The Regulation and Quality Improvement Authority

Access to Evidence Based Psychological Therapies for Adults who Subsequently Complete Suicide

December 2013

Assurance, Challenge and Improvement in Health and Social Care

1.0 Background

1.1 Role of RQIA

The Regulation and Quality Improvement Authority (RQIA) is Northern Ireland's independent health and social care regulator. Established in 2005 as a non-departmental public body under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, RQIA encourages continuous improvement in the quality of health and social care services through a programme of inspections and reviews.

The Mental Health (Northern Ireland) Order 1986 Article 86(2)(a) requires RQIA to make enquiry where it appears that there may be ill-treatment, deficiency in care and treatment and by Article 86 (2) (c) to secure the welfare of any patient by (ii) remedying any deficiency in care and treatment.

1.2 Monitoring of Serious Adverse Incidents (SAIs)

With effect from 1 May 2010, interim arrangements for reporting serious adverse incidents (SAIs) were established by the DHSSPS. SAIs are reported to RQIA and to the HSC Board, working in partnership with the Public Health Agency (PHA).

RQIA takes into consideration relevant standards and guidelines, the views of the public, health care experts and current research in any review of services provided. We highlight areas of good practice, make recommendations for improvements and publish inspections reports of our findings on our website.

Of particular interest to RQIA is the review of suicides in hospital and community, with an emphasis on the quality of care and treatment provided to the deceased and their family, during their contact with mental health and learning disability services.

1.3 Table Top Review of Access to Psychological Therapies for Patients who subsequently Completed Suicide

Within a context of ever-increasing suicide rates it was agreed that a review of the access to evidence-based psychological therapies afforded to those individuals attending mental health and learning disability services within Northern Ireland who subsequently complete suicide should be undertaken by RQIA.

2.0 Methodology

The review has been informed by national guidance, including the:

- National Institute of Clinical Excellence (NICE) Clinical Guidelines[1], e.g. the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2013)[2]
- UK and local data, together with local strategy, guidance and research including the Northern Ireland Suicide Prevention Strategy 'Protect Life: A Shared Vision' (2006)[3]
- the Bamford Review of Mental Health and Learning Disability (2007)[4] and
- The Northern Ireland Strategy for the Development of Psychological Therapy Services (2010)[5].

Common to all of these documents is the acknowledgement of patients' demands for psychological therapies[6] and the advances in the sophistication and range of psychological therapy services and their effectiveness in the treatment of particular mental health conditions.

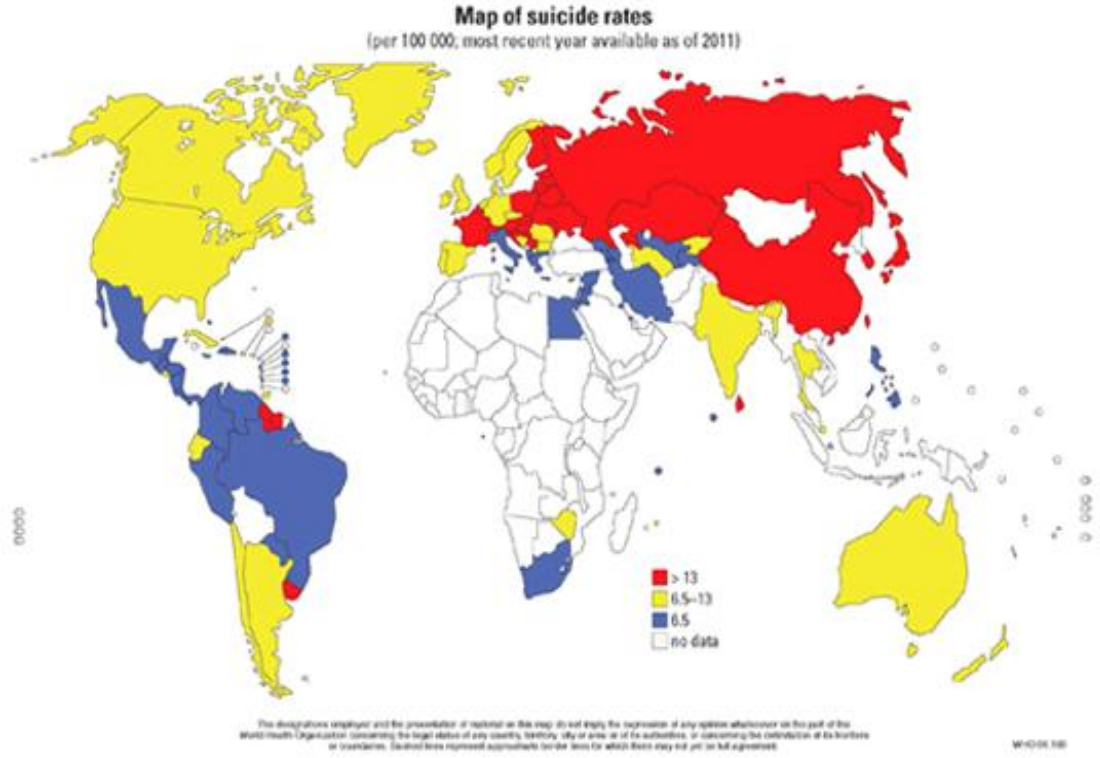
As part of the on-going review of SAIs conducted by RQIA, utilising the HSC regional template and guidance for incident review reports (2007), 40 files were randomly selected for in depth scrutiny in relation to access to treatment and care, focussing on access to evidence-based psychological therapies. The findings are summarised with reference to individual case discussions and implications for future management are discussed.

