Review of the care and treatment provided to five persons who attended the CCDHB Mental Health, Addictions and Intellectual Disability Services.

Report prepared July 2016

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1. Executive Summary

**Background:** Five users of Mental Health, Addictions and Intellectual Disability Service 3DHB (MHAIDS 3DHB) were charged with homicide in a fifteen month period. As such this review was prepared in response to these incidents.

**Review Objective:** To provide recommendations on possible service system improvements

**Review Methodology:** One member of the review team inspected the available clinical files and the three reviewers then met with those relatives of the service users and relevant staff who agreed to contribute information to the review.

**Review Findings:** The review team concluded that improvements could be made in a number of areas. These particularly included:

- The mental health (MH) clinical record system
- Placing greater emphasis in communications on the centrality of an up-to-date comprehensive clinical management plan
- The functioning of the multidisciplinary team
- Staff education on consistency in the setting of thresholds for compulsory intervention. This would be within the context of a (national) commitment to the recovery approach underpinning the model of care and treatment in the “least restrictive” environment
- The availability of service user living situations in the community which have appropriate levels of observation and opportunities for social engagement.

1.1 Terms of Reference

The terms of reference (ToR) were to undertake a casefile review and meta-analysis of the care and treatment provided to five service users by Mental Health, Addictions and

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4 Meta-analysis: Oxforddictionaries.com 2016 “Analysis of data from a number of …studies of the same subject especially in order to determine overall trends and significance”, From meta=after, later or behind analysis.
Intellectual Disability Service 3DHB (MHAIDS 3DHB) who were involved in incidents of alleged homicide”.

This review is part of MHAIDS 3DHB on-going commitment to improve and protect the health and safety of service users, their families and the public and to ensure the effective conduct of MHAIDS 3DHB’s affairs by:

- Ascertaining as far as practicable the factual circumstances surrounding each event;
- Providing individual analysis;
- Identifying any systemic or shared issues that may have contributed to the five incidents;
- Recommending any further action MHAIDS 3DHB should take as a result of these events.

1.2 Background

In the fifteen months from the beginning of 2015 until the end of March 2016 five persons who had attended the Wellington based Mental Health Services provided by CCDHB were involved in events which lead to them each being charged with homicide. In this report they will each be referred to as follows:

- Service user 1
- Service user 2
- Service user 3
- Service user 4
- Service user 5

2. Review Methodology

(i) The CCDHB clinical files of the five service users were examined to allow the reviewers to gain an understanding of the clinical conditions, functioning and community/family supports of each of the five, and the appropriateness of their clinical care in all its usual facets. That includes the standards of assessment, diagnosis and formulation and the clinical management plan delivered.
(ii) From the files the reviewers established a list of which persons could most usefully be interviewed to inform the review in the light of its terms of reference. Those people were contacted by CCDHB and asked to meet with the review team in early June. Not all those asked attended.

(iii) The reviewers compiled a brief collection of recent literature relevant to the ToR.

3. Summaries of the Care delivered to the Five Individual Service Users

The printed copies of the electronic records did not always allow an easy assignment (by the reviewer) of dates as “pages” were rarely sequential, sometimes duplicated (up to eight times) and often in reverse temporal order.

a] Service user 1

[SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]

b] Service user 2

Service user 2 was involved in an incident which led to a death which service user 2 is accused of causing.

[SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]

c] Service user 3

Service user 3 seriously assaulted a family member leading to that person’s death. The care of service user 3 was examined in an earlier review, completed in March of this year. Much of what follows in this section is derived from that review.

[SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]

The post event review (77192) identified multiple gaps in service user 3’s care over the months leading to the incident. The Review Team expressed concern at:

- the lack of engagement during the [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL] transition period by team G
- the failure of current systems around risk documentation to allow assessing teams to understand previous patterns of risk
• the lack of awareness of the potential risks that resulted from this in the immediate period prior to the incident.

Further, a tragic failure of technology and/or systems of communication resulted in a fax from the GP on July 1 that demonstrated how acutely unwell service user 3 was and how changeable service user 3’s presentation was, had not been received by the CAT team at the ED on the day of the incident. That Review Team was also concerned at the lack of clarity of the purpose of the assessment at the ED with a narrative from interviewees suggesting a different approach to the electronic documentation is required. The Review Team was concerned at amendments to service user 3’s electronic documents being made after the incident and either the lack of governance or the lack of training around electronic documentation.

The Review Team were concerned at the lack of attempts at assertive engagement at a crucial time of transfer of care for service user 3 to team G. The documentation during the period of transition was lacking. [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]. It is unclear to what extent staffing levels at team G and particularly medical staffing levels impacted on the assessment and engagement process and whether this was an issue at that time or remains an on-going risk issue.

[SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]

The current risk documentation system within the electronic record does not allow an assessing team to establish patterns of risk with ease. The Review Team believes that a more robust system of risk assessment should be put in place. More widely, the Review Team was concerned at the current systems of recording clinical notes i.e. it was not straightforward to piece together the clinical history. There was no comprehensive clinical history of service user 3 immediately apparent and the timeline constructed in the body of the Review was an amalgamation from various entries overtime.

The Review Team also noted aspects of service user 3’s care by mental health services within and outside the DHB that were of a high standard. This included the correspondence and communication between [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL] and the prompt actions of [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL].
Although there were a number of deficiencies that the Review Team identified in the systems, governance, and processes and indeed in the practice of clinicians involved in her care, that Review Team did not find evidence of a single factor or individual that impacted on her care, leading to the incident. Rather, as is often the case, there were multiple factors that led to the decisions that were made on 1 July 2015 with tragic consequences for service user 3 and her family.

d] Service user 4
Service user 4 is alleged to have killed a family member.

[SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]

e] Service user 5
Service user 5 was involved in an incident which has apparently lead to him being charged with murder.

[SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]

4. Shared and Unshared Care Issues

In line with the instructions given to the reviewers and the ToR, this review does not seek to determine every contribution to the tragic events that precipitated the review, but concentrates on determining the nature of any improvable CCDHB MHAID service system weaknesses or faults which, if addressed, could help prevent further similar tragic events.

By the time of the review it was known that two of the five service users had been found not guilty of homicide on the grounds of insanity (meeting the criteria of section 23 of the 1961 Crimes Act), one had been found guilty (with therefore a presumption of sanity), and two were yet to come to trial. Each of the five cases reviewed is very individual but there were features common to the care of several. Also to be noted is that the second case, service user 2, was mainly being treated by the MH&A services Hutt Valley DHB, with only the one brief presentation to CCDHB via the ED. The shared and unshared care issues are summarized for each service user as follows:

Service user 1
- [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]
- There is no evidence of psychiatrist assessment in the face of [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL], including no detailed mental status report, no diagnosis, no formulation and no discernible comprehensive service user recovery plan. But there is ongoing care particularly involving [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]

- The printed version of the electronic record does not provide a coherent account, with its many repetitions, and probably missing real information. Most particularly, no comprehensive, service user recovery plan (SURP) was recorded or available.

- The CM put considerable effort into arranging appropriate care, including meeting with the family [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL] but appeared to have significant difficulty in getting [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL] services to play an ongoing role or their foreshadowed care package delivered after the withdrawal of the foreshadowed ACC option for funding. The reviewer is left with the impression that by February 2015 service user 1 was possibly under the wrong service and should have remained under some [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL] expert psychiatric opinion (e.g, consult/liaison) availability.

Service user 2

- [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]

Service user 4

- To opine that [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL] does not meet the criteria of the Mental Health Act (1992) for compulsory assessment and treatment, does appear to the reviewers to be a stretch too far in trying to maximise a person’s autonomy.

- There was minimal therapeutic response to service user 4’s deteriorating mental state, which appeared sufficiently severe to cause concern to [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]. Seemingly only the one assessment by a psychiatrist and the conclusions of that appear hard to justify.
There is no documentation of a comprehensive psychiatric assessment, diagnosis, formulation and derived management plan.

Service user 5

While the treating teams were often recording their concerns it is not clear whether their reluctance to keep him in a more secure environment was driven by service pressures, service treatment philosophies, or other attitudinal factors associated with the “antisocial” label that had been applied to him.

The community based team H were firmly of the view that his care would have been better handled if service user 5 had been able to be placed in level [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL] accommodation, but this was not available (or not purchased).

A drop-in centre previously available to be used by team H service users, and which team H staff regarded as helpful in socially engaging service users like service user 5, had also recently been closed.

Service user 3

The wisdom of agreeing to home management, rather than more constant, professionally trained observation appears consistent with a “least restrictive” practice approach and a team commitment to maximising service user autonomy within a recovery philosophy. However, in the view of the review team balancing such as approach has led the clinicians to ascribe insufficient importance to service user 3’s need for treatment. [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]
The review team also noted particular concerns about the fitness for purpose of the electronic record as used. The files of all five service users appeared incomplete. Most frequently not including direct written reports by the relevant registrars or psychiatrists, comprehensive psychiatric assessments and/or comprehensive management plans. Overall, the review team have formed the view that there are at least three particular service system issues (see section 5 below) which are likely to have significantly contributed to the lack of resolution of the clinically abnormal states of the five service users at the times of the alleged homicides. And a number of other contributors to individual cases which may lend themselves to service improvements.

5. Key Informant Interviews

The discussions opened with introductions and an outline of the review process. The review team indicated that if there was anything that we need to know in order to improve services we would welcome any such discussion. Lastly it was mentioned further that we aspired to be able to produce a review report that may prevent further issues happening or mitigating them to some extent.

(i) Staff

Service user 1.

