

Part 4
Analysis Of Homicide
Cases

Analysis of Homicide Cases

KEY FINDINGS

- Illicit substance abuse and homelessness are common accompaniments of homicide.
- Liaison with the NSW Police Force was sub-optimal.
- Clinicians do not always use the Mental Health Act to apprehend and detain mentally ill persons as early as possible.
- Community Treatment Orders are not always implemented when clearly indicated on the basis of risk.
- Not all referrals by courts for psychiatric assessment are reported adequately.
- Pressure on beds may have led to premature discharge of three persons who later committed homicide.
- Inadequate follow up, clinical care and support of some high risk patients of mental health services led to fatal consequences.

INTRODUCTION

The work of the Committee during 2005 -06 included the analysis of cases of homicide committed by persons who were receiving care or had recently received care from public mental health services in NSW. The Committee focused on the standards and processes of care with a view to making recommendations in relation to systemic issues, as illustrated by the analysis. In this respect, these tragic incidents serve as a window onto the standards and delivery of care by our public mental health services. The Committee's recommendations are intended to provide direction as to remedial, system-wide actions that might be taken by the NSW Department of Health and Area Health Services in the light of the lessons derived from individual cases.

While the Committee acknowledges that the number of actual homicide cases involving mental health clients each year is small, each case involves immense tragedy and sadness for all concerned. Each case deserves careful analysis to ensure, as much as humanly possible, that such tragic incidents are prevented in the future. However, the Committee also deliberated over whether there would be value in increasing the scope of its work to include cases of assault resulting in serious injury. This would be within the scope of the first term of reference of the Committee:

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).

The Committee was of the opinion that widening the scope of cases reviewed might reveal important information about clinical care, service delivery and risk management practices. A larger number of incidents of serious injury will provide a wider surveillance of the systems of care and greater analytical power. The NSW Health Incident Information Management System (IIMS) is able to identify incidents of serious injury through the Reportable Incident Brief Severity Assessment Coding.¹

The Committee proposes to broaden its work in 2007 to include the analysis of serious injury reported by Area Mental Health Services within the New South Wales Health Incident Information Management System where the incidents are rated as Severity Assessment Code 1.

The Committee is uncertain as to whether the NSW Department of Health, and therefore the Committee, is informed about all homicides that involve mental health patients. There are gaps in the reporting mechanism that the Committee addressed in its recommendations in its First and Second Reports to the Minister: *Tracking Tragedy and Tracking Tragedy 2004*. Also in 2004 the Committee recommended that NSW Health ensure the development of a unique identifier and electronic record systems to ensure the constant availability and prompt transfer of relevant clinical information

¹ NSW Health Department. *Reportable Incident Briefs to the NSW Department of Health*. Circular No. 2003/88 (PD 2005_337); 8 December 2003.

between services and between service providers (Recommendation 4). For example, a person may be discharged from a mental health service or not have gained appropriate access to services, and commit a violent crime while suffering from a mental disorder. The Committee believes that implementation of the Mental Health Unique Patient Identifier (MHUPI) will assist in identifying any person who had contact with mental health services. However, privacy issues may remain a barrier to the Committee's access to data in some cases.

The Committee is advised that the MHUPI process was technically complete by October 2005, but due to technical issues it was July 2006 when the quality of all identifying and demographic information from AHS was considered adequate.

The Committee understands that while gradual progress is being made, there are significant technical and resource barriers to the implementation of the electronic medical record. The Committee urges NSW Health to expedite the implementation of critical infrastructure such as the electronic medical record to provide clinicians with appropriate clinical decision support. **The Committee requests that it be provided with regular status reports in relation to the implementation of the electronic medical record for mental health services.**

The Committee also looked at the progress on implementation of previous Committee recommendations and noted with particular concern the lack of progress on the development of a NSW Mental Health Services framework for the assessment and management of risk of harm to others. This issue has been the subject of recommendations of the Committee's First and Second Reports to the Minister: *Tracking Tragedy* and *Tracking Tragedy 2004*.

A presentation was made to the Committee on two clinical risk assessment tools: the Short-Term Assessment of Risk and Treatability (START)² and the HCR-20³. The excellent article by Kumar and Simpson (2005) which presents the HCR-20 as a conceptual framework to guide clinicians was tabled and the Committee felt this article should be widely recommended⁴. The Committee emphasises the importance of a clinician decision support framework for the assessment and management of the risk of violence, and again refers this matter to the NSW Department of Health for action.

The invaluable information and insight made available through external review reports for a number of these incidents assisted the Committee's analysis of these events. The Committee notes the introduction of Root Cause Analysis⁵ by all Area Health Services

² Webster CD, Martin M, Brink J, Nicolls TL, Middleton C. *Short-Term Assessment of Risk and Treatability (START): An Evaluation and Planning Guideline*. St Joseph's Health Care Hamilton. Forensic Psychiatric Services Commission, Ontario, Canada; 2004.

³ Webster D, Douglas KS, Eaves D, Hart SD. *HCR-20 Assessing Risk for Violence Version 2*. Mental Health Law and Policy Institute, Simon Fraser University. Published in cooperation with the British Columbia Forensic Psychiatry Services Commission; 1997.

⁴ Kumar S, Alexander I, Simpson F. Application of risk assessment for violence methods to general adult psychiatry: a selective literature review. *Australian and New Zealand Journal of Psychiatry*. 2005; 39(5):328-335.

⁵ NSW Health Department. *Reportable Incident Definition under section 20L of the Health Administration Act 1982*. PD2005_634; 17 November 2005.

and the quality of RCA reports is expected to improve. However, the Committee was again hampered in its work by the poor level of documentation of incident reviews performed by some Area Health Services. Frequently the detail of the information available through the RCA reports was scant, often insufficient to allow testing of whether all concerns or issues in the case had been captured in the summary findings and recommendations of the RCA. For this Report the Committee had the benefit of access to the medical record in most cases. Analysis of the medical records was led by one of the Committee's clinicians in each case that this material was available.

The Committee's general approach in reviewing sentinel events is to examine the systems issues and make recommendations that will improve the delivery and processes of care within NSW Health Services. The Terms of Reference of the Committee no longer provide for the referral of matters to relevant professional registration boards in the event that clinician performance is considered to be a contributing factor in respect to any incident reviewed by the Committee. They do allow for the Committee to generally advise the Minister for Health and the Department of Health on means to minimise or prevent sentinel events. One concern as to practitioner performance arising from the Committee's work was notified by the Committee to the Minister for Health in December 2005 for consideration of Ministerial referral to the Medical Board of New South Wales for further investigation. The outcome will not be referred to further in this or subsequent Reports of the Committee.

DEMOGRAPHIC AND RISK FACTORS

Ten cases were referred to the Committee. One case was excluded from this analysis after evaluation of the available information led to the conclusion that the incident did not involve patients of the mental health service.

One case was of a man who had not had contact with mental health services for a period of 9 months at the time of the homicide. However, the Committee decided that this case fell within its terms of reference as the person had a mental illness at the time of the incident and had been a patient of the mental health service previously. This case and the prevalence of co-morbid drug and alcohol disorders in cases considered by the Committee raise the importance of Mental Health Services having better access to expertise in Drug and Alcohol disorders. The membership of the Committee has now been expanded to include an Addictions Medicine specialist.

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

Two of the nine cases involved the death of children. Three cases were homicides associated with suicide. Eight cases involved the killing of a family member or close acquaintance of the perpetrator. Eight of the perpetrators were men. The average age of the group was 29.8 years, the range was between 19 to 44 years. There was substance abuse, mainly cannabis and amphetamines, in seven cases. In five cases the perpetrator was homeless and/or itinerant.

