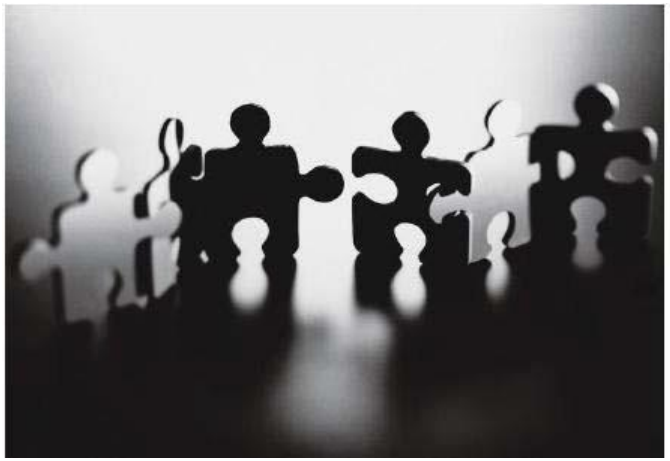

National Confidential Inquiry into
Suicide and Homicide
by People with Mental Illness

20 Years of the National Confidential Inquiry

SAFER SERVICES: A TOOLKIT FOR SPECIALIST MENTAL HEALTH SERVICES AND PRIMARY CARE

10 KEY ELEMENTS TO IMPROVE SAFETY

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) has made recommendations to improve the safety of mental health care over a number of years. Based on evidence from 20 years of research on patient safety we have drawn up a list of key elements of safer care in mental health services and in the wider health system. In this toolkit, these elements of safer care have been presented as quality and safety statements about clinical and organisational aspects of care. This toolkit is intended to be used as a basis for self-assessment by specialist mental health care providers and responses should ideally be based on recent local audit data or equivalent evidence.

We welcome your feedback on this toolkit (email: nci@manchester.ac.uk).

This toolkit has been developed by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH).

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SAFER SPECIALIST MENTAL HEALTH SERVICES: A TOOLKIT

Safer care in mental health services

Quality/safety standard	Response		NCISH data	Source of data
	Yes	No		
Safer wards				
Removal of ligature points • There has been a redesign/removal on acute in-patient wards (including PICU, forensic units) of: i. Non-collapsible curtain rails ii. Low lying ligature points (e.g. door handles) • There has been a comprehensive review of in-patient safety			Suicide by mental health in-patients continues to fall, though the longstanding downward trend has recently slowed. This fall began with the removal of ligature points to prevent deaths by hanging. The number of deaths by hanging on the ward in England fell by 14.3% from 2005 to 2014. Despite the focus on the safety of the in-patient environment, in 2014 there were still 24 confirmed hanging deaths on mental health wards in England. Deaths by hanging on the wards are usually from low-lying ligature points (i.e. strangulation). The removal of ligature points from wards is linked with lower suicide rates.	Annual report (2017) Hunt et al (2012) Avoidable Deaths (2006) Kapur et al (2016)
Reduced leave from ward without staff agreement • There is a standard response/protocol for in-patients who leave the ward without staff agreement			In England there were 251 in-patients who died after leaving the ward without staff agreement over a 10 year period from 2005-2015, 22% of all in-patient suicide deaths, an average of 23 deaths per year. The percentage of suicides among patients who left the ward without staff agreement was 32%, 27% and 12% for Northern Ireland, Scotland and Wales respectively.	Annual report (2017)

Quality/safety standard	Response		NCISH data	Source of data
	Yes	No		
Safer wards (continued)				
• There are measures in place to prevent patients from leaving the ward without staff agreement through better monitoring of acute in-patient ward access and exit points, specifically: i. Technology to improve monitoring of access/exit points (including CCTV, swipe card access) ii. Staffing, observation protocol • Policies specifically acknowledge the in-patient experience (i.e. support and recreation, privacy and comfort) can be linked to risk of leaving the ward without staff agreement			A qualitative paper of clinicians' views of patients who died by suicide after leaving the ward without staff agreement indicated a number of patients were close to being discharged or transferred from the in-patent ward when they left the ward. Often there were problems with the intended discharge destination.	Hunt et al (2016) In-patient suicide under observation (2015)
Skilled in-patient observation • Observation policies recognise that observation is a skilled intervention to be carried out by experienced staff of appropriate seniority			There was an average of 23 suicides by in-patients under observation per year in the UK between 2005 and 2015. In a study of suicide by patients under observation, we found that half of in-patient suicides under observation occurred when observation was carried out by less experienced staff or staff who were unfamiliar with the patient (e.g. health care assistants or agency staff).	Annual report (2017) In-patient suicide under observation (2015)

