

Part 1

Introduction

The NSW Mental Health Sentinel Events Review Committee

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

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

Introduction

The NSW Mental Health Sentinel Events Review Committee

The New South Wales Mental Health Sentinel Events Review Committee (the Committee) was established in response to an urgent need for an independent body to review and report on morbidity and mortality issues associated with incidents relating to the care, management and control of persons suffering from a mental illness, and on any future sentinel events.

The Minister for Health established the Committee on 27 May 2002 by Order of authority under section 23 of the Health Administration Act 1982, as to Specially Privileged Information. It was established as a Ministerial Advisory Committee pursuant to section 20(4) and (6) of that Act, and is comprised of Ministerial appointees who represent a selection of consumer, carer and professional groups.

The Committee reports directly to the Minister for Health through the Chairman. Its first report entitled *Tracking Tragedy – a systemic look at suicides and homicides amongst mental health inpatients* was submitted to the Minister and released in December 2003. The Committee's second report, entitled *Tracking Tragedy 2004 – a systemic look at homicide by mental health patients and suicide death of patients recently discharged from mental health inpatient units* was submitted to the Minister for Health and released in April 2005.

The terms of reference, membership and objectives are reviewed on a regular basis to determine whether the Committee should continue activities under the same conditions. Modifications to the terms of reference of the Committee and membership require the approval of the Minister. The terms of reference were modified with the approval of the Minister for Health in November 2005.

The current term of appointment to the Committee is up to and including 29 February 2008.

Terms of Reference

1. To review Sentinel Events (that is, events associated with an incident involving serious injury to or the death of a person, where a person suffering or reasonably believed to be suffering from mental illness is involved, commits or is closely associated with the sequence of events that led to the incident);
2. To review Sentinel Events involving the death of a person suffering or reasonably believed to be suffering from mental illness, in circumstances where a public sector agency was involved in that person's care, management or control;
3. To generally advise the Minister for Health and the Department of Health on means to minimise or prevent such Sentinel Events;
4. Without limiting the generality of paragraph 3, the NSW Mental Health Sentinel Events Review Committee ("the Committee") will -
 - (a) review aggregate data on Sentinel Events which have had fatal consequences and examine the events or circumstances surrounding such deaths;
 - (b) identify factors which might have prevented such fatal Sentinel Events and make policy recommendations for the prevention of such events;
 - (c) provide advice on clinical policy issues relating to the morbidity and mortality of persons suffering from mental illness, arising from matters coming to the Committee's attention from public sector agencies;
 - (d) provide advice on a systemic basis to public sector agencies on matters arising from the consideration of fatal Sentinel Events with a view to the improvement of the care of persons suffering from mental illness or a decrease in the morbidity or mortality of such persons; and
 - (e) contribute expertise to the preparation of regular reports of aggregate data on Sentinel Events and morbidity or mortality trends in persons suffering from mental illness.
5. The Committee will report directly to the Minister for Health through the Chairman of the Committee.

Committee Structure, Tasks and Methods

The Committee is comprised of two sub-committees, the Homicide Sub-Committee and the Suicide Sub-Committee, which meet and report separately to the Head Committee through their Chair in respect of their progress. The Committee determined that the work of the sub-committees will continue in 2007.

Since the Committee's establishment the Department of Health has made recommendations to the Minister for Health with regard to membership changes due to resignations and retirements and also with regard to the need to enhance clinician representation. The recommendations were accepted by the Minister and new appointments approved in 2004, 2005 and 2006. In 2006 the senior clinician membership was enhanced with the inclusion of an addictions medicine specialist to assist in addressing matters where substance misuse or dependence may have been a contributing factor to a sentinel event (see Appendix).

The Committee's reviews are restricted to systemic analyses. It does not address the practices of individual clinicians or the mental state of clients at the time of the sentinel event. However when analysing emerging cases the opportunity arises to report on individual cases, and to bring them to the attention of the Coroner, Health Care Complaints Commission and relevant professional registration boards if appropriate. It remains the role of the Committee to review incidents, identify systemic issues and to refer on any cases of gross incompetence.

Suicide Sub-Committee

The Suicide Sub-Committee reviews suspected suicide deaths of patients of public health facilities who were suffering or reasonably believed to be suffering from a mental illness, reports on trends and makes recommendations to the Head Committee.

Cases for review are identified from Department of Health Mental Health Service Client Death Reports from which NSW Health records the demographics of suspected suicide deaths of patients of mental health services. **Until confirmed by Coroner's investigation, a reported suspected suicide death remains unconfirmed. It is important to note that Client Death Reports notify cases of suspected or possible suicide death that must be confirmed by coronial investigation.**

The Sub-Committee classified suspected suicide deaths into four general categories to assist in developing an approach to the identification of risks associated with those deaths:

1. Inpatient deaths (including deaths within public mental health facilities, deaths of patients on leave and deaths of patients who had absconded – AWOL)
2. Post-discharge deaths (death occurred within one month of discharge from an inpatient facility)
3. Community outpatient deaths (those who have had an interface with community)

- mental health services)
4. Non-contact deaths (where the suicide victim did not have a known interface with any mental health service).

While it is likely that the cases of suicide victims who had no prior contact with health services would be outside the terms of reference for the Committee, the Committee considered it important to keep a watching brief, in the event that a link may be established 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.

In 2003 the Suicide Sub-Committee reviewed the suspected suicide deaths in the previous five years of clients of public health facilities who were suffering or reasonably believed to be suffering from a mental illness, to reported on trends and made recommendations based on a review of cases.

In 2004 the Sub-Committee reviewed, reported and made recommendations on the clarity of the discharge process and the effectiveness of the transfer of care.

In 2005 and 2006 the Sub-Committee considered cases of people suspected to have died by suicide while receiving community mental health care, with a focus on the treatment of depression.

Homicide Sub-Committee

Harm minimisation in a risk management environment is the philosophical basis for the Homicide Sub-Committee's work and its subsequent recommendations, which therefore focus on minimising potential causes and on systemic analysis.

In 2003 the Sub-Committee analysed case reviews of homicides that took place in 1999 - 2002, involving clients of public mental health facilities who were suffering or reasonably believed to be suffering from a mental illness.

In 2004 the Sub-Committee analysed case reviews of six homicides that occurred in 2002 to January 2004. The Sub-Committee looked specifically at systemic issues around child deaths caused by adults with a mental illness, as a sub-group of homicides.

In 2005 and 2006 the Sub-Committee analysed cases which occurred from 2004 to 2006, including new cases as they arose. In any year the coronial process will influence the number of cases available for analysis.

Sources of information

Documentation available to the Sub-Committees includes:

- NSW Health Department Mental Health Service Client Death Reports
- Reportable Incident Briefs
- Area Health Service case files, including inpatient records, and community mental health records
- Root Cause Analyses
- External and Internal reviews, including Critical Incident Reviews
- Police Records
- Coroners Reports
- Coroners Recommendations

Area Health Service case files are matched with reports from the Office of the State Coroner, including Police Records, Briefs of Evidence and Coroners findings or opinions where these are available.

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

The First Report of the Committee, *Tracking Tragedy – a systemic look at suicides and homicides amongst mental health inpatients* was submitted to the Minister for Health in December 2003.

The NSW Government Response to the First Report of the Committee was released in December 2004. All but one of the 52 recommendations of the First Report were supported. The exception was not accepted because of its current form, although its underlying purpose and objective were acknowledged. The Committee noted the advice that the vast majority of recommendations were implemented or that their implementation was ongoing.

The Implementation Taskforce established as part of the Government's response to the Upper House Select Committee Report on Mental Health also oversees the implementation of the Committee's recommendations.

The Committee determined that in order to evaluate its work and to assist in preparing future reports, it required advice from NSW Health on progress with the implementation of the recommendations, including the requested timeframes. Accordingly, the Chairman asked the NSW Department of Health to provide progress reports on priority matters for implementation. He also requested to be advised of any feedback from Area Health Services on the usefulness and practicality of adopted recommendations and on any barriers to their implementation. Two Progress Reports on the First Report of the Committee have been made to date: in March 2005 and in December 2005.

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

The Second Report of the Committee, *Tracking Tragedy 2004 – a systemic look at homicide by mental health patients and suicide death of patients recently discharged from mental health inpatient units* was submitted to the Minister for Health in April 2005.

The NSW Government Response to the Second Report of the Committee was released in December 2005. All the recommendations were accepted, and again the Committee noted the advice that the vast majority of recommendations were implemented or that their implementation was ongoing.

The Committee notes with concern that Recommendation 1 of the First Report and Recommendation 8 of the Second Report have not been implemented with regard to the development of a risk assessment and management framework for risk of harm to others.

The Committee recommends, accordingly, that

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.

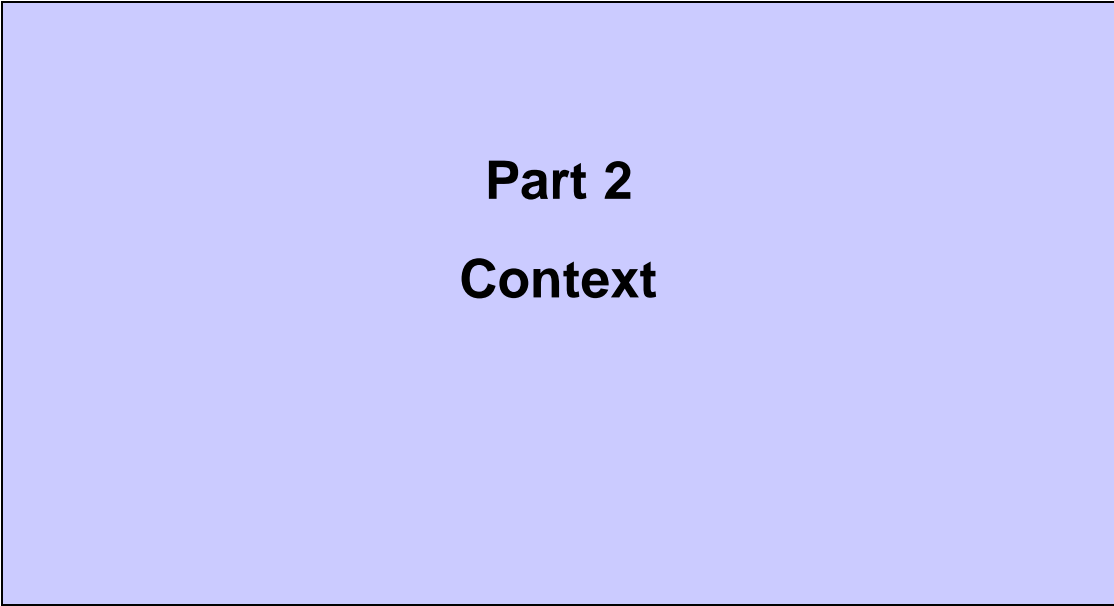
Recommendation 1

Commencement: Immediate; Implementation timeframe: 6 months

The Chairman again asked the NSW Department of Health to provide progress reports on priority matters for implementation. One Progress Report on the Second Report of the Committee has been made to date: in October 2006 covering the period from December 2005 to March 2006.

Part 5 of this Report addresses the extent that previous recommendations have been implemented in practice. This is the first Report in which the Committee has commented on the implementation of past recommendations. Its sources of information are

- NSW Government Responses to past Reports;
- Progress Reports available to the Committee at the time of writing, in which the Mental Health and Drug and Alcohol Office has monitored the implementation of the Committee's recommendations;
- members' observations.



Part 2
Context

Context

As discussed in the Second Report of the Committee, there is a common perception that a suicide death or any 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 and one of the purposes of the Committee is to review these incidents and examine systematic problems within the mental health services which may have contributed to the tragic outcome and to suggest solutions.

Issues of service capacity and unpredictability often inform the Committee's deliberations and underlie the systemic problems which become evident as a result of its analyses.

Service capacity

It is difficult to quantify the relationship between resource limitations (particularly access to inpatient beds and community mental health services, experienced psychiatrists, other mental health clinicians, and addiction medicine specialist services) and sentinel events. However, in addition to the identified difficulties in carrying out a comprehensive risk assessment, the capacity of many services to put in place risk mitigation strategies in response to the identified level of risk that would meet community expectations, while operating within available budget, is questionable.

Admission to mental health beds is widely seen as the most effective short-term risk mitigation strategy in high-risk cases. However, community-based programs are an essential component of a comprehensive mental health service, as mental health conditions that require continuing care that can be provided in the community, are those that cause the greatest disability and mortality. The Committee recognises that these are ongoing conditions that require continuing care, most of which can be provided in the community.

Community mental health services are currently undergoing much needed reform and investment. Demand has been increasing with increased substance abuse, changing social mores and population growth. A policy decision taken many years ago at government level has resulted in smaller numbers of people being in psychiatric hospitals and a lot more receiving care in the community. The Committee believes that the increased demand has led to mental health clinicians and Area Health Services having more limited options in providing adequate and appropriate ongoing care on a case by case basis. Duration of stay in inpatient units has reduced, resulting in more complex patients requiring more sustained community follow-up and assertive treatment. Whereas in previous decades it was possible to admit more easily a potentially suicidal or dangerous patient for a sustained period of containment, that option is more limited now.

As a result, it may be assumed that the risk to the community 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 most appropriate level of care is also higher.

At the same time there is a greater expectation in the broader community and by police services that people with an increased range of behavioural problems should be managed by the mental health services. It is expected that increasing numbers of persons will require care and treatment as a result of drug use, especially where that is combined with a mental illness.

