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The University of Manchester

NATIONAL CONFIDENTIAL INQUIRY INTO SUICIDE AND HOMICIDE BY PEOPLE WITH MENTAL ILLNESS

Annual Report:
England, Northern Ireland, Scotland and Wales
July 2015

HQIP
Healthcare Quality Improvement Partnership

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The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2015: England, Northern Ireland, Scotland and Wales July 2015. University of Manchester.

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KEY FINDINGS

Suicide numbers and rates

1. We collected information on all suicides in the UK between 2003-2013. Suicide figures show different patterns across the UK countries. In the general population suicide rates are higher in Scotland and Northern Ireland but recent rises have occurred mainly in England and Wales - the rate in Scotland has fallen over the last decade.

2. The general population suicide rate also varies by NHS area. In England the lowest rates are in London and the south-east, with higher rates in the north and south-west. In Wales the highest rates are in the south-west.

3. In general patient suicides in the UK have become substantially more common since 2009 - 1,876 in 2013 - but this rise is mainly the result of a rise in England where patient numbers overall have also increased. As a proportion of all suicides, patient suicides have increased from 27% in 2003 to 30% in 2013 - this may similarly reflect a rise in patient numbers, though safety problems in care may contribute. A higher proportion of patients could also occur if services improve access and long-term contact for people at high risk.

Suicide in males

4. There were 4,799 male suicides in the general population in 2013. Suicide in men has risen in the UK since 2006-2008, although the pattern varies between UK countries - in Scotland the overall male rate has fallen. In general the rise, since low figures in 2006, is most marked in men aged 45-54: 37% in England, 20% in Scotland, 32% in Wales.

5. Similar but generally larger increases are seen in the number of male patient suicides, the rise in the UK overall being 29%. The rise in male patients aged 45-54 since 2006 is very large, the UK rise being 73%. It is important to stress that these figures are numbers rather than rates and are strongly influenced by numbers of patient suicides in England, where the number of patients overall has risen.

6. Suicide in men is sometimes blamed on a reluctance to ask for help but the figures we are reporting are for men who are receiving mental health care. Our findings suggest the drivers of these increases may be risk factors such as (a) alcohol – alcohol misuse is a common antecedent but most patients are not in contact with alcohol services, (b) economic pressures – unemployment having become a more frequent antecedent of patient suicide in most UK countries. It may also result from increased use of hanging, an especially dangerous method.

Pressure on acute mental health care

7. We have looked for evidence of changing risk in acute settings, following recent reports of financial pressures affecting acute care. The pattern is most apparent in England where suicides by in-patients and patients recently discharged from hospital have fallen, although suicides following discharge from a non-local ward have increased.

8. Suicides by patients under crisis resolution/home treatment (CR/HT), however, have increased. In England there are now three times as many suicides under CR/HT as in in-patient care; in 37% the patient has been under CR/HT for less than a week.

9. These findings together may reflect reduced availability of local in-patient beds, with increasing reliance on home treatment as an alternative to admission, and on beds that are out of the local area.

Suicide by opiate overdose

10. The most common type of drug taken in fatal overdose by mental health patients is now opiates - 141 deaths in 2013 across the UK, with proportionately higher numbers in Scotland and Northern Ireland, and a total of 1,215 suicides over the study period.

11. In this year's report we have presented figures showing that in nearly half of these deaths, the source of opiates is prescription, mainly for the patient, though sometimes for someone else. People who die after taking prescribed opiates are more often older, female, with physical illness and affective disorder. We do not yet have comprehensive data on the type of prescribed drug.

Working with families

12. Our findings make it clear that working more closely with families could improve suicide prevention. Staff told us that greater involvement of the family by the service would have reduced the risk in 14% of cases, a total of 2,338 deaths over the whole study period. The figure is slightly higher, at 16%, in England where it has also risen in recent years - this may reflect a growing need to consult families or a greater awareness of their potential role. The equivalent figure for reducing homicide risk is higher at 28%.

13. One example of how services can improve contact with families is shown in our figures on how services respond when a patient does not attend an appointment. In only 22% the service contacted the family when the patient missed the final appointment before the suicide occurred.

Physical illness

14. Physical illness is known to be a risk factor for suicide. We have found that around a quarter of patients who die by suicide have a major physical illness - 3,410 deaths over 2005-2013 - and the figure rises to 44% in patients aged 65 and over. In most cases the illness has been present for over 12 months.

15. In 2013 there were 445 mental health patients who were reported to have major physical illness and who died by suicide - this figure has risen since 2008, though the rise may reflect a greater awareness of physical illness among staff.

Sudden unexplained death

16. We collected information on sudden unexplained death (SUD) in England and Wales between 2003-2013. The number of SUD cases on mental health wards is unchanged. In this report we are highlighting SUD cases in which the patient was under 45. There were 96 cases in the report period, around 9 per year.

17. Most younger patients who die suddenly on mental health wards have a lower rate of known physical illness, compared to older patients in whom SUD occurs. They also have a higher rate of polypharmacy - although this is still found in a minority at 16%, it is a possible causal factor that clinical staff can address.

Homicide

18. We collected information on all homicides in the UK between 2003-2013. Lower patient homicide figures since 2008 have been maintained, mainly because of lower figures in England. However, the report presents only confirmed convictions and patient figures will increase as we receive confirmation from Trusts and Health Boards. In particular the 2013 figure for England is higher than at the equivalent stage in recent years and it is possible that the final figure may be comparatively high.

Stranger homicide

19. Homicides in which the perpetrator and victim are unknown to each other (stranger homicides) are important in mental health because, when the perpetrator is a mental health patient, they are thought to increase public opposition to patients living in the community. Our findings show that only 7% of stranger homicides are committed by mental health patients and that the figure has fallen since a peak in 2006. However, the total figure in 2003-2013 is 117 and mental health care continues to have an important role in improving public safety.

CLINICAL MESSAGES

20. This report, which presents findings from 2003 to 2013, highlights areas of health care where safety should be strengthened. Responsibility for this is shared between mental health providers, partner agencies, commissioners (in England), education and training bodies and professional organisations. Although the data are from specialist mental health services, several clinical messages - on male patients, opiate prescribing, working with families and physical illness - are also applicable to primary care. The findings and recommendations in this section emphasise common areas across the UK countries but country-specific findings may also require actions by services.

Suicide in male patients

21. Our findings show that recent concerns over the risk of suicide in middle-aged men are equally relevant in mental health - in fact, the rise in male patient suicide appears to be greater than in the general population. This should now be seen as a suicide prevention priority, specifically:

- Services should ensure that they and partner agencies address factors that add to risk in male patients - especially alcohol misuse, isolation and economic problems such as debt and unemployment.
- It is important that male patients have access to psychological as well as drug treatments within the service, that contact is not easily lost and risk is monitored, and that courses of treatment are completed.

Pressures on acute care

22. Our findings suggest that it is in the safety of crisis resolution/home treatment (CR/HT) that current bed pressures are being felt. CR/HT has brought a number of benefits to patients, but the safe use of these services should be monitored. Commissioners (in England) and providers should review their acute care:

- CR/HT should not be used by default for patients who are at high risk or who lack other social supports.
- CR/HT should be an intensive community-based alternative to in-patient care; skills and contact time should reflect this specialised role.
- Acute admissions out of area should end - they are likely to make care planning more difficult and to add to suicide risk at the time of discharge.

Suicide by opiate overdose

23. Clinicians should be aware of the potential risks from opiate-containing painkillers and should enquire about patients' access to these drugs when assessing suicide risk.

24. Prescribers of these drugs should limit the duration of prescription of opiates, as they do with antidepressants, to reduce the risk of accumulating a lethal quantity. This is primarily a role for primary care but pharmacists can play a part in encouraging safe prescribing.

Working with families

25. Families and carers are a vital but under-used resource in mental health care. Our findings suggest that closer working with families would have safety benefits:

- Services should consult with families from first contact, throughout the care pathway and when preparing plans for hospital discharge and crisis plans.
- Staff should make it easier for families to pass on concerns about suicide risk and be prepared to share their own concerns.

Physical illness

26. Our findings suggest that good physical health care may help reduce suicide risk in mental health patients:

- Physical health needs, especially long-term needs, should be reflected in mental health care plans.
- Mental health staff should regularly review care with GPs or specialist clinics.

Sudden unexplained death

27. A number of sudden and unexplained deaths in younger in-patients continue to occur. We intend to study these deaths more closely for possible antecedents and background risk.

28. These deaths should always be subject to investigation and reporting by the mental health trust, and to coroner referral.

29. Wards should take precautionary measures including physical health assessment as soon as practicable after admission, and avoidance where possible of high drug dosage and polypharmacy.

PRESENTATION OF FINDINGS AND METHODOLOGY

Definitions

Suicide

30. General population suicides are defined as deaths by intentional self-harm and deaths of undetermined intent by individuals aged 10 and over. Patient suicides are those that occur within 12 months of mental health service contact.

Homicide

31. General population homicides are defined as convictions for murder, manslaughter, (culpable homicide in Scotland), infanticide, and verdicts of not guilty by reason of insanity and unfit to plead and are presented by year of conviction. Patient homicides are those that are committed by people who have had mental health service contact within 12 months before the offence. Identification of mental illness in non-patients relies on information from psychiatric reports prepared by psychiatrists for the court.

Sudden unexplained death (SUD)

32. A sudden unexplained death is defined as a death in which a person dies a) from an unknown, uncertain or cardiac cause (other than confirmed myocardial infarction), b) within 1 hour of symptom onset.

Changes to suicide death coding

33. Following an update to the International Statistical Classification of Diseases and Related Health Problems (ICD-10) in 2011, new rules for coding drug misuse deaths were introduced. Some drug-related deaths previously coded as due to 'mental and behavioural disorders due to psychoactive substance use' are now coded as suicide or undetermined deaths. Analysis by the Office for National Statistics (ONS) has shown these new coding rules have had no significant impact on the suicide figures in England.[1] However, they have affected numbers in Scotland and therefore the overall numbers of suicides in Scotland in 2011, 2012 and 2013 are not directly comparable with previous years. For Scotland, the number of suicides using the new coding rules is reported and we also estimate what the figures for 2011-2013 would have been following the old coding rules. In some of the figures of longitudinal trends, we show data using both old and new rules.

Report period

34. In this report, findings are presented for England, Northern Ireland, Scotland, and Wales for:

- Suicide (based on date of death - **this differs from the ONS who present figures by date of death registration).**
- Homicide (based on year of conviction).
- SUD (this data collection takes place in England and Wales only and is based on date of death).
- Homicide-suicide (based on date of offence, England and Wales only).

35. Findings are presented for the baseline year of 2003 and the subsequent 10 years including the most recent year (2013).

Method of data collection

36. The Inquiry method of data collection is similar across all UK countries. Briefly, to identify patients (i.e. individuals in contact with mental health service within 12 months of suicide or homicide) national data are used to identify the individuals' addresses. Data are then sent to mental health services in each individual's district of residence. Detailed clinical data are obtained for these individuals via questionnaires sent to the consultant psychiatrist. A full explanation is provided in the FAQ section of our website or in our previous national reports: Annual Report (2009, 2010) [2,3], and Avoidable Deaths (2006) [4] Suicide and Homicide in Northern Ireland [5] Lessons for Mental Health Care in Scotland, [6] which are accessible on our website at: **www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci**

Data completeness

Suicide

37. For the period 2003-2012 overall data completeness for patient suicide is 96% in England, 97% in Wales, and 98% in Northern Ireland and Scotland. Completeness is lower in the more recent years reported, reflecting the time required to process the data. For example, in 2012 and 2013 completeness for England is 91% and 63% respectively. For the five most recent years (2009-2013) of the patient suicide analysis completeness is below 98% and we have, therefore, uplifted the number of cases based on the expected final return of Inquiry questionnaires for the previous six years (2003-2008).

Homicide

38. For the period 2003-2013 we have presented patient homicide numbers notified to the Inquiry plus additional cases for 2007-2013 which account for questionnaires sent to Trusts/Health Boards but had not been returned at the time of analysis. For example, for 2013, we have received notification confirming 36 patient homicides, 27 questionnaires have been returned with a further 9 currently outstanding.

39. We are aware that data on homicide convictions for Scotland previously provided to us may be incomplete, therefore the figures presented may be an underestimate. Offender data relating to previous convictions were less complete due to a delay in the renewal of the data sharing agreement with the Scottish Police Service.

Psychiatric reports

40. Our figures for patient homicide are based on Trust records only. In addition we obtain psychiatric reports and use these for our figures on symptoms of psychosis at the time of the offence, diagnosis history of schizophrenia, and history of alcohol and drug misuse, whether the offender was a patient or not. The number of psychiatric reports undertaken and disclosed in court has fallen over the report period. We assume that those with serious mental illness, particularly psychosis, are more likely to have been assessed, but there is no direct way of confirming this. However, of the people we know to have serious mental illness (i.e. patients with schizophrenia) nearly all had a psychiatric report (94%). We therefore think it is probable that non-patients with serious mental illness will also have a psychiatric report. We acknowledge that these figures may be underestimated.

Analysis

Trends over time

41. To examine for statistically significant time trends, trend tests were carried out using categorical data methods in Stata v13.[7] Poisson models were fitted with the number of suicides or homicides per year as the outcome and year as a linear predictor. For rates, general population per year was the exposure. Within the patient sample, the exposure was the total number of suicides or homicides per year. Tests for trends over time were calculated excluding the final year which was least complete (i.e. 2013) for suicide and homicide, for both general population and patients. For each model, the likelihood-ratio-test p-value and the predictor (and 95% confidence intervals) for year were examined.

Rates of suicide

42. General population and patient rates for suicide were calculated using mid-year population estimates revised in light of the 2011 census (age 10 and over) as denominators obtained from ONS and National Records of Scotland (NRS). These were also used to calculate rates for suicide by NHS England Area Team (England) and Health Boards (Northern Ireland, Scotland, and Wales). Discrepancies may arise between Inquiry national numbers and rates and those presented by the ONS, the Department of Health[8], the Scottish Public Health Observatory website[9], and the Northern Ireland Statistics and Research Agency (NISRA) website[10] due to differences in measurement described in Avoidable Deaths[4], Suicide and Homicide in Northern Ireland[5] and Lessons for Mental Health Care in Scotland[6]. Our website FAQs summarises how discrepancies may be explained.

One important difference in comparison to ONS figures is that our suicide figures are presented by date of death, not date of registration.

43. Estimated numbers in the final year (2013) are presented as dotted lines in the figures or in a different shade in the bar diagrams. Changes in annual figures will occur subject to further information received.

ENGLAND

SUICIDE

44. Between 2003-2013, the Inquiry was notified of 49,251 deaths in the general population that were registered as suicide or "undetermined", an average of 4,477 per year. These are referred to as suicides throughout the report.

Suicide in the general population

45. Our suicide rates differ from ONS rates because Inquiry rates are based on date of death in those aged 10 or over and are not adjusted for age - ONS rates are based on date of death registration in those aged 15 or over and are age-standardised.

46. Some deaths are not registered for several months or longer which means that our figures for the most recent years underestimate the final figures. We therefore calculate figures that take this delay into account for 2012 and 2013 (Table 1).

47. Figures for the report period show a range of 4,227 (2006) to an estimated 4,840 (2012) suicides, with a male to female ratio of 3:1 overall, currently 3.4:1 (Table 1).

Table 1: Number of suicides in the general population, by gender

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Male	3430	3428	3312	3202	3232	3474	3304	3292	3442	3728 3765†	3371 3674†
Female	1228	1241	1151	1025	1017	1147	1044	1096	1031	1064 1075†	992 1081†
Total	**4658**	**4669**	**4463**	**4227**	**4249**	**4621**	**4348**	**4388**	**4473**	**4792 4840†**	**4363 4756†**

†indicates the estimated final number based on delays recorded in previous years, i.e. a 9% increase in 2013 and 1% increase in 2012

48. The changing pattern of suicide since 2003 is complex. There has been little overall change in the suicide rate but figures for 2012 and 2013 are comparatively high and there was a peak in 2008 after a historical low in 2006-2007 (Table 1; Figure 1). This pattern largely reflects male rates: in females there has been a fall in the rate and number of suicides since 2003, though no further fall has occurred in 2011-2013.