The treating team\(^5\) referred to the confusion inherent in the dual clinical record system, and to its other imperfections. Team members have subsequently recognized the inadequacy of some of their own note keeping.

Service user 4

\[^{5}\text{All staff interviewed are recorded by their role, rather than their names.}\]
the fact that they are not populated with this information is a big issue for them. [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]

[SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]

[SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL] noted that links with GPs varied depending on GP or psychiatrist having the time to be in touch with them. The locum does ask GPs to call if they have any questions. CATT staff has a system of keeping GP up to date with plans by sending a copy of e-notes to GP and follows up with phone call to practice nurse to make sure all info received and then all clinicians are clear about what the ongoing plan is. [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]

CATT staff reported that as non-medical staff they did not have access to the tab in the e-notes that is called ‘shared care’, some of the doctors in MH may have ability to log in but not CATT. If they had access they may be able to find more information between psychiatrist and GP and may also be able to contribute to the treatment planning section.

Te Haika clinician also ensures that three months before discharge of all service users, the clinician contacts the GP to invite them to do preparation time but GPs may not get back to us so we then talk to the practice nurses.

Service user 5

[SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]

Issues with e-notes raised – team H find using paper notes is more common rather than e-notes as these tend not to be populated with up to date info. Also can’t get medication chart/list unless prescribers write these into the e-notes so can’t rely on paper notes as they need this info about meds much quicker.

[SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]

Service user 3

CATT & team G Representatives:

The teams and individuals began with a number of important points:
• That there had been issues of the earlier transfer of care (TOC)
• It was of the opinion that the quality of the TOC was diluted
• That the timeframe [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL] could have been unrealistic and confusing
• No clear guidelines around the TOC and limited face to face contact for handover
• Team documents in terms of transfer of care were mentioned as being problematic with a dual recording system
• Discussion of the frequency of hand over and clear guidelines around this
• The problem of cross service documentation
• Consistency of information sharing across services
• The role of the case manager in this instance

One of the important points made in this discussion was the resourcing which people considered to be a major issue. There was discussion on capacity issues within the teams and of the quality of care in particular around available and consistency of the medical team.

[SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]

Main points to this:
• Difficulties with having both a paper and electronic record
• Concerto needs better functionality and access to specific files and documents

[SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]

What came out of this was:
• Policy around faxes needs to be seriously reviewed. Discussion on whether the alleged fax could have made a difference.
• Procedure outlined in regards to faxes from GP, ED, CATT and community  The ‘Pink Sheet’.
• Process of assessment was explained
• Crisis Resolution Plan discussed
• [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]

Also mentioned was issues around ED:
• Issues of client and family centered care
• Not an ideal environment to be in for some mental health presentations
• Security issues and problems around this

[SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]

Discussion that recovery based approaches and taking responsibility was a whole of system approach not individuals and teams. Face to face appointments and weekly planned visits is the ideal but due to workforce development issues there were:

1. Caseloads in excess of 400+
2. High acuity with 30 to 40 admissions and some discharges
3. Communication issues
4. Stretched medical staff services
5. Difficulties recruiting in Wellington with vacancies and little consistency between different medical opinions in the care of individuals
6. Overload
7. Complaints and issues not being feedback or heard

The discussion on complaint, on occasion feeling unsafe clinically, communication issues between individuals and teams. This was in regards to PHOs; ED and relationships with medical teams.

Service user 2
Team Consultant Psychiatrist and Team Leader

[SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]

Also of note was that:

• The use of the panic alarm – there was a transition to a new building and these were not ready
• That there were screening issues at the clinic
• Difficulties with managing difficult clients
• Discussion on prescribing and not prescribing

[SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]
(ii) Service users.
Direct interviewing of the five was not undertaken as all were subject to various, relevant, legal situations.

(iii) Families.
Families of only two of the five service users indicated a willingness to contribute to the review process.

Family of service user 1
Attendees: Three family members

[SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]

Also mentioned were that the family:

• Didn’t seem to get the help and support they needed. Comments about poor service whilst at Non-government organisation D [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]
• Didn’t seem to the family that anyone would take responsibility for how things were and what happened

• [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]
• Family discussed this rigorously talking in depth about a lack of resources for a service user with these issues
• [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL] was mentioned in depth and some of the issues around access [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]

Family that attended also mentioned that:
• There needed to be a better way for conveying information on their loved one
• Point of contact to be revised
• “Tell me what I needed to know” as a family member
• Discussion around disability access to family meetings
• People need to listen to family. Family felt that they had been let down terribly by services.
• Wheelchair access issues to Non-government organisation D
- Lack of understanding of the language used which is a definite barrier
- Issues around the prescribing of medication
  - Issue over dual disability [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]

[SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]

At the time, there was discussions about who was responsible for [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]

This clearly was a dilemma for staff as to who directly would be responsible for [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]. There are definite communication issues between the two organisations that ultimately need to be further discussed e.g. being denied the funding for continuing assistance post-discharge when current ACC manager found out [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]. This was highlighted in the lack of follow up according to family after [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]

Also of interest to this interview is that

- [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]
- The family’s perspective of some system failures:
  - [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]
  - Family did not receive any family “packs” - information about what services are available along with contact details such as phone numbers and addresses of those team.