Retention and other workforce issues within mental health services remain a significant concern. Nursing, medical and allied health professions continue to experience difficulties in attracting staff to mental health services. Overburdened services are unable to retain experienced staff and the increased reliance on an inexperienced workforce further erodes system confidence. Services which lack experienced clinical leadership are unable to provide adequate support and supervision to junior staff increasing the risk of poor clinical decision making. The Committee applauds the recent enhancements in funding for community-based programs, staff and training, but there remain significant resource issues inhibiting provision of effective mental health care within NSW. The Committee in its previous report addressed this issue in its recommendations.

It should be emphasised that in general, most privately funded agencies opt out of providing care to highest risk patients suffering from mental illness. Private psychiatric hospitals cannot take involuntary patients, and transfer anyone who needs involuntary care. Thus at present the responsibility for managing the most acute and at risk patients rests with the public system.

Unpredictability

Accurate prediction of homicide or suicide is difficult. Large studies have identified factors that are correlated with future risk for violence or self harm. These factors are however applicable to groups over the long term. Based on these factors it is possible to identify with reasonable accuracy groups of individuals who may pose a higher risk of violence or self harm than others. However, the difficulty for clinicians is to identify which individuals in the higher risk group will self harm or commit actual violence and to identify correctly at what period in an individual's life they are more at risk of harm to self or others.

Accurate risk assessment is reliant on the clinician identifying the type of risk (suicide, self harm, harm to others, sexual vulnerability are examples), the level of risk (high, medium, low) and the immediacy of the risk. The clinician also considers the person's capacity to cope with stressful life events and supports available to the individual. When determining the level of risk the clinician is also required to assess the degree of confidence in the assessment and likelihood that the risk may change. Risk assessment and management is a complex task requiring competent clinicians and sufficient resources to allow time for accurate information gathering and management planning. Effective risk management strategies ameliorate risk. Decisions need to weigh up an individual's rights to self-determination with the seriousness of the risk they pose to themselves and others. Ultimately the risk management question is not "what level risk does this person pose," but rather "having regard to the identified risk factors, what management plan needs to be implemented to manage the risk safely."

Predicting accurately a person's potential to harm themselves or others is a complex process, and caution needs to be exercised in criticising a mental health service or clinician engaged in the care of a person who subsequently dies by suicide or commits homicide. This is not to say that errors were not made by clinicians in some of the deaths that came before the Committee and in one circumstance it was recommended that a clinician be referred to the Medical Board of NSW for its attention.

A greater emphasis on risk management will increase demand on already stretched mental health services, and have the effect of further concentrating resources on those with psychosis, substance use, mood and personality disorders. This could potentially reduce services for other people suffering mental disorders who may pose a lesser risk to themselves or others. In the longer term this could have the effect of increasing disability of the patient and risk to the community as resources are moved from one patient group to another. Thus additional resources need to be available for effective risk management without undermining current resources and services.

Substance Use Co-Morbidity

As stated above, demand for mental health services has been increasing with increased substance abuse, changing social mores and population growth. Indeed, community mental health services frequently provide support and treatment for individuals grappling with complex mixtures of mental illness, substance abuse and personality difficulties. Recognition of the co-occurrence of substance abuse and mental disorder has resulted in increased collaboration between clinicians with different specialities.

In its current review of the treatment of depression amongst community mental health patients who died by suicide, the Committee found that while the majority (64%) of records did not include additional diagnoses, amongst those which did the most common additional diagnosis was of a substance abuse disorder (21%). Comparative data are not available regarding the expected rate of co-morbid medical or psychiatric conditions amongst NSW community mental health outpatients, but the assessment documentation did not suggest that persons with these complex problems were a higher percentage of the review group than of the general mental health population¹.

Of the nine homicide cases reviewed there was substance abuse, mainly cannabis and amphetamines, in seven cases. The prevalence of co-morbid substance use disorders in cases considered by the Committee raises the importance of mental health services having better access to expertise in these disorders. In recognition of this, the membership of the Committee has now been expanded to include an Addictions Medicine specialist.

In its Second Report the Committee recommended increased support for drug and alcohol services in the development of policies and training for suicide risk assessment (Recommendation 21) and that the effectiveness of reporting and review processes for suicide death be examined (Recommendation 1).

¹ Alnaes R., Torgerson, S. DSM-III personality disorders among patients with major depression, anxiety disorders and mixed conditions. *Journal of Nervous and Mental Disease*. 1990;178: 639-698.

The Committee notes that the Centre for Mental Health and the Centre for Drug and Alcohol underwent a merger in 2007 and that a number of Area Health Services have brought these two services under one governance. In the light of the desirability of a closer relationship between Mental Health and Drug and Alcohol Services, the Committee suggests the expansion of the role of the Committee to include the review of deaths occurring in Drug and Alcohol Services.

Accordingly, the Committee recommends that:

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.

Recommendation 2

Commencement: Immediate; Implementation timeframe: 6 months

Suicide Death

As stated in the previous reports of the Committee, where a person's death has been the result of suicide the impact on family and friends is profound and the consequences impact throughout the social fabric of our communities. Each such death raises questions about individuals' attitudes to life, to each other, and to the supports that can and should be provided to those in need. A suicide death of a patient in care adds to the distress of other patients and staff, and increases the burden on staff of the health service.

The international research into suicide identifies a past history of mental illness as a significant risk factor. However, the literature has identified a number of risk factors which reflect wider changes in our social culture including unemployment and financial hardship, broken relationships, violence, and increased drug and alcohol use. These factors are increasingly common in the population of Australians presenting for care through the public health care setting, yet overall rates of suicide death have remained fairly constant in the recent years of study.

Every year in NSW community mental health services are estimated to see between 60,000 and 100,000 individuals². Reducing suicide risk requires a comprehensive system which links effective inpatient care with community management and responsive emergency support for mental health patients and their carers and families.

In NSW, Privacy Legislation and the Area Health Service structure established within the Health Services Act restrict and inform the extent to which a centralised mental health case register or health records may be linked with coronial records, as is possible in some jurisdictions. Therefore detection of community-based suicide deaths relies on a network of mainly local systems, including links between mental

² NSW Health Department. *Mental Health Client Death Surveillance System* - includes reporting in RIB and CDRF - Mental Health and Drug and Alcohol Office.

health services, families, police, emergency departments and – in some areas – local coroners' courts. These "suspected suicides" are reported to the Mental Health and Drug and Alcohol Office by all services. Nevertheless, the Committee is concerned that relevant clinicians should always have sufficient information to enable them to treat patients, and has concerns when important information might be withheld unreasonably within the current legislative arrangements.

The Committee recognises that suicide is a complex issue with many factors contributing. There is no single cause or simple solution for suicide. Preventing suicide death involves a range of government agencies, non-government organisations, communities and individuals working in partnership.

Homicide

The homicide cases reviewed represent one of the worst outcomes of severe mental illness. They represent an unmitigated tragedy for the victims, their families, friends and local community, and often result in great distress and suffering. They result in great distress to the staff of mental health services, to other patients and even to the perpetrator who has to live with the consequences of their actions. The fear and concern these events raise in the community are significant and largely responsible for the continuing and unjustified stigmatisation of the vast majority of people experiencing mental illness who pose no risk except to themselves.

Some facts about homicide as it relates to mental illness need to be borne in mind.

- It is estimated that about 10% of those experiencing mental illness have a history of violence;
- Homicide in the community is itself a rare event. In 2005 there were 79 Recorded Victims of Murder in NSW, or 1.2 per 100,000 population³;
- Of men with serious mental illness who were convicted of an offence of violence, it is estimated that one-third had prior contact with mental health services⁴;
- The probability that any person with a serious mental illness such as schizophrenia will commit a homicide is 1:3000 for men and 1:33000 for women⁵;
- Homicide perpetrated by those experiencing mental illness is not always motivated by the mental illness symptoms. A person experiencing mental illness can commit a homicide for the same reasons as a person not experiencing mental illness;
- There is a myriad of unpredictable events that can change a person's level of risk. Sometimes violence can be foreseen, but sometimes events change and foresight is difficult or impossible;

³ NSW Recorded Crime Statistics 2005. The Homicide Victims Support Group recorded 90 cases for the same period, the difference due to delays in reporting.

⁴ Wallace, Mullen et al: Serious Criminal Offending and Mental Disorder. Case Linkage Study. *British Journal of Psychiatry*. 1998; 172 (6): 477-484.

⁵ Ibid.

- Alcohol and substance abuse have a strong association with violence in people experiencing serious mental illness^{6,7,8};
- The ability to provide a comprehensive range of quality mental health services is limited by the available resources;
- The capacity of clinicians to identify accurately those who will commit a violent offence is limited.

It is these last two points that are of most direct relevance to the Homicide Section of this report.

The results of the present review highlighted the risk that family members are exposed to when another member of the family experiences a serious mental illness. Over 50% of victims of violence perpetrated by those experiencing a serious mental illness are family members. Children are a very vulnerable group, although filicide is extremely rare. This is why it is important to take family concerns about risks seriously, and family involvement is imperative.

One of the purposes of the Committee in reviewing incidents of suicide death and homicide is to examine systemic issues within the mental health services that may have contributed to these tragic outcomes, on the assumption that changes which address the identified areas may make the most significant impact in improving future outcomes. It is the intent of the Committee to continue its work focussing on different aspects of mental health care, and consequently different systematic issues.

⁶ Swanson JW, Holzer CF, Gangu VK, Jano RT. Violence and psychiatric disorder in the community: evidence from the epidemiological catchment surveys. *Hospital and Community Psychiatry*. 1990; 41:761-70.

⁷ Swartz MS, Swanson JW, Hiday VA, Borum R, Wagner HR, Burns BJ. Violence and severe mental illness: the effects of substance abuse and non-adherence to medication. *American Journal of Psychiatry*. 1998; 155:226-231.

⁸ Foley SR, Kelly BD, Clarke M, McTigue O, Gervin M, Kamali M, Larkin C, O'Callaghan E, Browne S. Incidence and clinical correlates of aggression and violence at presentation of inpatients with first episode psychosis. *Schizophrenia Research*. 2005; 72(2):161-168.

Part 3
**Review of Suicide Death
in Persons Receiving Community
Treatment for Depression**

Review of Suicide Death

KEY 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 was 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.

SUMMARY OF FINDINGS

This review examined 113 persons entering community-based mental health care for depression who ultimately died by suicide. Of these 98 were fully assessed, 67 commenced treatment and 31 remained in continuing treatment after three months of contact. Nearly half of the suicide deaths occurred within one week of last contact, but some deaths occurred months or even years after the last contact with mental health services.

The review acknowledges significant limitations in its methodology, including a reliance on *reported* suicides, the use of file review as a methodology and the absence of a comparison group. The review was based on untested criteria derived by the Committee from the Australian and New Zealand Clinical Practice Guidelines for (ANZ CPGs) for Depression. A number of the findings may reflect omissions in documentation rather than omissions in care.

The persons included in this review were a diverse group, whose demographics were in keeping with the demographics of depressive illness. Most were adults aged between 30 and 60, many were in work or study, about one-quarter were married, and about one-quarter were parents living with dependent children. Conversely, about half of the group were significantly isolated or disadvantaged.

The majority of the group had a history of past contact with mental health services, usually with the same service that was currently providing treatment. More than 80% had a past history of depression or suicide attempts and more than 40% had a history of two or more previous suicide attempts. They mainly entered mental health services during this episode of care following a further suicide attempt or suicidal ideation, were most frequently referred by a mental health inpatient unit but also frequently referred by GPs, self or family.

The review found that assessment was typically conducted by psychiatry registrars or nurses. Their documents suggested that these assessments were conducted in apparent isolation. Only a minority of persons was seen by or discussed with a consultant psychiatrist, psychologist or clinical nurse consultant. Aspects of care such as past medical and psychiatric history and past suicide attempts were well documented. Pleasingly, documentation nearly always addressed assessment of risk, strengths, stressors and social supports. However, other aspects of assessment were less well-documented, especially specific diagnostic information regarding severity and subtype of depression, and physical examination. Parental status was poorly documented. Corroborative history was rarely obtained from family, carers or GPs even where these were apparently available.

Treatment for this group was mainly brief. About half of this group received only one or two treatment contacts. The focus of treatment appeared primarily medical. All persons received antidepressants. Sample size and design did not allow for an assessment to be made as to any contribution of Selective Serotonin Reuptake Inhibitor (SSRI)

medication to subsequent suicide death. Documentation of education and patient involvement in medication choice and continued monitoring of medication tolerability was good. However, only a minority of persons received psychological treatment. Ongoing risk assessment was less well documented during the initial treatment phase than during the assessment phase.

For the smaller number (31) of persons remaining in contact with services at three months, involvement of senior clinicians or the multidisciplinary team in their care was more likely, and treatment appeared mainly consistent with the ANZ CPGs. For persons discharged from care prior to suicide death, communication with the GP occurred in most cases. However the quality of discharge planning and communication appeared limited, with relapse planning or strategies for seeking future care rarely addressed, and families or other supports rarely involved.

Could some of these suicide deaths have been prevented?

It should be acknowledged that each year, NSW public mental health services assess or treat up to 30,000 persons with depression. Data from this review suggest that around 1 in 1000 of those persons are reported to have died by apparent 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 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 identified some apparent departures from the components of care recommended by the ANZ CPGs. In the absence of a comparison group it cannot be concluded that these departures were more frequent in this group than in persons treated who did not die by apparent suicide.

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 deaths. 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.

Can CPGs be used to assess clinical care?

Caution must be exercised in using a specific Clinical Practice Guideline to assess care. The ANZ CPGs represent a consensus statement developed by a group of clinicians, typically working in a particular service or system context, summarising literature available at a particular point in time. They often focus on prototypical care, and most are intended as a broad guideline rather than a rigid prescription or a defined standard which all care should be expected to meet.

