Psychiatrist / Crown Health Enterprise

Report on Opinion - Case 97HDC9553

Complaint

The Commissioner received a complaint from the consumer. The complaint is that the psychiatrist prescribed *antabuse* inappropriately for the consumer's medical condition from early January 1997 until early February 1997. The complaint was made on two grounds:

- *That antabuse was prescribed when it was clinically contraindicated.*
- *That antabuse was not indicated because he did not have an alcohol-related* problem.

Investigation

The complaint was received on 22 October 1997 and investigation was commenced. Information was obtained from:

The Consumer
The Psychiatrist
The General Manager of the CHE
The Clinical Leader, Mental Health, at the CHE

The Commissioner also received advice from two independent psychiatrists and following this, additional information from a forensic psychiatrist and a consultant physician who reported for the psychiatrist.

Information Gathered During Investigation

The consumer was admitted to the hospital in August 1996 under a compulsory treatment order. From December 1996 until March 1997, the psychiatrist was responsible for the consumer's care as his consultant psychiatrist and responsible clinician under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

Prior to the events under investigation, the consumer had been admitted twice to hospital with mania. He was admitted for the third time in early August 1996. He was admitted at this time to the intensive acute ward and was transferred to a semi-acute ward in late August 1996. He was transferred back to the intensive acute ward in early December 1996.

Continued on next page

Psychiatrist / Crown Health Enterprise

Report on Opinion - Case 97HDC9553, continued

Information Gathered During Investigation, *continued*

The consumer had a history of bipolar disorder which was first diagnosed in 1986. The consumer also had a history of ischaemic heart disease, asthma and hypercholesterolaemia (gallstones). He had a mitral valve replacement for mitral regurgitation in 1993. He also had a coronary artery bypass operation for mild coronary artery stenosis, and had suffered a right cerebellar vascular accident (CVA) in August 1995.

Concern about the consumer's alcohol use was consistently expressed in the medical notes and in assessments. A neuropsychological assessment report prepared by an assistant clinical psychologist, and the senior clinical psychologist in October 1996 stated that during the assessment, the consumer:

"...frequently minimised or denied any problems with consuming alcohol or driving which was in contrast to observations reported in his psychiatric file and from significant others.

[The consumer] *drank alcohol regularly, every day for approximately 30 years. He explained that in the past he usually drank a "large bottle of beer", but now he was more likely to consume a couple of glasses of wine with dinner. He added that he also tended to drink whisky and he quantified his consumption as a couple of nips, every two days."*

During the admission from October 1996 to March 1997, there were repeated reports from hospital staff of the consumer being intoxicated, aggressive and secretly drinking alcohol both in hospital and while on leave, the most serious incident occurring in early December 1996 when the consumer had to be placed in seclusion. On this occasion, the consumer had been on unsupervised leave and was returned to the hospital by the police at 8.10pm. The clinical notes record that the consumer presented as intoxicated and verbally abusive towards staff. In early January 1997, the clinical notes for the evening record that, following unsupervised leave, his bag *"made a sound like two bottles knocking together"* and that *"his breath smelt of alcohol"*. A breath alcohol test was recorded as positive. The following day, the clinical notes record that a blood alcohol test produced a result of 22. It was also noted that one unopened bottle of wine was found in his room.

Continued on next page

Psychiatrist / Crown Health Enterprise

Report on Opinion - Case 97HDC9553, continued

Information Gathered During Investigation, *continued*

The CHE advised that the consumer was referred to the alcohol and drug service in mid-November 1996 and was seen three days later. The notes from this meeting state:

> "[The consumer was] *happy with his present drinking pattern, but did agree to follow-up in 3 weeks time."*

The consumer was given an appointment for early December 1996, however, there is no record of any further follow-up from the alcohol and drug service. The clinical leader of mental health at the CHE reported it was clear from the documentation that the consumer had considerable advice from medical and nursing staff regarding the inadvisability of drinking.

The consumer's discharge was being planned in January 1997 and the consumer had elected to live independently in the community rather than in supported accommodation as recommended by staff. The psychiatrist stated it was therefore important he demonstrate some ability to manage increasing periods of leave without becoming intoxicated.

