Counties Manukau District Health Board (now Te Whatu Ora Counties Manukau)

A Report by the

Deputy Health and Disability Commissioner

(Case 20HDC00354)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the mental health care, and in particular cultural support, provided to a woman by Counties Manukau District Health Board (CMDHB) (now Te Whatu Ora Counties Manukau)[1] in 2017, after she was referred to its services for severe anxiety. The woman had received mental health services five years prior to the events of this case, including one admission to an acute mental health inpatient unit for low mood and thoughts of self-harm.

2. The woman identified herself to CMDHB staff as being Cook Islands Māori. Despite the many opportunities CMDHB staff had to consider culturally appropriate care for the woman over nearly three months, her cultural needs were not assessed, nor were options for culturally safe care specific to her needs discussed.

3. The woman was found unconscious in her home and, tragically, she died shortly thereafter. Her mother complained that CMDHB failed to provide an appropriate cultural response to support her daughter during a critical period of care.

Findings

4. The Deputy Commissioner found that CMDHB breached Right 1(3) of the Code by failing to consider and assess the woman's cultural needs adequately, or provide the woman with services that took into account her cultural values and needs.

Recommendations

5. The Deputy Commissioner recommended that CMDHB provide a written apology to the woman's whānau for CMDHB's breach of the Code; conduct an audit of 30 Pacific and Māori mental health and addiction service users from the last year and report the results back to HDC; and provide reports to HDC detailing analysis of the effectiveness of CMDHB's Pacific and Māori Cultural Liaison teams in meeting consumers' cultural and health needs.

Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from Mrs B about the services provided to her daughter, Ms A, by Counties Manukau District Health Board (CMDHB). The following issue was identified for investigation:

- *Whether Counties Manukau District Health Board provided Ms A with an appropriate standard of care and culturally appropriate services in 2017.*

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all 20 district health boards. Their functions and liabilities were merged into Te Whatu Ora — Health New Zealand. All references to CMDHB in this report now refer to Te Whatu Ora Counties Manukau.

7. This report is the opinion of Deputy Commissioner Vanessa Caldwell, and is made in accordance with the power delegated to her by the Commissioner.

8. The parties directly involved in the investigation were:

Mrs B	Complainant/consumer's mother
Mr B	Consumer's father
CMDHB	Provider

9. Further information was received from:

Medical centre	General practice
Respite care service	Mental health service provider
The Coroner	

10. Also mentioned in this report:

Dr C	Psychiatrist
RN D	Registered nurse (RN)
Dr E	Senior medical officer
Dr F	Psychiatrist
Ms G	Clinical psychologist

11. Independent expert advice was obtained from consultant psychiatrist Dr Jubilee Rajiah (Appendix A).

Information gathered during investigation

Introduction

12. This report concerns the mental health care provided by CMDHB to Ms A, a Cook Islands Māori woman in her thirties, following a referral by her general practitioner (GP) to its services in Month4.[2] In Month7, Ms A was found unconscious in her home, and, sadly, she died four days later.

13. Mrs B told HDC that she believes CMDHB breached her daughter's rights regarding an appropriate cultural response to support her during a critical period of care.

Background

14. Ms A had a history of engagement with mental health services. This included one admission to an acute mental health inpatient unit at a district health board (DHB1) five years prior to the events of this report. This admission occurred following a referral from Ms A's GP, who was concerned about her low mood and thoughts of self-harm. Ms A voluntarily admitted

[2] Relevant months are referred to as Months 1–7 to protect privacy.

herself to the unit in 2012, and was discharged a few days later. She took regular medications for managing her mental health.

Policies

15. CMDHB told HDC that it serves the largest Pacific population in New Zealand, and has had both a Pacific and Māori based service as part of its Mental Health Services (MHS) "for many years".[3]

16. The "Risk Assessment and Management in Mental Health" policy in place at CMDHB at the time of these events (2017), which applied to all CMDHB mental health employees, stated that factors to consider when assessing risk include cultural considerations and historical information, and that cultural support and advice will be part of how service users and their partners in care are supported to participate in the assessment and implementation of strategies to manage risk and safety concerns. The policy further stated:

> "An ongoing and consistent process of timely risk assessment, review, planning and implementation of appropriate interventions and supports will serve to minimise any potential safety risks to service users and those around them.
>
> The assessment and management of risk is an integral part of every clinical observation and/or assessment by all mental health staff and should occur at each and every intervention."

17. The Intake and Acute Assessment Pathway in use at the time stated that during triage, staff were to "identify any cultural or specialist needs, consult/access services or support as indicated".[4]

Timeline of events

18. On 12 Month4, Ms A's GP referred Ms A to CMDHB MHS. The referral form stated that the reason for the referral was "severe anxiety disorder". It further noted that Ms A had a "long history of mild to moderate stress related anxiety with depressive components", and that she was unable to leave her house without support due to anxiety.

19. On 21 Month4, Ms A was assessed by the MHS Intake and Acute Assessment (IAA) team consultant psychiatrist, Dr C. Ms A attended the appointment with a support person.

20. In a letter to Ms A's GP, Dr C documented her assessment of Ms A's presenting issues, personal and psychiatric history, and mental state. Dr C noted that Ms A reported having had a difficult relationship with her mother and father, and that she identified as a Cook Islands Māori woman, but there is no evidence that this information was considered in the formulation of care for Ms A. In response to the provisional opinion, Mrs B disagreed with Dr C's documentation that her daughter had a difficult relationship with her parents. She

[3] CMDHB told HDC that, as of 16 April 2021, its mental health workforce comprises 21% Pacific and 15% Māori staff members.

[4] CMDHB stated that the Intake and Acute Assessment Pathway was a working draft that the acute services team was using in practice at the time, and it had been "socialised" among the team.

said: "We are an extremely close family, supporting one another through the good and the bad."

21. Dr C recorded her diagnostic impression as follows:

> "[Major Depressive Disorder] recurrent with some psychotic features (but her depression is not severe to have psychotic symptoms) … Untreated low grade psychosis (Psychosis NOS[5] with depressive symptoms)."

22. Dr C also noted that during the assessment Ms A told her that she had been admitted to a mental health inpatient unit at another district health board (DHB1) "a few years ago", but that she could not remember the details. The IAA team did not contact DHB1 for a copy of its historical mental health records for Ms A.

23. Ms A was referred to the CMDHB Community Mental Health Centre (CMHC). Dr C noted that follow-up by IAA was not required, and that Ms A and her support person had advised that they were happy to call the IAA if the need arose.

24. Ms A's CMHC referral was triaged and accepted on 27 Month4. RN D was assigned to make initial contact with Ms A.

25. The next day, RN D called Ms A and they arranged to meet at the CMHC clinic on 2 Month5 for an initial assessment. This was later rearranged for the morning of 4 Month5 at Ms A's home, as she was unable to attend the original appointment.