Balance and clinical judgement are required in the application of CPGs. There may be situations in which departure from a CPG is clinically appropriate or necessary and reflects expert practice rather than poor care. A potential confounder for this review is

that it may be precisely in more complex patients and those at greater risk of suicide death (for example with severe or treatment resistant depression, co-morbidity with substance abuse or personality disorder) that departure from CPGs may be appropriate or necessary. However, in such case one would expect evidence of careful assessment, consultation with senior or skilled clinical staff, and detailed management planning. These were usually not evident in the files reviewed. Where there is departure from “conventional” practice as reflected in CPGs then the Committee strongly believes that this should trigger some documentation of the rationale for treatment decisions. In other words, the direction of departure from CPGs should be towards greater complexity of care planning. This was not evident in the cases reviewed.

The review needs to consider the issue of timing. The ANZ CPGs were published in 2004. Some cases in this review precede their publication. However, in the Committee’s view it is still valid to base this review on those guidelines. Guidelines do not reflect a sudden change in standards or modalities of treatment, but rather they reflect a widely understood view of what constitutes effective care. The ANZ CPGs adopted similar principals to other CPGs for the treatment of depression. This study does not aim to measure the degree of implementation of ANZ Guidelines, but rather the degree to which treatment complied with the general principals of evidence-based care as expressed in those Guidelines and as reflected in usual professional opinion and practice at the time of their development.

Clinical care and service system capacity

The Committee believes that most NSW mental health clinicians have knowledge and understanding of the principles of effective treatment of depression, as outlined in the ANZ CPGs and other similar guidelines. The importance of accurate diagnosis, exclusion of physical co-morbidity, psychological treatment, engagement of social supports, communication and relapse planning are non-controversial. Why then were these aspects of care often not implemented in the files reviewed?

There is unlikely to be a single cause for these departures, and system issues are likely to be as relevant as individual clinical practice.

As this review has discussed, resources do not appear to have been a strong driver of the quality of depression care in the group reviewed. On the other hand, many of the findings in this review may be seen as at least partly related to the degree of organisational support for the treatment of depression. NSW community mental health services derive their structures and procedures from their history: most were established with a primary focus on the long-term community treatment of chronic psychoses.

Community mental health services have operated typically with staffing models based on hospital care. Predominantly nursing teams are supported by junior medical staff. Medical modalities have been the primary focus of intervention, and are usually well-monitored. Allied health staff roles are often generic and have not always supported the

development of skills in specific interventions or therapies. Senior clinicians, including consultant psychiatrists, typically are involved in supervisory roles within the multidisciplinary team, often at a later stage of care. Care has an individual focus, with links to families and broader social supports often a secondary consideration¹.

This review suggests that the typical community mental health service model provides limited support for the effective treatment of depression. 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.

¹ This may be partly a caricature. There is considerable diversity in service models, and significant innovation is occurring in many services. However, at least some of the attributes described may continue to apply in many public mental health services throughout Australia.

INTRODUCTION

The Committee divided consideration of suicide death into three groups: inpatients, people who died by suicide within one month of discharge from a mental health inpatient unit, and people in community psychiatric care who died by suicide. All are equally important. This report considers only the third group: people suspected to have died by suicide while receiving community mental health care. The first two groups were reviewed in previous reports of the Committee.

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.

Depression, effective care and the prevention of suicide

The First and Second Reports of the Committee focused on essential but diagnostically non-specific aspects of care such as suicide risk assessment, communication, clinical documentation, and the provision of appropriate clinical environments and resources.

This Report seeks to explore another dimension of care: the effectiveness of specific treatment in the prevention of suicide. Preventing suicide requires more than risk assessment. It requires effective care for those conditions which increase suicide risk.

Mental health services see people suffering from a diverse range of mental health conditions or disorders. Each disorder requires its own specific treatment. Therefore, it is a complex task to assess whether individuals received appropriate and effective care. In order to simplify this task, the Committee chose to focus this review on the care of depression. There are several reasons for this choice.

Depression is a common disorder, which is frequently seen within mental health services. Each year in NSW, community mental health services are estimated to see between 60,000 and 100,000 individuals, of whom between one quarter and one third (15,000 – 30,000 persons) experience depression as the primary problem.

Depression is associated with a 30-fold increase in risk of suicide compared with the general population². There is a clear evidence base that the treatment of depression halves the risk of suicide, indicating that many suicides are preventable³.

This evidence base has been translated into Clinical Practice Guidelines (CPGs). There is legitimate debate about the overall place of CPGs, however, there is a broad

² Lee AS, Murray RM. The long-term outcome of Maudsley depressives. *British Journal of Psychiatry*. 1998; 153:741–751.

³ Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Depression. Australian and New Zealand clinical practice guidelines for the treatment of depression. *Australian and New Zealand Journal of Psychiatry*. 2004; 38:389–407.

professional consensus regarding key elements of depression treatment that is clearer than that for some other areas of mental health care.

In particular, 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, provide a valuable framework for this review. These have been recently developed, with input from clinical leaders from a range of health care disciplines within Australia and New Zealand. They therefore represent a statement of a reasonable standard of care for depression within a current Australian service context. They are in a format which allows development of operational criteria against which the quality of care may be assessed.

Therefore this review seeks to ask 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 has a range of methods available to it. Its particular focus has been on review of clinical documentation, both direct file review and specific review of additional reports such as Coronial reports and critical incident reviews. The number of incidents under review has typically meant that it is not possible for the Committee to directly review each clinical file. 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.

There are two important limitations to the conclusions that can be drawn from a review using the proposed methodology. First, even "perfect" application of evidence-based treatment of depression does not completely remove suicide risk. As pointed out within the ANZ CPGs, effective treatment may only halve the risk of suicide in depression.

Second, without a control group, it cannot be concluded that any departure from evidence-based practice (as reflected in the ANZ CPGs) is more common in the suspected suicide group than in other clients of NSW mental health services. The extent of compliance with ANZ CPGs for Depression in general NSW health services/clients is not known. Non-compliance with these CPGs may be no more common in those who died by suicide than in other clients. Therefore this review cannot conclude that departures from the ANZ CPGs necessarily result in an increased risk of suicide death.

METHODS

Detecting and reporting of suspected suicide deaths

This study examines *reported* suicides of NSW Community Mental Health Service patients; it is not a study of all suicide deaths occurring within the review period.

Detection of suicide deaths in NSW occurs through a network of local systems, including links between mental health services, families, general practitioners, police, emergency departments and local Coroners Courts. Where mental health services become aware of the death of a person who has recently been in their care, they are required to report these deaths to the Centre for Mental Health, NSW Health. These are referred to as “suspected suicides”, as the final cause of death cannot officially be confirmed until after appropriate investigation by the NSW Coroner.

Suspected suicides are reported to NSW Health via the NSW Client Death Report Form (CDRF). As in previous reviews, this system has been used as the basis for case selection in this review.

In NSW, privacy legislation restricts and informs the extent to which a centralised mental health case register, or health records may be linked with coronial records as is possible in some jurisdictions. Therefore the rate of suspected suicides known to mental health services will inevitably be an underestimate. Some patients may have lost contact with a mental health service prior to their suicide death, and the service may therefore not be notified of their death. The Committee believes that there are costs as well as benefits to such a system and that the benefits outweigh the costs; it is for elected representatives to decide where the correct balance lies.

The exact extent of under-reporting of suicide deaths is not known, but it is likely that the detection and reporting of suspected suicide deaths is more complete in the initial period following contact and becomes less complete with greater time elapsed since last contact. NSW Health data suggest that in NSW the rate of reporting of suspected suicides of people within one month of contact with a mental health service is similar to that found in Western Australia, where centralised mental health and coronial registers permit more complete reporting.

Sources of information

Case selection was based on the Centre for Mental Health Client Death Report Form (CDRF) Database, using the criteria outlined below.

The CDRF Database records clinical, service and demographic information. Diagnosis recorded within the CDRF Database was used to screen for possible records for inclusion in this study. However, diagnosis for final inclusion within this review, and for use in further analysis, was based on that recorded within the individual clinical record.

A small number of CDRF records included no specified diagnostic codes. Text fields for those records were examined for text suggesting depression as a component of the

presentation and recoded as diagnosis F32.9 (Depression Unspecified)⁴ if the apparent problem included depression.

For all persons identified for possible inclusion in this review, the following sources of information were requested where available:

- NSW Client Death Report Form
- Community and Inpatient medical records for that person
- Any Reportable Incident Brief reports or other documents arising from incident reporting or review processes
- Coronial reports

Inclusion criteria

Cases identified for possible inclusion in this review were selected from the Centre for Mental Health CDRF Database, using the following selection criteria:

- Person was a client of community mental health service at time of suicide death;
- The suspected suicide death occurred in 2003, 2004 or 2005; and
- CDRF report recorded a primary diagnosis of a Depressive Disorder (including F32 Major Depression, and all subtypes and specifiers); or
- CDRF text indicated Depression as a secondary diagnosis to a primary diagnosis of other conditions frequently co-morbid with depression, where the basic principles for the treatment of depression are not substantially modified by the presence of this co-morbidity. This included:
 - F40 - F44 Anxiety, where CDRF text also includes "Depression" or "Major Depression";
 - F10 - F19 Substance abuse - where CDRF text also records "Depression" or "Major Depression" (as a co-morbidity);
 - F43.2 Adjustment Disorder with Depressed Mood.
- Clients of community mental health services with a suspected suicide occurring in 2005 who had not been included in the previous review involving persons who died by suicide within 28 days of discharge from mental health units.

Exclusion criteria

Cases identified for inclusion were further screened and excluded from analysis if:

- The available records were so incomplete as to significantly limit data collection, eg:
 - No community mental health record was available;
 - The community mental health record was fragmentary or incomplete, with multiple and significant omissions.
- Information gained during file review indicated a different diagnosis or other inclusion criteria from data recorded on the CDRF Database. Initial record selection is based on values from three fields within the CDRF Database: date of suspected suicide, primary diagnosis and location of suicide (hospital or community). All may be subject to revision through the process of file review. In particular, records were excluded if:

⁴ American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. Fourth Edition. American Psychiatric Association, Washington DC; 1994.

- ❑ Suicide group = inpatient or AWOL;
 - ❑ Date of suspected suicide was outside the target period;
 - ❑ Diagnosis at assessment did not include depression;
 - ❑ There was primary or co-morbid diagnosis at assessment of psychosis or organic mood disorder⁵;
 - ❑ The diagnosis was revised during treatment to psychosis, organic mood disorder or other disorder requiring a substantial change in treatment approach.
- Clients were hospital inpatients (including persons on authorised or unauthorised leave from inpatient units) at the time of their suspected suicide. This group was excluded as the CPGs do not specifically focus on inpatient care of depression.

Development of operational criteria for ANZ CPGs for Depression

The ANZ CPGs for Depression were funded under the National Mental Health Strategy (Australia) and by the New Zealand Ministry of Health. A CPG team of clinicians coordinated by the Royal Australian and New Zealand College of Psychiatrists developed the guidelines based on literature review, consumer consultation and consultation with mental health practitioners and professional groups.

The ANZ CPGs describe evidence-based treatment for a range of subtypes of depression, over three broad clinical stages: assessment, initial treatment and ongoing treatment.

The Committee developed operational criteria based on these CPGs, attempting to define both the stages of care and specific aspects of treatment. These criteria aimed to allow aspects of treatment to be identified and coded from a clinical file review conducted by an experienced medical file reviewer who is not an expert clinician in the treatment of depression.

The Committee acknowledges the preliminary nature of these criteria, and makes no claim for their universality. The Discussion section of this report will include some consideration of their performance, and suggestions for possible refinement.

⁵ Treatment of co-morbid Depression in these conditions is not included within the scope of the ANZ Depression CPGs. On the other hand, co-morbid Personality Disorder or Substance Use Disorder is common, and while often requiring judgment and juggling in CPG application, does not negate the basic principles or logic of CPGs.

Stages of care

The study group was likely to include differing numbers of people at very different stages of treatment of depression, from those in the initial stages of assessment to those receiving months or years of care. To avoid confounding of these groups, the Committee adopted the following operational definitions to allow separation of treatment stages:

Stage of care	Operational criteria
PRE-ASSESSMENT	Contact during the triage and referral stages, prior to commencement of specific assessment.
ASSESSMENT	Contact in the initial few sessions, where the focus is on recording of past history and current presentation. Includes: <ul style="list-style-type: none"> ▪ The first and second face to face clinical contact; ▪ The first medical contact; ▪ All data included in a structured assessment document (eg MH-OAT A1)⁶; ▪ Any other data recorded before the initiation of definitive treatment of depression.
INITIAL TREATMENT	Contact from the completion of assessment to 13 weeks (3 months) from the date of assessment. Includes: <ul style="list-style-type: none"> ▪ Information recorded from the third session of contact; ▪ Information about treatment recorded in the first two sessions if it appears that definitive treatment has been initiated during those contacts.
CONTINUED TREATMENT	Contact occurring after 13 weeks (3 months) from the date of assessment.

Coding and quantifying care

For each stage of care the Committee extracted from the CPGs statements of the expected standard or details of care. For each of these statements an attempt was made to define one or more operational criteria by which the medical record could be coded as demonstrating that this aspect of care was provided. These criteria were developed into a coding template for use in file review. The criteria are described in the sections below related to each stage of care.