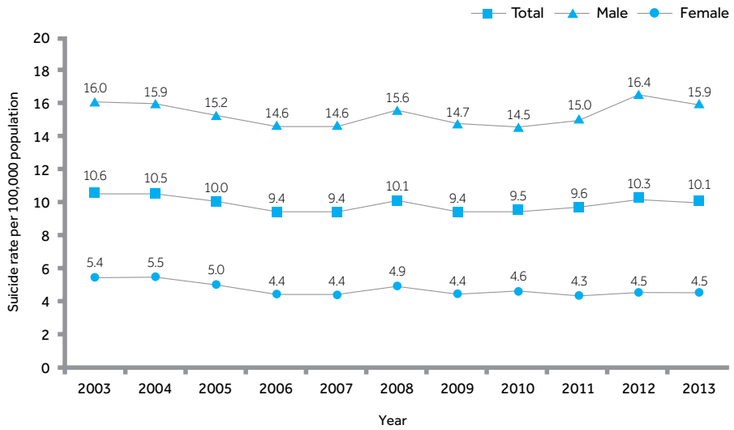
49. Higher figures after 2007 are thought to reflect financial pressures leading to unemployment and debt. The rise may have been partly offset by narrative coroner verdicts that were not officially recorded as suicides.

50. The pattern of male suicide rates during the report period varied by age-group (Figure 2). Since 2003, there has been a fall in male suicide rates in those aged 25-34 and 65 and over; an increase in those aged 45-54 and 55-64; and no change in those aged under 25 or 35-44. In females, rates fell in those aged under 25, 25-34 and 65 and over.

51. These changes have been substantial and largely maintained year on year. The rise in suicide in men aged 45-54 since 2006 is 37%, in men aged 55-64 it has been 29%. The fall in men aged 25-34 from 2003 to 2011 was 28%.

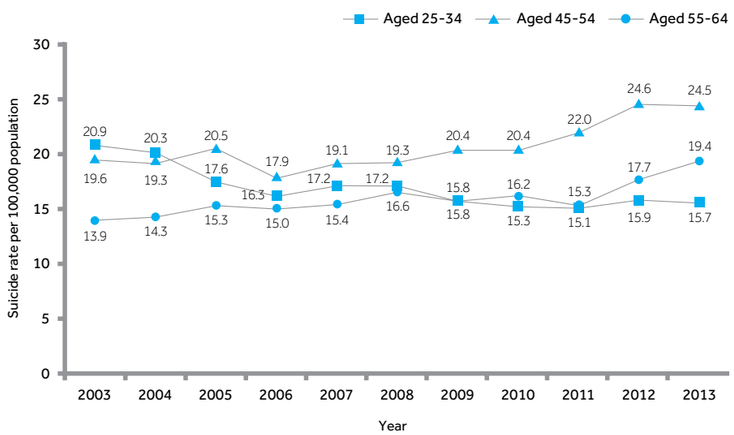
SUICIDE RATES IN MEN AGED 45-54 HAVE RISEN BY 37% SINCE 2006. RATES HAVE RISEN BY 29% IN MEN AGED 55-64.

Figure 1: Rates of suicide in the general population, by gender



Note: rates in 2012 and 2013 are estimated to take into account delays in data collection.

Figure 2: Male suicide rates in the general population in those aged 25-34, 45-54 and 55-64



Note: rates in 2012 and 2013 are estimated to take into account delays in data collection.

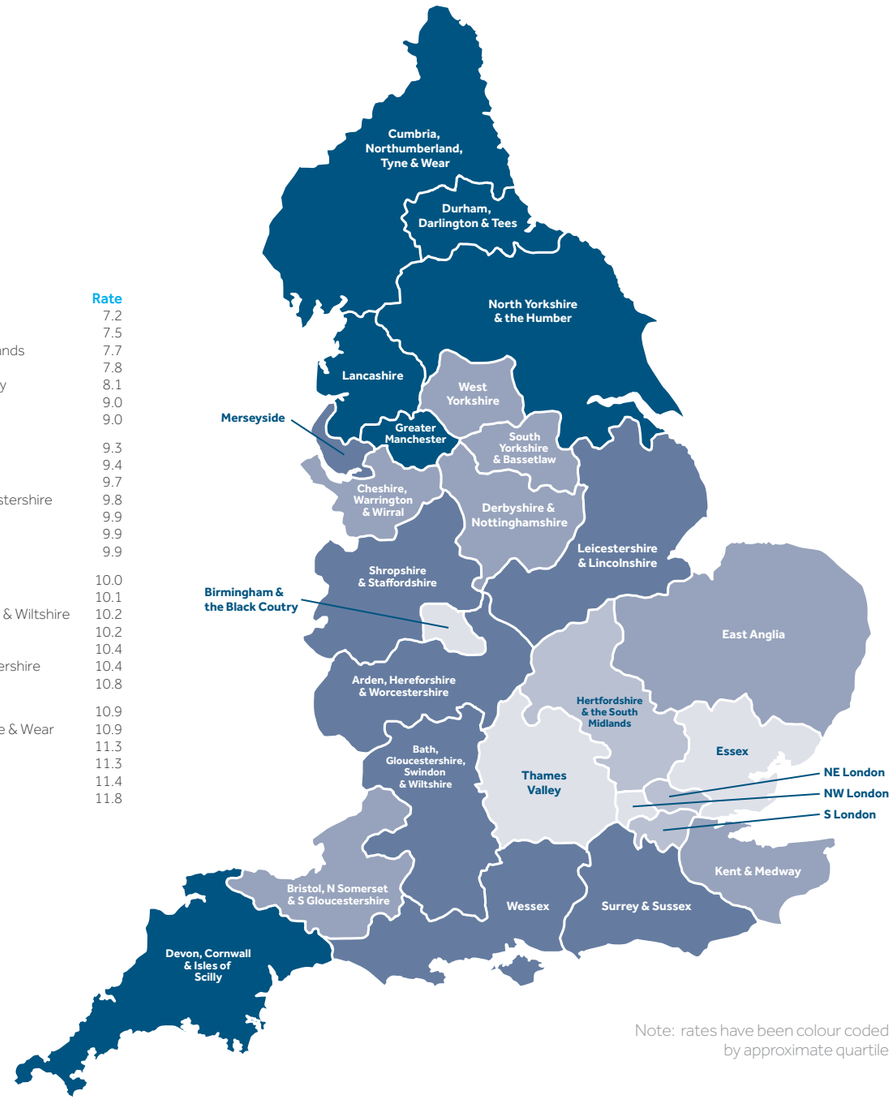
Variation in suicide rates by area of residence (NHS England Area Teams)

52. Suicide rates varied by area of residence (by NHS England Area Team) at the time of death. Average rates for 2011-2013 are shown in Figure 3. The highest rate of suicide was in Lancashire, at 11.8 per 100,000 population and the lowest in North West London, at 7.2 per 100,000 population. In general the highest rates were in the north and south-west, with the lowest rates in London and the south-east.

53. ONS suicide rates mapped to English local authorities can be found on the Public Health England website at: **http://fingertips.phe.org.uk/search/suicide**

Figure 3: Rates of suicide per 100,000 population, by NHS area of residence (average rate 2011-2013)

Area	Rate
North West London	7.2
South London	7.5
Hertfordshire & the South Midlands	7.7
North East London	7.8
Birmingham & the Black Country	8.1
Essex	9.0
Thames Valley	9.0
Derbyshire & Nottinghamshire	9.3
South Yorkshire & Bassetlaw	9.4
Cheshire, Warrington & Wirral	9.7
Bristol, N Somerset & S Gloucestershire	9.8
East Anglia	9.9
West Yorkshire	9.9
Kent & Medway	9.9
Wessex	10.0
Leicestershire & Lincolnshire	10.1
Bath, Gloucestershire, Swindon & Wiltshire	10.2
Surrey & Sussex	10.2
Shropshire & Staffordshire	10.4
Arden, Hereforshire & Worcestershire	10.4
Merseyside	10.8
Greater Manchester	10.9
Cumbria, Northumberland, Tyne & Wear	10.9
Durham, Darlington & Tees	11.3
Devon, Cornwall & Isles of Scilly	11.3
North Yorshire & the Humber	11.4
Lancashire	11.8



Note: rates have been colour coded by approximate quartile

Method of suicide

54. The most common methods of suicide were hanging and strangulation (referred to as hanging in the remainder of this report) (22,724, 46%), self-poisoning (overdose) (10,845, 22%), and jumping and multiple injuries (mainly jumping from a height or being struck by a train) (5,148, 10%). Less frequent methods were drowning (2,244, 5%), carbon monoxide (CO) poisoning (1,697, 3%), cutting and stabbing (1,381, 3%), and firearms (1,009, 2%).

55. Deaths by hanging have increased since 2003 (Figure 4). Deaths by self-poisoning decreased, and those by jumping and multiple injuries did not change. Of the less common methods, deaths by drowning and CO poisoning decreased (Figure 5).

56. The increase in hanging may be related to restrictions on the availability of other methods, e.g. drugs used in overdose, and to a misconception that hanging is a quick and painless method.[11] The fall in CO poisoning deaths since the 1990s is related to the introduction of catalytic converters in 1993.[12]

Figure 4: Suicide in the general population: main causes of death

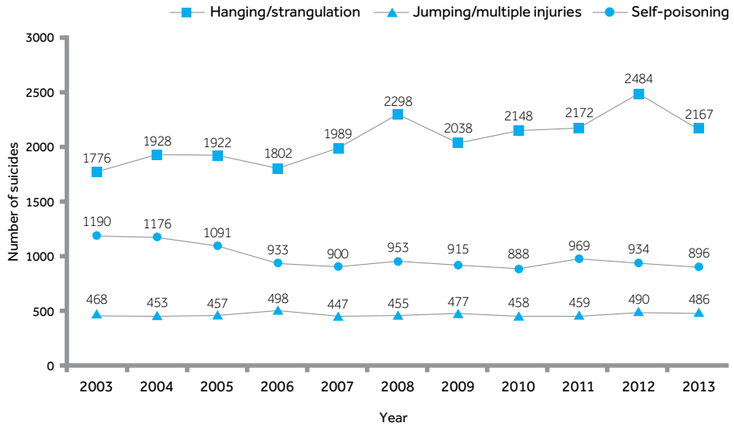
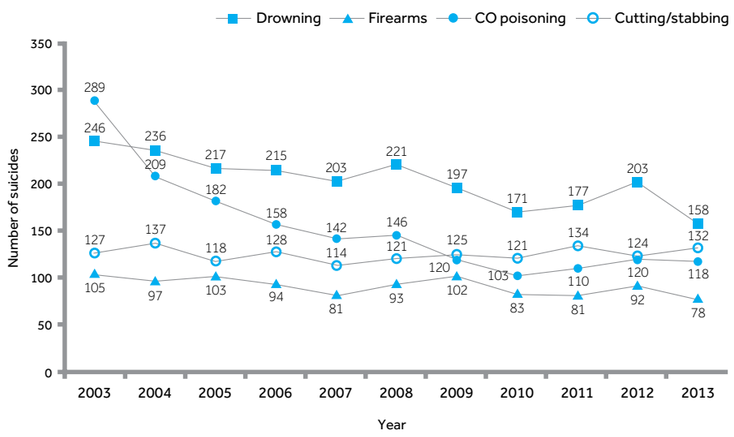


Figure 5: Suicide in the general population: other causes of death



PATIENT SUICIDE

Patient suicide: numbers and rates

57. During 2003-2013, 13,972 deaths (28% of general population suicides) were identified as patient suicides, i.e. the person had been in contact with mental health services in the 12 months prior to death. This represents an average of 1,270 patient suicides per year.

58. There was an overall increase between 2003 and 2012 in the number of patient suicides (Figure 6). Our figure for suicide by patients shows an estimated increase in 2013. The figure for 2013 should be interpreted cautiously as it is a provisional figure based on incomplete data. However, we are estimating a higher number of patient suicides than in the rest of the report period.

59. The annual number of suicides in male patients has been increasing since 2006 (Figure 7), while for females the number has fallen between 2003-2012. The rise in male patients since 2006 is 34%, whereas the general population rise in males is 15%.

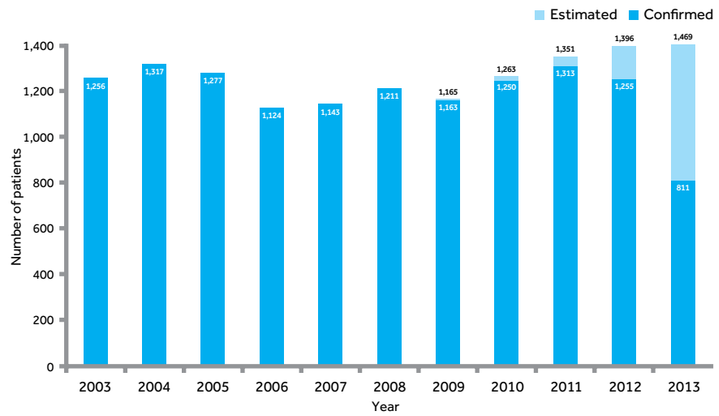
60. There was an increase in the number of male suicides in those aged 45-54, 55-64 (Figure 8) and 65+. The annual number of suicides in male patients aged 25-34 has fallen in the report period (Figure 8) and there has also been a fall in female patients aged 65+. The rise in male patients aged 45-54 has been particularly striking, around 90% since 2006 (Figure 8).

61. Higher numbers of suicide may reflect rising numbers of people under mental health care. We have calculated patient suicide rates with figures from the Mental Health Learning Disabilities Data Set (MHLDDS)[13] † as the denominator (Figure 9). Falling rates are seen from 2004 but changes in MHLDDS methodology[14] mean that rates from year 2011 onwards are not directly comparable to earlier years. Patient suicide rates measured in this way show no increase after 2011.

62. In 4,031 (33%) the suicide occurred within a year of mental health service contact; in 4,746 (39%) it was over 5 years.

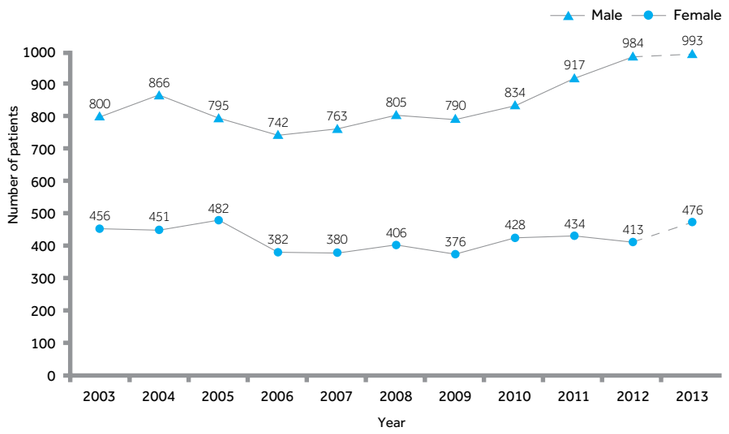
† formerly known as the Mental Health Minimum Dataset (MHMDS).

Figure 6: Number of patient suicides



THERE HAS BEEN A 34% INCREASE IN MALE PATIENT SUICIDES SINCE 2006. THE INCREASE IS PARTICULARLY IN MALES AGED 45-54.

Figure 7: Number of patient suicides, by gender



Note: some figures do not tally with the total figures in Figure 6 due to rounding

Figure 8: Patient suicide: number of male suicides in those aged 25-34, 45-54 and 55-64

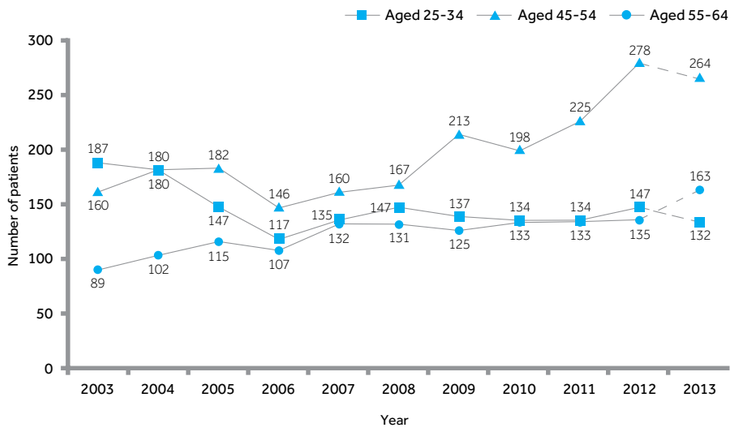
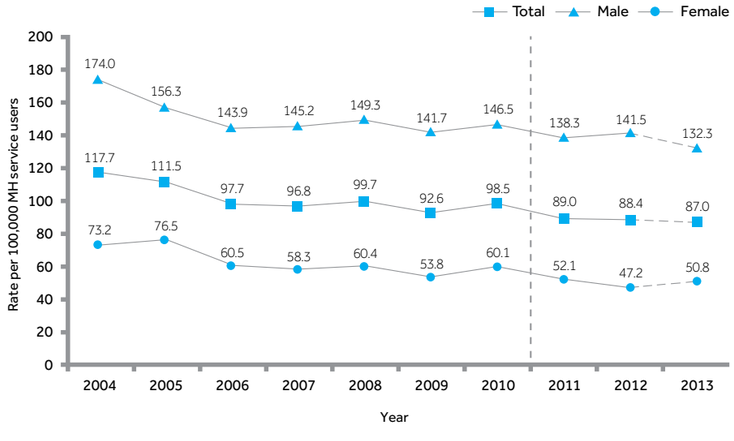


Figure 9: Rates of suicide per 100,000 mental health service users†



†The Mental Health Learning Disabilities Data Set (MHLDDS) was used to calculate rates for the available years (2004-2013). Changes in MHLDDS methodology [14] means rates between 2004-2010 and 2011-2013 are not directly comparable. Rates in 2011-2013 are based on 1,517,613 service users in 2011, 1,578,409 in 2012 and 1,688,955 in 2013.