  - No one – family nor [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL] were getting support they needed. Feel there have been failings in the meetings in [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]
Family of service user 3

Attendees: Four family members.

In response to both open ended questions and some specific questions from the review team members, the family made the following points:

- Communication with GP – according to the family, a fax was sent through to the ED in regards to service user 3 that was not viewed. The family viewed this fax as being important to the assessment of service user 3 and highlights an important part to the process that may need further discussion:
  1. That this was not a casual referral.
  2. Was this (fax) the best method for communication?
- Question from family about appropriateness of GP prescribing [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]
- GP had rung case manager – case manager contacted CATT. Some discrepancies in fax and what GP told case manager
- Contact with police and transportation issues. Is this a more appropriate and safer option than the family? Mention made on ownership whether or not it is more suited for the police to be available rather than responsibility of the family to transport service users for CATT assessments.
- Discussion on ED wait times – the time spent in ED was lengthy prior to being seen by CATT and may have contributed to the decision to discharge service user 3 home. Mention made that ED focus and environment though was only on the medical issues and not specifically around being more accommodating for service users and their families with issues of mental health.
- Family want to know if there is some way there could be a 24 hour observation within ED
- Family feels previous report implies family were desperate to take service user 3 home and once again gives ownership of the issue to the family to deal with.
- Specific recommendation around the role of the non-government organization D navigator in this process especially in being able to influence [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]
• Comments made about what supports there are in the community e.g. family burn out. Family acknowledged that the current CCDHB Family Advisor had been helpful and supportive in her earlier role in the initial time of service user 3’s admission to the services.

• Though [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL] explained that her recollections of the evening is still sketchy, the family reiterated that there was little, to no communication between the CATT team and the family that could well have influenced the result e.g. family reiterated that ensuring that CAT staff interviewed the family in absence of service user 3.

• Family thought that the approach the CATT team took in hindsight might not have been the best e.g. early discharge from ED. Unclear communication about where service user 3 should be admitted but bed pressures have been mentioned.

• [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]
  - Could there have been alternatives or other options around service user 3’s treatment? [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL]
  - In response, the review team note that although the treating teams were often in positions of some debate, if not conflict (e.g. with family over the role of [SECTION REDACTED TO PROTECT THE PRIVACY OF THE INDIVIDUAL] treatments, with non-psychiatric health services over which service should be primarily responsible, or with other DHBs over where a service user was living) any influence of those on the bad outcomes appear to the review team to be matters of pure speculation.

• CATT team to be more accountable. Feel the CATT team were addressed in the recent SAER 77192 report. However concerns were raised by the family in particular around insufficient use of the MH Act.

6. 2015/16 Service Context and Function

6.1 The figures provided to the review team indicate that during 2015 the CCDHB community services were receiving 400-500 referrals/month. Within that, the CATT service opened and closed approximately 250 “episodes of care” each month with a “point prevalence” workload of around 300 open cases/files. Of whom, about 15% were registered
as Maori, which is close to the denominator population ethnic distribution. CATT is said to have 19 FTE staff, plus 2.1 FTE psychiatrist time and 1 registrar. The team H service opened and/or closed an average of 6 clinical care episodes/month and carried 70 – 80 on their books at any one point in time. Their service users are approximately 20% Maori. team H is said to have 7 FTE clinical staff plus a psychiatrist.

The acute unit L admitted 32 – 55 persons/month with an ALOS, calculated monthly, of 16 – 32 days. The bed occupancy was usually close to 100%

6.2 Service philosophies

Recovery and least restrictive care

At the heart of the recovery competencies (Mental Health Commission, 2001), is the right of service users to be treated with respect, dignity and equality. This means mental health & addiction services offer the most possible independence and choice to service users about their treatment and management of the symptoms of their mental illness, and the support required in their recovery journey. The ‘dignity of risk’ is a term that is used in the disability and aged care sectors, and has application within mental health settings (Lord, 2011). Dignity of risk supports the recovery journey of the person when the individual has a right to choose to take some risks in engaging in life experiences; it includes the idea of making an informed choice, and the idea of accepting the possibility of harm or failure. However, a tension occurs when the persons ‘dignity of risk’ comes into conflict with what professionals see as their duty of care or the needs/safety of others.