[1] http://www.nice.org.uk/guidance/index.jsp?action=byType&type=2&status=3
[2] http://www.bbmh.manchester.ac.uk/cmhr/centreforsuicideprevention/nci/reports/AnnualReport2013_UK.pdf
[3] http://www.dhsspsni.gov.uk/phnisuicidepreventionstrategy_action_plan-3.pdf
[4] http://www.dhsspsni.gov.uk/comprehensive_legislative_framework.pdf
[5] http://www.dhsspsni.gov.uk/a-strategy-for-the-development-of-psychological-therapy-service-june-2010.pdf
[6] http://www.mind.org.uk/campaigns_and_issues/we_need_to_talk

3.0 Suicide: The Scale of the Problem

In the last 45 years suicide rates have increased by 60% worldwide. Every year almost one million people die from suicide, a global mortality rate of 16 per 100,000, or one death every 40 seconds. According to the WHO suicide attempts are up to 20 times more frequent than completed suicide.[7]

Although traditionally suicide rates have been highest among the male elderly, rates among young people have been increasing to such an extent that they are now the group at highest risk in a third of countries, in both developed and developing countries. Suicide is among the three leading causes of death among those aged 15-44 years and the second leading cause of death in the 10-24 years age group.



[7] WHO SUPRE (WHO Department of Mental Health and Substance Abuse, 2013).

4.0 The Northern Ireland and UK Context

The incidence of suicide in Northern Ireland has been a particular concern in recent years. Suicide increased by 64% between 1999 and 2008, mostly as a result in the rise of suicides amongst young men. In 2010, 77% of all suicides in Northern Ireland were male, 40.5% of all suicides were in the age group 15-34 and 42% were in the age group 35-54.

The trend for male suicides in Northern Ireland has fluctuated over the last ten years but overall has shown an increase over time (the female rates for suicide have remained more stable). This contrasts with a decrease in suicides in the UK as a whole and in other countries within the UK over the period 2000 to 2010.

Figures for 2011, obtained from the Samaritans Suicide Statistics Report 2013,[8] are summarised in the table and graphs below;

Table 1 Number of Suicides in UK, 2011

	Overall	Male	Female
UK	6045	4552	1493
England	4509	3415	1094
Wales	341	270	71
Scotland	889	639	250
Northern Ireland	289	216	73

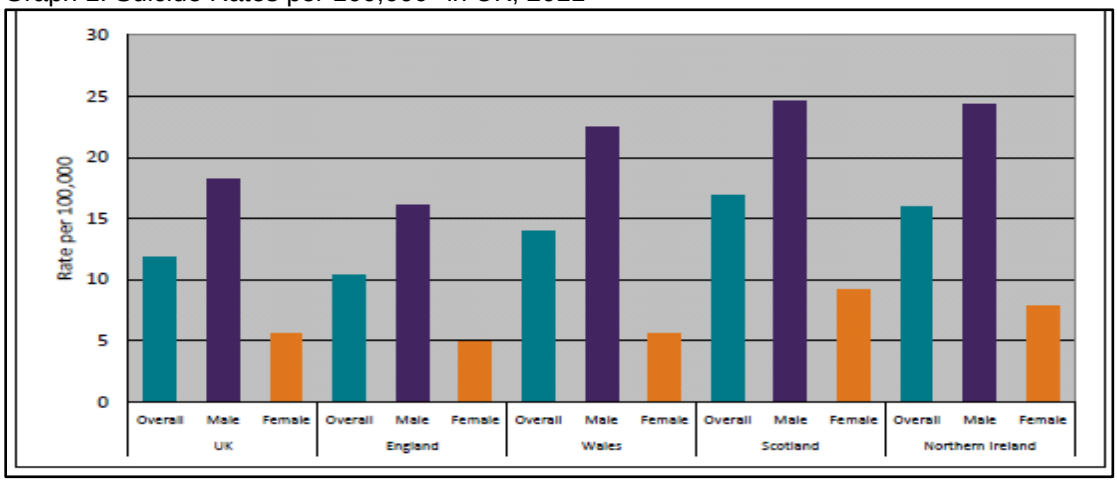
As can be seen from the graph below, the highest suicide rate per 100,000 for males, females and for all persons was in Scotland; the lowest rates for these three groups were in England.

Across the UK, male suicide rates are consistently higher than female rates. For the UK as a whole, England and Scotland the male suicide rate is approximately 3 times higher than the female rate.
In Wales the male suicide rate is approximately 4 times higher than the female rate.

