Report
of the
Queensland Review of Fatal Mental Health Sentinel Events

ACHIEVING BALANCE

A review of systemic issues within Queensland Mental Health Services 2002 - 2003

March 2005

Queensland Government
Queensland Health

Executive Summary

In February 2004, the Director-General of Queensland Health established a Committee to undertake a Queensland Review of Fatal Mental Health Sentinel Events. The task of the Review was to investigate deaths that had occurred in a two year period 2002-2003, involving people with serious mental illness and to determine if there were systemic issues in mental health services that needed to be addressed. The deaths included suicides and unexpected deaths of people receiving mental health assessment or treatment in acute inpatient units or emergency departments, homicides where the offender had a mental illness, and people with mental illness who were shot by police.

In carrying out this investigation the Committee has been mindful of the context of major reform in mental health service delivery away from institutional care to community based care that has occurred over the last forty years, but particularly in Queensland since 1993.

Method

The Review Committee met for the first time on 15 April 2004 and completed its deliberations on 16 December 2004.

In accordance with its Terms of Reference the Committee:

1. Identified 45 fatal mental health sentinel events that met the criteria.
2. Reviewed relevant documentation in relation to each of the sentinel events.
3. Examined relevant systemic reviews, investigations and quality improvement services and the progress of implementation of recommendations resulting from these.
4. Consulted key stakeholders.

As well as meeting with key individuals and organisations as a Committee, individual members of the Review Committee visited 13 of the 16 health service districts where sentinel events under consideration had occurred. During these visits Committee members met with managers and directors of mental health services, other key mental health staff, directors and other clinical staff of emergency departments and some representatives of health service district management.

Context of the Review

It is now more than four decades since the process of deinstitutionalisation of mentally ill people started, shifting the care and support for these patients from psychiatric custodial institutions to community based settings. The closing or downsizing of former asylums has had significant effects on the long term care of these people throughout Australia and in the majority of western developed countries.

Deinstitutionalisation has received bad press in countries such as the United States of America where institutions were closed without providing adequate support in the community. In Europe, while the situation varies across countries, bed closure has generally been accompanied by establishment of community mental health teams, in many instances utilising some if not all of the resources freed by bed closure. This in general has been the process in Australia, and certainly in Queensland, since the launch of the 1992 National Mental Health Policy and Plan of which mainstreaming and a balanced hospital and community service system are the two main planks.

It is important to state that delivering mental health services in the community is a long term labour intensive activity requiring face to face contact between mental health professionals and clients. The extent to which appropriate care can be given with a community approach is very sensitive to resource constraints and work practices. The serious mental disorders have mortality through suicide associated with them despite optimal care. Rates of death by suicide of 10% for schizophrenia and 15% for bipolar disorder are often quoted. Rates of homicide are also higher than in the general population. Australian data indicate that while around 3% of the population have a serious mental illness, 5% of homicides are committed by people who are considered to be mentally disordered.

The Committee supports achieving balance between individual rights of mentally ill people and rights of the general community to public protection and safety. In addition there is a need to balance the right to freedom and the risk of self harm for individual patients.

Similar inquiries in the United Kingdom and in New South Wales have also addressed these issues:

- *Safety First: Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, Report 2001* (*Safety First, UK*).
- *Tracking Tragedy: A Systemic Look at Suicides and Homicides amongst Mental Health Inpatients, December 2003* (*Tracking Tragedy, NSW*).

There is often the tendency in such inquiries to foster a “name, shame and blame” culture. The community expects mental health professionals to minimise the risk they face from mentally disordered individuals and, not unreasonably, they do not distinguish between those rendered suicidal or homicidal by psychosis, chronic intoxication or personality disorder. The community is not necessarily aware of the inherent difficulty of risk assessment, particularly in predicting rare behaviours (e.g. suicide and homicide) even when conducted by experienced and committed professionals.