Table 35. Demographic and Other Factors

Sex	Age range (yrs)	Diagnosis	Time between last contact and event	History of violence	Other factors
M*	21 - 25	Psychotic illness	3 days ¹	Previous violence; Known to police; Apprehended Violence Order (AVO).	Amphetamine and cocaine use. First contact with MHS a couple of days before incident. Court appearance pending at time of incident. Unemployed. Victim was close friend.
M**	41 - 45	Schizophrenia	1 day		History of hearing impairment. Cannabis use. Itinerant. Victim was a friend.
F#	41 - 45	Psychotic depression	2 days		Previous depression. Multiple antenatal risk factors. Victim was perpetrator's child.
M	21 - 25	Schizophrenia	12 months	Previous violence; Prior convictions for assault.	Homelessness. Cannabis use. Previous multi-substance abuse. Victim was an acquaintance.
M*	31 - 35	Depression	16 months		Access to firearms restored. Victims were family.
M	31 - 35	Schizophrenia	11 months	Previous violence.	Cannabis and heroin use. Homelessness. Victim was unknown to perpetrator.
M	31 - 35	Schizophrenia	2 months	Previous violence; Previous AVO.	Periods of homelessness. Itinerant. Drug use. Vehicle, property and drug possession offences. Court appearance pending at time of incident. Victim was an acquaintance.
M	21 - 25	Schizophrenia	1 week ²	Previous violence.	Cannabis and amphetamine use. Court appearance pending at time of incident. Victim was close friend.
M	16 - 20	Schizophrenia	12 months ³	Previous violence; Previous AVO.	Cannabis and amphetamine use. Periods of homelessness. Itinerant. Victim was a friend.

* Homicide-suicide.

** Perpetrator's suicide occurred subsequent to imprisonment.

Attempted suicide

1. from referral to incident; patient not seen despite repeated attempts by team.
2. from last contact phone call; 3 weeks from last face-to-face contact.
3. from last contact by NSW mental health service; 3 months from last contact with interstate mental health service. Incident took place in NSW.

Although this series is small it is a matter of concern that of the nine cases analysed, five cases were of homeless or itinerant men with a history of psychotic illness. There was a history of recent substance abuse in seven cases. It was also noted that pressure on acute bed places was a factor in three cases being discharged inappropriately early from care.

REPORT OF CASE ANALYSES

The Committee in providing this report and making these recommendations endeavours to highlight areas for focus and actions that can be taken to improve the quality of care and the safety of patients and the community.

The Committee developed a number of recommendations from the analysis of the 9 case histories. In summary these covered the following key areas:

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

The recommendations are presented below with discussion of the Committee's findings and associated contextual issues.

A. Standards for scheduling and guidelines for early contact with police

In one case the perpetrator was previously unknown to the mental health service. There was a court case pending in relation to a car accident. There was a history of aggression towards the perpetrator's girlfriend and an apprehended violence order had been made. There had been threats and actual assault of a family member. Some of this information only emerged after the initial contact by the mental health service with the client.

The case is a salutary reminder of the counterfactual nature of hindsight. The perspective of a dispassionate reviewer is different from that which confronts a front line clinician needing to make rapid decisions on available information. The clinical team had inquired about access to firearms and been falsely reassured there were no firearms. Had a more assertive approach to intervening at the home been undertaken by police and clinicians, there may have been fatalities amongst the police and clinicians. On the other hand, there had not been the early sharing of vital information between police and the mental health service in this case. Nonetheless, this case led to discussion of the apparent range of practices in relation to when a schedule would be written and police deployed to bring a person at risk to hospital. The Committee was informed that across NSW there is a range of practice and differing 'thresholds' for writing a schedule under the Mental Health Act.

The Committee is aware that there is great variation in clinicians' views about criteria for scheduling, and that these variations in practice are due to differences in the approach of individual clinicians and service culture. Some feel obliged to try to talk patients into care, build rapport and trust, and often there is a thought that the patient might improve sufficiently to realise they need professional help. Early and assertive intervention with

psychotic patients in the community often means asking the police to make a forced entry and staff have to make a judgement that this is appropriate or clinically necessary.

The expectation that patients in such circumstances will rapidly improve may be unrealistic. There is often a tendency to minimise risk when clinicians err on the side of individual rights rather than safety. Many clinicians are accustomed to the level of risk indicated by violent behaviour, or take comfort in the fact that the violence or risk of violence is understandable because of the person's psychotic state. Risk and safety have to be priorities. In addition to the personal and family tragedy that is associated with such events other impacts are very significant, in terms of further stigmatising mental illness and undermining confidence in the mental health services. Aggression caused by mental illness cannot be accepted, yet often services do accept it.

It is the Committee's view that a more appropriate weighting should be applied between issues of safety to the community and individual rights. There is a need for clearer standards for scheduling.

Mental health staff should initiate liaison with local police at the earliest stage when it is likely that there may be a requirement for police involvement in bringing a person in the community into care under the Mental Health Act. There should be an exchange of information between the two agencies at this early stage for the purpose of accurately determining any safety risks, and to ensure a rapid and well prepared response if required.

Two issues emerged from this case:

- the wide differences amongst clinicians in the threshold for scheduling and
- need for police and health services to work closely and share information.

The Committee believes that these issues are amenable to a quality improvement approach and that there is an opportunity to incorporate this within the current revision of the NSW Mental Health Act.

Accordingly, the Committee recommends that:

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

Recommendation 9

Commencement: 6 months; Implementation timeframe: 6 months

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

Recommendation 10

Commencement: 6 months; Implementation timeframe: 6 months

B. Risk assessment and management

Two cases in this series led to a recommendation about risk assessment and management. In one case a patient was admitted to hospital with homicidal ideation and a history of violence in the context of a psychotic illness. The admission was for a number of months. Prior to discharge there were numerous occasions of leave. There had been evidence of ongoing psychotic preoccupation with violent intentions during the early periods of leave. While the patient was well on discharge, there were problems with follow up, and at some point the patient dropped out of close contact with the mental health service. There were indications of improvement and his return to work meant the patient could not see his case manager in normal hours.

Review of this case indicated concerns regarding risk assessment and management. The principles of least restrictive care and social re-integration were given higher priority than risk management. Risk management planning for the post-discharge period and communication of clear arrangements around the time of discharge were inadequate.

There was a failure to warn adequately the person about whom the perpetrator had psychotic homicidal delusions. This issue was the subject of Recommendation 28 of the Committee's First Report.

It is the Committee's view that in addition to other services whose role it may be to provide support to victim's families, mental health services have a role to ensure that families bereaved by a homicide are provided with support and counselling.

In a different case the RCA report noted that the "extreme pressure for beds" seemed to contribute to sub-optimal patient management of a man who had travelled from interstate. Inpatient units should have a high threshold for repatriating a person to care in their 'home town', and should continue to manage a person who has presented to their unit until a detailed review assessment is made and improvement is evident. The lack of a comprehensive risk assessment prior to discharge meant that relevant information that may have delayed the patient's discharge until he was more stable was not considered.

The HCR-20 Risk Management Tool had been discussed by the Committee late in 2004. A further discussion by the Committee occurred in relation to this case. The HCR-20 is a guide to clinicians for the assessment of risk, listing factors known to be associated with risk of violence. It has acceptable validity and reliability⁶ in identifying high levels of such risk, for assisting in making decisions to discharge and in developing risk management plans. It measures long term historical factors (H), clinical factors (C) and current risk factors for violence (R).

The NSW Government Response to the First and Second Reports of the Committee were released in December 2004 and December 2005 respectively. The Committee noted the advice that the vast majority of recommendations were implemented or that

⁶ Douglas KS, Guy LS, Weir J. *HCR-20 Violence Risk Assessment Scheme: Overview and Annotated Bibliography*. Summary of validity studies at www.violence-risk.com/hcr20annotated.pdf

their implementation was ongoing.

The Committee notes with concern that Recommendation 1 of the First Report and Recommendation 8 of the Second Report in relation to the development of a risk assessment and management framework have not been implemented and 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

C. Transferring care across services and jurisdictions

Another case was that of a man with a history of schizophrenia, drug abuse and assaultive behaviour. He was at times homeless and itinerant, crossing into another State for periods to reside with family. The review of this case indicated that there were lessons to be learnt in relation to referral pathways and communication of important patient information between the teams within a mental health service. A second issue was in relation to ensuring continuity of care and follow up for a person with multiple risk factors who moved across jurisdictions.

