provided notes. While I am unable to directly comment further on this aspect of her mental health care, as noted I believe a more robust, collaborative discharge process would have usefully clarified the roles and expectations of her ACC providers, which may have improved her experience.

I commend [Ms A] and her whānau for raising these issues, and I wish them all the best for the future.

Yours sincerely

Dr Paul Vroegop"

Further clinical advice

"**Independent Report for the Health and Disability Commissioner**

File Number C18HDC02016

Addendum (July 18 2021)

I was asked by the office of the Health and Disability Commissioner to review the responses to my additional Independent Report as above, and advise whether any of the explanations/information provided changed my previous advice. As part of this, the HDC also requested whether I could also advise whether any criticisms are attributable to individual providers, or are attributable to systems in place.

I had the opportunity to review [the DHB's] responses from [the] General Manager, [Ms B] (Occupational Therapist and Keyworker), [the] on call Psychiatry Registrar, [Dr E] (Consultant Psychiatrist), [RN C] (Registered Nurse), … (Consultant Psychiatrist), … (Registered Nurse) and [the] ED Consultant and Clinical Lead. I also reviewed the response from [the facility's Medical Director).

In addition [the DHB] also provided further process and policy documents which I have reviewed …

Together these documents clarified some aspects of [Ms A's] care, and my responses to these are outlined below; I have elected to provide these separately from my original report in the interests of clarity.

Responses to issues raised in the original report:

1. **Whether the information supplied by [the facility] to other providers, prior to and upon [Ms A's] discharge, was sufficient and timely.**

It is clear from the additional [DHB] responses provided that there was no updated management plan (equivalent of the [DHB] WSRP) for [Ms A] available to either [Ms A], her family or [the DHB] clinicians. [The facility's Medical Director] acknowledged a lack of detail in [Ms A's] transfer of care. [The facility's Medical Director] acknowledged that [the facility's] expectation would be that the accepting MHS would conduct a thorough assessment to determine the fit between a person's needs and the available services, as [the facility] cannot reasonably be expected to know what resources the local services have, and that this was further complicated by not knowing which team her care would be going to, and a lack of communication with [the facility] once transfer of care had occurred.

I stand by my previous opinion, that I consider this to be a **moderate departure from accepted practice**, given the complexity and risk of [Ms A's] needs, her identified challenges in moving back to [her home town], and the different services and supports available. In addition I again note the lack of clarity around the role that her ACC funded private therapist would be expected to provide prior to transfer.

I consider these to be **systems issues**, rather than one attributable to individual providers.

2. **Whether the supports put in place by [the facility] for [Ms A] post discharge were appropriate.**

See above; no change in opinion. I note that the responsibility for supports and discharge planning was a collective one involving [the facility], [Ms A's] ACC providers and [the DHB].

3. **Any other matters you consider warrant comment about [the facility].**

4. **Whether the care provided by [the DHB mental health service] during 21 September 2018–3 October 2018 was appropriate and timely.**

Referral and allocation: No departure from accepted practice.

Initial Crisis presentation (3rd October): I stand by my earlier opinion that this was a **mild departure** from accepted practice, clearly attributable to the **system of care** (as evidenced by the non evidence based approach of MHS not assessing people in ED until 'medically cleared' as quoted by [RN C]). I recognise but do not accept as completely

valid the [DHB] response that [Ms A] needed to take responsibility for her mental health — I argue that she was doing so by phoning Mental Health Crisis. It would have been reasonable for [the contact centre's] duty clinician to have transparently informed the Emergency Department staff of her suicidal thoughts following [Ms A's] phone call, rather than insisting [Ms A] do so herself. However this had no impact on the outcome given that [Ms A] divulged her suicidal ideation to the treating ED doctor.

Delay in MH Crisis assessment: No departure from accepted practice; the delay in face to face mental health assessment until the next morning (as above), which was undertaken by her new Mental Health Keyworker [Ms B].

5. Whether the treatment provided by [the DHB mental health service] on 4 and 5 October 2018 was adequate/appropriate.

[Ms A] was seen in ED on the morning of 4th October by her keyworker [Ms B], which [Ms A] was clear about (though there is dispute about the content of that assessment conversation). She had presented the previous day for physical health issues … and after noting to ED staff that she felt unsafe (suicidal) she was seen the following morning (and driven to her grandmother's house) by [Ms B]. It was clear from the added information provided by [the DHB] that in that assessment [Ms A] presented as future focused and not distressed or suicidal, and an appropriate follow-up plan was arranged (in the context of [Ms A's] availability for MH appointments this was agreed for 8th October). [Ms A] had acknowledged [harming herself] some 48 hours earlier, which was appropriately discussed with the Mental Health team and the ED doctor, with the agreement that no further medical follow-up was required.

a) What is the standard of care/accepted practice?

