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# Issues Paper on Reportable Deaths: February 2015

## *Background*

The introduction of new reportable death requirements under the Mental Health Act 2014 has created new responsibilities for the Mental Health Community Support Services (MHCSS) sector. The 'Reportable deaths: Chief Psychiatrist's guideline' released in September 2014 was intended to qualify and clarify these newfound responsibilities, however the guidelines have been perceived by MHCSS as ambiguous and problematic.

There is concern that the ambiguity and clinical focus of the guidelines will leave MHCSS staff unsure or unaware of what their new reporting responsibilities are, which in turn will expose the MHCSS sector to risk of liability.

## *Scope and aim of this paper*

This paper provides an overview of the issues faced by the MHCSS sector in the wake of these new reporting requirements and provide recommendations as to how the guidelines could be amended to make reporting clearer and more operationally efficient.

## *Summary of Issues and Recommendations*

### Issue 1: Services covered by the guidelines and their responsibilities

It is unclear whether only Victorian-funded community mental health support services are required to report. By referring to "mental health community support services" it is not clear whether other Community Managed Mental Health Services (CMMHS) are also covered by the guidelines.

The guidelines also do not make it clear which reporting requirements are for the MHCSS / CMMHS sector and which are for the clinical sector.

For example:

- The terminology used throughout the guideline is inconsistent: "mental health service", "health service", "mental health community support service" and "public health services" are all used inconsistently and/or interchangeably, creating confusion.
- Under 'health services that must report' on page 2 is listed "all publicly funded mental health community support services." It is unclear whether this means only the Victorian-funded MHCSS sector, or Commonwealth-funded Victoria-based services as well (i.e. the CMMHS sector).

- The requirements for clinical services and other mental health services are not clearly delineated.
- The flowchart does not mention MHCSS / CMMHS at all.

Recommendations:

- Create separate guidelines and flowcharts for the MHCSS / CMMHS and clinical sectors.
- For non-clinical services, create separate guidelines and flowcharts for different service types (residential rehab, community mental health centres, mutual support and self-help).
- Rework the language of the guidelines to be consistent and clear.

## Issue 2: Clinical focus of the guidelines

The guidelines are written in a way that suggests MHCSS / CMMHS have the same capacities and roles as clinical services. The guidelines outline reporting requirements that are clinical in nature, and are not possible to be completed by MHCSS / CMMHS.

For example:

- There is a requirement on page 7 of the guidelines that a "detailed clinical report" by a psychiatrist be completed. However, MHCSS / CMMHS do not have psychiatrists on staff and would not be able to provide such a report.
- The MHA 125 Notice requires ICD codes to be completed, MHCSS / CMMHS do not diagnose, and as such are not able to complete diagnostic codes.

Recommendations:

- Any clinical information should be required to be provided by MHCSS / CMMHS "only where available."
- MHCSS / CMMHS should be exempt from filling out certain information on the Notice, which should be specified on the form. (E.g. "MHCSS service providers, proceed to Qu.13").

Given the nature of information on the MHA125 form, it may be unreasonable to require MHCSS / CMMHS to provide this form at all.

Recommendations:

- That MHCSS / CMMHS be required to submit to the Chief Psychiatrist an Incident Report, in lieu of a MHA 125 Notice, where a report is required of the service.

## Issue 3: Reporting requirements are broad, ambiguous and procedurally onerous

The requirements outlined in the guidelines impose responsibilities onto MHCSS / CMMHS staff which are unreasonable and, to a large extent, impractical.

For example:

- Page 3 of the guidelines states that a reportable death of a consumer includes a person who "sought or is seeking mental health services… and was or is not provided with mental health services."

This raises a number of issues about when a person becomes a consumer and how the service maintains records of all contacts with potential clients.

For example:

- Are central intake workers (who conduct an initial assessment and then refer onwards immediately) required to follow up with and report on their one-off clients?

There are further unreasonable and impractical requirements laid out in the guidelines.

For example:

- The requirement that MHCSS must report on deaths that occur up to three months post-discharge (stipulated on page 7 of the guidelines) is somewhat onerous and impractical.

It is unreasonable to expect that services would be aware of a former client's death following discharge from their program. In practice, to meet this requirement, services would have to introduce an onerous and time-wasting procedure for following up with clients three months after discharge.

Measuring time from the last attempted contact with a client is suggested as being clearer than measuring from the time of discharge. One month is suggested as being a more reasonable timeframe for follow-up than three.

Recommendations:

- Reconsider the requirement for MHCSS / CMMHS to report deaths occurring within three months of discharge.
- Define more clearly what is meant by "discharge".

## Issue 4: Duplication

Page 6 specifies that where the deceased accessed both MHCSS / CMMHS and clinical services, both sector services are required to report. This creates duplication and inefficiency.

For example:

- In the case of shared care arrangements (e.g. consumers on both CTOs and NCSOs) both clinical services and MHCSS / CMMHS would be reporting on the same death.

It is unclear what purpose this double-reporting serves.

This issue raises the question of whether the utility of receiving a notice of death from MHCSS / CMMHS outweighs the immense procedural burden it would create?

Recommendations:

- MHCSS / CMMHS should not be required to report a death to the Coroner if the client was an inpatient at the time of death.
- MHCSS / CMMHS should only be required to report a death upon request of the Chief

Issue 5: Guidelines are not user-friendly

The guidelines are heavy in background content and formatting is inconsistent, making them difficult to follow.

For example:

- Page 3 contains a great deal of information which does not deal directly with reportable death procedure.
- Guideline document lacks consistency in formatting and layout, which creates confusion.

Recommendations:

- Consistency in format and language, for easy reference.
- Guidelines should be less legislative and more instructional. A good example is the Department of Health's 'Critical client incident management summary guide and categorisation table: 2011'.
- Page 3 sections on 'Reporting to the Coroner' and 'Procedures in the event of a reportable

## *Questions for consideration*

What would expose MHCSS to liability?

1. Could MHCSS / CMMHS services be liable for submitting an incomplete MHA 125 form (as the content of the form is not core to the role of MHCSS / CMMHS)?
2. What would be the consequences for a MHCSS / CMMHS organisation if it failed to report?
3. If an MHCSS / CMMHS organisation never becomes aware of a client's death within the three months post-discharge (e.g. the client becomes uncontactable), could the service be liable for failure to report?

What is best practice for reporting deaths?

4. Should services be introducing procedures to call clients after three months post-discharge to check off our reporting requirement? Is this prudent or unreasonable?
5. What is the best model procedure for reporting a death?