Lack of family input into decisions made about a consumer's care under the Mental Health Act
20HDC00079

This case concerns the lack of family input into decisions made about a consumer's care under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act). The case highlighted the importance of family inclusion and consultation when providers are making decisions for patients under the Mental Health Act, including when making the decision to discharge a consumer from the Mental Health Act.

The consumer was under a Community Treatment Order (CTO) for their anti-psychotic medication, as they were noted to have poor insight into their mental health and a history of non-compliance with their medication regime. The consumer had given permission for the DHB to liaise with their family when needed, and the family had been involved in the consumer's care previously.

In 2019, the consumer's psychiatrist made the decision to discharge the consumer from the CTO. Their family was not consulted about this decision, and were not informed that the consumer was no longer under the CTO until later. After the removal of the CTO, the consumer stopped taking medication and, just under two months later, the consumer harmed themselves, and ended up in hospital.

The consumer's family was also concerned about the timing of the removal of the CTO, noting it was a difficult time for the consumer and his family.

The Deputy Commissioner found the DHB in breach of Right 4(1) of the Code for inadequate communication and consultation with the consumer's family (both before and after their removal from the CTO); for the lack of a formal review process to assess whether transition to voluntary treatment had been successful; and for the lack of follow-up care provided as a result of a change in frequency of review contrary to the consumer's care plan, when such change should have been a multidisciplinary decision.

Adverse comment was made about the consumer's psychiatrist, as the Deputy Commissioner considered that more consideration should have been given to the timing of the removal of the consumer's CTO, and that the psychiatrist should have consulted the consumer's family before finalising this decision (as per section 7A of the Mental Health Act). In addition, adverse comment was also made about a registered nurse who provided follow-up care to the consumer after their removal from the CTO.

The Deputy Commissioner made multiple recommendations to the DHB in order to improve its family and/or whānau consultation in relation to section 7A of the Mental Health Act, which included developing relevant protocols/guidelines, and providing training to its Mental Health staff. She also recommended that the psychiatrist provide HDC with an apology to the consumer's family, together with anonymised case

summaries which show that he has considered and actioned family consultation appropriately since the events of this case.