I accept the challenges in assessing risk in a client with a significant history of mental health difficulties and high risks, especially when they are not well known to the service. It appears that the initial assessment of [Ms A] by her newly allocated care manager [Ms B] (under less than ideal circumstances) was reasonable. However there is a question as to whether she should have been re-assessed by a Mental Health clinician following her return to ED several hours later on the afternoon of 4th October with self harm and expressed suicidal ideation; I believe that given the change in her presentation (with significantly heightened risk) from the earlier assessment by [Ms B] that morning, accepted practice would be for a mental health clinician to undertake a face to face reassessment prior to her being discharged from ED. I do not believe the assumption that this was NSSI (non-suicidal self-injury) by [Ms A] was warranted without a re-assessment and analysis of her behaviour. Instead the ED triage nurse was advised that [Ms A's] 2016 management plan 'stood' and that no [CMHT] clinician would attend Emergency Department to assess her mental state.

b) If there has been a departure from the standard of care or accepted practice, how significant (mild, moderate, or severe) a departure do you consider this to be?

i. Initial assessment in ED 3rd/4th October — **No departure from accepted practice.**

ii. Second ED presentation afternoon 4th October — I stand by my earlier opinion that this was a **moderate departure from accepted practice**, though not a severe departure as [Ms B's] assessment that morning was more extensive than I had previously recognised. I accept that the Mental Health clinicians involved felt that her behaviour was consistent with her history of emotional dysregulation, and that therapeutic principles around not reinforcing unhelpful responses to overwhelming distress (reinforced by her 2016 WSRP) supported this approach. However I still feel [Ms A] should have been reassessed at this point, given that she was demonstrating a significant escalation in risk since her initial face to face assessment that morning, and was essentially new to the service. I appreciate that treating her injuries was an immediate priority, and therefore see this as being primarily a **systems issue** rather than one attributable to any specific provider (as I have no opinion on which Mental Health clinician(s), or at what time, this assessment should have been undertaken, and as all the consulted Mental Health clinicians concurred with this plan).

6. Whether it was reasonable to use the 2016 Whole Service Response Plan to guide treatment during the period post [Ms A's] discharge from [the facility].

My opinion remains that this was not reasonable, which appears generally supported by the [DHB] responses, though several noted that the WSRP provided useful background historical understanding of [Ms A].

a) If it was reasonable, please also advise:

i. Whether the care provided from 21 September 2018–5 October 2018 was consistent with the plan.

[Ms A's] care appeared to be broadly consistent with her 2016 Whole Service Response Plan (WSRP), however I accept from multiple [DHB] clinicians that the weight both [Ms A] and her family at the time and in retrospect, felt was placed on this as a guide to her management may well have been overstated. This impression was probably unhelpfully exacerbated by the events of the afternoon of 4th October (5 above), where the ED triage nurse was advised that [Ms A's] 2016 management plan 'stood' and that no [CMHT] clinician would attend Emergency Department to assess her mental state. This impression may have also been exacerbated by reference to the WSRP in the clinical notes, as a shorthand explanation/validation for the therapeutic approach taken.

ii. Whether her presentation, particularly on 4 and 5 October 2018, suggested more acute risk or deviation from usual patterns.

[Ms A's] presentation on the afternoon of 4th October demonstrated a significant and rapid escalation in her distress and risk since her initial face to face assessment that morning. As she was essentially new to the service at that point, and it was predictable that she would likely be more vulnerable in the context of moving city and living in the

community after 2.5 years in a residential treatment facility, a deviation from 'usual' patterns may be likely.

a) What is the standard of care/accepted practice?

Accepted practice is that a Whole Service Response Plan, such as [Ms A's] 2016 one, should be collaboratively revised on a regular basis (at least every 3 months, or with any change in status such as from inpatient to outpatient treatment).

b) If there has been a departure from the standard of care or accepted practice, how significant (mild, moderate, or severe) a departure do you consider this to be?

