NSW Government's Interim Response to Tracking Tragedy (2007)

3rd Report of the NSW Mental Health Sentinel Events Review Committee

INTRODUCTION

The Minister for Health established the Mental Health Sentinel Events Review Committee in 2002 as a ministerial advisory committee to provide an independent review of deaths in which clients of public mental health services were involved as suicide victims or as suspected perpetrators of homicide.

The Committee's objectives are to identify systemic problems and advise on opportunities for improving the safety and quality of service delivery for consumers of mental health services and the wider community. It produced its first Tracking Tragedy report in 2003 and its second report in 2005.

The Committee has now produced its third Tracking Tragedy report – *A systemic look at homicide by mental health patients and suicide deaths of patients in community mental health settings.* I thank the Committee for its important work. The NSW Government appreciates the Committee's contribution to improved quality and safety in NSW mental health services and welcomes this opportunity to provide an interim response to the Committee's recommendations.

The third Tracking Tragedy report focuses on suspected suicide deaths of consumers of NSW community mental health services who were receiving care for a depressive disorder. The Committee also looked into homicides during 2005-06 that involved mental health consumers.

In so doing, the Committee has acknowledged that suicide deaths of mental health consumers are rare, given the many thousands of people with serious mental illness who are consumers of mental health services in NSW. Homicide cases involving mental health consumers are much rarer again. It is also important to recognise that suicide rates have been dropping across Australia in recent years, and that NSW has the lowest rate of all States and Territories.

The Committee in its third report makes sixteen recommendations for systemic improvements. In making the recommendations, the Committee has focussed on the assessment and management of risk of violence among mental health patients and standards of care provided to consumers of community mental health services referred for care in relation to depressive disorders.

NSW Health and Area Mental Health Services are committed to continuous improvements for the mental health consumers in their care. Implementation of the recommendations of the earlier Tracking Tragedy reports has contributed to number of service enhancements.

In 2006 the NSW Premier announced a major increase of funds to mental health services - $939 million over five years. This investment is directed to the significant expansion of services including an additional 300 acute and non-acute mental health beds and a boost to the mental health workforce capacity. These increases in acute bed numbers, supported by additional non acute and community care support services will provide greater flexibility in the mental health system and optimise access to the most suitable level of care at the right time.

NSW Health has been working actively to improve the range, quality and safety of mental health services, including community mental health services, across the State. A number of structural initiatives set in place since the second Tracking Tragedy report in 2005 aim to contribute to improved patient safety and clinical quality.

These initiatives include the formation of the Mental Health Clinical Advisory Council, established to provide broad clinical expertise to contribute to improved standards of clinical practice and quality of care. Matters currently being dealt with by the Council include some of the earlier Tracking Tragedy recommendations, and physical health care guidelines for mental health consumers.

The NSW Government's interim response provides initial comments on the recommendations made in the third Tracking Tragedy report. The Government will consult widely with Area Health Services, the Mental Health Program Council and its subcommittees, and other stakeholders in the preparation of its final response. I expect to make the Government's final response to the report available within six months.

The NSW Government is committed to the provision of safe, high quality services for people in our community with serious mental health problems and commends the NSW Mental Health Sentinel Events Review Committee's contribution to this objective.

Paul Lynch MP
Minister Assisting the Minister for Health (Mental Health)

INTERIM RESPONSE TO RECOMMENDATIONS

REPORTING AND REVIEW SYSTEMS

Recommendation 1

NSW Health gives priority to expediting the full implementation of recommendations of previous reports of the Committee. In particular, a standardised framework for the assessment and management of risk of harm to others should be implemented as an immediate priority.

This recommendation is supported.

Progressive Implementation of earlier *Tracking Tragedy* Recommendations

The two earlier Tracking Tragedy reports looked into the suicide deaths of mental health patients of adult mental health inpatient units, and those recently discharged. Each Report also reviewed a small number of homicides involving mental health patients. The NSW Government accepted 51 of the 52 recommendations from the first Tracking Tragedy report, and each of the 24 recommendations of the second Report. The process of implementing these recommendations has involved broad and complex systemic enhancements across the NSW mental health service system and within the wider health service system.

Overview of progress

Forty-nine of the fifty-one recommendations from the first Tracking Tragedy Report have been addressed. Full implementation of a few of those recommendations is dependent on action more broadly across the NSW Health system, or are ongoing activities. These include:

- The development of complex information technology and statewide data exchange systems, for which Mental Health is leading the way, are dependent on new data record systems and wider IT developments becoming operational across all NSW Health services.
- The ongoing review and improvements in the Mental Health Assessment and Outcome Tools (MH-OAT) is a major project that is continuing with a view to standardising and improving the quality of clinical communication and documentation.
- Statewide comprehensive discharge policy and guidelines for Adult Mental Health Inpatient Services have been developed to incorporate the requirements of the new Mental Health Act (2007), other recent NSW Health policies, and the interests of interagency stakeholders. The process has also been informed by coronial recommendations and those of Health's investigations of serious incidents within mental health services. The discharge policy is due for release in October 2007.