As a result the psychiatrist decided to prescribe *antabuse*, which is an alcohol-sensitising medication that produces an aversive reaction when alcohol is taken. *Antabuse* is used therapeutically to deter alcohol use. In a letter to the Commissioner dated 26 May 1998, the psychiatrist stated her reasons for prescribing *antabuse* were:

- The consumer's history suggested that alcohol consumption exacerbated his bipolar disorder.
- The consumer had returned from home leave in an intoxicated and abusive state on several occasions.
- The consumer had a lowered tolerance to alcohol due to his previous CVA suffered in mid 1995.
- Abstaining from alcohol use would have physical and mental benefits for the consumer, especially when he was living in the community, and would help him to gain better control of his bipolar disorder.

Continued on next page

Psychiatrist / Crown Health Enterprise

Report on Opinion - Case 97HDC9553, continued

Information Gathered During Investigation, *continued*

The psychiatrist explained to the Commissioner that as the consumer had decided, against advice, that he wished to live independently in the community, it was particularly important that he was able to successfully manage at home. She stated that abstinence from alcohol was a condition of his leave and that he had been unable to demonstrate that he was able to comply with requests to abstain from alcohol while home on leave.

The psychiatrist reported that a discussion took place in early January 1997 with the consumer and his primary nurse or another team member. She said that while the consumer initially took issue with the suggestion he take *antabuse*, he did ultimately agree to take it. The psychiatric registrar documented notes from this meeting and wrote that the consumer complained of feeling tired and sleepy and thought it might be due to *carbamazepine* medication (a recent addition to his mood stabilizer regime). The registrar then noted that he was, *"*[a]*sked if he would be prepared to go on to "antabuse" and* [the consumer] *accepted."* The consumer was under a compulsory treatment order at this time. There is no record of any discussion of the possible side-effects of *antabuse* if the consumer were to continue to drink while taking *antabuse*.

The psychiatrist made the following statements to the Commissioner:

> *"The use of antabuse was raised as a means to deter him from drinking alcohol. The mode of action of alcohol was outlined, namely that it interferes with the metabolism of alcohol so that if alcohol is consumed a build up acetaldehyde occurs which gives rise to unpleasant physical effects such as flushing, headache, nausea and vomiting and palpitations. It was stressed that such a reaction was likely to occur even with small amounts of alcohol but with heavier use that a severe reaction was possible with a profound drop in blood pressure, irregularities of heart beat and collapse. Thus it was important that he abstain from alcohol totally whilst taking antabuse. Possible side effects of antabuse ... were mentioned ... Provided with this information and in the light of the above discussion* [the consumer] *agreed to take antabuse and to abstain from alcohol."*

Continued on next page

Psychiatrist / Crown Health Enterprise

Report on Opinion - Case 97HDC9553, continued

Information Gathered During Investigation, *continued*

The consumer therefore started taking *antabuse* in early January 1997. The consumer stated in his complaint that a few days after he started taking *antabuse*, he began to experience confusion, difficulty in concentrating, severe visual impairment, loss of co-ordination, and difficulty moving due to his legs and arms feeling weak and heavy. He also stated that after two weeks he could neither read nor write and was forced to pull out of all but one university class.

In early January 1997 the consumer was reported to have returned from leave smelling slightly of alcohol and admitted to staff that he had consumed a can of light beer. The psychiatrist saw him the next day and documented, *"*[H]*e has been clearly explained the side effects and consequences of mixing alcohol with* [antabuse]*".*

The psychiatrist initially prescribed *antabuse* at 100mg in the morning but increased the dose to 200mg at night, after two days. The consumer continued to have regular short leave from the ward, and was generally noted by staff to be "*warm and pleasant*", "*settled*" and "*stable*".