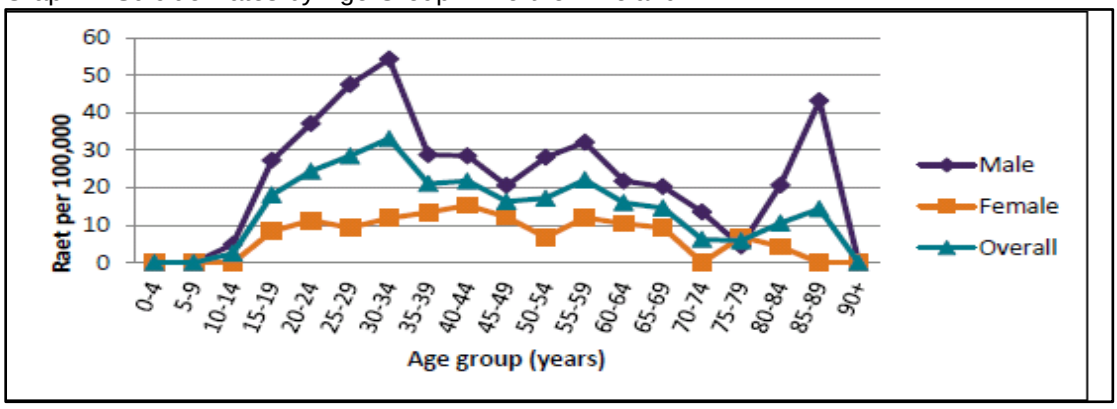
In Northern Ireland the male suicide rate is approximately 5 times higher than the female rate.

[8] http://www.samaritans.org/sites/default/files/kcfinder/files/research/Samaritans%20Suicide%20Statistics%20Report%202013.pdf

Graph 1: Suicide Rates per 100,000* in UK, 2011



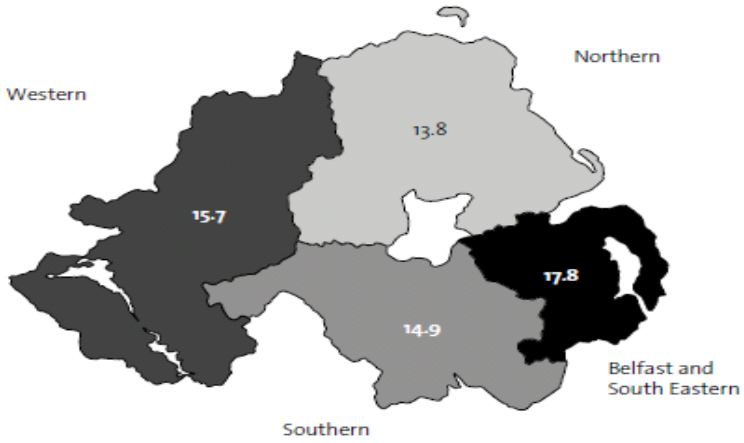
Graph 2: Suicide Rates by Age Group in Northern Ireland



Graph 2 shows that in Northern Ireland, the age group with the highest suicide rate per 100,000 for all persons and males is 30-34 years; and for females is 40-44 years.

The graph also shows that the suicide rate is high for males in the 85-89 years group, although, this could be due to the small size of the population of that age.

The map below illustrates the rate of suicide per 100,000 population, by Health and Social Care Trust of residence (average rate 2009-2011).



The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report July 2013

According to the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report July 2013[9], during 2001-2011, 713 suicides were identified as patient suicides, i.e. they had been in contact with mental health services within the 12 months prior to death. This represented an average of 65 patient suicides per year. Thirty eight (5%) of patient suicides were in-patients (average 3 per year).

There were 33 suicides in patients receiving crisis resolution/home treatment services and 160 (23%) suicides within 3 months of discharge from in-patient care. Post discharge suicides were most frequent in the first week after leaving hospital.

Seventy four (12% of the total sample) patients had refused drug treatment in the month before death and 29% of suicides (192 in total) were carried out by people who had missed their last appointment.

[9]http://www.bbmh.manchester.ac.uk/cmhr/centreforsuicideprevention/nci/reports/AnnualReport2013_UK.pdf

5.0 The Most Common Method of Suicide

The most common methods of suicide by patients were hanging/strangulation (49%), self-poisoning (31%) and drowning (11%).

Deaths by hanging had increased overall between 2001 and 2010, although the peak year was 2007, while figures for other methods did not change. The most common substances used in self-poisoning were opiates (24%), anti-psychotic drugs (12%), benzodiazepines/hypnotics (11%), and paracetamol / opiate compounds (9%).

Other interesting statistics revealed by the Confidential Inquiry revealed that 61% of the total sample (approximately 40 deaths per year) involved people with a history of alcohol misuse and 37% had a history of drug misuse (average 23 deaths per year). It was reported that 16% of suicides had dual diagnosis. This information provides challenges to those delivering mental health services to ensure that service design and models of delivery can adapt to meet the needs of those presenting with mental health difficulties.