Method of suicide by patients

63. The most common methods of suicide by patients were hanging (5,807, 42%), self-poisoning (3,604, 26%), and jumping/multiple injuries (2,154, 15%).

64. Hangings increased in number during 2003-2012, and we are estimating a further rise in 2013 (Figure 10). The number of self-poisoning deaths fell after 2004 but there has been an increase since 2006 (Figure 10). The number of suicides by CO poisoning and drowning decreased over the report period.

65. Opiates were the most common type of drug in self-poisoning (767, 24%; Figure 11). The number of deaths by opiates increased over the report period.† These deaths are discussed in more detail in the UK-wide data section on page 86.

66. The next most common substances used in deaths by self-poisoning were tricyclic antidepressants (416, 13%), anti-psychotic drugs (357, 11%), and paracetamol/opiate compounds (301, 9%). Paracetamol was used in 213 (7%) patient suicides.

67. The annual number of self-poisoning deaths by tricyclic antidepressants fell after 2003 but there has been no further fall since 2006 (Figure 11). There has been an increase in paracetamol deaths since 2009, with the highest number over the whole report period estimated in 2013. The number of deaths by SSRI/SNRI antidepressant self-poisoning increased over the report period.

68. There were 243 deaths by suicide in the general population which followed inhalation of helium gas, increasing from an average of 7 per year in 2003-2008 to 41 per year in 2009-2013. Of these, 67 (28%) were patients, similar to the proportion for all suicides. Though this is less than 1% of all patient suicides during the report period, there has been a rise in deaths by this method in line with the general population pattern. For example, there were 10 deaths from helium in 2003-2008 and 20 in 2013 alone.

†The increase in the number of deaths by opiates may partly reflect the coding change in the cause of death since 2011.

Figure 10: Patient suicide: main causes of death

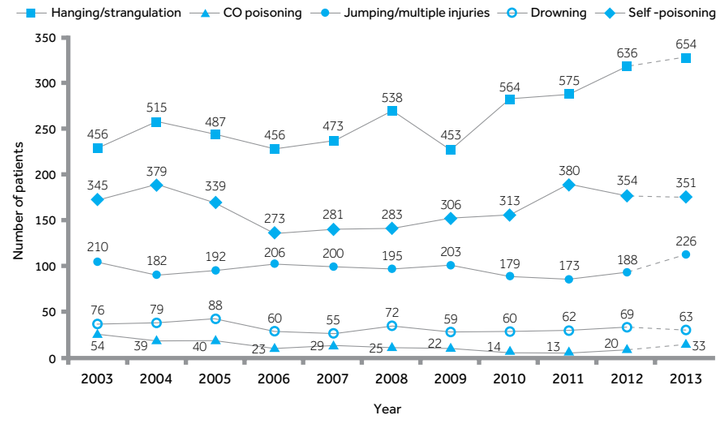
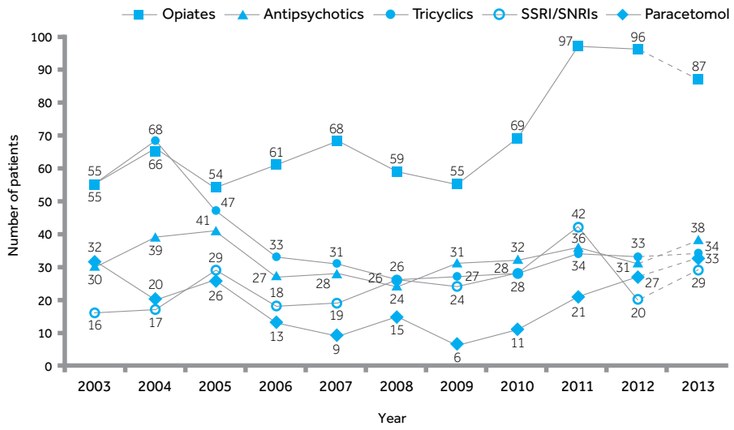


Figure 11: Patient suicide: main substances used in deaths by self-poisoning



Suicides in people aged under 25

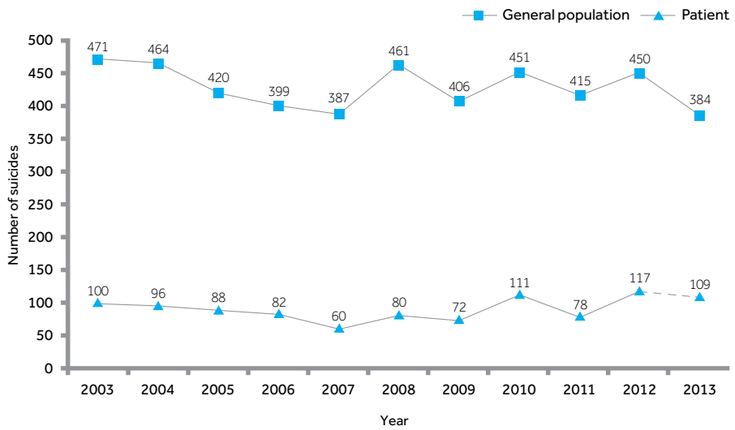
69. During 2003-2013, there were 4,708 suicides in the general population in people aged under 25, 10% of all suicides, an average of 428 per year. 1,504 were aged under 20, an average of 137 per year, and 658 were aged under 18, an average of 60 per year.

70. 993 of those under 25 were patients, 7% of patient suicides and 21% of all suicides in this age-group. This represents an average of 90 deaths per year. 262 were aged under 20, an average of 24 per year, and 104 were aged under 18, an average of 9 per year.

71. Patient suicides in under 25s decreased until 2007 after which there has been an increase (Figure 12). The peak number was in 2012.

72. We are currently establishing a national investigation of suicides in this age group and will be publishing preliminary findings in 2016.

Figure 12: Number of general population and patient suicides in those aged under 25

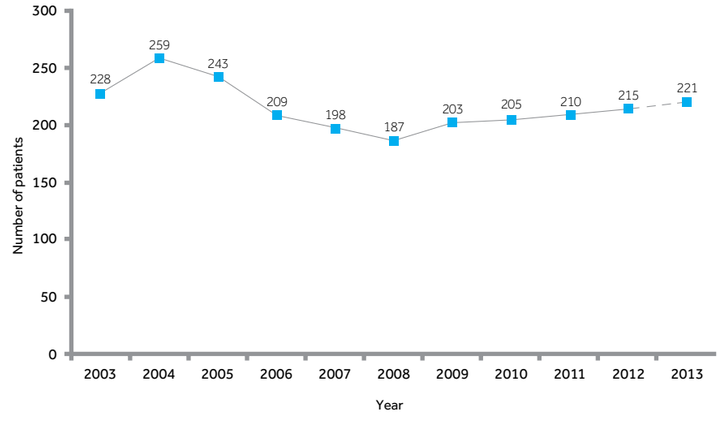


Patients with schizophrenia

73. There were 2,378 suicides in patients with a primary diagnosis of schizophrenia (includes other delusional disorders), 17% of the total sample, an average of 216 deaths per year.

74. The number of suicides in patients with schizophrenia fell after 2004 but there has been a gradual rise since 2008 (Figure 13).

Figure 13: Patient suicide: number with a primary diagnosis of schizophrenia and other delusional disorders

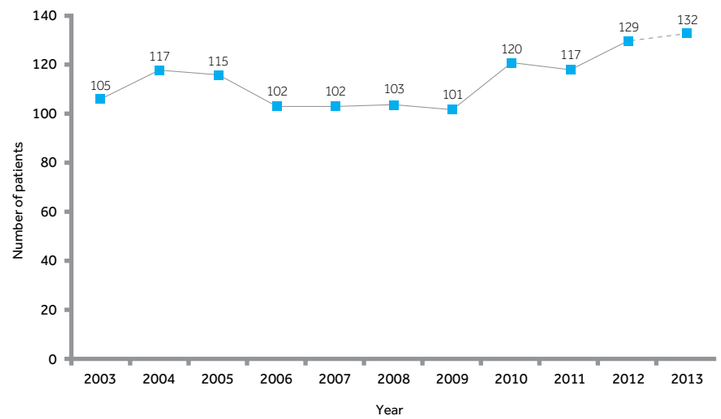


Patients with personality disorder

75. There were 1,243 suicides in patients with a primary diagnosis of personality disorder, 9% of the total sample, an average of 113 deaths per year (Figure 14). The number has increased since 2009.

76. We are currently carrying out a detailed study investigating suicide in patients with personality disorder which will be published in 2017. We have also studied suicide in personality disorder in primary care and will be publishing this study soon.

Figure 14: Patient suicide: number with a primary diagnosis of personality disorder



Patients with alcohol and drug misuse

77. There were 6,124 suicides in patients with a history of alcohol misuse, 45% of the total sample, an average of 557 deaths per year (Figure 15).

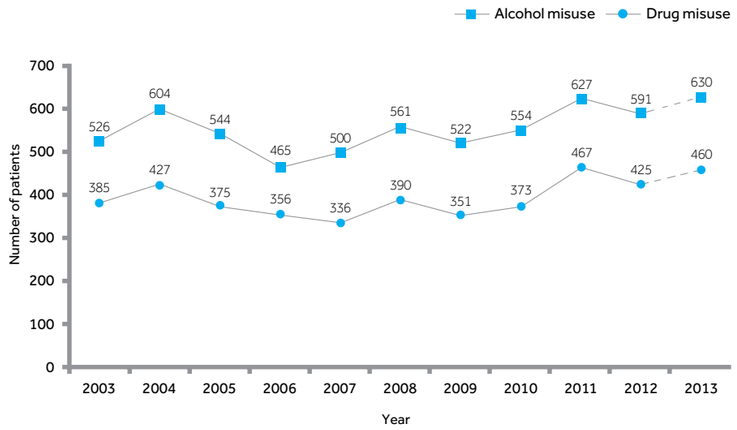
78. 4,345 had a history of drug misuse, 32% of the total sample, an average of 395 deaths per year (Figure 15).

79. 7,381 had a history of either alcohol or drug misuse or both, 54% of patient suicides, an average of 671 deaths per year.

80. The number of suicides in patients with a history of alcohol misuse has increased. The number with drug misuse has followed a similar pattern, but the overall rise does not reach statistical significance (Figure 15).

81. Between 2011-2013, 249 (7%) patients were under drug services and 268 (7%) were under alcohol services.

Figure 15: Patient suicide: number with a history of alcohol or drug misuse



Socio-economic factors

82. In 2012 and 2013 there were 283 (18% excluding unknowns) suicides in patients who had experienced serious financial difficulties in the 3 months before death.

83. In 2008-2012, a higher proportion of patients were unemployed (2,784, 46%) compared to the pre-recession years of 2003-2007 (2,405, 41%). 919 (7%) patients were in unstable housing, i.e. homeless or living in bed and breakfast or a hostel. This proportion did not change over the report period.

Websites promoting suicide

84. In 2011-2013 there were 94 patients who died by suicide after visiting a "pro-suicide" internet site, i.e. providing information on methods or encouraging suicide. This represents an average of 31 per year, 2% of all patient suicides during this period. This proportion increased to 6% (18 patients) in patients aged under 25. As these figures are based on clinical reports, they may underestimate how often this occurs.

Significant dates

85. In 2011-2013, 171 patients died on a date that carried significance (e.g. birthday), an average of 57 per year, 4% of all patient suicides. Again, this may be an underestimate.

MENTAL HEALTH CARE

In-patient suicide

86. There were 1,295 in-patient deaths by suicide in 2003-2013, 9% of patient suicides.

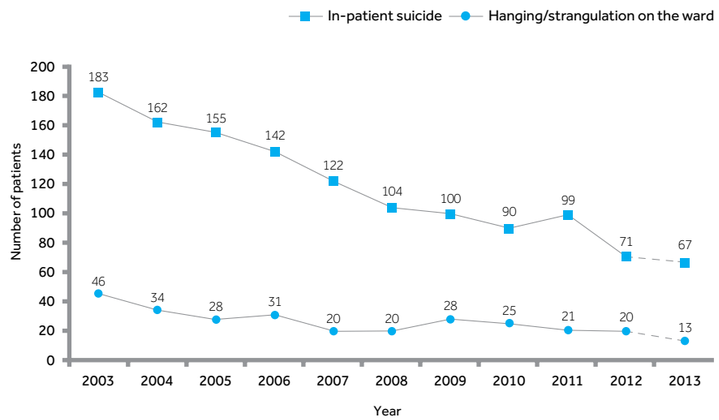
87. From 2003 to 2012, there was a 61% fall (112 cases) in the number of in-patient suicides (Figure 16). We are estimating a continuation of this trend in 2013 but in-patient deaths are more often subject to late notification and our estimated figure should be viewed with caution. A reduction in the rate of in-patient suicide has previously been found (i.e. taking into account admission figures and time under in-patient care). [15, 16]

88. Deaths by hanging on the ward are usually from low-lying ligature points (i.e. strangulation). The number of deaths by this method fell by 57% (26 cases) from 2003 to 2012 (Figure 16).

89. There were 351 suicides in detained in-patients, 27% of all in-patient suicides, an average of 32 per year. The number of these deaths decreased annually over the report period.

90. 282 in-patients died after absconding from the ward, 22% of all in-patient suicides, an average of 26 deaths per year. There was an overall fall in the annual number of suicides after absconding.

Figure 16: Patient suicide: number of mental health in-patients; number who died by hanging and strangulation on the ward



Crisis Resolution/ Home Treatment

91. There were 1,852 suicides in patients under crisis resolution/home treatment (CR/HT) teams, 14% of the total sample, an average of 168 deaths per year.

92. Overall, the annual number of suicides under CR/HT increased over the report period, reflecting its introduction in 2004-06. The number changed little from 2008 to 2012 but we are estimating a rise in 2013 (Figure 17).

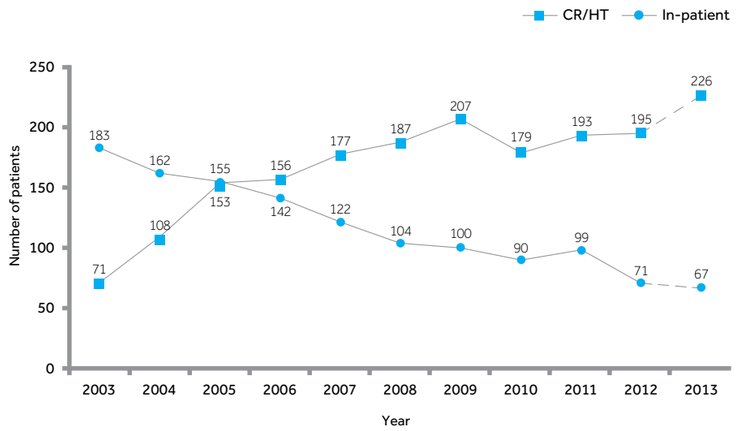
93. Since 2005 there have been more patient suicides under CR/HT than in in-patient care, reflecting a change in the nature of acute care. Our estimates for 2013 mean there are now three times as many patient suicides under CR/HT (Figure 17).

94. In 578 (33%) the patient had been discharged from in-patient care in the preceding 3 months; 132 (24%) died within a week of discharge.

95. We have collected data on length of time under CR/HT since 2012. 109 (37%) patients who died had been under CR/HT services for less than a week, 24 (22%) of whom died within 3 months of discharge from in-patient care.

96. In 795 (43%) the patient lived alone. In 169 (56% excluding unknowns) the care plan included additional social support at home, e.g. from a relative, friend or neighbour. However, those living alone were less likely to receive additional support (52, 41%).

