



Health Services Safety
Investigations Body

Investigation report

Care delivery within community mental health teams

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Mental health

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Contents

[A note of acknowledgement](#)

[About this report](#)

[Providing feedback and comment on reports](#)

[Executive summary](#)

[Background](#)

[The reference event](#)

[The national investigation](#)

[Findings](#)

[HSIB makes the following safety recommendations](#)

[HSIB makes the following safety observations](#)

[HSIB notes the following safety action](#)

[1 Background and context](#)

[1.1 Community mental health teams](#)

[1.2 NHS plans for community mental health services](#)

[1.3 Suicide](#)

[1.4 Psychosis](#)

[1.5 Psychosis pathway](#)

[1.6 Risk assessment](#)

[1.7 Mental Health Act assessment](#)

[1.8 Care Programme Approach](#)

[1.9 Crisis resolution and home treatment team](#)

[1.10 Impact of COVID-19 on continuity of care](#)

[1.11 Menopause and perimenopause](#)

[2 The reference event](#)

[2.1 Ms A's first admission to hospital \(September to October 2019\)](#)

[2.2 Ms A's first experience of mental health care in the community \(October 2019 to May 2020\)](#)

[2.3 Ms A's second admission to hospital \(May to June 2020\)](#)

[2.4 Ms A's second experience of mental health care in the community \(June to August 2020\)](#)

[3 Involvement of the Healthcare Safety Investigation Branch](#)

[3.1 Notification of the reference event and decision to investigate](#)

[3.2 Decision to conduct a national investigation](#)

[3.3 Scope of investigation](#)

[3.4 Investigative approach](#)

[4 Analysis and findings](#)

[4.1 Risk assessment](#)

[The national investigation](#)

[HSIB makes the following safety recommendation](#)

[HSIB notes the following safety action](#)

[HSIB makes the following safety recommendation](#)

[HSIB makes the following safety observation](#)

[Family engagement](#)

[HSIB makes the following safety observations](#)

[4.2 Impact of menopause on mental health](#)

[HSIB makes the following safety recommendation](#)

[HSIB makes the following safety recommendation](#)

[4.3 The first episode of psychosis pathway](#)

[HSIB makes the following safety observation](#)

[5 Summary of findings, safety recommendations, safety observations and safety action](#)

[5.1 Findings](#)

[5.2 Safety recommendations, safety observations and safety action](#)

[HSIB makes the following safety observations](#)

[HSIB notes the following safety action](#)

[6 References](#)

[Providing feedback and comment on reports](#)

A note of acknowledgement

The Healthcare Safety Investigation Branch (HSIB) would like to thank the family of the patient whose experience is documented in this report. We would also like to thank the healthcare staff who engaged with the investigation for their openness and willingness to support improvements in this area of care.

About this report

This report is intended for healthcare organisations, policymakers and the public to help improve patient safety in relation to care delivery within community mental health teams. For readers less familiar with this area of healthcare, medical terms are explained throughout.

Ms A's sister asked the investigation team to include the following words:

Some people reading this report will already know the deep pain of losing a loved one to suicide. In life, my sister was kind, thoughtful, resourceful, funny and caring. She was loved and valued by her family, friends and the people she worked with through her long NHS career.

In the last 10 months of my sister's life she was thrown into unknown territory as she experienced a first episode of psychosis. She became convinced that people close to her were trying to harm her and she lost all trust in everything that had previously given her life meaning. This frightening world became her reality and she lost the ability to see what was happening to her as an illness she could recover from.

Even on her worst days my sister would shower, shop and keep her home clean. In her last email she enquired when she may be able to return to her ecological volunteering work and that day's newspaper crossword was left completed. She was trying to live normally in a world where her delusions made every moment frightening.

Our family have shared information about my sisters experience in the hope that others like her can be better supported to stay safe and recover.

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Executive summary

Background

The purpose of this investigation was to support improvements in the work of community mental health teams (CMHTs). Specifically, the investigation looked at the following four areas: (1) assessing a patient's risk of self-harm or suicide; (2) considering menopause as a risk factor for mental health conditions; (3) engaging with families; and (4) caring for people with a first episode of psychosis. The investigation uses, as an example, a real patient safety incident in which a woman died by suicide while under the care of a CMHT; this is referred to as 'the reference event' and was used to examine national issues.

The reference event

The reference event relates to a 56-year-old woman (Ms A), who came into contact with mental health services for the first time in September 2019 following a suicide attempt. Ms A spent a month in hospital, and was then discharged home under the care of a CMHT with a diagnosis of psychotic depression. At the end of May 2020, Ms A was again admitted to hospital following a second suicide attempt. She again stayed in the hospital for about 4 weeks before being discharged home under the care of a CMHT. Ms A was seen by CMHT workers regularly throughout July, and had a telephone review with a consultant psychiatrist. At the end of July, Ms A's family became increasingly concerned about her mental state and were unable to make contact with her. On 2 August, Ms A was found deceased at home having died by suicide.

The national investigation

The national investigation sought to understand how people at risk of suicide are cared for by CMHTs, and the factors that contribute to care being delivered outside of national guidelines. Specifically, the national investigation looked at the areas of:

- assessing a patient's risk for self-harm or suicide
- identifying menopause as a risk factor for mental health
- engaging with families
- managing a patient with a first episode of psychosis.

Findings

- While national guidance says that a patient's risk of harm should not be stratified into categories such as high, medium low or, such stratification remains common in many trusts. This is because other methods of assessing and documenting risk are not available, and because staff fear being blamed if a patient comes to harm without a risk assessment, including risk stratification, having been completed.
- Current research only demonstrates a link between menopause and low mood, and not between menopause and more severe mental health symptoms.
- Women are frequently prescribed antidepressant medication when hormone replacement therapy may be a more appropriate treatment for their symptoms.
- Menopause is not routinely considered as a contributing factor in women with low mood who are assessed by mental health services, and staff do not receive training in this area as standard.
- While there is a significant amount of national guidance relating to family engagement when treating patients with mental health conditions, mental health practitioners often find it difficult to know how and when to engage with families with complicated relationships or when the patient withdraws their consent for information sharing. There is a lack of training in this area to support staff with decision making.
- National guidance raised the upper age limit for referral to the Early Intervention in Psychosis pathway in 2016. Some trusts continue to prioritise younger patients for a variety of reasons – including funding, capacity and misconceptions about whether an older person can actually be experiencing a true first episode of psychosis in later life.

HSIB makes the following safety recommendations

Safety recommendation R/2023/220:

HSIB recommends that NHS England works with appropriate stakeholders, including experts with appropriate experience, to create guidance on culture change. A quality improvement programme should also be developed to support practitioners in undertaking psychosocial assessments that are in line with guidance from the National Institute for Health and Care Excellence. Person-centred safety planning should be embedded within the process.

Safety recommendation R/2023/221:

HSIB recommends that the Care Quality Commission evaluates the way in which it reviews how community mental health services assess risk of harm, to ensure its inspections are in line with the latest national guidance.

Safety recommendation R/2023/222:

HSIB recommends that the National Institute for Health and Care Excellence evaluates the available research relating to the risks associated with menopause on mental health and if appropriate, updates existing guidance.

Safety recommendation R/2023/223:

HSIB recommends that the Royal College of Psychiatrists forms a working group with relevant stakeholders to identify ways in which menopause can be considered during mental health assessments.

HSIB makes the following safety observations

Safety observation O/2023/208:

It may be beneficial for mental health organisations to have a dedicated liaison officer who acts as a point of contact for both families and clinicians when navigating involvement in a patient's care and decision making.

Safety observation O/2023/209:

It may be beneficial for organisations to involve families in care planning and assessments, and that practitioners are appropriately trained in working with families.

Safety observation O/2023/210:

It may be beneficial for education bodies to develop training programmes in safety planning and psychosocial assessments, once NHS England has provided guidance on how such assessments should be conducted.

Safety observation O/2023/211:

It may be beneficial for mental health organisations to ensure their Early Intervention in Psychosis referral process is in line with the national guidance, and that staff are clear about the upper age limit of patients accepted onto the pathway.

HSIB notes the following safety action

Safety action A/2023/058:

NHS England has written to all mental health trusts in England to highlight the importance of taking a person-centred approach to psychosocial assessments and safety planning. The communication asks trusts to move away from risk assessment tools that stratify an individual's risk of suicide or self-harm.

1 Background and context

1.1 Community mental health teams

1.1.1 Community mental health teams (CMHTs) support people with mental health problems living in the community and their carers. The team may include a community psychiatric nurse, psychologist, occupational therapist, counsellor and community support worker, as well as a social worker. Often, a specific member of the team will be appointed as an individual's care coordinator, to keep in regular

contact with them and help plan their care (Mind, 2017). Care Coordinators will be replaced with key workers with the introduction of Community Mental Health Framework/ CPA Position statement (NHS England, 2022).

1.1.2 Individuals under the care of a CMHT can be receiving support for a variety of diagnoses. They should be offered support services which may include cognitive behavioural therapy or group work.

1.2 NHS plans for community mental health services

1.2.1 Under the NHS Long Term Plan, the following should have occurred by 2023/24:

- All sustainability and transformation partnerships/integrated care systems will have received funding to develop and begin delivering new models of integrated primary and community care for adults and older adults with severe mental illness.
- A total of 390,000 people with severe mental illness will have received a physical health check.
- New local funding will be used to maintain and develop new services for people with specific or additional needs, including the Early Intervention in Psychosis (EIP) pathway.

1.2.2 New community services will include access to psychological therapies, improved physical health care, employment support, personalised and trauma-informed care, medicines management, and support for people who self-harm and with coexisting substance use. The aim is that, by 2023/24, at least 370,000 adults and older adults each year nationally will have greater choice and control over their care, and be able to live well in their communities. This is supported by an additional £1 billion new Long Term Plan funding per year by 2023/24 to ultimately transform the provision of community mental health care for adults and older adults with severe mental illnesses.

1.3 Suicide

1.3.1 In the UK, 1 in 5 adults has considered suicide at some time, and 1 in 15 has attempted suicide (McManus et al, 2016). Patients who present to health services with thoughts of suicide, self-harm or suicide attempts, and those who present as significantly distressed or mentally ill, can be challenging to manage. Doctors are often advised to use suicide risk assessment to help them decide on a management

plan (Large et al, 2017). However, it is recommended that risk assessments are not used to predict risk of suicide. Safety plans and safety planning approaches are used to help decide on care/management plans.

1.3.2 Nearly three quarters of people who die by suicide are not under the care of mental health services. Mental health services nonetheless have an important role to play, as psychiatric patients are one of several high-risk groups (Royal College of Psychiatrists, 2020).

1.4 Psychosis

1.4.1 Psychosis is a severe mental illness that affects up to 3% of the population. People with psychosis can find it difficult to function in society and have a shorter life expectancy than those without the condition. It is ranked as one of the top causes of disability and one of the most expensive illnesses worldwide, with costs related to hospital admissions, physical health comorbidities and unemployment.

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1.5 Psychosis pathway

1.5.1 A 'first episode of psychosis' is the term used to describe the first time a person experiences a combination of symptoms known as psychosis. During an episode of psychosis, a person's perception, thoughts, mood and behaviour are significantly altered. People with a first episode of psychosis should be treated through an EIP pathway.

1.5.2 An 'early interventions in psychosis standard' was introduced in April 2016 (NHS England, the National Collaborating Centre for Mental Health and the National Institute for Health and Care Excellence, 2016). This requires that more than half of people experiencing a first episode of psychosis begin treatment with a National Institute for Health and Care Excellence (NICE) approved care package within 2 weeks of referral to the EIP. The standard is targeted at people aged 14–65 years. Before this standard was introduced, the pathway was aimed at providing services to those aged up to 35.

1.6 Risk assessment

1.6.1 'Best Practice in Managing Risk' guidance defines risk as relating to the likelihood, imminence and severity of a negative event occurring (that is, violence, self-harm/suicide or self-neglect) (Department of Health and Social Care, 2009). NHS England will be reviewing this guidance in line with NICE guidance and moving towards a personalised safety planning approach.

