MK Together Review Board
Safeguarding Adults
Thematic Review

Mental health care for adults in crisis in Milton Keynes

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Introduction

1. Understanding and interpreting the vulnerabilities and risk factors of suicidality is one of the most complex and uncertain areas for all professionals working in mental health services as well as for other colleagues working in agencies where they need to understand when to intervene, refer to other services and to admit or to safely discharge patients from A&E or acute mental health services. When a patient dies by suicide this impacts mental health professionals as well as the individual's family and friends. We know that just over 50% of the people who died by suicide in Milton Keynes during 2018[1] had contact with mental health services and there are strong links between suicide and some mental health conditions. Other professionals who also come into contact with vulnerable adults, look to the acute mental health services to provide expertise in this the most challenging of work with individuals in distress.

2. This report presents the findings of a thematic review into suicide and mental health commissioned by the MK Together Review Board. The review was undertaken by Jane Shepherd, Maddocks Associates between February and December 2021. The MK Together Review Board identified 10 individuals who had some contact with the local mental health services and who had died by probable suicide. Clinicians, professionals and managers at CNWL (Central and North West London NHS Foundation Trust), Milton Keynes University Hospital Foundation Trust (MKUHFT) Thames Valley Police (TVP) and Adult Social Care were interviewed and contributed to the review.

3. The review aimed to identify patterns and themes and to learn lessons from the unexpected deaths so that future suicide prevention planning is improved, patient safety is enhanced and identified gaps in provision that could underpin future commissioning intentions.

4. Ten individuals were identified by the Review Board, six male and four female, aged between 20 and 58 years, nine of whom died during the sixteen months between May 2019 and September 2020. One individual died in 2018. This covered both pre-

[1] Milton Keynes Suicide Audit Summary

pandemic and the early lockdown Covid-19 period when the services were severely disrupted. It allows a comparison to be made and to potentially identify improvements to systems as well as areas of weakness.

5. Although the thematic review is about suicide and mental health, the length of time the individuals were in contact with the acute mental health teams varied and for some individuals, the point of entry to mental health services was via primary care, others were known to the mental health services and for some, their mental health was stable and they were well supported at the time of their death. The pathways between the acute mental health services and other services including A&E, primary care and drug and alcohol services are crucial for the safe management of patients experiencing a crisis where there are multiple risk factors.

   The first period of the national lockdown caused by the coronavirus pandemic which began in March 2020 was an unprecedented time when the acute hospitals were under enormous pressure to clear hospital beds because of the public health emergency, particularly in the early phase of the pandemic and before the vaccines were developed. Additionally, those using services were impacted in different ways by the closure of many of the community services and a shift away from face-to-face work to online and telephone contact. For some individuals, the risk factors increased because they became unemployed or homeless because of coronavirus restrictions.

6. The review highlights the need to work together across agencies, to implement system-wide improvements. Individuals often repeatedly sought help across different health settings, as well as adult social care, housing and the department for work and pensions (DWP). The police's role in the death of the individual was to assist the coroner when there had been an unexplained death. However, the police also regularly transport people in distress to the designated health-based place of safety (HBPoS) which in Milton Keynes is The Campbell Centre, which has one S136 suite and the review has considered the unique perspective of Thames Valley Police (TVP).

7. Suicide prevention is challenging and complex and because it is a potentially preventable cause of death, it causes staff distress and can trigger a range of emotions. This review must be considered as a learning exercise by professionals, practitioners and managers and not a criticism of the professionals working in the services.

Scope of the review

8. The thematic review was a two-part exercise. The first part was a desktop exercise to consider the emerging themes. Agencies were asked to complete a report about each of the 10 individuals. The second part of the review was to consult with the statutory agencies. This was via a series of interviews which were followed up by specific questions. The voluntary and non-statutory organisations and their role in suicide prevention, whilst important were outside the scope of the review.

9. The review considered the following areas:

- Information sharing
- Understanding of what is possible and what is not possible within individual agencies
- Collective responses to individuals presenting as a suicide risk
- The boundaries set by the application of thresholds and different legal requirements
- Any barriers to joint working and how services are managed
- Links and gaps within the system
- How the picture of risk is built and reviewed by agencies
- Whether there are messages to inform future commissioning intentions
- Discharge planning where the person has been admitted to the Campbell Centre or MKUHFT (Milton Keynes University Hospital Foundation Trust)
- Support that is available for families who have concerns that their loved ones are at risk of suicide but are not engaging with services.

Methodology

10. MK Together Review Board selected 10 individuals to be included in the thematic review. The reviewer was provided with basic details of the individuals and this was followed up with a request to the agencies to provide a report giving information, including details about marital status, employment status, job or financial loss, housing status, homelessness, substance misuse, recent bereavement, access to lethal means, lack of social support/isolation, cultural and or religious beliefs, previous suicide attempt, family history of suicide, domestic violence, major physical illness, pain, chronic conditions, mental disorder, mood disorder - depression, schizophrenia, anxiety disorder and personality disorder. These are the areas that we know from research form the static and dynamic risk factors for suicide.

