MANCHESTER 1824
The University of Manchester

National Confidential Inquiry into Suicide and Homicide

by ***People with Mental Illness***

Annual Report 2017
Executive Summary

HQIP
Healthcare Quality Improvement Partnership

Annual Report:
England, Northern Ireland, Scotland and Wales
October 2017

EXECUTIVE SUMMARY

INTRODUCTION

i. The 2017 annual report from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) provides findings relating to people who died by suicide or were convicted of homicide in 2005-2015 across all UK countries. Additional findings are presented on sudden unexplained deaths (SUD) under mental health care in England and Wales.

ii. The NCISH database is a national case series of suicide, homicide and SUD by mental health patients over 20 years. The current suicide database stands at almost 120,000 suicides in the general population, including over 30,000 patients. This large and internationally unique database allows NCISH to examine the antecedents of these incidents and make recommendations for clinical practice and policy that will improve safety in mental health care.

iii. As with previous annual reports, the main findings are presented here by country for the baseline year of 2005 and the subsequent 10 years, including the most recent year for which comprehensive data are available (2015). A UK-wide section provides selected findings from the UK as a whole.

METHODOLOGY

iv. The NCISH method of data collection is equivalent across all UK countries and consists of three stages:

- National data used to identify individuals in the general population who die by suicide or are convicted of homicide.
- Those who have been in contact with specialist mental health services in the 12 months before the incident are identified with the help of mental health providers.
- Detailed clinical information obtained for individuals via questionnaires completed by clinicians.

v. Co-operation from front-line professionals is excellent - the questionnaire response rate is around 95% overall. In the final year of a report period - 2015 in this report - the completeness figures are lower and we therefore estimate final figures taking into account the number of outstanding questionnaires and the accuracy of our estimates in previous years.

ANALYSIS

vi. The main findings of the report are presented in a combination of figures, maps and tables. These show changes in key figures in patient safety over the report period.

vii. General population and patient rates for suicide are calculated using ONS mid-year population estimates and, where available, denominators based on patient activity obtained from NHS Digital (England).

viii. We examine for statistically significant time trends over the report period. However, because 2015 figures are partly estimates, these are not included in the analysis of trends.

KEY FINDINGS

Suicide numbers and rates

ix. Northern Ireland continues to have the highest general population suicide rate, while the rates in the other countries have fallen, especially in Scotland which had the highest rate previously.

x. There were 1,538 patient suicides in the UK in 2015, the figure having fallen in recent years, particularly in England and Scotland. During 2005-2015, 28% of suicides in the UK general population were in mental health patients, although this figure is slightly higher in Scotland and slightly lower in Wales.

xi. Similar falls are also apparent in specific patient groups that have been of concern. There has been a downward trend in the number of suicides by patients recently discharged from hospital in England and Scotland: there were 230 post-discharge deaths in the UK in 2015, down from 299 in 2011. A similar fall is found in suicides by patients who were non-adherent with drug treatment in the month before death, in England down from 160 in 2010 to 110 in 2015. These downward trends have occurred despite more patients being treated by mental health services.

In-patient suicide

xii. Suicide by mental health in-patients continues to fall but the longstanding downward trend has slowed. In the 5 years after 2005, in-patient suicide numbers in the UK fell by 39%; in the 5 years after 2010, the fall was 10%. In England the equivalent in-patient suicide rates, i.e. taking into account the number of admissions, were similar: 31% and 14%. In recent years there has been an average of 114 suicides by in-patients in the UK per year, including 89 in England.

Diagnostic groups

xiii. In previous reports, our focus has been on the diagnoses that are found most frequently in studies of patient suicide, e.g. depression and schizophrenia. In this report, we present figures for less common diagnoses to highlight the need for vigilance in these groups also. The diagnoses examined were:

Eating disorders:
In the UK in 2005-2015, there were 205 suicides by patients with a diagnosis of an eating disorder – 19 deaths per year on average. The number of deaths has risen and our estimate for 2015 is 27 deaths, though it should be treated with caution at this stage. Over two thirds had been ill for longer than 5 years. However only 7% were in contact with specialist eating disorders services. A history of self-harm was common, presenting an important sign of risk and opportunity for intervention.

Autism spectrum disorder:
There were 119 suicides by patients with a diagnosis of an autistic spectrum disorder (ASD) in 2005-2015 in the UK, an average of around 11 deaths per year. The annual figure has risen during the report period and our estimate for 2015 is 17 suicides. Certain risk factors, including alcohol misuse, were less frequent in this group compared to all patients who died by suicide, while previous self-harm was more common.

Dementia:
There were 203 suicides by patients with a diagnosis of dementia in 2005-2015 in the UK, an average of around 18 deaths per year. This figure has risen steadily since 2011 and our estimate for 2015 is 24 suicides. Only 16% overall were in the early phase of dementia, having been ill for less than a year.

xiv. The numbers of suicides in patients with a diagnosis of an eating disorder, ASD or dementia have risen. However, this is likely to reflect a rising number of patients with these diagnoses under mental health care. We cannot conclude that care has become less safe in these conditions.

