NSW Mental Health Sentinel Events Review Committee

Tracking Tragedy

A systemic look at suicides and homicides amongst mental health inpatients

First Report of the Committee

December 2003

“…any man’s death diminishes me…”

"All mankind is of one author, and is one volume; when one man dies, one chapter is not torn out of the book, but translated into a better language; and every chapter must be so translated...As therefore the bell that rings to a sermon, calls not upon the preacher only, but upon the congregation to come: so this bell calls us all: but how much more me, who am brought so near the door by this sickness....No man is an island, entire of itself...any man's death diminishes me, because I am involved in mankind; and therefore never send to know for whom the bell tolls; it tolls for thee."

John Donne
Meditation XVII

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Executive Summary

1. INTRODUCTION

Each death involving a mental health patient in care raises questions about our collective attitudes to life and to each other, and to the supports we can and should provide to those in need. Where any death has been the result of suicide the impact on family and friends is profound and has consequences throughout the social fabric of our communities. A suicide death of a patient in care represents in addition, great distress to the staff of the mental health service and to other patients. Homicide cases represent the worst outcomes of severe mental illness. Such events are an unmitigated tragedy for the victims, their families and their friends, and also result in great distress to the staff of mental health services and to other patients. The fear and concern they raise in the community is significant, and is largely responsible for the continuing and unjustified stigmatisation of the vast majority of people suffering from mental illness who pose no risk except to themselves. And lastly, such events often result in great distress and suffering for the perpetrator, who has to live with the consequences of their actions. These actions may be the result of an abnormal mental state, and commonly a close relative of the perpetrator is the victim. When the perpetrator's mental illness is treated and they are able to understand what they have done they are faced with a lifetime of grief and remorse.

There is a common perception that any suicide death or homicide by a person in contact with public mental health services represents a failure on the part of mental health services. This is not always so, as will be discussed later in the report. Mental health services in general do a very effective job of managing people with severe mental illness, as detailed below, and in all likelihood prevent many incidents of minor and major self-harm, and violence towards others.

Indicative data from NSW Health shows that of 22,061 admitted patients' episodes of care in public psychiatric hospitals and mental health units of general public hospitals in 2002-3, there were 8 possible suicide deaths of patients who were in care as inpatients at the time of their death. In the 3-year period from 2000-1 to 2002-3, there were almost 62,000 admitted patient episodes of care. During this time there were 8 homicides perpetrated by patients in contact with mental health services. While the incidence of death might be extremely low, it is not, as would be preferred, zero.

One of the purposes of the NSW Mental Health Sentinel Events Review Committee (the Committee) is to review these incidents and examine systematic problems within the mental health services that may have contributed to the tragic outcome and to suggest solutions. The Committee is aware that, while systemic problems must be addressed, there is a need to balance deaths with those who do well under current practices.

Clinician Responsibility

The Committee recognises that ultimately, clinical judgement is relied on in every setting within mental health services. While the Committee has no wish to interfere unreasonably with the valuable function performed by bodies that train mental health staff, it will draw attention to matters of relevance raised in the report to be suitably incorporated by training authorities into curricula.

While the Committee recognises that tragic events such as suicide deaths and homicides are not necessarily predictable amongst mental health patients under care, its findings indicate that a level of accountability nevertheless must be accepted.

Resources
The ability to provide a comprehensive range of quality mental health services is limited by the available resources.

It is difficult to estimate the impact of resource limitations – particularly access to inpatient beds and experienced psychiatrists. However, there must be questions over the capacity of many services, using currently available resources, to undertake the most appropriate risk mitigation strategies in response to the identified level of risk.

Admission to mental health beds is widely seen as the most effective short-term risk mitigation strategy in high risk cases. However, anecdotal evidence strongly suggests that on occasions patients are not being admitted, or are being discharged early or without comprehensive follow up, due to an inability to access an available inpatient bed. As the overall number of mental health beds has shrunk in the last decade (although there has been a marginal increase recently), and as demand has increased (in parallel with increased substance abuse and changing social mores) it is now clear that the bar to mental health admission has been raised. In turn this has led to mental health clinicians and Area Health Services having more limited options.