5.1 Suicides per HSC Trust.

The table below summarises the suicides per Trust from 1/4/2012 - 31/3/2013

HSC Trust	Completed Suicides and (Unexplained deaths)
BHSCT	21 (6)
SET	26(2)
WHSCT	17(5)
NHSCT	16(5)
SHSCT	12(3)
Total	**92(21)**

The HSCB keep and monitor figures and trends of all mental health SAIs, including suicides and unexplained deaths. The figures provided for April 2012 - March 2013 illustrate that the South Eastern Health and Social Care Trust reported the highest number of completed suicides, with the Belfast Trust having the second largest. The Southern Trust reported the lowest completed suicide rate**.**

6.0 Why do some of us kill ourselves?

The complexity of suicide is underpinned in the statement of the Joint Committee on Health and Children which states:

"The causes of suicide are multi-faceted, and entail an interaction of biological, psychological, social and environmental factors occurring in an individual who may have socio-demographic vulnerabilities interfacing with lifelong susceptibilities that are usually subject to a precipitating event, with catastrophic consequences".[10]

While it is accepted that not all suicides or incidents of self-harm are preventable and that each of us has the right to decide to end our own life, this acknowledgement should not translate into an acceptance of any individual death as inevitable. Despite the recognised complexity the growing body of research, case reviews and clinical practice, have identified risk factors for suicide, together with guidance on effective evidence-based interventions to alleviate underlying mental disorder and distress and promote psychological resilience.

6.1 Suicide Risk Factors

Well recognised suicide risk factors include;

- Depression
- Alcohol/drug problems
- Personality disorders
- History of child sex abuse/maltreatment
- Stressors, e.g. Relationship crises/loss and bereavement
- Issues around sexuality
- Reduced social networks/isolation
- Bullying/cyber-bullying
- Lack of prospects/unemployment
- Poverty/deprivation
- **Previous attempt (Best predictor)[11] [12]**

In his synthesis of international work Foster (2011) reports that nearly all [people who have died by] suicide have experienced at least one, (usually more) adverse life events within one year of death (concentrated in the last few months). Foster postulates that, interpersonal conflict poses the greatest risk followed by, in no particular order, relationship break-downs, forensic events, physical illness, unemployment, job problems, financial problems, serious injury/assault, bereavement, domestic violence and accommodation problems (elderly).

[10] (Joint Committee on Health & Children, Seventh Report, The High Level of Suicide in Irish Society, Houses of the Oireachtas, July 2006)
[11] Chang, B; Gitlin, D; Patel, R (2011 Sep). "The depressed patient and suicidal patient in the emergency department: evidence-based management and treatment strategies.". Emergency medicine practice 13 (9): 1–23;
[12] 'Why disadvantaged men in mid-life are at excessive risk of suicide' O'Connor, R 2013, BPS Public lecture, Belfast

Some of the risk associated with interpersonal events, forensic events, physical illness, major debt, unemployment and loss events is independent of mental disorder. [13]

A recent review commissioned by the UK Healthcare Quality Improvement Partnership[14] looked at the quality of the risk assessment process in 42 cases of patient suicide and 39 cases of patient homicide.
The overall quality of risk assessments was considered unsatisfactory in 36% (*n* = 15) of the patient suicides and 41% (*n* = 16) of the patient homicides, with risk formulations and management plans most likely to be judged unsatisfactory in both suicides and homicides.
Unsatisfactory assessments prior to homicide were associated with a diagnosis of personality disorder or alcohol misuse.

Subsequent recommendations concluded that risk assessment and management **should**:

- Be individual to each patient
- Assess current risk factors and past history
- Include a management plan that follows on from the risk assessment.

Risk assessment and management **should not**:

- Ignore past history
- Equate the completion of a checklist with good risk formulation and management
- Rely on a generic plan of clinical management.

[13] Foster, T (2011) Archives of Suicide Research 15, (1) pp. 1-15)
[14] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) 2013

7.0 Psychological Approaches to Suicide Prevention

Across the applied psychology and mental health literature there has been acknowledgement of the advances in the sophistication and range of psychological therapies and their effectiveness in the treatment of particular mental health conditions. In recognition of this knowledge and in a bid to improve psychological services provision within Northern Ireland the Department of Health and Personal Services in 2010 published the Strategy for the Development of Psychological Therapy Services, which made 14 recommendations to ensure improved access to psychological therapy services. These included;

Recommendation 1
The provision of psychological therapies should be a core component of mental health and learning disability services. Services should be delivered by staff with the skills and competence appropriate to the level of interventions required, and to national and regionally agreed standards and guidelines.

Recommendation 2
Recognising the importance of psychological interventions, if a new care pathway or service framework is being developed, due consideration should be given to the inclusion of psychological therapies within the pathway and service standards.

Recommendation 3
The public, service users and clinicians should have information on the range of psychological therapy services that are available and how to access them.

Recommendation 7
Trusts should re-design mental health and learning disability services around a stepped care model with access to psychological therapy services at all levels.

