**Shared learning bulletin**

**A group of service users involved in a homicide in the community**

**Introduction**

A person was fatally wounded in an incident involving several individuals. These individuals were, or had recently been, under the community mental health services of a mental health trust at the time of the incident. To protect the anonymity of these people, and their loved ones, we have minimised detail in this learning bulletin which may make those involved identifiable.

Niche was asked to undertake a desktop independent review of the care and treatment that these individuals had received, and to identify any common areas for learning.

**Theme areas for learning**

The themed learning areas were:

**1. Trauma-informed care**

These service users had all described their difficult and complex backgrounds to services, including varying degrees of childhood trauma. This included, for example, significant childhood abuse and neglect; growing up in care; and the absence of consistent education.

We found a lack of trauma-informed approaches to these individuals’ care, and examples in care records which could suggest potential systemic difficulties related to implementing trauma screening or routine enquiry as part of CMHT assessments – this could include the availability of staff resources, clinician confidence, or awareness, about trauma informed approaches, as well as the cultures of the different teams.

**2. Barriers to accessing treatment**

It appears that some of the ways that this trauma and the adverse experiences in childhood may have manifested led to barriers in accessing care. For example:

* One of the service users was discharged from the community mental health team (CMHT) because they missed a telephone appointment. This individual struggled with reading and writing and may have required information about their appointments in another format.
* They were discharged from the CMHT for a second time due to them having issues participating in group work.
* A GP made several urgent referrals to the CMHT for another service user. One of these referrals was not acknowledged, and the others were rejected, with the service saying that the service user's alcohol use was the primary factor or that their needs didn’t require the intervention of secondary mental health services. The link between childhood trauma and substance misuse is well-known.
* Another GP referred one service user to the CMHT for support with increasing anxiety, depression and suicidal thoughts. The referral was not accepted on the basis that they did not meet the criteria for CMHT involvement. A close family member had sought to advocate for them to get help with their mental health needs.

**3. Health inequalities**

Important health inequalities issues were not considered in various aspects of the service users’ care, and in some cases, this contributed to these barriers in accessing care. For example, appointments being confirmed via text message to a service user who was known to be unable to read, innumerate and unable to use a smartphone. Clearer consideration of these issues may have helped their engagement with services.

Another service user came from the Traveller community and had interrupted education. Although their background was known, there is no evidence that it was given consideration during their care and treatment. There is evidence that Travellers experience significant mental health inequalities, and that more flexibility within services (for example, not discharging after a missed appointment) can help overcome the barriers which may lead Gypsy, Roma and Traveller people to feel that services are not designed for their communities and feeling excluded from care.

**4. Working with other agencies**

There was an absence of joint work with substance misuse services. This led to barriers in accessing care due to co-existing issues with substance misuse. For example, one service user’s referrals to services were rejected because of their struggles with alcohol, without any attempts to explore how working together with substance misuse services to provide their care and treatment might benefit them.

**5. Pathway clarity**

We identified a lack of clarity about the care pathways for all of the service users, who were being treated under standard case, and not Care Programme Approach (CPA). This meant that care planning and oversight arrangements were vague. In particular, there was a lack of oversight within the CMHTs of the risks presented by all of the service users. Two had significant forensic histories, and all of them had reported specific thoughts of harming others and had come to the attention of the police or other agencies. The risk assessments were too high level and lacking in detail about how to manage their risks.

**6. Patient and family voice**

There was very little evidence of services working with families, carers or loved ones in the care of these service users, including seeking their views on care planning, sharing important information with them where possible, and signposting them to local support offers.

In one case, safeguarding protocols were not followed when one of the service users reported violent feelings towards a family member (who themselves had told the service they felt fearful of this service user). There should have been consideration of whether the family member was an adult at risk and if so, whether to raise a safeguarding concern with the local authority.

**Critical learning points**

1. Services should be designed to provide a trauma-informed approach that supports all patients, especially those with the most complex and challenging needs. Organisations must seek to understand if there are any systemic issues to implementing a trauma informed approach to care.
2. When planning care and assessing risks, it is important to look at the whole picture of a patient’s situation and circumstances. If new risks come to light, these should be reviewed using the right tools. Primary care practitioners should also have a clear process to escalate their concerns when they feel a patient’s risks are increasing.
3. If a patient struggles with communication, this should be considered in their care plan, and staff need to follow these plans to ensure no one is excluded or unable to access the care and treatment they need.
4. More work needs to be done to support how individuals who are unable to read and/or those without access to digital technology are facilitated to access services. This includes making sure mental health service information is co-developed with those with lived experience, and is available in ways that work for everyone.
5. Implement the recommendations of the Tackling Mental Health Inequalities for Gypsy, Roma and Traveller People report[[1]](#footnote-1) and create a way of highlighting this in assessment processes to direct staff to the relevant guidance.
6. Establish proactive working relationships and lines of communication between mental health services and the substance misuse service.
7. Some close family members are seen as protective factors in supporting a patient’s mental health. This should not also prevent services from also considering any safeguarding needs where necessary.

**Learning Quadrant**

|  |  |
| --- | --- |
| **Individual practice*** How often does my practice consider the impact of a service user’s story (including their childhood) on their mental health presentation?
* How do I plan and co-produce care packages with service users who are unable to read or write?
* How do I respond when a patient is behaving in a way that triggers frustration in me?
* Am I clear where to go to for support when service users have difficulties participating in group work?
* To what extent have I reflected on any unconscious bias I may be holding towards minoritised groups and how this might impact on the care I give?
 | **Governance focused learning*** How is our organisation communicating with service users who are unable to read and write, or find this difficult?
* Is this forming a barrier amongst an already vulnerable patient group?
* When patients report feelings of violence towards an adult at risk, how are we assured the Safeguarding Adults Policy is followed?
* To what extent do staff understand that close family members can be both a protective factor for a patient, and also some of the people most at risk of violence from the patient?
* What would the learning response be in my organisation if something like this happened in our Trust?
 |
| **Board assurance*** How are we assured that staff are confident in delivering trauma-informed care?
* How do we ensure that the Accessible Information Standard is being effectively implemented by staff to meet the communication needs of all service users?
* Does our organisation ensure that our mental health services are flexible enough to address barriers that may make Traveller communities feel excluded?
 | **System learning points*** Do we, as a system, understand which minoritised groups are most likely to face barriers in accessing care, and how has pathway design taken this into account?
* How do we ensure that service design takes dual diagnosis into account, and that this does not form a barrier to care?
* How are services using population health intelligence to inform their care? For example, how well do pathways take into account the specific needs of the Traveller community?
* Does our assessment system include prompts to guide staff to the appropriate guidance when caring for a patient from the Traveller community?
 |

1. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://nspa.org.uk/wp-content/uploads/2024/05/Tackling-Mental-Health-Inequalities-for-Gypsy-Roma-and-Traveller-People-final-May-2024.pdf [↑](#footnote-ref-1)