Inadequate coordination of mental health care
14HDC01343, 29 June 2017

District Health Board ~ Psychiatrist ~ Key worker ~ Registered nurse ~ Older persons mental health ~ Community mental health ~ Inpatient mental health ~ Continuity of care ~ Depression ~ Rights 4(5), 4(1)

A woman, in her 60s at the time of these events, had an accident and sustained injuries to her body. The woman's mental health declined following this.

The woman self-referred to Mental Health Services (MHS) at the District Health Board (DHB). The woman was reviewed by a psychiatrist, who diagnosed a major depressive episode and prescribed antidepressants and sleeping medication. The psychiatrist was the woman's lead clinician, and the woman was assigned a registered nurse as her key worker. Following this review, the woman received regular input from MHS. She was also being seen by her GP and by the relevant team for the injuries she had sustained.

Two months later, the woman self harmed and was taken to the Emergency Department. Subsequently she was admitted to an inpatient mental health service (the inpatient service). The woman refused regular antidepressant medication and denied suicidal intent. She was discharged. The woman was readmitted to the inpatient service the following day after a further incident of self-harm. The woman denied thoughts of self-harm and was discharged with key worker follow-up.

The woman was reviewed by the key worker on one occasion, and by the key worker and the psychiatrist the following day. The plan was for daily key worker contact following the review, but this did not occur. There was confusion about the key worker care arrangements for the woman. The woman was found dead a short time later.

Findings

Between the woman's first and last engagements with the MHS, there were a number of inadequacies in the coordination of her care, which the Mental Health Commissioner considered were attributable to the DHB — most notably, the failures in treatment planning and the poor coordination of key worker care. For not ensuring continuity of care for the woman, the Mental Health Commissioner found that the DHB breached Right 4(5).

There are numerous aspects of the woman's care from the psychiatrist that the Mental Health Commissioner considered were inadequate. In particular, the inappropriate decision to discharge the woman from the inpatient service the second time; the inadequate risk assessment during the final clinical review of the woman; the lack of documentation regarding the decision not to use the Mental Health (Compulsory Assessment and Treatment) Act 1992 provisions to treat the woman; and poor documentation in relation to risk assessment. Overall, the Mental Health Commissioner considers that the psychiatrist did not provide services of an appropriate standard to the woman and, accordingly, breached Right 4(1).

The Mental Health Commissioner made adverse comment about the key worker's communication of her expectations to a colleague, and her documentation.

Recommendations

The Mental Health Commissioner recommended that the DHB:

- Develop clear protocols for circumstances where key worker care may be shared in relation to a mental health care consumer. This should include a clear method of documenting the care arrangement, and the role of each key worker in the circumstances.

- Use this case as an anonymised case study for education of its key worker and psychiatrist staff, including in relation to their respective roles.

The Mental Health Commissioner recommended that in the event that the psychiatrist returns to practise medicine that the Medical Council of New Zealand consider whether a review of the psychiatrist's competence is warranted.

In the event that the key worker returns to practise nursing, the Mental Health Commissioner recommended that the key worker undertake a course on documentation.

The Mental Health Commissioner recommended that the DHB and the psychiatrist each provide a written apology to the woman's husband.