26. RN D visited Ms A at 9.30am on 4 Month5. In her assessment, RN D documented that Ms A reported being very anxious and afraid to go out of the house by herself, that she had self-harmed but did not wish to see her GP for any treatment, and that two days previously she had "felt so miserable … that she wanted to end herself …".

27. RN D suggested that Ms A be reviewed by a doctor and attend a respite care facility. Following consultation with her support person about these options, Ms A agreed with that plan. RN D recorded that Ms A needed urgent review by a doctor, and respite care for safety.

28. RN D subsequently entered a record from this meeting into the "CMDHB MHS Client History Adult" form.

29. Assessment information was noted under several section headings of the form, including "Past Mental Health History", "Interventions and Supports Provided", "Physical Health History", "Personal History", "Risk History", and "Impression/Formulation". RN D noted that Ms A's supports included a relative and a counsellor, and further documented:

> "[Ms A] presents with emotional dysregulation leading to [self-harm] … Her situation is further complicated by anxiety and fear to get out of the house by herself. Her

[5] Not otherwise specified.

relationship with parents also complicates her life situations. Protective factors include her [child and family pet]."

30. The form also included a section under the heading of "Culture", which asked staff to consider: "Cultural identity, Iwi. Include past input from specialist cultural services, need for Interpreter, language, person's relationship with their cultural heritage — sense of belonging/identity? Desire to reconnect or increase cultural knowledge?" However, no information was recorded under the "Culture" heading.

31. RN D also completed a care plan for Ms A dated 4 Month5.

32. Issues that were identified for Ms A in the care plan included the risk of self-harming when extremely anxious, becoming stressed/anxious due to unfavourable life changes, the importance of monitoring the effect of Ms A's medications, and that she did not want to leave her house due to anxiety. A number of interventions are noted in the care plan for how to address each of the issues, including:

- "Provide safety by way of respite if alone at home. If [Ms A] does not wish respite, check if she would be safe with other whānau members. If whānau members not at home, inform them."
- "Monitor [Ms A] frequently due to being new to our services and getting to know her. Check efficacy of medications and liaise with her doctor about same."

33. The care plan template prompts staff to consider "Cultural Assessment & Spiritual Needs" when completing the care plan; however, there is no evidence that this occurred for Ms A.

34. In response to the provisional opinion, Mrs B stated that she does not believe that her daughter did not want to leave her house because of anxiety, and that "[w]henever [Ms A] was anxious, she loved to … be outdoors to go to the beach or to any green belt areas as this always puts her in a better frame of [mind]".

35. Ms A was reviewed by CMHC senior medical officer Dr E at 1pm on 4 Month5. Dr E noted that Ms A was a Cook Islands Māori woman, and that he had reviewed the clinical notes and the details of Ms A's history that were available in the assessments. Dr E's impression was: "Anxiety with depressed mood and thoughts of self harm." His plan was to continue Ms A on her usual medications, and he prescribed her quetiapine 25mg three times per day for anxiety, but noted that Ms A declined lorazepam "as it ha[d] not helped in the past".

36. At no point during Ms A's reviews on 4 Month5 is there evidence that CMHC staff considered cultural elements in their consideration of appropriate care planning for Ms A, or engaged with her about this and specific cultural care options available. Staff also did not contact DHB1 to request Ms A's mental health clinical records from her inpatient admission in 2012.

37. Ms A entered respite care shortly after her CMHC review on 4 Month5.

38. RN D visited Ms A the next morning on 5 Month5. She noted that Ms A reported feeling better, and asked if she could go home. RN D also documented: "[Ms A] said that her mother has been at her place since yesterday and will be there until Friday." In response to the provisional opinion, Mrs B told HDC: "I wish to state that I was not living with [Ms A] … I had a phone call from one of her friends who said that [Ms A] wasn't in a good space so I travelled up the same day that she was taken to respite." Following a discussion with Ms A about the risks and supports available to her, it was agreed that Ms A could exit respite when her mother arrived to collect her. RN D gave Mrs B the mental health service's after-hours contact telephone numbers and communicated the plan for Ms A to exit respite care to Dr E and respite staff.

39. Ms A was discharged from the respite facility later on 5 Month5.

40. On 6 Month5, Ms A's mother advised RN D that Ms A would be away with family until 9 Month5. On 10 Month5, Ms A informed RN D that she was back at home. RN D noted the plan to see Ms A at her home the same day, and that she had put in a request for a psychiatric review.

41. RN D visited Ms A at her home that day at 11.30am. Ms A's father was also present, and he advised that he would be staying with Ms A until the weekend. RN D told Ms A that an appointment had been made for her to see CMHC consultant psychiatrist Dr F on 12 Month5 at 1pm, and noted her suggestion to Ms A that she bring a family member with her for support.

42. Dr F reviewed Ms A at the appointed time. Ms A's father and RN D were also in attendance. Dr F noted that Ms A was a "Polynesian" woman, and assessed that she was not at imminent risk to herself, but that she was going through a "rough time" and had intermittent self-harm urges. While Ms A's ethnicity was acknowledged in the clinical notes, there is no indication of how this or other cultural considerations were factored in for her assessment and treatment plan.

43. In response to the provisional opinion regarding this review, Ms A's father stated:

> "[Ms A] was open, honest and sincere when explaining problems that were always an ongoing issue with her mental state. At the end of the session, [Dr F] made her summary which had nothing to do with what [Ms A] had just spoken about and [Dr F's] solution was try these different meds on top of what [Ms A] was taking."

44. Later that day, RN D completed a Recovery and Wellness Plan[6] with Ms A. In the plan, Ms A nominated her support person and father as people she could turn to when she needed help, and their contact telephone numbers were noted. RN D documented that she would contact Ms A again in four days' time. There is no indication that cultural considerations were factored in at this point.

[6] This is alternatively referred to as the Relapse Prevention Plan in the clinical notes.

45. RN D spoke to Ms A by telephone at 11am on 16 Month5. Ms A reported that currently she was living alone, but that her mother said that she would visit her if needed. The clinical notes state that Ms A expressed a willingness to have a community support worker, and that a referral would be made to the respite care service for a community support person. The respite care service received a referral the following day.

46. RN D met with Ms A on 18 Month5, and then on 20 Month5, when Ms A asked for psychology intervention as her counsellor was on leave.

47. On 25 Month5, RN D referred Ms A for psychology treatment.

48. Following a further review with Dr F on 26 Month5, as planned, RN D met with Ms A at her home on 31 Month5.

49. On 3 Month6, Ms A received a call from clinical psychologist Ms G,[7] and Ms A was placed on the psychology waitlist.