Twelve of the twenty-four recommendations of the second Tracking Tragedy Report had been fully implemented by March 2007, while action to address the remainder is progressing. As an outcome of the second Tracking Tragedy report, the Mental Health Clinical Advisory Council was established with

membership from Area mental health clinicians from a range of disciplines. Three recommendations were referred to this committee for expert advice, and for input to the development of clinical standards as recommended In the Tracking Tragedy report. This advice will be reported in the Final Government Response due within 6 months of the release of the third Tracking Tragedy Report.

The assessment of risk of violence to others is a core component of any mental health assessment. NSW Health is enhancing the capacity to assess and manage risk of harm to others through an initiative led by Justice Health, a specialist Unit of NSW Health.

The NSW Government allocated $480,000 to Justice Health for the delivery of a state-wide training program for Area mental health professionals working with patients who may be at risk of violence towards others. Initially it is expected that 100 clinicians will be trained and will form a cohort of clinicians who are accredited in the application of empirically supported risk assessment tools, and specifically accredited to work with forensic and high risk mental health consumers in the assessment of risk for violence and aggression.

Justice Health has forensic mental health specialists who will provide the training and ongoing supervision to clinicians entering the program. This will include supervision in clinical situations to ensure that learning has been incorporated into clinical practice.

Future Role of the Committee

Recommendation 2

The Minister for Health extend the Terms of Reference of the NSW Mental Health Sentinel Events Review Committee to include the review of events associated with the incidents involving serious injury to or the death of a person in circumstances where a person in the care of public sector Drug and Alcohol Services commits or is closely associated with the sequence of events that led to the incident.

This recommendation will be considered in the context of the future role of the Committee.

NSW Health recognises that serious mental health problems and drug and alcohol misuse are frequently occurring comorbidities. Since February 2007, NSW Health's mental health and drug and alcohol policy areas have been incorporated in a new single structure the Mental Health & Drug & Alcohol Office to support better understanding, integration and referral practices for clients of Area Health Services.

Service Standards

The Committee made six recommendations that refer to the development of service standards.

These recommendations cover Community Mental Health Service documentation where the Committee considers that clinical practice has not adequately met national standards, clinical guidelines or NSW Health policies.

These issues have been referred to the Mental Health Clinical Advisory Council to consider the recommendations to provide advice.

Recommendation 3
NSW Health develop strategies and allocate resources to increase the compliance with the recording of standardised measures of patient outcomes.

Recommendation 4
NSW Health develop and implement a service standard for the treatment of depression.

Recommendation 5
NSW Health as a matter of urgency develop a process for ensuring that all patients of mental health services have a full medical history recorded at least annually while in active care.

Recommendation 6
NSW Health develop and implement a process which identifies and records for each patient of a mental health service a senior clinician responsible for ensuring that appropriate service standards are met, including the maintenance of the required standard of medical record documentation.

Recommendation 7
Area Health Services undertake at least twice yearly audits of active clinical files to assess adherence to the service standard of treatment of depression, and these audits should be signed off by the responsible clinician.

Recommendation 8
Area Health Services ensure that no patient of a community mental health service is discharged without a signed approval of the responsible clinician following review and confirmation that the appropriate service standard was met.

Involuntary Detention and Assessment

Recommendation 9
NSW Health commence work on the development of guidelines for involuntary detention and assessment under the revised Mental Health Act, ensuring that the guidelines address in their application the education of clinicians and the regular monitoring of clinicians' practice.

This recommendation is supported.

The Mental Health Act 1990 and the Mental Health Act 2007 prescribe the same set of specific criteria to be considered in determining whether a person is a mentally ill or mentally disordered person. In the implementation of the 2007 Act, education and training will be conducted for clinical staff to ensure an appropriate level of understanding of these criteria. For example NSW Health maintains a Mental Health Act Guidebook which provides clinicians step-by-step advice on the criteria and process for involuntary admission.

Recommendation 10
NSW Health ensure that the guidelines for involuntary detention and assessment under the revised Mental Health Act include guidelines for early communication and exchange of information between the health service and NSW Police.

This recommendation is supported

This recommendation is addressed in the Memorandum of Understanding (2007) between NSW Health, Ambulance Service of NSW and NSW Police Force which was signed in July 2007. The MOU provides a framework for the effective management of people with a mental illness or mental disorder where more than one of the agencies is involved and defines clear roles and mechanisms for timely communication. The implementation of the MOU will involve the development of local interagency agreements.