For example, in two of the staff interviews it seems that reluctance to invoke the Mental Health Act was balanced with providing least restrictive care at that time. The review team note, that in hindsight had invoking the Act happened, it may have led to compelling the person to accept treatment (particularly their medication) over a period of a few days to stabilize the person’s risk and mental state. The review team understands that the recovery approach is not the antithesis of acute care and assertive risk management. Clinicians can offer support to service users to develop collaborative risk plans, including decisions about, and support for, adherence to treatment plans. Noting also that recovery is a journey and taking into account advanced directives.
Involvement of family/whanau

Whanau and other community voices are understood by the mental health sector to have important contributions to make to both the assessment processes and to the definitive, comprehensive, service user recovery plans (SURPs). The family members interviewed wished for more information and updates about care and treatment via a consistent contact person in the treating team.

Information provided by family about risks is evident in some of the notes reviewed. In two of the five there are some discrepancies between the current views of family members and to some extent clinical information provided in the files. Those files also note elevated risk concerns raised by NGO partners but not reflected in the management plans.

There was also an emerging theme within the family interviews that clinicians were placing responsibility on the family to monitor medication adherence, and signs and symptoms and escalation of risk e.g. a family member of service user 4 was regarded as being familiar with the MH Act and would request invoking that (with GP). This can be a difficult call for the family to make and risks further alienating or reducing trust between the service user and their loved ones when expected to take action to invoke/support the Mental Health Act.

Consumer Participation

Within the collaborating 3 DHBs the role of the navigators (as peers) is to support the clinical arm of treatment whilst at the same time, focus on the future goals and aspirations of the service user. Its success requires the collaboration of clinical, NGO - peer support workers, loved ones, and primary care clinicians to support the recovery journey of the individual wherever they enter the system. The engagement of a navigator was only referred to in the service user documentation for one of the five individuals reviewed. Of note was the comment that the navigators also played an important function in providing support around medication compliance also which is useful.

6.3 Multi-Disciplinary Team (MDT) Function - Assessment, Decision Making and Review

MDTs are the common units of service delivery in New Zealand public Mental Health Services. The MDTs need to have an appropriate spread of expertise, sufficient FTE, and be managed in a way which utilizes their potential to deliver on a comprehensive service user
management plan (SURP). The role or contribution of the MDTs to the management of the five was often unclear, non-contributory or just not documented.

Role of the Case Managers

The , CATT and Community mental health teams all operate as MDTs, with a case manager for each service user. The amount of psychiatrist back-up or availability to the CMs varied. It appeared to the reviewers that a service user new to a team could go for > two months without being seen for a face-to-face assessment by a psychiatrist. There did not appear to be a template in the electronic record for recording MDT formulations and/or SURPs. These factors appeared to contribute to a number of issues, such as: inconsistency or lack of direction in medication choice; variable use of LAI; assertiveness of efforts to contact service users for treatment; discussion and decisions about referral on or discharge. And support for both service user and their families.

6.4 Relevant 3DHB Policies

The review team was provided with a copy of the Hutt Valley DHB Health Records Policy. This notes, inter alia, “There should be one fully integrated health record for each service user” and that the health record must contain sufficient detail to; ensure effective continuity to help the health team communicate effectively”.

The Hutt Valley DHB Crisis Assessment and Treatment team policy covering review of Tangata Whaiora (service users) makes reference to using Concerto for recording the management plan and for a separate risk management plan to be recorded wherever any risk was identified.

CCDHB has a 133 page Operations and Procedure Manual covering the general adult community mental health pathway. It has approximately 40 sub-chapters one of which notes assessment and management of risk is fundamental to health team work. It also notes that risk management will draw on the tangata whaiora/service users’ strengths and protective factors and will emphasise recovery.

It also notes “decisions about care and treatment may carry some risks….” And that staff “be mindful of the harmful effect of defensive risk management, serve to disempower the tangata whaiora/service users and thwart the recovery process. Management needs to be provided in
the least restrictive environment possible to allow tangata whaïora/service users to take as much personal responsibility as possible for managing their wellness”. There is also a 70 page Crisis Assessment and Home Based Treatment procedure.

It is important to make note that with such a large operations manual that it may prove to be detrimental in accessing important information easily or in a timely manner.

6.5 Contributions to Individual Care and Treatment Planning

The range of specific therapies available will not be detailed in this section. It will refer briefly to some of the health services structural or facilitatory tools.

**Compulsory Treatment** –

Short term restrictions on autonomy that lead to longer term gain for the service user is a basic precept of risk management. Krawitz et al., (2004) note that professionally indicated risk taking is a helpful guide to help clinicians support both the autonomy and the safety of service user when risk is escalating. The development of comprehensive treatment plans for at risk individuals, supported by robust MDT review meetings, provides for thorough clinical and medico legal practice to be demonstrated when compulsory treatment is indicated. In one of the five reviewed the clinicians’ threshold for invoking the legislation for compulsory treatment appears to the reviewers to have been too high. Clinicians’ thresholds (high/low) and when to consult on/invoke legislation for compulsory treatment are an area where different ideological and legal positions have been often debated.