50. Dr F reviewed Ms A again on 6 Month6, with RN D also in attendance. Dr F noted that there had been no significant change, and the plan was to continue on the current medications. At this time, RN D introduced Ms A to her new community support worker from the respite care service, and Ms A informed them that she would be away on holiday from 22 Month6 until 2 Month7.

51. Two days before Ms A was due to go on holiday, RN D checked in on her by telephone. The clinical notes state that Ms A was "sounding well" and reported no concerns.

52. On 4 Month7, Dr F met with Ms A again, along with RN D. Dr F noted that Ms A reported having "had an argument with her family …", but declined to talk about what happened.

53. Shortly after this review, Ms G spoke with Ms A on the telephone, and they arranged a psychology appointment for later that week. The appointment took place on 8 Month7 at the CMHC. Ms G noted that the purpose of the session included understanding the circumstances of the current presentation to MHS, obtaining background information, and assessing goals for therapy. Ms G documented that Ms A denied any current risk of harm to herself, but reported having argued with her parents during her recent time away.

54. On 11 Month7, Ms A was found unconscious on the floor of her home. Her father told RN D that Ms A had been fine on Saturday, and that she had harmed herself. Ms A was admitted to the Critical Care Complex Unit. Sadly, she died a few days later.

[7] CMHC staff had previously tried (unsuccessfully) to reach Ms A by telephone on 27 and 31 Month5 to triage the psychology referral.

Further information

Whānau

55. In a complaint to CMDHB about the care her daughter received, Mrs B stated that there had been "an absence of an appropriate cultural response", with no evidence of cultural assessment or input, and a disregard for the involvement of whānau. Mrs B wrote:

> "[Ms A] presented and identified herself as Cook Island Māori. My family and I hold a worldview of cultural values where whānau/family are the cornerstone of one's world. This worldview is stated in Professor Mason Durie's Whare Tapa Wha model.[8] … There is no evidence noted regarding an exploration or examination by the health providers of what that meant for [Ms A] and my family. The evidence reveals that [Ms A] was treated as an individual and she 'stood alone', thereby increasing the risks around support and well-being for her."

56. Mrs B also complained that there was no evidence that CMDHB staff had obtained relevant historical records in the care of her daughter, in particular regarding her hospitalisation at DHB1 for depression in 2012, when Ms A spent six days in the mental health ward.

CMDHB

Internal review

57. CMDHB conducted an internal review of the quality of care delivered to Ms A leading up to her death. The main findings of the review were that:

- Ms A's cultural needs were not assessed at the point of triage and assessment, and therefore the option of follow-up from a cultural mental health team was not offered. The cultural components of the Intake and Acute Assessment pathway were not followed.
- Ms A's mental health records should have been requested regarding her previous acute inpatient admission at DHB1.

58. The review also noted:

> "At [Ms A's] last medical review on 4 [Month7] when asked by the clinician she did not wish to talk about the argument she had with her family while on holiday. The clinician did not press [Ms A] on the matter. Appropriate cultural intervention could have supported the communication process and involved [Ms A's] family in pursuing this situation further."

59. Other than the above, CMDHB found that the treatment, care, and support provided to Ms A by the treating community team and the MHS was timely. It is noted that in her response to the provisional opinion, Mrs B stated that she disagrees with this statement.

[8] A model for understanding Māori health, consisting of four "cornerstones" — Taha tinana (physical health), Taha wairua (spiritual health), Taha whānau (family health), and Taha hinengaro (mental health). https://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-whare-tapa-wha.

Additional comments

60. CMDHB's Chief Medical Officer told HDC that CMDHB deeply regrets the missed opportunity to assess Ms A's cultural needs adequately at the point of triage and assessment. He stated:

> "I would like to acknowledge and apologise for the distress experienced by [Mrs B] and family regarding the care our Mental Health and Addictions (MH&A) service provided to their daughter leading up to her death. It is important to review care provided in a robust and transparent manner, identify what could have been managed better, and implement changes to improve the quality of care. We have endeavoured to do that in this case."

61. The Chief Medical Officer told HDC that CMDHB is continually working to create a more culturally responsive service, and is committed "to ensuring the cultural needs of all of our tangata whaiora[9] are met as part of their receipt of mental health services". He stated that CMDHB has made significant changes to its cultural services since these events (discussed below).

62. In relation to her role in Ms A's care, RN D told HDC:

> "On reflection, whilst focusing on [Ms A's] immediate specialist clinical support, I did not focus on her cultural needs as much as I should have. … In future, I intend to ensure that all my service users have their cultural needs addressed."

Responses to provisional opinion

63. Mr and Mrs B were given a copy of the "Information gathered" section of the provisional report for the opportunity to comment. Their comments have been incorporated into the report where relevant.

64. In relation to the importance of cultural considerations in her daughter's care, including family culture, Mrs B told HDC: "Doesn't matter where we come from anywhere in the world, family is the most important culture to us, we weren't involved in this." Ms A's father emphasised this also: "[CMDHB] never took any consideration to actually speak to even myself and [Mrs B], or her sister, or [to get] a deeper understanding of real basic strong connections with the family." Mrs B said that she hopes that all of the changes made since these events are adhered to by all CMDHB staff.

65. CMDHB accepted the findings of the provisional opinion.

[9] A term that refers to people who are the subject of care, assessment, and treatment processes in mental health.

Opinion: Counties Manukau District Health Board — breach

Introduction

66. This is a case of a Cook Islands Māori woman who on 12 Month4 was referred by her GP to CMDHB mental health services for severe anxiety. Tragically, Ms A died three months later, having been found unconscious in her home as a result of self-harm. I offer my sincere condolences to Ms A's whāmere and all who knew her.

67. This opinion focuses on the lack of cultural support and the failure to obtain past clinical notes.

68. CMDHB has a duty to provide care that takes into account the needs of different cultural groups. It must provide care that is culturally appropriate, in coordination with other services as required. While Ms A received care from non-CMDHB services during the period discussed in this report, this opinion focuses only on the appropriateness of care provided by CMDHB. It is also important to note at the outset that it is not my role to determine the cause of Ms A's death. Any findings made in this report about the care provided to Ms A are not intended to imply or indicate responsibility for the outcome.

Relevant right

69. Right 1(3) of the Code of Health and Disability Services Consumers' Rights (the Code) states:

> "Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Māori."

Provision of culturally appropriate services

70. CMDHB's "Risk Assessment and Management in Mental Health" policy at the time of Ms A's care stated that staff must consider any cultural factors when assessing risk, and that cultural support is part of how consumers are supported to participate in the assessment and implementation of strategies to manage risk. The policy further stated that risk assessment and management should occur at each and every intervention to minimise potential safety risks to service users and those around them. In addition, the Intake and Acute Assessment Pathway stated that during triage, staff were to "identify any cultural or specialist needs, consult/access services or support as indicated", and MHS's "Client History Adult" and care plan forms used in the course of Ms A's care explicitly guided clinicians to consider cultural factors in Ms A's assessment and treatment plan.

