Lessons and Learnings

The Clinical Excellence Commission, Patient Safety Directorate developed the following summary from Mental Health, Alcohol and Other Drugs Serious Incident Reviews.

Clinician engagement with the consumer's GP

It is vital to contact the consumer's General Practitioner (GP) for corroborative information.

Case Background

A male consumer was receiving care from the community mental team following referral from the Mental Health Line. He had a history of a previous suicide attempt and suicide ideation. He had been receiving care from his GP who had prescribed an antidepressant medication.

A few weeks after his contact with the community mental health team he self-discharged from the service reporting that he was well-cared by his GP. However, he re-referred himself back to the service a few weeks later reporting low mood. A plan was made to investigate organic causes for his low mood; however, he was found in a serious condition before the investigations were undertaken.

Case Discussion

In this case a written discharge plan was provided to the consumer's GP, however there was no direct contact made. Direct contact with the GP provides an opportunity to corroborate the consumer's reports, particularly in circumstances when the consumer has been evading care or minimising disability.

For incidents where the consumer's GP is involved in care, consideration should be given to interviewing the GP as part of the Serious Adverse Event Review (SAER).

Collaborative care planning

Collaborative care planning enhances safety planning and harm minimisation interventions.

Case 1: Background

A male consumer with a history of treatment for psychosis, in the context of drug and alcohol use, was receiving care from the community mental health team. He was also receiving counselling from an Alcohol and Other Drug Service, however his attendance at sessions was noted to be intermittent.

He was receiving an antipsychotic depot injection under a Community Treatment Order (CTO) from his GP. The community mental health case manager contacted the GP and was advised that the consumer did not attend the appointment for the depot injection. The consumer was found in a serious condition a week later.

Case 1: Discussion

In this case there were no formal care planning processes for consumers of both Community Mental Health and Alcohol and Other Drug Services. Structured communication that is informed by the clinical information and expertise of the other service provides an

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opportunity to enhance consumer safety planning and harm minimisation interventions.

A structured communication process or joint care planning meeting will enable collaborative care planning and provides an opportunity to escalate concerns regarding deterioration or disengagement with services.

Responsibility for CTO

When responsibility for administering medications under a CTO is allocated to a GP, there needs to be explicit information provided to the GP regarding the escalation process, including who to notify if the consumer defaults or delays treatment. The Mental Health Service retains responsibility for monitoring consumers under a CTO.

In circumstances when there is a CTO breach, the mental health facility should take all reasonable steps to implement the order and inform the affected person that he or she is not complying with the conditions of the order and remind the person of the possible consequences in accordance with section 58 of the *Mental Health Act 2007*.

Case 2: Background

A male consumer with a history of psychosis in the context of comorbid alcohol and drug use, was brought to the Emergency Department (ED) after a reported suicide attempt. He had previously received care from the community mental health team however was discharged as he was reportedly not engaging with the service.

During his stay at the ED, he underwent a mental health assessment. He explained he was remorseful of the events that brought him to the ED and denied self-harm or suicide ideation. He was discharged with a plan for community mental health service follow-up. Prior to his discharge, the consumer's mother was contacted regarding the discharge plan; however, she expressed concern that he had a history of agreeing to follow-up plans but then failing to engage. Several attempts were made by the community mental health service to contact the consumer by telephone. The consumer was found in a serious condition a week later.

Case 2: Discussion

When it is identified that there are issues with consumer engagement, Alcohol and Other Drugs clinicians should be involved in the community treatment plan alongside mental health clinicians. Alcohol and Other Drugs clinicians should also participate in the assessment and management planning in the Emergency Department.

Obtaining corroborative information from family and carers provides an opportunity to develop a strengthened safety plan with involvement from the consumer's carer and/ or family prior to the consumer's discharge from the ED. Concerns raised by family and carers must be taken into consideration when care planning.

We value your feedback. If you have any questions or comments about this report, please email CEC-PatientSafety@health.nsw.gov.au