As a result, the risk to the general public is higher, the risk to the patient is higher, the risk to the mental health clinician is higher and the risk to Area Health management being held responsible for not supplying the responsible level of care is also higher.

Any demand for greater use of risk assessment will increase demand on already stretched mental health services, and have the effect of further concentrating resources on those with psychosis, substance use and personality disorders. This will reduce the capacity of services to care adequately for the vast majority of patients with mental illness who have other disorders such as anxiety or depression. This in itself could increase the risk to the community. Thus adequate resources need to be available for effective risk management without undermining current resources and services.

2. ANALYSIS OF SYSTEMIC FACTORS IN A SAMPLE OF SUICIDE CASES

The Committee determined that in its first year it would focus on inpatient suicide deaths. This small subsection of all suicide deaths presented an achievable task and represents the spectrum of highest need and of mental illness where there is the highest expectation of the level of support available. The Committee intends to study other groups sequentially.

The National Centre for Classification in Health (NCCH) undertook a consultancy for the Committee in June 2003. The consultancy's brief was to review a sample of the medical records and related documentation of patients who had suicided while under the care of mental health services in NSW between 1999 and early 2003. The purpose of the review was to identify and explain any systemic factors inherent in care delivery to these patients, which may have had a causal or influential role in the patients' outcome.

The delivery of care to mental health patients is complex, both procedurally and clinically. The patients themselves exhibit a constellation of problems that complicate the delivery of care. Further, it was concluded that although patients may share a number of characteristics (history, diagnosis, assessed risk etc), they are nonetheless a heterogeneous group.

The review was successful in identifying a number of systemic factors which, in concert, impacted on the delivery of care and as a consequence, the patient outcome.

Foremost among these were risk assessment, patient characteristics, environment, care management, communication and documentation, family involvement, staff issues and dissemination and implementation of NSW Health policies and guidelines.

Risk assessment
Assessment of patients and subsequent admission protocols were variable. Some patients assessed as being at high-risk of self-harm were not immediately placed on high frequency observation protocols on admission.

Assessment protocols were not uniformly applied or documented. About one third of patients in the sample group appear not to have been assessed formally, and the instruments and measures used were not standardised.

About half the patients in the sample group who subsequently died by suicide had been assessed as a medium to low risk of self-harm. The assessment instruments may warrant further investigation as their predictive validity appears quite low given that all patients in the sample ultimately suicided.

Patient characteristics
Most patients had a history of mental illness, previous suicide attempts, substance abuse problems, and a diagnosis of schizophrenia, psychosis, depression or personality disorders. Many had experienced previous episodes of care in mental health facilities. Many patients had more than one problem, for instance, schizophrenia and substance abuse issues or personality disorder and malnutrition. Variable levels of family support, interaction with police and other services were also identified.

These characteristics should be referred to as "red flags" for the purposes of identifying cases at heightened risk of self-harm, especially where presented in combination.

Environment
Two major systemic factors of concern refer directly to the physical facilities available to mental health patients. These factors are access to means and methods, and security and egress.

- Access to means and methods

Almost half of those who died by suicide while under care, did so within the mental health facility. This speaks loudly about access to means and methods of inpatient death. More vigilance and preventive action on removing hanging points (coat hooks, door hinges, locks and fittings) and hanging implements in particular (cords, pyjama sashes, other cables), are necessary.

- Security and egress

Approximately 30% of the patients suicided while they were absent without leave (AWOL) from the mental health facility. The systemic factor of security and egress therefore also warrants further attention. If suicidal patients can be prevented from leaving the facility their access to means and methods of death is likely to be reduced significantly. In the view of the Committee the requirements of "duty of care" are paramount.

