Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

September 2013

District health board mental health and addictions services

Serious adverse events reported to the Health Quality & Safety Commission 1 July 2012 to 30 June 2013

Contents

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Introduction

In 2011, the Health Quality & Safety Commission (the Commission) made a decision to separate district health board (DHB) mental health and addictions services serious adverse events (SAEs) from the main SAE report, and to support the sector in its approach to reviewing and reporting SAEs. The following report is the first from the Commission specifically focused on SAEs affecting patients[1] of DHB mental health and addictions services.

The majority of events summarised in this report resulted in serious harm to a patient of a DHB mental health and addictions service. They were subsequently reported to the Commission in accordance with the process for reporting SAEs set out in the Commission's national reportable events policy.[2]

The number of SAEs reported by each DHB reflects the size of the population served and the services provided by each. However, it should be emphasised that SAE reporting is not intended to be an epidemiologically accurate 'count' of events to allow comparisons between hospitals or services. Reporting of SAEs to the Commission is strongly encouraged but is voluntary. The significance of reporting these events lies in the lessons learnt following local review of the incidents.

Summary

- 177 SAEs affecting patients of mental health and addictions services were reported by DHBs between 1 July 2012 and 30 June 2013.
- SAEs by type:
  - 134: death by suspected suicide
  - 17: serious self-harm
  - 17: serious adverse behaviour
  - 5: going missing from inpatient facility (no harm)
  - 4: other event resulting in patient harm.
- The Commission has agreed in principle to a two-year working partnership with the Ministry of Health to develop a trial of a suicide mortality review function to improve knowledge of contributing factors and patterns of suicidal behaviour, and to better identify key intervention points for suicide prevention.

1 The term 'patient' is used for consistency in this report, although the Commission recognises that people who access mental health and addictions services are also called service users, clients, residents and consumers.
2 http://www.hqsc.govt.nz/our-programmes/reportable-events/national-reportable-events-policy/

Reported events

Between 1 July 2012 and 30 June 2013, 177 SAEs affecting patients of mental health and addictions services were reported by DHBs.[3]

The SAEs were reported in accordance with the process set out in the national reportable events policy, whereby health and disability providers identify, review and report events which have caused, or could have caused, serious harm to the patient.

For the purposes of this report, the events have been collated into the following categories:

- death by suspected suicide
- serious self-harm (includes events reported to the Commission as 'attempted suicide')
- serious adverse behaviour (includes allegations of assault by patient on staff, another patient, or another person, and allegations of criminal acts)
- going missing from an inpatient facility.

Four other incidents occurred that fall outside the above four categories. These are described in the report as 'Other event resulting in patient harm'.

The SAEs have also been separated into the location or context in which the incident occurred:

- inpatient facility
- outpatient, where the patient's care is provided in the community
- while on approved leave from an inpatient facility
- having gone missing from an inpatient facility.

3 Some cases where a mental health and addictions services patient died of natural causes were also reported to the Commission. These cases were excluded from this report.

Learning from serious adverse events

One of the key purposes of reviewing any adverse event is to examine the case in detail to see whether anything else can be learnt that will benefit either the patient involved, or future patients. This is the same concept regardless of the type of incident – a medication error that results in a patient receiving an incorrect dose, or a mental health patient who is suspected of having taken their own life.

In relation to mental health and addictions services, a change occurred during 2011–12 and 2012–13 to introduce a review mechanism that is more appropriate to the needs of mental health patients. In particular, the national reportable events policy required DHBs to review SAEs using a strict root cause and analysis methodology. However, in the case of mental health and addictions services patients, there is often no identifiable root cause, and an alternative approach was proposed by the mental health sector.

One key change is the introduction of a preliminary review of an incident to ensure that each serious event is reviewed correctly. The facts surrounding every serious event are formally reviewed by a DHB committee (which includes a family representative) to ascertain whether there was a need to perform a more detailed review. Should the facts raise questions about the care provided, a further more detailed review process will follow.

Any lessons that can be learnt from the review are subsequently shared within the local service, but the improvement in central reporting to the Commission will also allow any lessons to be shared nationally. During 2013–14, DHBs will all be moving to use the same tool to review serious events involving mental health and addictions services patients (the London Protocol),[4] and to expand on the information provided to the Commission subsequent to reviews being completed.