Quality/safety standard	Response		NCISH data	Source of data
	Yes	No		
Care planning and early follow-up on discharge from hospital to community				
• The discharge policy specifies follow-up of patients discharged from psychiatric in-patient care occurs within 2-3 days in all cases			In England, there were 2,288 suicides within 3 months of discharge from in-patient care between 2005 and 2015. Sixteen per cent of these post-discharge suicides occurred within the first week of leaving hospital, with the highest number occurring on day 3 (21%). The figures for Northern Ireland, Scotland and Wales for suicide within 3 months of discharge were 131 (17%), 416 (17%) and 149 (18%) respectively.	Annual report (2017)
• There is a care plan in place for patients discharged from acute care			In England, 269 (12%) post discharge suicides occurred before the first follow-up appointment. Deaths in the first two weeks after hospital discharge are linked to admissions lasting less than 7 days, lack of a care plan on discharge and adverse life events.	Bickley et al (2013)
No 'out-of-area' admissions for acutely ill patients				
• There are no acute out-of-area admissions. Where patients are discharged from a non-local in-patient unit, there is a policy in place for close follow up in the community			In England, 212 (10%) patients died after being discharged from a non-local in-patient unit. This increased to 79 (13%) of those who died within 2 weeks of discharge. There has been a downward trend in the number of suicides by patients recently discharged from hospital in England and Scotland: there were 230 post-discharge deaths in 2015, down from 299 in 2011.	Annual report (2017)

Quality/safety standard	Response		NCISH data	Source of data
	Yes	No		
24 hour crisis resolution/home treatment teams				
• Community mental health services include a 24 hour crisis resolution/home treatment team (CRHT) with satisfactory staffing levels			The main setting for suicide prevention is now the crisis team, following a fall in in-patient suicides and a rise in the use of CRHT as an alternative to admission in acute care, since 2005. In England, there are on average 186 suicides per year by CRHT patients – around two to three times as many as under in-patient services. Our research suggests the introduction of 24 hour CRHT appears to add to the safety of a service overall, with a fall in the suicide rate in implementing Trusts.	Annual report (2017) Kapur et al (2016) Hunt et al (2014) While et al (2012) Safety first (2001)
• The assessment for CRHT takes into account individual circumstances and clinical need, and recognises that CRHT may not be suitable for some patients; especially patients who are at high risk or who lack other social supports (e.g. live alone)			Our findings indicate that CRHT is used for too many patients at high risk of suicide. 44% of CRHT patients who die by suicide live alone. 43% die within 2 weeks of leaving hospital, and a third of CRHT patients who die by suicide have been under the service for less than one week.	Annual report (2017) Hunt et al (2014)
Community outreach teams to support patients who may lose contact with conventional services				
• Community mental health services include an outreach service that provides intensive support to patients who are difficult to engage with conventional services (i.e. community patients who are non-adherent with medication or who are missing appointments)			Implementation of an assertive outreach policy was associated with lower suicide rates among patients who were non-adherent with medication or who had missed their last appointment with services, and with lower suicide rates overall in implementing Trusts.	Kapur et al (2016) While et al (2012) Avoidable deaths (2006)

Quality/safety standard	Response		NCISH data	Source of data
	Yes	No		
Specialised services for patients with mental illness and co-morbid alcohol and drug misuse				
• Specialist alcohol and drug services are available, with a protocol for the joint working with mental health services (including shared care pathways, referral, and staff training)			Alcohol and drug misuse is a common antecedent of patient suicide in all UK countries varying between 45% and 63% (alcohol) and between 33% and 46% (drugs) of suicides in patients between 2005 and 2015. The number of suicides in patients with a history of alcohol or drug misuse has fallen since a peak in 2011. Only a minority of patients are in contact with specialist substance misuse services.	Annual report (2017) Avoidable Deaths (2006)
• There is a specific management protocol or written policy on the agreed management of patients with co-morbid alcohol and drug misuse			In England, there was a 25% fall in rates of suicide in patients following implementation of a recommendation to have a policy on the management of patients with co-morbid alcohol and drug misuse.	Kapur et al (2016) Patient suicide: the impact of service changes (2013)
Multidisciplinary review (working with carers)				
• There is a specific policy on multi-disciplinary reviews following all suicide deaths, including involving and sharing information with families			Policies for multi-disciplinary review and information sharing with families were associated with a 23.5% fall in suicide rates in implementing Trusts, indicative of a learning or training effect.	Kapur et al (2016) Healthy Services and Safer Patients (2015)
• There are frequent meetings with carers of patients to monitor their wellbeing • There are measures to support the mental health of carers • There are specific measures in place to provide mental health care to patients who care for young children			There were 938 patients who died by suicide in the UK in 2005-2015 who were carers (i.e. providing care for young children or someone else at home, or living with a mental health patient). This equates to 5% of all patient suicides and does not take into consideration suicide by carers within the general population. Carers had fewer risk factors for suicide compared to other patients who died.	Annual report (2017)

