NSW Mental Health Sentinel Events Review Committee

Tracking Tragedy

A systemic look at homicide by mental health patients and suicide death of patients in community mental health settings

Third Report of the Committee

May 2007

“…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

Contents

Part	Page
List of Tables and Figures	
Executive Summary	i
Recommendations	ix
1 Introduction ❑ The NSW Mental Health Sentinel Events Review Committee ❑ Terms of Reference ❑ Committee Structure, Tasks and Methods ❑ NSW Government Response to Tracking Tragedy (First Report of the Committee) ❑ NSW Government Response to Tracking Tragedy 2004 (Second Report of the Committee)	1
2 Context	11
3 Review of Suicide Death in Persons Receiving Community Treatment for Depression ❑ Key Findings ❑ Summary of Findings ❑ Introduction ❑ Methods ❑ Details of the Sample ❑ Assessment ❑ Initial Treatment ❑ Continued Treatment ❑ Reflections on the Rating Criteria ❑ Other Aspects of Care ❑ Details of Suicide Death	19
4 Analysis of Homicide Cases ❑ Key Findings ❑ Introduction ❑ Demographic and Risk Factors ❑ Report of Case Analyses	71
5 Monitoring Recommendations	91

Part	Page
Appendix	115
❑ Members	
❑ Privilege	
❑ Meetings	
Glossary	123
References	129

List of Tables and Figures

Table		Page
1	Stage of Care by Operational Criteria	31
2	Type of record by number of cases	33
3	Demographic Data	35
4	Source of referral by number of cases	36
5	Reason for referral by number of cases	37
6	Past psychiatric contact and suicide attempts by number of cases	37
7	Assessment Stage: CPG and review criteria	38
8	Assessment Stage: Diagnosis at assessment by number of cases	39
9	Assessment Stage: Co-morbid diagnosis at assessment by number of cases	40
10	Assessment Stage: Aspects of medical history at assessment by number of cases	40
11	Assessment Stage: Factor documented by profession	41
12	Assessment Stage: Stressors, supports and coping style by number of cases	42
13	Assessment Stage: Documentation of suicide risk at assessment by number of cases	43
14	Assessment Stage: Documentation of past suicide attempts by number of cases	44
15	Assessment Stage: Documentation of corroborative history by number of cases	44
16	Assessment Stage: Documentation of child safety issues by number of cases	44
17	Assessment Stage: Use of standardised measures of severity by number of cases	45
18	Initial Treatment Phase: CPG criteria by operational criteria for file review	49
19	Initial Treatment Phase: Number of treatment contacts, by treatment groups	50

List of Tables and Figures *continued*

Table		Page
20	Initial Treatment Phase: Clinical alliance, by number of persons	51
21	Initial Treatment Phase: Factors documented, by number of persons	51
22	Initial Treatment Phase: Antidepressant medications prescribed, by number of persons	52
23	Initial Treatment Phase: Adjunctive medications prescribed, by number of persons	53
24	Initial Treatment Phase: Specific psychological treatment documented, by number of persons	54
25	Initial Treatment Phase: Monitoring during initial treatment, by number of persons	55
26	Continued Treatment Phase: CPG criteria and operational criteria for review	59
27a	Continued Treatment Phase: Depression severity by no. of persons	60
27b	Continued Treatment Phase: Depression course by no. of persons	60
28	Continued Treatment Phase: Severity at 3 months by variation in medication	61
29	Continued Treatment Phase: Course at 3 months by variation in medication	61
30	Other Aspect of Care: Communication and discharge planning, by number of persons	66
31	Other Aspects of Care: Reported suicide deaths and community MH funding, by least and best-funded Area Health Services	68
32	Other Aspects of Care: Reported suicide deaths and rurality, by rural/regional and metropolitan Area Health Services	69
33	Details of Suicide Death: Method of suicide death, by number of persons	70
34	Details of Suicide Death: Time from last contact to suicide death	70
35	Demographic and Other Factors (Homicide cases)	78
Fig.1	Number of patients proceeding through the stages of care for depression	34

Executive Summary

NSW Government Response to Tracking Tragedy 2004 (Second Report of the Committee)

The NSW Mental Health Sentinel Events Review Committee (the Committee) determined that in order to evaluate its work and to assist in preparing future reports, it required advice from the Department of Health on progress with the implementation of the recommendations, including the requested timeframes. Accordingly, the Chairman asked the NSW Department of Health on behalf of the Committee to provide progress reports on priority matters for implementation.

The NSW Government Response to Tracking Tragedy 2004 (Second Report of the Committee) was released in December 2005. All the recommendations were accepted. The Committee noted the advice that the vast majority of recommendations were implemented or that implementation was ongoing.

Overview of the Third Report of the Committee

The Committee continues its work to review independently and report on incidents involving serious injury to or the death of a person, where a person experiencing mental illness is involved, in circumstances where a public sector agency was involved in that person's care, management or control. The Committee reviews aggregate data on such events and provides advice on a systemic basis with a view to the improvement of the care of persons experiencing mental illness, and a decrease in the morbidity or mortality of such persons.