The review of cases of suspected suicide – which make up a large proportion of cases in this report – is particularly difficult because of the multiple risk factors and life events which are involved in a person taking their own life. A review of an individual case may identify some issues relating to documentation or planning of care, but to find any direct cause of a person deciding to commit suicide is challenging, and in many cases a direct cause cannot be identified.

This report describes the action being taken by the Commission to work with the Ministry of Health to pilot a suicide mortality review process, whereby it is hoped that a detailed review of cases of suicide may identify lessons that can be learnt. It is accepted that this first report is limited in information that can have a direct impact on improving the quality of care, but it is hoped that, with improved reporting from DHBs and the pilot review process, the Commission can better support clinicians to provide improved care.

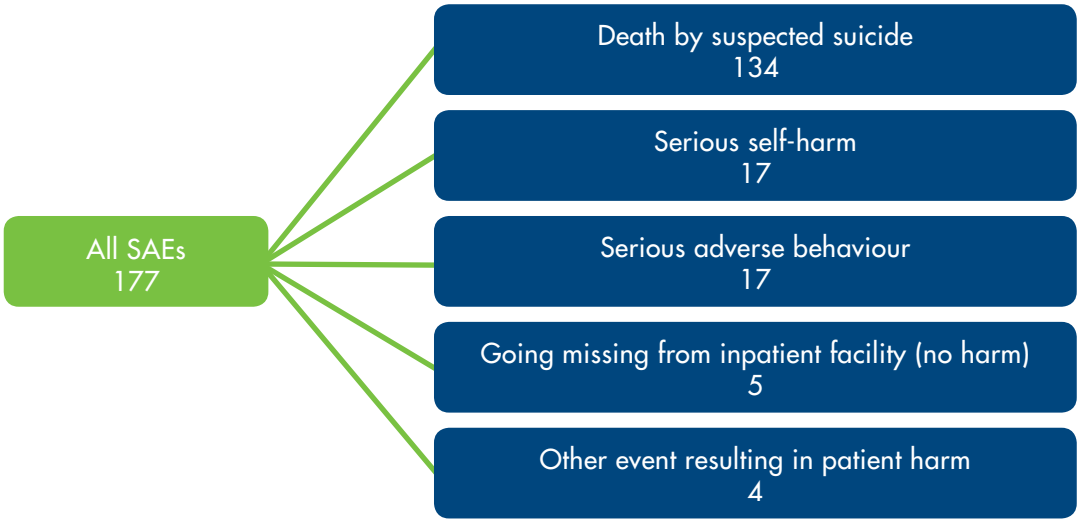
4 http://www1.imperial.ac.uk/medicine/about/institutes/patientsafetyservicequality/cpssq_publications/resources_tools/the_london_protocol/

Serious adverse events

According to the 2011 annual report by the Office of the Director of Mental Health, 92 percent of mental health and addictions services users access only community services. The remaining 8 percent receive a mixture of community and inpatient services.

During 2012–13, 87 percent of SAEs involved patients who were not inpatients of a mental health facility; the event occurred when the patient was either an outpatient, had gone missing from an inpatient facility, or was on approved leave from an inpatient facility.

Figure 1: Type of event



Outpatient and inpatient events

As stated above, over 90 percent of care is provided in the community, and the reporting of SAEs is broadly in line with this proportion, with 87 percent of reported SAEs occurring while the patient was not in an inpatient facility.