**Role of General Practitioners (GP)**

The expectations of GPs to prescribe or monitor a person’s mental health without clear discussion and documentation that these plans are mutually agreed by GP & secondary services is not sound practice. This is where the role of primary care liaison nurses and shared care approach can bridge the gap. Te Haika is the single point of entry intake team that co-ordinates care that is required across what was CCDHB, and as is customary that single point of entry teams connect and support GPs the system needs to ensure that contact with GPs during the service users’ pathway through the service is evident.
Place of Residence

With most psychiatric care being delivered in community settings, and given the very brief amount of time service users’ spend in IP units, where people live and are accommodated is an important consideration. There are a great variety of appropriate settings, including their own rented or owned residences, family based living, accommodation available to any in the community, and various levels of supported accommodation. In the current New Zealand system, these resources, though publicly funded, are not usually under the control of the DHB service provider arm. They do not control the number, availability or access. Lack of suitable supportive accommodation appeared to be very relevant to the course taken by one of the five service users in the care of team H.

Risk Assessment and Management

The reviewers noted that it is difficult for the reader of the e-notes to consistently assess and manage risk in a logical way, therefore a template needs to be re-established to maintain a visual, clearly set out and well populated risk history, current risk, diagnostic formulation and all recorded in a place which allows quick and easy access to the information. Above all, a SURP readily updated whenever necessary. Most adult service users attend adult mental health services such as those under this review.

In most countries such services generally have higher service user/clinician ratios than do the sub-specialty forensic mental health services who also have more long term IP users. It can be argued that the requirement for accurate risk prediction and management is therefore greater and more difficult in the general adult services. Because most general adult service users are not a homicidal threat (i.e. therefore predictions being those of rare events on big denominators), accurate and timely prediction is usually an unachievable goal. As illustrated in the review, at least one of the above five had a clinical course and behavior equally displayed over many years, making any task of accurate temporal prediction impossible.

7. Benchmarks

In determining what should be of concern to a service provider, comparisons with other services can be illuminating and/or motivating. There are a number of parameters which would be of interest in both writing and interpreting this review. However, we do not have access to quantitative data that would allow this. For example, on rates of comparable events in the rest of New Zealand, staff caseloads, or on the utility of the various forms of clinical
record keeping. Rates of rare events, even where they are as sentinel and tragic as those which have led to the present review, do not lend themselves to valid inter-service comparisons even were they reliably available. Proper modal outcome information for case mix controlled benchmarking is potentially available now through the national PRIMHD data set to which all DHB provider arm services contribute.

8. Discussion

The care delivered to the five service users allegedly involved in the tragic events needs to be appraised within a variety of extant contexts. These include the epidemiology of psychiatric service user crime, current knowledge of clinical best practice including risk evaluation and management, NZ mental health service resources and practices, and the relevant principles and policies promulgated by the Ministry of Health.

Simpson et al. (2003) studied 30 years of epidemiologically relevant NZ data. They concluded that over that long period approximately 8% of NZ homicides were perpetrated by “mentally abnormal offenders”. That average was in a context of an overall decreasing rate as the figure in 1970 had been 19%, but by 2000 it was only 4%. Those changes in percentage mainly reflected an increasing denominator population, as the national absolute number of “mentally abnormal homicides” had remained relatively constant, though there was also a contribution from the trend towards decreasing absolute numbers.

The authors noted that “the population rate of mentally abnormal homicide perpetrators has been constant at 0.13 per 100,000 population/year”. On that basis, over a fifteen month period the Wellington 3DHB District could expect up to one such event. However, the Simpson data is >15 years old and did not include those mental health service users who may have been found guilty of homicide, as opposed to not guilty by reason of insanity (NGRI). That is, the Simpson data cannot be taken as a fully valid predictive baseline.

The review team is not aware of current NZ data on the above, or of the rates of such events within other NZ health districts. Also of potential relevance to clinical best practice, but not epidemiology, is a more recent NZ study (Brand et al., 2015) which reported on aspects of the care of 222 persons diagnosed as suffering from psychotic disorders who had attended various psychiatric services in the 12 months prior to being charged with committing an offence (i.e. any offence, not limited to homicide).
The authors concluded that frequency of service contact with assessment were generally adequate. Risks were also generally documented, but medication non adherence in that context was apparently a major contributor to the adverse outcomes (i.e., offending when unwell). They observed a general lack of staff assertiveness in the face of service user non adherence to oral or LAI medication. Non assertiveness in the sense of not fully utilising the available legal powers or assertively contacting apparent treatment avoiders. Aspects of this can be seen in some of the above five service user care situations. Given this lack of assertiveness reported by Brand et al., service users can thus be ‘at risk’ of being denied the opportunity to receive the appropriate range of treatments that are required to be available within secondary mental health services e.g. medication, interpersonal or cognitive therapy, relevant peer support or guidance, etc.