1.6.2 During a risk assessment, psychological and social factors should be considered as part of a holistic (that is, whole person) review to determine the patient's care needs and assess their risk of harm to themselves or others. Assessments often aim to categorise patients as being at high, medium or low risk. Checklists or risk tools are sometimes used for risk assessment, but research suggests they are poor at predicting suicide (National Confidential Inquiry into Suicide and Safety in Mental Health, 2018).

1.6.3 The most recent NICE guidance in this area (NICE, 2022) documents that risk assessment tools and scales should not be used to predict future suicide or repetition of self-harm.

1.6.4 Risk assessments are based on multiple factors, including any existing risk assessments, and experiences; new information (regardless of source). Risk assessments are an integral part of mental health care.

1.7 Mental Health Act assessment

1.7.1 A Mental Health Act assessment is used to decide whether a person should be detained in hospital under the Mental Health Act so that they can receive care and medical treatment for a mental disorder. The assessment may find that the person can remain in hospital voluntarily as an informal patient.

1.7.2 Section 2 of the Mental Health Act authorises a person to be detained in hospital so that their mental disorder can be assessed (or assessed and then treated). These detentions can normally only last for up to 28 days.

1.8 Care Programme Approach

1.8.1 At the time Ms A was engaged with mental health services, the Care Programme Approach was in place (CPA). The CPA was a package of care that was used by mental health services. A patient being treated under a Care Programme

Approach would have a care plan and a specific person to coordinate their care. All care plans must include a crisis plan. In 2021, the Community Mental Health Framework replaced the CPA for community mental health services.

1.8.2 A care coordinator is the person responsible for coordinating, facilitating and integrating a patient's mental health treatment, care and support. Treatment and support should be tailored to meet the specific needs of the patient.

1.9 Crisis resolution and home treatment team

1.9.1 Crisis resolution and home treatment teams provide intensive support for people experiencing an acute or 'crisis' episode during their mental illness. Also known as 'hospital at home' teams, this service is available 24 hours a day, 365 days a year. The team will consist of psychiatrists, clinical psychologists, nurses, occupational therapists and support workers, who work with patients to treat them outside of hospital.

1.10 Impact of COVID-19 on continuity of care

1.10.1 The first wave of the COVID-19 pandemic (March to June 2020) impacted on the ability of community mental health services to deliver face-to-face care. While this investigation does not focus specifically on care delivery during COVID-19, there were inevitably cases where contact was reduced or changed because of the pandemic.

1.10.2 In addition to changes in care delivery, national restrictions impacted the mental health of some people. Research from the first 6 weeks of lockdown (beginning 31 March 2020) showed a clear increase in mental health problems compared with before the pandemic (O'Connor et al, 2021). In addition, rates of suicidal ideation (that is, having thoughts or ideas about suicide) increased during this period, despite feelings of entrapment decreasing. Importantly, one of the subgroups most affected by the COVID-19 pandemic and lockdown was those with pre-existing mental health problems.

1.11 Menopause and perimenopause

1.11.1 Menopause is the stage in a woman's life when she stops menstruating and reaches the end of her natural reproductive life (National Institute for Health and Care Excellence, 2015). It is usually defined as having occurred when a woman has not had a period for 12 consecutive months (for women reaching menopause naturally and not because of, for example, having a hysterectomy). The average

age of menopause in the UK is 51 years. However, this varies widely, and one in 100 women experiences menopause before the age of 40 (Women and Equalities Committee, 2022).

1.11.2 The perimenopause is the time in which a woman has irregular cycles of ovulation and menstruation leading up to menopause. The perimenopause is also known as the menopausal transition or climacteric.

1.11.3 Menopause is associated with loss of oestrogen. Oestrogen has important neuro- and psychoprotective activities, and its decline and/or instability can therefore trigger or aggravate mental disorders, including psychotic ones. As a result, perimenopause or menopause may lead to an enhanced risk of first onset of schizophrenic psychoses or 'late-onset schizophrenia'. Women with pre-existing chronic schizophrenia tend to find their illness worsens after menopause (Riecher-Rössler, 2009).

1.11.4 Hormone replacement therapy is a treatment used to relieve the symptoms of menopause by replacing the decreased hormones.

2 The reference event

The investigation used the following patient safety incident, referred to as 'the reference event', to examine the assessment of patients within community mental health services.

2.1 Ms A's first admission to hospital (September to October 2019)

2.1.1 Ms A was a 56-year-old woman who lived alone. She had a close relationship with her sister, brother and niece and was incredibly fond of her nieces children with whom she enjoyed providing childcare for. Ms A had worked in London most of her life but had felt the need to leave her employment following ongoing complications following a hysterectomy which impacted her both physically and mentally. Ms A had a history of depression which had been managed by medication provided by her GP as and when required. She had never had contact with mental health services until 2019.

2.1.2 In September 2019, Ms A was taken to hospital by ambulance after her family raised concerns following her disclosing suicidal thoughts. Ms A was found to have self-harmed, making superficial cuts to her left wrist with a kitchen knife. She was

first assessed in the hospital's emergency department, where her history of depression and anxiety were noted. Ms A had not had any previous contact with secondary mental health services.

2.1.3 Following a Mental Health Act assessment, Ms A agreed to an informal stay in hospital. After a few days, following concerns about her refusing food and medication, she was detained under Section 2 of the Mental Health Act.

2.1.4 Ms A was initially reluctant to take medication but, after a couple of weeks, her engagement was noted to improve. Just over 3 weeks into her stay Ms A began taking leave with family, and her notes state that this had "been successful". Just over a month into her stay, Ms A was considered ready for discharge.

2.1.5 At the time of discharge, Ms A was recorded as being at no current risk of harm to herself. On the discharge summary, her working diagnosis was "Recurrent depressive disorder, current episode severe with psychotic symptoms."

2.2 Ms A's first experience of mental health care in the community (October 2019 to May 2020)

2.2.1 Upon discharge in October 2019, Ms A's care was transferred to a community mental health team (CMHT), and a registered nurse from that team was assigned as her care coordinator. Ms A's transition from hospital to the community was also supported by the crisis resolution home treatment team (CRHTT), who helped Ms A find community groups, activities and volunteering roles.

2.2.2 On 8 January 2020, Ms A was reviewed by the CMHT consultant psychiatrist and changes were made to her medications. A referral was sent to the department of psychological medicine within a different health trust, requesting cognitive behavioural therapy (a talking therapy that supports individuals to change the way they think and feel). However, an assessment was not offered because of a lack of available resources to offer outpatient psychological therapy to her.

2.2.3 Ms A met with her care coordinator weekly during January 2020 and a care plan was written. On 13 January 2020 it was recorded that Ms A felt that she was "managing ok", but reported continued low mood and poor motivation. Ms A was also concerned that the medication might not be helping. Ms A had no contact with mental health services between February and May 2020.

2.2.4 Ms A contacted her care coordinator at the beginning of May 2020 (encouraged by her Sister) to report that she had been reducing her medication. At this point she disclosed to her sister that she had not had any contact with her

mental health team since February. She was urged to continue with her medication at the prescribed doses and a review with a consultant psychiatrist was arranged for July 2020.

2.2.5 On 22 and 23 May 2020, Ms A and her Sister called the CRHTT as Ms A was displaying signs of a psychotic relapse. Ms A was reviewed by her care coordinator and, after consultation with the CMHT consultant psychiatrist, a request was made for the CRHTT to call Ms A the following day to check on her wellbeing and encourage her to take her medication. Ms A did not answer the calls from the CRHTT.

2.2.6 That week, Ms A's Sister raised concerns with CMHT because she had not heard from Ms A for a few days. The police visited Ms A's home and she expressed feeling suicidal. She said she had taken an overdose of medication over a 2-day period with the aim of ending her life. She was examined in an emergency department and declared medically fit before being transferred to a mental health hospital. Ms A was admitted to hospital on 27 May 2020 and placed under Section 2 of the Mental Health Act.

2.3 Ms A's second admission to hospital (May to June 2020)

2.3.1 During the early part of her admission, Ms A was under constant observation and was described as low in mood. Due to COVID-19 restrictions, Ms A's family were unable to visit her.

2.3.2 During an inpatient review on 17 June, Ms A said that she had been in contact with her family (her Brothers and Sister), which she felt was "probably a good thing". She gave consent for staff to speak with her family if they contacted the ward. Following this review, Ms A was moved to informal patient status and was no longer under any restrictions of the Mental Health Act.

2.3.3 Ms A requested early discharge as she believed she would feel better at home, away from the ward environment. Ms A was documented as presenting a minimal risk to herself.

2.3.4 Ms A's Sister was recorded as her next of kin/carer. The records do not show if Ms A's Sister was made aware of plans to discharge Ms A.

2.3.5 Ms A was discharged home after almost a month in hospital.

2.4 Ms A's second experience of mental health care in the community (June to August 2020)

2.4.1 Ms A was visited at home by a member of the crisis resolution and home treatment team (CRHTT) on 27 June 2020 (the plan was for her to be seen three or four times a week). The notes state that Ms A engaged well, and the team member and Ms A completed a crisis plan and went through goal planning. A further planned visit took place the next day, with Ms A reported as being pleased to be home but feeling isolated. The plan was for a telephone call from the CRHTT the following day.

2.4.2 During that call, Ms A reported that she was "managing OK", but still believed that things were being "staged in the house" – she would not elaborate. Ms A and the CRHTT member discussed jointly working with Ms A's CMHT care coordinator, with a view to the CRHTT handing over care to the care coordinator in about a week, if appropriate.

2.4.3 Ms A's risk of harm or suicide was routinely assessed and categorised as high, medium or low risk. This method of grading risk was in line with the policy of the local Trust at that time, but not with guidance from the National Institute for Health and Care Excellence, which states that risk of suicide should not be stratified into categories.

2.4.4 At a crisis team multidisciplinary team meeting about Ms A on 28 June 2020, consideration was given to reducing her care to within the medium (amber) category within the crisis team pathway. At this level, it is considered that patients can be supported through reduced contact, potentially by phone, but regular contact is still required.

2.4.5 A further home visit took place on 29 June. It was recorded that Ms A did not consider herself to be in crisis anymore and questioned the need for the CRHTT. The plan continued for Ms A to be considered for handover to the CMHT care coordinator. In addition, an appointment was made for a CRHTT consultant psychiatrist to call Ms A for a medical review/general discussion about her medication 2 days later, on Friday 3 July 2020.

2.4.6 A crisis resolution and home treatment team medication chart completed on 3 July 2020 states that Ms A was prescribed oestradiol, which is an oestrogen hormone used to reduce some of the side effects of menopause. The chart says she started on this medication on 28 June 2020.

2.4.7 On 3 July 2020, the CRHTT consultant telephoned Ms A as planned. Ms A continued to report feeling isolated and described a feeling of “being watched”. The medical notes describe Ms A as having ‘irrational thoughts’, but the consultant recorded that Ms A ‘doesn’t feel in danger of overdose, denies suicidal thoughts’. He also documented that Ms A had recently been discharged from hospital with ‘severe depression and psychosis associated with high risks of completed suicide’. He wrote that there was ‘Some evidence of potential deterioration today with re-emergence (or more openness) about depressive symptoms and residual delusions with only partial insight.’ The consultant noted that Ms A appeared to be ‘more well than at the point of admission but deterioration in her mental state is obviously concerning’.

2.4.8 The records state that following the consultant’s assessment, Ms A appeared more ‘open’ on the telephone than in person. It was agreed that the next visit would be moved from face to face to telephone.

2.4.9 A member of the CRHTT called Ms A on 5 July 2020. The practitioner recorded that during their call, Ms A highlighted that her mood had dipped. She attributed this to feeling isolated and restricted by the COVID-19 lockdown and issues with family relationships. Ms A explained that CCO/CMHT had previously referred her for counselling/access to wellbeing, but she had not heard back – she said she wanted to engage in this in the future. The practitioner agreed to follow up.

2.4.10 The records state that the crisis practitioner emailed the CMHT care coordinator later that day to discuss the possibility of joint working until Ms A was considered ready for her care to be transferred from the crisis team to CMHT. The care coordinator responded to say he would visit Ms A on Thursday (2 days after her next appointment with the crisis team).