But it is important to state that not every case of suicide or homicide represents a failure of clinical care or the mental health system. In some instances the intrinsic severity of the condition, or the discouragement that can arise from suffering from what an editorial in *Nature* has described as "the worst condition known to man bar none", combined with an inability to provide constant long term 24 hour supervision and control of an individual, can lead to an unexpected fatal outcome. On the other hand in some cases a series of decisions which may have appeared reasonable at the time turn out in retrospect to have been errors of judgement. It is the latter group that this report is concerned with, highlighting systemic issues that appear to be common to the cases investigated.

It is also important to state the caveat that it is impossible to say with any degree of certainty that if these "errors" had been attended to, or processes had been different, the fatal outcome could have been prevented. There are undoubtedly many thousands of cases where similar clinical decisions have been made but not led to sentinel events.

Analysis of Systemic Issues

Description of Cases

There were 45 sentinel events reviewed by the Committee as follows:

1. Inpatient suicides (n=23 - 9 in 2002 and 14 in 2003).
2. Unexpected deaths (n=7 - one in 2002 and 6 in 2003).
3. Homicides (n=12, - 7 in 2002 and 5 in 2003 including one murder/suicide).
4. Police shootings (n=3 - one in 2002 and 2 in 2003).

The following is a brief description of each group. (N.B. The figures presented in this section have been rounded up.

Inpatient Suicides

Inpatient suicides consisted of 7 females (30%) and 16 males (70%). Age of patients ranged from 23-74 years with a mean age of 40 years. The majority of patients were aged between 25-44 years of age (n=15, 65%). Over half of the patients had never been married (n=13, 57%), while approximately one quarter (n=6, 26%) of patients were either married or in a defacto relationship at the time of the incident. The two most common primary diagnoses were (1) schizophrenia and other psychotic disorders (n=10, 43%) and (2) mood disorders (n=10, 43%). In addition, approximately one quarter of patients (n=6, 26%) had a co-morbid mental health condition. The means of suicide included hanging (n=9, 39%), jumping from a height (n=6, 26%), jumping or lying before a moving train (n=3, 13%), overdose (n=2, 9%), drowning (n=2, 9%) and suffocation (n=1, 4%).

Unexpected Deaths

Unexpected deaths consisted of 2 females (29%) and 5 males (71%). Age of patients ranged from 23 to 61 years with a mean age of 41 years. Over half of the patients had never been married (n=4, 57%) while approximately one quarter (n=2, 29%) of patients were separated or divorced at the time of the incident. The majority of patients (n=4, 57%) had a primary diagnosis of schizophrenia while only one of 7 had a co-morbid mental health condition. In addition almost three quarters of patients (n=5, 71%) had a serious co-morbid physical condition. The causes of death included pulmonary thromboembolism (n=2), cardiac event (n=1), compression of the neck (n=1), coronary atherosclerosis (n=1), choking on a bolus of food (n=1) and myocarditis (n=1). Of particular note 3 who died during restraint were young black men (one Aboriginal and 2 Papua New Guinean) and the existence of cardiac disease in all 3 cases was revealed at autopsy and considered to be the cause of death in 2 cases.

Homicides

Homicides consisted of 8 females (67%) and 4 males (33%). Age of offenders ranged from 22 to 57 years with a mean age of 32 years. The majority of offenders fell into the 25-34 age range (n=5, 42%). Three quarters of male offenders (n=3) and half of female offenders (n=4) were married or in a defacto relationship at the time of the incident. The majority of offenders were Australian born (n=9, 75%) including 2 Aboriginal Australians. One quarter (n=3, 25%) of offenders were born overseas of culturally and linguistically diverse backgrounds (CALD) including Cambodia, Finland and the Philippines. Over half of offenders have a primary diagnosis of schizophrenia (n=7, 58%). The remaining 42% of offenders have a primary diagnosis of schizoaffective disorder (n=2), depressive disorder (n=2) and delusional disorder (n=1). The means of homicide included sharp instruments (n=6, 50%), suffocation (n=3, 25%), blunt instruments (n=2, 17%) and a firearm (n=1, 8%). There were 13 victims in total, 7 males (54%) and 6 females (46%). In regard to the relationship between the offender and victim, all bar one victim were intimate partners or family members.

