

Who cares about the rising number of suicides by mental health patients?

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The Centre for Health and the Public Interest (CHPI) is an independent think tank committed to health and social care policies based on accountability and the public interest. The Centre seeks to frame the policy debate in a way that is evidence-based and open and accessible to citizens.

Introduction

The government says it wants to ‘save lives’, and it’s possible in psychiatry if you want to. It’s primarily about common sense and treating people decently. For years there has been an abundance of good practice guidance,^{[1][2]} advice by the National Confidential Inquiry into Suicides and Homicides (NCISH)^[3] and national suicide prevention strategies.^[4] Why then has the number of suicides by mental health patients in the UK not been falling in recent years, but rising, from 1,453 in 2006 to 1,876 in 2013?^[5] Why has yet another inquiry on suicide prevention just been launched, this time by the Health Select Committee?^[6]

1. A wide variety of reasons for the rise in suicides have been suggested:

- Chronic underfunding, and most recently real cuts to mental health services (8% in the five years from 2010), and some question, due to the fragmentation of structures lack of government transparency since 2013, as to whether some of the funds allocated to mental health may have been diverted to other purposes.^{[7][8][9]}
- Traditional political neglect of mental health services, and social taboo.
- A trend towards greater managerialism.^{[10][11]}
- The introduction in 2005 of a cost-saving policy, ‘New Ways of Working’, which reduced patient access to psychiatrists.^[12]
- Insufficient staffing mix and levels to properly implement the ‘Care Programme Approach’, which helps to ensure that patients’ needs are systematically met and reviewed, and that clinical risk management is effective.
- Continuing bed cuts (a 17% reduction in adult psychiatric beds in the three years up to 2015) and a failure to re-provide suitable support in the community.^[13]
- Implementation of crisis care models which appear to be associated with two to three times as many suicides as inpatient care.
- Closure of day hospitals and day centres.

- Lack of good quality supported accommodation.
- Austerity and welfare policies that have disadvantaged people with mental illness.^{[14][15][16]}

Taken together these undoubtedly constitute a more than sufficient explanation.

What alarm systems are in place?

2. But what of the safety nets and alarm systems that are supposed to keep patients safe? That is, nationally defined standards of care; the promise by the government after Mid Staffs to deliver fundamental standards of care and to provide transparent data on safety;^[17] national standards for reporting, investigating and learning from incidents,^[18] the national policy of Being Open with families after serious incidents,^[19] and oversight by both NHS England and the CQC.

3. It is evident from unhappy patients and families, and the all too familiar headlines about failings, that we do not have reliable, safe mental health care. The CQC has now acknowledged that about two-thirds of mental health trusts 'require improvement' on safety. The CQC also acknowledged in 2015 that there was sharply rising use of the Mental Health Act (that is, increased episodes of 'sectioning'), over-occupancy of beds and excess use of out of area beds.^{[20] [21]} But in spite of all this we have no systematised or fully transparent data on mental health deaths.^[22] The National Confidential Inquiry into Suicides and Homicides gives data on national trends but no analyses by organisation. A Freedom of Information disclosure by NHS England showed that the data reported by trusts under the National Reporting and Learning System was obviously flawed.^[23] The report on the Southern Health scandal by the accountancy consultants Mazars showed that failure by the trust to investigate hundreds of unexpected deaths had either not been detected, or had been noted but not addressed, by oversight bodies.^[24] An inspection report on Southern Health by the CQC prior to the Mazars investigation gave no indication of the scale and gravity of the governance failings subsequently found by Mazars.^[25]

4. Given the dearth of organisation-level mental health safety data, a study of coroners' warning reports (Reports To Prevent Future Deaths, formerly known as Rule 43 reports) was undertaken. Since 2008 almost 400 coroners' warning reports have been issued to or about mental health trusts.^[27] These provide un-standardised data that is subject to many variables, but there is nevertheless a striking repetition of failings, both system-wide and by individual organisations. Some trusts have had as many as 22 coroners' warning reports since 2008. The warning reports by coroners described elementary failures of care, risk management, serious incident processing and organisational learning, which all suggest that mental health services are under strain. At least 30 of the warning reports explicitly expressed concern about resource

pressure. In some instances the level of risk-taking was extreme: one patient took his own life without having been seen in six months after discharge from hospital because the community service was seeing 'higher priority' cases. One coroner expressed concern about *'The use of CRHTT [Crisis Resolution Home Treatment Teams] as a filter to prevent patients in need of a bed from having access to a bed'*. In some trusts, too, the passing of patients between generic teams, crisis teams and inpatient teams is at odds to the government's stated suicide prevention policy of continuity of care.

