PE1604/F

SAMH Letter of 14 October 2016

SAMH response to PE01604

> *Calling on the Scottish Parliament to urge the Scottish Government to expand the remit of the review into the arrangements for investigating the deaths of patients under Section 37 of the Mental Health (Care and Treatment) (Scotland) Act 2015 to include an inquest-type system for all deaths by suicide in Scotland; and to include both patients who were released from hospital or receiving care in the community under Compulsory Treatment Orders.*

Introduction

We thank the Committee for contacting SAMH about this petition. As the Committee is aware, a SAMH service was providing support to the petitioner's son at the time of his death. We will send a copy of this response to Catherine Matheson and we take very seriously the responsibility of responding to her evidence to Committee. We respect the family's commitment to improving healthcare and investigations and seeking to protect other families from their experience.

Almost two people die by suicide in Scotland every day, with 672 deaths across Scotland in 2015 – each one a tragedy, devastating families and communities. Over the past ten years there has been an 18% drop in suicide, which is excellent progress, but Scotland still has higher rates of suicide than the UK overall.[1]

Current process for investigating suicide

All NHS Boards are required to report to Healthcare Improvement Scotland any suspected suicide of a person who has been in touch with mental health services within the twelve months prior to their death. Healthcare Improvement Scotland states that:

> "When a person who was in contact with mental health services in Scotland takes their own life, those services carry out a review of the person's care to see if anything can be done differently."[2]

Healthcare Improvement Scotland identifies and disseminates national and local learning points and recommendations from these local reports.

The Procurator Fiscal must enquire into any death where the circumstances point to suicide. The purpose of these inquiries is to establish where there is a need for criminal proceedings or a Fatal Accident Inquiry.[3]

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[1] ScotPHO website, accessed 12 October
[2] Healthcare Improvement Scotland website, accessed 12 October

The Mental Welfare Commission receives notification of all deaths which occur while someone is receiving compulsory treatment. The Commission can investigate if there appears to be any abuse, neglect or deficiency of care.

Policy background

In his 2009 review of Fatal Accident Inquiries (FAIs), Lord Cullen recommended a mandatory FAI for all persons who die whilst subject to compulsory detention by a public authority.[4] At Stage 3 of the subsequent Fatal Accident and Sudden Deaths Bill, amendments were tabled to introduce mandatory FAIs for everyone who died while under the care of mental health services, even if they were voluntary patients. These amendments were voted down, having been opposed by SAMH, the Mental Welfare Commission and the Royal College of Psychiatrists.[5]

The reason we opposed these amendments was, primarily, that two-thirds of patients who died while receiving compulsory treatment died through natural causes, not related to their mental health treatment.[6] Therefore we did not think it was proportionate to require an FAI in every case. In his evidence, Lord Gill also made the point that the circumstances related to the cause of death are often conclusive in cases of suicide. He told the Justice Committee "it would be very difficult to legislate in such a way as to make FAIs mandatory only for those particular deaths."[7]

Suicide prevention

The Committee specifically asked us whether there are "warning signs that a person receiving care in the community under a compulsory treatment order may be at risk of committing suicide".

We note that the petitioner's son frequently cancelled appointments while on a Community Compulsory Treatment Order and that on the day of his death, our staff flagged up with the CPN the fact that he had cancelled an appointment with our service. While we don't feel able to comment on the specifics of this case, we would expect that frequent non-engagement with services while on a community CTO would lead to follow-up action. But we would not suggest that this should necessarily be taken as a sign of suicidal ideation.

In terms of risk of suicide, men are two and a half times more likely than women to die by suicide.[8] The risk of suicide increases significantly in areas of greater deprivation. And while the majority of people experiencing distress or crisis will not take their own life we know

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[3] SAMH, After a Suicide, 2012
[4] Lord Cullen, Review of Fatal Accident Legislation: The Report, 2009
[5] SAMH, Stage 3 Briefing on Inquiries into Fatal Accidents and Sudden Deaths Bill, 2015
[6] MWC Death in Detention Monitoring
[7] Scottish Parliament Justice Committee, Stage 1 Report on the Fatal Accidents and Sudden Deaths etc Scotland Bill
[8] ScotPHO website, accessed 12 October

that people experiencing distress or a mental health crisis are at an increased risk of suicide.[9] It is therefore vital that we get their care and support right.

We hope that the forthcoming Suicide Prevention Strategy, due for publication in 2017, will give a renewed focus to local suicide prevention work through Choose Life.

Suicide in Scotland

The University of Manchester's National Confidential Inquiry into Suicides and Homicides by People with Mental Illness provides analysis of all deaths by suicide over the period 2004-2014.[10] It reports that during this time, 31% (N=2697) of people who died by suicide in Scotland had been in contact with mental health services in the twelve months prior to their death. Of these, 2% (N=51) were detained in-patients at the time of their death. Over the same period, there were 205 suicides in people under crisis resolution/home treatment (CRHT) teams.

There were 31 suicides in patients subject to a compulsory treatment order in the community between 2007-2014.. Forty-two per cent of those who died were not receiving care as intended despite compulsory treatment order powers.

The report notes that post-discharge suicides were most frequent in the first week after leaving hospital when 80 deaths occurred, an average of 7 per year. Nineteen per cent of all such suicides occurred within 3 months of hospital discharge .

It is notable that in cases where there had been contact with mental health services in the twelve months prior to death, the immediate risk of suicide at last contact was judged to be low or not present in 89% of cases, and long-term risk low or not present in 60%.

Conclusions

From the information above, we would suggest that support while someone is on a Community Compulsory Treatment Order needs to be better managed. While we know that it is not possible to predict every suicide, we would also suggest that risk assessment needs to improve.

We note that Section 37 of the Mental Health Act 2015 requires the Scottish Government to review arrangements for investigating deaths of patients who were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003, Criminal Procedure (Scotland) Act 199 or were voluntary patients being treated for a mental disorder.

We agree with the recent Mental Welfare Commission recommendation that this review should also consider deaths by suicide of patients who are under suspension of detention. We also support the recommendation that pending the outcome of this review, NHS Boards should ensure that a critical incident review takes place when a person dies by suicide while

[9] Scottish Government Suicide Prevention Strategy 2013 – 2016 (2013)
[10] University of Manchester, National Confidential Inquiry into Suicides and Homicides by People with Mental Illness, 2016

on suspension of detention or a community based Compulsory Treatment Order, or within 12 months of moving from inpatient mental health care to community-based residential services.[11]

Finally, we note that the Section 37 review must involve the nearest relatives of those who have died by suicide, and hope that this will provide an opportunity for Catherine Matheson and her family to have their voices heard.

For the reasons discussed during the Fatal Accident and Sudden Deaths Bill debates, we are not persuaded that an inquest should take place for all deaths by suicide.

We hope this is helpful and will be happy to discuss our submission further.

Carolyn Lochhead
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October 2016

[11] Mental Welfare Commission, Investigation into the death of Ms MN, January 2016