File review for coding

The QaRNS team (Northern Sydney Central Coast Area Health Service) was appointed to review the files, and worked with the Suicide Sub-Committee to develop the audit methodology and tools. All available records were provided in confidence, including

⁶ NSW Health Department. *Standardised Mental Health Outcomes and Assessment Tools (MH-OAT) Clinical Assessment Protocols and Modules*. NSW Health Circular 2004/30; 2004.

inpatient medical records, community medical records, client death reports, incident reports/briefs and Coronial reports.

Records were screened for exclusion criteria, and any cases flagged for possible exclusion were discussed with the Committee, where a final decision to include or exclude the record was made. The records were reviewed by an experienced senior QaRNS reviewer using the criteria outlined above. A brief clinical summary of each record was prepared.

The data were entered into a secure database and reported using Business Objects®. Supplementary analyses were conducted by the Committee using Microsoft Excel.

Qualitative file review

As a final stage, a working group mainly comprising clinician members of the Committee reviewed a subset of clinical files. This review aimed to ensure that the Committee better understood the human and clinical issues which may not always be evident in coded and aggregated data. The Committee was specifically interested in reviewing files of persons who had not entered or continued in care, that is, where a service had made a decision to discharge or not to begin treatment. For these persons the criteria based on the Clinical Practice Guidelines may provide only limited information. Finally, the Committee wanted to assess any obvious limitations or issues with the rating criteria used.

DETAILS OF THE SAMPLE

One hundred and thirty two (132) patient records satisfying the inclusion criteria were identified in the NSW Health CDRF Database. Clinical files were collated on all 132 patients. On initial review, 19 cases were excluded due to the presence of one or more exclusion criteria. The most frequent reason for exclusion was a primary diagnosis other than depression recorded at assessment within the community file.

One hundred and thirteen (113) patients were therefore included in this review. Sources of information regarding their care were as follows:

Type of record	Number	%
Community medical record	113	100%
CDRF	112	99%
Reportable Incident Brief (RIB)	89	79%
Root Cause Analysis (RCA) Report	24	21%
Last hospital inpatient record	13	12%
Coroner's report	26	23%
Case/file review	6	5%
Other report	23	20%

The Committee was concerned at the incomplete nature of the available source material, particularly the absence of RIBs in 21% of cases.

Numbers of patients proceeding through the stages of care for depression are summarised in Figure 1. The numbers given for each stage are as determined by the clinical coding team at QaRNS. As discussed below, review of case files by the Committee suggests that in some situations it may be difficult to distinguish reliably between Assessment and Treatment stages.

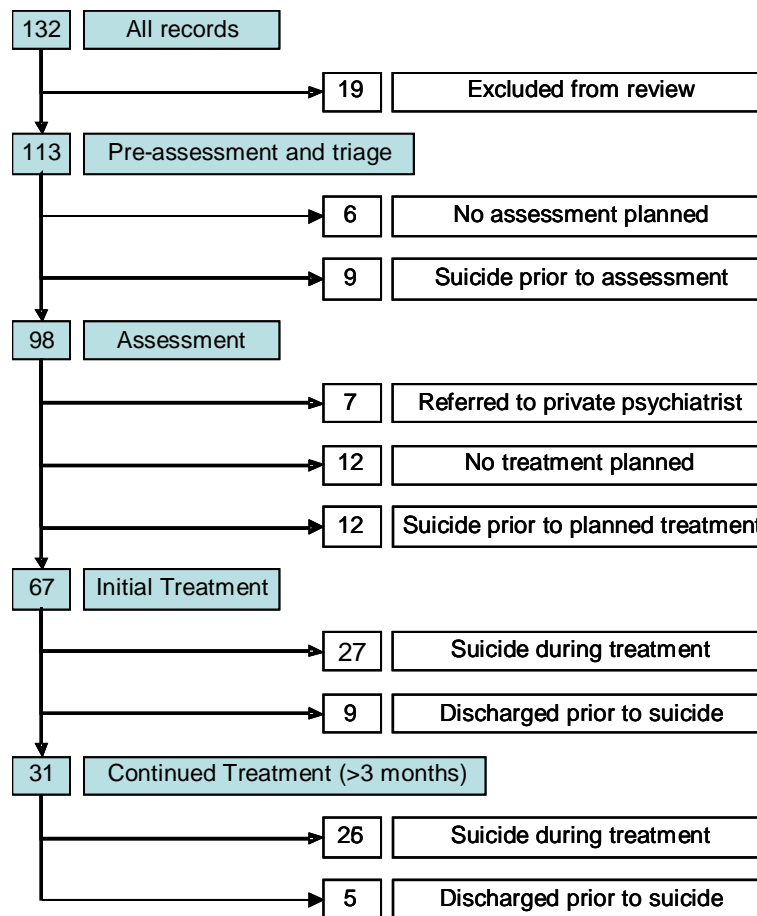


Figure 1. Numbers of patients proceeding through the stages of care for depression

Demographics

Demographic data are provided in Table 3. NSW population data are from the ABS 2001 Census of Population and Housing. In summary:

- Sixty eight (68) persons (60%) were male. Most were middle-aged adults: 64% of the group was aged between 30 and 60 years at the time of death. Mean age at death was 42 years for males and females.
- Forty five percent (45%) of the group were in full-time or part-time employment or were students (36% were in full-time or part-time employment compared with 53.2% of the NSW population), while 39% were unemployed or on social benefits (26% were unemployed compared with 4.3% of the NSW population), with a further 10% retired or in home duties and 6% unknown. More men (47%) than women (22%) were employed.
- Thirty percent (30%) of the group were married or in a de-facto relationship, while 45% (41% of males and 49% of females) were separated, divorced or widowed (compared with the NSW population of 45% married/de facto and 17% separated, divorced or widowed).

	Male		Female		Total		NSW Pop.
	N	%	N	%	N	%	%
Total	68		45		113	100%	
Age group							<i>a</i>
13 - 19	4	6%	2	4%	6	5%	10%
20 - 29	9	13%	9	20%	18	16%	13%
30 - 39	17	25%	13	29%	30	27%	15%
40 - 49	17	25%	6	13%	23	20%	15%
50 - 59	12	18%	7	16%	19	17%	12%
60 - 69	6	9%	4	9%	10	9%	8%
70 - 79	3	4%	3	7%	6	5%	6%
80 - 89	0	0%	1	2%	1	1%	3%
Total	68	100%	45	100%	113	100%	
Employment status							<i>b</i>
Employed full-time	30	44%	4	9%	34	30%	36%
Employed part time	1	1%	6	13%	7	6%	17%
Student	4	6%	6	13%	10	9%	}
Home duties	0	0%	5	11%	5	5%	
Retired	4	6%	2	5%	6	5%	}
Pension	4	6%	11	25%	15	13%	
Unemployed	23	34%	6	13%	29	26%	4%
Unknown	2	3%	5	11%	7	6%	-
Total	68	100%	45	100%	113	100%	
Marital status							<i>d</i>
Married	16	23%	9	20%	25	22%	40%
De facto	3	4%	2	5%	5	4%	5%
Divorced	4	6%	7	16%	11	10%	7%
Separated	20	29%	11	24%	31	28%	3%
Widowed	3	5%	5	11%	8	7%	6%
Single	21	31%	11	24%	32	28%	32%
Unknown	1	2%		0%	1	1%	-
Total	68	100%	45	100%	113	100%	100%
Type of residence							<i>e</i>
Alone	20	29%	16	36%	36	32%	9% <i>f</i>
With family of origin	20	29%	14	31%	34	30%	39% <i>g</i>
With spouse or partner	21	31%	12	27%	33	29%	45% <i>h</i>
Group or shared home	6	9%	0	0%	6	5%	3%
Boarding house		0%	2	4%	2	2%	-
Other/unknown	1	1%	1	2%	2	2%	-
Total	68	100%	45	100%	113	100%	

Notes: ABS 2001 Census of Population and Housing:

a. % of total NSW population

b. % of total NSW population 15-65+yrs

c. % not in the labour force

d. Registered marital status by age by sex and Relationship in household by age by sex

e. % of total NSW population 15yrs +

f. Relationship in household by age by sex. Lone person % of total persons

g. Related individuals; not husband/wife or de facto partner

h. Husband/wife or de facto partner

Thirty two percent (32%) of the group lived alone (compared with 9% of NSW population), while 59% lived with their family of origin, a spouse or partner (compared with 84% of NSW population). Twenty six percent (26%) of the group were parents living with dependent children.

Together these figures suggest a diverse range of social and living situations, with about half of the group significantly isolated in work, housing or relationships.

Four percent (4%) of the study group were identified as Aboriginal or Torres Straight Islander people. Data were not available to the Committee for NSW mental health community patients, however 4.4% of patients of NSW Mental Health inpatient services were reported as being of Aboriginal or Torres Straight Islander background in 2003, compared with about 2% of the NSW population.

Only 3% of persons were identified as being of a non English-speaking (NESB) or Culturally and Linguistically Diverse (CALD) background, a proportion much lower than expected from the NSW population (of which 16% were born in a non English-speaking country) or from the limited available data about demographics of NSW mental health service patients. This under-representation also occurred in the previous Report of the Committee; poor documentation of NESB or CALD status is a possible explanation, however poor access to treatment services and under-detection or reporting of suicide death in this group are also possible contributors. The available data do not allow these possible factors to be further explored in this review.

Pathways to care

Referral to community mental health care occurred most frequently from inpatient mental health units, GPs and self or family. Overall, 68% came from other than inpatient units. Referral sources are summarised below:

Source of referral to Community Mental Health	N	%
Inpatient Unit	36	32%
GP	28	25%
Family or friends	23	20%
Self	16	14%
Other service	9	8%
Police	1	1%
Total	113	100%

All persons were referred with suicidal ideation or attempts (56%), or with other symptoms of depression:

Reason for referral to Community Mental Health	N	%
Following suicide attempt	29	26%
Suicidal ideation	34	30%
Symptoms of depression	50	44%
Total	113	100%

Past psychiatric history

A majority of the group had past contact with mental health services or a history of suicide attempts: only 23% of persons had no past mental health contact, and 29% had no history of suicide attempts prior to the episode being treated in the period under review.

Past psychiatric contact and suicide attempts	N	%
Past mental health treatment	85	75%
No past mental health treatment	26	23%
Past treatment unknown	2	2%
No past suicide attempts	33	29%
1 previous suicide attempt	36	32%
2 previous suicide attempts	21	19%
3 previous suicide attempts	10	9%
4 previous suicide attempts	5	4%
>4 previous suicide attempts	6	5%
Past suicide attempts unknown	2	2%

Eighty five (85) persons had received past mental health treatment. For 79 (93%) of these, this treatment had been for depression whether alone or in combination with other problems. For 57 (67%) of the 85 persons with past treatment, this treatment had been with the same mental health service as was involved in their care in the episode under review.

ASSESSMENT

Data were available for 98 persons who received assessment resulting in a diagnosis of a depressive disorder and where other exclusion criteria were not present. For these persons, the following operational criteria were applied as indicators of the extent to which assessment as documented met the standards articulated in the ANZ CPGs.

CPG criteria	Operational criteria for file review
Assessment should include the type, severity and duration of depression	<ul style="list-style-type: none"> ▪ Is a diagnosis recorded in the medical record? ▪ Does diagnosis include any specifier for the type or severity of depression?
Assessment should identify co-existing psychiatric or physical disorders	<ul style="list-style-type: none"> ▪ Are diagnoses recorded in multiaxial format? ▪ Are any additional psychiatric diagnoses recorded other than depression? ▪ Is physical examination documented? ▪ Is past medical history recorded? ▪ Are current medications documented? ▪ Are past adverse drug reactions recorded?
Assessment should identify contributing stressors, supports and coping style	<ul style="list-style-type: none"> ▪ Is any summary or formulation statement recorded? ▪ Are stressors discussed in the formulation/summary statement or elsewhere in the assessment? ▪ Are family or supports discussed in the formulation/summary statement or elsewhere in the assessment? ▪ Are coping style, defences or strengths discussed in the formulation/summary statement or elsewhere in the assessment? ▪ Is any discussion of dependents, children, or carer responsibilities recorded? ▪ Is DSM Axis IV⁷ recorded?
Assessment should identify risk to self or others	<ul style="list-style-type: none"> ▪ Is a corroborative history obtained from family/carers or supports? ▪ Does the assessment include any discussion or rating of risk (using the MH-OAT A1 form, other structured risk assessment form, or discussion of risk within clinical notes?) ▪ Does the assessment document whether there is a history of past suicide attempts? ▪ Where appropriate, does the assessment document consideration of risk to children? ▪ If so – does corroborative history include any discussion of risk?
Assessment should include standardised measures of depression severity	<ul style="list-style-type: none"> ▪ Does the assessment include a HoNOS⁸ scale completed within the first two sessions? ▪ Does the assessment include any other rating scale within the first two sessions?

⁷ American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. Fourth Edition. American Psychiatric Association, Washington DC; 1994.

⁸ Health of the Nation Outcome Scale (HoNOS) – a tool used to assess symptoms/functionality.

Type, severity and duration of depression

Details of diagnoses recorded at assessment are summarised in the following table.

Diagnosis at assessment	N	%
No diagnosis	7	7%
Depression, unspecified	64	65%
Major depression, type or severity unspecified	14	14%
Severe or melancholic depression	7	7%
Depression with psychotic symptoms	6	6%
Total assessments	98	100%

In seven cases, files did not record a diagnosis within the assessment documentation, however these persons remain included in this review as other sources of documentation (such as CDRF, treatment records, documentation at follow-up) indicate that a depressive disorder is the primary diagnosis. A further seven files included diagnoses which have been grouped as “severe or melancholic depression” (severe major depression: four, severe depression: two, melancholic depression: one).