71. Despite the many opportunities staff had to consider culturally appropriate care for Ms A, particularly as Ms A had identified herself as a Cook Islands Māori woman, there is no evidence in the clinical records or otherwise that her cultural needs were assessed or that options for culturally safe care specific to Ms A's needs were discussed. CMDHB's internal review also found that Ms A's cultural needs were not assessed at the point of triage, and that the option of follow-up from a cultural mental health team was not offered. RN D has acknowledged that she was not as focused on cultural care as she could have been, and it is

also noted that when Ms A raised family issues at her review on 4 Month7, appropriate cultural intervention that could have better supported her care was not offered.

72. My expert advisor, Dr Rajiah, advised that the standard of care is to ensure cultural safety in the provision of care for ethnic and social groups, and that this includes "recognition and acknowledgement of the importance of culture in the identity and selfhood of a person, and to respect this". She said that the definition of a person's culture includes their ethnicity, age, gender, sexuality, spirituality, religious practices, disability, and political beliefs.

73. Dr Rajiah advised that in this case, CMDHB did not provide Ms A with an acceptable standard of cultural care. Dr Rajiah said that, to some extent, CMDHB's departure from expected practice was exacerbated because Ms A had told staff about her whānau relationships, her perspective of the family dynamics in her formative years, and her perception of strain developing in the relationship with a family member. Dr Rajiah advised that even though it appears that Ms A was carefully monitored and supported in certain respects, culturally appropriate support "might have assisted greatly in helping [Ms A] to feel heard and understood about the family issues, and to support her to work through the difficulties she talked about, and to engage fully with the family support that was clearly readily available to her".

74. Dr Rajiah advised that in her view, overall, CMDHB staff departed moderately from the standard of care in failing to provide appropriate cultural services. I agree that this was a moderate departure.

75. Dr Rajiah advised:

> "Patients and their whānau should not be expected to ask for cultural support and intervention. The mental health team should provide information about available services and resources, make the referral, and support and facilitate an introduction to the culturally appropriate service."

76. Considering in particular my expert's advice, the responses from both CMDHB and RN D, and the fact that the clinical records show no evidence of cultural factors being assessed or incorporated into the treatment plan, I agree that there was a departure from the expected standard of care. In my view, this can be attributed to CMDHB, because multiple CMDHB staff over a period of nearly three months (from Month4 to Month7) had opportunities to consider the relevant cultural factors and how these may have affected Ms A's care plan and the support options offered to her. Unfortunately, this did not occur. This suggests a systemic issue, for which ultimately CMDHB is responsible. I note that CMDHB accepts that the services were not culturally appropriate. Had Ms A's cultural needs been assessed and the appropriate options been made available to her, this could have improved the treatment she received at CMDHB.

77. I also note that while Ms A's Cook Islands Māori heritage was acknowledged and documented by her clinicians, it does not appear that this had any specific influence on how her assessments or care plans were managed, or what options were discussed with her. I

consider that it is not sufficient for clinicians simply to acknowledge a consumer's ethnic and cultural background, but that such information also needs to be considered appropriately for the provision of culturally safe care.

Conclusion

78. I am critical of the multiple failures by CMDHB staff to consider and assess Ms A's cultural needs adequately from Month4 to Month7. Ms A was not informed about the cultural support options available to her, or offered any specific cultural support that met her needs. I consider that CMDHB failed to provide Ms A with services that took into account her cultural values and needs as a Cook Islands Māori woman, and accordingly I find that CMDHB breached Right 1(3) of the Code.

Failure to obtain relevant clinical history — adverse comment

79. Prior to the events of this report, Ms A had been an inpatient of the acute mental health unit at DHB1 in 2012 for several days. At her initial assessment with CMDHB MHS on 21 Month4, she informed Dr C about this previous admission. However, subsequently the MHS did not request a copy of Ms A's historical mental health records.

80. Dr Rajiah advised that in this case, CMDHB's failure to request Ms A's clinical notes from her 2012 inpatient admission at DHB1 was a mild departure from accepted practice. Dr Rajiah noted that the length of time that had passed since the previous admission (five years), and that it was of short duration (less than one week) were mitigating factors in this case. CMDHB's internal review also found that the historical records should have been requested.

81. I agree with Dr Rajiah, and consider that CMDHB staff should have asked DHB1 for Ms A's historical inpatient records to assist with the management of her care. It is a concern that this did not occur, but I acknowledge the mitigating factors noted by my expert.

Changes made

82. As a result of these events, CMDHB's Mental Health & Addiction service made changes to the structure and delivery of its mental health services, including:

- The creation of Pacific and Māori Cultural Liaison teams that function as a liaison service in support of all Mental Health & Addictions staff, positioned at the point of triage to ensure that the appropriate cultural support and follow-up is provided from the beginning of an individual's engagement with its services. CMDHB advised that these liaison services are based on the Te Whare Tapa Whā and Fonofale models of care.
- The development of an "Initial Psychiatric Assessment" policy and guideline in 2018. These state that a consultant psychiatrist's initial assessment will be appropriate to the service user's needs with respect to cultural support, and consider how an individual's culture impacts the current presentation and assessment process. The guideline includes a specific section on "Culture" that discusses its role and importance in detail.

- The policy "Clinical Safety and Risk Assessment, Safety Planning, and Risk Management with Individual Service Users" was revised to adopt a broader definition of "safety" that CMDHB states goes beyond the meaning of "safety from harm to self or others", and now also considers other factors that adversely affect a person's health and wellbeing.
- The Intake and Acute Assessment Pathway was revised.
- CMDHB told HDC that coaching and teaching to improve health literacy for service users and their whānau and helping to improve the cultural responsiveness of all mental health clinicians are also essential components of the model of care.
- Standard operating procedures for requesting mental health records from other DHBs were reviewed and revised. CMDHB said that it has reset its expectations with staff that collateral information obtained during a comprehensive assessment includes information from prior admissions with other DHBs.

Recommendations

83. I recommend that CMDHB:

a) Provide a written apology to Ms A's whānau for the breach of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A's whānau.

b) In my provisional opinion I recommended that CMDHB conduct a random audit of 20 Pacific and Māori mental health and addiction services patients from the last year to ensure that they have been provided opportunity to access culturally appropriate services, and to report the result of the audit to HDC. In response to my provisional recommendation, CMDHB said that it accepts the recommendation and proposes to increase the audit number to 30 service users, with those audited spread evenly throughout different areas of its service, including acute and community services. I appreciate and accept CMDHB's proposal and look forward to receiving the results of its audit within three months of the date of this report.

c) In my provisional opinion I recommended that CMDHB conduct a review of its Pacific and Māori Cultural Liaison teams to determine how many patients have been referred to their services since their commencement, the types of support that service users have received in their care, and the success of those services in meeting cultural and health needs. In response to the provisional opinion, CMDHB stated:

> "The service already has a structure in place for analysing our Māori Cultural Liaison team service delivery, and we have a report conducted for the 2020/2021 annual report of Rapua Whaioranga [Māori Clinical Cultural Liaison Services]. The service proposes to adjust the review report framework to analyse the Pacific Cultural Liaison Team. We can submit both reports to the HDC within three months of the date of [this] report."