2.4.11 The CRHTT practitioner spoke with Ms A on Tuesday (7 July 2020) as planned. He documented that there were no significant indicators of a deterioration in Ms A’s mood. However, he recorded that Ms A’s presentation did indicate a gradual dip in her mood.

2.4.12 Regarding risks, the practitioner noted that Ms A denied any thoughts of harm to herself or others when asked directly, and that she said she felt capable of contacting the CRHTT if required.

2.4.13 Ms A was visited by the CMHT care coordinator on Thursday 9 July 2020. He documented that she reported low mood and a sense of isolation. Despite this, she reported feeling better than immediately before her hospital admission and said she had no thoughts of self-harm or suicide.

2.4.14 The plan was for the care coordinator to see Ms A each week (in addition to the CRHTT visits) for work to stabilise her mental state before Ms A's care was transferred to the CMHT.

2.4.15 A further visit from the crisis team took place on 11 July 2020. The team member had not met Ms A before and Ms A was not happy for the team member to enter her home wearing personal protective equipment. They therefore agreed to carry out the appointment by telephone. The practitioner documented that the main conversation focused on antidepressants, with Ms A stating that she wanted to increase her medication and that she might do this herself as she had enough tablets. The practitioner advised Ms A to wait until Ms A had discussed her medication with the consultant psychiatrist.

2.4.16 The records state that a multidisciplinary team meeting took place on 13 July 2020. It was noted that the last contact with Ms A had been difficult, as Ms A had been unwilling to let the team member into her house wearing personal protective equipment. It was suggested that this might be linked to a deterioration in Ms A's mental health.

2.4.17 During a visit on 13 July 2020, an advanced nurse practitioner from the CRHTT described Ms A as casually dressed with no evidence of self-neglect. The practitioner noted that Ms A appeared flat, gave limited answers and acknowledged feeling "depressed". They discussed medication and Ms A agreed to an increase in an antidepressant medication but declined an increase in antipsychotic medication. The notes state that Ms A denied any psychotic symptoms and felt that medication was 'too sedating'. She denied any current thoughts of suicide, but acknowledged her recent overdose and that she had not sought help.

2.4.18 It was documented that Ms A was keen to explore support options moving forward. She said that she had received treatment from the CRHTT for 3 weeks since discharge and felt she had improved in this time. She also said that she did not like the frequency and inconsistency of the visits and was keen to work with her care coordinator. It was documented that while Ms A was an informal (voluntary) patient who demonstrated capacity (that is, she was able to understand the information given and to make decisions), she appeared to be at high risk of relapse of her psychosis and had historically been reluctant to engage with services, leading to deterioration. The plan was for the nurse practitioner to continue to raise the possibility for transfer of care with Ms A's care coordinator.

2.4.19 On 15 July 2020, Ms A's care coordinator visited her at home. He documented that she continued to report low mood and isolation. She remained guarded, referring to ongoing 'gaslighting' and describing herself as irritable.

2.4.20 He documented that Ms A did not want any further input from the CRHTT at this time. She spoke about her belief that there was evidence all around her that "things aren't right" but would not elaborate initially, saying it would sound as if she were psychotic, which she denied. She denied any suicidal ideation or intent, and spoke positively about focusing on managing her anxiety through practising mindfulness techniques.

2.4.21 Early warning signs were recorded as:

- reported ongoing low mood
- evidence of strong unreasonable beliefs.

2.4.22 Risk was documented as 'No self-harm or suicidal ideation expressed.'

2.4.23 The plan was recorded as 'Weekly appointments with care coordinator for stabilisation work prior to transfer to central team.'

2.4.24 Two days later, the care coordinator wrote to the CRHTT relaying details of his recent visit with Ms A. He recorded that he was happy with a transfer of care from the CRHTT and that this was also Ms A's decision, which he considered she had capacity to make. He reiterated the plan was for weekly appointments to monitor Ms A's mental state and risk of harm to herself, and stabilisation work prior to transfer to the CMHT.

2.4.25 On 22 July 2020, the care coordinator telephoned Ms A. He documented that she presented as irritable during the conversation and stated that after a few minutes she said she 'did not feel up to doing this today'. She said that she had no thoughts of harming herself and they agreed to a face-to-face appointment the following day (23 July).

2.4.26 The next entry in the records refers to a face-to-face meeting on 27 July 2020. The care coordinator documented that Ms A continued to report low mood, a sense of isolation and thoughts that "Things are generally not right - lots of contradictions that don't make sense." She said that some days were slightly better than others, but that there were no good days.

Early warning signs were documented as:

- reported ongoing low mood
- poor sleep.

Risks were documented as:

- denied any suicidal ideation or intent
- no evidence of risk to or from others.

2.4.27 The plan remained for weekly visits with the care coordinator for stabilisation work prior to transfer to central team.

2.4.28 On 28 July 2020, a scheduled review took place by telephone between Ms A and a consultant psychiatrist. He documented that Ms A was feeling 'quite low not great'.

2.4.29 The consultant documented that Ms A believed that when she was in the emergency department for cutting her wrists, an implant had been put in her wrist when the wound was stitched. Ms A told the consultant that the implant made her react to things she wouldn't normally react to and that "some sort of investigation is going on". The consultant documented that Ms A had no thoughts of self-harm.

2.4.30 The consultant documented that he explained to Ms A that he considered she was experiencing ongoing psychotic depression, which he documented that she understood.

2.4.31 The consultant assessed Ms A as being at low risk of self-harm/suicide at that point, as she was engaged with services and willing to take her medication for 1 year and to follow advice, even if she did not fully agree with it. He documented that this demonstrated that Ms A had some insight and collaboration. He also documented that there was a risk of Ms A stopping her medication and therefore relapsing, which would increase her risk of self-harm.

2.4.32 The consultant recommended a clinic follow up in 3 months, alongside more regular meetings with her care coordinator, to be arranged via the care coordinator. He documented that Ms A needed ongoing care coordinator input with another member of the team due to the risk of impact of both care coordinator and consultant leaving their roles imminently.

2.4.33 On 2 August 2020, Ms A's Sister contacted the crisis response service with concerns regarding Ms A's welfare. She was worried that Ms A was relapsing and may have caused intentional harm to herself. Ms A had not answered the telephone in days and has not answered the door to her neighbours, which was out of character.

2.4.34 Police visited the address and found Ms A deceased at home. The coroner later reached a verdict of death by suicide.

3 Involvement of the Healthcare Safety Investigation Branch

This section outlines how HSIB was alerted to the issue of care delivered within community mental health teams (CMHTs). It also describes the criteria HSIB used to decide whether to go ahead with the investigation, and the methods and evidence used in the investigation process.

3.1 Notification of the reference event and decision to investigate

3.1.1 HSIB was alerted to the reference event by a referral from a family member.

3.2 Decision to conduct a national investigation

3.2.1 HSIB conducted an initial scoping investigation, which determined that the patient safety concern met the criteria for investigation (see below). HSIB's Chief Investigator authorised a national investigation.

Outcome impact - what was, or is, the impact of the safety issue on people and services across the healthcare system?

- There is a risk of death or self-harm. Psychosis and psychotic disorders can be extremely debilitating. People with severe and prolonged mental illness (diagnoses that usually involve psychosis) are at risk of dying on average 15 to 20 years earlier than other people. There is also a risk to the emotional and psychological wellbeing of both the patient and their family/carers.
- For society, the cost of psychosis was estimated to be £11.8bn per year. This results from direct healthcare costs, lost productivity due to unemployment or death and informal costs to families and carers.

Systemic risk - how widespread and how common a safety issue is this across the healthcare system?

- Research suggests that many people who die by suicide have a mental illness at the time of death, and that more than a quarter are in touch with mental health services.
- The CQC have published peoples' experiences of NHS community mental health services, and includes those with a negative experience. For example, poor experiences were reported for support and wellbeing, crisis care and accessing care. The CQC also found disparity in the experiences of different groups of people, especially among respondents with different diagnoses.
- There continues to be little consistency in the content or use of tools for assessing the risk of self-harm or suicide in patients with mental health concerns.

Learning potential - what is the potential for an HSIB investigation to lead to positive changes and improvements to patient safety across the healthcare system?

- There are opportunities to consider a more holistic approach to risk management and moving away from risk stratification.
- There is also the potential to explore the benefits of engaging with the families/ carers of those with mental health conditions, and methods of ensuring this happens consistently and in a timely manner.
- The investigation also recognised the opportunity to better understand pathways of care and why patients who meet the criteria do not get referred. Finally, there is room for healthcare teams to develop a better understanding of the link between menopause and mental health.

3.3 Scope of investigation

3.3.1 After the initial scoping investigation, it was agreed that the national investigation would seek to understand:

- the process for assessing the risk of harm to themselves or others of patients receiving treatment for mental health disorders in the community
- factors influencing the care pathway for patients with a first episode of psychosis, and how this is driven by and influences risk assessment and management

- factors influencing the care pathway for patients with a first episode of psychosis, and how this is driven by and influences risk assessment and management
- the ways in which mental health services consider menopause when assessing peri- or postmenopausal women with new-onset mental health conditions and how this informs risk.

3.4 Investigative approach

3.4.1 The investigation was conducted between June 2021 and August 2022.

3.4.2 HSIB uses the following standard process in all of its investigations.

- Gather all relevant evidence.
- Establish the factual circumstances leading up to the reference event.
- Analyse the evidence.
- Identify safety factors that contributed to the reference event.
- Identify which safety issues are likely to contribute to future similar events, nationally. These inform the wider investigation (see section 4).
- Develop safety recommendations and safety observations to reduce the identified safety risks.

Evidence gathering for the reference event

3.4.3 The investigation into the reference event was informed by review of:

- Ms A's clinical records across the different care settings
- relevant local and national guidance, policies and procedures
- published research literature relevant to the safety risk.

3.4.4 In addition, formal interviews using a semi-structured approach were undertaken with:

- Ms A's Sister
- Ms A's Niece
- clinical and managerial staff in the CRHTT and CMHT that cared for Ms A.

3.4.5 The investigation faced some limitations in accessing information. For example, few members of the team directly involved in Ms A's care were still working in the Trust, and the investigation was unable to locate or interview them.

Analysis of the reference event

3.4.6 Multiple methods of analysis were used to verify findings using more than one source. The analysis aimed to understand:

- how aspects of care within the CMHT (including menopause identification and management, first episode of psychosis, family engagement and risk assessment) are currently delivered or imagined to be completed
- how the system constrained or supported staff to deliver the work required in the context of the reference event.

3.4.7 Using the collected data, the investigation developed visualisations of the systems involved in Ms A's pathway and a timeline of the events. This helped the investigation to identify communications, interactions, timings and decisions that influenced Ms A's experience.

3.4.8 The findings were considered in the context of local and national guidance and practices that have been reported or detailed in the research literature. Discussions were conducted with subject matter advisors, and together this enabled the investigation to describe how the current systems and pathways influenced this reference event.

National investigation

3.4.9 Following investigation of the reference event, the HSIB investigation and executive teams discussed the potential for national learning. The investigation team identified and explored various sources of evidence to collect further data and understand the reference event in the national context. This involved:

- reviewing the research literature
- engaging with multiple stakeholders
- engaging with multiple national experts in different aspects of mental health
- engaging with service providers
- engaging with patients and families through the National Suicide Prevention Alliance.

Verification of findings

3.4.10 The findings were shared with the healthcare organisation involved in the reference event. This allowed the investigation’s interpretation of the findings to be checked for factual accuracy and sense. The findings and draft safety recommendations of the investigation were presented to the stakeholder groups, who contributed to the verification and design of the final safety recommendations. Data verification and understanding were tested throughout the investigation process.

3.4.11 Further verification and sense checking were achieved by consulting with influential national organisations and stakeholders, including professional bodies (see table 1). In addition, the investigation engaged with a roundtable working group that was newly formed and included many experts in mental health and risk assessment.