In mid-January 1997, the registrar noted the consumer to be *"quite active academically and doing a reasonable amount of writing"*. On two dates in mid-January 1997 the consumer used alcohol again, in spite of the *antabuse* treatment. The clinical notes for mid-January 1997 record that the consumer *"admitted to consuming 1 x can of alcohol"* and two days later that after leave he was *"observed to be smelling of alcohol"* and a blood test showed a blood alcohol level of 38.

During an interview at the Commissioner's Office on 20 July 1998, the consumer stated he drank alcohol during this period of *antabuse* treatment (two glasses of wine in the morning, while on day leave) to test out whether or not it was actually *antabuse* he was receiving. The consumer reported he was concerned staff might have given him another drug under the guise of *antabuse*. The consumer said he suffered no effects from drinking alcohol while on *antabuse*.

Continued on next page

Psychiatrist / Crown Health Enterprise

Report on Opinion - Case 97HDC9553, continued

Information Gathered During Investigation, *continued*

The psychiatrist assessed the consumer in mid-January 1997 for a three-monthly review of his compulsory treatment status. In this report the psychiatrist wrote she discussed with the consumer the need to continue the compulsory treatment order to ensure compliance with medications, including *antabuse*. She stated that the consumer was *"accepting of this."*

At the end of January 1997 the notes recorded the consumer's first complaint to the staff about the *antabuse*. The notes stated:

> *"Was reluctant to take* [antabuse] *tonight. Seemed to think it, with other medication, was affecting his eyes and sight. With a bit of persuasion he was compliant with all medication."*

In late January 1997, the consumer complained once more that *antabuse* made him *"sleepy all the time"*. Another psychiatrist and the same registrar reviewed the consumer two days later and they record that he felt *"mentally well"* and that he considered the *carbamazepine* was helping his mood although he had blurred vision and sore eyes. The consumer was further reported in the notes as saying he was *"more confident, more creative and has a better memory since he had the stroke."*

No further complaints of side effects were recorded in the notes until early February 1997 when the consumer complained of dizziness, fatigue, nausea and restlessness. Any use of alcohol was denied at this time and a medical examination and tests did not reveal any clear cause. Over the following two days he is reported to have felt better but on three days later he complained to staff that he had *"been feeling terrible for about a week (started after being on antabuse a week)."* The consumer had by this time been taking *antabuse* for about five weeks. His complaints included tiredness, blurred vision, nausea and feeling disoriented and uncoordinated. A full physical examination undertaken at this time showed poor attention, mild abdominal tenderness, poor co-ordination on the CVA-affected side, poor vision and difficulties with breathing (intermittently a problem due to his asthma). No clear cause for these symptoms was uncovered.

Continued on next page

Psychiatrist / Crown Health Enterprise

Report on Opinion - Case 97HDC9553, continued

Information Gathered During Investigation, *continued*

On this day a meeting was held where the consumer requested that *antabuse* be discontinued. Present at the meeting were: a representative from the manic depressive support trust, a patient advocate, the psychiatrist and the consumer. At this meeting, the psychiatrist outlined the reasons for having prescribed *antabuse*. It was decided that *antabuse* should stop as the consumer gave assurances that he would not drink alcohol. The psychiatrist reported in the notes:

> *"*[The consumer] *complaining of numerous physical symptoms for which he has been checked medically this am – no abnormalities detected. Attributing this to his antabuse which he sees as further evidence for stopping this. Other evidence that he had is that he does not have an alcohol problem so doesn't need it.*
>
> *Reminder to* [the consumer] *that I prescribed the antabuse with his consent to prevent him from consuming alcohol while an inpatient here and also on return to the community given that he has a lower tolerance for alcohol now secondary to his CVA and that this use of alcohol adversely affects his mental status ie bipolar disorder.*
>
> *I added that the onus will ultimately be upon him to take the antabuse in the community so if he disliked it he would be unlikely to comply once discharged anyway.*
>
> *Decided to stop his antabuse to see if* [the consumer] *able* [sic] *to abstain from alcohol without it – stressed that my expectation was that he would abstain completely while an inpatient there.* [The consumer] *adamant that he was able to abstain."*

The consumer reported to the Commissioner that he was started on *antabuse* for no clear reason, as his drinking was not problematic at the time. The consumer also considers *antabuse* should never have been prescribed because he had a psychotic disorder as well as a heart condition.