Therefore most assessments did not record the type or severity of depression. Diagnosis was not recorded or not specified for between 72% - 87% of records, depending on whether “major depression” alone is seen as constituting an adequate description of type or severity of depression.

There are differing views on whether a diagnosis of “major depression” without other specification should be considered consistent with the recommendation of the ANZ CPGs. The diagnosis of major depression reflects terminology from the widely-used Diagnostic and Statistical Manual (eg DSM-IV). While the term may imply a more severe depression, the criteria for the major depressive episodes cover a wide spectrum of severity.

The potential impact of staffing mix and professional background of the clinician conducting the assessment is explored further below.

Co-existing psychiatric or physical disorders

Co-morbid psychiatric and medical conditions are summarised in the table below. Most records (64%) did not include additional diagnoses. The most common additional diagnosis was of a substance use disorder (21%). Only three persons were recorded as suffering with a co-morbid personality disorder.

Sixteen (16) persons had an identified co-morbid medical condition, including two persons with advanced or metastatic carcinoma, and one person with Huntington’s Chorea.

Co-morbid diagnoses at assessment	N	%
No additional psychiatric diagnoses	63	64%
Substance abuse disorder	21	21%
Post traumatic stress disorder	4	4%
Borderline personality disorder	3	3%
Obsessive compulsive disorder	3	3%
Agoraphobia	1	1%
Anorexia nervosa	2	2%
Attention deficit disorder	1	1%
Co-morbid medical conditions	16	16%

Comparative data are not available regarding the expected rate of co-morbid medical or psychiatric conditions in a NSW community mental health outpatient group. The prevalence of co-morbid substance use disorder appears consistent with that recorded from other sources⁹. The rate of documented personality disorder appears lower than might be expected from systematic studies of personality disorder prevalence in outpatient mental health patients¹⁰.

Community mental health services frequently provide support and treatment for individuals grappling with complex mixtures of depression, substance abuse and personality difficulties. Persons with these complex problems did not appear to be over-represented in the records reviewed in this study.

Documentation

The following table summarises other aspects of the documentation of the medical history:

Aspects of medical history at assessment	N	%
Physical examination documented	5	5%
Past medical history documented	93	95%
Current medications documented	93	95%
Past adverse drug reactions documented	97	99%

Past adverse drug reactions were rated as having been documented if (i) a specific reaction was documented, (ii) the file recorded "nil adverse drug reactions" or (iii) the file

⁹ NSW Health Department. *The Management of People with a Co-existing Mental Health and Substance Use Disorder*, 2000.

¹⁰ Alnaes R, Torgerson S. DSM-III personality disorders among patients with major depression, anxiety disorders and mixed conditions. *Journal of Nervous and Mental Disease*. 1990; 178:639-698.

recorded “nil medications”. Ninety nine percent (99%) of persons had the presence or absence of past adverse drug reactions documented.

Documentation of current and past medical history was relatively complete. In contrast, only five percent (5%) of files recorded a physical examination, and these were all referred from inpatient units.

Differences in assessment depending on discipline of clinician

The Committee further examined whether there were any apparent differences in documentation between professions. This is summarised in the table below. Note that in this table some persons have been seen by more than one profession.

Table 11. Assessment Stage: Factor documented by profession (persons assessed = 98)

Factor Documented	Psychiatrist		Psych Reg		Nursing	
	31	(%)	47	(%)	78	(%)
Seen by profession	31	(%)	47	(%)	78	(%)
Current treatment documented	30	97%	47	100%	77	99%
Medical history documented	30	97%	45	96%	73	94%
Adverse drug reactions documented	31	100%	47	100%	77	99%
Stressors documented	30	97%	46	98%	77	99%
Supports documented	30	97%	47	100%	77	99%
Strengths/style documented	30	97%	46	98%	72	92%
Parental responsibility documented	9	29%	15	32%	29	37%
Child risk documented	3	10%	7	15%	12	15%
Risk discussed with family	9	29%	4	9%	14	18%
Depression severity/type specified	3	10%	8	17%	11	14%
Physical examination documented	0	0%	5	11%	4	5%

Note: In this table some persons have been seen by more than one profession. In these cases the data in the following table indicates whether these aspects of care were documented in any file entry and not merely by the profession listed. For example, 97% of persons seen by a psychiatrist had current treatment documented, however this may have been documented by a psychiatry registrar or nurse. As numbers of persons seen by a psychologist were very low, they have not been included in this table.

In summary, for the 98 persons with a documented assessment, there did not appear to be major differences between professions. Issues where documentation was limited appeared to apply across professional groups. Of the 31 persons seen by a consultant psychiatrist only three (10%) had any specification of the type or severity of depression.

Examining the characteristics of staff conducting these assessments:

- Assessments were most frequently conducted by nursing staff (78) or psychiatry registrars (47), either alone or in combination;
- A smaller number were assessed by a psychiatrist (31), a psychologist (11) or a clinical nurse consultant (9);
- Overall there appears to be little documentation of consultation between the clinician conducting the assessment and other more senior staff responsible for supervising care;

- In about two-thirds of assessments the person was neither seen by nor discussed with a psychiatrist;
- Over 80% of clients were neither seen by nor discussed with a psychologist or a clinical nurse consultant.

Physical examination was documented in only five persons. All had been referred from inpatient mental health services; it is likely that the documentation of physical examination was in discharge or referral documentation. Physical examination was not documented in any self-referred or family-referred person. The Committee is concerned that psychiatrists are apparently not ensuring the physical examination of persons whose care they are either directly providing or supervising in the community setting.

Contributing stressors, supports and coping style

Files were examined for the presence of any documentation or discussion of these aspects of care. No attempt was made to rate the depth or quality of this documentation where it was present.

The following table summarises aspects of documentation of stressors, supports and coping style.

Stressors, supports and coping style	N	%
Discussion of family/supports documented	97	99%
Stressors or triggering factors documented	95	97%
Coping style, strengths or defences documented	92	94%
Summary or formulation statement documented	91	93%
Parental or carer responsibilities documented	34	35%
DSM Axis IV documented	14	14%

These aspects of assessment were generally well-documented; some consideration of them was found in almost all files reviewed. The exception to this was the documentation of parental or carer responsibility. This is particularly critical in ensuring adequate consideration of child safety issues. Twenty nine (29) persons (26% of the study group) were parents. Where this sub-group alone was considered, issues of parental responsibilities were documented in 15 cases (52%).

The Diagnostic and Statistical Manual of Mental Diseases (DSM) is the most commonly used diagnostic framework in mental health services. It proposes five "Axes" for diagnosis. The first three (psychiatric disorders, personality and developmental disorders, medical conditions) are widely used. DSM also proposes a fourth Axis for documentation of stressors and precipitants to illness, and a fifth axis to document level of functioning. There is legitimate variation in practice in the use of this approach, and no clinical consensus or NSW policy position regarding the utility of Axis IV and Axis V. The Committee did not assume that completion of DSM Axis IV is necessary for or even correlated with good documentation of stressors, but merely that where Axis IV has

been employed this could be seen as evidence that stressors have been considered. The files reviewed suggest that DSM's Axis IV is not being systematically used in NSW mental health records. The Committee has no specific concern regarding this finding, as the stressors and supports appeared to be well-documented.

Risk to self or others

This review assumes that assessment of risk requires more than completion of a risk assessment form or documentation of a person's stated (or denied) suicide intent. In particular, effective risk assessment usually requires consideration of corroborative history, and aspects of past history such as the presence of previous suicide attempts.

Documentation of suicide risk The table below summarises specific documentation of suicide risk. The review examined for assessment of risk in both structured clinical records or forms (eg the NSW MH-OAT A1 module) or in any unstructured clinical notes. This review considered both to be valid approaches to the documentation of risk assessment.

Nearly all records (92%) documented an assessment of the level of suicide risk, primarily using the suicide risk assessment scale included in the MH-OAT A1 form.

Documentation of suicide risk at assessment	N	%
MH-OAT A1 suicide risk rating completed	81	83%
Suicide risk rating in notes or other tool	9	9%
<i>Total with documented suicide risk assessment</i>	<i>90</i>	<i>92%</i>
MH-OAT A1 present but risk rating not completed	4	4%
No MH-OAT A1 present	4	4%
<i>Total with no documented suicide risk assessment</i>	<i>8</i>	<i>8%</i>

For the 90 records where the level of suicide risk was documented, this level was assessed as high in six records, moderate in 29 records and low in 55 records.

Past history of suicide attempts is an important dimension of risk assessment. This had been documented in 90% of records, of which half had past suicide attempts recorded and half had no such attempts recorded. Ten percent (10%) of files included no discussion of the presence or absence of past suicide attempts.

Table 14. Assessment Stage: Documentation of past suicide attempts by number of cases

Documentation of past suicide attempts	N	%
Presence of past suicide attempts documented	88	90%
<i>No past suicide attempts</i>	44	45%
<i>Past suicide attempts</i>	44	45%
No documentation of past suicide attempts	10	10%

Corroborative history is a vital part of risk assessment for all patients. Examining this aspect of care in a clinical file review is confounded by the wide variation in patients' living and social situations. In some situations it may not be possible to seek corroborative history, however the reasons for this may not be systematically documented. The Committee is disturbed that corroborative history was documented in about only one-third of files reviewed, with no apparent increase in this rate for those persons living with their family of origin, but an apparent increase (to 50% of files) for those living with a spouse or partner.

Table 15. Assessment Stage: Documentation of corroborative history by number of cases

Documentation of corroborative history	Yes		No		Total	%
	Yes	%	No	%		
Living with family of origin	9	30%	21	70%	30	100%
Living with spouse or partner	14	50%	14	50%	28	100%
Living alone or other	11	28%	29	73%	40	100%
All records	34	35%	64	65%	98	100%

Child safety is a further important dimension of risk assessment in a subset of people experiencing depression. Twenty nine (29) records were identified where the patient was documented as a parent or carer living with dependent children. Of these, the presence or absence of child risk was documented in 16 (55%). Two records identified concerns regarding risk to children; in both cases notification to the Department of Community Services (DOCS) is documented to have occurred.

Table 16. Assessment Stage: Documentation of child safety issues by number of cases

Documentation of child safety issues	N	%
Persons identified as living with dependent children	29	100%
Assessment of child safety documented	16	55%
<i>Safety risk: nil risk identified</i>	14	48%
<i>Safety risk: risk identified</i>	2	7%
No assessment of child safety documented	13	45%

In summary, nearly all files included specific documentation of risk assessment, (typically using the structured format of the MH-OAT A1 form) and documentation of the presence or absence of past suicide attempts. However there were apparent deficiencies in some broader aspects of risk assessment: around two-thirds of files did not include corroborative history, even in situations where it would usually be possible or desirable to obtain such history. The Committee is concerned that no assessment of child safety was documented in 14 of 29 cases where the patient is documented as living with children.

Standardised measures of depression severity

Current Commonwealth data collection protocols require the routine completion of a suite of standardised measures: the HoNOS, LSP and K10 (and related measures for older persons and children/adolescents)¹¹. Protocols mandate these measures at admission, review, and discharge, for all mental health clients in all mental health service settings¹².

Both the HoNOS (clinician rated scale) and K10 (patient rated scale) include consideration of depressive symptoms. This review focused on the HoNOS, as information from other sources suggested that this measure is currently more reliably collected than are the other measures.

Use of standardised measures of severity	N	%
No standardised measure in file	50	51%
HoNOS scale in file	30	31%
<i>HoNOS Depression subscale completed</i>	4	4%
<i>HoNOS incomplete</i>	26	27%
Other symptom rating scale documented	18	18%

About half of files included no standardised measures of depression severity. Thirty one percent (31%) of files included a HoNOS scale, however in most of these the depression subscale had not been completed. Therefore in total 76 files (78%) had no completed standardised measurement of depression, despite the potential benefits for adequate assessment and the delivery of appropriate treatment and care.

Accordingly, the Committee recommends that

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

Recommendation 3

Commencement: Immediate; Implementation timeframe: 12 months

¹¹ Health of the Nation Outcome Scale (HoNOS) – tool used by clinician to assess symptoms/functionality; Life Skills Profile (LSP) – disability scale; Kessler 10 point scale (K10) – self assessment by the patient.

¹² NSW Health Department. Mental Health Outcomes and Assessment Tools (MH-OAT) Data Collection Reporting Requirement PD2006_0141; July 2006.

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.

Recommendation 4

Commencement: 6 months; Implementation timeframe: 12 months

Discussion: The Assessment Phase

The assessment documentation reviewed was of variable quality. The Committee acknowledges that the ANZ CPGs, the criteria derived for this study and the method of file review all contain imprecision and possible error. Therefore detailed comparison between specific aspects of care may be misleading. However, some broad conclusions may be drawn.

Some aspects of assessment aligned well with the recommendations of the ANZ CPGs. These included:

- Aspects of medical care such as past medical history, medications and adverse drug reactions were well documented;
- Most records included documentation of the history of past suicide attempts;
- Most records included documentation of assessment of risk, typically using a structured risk assessment guide;
- Most records included documentation of the person's supports, stressors and coping styles.

For other issues the records did not demonstrate adherence with the ANZ CPGs and thereby may reflect a missed opportunity to reduce the risk of eventual suicide death.

The issues which were most poorly documented included:

- The subtype and severity of depression;
- Physical examination;
- Parental responsibility, and specific documentation of the presence or absence of risk to children where a person was identified as a parent;
- Corroborative history, even where patients reside with families or partners;
- The use and completion of standardised measures of depression severity.

Evidence from many other sources identifies the critical role of corroborative history and communication with families and other supports in the assessment and management of suicide risk, and it is reasonable to assume that improvement in this aspect of care may prevent some proportion of suicide death in those being treated for depression.

