Care of young woman with borderline personality disorder and depression (05HDC05329, 24 May 2007)

Residential care unit ~ District health board ~ Child and adolescent mental health service ~ Key worker ~ Crisis assessment treatment team ~ Risk assessment ~ Psychiatric assessment ~ System failures ~ Rights 4(1), (5)

The mother of a 17-year-old woman complained about the care her daughter received in a residential care unit. The young woman had been diagnosed with several mental health disorders, borderline personality disorder (BPD) and depression, and committed suicide while in the residential care unit.

The young woman was transferred from a Child and Adolescent Mental Health Service (CAMHS) to Serenity Trust Home (STH). STH treats BPD but is not equipped to deal with acute mental health problems and relies on the CAMHS for psychiatric services. A social worker was appointed as the woman's key worker. STH and the district health board did not have an established working relationship and did not clarify roles, expectations, and requirements prior to accepting the woman as a patient, who was younger than their usual clients. The social worker was told by a STH worker that she was not needed for therapeutic involvement and her request to return to undertake a full risk assessment declined. Other staff at the DHB, including the psychiatrist, were also unclear about the relationship and roles, which led to delays in getting psychiatric assessments.

STH did not inform the CAMHS of signs of mental deterioration until the woman attempted suicide. On that day a decision was made by the CAMHS and STH to remove the social worker as key worker and close the CAMHS file. Shortly afterwards, after a second self-harming episode and signs of deepening depression, STH asked the Crisis Assessment Treatment Team (CATT) to assess her. The CATT nurse decided to leave her at STH. In the early hours the following day the woman committed suicide.

It was held that Serenity Trust Home failed to consult with the DHB prior to accepting a CAMHS-aged client, did not encourage or facilitate CAMHS involvement in her care, and did not keep the key worker informed about critical incidents and deterioration in the woman's mental health. They were found to have reached Right 4(5).

It was also held that the DHB did not appropriately define the relationship between CAMHS and STH, breaching Rights 4(1) and (5).