Cross-Jurisdictional Care

Recommendation 11
NSW Health, in consultation with Area Health Services, develop and implement a process to ensure continuity of care when care is being transferred across jurisdictions, including State borders.

Recommendation 12
NSW Health implements a process to ensure the recognition and transfer of a Community Treatment Order within and across State jurisdictions.

This recommendation is supported

These recommendations focus on those Community Mental Health consumers who have formal treatment orders and where cross-border issues or other cross-jurisdictional issues are relevant.

In accordance with undertakings given under the National Mental Health Strategy all States and Territories have agreed to work towards the making of arrangements for portability across borders of involuntary inpatient and community treatment orders. Not all jurisdictions have legislative capability for this at present.

NSW has completed formal Interstate Agreements with Victoria and the Australian Capital Territory and they have been operational for some time. An agreement is currently under negotiation with Queensland.

Court Referrals

Recommendation 13

NSW Health, in consultation with Area Health Services, develop procedures for the assessment and follow up of persons referred by the Courts that ensure that:

1. minimum standards of report writing and documentation include:
   - a thorough psychiatric examination\a physical examination
   - corroborative history
   - a formal risk assessment
   - a management plan, and notation of case discussion/s with the senior clinician;
2. outcomes are communicated back to the Courts and to other relevant service providers.

This recommendation is supported

The NSW Government agrees with the Committee's view that where the Court makes referrals for psychiatric assessment and management, a high standard of assessment, management and documentation is required. Over the past three years, NSW Health has initiated several measures to enhance and further resource services for people referred by the justice system.

These measures include the formation of a state-wide Court Liaison Service operated by Justice Health in seventeen magistrates' courts. In addition, local Area mental health services provide liaison services at Port Macquarie, Newcastle and Wollongong courts. Under this initiative senior mental health clinicians located at courthouses assist the Court by providing initial screening and a verbal report to the Court on the referred person's mental health status. The Court then determines whether to refer the person to an Area Mental Health Service for further assessment and management under S32 or S33 of the Mental Health (Criminal Procedure) Act 1990. If the Court refers a person charged with an indictable offence for assessment, a psychiatrist will provide a full assessment at the place of custody.

Additional support measures for Area mental health services include the provision of support and advice by Court liaison clinicians involved. Specific training has also been introduced for Area mental health clinicians to enhance their risk assessment and management skills when dealing with this patient group, and to improve their understanding of the Court's requirements. These initiatives are continuing and will facilitate the requirements of this recommendation.

Implementation of this recommendation may also be influenced by the outcome of a review of S32 and 33 of the Mental Health (Criminal Procedure) Act 1990 which is currently being undertaken by the NSW Government.

Education and Training

Recommendation 14

NSW Health commence work immediately with professional bodies to develop and implement training guidelines regarding the diagnosis of malingering and the application of the diagnosis, particularly where mental illness and criminal charges co-exist. As minimum provisions these guidelines should include that:

- a conclusion of malingering should be reached only after a second opinion is sought, and
- a diagnosis of malingering per se should not be the basis for excluding a person from care by a mental health service,

This recommendation is supported

NSW Health will consult with the Royal Australian and New Zealand College of Psychiatrists and the Mental Health Program Council in relation to this recommendation and report on the outcome in the full Government Response Report due within 6 months of the release of the third Tracking Tragedy Report.

Firearms

Recommendation 15

The Minister for Health request the Attorney General to review urgently the utility of existing police powers to seize firearms from persons suffering from or reasonably suspected of suffering from mental illness.

The recommendation will be referred to the Attorney General as recommended by the Committee and the NSW Police Force.

Discharge and Follow up

Recommendation 16

NSW Health put in place a mechanism that ensures, that for high risk patients who have required involuntary admission and are referred on discharge to another care provider:

- a recommended period of follow up is specified;
- at least one subsequent communication is made to ensure that contact with the new provider has occurred.

This recommendation is supported

The requirements of this recommendation have been included in the Adult Mental Health Inpatient Discharge Planning policy; the follow-up guidelines in the Framework for Risk of Harm to Others; and the existing mechanisms and requirements under the Mental Health Act to promote safety and an

appropriate level of care for consumers who have been identified as being at risk of harming others.

The current NSW Mental Health Act 1990, and the yet–to-be proclaimed Mental Health Act 2007, both provide for the making of Community Treatment Orders. These orders allow for involuntary treatment to continue upon discharge of patients into the community. They are aimed both at ensuring the maintenance of necessary treatment and providing for a period of contact between the patient and the community mental health service in which a therapeutic alliance can develop.