Cultural care plan and psychiatric review of at-risk patient
16HDC00195, 11 April 2019

District health board ~ Consultant psychiatrist ~ Mental health ~ Cultural care plan ~ Communication ~ Right 4(1)

A woman in her forties had been a consumer of mental health services since the mid-1990s. She had been diagnosed with bipolar affective disorder and admitted to mental health services a number of times, including an admission under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the MHA).

In 2015, the woman's mother contacted the district health board's (DHB's) mental health emergency team (MHET) about her concerns for her daughter's mental health, and requested that she be admitted under the MHA. A consultant psychiatrist undertook a psychiatric assessment, concluding that hospital admission was not necessary and that the woman could be managed by the community mental health team. MHET made regular contact with the woman and her mother following this assessment.

The following month, the mother told MHET that her daughter had hunting knives in her possession, which she confiscated. She also reported that her daughter's highs and lows were more extreme. A short time later, the woman was taken into Police custody after harming a woman unknown to her.

Findings

It was held that the DHB did not have an adequate care plan in place, which was contributed to by a lack of psychiatric review over a protracted time. This issue was compounded by the absence of a cultural care plan, and the lack of elementary factors of Māori communication and care in the DHB's engagement with the woman. The DHB was found to have failed to provide services with reasonable care and skill, in breach of Right 4(1).

Individual criticism of the psychiatrist was made for his inadequate documentation, and for failing to discuss the woman's mental health with her mother at the time of the psychiatric assessment.

Recommendations

It was recommended that the DHB assess how its cultural and clinical care can be best coordinated and integrated, in collaboration with local Māori communities, and with input from consumer and family/whānau advisors. It was also recommended that the DHB provide a further update to HDC in relation to the changes made since this complaint, and in relation to the outstanding recommendations made following the DHB's Serious Adverse Event Review.

The DHB provided letters of apology to the consumer and her family.