Figure 2: Outpatient events

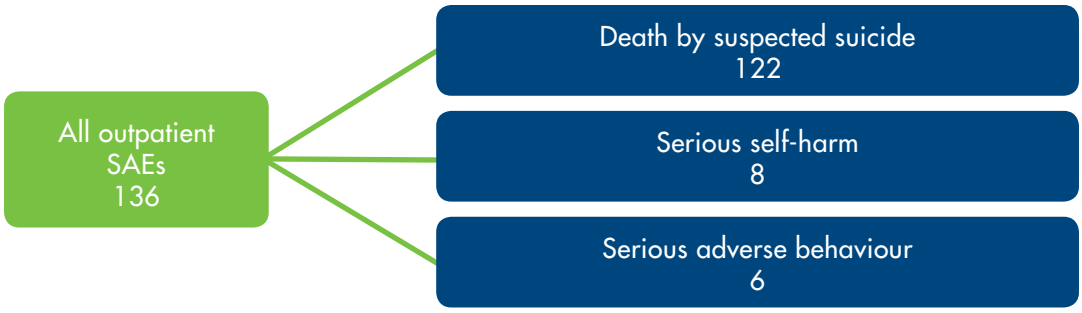


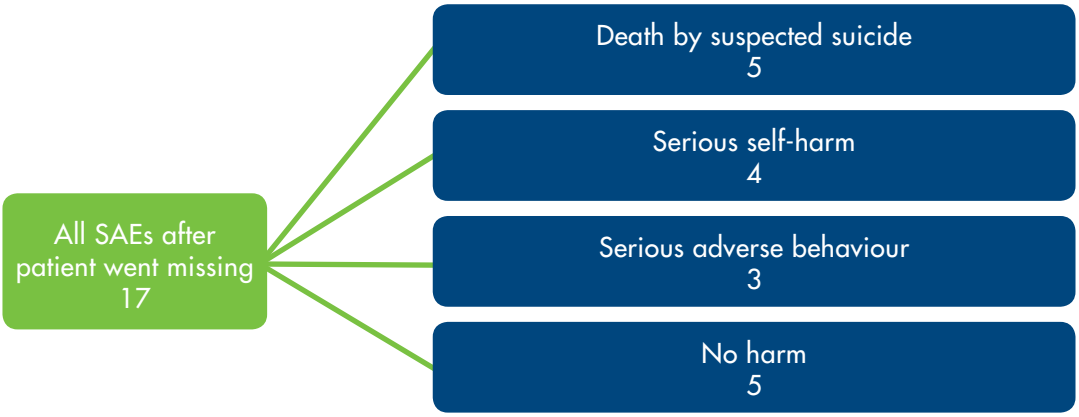
Figure 3: Inpatient facility events

Events occurring after patients went missing from an inpatient facility

In total, 17 SAEs were reported which involved patients going missing from an inpatient facility without approved leave. Five of these resulted in no subsequent SAE, and in 12 cases a further SAE occurred – either death by suspected suicide, serious self-harm or serious adverse behaviour (see Figure 4).

DHB reporting does not currently include information that would identify whether the patients involved were voluntary patients who could choose to leave, or were subject to a formal restriction under the Mental Health (Compulsory Assessment and Treatment) Act 1992, or the Criminal Procedure (Mentally Impaired Persons) Act 2003.

Figure 4: Gone missing from inpatient facility



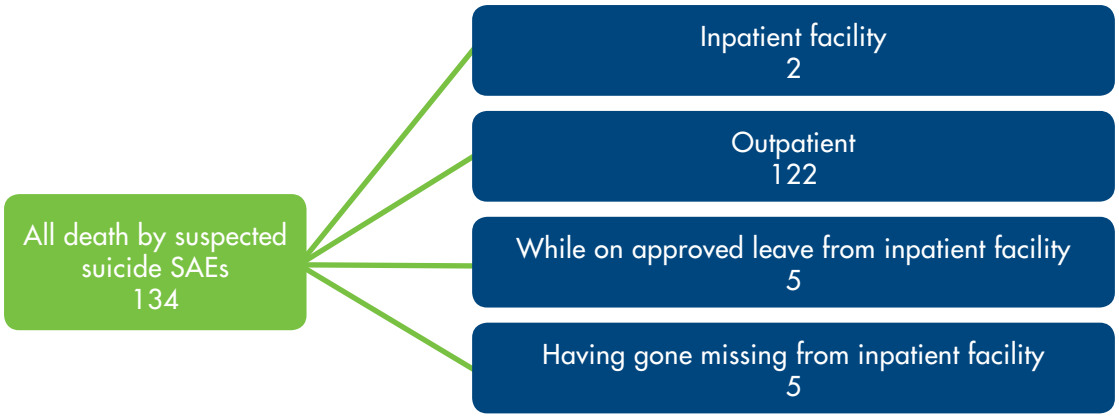
Events occurring while the patient was on approved leave

Five reported SAEs related to events that occurred while patients were on approved leave from an inpatient facility. All were cases of death by suspected suicide.