There were 6 factors which indicated that a Community Treatment Order (CTO) should have been applied, for greater control and assertive management. These factors were:

- Chronic psychosis
- Non-compliance with medication
- Substance abuse
- Danger to self
- Problems with family
- Homelessness

However, difficulties in implementation of a CTO would have occurred because of the man's movement interstate. While the best endeavours should be made, there is no control over treatment once a patient is out of the system.

Continuity of care when care is being transferred across jurisdictions, including State borders would be ensured by arrangements which include:

- a formal handover which identifies and documents both the entry into the new service and the future re-entry pathway to the referring service, including identified clinicians responsible for care;
- a thorough risk assessment of both harm to self and others, prior to transfer;
- full consultation between both teams;
- consideration of applying a CTO, where there is risk of relapse or recurrence of a psychotic illness.

Electronic records would improve the quality and safety of care by providing a discharge summary and other relevant information at central intake when such a patient re-presents. The transfer of information between treating clinicians in other Area Health Services and across State jurisdictions would also be considerably enhanced by an electronic medical record.

The Committee understands that gradual progress is being made, but there are significant technical and resource barriers to the implementation of the electronic medical record. The Committee regards the development of pivotal infrastructure to support appropriate clinical care and decision making as a matter of urgency, and requests NSW Health to provide status reports in relation to the implementation of the electronic medical record for mental health services.

In the interim, NSW Health should advocate the guided, active and supported use of telephones and faxes to expedite the transfer of patient information.

The Committee recommends that:

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

Recommendation 11

Commencement: 6 months; Implementation timeframe: 12 months

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

Recommendation 12

Commencement: 6 months; Implementation timeframe: 12 months

D. Assessment of persons referred by the courts

A person may be referred by the courts for a psychiatric assessment (Section 32, 33 Mental Health [Criminal Procedure] Act 1990; Section 25, 27 Mental Health Act 1990). Generally such court referrals represent an important opportunity to link the referred person with appropriate mental health care. A comprehensive psychiatric assessment is crucial.

Area Mental Health Services must ensure that persons referred by the courts for psychiatric assessment, receive an appropriate level of assessment and that the assessment, management and follow up plans are documented in the medical record and communicated back to the courts and to other relevant service providers.

One of the cases reviewed involved a man who had been referred by the courts on at least two occasions but did not receive a definitive assessment, accurate diagnosis or appropriate care. The case highlights the need for careful, detailed risk assessment and the importance of corroborative history. Clinicians need to synthesise all available information. In this case there was a family history of chronic psychosis, and the patient had a history of psychosis, drug abuse, itinerancy, social deterioration, as well as antisocial petty criminal behaviour and violence. A provisional diagnosis of psychosis was changed to one of malingering.

While it is conceded that in this case the patient's symptoms may not have been sustained on clinical review, the Committee was concerned that persons with criminal charges are often assumed to be malingering. The Area Health Service commissioned an external senior clinician to review this case. The external reviewer noted pressure on acute beds as a possible factor in clinicians making the decision to discharge a person who was of uncertain diagnosis in favour of admitting other patients who might be clearly psychotic or suicidal.

The Committee agreed with the external reviewer's concerns regarding the diagnosis of malingering. The literature shows that many people so diagnosed are later found to be mentally ill⁷. Malingering and an Axis 1 diagnosis such as psychosis can co-exist. A diagnosis of malingering per se should not rule a person out of scope of care from the mental health service.

⁷ Rogers R. *The Clinical Assessment of Malingering and Deception*. Guilford Press, 2nd Edition; 1997.

Accordingly, the Committee recommends that:

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

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

Recommendation 13

Commencement: Immediate; Implementation timeframe: 6 months

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

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

Recommendation 14

Commencement: Immediate; Implementation timeframe: 12 months

E. Gun licences

Two cases involved firearms. In both cases little information was available to the Committee in relation to the granting of gun licences. However, in one of these cases the homicides of family members and the man's suicide occurred after his gun licence had been restored to him on application following supporting medical reports to the Firearms Registry.

Possession or access to firearms by a person suffering or reasonably believed to be suffering from mental illness is a critical factor in some Sentinel Events. The Committee noted that section 79 of the Firearms Act 1996 provides for health professionals to advise police if they form an opinion that a person to whom they are providing professional services may pose a threat to public safety or their own safety, if in possession of a firearm.

The Committee took some advice on police power to seize firearms from persons, licensed to possess or use them, who are suffering from mental illness. There will be circumstances where the current police powers will not be sufficiently expeditious or practical in the public interest. The Committee understands that the Firearms Act 1996

empowers police to suspend licences (pending revocation) by the service of a written notice (s22), the suspension thereby requiring the immediate surrender of firearms (s25), and that there are consequent provisions for application for a search warrant in the event of non-surrender (s47 Law Enforcement (Powers and Responsibilities) Act 2002 [LEPR Act]). It seems to the Committee that a legislative regime at least equivalent to (if not stronger than) Part 6 of the LEPR Act 2002 which applies to search, entry and seizure powers relating to domestic violence offences, should apply (in a simplified form) to mentally ill persons who have access to firearms.

Accordingly the Committee recommends that

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

Recommendation 15

Commencement: Immediate; Implementation timeframe: 6 months

F. Assertive follow up of patients with continuing high risk

In a number of cases in this series the fatal event was perpetrated months after the patient exited the care of a mental health service. Yet these people were at some stage considered so unwell as to be brought under the Mental Health Act. Cases in this and the previous series reported by the Committee describe patients who continue to be at high or moderate risk of violence being discharged with inadequate follow up arrangements.

The impression is of very busy clinical work environments with resource pressures and insufficient time to explore issues, where assumptions are made that once a patient disclaims illness, they have indeed improved. The Committee accepts that the context of the lack of resources cannot readily be changed, but considers that decisions must be based on the assessment of risk. Assessment at discharge must be sufficiently thorough. In one relevant case the person who was psychotic was scheduled to hospital but only detained for four days. Step-down care and follow up should have been provided but were not. The probability of compliance, conflict and relapse should have been considered. The Committee believes that there is a responsibility to ensure that patients assessed at high risk remain linked to care. Their requirements over the next 12 months should be considered, as should the level of support offered to them and to their General Practitioner.

Another case was that of a man whose psychosis during admission to hospital appeared to start to respond to treatment. There was a history of drug abuse and aggression when unwell. The discharge summary for that admission identified florid psychosis with advice that he take medication, live properly without drugs or alcohol and attend follow up sessions with the community mental health team. His risk status was documented as moderate to high for harm to others, and he remained psychotic. However, there is no indication that the discharge summary was sent to anyone. There

was no case management and no specific follow up documented. His housing and treatment needs were not addressed, although the man himself made some attempts regarding public housing.

The Committee found it difficult to understand why assertive community treatment did not occur and why there was no structured discharge plan. The circumstances of the case (violence, incarceration in gaol, substance abuse, non-compliance and psychosis) indicate the need for assertive case management. A case manager was required to organise housing and consistent treatment to stabilise his psychotic symptoms. Additionally, the Parole Officer should have overseen his access to care. Even though Parole, GP and the community mental health team were 'ticked' in the medical record as being involved in the man's care, there is no indication that any action was taken. The case presented an opportunity for mitigation strategies to be put in place, including a CTO, or the involvement of Parole.

The Committee has previously recommended that a patient not be discharged until a case manager has been identified. Follow up is certainly required in an acute case such as this.

If a patient who requires ongoing treatment and care is discharged from hospital or a community mental health service to another care provider, there is no control over the patient's treatment and follow up once the patient is outside the mental health service.

Accordingly, the Committee recommends that:

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

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

Recommendation 16

Commencement: Immediate; Implementation timeframe: 12 months

The one female in this series killed her six month old baby while acutely psychotic. Ante-natal notes stated that she was at high risk of post-natal depression, but otherwise there was not much detail. There was some conflicting information regarding the regularity of her contact with her general practitioner.

The woman was discharged into the care of her GP a few days after the birth and was said to be well. Child and Family Team notes focused on post-natal care and were positive about the woman's general welfare. Calls to the team three days before the death of the baby reassured them of her welfare. The woman was found floridly psychotic where the baby died, and had attempted suicide.