Static and stable risk factors for suicide	Dynamic risk factors for suicide
History of self-harm	Suicidal ideation, communication and intent
Seriousness of previous suicidality	Hopelessness
Previous hospitalisation	Active psychological symptoms
History of mental disorder	Treatment adherence
History of substance use disorder	Substance use
Personality disorder/traits	Psychiatric admission and discharge
Childhood adversity	Psychosocial stress
Family history of suicide	Problem-solving deficits
Age	
Gender	
Marital status	

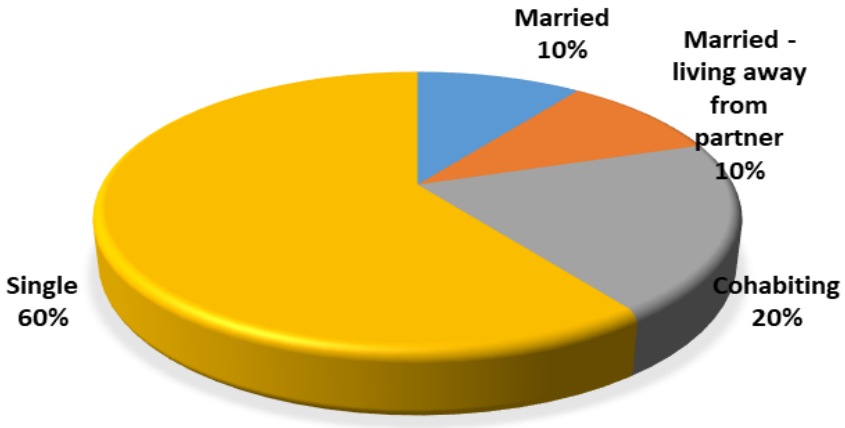
[2]Ref: Bouch and Marshall Suicide risk: Cambridge University Press: 02 January 2018

11. The review began by looking at the circumstances of the lives of the 10 individuals using the basic information provided.

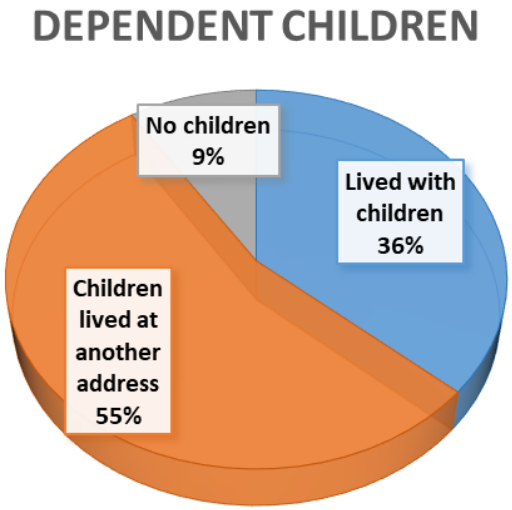
[2] Bouch, J Marshall, J. Suicide risk: structured professional judgement Published online by Cambridge University Press: 02 January 2018

Findings

Marital status



12. Marriage is a known protective factor[3] and of the 10 individuals, although only two were married, one of those was living alone. Two of the 10 were cohabiting, but one of them was in the process of trying to leave a partner, but as the flat was in the partner's name, this made her housing insecure. Six of the individuals were single, but five of them had children who were living elsewhere. Having dependent children living in the same household is a known protective factor and separation from dependent children is a known risk factor. As well as the stress of being separated from children, there is often added tension during divorce and separation as well as potential problems with contact arrangements and hostility during Family Court proceedings.



[3] Smith, J.C 1, Mercy, J A. Conn J M; Marital status and the risk of suicide; Am J Public Health. 1988

Employment status

	Employment status
1	Employed -– bricklayer construction industry – had been unemployed but started a new job on the day of death
2	Employed
3	Unemployed – worked in construction industry
4	Employed – Scrap metal dealer
5	Employed – bricklayer in the construction industry
6	Unemployed – Made redundant and lost her accommodation which was provided through her job.
7	Unemployed – Had never worked
8	Employed - Multiple occupations leafletting, pizza delivery, painter and decorator – worked in construction – Well educated and 'under-employed' in the UK
9	Unemployed – left work as a nurse due to physical illness
10	Unemployed

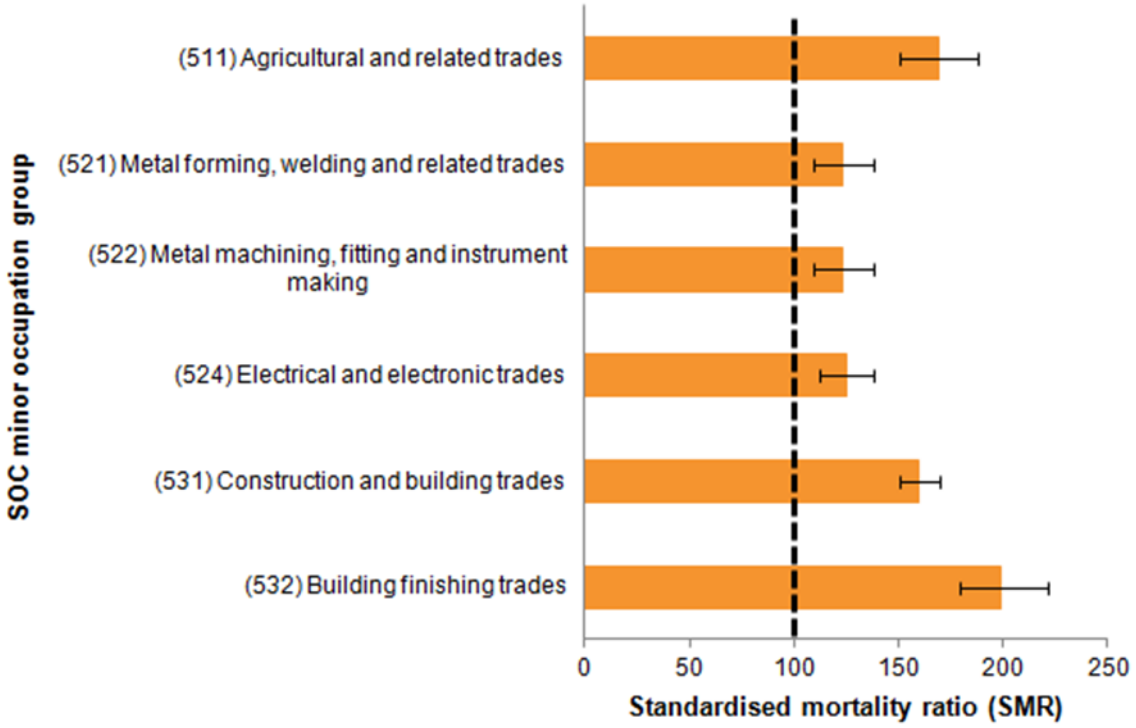
13. Five of the individuals were employed and five unemployed but further analysis showed that employment insecurity was a feature for seven of the individuals at the time of their death. One of the unexpected findings of the review was that four of the 10 individuals had worked in the construction industry.