Table 1 National stakeholders that engaged with the investigation

National bodies and organisations	Individual experts and advisors
National Institute for Health and Care Excellence	Professor of psychiatry
Department of Health and Social Care	GP expert in menopause
NHS England (mental health policy)	Mental health nurse consultant
Royal College of Psychiatrists	National clinical director
Care Quality Commission	
National Suicide Prevention Alliance	
The Samaritans	

4 Analysis and findings

This section sets out the investigation’s analysis and findings. The findings are grouped according to four key themes that emerged following the analysis of the evidence collected from the reference event and wider national work. These were:

- risk assessment
- family engagement
- impact of menopause on mental health
- the first episode of psychosis pathway.

4.1 Risk assessment

The reference investigation

4.1.1 The Trust's clinical risk policy placed an emphasis on staff working in collaboration with patients to minimise the risk of harm. It stated that an individual, personalised plan should be produced in collaboration with the patient. The policy encouraged staff to consider the questions outlined in figure 1 in order to assess risk and formulate a safety plan.



Figure 1 Questions used by the Trust in the reference event to assess risk and formulate a safety plan.

4.1.2 The policy describes the importance of identifying risks and the steps that professionals, working alongside the patient, should undertake. The policy also describes the difference between 'static' and 'dynamic' risk factors. Static factors are those that do not change – for example, past suicide attempts. While these factors will always be present, their relevance will vary among individuals and over time. In contrast, dynamic risk factors are those that change over time. Examples are attitudes and beliefs, and alcohol and substance misuse.

4.1.3 During interviews with Trust managers and clinicians, the investigation was told that the risks identified for an individual should be formulated into safety plans and care plans. These plans should then be saved on the Trust's care record system

and regularly reviewed. Staff told the investigation that the risk to self and others should be formally assessed at regular intervals, including when a patient displays a change in behaviour.

4.1.4 While she was cared for in the community by the crisis resolution home treatment team (CRHTT) and community mental health team (CMHT) Ms A's risk of self-harm or suicide was routinely documented following meetings between Ms A and practitioners (face to face or on the telephone). In the records viewed by the investigation, practitioners routinely documented that Ms A did not have any current suicidal thoughts or plan. On occasion, it was noted in her records that her risk would increase if she displayed relapse symptoms, such as isolation, disengagement or paranoid ideation. When these symptoms were present, Ms A's risk did not appear to have been reconsidered. The investigation was unable to determine why this did not occur.

4.1.5 Ms A's family told the investigation that they did not feel that the caseload risk assessment recognised the impact of isolation due to national restrictions would have on Ms A's mental health. The family highlighted the importance of interaction with family and friends for the stabilisation of her mental health.

4.1.6 Ms A's care plan was written in January 2020 when she was making progress towards recovery. The care plan was not updated to reflect Ms A's relapse in May 2020, which resulted in her being admitted to hospital under Section 2 of the Mental Health Act and a subsequent need for increased input by CRHTT and the CMHT upon discharge. Trust staff could not explain why the care plan was not updated. However, they described the busy context in which they were operating and how this may have impacted on the completion of documentation. The CMHT that cared for Ms A covers a large population, and managers told the investigation that staff were carrying high caseloads, with each clinician managing up to 70 patients. A senior manager told the investigation that caseloads were 35-40% higher than before the COVID-19 pandemic.

4.1.7 There were differing views among CMHT staff regarding how risk assessments should be undertaken and documented. Some staff said that risk assessments should be purely based on clinical judgement, while others felt that risk should be stratified using risk tools and documented.

4.1.8 At a crisis team multidisciplinary team meeting about Ms A on 28 June 2020, consideration was given to reducing her care to within the medium (amber) category within the crisis team pathway. At this level, it is considered that patients can be supported through reduced contact, potentially by phone, but regular contact is still required.

4.1.9 The Trust's clinical risk policy was in line with national policy and guidance, in that it focused on assessing risk and considering psychosocial factors that impact on risk and the individual. The Trust's policy encouraged professionals to stratify risk – asking that a high, medium or low risk of harm to themselves or others was assigned to a patient. This is no longer in line with national thinking about the most appropriate way of undertaking a holistic assessment, which should take into account all of the factors and needs of an individual.

The national investigation

Risk categorisation

4.1.10 The main focus of risk assessment and suicide prevention in mental health services has been on predicting the risk of suicide or self-harm in individual patients (Department of Health, 2009). Historically, patients may have been categorised into high, medium or low risk of a particular outcome. Checklists of characteristics or risk scales are sometimes used to estimate the likelihood of harm.

4.1.11 The National Confidential Inquiry into Suicide and Safety in Mental Health (2018) looked at different perspectives on the use of clinical risk assessment tools, with the aim of identifying areas for improvement. All 85 NHS mental health organisations in the UK gave details of the main clinical risk assessment tools used in their service. The study found the following.

- Most tools encouraged staff to predict future behaviours, and more than half asked clinicians to stratify risk into, for example, high, medium and low risk categories.
- Ten organisations had introduced safety planning into the risk assessment process.
- Only around a third of nurses and managers, and none of the doctors in the study, thought the tools had predictive value, compared with around two thirds of psychologists.

4.1.12 A further study looked specifically at the suicide risk assessment tools used in the NHS (Graney et al, 2020). The study obtained 156 risk assessment tools from the UK's 85 NHS mental health organisations, and 85 (one per organisation) were included in the analysis.

4.1.13 The study found little consistency among the tools, with 33 of 85 organisations (39%) using locally developed tools. Most tools aimed to predict self-harm or suicidal behaviour (84, 99%), and for 80 (94%) of the tools the score was used to determine how the patient was managed (Graney et al, 2020).

4.1.14 While clinicians described positive aspects of risk tools (such as facilitating communication and enhancing therapeutic relationships), they also held negative views associated with inadequate training in the use of the tools and that they were time-consuming to complete (Graney et al, 2020).

4.1.15 The 'Safer Services' inquiry into suicide and homicide by people with mental illness found that 85% of patients who went on to die by suicide had their risk rated as low or absent at their last contact with mental health services (figure 2) (Department of Health, 1999).

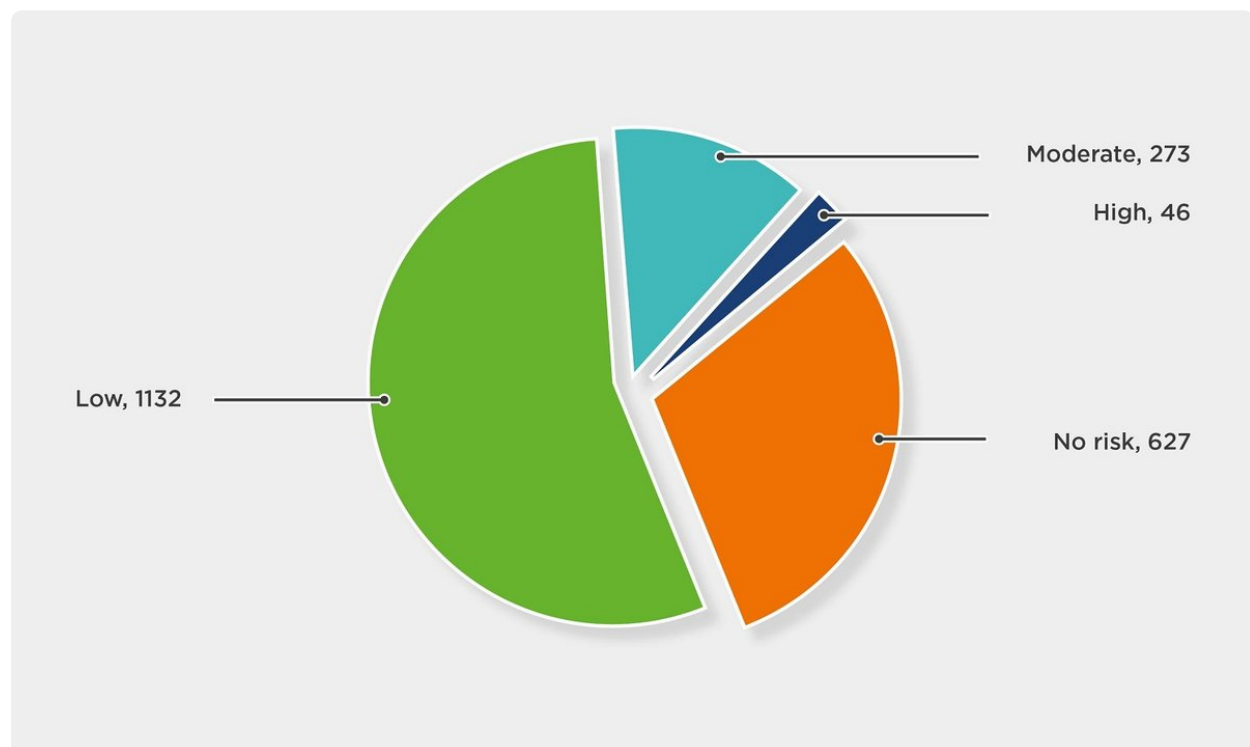


Figure 2 Estimate of risk at last contact (Department of Health 1999)

4.1.16 The challenge of assessing suicide risk does not appear to be limited to the UK. An Australian study looked at people who died by suicide between 2014 and 2016 and who had contact with a public mental health service within 31 days before their death (Wyder et al, 2021). Of the 68 people who had contact, 70.5% had a formal risk assessment through which 75% were classified as being at low risk of suicide. No-one was identified as being at high risk. The study authors concluded that 'Risk categorisation contributes little to patient safety.'

4.1.17 A national CMHT expert told the investigation that it has been established that scales and tools for assessing suicide risk have a positive predictive value of about 5% - meaning that they do not accurately predict the risk of suicide 95% of the time, and that suicide deaths in the large 'low-risk' group are often missed. This is reflected in national reports (for example, National Confidential Inquiry into Suicide and Safety in Mental Health, 2018).

4.1.18 Multiple clinicians told the investigation that risk assessment in itself is unhelpful - rather, it is the risk management and what is done with the identified risks that are important. If assessments and stratification are used in a way that does not reflect the dynamic (that is, changeable) nature of risk or in a way that rationalises care (by justifying who does and does not receive it), then they are not helpful. They told the investigation that the focus should be on managing patients holistically and recognising that many factors play a part in successfully managing an individual's risk.

4.1.19 National experts in suicide and self-harm told the investigation that categorising patients as being at high, medium or low risk of suicide can lead to resources being focused on those assessed as high risk. While it is logical to focus limited resources on those deemed most at risk, it does not take into account the dynamic nature of risk; for example, if a person deemed 'low' or 'medium' risk is not given appropriate interventions, their risk can increase.

4.1.20 Clinicians told the investigation that risk categorisation is often used as a justification for not providing care. For example, a patient assigned a low risk level might not meet the criteria for a particular intervention or pathway. The data, as outlined above, suggests that focusing resources purely on those who are deemed 'high' risk is not successful in preventing or reducing the likelihood of suicide.

4.1.21 The low positive predictive value of risk stratification means that most people who receive a treatment because of their high-risk status will not die by suicide, while the limited sensitivity means that some low-risk patients, who will die by suicide, might be deprived of treatment options (Large et al, 2017).

National support for a change in risk assessment

4.1.22 The investigation sought to understand how the system might be changed to promote more holistic assessments of individuals.

4.1.23 Guidance from the National Institute for Health and Care Excellence (NICE, 2011) which was updated in 2022 states that risk assessment tools and scales should not be used to predict future suicide or repetition of self-harm. Further, risk assessment tools and scales should not be used to determine who should be offered treatment and who should be discharged.

4.1.24 NICE produced further guidance in 2022. In relation to risk assessment tools, the guidance states that “risk assessment tools and scales cannot accurately predict risk of self-harm or suicide, and that determining access to treatment or hospital admission based on inaccurate risk assessment tools could lead to repeat self-harm, distress and lower patient satisfaction” (National Institute for Health and Care Excellence, 2022).

4.1.25 The guidance goes on to state:

‘The committee agreed that the potential harms of risk stratification, including the implication that risk is static instead of dynamic, outweigh any benefits it has as a clinical communication tool or an adjunct to clinical assessment, so agreed that risk stratification should not be used.’