On consideration of the additional information provided as above, I have revised my opinion from moderate–severe to a **mild departure from accepted practice**. While the WSRP should have ideally been rapidly updated in collaboration with [Ms A] and her inpatient treating team at [the facility] on discharge, I appreciate that there was practically insufficient time to develop a sufficient therapeutic relationship to do this following her initial assessment by [the DHB] Mental Health.

7. The level of communication with [Ms A's] family.

From the additional information provided, [Ms A's] visit and unescorted entry to her parents' house on 12 November was part of a considered management plan explicitly involving her, with her consent, taking increasing self-responsibility for her risk, which aligned with her then being able to take up to 3 hours' unescorted leave from respite.

Given the information provided I'm unable to provide an updated comment on communication with [Ms A's] family.

If there has been a departure from the standard of care or accepted practice, how significant (mild, moderate, or severe) a departure do you consider this to be?

I have revised my opinion from mild departure to **no departure** from accepted practice (around communication on 12th November) as above. I do consider under the circumstances communication with family (with [Ms A's] agreement) about the visit would have been good clinical practice.

No departure from accepted practice (level of communication with [Ms A's] family generally).

Thank you for the opportunity to respond to feedback on my opinion. I again commend both [Ms A] and her family on raising these issues, and hope she has found the process useful. I also would like to thank the clinicians involved for their thoughtful and reflective responses. Lastly I'd like to make the observation that [Ms A's] distress may have been exacerbated by what she experienced as initially invalidating responses to the concerns she raised, which I have certainly reflected on insofar as my own practice.

Yours sincerely

Noho ora mai

Dr Paul Vroegop"

Further clinical advice

"**Independent Report for the Health and Disability Commissioner**

File Number C18HDC02016

Second Addendum (12 February 2022)

I was asked by the office of the Health and Disability Commissioner to review the further responses following the addendum to my Independent Report. I was specifically requested to read [the DHB's] response and [the facility's] response, and consider whether these altered my previous advice and level of departures identified, and if so why.

I have had the opportunity to review the responses by [the] Executive Director, [the DHB mental health service] dated 19th November 2021 and the response by [Dr G], Consultant Psychiatrist [the facility] dated 16 December 2021. In the interests of clarity I have provided responses to these separately from my original report and addendum.

[DHB] Response:

1. **Whether the care provided by [the DHB] during 21 September 2018–3 October 2018 was appropriate and timely.**

No additional information was provided, and I therefore stand by my previous opinion, that I consider this to be a **moderate departure** from accepted practice.

2. **Whether the treatment provided by [the DHB] on 4 and 5 October 2018 was adequate/appropriate.**

I appreciate the feedback provided by [the DHB] regarding [Ms B's] initial assessment of [Ms A] on 4th October 2018 'Her training and expertise, her awareness that [Ms A] [harming] herself was not an unusual response to unpleasant emotions, her understanding of the approach to treatment which had proven successful at [the facility], and widely accepted principles for supporting individuals who are susceptible to resorting to NSSI in response to unpleasant emotions'. As noted, I do not feel that [Ms B's] assessment was a departure from accepted practice.

However no additional information has been provided as to my opinion that [Ms A] should have been reassessed at the point she re-presented to the ED. She was demonstrating a significant change (escalation) in risk since her initial face to face assessment by [Ms B] that morning. She was to all intents and purposes new to this Mental Health Service and team ([the DHB]), having only had a single (cross-sectional) assessment that morning. She had not yet had the opportunity to develop pre-existing therapeutic relationships. On the basis of these factors, I do not believe that her treating team of [the DHB mental health service] clinicians could confidently either assess her risk or determine the best (collaborative) therapeutic approach on her second presentation to ED on 4th October without re-assessment.

I therefore stand by my earlier opinion that this was a **moderate departure from accepted practice**. My opinion is also that this was a [DHB] **systems issue** — the decision not to reassess her at that point was a collective team one, rather than one attributable to any specific provider (such as [Ms B]).

3. Whether it was reasonable to use the 2016 Whole Service Response Plan to guide treatment during the period post [Ms A's] discharge from [the facility]

The [DHB's] response suggested that 'even a finding of a mild departure from the standard of care is not justified, given that the intention was to revise the WSRP once a sufficient therapeutic relationship was established, and that it was acknowledged that there was insufficient time to develop such a relationship'. I accept there almost certainly was an intention to revise the WRSP. The problem is that [Ms A's] clinical care was likely influenced at least somewhat by a long out-of-date WSRP, as evidenced by the [DHB team's] decision not to reassess her on re-presentation to ED (as in question 2 above) using the WRSP as justification to ED staff.