14. Milner et al[4] in a systematic review of the studies into unemployment and suicide found that the highest rate of suicide was among the lowest skilled occupations (e.g., construction workers) and the lowest rate among the second most skilled occupations (e.g., technicians). The suicide rate amongst construction workers is significantly higher than the national average. Between 2011-2015, ONS figures show that there were 13,232 suicides by working people. 13.2% of those were construction workers despite construction accounting for only 7% of the workforce. Of the skilled trade occupations, 6 have an increased risk of suicide. The largest elevated risk was among building finishing trades (twice the national average). This is largely due to the high risk of suicide among plasterers, painters and decorators. This is a predominantly male workforce, there is often a 'male culture' of the 'tough guy'. But the work is often insecure with many skilled traders being self-employed and job insecurity increases as contracts come to an end. The work often involves travelling long distances to work and being away

[4] Milner A, Page A, LaMontagne AD (2013) Long-Term Unemployment and Suicide: A Systematic Review and Meta-Analysis. PLoS ONE 8(1): e51333.doi:10.1371/journal.pone.0051333

from family. Where individuals stay in caravans or other poor-quality accommodation close to fellow workers, there is often a 'drinking and smoking culture.'

Source ONS: Male suicides among skilled trade occupations, deaths registered in England, 2011 to 2015



Housing status/homelessness

	Housing status/homelessness
1	Insecure housing – Living with partner and child at parent's house
2	Insecure housing status – lived with an ex-partner in a one bedroomed flat. Trying to save for a deposit on a flat to move out.
3	Insecure housing status – Living with mother
4	Secure housing status
5	Secure housing status
6	Insecure housing – recently made homeless and placed in temporary accommodation, shown as no further action on the police records
7	Insecure housing – house but plan to move him from council property as his flat had been cuckooed by predatory drug dealers
8	Insecure housing status – Privately rented accommodation but landlord actively seeking to evict.
9	Secure housing status
10	Secure housing status – Local authority tenant

15. Homelessness or insecure housing is a known risk factor and six of the ten individuals had insecure housing or were homeless or at risk of becoming homeless. Links between the mental health professionals and the housing services and/or Citizen's Advice Bureau (CAB) were highlighted in the agency reports as being essential to secure emergency accommodation or prevent eviction.

Substance misuse

	Substance misuse
1	Alcohol, cocaine – Not recent use
2	No drug or alcohol issues
3	Alcohol and other substance use. History of ketamine addiction used cannabis, ecstasy, LSD, cocaine and amphetamine from ages 11 to 18. Relapsed at time of death but refused engagement with drug and alcohol services.
4	Binge alcohol in the past.
5	No drug or alcohol issues

6	Described self as alcohol binge drinker – Refused intervention from alcohol services
7	A long history of drug and alcohol misuse. Using at the time of death. Had been under the care of drug and alcohol services in the past.
8	No drug or alcohol issues
9	No drug and alcohol issues
10	Moderate alcohol. No drugs

16. Substance misuse can be seen as a spectrum with two of the individuals experiencing problematic use of drugs and alcohol which was a significant risk factor. One individual was fleeing predatory drug dealers who had taken over their property and another was a long-term drug and alcohol user who had been in rehabilitation and relapsed several times. Two individuals described themselves as 'binge drinkers'.

17. Pompili et al[5] found that alcohol abuse may lead to suicidality through disinhibition, impulsiveness and impaired judgment, but it may also be used as a means to ease the distress associated with completing an act of suicide.

18. In a cross-sectional before-and-after observational study While et al[6] found that although many risk factors for suicide in the general population also apply to individuals addicted to drugs, suicide is closely linked to substance use. Whilst the suicide rate in the general population is decreasing, certain sub-groups remain at heightened risk, including people with substance misuse and dependence problems

[5] Suicidal Behavior and Alcohol Abuse Maurizio Pompili,1,2,* Gianluca Serafini,1 Marco Innamorati,1 Giovanni Dominici,1 Stefano Ferracuti,1 Giorgio D. Kotzalidis,1 Giulia Serra,1 Paolo Girardi,1 Luigi Janiri,3 Roberto Tatarelli,1 Leo Sher,4 and David Lester5 Int J Environ Res Public Health. 2010 Apr; 7(4): 1392–1431. Published online 2010 Mar 29. doi: 10.3390/ijerph7041392

[6] While D, Bickley H, Roscoe A, Windfuhr K, Rahman S, Shaw J, et al. Implementation of mental health service recommendations in England and Wales and suicide rates, 1997-2006: a cross sectional and before-and-after observational study. The Lancet,2012;379: 1005-12.

Self-harm / Previous suicide attempt

19. Research[7] shows that one of the most common risk factors identified is a history of self-harm and previous suicide attempts, which is present in approximately 40% of completed suicides.

20. From the ten individuals identified for this thematic review, eight of the 10 individuals had made a previous suicide attempt. One person had a lengthy history of multiple suicide attempts, five had made several attempts and one individual had described an accidental overdose. Two individuals had attempted suicide in the weeks before their death and another person had attempted suicide 5 years earlier. The incidence is likely to be higher amongst the individuals selected because all were service users known to the NHS Mental Health Services in Milton Keynes and did not rely on self-reporting but records of previous admissions. Nevertheless, this is a significant finding and gives a strong indication of the need for all professionals completing risk assessments to ask about previous attempts and record this information accurately and share the information across the services to build the picture of risk.

21. In a thematic review[8] of 12 studies looking at four factors (previous episodes of self-harm, suicidal intent, poor physical health and male gender) are associated with a higher risk of dying by suicide, in each of these studies, at least 32% of people had a prior history of self-harm before the index episode.