Queensland Police Shootings

Queensland Police shootings consisted of 3 males aged 30, 36 and 40 years. One person was married at the time of the incident while 2 had never been married. Of the 3 people shot by police, one was a white Australian, one was Vietnamese and one was a white New Zealander. In regard to primary diagnosis, one person had a formal primary diagnosis of schizophrenia, one person had an unclear mental health diagnosis with a differential diagnosis of schizophrenia, and one person had no formal diagnosis as he had no contact with a mental health service prior to the incident. Of particular note is that one of the 3 police shootings was a current patient at the time of the incident and his last contact with the mental health service was 2 days prior to the incident. Furthermore, one patient had been discharged 23 days prior to the incident.

Overall Findings

The Committee noted the enormous amount of work that has been undertaken in the reform and enhancement of mental health services in Australia, and specifically in Queensland, particularly over the last 12 years. There have been a large number of reviews and inquiries, frequently in response to specific incidents, during this time. Many of the findings of these reviews have been taken into account in the operation of mental health services and many of their recommendations have been adopted. The Committee was impressed with the overall quality and professionalism of mental health workers of all disciplines and at all organisational levels of services.

The Committee does not believe that it will be possible to eliminate all sentinel events whatever approach is taken to the reform of mental health services. There is no evidence of an epidemic of suicides by people with mental health disorders, nor of increasing violence against others in the community as a result of mental health reform. The evidence available to the Committee does not suggest that the community is at greater risk because of the deinstitutionalisation of mentally ill people. These matters are addressed in greater depth in the body of the report. In summary, the Committee does not believe that the pendulum of mental health reform has swung too far.

Nevertheless, the Committee identified a substantial number of systemic issues where it considered that improvements could be made to existing systems with consequent improvement in overall clinical practice and in the safety of patients and the wider community.

Inevitably some areas were identified by the Committee where individual clinical practice may have been improved. The Committee stresses that this is with the wisdom of hindsight and that, at the time in question and in the prevailing circumstances, the approach taken was believed to be appropriate by the particular clinicians involved.

Systemic Issues

The issues identified by the Committee and its findings and recommendations are discussed in detail in the body of the report. Only the issues which the Committee considers to be of critical importance will be briefly highlighted here.

Assessment

Issues related to assessment were identified by the Committee in 31 of the 45 cases reviewed: 21 suicides, 8 homicides, and 2 people shot by police.

The Committee believes that comprehensive mental health assessment should be undertaken on admission of all patients to mental health services. This is of particular importance when patients transfer between different district mental health services as this seems to be a time of particular vulnerability for many patients. The development of structured tools to facilitate the assessment process; systematic training and

updating for all mental health workers in assessment; and the central importance of giving due attention to collateral information are all of fundamental importance.

A comprehensive physical assessment should be performed in a timely way on all patients of district mental health services, both at the time of admission and at times of substantial change in mental or physical state.

Detailed consideration was given by the Committee to the formal assessment of risk of patients with mental health disorders. A wide variation in approaches taken to assessment of risk was noted. Risk screening tools were often used but it was stressed by experienced staff of many mental health services that they are only an adjunct to good clinical practice and must be accompanied by a thoughtful analysis of the information obtained. The Committee has made recommendations specifically about the processes used in performing risk assessments, the importance of regular training in risk assessment, the patients for whom and the times at which formal assessment of risk should be undertaken and the actions which should be taken as a result of the risk assessment.

Treatment

Treatment issues were identified for most of the deaths under investigation (19 of 23 inpatient suicides, 3 of 7 unexpected deaths, 7 of 12 homicides, and 2 of 3 police shootings). These covered a range of issues but predominantly fell into 2 groups - those involving the use of medication and other treatment issues. The Committee noted the complexity of the majority of patients under review, with 73% (n=33) having co-morbid drug and/or alcohol use, 33% (n=15) having serious physical health problems, and 20% (n=9) having more than one mental health diagnosis, including 4 with personality disorders. The high proportion of people of Indigenous background or culturally and linguistically diverse background in 2 of the groups was also noted as an added complexity.

