NIHR | Yorkshire and Humber Patient Safety Translational Research Centre

UNIVERSITY of BRADFORD
Social Work & Social Care

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Serious incident investigations and suicides under adult community mental health services; protocol and findings from the literature

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Research team also includes

Professor Gerry Armitage, Emeritus Professor, University of Bradford, BDCFT Research Advisor

Carer representatives with lived experience; Keith Double (Involvement Partner, BDCFT) and Assistant Professor Lisa Edwards (Health Studies Lecturer, University of Bradford)

Mel Dawson, Knowledge Manager, Library and Health Promotion Resources, BDCFT.

Expert panel including relevant experts from the field.

Safety warning

Background

- In 2021, 5,583 suicides were registered in England and Wales (ONS, 2022)
- Suicide prevention is an NHS imperative within England (NHS, 2019)
- 27% of the general population who took their own lives had been in contact with MH services within 12 months (NCISH, 2022)
- The CQC (2017) have raised concerns about the quality of investigations in MH services
- Furthermore, evidence now suggests deficiencies in suicide risk assessment, the associated guidance and staff training (NCISH, 2018)
- PSIRF (NHS England, 2022) and Standards for Serious Incident Reviews (Baker-Glenn et al, 2022) implemented without robust evidence base.

Protocol

Research objectives in relation to adult community suicides

- The process of serious incident investigation (SII) and how this incorporates the views of key individuals
- Risk factors/barriers and facilitators to the investigative process advising organisational learning
- Evidence-based approaches to SII and judging of suicide risk assessment

Study design

1. Undertake literature review
2. Empirical study

- Undertake focus groups with carers and mental health clinicians to inform;
- One to one semi structured interviews with serious incident investigators and senior managers overseeing SII processes.

Involvement

Carer representation within study team was an integral part of the study and was part driven by their experiences in relation to community suicides.

Carer representatives roles included;

- Contributed to writing of initial funding application and study design
- selection criteria for literature review
- advised recruitment methods for carers in empirical study
- supported undertaking of carers focus group
- reviewing papers prior to publication.

Progress to date

Integrative review and narrative synthesis

- First draft is complete and currently out for comments with our expert panel
- Due to be submitted for peer review publication
- Informed our knowledge of the empirical and non empirical evidence base

Progress to date

Empirical study

- Mental health clinicians focus group - completed
- Initial recruitment of carers did not meet numbers required, widened recruitment sites to include local and national carers suicide bereavement services. Focus group - completed
- Interviews with senior managers - completed
- Initial recruitment of serious incident investigators did not meet recruitment target, widened recruitment sites to include other mental health trusts. Focus group - completed
- Findings currently under analysis and write up is to follow.

Literature review main findings

Objectives;

- determine the nature and extent of key individuals’ involvement in the investigative process
- consider the influence of various investigative approaches upon organisational learning
- Appraise the strengths, limitations and evidence base underpinning the approaches taken

Literature found

- 16 papers found internationally, 8 empirical and 8 non empirical.

Literature review main findings

(1) Root Cause Analysis (RCA) dominant approach but increasingly critiqued

(2) Mental Health incidents identified as complex, especially community-based suicide

(3) Notable lack of attention to service user context and meaning, especially longitudinal, cumulative risk over time.

Literature review main findings

(4) Concerns around opportunities for involvement of all key perspectives and how these are incorporated within organisational learning

(5) Technical rational vs experiential approaches

(6) Contemporary literature proposes Safety II approach underpinned by Restorative Just Culture and Zero Suicide Framework, and carer partnerships. Safety II caveats require greater appraisal.

Examples of further reading

Jun, G. T., Canham, A., Noushad, F., and Gangadharan, S. K. (2019) Safety I and Safety II for suicide prevention – lessons from how things go wrong and how things go right in community-based mental health services. In: *Advances in Intelligent Systems and Computing*, 818, p.449-452. IEA 2018, Florence, Italy, 26-30th August 2018

Turner, K., Stapelberg, N. J. C., Sveticic, J., and Dekker, S. W. A. (2020) Inconvenient truths in suicide prevention: Why a Restorative Just Culture should be implemented alongside a Zero Suicide Framework. *Australian & New Zealand Journal of Psychiatry*, 54(6), 571-581

Turner, K., Sveticic, J., Almeida-Crasto, A., Gaee-Atefi, T., Green, V., Grice D., Kelly, P., Krishnaiah, R., Lindsay, L., Mayahle, B., Patist, C., Van Engelen, Heidy., Walker, S., Welch, M., Woerwag-Mehta, S. and Stapelberg, N. J. C (2021) Implementing a systems approach to suicide prevention in a mental health service using the Zero Suicide Framework. *Australian & New Zealand Journal of Psychiatry*, 55(3), 241-253.