National clinical guidelines, provided via NICE, articulate the psychological therapies with the strongest evidence base for treating many common mental health problems. These therapies are derived from four schools of psychological therapy (as defined in the National Skills for Health Initiative):

- Cognitive Behavioural Therapy
- Psychodynamic/Psychoanalytic Psychotherapy
- Systemic and Family Therapy
- Humanistic Psychotherapies

Table 3 below summarises which psychological interventions are recommended by NICE[15] in the management and treatment of the more common clinical presentations within mental health and learning disability services.

Presenting problem	NICE Recommended Psychological intervention	Guideline
Moderate to severe depression	Cognitive Behaviour Therapy (CBT) Interpersonal Psychotherapy (IPT) Couple Therapy Consider inpatient treatment for people who are at significant risk of suicide, self-harm or self-neglect. **The full range of high-intensity psychological interventions should normally be offered in inpatient settings. However, consider increasing the intensity and duration of the interventions and ensure that they can be provided effectively and efficiently on discharge.**	CG90
Generalised anxiety disorder (GAD) and panic disorder (with or without agoraphobia) in adults	CBT Relaxation training Structured Problem Solving	CG113
PTSD	Trauma focussed CBT Eye Movement Desensitisation and Reprocessing (EMDR). Psychodynamic psychotherapy NB 'Drug treatments for PTSD should not be used as a routine first-line treatment for adults (in general use or by specialist mental health professionals) in preference to a trauma-focused psychological therapy'.	CG26

[15] http://www.nice.org.uk/guidance/index.jsp?action=byType&type=2&status=3

Alcohol-use disorders	Cognitive behavioural therapies, behavioural Therapies/behavioural activation or social network and environment-based therapies (focused specifically on alcohol-related cognitions, behaviour, problems and social networks). Behavioural couples therapy (for service users who have a regular partner who is willing to participate in treatment). Motivational Interviewing Contingency Management CBT for depression and anxiety	CG115
Drug Misuse	Motivational Interviewing Contingency Management Behavioural couples therapy (for service users who have a regular partner who is willing to participate in treatment). CBT Psychodynamic Psychotherapy	CG 51&52
Schizophrenia	CBT. (Offer to all people with schizophrenia. This can be started either during the acute phase or later, including in inpatient settings). Family interventions; (Offer to all families of people with schizophrenia who live with or are in close contact with the service user. This can be started either during the acute phase or later, including in inpatient settings).	CG82

Borderline Personality Disorder	Dialectical Behaviour Therapy Mentalisation-based therapy Schema-focused cognitive therapy Cognitive Analytic Therapy (CAT) Psychodynamic Psychotherapy When providing psychological treatment for people with borderline personality disorder, especially those with multiple comorbidities and/or severe impairment, the following service characteristics should be in place: – an explicit and integrated theoretical approach used by both the treatment team and the therapist, which is shared with the service user – structured care in accordance with this guideline – Provision for therapist supervision. Although the frequency of psychotherapy sessions should be adapted to the person's needs and context of living, twice-weekly sessions may be considered. **Do not use brief psychological interventions (of less than 3 months' duration) specifically for borderline personality disorder or for the individual symptoms of the disorder.** **Drug treatment should not be used specifically for borderline personality disorder or for the individual symptoms or behaviour associated with the disorder (for example, repeated self-harm, marked emotional instability, risk-taking behaviour and transient psychotic symptoms).**	CG78

8.0 Methodology

Eight files were selected at random, per trust, (dating from January 2011-January 2013) from the RQIA data base for review, with reference to the additional care management questions. The data collected is presented below and will be discussed in relation to evidence-based practice, and underpinned by national and local guidance.

8.1 Current Study

In accordance with NICE guidance and international research evidence, and informed by the DHSSPS Strategies on Suicide Prevention (Protect Life: A Shared Vision)[16] and the Development of Psychological Therapy Services[17], the current review aims to investigate whether those individuals who have been involved with our mental health services and have subsequently completed suicide have had access to Psychological Therapies. Experience of reviewers and inspectors was also garnered to develop further questions to be explored along with the Regional Template information routinely collated within the SAI review process. Interviews with RQIA inspectors and professional advisors identified a number of recurring areas of concern. Some involved questions about the SAI review process itself and the particular roles attributed to RQIA, the Health and Social Care Board and the Public Health Agency. These issues will be raised and discussed in the appropriate forum.

Particular to this review were concerns about the quality of some of the review reports, and the issue of recurring themes that ought to be highlighted to inform future practice or question current models of service delivery. These included lack of consideration of psychological interventions as an adjunct or alternative to medication; the lack of formulation and pulling together of the patient history into the risk assessment; the management of co-morbid presentations and dual diagnoses, where this involved working across teams; poor family involvement and the lack of reported learning in relation to clinical care. A frequent comment was that reviewers had to check if they had reviewed the file before, as the issues presented were so similar.

