Care of man with complex mental health issues
15HDC01279, 7 June 2018

District health board ~ Psychiatrist ~ Keyworker ~ Alcohol and drug service ~ Suicidal ideation ~ Complex case conference management plan ~ Crisis plan ~ Discharge ~ Right 4(1)

A man was admitted to a public hospital following an episode of self-harm. He was diagnosed with adjustment disorder, alcohol dependence, and antisocial personality disorder. He declined voluntary admission to the Acute Psychiatric Unit (APU), so it was decided to treat him as an outpatient. He was prescribed quetiapine to help with sleep. He was seen by the Crisis Team several times, and was then referred to the Alcohol and Drug Service (AOD). Following this, he was seen by his keyworker a number of times, and a personal crisis plan was drafted.

The following month, the man called the Mental Health and Addiction Service (MHAS) Crisis Team number stating, "It's all over." He was taken to the police station and disclosed suicidal thoughts to the Crisis Team. He was admitted to the APU the next day, as a voluntary patient. He was prescribed quetiapine to assist with sleep and reduce agitation. He was discharged with a moderate to high risk of harm to self and/or others two days later. The plan was for ongoing AOD follow-up.

That evening, the man called the Crisis Team number, saying "goodbye". He was taken to the police station. When initially seen it was recorded that he was heavily intoxicated. He was assessed early the next morning by the Crisis Team, but the man denied any previous or current plan to self-harm. The man was discussed at a multidisciplinary meeting later that morning and the plan was to continue with follow-up by AOD.

Two days later the man sent an inappropriate text message to his AOD keyworker. The next day, he told her that he had abused prescription medication, but then retracted this statement. The keyworker informed the psychiatrist who had assessed the man during his first admission to APU, and it was agreed that the man was to remain at home, to continue engaging with AOD, and to contact the Crisis Team if necessary. The following day, the man sent another inappropriate text to the keyworker. This was discussed with the psychiatrist, who suggested that a formal complaint be made to the police. The keyworker also spoke to her manager about the inappropriate text messages, and said that she was not told to complete an incident form.

A couple of days later, the man was admitted voluntarily to the inpatient unit after calling the Crisis Team number and making suicidal threats while intoxicated. During his admission, he was visited by a friend who offered support and was added as a contact person. The man was discharged home later on the day of this visit. A nurse recorded that the man continued to be a moderate to high risk in the community for harm to himself and others. She noted that he had the 0800 Crisis Team number and a crisis plan. This was the crisis plan that had been developed earlier by the keyworker, which stated that the man was to attend weekly appointments with the

keyworker, call the Crisis Team or the police in high-risk situations, and call the keyworker for urgent review if necessary.

A Complex Case Conference was held to discuss the man's care on the day of discharge, and the keyworker then drafted a management plan. The case management plan included a plan that if the man made any threats of self-harm, the appointment would be cancelled immediately and the police contacted, and he would be discharged from the AOD. The keyworker discussed the plan at an appointment with the man, and said that she still encouraged the man to seek support if he felt suicidal. The support person said that the keyworker advised the man that she could not help him if he was going to continue to make suicidal threats.

During the appointment, the man reported having experienced some suicidal thoughts two days previously, but said that taking two quetiapine tablets from an old prescription had had a settling effect. The keyworker cancelled the prescription because of recent threats of self-harm. The support person offered to supervise the man's medication administration and requested that this be discussed with a psychiatrist.

The next day, the keyworker recorded that the man was discussed at the multi-disciplinary team (MDT) meeting and it was decided to consult a psychiatrist more familiar with the man's case about the possibility of a small amount of quetiapine being given to the man. The keyworker recalls that a prescription was decided against, owing to the man's changeability in mood and threatening behaviour when intoxicated, and the potential impact on the man's support people.