I look forward to receiving both reports within three months.

Follow-up actions

84. A copy of this report will be sent to the Coroner.

85. A copy of this report with details identifying the parties removed, except CMDHB and the expert who advised on this case, will be sent to the Health Quality & Safety Commission, the Mental Health and Wellbeing Commission, and the Director of Mental Health and Addictions, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following expert advice was obtained from consultant psychiatrist Dr Jubilee Rajiah:

"Dr Jubilee Rajiah
M.B.B.S; FRANZCP
Consultant Psychiatrist

09.11. 2020

…

Re: [Ms A]/Counties Manukau District Health Board

Ref: C20HD00354

Thank you for your letter of 17th September 2020 requesting expert advice to the Health and Disability Commissioner (the Commissioner) with an opinion on the care provided by Counties Manukau DHB to [Ms A] between 12th [Month4] and 12th [Month7].

I state at the outset that I do not have a conflict of interest preventing me from giving an opinion on the complaint.

I work part-time at the University of Otago, Student Health Services as a Consultant Psychiatrist and part-time with the Southern District Health Board.

I work at the University of Otago Student Health Service on Monday and Thursday of each week.

I work in the North Community Mental Health Team of the Southern District Health Board on Tuesdays, Wednesdays and Fridays.

I have a very limited Private Practice for which I rent rooms from a psychotherapist who has a private practice in Dunedin.

My qualifications are M.B.B.S. (Bachelor of Medicine, Bachelor of Surgery) obtained through University of Madras, India in 1984.

I am a Fellow of the Royal Australian and New Zealand College of Psychiatrists, (FRANZCP), the Specialist Psychiatrist qualification obtained in 2003.

I have read and agreed to follow the Commissioner's Guidelines for Independent Advisors.

In preparing this report and providing an opinion, I have relied on the information contained in the documentation provided to me with your letter.

Documents provided:

1. Copy of complaint dated 28th August 2019.
2. Counties Manukau DHB's responses dated 12th May 2020 and 31st August 2020.
3. Correspondence between Counties Manukau DHB and complainant.
4. Counties Manukau Mental Health Service Review (sections redacted).
5. Clinical records from Counties Manukau DHB Mental Health Service covering the period 12th [Month4] to 28th [Month7]. Sections are bookmarked as follows:

   a. Clinical notes (page 1)
   b. Referrals (page 20)
   c. Acute Community Options Forms (page 32)
   d. Client history (page36)
   e. Letters to G.P. (page 40)
   f. Appointment letters (page 50)

6. Counties Manukau DHB policy for Risk Assessment and Management in Mental Health Services, current from 1st June 2017 to 1st May 2019.
7. Clinical records from the respite care service covering the period 3rd [Month5] to 20th [Month7].
8. Clinical records from [DHB1] [2012–2013]

Background:

[Ms A] was a [woman in her thirties] of Cook Island Māori descent who was referred to mental health services by her General Practitioner (GP). She was assessed by the Counties Manukau DHB Mental Health Intake and Acute Assessment Team (IAAT) on 21st [Month4] for severe anxiety and depression. The IAAT Consultant Psychiatrist's impression was of Psychosis NOS with depressive symptoms or Major Depressive Episode with psychotic symptoms. It was noted that [Ms A] advised she had previously had an informal admission to the adult mental health inpatient unit in [DHB1] but no further details were given. [Ms A] was referred to the Manukau Community Mental Health Centre.

In the period from [Month4] to [Month7], [Ms A] was supported by community mental health services. She also attended regular medical reviews for review and adjustment of her medications and spent one night in respite care on 4th [Month5]. During this period, [Ms A] reported intermittent urges to self-harm …

On 10th [Month7], [Ms A] was found unconscious at her home … [Ms A] was taken to [the public hospital] where she died when life support was withdrawn [a few days later].

Expert advice requested:

Please review the enclosed documentation and advise whether you consider the care provided to [Ms A] by Counties Manukau DHB was reasonable in the circumstances and why.

Expert opinion:

The information which is the focus of this advice is contained in the documents/file sent to me. Particular attention was paid to the clinical notes (progress notes) that were recorded while [Ms A] was under the care of Counties Manukau DHB.

These notes contain information on the care and treatment [Ms A] received.

The information was carefully considered, and is summarised below.

I have sought opinion from peers on the salient features of the anonymised and de-identified information pertaining to this case.

The peers I consulted are consultant psychiatrists who work in community mental health teams and I have talked to a senior nurse colleague.

Expert advice requested

1. Whether [Ms A] was provided appropriate cultural support and referred to appropriate cultural services?

[Ms A] was not provided appropriate cultural support and she was not referred to appropriate cultural services.

a. What is the standard of care/accepted practice?

Standard of care/accepted practice.
The standard of care is to ensure cultural safety in the provision of care for ethnic and social groups.

Recognition and knowledge that the definition of culture includes ethnicity, age, gender, sexuality, spirituality, religious practices, disability, political beliefs.

The underlying premise is recognition and acknowledgement of the importance of culture in the identity and selfhood of a person, and to respect this, and endeavour to provide culturally safe and appropriate care and treatment.

The standard of care/accepted practice for Māori service users is based on the Treaty of Waitangi, and the District Health Board's commitment to the principles of the Treaty which are partnership, participation and protection.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, severe) do you consider this to be? Please explain.

There has been a departure from the standard of care and accepted practice.

The departure from the standard of care is moderate to severe.

The standard of care is deemed moderate to some extent, because there is evidence from the notes that [Ms A] engaged well with the services provided to her and she was carefully monitored and supported.

There is no evidence of difficulties arising in the therapeutic relationships indicating problematic cultural differences, or any difficulty in engagement and establishing a therapeutic alliance.

There is also evidence from the notes that the mental health staff involved in [Ms A's] care were open to, and welcomed the involvement of [Ms A's] family and her friend who were her primary support group. There were no barriers to [Ms A's] family and friend being involved.

This provided an opening for culturally appropriate support to be considered and put in place, and also provided the opportunity for [Ms A] and her family to explicitly request this support.

However, anecdotal evidence is that it is unlikely that service users or their family would request cultural support and care unless they are specifically informed of what is available to them.

The departure from the standard of care is moderate to severe in that [Ms A] did discuss family relationships and her perspective of the family dynamics in her formative years, and her perception of strain developing in the relationship with her father recently. This perception might have been influenced by her depressed mood.

