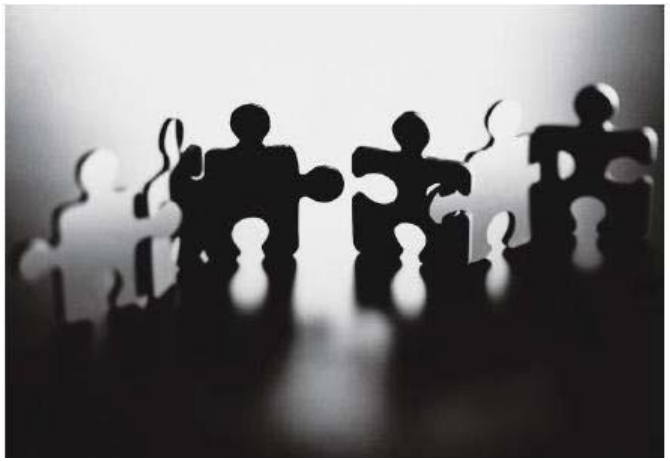

National Confidential Inquiry into
Suicide and Homicide
by People with Mental Illness

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

Suicide and homicide by mentally ill people is a major concern for mental health care providers. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) has made recommendations for clinical services over a number of years. Implementation of these recommendations was associated with a lower suicide rate in a before-and-after analysis published by NCISH in 2016. 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 key elements of safer care have been formulated into quality and safety statements regarding clinical, organisational and training 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), with thanks to Dr Seri Abraham.

V4 February 2017

SAFER SPECIALIST MENTAL HEALTH SERVICES: A TOOLKIT

Part one: 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).			Suicide by mental health in-patients continues to fall. This fall began with the removal of ligature points to prevent deaths by hanging. The number of deaths by hanging on the ward fell by 56% from 2004 to 2013. However, in 2013 and despite the focus on the safety of the in-patient environment, there were still 15 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 (2016) Hunt et al (2012) Avoidable Deaths (2006) Kapur et al (2016)
Reduced absconding • There is a standard response/protocol for in-patients who abscond or escape. • There are measures in place to prevent absconding/escaping 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.			In England there were 254 in-patients who died after absconding from the ward over a 10 year period from 2004-2014, 21% of all in-patient suicide deaths, an average of 23 deaths per year. The percentage of suicides among patients who absconded was 32%, 27% and 19% for Northern Ireland, Scotland and Wales respectively. A qualitative paper of clinicians' views of patients who died by suicide after absconding indicated a number of patients were close to being discharged or transferred from the in-patent ward when they	Annual report (2016) Hunt et al (2016) In-patient suicide under observation (2015)

Quality/safety standard	Response		NCISH data	Source of data
	Yes	No		
Safer wards (continued)				
• Policies specifically acknowledge the in-patient experience (i.e. support and recreation, privacy and comfort) can be linked to absconding risk.			absconded. Often there were problems with the intended discharge destination.	
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 18 suicides by in-patients under observation per year in the UK. Half of in-patient suicides under observation occurred when observation was carried out by less experience staff or staff who were unfamiliar with the patient (e.g. health care assistants or agency staff).	In-patient suicide under observation (2015)
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 2,305 suicides within 3 months of discharge from in-patient care between 2004 and 2014. Fifteen per cent of post-discharge suicides occurred within the first week of leaving hospital, with the highest number occurring on day 3 (20%). The figures for Northern Ireland, Scotland and Wales for suicide within 3 months of discharge were 141 (19%), 433 (16%) and 145 (18%) respectively. In England, 274 (13%) post discharge suicides died before their first follow-up appointment.	Annual report (2016)
• There is a care plan in place for patients discharged from acute care.			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)

Quality/safety standard	Response		NCISH data	Source of data
	Yes	No		
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.			195 (9%) patients died after being discharged from a non-local in-patient unit. This increased to 67 (11%) of those who died within 2 weeks of discharge. The annual number of suicides after discharge from a non-local unit has increased from 85 (8%) in 2004-2008 to 96 (10%) in 2009-2013.	Annual report (2016)
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 over 200 suicides by CRHT patients – around three times as many as in in-patients. 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 (2016) 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 for patients who are at high risk or who lack other social supports (i.e. 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. 40% 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.	Hunt et al (2014)

Quality/safety standard	Response		NCISH data	Source of data
	Yes	No		
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)
Specialised services for alcohol and drug misuse and "dual diagnosis"				
• Specialist alcohol and drug services are in place, 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 45% (drugs) of suicides in patients between 2004 and 2014, and was more frequent in 2011-2013 compared with 1998-2000. However, only a minority of patients are in contact with specialist substance misuse services.	Annual report (2016) Avoidable Deaths (2006)
• There is a specific management protocol or written policy on the agreed management of patients with dual diagnosis.			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 dual diagnosis.	Kapur et al (2016) Patient suicide: the impact of service changes (2013)
Multidisciplinary review of patient suicides, with input from family				
• 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)

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) Annual Report (2015)
• 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 14% of suicide deaths clinicians believed greater involvement of the family by the service would have reduced risk.	Annual Report (2015)
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

Part two: Safer care in the wider health system

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 72% of patient suicides between 2004 and 2014. Over half of children and young people (under 20) who die by suicide had a history of self-harm – 10% in the week prior to death.	Annual report (2016) Suicide in children and young people in England (2016)
• There is a policy in place for all patients who self-harm to have a full 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 prescribing of opiates and antidepressants				
• There is a standard procedure in place for safer prescribing of opiate analgesics and tricyclic antidepressants in primary care and accident and emergency departments, 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 24% of suicide deaths, followed by tricyclic antidepressants (12%), antipsychotics (11%), paracetamol/opiate compounds (9%), and SSRI/SNRI antidepressants (9%). Paracetamol was used in 6% of deaths by self-poisoning. A similar trend was notes for other UK nations.	Annual report (2016)

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 who present with major physical health issues 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
• 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 (i.e. sporting communities).			The highest suicide rates are in men in middle age. Suicide rates in men aged 45-54 have risen by 26% since 2006, and by 20% in men aged 55-64. The rise in male patient suicide (22%) since 2006 appears to be greater than in the general population (12%), although this may be a reflection of greater patient numbers.	Annual report (2016)