(National Institute for Health and Care Excellence, 2022)

4.1.26 In April 2022, an open letter was sent to the Secretary of State for Health and Social Care from various representatives of mental health charities (including the cofounder of Zero Suicide Alliance and the chief executives of Mind and the Samaritans), calling for a change in suicide risk assessments (figure 3). It also asked that, in line with NICE guidelines, standardised risk assessment tools are no longer used to predict risk.



HOUSE OF COMMONS

LONDON SW1A 0AA

The Rt Hon Sajid Javid MP
Secretary of State for Health and Social Care
Department of Health and Social Care
Ministerial Correspondence and Public Enquiries Unit
39 Victoria Street
London
SW1H 0EU

19th April 2022

Dear Secretary of State,

We are writing to raise an urgent concern regarding current suicide risk assessment practices used in the mental health sector.

According to the most recent data, 6,211 people in the UK died by suicide^[i] and, tragically, suicide is the most common cause of death among young people aged 20-34.^[ii] We are alarmed that, of the 17 people who die by suicide each day in this country,^[iii] five are in touch with mental health services and four of those five are assessed as 'low' or 'no risk'.

Standardised risk assessment tools are poor predictors of suicide. National guidelines, including those drafted by NICE in January 2022, determine they should therefore not be used for that purpose.^[iv] However, most tools remain as checklists which still seek to predict future behaviour.^[v]

The severity of our concern is highlighted in the Royal College of Psychiatrists' report published in July 2020, which concluded that the approach to suicide risk assessment is 'fundamentally flawed'.^[vi]

Further, nearly half of the patients consulted in the Lancet Psychiatry report, published in November 2020, were critical of the assessment process - highlighting the impersonal nature of the assessment, and reporting that their feelings and views were disregarded.^[vii]

Every suicide is a heart-breaking tragedy for family and friends who lose loved ones, and every effort should be made to save lives. Risk should not be defined as a number, nor treatment determined by a 'score'.^[viii]

We welcome the recently announced review of the 2012 Suicide Prevention Strategy for England and see this as an opportunity to reassess current suicide risk assessment practices used in the mental health sector.

We therefore urge you, the Secretary of State for Health and Social Care, to ensure that the new suicide prevention strategy includes a review of the use of suicide risk assessments in breach of current guidelines, and to take appropriate steps to ensure that existing guidance around not using these tools to assess suicide risk be strictly followed by both the public and private health sectors.

Yours sincerely,

Sarah Olney
MP for Richmond Park

Steve Mallen
Co-Founder Zero Suicide Alliance

Figure 3 Open letter to the Secretary of State for Health and Social Care.

4.1.27 Despite the developing work in this area, the investigation found that organisations and practitioners may still revert to completing risk assessments in the absence of other ways to assess and document risk as part of a more holistic assessment.

4.1.28 Clinicians told the investigation that there was a fear that by not completing a risk assessment, they could be criticised if the patient subsequently died by suicide. The investigation was told that coroners and other organisations reviewing care often look to see whether risk assessments were completed in a particular format and whether the patient had been graded as high, medium or low risk. National experts told the investigation it would therefore require a complete shift in thinking and in practice to move away from formulaic risk assessments. Staff would need to feel safe in not completing an assessment, and a robust alternative would need to be in place to avoid staff being blamed if a patient subsequently came to harm.

4.1.29 The investigation met with the Care Quality Commission (CQC) to discuss risk assessments. The CQC told the investigation that their current regulatory methodology uses an assessment framework which comprises five key questions (safe, effective, caring, responsive, and well led). On inspection of community mental health services, as with inpatient mental health settings risk is assessed under the 'Safe' key question. On site, the inspection team use patients' risk assessments to form the basis of the document review. The inspection team will cross reference patients' risk assessments with other patient documentation to ensure it is comprehensive and reflects all aspects of risk relevant to that person.

4.1.30 The investigation asked whether the way in which inspections are conducted could contribute to clinicians feeling the need to document assessments and risk stratification in a particular way. The CQC told the investigation that inspectors are directed to look for particular risk assessment documentation, additionally each inspector brings their own background and areas of interest which may inform what evidence they look for.

4.1.31 CQC described to the investigation team the new regulatory model and approach, due for implementation later in 2023, which is part of their transformation to improve how technology and data is used to regulate services and drive improvement. CQC has developed a Single Assessment Framework (SAF) which will allow for an up-to-date view on service quality. In the new SAF, Quality statements will replace key questions. Quality statements will demonstrate how services and providers need to work together to plan and deliver quality care. Risk documentation reviewed to help inspection teams make a judgement about risk will be the same as in the current methodology however the collection will differ to facilitate ongoing collection using new technology and data systems.

4.1.32 The CQC acknowledged the importance of ensuring that inspectors do not assess trusts' risk assessments in a way that is not aligned with the latest guidance, and that there is the potential for staff to be educated in this regard.

HSIB makes the following safety recommendation

Safety recommendation R/2023/221:

HSIB recommends that the Care Quality Commission evaluates the way in which it reviews how community mental health services assess risk of harm, to ensure its inspections are in line with the latest national guidance.

Capability to provide holistic risk assessment

4.1.33 The latest NICE guidance supports a shift in the way risk of self-harm or suicide is considered, assessed and managed, by stating that ““risk” should not be used to determine care management in isolation of other factors’ (National Institute for Health and Care Excellence, 2022). It states that every assessment should consider the person’s needs, vulnerabilities and safety, and that staff should use their clinical judgement when assessing someone who has self-harmed. The guidance also says that mental health staff should conduct a ‘risk formulation’ to place the person’s safety considerations in context with their strengths and difficulties.

4.1.34 A 2020 study of suicide risk assessment in UK mental health services concluded that assessment processes need to be consistent across mental health services, and that staff should have sufficient training on assessing, formulating and managing suicide risk, with an emphasis on patient and carer involvement (Graney et al, 2020). The study found that patients and carers reported little involvement during risk assessment, and were unclear on what they should do in a crisis. As such, the researchers also concluded that management plans should be collaboratively developed with patients, their families and carers, and that plans should be personalised (Graney et al, 2020).

4.1.35 In a patient safety report on self-harm and suicide in adults, the Royal College of Psychiatrists (2020) describes the importance of including an immediate ‘safety plan’, co-produced with the patient, for any patient who is considered to be at risk of suicide. The safety plan should specifically refer to removing or mitigating

any means by which the patient might harm themselves. The plan should list activities and coping strategies, and provide information on accessing psychological, social and emergency support.

4.1.36 The investigation was invited to attend an online discussion regarding clinical risk assessment in adults with mental health conditions. The meeting was attended by more than 25 people, including consultants, nurses, managers and practitioners – all experts within their field. The investigation found that attendees welcomed the opportunity to join this forum and hear so many experts respectfully debate the factors they consider to be important in assessing risk.

4.1.37 The investigation observed consensus among the clinicians (in line with policymakers) that risk assessment should move towards a personalised, collaborative, inclusive and comprehensive assessment and management of the whole individual. However, they considered that staff would need “permission” to move away from using the tools to assess and grade risk. The importance of not just replacing one checklist with another was also expressed.

4.1.38 During the meeting, the investigation asked clinicians about the barriers to moving away from risk assessments in their current form. The following barriers were described.

- The absence of anything else – some clinicians felt uneasy about not completing a form. In the absence of a new way to consider and document risk, they felt they would revert to the traditional assessment.
- The need for permission – clinicians felt they would be criticised by external organisations, such as the CQC, if risk assessments and stratification were not documented in the way expected by that organisation. As such, clinicians felt uncomfortable moving away from these expectations. Some local policies also encourage the stratification of risk, and clinicians said they did not want to operate outside of their local policy.
- Time and resources to do anything differently – staff in CMHTs are under considerable pressure, and have limited time and resources to consider how things might be done differently and to train staff in a new methods.

4.1.39 The investigation met with the Department of Health and Social Care and with NHS England to discuss the barriers to providing holistic risk assessments. NHS England agreed it would take action to ensure staff providing mental health services felt they had permission to move away from risk assessment tools that stratify risk.

HSIB notes the following safety action

Safety action A/2023/058:

NHS England has written to all mental health trusts in England to highlight the importance of taking a person-centred approach to psychosocial assessments and safety planning. The communication asks trusts to move away from risk assessment tools that stratify an individual's risk of suicide or self-harm.

4.1.40 The latest NICE guidance sets out a recommendation for research to be undertaken into the most effective approaches to assessment in non-specialist settings to better inform future guideline development (National Institute for Health and Care Excellence, 2022). This may help to identify factors that can both help and hinder staff in providing holistic assessments. However, wider work is required to ensure that a whole system-wide approach to risk assessment is adopted.

4.1.41 The investigation spoke with the Department of Health and Social Care to understand how the department could support a move to a holistic approach to assessing risk, and how NICE guidance can be put into action and really embedded in practice. The Department of Health and Social Care told the investigation that it is working closely with NHS England to consider ways in which this can be done. NHS England told the investigation that quality improvement work first needs to take place to ensure it is understood what 'good' looks like in risk assessments. This can then be operationalised, with a shift from clinicians purely assessing risk to holistically considering the needs of individuals.

HSIB makes the following safety recommendation

Safety recommendation R/2023/220:

HSIB recommends that NHS England works with appropriate stakeholders, including experts with appropriate experience, to create guidance on culture change. A quality improvement programme should also be developed to support practitioners in undertaking psychosocial assessments that are in line with guidance from the National Institute for Health and Care Excellence. Person-centred safety planning should be embedded within the process.

HSIB makes the following safety observation

Safety observation O/2023/210:

It may be beneficial for education bodies to develop training programmes in safety planning and psychosocial assessments, once NHS England has provided guidance on how such assessments should be conducted.

Family engagement

The reference investigation

4.1.42 Ms A's Sister told the investigation that contact with the family during Ms A's first hospital admission in September 2019 was generally positive and forthcoming. It was known that when Ms A's mental health deteriorated she became paranoid and suspicious, and this included becoming untrusting of her family. When Ms A was well she recognised this was the case and that her family was an important protective factor for her.

4.1.43 Ms A was under a Care Programme Approach (CPA). A CPA supports people who are considered to have complex mental health needs and who often require the support of several services. The CPA recognises the importance and value of friends, family and carers in supporting the patient, and of involving these individuals - with the patient's agreement - in the patient's assessment, care plan and reviews.

4.1.44 Ms A's Sister told the investigation that when Ms A was admitted to hospital for the second time in May 2020, staff did not include the family in any assessments or planning for discharge. The records suggest that ward staff contacted Ms A's family to obtain information from them. Information was not shared with them as Ms A did not give her consent.

4.1.45 Ms A's Sister told the investigation that the family learned that Ms A's hospital admission in May 2020 was because of a suicide attempt only after Ms A's death. Ms A's Sister told the investigation that she and her family would have been better equipped to support Ms A if they had been made aware of the reason for her admission.

4.1.46 Staff told the investigation that Ms A did not want them to speak with her family and therefore it was difficult to include them. Staff said that they try to engage with family wherever possible. They recognised that engagement can be

difficult when patients explicitly ask staff not to speak with their family members. They said that they still try to gather information from families, even if they are unable to share information because of the patient's wishes.

4.1.47 The medical records indicate that inpatient staff felt that Ms A was reconnecting with her family because she reported sending a WhatsApp message to the family group. Ms A later gave consent for staff to speak with her family if they contacted the ward. There is nothing recorded in the notes about family contact after this point, and the investigation could not determine what further specific attempts were made to understand Ms A's engagement with her family. Staff involved in Ms A's care are no longer at the Trust and were unavailable for interview.

4.1.48 Staff told the investigation that the COVID-19 lockdown had a substantial impact on family engagement in general, and was likely to have influenced the way in which staff engaged with Ms A's family. For example, with family visiting being prohibited or restricted, there was little opportunity for informal engagement. Staff also told the investigation that, in complex cases where patients change their mind, it can be difficult to know when and how to include family members in decision making.