Mental health treatment is provided in accordance with clinical guidelines developed by professional bodies and in accordance with what is known to be accepted good practice. Queensland Health does not currently have a comprehensive set of clinical guidelines for mental health clinicians to use as is the case in some states particularly Victoria, nor is there any system of clinical review of mental health services. The Committee is aware that the Director of Mental Health has circulated a small number of clinical guidelines for use by mental health services, and of a proposal within Queensland Health to pilot the use of multidisciplinary peer clinical review of mental health services.

The Committee supports both the proposal to introduce peer clinical review and the development of statewide clinical guidelines and has recommended areas where guidelines should be developed in the first instance.

The Committee notes the importance placed on written documentation by coroner's investigations and supports the continuation of efforts by health service districts to raise the quality of written documentation in the knowledge of its medical and legal importance. Standardised policies would greatly assist these efforts.

Leave and Discharge Planning

The Committee noted that issues related to leave or discharge planning were relevant in a total of 16 of the 45 sentinel events: 11 inpatient suicides, 4 homicides and one police shooting. Issues included inappropriate emphasis on leave and discharge planning where there is no observed improvement in mental state, inadequate information provided to family and carers, and inappropriate discharge from the service of patients who are known to be psychotic but fail to attend appointments.

There is abundant evidence that patients of mental health services are particularly vulnerable following their discharge from mental health units and when on leave. In view of this high level of risk, the Committee supports an approach that includes greater emphasis on formal risk assessment, ensuring adequate community resources to care for people on leave from inpatient units or following their discharge, and appropriate discussion with family and carers to obtain collateral and to provide information and education about circumstances under which the patient should return immediately to the inpatient unit.

The Committee also supports the development of models for continuing support of general practitioners when patients with major mental illness are discharged from mental health services to their care.

Inpatient Observations

Problems with observations performed in mental health units, which were considered by the Committee to be of relevance to the sentinel event, were identified in 10 of the 23 inpatient suicides and in one of the 7 unexpected deaths.

The Committee noted significant variations between mental health services with respect to when observations are ordered, the nature of the observations ordered and how meticulously policies regarding observations are followed and documented. In many cases there was a lack of clarity about the various roles and responsibilities of staff members.

The Committee supports a standardised approach that establishes clearly these roles and responsibilities. The type and frequency of observations should be derived from the risk assessment, should form part of the risk management/ treatment plan, and include documentation about action to be taken in the event that the patient is exhibiting signs of concern or is absent. There should a collaborative approach to reviewing the type and frequency of observations.

Observations of patients with mental health disorders in emergency departments and in general medical or surgical facilities should also be addressed and clarified.

Environment and Means to Suicide

Issues related to the environment and access to means of suicide were identified by the Committee in 11 of 23 inpatient suicides and one of 7 unexpected deaths. In 8 of the 23 inpatient suicides the Committee identified structural issues relevant to the suicide including 4 cases where the patient jumped from the hospital car park. In the

prevention of suicide, important environmental issues include the structure of wards and nearby facilities such as car parks and railway stations, access to the means of suicide such as hanging points and ligatures, and security in inpatient wards.

Five of the 7 patients who suicided in mental health wards, used materials that they had brought with them, such as shoelaces, belts and a parka cord. There are detailed provisions in the *Mental Health Act 2000* around the searching of patients and visitors and the Committee supports the development and application of standardised policies on searching and the removal of harmful things whilst preserving the dignity and privacy of patients.

The design of some units was clearly inappropriate, and fixtures and fittings such as door handles in high dependency units require review.

Control and Restraint

Three men died during restraint - 2 were of Papua New Guinean origin and the third an Aboriginal Australian. Two were well known with significant histories of major mental illness and aggression. Drug and alcohol use was prominent in 2 of the 3 cases. All 3 men were found to have cardiac disease at autopsy and this was the cause of death in 2 cases.