To avoid the possibility that patients will choose alternate means and methods of death (or take whatever means are most easily available to them), both these issues need to be addressed in parallel.

Care management

- Specialist services

The interaction between mental illness and substance abuse is cited as a complicating and contributory factor in patient care. Documentary evidence suggests that mental health services are ill equipped to treat drug addiction or withdrawal, and specialist Drug and Alcohol units likewise may be not be the best place to manage mentally ill patients. The need for specialist services (or specialised protocols) that can deal with both mental health and drug and alcohol problems should be considered.

- Restrictive practices and the Mental Health Act

The Mental Health Act stipulates that the least restrictive level of care be given to patients with a mental illness or mental disorder, and makes provision for their privacy and dignity. However it is the view of the Committee that the terms of Section 4, sub-section 2, requiring the provision of the best possible care and treatment in the least restrictive environment *enabling the care and treatment to be effectively given* (emphasis added), are often overlooked. Also, this sub-section requires that any interference with patients' rights, dignity and self-respect are kept to the minimum *necessary in the circumstances* (emphasis added). It is the view of the Committee that patients assessed at high risk of self-harm require more restrictive care, and that this is consistent with the letter and intent of the Mental Health Act.

There appeared to be a propensity to decrease observational levels, or to grant leave or other privileges to patients as soon as any minimal improvement was noted in patient symptoms, their behaviour or compliance with treatment. This was sometimes done without record of formal evaluation or assessment of their progress in treatment. It could be inferred that some such decisions were more the result of resource pressures than they were of considered clinical judgements.

Of more concern was that decisions to allow more freedoms and less frequent observations were occasionally made very early in the episode of care, and with no discernible regard to the prior assessment of the level of risk of self-harm.

- Granting leave

Of the 15 patients in the sample who were granted leave throughout their episode of care, three suicided while on leave. Most patients who were granted leave successfully returned to the mental health facility for ongoing treatment. However, the reviewers noted with some concern that there appeared to be variable and inconsistent criteria applied to determine whether leave should be granted.

A more pressing concern is the timing of granting leave. There were several instances where high risk patients were granted leave very early in their episode of care, and often without documentation of further assessment to ascertain their progress in treatment or their preparedness to return.

While the review did not provide clear evidence that leave granting was a major systemic or causal factor within this sample, the variability in its application was of concern.

- Length of stay

The review found that half the sample of patients died by suicide before the tenth day of their stay in mental health facilities, and 30% died within the first three days of their episode of care. While it could be concluded that in general it is the sicker mental health patients, who are more likely to die by suicide, who are being admitted, the timing of events points to the need for more vigilant care management strategies in the early days of patient admissions.

Communication and documentation
The quality of communication or documentation practices did appear to exert a major influence on the ability of staff to co-ordinate and manage care delivery and to make informed clinical decisions. Without a doubt, documentation issues were the most obvious problem and of most concern from a medico-legal, care management and coordination point of view. The quality of about one third of the medical records reviewed was considered poor; a few were appalling.

Family involvement
Issues of clinician-patient confidentiality and patient rights have implications for communication and information exchange with family. Family members complained about the lack of consultation and information received while their loved one was under the care of mental health services. This was especially the case where family was not informed of a patient's admission or change of care management practices (especially granting of leave).

Staff issues
The review identified resource issues including the documented availability of staff. Types and levels of staffing commensurate with level of identified risk were not always immediately available for patients on admission. In terms of the availability of intensive nursing, patients were sometimes transferred to other facilities where intensive (1:1) nursing was available. In terms of delays due to staff availability, in almost half the cases patients had to wait to be appropriately reviewed, assessed or accommodated.

Low staffing levels also had negative implications for handover practices at shift-change times and for the poor quality of communication that sometimes resulted.