Family history of suicide

22. One of the ten individuals had a family member who had died by suicide and that was a cousin who had died some years before. This did not appear to be a significant finding amongst the ten individuals in the review.

[7] Cooper J, Kapur N, Webb R, Lawlor M, Guthrie E, Mackway-Jones K, Appleby L. (2005) Suicide after deliberate self-harm: a 4-year cohort study. American Journal of Psychiatry, 162(2), 297-303.

[8] Predicting suicide following self-harm: A systematic review of risk factors and risk scales Chan, M.K.Y., Bhatti, H., Meader, N., Stockton, S., Evans, J., O'Connor, R.C., Kapur, N., & Kendall, T.

Mental health

23. The most frequent psychiatric illnesses associated with suicide or severe suicide attempt are mood and psychotic disorders. The literature associated with suicidal behaviour often links poor mental health, in particular depression and emotionally unstable personality disorder (EUPD). The ten individuals included in the thematic review had all been in contact with the NHS Mental Health Services in Milton Keynes. The review did not include individuals whose death occurred in other high-risk settings e.g prisons, or individuals whose contact was solely within a primary care setting. It is, therefore, to be expected that the ten individuals were likely to have a mental health diagnosis. Other agencies will also have contact with individuals who are high risk and may have undiagnosed conditions but present across multiple agencies.

24. The level of contact with the acute mental health services varied amongst the ten people and some individuals were also seen by other services, e.g. A&E, substance misuse services and primary health care settings. Six of the 10 individuals were not known to Adult Social Care. However, further discussions with the Approved Mental Health Professionals (AMHP) Service which is run by Adult Social Care and the staff working in it are MKC employees showed that some individuals were known to this service or through multi-agency safeguarding arrangements or other social work contacts, *eg* known to children's social care.

25. Two of the ten individuals had a diagnosis of emotionally unstable personality disorder (EUPD) and another individual had a diagnosis of a personality disorder but this was not specified. In research[9] conducted in the USA on patients with EUPD (Formerly classified as a borderline personality disorder (BPD)), it was found that up to 10% of BPD/EUPD patients will die by suicide. The study concludes that there is no research data to support the effectiveness of suicide prevention in this disorder. The most evidence-based treatment methods for BPD/EUPD are specifically designed psychotherapies.

[9] Suicidality in Borderline Personality Disorder; Paris, J. Published online 2019 May 28. doi: 10.3390/medicina55060223

Involvement of families

26. The involvement of families can be challenging, particularly when an individual has mental capacity and states that they do not want their family to be given information about their health or to be involved in their discharge planning. Thames Valley Police (TVP) have a unique perspective on family involvement because of their role in assisting the coroner after an unexplained death and liaising with the families of the bereaved.

27. In the agency reports, TVP has recorded feedback from some family members that makes for uncomfortable reading. One of the excerpts comes from a family who had been trying to get help from the acute mental health team:

> "I had been calling and calling for help."
>
> "I felt they expected us to know what to do and that we had taken some of the burden off (the professional) when at the end of the day we called them for help."

28. In qualitative research with families of people who died by suicide, Owens[10] found that the proximity to the distressed person and emotional investment in the relationship, together with a range of other factors, often prevented them from seeing, saying, and doing anything at all. The lesson from this research is that family members should be listened to when they approach services for help with a member of the family they are concerned about. In the second stage of the research in the follow up with agencies, a 'Think Family' approach was being developed and utilised from admission. CNWL has been promoting Think Family for the past two years and a launch event was held on 10 March 2020 when family members spoke to the 100+ attendees.

29. It is clear that there are times when families are either estranged, or there is domestic abuse or discordant family relationships that may intensify a crisis:

> "Mother reported that she had returned home and her son was behaving erratically. She removed what she believed to be cocaine from him. He started to tear the house apart. He declined to attend hospital or see a mental health nurse."

[10] C Owens. Recognising and responding to suicidal crisis within family and social networks: qualitative study BMJ 2011; 343 doi: https://doi.org/10.1136/bmj.d5801 (Published 18 October 2011)

'Police National Database indicated that she was known to another police force and that there had been an altercation between the individual and her parents.'

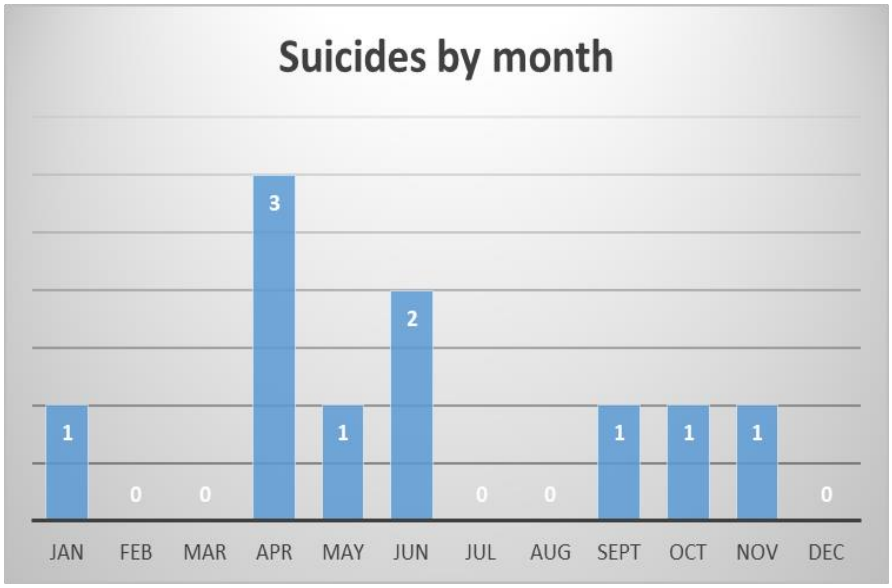
30. TVP in their investigation following a probable suicide reported that the family were alerted to early warning signs.

