Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Poor coordination of mental health care for prisoner by Corrections and two DHBs
18HDC01605

Deputy Health and Disability Commissioner Vanessa Caldwell has today released details of a case that raised concerns about the coordination of mental health support provided between prisons and District Health Boards.

Dr Caldwell found the Department of Corrections, Southern District Health Board and Canterbury District Health Board in breach of the Code of Health and Disability Services Consumers' Rights (the Code), for an overall poor standard of care for a young man using their services.

The young man, in his late teens, had a known history of mental health issues. He was in prison custody for a year. Following his release, he was remanded in custody at another prison on further charges, and he remained there until he was transferred back to the first prison. Sadly he died from suspected suicide while he was in prison.

The Deputy Commissioner identified a number of issues in relation to the care provided by Corrections, Southern DHB and Canterbury DHB.

"Individually some of the deficiencies in care provided by each of these services may appear minor, but cumulatively they led to a poor overall standard of care for the man," said Dr Caldwell.

"The issues illustrate poor coordination of care between Corrections and both DHBs, and inadequate transfer of information within or between one service and another."

She was concerned about the overall level of coordination between the providers in this case.

"Effective coordination of care is vital in a forensic mental health setting where a vulnerable person with complex mental health needs is receiving care from multiple providers at the same time, and, often, transitioning between providers," said Dr Caldwell.

"This case highlights the importance of Corrections and DHBs providing appropriate and coordinated care to prisoners with mental health conditions.

"I express my sincere sympathy to the man's family for their loss. Their complaint has given all three services an opportunity to reflect on the care they provided and take actions to improve the care they provide," she said.

HDC has invited the Ministry of Health, the DHBs and Corrections to review the issues identified in this case and to consider what further actions and improvements can occur in order to help prevent a similar situation occurring in the future.

Changes made since incident

CDHB told HDC that as a result of this incident it addressed issues and made several improvements, including the following:

An audit of the administrative processes in the Youth Forensics Team identified a number of lapses in documentation, which occurred across all case managers. They have taken steps to improve this through education and six-monthly supervision so standards are raised and maintained. Communication with the prison has been replaced by letter instead of email.

CDHB have reinforced expectations that documentation of core information data is checked and updated.

Staff will leave telephone messages and a short text message so clients and their whānau have a record of contacts and can more easily engage with CDHB using the 0800 number.

CDHB's Youth Forensic Team will be involved in the re-negotiation of the Service Level Agreement between Corrections and CDHB Forensic Service when it occurs.

Meetings between the Youth Forensic Team and the Adult Forensic Team and the prisons will be arranged to ensure there are clear expectations about process and communication between the services.

Southern DHB told HDC that they've made changes to the prison liaison assessment to include a comprehensive risk assessment and consent to liaise form. The service has also reviewed the Clinical Focus and the Acceptance and Discharge Criteria. They are currently reviewing all policies, procedures and guidelines with the forensic services.

Southern DHB has also made a number of changes, including allowing only one administrative staff member to be on leave at any one time. Administrative staff will type up assessments and once these are checked and approved by the health practitioner, a hard copy is provided to the Prison Liaison Nurse to hand over to the prison health staff, and an electronic copy is emailed to the nurses and administrative staff at the prison health centre. Copies of assessments are uploaded to the online clinical portal.

The Service Level Agreement between Corrections and Southern DHB's Regional Forensic Psychiatric Service captures responsibility for a verbal handover.

Recommendations

Dr Caldwell recommended that Corrections and the DHBs use the report as a case study to review co-operation and coordination between health providers and Corrections in a forensic mental healthcare context.

She recommended that Corrections and Southern District Health Board provide a written apology to the man's family.

Dr Caldwell recommended that Corrections:

a) Consider the recommendations made in relation to the importance of reliable data such as family contact details, clear and direct communication about expected roles of the relevant stakeholders, including family, Non-Government Organisation services, and specialist services, and clear documentation of these discussions.

b) Consider the following advice: "There appear to be problems where Corrections and health use different systems to record notes/information. It would be helpful if there was a method to streamline or merge information for all relevant staff to view."

c) Remind its staff of the requirement outlined in its policy in regard to completing a treatment plan and involving the patient's whānau.

d) Review its system for flagging scheduled reviews of at-risk consumers.

e) Conduct a random audit of prisoners receiving care from forensic mental health services, of staff compliance with policies.

f) Use the anonymised version of the report as the basis for a discussion with Health Services staff, focusing on the issues identified.

Dr Caldwell recommended that Canterbury District Health Board:

a) Consider advice that "CDHB should consider whether its existing policies and processes for reporting assessments, especially for newly transferred patients, are adequate".

b) As per its response to the provisional report that it is working with Corrections to promote its service to people being released and on probation.

c) Report back to HDC on the effectiveness of, and staff compliance with, the changes it has made regarding documentation and communication with clients and their whānau, and any actions planned to arise from this assessment.

d) Update HDC regarding the quality improvement recommendations outlined in its Independent Review, including its plan to update guidelines and processes specific to Youth Forensic Team.

e) For five prisoners receiving care from the Youth Forensic Team, conduct a random audit of compliance with CDHB's "Family-Whānau involvement in the consumer's treatment" policy.

f) Use the anonymised version of the report as a basis for discussion with its Forensic Mental Health Team, focusing on the issues identified.

Dr Caldwell recommended that Southern District Health Board:

a) Consider advice that:

   i. "SDHB should review [its Review and Discharge Process] and consider whether it should address actions to be taken when a prisoner receiving a mental health service is transferred to another Corrections [facility]"; and

   ii. "SDHB forensic services should review this report in light of the relevant policies and consider the extent of assessment and documentation needed when there is an escalation in a consumer's level of self-harm, especially when there has been a new concern raised by Corrections staff."

b) For five prisoners receiving care from SDHB's Forensic Mental Health Team, conduct a random audit of staff compliance with SDHB's "Intake and Referral Process (51899) — Prison Liaison" policy.

c) Report back to HDC about the effectiveness and the changes that have occurred since the return of Māori Mental Health Services to the Mental Health, Addictions and Intellectual Disability Directorate (MHAID) as of 3 March 2020.

d) Use the anonymised version of the report as a basis for discussion with its Forensic Mental Health Team, focusing on the issues identified.