With these considerations in mind, the randomly selected case files were reviewed with regard to the following considerations:

1. Did the service user have substance misuse problems?

2. Where there co-morbid difficulties/dual diagnosis and how was this managed via care plan?

3. Was the service user involved with more than one team/service?
   (If so, were there good liaison/joint working arrangements?)

[16] http://www.dhsspsni.gov.uk/phnisuicidepreventionstrategy_action_plan-3.pdf
[17] http://www.dhsspsni.gov.uk/a-strategy-for-the-development-of-psychological-therapy-service-june-2010.pdf

4. Was there evidence of care/treatment plan?

5. Were other risk factors indicated and were these addressed in care planning?

6. Was there any reference to evidence based psychological interventions/practice?

7. Was the patient referred to/ receive psychological therapies?

8. Did the service user disengage from services and if so what happened?

9. Were families appropriately involved in care planning and the review?

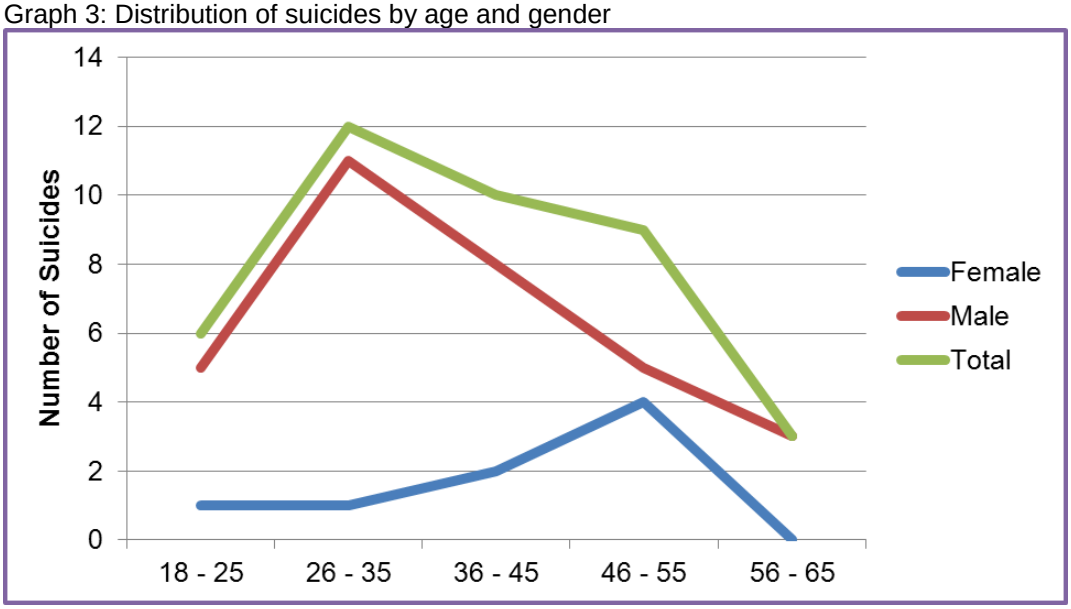
8.2 Findings

8.2.1 Patient profiles

Gender
Thirty-two (80%) of the forty suicides selected were carried out by males. These figures are in keeping with the Confidential Inquiry into Suicides in Northern Ireland (2013).

Age
Graph 3 illustrates the distribution of suicides by age and gender.
Overall the majority of suicides (30%) were carried out by individuals in the 26-35 age group, with the male suicides peaking during these years. 25% suicides occurred in the 36-45 age group.

Graph 3: Distribution of suicides by age and gender



Suicide method
Twenty-four (60%) of suicides were by hanging and 10 (25%) involved drug overdose. Other methods included drowning, jumping, burning, and carbon-monoxide poisoning**.**

Clinical Profile
Of the forty cases chosen, 22 (55%) presented with a history of alcohol and/or drug misuse. The main diagnosis (65%) was depression/low mood, followed by anxiety (10%), PTSD (8%) schizophrenia (5%) and personality disorder. Other diagnoses included Aspergers, grief reaction, adjustment disorder and OCD.

Eighteen (45%) individuals had recorded previous suicide attempts and six (15%) had lost a family member or close friend through suicide, with a further eight individuals (20%) experiencing a recent death of a family member. Thirteen individuals (33%) were described as experiencing relationship breakdown, with four (10%) being reported as homeless with financial problems.

8.3 Engagement with Mental Health Services

All but one was receiving care from mental health services at the time of their death. However, this individual had been assessed at point of access and directed back to GP care before completing suicide within days of the assessment.

Of the remaining 39 cases, one (2.5%) was an in-patient who had absconded from a mental health ward. Ten individuals (25%) had been discharged from in-patient care within three months of their death. Twelve (30%) of individuals had disengaged with services. The majority of these had been discharged following one or two DNAs, or after not replying to 'opt in' letters.

8.3.1 Involvement with more than one mental health service/team

Eighteen (45%) patients were involved with a minimum of two mental health services and teams. A recurring theme in the trust reviews was the poor co-ordination and communication across services. Such systemic issues was the most common finding in trust reviews, with 33% of reviews including recommendations regarding the appointment of a key worker/co-ordinator and/or improved discussion and information sharing.