The Committee was concerned at the surprising lack of detail and specificity in the assessment and diagnosis of depression. As outlined in the ANZ CPGs, accurate diagnosis (including identification of the type and severity of depression) is important in both risk assessment and management planning. It is likely that where diagnosis has not been made in a detailed and specific way, treatment planning may consequently fail to address important issues in risk assessment and the choice of appropriate pharmacological and psychological treatment.

The Committee was concerned at the low rate of physical examinations recorded. Physical conditions may cause or worsen psychiatric conditions. Improvement in psychiatric conditions, or a reduction of the risk of deterioration, might result from recognition and treatment of medical conditions. The ANZ CPGs do not specify where, when or by whom a physical examination should be done, although they do call for the exclusion of other (medical) problems. Given the interrelationship between mental illness, effective medication and the incidence of chronic disease, adequate history and physical examination should be essential components of mental health care. This may be done by medical staff working in a mental health service, or in collaboration with a GP. However, it is difficult to justify the large number of persons in this study who were self-referred, where there was no evidence of contact with a GP, and there was no evidence of physical examination.

Accordingly, the Committee recommends that:

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 5

Commencement: Immediate; Implementation timeframe: 12 months

The Committee considered the possibility that some of the findings may reflect the experience or discipline of the clinical staff responsible for the assessment and treatment of depression. Many community mental health services report significant difficulties in recruiting experienced mental health clinicians in a range of disciplines, and systems for staff supervision or support may differ widely between clinical services.

The Committee is concerned at the lack of direct or indirect involvement of senior staff in assessments. It may not be possible or even necessary for every individual to be directly assessed by a senior clinician. However, effective treatment of depression requires accurate diagnosis, the identification of and planning for complex co-morbidity, and the balanced use of medication and psychological treatments. All require the input of experienced clinicians. The Committee believes that people seeking help from specialist mental health services would expect that such clinicians would be involved in overseeing or supervising their care. While this may have occurred, it was not systematically documented in the clinical files reviewed.

It may be especially important that where persons with complex depression are referred by other treatment services (including GPs), then assessment should involve senior clinicians in direct care or active supervision. Many have argued that public mental health services should work in closer partnership with other services such as GPs and private psychiatrists in the treatment of depression and other disorders. In the files reviewed, senior clinicians did not appear to be involved in assessment at a level which would be consistent with such a service model.

INITIAL TREATMENT (the first three months)

The initial treatment stage was defined as commencing from the end of assessment and the initiation of treatment, or from the third contact session where the initiation of treatment could not otherwise be clearly identified. The initial treatment stage was defined as ending at three months from the initial assessment.

Of 98 persons assessed, seven were referred to private psychiatrists and six to GPs for further treatment. For 12 persons it appeared that no further contact with any mental health service or provider was planned. However, as will be discussed below, the qualitative file review suggests that this number may be overstated and could be revised downward. For a further 12 persons treatment by the mental health service was planned but suicide occurred prior to planned treatment commencing.

Data were available for 67 persons who received initial treatment for a depressive disorder. For these persons, the following operational criteria were applied as indicators of the extent to which treatment as documented met the standards articulated in the ANZ CPGs. (More detail on persons not seen will be provided in the later section on diagnostically non-specific aspects of care.)

Table 18. Initial Treatment Phase: CPG criteria by operational criteria for file review	
CPG criteria	Operational criteria for file review
Treatment should be based on a sound clinical alliance, with patient involvement in treatment choice.	Is there documented evidence of patient involvement in treatment choice, such as discussion of treatment options or provision of educational material?
Medical conditions and possible drug interactions are considered in medication choice.	<ul style="list-style-type: none"> ▪ Are past adverse drug reactions recorded in assessment? ▪ Are past medical history and/or physical examination recorded in assessment?
Treatment choice should be linked to severity and subtype.	<ul style="list-style-type: none"> ▪ Is Cognitive Behaviour Therapy (CBT) or other specific psychological treatment documented for persons with mild to moderate depression? ▪ Is severe or melancholic depression treated with Venlafaxine or a tricyclic antidepressant? ▪ Is psychotic depression treated with antipsychotic medication?
Mild-moderate depression should be managed in collaboration with a GP.	<ul style="list-style-type: none"> ▪ Are GP contact details documented in the clinical file? ▪ Is there evidence of contact with the GP?
Side effects should be monitored throughout treatment.	<ul style="list-style-type: none"> ▪ Are side effects and medication tolerability documented during treatment visits?
Risk assessment should continue throughout treatment.	<ul style="list-style-type: none"> ▪ Is there evidence of continued risk assessment (structured or unstructured) during treatment visits?
Symptom progress should be monitored with specific measures.	<ul style="list-style-type: none"> ▪ Are any standardised measures of depressive symptoms applied during treatment visits?

Number of Treatment Contacts

Of 67 persons who entered the Initial Treatment stage

- Thirty one (31) remained in treatment by the health service three months after Assessment
- Thirty six (36) persons died by suicide during the first three months of treatment
 - ❑ for 27 persons suicide occurred between planned treatment visits in the first three months, and
 - ❑ for nine persons suicide occurred following discharge from treatment.

The table below summarises the number of treatment contacts (excluding the initial assessment) for each of these groups. The 36 persons who died by suicide during Initial Treatment had only brief contact, with an average of 2.0 treatment contacts per person. Sixty nine percent (69%) had only one or two contacts before suicide death. Persons continuing in treatment at three months had a higher number of contacts; an average of 3.9 contacts per person, with 65% receiving more than two treatment contacts.

Number of contacts during Initial Treatment (13 weeks)				
	Discharged during treatment	Suicide during treatment	Continuing treatment	Total
Persons	9	27	31	67
1 Contact	5	13	3	21
2 Contacts	2	5	8	15
3 Contacts		5	3	8
4 Contacts	1	4	3	8
5 Contacts			5	5
6 Contacts	1		9	10
Average contacts	2.1	2.0	3.9	2.9

These data should be interpreted with caution. The ANZ CPGs do not specify a desirable number of treatment contacts or duration of treatment for depression. The ideal frequency and duration of treatment is difficult to define by algorithm, and may be determined by many factors including the severity of depression, the nature of the individual's personal and social resources, and the level of risk.

It should be noted however, that the evidence supporting psychological therapies such as CBT are based on weekly appointments. At a minimum, regular sessions help to maintain a sound therapeutic relationship, known to be a positive predictor of good outcome in treatments for depression. The evidence here suggests that the contacts average at once a month (2.9/13 weeks), less than would be expected from the evidence.

It can be concluded that in this group, those who died by suicide during initial treatment for depression had received only a limited number of treatment contacts. It is possible that the brevity of contact may have failed to prevent the suicide death outcome in some of these persons. It is also possible that the brevity of contact in this group is an effect rather than a cause of suicide: more intensive planned treatment may have been cut short by the death of some of these persons. In either case, the data may serve as a reminder of the well-documented increase in risk during the early stages of treatment for depression and the need for careful risk management during initial treatment or when considering discharge following brief treatment.

Consumer involvement

Issues such as the quality of the clinical alliance, while essential for good care, are difficult to assess directly via a file review. This review has adopted two indicators which may indirectly reflect aspects of treatment alliance:

Clinical alliance	N	%
Documented patient involvement in treatment choice	50	75%
Documented education about treatment options	39	58%

While acknowledging that these indicators provide a very indirect measure of the quality of the therapeutic relationship, or the treatment alliance, the Committee felt that they reflected aspects of care which are often poorly documented. In this context the rate of documentation of these issues in these files was higher than would have been expected.

Medical conditions and drug interactions

Indicators of this aspect of care have already been described in the section on Assessment, above. At Assessment, past medical history, medication history and adverse drug reactions were usually recorded. Considering only the subset of persons proceeding to initial treatment (n=67), the same pattern was evident as for the larger group (n=98): most aspects of medical history were well documented, with the notable exception of physical examination which was rarely recorded (4%) in this group.

Factors documented	N	%
Total receiving initial treatment	67	100%
Current treatment documented	65	97%
Adverse drug reactions documented	65	97%
Medical history documented	61	91%
Physical examination documented	3	4%

Medication choice

The ANZ CPGs recommend some specific medication strategies for specific subtypes of depression. As described above, a large proportion of diagnoses documented at assessment included no specifier for severity or subtype of depression. Therefore this limits the capacity to analyse the relationship between depressive subtype and treatment choice.

All 67 persons in the initial treatment group were prescribed antidepressants. For 35 of these persons, antidepressants were commenced by a GP or inpatient psychiatry unit prior to referral to the mental health service.

Selective Serotonin Reuptake Inhibitors (SSRIs) and Venlafaxine were the most commonly used agents. Antidepressants used are summarised in the following table:

Antidepressant medications prescribed	N	%
Selective Serotonin Reuptake Inhibitors (SSRIs)	35	52%
Venlafaxine	17	25%
Mirtazapine	11	16%
Tricyclics	4	6%
Monoamine Oxidase Inhibitors (MAOIs) and Reversible Monoamine Oxidase Inhibitor RIMAs)	0	0%
Total prescribed antidepressants	67	100%

The Committee acknowledges the current debate about the possible role of SSRIs in increasing agitation or suicidal ideation¹³. The sample size and design of the current review do not allow any conclusion to be drawn on this issue.

About one-third of persons were prescribed one or more adjunctive medications. Antipsychotics were the most commonly used agents, and in most cases these were novel antipsychotics. Of the 67 persons proceeding into treatment, three were identified as suffering from a psychotic depression, and none as suffering from the depressed phase of a bipolar disorder.

¹³ Hall WD, Lucke J. How have the selective serotonin reuptake inhibitor antidepressants affected suicide mortality? *Australian and New Zealand Journal of Psychiatry*. 2006; 40:941-50.

Adjunctive medications prescribed	N	%
Antipsychotic medications	23	34%
<i>Novel antipsychotics</i>	20	30%
<i>Conventional antipsychotics</i>	3	4%
Mood stabilisers	20	30%
Benzodiazepenes	16	24%

These data suggest either that the recorded diagnoses under-reflect the rate of psychotic depression and bipolar disorder in this group, or that antipsychotics and mood stabilisers are being used in non-specific ways (eg for sedation or augmentation) in the treatment of depression. This issue is discussed further below.

The ANZ CPGs advise that for melancholic depression a tricyclic antidepressant or Venlafaxine are the preferred first-line treatment. Numbers of persons with a diagnostic specifier for severe or melancholic depression were small, however five of nine persons with a severe depression were prescribed Venlafaxine compared with a minority in those where the diagnosis was not specified. None of this “severe” group was prescribed tricyclics, which were used in four persons: three with an unspecified diagnosis and one person with a diagnosis of psychotic depression.

For persons with a diagnostic specifier of psychotic depression, five of six were prescribed an antipsychotic medication.

Use of psychological treatment

Cognitive behavioural therapy (CBT) is used by many clinical psychologists, psychiatrists and other mental health practitioners. It is based on helping the patient to understand, manage and change their thoughts, feelings and actions, and has been shown to be effective in the treatment of depression and other conditions. It aims to change negative thinking, which is associated with a cascade of maladaptive behaviours and emotions such as anxiety and avoidance. It also aims to help people find more flexible and adaptive ways of managing their problems by analysing and challenging self-defeating thoughts and behaviours.

Interpersonal Psychotherapy (IPT) is also widely used. It is based on helping the patient understand the relationship between their thoughts, feelings and behaviours within the context of their interpersonal relationships, and has also been shown to be effective in the treatment of depression and other conditions. The main focus of treatment is on helping patients bolster their current relationship functioning which is associated with overcoming symptoms. Interpersonal conflicts, role transitions, complicated grief and interpersonal deficits are assessed and addressed using a combination of techniques.

For moderate depression the ANZ CPGs recommend the use of CBT or IPT, while acknowledging that other therapies may also share properties shown to be effective.

This review examined files for documentation indicating the use of specific psychological treatments. The threshold adopted was a low one: no attempt was made to rate the quality of psychological therapy or its adherence to specific guidelines.

Of 67 persons treated for depression, 8 had documented diagnoses of psychotic, melancholic or severe depression where specific psychological treatments would not normally be provided as first-line care.

Excluding this more severely depressed group, 59 persons started treatment for a depression of mild-moderate severity or where depression severity/subtype was not specified. Of these 59, only 25 files (42%) documented any form of specific psychological treatment.

Specific psychological treatment documented	N	%
No specific psychological treatment	34	58%
Specific psychological treatment:*	25	42%
<i>Cognitive Behaviour Therapy</i>	18	31%
<i>Interpersonal Therapy</i>	8	14%
<i>Other</i>	3	5%
<i>Total excluding psychotic/melancholic/severe depression</i>	59	100%

*Note: More than one type of psychological treatment was documented for some individuals

In addition two persons with diagnoses of more severe depression (psychotic, melancholic) were also documented as having commenced some form of specific psychological treatment.

The professional discipline of staff involved in treatment may also provide an indirect indicator of the use of specific psychological treatments. Psychotherapies are typically delivered by psychologists, although many contacts by psychologists do not involve such treatment and many clinicians of other disciplines are trained in CBT or IPT. Of the 67 persons receiving initial treatment, only eight records indicated that the person was seen by or discussed with a psychologist. For six of these, specific psychological treatment was documented. This suggests that in this group, psychologists played a limited role in delivering or supervising psychological treatment for depression. The low level of involvement of psychologists and the low uptake of psychotherapies generally, warrants further investigation.

Shared management with GPs

The ANZ CPGs recommend that mild and moderately severe depression should be managed with a GP. This review examined communication with the GP during assessment and discharge as possible markers of collaborative management. While evidence of correspondence from the mental health service to a GP does not guarantee that shared management has occurred, it is reasonable to assume that such management is unlikely to have occurred where there is no documented communication.