There were several reasons the woman should have been flagged for careful follow-up by the health service. These included geographic and social isolation, late antenatal presentation, maternal age, previous history of abuse (as a child) and a history of depression. The case highlights the importance of adequately resourced perinatal screening. The Committee is aware that NSW Health has rolled out an Integrated Perinatal Care Program but that no resources were specifically allocated. There was limited provision of postnatal follow up and no outreach Social Work service in this case. The benefit of sharing and integration of health provider information is also illustrated by this case.

This case and the two cases of suicide during post-natal depression highlight the potential seriousness of depressive illness in the post partum period.

G. Quality of documentation

Some clinical assessments in this series were deficient in detail. The Committee discussed the reasons clinicians do not adequately document assessments and clinical reviews. There is resistance by some psychiatrists to the Mental Health Outcomes and Training Tools (MH-OAT) proformas. The Committee understands that one group of psychiatrists has written to the Royal Australian and New Zealand College of Psychiatrists about their concerns that the MH-OAT forms may compromise the standard of assessment. That group stated that registrar training in taking comprehensive histories is incompatible with MH-OAT. Clinicians may feel that if their assessment is recorded in the notes the completion of the MH-OAT forms is superfluous, or that the completion of the first part of the form is sufficient for medico-legal purposes. However clinicians are often embarrassed by the quality of their notes when facing incident reviews and the Coroner. It is clear that the communication function of the medical record is often compromised by inadequate documentation of issues such as risk and management planning.

The difficulty lies in reaching agreement amongst stakeholders about the standard required. MH-OAT represents an attempt to set a minimum standard of assessment, documentation and communication. Additionally, it has been suggested that RCA Teams should refer inadequate documentation found incidentally to the Area Directors of Clinical Governance.

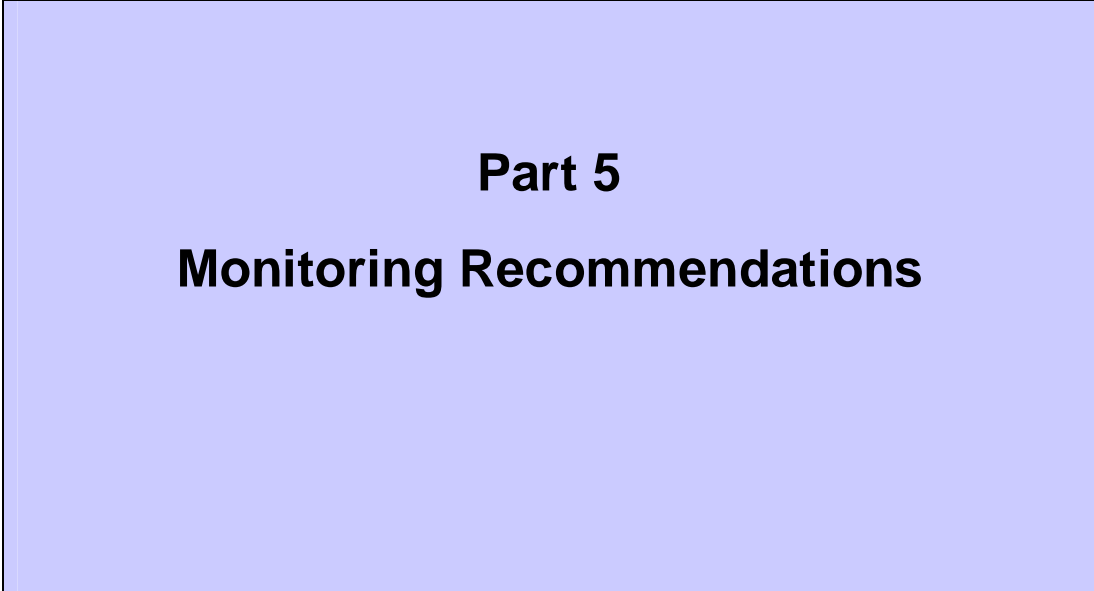
On the other hand, the Committee has found that the overall standard of documentation has improved greatly since the introduction of MH-OAT. Significant reform of clinical practice and culture occurs over time. The Committee is loathe to support a 'stick' approach whereby fear of failing to meet the requirements of a process, identified by an RCA for example, may become a negative motivation. However, documentation of risk assessment and management will be integral to the implementation of an effective assessment and management framework in relation to reducing violence.

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



Part 5
Monitoring Recommendations

Monitoring Recommendations

The Committee's Terms of Reference specify that its functions are to review

- aggregate data on sentinel events which have had fatal consequences and examine the events or circumstances surrounding such deaths;
- identify factors which might have prevented such fatal sentinel events and make policy recommendations for the prevention of such events.

The Committee's recommendations arise from examination, review and analysis of sentinel events to advise the Minister and the Department of Health on means to minimise or prevent them, whether through legislation, policy or practice.

This is the first Report in which the Committee has commented on the extent that previous recommendations have been implemented in practice. Its comments are based on the Government Responses to past Reports, on a series of 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, and on members' observations.

Committee Report to Minister	Government Response	Progress Reports	Progress for period
<i>First Report</i> , December 2003	December 2004	1. March 2005 2. December 2005	to March 2005 April – September 2005
<i>Second Report</i> , April 2005	December 2005	1. October 2006	Dec 2005 – March 2006

In total 76 recommendations are monitored in this chapter: 52 from the *First Report* and 24 from the *Second Report*. These recommendations were grouped around the following themes. The Committee has commented on the progress of implementation of each recommendation.

First Report of the Committee	Recommendation	Second Report of the Committee	Recommendation
Clinical practice and care	21-33	Clinical practice and care	12-16
Family involvement and application of the Mental Health Act	14-15	Children, families and carers	6-7
Risk assessment and management	1-5	Assessing and managing risk of harm to others	8-9
Reporting, data collection and monitoring	40-45	Reporting and review systems	1-5
Resources	51	Resources and development	22-24
Staffing levels	6-8	Forensic patients	10-11
Environment	9-13	Discharge and follow-up	17-19
Communication	16-18	Service partnerships	20-21
Documentation	19-20		
Application and review of the Mental Health Act	34-37		
Education and training	38-39		
Rapid response to suicide death or homicide	46-47		
Coroner's recommendations	48-50		
Future of the Committee	52		

The Committee notes the Government's acceptance of its recommendations and commitment to implementation by certain dates, but that in many cases substantial delays are evident. Where recommendations have been implemented, it would assist the Committee to know what monitoring processes are in place to ensure that implementation is sustained. Progress towards implementation will continue to be monitored in future Committee Reports.

The Committee's comments in this chapter are based on information and Progress Reports available to it as at April 2007.

The Committee thanks the staff of the Department of Health and Area Health Services who have committed their resources and expertise to the ongoing implementation of many of the recommendations, and particularly the staff of the (previous) Centre for Mental Health Prevention Team, for drawing together the significant quantity and complexity of data provided by the services in order to prepare the Progress Reports. It is through the efforts of all these staff that sentinel events can be prevented.

Progress on Recommendations of the First Report of the Committee

Recommendation	Progress Report of NSW Health and AHS activity	Committee's Comment
1, 4, 7, 8, 9, 12, 13, 15, 18, 20, 21, 22, 24, 28, 29, 32, 33, 34, 36, 37, 39, 40, 41, 42, 43, 44, 46, 48, 49, 50, 51, 52.	Implemented (may be an ongoing activity)	The Committee is satisfied with the NSW Health response and compliments all parties on their progress.

Theme: Risk Assessment and Management

Recommendation 2: By the end of 2004, NSW Health shall have established measures and processes to develop and implement by the end of 2004 statewide policy and procedures to govern risk assessments and risk management care plans for the following key points of the clinical pathway for mental health patients:

- triage
- admission
- after critical events
- at discharge
- when the family or the community raise concerns
- when the patient defaults on treatment, or follow up, or goes AWOL.