Coroners' investigations have been completed into 2 of the cases and made extensive recommendations focussing on regular practical training in restraint techniques and code blue response to medical emergencies. The Committee notes that there are two major restraint techniques used in Queensland Health and that training has not yet been provided to all mental health staff in view of the costs involved in releasing staff for up to 5 full days of training. The Committee supports the need for immediate and regular follow-up training in the management of aggressive behaviour but believes this should be in the context of comprehensive training in mental health service delivery and the use of verbal de-escalation skills as well as physical restraint.

Administration of the Mental Health Act 2000

Issues related to the *Mental Health Act 2000* and its administration were identified in 11 of the 45 sentinel events: 4 inpatient suicides, 4 homicides, one unexpected death and 2 people shot by police. There were instances in the cases examined in this Review where patients may have required a more restrictive environment than was provided for them. The issues indicate deficiencies in knowledge of the provisions of the *Mental Health Act 2000* among mental health services staff and other key agency staff including the Queensland Police Service and Queensland Ambulance Service.

Particular issues noted by the Committee were the failure to give sufficient weight to previous aggressive behaviour when psychotic because many years had elapsed since the behaviour occurred, and lack of clarity in procedures to be followed when forensic order patients do not adhere to the conditions of their limited community treatment.

Drugs and Alcohol

The Committee considered that the use of alcohol and/or other drugs was significant in the mental health state of at least 20 of the 45 cases under review at the time of the sentinel event (10 inpatient suicides, 5 homicides, 3 unexpected deaths and 2 shootings by police).

The changing pattern of drug use over recent years, with increasing use of psycho-stimulants and continuing high levels of cannabis use, seems to be of particular importance in impacting on mental health. The co-existence of mental health and alcohol and other drug problems has been called "dual diagnosis". Services which address alcohol and other drug problems have to a substantial extent developed separately from mental health services. This separation is said to have been of value in "de-stigmatising" people with alcohol and other drug problems and in the development of some prevention and early intervention initiatives in the alcohol and drug field. However, in the opinion of the Committee, this separation has resulted in the development of structural barriers between the services which constitute real impediments to the provision of integrated management of people with dual diagnosis.

Consequently, the Committee has recommended that the structural impediments to the provision of integrated treatment for people with dual diagnosis be addressed as a high priority issue. The Committee believes that there is also a need for increased community awareness of the importance of cannabis and psycho-stimulant use in causing/aggravating mental health disorders and for closer supervision of the alcohol and other drug use of people on involuntary treatment orders and forensic orders.

Communication and Information Management

Large decentralised health services are very aware that their ability to provide good quality treatment relies heavily on effective communication. It is perhaps not unexpected that the Committee identified problems in communication in a total of 19 of the 45 sentinel events: 8 inpatient suicides, 7 homicides, one unexpected death and 3 people shot by police. However on the whole the Committee was impressed with the level of communication and documentation and noted evidence of considerable work that had gone into improving relationships with key agencies such as the Queensland Police Service and the Queensland Ambulance Service.

The lack of access to previous clinical information about patients was seen as significant to the sentinel event in 3 inpatient suicide cases and 2 homicide cases, and there were many other cases where the availability of such information would have improved the provision of service. The lack of clinical information was identified as significant in both mental health services and emergency departments.

The Committee has been advised that there is no mental health information system that is currently available or planned that will be capable of providing timely, accurate clinical information either to mental health services or emergency departments across health service districts. The Committee believes that access to current mental health information systems should be enhanced to enable the following minimum

information to be available between health service districts: diagnosis, *Mental Health Act 2000* status and mental health service contact person.

Immediate Responses to Sentinel Events

The sudden collapse of a mental health inpatient through self harm, unexpected medical problems or while being restrained is not common and almost always unforeseen to those in the surrounding environment. The Committee identified problems related to the mental health services' response to the incident in 5 of the 23 inpatient suicides and 4 of the unexpected deaths. Of these the Committee noted that in 3 of the inpatient suicides and 4 of the unexpected deaths following the collapse of a patient, there were problems in gaining access to emergency response services. There were variations among the facilities as to where emergency equipment was located, the ease of access to the required area and the type and working order of the equipment provided.