Quality/safety standard	Response		NCISH data	Source of data
	Yes	No		
Implementing NICE guidance on depression and self-harm				
• There are local Trust policies based on NICE (or equivalent) guidelines for depression and self-harm			Services that implemented NICE guidance for depression and self-harm and depression guidelines had significant reductions in suicide rates of 26% and 23% respectively.	Kapur et al (2016) Patient suicide: the impact of service changes (2013)
Personalised risk management, without routine checklists				
• There is a comprehensive management plan based on assessment of individual/personalised risks, and not on the completion of a checklist			In a random sample of patient suicides in 2008, the quality of assessment of risks and management was considered by clinicians to be unsatisfactory in 36% of patient suicides. Despite common risk factors, what puts a patient at risk is often individual, suggesting risk management should be personalised.	Quality of risk assessment prior to suicide and homicide (2013)
• There is a guide in place on the effective communication of personalised risk management between different agencies, services and professionals involved with the patient, including their family			Working more closely with families could improve suicide prevention. In 18% of suicide deaths clinicians believed greater involvement of the family by the service would have reduced risk.	Annual Report (2017)
Low turnover of non-medical staff				
• There is a system in place to monitor and respond to non-medical staff turnover rates (i.e. nurses, qualified allied health professions and other qualified scientific, therapeutic and technical staff)			Lower patient suicide rates are associated with a low turnover of non-medical staff and in services where staff turnover was high, the effect of service change on suicide rates was low.	Kapur et al (2016) Healthy Services and Safer Patients (2015)

SAFER SPECIALIST MENTAL HEALTH SERVICES: A TOOLKIT

Safer care in the Emergency Department

Quality/safety standard	Response		NCISH data	Source of data
	Yes	No		
Psychosocial assessment of self-harm patients				
• There is a fully integrated liaison psychiatry service in place offering 24 hour specialist assessment and follow-up for self-harm patients			Over the last 20 years, recent self-harm has become more common as an antecedent of suicide. In the UK, a history of self-harm varies between 68% and 73% of patient suicides between 2005 and 2015. Over half of children and young people (under 20) who die by suicide had a history of self-harm – 7% in the week prior to death.	Annual report (2017) Suicide by children and young people in England (2016) Suicide by children and young people (2017)
• There is a policy in place for all patients who self-harm to have a skilled psychosocial assessment of risk			The percentage of patients who had been seen in an emergency department for self-harm in the 3 months before death increased from 129 (11%) in 1999 to 278 (18%) in 2013.	Annual report (2016)

SAFER SPECIALIST MENTAL HEALTH SERVICES: A TOOLKIT

Safer care in Primary Care

Quality/safety standard	Response		NCISH data	Source of data
	Yes	No		
Safer prescribing of opiates and antidepressants				
• There is a standard procedure in place for safer prescribing of opiate analgesics and tricyclic antidepressants in primary care, which takes into account the toxicity of these drugs in overdose (i.e. reduced, short-term supplies)			Opiates are the most commonly used type of drug in fatal overdose. In England, opiates including both prescribed and illicit, are used in 26% of patient suicide deaths, followed by antipsychotics (11%), tricyclic antidepressants (10%), SSRI/SNRI antidepressants (9%), and paracetamol/opiate compounds (8%). Paracetamol was used in 6% of deaths by self-poisoning. A similar trend was noted for other UK nations.	Annual report (2017)
Diagnosis and treatment of mental health problems especially depression in primary care				
• There is a mechanism in place to ensure that patients who present with major physical illness are assessed and monitored for depression and risk of suicide			A quarter of patients who die by suicide have a major physical illness - 3,410 deaths over 2005-2013 - and the figure rises to 44% in patients aged 65 and over. Depression is linked to increased suicide risk among physically ill people, particularly in certain diagnoses such as coronary heart disease, stroke, chronic obstructive pulmonary disease and cancer. 71% of people who died by suicide and had presented to their GP had a diagnosis of depression.	Annual Report (2015) Webb et al (2012) Suicide in Primary Care in England: 2002-2011

Quality/safety standard	Response		NCISH data	Source of data
	Yes	No		
Diagnosis and treatment of mental health problems especially depression in primary care				
• There is a mechanism in place to ensure that patients with certain markers of risk (i.e. frequent consultations, multiple psychotropic drugs and specific drug combinations) are further assessed and considered for referral to specialist mental health services			Only 8% of people who died by suicide in a case-control study of suicide and primary care had been referred to specialist mental health services in the previous 12 months.	Suicide in Primary Care in England: 2002-2011
Additional measures for men with mental ill-health, including services online and in non-clinical settings				
• There are specific measures in place to reduce suicide risk in men with mental ill-health, including services and interventions that are available online and in non-clinical settings (e.g. sporting communities)			The highest suicide rates are in men in middle age, though numbers have fallen since a peak in 2012. The rise seen in the number of male patient suicides aged 45-54 and 65+ appears to be a reflection of increased overall patient numbers.	Annual report (2017)