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>The five recommendations referred to under Risk Assessment & Management theme have been substantially implemented in each of the Area Health Service. Each Area reported</p> <ul style="list-style-type: none"> • Identified positions have been established within Mental Health with responsibility for Area wide mental health governance issues and link to local Clinical Governance Units. • Action to align existing local policies and procedures to the Framework for Suicide Risk Assessment & Management for NSW Health Staff. <p>The implementation of the <i>Framework for Suicide Risk Assessment and Management for NW Health Staff</i> within mental health services has also been identified as a regular item for the Area Mental Health Quality, Safety and Service Evaluation Committee.</p> <ul style="list-style-type: none"> • Implementation of the Framework has taken place across the State. <p>In addition, NSW Health has plans in place to further promote staff training and the changes necessary to support the implementation of the Framework for Suicide Risk Assessment and Management. As part of this strategy, NSW Health has released its interactive multimedia CDROM an online learning program for the Framework. This flexible and accessible learning program targets the training needs of staff working in Emergency Departments, General Hospital Wards, General Community and Mental Health Services, Mental Health Inpatient Units and in Justice Health Long Bay Hospital (Second Progress Report, Dec. 2005).</p>	<p>The Committee notes the substantial implementation of these recommendations, and would like to be informed of the outcome of the regular monitoring of the implementation of the <i>Framework</i> by the Area Mental Health Quality, Safety and Service Evaluation Committee.</p>

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

The following “red flags” are identified as markers for heightened risk of self harm in mental health patients:

- principal diagnosis of psychiatric disorder
- previous history of self harm, or suicide attempts
- suicidal ideation
- showing evidence of substance use/abuse
- known to police and/or other service groups in relation to impulsive or aggressive acts or behaviour.

The following “red flags” are identified as markers for heightened risk of violence towards others in mental health patients:

- principal diagnosis of psychiatric disorder
- previous history of violence towards others
- known to police and/or other service groups in relation to impulsive or aggressive acts or behaviour and/or antisocial behaviours.
- showing evidence of substance use/abuse

Government Response and Progress Report on Recommendations (extracts)	Committee’s Comment
<p>NSW Health acknowledges the underlying purpose and objective of this recommendation but does not support it in its current form. NSW Health will commence an education and training program in 2005, to accompany the implementation of the <i>Framework for Suicide Risk Assessment and Management</i>, for all staff to strengthen their risk assessment skills. (Government Response, Dec. 2004)</p> <p>The five recommendations referred to under Risk Assessment & Management theme have been substantially implemented in each of the Area Health Services (Second Progress Report, Dec. 2005).</p>	<p>The Committee notes that NSW Health did not initially accept this recommendation in its current form. The Committee felt that there was a misreading of the words in this recommendation, and notes that the recommendation has now been substantially implemented.</p>

Theme: Staffing Levels

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

Government Response and Progress Report on Recommendations (extracts)	Committee’s Comment
<p>All recommendations relating to Staffing Levels have been implemented with the exception of Recommendation 6 concerning guidance on safe staffing levels. As reported in the first Progress Report, the Centre for Mental Health (CMH) is addressing the issue through its participation in the NSW Health Nursing Reasonable Workloads Project, which is in the process of developing a tool for measuring workload and staffing levels for nurses in NSW mental health services. The tool is currently being piloted (Second Progress Report, Dec. 2005).</p>	<p>The Committee looks forward to the eventual implementation of this recommendation.</p>

Theme: Environment

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

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
Action to address the environmental recommendations has continued. All Areas have now reported that patient security and safety modifications have taken place across the range of inpatient mental health facilities (Second Progress Report, Dec. 2005).	The Committee notes that one Area Health Service has not fully implemented the Recommendation.

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

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
This recommendation is supported and has been implemented. All practicable steps are being taken to ensure that inpatient mental health facilities are as safe as possible by minimising patient access to means of suicide. Risk Audits of all mental health facilities were conducted in late 2003, focusing on hanging points and high-risk areas. Hanging points can be reduced substantially but not completely removed. Most acute units have already achieved an optimal reduction in hanging points. Area Health Services have been asked to provide a report outlining proposed actions and progress in reducing the level of risk for all matters identified as being of moderate risk or greater; and to ensure that staff complete training concerning suicide risk in inpatient units. They have identified risk points and taken various actions to reduce risks, including review of procedures to better manage risk points. NSW Health will ensure that Area Health Services conduct environmental audits of potential risks in all mental health units across NSW as a quality improvement process, and report those results to the Area Clinical Governance Units so that they can be integrated with other risk monitoring strategies (Government Response, Dec. 2004).	The Committee notes that this recommendation has been implemented, but is aware that hanging points remain at some mental health units. Delays due to plans to re-locate units where hanging points remain are considered unacceptable and mitigation strategies should be in place immediately.

Theme: Communication

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

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>Currently the <i>Framework for Suicide Risk Assessment and Management for NSW Health Staff</i>, local protocols and MH-OAT provide guidance on the different levels of communication necessary to support discharge of mental health patient from an inpatient unit. In addition, the <i>Discharge Planning Guidelines – Inpatient Mental Health Services</i>, are nearing completion. This document will outline policies and practices required for communication between clinical staff, carers and other service providers to ensure adequate and appropriate continuity of care for patients who are being discharged to the community (Second Progress Report, Dec. 2005).</p>	<p>The Committee notes that the Discharge Planning Guidelines referred to in the Government Response have not yet been released, and is of the view that they should be released and implemented immediately.</p>

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

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>As previously reported the matter was referred to the Human Services Cabinet Committee which referred the issue to an interagency working group. Representatives of the Departments of Health, Community Services, Housing and Education met in April 2005 to consider this recommendation. The interagency group recognised the relevance of following major policy and procedural documents in dealing with the communication issues that Recommendation 17 sought to address. These are:</p> <ul style="list-style-type: none"> • Child Protection Risk Assessment for Mental Health Services Policy Directive which will be released in early 2006. This requires all new/acute assessments under MH-OAT where a dependent child is identified to perform a comprehensive risk assessment, and action plan to respond appropriately. • A standardised Discharge Guidelines for mental health services is in the final stages of development following consultation with other Human Service agencies. These guidelines are due for release in early 2006. • The <i>NSW Interagency Guidelines for Child Protection Intervention</i> has been revised over the last six months and now provides clear direction for ongoing assessment of risk and simplified the processes of communication between agencies. (Second Progress Report, Dec. 2005). 	<p>The Committee notes that this recommendation is being implemented, but is aware that not all documents have been released and that therefore processes for the implementation of this recommendation are not yet in place.</p>

Theme: Documentation

Recommendation 19: By July 2004, Area Health Services shall ensure that the requirements of MH-OAT protocols are met so that standards of documentation are improved, especially with regard to

- the recording of critical information
- the recording of handover information
- information received from families
- legibility and
- consistency in the recording of author, position title, date, and times of observation.

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>There has been considerable progress made to support the implementation of this recommendation. Several Area Health Services reported that MH-OAT audits had been conducted and the findings are being implemented. In addition InforMH has been conducting a review of MH-OAT. It is this aspect of Recommendation 19 that is identified as being an ongoing process. All Area Health Services have reported system enhancements which allow Emergency Departments access to existing case records of mental health patients to assist in current assessments (Second Progress Report, Dec. 05).</p>	<p>The Committee looks forward to the full implementation of this recommendation.</p>

Theme: Clinical Practice and Care

Recommendation 23: By July 2005 NSW Health shall develop statewide evidence based clinical guidelines and mandated behaviours pertaining to the admission of mental health patients assessed as being at risk of self-harm and/or violence to others. These will be developed in consultation with clinicians and consumers and will include consideration of

- levels of staffing
- levels of security of accommodation
- frequency of observation
- aspects of more restricted care in early days of admission, which may include no leave and supervised medication dosing
- timing of review and follow up arrangements
- post-discharge supervision of medications until stable therapeutic levels of medication are considered achieved.