Psychiatrist / Crown Health Enterprise

Report on Opinion - Case 97HDC9553, continued

Advice to the Commissioner

The Commissioner sought advice from two psychiatrists.

Antabuse

The Commissioner's first independent psychiatrist stated that:

> *The effects of drinking while using* [*antabuse*] *are at the least, unpleasant, and can be dangerous if the reaction is extreme or the individual medically compromised. ...* [*Antabuse*] *is contraindicated in patients with cerebrovascular, cardiovascular or severe respiratory disease, or psychosis. ...* [*Antabuse*] *is indicated only as an additional treatment for "highly motivated" individuals who are voluntarily engaged in follow-up and an alcohol abstinence programme such as Alcoholics Anonymous.* [The consumer] *fulfilled none of these criteria. He had cerebrovascular and cardiovascular disease and some degree of respiratory disease as well. I do not regard his bipolar disorder as "psychosis" and as a clear contraindication,* [because] *the risk of psychosis as* a *side-effect of* [*antabuse*] *appears to be a fairly low one.*
>
> *The consumer was clearly not an insightful, motivated out-patient, freely engaging in support groups and general counselling. He had poor insight into his mood disorder and virtually no insight into his alcohol abuse problem. His CVA had resulted in cognitive deficits affecting the frontal areas of the brain ... making it far less likely that he could comply with abstinence while on* [*antabuse*]. *This testing* [for frontal lobe impairment] *had been done in October 1996, so the results were available to the psychiatrist at the time of the* [*antabuse*] *decision.*
>
> [The consumer] *took no notice of the* [*antabuse*] *and continued to drink. Despite the treatment clearly failing to be effective, and despite the ongoing drinking while on* [*antabuse*], *it was not ceased for five weeks. During that time there was considerable risk of a severe reaction which could have been medically disastrous if the consumer had consumed enough alcohol to cause a serious interaction ...*

Continued on next page

Psychiatrist / Crown Health Enterprise

Report on Opinion - Case 97HDC9553, continued

Advice to the Commissioner, *continued*

> *Luckily the amount of alcohol he consumed on these occasions was small, and he appears to have had no medical sequelae or unpleasant side-effects. This may have led to* [the consumer] *becoming blasé about* [drinking] *alcohol despite the* [*antabuse*].
>
> *In addition,* [the consumer was not] *... fully and exhaustively informed of the dangers of alcohol use while on* [*antabuse*], *prior to starting treatment. If so, this is not documented. Several sources emphasise the vital importance of describing in great detail the unpleasant and dangerous side-effects of* [*antabuse*] *use ....* [The consumer] *was a compulsory patient who was aware that treatment and hospitalisation were being enforced under the Mental Heath Act. This is likely to have made him more acquiescent to treatment suggestions. He had very poor insight, especially into his drinking and would* [possibly not] *have readily agreed to* [*antabuse*] *had the side effects been properly emphasised... ."*

The consumer stated he suffered prolonged side effects which continued for some months after the *antabuse* was discontinued. These side effects include confusion, disorientation and impaired creative abilities.

The first independent psychiatrist stated that the consumer's symptoms could not be distinguished from possible side effects of *carbamazepine*, his earlier CVA, his current medical conditions, possible interactions with alcohol or from the effects of his bipolar disorder:

> *"Overall there is no clear evidence ... that the short-term or long-term symptoms described by* [the consumer] *and attributed by him to* [*antabuse*] *were actually caused by this drug."*

Continued on next page

Psychiatrist / Crown Health Enterprise

Report on Opinion - Case 97HDC9553, continued

Advice to the Commissioner *continued*

The Commissioner's second independent psychiatrist made the following statements:

> *"Antabuse is a useful medication for the treatment of alcohol dependence and is underutilised. While the reaction experienced when antabuse is combined with alcohol can be serious and potentially fatal, these consequences are rare.*
>
> *There are several relative contraindications to the prescription of antabuse including those mentioned in the report but I do not consider any of those present in* [the consumer's] *case are absolute contraindications. It is interesting to note that the New Ethicals Catelogue* [sic] *(May 1999 edition), widely considered a reliable guide to the pharmocodyamics of prescription medicines lists only severe myocardial disease and coronary occlusion, psychosis and pregnancy as contraindications. While a history of Cerebrovascular Accident suggests antabuse should be prescribed with caution in* [the consumer's] *case, I do not consider this an absolute contraindication. Similarly, the fact that he suffers from asthma is also a relative rather than an absolute contraindication. Furthermore,* [while] *his past mitral valve and coronary artery bypass operations suggests antabuse should be prescribed with caution, these are not absolute contraindications in his case. Similarly, the fact that his compliance with antabuse and with abstinence could not be closely monitored at home is a relative rather than an absolute contraindication.*

Continued on next page

Psychiatrist / Crown Health Enterprise

Report on Opinion - Case 97HDC9553, continued

Advice to the Commissioner *continued*

In other words, the prescription of antabuse to [the consumer] *would need to have been undertaken with great caution but may have been justified if his responsible clinician believed the risks were outweighed by the risks of continued drinking and its effects on his bipolar disorder. ...* [His bipolar disorder] *would need to be severely impairing and potentially life threatening to justify the risks of antabuse. Furthermore, I would expect clear and extensive documentation in the clinical file weighing these relative risks, indicating the reasons for the decision to prescribe antabuse and detailing that* [the consumer] *was fully informed of these risks.*

The psychiatrist also obtained advice from a physician with experience in pharmacological treatments of addictive disorders. This physician stated:

"Ideally, antabuse is prescribed to motivated alcoholics involved in treatment. However, antabuse has been used in less motivated patients with supervised dosing being a condition of parole, employment, etc or detention under the Alcohol and Drug Addiction Act.

...It is not uncommon for patients to experiment with low doses of alcohol in the early stages of antabuse treatment. Patients are kept under review because of this (as was [the consumer].

… In the New Ethical Compendium and Catalogue (NZ), which is standard readily available information, the relevant contraindications referred to are "decompensated heart disease" and "severe myocardial disease or coronary occlusion". From my knowledge of the patient from the psychiatric records I would not place him in those categories."

Continued on next page

Psychiatrist / Crown Health Enterprise

Report on Opinion - Case 97HDC9553, continued

Advice to the Commissioner *continued*

In addition, the psychiatrist obtained advice from a forensic psychiatrist who stated:

> *"...*[T]*he treatment goal of stopping* [the consumer] *from drinking alcohol was rightly seen as being important and the therapeutic course to be taken required an assessment of a complex presentation. One must not underestimate the value of a clinician's perceptions of the patient as presented at the time. Judgements made on assessing the insight of a patient are, in my experience, usually much clearer in retrospect.*
>
> [The psychiatrist] *was in the position of an acting consultant and had limited experience in that role, yet it fell to her to take this decision. I consider that the decision taken by* [the psychiatrist] *to prescribe antabuse to this patient is a decision that a reasonably competent clinician (in* [the psychiatrist's] *position) may well have taken. A practitioner of greater experience may not have prescribed antabuse to this patient (myself included), but this is a matter of judgement, which is only gained by experience."*

Dual Diagnosis

The Commissioner's first independent psychiatrist advisor stated:

> *"Despite the concern that* [the consumer's] *alcohol use elicited in the treating team, leading to the unwise use of* [*antabuse*], *there is no mention made of referral to or consultation with any dual diagnosis team.*

Continued on next page

Psychiatrist / Crown Health Enterprise

Report on Opinion - Case 97HDC9553, continued

Advice to the Commissioner *continued*

The Commissioner's second independent psychiatric advisor stated:

> *"It is reasonable to expect a competent psychiatrist to have some knowledge of alcohol and drug issues, and many working in general psychiatric settings have considerable experience and skill in this area. It must also be appreciated that the prevalence of dual diagnosis in acute psychiatric settings is generally higher than that in alcohol and drug services. Dual diagnosis is not the preserve of alcohol and drug services, and many of the clinicians most skilled in dual diagnosis in New Zealand are not working in alcohol and drug dedicated services. Furthermore, many alcohol and drug workers have limited mental health experience.*
>
> *While it was reasonable of* [the psychiatrist] *to refer* [the consumer] *to the Community Alcohol and Drug Service for assessment and intervention, I do not think this should have been an expectation. In other words,* [the psychiatrist] *may well have had sufficient experience and skills to deal with the alcohol and drug component of the consumer's illness without the need for a "specialist" alcohol and drug opinion.*

The psychiatrist's physician advisor stated:

> *"...*[The psychiatrist] *has experience in the Alcohol and Drug Service and probably more familiarity with antabuse than many of her colleagues and other doctors. I do not agree that a referral for dual diagnosis was necessary in those circumstances notwithstanding that the patient had previously attended the Alcohol and Drug Service."*

Continued on next page

Psychiatrist / Crown Health Enterprise

Report on Opinion - Case 97HDC9553, continued

Advice to the Commissioner *continued*

Policies Relating to Dual Diagnosis

The CHE advised in a fax on 12 January 1999:

> *"*[The CHE's] *Mental Health Service does not have specific policies relating to dual diagnosis. Many inpatients have a dual diagnosis, ... in each case delivery of care is determined according to the needs of the individual patient."*

The CHE advised it *"has greatly increased its focus on record-keeping so that it is accurate and inclusive, and will continue to reinforce the importance of accurate and full record keeping."*

The Commissioner's second psychiatric advisor stated:

"[The CHE's protocols and policies] *appear woefully inadequate. They are vague, give little clear direction as to standards of treatment and do not define or cross-reference definition of key procedures such as "assessment". I doubt if they gave any useful direction to clinicians or managers."*

Psychiatrist / Crown Health Enterprise

Report on Opinion - Case 97HDC9553, continued

Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

…

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

…

4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

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

RIGHT 6
Right to be Fully Informed

…

2) Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.

…

Jurisdiction

While the consumer's status as a compulsory patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992 meant that he could be provided certain services without giving his informed consent, he nevertheless retained all the other rights in the Code of Rights, as well as certain specific rights in the Mental Health (Compulsory Assessment and Treatment) Act. Accordingly, the Commissioner has jurisdiction to consider whether his Rights in the Code had been met, in relation to standards and information given.

Psychiatrist / Crown Health Enterprise

Report on Opinion - Case 97HDC9553, continued

Section 59 and section 67, Mental Health (Compulsory Assessment & Treatment) Act 1992

Section 59 Treatment while subject to compulsory treatment order—
(1) Every patient who is subject to a compulsory treatment order shall, during the first month of the currency of the order, be required to accept such treatment for mental disorder as the responsible clinician shall direct.
(2) Except during the period of 1 month referred to in subsection (1) of this section , no patient shall be required to accept any treatment unless—

(a)The patient, having had the treatment explained to him or her in accordance with section 67 of this Act, consents in writing to the treatment; or

(b) The treatment is considered to be in the interests of the patient by a psychiatrist (not being the responsible clinician) who has been appointed for the purposes of this section by the Review Tribunal.

(3) Where, during the period of 1 month referred to in subsection (1) of this section, the responsible clinician is satisfied—

(a) That the patient will need further treatment of a particular kind beyond the expiry of that period; and

(b) That the patient is unlikely to consent to that treatment, —

the responsible clinician may, notwithstanding that the period has not expired, refer the case to a psychiatrist referred to in subsection (2)(b) of this section for consideration, so as to ensure that the opinion of that psychiatrist is available on the expiry of that period.

(4) The responsible clinician shall, wherever practicable, seek to obtain the consent of the patient to any treatment even though that treatment may be authorised by or under this Act without the patient's consent.