Figure 17: Patient suicide: number under crisis resolution/ home treatment services and mental health in-patients



THERE ARE NOW 3 TIMES AS MANY SUICIDES UNDER CR/HT AS IN IN-PATIENT CARE.

Patients recently discharged from hospital

97. There were 2,368 suicides within 3 months of discharge from in-patient care, 17% of all patient suicides and 19% of suicides in community patients, an average of 215 deaths per year.

98. There was an overall fall in the annual number of post-discharge suicides between 2003-2012, and we are estimating a continued fall in 2013 to the lowest figure over the report period (Figure 18).

99. Post-discharge suicides were most frequent in the first week after leaving hospital when 343 deaths occurred, an average of 31 per year, 15% of all suicides within 3 months of hospital discharge (Figure 19). The number and proportion who died in the first week after discharge has not changed over the report period. Of all patients who died in the first week after discharge, the highest number occurred on day 3 (22%).

100. Deaths in the first week were more common in those who discharged themselves from hospital, 45 of 168 (27%).

101. 306 (14%) died before the first follow-up appointment. Between 2003 and 2012, there has been a decrease in the number and proportion of patients who died before first follow-up, though figures have remained stable since 2006.

102. 182 (8%) died after being discharged from a non-local in-patient unit. This increased to 66 (11%) of those who died within 2 weeks of discharge. The annual number of suicides after discharge from a non-local unit has increased from 68 (6%) in 2003-2007 to 109 (11%) in 2008-2012.

Figure 18: Patient suicide: number who died within 3 months of in-patient discharge

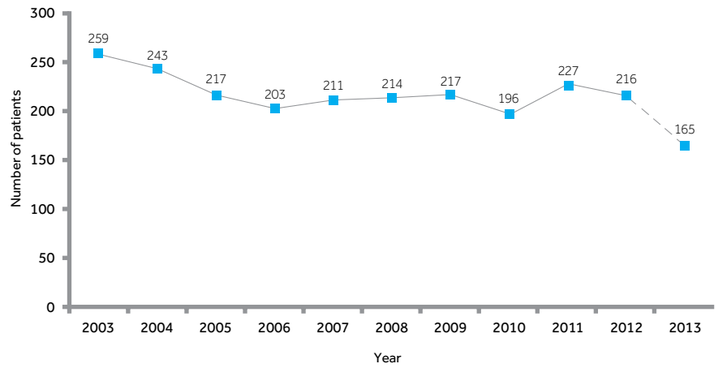
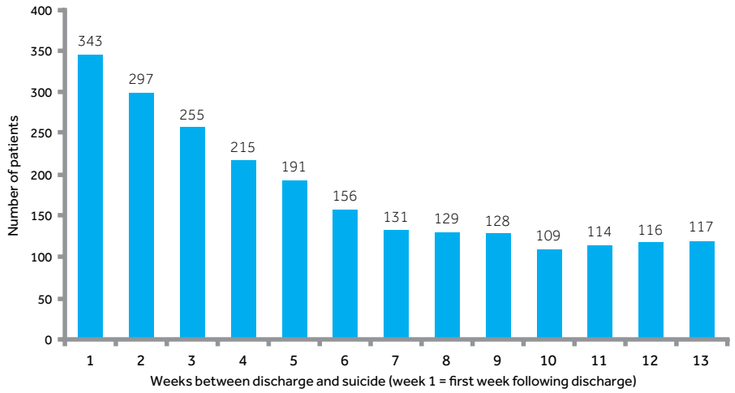


Figure 19: Patient suicide: number per week following discharge (2003-2013)



Section 136 of the Mental Health Act

103. In 2012-2013, 45 (3%) community patients had been conveyed to a hospital-based place of safety under Section 136 of the Mental Health Act within the preceding 3 months; 24 (2%) had been conveyed to a custody-based place of safety under this section.

Urgent referral

104. In 2012-2013, 273 (18%) community patients had been referred urgently to mental health services by a GP in the 3 months prior to death, an average of 137 per year.

Clinicians' views on prevention

105. In 2011-2013, clinicians indicated a number of factors related to acute care that in their view would have made the suicide less likely. These included: less frequent use of agency/locum staff (69, 2% of all patients; 14 (6%) of in-patient suicides); better out-of-hours care (197, 5%); more psychiatric beds (197, 5%); and better crisis facilities (308, 8%).

Community Treatment Orders

106. There were 42 suicides in patients subject to a community treatment order (CTO) in 2009-2013, less than 1% of all patient suicides in this time period, an average of 8 per year. 37 patients who died had previously been on a CTO but were not on a CTO at the time of suicide. The rate of suicide in patients under CTO was 2.0 per 1,000 CTOs in 2009-2013.

107. 19 of the 42 deaths under CTO (45%) occurred within 3 months of hospital discharge.

108. 6 patients who died while subject to a CTO had been non-adherent with drug treatment in the month before death and 9 had missed the last appointment with services; 2 had both refused treatment and missed the last appointment. Therefore 31% of those who died were not receiving care as intended despite CTO powers.

IAPT

109. There were 98 suicides in patients under IAPT services in the years 2011-2013, 3% of all patient suicides in this time period, an average of 33 per year.

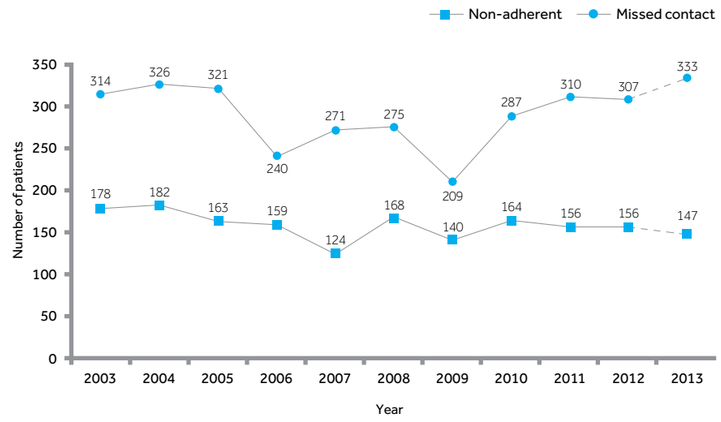
Non-adherence and missed contact

110. 1,737 (14%) patients had been non-adherent with drug treatment in the month before death, an average of 158 deaths per year.

111. 3,193 (26%) patients missed their final service contact before death, an average of 290 deaths per year.

112. There was no overall change in 2003-2012 in the annual number of patient suicides following non-adherence or missed contact. However, there has been an increase in those following missed contact since a low figure in 2009 and we are estimating a further rise in 2013 (Figure 20).

Figure 20: Patient suicide: number non-adherent with drug treatment or missed contact



HOMICIDE

113. In 2003-2013, the Inquiry was notified of 5,835 homicide convictions, an average of 530 per year. There were 6,141 victims, an average of 558 per year.

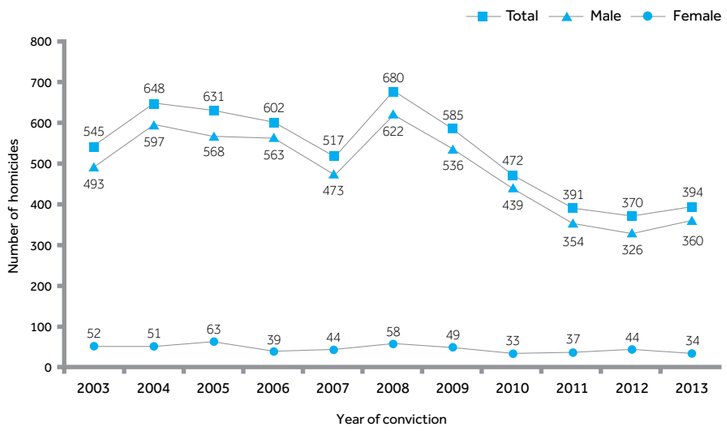
Homicide in the general population

114. The annual number of convictions in the general population is shown in Figure 21. More recent statistics have been published for England and Wales by the Office for National Statistics (ONS) based on the number of offences recorded annually.[17]

115. There has been a decrease in the number of people convicted of homicide annually since a peak in 2008 (Figure 21).

116. The most common method was the use of a sharp instrument (2,259, 41% of cases) and hitting and kicking (1,083, 20%).

Figure 21: Number of homicide convictions in the general population, by gender of offender

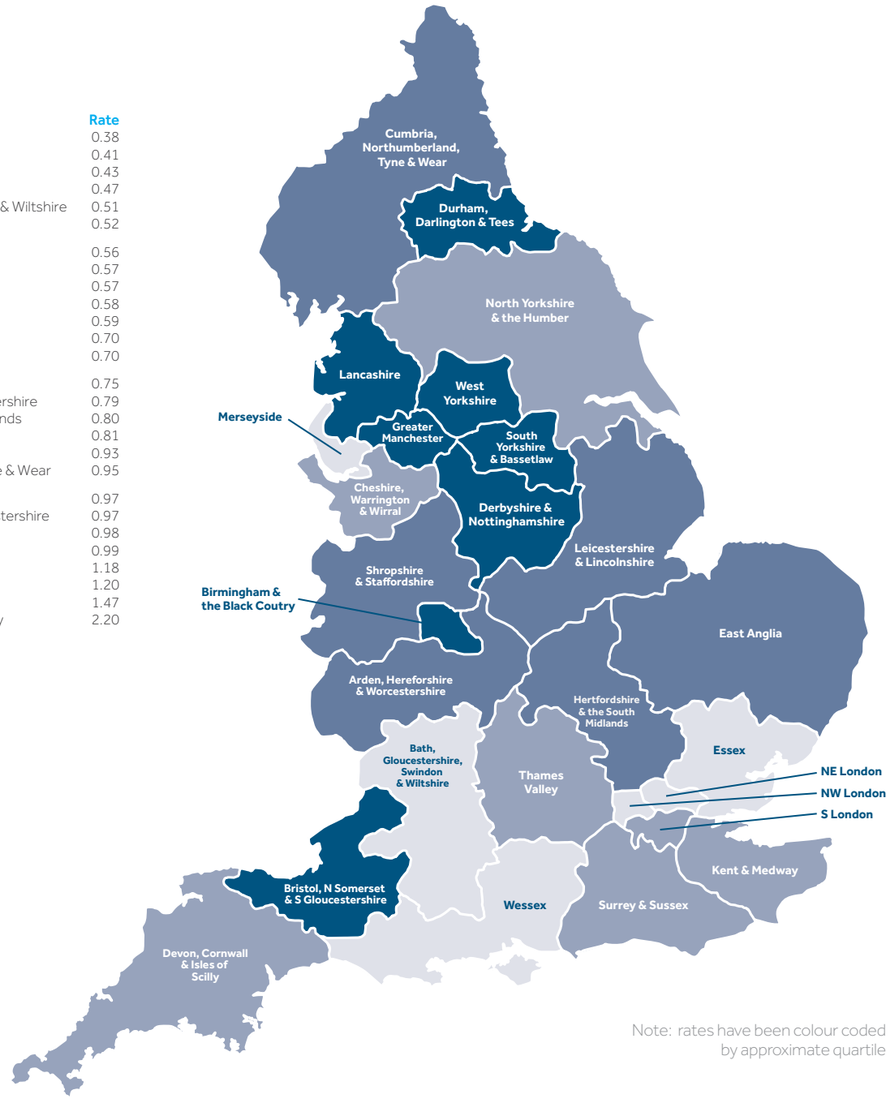


Variation in homicide convictions by area of residence (NHS England Area Teams)

117. Homicide conviction rates varied by area of residence (by NHS England Area Team) (average rate 2011-2013). The highest rate was in Birmingham and the Black Country at 2.20 per 100,000 population, and the lowest in North West London at 0.38 per 100,000 (Figure 22).

Area	Rate
North West London	0.38
Merseyside	0.41
Essex	0.43
Wessex	0.47
Bath, Gloucestershire, Swindon & Wiltshire	0.51
North East London	0.52
Thames Valley	0.56
Surrey & Sussex	0.57
Devon, Cornwall & Isles of Scilly	0.57
Cheshire, Warrington & Wirral	0.58
Kent & Medway	0.59
North Yorshire & the Humber	0.70
South London	0.70
East Anglia	0.75
Arden, Hereforshire & Worcestershire	0.79
Hertfordshire & the South Midlands	0.80
Shropshire & Staffordshire	0.81
Leicestershire & Lincolnshire	0.93
Cumbria, Northumberland, Tyne & Wear	0.95
West Yorkshire	0.97
Bristol, N Somerset & S Gloucestershire	0.97
Lancashire	0.98
Durham, Darlington & Tees	0.99
Greater Manchester	1.18
Derbyshire & Nottinghamshire	1.20
South Yorkshire & Bassetlaw	1.47
Birmingham & the Black Country	2.20

Figure 22: Rates of homicide convictions per 100,000 population by NHS area of residence (average rate 2011-2013)



Note: rates have been colour coded by approximate quartile

PATIENT HOMICIDE

118. The following analysis is based on the patient cases notified for 2003-2013 plus additional confirmed cases for 2007-2013 to take account of cases for whom questionnaires have yet to be returned, a total of 630 (Figure 23). This represents an average of 57 homicides per year. There were 668 victims, an average of 61 per year.

119. There was a fall in the number of patient homicides over the whole report period when examined by year of conviction, and by year of offence (Figure 24 and Figure 25).

120. However, this fall has not continued after 2009 and there may have been an increase in 2013, as our current confirmed figure is higher than at the same point in data collection in previous years.

Figure 23: Number of patient homicides

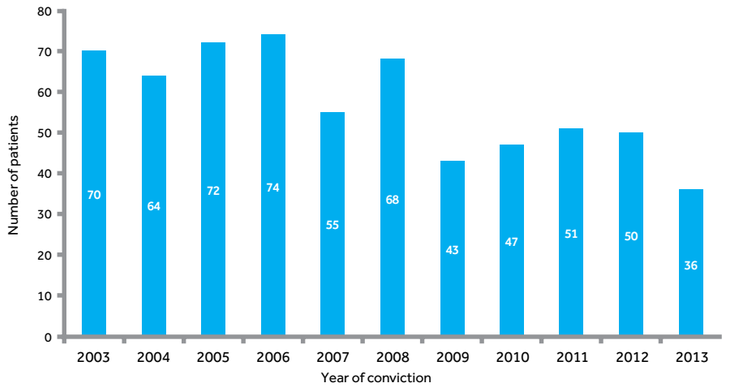


Figure 24: Number of patient homicides, by year of offence and year of conviction

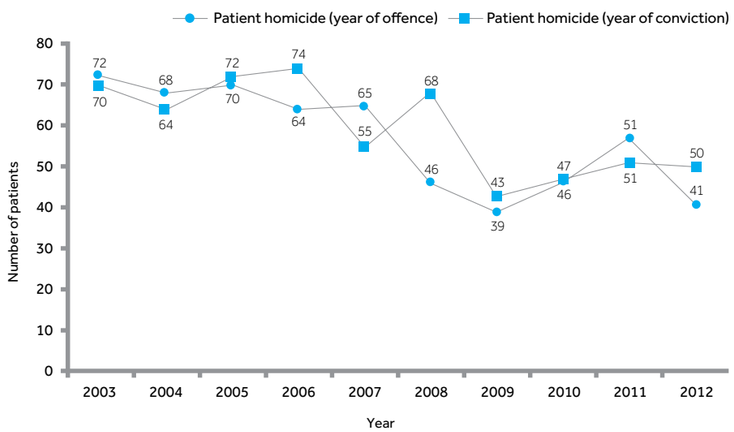
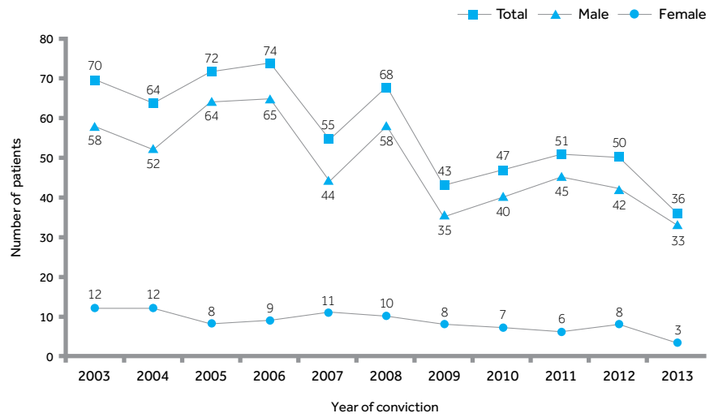


Figure 25: Number of patient homicides, by gender of offender



Mental health care

121. 17 (3%) were in-patients at the time of the offence. There were 42 homicides within 3 months of discharge from in-patient care, 7% of all patient homicides. 25 (6%) patients in 2005-2013 were under crisis resolution/home treatment (CR/HT) teams at the time of the homicide.

