Management of patient with severe, deteriorating mental illness (01HDC13687, 7 July 2004)

Psychiatrist ~ Social worker ~ District Health Board ~ Crisis assessment and treatment team ~ Community-based health care ~ Reporting systems ~ Co-ordination of services ~ Follow-up ~ Admission to hospital ~ Tricyclic antidepressants ~ Rights 4(1), 4(5), 6(1)(b)

A 44-year-old woman, who had a history of severe postnatal depression, was referred by her GP to a DHB community mental health team when she presented with insomnia and extreme anxiety that did not appear to be responding to medication. That team was to have overall management of her care, although she was to contact a crisis assessment and treatment team (CATT) if she needed urgent or after-hours care.

Referrals to a community health service are triaged for urgency; in this instance, the GP had marked his letter of referral "semi-urgent", although the body of the letter indicated that "urgent management" was required. The health service's social worker organised an appointment with the community consultant psychiatrist for the following week. The woman denied any suggestion of suicidal ideation, although she admitted that her stress levels were out of control. It was noted that she had found counselling very helpful in the past.

In the interim, the woman continued to deteriorate, and her husband took her to the team medical officer, who prescribed a month's course of tricyclic antidepressants. The medical officer turned down the woman's request to be hospitalised, as he felt that her condition did not warrant it, and that her claim that she was no longer suicidal meant she was not at risk.

The following day, the woman overdosed on the antidepressants and paracetamol, although she denied that it was a suicide attempt.

Over the next fortnight, the woman suffered a number of severe panic attacks, including leaping from a moving vehicle. The CATT assessed her but refused to admit her to hospital, even though she requested this as she felt she was placing too much strain on her family and support people. A note was made to consider crisis respite care, but the community health team did not follow this up.

An appointment with the team's consultant psychiatrist four days later resulted in a change to the woman's medication, but the lack of an available psychologist meant that no biopsychological assessments were made, nor counselling arranged. The woman continued to experience panic attacks of escalating severity, and the delay in access to counselling and psychiatric services increased her anxiety. A fortnight after the appointment, the woman consulted a psychiatrist in private practice. However, he was not prepared to treat her until she or the community team's psychiatrist confirmed that she was not suicidal. These assurances were not forthcoming.

Over the following few days, the woman's family felt they noticed an improvement in her condition. However, within five days she had committed suicide.

The DHB, the team social worker and the consultant psychiatrist were all found to have breached Rights 4(1) and 4(5), as the woman was not admitted to hospital when she should have been. While suicide can be difficult to predict, this is all the more reason for vigilance in the co-ordination and continuity of care. Although the DHB had good reporting systems in place regarding individual interventions, no one was taking ultimate responsibility for overseeing the patient’s ongoing care. Information from individual contacts was logged, but no one was analysing the information and following it through with a co-ordinated, monitored care plan. Consequently, the cumulative effect of these individual events, and the worrying picture they painted, was missed. Moreover, no one communicated adequately to the woman or her carers about why she was not being admitted to hospital, where she believed she would be safe. Responsibility for overseeing the woman’s care lay with the community mental health team, and ultimately with the social worker who was the case manager.

Following the woman’s death, the DHB undertook considerable work to minimise the chances of similar deficiencies in community health care in the future. In addition to training, there is a home-based treatment team, and electronic reporting systems that clearly identify the person with primary responsibility for a patient. A day hospital has been opened in the area, and there has been an increase in the number of crisis respite beds.

The Director of Proceedings considered this matter and decided not to issue proceedings before the Health Practitioners Disciplinary Tribunal or the Human Rights Review Tribunal.