Culturally appropriate support might have assisted greatly in helping [Ms A] to feel heard and understood in this regard, and to support her to work through the difficulties she talked about, and to engage fully with the family support that was clearly readily available to her.

c. How would it be viewed by your peers?

My peers agree that appropriate cultural support was not provided, and referral to appropriate cultural service was not done.

They agree about the standard of care/expected practice.

One of the peers consulted, stated that the quality of therapeutic engagement and inclusion of the whānau was positive, but that this question relates specifically to the provision of appropriate cultural support, and as such significant concern exists.

The underlying principle of partnership, participation and protection has not been represented.

Patients and their whānau should not be expected to ask for cultural support and intervention.

The mental health team should provide information about available services and resources, make the referral, and support and facilitate an introduction to the culturally appropriate service.

d. Do you have any recommendations for how this aspect of care could be improved?

This aspect of care could be improved by ensuring that explicit policies and procedures are in place, and embedded in day to day practice that culturally appropriate and culturally safe services and support are available and offered to service users right from the triage process, and throughout the patient's journey in mental health services.

The notes of the Complaint Feedback Hui on 2nd May 2018 state that the Counties Manukau Mental Health Services are *imminently transforming to a new model where community teams are Māori and Pacific led.*

2. Whether you consider that Counties Manukau DHB involved [Ms A's] whānau/next of kin appropriately in her care?

The notes indicate that [Ms A's] whānau/next of kin were appropriately involved in her care.

a. What is the standard of care/accepted practice?

The standard of care and accepted practice is that there is effective communication, liaison and a collaborative working relationship with the whānau/next of kin/primary support group of the person receiving care from a mental health service.

The family may include relatives, a mixture of relatives and friends who are in a support network for the person, and/or family members or extended family or friends who are important to the consumer.

The communication and contact is for sharing information, for planning care and treatment, decision making and for providing support and education as appropriate.

This entails a careful balance between the rights and responsibilities to maintain the privacy of the consumer, while enabling and encouraging family involvement.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, severe) do you consider this to be? Please explain.

There was no departure from the standard of care or accepted practice.

c. How would it be viewed by your peers?

The peers I have consulted are of the view that there was appropriate contact and involvement of the family and nominated supportive friends of [Ms A] through the assessment, care and treatment period.

d. Do you have any recommendations for how this aspect of care could be improved?

This aspect of care could be improved by providing the family and the consumer written information of the reach and range of the contact and involvement of the whānau/next of kin in the assessment, treatment and care of their family member.

Explain that this is a process, and fluid in nature and can be initiated by the family, the consumer or the mental health staff. Explanation of the privacy and confidentiality issues while ensuring that this is not a barrier to effective communication and collaboration.

3. Whether you consider there was adequate follow-up after [Ms A's] stay in respite care on 4th [Month5]?

There was adequate and good follow up after [Ms A's] stay in respite care.

There is documented evidence as recorded below that [Ms A] was seen face to face or contacted by telephone every few days and there was close monitoring of her mood, mental state and safety. She was also supported and assisted to deal with the psychosocial stress she was under at that time.

a. What is the standard of care/accepted practice?

The standard of care/accepted practice is to provide close monitoring, support and follow-up following discharge from hospital or a respite facility.

The frequency and duration of the intensive contact is determined by the client's mood and mental state and safety. Usually after two weeks, the contact and follow-up may be less frequent or continue to be frequent depending on the progress and the support needs of the person. Psychosocial support and practical assistance is also provided such as assistance required with WINZ, accommodation and work issues.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, severe) do you consider this to be? Please explain.

There was no departure from the standard of care or accepted practice.

c. How would it be viewed by your peers?

My peers view this as appropriate and standard level of care following discharge from a Respite facility.

d. Do you have any recommendations for how this aspect of care could be improved?

It may be helpful to explain to the patient and their family what the usual level of contact and standard of care is following discharge from a Respite facility, and to assure and remind them that they can make contact with the Case worker at any time if they have any concerns. And provide emergency and after hours contact details.

4. Whether Counties Manukau DHB should have requested [Ms A's] clinical notes from her previous inpatient admission at [DHB1]?

Counties Manukau DHB could have requested [Ms A's] clinical notes from her previous inpatient admission at [DHB1].

If the admission to [DHB1] was much more proximal in time to [Ms A's] presentation at Counties Manukau DHB, then her notes should have been requested.

a. What is the standard of care/accepted practice?

It is best practice to request notes regarding previous treatment, and to obtain objective evidence of the previous psychiatric history.

Useful information can be gained about the onset and evolution of the person's illness, the longitudinal course of the illness, the typical or signature symptoms, and treatment response, and treatment that has been beneficial. Information on the longitudinal course of the illness is of diagnostic value as well.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, severe) do you consider this to be? Please explain.

The departure from the standard of care or accepted practice in this instance was mild. The reason the departure from the standard of care was mild is because the admission to [DHB1] was of short duration, and occurred five years ago.

The information regarding the inpatient admission, if it had been obtained would have been helpful, but the lack of this information did not result in an inaccurate diagnosis, or adversely influence the treatment and care that [Ms A] received.

c. How would it be viewed by your peers?

The peers I have consulted agree that it is best practice to obtain the notes of previous psychiatric treatment, particularly of inpatient treatment.

They commented that it is unlikely that doing so would have altered the course of treatment.

d. Do you have any recommendations for how this aspect of care can be improved?

This aspect of care can be improved by making it standard practice to request all previous psychiatric notes when a person is first seen in a mental health service.

This task of requesting the notes and obtaining the notes can be delegated to administrative staff, establishing a policy that makes it routine practice to request and obtain previous notes.

5. Whether [Ms A's] medication regime was adequately monitored?

[Ms A's] medication was adequately monitored.

a. What is the standard of care/accepted practice?

The standard of care/accepted practice is that medication is prescribed after an adequate assessment, and the medication that is safe and appropriate for that person is chosen.

The indications, adverse effects, contraindications, major drug interactions, appropriate dosage and effectiveness is carefully considered. The prescribing should be within the parameters of accepted practice.

This is the responsibility of the prescribing clinician.

Informed consent is obtained from the patient, by providing information about the medication and also explaining the rationale for the medication.

Information about the prescribing is shared with other health professionals involved in the person's care to ensure continuity of care and patient safety.

A clear and accurate record is maintained in the clinical notes.

Periodic review of the patient is organised.

Within community mental health teams, it is implicit that the case worker's role includes careful follow-up, close monitoring of the patient's mood, mental state and wellbeing and safety, and their response to medications.

Including side-effects and benefits.

The case worker will let the prescribing doctor know if there are any problems with the medications, and if the patient needs earlier review.