The national investigation

4.1.49 The latest guidance from NICE on assessing, managing and preventing the recurrence of self-harm states:

“Staff working with people who self-harm should be aware of the benefits of involving the person's family and carers and sharing information, and should recognise the need to seek consent from the person as early as possible.”

(National Institute for Health and Care Excellence, 2022)

4.1.50 In August 2021 the Zero Suicide Alliance produced a report funded by the Department of Health and Social Care titled Consent, Confidentiality and Information Sharing in Mental Healthcare and Suicide Prevention (Zero Suicide Alliance, 2021). The guidance acknowledges the conflict between a patient's right to confidentiality and the need to share information which may prevent harm or protect life. The report states that concerns remain that practitioners may not feel sufficiently trained to seek consent and share information as a central, positive part of patient care.

4.1.51 Additional guidance from NICE on improving the experience of care for people using adult NHS mental health services also supports the importance of family engagement where appropriate (National Institute for Health and Care Excellence, 2011). A consensus statement from the Department of Health and Social Care together with professional organisations, including the Royal College of Psychiatrists and the Mental Health Network NHS Confederation, states that:

‘In line with good practice, practitioners should routinely confirm with people whether and how they wish their family and friends to be involved in their care generally, and when looking at information sharing and risk in particular.’

(Department of Health and Social Care, 2021)

4.1.52 The NICE guidance mentions the importance of talking with patients about family involvement at intervals, rather than just once, to allow for any changes in circumstances (National Institute for Health and Care Excellence, 2011).

Interviewees told the investigation that difficulties often arise when the patient withdraws consent, usually when unwell. It is then challenging for staff to know how to best engage with families.

4.1.53 The NICE guidance also states that due to the complex nature of involving families and carers, ‘staff should receive training in the skills needed to negotiate and work with families and carers, and also in managing issues relating to information sharing and confidentiality’ (National Institute for Health and Care Excellence, 2011). Most staff told the investigation that they do not recall having specific training on how to engage with the families and carers of patients and that they often have to use their own judgement as the guidance does not cover the specific issues they need to consider.

4.1.54 Figure 4 shows the important role of family and friends in supporting people with mental health needs.

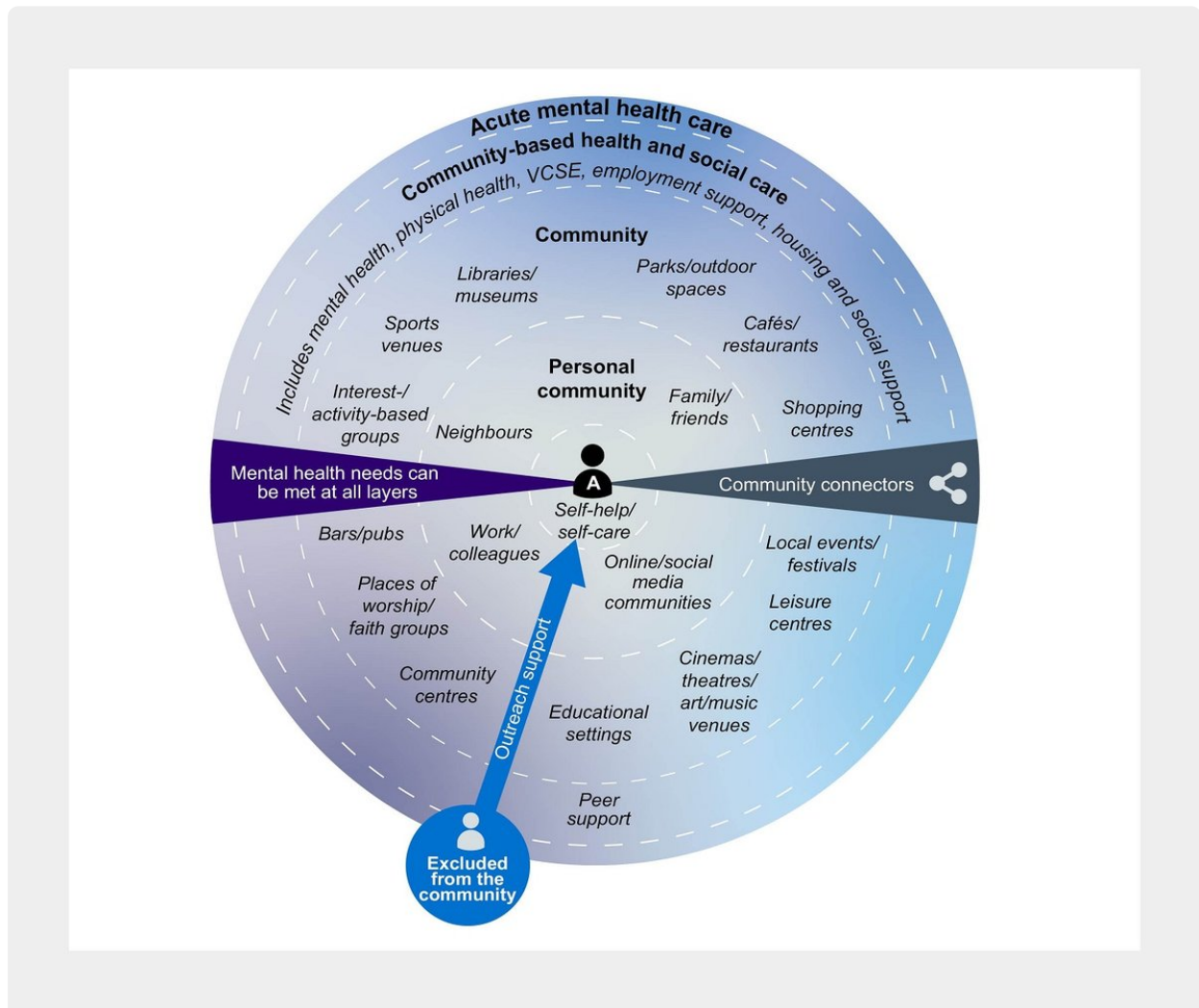


Figure 4 Role of family and friends in supporting people with mental health needs. VCSE, voluntary, community and social enterprise (NHS England and NHS Improvement and the National Collaborating Centre for Mental Health 2019).

4.1.56 The way in which different mental health services engages families can vary highly (Dirik et al, 2017). The National Confidential Inquiry into Suicide and Safety in Mental Health (2018) asked carers to share their experiences in an online survey. A total of 26 carers completed the survey, and the findings are shown in figure 5. age high caseloads, they often do not have the time – or sometimes the expertise or understanding of legal requirements – to work through complex engagement issues. One trust told us that it has produced a ‘common sense’ guide to family and carer involvement. Again, however, this will not be able to cover every possible situation that might occur, and therefore access to further advice or the ability to talk through cases with others may be beneficial.

4.1.56 The way in which different mental health services engages families can vary highly (Dirik et al, 2017). The National Confidential Inquiry into Suicide and Safety in Mental Health (2018) asked carers to share their experiences in an online survey. A total of 26 carers completed the survey, and the findings are shown in figure 5.

4.1.57 Nine carers (45%) reported being present at an assessment where a patient's safety was discussed. Despite this, carers expressed frustration and disappointment at their lack of involvement in safety planning, despite having raised concerns. Only nine carers (45%) felt their views were acknowledged, while 11 felt they were not given the chance to express their views on potential risk factors. Carers reported a lack of communication and consultation, a lack of involvement in safety planning processes and limited reassessment of plans.



Figure 5 Carers' experiences of risk assessment tools (National Confidential Inquiry into Suicide and Safety in Mental Health 2018).

4.1.58 In interviews with the investigation, frontline staff demonstrated that they understood the importance of involving families in care planning, where appropriate. Some interviewees described difficulties in navigating engagement when the patient withdrew consent for involving their family as their mental health declined. Other staff described difficulties in engaging families and hearing their experiences without sharing specific information about the patient.

4.1.59 The investigation acknowledges the multiple scenarios that can arise and the complexities of engaging with families. The investigation feels it would be impossible to create guidance that covers every potential scenario and complexity that may occur within a family dynamic. Instead, mental health experts have advised the investigation that the focus should be on ensuring practitioners are suitably equipped to make decisions and engage in constructive conversations – either through training or support offered via a dedicated role.

4.1.60 In July 2022, the Royal College of Psychiatrists (2022) recommended that mental health organisations employ a family liaison officer or family liaison service. Whilst the primary focus of this role is to support families after a suicide, there is appetite to use the role to support families when their family member is within mental health services. Families and practitioners would be able to contact the family liaison officer/services where engagement might be complex and further support is likely to be needed.

4.1.61 The guidance describes ways in which clinicians can try to encourage family engagement when the patient is reluctant. The guidance says that clinicians should:

- negotiate between the patient and their family or carers about confidentiality and sharing of information on an ongoing basis
- explain how families or carers can help support the patient and help with treatment plans
- ensure that no services are withdrawn because of the family's or carers' involvement, unless this has been clearly agreed with the patient and their family or carers.

4.1.62 The investigation heard that organisations and services should set the expectation that healthcare professionals will engage with families wherever possible, instilling a culture of inclusiveness. However, the question remains as to how this expectation can be implemented when a service user withdraws their consent.

4.1.63 The investigation met with one of the first joint authors of a study (Gorman, et al, 2023) into family involvement when a patient is in crisis. The research observed mental health services at two sites. The aims of the study were to explore how family engagement works in practice compared with guidelines; the challenges and benefits of involving family members; and what services can do to promote their involvement.

4.1.64 The study team concluded that families can perform important functions in improving patient wellbeing and contextualising information for clinicians. However, they also found that it was often difficult for staff to navigate confidentiality; that staff had to gain and reconfirm consent throughout care; and that debriefs with families were not always as effective as they might be. The researchers noted that families were often invited to meet with staff at the end of a patient stay and asked if they had any questions, rather than focusing on providing tips for the family on keeping the patient safe or giving an update on care and treatment. The study also found that conversations with family were often risk based, focusing on whether the family had identified any changes in the patient's health.

4.1.65 The study found that few staff had received any form of training in family engagement. Staff reported the desire to learn from each other and suggested that an interprofessional forum for shared learning may be beneficial. There was a suggestion that such a forum could be held on a monthly basis, with the opportunity to take complex cases to the forum to discuss.

4.1.66 In a different study, patients and carers said they had little involvement in risk assessments and felt unclear on what to do in a crisis (Graney et al, 2020).

4.1.67 The investigation engaged with the National Suicide Prevention Alliance to undertake a survey on behalf of the investigation. The alliance has a Lived Experience Network, which consists of people who have experienced or live with suicidal thoughts, people who have attempted suicide, people living with or in a relationship with those with suicidal thoughts, and people who have been bereaved by suicide. The purpose of the survey was for the investigation to understand the experience of those engaging with CMHTs as either a family member or patient.

4.1.68 A total of 31 people responded to the survey: 14 as patients and 23 as family members or carers (some had been both a patient and a family member/carer). Those responding had a variety of experiences related to suicide, including having made a suicide attempt (39%), living with suicidal thoughts (61%) and being bereaved by suicide (65%).

4.1.69 Participants were asked: "How helpful did you find the contact you have had with CMHT?"

- 6% said "very helpful" (one person)
- 13% said "mostly helpful" (two people)
- 4.1.69 Participants were asked: "How helpful did you find the contact you have had with CMHT?"

- 19% said “very unhelpful” (three people)
- 25% said “a mixture of helpful and unhelpful” (four people).

4.1.70 Respondents said that there was a lack of consistency from staff and how information translated into care for their family member. Many respondents said that they had noticed staff shortages, and saw improved staff capacity as a key to improving care.

4.1.71 The most common theme was for improved communication by CMHTs. This encompassed a broad range of topics, from engaging proactively with loved ones verbally, to responding to loved ones when they raised concerns with CMHTs. One respondent gave the following advice:

“Be aware of the individual carer’s needs. Help them to understand the diagnosis of their loved one and how they can support recovery. Make time to speak to carers without the patient being in the room – this can be done without breaking confidentiality.”

4.1.72 A number of respondents expressed the importance of being listened to and of CMHTs taking action when they raised concerns. Many described experiences where they did not feel they were heard.