'Had contact with family members when in difficulty – would tell the family when feeling depressed.'

31. Relatives, friends and colleagues may be the first people to know that an individual is distressed, and the burden of care can be entirely with them until an individual is persuaded to consult a doctor. When families contact staff in agencies it is important to record their concerns to build a picture of risk. It is possible to do this without divulging personal information about the individual by careful listening.

32. Family therapists have a specific role and can assist individuals to decrease destructive family interaction and deal with anxiety during contact with family members. As part of the follow-up stage, the consultants informed that they used to have a family therapist as a member of the multi-disciplinary team who brought a useful different professional perspective.

Suicides by month



33. Research[11] has consistently shown that there is a high incidence of suicide in spring and also a low incidence in winter of suicide rates. Six of the ten individuals died during April, May and June.

Method of suicide

34. The method of suicide from the 10 individuals is worth noting as it is in line with national findings. Four of the individuals died by hanging. Two died on the railway. One person set fire to themselves. One individual died from an overdose. One person cut their throat and another died from hypovolemic shock from bleeding from a wrist laceration.

Access to lethal means

35. This information was most reliably taken from TVP who have a role in investigating the cause of death. They recorded that five of the individuals had access to their own prescribed medication. Two had knives, one person had concealed razor blades, one had an accelerant - fuel and another had a ligature. The finding that half had prescribed medication is significant and it is important that in suicide prevention planning thought is given to safe prescribing practices. NICE Guidance[12] highlights the importance of restricting the availability of medicines for purchase, prescription and in the home, reducing stockpiling and carrying out medication reviews.

Agency input to the review

The role of the Police

36. TVP have a role in suicide prevention that includes:

- Protecting the public and individuals when they are in crisis

[11] Bridges, F. S.; Yip, P. S. F.; Yang, K. C. T. (2005). "Seasonal changes in suicide in the United States, 1971 to 2000". Perceptual and Motor Skills. 100 (3 suppl): 920–924. doi:10.2466/pms.100.3c.920-924. PMID 16158678. S2CID 26835398.

[12] Suicide prevention: optimising medicines and reducing access to medicines as a means of suicide Key therapeutic topic Published: 1 March 2019 www.nice.org.uk/guidance/ktt24

- Investigating sudden and unexplained deaths and assisting the coroner with inquiries
- Arresting individuals involved in suspected crime – criminal activity is a recognised social risk factor for suicide

37. TVP attend a monthly Criminal Justice and Mental Health Panel meeting chaired by a TVP Sergeant. This includes representatives from the mental health services and TVP evidential review officers. The panel began in March 2021 and considers the criminal justice process as it affects mentally unwell individuals.

38. The police have a crucial role in keeping individuals safe and can use S136 of the Mental Health Act 1983 (MHA) to transport a person to a place of safety. In Milton Keynes, the designated HBPoS is The Campbell Centre, which has one S136 suite. Doctors approved under Section 12 of the MHA and AMHPs then decide whether an individual is to be detained under Section 2 of the MHA following assessment. There are occasions when a person has been held by the police under S136, released following assessment by the mental health professionals and then held again shortly afterwards by police under the same powers. The police recognise that they do not have the necessary knowledge and expertise of the mental health professionals. Sometimes there is a repeat of an S136 MHA holding power being used if an individual appears to be at risk of suicide and cannot be left to manage the risk in isolation. The individual may be safe in a hospital or other supportive setting, but would not be safe alone in a crisis.

39. The Thames Valley Police area includes Berkshire, Oxfordshire and the Buckinghamshire South Central Ambulance Service (SCAS) footprint. The response provided by TVP was informative as there is work at a strategic level across other parts of the region. System transformation in other areas includes improving the Mental Health Street Triage scheme to include access to clinical as well as amental health and police resources. In other parts of the region more appropriate transportation is available to individuals in a crisis, providing access to trusted mental health professionals to triage and signpost individuals when they call the 999 ambulance service or NHS 111.

40. Discussions with professionals during the review generally agreed that having a mental health professional available to triage patients using the ambulance service at weekends should be extended through the week as this had greatly improved the emergency responder's ability to manage risk in the community placing less strain on A&E. The plan is to expand the service from 20 hours to 24 hours.

Discussions with other agencies

Information sharing

41. Each of the agencies was asked to respond to how information sharing works between other agencies as well as within their organisation.

TVP gave examples:

- With one person on three occasions, S136 powers were used to detain the individual but they were discharged by the mental health service.
- There was a failure to share information as agreed between MASH and the local authority on one occasion.
- An Individual had been seen whilst expressing suicidal ideation in a situation that raised adult protection concerns – no information was shared.
- TVP used S136 powers – a decision was taken not to make any referral as the individual was already in the care of medical service. This practice has now been tightened.
- An individual came to the attention of the police but not in the context of suicide ideation. This concerned being cuckooed and the tenancy was taken over by a known drug dealer.

42. Central and North West London Foundation Trust (CNWL) gave several examples:

- All information is entered onto a central IT system and there is generally a good flow of information across the trust services.

- In one case, it was noted that they should have considered referring to housing services or Citizen's Advice Service but didn't.
- An individual who had not been seen by the mental health service for 18 months before his death attended A&E and after dressing his wounds was discharged before seeing the liaison service. Staff reviewed his notes and referred him to his GP rather than any other service.
- There was a failure to inform housing of imminent eviction and homelessness.
- One individual with a long history of suicide ideation where staff could see detailed notes from the two previous areas where she had lived was an example of information sharing working well.
- A person was under the care of the drug and alcohol service but there was no joint information sharing or planning between the drug and alcohol services and the mental health teams. This has now been rectified as the provider is managed by CNWL and uses the same IT system.
- There was a lack of information sharing between CNWL and MKUHFT because they were using different electronic systems in one case. It was also noted that the serious incident investigation review into this individual's death had noted that there were communication issues between CNWL services and that teams seemed to work in isolation.
- The police and CNWL set up a street triage service and information is now shared between these services.