Twenty eight (28) of 98 persons assessed were referred by a GP. Of this group

- Only five had evidence that corroborative history was obtained from the GP during the assessment process.
- There was communication with the GP for only five of 24 persons discharged from care prior to suicide.

Continued monitoring

The ANZ CPGs recommend that during treatment there should be continuous monitoring of risk, and of medication side effects. Clinical progress should also be monitored, and this may include the use of standardised measures of depression symptoms.

During the initial treatment phase 192 treatment contacts were recorded for 67 persons. Thirty six (36), or 59% of 67 clients receiving initial treatment had only one or two treatment contacts following assessment. Therefore data on the quality of continued monitoring may be limited by the brief nature of the contact for many persons.

Monitoring during initial treatment	N	%
Persons receiving initial treatment	67	100%
Treatment visits recorded	192	100%
Persons where medication side effects documented	41	61%
Visits where medication side effects documented	96	50%
Persons where risk documented	18	27%
Visits where risk documented	39	20%

The presence or absence of medication side effects was documented for 61% of clients and at 50% of treatment visits.

The presence or level of suicide risk was documented less frequently: for only 27% of patients and 20% of treatment visits.

The following case vignette demonstrates the complexity of co-morbid, social and resource issues which may simultaneously present with mental illness, requiring senior

clinical input as well as co-ordinated and continued monitoring. The question may indeed be asked as to why this person was not admitted, to an alternative bed or other ward or facility if no psychiatric bed was available. Part 4 of this Report refers to patients who continue to be at high or moderate risk of violence being discharged with inadequate follow up arrangements. While the Committee accepts that the context of lack of resources cannot readily be changed, it considers that decisions must be based on the assessment of risk, and that patients assessed at high risk remain linked to care.

A 55 year old female patient was referred to the community mental health service after assessment by the Emergency Department. The patient had a history of chronic physical illness, and not been eating or sleeping for two weeks. She was diagnosed with depression. The patient was non English-speaking and an interpreter was used in all contacts. After referral the patient was assessed by the mental health RN and the psychiatry registrar and a diagnosis of Depression made. She was advised to continue antidepressants commenced by her GP. Community team follow up was planned. Over the next week daily telephone calls were made, the patient stated she had no suicidal thoughts but felt much the same. Thirty five days after referral, a home visit was made and the patient's mental state noted as deteriorated. She had not been taking medications, not risen from bed and had lost 20 kgs since first seen. An inpatient admission was booked, but a bed was not available and still not available two days later. Telephone contact was made then, and was to continue daily. The following day the family informed the team that the patient was missing. The team recommended they notify the Police. The team rang the next day and were informed that the patient had died by suicide the previous evening.

The use of standardised measures for monitoring symptom progress is discussed below for persons proceeding to continued treatment.

Discussion : The Initial Treatment Phase

Sixty seven (67) persons commenced treatment for depression. Of this group:

- Thirty one (31) remained in continued treatment with the service at three months following assessment;
- Nine (9) were discharged from treatment prior to suicide death;
- Twenty seven (27) died by suicide during treatment.

The care of these 67 persons can be summarised as follows:

- Most received a small number of treatment contacts (mean 2.8 contacts, maximum six contacts, 59% of clients received only one or two contacts);
- Only a minority of persons received psychological treatments;
- All persons were treated with antidepressant medication, although for around half of these this had been commenced prior to referral to the community mental health service. SSRIs and Venlafaxine were the most commonly prescribed antidepressants in this group;
- As most assessment diagnoses lacked specifiers for the severity or subtype of Depression, it is difficult to assess whether medication choice was linked to

Depression subtype as recommended by the ANZ CPGs. However, it appears likely that prescribing practice is broadly consistent with these CPGs. Persons with Severe Depression appeared more likely to be treated with Venlafaxine or Tricyclic antidepressants, as recommended by the CPGs;

- About one-third of persons were treated with adjunctive medications, especially antipsychotics and mood stabilisers. The level of use of these agents was greater than would have been expected from the diagnoses documented;
- Medication tolerability was usually monitored during treatment;
- Most records included documentation indicating the discussion of treatment alternatives and/or the provision of education material about treatments;
- Ongoing assessment of suicide risk was documented for only about one-quarter of patients.

There may be many reasons why it may be clinically appropriate or necessary to depart from the general treatment approach outlined in the ANZ CPGs or other treatment guidelines. However, some of the areas of departure may be of significance in the prevention of suicide in persons being treated for depression.

The Committee is concerned about the apparent under-utilisation of psychological treatments in the group reviewed. There is a significant body of evidence that psychological treatments are as effective as medication in the treatment of mild to moderate depression, and may have greater benefit in preventing future relapse¹⁴. Public mental health services often see persons with Severe Depression or complex co-morbidity where “standard” psychological treatments may be less appropriate or more difficult to apply. However, the available data (while possibly limited) do not suggest that the persons in this review fitted this category. Most did not have a recorded diagnosis of Co-morbid Substance Use Disorder or Personality Disorder, or a diagnosis of Severe or Complicated Depression.

Overall, the Committee is concerned at a number of aspects of treatment, specifically the small number of treatment contacts recorded. Thirty one (31) persons remained in care at three months. All were considered to have had depression of sufficient severity to require continued treatment by a mental health service. A number had severe, melancholic or psychotic depression. Yet, the average number of treatment contacts in three months was less than four per person, and 35% of the group (11 persons) had only one or two treatment contacts within the three months.

The frequency of the adjunctive use of antipsychotics and mood stabilisers, in the absence of documented diagnosis of a psychotic or bipolar illness, appeared higher than expected. There are at least two possible explanations for this finding. First, these medications may be being used in symptomatic ways, such as for the management of anxiety, agitation or insomnia. This is not an uncommon use of these medications. Second, it is possible that a subset of this group were thought to have a psychotic

¹⁴ Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Depression. Australian and New Zealand clinical practice guidelines for the treatment of depression. *Australian and New Zealand Journal of Psychiatry*. 2004; 38:389–407.

depression, a bipolar disorder or a severe or resistant depression requiring augmentation therapy but that this was not reflected in the diagnoses recorded. The Committee would be concerned if this explanation applied. As indicated by the ANZ CPGs, documentation of a specific diagnosis is an important basis for risk assessment, management planning and communication. Treatment of a serious depression without documentation of that diagnosis may signal limitations in these aspects of care.

Furthermore, the overall pattern of service contact (that is, apparent assessment by less experienced staff, relatively brief treatment contact, relatively limited ongoing risk assessment) would not constitute an ideal service model for treatment of severe depression. The Committee believes a contributing factor is a lack of a standardised approach to care within the community health setting. Community mental health teams would be supported by clearer clinical management processes including a system of regular case management and clinical file review.

Accordingly, the Committee recommends that

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 6

Commencement: Immediate; Implementation timeframe: 12 months

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.

Recommendation 7

Commencement: 6 months; Implementation timeframe: 12 months

CONTINUED TREATMENT (after three months)

For the purposes of this review persons were defined as entering a “continued treatment” phase if they remained in contact with the mental health service three months after the initial assessment.

Of 67 persons commencing treatment:

- nine were discharged from care after some treatment contact
- twenty seven died by suicide during the course of treatment, leaving
- thirty one people remaining in contact at three months

The following criteria related to ongoing treatment were derived from the ANZ CPGs.

CPG criteria	Operational criteria for file review
Symptom progress should be monitored with specific measures	<ul style="list-style-type: none"> ▪ Are any standardised measures of depressive symptoms applied at 13 weeks (plus or minus four weeks)?
Non-response is detected and leads to review of diagnosis, treatment adherence and perpetuating factors	<ul style="list-style-type: none"> ▪ If patient remains in contact with service at three months, is there any documentation of the level of severity or course of illness? ▪ Is there any documented clinical review (documented discussion at team meeting, assessment by consultant psychiatrist or completion of MH-OAT R1 form) in period 8-16 weeks of contact?
Non-response leads to increased medication dose	<ul style="list-style-type: none"> ▪ Is there any documented increase in medication dose following review?
Non-response leads to alternative, second-line strategy	<ul style="list-style-type: none"> ▪ Is there any documented change in medication following review?
Continued non-response leads to further review (eg second opinion, referral to mood disorders unit)	<ul style="list-style-type: none"> ▪ Is there any documented referral for second opinion or to a specialist mood disorders unit?
Side effects are monitored throughout treatment	<ul style="list-style-type: none"> ▪ Are side effects and medication tolerability documented during treatment visits?
Risk assessment continues throughout treatment	<ul style="list-style-type: none"> ▪ Is there evidence of continued risk assessment (structured or unstructured) during treatment visits?

Monitoring and review

For the 31 persons entering the continued treatment phase, 24 (77%) had evidence of documented clinical review at three months (plus or minus four weeks), where review was defined as one or more of: documented discussion at a team meeting (15 persons); assessment by a consultant psychiatrist (23 persons); completion of a MH-OAT R1 form (11 persons). There was no documentation of such review for six persons entering this phase. The Committee acknowledges the arbitrary nature of the 13 +/- 4-week timeframe chosen for this review, and with that constraint it appears that the majority of persons in continued contact with the service at three months do receive some form of documented review.

The severity and course of depressive symptoms were examined in the first clinical entry following three months of contact. The arbitrary nature of this time period is likely to result in an under-reporting of documentation of these aspects of care. Despite this, such information was documented in a majority of files. Twenty five (25) files (81%) documented the level of severity of depression and 28 files (90%) documented the course of depression. The tables below summarise the information recorded regarding severity and course of depression.

Depression course	N	%
Not documented	3	10%
Improving	8	26%
Stable	16	52%
Deteriorating	4	13%
Total	31	100%

Depression severity	N	%
Not documented	6	19%
Mild	14	45%
Moderate	10	32%
Severe	1	3%
Total	31	100%

For persons in continued treatment, symptom progress was not typically monitored through use of any standardised rating scale: such a scale was present for only eight (26%) of 31 persons.

For about half of the persons in continued treatment (14 persons) was there documentation of the presence or absence of medication side effects in the first two visits following three months of contact.

Treatment response to condition

All persons in continued treatment at three months had either an increase in medication dose (12 persons) or change in antidepressant medication (19 persons).

Data on course and severity of depression is summarised in the tables below. Of 31 persons in continued treatment at three months, most were described at that time as having depression of mild to moderate severity, and as either improving or stable in the course of their depression. About one third of the group were missing information on either course or severity of depression, however only three persons were missing information on both of these aspects.

Severity at 3 months	N	Medication increase		Medication change	
		Y	%	Y	%
Mild	11	5	45%	2	18%
Moderate	10	5	50%	5	50%
Severe	1	0	0%	1	100%
Unknown	9	2	22%	2	22%
TOTAL	31	12	39%	10	32%

Course at 3 months	N	Medication increase		Medication change	
		Y	%	Y	%
Improving	7	2	29%	2	29%
Stable	14	7	50%	4	29%
Deteriorating	4	1	25%	3	75%
Unknown	6	2	33%	2	33%
TOTAL	31	12	39%	11	35%

A very small group was described as suffering from severe depression (n=1) or having a deteriorating course (n=4) at three months. For all people in this group there was a documented response, primarily changing the antidepressant agent used.

Within the limits of these small numbers, it appeared that service response to deteriorating or continued severe depression was consistent with the ANZ CPGs.

Discussion: The Continued Treatment Phase

The number of persons in continued treatment was small. Criteria for this stage of care were more limited in number and scope than those for earlier stages of care. Arguably the criteria used are not well designed to tap into vital aspects of ongoing care such as the accuracy of diagnosis and formulation, the quality of alliance and psychological or social aspects of care, aspects of medication choice and dosage adjustment.

Despite these limitations, some conclusions may be drawn. Compared with the apparent pattern of service contact during assessment and initial treatment, it does appear that most persons in this continuing treatment group were seen or reviewed by more senior clinicians, and that the aspects of care addressed in this review complied reasonably with the criteria derived from the ANZ CPGs.

REFLECTIONS ON THE RATING CRITERIA

The Committee developed a set of rating criteria for this study, and acknowledges their preliminary nature. The Committee was keen to reflect on their strengths and limitations, both to ensure balance in the interpretation of the findings of this review and to inform further development of operational criteria based on the ANZ CPGs. Information in this section is based on qualitative review of a number of clinical files as a final stage of the review, and more broadly on the reflections of the Committee during the process of review.

Clinical and coding expertise

Assessing clinical care through file review is a labour intensive process. As well as an understanding of clinical care, reliable file review also requires broader skills in coding and data organisation.

The criteria used in this study were designed for use by experienced clinical coders who were not clinical experts in mental health. The Committee continues to feel that this is a reasonable strategy for the review of large clinical data sets.

Identifying active clients and stages of care

The ANZ CPGs make clinical recommendations relevant to different stages of the care of depression. The Committee's criteria, based on these CPG's, defined three main stages of active care (Assessment, Initial Treatment, Ongoing Treatment). The Committee anticipated that Assessment and Initial Treatment stages may frequently blur. However, it was not anticipated that there would be major difficulty in allocating persons to one of these stages of care.

However, the qualitative review of clinical files suggested that in a surprisingly large number of cases it was difficult to obtain clarity about whether the person was a client of the mental health service, whether treatment was planned or whether treatment had in fact commenced.

A working party of the Committee reviewed the records of all 12 persons coded as having no treatment planned after assessment. This working party was surprised to find very low inter-rater agreement about whether treatment had in fact been planned or commenced, both between members of the working party and between the working party and QaRNS. For up to 10 of the 12 persons coded as "No treatment planned after assessment", it can be argued from the records that treatment had been planned or had commenced.

