**Assessment and treatment of young man by a mental health service**
**13HDC00859, 16 February 2017**

*District health board ~ Mental health service ~ Psychiatrist ~ Relapse plan ~ Care and crisis planning ~ Right 4(1)*

A young man attended a health service and was later admitted to a mental health in patient service. The man had requested his ears be checked to ensure there were no transmitters in them and reported that he could hear voices. When the man was discharged a month later, he was taking olanzapine (an antipsychotic medication) twice daily.

The man was discharged into the care of a psychiatrist and psychiatric district nurses under a mental health service.

Over a period of ten months, the man's care was discussed regularly at multidisciplinary team meetings, and he was seen regularly by the mental health service. During this period, his antipsychotic medication was decreased progressively, partly because he had reported sedation and apathy as side effects of the drug. He experienced some improvement in his symptoms but continued to report auditory hallucinations intermittently.

The man's parents made contact with the mental health service on a number of occasions expressing concern about their son's well-being, including his lack of motivation, personal hygiene, sleep patterns, and use of alcohol and drugs. The psychiatrist reviewed the man and noted that there was no evidence of psychotic phenomena.

When on holiday with his father, the man self-presented at another hospital. The man reported anxiety, auditory hallucinations including voices, poor sleep, and the belief that he had a microchip in his ear that had been planted by his parents. He denied any thoughts of harming himself or others. The man was assessed, prescribed additional olanzapine, and advised to attend the mental health service as soon as possible. A copy of the records made at the hospital was faxed to the mental health service. Following the man's return home, the psychiatrist noted that the man had "gradually come off olanzapine" and that he had "no ongoing voices".

Over the next three months, there were significant signs that the man's mental condition may have been deteriorating. He self-presented at an emergency mental health service requesting sleep medication and later did not attend a number of scheduled appointments. His parents made a number of telephone calls to the mental health service expressing concern for his well-being.

The psychiatrist and a psychiatric district nurse visited the man at his mother's home. The psychiatrist recorded that the man had consumed a large amount of alcohol over the weekend and could not recall what had happened but believed he had been beaten up. The psychiatrist noted that there were no signs of psychosis and no evidence of any further drug use.

Over the next few days, the man's parents each separately rang the mental health service expressing concern that the man was mentally disordered and needed hospital treatment. The man's mother contacted the mental health service and requested a second opinion on his condition. The man's mother told the psychiatric district nurse that her son's injuries from the weekend were self-inflicted, and that she believed he was mentally disordered and needed hospital treatment. The psychiatric district nurse rang the man and asked him to

attend an appointment with the psychiatrist. The man denied any psychotic symptoms or wanting to harm himself, and did not attend the scheduled appointment.

The following morning, the man's mother telephoned the emergency mental health service a number of times stating that she did not know her son's current whereabouts and asking for him to be hospitalised. Sadly, it later transpired that the man had died.

**Findings**

It was held that the man's relapse plan was developed without input from the man and his parents. The lack of a relapse plan that had been discussed with the man and his family (with his consent) amounted to suboptimal care by the DHB.

Furthermore, the man was not made sufficiently aware of the alternative treatments available following his presentation to the other hospital. There were sufficient indications that the man's behaviour was escalating, but the mental health service clinicians did not recognise the signals in that regard. The man's self-presentation at the emergency mental health service, the family's escalating concerns and reports about the man's behaviour, should have led to consideration that he may have been relapsing.

The DHB failed to provide services to the man with reasonable care and skill and, accordingly, breached Right 4(1). It was held that the psychiatrist also failed to provide services to the man with reasonable care and skill and breached Right 4(1) because the man was not made sufficiently aware of the alternative treatments available, following his presentation to the other hospital.

The Mental Health Commissioner made a number of recommendations, including that the DHB review its processes for the development of recovery plans and for collaborative care planning with consumers and their families; provide refresher education sessions for the mental health service staff on the treatment of co-existing disorders; and arrange an independent audit of documentation within the service.

He also recommended that the DHB and the psychiatrist apologise to the man's family for their breaches of the Code; and that the psychiatrist undertake further education and training on recognition of deteriorating consumers.