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Do English mental health services know whether they followed N.I.C.E. treatment recommendations for depression with patients who killed themselves?

Summary

Freedom of Information Act requests sent to 51 NHS mental health providers in England showed an average of 20.5 suicides per organisation. Only one provider, however, could report how many people that had killed themselves had been offered N.I.C.E. recommended psychological therapy. Information that might prevent suicides is being ignored.

Practitioner Points

- Mental health services need, urgently, to develop data systems that can inform clinical team leaders about gaps in their services to suicidal people in their care
- Clinical psychologists have a particular responsibility to pressure managers to effectively monitor the provision of evidence-based treatments to suicidal people
- Trusts and commissioners must be aware of, and rectify, any failings of their services in relation to the prevention of suicide

Key words: Suicide; prevention; psychological therapies; NICE guidelines; mental health services; NHS

Declaration of Interest: None of the authors have any conflicts of interest in relation to this paper.

Introduction

Risk of suicide is one of the reasons people are compulsorily detained, assessed and treated by mental health services. Gathering and analysing data related to whether these services prevent suicide, and - if so - how, should be of paramount importance. A 2016 national report on suicide in mental health services identified ten 'key elements of safer care in mental health services' (Appleby et al., 2016). One was: 'Implementing NICE guidance on depression and self-harm.' NICE guidelines for the treatment of depression recommend, for mild to moderate depression, an antidepressant *or* CBT *or* Interpersonal Therapy (IPT); and, for moderate or severe depression, a combination of antidepressants *and* either CBT or IPT. Counselling or short-term psychodynamic psychotherapy is recommended for people who decline the other treatments (N.I.C.E., 2016). The 2016 report did not, unfortunately, present any data on mental health Trusts' implementation of these guidelines.

Method

Ethical approval was unnecessary as the study involved no interactions with patients.

A Freedom of Information (FOI) request was piloted on two NHS Trusts. After making it simpler and shorter to maximise response rate, it was sent to 51 NHS mental health providers, in November, 2016. It asked for:

Number of suicides from January 1, to 2012 to October 31, 2016:

Average years in MH services

In the 12 months prior to the suicide -

How many of these were offered a NICE recommended psychological therapy?

How many received at least one session (excluding assessments) of NICE recommended psychological therapy?

What psychological intervention did they receive?

Number offered multi-disciplinary assessment

Number offered medication

Number in receipt of medication

Number offered ECT

Number in receipt of ECT

What evidence are you using for these figures?

Results

FOI compliance rates

Five of the 51 organisations failed to respond. Five acknowledged the request but did not respond further. Three stated they were not subject to the FOI Act because they were 'a private company', 'a non for profit charity organisation and a registered independent hospital' or 'not a public authority'. Ten could not provide any of the information requested because it would take too long to collate it, often citing relvant provisions in the Act. Thus 23 of the 51 (45.1%) failed to provide any information.

Twenty seven (52.9%) answered only the question about number of suicides. Only one (the *2gether NHS Foundation Trust*) also provided information about how many of the people had been offered and/or received the various treatments. Almost all (24) of the 27 who failed to provide data about treatments, cited the provisions in the Act about time and

expense, with some explaining that only by a manual trawl of records could the requested information be obtained.

Suicide rates

Among the 28 Trusts providing numbers (for January 2012 to October 2016) there was a total of 2,780 suicides. There was a substantial range, from 29 to 261 (mean - 99.3; SD - 48.3). The average number of suicides per Trust annually (i.e. divided by 4.833 years) was 20.5.

The single Trust complying with the request, *2gether NHS Foundation Trust*, reported 77 suicides, at an average of 15.9 per year. The Trust indicated that 63 (81.8%) had been offered medication and 61 (79.2%) had used it. It was reported that 47 (61.0%) had been offered psychological therapy and 27 (35.1%) had used it. None had been offered Electroconvulsive Therapy. There had been 41 'multidisciplinary assessments'. The 77 people had, on average, been 'in service' for four years. This information had been compiled 'Using clinical systems records (RIO, IAPTUS), and Serious Incident Investigation Reports'.

Discussion

FOI compliance

One third of FOI requests across all government bodies are fully responded to (Cabinet Office, 2016). This was the case, however, for just one Trust (2%). Although this may be partly due to inadequate staffing, the gathering and sharing of data about suicide, within and between services, should surely be of the highest priority.

Number of suicides

Multiplying 20.5 (the average number of suicides annually per organisation) by 51 (the number of mental health service providers) produces an estimate of 1,025 patient suicides per

year. This is similar to the 1,266 calculated by the 2016 national report (Appleby et al., 2016). One might hope that unit managers and service commissioners have easy access, in collated form, to all the pertinent data (including access to treatments that might have prevented the suicide) from the medical records, to inform efforts to prevent suicides in their services. If this were so the Trusts would easily have been able to extract the information requested, from these collated summaries. It seems essential that the lessons learned from the many hours investigating each individual tragedy should be understood in the context of the other 20 or so occurring each year in the same service, to enable a systemic approach to the problem.

Accessing suicide related information

The UK government just published a National Suicide Prevention Strategy (Public Health England, 2017). One of its five action areas is 'Improving data at national and local level and how this data is used to help take action and target efforts more accurately'.

Given that preventing suicide is one of the primary purposes of any mental health service and one of the justifications for forcibly detaining and medicating people, services must have systems for monitoring compliance with NICE guidelines.

It is concerning that 45% of the organisations provided no information. It seems particularly problematic that we found four organisations operating beyond the jurisdiction of the FOI Act. Three stated this explicitly. One simply ignored the request. There should be a level playing field for NHS providers and private organisations serving NHS patients.

A recent meta-analysis of 131 randomised trials found no difference between antidepressantsand placebos for suicides, suicide attempts or suicide ideation (Jakobsen et al., 2017). Access to NICE recommended psychological therapies may, therefore, be even more important than previously thought.

Limitations

It is conceivable that some Trusts had an accessible report containing the relevant information but their FOI Officer was unaware of it. This would mean, however, that the people s/he asked were also unaware.

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