4.1.73 Several respondents described similar experiences of a lack of communication from CMHTs. This made family and friends feel that they were supporting and caring for their loved one on their own, in some instances without all of the available information. One respondent said:

“They do not really include family members as they could or should, citing confidentiality as a reason not to share but then leaving the struggling person in the care of the family without full knowledge of what the family are managing. This only increases risk for all, especially the person who is unwell.”

HSIB makes the following safety observations

Safety observation O/2023/208:

It may be beneficial for mental health organisations to have a dedicated liaison officer who acts as a point of contact for both families and clinicians when navigating involvement in a patient's care and decision making.

Safety observation O/2023/209:

It may be beneficial for organisations to involve families in care planning and assessments, and that practitioners are appropriately trained in working with families.

4.2 Impact of menopause on mental health

The reference investigation

4.2.1 Ms A's Sister told the investigation that menopause had had a profound impact on Ms A's physical and mental health. Ms A had experienced physical health concerns that impacted on her confidence, ability to work and mental health.

4.2.2 A crisis resolution and home treatment team medication chart completed on 3 July 2020 states that Ms A was prescribed oestradiol, which is an oestrogen hormone used to reduce some of the side effects of menopause. The chart says she started on this medication on 28 June 2020. Ms A's medical records suggest she began taking hormone replacement therapy (HRT) in 2015, and it is documented as being a prescribed medication during her first admission in September 2019.

4.2.3 Staff told the investigation that they were, in general, aware of the impact of menopause on individuals' mental health, particularly the increased risk of low mood and depression. However, they were not aware of any specific secondary mental health services for women experiencing a decline in their mental health during menopause. Interviewees also told the investigation that questions regarding menopause were not included in risk assessments or wider considerations of an individual's needs.

4.2.4 The investigation did not find anything in the Trust's policies or guidelines that would direct staff to consider whether a patient's mental health is impacted by menopause. Staff told the investigation that there was no training in the Trust to raise awareness of possible links between menopause and deteriorating mental health.

The national investigation

Impact of menopause on mental health concerns

4.2.5 In the reference event, menopause was a potentially unconsidered physical health factor that might have impacted on Ms A's mental health. The investigation has therefore sought to consider how menopause is addressed in mental health services nationally.

4.2.6 A CMHT expert told the investigation that midlife is a point of increased risk of mental health deterioration; this is supported by research that shows an increase in risk of suicide at this time. In addition, women are at increased risk of developing schizophrenia or other psychotic disorders at or around menopause, when oestrogen levels drop.

4.2.7 In the UK, NICE has produced guidance on the diagnosis and management of menopause (National Institute for Health and Care Excellence, 2015). In relation to mental health, the guidance references possible psychological symptoms associated with menopause. It states that practitioners should:

- consider HRT to alleviate low mood that arises as a result of menopause
- consider cognitive behavioural therapy to alleviate low mood or anxiety that arise as a result of menopause.

4.2.8 Some studies have suggested that there may be a link between menopause and more severe mental health conditions. For example, one study has reported that women with menopause-related symptoms may have a higher risk of subsequently developing psychiatric disorders, especially depressive disorder, anxiety disorder, sleep disorder and bipolar disorder (Hu et al, 2016).

4.2.9 Data from Australia for 2015 show that the highest age-specific suicide rate for females was in the age group of 45–49 years, with 10.4 deaths per 100,000 population (Kulkarni, 2018). The second highest rate of suicide was in women aged 50–54 years. The paper suggests that this may be related to the biological changes associated with menopause.

4.2.10 The NICE menopause guidance is currently being updated, with an expected publication date of January 2024 (National Institute for Health and Care Excellence, n.d.). The updated guidance intends to recommend cognitive behavioural therapy to treat the psychological symptoms of menopause. as being a prescribed medication during her first admission in September 2019.

4.2.3 Staff told the investigation that they were, in general, aware of the impact of menopause on individuals' mental health, particularly the increased risk of low mood and depression. However, they were not aware of any specific secondary mental health services for women experiencing a decline in their mental health during menopause. Interviewees also told the investigation that questions regarding menopause were not included in risk assessments or wider considerations of an individual's needs.

4.2.4 The investigation did not find anything in the Trust's policies or guidelines that would direct staff to consider whether a patient's mental health is impacted by menopause. Staff told the investigation that there was no training in the Trust to raise awareness of possible links between menopause and deteriorating mental health.

HSIB makes the following safety recommendation

Safety recommendation R/2023/222:

HSIB recommends that the National Institute for Health and Care Excellence evaluates the available research relating to the risks associated with menopause on mental health and if appropriate, updates existing guidance.

4.2.11 Mental health practitioners told the investigation that they do not recall having specific training on menopause-associated psychological symptoms. Staff also told the investigation that current mental health assessments do not prompt practitioners to consider menopause as part of the holistic assessment of an individual.

4.2.12 While NICE guidance advises clinicians to consider HRT to alleviate low mood in menopause (National Institute for Health and Care Excellence, 2015), interviews with experts in menopause care suggested that the symptoms of menopause (and perimenopause) are often mistaken for depression, resulting in women being prescribed antidepressants rather than HRT. Research has found that many women

who experience depressive symptoms or a major depressive disorder at the time of menopause may find relief of these symptoms and even the disorder by using HRT (Leonhardt, 2019).

4.2.13 NICE guidelines on menopause states that healthcare professionals should understand that there is no clear evidence for antidepressants to ease low mood in menopausal women who have not been diagnosed with depression.

Awareness of women's health needs in menopause

4.2.14 On 11 October 2022, a report from the All-party Parliamentary Group on Menopause said that more should urgently be done to help women at the time of menopause, including:

- boosting support in the workplace
- introducing fresh training on symptoms for health workers
- improving access to treatment.

4.2.15 The report welcomed the fact that incoming medics from 2024/25 will receive training and assessments on menopause, but said further action is needed to ensure existing doctors 'deliver the best menopause treatment possible' (Gregory and Geddes, 2022).

4.2.16 In August 2022, the first ever Women's Health Strategy for England was published by the Department of Health and Social Care. The ministerial foreword to the strategy states:

"Not enough focus is placed on women-specific issues like miscarriage or menopause, and women are under-represented when it comes to important clinical trials. This has meant that not enough is known about conditions that only affect women, or about how conditions that affect both men and women impact them in different ways."

(Department of Health and Social Care, 2022)

4.2.17 The Women's Health Strategy was in part informed by a public survey, which was open to all individuals in England aged 16 years and over; more than 97,300 individuals responded. Menopause was the third most selected topic that respondents picked for inclusion in the strategy, and was selected by 48% of respondents. Many respondents reported finding it difficult to access appropriate menopause care, often due to a lack of symptom recognition among both women

and healthcare professionals. Some written submissions noted that the symptoms of menopause can be confused with other conditions, with women sometimes being prescribed antidepressants rather than menopause treatments (Department of Health and Social Care, 2022).

4.2.18 In February 2022, the government established the UK Menopause Taskforce to improve healthcare support for women undergoing menopause; educate and raise awareness in the population and among healthcare professionals; encourage workplace support; and consider where further research, evidence and data are needed.

The Women's Health Strategy outlines the health needs of women throughout their life course (figure 6). As shown, the perimenopause and menopause are important areas in the middle and later years of life, while mental health needs stretch across all ages.

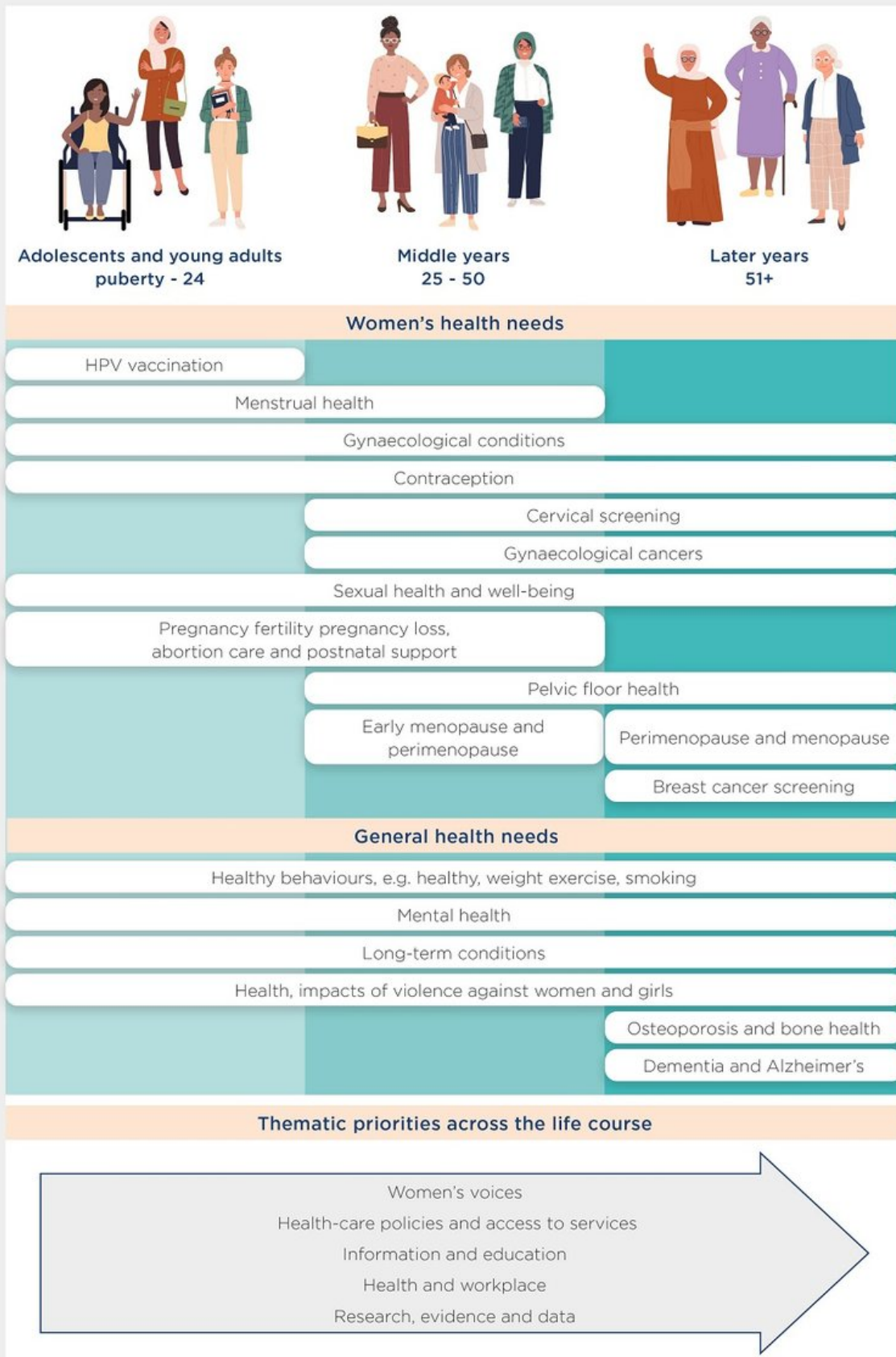


Figure 6 Women's health across the life course (Department of Health 2022).

4.2.20 The UK Menopause Taskforce has considered the existing evidence base on menopause and identified gaps in the research about its impacts. The Taskforce has stated that:

'[The] government must fund and commission more research into:

- the benefits of HRT in different use cases and its long-term health benefits;
- the link between menopause and health conditions including mental health illness such as depression and psychosis.'

4.2.21 Within menopause care, NHS England and NHS Improvement has established a 'Menopause Pathway Improvement Programme'. This programme is developing decision-support tools to help women better understand their symptoms and to inform discussions with healthcare professionals. Specific to mental health, experts told the investigation that there is a need for a menopause pathway that ensures women's physical and mental needs are met.

Incorporating menopause into mental health care

4.2.22 The investigation considered how an increased understanding of the potential mental health impacts of perimenopause and menopause could be encouraged among mental health professionals.