5. These warning reports are arguably the tip of an iceberg, because coroners are not always given the full facts and they do not always detect problems. The Health Service Journal has reported a worrying discrepancy in official deaths figures. The Independent Advisory Panel on Deaths in Custody (IAP) shows that 1,115 deaths of mental health patients detained under the Mental Health Act occurred in England and Wales between 2011 and 2014, but data published by the Ministry of Justice shows that only 373 of the deaths were actually reported to coroners. This difference of 742 cases is very serious because all deaths of detained patients must be reported to coroners.^[28] The IAP's data on detained mental health patients' deaths is supplied by the CQC and by the Health Inspectorate for Wales. Of particular concern, Mazars found that the CQC did not have a complete list of deaths of Southern Health patients detained under the Mental Health Act. The CQC informed Mazars that there had been 18 deaths of detained patients at Southern Health, but Mazars' investigation showed that an additional 9 deaths of detained patients had actually been reported to the CQC. That is, the CQC underestimated the number of deaths under detention by 33%. Therefore, it is possible that there have been significantly more than 742 unreported deaths of detained patients nationally.

6. Southern Health had 722 deaths in four years that were categorized as 'unexpected'; it was involved in at least 375 inquests, and had 123 findings of confirmed suicide and 15 open verdicts over the same period, but only had five coroners' warning reports.^[29] The number of coroners' warning reports issued against trusts is likely to depend in part on the degree to which trusts cover up or litigate aggressively to avoid accountability.

Government inaction on warning reports

7. The question arises of why governments have failed to act sufficiently on coroners' feedback to preserve life, particularly given that at least 59, 15 and 19 coroners' warning reports were sent to the Department of Health, the CQC and NHS England respectively, most of them in the last 3 years. The CQC was criticised in 2015 for failing to respond to coroners' warnings and promised in response to undertake analyses of coroners' intelligence,^[30] but no outcome from this work has yet been published.

8. The National Confidential Inquiry into Suicides and Homicides (NCISH) has alerted the government to mental health deaths that occur too soon after discharge from hospital (an average of 215 patients die by suicide annually within three months of discharge from hospital), and in 2014 it advised that deaths within three days of discharge should be designated as an NHS Never Events ('serious incidents that are wholly preventable' and should never occur), but the government has not accepted this recommendation.^{[31][32]} Neither has there been convincing evidence of any effective response to the NCISH's 2015 recommendation that 'out of area' admissions should cease because they are associated with increased risk of suicide.

9. The last regulatory investigation of a mental health trust was triggered by the Healthcare Commission, the CQC's predecessor.^[33] The failings described by that investigation have been repeatedly echoed in subsequent coroners' warning reports, but the CQC itself has not triggered any special 'Section 48' investigations of mental health trusts.^[34] (Under section 48 of the Health and Social Care Act 2008 the CQC has discretion to investigate if it becomes '*aware of evidence of a problem that poses a significant risk to the health, safety or welfare of people receiving health or social care, often due to systemic failings, and where enforcement action has not resulted in the required improvements*'.)^[35] There have arguably been instances where the CQC could have exercised this power with regard to a mental health trust – for example at the Norfolk and Suffolk Foundation Trust, which has had 22 coroners' warning reports and has been rated 'inadequate' since 2014, and where concerns about deaths continue.

Conclusion

10. After the Mazars report on Southern Health the government promised a review of the way deaths are handled by the NHS, but entrusted this to the CQC,^[36] which is only looking at how trusts deal with deaths, and not at how far weaknesses on the part of oversight bodies – i.e. CCGs, the Department of Health or the CQC itself – may contribute to the problem. The CQC has indicated that regulatory processes may change as a result of other work by the Department of Health, but no information has yet been published about this work.

11. We come back to the key question - who really wants to save lives? There is little evidence of parity of esteem with physical health in mental health spending, the lack of assurance of safe and evidence-based care, the lack of transparency about serious incidents, or the lack of learning from them. It is perhaps not surprising that when a government embarks on a risky strategy of cuts it is not disposed to display the consequences. A return to promised fundamental standards of mental health care is needed. Complete and transparent data on mental health spending and safety measures would assist.

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