Dissemination and implementation of NSW Health policies and guidelines
Reviewers noted with some concern that policies, guidelines and protocols often took a long time between development by NSW Health and dissemination to Area Health Services, and then to implementation by mental health services. There is then a non-uniform approach to these policies and guidelines, the flexibility of which may increase the ability to meet specific local needs, but may also act to impede the efficient provision of a standardised approach to care delivery.

3. ANALYSIS OF SYSTEMIC FACTORS IN A SAMPLE OF HOMICIDES

The Committee commissioned an analysis of its review of a sample of seven cases of homicides perpetrated by patients of mental health services, which had occurred between 1999 and 2002. These cases had been subject to recent detailed review and were able to be further analysed by the Committee in order to explain the possible or probable influence of systemic factors in each of these events and to determine whether there were any discernible trends that point to the need for specific reforms.

The analysis identified the demographics and the risk factors associated with the assailant in

each case, specifying static factors that denote baseline risk and dynamic factors that could potentially have been ameliorated with clinical intervention. The analysis focused on systemic issues and clinical issues. Systemic issues included policies and procedures, resources and environment, and communication. Clinical issues included risk assessment and management, clinical practice and care, clinical staff, and application of the Mental Health Act.

Similar systemic factors were examined in the analysis of homicide cases and the review of suicide cases and it was not surprising that both reviews revealed similar trends, even though the suicide review was based on an analysis of medical records, and the homicide analysis was based on case reviews. Indeed both reports should be read in conjunction.

However some important differences in trends did emerge, and those factors with specific relevance to the analysis of homicide cases, are summarised below.

- Clear policy that defines sentinel and high-risk situations for clinicians, and clear procedure that outlines the minimum clinical response required in the context of high risk and crisis events were not apparent.
- There did not appear to be any available risk assessment tool to assist clinicians in the assessment of risk of harm to others.
- Accountabilities and responsibilities in relation to consultants' and registrars' clinical involvement did not appear to be well defined.
- There did not appear to be mandatory training in the assessment of risk of harm to others and risk management for clinicians in NSW.
- At critical times, especially in rural settings, communication protocols to access specialist consultation in an emergency situation were unclear.
- Communication with outside agencies such as the Department of Community Services was inadequate and was not assertively followed up even when it was clear that the external agencies were failing in their response.
- There did not appear to be standardised communication pathways between clinicians, or between mental health services and outside agencies, nor did there appear to be communication protocols in relation to the transfer of care.
- Inadequate contingency risk management plans were developed in circumstances where an increase in risk was foreseeable.
- Too much reliance tended to be placed on the patient's family to protect the potential victims and there was too little response from the mental health service to implement protective measures.
- Suicidal and homicidal patients were sometimes discharged when clinicians had knowledge that they had access to weapons.
- People at risk of violence by mental health patients, even though aware of threats, tend to minimise or deny or be naive about the risks that they may be under. Clinicians should not expect members of the community to appreciate the relationship between mental illness and violence.
- Forensic psychiatric opinion was never sought in this sample.
- Community Treatment Orders were not considered in this sample even though there was clear evidence of ongoing risk after discharge.
- There was a tendency to rely on Apprehended Violence Orders (AVO) as an adequate risk intervention strategy in those with mental illness. An AVO does not prevent violence - it apportions blame. Admission to a secure Unit using the Mental Health Act does prevent violence.

4. CORONERS RECOMMENDATIONS

The Coroner's Sub-Committee of the NSW Mental Health Sentinel Events Review Committee examined and considered the recommendations made by NSW Coroners flowing from inquests during 2001 and 2002 into deaths falling under the terms of reference for the Sentinel Events Review Committee.

Three central issues emerged and occupied the Sub Committee's focus. These were
1. How to ensure the development of a closer working relationship between Coroners and Mental Health Services.
2. How to ensure Coronial recommendations are implemented appropriately at the coalface.
3. How to ensure that research priority is given to recurring themes raised in recommendations, particularly in the area of personality disorder.

