NorthWestern Mental Health

Northern Area
Mental Health Service
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Coroner Parkinson
Level 11, 222 Exhibition St
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Dear Ms Parkinson

In the matter of inquest into the death of Domenic Chiodo. Court Reference: 1251/10

Pursuant to the *Coroners Act 2008* we now provide a response to the recommendations in this matter.

Recommendation 1: That upon revocation of mental health community treatment orders, patients be transferred to a dedicated mental health facility inpatient unit and that they not be admitted to an acute hospital emergency department unless there are sound medical reasons for such an admission.

In situations where there is capacity to directly admit to a psychiatric in-patient unit and it is appropriate to do so with due consideration having been given to the physical health condition of the patient, direct admission does occur.

Since the tragic death of Mr Chiodo, many changes in practice across the Northern Area Mental Health Service have occurred. These changes have predominantly been possible as a result of an additional 25 beds (Northern Psychiatric Unit 2) becoming available in early 2011.

Northern Psychiatric Unit **(NPU 1 & 2)** strives to have 4 beds vacant to enable timely admission of psychiatric patients from the Emergency Department **(ED)** at the Northern Hospital, and/or the direct admission of patients from the community. The other NWMH acute inpatient units also now practice in this way, and a coordinated and collaborative approach is taken across the129 beds in the 5 adult acute units (Sunshine Acute Psychiatric Unit, Broadmeadows In-Patient Unit, John Cade Unit 1, NPU 1 & 2) to enable timely and efficient access to acute beds.

In the context of the additional 25 adult acute beds at NPU, NorthWestern Mental Health **(NWMH)** has been able to develop and implement acute access processes and patient flow management systems designed to match capacity to demand. In most instances, these processes enable NWMH to absorb or modulate the inevitable peaks and troughs in demand for acute beds. However, due to finite bed numbers it is still sometimes the case that there is not a bed immediately available and acutely unwell psychiatric patients are admitted to Emergency Departments for treatment and care. Emergency Departments are part of the gazetted facilities (section 94 of the *Mental Health Act 1986)* and are therefore part of an approved mental health service where assessment, diagnosis and treatment can be provided to acutely unwell psychiatric patients.

Recommendation 2: That the timing of apprehension of patients pursuant to a restricted community treatment order be determined (where possible having regard to the urgency of the apprehension) by reference to the availability of inpatient mental health beds.

Revocation of community treatment orders is a clinically driven process, and although important, bed availability is a secondary issue. It is axiomatic that the timing and provision of care for mental health consumers should be needs rather than resource led. The urgency of subsequent apprehension of the patient must outweigh any consideration of the immediate availability of in-patient beds. In regard to Mr Chiodo, unfortunately there was no capacity to defer the revocation of his community treatment order. There was a clear and present risk and that risk was acted on immediately.

Revocation and urgency of apprehension is (and should be) determined by the imminent risk of harm to self or others. In the context of patients on Restricted Community Treatment Orders **(RCTO)** the risk of harm to others is implicit and therefore following revocation of the RCTO, the urgency of apprehension is time critical

Northern Area Mental Health Service **(NAMHS)** has implemented guidelines regarding the communication that should occur between consultant psychiatrists and the Crisis Assessment Treatment Team **(CATT)** regarding patients on a CTO/RCTO when revocation of an order is occurring. This communication includes discussion about bed availability and determination about the most appropriate management of each situation. Strong links between the Emergency Crisis Assessment Treatment Team **(ECATT)** and NPU now ensure ongoing discussion about the timely transfer of patients who have been admitted to the ED and are in need of a psychiatric bed.

Recently the Northern Police and Clinician Emergency Response **(NPACER)** initiative has been implemented which has enabled further improvement in the management of acutely unwell mental health patients. NPACER involves a clinician from the CATT and a Police Officer working together to respond to all apprehensions pursuant to section 10 of the *Mental Health Act 1986*. Prior to this initiative, all persons apprehended under section 10 were transported by police to the ED at the Northern Hospital, where they would be assessed by an ECATT clinician.

NPACER provides an enhanced police and area mental health service capability to respond to incidents involving the mentally ill, whilst also reducing the amount of time police operational units spend with people presenting with mental illness and risk issues. The model involves police and mental health clinicians providing a dual secondary response following an initial response by a police patrol unit. This dual response reduces the risk of behavioural escalation and provides a better outcome for clients with mental health issues. The model enables a focus on early intervention and assessment by skilled and experienced police officers and mental health clinicians as a means to ensuring timely, appropriate and effective decisions regarding the most appropriate disposition for each referral. This approach results in a highly effective use of resources as well as prompt, "client centred" decisions. Further, NPACER has been highly successful in ED diversion for those patients assessed as requiring psychiatric admission as NPU and Broadmeadows Inpatient Unit (**BIPU**) now designate a specified number of beds for direct admission via NPACER. In a number of ways NPACER has provided the solution to Recommendation 1.

Recommendation 3: That additional inpatient mental health beds be made available to the public mental health system in Victoria.

NWMH agrees and supports this recommendation.

Yours sincerely

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Director Clinical Services, NAMHS

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Ms Jane Fiske, Senior Associate, Lander & Rogers Lawyers