A number of factors contributed to this poor inter-rater agreement in these cases:

- Complexity or ambiguity of clinical records. For some of these persons the clinical files remain complex and difficult to navigate, and are frequently split over several settings or contained in multiple files (eg inpatient, Community, ED files).

For a smaller number the clinical information documented was scanty or ambiguous.

- Complexity of clinical pathways. For some of these persons, the process of referral, assessment and planned treatment involved three or more services, often in different sites and in one case in different states. The clinical status and trajectory of the person through these services was often ambiguous within the available records.
- Difficulties in contact or acceptance of treatment. A number of persons in this group died by suicide after loss of contact with the service or refusal of treatment. In many the service was continuing to make some efforts to contact or engage the person, through home visits, planned appointments or phone-calls. These efforts varied in intensity and assertiveness, leading to disagreement between raters regarding whether treatment was planned in these situations.
- Use of ambiguous or non-standardised clinical terms. In particular, the term “Crisis Management Only” was used in several files where a person had had multiple presentations or where there were engagement difficulties. The term has no universally agreed meaning. There was disagreement between raters whether it indicated a specific planned treatment for depression (eg involving elements of social or psychotherapeutic support) or whether it instead signified a lack of planned treatment, an intention for the service to offer no intervention until a future crisis. In at least some files the term “Crisis Management Only” appeared to be little more than a euphemism for “No Care Planned”.

It may therefore be said that the Committee had assumed that the major task of the criteria would be to address the question “What treatment did these persons receive?” The Committee also found that at times it is was difficult to be clear about two apparently simpler questions – was the person a client of the mental health service, and were they receiving treatment by the service? If an opportunity arose to refine the criteria used, greater attention would be paid to defining these questions.

The Committee considered whether those records for whom there was inter-rater disagreement should be excluded from the analyses. However, this was felt to be neither necessary nor desirable.

In particular the Committee felt that this very confusion or disagreement about some basic aspects of care was itself highly relevant to the issue of effective clinical care. The working party reviewing these files included experienced clinicians who were provided with all available files and reports, and were able to study a relatively small number of cases without significant time pressure. Even in these arguably optimal conditions, there was a small but significant group of persons for whom it was very difficult to be clear about some fundamental clinical questions, such as: “Is this person a client of the mental health service? Is treatment planned? What treatment is being offered?”

Confusion about these issues must be at least as great in everyday clinical settings, where urgent clinical decisions often must be made after-hours, where decisions must

be made by staff not involved in earlier aspects of care or with limited access to files and reports. How can an after-hours psychiatry registrar or Emergency Team member assess properly or communicate clearly with family or other staff if even these basic questions are ambiguous?

This report does not repeat previous recommendations concerning documentation. However the files reviewed further highlight the importance of these recommendations, and the Committee is keen to monitor NSW Health commitments towards improving the quality and consistency of community mental health files, including progress towards unique patient identifiers and integrated information systems for community mental health care.

A 31 year old male was referred to the team leader of the community mental health service by a counsellor due to concerns raised after the patient expressed suicidal thoughts. The following day the treating psychiatrist from the program also contacted the service regarding the referral and his concerns of the patient's suicidality (the patient had seen the psychiatrist every 6 weeks). On the 8th and 9th days after the referral the patient was contacted by telephone, and any thoughts of harm or suicide plans were denied. At a multidisciplinary meeting 11 days after the referral the decision was made to provide crisis management only on request. The patient's psychiatrist was notified of the decision. The team was notified of the patient's suicide death, which occurred 25 days after the referral.

30-year-old male was referred to the community mental health team following admission to hospital for a drug and alcohol overdose due to depression over family issues. He was seen by the community RN and given crisis phone numbers and advice regarding availability of counselling as required. His diagnosis at initial assessment was "slight depression / family issues". Two days following discharge from hospital the patient was contacted by telephone, and stated he was 'OK' and attending D&A counselling (no risk documented). There were two further telephone contacts, and following the second call the patient stated he did not need any further contact and he was discharged from the service. The team was notified the patient had died by suicide 91 days after last contact with the community mental health service.

POST-NATAL DEPRESSION

The Committee notes that two of this cohort had post-natal depression, and also that one homicide case involved post natal depression. Postnatal depression (PND) refers to a range of depressive disorders, and affects one in seven mothers who are within six months of confinement. Untreated it has devastating impact on the mother and her family, including the children having a higher risk of cognitive and behavioural difficulties and depression.

If women at risk of PND are identified during pregnancy and effective psychological and social interventions are provided, postnatal depression may be reduced in severity or prevented altogether. However a number of factors have been identified as reducing access to care including transport difficulties and isolation, fatigue, social mores, and childcare responsibilities.

The cases in this review are small in number, but highlight the need for better integration of perinatal care, perinatal screening, and mental health services that are responsive and appropriate to this sector of the population. Patients diagnosed with post natal depression seem particularly vulnerable, indicating the need for special identification and consideration when developing standards of care. The following case vignette highlights the lack of communication between community mental health services and the GP.

A 29 yr old female was referred by Child and Adolescent Family Services to the community mental health service following an attempted overdose four weeks previously. The patient had a six-month old child and three other children under 10 years of age. The patient was assessed 10 days after the referral and a diagnosis of post partum major depression was made. Follow up by telephone contact and review by a psychiatrist was planned. Two phone calls were made in the week following the assessment, and on the second call the patient stated she did not want to see the psychiatrist. The patient was advised to go to her GP for medication. There was no documentation of communication with the GP. The team discussed the case 10 days after the assessment and closed the file. The patient died by suicide 33 days after the date of the assessment.

The second vignette highlights an apparent failure of adequate follow-up.

A 25 yr old female was referred by a childcare centre worker to the community mental health service with concerns that the patient was depressed post partum. The patient had an eight-week-old baby and was due to attend a mothercraft unit. The patient was assessed two days after the referral and a diagnosis of depression post partum was made. A home visit was planned for the following day and a psychiatrist review booked for two weeks later. The patient cancelled the home visit two days in a row. On discussion by telephone, she stated her mood was fine with no suicidal thoughts. The home visit was booked for the following week and the patient given crisis numbers to call if required. The team was notified of the patient's suicide death seven days after the referral.

OTHER ASPECTS OF CARE

This review focused primarily on the specific treatment of depression. However, the review also allows some limited comment on other aspects of care. Past reviews, including those previously undertaken by the Committee, have identified a number of common themes or issues which may be associated with preventable suicide death.

Assertiveness of care

A challenge for clinical services is to ensure an appropriately assertive reaction to loss of contact or non-attendance by patients. This requires balance: persons have a right to choose whether or not to attend a service, and often there are appropriate reasons for loss of contact. However, past reviews have frequently identified points of loss of contact as missed opportunities for prevention of suicide.

Of 98 persons assessed and treated for depression in this review, for only six persons was there loss of planned contact prior to the reported suicide. For five of these persons there was documented evidence that the service successfully initiated action to re-establish contact.

Communication and handover of care

Communication at the point of transition between care settings has frequently been identified as one of the most important factors in the prevention of suicide. Referral from the mental health service back to care by a GP or other provider must involve communication with the person, their families or supports, and the GP or other provider of care.

Depression is often a chronic or recurring condition. Therefore it is critical that the patient and their family or supports are aware of the nature of depression, possible warning signs for future relapse, possible signals of increased risk, and steps to take (including pathways back to care) if there are signs of further difficulties.

In this review 27 of 98 persons assessed and treated for depression had been discharged from community mental health care and referred to another service prior to the reported suicide death. Aspects of communication and planning in this group are summarised below:

Communication and discharge planning	N	%
Discharged from care prior to suicide	27	100%
Documented communication with GP	22	81%
Documented communication with family/supports	8	30%
Evidence of relapse education or planning	2	7%
Documented plan for future care or contact	5	19%

For most persons (81% of the 27 persons discharged from care) there was evidence of communication with the person's GP. While this is positive, the Committee remains concerned that five persons in this group were discharged from care without such communication.

While the *quantity* of discharge communication appears reasonable, the above data may suggest concerns regarding the *quality* of such communication: in only a minority of persons was there documented evidence of communication with family or supports, relapse planning or contingency planning for any future episodes of depression.

Accordingly, the Committee recommends that

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.

Recommendation 8

Commencement: Immediate; Implementation timeframe: 6 months

Access to care

Care can only be effective if it is accessible. Past reviews have identified access to care, in particular access to appropriate inpatient care, as a factor in some suicide deaths. An association has been found between short lengths of stay and preventable suicide death^{14, 15,16,17} and in NSW post-discharge suicide death was reported more commonly by Area Health Services with lower numbers of inpatient mental health beds compared with their estimated population need¹⁸.

However, this review focuses on **outpatient** treatment of depression. It may be possible to use NSW Area Health Services community-based mental health staffing levels as an indirect measure of the resources available for community care, including for the care of depression.

There are three important limitations to such an analysis. First, this review has data only on *reported* suicides, and therefore apparent differences between Area Health Services may reflect differences in reporting rather than differences in the underlying

¹⁴ Steering Committee of the National Confidential Inquiry. *Safety First: Five Year Report of the National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness*. National Institute for Clinical Excellence. London; 2001.

¹⁵ Burgess P, Pirkis J, Morton J, Croke E. Lessons from a comprehensive clinical audit of users of psychiatric services who died by suicide. *Psychiatric Services*. 2000; 51:1555-1560.

¹⁶ Pirkis J, Burgess R, Jolley D). Suicide among psychiatric patients: a case-control study. *Australian and New Zealand Journal of Psychiatry*. 2001; 36:86-91.

¹⁷ Lawrence D, D'Arcy C, Holman J, Jablensky A, Fuller S, Stoney A). Increasing rates of suicide in Western Australian psychiatric patients: a record linkage study. *Acta Psychiatrica Scandinavica*. 2001;104:443-451.

¹⁸ NSW Mental Health Sentinel Events Review Committee: *Tracking Tragedy 2004 Second Report to the Minister*; 2004.

rate of suicide death. Second, suicide death is an infrequent event, and therefore comparison of small population areas may produce large apparent differences which are merely the product of chance. Third, such an analysis assumes that all Area Health Services have a similar proportion of their overall community staff resource available for the treatment of depression.

While noting these limitations, the Committee examined whether within the group of persons being treated for depression currently being reviewed there was a relationship between Area of residence and community mental health resources. NSW has eight geographically based Area Health Services, four primarily metropolitan (Northern Sydney Central Coast, Sydney West, Sydney South West, South Eastern Sydney Illawarra) and four primarily regional or rural (North Coast, Hunter New England, Greater Western, Greater Southern).

Financial and population information were obtained from the NSW Mental Health Clinical Care and Prevention (MH-CCP) model, NSW Centre for Mental Health. Area Health Services were grouped into two groups of four based on their reported ambulatory mental health funding per 100,000 population. There was no obvious relationship between rate of suicide death and funding level.

Reported suicide deaths and community MH funding	4 "least funded" AHSs	4 "best funded" AHSs
Population served	4,073,943	2,712,248
Ambulatory mental health budget (\$000)	\$106,244	\$98,952
Ambulatory \$ per 100,000 population	\$2,608	\$3,648
Reported suicides, depression (n=113)	70	43
Reported suicides per 100,000 population (standard deviation)	1.72 (0.69)	1.59 (0.70)

NSW Health Department. *NSW Mental Health Performance Report - Financial and Population Data. July-Dec 2005.*

Specific concerns have been raised regarding access to services and effective suicide prevention in rural areas. Rural Area Health Services have a *higher* level of community mental health funding on a per capita basis than Metropolitan Area Health Services. The above analysis was repeated, grouping the four rural/regional Area Health Services and the four primarily metropolitan Area Health Services. There was no obvious relationship between rate of reported suicide death and rurality of the reporting Area Health Service.

Reported suicides and rurality	Rural/Regional AHSs	Metropolitan AHSs
Population served	2,099,069	4,687,122
Ambulatory mental health budget (\$000)	71,116	134,080
Ambulatory \$ per 100,000 population	3388	2861
Reported suicides, Depression (n=113)	38	75
Reported suicides per 100,000 population (Standard Deviation)	1.81 (0.63)	1.60 (0.68)

DETAILS OF SUICIDE DEATH

The following section provides supplementary information on the method of suicide death in this group and the time between last service contact and death.

Method of suicide death

The most frequent methods of suicide death were hanging, carbon monoxide poisoning and overdose, together accounting for more than 70% of reports. Hanging, firearm use and carbon-monoxide poisoning were proportionally more frequent amongst men, while overdose was proportionally more frequent amongst women.

Of the 17 persons who died by overdose, the substance used was unknown, or not recorded, for five persons, prescription medication for 10 persons, over the counter medication for one person and illicit drugs for one person.

Method of suicide death	M	F	Total	%
Hanging	29	17	46	41%
Carbon monoxide and other poisoning	16	2	18	16%
Overdose of prescribed or illicit substances	5	12	17	15%
Firearms	7	1	8	7%
Jumping from height	3	4	7	6%
Drowning	2	3	5	4%
Asphyxiation	1	3	4	4%
Train	1	2	3	3%
Cutting	1		1	1%
Method unknown	3	1	4	4%
Total	68	45	113	100%

Time since contact

Forty five percent (45%) of persons had contact within seven days prior to suicide, and 75% had contact within 40 days prior to suicide.

Time from last contact to suicide death	n	%
0-7 days	44	45%
8-20 days	20	20%
21-40 days	10	10%
41-60 days	7	7%
60 days - 2 years	14	14%
> 2 years	3	3%
Total	98	100%