A closer working relationship between the Coroner's Office and Mental health Services should be developed particularly when a Coroner may be considering making recommendations.

A register of 'authorised persons' should be made available to the Coroner's Office for consultation in relation to understanding clinical and/or service delivery systems.

A detailed investigation should be carried out into the pathways followed by recommendations to determine where barriers were encountered with a view to system adjustment. This would indicate how such recommendations travel through the system toward dissemination and implementation. This journey could also be tracked in terms of feedback to the recommending Coroner.

Given the prominence of personality disorders and self-harming behaviours in Coroners' reports, considerable effort to support research in the domain is essential in the future.

5. RAPID RESPONSE AND FAMILY LIAISON

Family involvement in the immediate response to suicide death or homicide, where appropriate, including an appropriate expression or regret or sympathy and the offer of counselling and support will assist them in the management of anxiety and distress. The response should also support staff and assist the broader health system.

Rapid responses should consist of an immediate review of the event to ensure the safety and welfare of other patients and staff, and liaison with the family of the deceased person to offer assistance and support and to make an appropriate expression of regret.

The Centre for Mental Health should develop guidelines and mechanisms for implementing the proposed process immediately. The Centre should conduct research to evaluate the process over a two-year period.

6. REPORTING, DATA COLLECTION AND MONITORING

The Committee favours an open and transparent annual reporting method for possible suicide deaths, and for homicides pertaining to mental health patients. A sound communication and media management strategy is needed. Initial reports of possible suicide deaths should commence in 2004, and cover the last five-year period. Thereafter, annual reports should be published as part of the Chief Health Officer's Report.

An appropriate process for mandatory reporting is needed to capture quality information both for the immediate identification of weaknesses in processes and systems, and for the later more detailed examination of cases and drawing of conclusions. Information needs to be available from the immediate review of the situation for the safety and welfare of other patients and staff, and in view of the public and media interest which sometimes follows these events.

Recommendations

RISK ASSESSMENT AND MANAGEMENT

1. By the end of 2004, NSW Health shall have standardised and implemented statewide risk management systems and processes, which will
   - include risk assessment tools for suicide and for violence to others
   - address dynamic factors such as the allocation of a responsible clinician and timing of reviews depending on need
   - be tested and evaluated by 2006.

2. By the end of 2004, NSW Health shall have established measures and processes to develop and implement by the end of 2004 statewide policy and procedures to govern risk assessments and risk management care plans for the following key points of the clinical pathway for mental health patients:
   - triage
   - admission
   - after critical events
   - at discharge
   - when the family or the community raise concerns
   - when the patient defaults on treatment, or follow up, or goes AWOL.

3. If any 3 “red flags” are present at the time of admission, then a high risk category shall be assigned automatically to the patient, the patient admitted under schedule, placed immediately on high frequency observations and the mental health team alerted that a more detailed risk assessment is to be undertaken. This process should be operationalised by July 2004.

   The following “red flags” are identified as markers for heightened risk of self harm in mental health patients:
   - principal diagnosis of psychiatric disorder
   - previous history of self harm, or suicide attempts
   - suicidal ideation
   - showing evidence of substance use/abuse
   - known to police and/or other service groups in relation to impulsive or aggressive acts or behaviour.

   The following “red flags” are identified as markers for heightened risk of violence towards others in mental health patients:
   - principal diagnosis of psychiatric disorder
   - previous history of violence towards others
   - known to police and/or other service groups in relation to impulsive or aggressive acts or behaviour and/or antisocial behaviours.
   - showing evidence of substance use/abuse [See also Recommendation 21]

4. By July 2004, Area Health Services shall ensure that medical or surgical patients, especially elderly, post-operative and post-natal patients who are being cared for outside mental health units and in whom active mental health pathology is identified, are recognised as at risk of self harm and further appropriately assessed and managed in terms of established level of risk.