There was also variation in the communication of deaths to family members, and in providing follow-up to family members. In 2 of the 23 inpatient suicides the Committee noted untimely and/or inappropriate communication with the family after the incident. In the case of suicide it is well known that surviving family members are considered to be at higher risk of suicide and the Committee believes there should be a process for providing information and support to these family members.

Investigations of Sentinel Events

An investigation following the sentinel event was carried out in 41 of the 45 sentinel events: 23 inpatient suicides, 8 homicides, 7 unexpected deaths and 3 police shootings. Of these, only 10 external investigations were conducted. Mental health services come under a much higher level of scrutiny than other health services in relation to investigation of deaths. Most mental health services carry out their own internal investigations to identify areas where processes may require improvement. In addition all unexpected deaths including deaths by suicide, homicide and police shooting are subject to autopsy, police investigation and in most cases are also the subject of coronial investigation or inquest. As a result there are many recommendations directed at changing aspects of mental health service delivery either at a statewide level or individual service level.

The Committee supports the standardisation of investigations into future mental health sentinel events in accordance with the Queensland Health Incident Management Policy (Queensland Health, 2004b) and believes each review team should include a participant who is external to the health service district. Recommendations of sentinel event reviews should be examined at the corporate level to assist district mental health services where there is a need for statewide guidelines or training to address issues that arise.

Emergency Departments

Emergency departments currently play an important role in the assessment and treatment of patients with mental health disorders. This role has increased substantially as a result of the reform of mental health services and the treatment of

greater numbers of people with mental health diagnoses in the community. It has been further complicated by the high prevalence of the use of psycho-active drugs and the detrimental effect which the use of many of these drugs has on mental health.

Issues related to the management of people with mental health disorders in emergency departments were regarded as important in 7 of the cases reviewed by the Committee (6 suicides and one homicide). Site visits undertaken by the Committee highlighted the variability in approaches of staff of emergency departments to the management of mental health problems. Accordingly the Committee considers that alternative models should be explored for the delivery of emergency mental health assessment and treatment to clients with mental health problems who currently present to emergency departments.

However, while the status quo remains, the Committee is of the view that it is critically important that the assessment and initial management of mental health problems is regarded as "core" business by emergency department staff and that they receive appropriate training and support to undertake this role. Emergency department staff should take responsibility for the care and supervision of people with mental health problems while they remain within the department, however it is imperative that they have ready access to high quality, timely, specialist mental health advice and support. The Committee believes that it is particularly important that the accommodation of patients with mental health problems in emergency departments should be such as to facilitate their optimal observation and management. A major emphasis is needed on the implementation of strategies to ensure that staff of emergency departments have timely access to clinical information and *Mental Health Act 2000* status of patients on a 24 hour basis.

Resources

The Committee concluded that the lack of inpatient beds affected the care of 4 people who suicided as inpatients and 2 homicide offenders. Further, at the time of 3 inpatient suicides there appeared to be inadequate numbers of specialist medical staff and/or inpatient nursing staff.

Several mental health services appeared to have insufficient acute inpatient beds. Community clinical staffing targets set in the *Ten Year Mental Health Strategy for Queensland, 1996* (Queensland Health, 1996b) have still not been reached in most services in spite of the financial commitment made by the Commonwealth and Queensland Governments.

Site visits indicated that skill levels have not been maintained particularly in inpatient units, with many experienced staff moving to community work, and in addition many services encounter difficulties in recruiting to vacant positions, particularly psychiatrists and mental health nursing staff.

The Committee believes that there is a need for a major emphasis to be placed on the recruitment, retention and training of mental health professionals of all disciplines.

Key Recommendations

The Committee has presented a series of recommendations that address systemic issues in mental health services. The following are considered to be the key recommendations.