The usual time frame for review by the psychiatrist for the purpose of reviewing the response to medications is two weeks, unless there are problems with tolerability of the medication or side-effects, in which case the review is conducted earlier.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, severe) do you consider this to be? Please explain.

There has not been a departure from the standard of care or accepted practice.

c. How would it be viewed by your peers?

I consulted with my peers and they agreed that [Ms A's] medication was adequately monitored.

They commented that the staff considered the possibility/risk of stock-piling of medication when [Ms A] disclosed being at risk of self-harm and suicide. Respite care was appropriately arranged.

On discharge from Respite care, her mother was asked to hold the medication in safekeeping and administer it to [Ms A].

d. Do you have any recommendations for how this aspect of care could be improved?

This aspect of care could be improved by providing written information regarding the medication, and the duration and frequency of monitoring, and also letting the patient know that they should contact their case worker if there are any adverse reactions or problems on the medication.

6. Whether alternative treatment options were sufficiently explored?

It is my understanding from reading the notes that the approach to treatment that was taken, involved the standard approach of considering and addressing the biological, psychological, social, lifestyle and spiritual factors that contributed to [Ms A's] mental health difficulties.

Appropriate referral for Clinical Psychology interventions were made, and [Ms A] engaged well in this counselling and found it beneficial.

It is my opinion that the mental health team carefully assessed, and attended to the difficulties that [Ms A] presented with. She had a depressive illness, history of deliberate self-harm, and previous cannabis use.

The triggers and additional stressors that caused this episode of depression were work stress, loss of her job, loss of accommodation, financial issues and her perception of conflict or disagreement with her family. Support and care from her family was readily available to her.

The pressing social and practical issues such as her WINZ Benefit and accommodation were being addressed and [Ms A] was supported with this.

ACC Counselling … was considered and referral for this about to be actioned.

She was encouraged to attend the group program …

With further engagement and more time, it is likely that the case worker and [Ms A] would have worked on her return to work, social connections, lifestyle and her core values and spiritual values.

a. What is the standard of care/accepted practice?

As above, the standard of care/accepted practice is to carefully assess and consider the biological, psychological, social, lifestyle, spiritual and cultural factors that contribute to the illness and tailor the treatment to address these factors.

The treatment options that were not sufficiently explored were the culturally appropriate approach to the care and treatment.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, severe) do you consider this to be? Please explain.

Please see response to the first question under expert advice — Whether [Ms A] was provided appropriate cultural support and referred to appropriate cultural services?

c. How would it be viewed by your peers?

The peers I consulted view [Ms A's] care as good, and the treatment options considered were appropriate. They agree that culturally appropriate services should have been offered.

d. Do you have any recommendations for how this aspect of care could be improved?

This aspect of care could be improved by a summary and formulation of the assessment that is discussed with the patient and their family regarding the biological, psychological, social, lifestyle, spiritual and cultural factors that contribute and impact on their illness and exploring the treatment options available. This would serve as a framework to help the patient understand the approach, and it would be a means of psychoeducation and support. It could promote discussion about alternative treatments, as it may not be clear to the treating team if the patient has a preference or desire to explore alternative treatments.

7. Any other matters in this case that you consider warrant comment?

This is a tragic outcome in someone who had engaged well in treatment and who was benefitting from treatment and support from the treatment team and her family.

I hope this opinion is useful to the Commissioner.

I am happy to be contacted if there are any queries or concerns regarding my report.

Yours sincerely,

Jubilee Rajiah
Psychiatrist."

The following further advice was obtained from Dr Rajiah:

"**Jubilee Rajiah**
M.B.B.S; FRANZCP
Consultant Psychiatrist
28th November 2021

…

Re: Further expert advice — 20HDC00354

Thank you for your e-mail of 21st September 2021 requesting further advice following the HDC receiving further response from CMDHB.

Thank you for allowing me more time to provide this advice as I was unable to undertake to do this when you first wrote to me due to my workload and commitments.

The information I have been sent include copies of:

- [Medical centre] Clinical Notes.
- Response CMDHB.
- CMDHB Correspondence with Coroner
- Coordinated Care Plan
- RecoveryWellnessPlan_Assessment_History.
- Client History
- [RN D's] Statement
- CMDHB Policy — Initial Psychiatric Assessment
- CMDHB Guideline Initial Psychiatric Assessment.
- CMDHB Policy. Coordinated Care Planning. Current
- CMDHB Policy. Coordinated Care Planning. time of event
- CMDHB Procedure Coordinated Care Planning.
- CMDHB. MHA. Intake. Acute Pathway. updated Oct17
- MOH-supporting-parents-healthy-children-sep15.
- SIRP MH Review Report Rec Update 2021.
- [Ms A] — Discharge Summary 05 [Month7].
- [Ms A] — Intake Summary 27 … 2017.
- [Ms A] — Progress Report 02 … 2017.
- [Ms A] — Progress Report 04 [Month7].
- [Ms A] — Intake Summary 07 [Month4].
- [Ms A] — Progress Report 05 [Month5].
- [Ms A] — Progress Report 26 [Month4].

I have been requested to review the above information, and the response from the CMDHB and provide further expert advice on the following:

1. **Advise on whether, having considered CMDHB's further response (including relevant policies and documentation), you have anything further to add or whether you wish to amend your previous advice.**

I have considered the CMDHB's further response and the relevant policies and documentation and wish to reiterate that the care and treatment provided to [Ms A] was of a good standard. She engaged well with the treatment team and the notes documented during the course of her care and treatment is evidence of appropriate treatment, careful monitoring and support.

The relevant policies and documentation from the CMDHB are thorough and adhere to guidelines for evidence based and good standard of practice.

I have nothing further to add, and there is no amendment to my previous advice.

2. Clarification on the level of departure regarding the failure to provide appropriate cultural support/approach to care. Please advise whether you consider this to be a mild, moderate, or severe departure from accepted standards.

I would like to clarify that the level of departure regarding failure to provide appropriate cultural support/approach to care was moderate.

Whilst no specific cultural support or approach to care was offered, there was very good engagement with [Ms A] and with her family.

Cultural support and approach to care could have enhanced her care and treatment. There is no evidence that the failure to provide this compromised her treatment, care and support.

I have copied below the previous advice provided on this question**.**

Whether [Ms A] was provided appropriate cultural support and referred to appropriate cultural services?

[Ms A] was not provided appropriate cultural support and she was not referred to appropriate cultural services**.**

a. What is the standard of care/accepted practice?

Standard of care/accepted practice.
The standard of care is to ensure cultural safety in the provision of care for ethnic and social groups.

Recognition and knowledge that the definition of culture includes ethnicity, age, gender, sexuality, spirituality, religious practices, disability, political beliefs.

The underlying premise is recognition and acknowledgement of the importance of culture in the identity and selfhood of a person, and to respect this, and endeavour to provide culturally safe and appropriate care and treatment.