Therefore on consideration of the additional information provided, my opinion remains that use of the 2016 WRSP to guide treatment to the extent that it did was not reasonable, and that this was a **mild departure** from accepted practice.

4. The level of communication with [Ms A's] family

I appreciate that [the DHB] now has a Whānau/Family Participation Policy and Framework for involving Whānau/Family guidelines available to all staff, and commend [the DHB] for this initiative.

5. Any other matter warranting comment about [the DHB]

[The DHB] is to be congratulated on implementing ED based MH Liaison Nursing roles to facilitate a person's access to [the mental health service] quickly and effectively and determine those who need to be seen for an urgent specialist mental health assessment in the Emergency Department. These roles should ensure that situations akin to that which arose during [Ms A's] second ED presentation on 4th October 2018 have better outcomes, from improved access to experienced MH clinicians and improved relationships with ED staff.

[Facility] Response:

Whether the information supplied by [the facility] to other providers, prior to and upon [Ms A's] discharge, was sufficient and timely.

In point 2 of [the facility's] response, [Dr G] notes the challenges from a service user and referring service perspective with a single point of entry service such as [the DHB's mental health service]. In point 4 [the facility] notes again the lack of opportunity to have a discharge teleconference, because [the DHB mental health service] had not yet assigned clinicians to [Ms A], and in point 5 [Dr G] notes that without such direct communication with accepting services, [the facility] may not know what services can/may be provided by [the DHB] or other accepting services.

Having considered these points, I stand by my previous opinion, that I consider this to be a **moderate departure** from accepted practice, given the complexity and risk of [Ms A's] needs, her identified challenges in moving back to [her home town], and the different services and supports available.

However as I noted previously, I consider this to be a **systems issue**, rather than one attributable solely to individual providers, with contributions from both [the facility] and [DHB] processes. In addition, I again note the lack of clarity around the role that her ACC funded private therapist was expected to provide prior to and following transfer of care.

Whether the supports put in place by [the facility] for [Ms A] post discharge were appropriate.

[Dr G] ([the facility]) noted [Ms A's] presentation had been stable for many months, and the single episode of serious self harm one month prior to discharge was not concerning to her [facility] team, noting they often see 'a return of old behaviours prior to discharge, and did not perceive it to be a harbinger of a psychological collapse'. [Dr G] also notes that 'the change in [Ms A's] acuity occurred towards the end of August after a visit home, with her discharge date being set for the 21st of September. In effect the change in her presentation and discharge plans occurred over a four-week period, and not several months as alluded to in Dr Vroegop's report.'

I remain unclear as to the role [Ms A's] ACC funded therapist would be expected to have on her return to [her home town], both insofar as psychotherapeutic input, coordination with other supports via [the DHB mental health service], and [Ms A] and her whānau understanding of this role.

I recognise that (as per point 1 above) [Ms A's] transfer of care information, and supports put in place, were influenced by the processes in the receiving as well as referring services. Taking this and the above comments provided by [the facility], I have revised my opinion that this was a mild–moderate departure from accepted practice, to that of a **mild departure** from accepted practice.

[The facility] is to be commended on reflecting on the discharge processes, policies and procedures, and considering developing transitional follow-up processes after discharge.

Any other matters you consider warrant comment about [Ms A's] care.

This comment is not directed at [the facility], as I acknowledge that ACC funded sensitive claims psychotherapy has a different model of care and funding model from both public mental health services and [the facility]. As I have noted previously, I remain unclear about the role of [Ms A's] ACC funded psychotherapist, and [Ms A's] engagement with this therapist. I wonder whether a transition plan that included her ACC therapist, made explicit the expectations around both roles, and collaboration and communication, may have been beneficial for [Ms A]. This may have influenced the acute care provided by [the DHB mental health service], especially if the therapeutic

aspects of mental health crisis responses had been able to be discussed prior to her acute presentations with [Ms A], her ACC therapist, her whānau and her [DHB mental health service] team.

I would like to take this opportunity to thank [Ms A] and her whānau for raising these issues, and wish them all the best for the future. I would also like to thank the clinicians involved from [the DHB] and [the facility] for their reflective and thoughtful responses, and the Office of the Health and Disability Commissioner for the critical role they perform.

Yours sincerely

Dr Paul Vroegop"