1. Develop core statewide standardised processes for mental health assessment, risk assessment and treatment accompanied by appropriate education and training. Particular attention should be given to addressing non-compliance with treatment.

2. Give high priority to developing an information system to ensure the access of emergency department and mental health staff across health service districts to timely, accurate clinical information.

3. Increase integration of mental health and alcohol, tobacco and other drug services.

4. Explore alternative models for the delivery of emergency mental health assessment and treatment to clients with mental health problems currently presenting to emergency departments.

5. Develop models for continuing support of general practitioners when patients with major mental illness are discharged from mental health services to their care.

6. Remove potential means of suicide wherever possible by implementing searching procedures in accordance with the *Mental Health Act 2000* and correcting potential structural factors in all inpatient mental health units and their immediate environment.

7. Establish an ongoing process for monitoring the results of analyses of mental health sentinel events at the corporate level to determine trends and communicate these to the services.

8. Accelerate the implementation of the *10 Year Mental Health Strategy for Queensland, 1996* in relation to staffing and bed resources. Particular emphasis should be given to recruitment and retention of clinical staff and provision of acute inpatient beds, complemented by access to additional secure beds and supported accommodation, in areas of high morbidity and high growth.

9. Provide standardised competency based training for staff who perform functions under the *Mental Health Act 2000* with particular emphasis on management of forensic order patients (including persons of special notification), and liaise with the Mental Health Review Tribunal regarding the conditions of limited community treatment for patients under the *Mental Health Act 2000*.

Background

It is now more than four decades since the process of deinstitutionalisation of mentally ill people started, shifting the care and support for these patients from psychiatric custodial institutions to community based settings. The closing or downsizing of former asylums has had significant effects on the long term care of these people throughout Australia and in the majority of western developed countries, particularly in the North Americas and in Western Europe. *The World Health Report* (World Health Organization, 2001), whilst acknowledging that almost 40% of countries world wide lack any community mental health services, has mandated this movement by making it one of its ten tenets for modern psychiatric practice. The maxim is "give care in the community". The report makes the point that shifting patients from mental hospitals to care in the community has a better effect on outcome and quality of life of patients and is also cost effective and respectful to human rights.

Deinstitutionalisation has received bad press particularly in the United States of America as a result of the fact that institutions were closed in that country without providing adequate support in the community.

In Europe, while the situation varies across countries, bed closure has been accompanied by establishment of community mental health teams, in many instances utilising some if not all of the resources freed by bed closure. This in general has been the process in Australia since the launch of the 1992 National Mental Health Policy and Plan of which mainstreaming and a balanced hospital and community service system are the two main planks.

However it is important to state that delivering mental health services in the community is a long term labour intensive activity requiring face to face contact between mental health professionals and clients. The extent to which appropriate care can be given with a community approach is very sensitive to resource constraints and work practices. Mentally ill patients also become more visible in the community and tend to come to the attention of community agencies more readily than when they were incarcerated. Emergency departments are one area in which an increasing number of mental health clients are now being seen. In addition disturbed behaviours tend to come to the attention of police and ambulance services. For example mentally ill patients can lack insight into their illness when ill, or believe that medication is unnecessary when well, resulting in a tendency to drop out of treatment services prematurely, leading in many cases to eventual decompensation.

In addition the serious mental disorders have a mortality through suicide associated with them despite optimal care. Rates of death by suicide of 10% for schizophrenia and 15% for bipolar disorder are often quoted. Rates of homicide by mentally disordered offenders are also higher than in the general population, with Australian data indicating that mentally disordered homicide offenders are over represented by about 50%.

Whenever sentinel events occur, particularly homicides or police shootings involving people with mental illness, they usually gain wide media coverage and lead to community concerns that deinstitutionalisation has failed. This is despite the fact that no increase in homicide involving people with mental illness was found for a decade in Denmark or the United Kingdom and only a small increase was found in Germany. Australian data did show higher rates of conviction for violence in those with schizophrenia but found that over a 25 year period a doubling of convictions for violence of people with schizophrenia (14% to 25%) paralleled rising levels of general societal violence. The proportion of convictions for violent crime increased from 5.1% to 9.6% over the 25 year period. The increasing incidence of drug and alcohol abuse over that period appears to be related to the increase in violence in both the schizophrenic and general population.