122. 1 homicide was committed by a patient subject to a community treatment order (CTO) at the time of the offence. 3 patients had previously been on a CTO at the time of their discharge from in-patient care but this has subsequently been rescinded.

Forensic and clinical history

123. 314 (51%) patients had been convicted of a previous violent offence, 266 (48%) had previously been in prison.

124. 34 (6%) had a history of admission to a high, medium or regional secure unit. 151 (26%) patients had previously been involuntarily detained under mental health legislation. The number of previously detained patients has decreased over the report period.

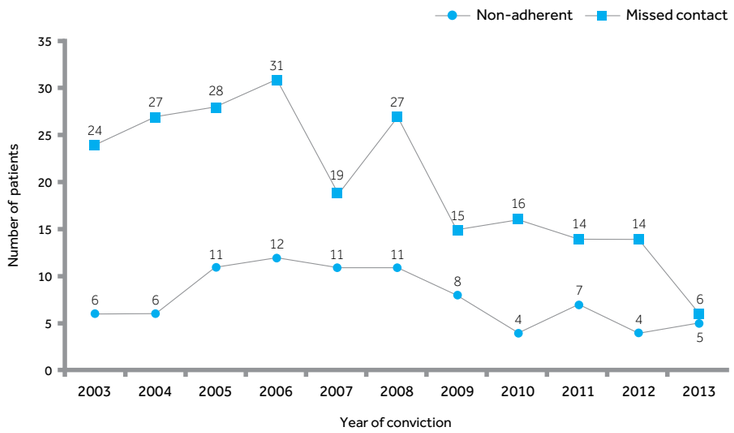
Non-adherence and missed contact

125. 85 (17%) patients had been non-adherent with drug treatment in the month before the homicide, an average of 8 per year. The numbers fell after 2008 (Figure 26).

126. 221 (39%) patients missed their final service contact before the homicide occurred, an average of 20 per year. The number has fallen since 2008.

127. In total, 261 (49%) were either non-adherent or had missed final contact with services and were therefore not in receipt of planned treatment just prior to the homicide.

Figure 26: Patient homicide: number non-adherent with drug treatment or missed contact

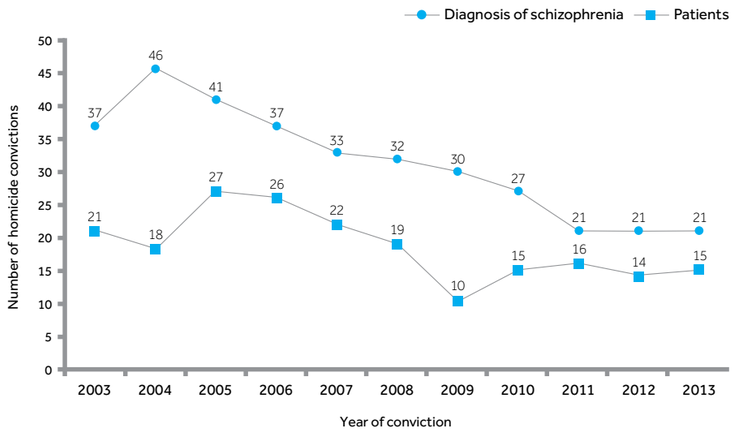


Homicide and schizophrenia

128. There were 346 homicides by people with a history of schizophrenia (includes other delusional disorders) over 2003-2013, 6% of the total sample, an average of 31 per year. Of these, 280 (81%) had symptoms of psychosis (delusions and/or hallucinations) at the time of the offence. 203 (59%) of those with schizophrenia were patients, an average of 18 per year (Figure 27). The figure for 2013 may rise as we receive further cases (see paragraph 118).

129. 50 (29%) patients with schizophrenia had been non-adherent with drug treatment in the month before the homicide, an average of 5 per year. 68 (39%) patients with schizophrenia missed their final service contact before the homicide, an average of 6 per year. In total 98 (57%) were either non-adherent or missed their final contact with services.

Figure 27: Offenders with a primary diagnosis of schizophrenia and other delusional disorders



Homicide and personality disorder

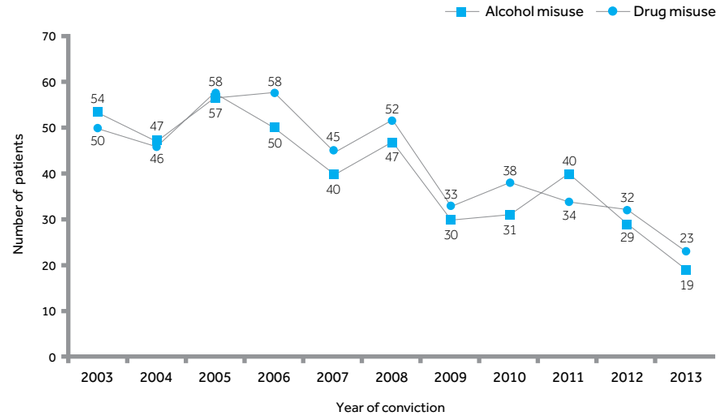
130. There were 253 homicides by people with personality disorder, 4% of the sample, an average of 23 per year. Of these, 90 (36%) were patients.

131. We are currently undertaking a new study to further our understanding of patients with personality disorder who commit homicide or die by suicide. Our findings will be published in 2017.

Patients with alcohol and drug misuse

132. 444 (75%) patients had a history of alcohol misuse, an average of 40 per year (Figure 28). 469 (78%) patients had a history of drug misuse, an average of 43 per year (Figure 28). 536 (89%, excluding unknowns) had a history of either alcohol or drug misuse or both, an average of 49 homicides per year.

Figure 28: Patient homicide: number with a history of alcohol or drug misuse



HOMICIDE FOLLOWED BY SUICIDE

133. Homicide followed by suicide is defined here as when the offender dies by suicide within 3 days of committing homicide. As there is no conviction for homicide, they are not included in the previous analysis.

134. We were notified of 194 offences between 2003 and 2013, an average of 18 per year. There were 290 victims in total. 32 (16%) incidents involved multiple victims.

135. Most were male (176, 91%). The median age of offenders was 45 (range 16-93).

136. The relationship of victim to offender (as a principal victim if there was more than one victim) was: spouse/partner (current/ex) (128, 67%); son/daughter including stepchild (30, 16%); other family member (14, 7%); acquaintance (12, 6%) and stranger (7, 4%). In 3 cases the relationship was not known.

137. 15 (8%) homicide-suicides were by patients under the care of mental health services prior to the offence, i.e. 1-2 per year.

NORTHERN IRELAND

SUICIDE

138. In 2003-2013, the Inquiry was notified of 2,701 deaths in the general population that were registered as suicide or "undetermined", an average of 246 per year. These are referred to as suicides throughout the report.

Suicide in the general population

139. There was an increase in the number and rate of suicides in 2003-2012. Figures reached a peak in 2010 and then fell but we are estimating a further rise in 2013 (Table 2, Figure 29).

140. Some deaths are not registered for several months or longer which means that our figures for the most recent years underestimate the final figures. We therefore calculate figures that take this delay into account for 2012 and 2013 (Table 2).

141. The increase in numbers and rates in 2003-2012 was observed in males only (Figure 29). The increase was mainly found in men aged 25-34 who have the highest suicide rate in recent years. Numbers (but not rates) also increased in men aged 55-64 and 65 and over. There has been no increase in any age-group in women.

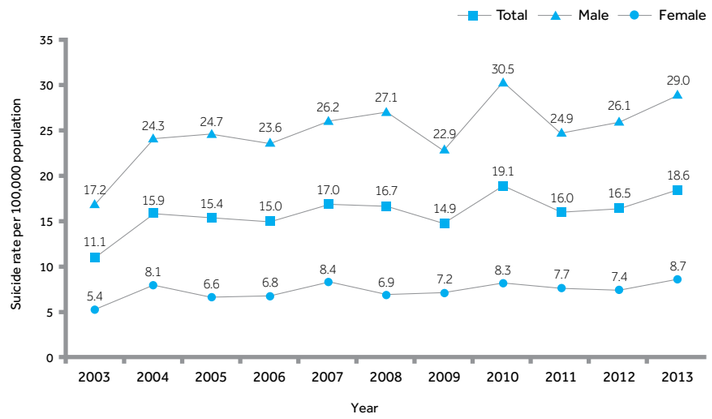
Table 2: Number of suicides in the general population, by gender

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Male	123	175	180	174	195	204	174	233	191	197 201†	213 224†
Female	41	62	51	53	66	55	58	67	62	59 60†	68 71†
Total	**164**	**237**	**231**	**227**	**261**	**259**	**232**	**300**	**253**	**256** **261†**	**281** **295†**

†indicates the estimated final number based on delays recorded in previous years, i.e. a 5% increase in 2013 and 2% increase in 2012

SUICIDE RATES IN MEN HAVE INCREASED, PARTICULARLY IN THOSE AGED 25-34

Figure 29: Rates of suicide in the general population, by gender



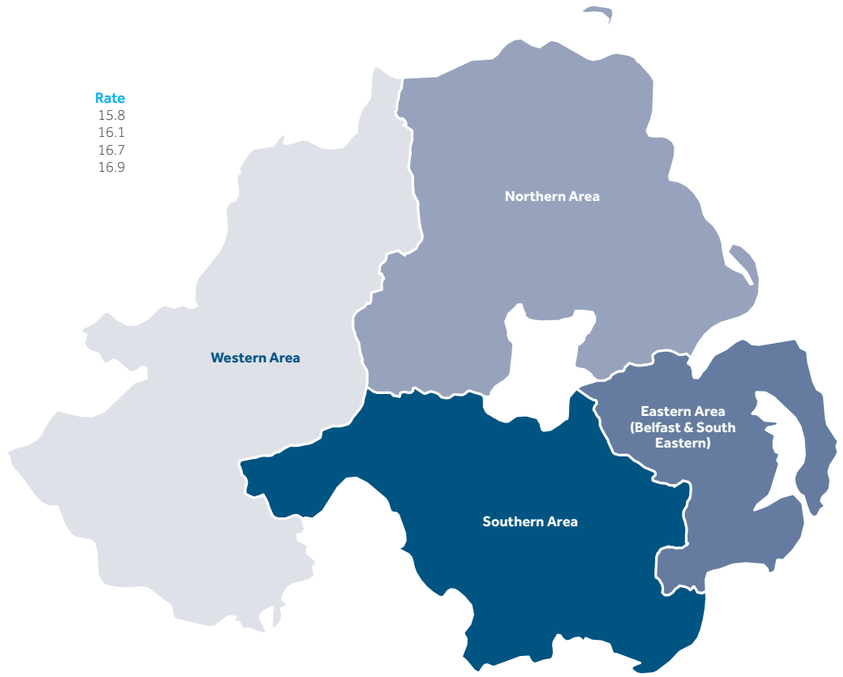
Note: rates in 2012 and 2013 are estimated to take into account delays in data collection

Variation in suicide rates by area of residence (Health and Social Care Trust)

142. There were only small variations by area of residence (by Health and Social Care Trust) at the time of death (average rate 2011-2013). The highest rate of suicide was in the Southern Area, at 16.9 per 100,000 population, and the lowest in the Western Area, at 15.8 per 100,000 population (Figure 30).

Figure 30: Rates of suicide per 100,000 population, by Health and Social Care Trust of residence (average rate 2011-2013)

Area	Rate
Western Area	15.8
Northern Area	16.1
Eastern Area	16.7
Southern Area	16.9

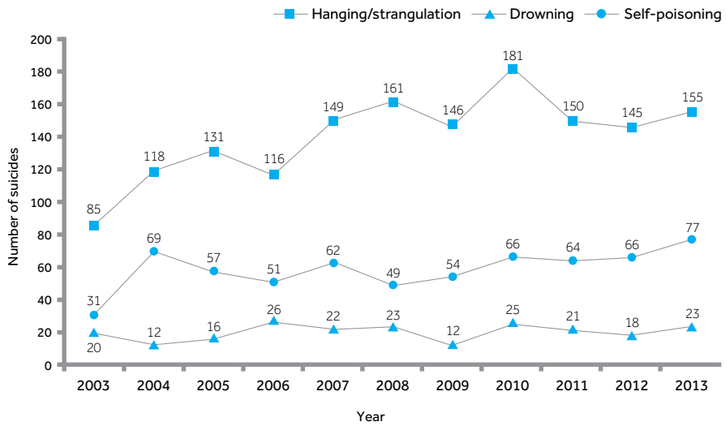


Method of suicide

143. The most common methods of suicide were hanging and strangulation (referred to as hanging in the remainder of this report) (1,537, 57%), self-poisoning (overdose) (646, 24%), and drowning (218, 8%). Less frequent methods were firearms (101, 4%), carbon monoxide (CO) poisoning (61, 2%), jumping and multiple injuries (mainly jumping from a height or being struck by a train) (48, 2%), and cutting and stabbing (33, 1%).

144. Deaths by hanging have increased since 2003, with a peak in 2010 (Figure 31). Deaths by self-poisoning increased overall and in 2013 rose to the highest number during the report period. Of the less common methods, deaths by CO poisoning and firearms decreased.

Figure 31: Suicide in the general population: main causes of death



PATIENT SUICIDE

Patient suicide: numbers and rates

145. During 2003-2013, 741 suicides (27% of general population suicides) were identified as patient suicides, i.e. the person had been in contact with mental health services in the 12 months prior to death. This represents an average of 67 patient suicides per year.

146. There was no overall change between 2003 and 2012 in the number of patient suicides overall or by gender (Figures 32 and 33), or in the rate of suicide (using a general population denominator) (Figure 34).

147. The annual number of patient suicides increased in females aged 45-64 but did not change in any other age-group or gender over the report period.

148. In 187 (28%) the suicide occurred within a year of mental health service contact; in 308 (46%) it was over 5 years.

Figure 32: Number of patient suicides

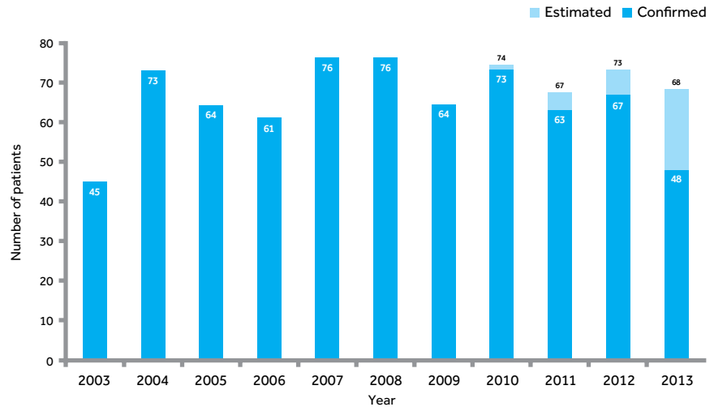


Figure 33: Number of patient suicides, by gender

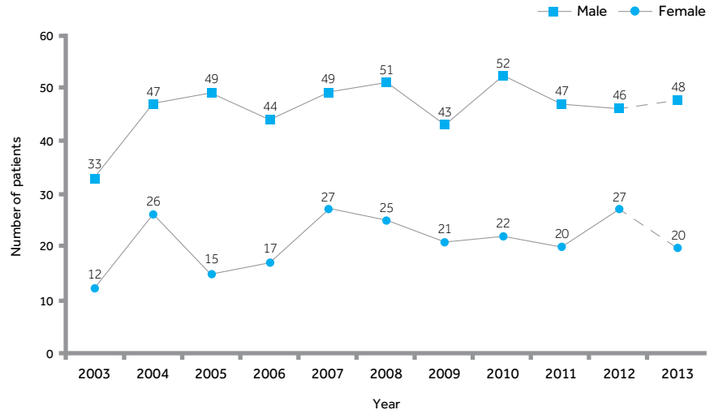
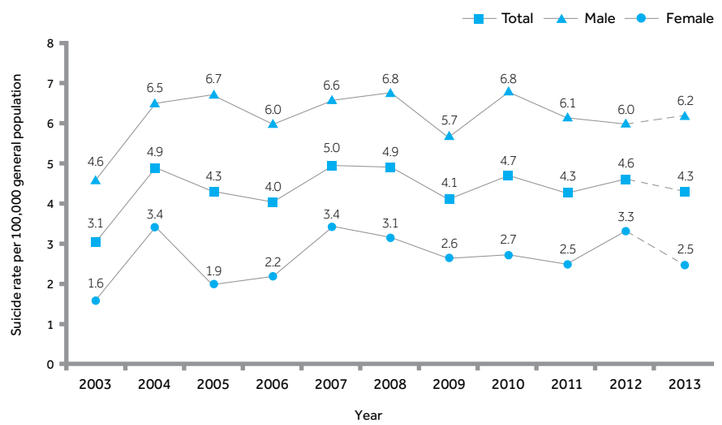


Figure 34: Rates of patient suicide, by gender



Method of suicide by patients

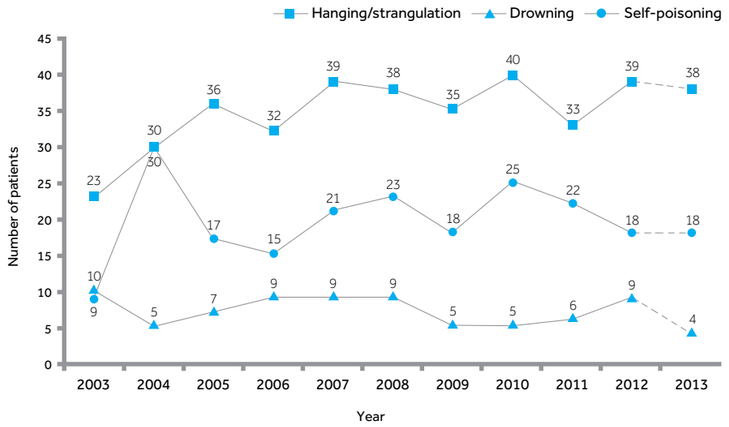
149. The most common methods of suicide by patients were hanging (383, 52%), self-poisoning (216, 29%) and drowning (78, 11%).