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>Many interrelated and complex issues are involved in addressing this recommendation. Since the release of the Tracking Tragedy recommendations in 2003, there has been number of safety and quality enhancement activities and innovations which provide guidance to clinicians admission practices. For example the guidelines provided in the <i>Framework for Suicide Risk Assessment and Management for NSW Health Staff</i>. Continuing action to develop models of care, referred to in relation to the Staffing Levels theme, also help to address the issues of concern covered by the recommendation. Other processes contributing to the implementation of Recommendation 23 include:</p> <ul style="list-style-type: none"> • NSW Health's Clinical Services Redesign Program, • Outcomes of Patient Safety measures such as the Reportable Incidents Briefs/ Root Cause Analysis of incidents, and Incident Information Management System (IIMS) (Second Progress Report, Dec. 2005). 	<p>The Committee looks forward to the full implementation of this recommendation.</p>

Recommendation 25: From July 2004, Area Health Services shall ensure that in relation to high-risk patients, when one of the following events occurs or is being considered:

- major change in the level of care or supervision
- discharge
- follow-up
- AWOL
- no show
- non-compliance

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

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>This recommendation is supported and will be implemented by end 2004. The <i>Framework for Suicide and Risk Assessment and Management</i> addresses a number of relevant matters, including risk assessment in triage, admission and discharge procedures, and otherwise identifying and managing levels of risk (Government Response, Dec. 2004).</p> <p>Substantial action has taken place towards improvements recommended of the 13 recommendations dealt with under the theme of Clinical Practice and Care. As reported in the previous Progress report seven recommendations remained for full implementation (Second Progress Report, Dec. 2005).</p>	<p>The Committee notes that this recommendation is not addressed specifically in the Second Progress Report, and that it is not yet implemented in one AHS.</p>

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

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>This recommendation is supported and will be implemented by March 2005. It is common practice in multidisciplinary mental health teams and core business of Area Mental Health Services to have in place policies for the management of, and care plans for, mental health patients, including dealing with cases of unresolved clinical conflict among members of the clinical team (Government Response, Dec. 2004).</p> <p>Substantial action has taken place towards improvements recommended of the thirteen recommendations dealt with under the theme of Clinical Practice and Care. As reported in the previous Progress report seven recommendations remained for full implementation (Second Progress Report, Dec. 2005).</p>	<p>The Committee notes that this recommendation is not addressed specifically in the Second Progress Report, and that it is not yet implemented in one AHS.</p>

Recommendation 27: By the end of 2004, Area Health Services shall ensure that initial care plans of mental health inpatients includes documentation of

- the formal assessment process and management goals
- the identity of the senior mental health clinician with primary responsibility for the patient's care
- the identity of the clinical team
- the identity of the patient care coordinator and
- the development of a time-limited management plan and a review date.

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>This recommendation is supported and will be implemented by end 2004. The extensive MH-OAT documentation and training program established by NSW Health will facilitate meeting these goals. Documentation of care is comprehensively covered through the 24 MH-OAT clinical modules. Documentation by treating team members is also facilitated by the clinical MH-OAT modules, the Care Plan and the Discharge Plan. NSW Health will encourage Area Health Services to audit compliance with the clinical modules and if required assist in developing strategies to improve compliance. (Government Response, Dec. 2004)</p>	<p>The Committee notes that the Second Progress Report does not directly address this recommendation, but notes that it has not been fully implemented in one Area Health Service.</p>

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

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>This recommendation is supported and has been implemented as standard practice in Area Health Services. The Mental Health Outcomes and Assessment Tool includes a risk assessment checklist at three stages: triage, assessment of current presentation, and discharge. Those risk profiles include absconding. The NSW Health reportable incidents process also requires that a Root Cause Analysis of more serious adverse events be conducted as a matter of routine or as determined by the Area CEO. Appropriate risk assessments and management strategies are undertaken at times of any change in risk and include all significant risks, such as patients who have gone</p>	<p>The Committee notes that this recommendation is implemented and therefore not addressed in the Second Progress Report, but is concerned that the Government Response does not address the gravamen of the recommendation. It seeks</p>
<p>AWOL. Review and development of clinical governance practices in Area Health Services will become the responsibility of each Area's Clinical Governance Unit. NSW Health encourages risk assessments and other quality clinical practices in regular and formal clinical case reviews in all health settings, including mental health teams (Government Response, Dec. 2004)</p>	<p>clarification as to how the response addresses the specifics of the Recommendation.</p>

Recommendation 31: By the end of 2004, Area Health Services shall ensure that discharge procedures for inpatient units routinely include:

- formal discharge plan covering conditions of discharge and any supports required
- nominated carer
- nominated clinician providing ongoing care
- formal arrangements for follow up review
- face to face communication (including video conferencing)
- a package of written advice for the patient and the nominated carer

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>This recommendation is supported and will be implemented by March 2005 following adjustments resulting from the Area Health Services restructure. The Framework for Suicide Risk and Management and the Discharge and Follow-up Protocols include detailed documentation concerning appropriate and safe discharge procedures (Government Response, Dec. 2004)</p>	<p>The Committee notes that this recommendation is not addressed specifically in the Second Progress Report and that it is not yet implemented centrally.</p>

Theme: Application and Review of the Mental Health Act

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

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>This recommendation is supported and has been implemented. The first discussion paper, <i>Carers and Information Sharing</i>, in the current review of Mental Health Act was released for public comment in February 2004. It addressed issues of privacy and information sharing with family members and carers. Submissions received in response to the discussion paper are being considered and will inform the next step in the consultation process – an Exposure Draft Bill, the release of which is expected to occur early in 2005 (Government Response, Dec. 2004).</p>	<p>The Committee believes the withholding of information is reasonable, only if parents or families are not the designated carers, and awaits still the assurance that this recommendation is, or will be, implemented.</p>

Theme: Education and Training

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

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>This recommendation is supported and will be implemented by July 2005. The Department of Health is developing a mental health training program for the <i>Framework for Suicide Risk Assessment and Management</i> for staff in NSW Health. The program will use interactive CD-ROM technology and will include a module on working with and engaging families of people with mental illness (Government Response, Dec. 2004).</p> <p>The Working With Families (WWF) Program focuses on improving clinician practice and achieving systemic change to enable clinicians to work in a family focussed way, be responsive to the unique needs of families and carers and ensure they are explicitly involved in the service system. Implementation of this strategy commenced in January 2005 and is expected to be completed in January 2007 (Second Progress Report, Dec 2005).</p>	<p>The Committee is pleased with the progress towards implementation, but notes the delay beyond the time frame indicated in the Government Response. It also seeks clarification as to how the response addresses the specifics of the Recommendation.</p>

Theme: Reporting, Data Collection and Monitoring

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

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>This recommendation is supported and will be implemented by end 2004. NSW Health proposes consulting with NSW Police and seeking its views on establishing an arrangement to provide information relating to homicides potentially committed by persons having recent contact with a mental health service to the NSW Forensic Mental Health Directorate (Government Response, Dec. 2004).</p> <p>This issue is part of the business plan for the Urgent Response and Transport working group for 2006. A potential pathway for notification has been agreed in principle. It requires protocols to be developed by Police and integration with the Centre for Mental Health adverse events monitoring processes (Second Progress Report, Dec 2005).</p>	<p>The Committee is concerned about the lengthy delay in implementation, but is aware of an interim process being introduced by NSW Police.</p>

Progress on Recommendations of the Second Report of the Committee

Theme: Reporting and Review Systems

Recommendation 1: NSW Health examine the effectiveness of current reporting and review processes for suspected suicide deaths of patients of Alcohol and Drug Services. *(Implementation timeframe 6 months)*

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>NSW Health supports this recommendation and the proposed timeframe. In line with current NSW Health policy, all Drug and Alcohol Services are required to complete a Reportable Incident Brief (RIB) as for the death of known drug and alcohol patients, including suspected suicide deaths. RIBs are completed as part of the Incident Information Management System (IIMS) according to the appropriate Severity Assessment Code (SAC) rating. These reports are then forwarded to NSW Health for appropriate action</p> <p>NSW Health will conduct an extensive investigation over the next 6 months to measure compliance with this policy within Drug and Alcohol Services. Any gaps in compliance will be identified and documented, and appropriate measures will be put in place to address any shortcomings in the reporting and review processes (Government Response, Dec. 2005).</p> <p>There are some concerns that the Centre for Drug and Alcohol (CDA) does not receive all relevant RIBs from AHSs. This will continue to be investigated. The CDA has met with the Quality and Safety Branch regarding the accuracy of the Severity Assessment Code applied to some RIBs (First Progress Report, Oct. 2006).</p>	<p>The Committee is concerned that the CDA does not receive all relevant RIBs at this time, and would like to be informed of the results of the investigations.</p>