8.3.2 Referral to Psychological Therapies

Six (15%) of the files reviewed mentioned referral to Clinical Psychology/Psychological Therapy services. Of these, one was redirected to group therapy, one was returned awaiting a risk assessment and two were discharged after non-engagement with the service. Two service users were also involved with Community Brain Injury Psychology services.

The main psychological intervention delivered was CBT and Psychotherapy, which were deemed by the reviewer to be the appropriate evidence-based interventions.

Fifteen (38%) of individuals were advised to contact Community and Voluntary organisations for psychological support, including Lifeline (8: 20%), PIPS (2: 5%) CRUSE (2: 5%), NEXUS, Mindwise and SHINE.

These referrals seem to be made on the basis of individuals getting generic supportive counselling, as opposed to matching the psychological presentation to the relevant evidence-based intervention.

Four individuals were receiving services from private services including a psychologist, a psychotherapist and two generic counsellors. This presented particular difficulties in relation to the sharing of information and provision of co-ordinated care.

8.3.3 Evidence of Care Plans

Ten (25%) files made reference to co-ordination of treatment and interventions as per the patients' care plans.

8.3.4 Evidence of Psychological Interventions Discussed in Care Plan

Six (15%) of the reviewed case files included specific reference to evidence-based psychological interventions. These included CBT, psychotherapy, bereavement counselling and WRAP. The majority of individuals were treated pharmacologically, without reference to other evidence based interventions. Inputs from CMHT and CRHTT services appeared to largely involve monitoring of medication, risk and mental state.

8.4 Outcomes of Investigations undertaken by Trusts

The majority of the trust review teams were reported as multidisciplinary, with 16 (40%) deemed to have an independent chair. However, there was variation across trusts with regard to the make-up of review teams and a lack of clarity about what constitutes independence. It was usually unclear whether there was a range of clinical knowledge and skills within the review teams as the designation of team members often referred to management roles rather than clinical background. Certainly the teams were not reflective of typical mental health multi-disciplinary teams. Three of the review teams involved Clinical Psychology.

This may explain why most recommendations focussed on systems and processes as opposed to clinical care.

Few reviews followed a true root cause analysis format. A significant number of reports included family members and the treating doctors/therapists as members of the reviewing team.

A common conclusion from the suicide reviews is the claim that the deaths were unexpected and could not have been predicted by staff.

Of the forty cases 16 (40%) identified opportunities for learning, although these were very rarely related to clinical care and treatment.

8.5 Recurring Themes

Evidence of good practice
There were very many examples of efforts to engage service users who had difficulty connecting with services. It was clear that in a number of cases every attempt was made to follow-up patients where staff was concerned for their safety and health. There were clear instances of sharing of information and good engagement with GP's. Generally reviews included areas of good practice that were noted during the investigation.

Managing co-morbid presentations
One area of particular concern is the passing of patients across teams where there is co-morbid (joint) alcohol and drug misuse (55% of the sample). This review found that a number of individuals presenting with self-harm and suicide attempts were referred from Community Mental Health Team (CMHT) to Community Addiction Services (CAT) with no follow-up from mental health services. A significant proportion did not engage with CAT and were often discharged without being seen. There appeared to be little evidence of outreach working or co-working across teams which may have promoted better patient engagement and risk management.

There also appeared, from investigation reports, to be a lack of co-ordination across physical health and mental health services where the individual had co-morbid chronic physical illness and may have been attending health psychology, older people's services or community brain injury teams. Such services are often located within different directorates and information sharing can be difficult. However, in keeping with one Trust review recommendation, there should be opportunities for other teams to be involved in case discussion and care plans.

Co-ordination of input across teams and services
Many patients experienced being passed between Home Treatment Teams (HTT) and CMHTs on a number of occasions. In addition, they were frequently seen by different psychiatrists, for example, in a case where one individual was referred to six different teams in the course of 7 months. Given that research demonstrates the importance of the therapeutic relationship in achieving good mental health outcomes, without the opportunity to engage with key workers it is perhaps unsurprising that many service-users disengage from services.

As identified in a number of trust review recommendations, there appeared to be poor co-ordination and sharing of information across services and teams.

An opportunity for therapists to attend case discussions should be encouraged, particularly where there is involvement of community and voluntary services, or private therapy services. Without this there is no way of ensuring a co-ordinated care plan which includes the delivery of evidence-based interventions.

An example of this involved the provision of generic counselling to an individual with chronic Post Traumatic Stress Disorder (PTSD). The NICE guidance and empirical evidence base identify trauma-focussed Cognitive Behaviour Therapy (CBT) and Eye Movement Desensitisation and Reprocessing (EMDR) as appropriate interventions, with counselling being contra-indicated in certain instances.

