Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Treatment of a woman with complex mental health needs

20HDC01226

A disability service has breached the Code of Health & Disability Services Consumer's Rights (the Code) for its treatment of a woman with complex mental health needs.

The woman, who suffered a traumatic brain injury in 2016, and had a complex mental health history since 2007, was a resident at the disability service. When her behaviour deteriorated, a psychiatrist assessed her at the residence as presenting "with a manic relapse of her bipolar mood disorder." The psychiatrist started an application for compulsory treatment under the Mental Health Act.

The woman was taken to a mental health service for assessment, but it was determined that she did not meet the criteria to be admitted or placed under a compulsory treatment order.

A Team Leader from the disability service then drove the woman to a hospital emergency department four hours away and left her there. No handover was provided and the woman's medication was not taken from the disability service to the hospital. When the woman was assessed, she was not admitted to the hospital and was left technically homeless in the days following.

Deputy Commissioner, Dr Vanessa Caldwell, found the disability service in breach of Right 4(2) which gives consumers the right to have services provided that comply with legal, professional, ethical, and other relevant standards, and Right 4(3) which gives consumers the right to have services provided in a manner consistent with their needs.

Dr Caldwell expressed concern about the decision to take the woman to the emergency department and leave her there unaccompanied, a significant distance from her home. She was also critical of the disability service's exit and lack of transfer of care process, and considered that the "exit" amounted to abandonment of the woman.

The disability service did not contact the hospital in advance to advise staff the woman would be coming for assessment. There was no contingency in place for what would occur if the hospital decided not to admit the woman, which was a foreseeable outcome given the earlier mental health service assessment. The woman did not have her medication with her, and the woman's mother (who is also her legal guardian) was not informed that the woman was being exited from the service.

Dr Caldwell made adverse comments about how the Team Leader left the woman at the emergency department. However, she accepted he did not have decision-making

power in this situation, and he was following direct instructions to take the woman to the hospital.

"Sadly, this case is not an isolated scenario, and it highlights the importance of robust systems and good communication between providers, to ensure coordinated care that is flexible in order to meet the changing needs of people with complex care needs," Dr Caldwell said. "I stress that it is entirely inappropriate for care facilities to utilise emergency departments as alternative accommodation solutions."

Dr Caldwell recommended the disability service provide a written apology to the woman and her mother, and provide HDC with copies of the disability service's policy for discharging residents, escalation policy and protocol for transfer of care, and training framework for managing challenging behaviours.

She also recommended the disability service, ACC, and Te Whatu Ora provide an update on further steps to improve co-ordination and co-operation between rehabilitation and mental health services.

4 September 2023

ENDS

Editor's notes

The full report of this case will be available on HDC's website. Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code, unless it would not be in the public interest, or would unfairly compromise the privacy interests of an individual provider or a consumer.

More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendation.

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