4.2.23 National experts in risk in mental health told the investigation that there is a need for joint training between staff concerned with physical health (such as menopause specialist nurses) and those who mainly deal with mental health. This would help to ensure that patients receive holistic assessments that take into account physical conditions that can impact on mental health. An expert told the investigation that even holding joint discussions between organisations responsible for mental health and women's physical health would help to develop collaborative ways of working and thinking about how best to increase awareness and share knowledge across the different fields.

4.2.24 To identify the training and other potential resources that are required, the investigation considers that intercollegiate working between mental health leaders and physical health leaders would be beneficial.

HSIB makes the following safety recommendation

Safety recommendation R/2023/223:

HSIB recommends that the Royal College of Psychiatrists forms a working group with relevant stakeholders to identify ways in which menopause can be considered during mental health assessments.

4.3 The first episode of psychosis pathway

The reference investigation

4.3.1 Ms A experienced a first episode of psychosis at the age of 56 years. Ms A was diagnosed with psychotic depression during her first inpatient stay in September 2019. Based on her symptoms, she met the criteria for a referral to the Early Intervention in Psychosis (EIP) pathway.

4.3.2 Trust managers told the investigation that all patients who are given a ‘first episode of psychosis’ diagnosis should be referred to the EIP. The assessment team should then decide whether that person meets the criteria for the EIP and should be managed on that pathway.

4.3.3 Ms A’s consultant psychiatrist told the investigation that they understood that Ms A was eligible for referral to the EIP services. However, the professionals involved in Ms A’s care considered that she would benefit from consistency in her care and therefore made the decision to continue to manage her within the CMHT, with regular visits from her care coordinator.

4.3.4 Staff acknowledged that this decision was not in line with Trust or national guidance, but considered it to be appropriate in Ms A’s case. They felt that her care would be best managed through one-to-one care coordination and access to group programmes.

4.3.5 NICE’s guideline on psychosis and schizophrenia in adults recommends that:

“individual CBT should be offered to people at risk of developing schizophrenia or psychosis, during first and subsequent acute episodes and during the recovery period for people with persisting positive and negative symptoms.”

(National Institute for Health and Care Excellence, 2014)

4.3.6 Ms A's family told the investigation that they believe Ms A's age impacted on the decision not to refer her to the EIP and feel that if she had been younger, she may have received a referral to the service.

4.3.7 Staff told the investigation that there were no issues with access to the EIP service and that they would have referred Ms A to the service if they felt she needed its input. They said that had they made the referral, Ms A would have received support within the 2 week timeframe proposed by national guidance. However, they felt that her care was not impacted by remaining within the CMHT.

4.3.8 Staff recognised that people of Ms A's age are quite uncommon in the EIP. Staff felt this reflected the age at which people commonly receive a first diagnosis of psychosis – in their late teens and early twenties.

The national investigation

4.3.9 The time from onset of psychosis to providing evidence-based treatment has a significant influence on long-term outcomes and recovery. The sooner people are able to access evidence-based treatment, the better the outcomes they achieve (NHS England, n.d.).

4.3.10 Figure 7 shows the number of people entering treatment on the EIP pathway between November 2019 and July 2022 (dark blue line). The light blue line shows how many people entered treatment within 2 weeks of referral to the programme. If it had been deemed necessary then Ms A would have been referred onto the EIP pathway in October/November 2019. At this point 3,539 people entered treatment on the EIP, with 2,582 receiving treatment within 2 weeks.

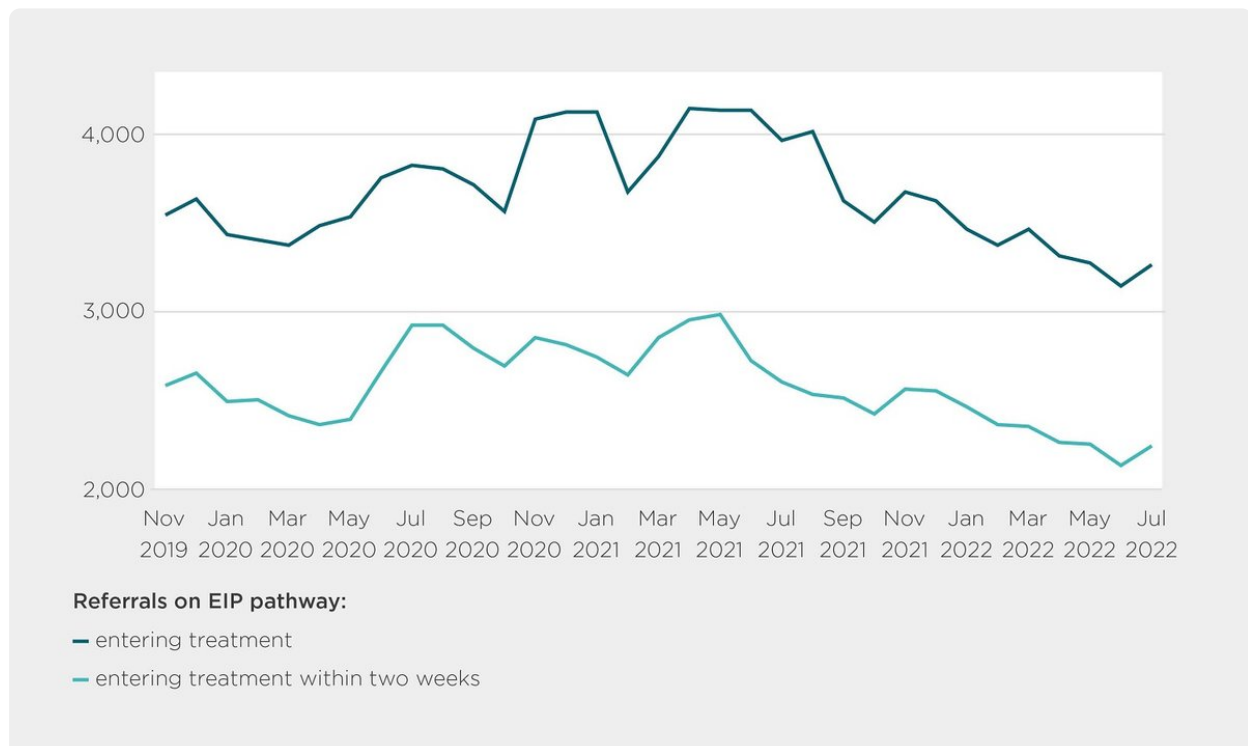


Figure 7 Number of people entering treatment on the EIP pathway between November 2019 and July 2022 (NHS Digital).

4.3.11 The investigation asked clinicians whether age and sex influence their decision as to whether to refer patients to the EIP pathway. Clinicians agreed that most referrals are for people in their teens and twenties, and that someone of Ms A’s age would have been unusual on the EIP. However, they said that if it was deemed to be a first episode of psychosis and the person was under 65 years and met the criteria for referral, then they would make the referral.

4.3.12 One expert told the investigation that the care of a middle-aged woman such as Ms A demonstrates the potential benefit of having women-specific healthcare services and that pathways for mental health treatments are designed with age and sex in mind. Another expert told the investigation that Ms A’s case serves as a reminder for practitioners to look out for psychosis when assessing middle-aged and older people. He told the investigation that clinicians are not always alert to the possibility of a first episode of psychosis when assessing people in these age groups, and are not always aware of the need for them to be managed within specialist services designed for treating first episodes.

4.3.13 Mental health experts told the investigation that mental health care should be delivered according to the intensity required, with an ability to scale management up and down as required. They said that care pathways should be flexible and take into account factors such as the patient’s age.

4.3.14 A UK-based study published in 2017 found that at entry to early intervention services, male patients presented with more violent behaviour and female patients had more suicide attempts (Tseliou et al, 2017). Following 1 year of care by early intervention services, men still presented as more violent towards others, whereas women were more likely to have been admitted to a psychiatric ward. The study concluded that to improve equity in outcomes, early intervention services should place greater focus on the specific needs of each sex in detecting and intervening for their mental health needs.

4.3.15 The investigation did not find knowledge gaps with respect to how to refer onto the EIP pathway or in identifying who should be referred onto the pathway. While there can be a wait of more than 2 weeks for patients to start treatment, clinicians did not describe this as a barrier to referral.

4.3.16 The investigation was told that some trusts still concentrate on delivering a service to those aged 14–35 years, which was the focus of the EIP pathway before new guidance was introduced in 2016 (NHS England, the National Collaborating Centre for Mental Health and the National Institute for Health and Care Excellence, 2016). Some trusts continue to prioritise younger patients for a variety of reasons – including funding, capacity and misconceptions about whether an older person can actually be experiencing a true first episode of psychosis in later life. The investigation asked managers in the trust where Ms A was cared for why the guidance may not be being followed, they told the investigation that it was purely based on historic behaviour, and that there is no pressure to not deliver a service in line with the latest guidance.

HSIB makes the following safety observation

Safety observation O/2023/211:

It may be beneficial for mental health organisations to ensure their Early Intervention in Psychosis referral process is in line with the national guidance, and that staff are clear about the upper age limit of patients accepted onto the pathway.

5 Summary of findings, safety recommendations, safety observations and safety action

5.1 Findings

- While national guidance says that a patient's risk of harm should not be stratified into categories such as high, medium or low, such stratification remains common in many trusts. This is because other methods of assessing and documenting risk are not available, and because staff fear being blamed if a patient comes to harm without a risk assessment, including risk stratification, having been completed.
- Current research only demonstrates a link between menopause and low mood, and not between menopause and more severe mental health symptoms.
- Women are frequently prescribed antidepressant medication when hormone replacement therapy may be a more appropriate treatment for their symptoms.
- Menopause is not routinely considered as a contributing factor in women with low mood who are assessed by mental health services, and staff do not receive training in this area as standard.
- While there is a significant amount of national guidance relating to family engagement when treating patients with mental health conditions, mental health practitioners often find it difficult to know how and when to engage with families with complicated relationships or when the patient withdraws their consent for information sharing. There is a lack of training in this area to support staff with decision making.
- National guidance raised the upper age limit for referral to the Early Intervention in Psychosis pathway in 2016. Some trusts continue to prioritise younger patients for a variety of reasons – including funding, capacity and misconceptions about whether an older person can actually be experiencing a true first episode of psychosis in later life.

5.2 Safety recommendations, safety observations and safety action

Safety recommendation R/2023/220:

HSIB recommends that NHS England works with appropriate stakeholders, including experts with appropriate experience, to create guidance on culture change. A quality improvement programme should also be developed to

support practitioners in undertaking psychosocial assessments that are in line with guidance from the National Institute for Health and Care Excellence. Person-centred safety planning should be embedded within the process.

Safety recommendation R/2023/221:

HSIB recommends that the Care Quality Commission evaluates the way in which it reviews how community mental health services assess risk of harm, to ensure its inspections are in line with the latest national guidance.

Safety recommendation R/2023/222:

HSIB recommends that the National Institute for Health and Care Excellence evaluates the available research relating to the risks associated with menopause on mental health and if appropriate, updates existing guidance.

Safety recommendation R/2023/223:

HSIB recommends that the Royal College of Psychiatrists forms a working group with relevant stakeholders to identify ways in which menopause can be considered during mental health assessments.

HSIB makes the following safety observations

Safety observation O/2023/208:

It may be beneficial for mental health organisations to have a dedicated liaison officer who acts as a point of contact for both families and clinicians when navigating involvement in a patient's care and decision making.

Safety observation O/2023/209:

It may be beneficial for organisations to involve families in care planning and assessments, and that practitioners are appropriately trained in working with families.

Safety observation O/2023/210:

It may be beneficial for education bodies to develop training programmes in safety planning and psychosocial assessments, once NHS England has provided guidance on how such assessments should be conducted.

Safety observation O/2023/211:

It may be beneficial for mental health organisations to ensure their Early Intervention in Psychosis referral process is in line with the national guidance, and that staff are clear about the upper age limit of patients accepted onto the pathway.

HSIB notes the following safety action

Safety action A/2023/058:

NHS England has written to all mental health trusts in England to highlight the importance of taking a person-centred approach to psychosocial assessments and safety planning. The communication asks trusts to move away from risk assessment tools that stratify an individual's risk of suicide or self-harm.

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