5. By July 2004, Area Health Services shall ensure that any Emergency Department assessment identifying active mental health pathology will involve consultation with a member of the mental health team, which includes the patient's GP-VMO in a rural setting, and, if high risk, a psychiatrist.

STAFFING LEVELS

6. By July 2005, to assist health services to provide safe and adequate care, NSW Health shall develop and distribute a guide to safe staffing levels as these relate to the outcomes of risk assessment and the level of staffing required to manage those risks.

7. By the end of 2004, a proposal for a community forensic mental health service shall be developed and will include services for forensic patients released into the community and a consultancy service to community mental health teams.

8. From July 2004 NSW Health shall ensure that specialist forensic psychiatric services to provide specialist consultation, advice and clinical care when required, in complex cases involving risk of violence to others, are available 24 hours a day, seven days per week, statewide.

ENVIRONMENT

9. By July 2004, Area Health Services shall ensure that the level of security of accommodation is commensurate with the level of assessed risk.

10. By July 2004, Area Health Services shall ensure that mental health units in which involuntary patients are cared for are secured.

11. By July 2004 Area Health Services shall have taken preventive action to remove potential hanging points from mental health facilities, especially in bathrooms, and will have implemented recommendations based on NSW Health audits of mental health facilities.

12. NSW Health shall ensure that by no later than 2007, appropriate environments and resources are provided within Emergency Departments to enable appropriate mental health assessments to be undertaken, as required in the Emergency Department Report 1998, Recommendation 9.

13. By the end of 2004, the Director, Centre for Mental Health, shall sign off Health Building Guidelines for Emergency Departments and any proposed alterations or redevelopment plans for Emergency Departments, to ensure that they are able to deal adequately with the management of mental health patients.

FAMILY INVOLVEMENT and APPLICATION of the MENTAL HEALTH ACT

14. The special discussion paper being drafted by the NSW Health Legal Branch in collaboration with the Centre for Mental Health for the forthcoming review of the Mental Health Act, should consider specifically the case of access by families to information under Mental Health Legislation, recognising privacy issues and the requirements of good clinical practice.

15. By April 2004, Area Health Services shall ensure that families and significant others, when recognised as active carers or guardians are given enough information and support to allow them to participate effectively in the assessment process, care provision and supervision of the acutely ill person before admission, during admission and after discharge, despite the current privacy requirements of the Mental Health Act.

COMMUNICATION

16. Effective immediately, Area Health Services shall ensure that the senior attending clinician shall be responsible for ensuring that the transfer of care of a mental health patient from one service to another should always occur with comprehensive communication to ensure adequacy of ongoing care and continuity of care.

17. By the end of 2004 NSW Health shall ensure that there is agreement within the Human Services Chief Executive Officers Forum that processes are put in place such that where there is an escalation in risk protocol, appropriate responses are made between agencies and communicated orally and in writing.

18. Effective immediately, NSW Health shall ensure that high-risk psychiatric patients are not managed in a non-psychiatric ward without prior consultation with the Area Clinical Director of Mental Health.

DOCUMENTATION

19. By July 2004, Area Health Services shall ensure that the requirements of MH-OAT protocols are met so that standards of documentation are improved, especially with regard to
    - the recording of critical information
    - the recording of handover information
    - information received from families
    - legibility and
    - consistency in the recording of author, position title, date, and times of observation.

20. By the end of 2004, Area Health Services shall ensure that preceding case records of patients presenting to Emergency Departments with a mental health problem are routinely available to the treating clinician at the time of assessment, so that re-presentations are recognised and included as part of the assessment.

CLINICAL PRACTICE AND CARE

21. By the end of 2004, Area Health Services shall ensure that once acute mental health pathology is identified in any patient presenting to a health facility, consultation with the most senior mental health clinician occurs and involves a formal assessment as soon as possible, and not later than 24 hours of admission to inpatient care.