While considering suspected suicide death of persons in contact with mental health services, it is important to acknowledge that most suicides in NSW occur in people not in contact with mental health services. Arguably the greatest scope for improved prevention of suicide may lie with strategies aimed at increasing access for people with mental health problems to mental health services.

Mental health services in general do a very effective job of managing people with severe mental illness, preventing many incidents of minor and major self-harm, and violence towards others. While the Committee recognises that tragic events such as suicide death and homicide are not necessarily predictable, its findings indicate that a level of accountability nevertheless must be accepted by all those involved in the provision of mental health services.

At times, the Committee observed poor clinical systems and standards of practice. The development of clinical systems and standards is a complex task requiring scientific and policy input, and extensive consultation with professional groups and consumers. The Committee has attempted to avoid defining specific clinical standards or methods, instead recommending that NSW Health should take responsibility for the management of such strategies where they are necessary.

The Committee accepts that in some circumstances, the setting of a minimum standard may pose immediate practical and resource issues. It is not possible to plan for an effective mental health system without articulating some minimum standards that the system should be designed, and resourced, to achieve.

The Committee's recommendations are a representative view, but not the only possible view, of the issues involved and are not intended to be absolute or non-negotiable. The spirit and intent of the recommendations may be met in a number of ways, for example by combining several recommendations into broader policy initiatives, or by evaluating these approaches through piloting and refinement rather than through immediate statewide implementation.

The implementation timeframes incorporated in the recommendations of this Report reflect the Committee's concern about the issues raised and its view of the urgency with which these matters should be addressed.

Review Of Suicide Death in Persons Receiving Community Treatment for Depression

The review this year focussed on people receiving community care for depression. The quality of care of depression was examined as measured against the Australian and New Zealand Clinical Practice Guidelines for Depression (ANZ CPGs), developed by the Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Depression. These guidelines provided a valuable framework for the review, and while they may change over time, provide the best framework available at present.

This review asked the question: For people receiving care for a depressive disorder who died by suspected suicide, to what extent did NSW Mental Health Services provide assessment and treatment which were in line with that suggested by the ANZ Clinical Practice Guidelines for treatment of depression?

The Committee's particular focus has been on review of clinical documentation, including case files and additional reports such as Coronial reports and critical incident reviews. As in previous years, the Committee briefed an external experienced medical file reviewer to review clinical documentation, and based its conclusions on this review. Also as in previous years, it has not been within the scope of the Committee's methods to commission a study of a comparison or control group.

Summary of findings

- One hundred and thirteen (113) clients were included in the review. Most (75%) had a past history of contact with mental health services and of past suicide attempts (71%).
- Assessments were mainly conducted by mental health nurses (80%) and psychiatry registrars (48%). Around two-thirds of assessments were neither seen by nor discussed with a psychiatrist.
- Most files (92%) documented an assessment of risk, mainly using the MHOAT A1 form.

- Most files included documentation of past medical history (95%), medications and adverse drug reactions (99%), past suicide attempts (90%) and the person's supports, stressors and coping styles (99%).
- There were some significant gaps in assessment documentation:
  - The subtype and severity of depression were not recorded in more than 70% of files;
  - Physical examination was recorded in only 5% of files;
  - In around half of files where a person was identified as a parent, child safety was not documented;
  - Corroborative history was only recorded for around one third of people living with their families;
  - Standardised measures of depression severity were used in only one fifth of files.
- Treatment provided was of brief duration. Fifty nine percent (59%) of clients received only one or two contacts. Even those continuing in care for three months averaged just over one contact per month. Around one third had only one or two contacts in the first three months of care.
- Medication was the main treatment modality. All persons received antidepressants, primarily Selective Serotonin Uptake Inhibitors (SSRIs, 52%) and Venlafaxine (25%). Around one third received adjunctive antipsychotic agents or mood stabilisers. Only 42% of persons received any documented psychological treatment.
- Monitoring of medication and side effects was documented in more than half of files, but risk monitoring in ongoing treatment was documented in only 27%.
- Communication with GPs was poor. Of those referred by a GP, 18% had evidence that history had been sought from the GP. Only 21% had any documented communication back to the referring GP on discharge from care.
- Persons continuing in care at three months were mainly reviewed by senior staff, and their care was mainly consistent with the ANZ CPGs.
- Some clinical notes remain complex and fragmented; in up to 10% of files it was difficult to determine whether the person was an active patient of a mental health service and/or whether further care was planned.

Clinical care and service system capacity

Of the 15,000 – 30,000 persons with depression assessed or treated each year by NSW public mental health services, data from this review suggest that around 1 in 1000 are reported to have died by suspected suicide during or after that treatment. The "true" rate of suicide death in this group cannot be known until better systems for detection and reporting of suicide death are implemented. However, it is clear that the vast majority of persons assessed and treated for depression do not have suicide death as an outcome.

This review may suggest that the typical community mental health service model provides limited support for the effective treatment of depression. In a number of cases assessment was conducted by nurses or registrars, with limited involvement of other senior medical or nursing staff and almost no involvement of psychologists. This was often followed by brief treatment focusing on medication rather than psychological intervention. Communication with families and GPs was poor.