A third area of context relevant, published literature is that of risk assessment. As a validated assessment tool, the HCR 20 (Webster et al., 1995) developed in British Columbia, has respected properties in forensic psychiatry but has not usually been directly incorporated into standard adult mental health service use. Its division of service user risk for violence predictors are divided into two classes, static and dynamic as listed below. Both were evident in some of the files reviewed.

The dynamic factors generally are seen as the predictors which are most susceptible to therapeutic alteration. A relatively recent review of the available instruments to predict violence, published in the British Medical Journal in 2012 (Fazel et al.), opined that much more work was required before one could have confidence that the right tool and how to use it was/were known. Amongst the unresolved problems, one is how to reduce the high numbers of false positives (Ryan et al., 2010). That is, if CCDHB MHAID services had many service users on their caseload with similar issues to one or more of the above five, how do they know which ones to subject to higher levels of observation or security? That is only easy to predict in retrospect. In any case, accurately predicting uncommon events has been demonstrated to be mathematically futile, even for an event as common as successful suicide, which highlights its futility for the much rarer homicide, except for in the immediately prior period (See Gale, 2015).

Due to such deficits in psychiatry’s evidence base for risk assessments validity, and that reviews of serious adverse events (such as this one) often find that risks are noted but not adequately addressed. The emphasis has shifted (see Kumar et al., 2009), to the importance
of not separating out, in the clinical files or in the clinicians’ minds, risk assessment and management from good comprehensive assessment and comprehensive management plans. However much of the available relevant literature is more focused on suicide prevention than on violence.

The Static factors are defined as follows:

- Previous violence
- Relationship instability
- Employment problems
- Substance abuse problems
- Young age at first violence
- Psychopathy
- Major mental illness
- Early Maladjustment
- Personality disorder
- Prior supervision failure

The dynamic factors are defined as follows:

- Lack of insight
- Relationship instability
- Employment Problems
- Active symptoms of major mental illness
- Unresponsive to treatment
- Negative attitudes
- Impulsivity
CCDHB has a 12 page risk management process and reporting procedure. The purpose of that is recorded as “…to describe the process of risk management and reporting requirements”. This document has a lot of formal, tabulated, schematic content which cover various definitions and topics such as indications for risk management, the process, risk assessment, risk categorisation, and there is little in it which refers to risk to service users. In the 12 pages there is one line which refers to reduction in service user’s safety and delivery under the heading of risk categorisation, and another which refers to possible adverse outcomes (= side effects) of clinical care. There is no reference in the document to the relevance or importance of good clinical management plans to reducing risk to service user or their context.

A fourth contextual knowledge area is that of current or recent NZ policies and/or philosophies. The most definitive and relevant of these are those concerning the recovery philosophy, “least restrictive” care and risk assessment (See above). Contributing to national level debate and the context within which DHBs and clinicians provide their services, NZ media have argued both for and against restrictions. Within 2016 there have been newspaper front page articles and editorials arguing for more restrictive care in one month and in another, for less restrictive care. For contemporary mental health clinicians, balancing the autonomy and dignity of the persons’ decision making regarding treatment with the need to maintain the person’s (and the publics) safety is a constant tension. It is possible that lack of consistent and contextual education about the recovery approach, its philosophy and the difference from standard rehabilitation approaches and models within DHBs, has led some clinicians to misinterpret the recovery approach as the need to support the person’s complete and unrestricted autonomy. Coupled with the emergence of the term ‘least restrictive environment/care’ embedded in the national goal to reduce seclusion and restraint (O’ Hagan et al. 2008; Te Pou, 2008; Ministry of Health, 2012; RANZCP, 2016), and lack of education and training of staff, some further confusion can occur.

Central to service quality is the delivery of evidence based, comprehensive, therapeutic clinical care. There are many necessary contributors to this. As a prime function, mental health service teams are expected to deliver comprehensive service user recovery plans (SURPs) which incorporate all the elements into one masterplan. These are expected to be developed with the service user, taking account also of the views of family or other key
persons. The SURPs need to be easily updated and readily available to inform the actions of all relevant staff. No such documented plans were apparent in the five cases reviewed.

To reduce the chances of communication failures, it is essential that whatever therapeutic activities have been developed for the service user with a “risk management” focus are also incorporated into that single, comprehensive SURP. Whenever daily clinical management decisions are being considered or undertaken, they need to be considered in the context of the "master plan". This is considerably more difficult where parts of the service mainly utilise a paper based clinical record (e.g. the IP unit) and other parts work entirely with an electronic record.

It is facilitatory of the service user’s recovery if the overall plan is displayed on a large screen whenever relevant updates or daily management details are being considered at team reviews or staff hand-overs. Notably, the CCDHB electronic record (EHR Medical Concerto, an Orion product) system does not have a template for clinical management plans (SURPs) and also suffers from a number of other deficiencies, such as no "continuation" templates. And of course, is separate from the paper based files used in the IP unit. Nor is there a template for recording the management plans as agreed at the MDTs. The alternative paper based records have a template for “partnership” plans, which are intended to be signed off by service user, clinical team, and potentially relevant other. In the case of the five records reviewed these were seldom completed, rarely updated, not comprehensive and of limited availability.