The standard of care/accepted practice for Māori service users is based on the Treaty of Waitangi, and the District Health Board's commitment to the principles of the Treaty which are partnership, participation, and protection.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, severe) do you consider this to be? Please explain.

There has been a departure from the standard of care and accepted practice.

The departure from the standard of care is moderate to severe.

The standard of care is deemed moderate to some extent because there is evidence from the notes that [Ms A] engaged well with the services provided to her and she was carefully monitored and supported.

There is no evidence of difficulties arising in the therapeutic relationships indicating problematic cultural differences, or any difficulty in engagement and establishing a therapeutic alliance.

There is also evidence from the notes that the mental health staff involved in [Ms A's] care were open to and welcomed the involvement of [Ms A's] family and her friend who were her primary support group. There were no barriers to [Ms A's] family and friend being involved.

This provided an opening for culturally appropriate support to be considered and put in place, and also provided the opportunity for [Ms A] and her family to explicitly request this support.

However, anecdotal evidence is that it is unlikely that service users or their family would request cultural support and care unless they are specifically informed of what is available to them.

The departure from the standard of care is moderate to severe in that [Ms A] did discuss family relationships and her perspective of the family dynamics in her formative years, and her perception of strain developing in the relationship with [a family member] recently. This perception might have been influenced by her depressed mood.

Culturally appropriate support might have assisted greatly in helping [Ms A] to feel heard and understood in this regard, and to support her to work through the difficulties she talked about, and to engage fully with the family support that was clearly readily available to her.

c. How would it be viewed by your peers?

My peers agree that appropriate cultural support was not provided, and referral to appropriate cultural service was not done.

They agree about the standard of care/expected practice.

One of the peers consulted, stated that the quality of therapeutic engagement and inclusion of the whānau was positive, but that this question relates specifically to the provision of appropriate cultural support, and as such significant concern exists.

The underlying principle of partnership, participation and protection has not been represented.

Patients and their whānau should not be expected to ask for cultural support and intervention. The mental health team should provide information about available services and resources, make the referral, and support and facilitate an introduction to the culturally appropriate service.

d. Do you have any recommendations for how this aspect of care could be improved?

This aspect of care could be improved by ensuring that explicit policies and procedures are in place and embedded in day-to-day practice that culturally appropriate and culturally safe services and support are available and offered to service uses right from the triage process, and throughout the patient's journey in mental health services.

The notes of the Complaint Feedback Hui [in] 2018 state that the Counties Manukau Mental Health Services are ***imminently transforming to a new model where community teams are Māori and Pacific led.***

The letter to [HDC] from [the] Chief Medical Officer CMDHB outlines the response to the previous advice.

The Mental Health Services were significantly restructured in 2018 to include changes to the community mental health services, and the structure and function of services for Māori and Pacific community. Faletoa and Rapua Whaioranga models of care have been introduced and this includes a consultation and liaison service to the community teams. Changes have been made so that there is a cultural presence at the front door of the service. This ensures that culturally appropriate support and approach to care is available and offered from the very first contact that someone has with the community mental health services.

3. Noting the involvement of [the respite care service], who provided respite care and then community support, as well as … Community Counselling, provide advice on the appropriateness of the service coordination with Counties Manukau Community Mental Health Centre (CMHC). In particular, were there any points during [Ms A's] treatment pathway where coordination of services could have been improved?

The notes indicate that [Ms A] spent one night in respite care with [the respite care service] on 4th [Month5]. She seemed to benefit from her time at respite and asked to be discharged the next day to the care of her mother. [RN D] assessed her at the respite facility and communicated with the respite staff that [Ms A] would be leaving respite care that day.

Thereafter [the respite care service] is mentioned twice in the notes.

There are no notes of the actual conversations/liaison with [the respite care service], but this is implied as arrangements for respite, and discharge from respite could not be made without active liaison with this provider.

There is also an implicit understanding of the role of the Community Support Worker. The notes above indicate that the Community Support Worker attended the review appointment with the psychiatrist [Dr F] and [RN D].

I gained the impression that the service coordination with [the respite care service] was well established, and that access and liaison was working well.

… Counselling is mentioned several times in the notes, in the context of [Ms A] seeing a psychologist there. [Ms A] spoke of the benefit she obtained from the counselling/psychology sessions … She discussed this a few times with her Case Manager [RN D] about the number of sessions, possibility of further sessions, and the recommendation to apply for ACC Sensitive Claim**.**

In [Month5], [Ms A] asked to be referred to the Psychologist in the Community Mental Health Service as the psychologist she was seeing … was on leave, and hadn't applied for further sessions for her, and also hadn't applied for ACC Sensitive Claim counselling.

[Ms A] was referred to the Psychologist in the Community Mental Health Service and she commenced working with the Psychologist.

There is no evidence of direct contact and communication or active liaison between … Counselling and Counties Manukau Community Mental Health Centre (CMHC).

[Ms A's] G.P. had regular communication from … Counselling.

The standard of care/accepted practice is to have regular and on-going contact with other health providers.

All those involved in the clinical care of a patient need to be informed of the diagnosis and on-going plan for management. Relevant clinical information should be updated regularly, particularly if there have been any changes to treatment, or a hospital admission.

This occurred regularly between the mental health treating team and the G.P.

Outcomes are much improved when the professionals involved work as a collaborative team. This requires regular communication concerning diagnosis, formulation, treatment planning and details of current treatment, including both psychological therapy and pharmacotherapy. It is helpful to have someone coordinate the care. This is usually the Case Manager assigned to the patient.

The relationship between the medical and psychological treatment team/providers is important, but this is not always straightforward.

It is much easier within multidisciplinary teams, as there are regular multidisciplinary team meetings where relevant information is shared and discussed.

When the care of a patient is shared between a team providing assessment and medical treatment, and an external provider of psychological treatment, there is less opportunity for regular or frequent communication. The general practice is to provide updates if there is any change in treatment, hospitalisation or safety concerns.

As personal issues and matters are often discussed and worked through in counselling, patients may find it inhibiting and intrusive, and it may disrupt the engagement and trust between the patient and counsellor if they believe the treatment team is regularly informed of the content of the sessions.

It is important that permission is sought, and agreement obtained regarding the parameters of contact and exchange of information.

It is usual to communicate if there are acute safety concerns, and/or when the counsellor finds that counselling is unable to progress due to non-response to medications, or other aspects of the treatment plan not working.

4. Comment on the changes made by CMDHB. Are there any further changes that would strengthen the service provision?

The changes made by the CMDHB to address the gap in providing services to the cultural and ethnic groups in the community have been undertaken promptly and are appropriate and comprehensive. They include a consult liaison service and a service that is available right from the start of a patient's journey in the service.

I hope this is helpful.

Yours sincerely

Jubilee Rajiah Psychiatrist"