Method of suicide

xv. The commonest method of suicide by patients in the UK is hanging; we estimate 751 patient suicides by hanging in 2015, almost half of all suicide deaths. The next most common method is self-poisoning: opiates (and opiate-containing compounds) remain the main type of drug taken in fatal overdose in the UK, including both prescribed and illicit drugs. However, the number of opiate deaths continues to fall in England, Scotland and Wales since a peak in 2011, resulting in a drop in fatal self-poisoning overall. In Northern Ireland, the number of opiate deaths has risen over 2005-2015.

Carers

xvi. 938 patients who died by suicide in the UK in 2005-2015 were carers (i.e. providing care for young children or someone else at home, or living with a mental health patient), 5% of all patient suicides, an average of 85 deaths per year. They had fewer risk factors for suicide compared to other patients who died; carers were more likely to be female.

Current or former members of the Armed Forces

xvii. In the UK in 2011-2015, 208 patients who died by suicide were current or former members of the Armed Forces, 3% of all patient suicides during this period, an average of 42 deaths per year. Most were male. A history of alcohol misuse was more common than in other patients, occurring in 57% of patient suicides in this group.

Patient homicide

xviii. During 2005-2015, 11% of homicide convictions were in mental health patients, a total of 835 patient homicides over the report period, an average of 76 homicides per year. In England, the number of patient homicides since 2009 has been lower than in previous years. Our estimate is for 45 patient homicides in 2015.

xix. The number of stranger homicides (victims and offenders unknown to each other) has fallen since a peak in 2006. There are around 11 stranger homicides committed by mental health patients in the UK per year.

xx. In all four UK countries, most patients convicted of homicide also have a history of alcohol or drug misuse, between 88% in England and 100% in N Ireland. In other words it is unusual for mental health patients to commit homicide unless there is a co-existing problem of substance misuse.

xxi. During 2005-2015, over half of mental health patients who committed a homicide in the UK were convicted of murder and 76% were sent to prison rather than hospital. Even in patients with schizophrenia, 34% were convicted of murder and 41% sent to prison (figures for England).

CLINICAL MESSAGES

In-patient care	**xxii.** There should be a renewed emphasis on suicide prevention on in-patient wards, with the aim of re-establishing the previous rate of decrease in in-patient suicide. This could include: (a) measures to improve the physical environment, e.g. removing low-lying ligature points, (b) ensuring care plans are in place during agreed leave, (c) measures to reduce leaving the ward without agreement, e.g. improvements to ward milieu, better monitoring of ward access and exit points, and observation protocols.
Post-discharge care	**xxiii.** Services should build on the recent fall in suicide following discharge from in-patient care: this remains a time of particularly high risk. This should include: (a) patient follow-up within 3 days of hospital discharge, [1] (b) care plans in place on discharge from hospital to community, [2] (c) ending 'out of area treatments' (OATs) for acutely ill patients.[1] National clinical guidelines have been developed with reference to NCISH findings (e.g. NICE guideline on transition between in-patient and community care settings[3]).
Diagnostic groups	**xxiv.** Services should be aware of the potential suicide risk in patients with a diagnosis of an eating disorder, ASD or dementia, and this should be part of a comprehensive assessment. Mental health staff should have access to specialist support in these conditions.
Reducing suicide by opiate overdose	**xxv.** Clinicians and pharmacists should be aware of the potential risks of opiate and opiate-containing analgesics. Safer prescribing in primary and secondary care remains crucial, particularly for patients with long-term pain, a group at high suicide risk. This should include prescribing only short-term supplies and enquiring about opiate-containing painkillers kept at home.
Alcohol and drug misuse	**xxvi.** Our findings add to the evidence that much of the risk to others from mental health patients is related to co-existing drug or alcohol misuse rather than mental illness itself. This is an important message in combating stigma. **xxvii.** A greater focus on alcohol and drug misuse is required as a key component of risk management in mental health care, with specialist substance misuse and mental health services working closely together as reflected in published guidance.[4,5]
Patient homicides and courts	**xxviii.** Our findings raise concern about patients with severe mental illness being sent to prison rather than hospital following conviction for homicide. Further investigation of the appropriateness of these decisions should now be undertaken by health and justice agencies.

Box 1: NCISH methodology

1. NCISH is a comprehensive national project collecting data on all patient suicides and homicides in the UK, with a response rate from clinicians of around 95%.

2. Suicide and homicide are defined legally, e.g. inquest conclusion or determination by a court. This provides consistency of definition but may under-estimate because of the high standard of evidence required.

3. Patients are defined by recorded contact with specialist mental health services in the 12 months prior to suicide/homicide - this omits some contacts, e.g. those seen in A&E but not referred to mental health.

4. NCISH is not a risk factor study but examines in detail circumstances in which deaths occur, e.g. the number of deaths in certain patient groups or settings, and how common remediable factors are. Findings describe the deaths that must be prevented to achieve a major reduction in suicide and homicide.

5. The comprehensive nature of the NCISH database spanning 20 years gives the opportunity to analyse large numbers, allowing the monitoring of changes in figures over time, including in patient sub-groups.

6. Additional NCISH studies use a range of methodologies, e.g. case control, evaluations, and triangulation with qualitative methods.[2,6,7]

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CONTACT US:
National Confidential Inquiry into Suicide
and Homicide by People with Mental Illness,
Centre for Mental Health and Safety,
Jean McFarlane Building,
University of Manchester, Oxford Road,
Manchester, M13 9PL

E-mail:
nci@manchester.ac.uk

Visit us on our website:
www.bbmh.manchester.ac.uk/cmhs

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