Limited Risk Assessment

The role of risk assessment in preventing suicide will always be a point of debate. Reviewing risk assessments in hindsight, does not have the benefit of the clinical presentation at the time. Nevertheless, it was noted that while the reviews had evidence of completed risk assessments, the patient reporting a lack of suicide plan seemed to over-rule other well established clinical risk factors.

A case example of this involves Patient A, a 56 year old man presenting with low mood, reported feelings of life not worth living, a previous suicide attempt, suicidal ideation, poor appetite and sleep, following his wife's death. The notes record that he 'denied having a plan and stated his children as protective factors'. He was judged to be of low risk and given the telephone number of Lifeline. He subsequently completed suicide by hanging. The findings of the review stated that Patient A's death 'could not have been foreseen'.

Obviously, each individual case is different and must be assessed in context. Nevertheless, it is suggested that had Patient A's presentation and history been considered in terms of psychological formulation, given his gender, age, history of loss, low mood and previous suicide attempt, he would have been judged to have a number of significant risk factors, which could then be weighed against his denial of an active plan.

Poor Access to Psychological Therapies

Despite the growing evidence base, professional guidelines, local and national strategy, together with service-user preference for psychological interventions, there is very little evidence of improved access to psychological therapies. Medication appears to be the intervention of choice for all presentations, even when managing self-harm despite NICE guidance (CG133) stating 'Do not offer drug treatment as a specific intervention to reduce self-harm**.'** This is not to say that those psychiatrists and mental health staff trained in evidence based therapies and interventions were not utilising them appropriately, but rather points to the lack of inclusion of such information within the investigation reports. However, it may well also relate to the fact that many mental health professionals express frustration over the

lack of time and supervision available to implement therapies in which they have been trained[18].

Furthermore, in relation to NICE guidelines for moderate to severe depression, there was little evidence that 'The full range of high-intensity psychological interventions should normally be offered in inpatient settings.' (CG90). It was often unclear about the nature of intervention and support being provided by community nursing services, other than the monitoring of mental state and adherence to medical regimen.

Where the cases reviewed had a history of relapse, there was no evidence, as per NICE guidelines, that 'People with depression who are considered to be at significant risk of relapse (including those who have relapsed despite antidepressant treatment or who are unable or choose not to continue antidepressant treatment) or who have residual symptoms, should be offered one of the following psychological interventions:

- Individual CBT for people who have relapsed despite antidepressant medication and for people with a significant history of depression and residual symptoms despite treatment.

- Mindfulness-based cognitive therapy for people who are currently well but have experienced three or more previous episodes of depression**.**[19,]

Involvement of families

Approximately 1/3 of families expressed dissatisfaction at their lack of involvement in their relative's care. There was a clear difference of approach in this respect when looking at statutory mental health services who report confidentiality issues as restrictive issues and Lifeline, who regularly engage a contact person when working with individuals.

A number of reviews had not engaged family members in the review process, while others appeared to include relatives as part of the review team.

[18] QUB QPsyC report into Psychological Therapies Training 2013 (commissioned by HSCB Psychological Therapies Implementation Group)
[19] NICE CG 90

9.0 Summary and conclusion

This study represents an opportunity to consider suicide reviews in a group context, with particular attention to quality of treatment and care provided and focusing on access to psychological therapies. The main methodological drawback is that the study only accessed trust review reports, as opposed to the patient clinical files, and is therefore reliant on the reports accurately recording clinical care decisions and the treatment provided.

Nevertheless, the study has used epidemiological data and trust investigations to identify recurring themes and potential learning opportunities, similar to those articulated by RQIA inspectors. This process can therefore add important information to a process that typically involves a range of professionals investigating an individual event.

The care and treatment issues identified in the current project largely reflect those articulated by RQIA inspectors. In summary they include;

- The management of co-morbid presentations and dual diagnoses, particularly where this involves working and communicating across teams.
- The practice of transferring individuals across a number of teams, which affords little consistency in therapeutic relationships and presents as service-centred, as opposed to patient- centred, care.
- The nature and role of risk assessments and the need to be aware of the contribution of well recognised risk factors.
- The need to ensure an integrated and shared care plan which should include the interventions provided by external bodies.
- the apparent lack of awareness of/access to evidenced based psychological therapies and interventions.
- The importance of considering each service user systemically, including appropriate family involvement and awareness of risk factors where children are involved.

In conclusion, as suicide rates in Northern Ireland continue to rise and constricting mental health services continue to manage increasing numbers of referrals, it is important to consider how best to review the treatment and care provided to our service users and their families. The current methodology may be viewed as a supplement to the SAI review process, whereby the identification of recurring themes of good practice and gaps in service provision provides an opportunity for increased learning and service improvement.

The findings of this report have important implications for the role of the RQIA in monitoring SAIs, identifying recurring themes and deficiencies in care and treatment and ensuring best practice. It is proposed that while thematic analyses provide important indicators of care and treatment, the table top review of investigation reports is limited in the information presented. It is the intention of RQIA, within the next year, to conduct an in depth inspection of

care and treatment provided to patients who have completed suicide, with particular emphasis on the themes identified in this report.

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ISBN 978-1-908660-31-2