Co-ordination of care of woman with mental health and addiction issues
15HDC01202, 13 December 2018

District health board ~ Mental health services ~ Self harm ~ Addiction ~ Clinical responsibility ~ Co-ordination of care ~ Right 4(5)

A woman was admitted to the Emergency Department (ED) at a district health board (DHB) following an episode of self harm. She was noted to have a background of anxiety and depression and daily alcohol use, and it was documented that she had suicidal intent. She was referred to the Psychiatric Emergency Service (PES).

The following morning, the woman was reviewed by a mental health nurse. The documented plan was for the woman to be discharged and to attend a PES risk review the next day.

The following day, the woman was involved in an accident while intoxicated. She was picked up from the police station by her father and taken to her PES appointment. The woman was assessed by a PES case manager and agreed to attend a support meeting that evening and a review with a PES consultant psychiatrist and the case manager the following day, and to be referred to the Alcohol and Other Drug Coordination Service (AOD).

The woman attended the review with the psychiatrist. It was documented that her mood disorder (depressive episode) could not be seen as primary while she was using alcohol in large amounts, and that her risk of suicide was currently low but that this could change depending on her level of intoxication. The woman was given information about rehabilitation programmes and agreed to attend two support meetings over the weekend, and was given a prescription to continue using an antidepressant.

The case manager verbally consulted with a clinical nurse specialist at the Community Alcohol and Drug Service (CADS) and requested a referral to the service regarding the woman's alcohol use. The clinical nurse specialist understood that PES would be continuing to work with the woman with regard to her mental health issues.

The PES case manager and the CADS clinical nurse specialist noted that they attempted to contact the woman several times, and left messages requesting return contact. A few days later, the case manager contacted the woman's father to advise that she would be discharged from mental health services owing to non-contact. The woman was discharged from PES that day.

The woman then contacted the CADS clinical nurse specialist, and an initial telephone screening was undertaken. The screening focused on the woman's motivation to engage in treatment pathways, and the clinical nurse specialist advised that he would arrange an appointment with the outpatient AOD service. Self-harm risks were not discussed.

The CADS clinical nurse specialist referred the woman to AOD during an allocation meeting, and accordingly the PES referral to CADS was withdrawn. It was agreed that the woman would be contacted by AOD regarding an appointment. The DHB advised that the intention was for the AOD service to organise an assessment for the woman in a few weeks' time.

The woman had no further contact with DHB services. The following week, the woman was found to have passed away.

The DHB undertook a Serious Incident Review and found that clinical documentation did not evidence assessment of the woman's mood and suicidality, that CADS assessment did not occur despite the criteria for assessment being met, and that there were communication issues with the family.

Findings

The Mental Health Commissioner commented that DHB staff were primarily focused on addressing the woman's alcohol addiction issues, but that the same level of attention was not being given to her mental health issues or to integrated, ongoing risk assessment. He considered that DHB staff separated the woman's mental health and addiction issues from one another and, as a result, the woman did not receive a co-ordinated and appropriate standard of care for her mental health issues, and the transfer of her support to alcohol and drug services in the community was insufficient for a consumer dealing with both mental health and alcohol addiction disorders.

It was held that the referral of the woman to AOD and her discharge from PES resulted in no one retaining clinical responsibility for her mental health issues, when either PES or CADS should have done so. Overall, there was a lack of critical thinking in relation to the co-existing disorders, resulting in inadequate co-ordination of care by the DHB. As the DHB did not ensure co-operation between providers to ensure quality and continuity of services to the woman, it breached Right 4(5).

Recommendations

In light of the issues identified by the investigation, the recommendations made in the DHB's Serious Incident Review, and the expert advisors' comments, it was recommended that the DHB review and update its Service Provision Framework to ensure that it explicitly clarifies and documents the following: the transfer processes between services; the CADS criteria for acceptance; and the CADS telephone screening process. Evidence was requested of changes made as a result of the review, and details of any other improvements to the interaction between PES, CADS, and AOD services. It was also recommended that the DHB provide an apology to the woman's family.