43. Adult Social Care recorded that in one case there was a lack of communication around discharge planning and there were concerns about the lack of a person-centred approach.

44. MKUHFT recorded the practical steps for each individual and their mental health hospital liaison (this is a CNWL provision) with other services, including GPs, COMPASS, the previous drug and alcohol service, referrals to a voluntary organisation, Live Life.

45. In the lessons learned from the serious incident investigation reports[13], better communication between the teams so that coordinated care could be provided and a need for better communication with the family was highlighted.

Collective responses to individuals presenting as a suicide risk

46. The agencies were asked to give a view about the collective response to individuals in crisis and presenting as a risk of suicide.

47. TVP reported that the mental health triage service was not available on one occasion and the police had to make a unilateral decision to use their powers under S136. In another case, the triage stated that nothing could be done because the patient was open to the Home Treatment Team prompting officers to use S136 powers after taking supervisory advice.

48. CNWL gave a detailed response to each individual case, and it is apparent that the services have referral pathways via A&E or GP referral and on discharge to the acute home treatment team (AHTT) and back to primary care.

- One individual was referred to Improving Access to Psychological Therapies (IAPT) as the individual's presentation was too severe for the service. An individual was given access to the crisis line and the mental health liaison team until the Mental Health Act assessment was completed.
- It was noted that one person presented in A&E and was later referred to the mental health services urgent care team. He was transferred back to the primary care team and did not attend an appointment. He died before another appointment had been arranged. This showed that for some patients, signposting and moving between services can have a negative impact. It may lead to a sense of not being listened to and valued and increase a sense of hopelessness.

[13] Serious Incident Investigation reports The Serious Incident framework describes the process and procedures to help ensure serious incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again. https://www.england.nhs.uk/patient-safety/serious-incident-framework/

- For one individual there was no indication that he had any suicidal ideation. This was a suicide no one could have predicted as there were no risks flagged.
- One individual needed to be housed but although the ward staff contacted housing, she was discharged with a contact telephone number and told to inform housing that she was homeless after her discharge. This was noted as poor practice in the reports.
- An individual presented at A&E and although the doctor called the mental health service for advice about the patient's mental health, because of concerns that the person may have been Covid-19 positive, he was sent home by A&E and told to self-isolate and then to refer himself to COMPASS – the drug and alcohol service. Although the MKUHFT services were stretched and coronavirus was making it dangerous for patients to remain in hospital if they could return home, good practice would have been to follow up and to ensure the individual made a referral or do it on their behalf with their consent.
- For another individual there was a pattern of use of S136 as a result of her presentation, followed by a MHA assessment, formal or informal admission and discharge to the care of the Acute Home Treatment Team.

49. MKUHFT recorded their collective responses to a number of the individuals in the review.

- One individual was discharged from the hospital and the doctor spoke to the patient and his son and they agreed that the patient would follow up with the GP and engage with support services. It transpired he was not registered with a GP.
- A second individual was not registered with a GP.
- Another individual did not have a risk assessment.

50. Adult Social Care had contact with only four of the 10 individuals.

- One individual was known to ASC because he was referred as he was being cuckooed and he was in the process of being re-housed.

The boundaries set by the application of thresholds and different legal requirements

51. TVP recorded that the appropriate use of S136 was used three times with one individual and within 24 hours the person was assessed under the Mental Health Act and deemed to have capacity and discharged which led to further detention under S136.

52. CNWL gave several examples of the boundaries set and different legal requirements.

- A patient was admitted informally but when he stated he wanted to leave he was asked by the doctor to wait until after an assessment had been completed. The report finds that consideration should be given to the use of Sec 5.2 MHA[14].
- Another patient was placed on Sec 5.2 MHA. The staff were unable to make contact with the nearest relative to seek their views. It is unclear whether a MHA assessment was started.
- One individual would have benefitted from a Care Act Assessment as she was a vulnerable adult. This did not happen.
- CNWL agreed with TVP that for one individual the use of S136 was appropriate although the mental health professionals did not detain under the Mental Health Act 1983.

53. MKUHFT also noted the same issues relating to the individuals who were detained by TVP under S136 and later discharged.

54. Adult Social Care did not note any issues but one of the improvements to the services has been the closer working relationship with MKUHFT on discharge from hospital where an individual meets the threshold for a Care Act assessment. This is prioritised and an assessment is completed urgently and preferably before discharge.

[14] Section 5(2) gives doctors the ability to detain someone in hospital for up to 72 hours, during which time you should receive an assessment that decides if further detention under the Mental Health Act is necessary. Section 5(3) of the Act allows this identified doctor or approved clinician to nominate a deputy to exercise the holding power in their absence

Any barriers to joint working and how services are managed

55. TVP reported that on one occasion there was no ambulance available to transport an individual to the place of safety; the designated HBPoS is The Campbell Centre, which has one S136 suite and so the officers transported her there in a police vehicle. This was likely to cause the person more distress and is inappropriate where someone is suffering in a mental health crisis.

56. Another individual when being detained under S136 was taken outside the TVP area to Northampton as there was no place of safety available. This also compounded another system failure as there was an assumption that the mental health service would make a referral to MASH but there was a failure to make the referral. In response, this approach has now changed, and a referral is made regardless of other agencies' involvement.

57. CNWL gave an example of the challenges regarding joint working between their inpatient staff and community services. The inpatient team assumed that the individual would be followed up by AHTT and made no provision if this changed. There should have been a joint assessment between AHTT and the inpatient team but the patient wanted to leave and there were no grounds to hold him.

58. CNWL recorded that for one individual there were delays in accessing psychology services. The patient also had to wait until after she had been discharged from the hospital before she could be allocated temporary housing. The notes identified miscommunication between the discharge team and housing officers.