About eight days later, the man sent the keyworker a text message stating that he wanted to die. When the keyworker called him, the man reported a number of stressors and stated that he did not want to live, although he denied any specific suicidal plans owing to fear of the police being called. The keyworker stated that during the call the man requested discharge from AOD. This was nine days after the keyworker had discussed the management plan with him.

Later that day, the keyworker visited the man and recorded that he had ongoing suicidal ideation, was using an intoxicating substance, appeared depressed, and was expressing thoughts of hopelessness. She also recorded that the man expressed no interest in addressing his issues regarding alcohol and substance misuse, and no intention of attending appointments with her. She informed him that he would be discharged from AOD owing to his unwillingness to engage in the treatment being offered.

A psychiatrist (different from that referred to above) was informed of the visit and agreed that the man should be discharged from AOD. The management plan was updated that day, confirming that the man would be discharged owing to non-engagement with the treatment plan.

The keyworker presented the man's case at an MDT meeting, at which the second psychiatrist was present. The man was discharged from AOD. The risk assessment

recorded that the man was at chronic risk of suicide, and noted the current factors that placed him at high risk to himself, including limited social support.

Some weeks later, the man was found dead at his home. The man's support people told HDC that for the first few weeks following discharge from AOD the man appeared to be managing, but he then appeared to deteriorate, and they felt that they were left to support him with no professional assistance.

Findings

It was found that the DHB failed to provide services to the man with reasonable care and skill and, accordingly, breached Right 4(1), by failing to have in place an accurate and up-to-date crisis plan for the man prior to his discharge following the second admission to APU, including failing to involve the man himself adequately, and, where appropriate, his support people; developing and implementing a management plan that was not appropriate; and discharging the man without greater consideration of other ways to foster engagement, including with his support people, given his ongoing risk, expressions of suicidal ideation and hopelessness, and substance abuse.

Adverse comment was made in relation to the DHB for not effectively assimilating the man's care into a dual diagnosis understanding; the limited planning around early psychiatric input following the man's discharges and the lack of psychiatric input within the community; and the lack of an apparent strengths-based approach. While it was found that it was reasonable for the man's quetiapine to have been cancelled, it was considered that it would have been prudent for this to have been considered in a more timely manner, the rationale better explained to the man and his support people, and alternative options for tranquillisation considered, so that the man did not resort to substance misuse. Criticism was also made in relation to the lack of policies in place at the DHB to assist the keyworker in the performance of her role, and that AOD policies also held deficiencies in the guidance they provided in relation to psychiatric involvement.

Adverse comment was made that the first psychiatrist did not document his concerns, his rationale for decision-making, and his management plan for the man during the discharge of the man from his first admission to APU.

Adverse comment was made that the second psychiatrist did not review the man prior to deciding whether to discharge him from AOD, given his ongoing risk, expressions of suicidal ideation and hopelessness, and substance abuse.

Adverse comment was made about the keyworker's lack of documentation of the meeting between the psychiatrist and the man after the man told her that he had abused prescription medication, and in relation to the keyworker's documentation of an inappropriate management plan.

Recommendations

The DHB confirmed that it had implemented weekly professional peer supervision for the Alcohol and Drug Service.

It was also recommended that the DHB undertake the following actions:

a) Assess its mental health and addiction services with reference to strengths-based practice to identify service improvements, and obtain input from family/whānau and consumer representatives in that assessment.
b) Report on the findings and actions taken as a result of the DHB's independent review of the assessment, care, and treatment of clients with dual diagnosis.
c) Implement professional supervision for clinical staff working in this area.
d) Report on progress in implementing new terms of reference for Complex Case Conferences that set out, amongst other things, lines of responsibility for decision-making and requirements for minutes to be taken.
e) Review policies and procedures in relation to boundary setting (including sexual safety for staff); professional supervision; incident reporting; discharge from the service; client engagement; and changing case workers.
f) Review the orientation of new staff to ensure that they are provided with training and appropriate supervision in relation to the policies in (e) above, including knowledge of escalation pathways when issues arise.
g) Report on the implementation of the above recommendations.