Section 67 Right to be informed about treatment*—Every patient is entitled to receive an explanation of the expected effects of any treatment offered to the patient, including the expected benefits and the likely side-effects, before the treatment is commenced.*

Psychiatrist / Crown Health Enterprise

Report on Opinion - Case 97HDC9553, continued

Opinion: Breach The Psychiatrist

Right 4(2)

In my opinion the psychiatrist breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights.

The psychiatrist did not comply with legal standards. Under section 59 of the Mental Health (Compulsory Assessment and Treatment) Act 1992, there is a requirement to obtain written consent for any new treatment which is required after the first month of the currency of a compulsory treatment order. Alternatively, if such consent is not given, the treatment can only be given if it is considered to be in the interests of the patient by a psychiatrist (not being the responsible clinician) who has been appointed for the purposes of section 59 by the Review Tribunal. In addition, section 67 of that Act entitles patients to receive an explanation of the expected effects of any treatment offered, including the expected benefits and likely side-effects, before the treatment is commenced. While the psychiatrist documented the consumer's agreement to commence *antabuse* in early January 1997, the psychiatrist did not note whether the side-effects and the full implications of combining *antabuse* with alcohol were discussed with the consumer.

In my opinion, there is no evidence that written informed consent to the treatment was obtained in accordance with section 59(2). This is especially important in the use of *antabuse* because of the potential risks and side effects from its use.

Continued on next page

Psychiatrist / Crown Health Enterprise

Report on Opinion - Case 97HDC9553, continued

Opinion: Breach – The Psychiatrist, *continued*

In regard to whether or not the psychiatrist should have prescibed *antabuse* at all, I consider that while the psychiatrist may have considered there were valid reasons for prescribing *antabuse*, in the consumer's case more caution should have been applied in using this form of treatment.

Firstly, *antabuse* is not recommended for those with medical conditions such as cerebrovascular disease, cardiovascular disease and respiratory disease. However, I accept the advice that in the consumer's case none of these conditions were severe enough to preclude the prescribing of *antabuse*.

Secondly, from an alcohol treatment perspective, the consumer had not demonstrated a readiness to abstain from alcohol, nor an understanding of the consequences of combining *antabuse* with alcohol. Both these factors are considered requirements for a positive outcome. Furthermore, the consumer did not appear motivated to change his pattern of drinking, nor did he consider he had an alcohol problem. *Antabuse* is recommended for motivated individuals, usually with support systems in place and participating in community programmes based on abstinence. The consumer did not fulfil these criteria. If the consumer had consumed a larger amount of alcohol while taking *antabuse* a more severe reaction could have occurred with life-threatening consequences.

Continued on next page

Psychiatrist / Crown Health Enterprise

Report on Opinion - Case 97HDC9553, continued

Opinion: Breach - The psychiatrist *continued*

Right 4(4)

In my opinion the psychiatrist breached Right 4(4) of the Code of Health and Disability Services Consumers' Rights. The psychiatrist did not provide treatment that minimised potential harm to the consumer when prescribing *antabuse* to him. Given the consumer's continued alcohol consumption while taking *antabuse* medication, and staff awareness of this, the psychiatrist placed the consumer at risk by not fully informing him of the harmful effects of drinking alcohol while taking *antabuse* and not taking into account the consumer's behaviour at the time.

It appears fortunate that the consumer consumed only small amounts of alcohol and that a potentially severe reaction was not experienced. Nevertheless, the *antabuse* treatment was not recommended given the consumer's lack of motivation to change his drinking pattern.

Right 6(2)

In my opinion the psychiatrist breached Right 6(2) of the Code of Health and Disability Services Consumers' Rights. Although the psychiatrist stated she did inform the consumer about the side effects and implications of taking *antabuse* medication at the initial discussion about *antabuse* treatment, these points were not documented in the clinical notes as being discussed.

Full discussion of all the information appropriate to the consumer's circumstances might have revealed that *antabuse* was not a suitable treatment for the consumer, particularly considering his lack of motivation and denial of using alcohol.

At the time, the consumer was being treated under a compulsory treatment order which may have influenced the consumer's outward compliance at the beginning of *antabuse* treatment. The consumer had poor insight into his illness and should not have been placed in a position to consent to *antabuse* treatment without demonstrating motivation and understanding of the treatment itself, including its side-effects and contraindication for persons suffering from his medical conditions.