Better service models may involve clearer roles for senior staff in assessment or consultation earlier in assessment and treatment, more systematic use of specific psychological interventions, and processes to support communication with other service providers and with the individual's family or supports. Such systems may require additional resources and additional training, but training and resources alone are unlikely to translate into better care without a broader approach to building capacity for treatment of depression.

Could some of these suicide deaths have been prevented?
Other systematic reviews of suicide[1] and previous work of this Committee suggest that around a third of suicides may realistically have been preventible with more optimal care. This review identified some apparent departures from the components of care recommended by the ANZ CPGs. Care that differs from that recommended by the ANZ CPGs is not necessarily ineffective or inappropriate. However, it is reasonable to assume that in a proportion of the cases reviewed, different care may have resulted in a different outcome. All health systems should aim continuously to improve care and minimise preventable death. Those aspects of care where there appear to have been the greatest departures from the ANZ CPGs may be useful starting points in considering such clinical improvement strategies.

Analysis of Homicide Cases

Introduction
The work of the Committee during 2005 -06 included the analysis of cases of homicide committed by persons who were receiving care or had recently received care from NSW public mental health services. The Committee focused on the standards and processes of care with a view to making recommendations in relation to systemic issues, as illustrated by the analysis. In this respect, these tragic incidents serve as a window onto the standards and delivery of care by our public mental health services.

The invaluable information and insight made available through external review reports for a number of these incidents assisted the Committee's analysis of these events. The Committee notes the introduction of Root Cause Analysis (RCA) by all Area Health Services and the quality of RCA reports is expected to improve. However, the Committee was again hampered in its work by the poor level of documentation of incident reviews performed by some Area Health Services. Frequently the detail of the information available through the RCA reports was scant, often insufficient to allow testing of whether all concerns or issues in the case had been captured in the summary findings and recommendations of the RCA.

For this Report the Committee had the benefit of access to the medical record in most cases. Analysis of the medical record was led by one of the Committee's clinicians in each case that this material was available. The Committee's general approach in reviewing sentinel events is to examine the systems issues and make

[1] UK National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. *Avoidable Deaths. Five Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*; The University of Manchester; 2006.

recommendations that will improve the delivery and processes of care within NSW Health Services.

Summary of findings
Ten cases were referred to the Committee. One case was excluded from analysis because the incident did not involve patients of the mental health service.

Two of the nine cases analysed involved the deaths of children. Three cases were homicides associated with suicide death or attempted suicide. Eight cases involved the killing of a family member or close acquaintance of the perpetrator. Eight of the perpetrators were men. There was a history of recent substance abuse, mainly cannabis and amphetamines, in seven cases. In five cases the perpetrator was homeless and/or itinerant.

Although this series is small these findings are a matter of concern. It was also noted that pressure on acute bed places was a factor in three cases being discharged earlier than would have seemed clinically appropriate.

The Committee developed a number of recommendations from the analysis of the nine case histories. These covered the key areas of

- Standards for scheduling and guidelines for early contact with police
- Risk assessment and management
- Transferring care across services and jurisdictions
- Assessment of persons referred by the courts
- Gun licences
- Assertive follow up of patients with continuing high risk
- Quality of documentation.

Recommendations

Recommendation	Commence	Implement	Page
Implementation of Recommendations			
1. NSW Health give 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.	Immediate	6 months	9, 83
Future Role of the Committee			
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 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.	Immediate	6 months	16, 77
Service Standards			
3. NSW Health develop strategies and allocate resources to increase compliance with the recording of standardised measures of patient outcomes.	Immediate	12 months	45
4. NSW Health develop and implement a service standard for the treatment of depression. This should address, but not be limited to: ▪ the use of standardised and structured tools suitable for use in depression; ▪ documentation of physical examination and specific diagnosis; ▪ documentation of parental responsibility and child risk assessment; ▪ access to or discussion with senior clinicians; and ▪ access to psychological treatments.	6 months	12 months	46
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.	Immediate	12 months	47

Recommendation	Commence	Implement	Page
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.	Immediate	12 months	58, 90
7. Area Health Services undertake at least twice yearly audits of active clinical files to assess adherence to the service standard for the treatment of depression, and these audits should be signed off by the responsible clinician.	6 months	12 months	58
8. Area Health Services ensure that no patient of a community mental health service is discharged without the signed approval of the responsible clinician following review and confirmation that the appropriate service standard was met.	Immediate	6 months	67
Involuntary Detention and Assessment			
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.	6 months	6 months	81
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.	6 months	6 months	81
Cross-jurisdictional Care			
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.	6 months	12 months	84

Recommendation	Commence	Implement	Page
12. NSW Health implement a process to ensure the recognition and transfer of a Community Treatment Order within and across State jurisdictions.	6 months	12 months	84
Court Referrals			
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.	Immediate	6 months	86
Education and Training			
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.	Immediate	12 months	86
Firearms			
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.	Immediate	6 months	87

Recommendation	Commence	Implement	Page
Discharge and Follow up			
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.	Immediate	12 months	88