Recommendation 2: NSW Health develop and trial a standardised terms of reference and documentation format for the external review of a homicide by a patient of a mental health service. *(Implementation timeframe 12 months)*

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>NSW Health supports this recommendation and will implement it within the timeframe proposed (Government Response, Dec. 2005).</p> <p>A revised Incident Management Policy will be release in April 2006, which will provide a standardised RCA template and guidelines for completion (First Progress Report, Oct. 2006).</p>	<p>The Committee notes the progress with implementation, and would like to be advised of the process for monitoring compliance and the outcomes of reviews.</p>

Recommendation 3: NSW Health work with the NSW Coroner to develop systems for communication between the Coroner and local mental health services to ensure that services receive prompt and comprehensive notification of suspected suicides deaths. *(Implementation timeframe 12 months)*

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>NSW Health supports this recommendation in principle, subject to consultation with the NSW Coroner. (Government Response, Dec. 2005).</p> <p>The issues raised in this recommendation will be addressed at the next meeting of the NSW Coroner and the Director Mental Health & Drug and Alcohol Programs (First Progress Report, Oct. 2006).</p>	<p>The Committee recognizes the legal complexities involved and looks forward to future progress reports.</p>

Recommendation 4: NSW Health ensure the development of

- a unique identifier, and
- electronic record systems

to ensure the constant availability and prompt transfer of relevant clinical information between services and between service providers. *(Implementation timeframe 24 months)*

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>NSW Health supports this recommendation and development of both a Unique Patient Identifier (UPI) and the Electronic Health Record is underway. (Government Response, Dec. 2005).</p>	<p>The Committee acknowledges that the NSW Health is on target for the implementation of the UPI and that implementation of the HER is progressing.</p>

Recommendation 5: NSW Health evaluate the effectiveness of the current system of reporting and review of suspected suicide deaths. This evaluation should consider whether RCA methodology facilitates meaningful involvement of local clinicians, and consider additional methods for such involvement if necessary. *(Implementation timeframe 24 months)*

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>NSW Health supports this recommendation and it will be implemented within the suggested timeframe. (Government Response, Dec. 2005). The Quality and Safety Branch is in the process of trialling a Root Cause Analysis quality improvement tool, to be disseminated to Branches including Centre for Mental Health in April 2006 (First Progress Report, Oct. 2006).</p>	<p>The Committee acknowledges the progress towards the implementation of this recommendation</p>

Theme: Children, Families and Carers

Recommendation 6: NSW Health commence immediately the development of a clinical guideline for the management of risk to children of a parent with a major psychiatric disorder, for implementation within 24 months. *(Implementation timeframe 6 months)*

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>This recommendation is supported and is in the process of implementation.</p> <p>There are a number of initiatives underway that address this recommendation (Government Response, Dec. 2005).</p>	<p>The Committee notes the strategies underway and looks forward to future progress reports and to advice on the process for monitoring compliance.</p>

Recommendation 7: NSW Health implement and audit minimum standards for the involvement and documentation of the involvement of families and carers in mental health care during:

- assessment;
- discharge planning from acute mental health inpatient units;
- ongoing community care; and
- contingency planning and response to escalating concerns or to changing clinical situations. *(Implementation timeframe 12 months)*

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>NSW Health supports this recommendation and has taken a number of steps towards its implementation (Government Response, Dec. 2005).</p>	<p>The Committee notes the progress made towards implementation and acknowledges that future reports on monitoring outcomes will be provided.</p>

Theme: Assessing and Managing Risk of Harm to Others

Recommendation 8: NSW Health develop an empirically based risk assessment and management framework of risk of harm to others. *(Implementation timeframe 24 months)*

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>NSW Health agrees in principle to this recommendation and work in this area has commenced. The Centre for Mental Health anticipates that this work will be completed within the timeframe (Government Response, Dec. 2005).</p>	<p>The Committee notes with concern the slow implementation of this recommendation.</p>

Recommendation 9: NSW Health liaise with mental health professional bodies to include in professional development programs defined minimum risk assessment skills (*Implementation timeframe 24 months*)

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
NSW Health supports this recommendation in principle and recognises the need to enhance clinicians' risk assessment skills (Government Response, Dec. 2005).	The Committee looks forward to future progress reports.

Theme: Forensic Patients

Recommendation 10: NSW Health develop a register of forensic patients in community care. (*Implementation timeframe 6 months*)

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
NSW Health supports this recommendation and implementation has commenced (Government Response, Dec. 2005).	The Committee looks forward to future progress reports.

Recommendation 11: NSW Health develop guidelines for the minimum level of care that should be provided to forensic patients in community care. (*Implementation timeframe 12 months*)

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
NSW Health supports this recommendation and work has commenced on the development of guidelines as recommended (Government Response, Dec. 2005).	The Committee notes the progress towards implementation but that the time frame is longer than recommended.

Theme: Clinical Practice and Care

Recommendation 12: NSW Health define standards in relation to the multidisciplinary review of critical points of the patient's pathway, including:

- new presentations;
- acute exacerbations or relapses of illness;
- changes in the level of risk of harm to self or others; and
- discharge from the mental health service.

These standards should specify the involvement of a treating psychiatrist or most senior attending mental health clinician. (*Implementation timeframe 12 months*)

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
This recommendation is supported and will be implemented within the 12 month timeframe. (Government Response, Dec. 2005).	The Committee looks forward to future progress reports.

Recommendation 13: NSW Health develop minimum standards for consultation with, and/or direct contact by, consultant psychiatrists:

- in the assessment of emergency presentations to mental health services and emergency departments;
- in the care of inpatients of mental health units; and for the recording of such contact. (*Implementation timeframe 12 months*)

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>This recommendation is supported and will be implemented within the 12 month timeframe. The Centre for Mental Health will oversight the development of standards with reference to the Clinical Safety and Standards Steering Group (Government Response, Dec. 2005). The recommendations of Statewide Mental Health Clinical Services Redesign Project suggest improvements to ED processes for mental health consumers, and for clinical leadership in mental health in-patient units by the appointment of staff Specialist Clinical Directors. These solutions are currently before the Mental Health Program Council which is devising an implementation strategy for these solutions (First Progress Report, Oct. 2006).</p>	<p>The Committee looks forward to future progress reports and to receiving advice on the solutions and implementation strategy being considered by the MH Program Council.</p>

Recommendation 14: NSW Health develop standards for the use and documentation of telephone contact in initial and ongoing assessment, treatment and post-discharge follow-up by mental health services. Reliance on telephone contact in high risk situations should be discouraged. (*Implementation timeframe 12 months*)

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>NSW Health supports this recommendation, which will be implemented within the timeframe. The Centre for Mental Health will oversight the development of these standards with reference to the Clinical Safety and Standards Steering Group. Current NSW mental health practices, policies and protocols addressing the use and documentation of telephone contact during assessment, treatment and post discharge follow-up will be considered in this process. Whilst there is a need for clear policy and direction on telephone contact in high risk situations, NSW Health considers that telephone contact with patients plays an important part of the clinical relationship (Government Response, Dec. 2005). In January 2006 the Centre for Mental Health commenced a review of all Mental Health Telephone services in NSW, to be complete by June 2006. This review will recommend service development directions, and standards for the use and documentation of telephone contact (First Progress Report, Oct. 2006).</p>	<p>The Committee notes progress towards implementation, but finds the second paragraph of the Government Response perplexing, as the recommendation does not state that telephone contact is not important. The Committee would like to be advised of the outcome of the Centre for Mental Health Review, to be completed by June 2006.</p>

Recommendation 15: NSW Health implements a procedure for flagging and reviewing patients who are failing to improve. *(Implementation timeframe 24 months)*