The reviewers noted much consistency in the recollections of the staff interviewed, the family views and the clinical records. Where there were discrepancies, it was not always clear to what extent these had developed in the time gaps between the events and this review. It is well established that memories of events gradually evolve over time, particularly with repeated telling and the natural tendency to increase understanding and meaning.

9. Conclusions

The reviewers have concentrated on trying to understand the care delivered to the five persons to attempt to inform the 3DHBs about service improvements which might reduce the likelihood of such significant adverse events. They have tried to do this in a fashion which uses hindsight to weight the potential learnings, but recognises that the mental health services are unable to use that vision in advance. In practice, the services would be heavily influenced both by many contextual issues and by the ubiquity of many of the relevant risk-enhancing
individual service user characteristics. That is, they have to work with dozens, or even hundreds, of service users who share many of the identified risks, but who do not go on to seriously harm themselves or others. And constantly in clinicians’ minds is the service and NZ commitment to treating "in the least restrictive environment".

While the review was focused on the care delivered by the last treating teams, which in all cases were CCDHB community based services, some of the information provided raises questions about the relationships between service components, including CCDHB IP units, 3DHB regional forensic services and the services of the other two DHBs.

Recognition of all that, both by the relevant international literature and informed by our own learnings from those who have been interviewed for this review, convinces us that the best way of reducing serious adverse events is by providing the best possible overall clinical management. Evidence based where possible and always attempting to maximise service user autonomy particularly in the medium and longer term, which sometimes will require more assertive "maternalistic" actions in the short term. Which is why the nation has compulsory assessment and treatment legislation and, for example, assertive community based treatment and long acting medication preparations which make it easier to ensure service user adherence.

It is very rare, possibly almost unknown, for a SAER review in mental health not to find that imperfect communications have contributed. This review has come across a number of examples in the five service user-care scenarios examined. For example, clinical staff not hearing the information families were allegedly giving, not viewing information from referring GPs or other community informants e.g. navigators. Inter (MH) staff communications have also often fallen well short of conveying all the relevant information to inform, what might have seemed at the time, to be minor management variations.

The ongoing influence of psychiatrists on team work and SURPs was insufficiently apparent, though the reviewers were unable to definitively establish how much that conclusion was attributable to the clinical work recording practices, the clinical file structures, or staff workloads.
10. Recommendations

a) Major Recommendations

(i) One record system: It is difficult for staff working at different locations within the one service to access identical information’s about their service users, given the existence of a dual record system. It is especially difficult to know where to look for a current, comprehensive overall management plan, within which context daily management decisions need to be made. Such a development would optimise management decisions.

(ii) Service user recovery plans (SURPs): To ensure that comprehensive information is documented from the first assessment onwards it is recommended that this information is clearly available in a central care plan. Therefore, clarity between the wellness plan and the personal(SURP) plan is required. It is the reviewer’s opinion that the current title of ‘wellness’ plan can be a distracting nomenclature. The title of ‘wellness’ could distract clinical staff from the thorough assessment of risk and treatment planning and could lead towards a perpetuation of staffs’ lean towards least restrictive care. The SURP needs to be template to allow the recording of the changing, comprehensive, up-to-date summary of the extant plan, for example to further assess, treat, monitor and/or refer. It should incorporate all that the team considers should be done for that service user, so reducing risk by both the delivery of “Best Practice” and incorporating any therapeutic activities which may be conceptualised as driven by a specific risk.

b) Supplementary and/or Subsidiary Recommendations

(i) The DAMHS should develop educational activities designed to improve the knowledge and competence of the relevant clinical staff in their decision making around thresholds for compulsory intervention, i.e. utilization of the Mental Health (Compulsory Assessment & Treatment) Act. 1992,

(ii) Clinical staff need education and guidance on how to apply some of the national/MOH principles and philosophies in the context of high risk e.g. while always to listen to service user service user and family viewpoints, staff require guidance on when to legitimately over-ride these viewpoints in the interests of service user, their loved ones or community.

(iii) While the quantity and type of accommodation for service users living in the community is not under the control of the mental health services, they should prepare a
submission to the DHB funding and planning section summarizing their evidential contribution to an argument for greater provision of residential accommodation which has the capacity to provide for service users with high and complex needs.

(iv) All service users new to a team should be assessed, a formulation developed and a care plan agreed to, by a psychiatrist at least within two weeks of entry into the services. Information from this process is then recorded (as noted above) in the electronic file in a predictable place.

(v) Any/every assessment or other intervention by a medical person should be in the electronic record and signed off by them

(vi) The whole MHAID 3DHB should conduct an internal policy and planning exercise which clarifies the roles and expectations of the different service components, so that the best match of user needs and service skills are achieved.

References