There is an inordinate focus in the literature on "the losers" rather than the "winners" of deinstitutionalisation. Many of the latter tend to remain silent. On the other hand critics list lack of treatment, social isolation, homelessness, incarceration, or other forms of significant loss of quality of life as consequences of deinstitutionalisation failure.

This is the theme of the recent report by the Mental Health Council of Australia, *Out of Hospital, Out of Mind* (Groom, Hickie & Davenport, 2003) which calls for significant increases in resources to fund adequate community services to provide the care that once was offered "cradle to grave" in the asylums. But it is important to balance that view by considering the success stories of deinstitutionalisation namely the many thousands of people who would have been incarcerated in Dickensian institutions now able to live their lives free of the symptoms of mental illness, or with these controlled by medication, in an unrestricted non stigmatised environment and with a considerable degree of freedom and autonomy. Many of these people only need to access the mental health system when in crisis. It is also now becoming apparent that severely mentally ill patients with high rates of co-morbidity, the new long stay patients who tend to clog up the emergency department and both community and hospital beds, and those with intellectual disabilities and mental health needs are just some of the groups who need additional attention.

A current trend is a move from unfettered individual rights for the mentally ill (as enshrined in the United Nations declaration of the rights of the mentally ill) to balancing those rights with those of the general community for public protection and safety. In addition there is a need for the individual patient to have a balance between the right of freedom and the risk of self harm. The community is not necessarily aware of the inherent difficulty of risk assessment, particularly in predicting rare behaviours (e.g. suicide and homicide) even when conducted by experienced and committed professionals.

In one sense this Review has to address this issue as have similar inquiries which have been held in the United Kingdom (*Safety First*) and in New South Wales (*Tracking Tragedy*). There is always the tendency in such inquires to foster a "name, shame and blame" culture. The community expects mental health professionals to minimise the risk they face from mentally disordered individuals and, not unreasonably, they do not distinguish between those rendered suicidal or homicidal by psychosis, chronic intoxication or personality disorder.

But it is important to state that not every case of suicide or homicide represents a failure of clinical care or the mental health system. In some instances the intrinsic severity of the condition, or the discouragement that can arise from suffering from what an editorial in *Nature* has described as "the worst condition known to man bar none" combined with an inability to provide constant long term 24 hour supervision and control of an individual, can lead to an unexpected fatal outcome. On the other hand in some cases a series of decisions which may have appeared reasonable at the time turn out in retrospect to have been errors of judgement. It is the latter group that this report is concerned with, highlighting systemic issues that appear to be common to the cases investigated.

It is important to state the caveat that it is impossible to say with any degree of certainty that if these "errors" had been attended to, or processes had been different the fatal outcome could have been prevented. There are undoubtedly many thousands of cases where similar clinical decisions have been made but not led to sentinel events.

A recent review of Tandon and Jibson (2003) reinforces the long standing observation that there continues to be a high prevalence of suicidal behaviour in schizophrenia and that rates have not increased as a result of deinstitutionalisation. Now however when they occur, they tend to be more public and consequently receive more publicity. Effectively treating positive symptoms and depression, reducing substance abuse, avoiding akathisia, addressing demoralisation and instilling hope are important elements in countering the trend. The newer generation of antipsychotic medication (particularly clozapine) and cognitive behavioural approaches may also play a role in reducing suicide and violent behaviour.

References

Queensland Health (2004b). *Queensland Health Policy Statement (No. 23360): Incident Management Policy*. Retrieved June 10, 2004, from http://qheps.health.qld.gov.au/hssb/risk/im/adobe/incident_mgt_policy.pdf

Queensland Health (1996b). *Ten Year Mental Health Strategy for Queensland, 1996*. Brisbane: Queensland Health.