Psychiatrist / Crown Health Enterprise

Report on Opinion - Case 97HDC9553, continued

Opinion: Breach – the CHE

Right 4(2)

In my opinion the CHE breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights. The CHE is vicariously responsible for the breaches of the consumer's rights by the psychiatrist in that they occurred while he was in the CHE's care.

In my opinion, the CHE has not provided services which comply with professional and other relevant standards. In particular, the CHE has not demonstrated an ability to manage dual diagnosis patients who are resident in the hospital. The alcohol and drug service responded inadequately to the consumer's referral and this contributed to the psychiatrist's poor treatment decision the following month. A comprehensive substance-use assessment as well as advice on management and possible treatment options was not provided. The one brief contact with the alcohol and drug service ignored the consumer's physical and mental problems and the on-going concerns expressed by staff.

Furthermore, the CHE has no policies or protocols on the management of dual diagnosis patients. This suggests the CHE does not acknowledge this complex group of patients who can at times be at considerable risk, both to themselves and others. Staff require guidance with appropriate policies and procedures on the correct management of these patients, particularly given the CHE's statement that there are many mental health patients who have a dual diagnosis.

In addition, the CHE has not complied with legal standards and requirements under the Mental Health (Compulsory Assessment and Treatment) Act 1992 which provides that any new treatment for patients on a compulsory treatment order must be consented to in writing or approved by a psychiatrist appointed by the Review Tribunal. The psychiatrist did not document whether or not a discussion took place with the consumer where the risks and benefits of *antabuse* treatment were clearly outlined. The CHE is vicariously liable for the psychiatrist's failure to obtain informed consent to the administration of *antabuse*.

Continued on next page

Psychiatrist / Crown Health Enterprise

Report on Opinion - Case 97HDC9553, continued

Opinion: Breach – the CHE *continued*

Right 4(5)

In my opinion the CHE breached Right 4(5) of the Code of Health and Disability Services Consumers' Rights by not ensuring co-operation and continuity of services between mental health services and alcohol and drug services for the consumer. The alcohol and drug service undertook a "brief intervention" which was not appropriate in the consumer's situation. This "brief intervention" did not include an assessment of his alcohol use or advice on management and treatment options at the time.

A follow-up appointment with the CHE's alcohol and drug service was arranged for the consumer in early December 1996 and there is no record to show that this appointment was kept. Staff at the CHE's alcohol and drug service who were expecting the consumer should have contacted the ward where the consumer was an inpatient and arranged another appointment time.

I do not accept that the advice given to the consumer from nursing and medical staff on the inadvisability of drinking was sufficient for the consumer's needs, given the repeated concerns expressed by staff about the consumer's drinking.

In response to my provisional opinion, the CHE sent a copy of a "*Dual Diagnosis*" policy from the community alcohol and drug service. This policy was dated August 1998 and subject to review in August 1999. The policy was minimal, was passive in terms of co-operation with mental health services and was not signed. No policy from mental health services was received apart from a fax of 12 January 1999 stating that none existed.

Psychiatrist / Crown Health Enterprise

Report on Opinion - Case 97HDC9553, continued

Actions: The psychiatrist

I recommend that the psychiatrist provides a written apology to the consumer for her breach of the consumer's Rights under the Code.

Actions: The CHE

I recommend that the CHE takes the following actions:

- Provides evidence of protocols and policies on the treatment of patients with dual diagnosis of mental health and substance use disorders. These protocols should be in line with guidelines recommended by the Ministry of Health and the Health Funding Authority.
- Provides a written apology for its breach of the Code of Rights to the consumer.

The apologies should be sent to this Office and will be forwarded to the consumer. Copies will remain on the investigation file.

Other Actions

A copy of this opinion will be sent to the Medical Council of New Zealand and the Royal Australian and New Zealand College of Psychiatrists. A copy of this opinion will be distributed for education purposes.