Death by suspected suicide

Cases of death by suspected suicide were the most frequently reported event (see Figure 5), with 134 SAEs. This is a greater number compared with cases reported prior to 2010–11. However there has been a significant change in the manner in which cases are reported, which makes meaningless any comparison with previous years. From 2006–07 to 2010–11, one of the criteria for reporting a case of death by suspected suicide to the Commission was for the SAE to have occurred within seven days of contact with a mental health and addictions service. As part of the 2011–12 review of the Commission's national reportable events policy, this criterion was voluntarily amended by DHB mental health and addictions services to include cases that had occurred within 28 days of contact with the service. This change allowed lessons to be learnt from a wider set of events.

Figure 5: Death by suspected suicide



There has been significant improvement in reporting since DHBs started notifying SAEs to the Commission. This can be seen in the increase in all SAEs in the three annual reports released by the Commission from 2009–10 to 2011–12. In relation to mental health and addictions services SAEs, DHBs reported a total of six cases of suspected outpatient suicides for the 2007–08 period, yet in 2011–12 reported 69 cases using the same criteria. It is likely that more cases of death by suspected suicide will be reported in coming years, because most if not all DHBs will use the 28-day review threshold that captures more events.

Suicide mortality review pilot

The rate of suicide in New Zealand has long been recognised as an area of concern, particularly among the young and in the Māori community. While the rate of suicide has declined from a high in 1998,[5] the Chief Coroner stated in his report of 26 August 2013, *'the annual suicide total has been stubbornly consistent since … July 2007, with between 531 and 558 suicides a year'*.[6]

In May 2013, the Ministry of Health published the *New Zealand Suicide Prevention Action Plan 2013–2016*.[7] The introduction to the Action Plan states:

> *'Multiple risk factors and life events are involved in a person ending their life. The link between mental illness and suicidal behaviour is well known, but other risk factors include exposure to trauma, a lack of social support, poor family relationships and difficult economic circumstances.*
>
> *The prevention of suicide is both complex and challenging, and no single initiative or organisation can prevent suicide on its own. A comprehensive approach is required across government and non-governmental organisations, and in partnership with the community.'*