59. In another individual's care, the serious incident investigation found that teams were working in isolation when responding to crisis presentations. On the day of the individual's death, she was seen in A&E and then sent home by the mental health liaison team. She later contacted the Acute Home Treatment team and urgent care team who suggested that she return to A&E. There appeared to be a lack of cohesive planning to manage her crisis interventions.

60. MKUHFT and Adult Social Care did not raise any major issues regarding barriers to working together.

How the picture of risk is built and reviewed by agencies

61. TVP use a Domestic Abuse Risk Assessment Tool (DOM5) and rate the level of risk and refer to the Multi-Agency Safeguarding Hub (MASH). The police noted that they would not be routinely informed about incidents that are dealt with by the Transport Police.

62. For one individual TVP used the 'ABCDE system', which looks at Appearance, Behaviour, Communication, Danger and Environment. This was shared with ASC.

63. In another case, the police used the ABCDE vulnerability tool, and this led to detention under S136. This occurred in a silo, but the process has now been changed and there is a multi-agency approach to risk occurrences.

64. CNWL has a risk assessment policy that uses a dynamic, person-centred assessment/safety planning model, which uses structured clinical judgement. The risk assessment takes place:

- Following a significant risk event
- On transfer to another service
- On discharge
- As part of a Care Programme Approach (CPA) review
- At the discretion of a practitioner
- At least every 12 months

65. CNWL noted that three individuals had missed risk assessments and some individuals had been identified as low risk.

66. Adult social care did not comment on risk assessment in their agency report but discussions with the manager of individual services built a picture of how risk is assessed as the AMHP service works closely with acute mental health services.

67. Multiple risk factors are not always present in high-risk individuals. Only one or two risk factors may present to a serious degree, but this may be sufficient. The risk can escalate rapidly over a short period and, if the outcome is not fatal, may just as quickly subside.

Messages to inform future commissioning intentions

68. Research shows that suicide is rarely a response to a single event. It is usually the result of a build-up of problems over time. The thematic review has shown that suicide is often an outcome of disadvantage, early trauma and loss, but also included experiences of homelessness, poor housing, unemployment, job loss and financial crises. Suicide can be preventable as part of a public health strategy, and it is the business of all the agencies. It may not always be predictable and in the ten individuals in the thematic review, there are unexplained deaths that could not have been foreseen. Professionals should consider the cumulative impact of adversities regardless of whether a person appears to be coping or not.

69. CNWL raised several issues identified in their agency report about the individual interventions that could inform future commissioning intentions. Some of the changes have already been made but are included because it helps to identify the direction of travel for future commissioning and strategic planning of the services.

- Inpatient staff and AHTT staff were not working closely together and sharing information with SCAS. Changes have been made as a result and both teams have a new consultant whose remit is to work collaboratively.
- A CNWL mental health professional works with SCAS on Friday and Saturday. An expanded service using a model as in other areas where combined police, ambulance and mental health workers provide a seamless service by sharing

information and staff working together would be effective and reduce pressure on A&E.

- CNWL identified that better information sharing between housing services and the inpatient team could have supported an individual to get temporary accommodation before she was discharged from the acute psychiatric ward.
- UCT and AHTT have been merged to create a 24/7 crisis team. A central hub went live in March 2021 taking all mental health referrals to streamline the service.
- A dedicated mental health housing liaison worker may have been able to alleviate some of the stress of the threat of potential homelessness.
- Better sharing of information between drug and alcohol services and acute mental health services. This has been addressed by CNWL taking over the running of the drug and alcohol services.
- The mental health liaison service has expanded in size, and they will support mental health patients on the MKUHFT wards including those on leave from Campbell Centre. This should include face-to-face assessments and supporting MKUHFT staff in managing mental ill-health.
- As a result of the lessons learned from the death of one individual, there have been many changes to the CNWL services. The specialist therapies team now offers therapy and a psycho-social service where patients who are not ready to commit to therapy can still access support. The service is mainly offering 'peer support' from people with lived experience.
- A Crisis Café has been established and this runs from 5.00 – 11.00pm and is managed by MIND. The hours could be extended.
- The coroner had stated that there is no facility within Milton Keynes for dealing effectively with patients suffering a mental health crisis to ensure they are brought to the hospital for assessment and treatment.

Learning points

1. The 10 individuals who were selected for this thematic review had all led very different lives and although themes emerged, it was apparent that in some circumstances suicide

is very difficult to predict. For one individual there were no warning signs, for others, the risk factors were apparent. **Signs of risk should always be recorded and acted upon.**

2. The diverse lifestyles and environments of the 10 individuals highlight the importance of practitioners understanding resilience and vulnerability**. It is vital to approach risk assessment in a person-centred manner.** A tick box exercise can lead individuals to feel they are not being heard or valued. Listening to the person and understanding their unique circumstances can be protective both for the individual who is authenticated by the conversation and the professional gains a much better idea of the potential risk.
3. **Where possible involve families**. There are circumstances where the individual wants their family involved. At other times if the person has the mental capacity and doesn't want them to be informed, this must be respected. Involvement from families can sometimes make matters worse. Clinical judgement must be used. Where families can be involved, especially at the time of discharge from the hospital, this can act as a protective factor. A family therapist as part of the multi-disciplinary team could be considered.
4. **Community support and targeted crisis support will have saved lives although this is difficult to quantify.** The Crisis Café is an innovative approach in Milton Keynes. The Community Support Team in adult social care works with people who are difficult to engage.
5. **TVP and S136.** The need to develop joint training with TVP and partners would enhance understanding of the powers and process between mental health professionals and police officers in the use of S136.
6. **Discharge planning needs to be robust.** Discharge from an acute mental health setting is a known period where the risk of suicide is highest, especially in the first four weeks. It is important that transfer back to the care of the primary care team is robust and support is in place and safety plans and strong risk assessments are monitored.
7. **Working with other agencies and services.** The thematic review has shown that although there are liaison arrangements in place between some services, particularly A&E and the acute wards, the substance misuse service also works with individuals at a higher risk of suicide than the general population. There need to be pathways between the services and joint working arrangements.