22. By July 2004, and consistent with the principles of child protection, Area Health Services shall ensure that all patients with active mental health pathology are asked basic questions about their children at assessment, discharge and follow-up, and their answers recorded. Questions will include, for example, the children's ages, where they are currently and how the patient is coping with them.

23. By July 2005 NSW Health shall develop statewide evidence based clinical guidelines and mandated behaviours pertaining to the admission of mental health patients assessed as being at risk of self -harm and/or violence to others. These will be developed in consultation with clinicians and consumers and will include consideration of
    - levels of staffing
    - levels of security of accommodation
    - frequency of observation
    - aspects of more restricted care in early days of admission, which may include no leave and supervised medication dosing
    - timing of review and follow up arrangements
    - post-discharge supervision of medications until stable therapeutic levels of medication are considered achieved.

24. By the end of 2004, NSW Health shall ensure that specialist services or specialised protocols that deal with dual diagnoses of mental illness and substance abuse are developed and distributed with a specific time frame for implementation and review.

25. From July 2004, Area Health Services shall ensure that in relation to high risk patients, when one of the following events occurs or is being considered:
    - major change in the level of care or supervision
    - discharge
    - follow-up
    - AWOL
    - no show
    - non-compliance

    the senior mental health medical officer responsible for the patient is consulted and a formal reassessment made.

26. By July 2004, Area Health Services shall ensure that, with assistance from NSW Health, a protocol is developed and implemented where in the case of any unresolved conflict amongst the members of the clinical team responsible for the care plan of the patient, another opinion is sought from an experienced mental health clinician. If the conflict remains unresolved, the matter will be referred to a higher authority, such as the Area Clinical Director of Mental Health. The operation of this protocol will be evaluated by 2006.

27. By the end of 2004, Area Health Services shall ensure that initial care plans of mental health inpatients includes documentation of
    - the formal assessment process and management goals
    - the identity of the senior mental health clinician with primary responsibility for the patient's care
    - the identity of the clinical team
    - the identity of the patient care coordinator and
    - the development of a time-limited management plan and a review date.

28. Effective immediately, Area Health Services shall ensure that if there is concern about a person at risk of harm from a mental health patient, or if there is evidence that the patient has identified a particular person at such risk, then clinicians must take reasonable steps to mitigate the risk, including taking steps to ensure that such persons are advised and that appropriate authorities with responsibility for protection are so advised.

29. By April 2004, Area Health Services shall ensure that high risk mental health patients will not be discharged subsequently, if it is known that they have access to firearms, until police have acknowledged that the firearms have been removed from the patient's access.

30. Effective immediately, Area Health Services shall ensure that if a patient goes AWOL or defaults on treatment, a determination of risk level by the clinical team responsible for the care of the patient occurs.

31. By the end of 2004, Area Health Services shall ensure that discharge procedures for inpatient units routinely include:
    - formal discharge plan covering conditions of discharge and any supports required
    - nominated carer
    - nominated clinician providing ongoing care
    - formal arrangements for follow up review
    - face to face communication (including video conferencing)
    - a package of written advice for the patient and the nominated carer

    and take into account the issues raised in Recommendation 22.

32. By July 2004, in the case of mental health sentinel events which have had fatal consequences the Root Cause Analysis required under Circular 2003/88 shall be led by an appropriately trained person from outside the Area Health Service where the sentinel event occurred.

33. By the end of 2004, NSW Health shall ensure the availability of video conferencing facilities to enable rural centres to access at short notice metropolitan psychiatrists and other specialist mental health staff for face-to-face interviews within their clinical network.

APPLICATION and REVIEW OF THE MENTAL HEALTH ACT

34. By April 2004, Area Health Services shall ensure that consensus is reached amongst the clinical team responsible for the care plan of the patient (or failing that, the provisions of Recommendation 26 would apply) and reasons documented before any decision is made to change the status of the patient under the Mental Health Act.