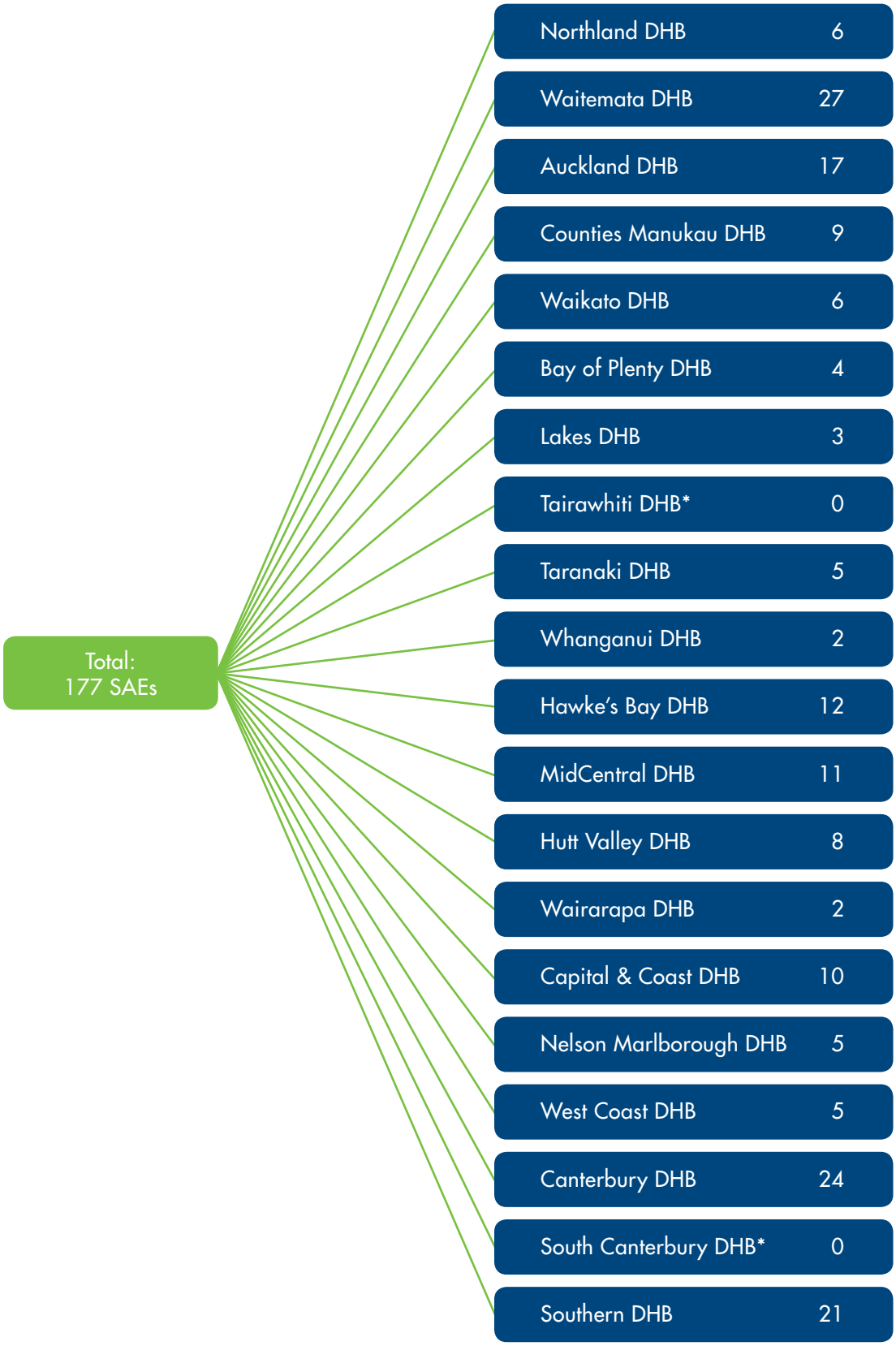
The Action Plan set out a total of 30 actions to be taken over the period 2013–16. Objective 5 set out a plan to *'[m]ake better use of the data the government already collects on suicide deaths and self-harm incidents'*.

The Commission has agreed in principle to a working partnership with the Ministry of Health to trial a suicide mortality review function. A two-year trial period will look at three key action points.

- Trial a suicide mortality review mechanism to improve knowledge of contributing factors and patterns of suicidal behaviour in New Zealand, and to better identify key intervention points for suicide prevention.
- Establish a process for analysing and sharing up-to-date provisional coronial data on suicide deaths with agencies working in local areas, to help prevent further suicides.
- Develop a suicide prevention outcomes framework to improve the monitoring and measuring of suicides and suicide risk factors in New Zealand.

5 Age standardised rate of 15.1 per 100,000 in 1998; 11.5 in 2010. See Ministry of Health. 2010. *Suicide Facts: Deaths and intentional self-harm hospitalisations*. Wellington: Ministry of Health.
6 http://www.spinz.org.nz/file/downloads/pdf/file_613.pdf
7 http://www.health.govt.nz/publication/new-zealand-suicide-prevention-action-plan-2013-2016

Appendix 1: Serious adverse events by DHB



* South Canterbury DHB and Tairawhiti DHB confirmed that local mental health and addictions services had experienced no events in 2012–13 that reached the threshold for reporting as an SAE.

Appendix 2: Serious adverse events by type and context/location

	Outpatient	Inpatient	On approved leave	Having gone missing	**TOTAL**
Death by suspected suicide	122	2	5	5	**134**
Serious self-harm	8	5	0	4	**17**
Serious adverse behaviour	6	8	0	3	**17**
Missing from inpatient facility	n/a	5	n/a	n/a	**5**
Other event resulting in patient harm	0	4	0	0	**4**
Total	**136**	**24**	**5**	**12**	**177**

New Zealand Government

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