8. **Non-attendance and non-compliance need to be noted and acted upon.** Several of the individuals had been referred to IAPT or substance misuse services but had not taken up the services.
9. **The pathways between the acute mental health services and other services including A&E, primary care and drug and alcohol** services are crucial for the safe management of patients experiencing a crisis where there are multiple risk factors
10. **Checks must be made that a person is registered with a GP.**
11. **Other agencies working with vulnerable individuals need to be confident about managing risk in community settings.** Other agencies do not necessarily have the training or expertise in suicide prevention. Health settings including cancer services, pain clinics need to be better trained to recognise signs of risk.
12. **High-risk industries.** The number of individuals in this review working in the construction industry in low paid low skilled roles has highlighted the vulnerability of this group of workers.
13. **Homelessness/housing insecurity.** The risk of suicide amongst people whose housing situation is precarious was a factor in several the individual's lives. Housing officers should be included in suicide prevention strategies. Mental health professionals need to liaise with housing when individuals present in a crisis.
14. **Suicide high-risk areas.** Milton Keynes has a high-speed rail link that makes it a high-risk area where suicides occur on the rail network. Two of the suicides in the review were by this method.
15. **The thematic review highlighted the significant link between previous suicide attempts and completed suicide.** Eight of the ten individuals had made previous attempts.

Conclusions

The thematic review was primarily concerned with the mental health services in Milton Keynes and the lessons to be learned from the ten individuals selected by MK Together for the purpose of the review. The range of different circumstances and life events was diverse and there did not immediately appear to be any discernible themes. However, the known suicide risk factors amongst the 10 individuals mainly mirrored national and international studies.

The review has identified that the powers of the police to use S136 to detain an individual and subsequent discharge from the hospital was an issue that all the agencies recognised as problematic. The review did not analyse the times of the detentions as that information was not available, but more use of S136 is likely at weekends or outside office hours. There was a consensus that having a mental health professional available to work alongside the police and ambulance services has been a positive service development that should be extended. Sometimes the individual could not be safely left if they were living alone or were unsupported at the time of the crisis.

The key points of intervention in an individual's life are before and after the hospital admission. If during these times, agencies are working together, sharing information, and building a risk assessment, this will impact the individual's experience, especially how they are referred or signposted to other specialist services. Whether this is conveyed to the person in a crisis as a personalised and empathetic response or as 'being passed on' can either be devastating to the individual or can increase the person's confidence and enable them to start to see beyond the immediate crisis.

The second key transition is the risk of suicide during the period immediately after discharge from in-patient acute mental health settings. It was notable that Adult Social Care had not known six of the individuals. There is now a social worker who attends all the key meetings especially discharge planning from the acute ward and where appropriate, a care assessment takes place before discharge. There have been other changes in service organisation and delivery in response to previous suicides and the Acute Home Treatment Team is now part of a wider Crisis Response Team. Services are more streamlined and there is one point of access.

Adult Social Care also has a team that is dedicated to working with 'hard to reach' isolated people who might otherwise present at A&E or be at an elevated risk of suicide.

Suicide is multi-faceted and although there are links between suicidality and mental health the review highlighted major risk factors including homelessness, unemployment, financial problems, problematic relationships and substance misuse. These are wider societal problems that are not easily solved but ensuring patients are well supported on discharge and that there is continuity are vital components of the response to the individual.

At the broader level, suicide prevention measures that are beyond the scope of this review, aimed at raising awareness of suicide, including amongst social workers, health care professionals, housing and DWP staff would help to support the maintenance of ongoing contact with people at risk of suicidal behaviour. There is also an important role for voluntary providers and charities to offer telephone-based or other support services to individuals as well as bereavement support to family members affected by suicide.

Recommendations

1. A strategic approach to crisis intervention could potentially reduce S136 detentions. Emergency responders if they received timely, professional and appropriate advice based on the individual's presentation at the time, with accountability and access to any existing patient care plans would allow a different intervention such as Community Mental Health Team (CMHT), GP, or Crisis Teams.
2. The issues identified around the use of S136 and MHA assessments would benefit from joint training as it was generally agreed that a better understanding of the roles of the police and mental health staff was needed.
3. Strategic planning ensures appropriate services *eg* the Crisis Café is providing support to individuals to prevent hospital admission. It is recommended that other interventions that prevent unnecessary hospital admissions such as the extended street triage service and ambulance service be considered as part of the joint commissioning arrangements.
4. It is recommended that an audit be undertaken of the voluntary and statutory organisations that can offer advice for individuals in financial hardship, housing difficulties, debt, relationship breakdown, bereavement, domestic abuse and social isolation.
5. A personalised approach to risk assessment could be further developed. Although there are robust risk assessments in place and there is contradictory evidence about the use of risk assessment, a person-centred approach and not using a 'tick-box' approach can have a significant impact on the individual and their self-esteem.
6. Consideration should be given to how to provide families with general and non-person specific information in their own right, such as how to access services in a crisis, especially where an individual has the mental capacity and does not consent to information being given about their treatment.

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Glossary

AHTT	Acute Home Treatment Team
AMHP	Approved Mental Health Professional
ASC	Adult Social Care
CMHT	Community Mental Health Teams
CNWL	Central and North West London NHS Foundation Trust
DWP	The Department for Work and Pensions
EUPD	Emotionally Unstable Personality Disorder
HBPoS	Health-Based Place of Safety
IAPT	Improving Access to Psychological Therapies
MHA	Mental Health Act 1983
MHHLT	Mental Health Hospital Liaison Team
MKAMHS	Milton Keynes Adult Mental Health Service
MKUHFT	Milton Keynes University Hospital NHS Foundation Trust
ONS	Office for National Statistics
PCP	Primary Care Plus
SCAS	South Central Ambulance Service
STT	Specialist Therapies Team
TVP	Thames Valley Police
UCT	Urgent Care Team