150. The number of suicides by hanging increased between 2003 and 2008 but there has been no increase since then (Figure 35).

151. The most common substances used in self-poisoning were opiates (58, 31%), anti-psychotic drugs (20, 11%) and benzodiazepines/hypnotics (18, 10%). The number of deaths by opiates and anti-psychotics increased over the report period.

152. Over the report period, there were 4 deaths by suicide, including 1 patient, which followed inhalation of helium gas.

Figure 35: Patient suicide: main causes of death



Suicides in people aged under 25

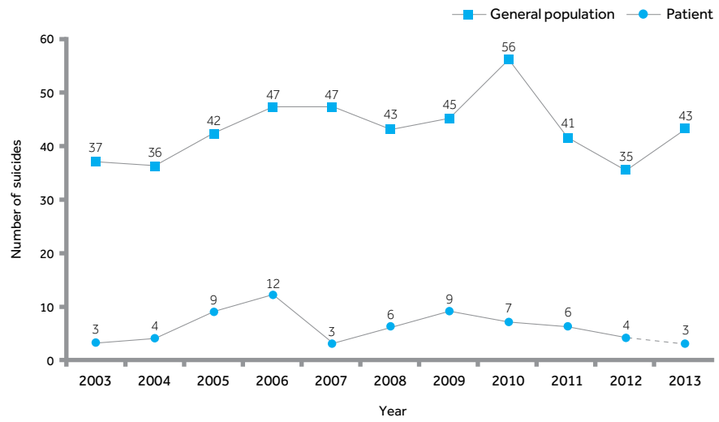
153. During 2003-2013, there were 472 suicides in the general population in people aged under 25, 17% of all suicides, an average of 43 per year. 199 were aged under 20, an average of 18 per year, and 96 were aged under 18, an average of 9 per year.

154. 66 of those under 25 were patients, 9% of patient suicides and 14% of all suicides in this age-group, an average of 6 per year. 15 were aged under 20 and 4 were aged under 18.

155. The number of general population suicides in people under 25 increased from 2003 and reached a peak in 2010 with lower (though possibly incomplete) numbers in 2011-2013 (Figure 36). However, there has been no change in the annual number of suicides in patients under 25 over the report period – numbers are small, with a peak in 2006 (Figure 36).

156. We are currently establishing a national investigation of suicides in this age group and will be publishing preliminary findings in 2017.

Figure 36: General population and patient suicides in those aged under 25

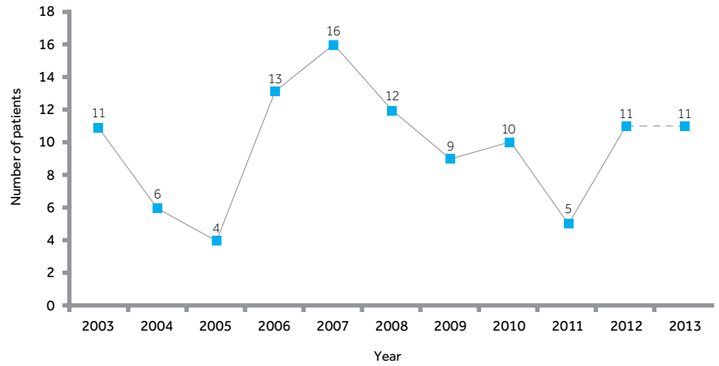


Patients with schizophrenia

157. There were 108 suicides in patients with a primary diagnosis of schizophrenia (includes other delusional disorders), 15% of the total sample, an average of 10 deaths per year.

158. There has been no overall trend in the annual number of suicides in patients with schizophrenia - numbers have been lower since a peak in 2007 (Figure 37).

Figure 37: Patient suicide: number with a primary diagnosis of schizophrenia and other delusional disorders



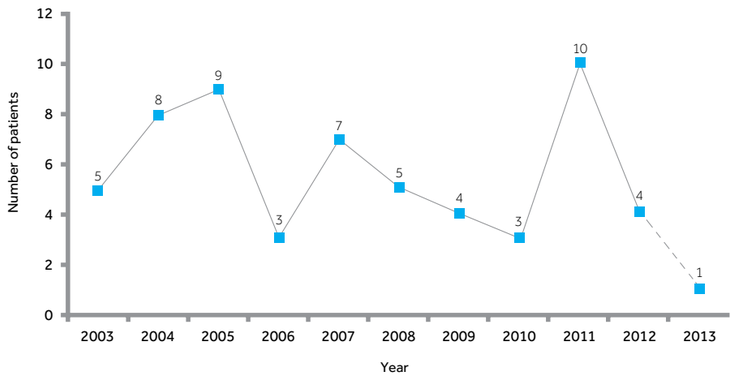
Patients with personality disorder

159. There were 59 suicides in patients with a primary diagnosis of personality disorder, 8% of the total sample, an average of 5 deaths per year.

160. The annual number of suicides in patients with personality disorder has fluctuated over the report period but there has been no overall trend (Figure 38).

161. We are currently carrying out a detailed study investigating suicide in patients with personality disorder which will be published in 2017. We have studied suicide in personality disorder in primary care and will be publishing this study soon.

Figure 38: Patient suicide: number with a primary diagnosis of personality disorder



Patients with alcohol and drug misuse

162. There were 459 suicides in patients with a history of alcohol misuse, 63% of the total sample, an average of 42 deaths per year (Figure 39).

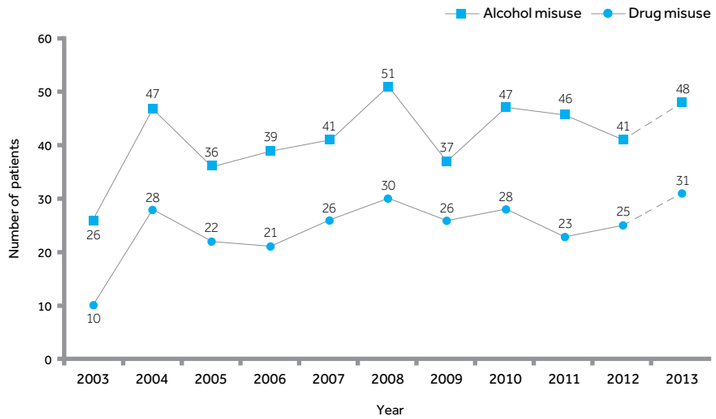
163. 270 had a history of drug misuse, 38% of the total sample, an average of 25 deaths per year (Figure 39).

164. 501 had a history of either alcohol or drug misuse or both, 69% of patient suicides, an average of 46 deaths per year.

165. Between 2003 and 2012, there was no overall trend in the annual number of patient suicides with a history of alcohol or drug misuse, though we are estimating higher figures in 2013.

166. Between 2011-2013, 20 (11%) patients were under drug services and 41 (21%) were under alcohol services.

Figure 39: Patient suicide: number with a history of alcohol or drug misuse



Socio-economic factors

167. In 2008-2012, a higher proportion of patients were unemployed (173, 50%) compared to the pre-recession years of 2003-2007 (131, 43%). 35 (5%) patients were in unstable housing, i.e. homeless or living in bed and breakfast or a hostel. This proportion did not change over the report period.

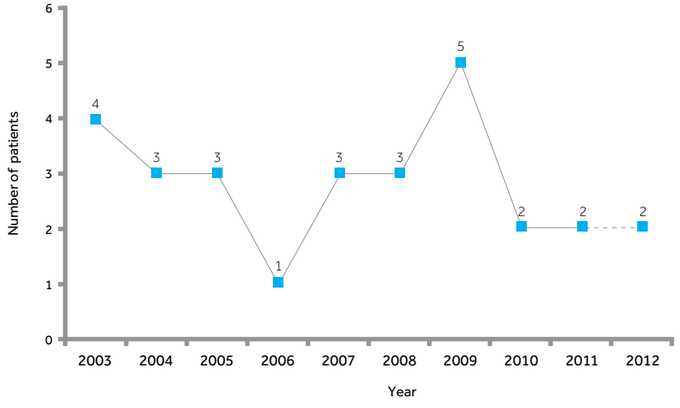
MENTAL HEALTH CARE

In-patient suicide

168. There were 28 in-patient deaths by suicide between 2003-2013, 4% of patient suicides. The highest number of in-patient suicides was in 2009 (5 deaths) (Figure 40).

169. 4 patients died on the ward by hanging over the report period. There were 3 suicides in detained in-patients, 11% of all in-patient suicides. 10 in-patients died after absconding from the ward, 36% of all in-patient suicides.

Figure 40: Patient suicide: number of mental health in-patients



Note: there are currently no in-patient suicides in 2013 and therefore we are unable to estimate a figure for this year

Crisis Resolution/ Home Treatment

170. There were 38 suicides in patients under crisis resolution/home treatment (CR/HT) teams, 5% of all deaths.

171. There was no overall trend in the number of suicides under CR/HT, but the highest figures were in 2007 (7 deaths) and 2012 (7 deaths). From 2005 there have been 35 suicides in patients under CR/HT compared to 21 in in-patient care.

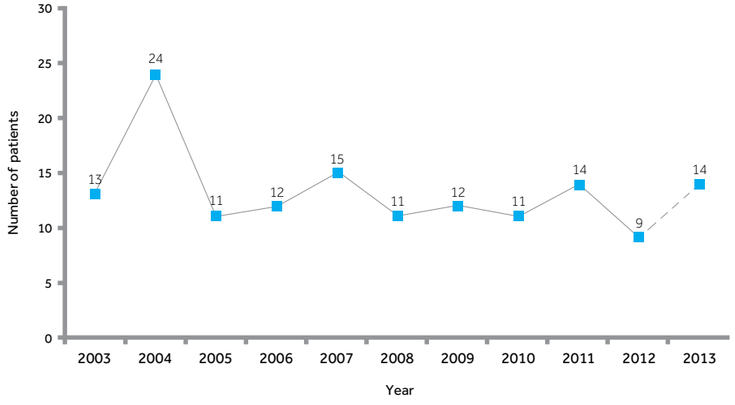
Patients recently discharged from hospital

172. There were 146 suicides within 3 months of discharge from in-patient care, 20% of all patient suicides and 21% of suicides in community patients, an average of 13 deaths per year.

173. The annual number of post-discharge suicides peaked in 2004 but otherwise there was no trend over the report period (Figure 41).

174. Post-discharge suicides were most frequent in the first week after leaving hospital when 30 deaths occurred, an average of 3 per year. Of these, the highest number occurred on the first day after discharge (9, 30%).

Figure 41: Patient suicide: number who died within 3 months of in-patient discharge



Urgent referral

175. In 2012-2013, 4 (6%) community patients had been referred urgently to mental health services by a GP in the 3 months prior to death.

Clinicians' views on prevention

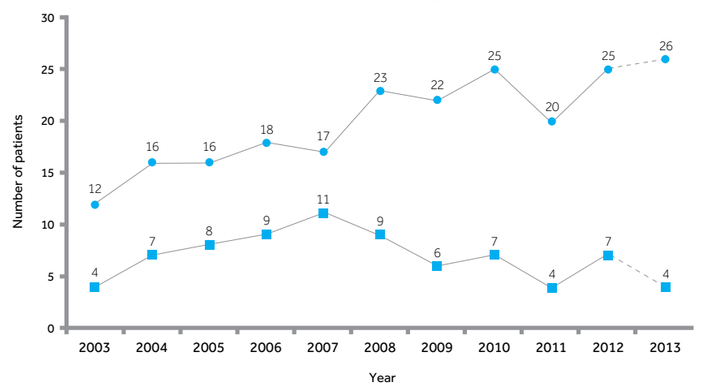
176. In 2011-2013, clinicians indicated a number of factors related to acute care that in their view could have made the suicide less likely. These included: better crisis facilities (15, 8%), better out-of-hours care (5, 3%) and more psychiatric beds (1, 1%).

Non-adherence and missed contact

177. 76 (12%) patients had been non-adherent with drug treatment in the month before death, an average of 7 deaths per year. 220 (32%) patients missed their final service contact before death, an average of 20 deaths per year.

178. There has been no overall trend in the number of patient suicides following non-adherence (Figure 42). There has been an overall increase in the number of patient suicides following missed contact (Figure 42).

Figure 42: Patient suicide: number non-adherent with drug treatment or missed last contact



HOMICIDE

179. In 2003-2013, the Inquiry was notified of 217 homicide convictions, an average of 20 a year. There were 224 victims, an average of 20 per year.

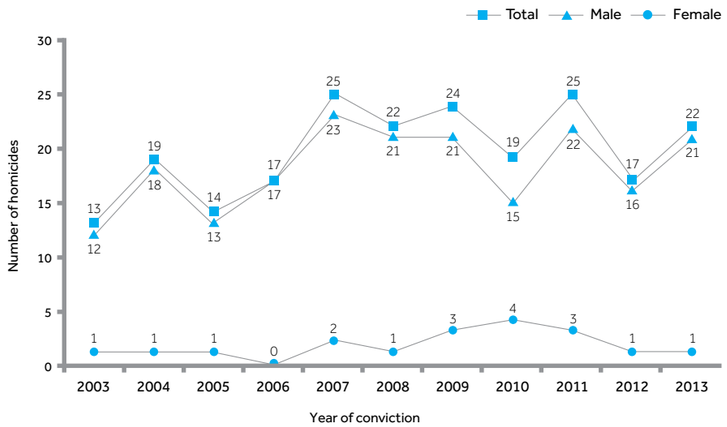
Homicide in the general population

180. The annual number of homicide convictions in the general population is shown in Figure 43. More recent homicide statistics are published by the Police Service of Northern Ireland.[18]

181. There has been a rise in homicide convictions up to 2007, but there has been no further increase since then (Figure 43).

182. The most common method of homicide was the use of a sharp instrument (73, 36%) followed by hitting and kicking (56, 27%).

Figure 43: Number of homicide convictions in the general population, by gender of offender



PATIENT HOMICIDE

183. During 2003-2013, 27 people convicted of homicide (12% of the total sample), were confirmed as patients, i.e. the person had been in contact with mental health services in the 12 months prior to the offence, an average of 2 per year. There were 28 victims. The numbers fluctuated over the report period but were too small to examine trends over time.

Mental health care

184. There were no homicides committed by in-patients or patients under crisis resolution/home treatment teams. There were 5 homicides within 3 months of discharge from in-patient care, 20% of all patient homicides.

Forensic and clinical history

185. 15 (68%) had been convicted of a previous violent offence. 10 (48%) had previously been in prison. 1 patient had a history of admission to a high, medium or regional secure unit. 1 patient had previously been involuntarily detained under mental health legislation.

Non-adherence and missed contact

186. 4 (20%) patients were known to have been non-adherent with drug treatment in the month before the homicide. 9 (41%) patients had missed their final service contact before the homicide. In total, 12 (57%) were either non-adherent or had missed final contact with services and were therefore not in receipt of planned treatment just prior to the homicide.