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>NSW Health supports this recommendation which will be implemented within the timeframe. The Centre for Mental Health will oversight the development and implementation of this procedure with reference to the Clinical Safety and Standards Steering Group (Government Response, Dec. 2005).</p> <p>In NSW it is mandatory to rate standard clinical measures for all mental health clients in all mental health service settings at admission, 3 monthly review and discharge. These measures can evaluate the degree of client improvement over time in treatment. Current compliance with rating the mandatory measures is about 65% and in some Areas where clinicians do not enter data directly into the electronic system, the reports have not been made available to them in a timely manner for use in client management (First Progress Report, Oct. 2006).</p>	<p>The Committee notes with concern the, at best, 65% compliance rate with a mandatory procedure, and looks forward to future progress reports on implementation.</p>

Recommendation 16: NSW Health ensure that risk assessments and risk management plans are routinely documented in the medical record, and that changes to the level of risk are documented and are accompanied by a specific and appropriate management plan. *(Implementation timeframe 24 months)*

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>NSW Health supports this recommendation and will work to promote its implementation within the timeframe.</p> <p>The Centre for Mental Health will take the lead on this clinical issue, with reference to the Clinical Safety and Standards Steering Group. Scope of work will be to determine the best approach to ensure that risk assessment and appropriate management plans are routinely documented in medical records (Government Response, Dec. 2005).</p> <p>The evaluation (of MH-OAT) will include examination of documentation regarding risk assessment and management planning (and will) consider strategies including further revision of MH-OAT Clinical Modules to support effective risk management and documentation (First Progress Report, Oct. 2006).</p>	<p>The Committee looks forward to future progress reports on implementation, and has seen evidence of improved documentation.</p>

Theme: Discharge and Follow up

Recommendation 17: NSW Health develop minimum standards for the frequency and duration of follow-up after discharge from an inpatient mental health unit. This should be linked to the level of clinical risk. *(Implementation timeframe 12 months)*

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>This recommendation is supported and will be implemented within the timeframe. The Centre for Mental Health will lead the development of these standards, with reference to Clinical Safety and Standards Steering Group. These standards will be informed by the work already underway in this area.</p> <p>Discharge and Follow-up Protocols for NSW Mental Health In-patient Services due for release in 2005, provide greater detail on minimum practices for discharge planning and post-discharge follow-up (Government Response, Dec. 2005).</p> <p>The final draft of the mental health inpatient discharge document has been completed. It will be submitted to the Inter-Agency Working Group for comment and will then be submitted to the Mental Health Program Council for endorsement. It will be submitted for release as a Policy Directive which mandates discharge and follow-up action (First Progress Report, Oct. 2006).</p>	<p>The Committee recognises that progress will be limited until the Discharge and Follow up Protocols are released, and would like to be advised as to how implementation of the recommendation will be monitored.</p>

Recommendation 18: NSW Health ensure that people with a first episode of psychosis or major mood disorder receive active follow up by the senior attending mental health clinician for at least 12 months following first service contact, in keeping with the National Psychosis Guidelines. Where this is impossible or unnecessary, the case should be reviewed and adequately documented. *(Implementation timeframe 12 months)*

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>This recommendation is supported in principle, and is current practice for early psychosis within many parts of NSW.</p> <p>Continued follow-up by the senior attending mental health clinician, may not always be directly possible particularly in rural areas, given the large geographic regions across which Mental Health Services are provided.</p> <p>The development of the service requirements within this recommendation will be led by the Centre for Mental Health with reference to the Clinical Safety and Standards Steering Group to ensure that achievable service standards will be developed within the 12 month timeframe for implementation by Area Health Services (Government Response, Dec. 2005).</p> <p>This recommendation will form a core component of the NSW Early Psychosis Strategic Plan which is currently under development (First Progress Report, Oct. 2006).</p>	<p>The Committee wishes to point out that the senior attending mental health clinician may refer to a Nurse or a GP, and looks forward to progress with this matter.</p>

Recommendation 19: NSW Health develop mandatory procedures for response to loss of contact or non-attendance at planned follow-up for people who may be at risk of suicide or risk of harm to others. If loss of contact occurs within 28 days of discharge for any patient, or at any time if a person remains at significant risk, then:

- immediate consultation should occur with a senior mental health clinician; and
- a considered action plan should be documented by the service. (*Implementation timeframe 12 months*)

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>NSW Health supports this recommendation and recognises that good risk management needs to be consistently practiced.</p> <p>The Centre for Mental Health will lead the development of the procedures with reference to the Clinical Safety and Standards Steering Group. Building on Circular 98/31 - policy guidelines for suicide risk assessment and management, the <i>Framework and Discharge and Follow Up Protocols</i>, the Clinical Safety and Standards Steering Group will determine what additional measures are required to fully meet this recommendation within the identified timeframe (Government Response, Dec. 2005).</p>	<p>The Committee looks forward to a Progress Report on this recommendation.</p>

Theme: Service Partnerships

Recommendation 20: NSW Health ensure that where multiple health providers (e.g. general practitioner, private psychiatrist, psychologist, non-government organisation) are involved in a shared management plan that there is effective flow of appropriate information between them. Where the patient refuses consent for the exchange of information there is review by the senior clinician. (*Implementation timeframe 12 months*)

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>NSW Health supports this recommendation, subject to legal requirements.</p> <p>The Centre for Mental Health will lead the development of policies required to address this recommendation within the timeframe, with reference to the Clinical Safety and Standards Steering Group (Government Response, Dec. 2005).</p>	<p>The Committee looks forward to a Progress Report on this recommendation.</p>

Recommendation 21: NSW Health ensure the development of policies and training for suicide risk assessment in Alcohol and Drug services. (*Implementation timeframe 24 months*)

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
<p>NSW Health supports this recommendation and is in agreement with the timeframe given (Government Response, Dec. 2005).</p> <p>A forum will be held in May 2006 to further explore the needs and future directions of the mental health and drug and alcohol sectors in relation to clients with complex needs, including those with suicidal ideation. There are a number of joint suicide prevention training initiatives currently underway between Mental Health and Drug and Alcohol Services (First Progress Report, Oct. 2006).</p>	<p>The Committee would like to be advised progress with implementation, and the results of these initiatives.</p>

Theme: Resources and Development

Recommendation 22: NSW Health establish clear timeframes for delivering on its previously made commitment to reach acute mental health bed targets, to ensure Area Health Services meet their population bed needs in terms of Department of Health accepted planning models. Clear timeframes and targets should also be set for the provision of community mental health services. *(Implementation timeframe 6 months)*

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
NSW Health agrees with this recommendation and it is being implemented. Since 2001, new acute mental health beds have opened throughout NSW and development for further beds and associated clinical staff are underway or are planned to the 2007/08 year. The Mental Health Clinical Care and Prevention Model (MH-CCP) is a valuable planning tool and NSW Health has planned to meet 80% of the acute bed need predicted by 2007/08. Further increases will be targeted to increase community based mental health services over 2005/06 – 2006/07. These include a comprehensive Mental Health Family and Carer Program across New South Wales and additional community mental health rehabilitation services (Government Response, Dec. 2005).	The Committee notes the progress made in the implementation of this recommendation.

Recommendation 23: NSW Health develop a mental health workforce strategy to build the necessary mental health workforce to meet service and quality goals across the life span, by the end of 2006. *(Implementation timeframe 6 months)*

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
Mental health workforce planning and development is a key priority for NSW Health, in the context of current vacancies and future projected demand. A wide range of initiatives and actions are currently underway as part of a coherent Workforce Strategy (Government Response, Dec. 2005).	The Committee congratulates all parties on the progress made implementing this recommendation, and would like future Progress Reports to address the matter of support for existing staff.

Recommendation 24: In order to maximise the effectiveness of existing strategies to build workforce capacity (including resources, policies and protocols), NSW Health develop in partnership with the Institute of Psychiatry, other professional bodies and Area Health Services an educational agenda to progress skill and knowledge development. This collaborative process should identify priorities and set learning goals for each year over the next five years. *(Implementation timeframe 6 months)*

Government Response and Progress Report on Recommendations (extracts)	Committee's Comment
NSW Health supports the direction of this recommendation and is engaged in a planned, systematised workforce capacity building strategy, which includes a number of specific initiatives (Government Response, Dec. 2005).	The Committee looks forward to future Progress Reports on the initiatives.