35. NSW Health shall ensure that the forthcoming review of the Mental Health Act in relation to privacy considers the importance of consultation with families, especially of patients assessed at high risk of self-harm or violence to others.

36. By July 2004 NSW Health shall obtain legal advice from the State Crown Solicitor or from another appropriate source as to the powers available to staff at a hospital to search and remove property of mental health patients admitted to hospital, and a protocol will be distributed to Area Health Services. If powers are considered inadequate, NSW Health

will commence consultation regarding the appropriate legislative changes needed to address this matter.

37. By July 2004 NSW Health shall obtain legal advice from the State Crown Solicitor or from another appropriate source as to the powers available to staff at a hospital to deal with visitors reasonably suspected of undermining or compromising treatment of a mental health patient and a protocol will be distributed to Area Health Services. If powers are considered inadequate, NSW Health will commence consultation regarding the appropriate legislative changes needed to address this matter.

EDUCATION AND TRAINING

38. By July 2005 NSW Health shall ensure that a training program is developed and provided through Area Health Services to develop the skills and knowledge of all key mental health professionals to engage with families in mental health assessments.

39. High priority shall be given to providing training to all persons involved in the care of mental health patients within a public health service, necessary to support the implementation of the recommendations of this report.

REPORTING, DATA COLLECTION AND MONITORING

40. From 2004, NSW Health shall report annually trend data for possible suicide deaths in mental health care.

41. From 2004, NSW Health shall mandate the implementation of the NSW Mental Health Client Death Report.

42. By July 2004 Area Health Services shall forward information from Root Cause Analyses to the Centre for Mental Health for centralised reporting, data collection and analysis, and the Centre for Mental Health will forward the information to the Committee to assist it undertake its duties.

43. By July 2004, NSW Health shall conduct a gap analysis of data currently collected for suicides of and homicides by patients in care, and advise the Committee and NSW Health on areas for improvement.

44. As a result of the gap analysis, if the need for additional data is evident, NSW Health shall ensure that the implementation of appropriate data collection tools is incorporated into the Root Cause Analysis process.

45. By July 2004, NSW Health and NSW Police shall develop and implement a protocol for the notification to the Committee of incidents of homicide involving a person who has had or is suspected of having recent contact with a mental health service.

RAPID RESPONSE TO SUICIDE DEATH OR HOMICIDE

46. By April 2004, Area Health Services shall make appropriate expressions of regret after a death to families and relevant support persons. The expressions should be made as soon as possible, without admitting liability and should come from the highest relevant level.

47. By July 2004 a rapid response protocol for possible suicide deaths shall by developed by NSW Health for implementation by Area Health Services and will include the following:
    - a rapid safety review to clarify the circumstances surrounding the death which may indicate a continuing safety risk
    - inform NSW Health and the Centre for Mental Health
    - offer of advice and support to the family of the deceased person
    - provision of support for staff involved in the care of the patient.

    The effectiveness of the protocol will be evaluated by 2006. A similar process will be put in place for homicide deaths, within the requirements of initial Police investigations.

CORONER'S RECOMMENDATIONS

48. By July 2004, NSW Health shall establish procedures to ensure bi-annual meetings take place between the Coroners Office and the Centre for Mental Health to ensure a closer working relationship.

49. By July 2004 NSW Health shall make available to the Coroner's office a register of persons from across the State's mental health services authorised to facilitate timely and effective consultation during and following relevant Coronial hearings.

50. By July 2005 NSW Health shall track Coroners' recommendations to enable the Centre for Mental Health to monitor their implementation and identify any barriers to implementation, to allow correction of those barriers.

FUTURE OF THE COMMITTEE

51. NSW Health shall allocate sufficient resources to enable the Committee to fulfil its functions, including the provision of permanent executive support.

RESOURCES

52. High priority should be given to providing additional budget necessary to implementing the recommendations in this report.