Homicide and schizophrenia

187. 8 people had a history of schizophrenia (includes other delusional disorders), 4% of the total number of homicides. Of these, 7 (88%) had symptoms of psychosis (delusions and/or hallucinations) at the time of the offence. 5 (63%) were patients.

Homicide and personality disorder

188. 13 people had a history of personality disorders over the report period, 6% of all homicides. 6 (46%) were patients.

Patients with alcohol and drug misuse

189. 25 (100% excluding unknowns) patients had a history of alcohol misuse. 19 (76%) patients had a history of drug misuse.

SCOTLAND

SUICIDE

190. In 2003-2013, the Inquiry was notified of 8,928 deaths in the general population that were registered as suicide or "undetermined", an average of 812 per year. These are referred to as suicides throughout the report.

Suicide in the general population

191. Table 3 and Figure 44 show trends in general population suicide. An apparent increase in 2011 occurred due to the introduction of new death coding rules for drug misuse deaths in the International Statistical Classification of Diseases and Related Health Problems (ICD-10). This meant deaths which would previously have been coded as due to 'mental and behavioural disorders due to psychoactive substance use' are in some cases now coded as suicide or deaths of undetermined deaths. We therefore show figures based both on old and new coding to enable comparison with earlier years.

192. Using the old coding rules, there has been a fall in male rates since 2003 (Figure 44). The fall has occurred in males aged 25-34 and 65 and over but there has been an increase in the number and rate in those aged 45-54 (Figure 45). In women, there has been a fall in the rate in those aged 65 and over.

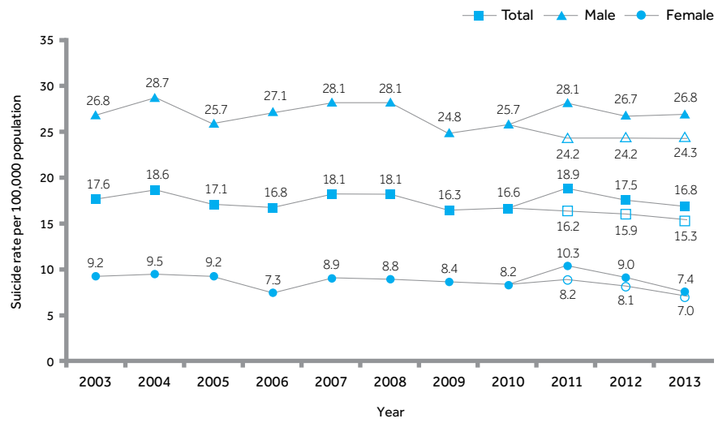
Table 3: Number of suicides in the general population, by gender

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Male	576	620	560	594	622	628	558	581	552 ‡ 641	553‡ 609	558‡ 614
Female	218	224	220	174	214	213	205	201	217‡ 252	199‡ 222	171‡ 182
Total	**794**	**844**	**780**	**768**	**836**	**841**	**763**	**782**	**769‡ 893**	**752‡ 831**	**729‡ 796**

‡indicates the number of suicides using the old death coding rules; see also the methods section on page 12.

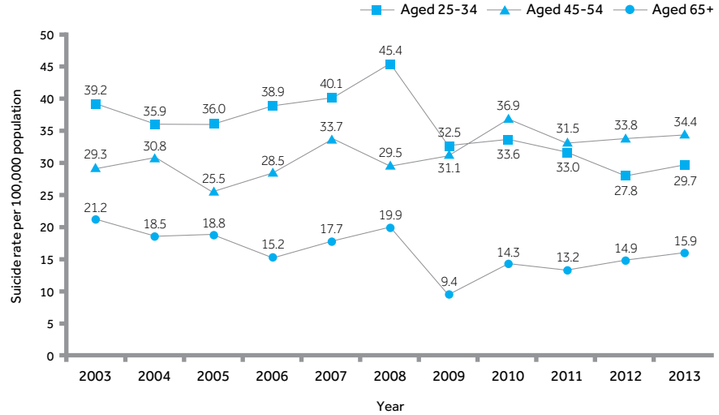
THERE HAS BEEN A FALL IN SUICIDE RATES IN MEN OVERALL BUT AN INCREASE IN MALES AGED 45-54.

Figure 44: Rates of suicide in the general population, by gender



Note: the unfilled markers in 2011-2013 indicate rates using the old death coding rules

Figure 45: Male suicide rates in the general population in those aged 25-34, 45-54 and 65+

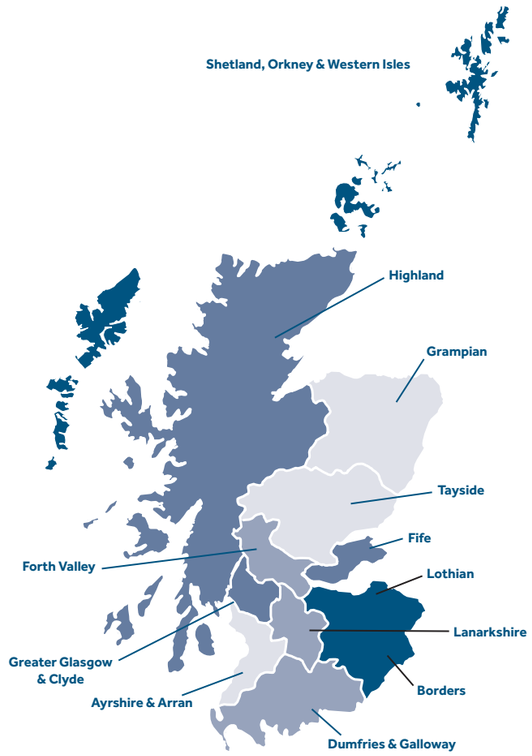


Variation in suicide rates by area of residence (NHS Health Board)

193. Suicide rates varied by area of residence (by NHS Health Board) at the time of death (average rate 2011-2013). The highest rate of suicide was in Lothian, at 21.3 per 100,000 population, and the lowest rate was in Ayrshire and Arran, at 12.9 per 100,000 population (Figure 46).

Figure 46: Rates of suicide per 100,000 population, by NHS Health Board of residence (average rate 2011-2013)

Area	Rate
Ayrshire & Arran	12.9
Grampian	13.9
Tayside	14.5
Forth Valley	16.5
Dumfries & Galloway	16.7
Lanarkshire	17.7
Greater Glasgow & Clyde	18.2
Highland	18.3
Fife	19.3
Shetlands, Orkney & Western Isles	19.6
Borders	19.9
Lothian	21.3



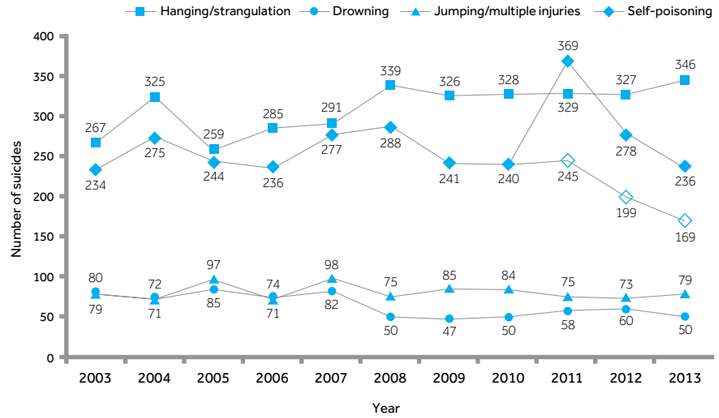
Note: rates have been colour coded by approximate quartile

Method of suicide

194. The most common methods of suicide were hanging and strangulation (referred to as hanging in the remainder of this report) (3,422, 38%), self-poisoning (overdose) (2,918, 33%), jumping and multiple injuries (mainly jumping from a height or being struck by a train) (887, 10%) and drowning (708, 8%). Less frequent methods were cutting and stabbing (194, 2%), carbon monoxide (CO) poisoning (181, 2%), and firearms (118, 1%).

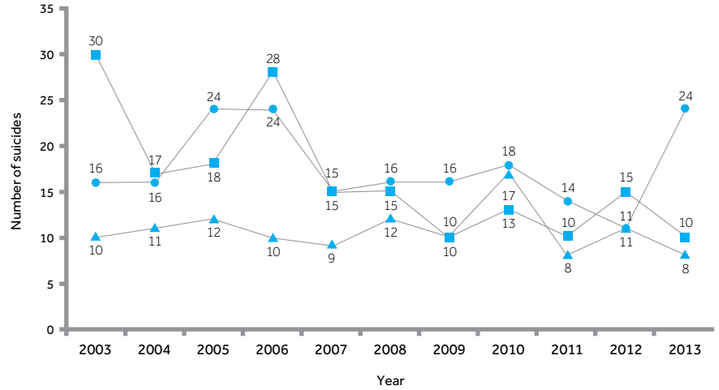
195. Deaths by hanging increased over the whole report period, though the number has not changed since 2008 (Figure 47). The apparent increase in suicides by self-poisoning in 2011-2012 is the result of the death coding rule change described above. Using the old coding rules, we estimate the number of self-poisonings in 2013 would drop from 236 to 169, the lowest figure for self-poisoning over the report period. Deaths by drowning and CO poisoning decreased (Figures 47 and 48).

Figure 47: Suicide in the general population: main causes of death



Note: the unfilled markers in 2011-2013 indicate rates using the old death coding rules

Figure 48: Suicide in the general population: other causes of death



PATIENT SUICIDE

Patient suicide: numbers and rates

196. During 2003-2013, 2,701 suicides (30% of general population suicides) were identified as patient suicides, i.e. the person had been in contact with mental health services in the 12 months prior to death. This represents an average of 246 patient suicides per year.

197. The increase in suicide figures in 2011-2013 for the general population resulting from a death coding change, is also reflected in the figures for patient suicides in these years (Figure 49). Based on the old coding rules, we calculate there would have been 32 fewer suicides in 2013, making the total 227 (Figure 50).

198. There was no overall change in the number or rate (using a general population denominator) of patient suicides in 2003-2012 (Figures 49-51). Figures for male patients are generally lower since a peak in 2007.

THERE HAS BEEN AN INCREASE IN MALE PATIENT SUICIDES AGED 45-54.

199. There was an increase in the annual number of male suicides in those aged 45-54 (Figure 52). Younger males showed a decrease. There was no change in females in any age-group.

200. In 558 (23%) the suicide occurred within a year of mental health service contact; in 1,314 (54%) it was over 5 years.

Figure 49: Number of patient suicides

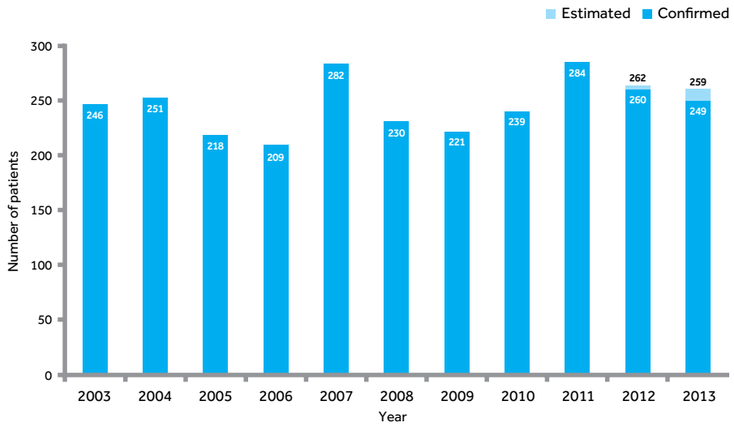
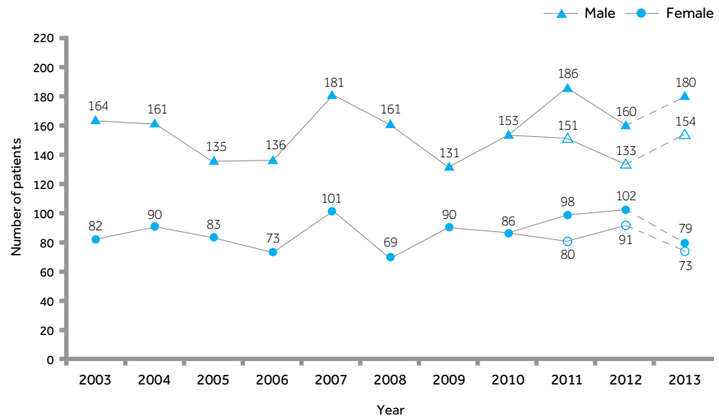
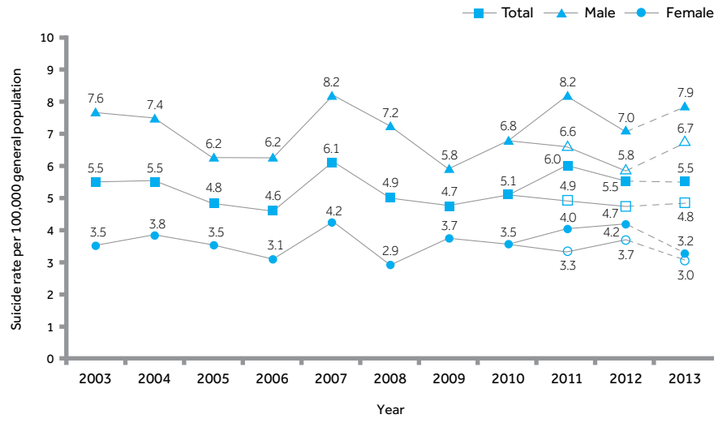


Figure 50: Number of patient suicides, by gender



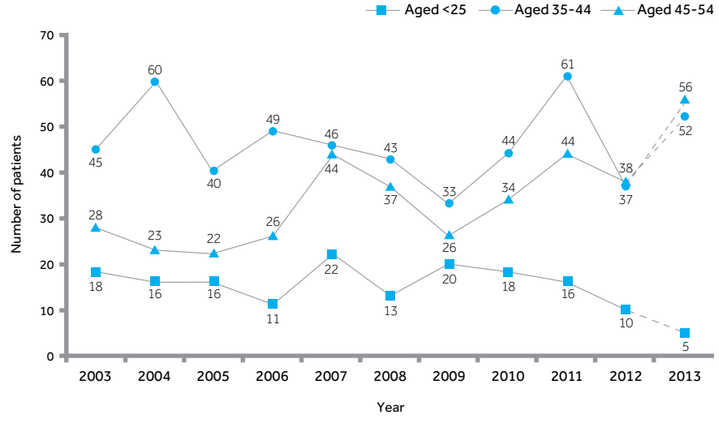
Note: unfilled markers in 2011-2013 indicate the number of suicides using the old death coding rules.

Figure 51: Rates of patient suicide, by gender



Note: unfilled markers in 2011-2013 indicate the rate of suicides using the old death coding rules

Figure 52: Patient suicide: number of male suicides in those aged <25, 35-44 and 45-54



Method of suicide by patients

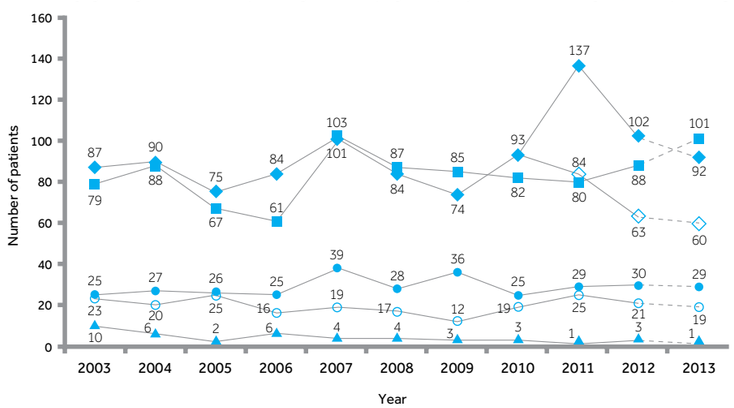
201. The most common methods of suicide by patients were self-poisoning (1,019, 38%) and hanging (921, 34%). The increase in deaths by self-poisoning from 2011 was the result of the coding rule change described above – recent figures are comparatively low (Figure 53). The annual number of deaths by hanging has fluctuated over the report period and we are estimating an increase in 2013 to the highest figure since 2007.

202. The most common substances used in deaths by self-poisoning were opiates (346, 37%), tricyclic antidepressants (103, 11%), anti-psychotics (93, 10%) and paracetamol/opiate compounds (90, 10%).

203. The increase in suicides by overdose of opiates in 2011-2013 reflects the change in coding rules (see above) (Figure 54). Using the old rules, there was no change in the annual number of opiate suicides over the report period. There has been a decrease in suicide by tricyclic antidepressants (Figure 54) and paracetamol/opiate compounds over the report period.

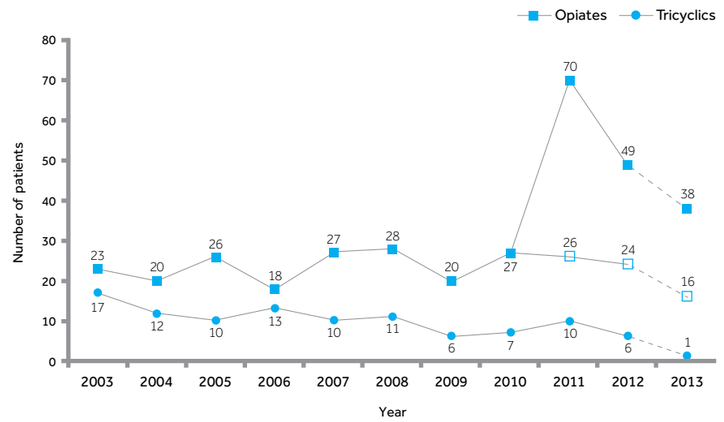
204. Since 2005, there were 45 deaths by suicide in the general population which followed inhalation of helium, increasing from an average of 3 per year in 2005-2008 to 7 per year in 2009-2013. Of these, 8 (18%) were patients.

Figure 53: Patient suicide: main causes of death



Note: unfilled markers in 2011-2013 indicate the number of self-poisonings using the old death coding rules

Figure 54: Patient suicide: main substances used in deaths by self-poisoning



Note: unfilled markers in 2011-2013 indicate the number of deaths by opiates using the old death coding rules

Suicides in people aged under 25

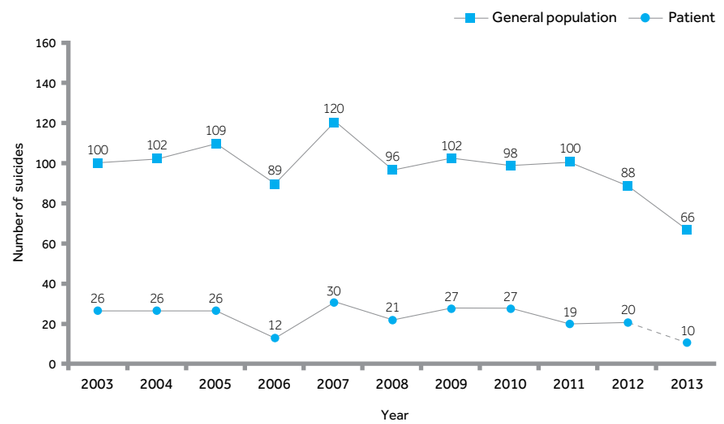
205. During 2003-2013, there were 1,070 suicides in the general population in those aged under 25, 12% of all suicides, an average of 97 per year. 38 were aged under 20, an average of 35 per year, and 174 were aged under 18, an average of 16 per year.

206. 244 of those under 25 were patients, 9% of patient suicides and 23% of all suicides in this age-group. This represents an average of 22 deaths per year. 80 were aged under 20, an average of 7 per year, and 36 were aged under 18, an average of 3 per year.

207. Figures for 2012 and 2013 have fallen, though it is too early to say whether this will be a sustained change (Figure 55).

208. We are currently carrying out a detailed study investigating suicide in this age group and will be publishing preliminary findings in 2017.

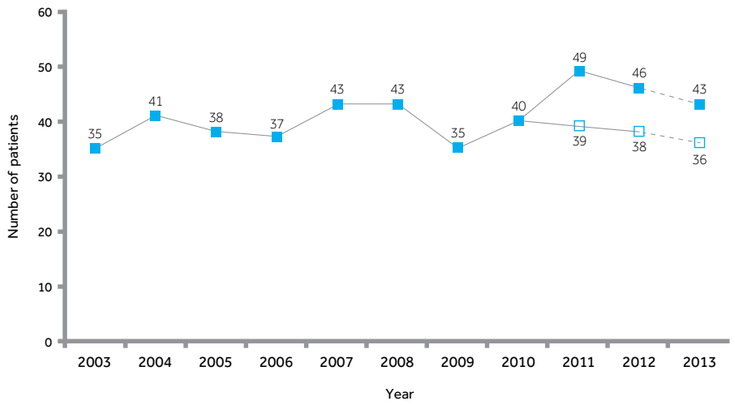
Figure 55: Number of general population and patient suicides in those aged under 25



Patients with schizophrenia

209. There were 450 suicides in patients with a primary diagnosis of schizophrenia (includes other delusional disorders), 17% of the total sample, an average of 41 deaths per year. There has been no overall trend in the number of suicides in patients with schizophrenia (Figure 56). The estimated increase from 2011 is the result of death coding changes.

Figure 56: Patient suicide: number with a primary diagnosis of schizophrenia and other delusional disorders



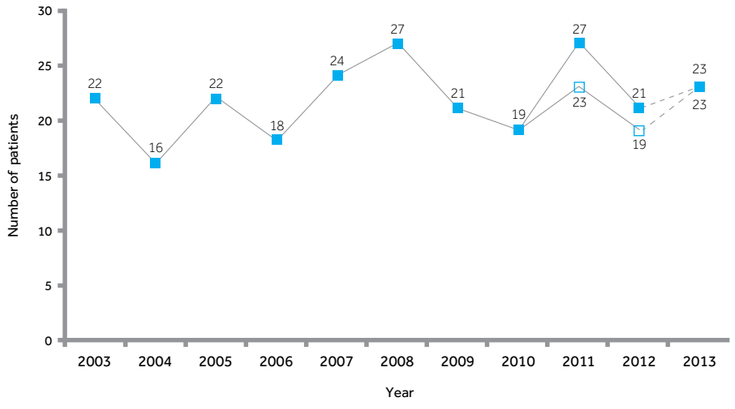
Note: unfilled markers in 2011-2013 indicate the number of self-poisonings using the old death coding rules

Patients with personality disorder

210. There were 240 suicides in patients with a primary diagnosis of personality disorder, 9% of the total sample, an average of 22 deaths per year. There has been no overall change during the report period (Figure 57).

211. We are currently carrying out a detailed study investigating suicide in patients with personality disorder which will be published in 2017. We have studied suicide in personality disorder in primary care and will be publishing this study soon.

Figure 57: Patient suicide: number with a primary diagnosis of personality disorder



Note: unfilled markers in 2011-2013 indicate the number of suicides using the old death coding rules

Patients with alcohol and drug misuse

212. There were 1,549 patients with a history of alcohol misuse, 59% of the total sample, an average of 141 deaths per year.

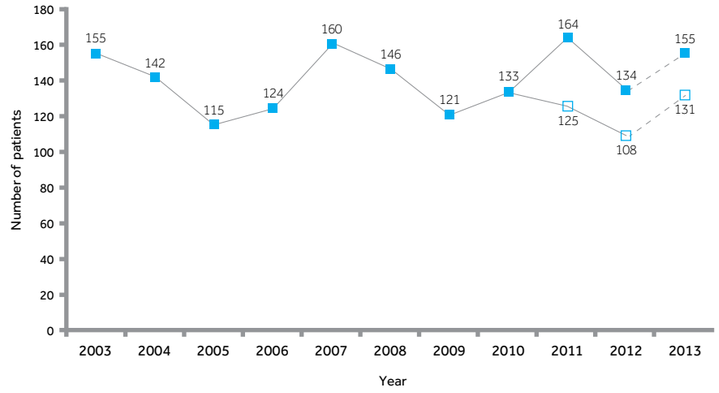
213. 1,166 had a history of drug misuse, 44% of the total sample, an average of 106 deaths per year.

214. 1,848 had a history of either alcohol or drug misuse or both, 69% of patient suicides, an average of 168 deaths per year.

215. Since 2007, the number of suicides in patients with a history of alcohol misuse has fallen (using old coding rules) though we are estimating a rise in 2013 (Figure 58). The apparent rise in the number with a history of drug misuse is the result of the change in coding rules (Figure 59).

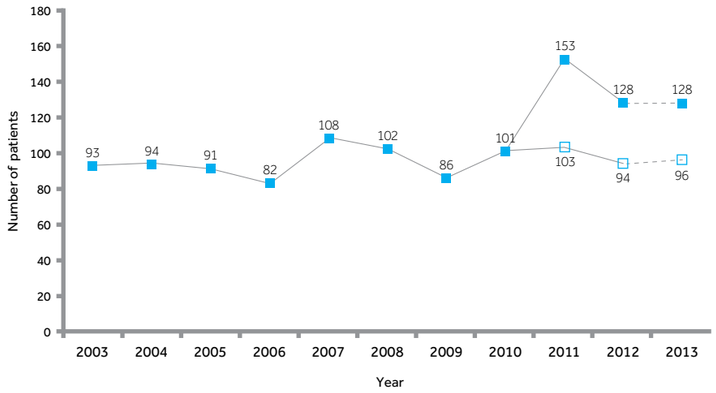
216. Between 2012-2013, 81 (18%) patients were under drug services and 60 (13%) were under alcohol services.

Figure 58: Patient suicide: number with a history of alcohol misuse



Note: unfilled markers in 2011-2013 indicate the number of suicides using the old death coding rules

Figure 59: Patient suicide: number with a history of drug misuse



Note: unfilled markers in 2011-2013 indicate the number of suicides using the old death coding rules

Socio-economic factors

217. In 2012-2013, there were 11 (13% excluding unknowns) suicides in patients who had experienced serious financial difficulties in the 3 months before death.

218. In 2008-2012, a higher proportion of patients were unemployed (616, 53%) compared to the pre-recession years of 2003-2007 (492, 43%). 156 (6%) patients were in unstable housing, i.e. homeless or living in bed and breakfast or a hostel. This proportion did not change over the report period.

Websites promoting suicide

219. In 2011-2013 there were 7 (2%) patients who died by suicide after visiting a "pro-suicide" internet site, i.e. providing information on methods or encouraging suicide. As these figures are based on clinical reports, they may underestimate how often this occurs.

Significant dates

220. In 2011-2013, 18 patients died on a date that carried significance (e.g. birthday), an average of 6 per year, 5% of all patient suicides. Again, this may be an underestimate.

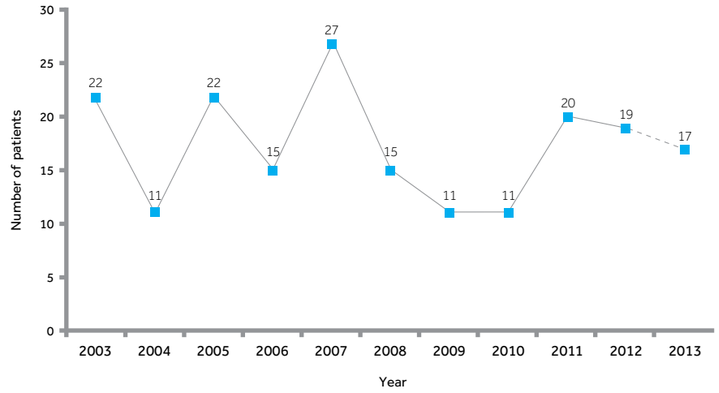
MENTAL HEALTH CARE

In-patient suicide

221. There were 190 in-patient suicide deaths between 2003-2013, 7% of patient suicides, an average of 17 deaths per year. The annual number of in-patient suicides has fluctuated with no overall trend since 2003 (Figure 60).

222. Over the report period, there were 37 patients who died on the ward by hanging; this number fluctuated from 1 to 7 per year. There were 52 suicides in detained in-patients, 28% of all in-patient suicides, an average of 5 per year. 51 in-patients died after absconding from the ward, 27% of all in-patient suicides, an average of 5 per year.

Figure 60: Patient suicide: number of mental health in-patients



Crisis Resolution/ Home Treatment

223. There were 194 suicides in patients under crisis resolution/home treatment (CR/HT) teams, 8% of the total sample, an average of 18 deaths per year.

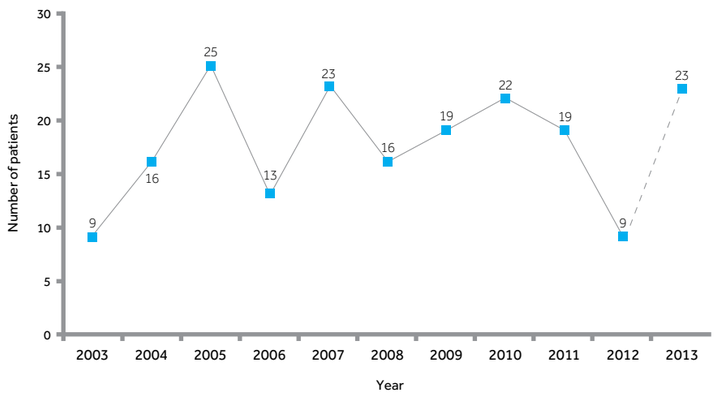
224. Suicides under CR/HT rose in the early part of the report period, reflecting increasing services of this kind. There has been no overall change since 2005 though we estimate an increase in 2013 after a low figure in 2012 (Figure 61).

225. Since 2005 there has been a similar number of patient suicides under CR/HT as in in-patient care, reflecting a change in the nature of acute care. Our estimates for 2013 mean there are now more patient suicides under CR/HT compared to in-patients.

226. 67 (36%) CR/HT patients died within 3 months of hospital discharge, 26 (21%) within 2 weeks. In 107 (56%) the patient lived alone.

IN 2013, WE ARE ESTIMATING MORE SUICIDES UNDER CR/HT THAN IN IN-PATIENT CARE.

Figure 61: Patient suicide: number under crisis resolution/home treatment services



Patients recently discharged from hospital

227. There were 450 suicides within 3 months of discharge from in-patient care, 17% of all patient suicides and 18% of suicides in community patients, an average of 41 deaths per year. Despite fluctuations, there has been a downward trend since a peak in 2007 (Figure 62).

228. Post-discharge suicides were most frequent in the first week after leaving hospital when 82 deaths occurred, an average of 7 per year, 18% of all suicides within 3 months of hospital discharge (Figure 63). Of those who died in the first week after discharge, the highest number occurred on the second day after discharge (18, 22%). 79 (20%) died before the first follow-up appointment.

229. Deaths in the first week were more common in those who discharged themselves from hospital, 17 of 62 (27%).

230. 29 (7%) patients died by suicide after being discharged from a non-local in-patient unit. This increased to 13 (10%) of those who died within 2 weeks of discharge.

Figure 62: Patient suicide: number who died within 3 months of in-patient discharge

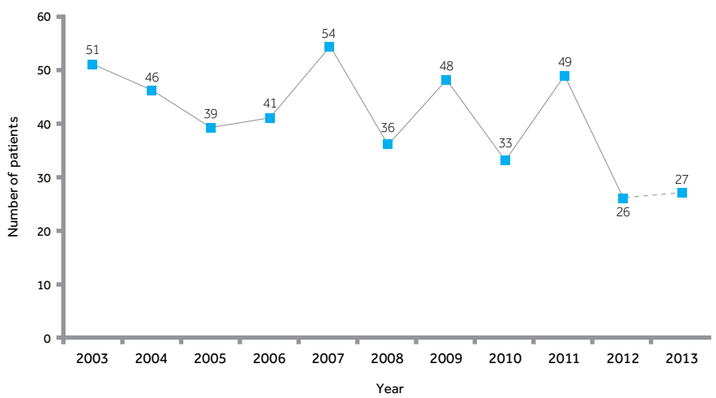
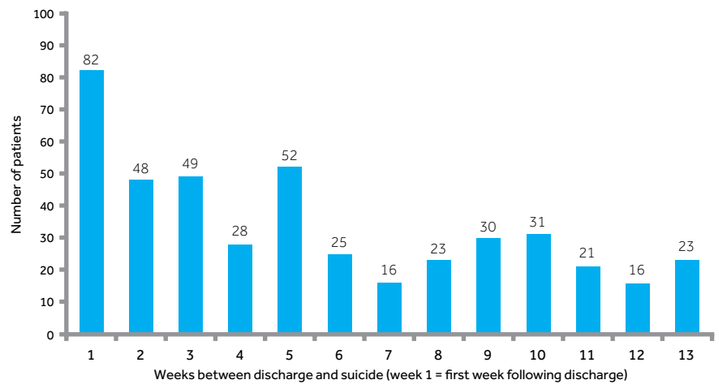


Figure 63: Patient suicide: number of suicides per week following discharge (2003-2013)



Urgent referral

231. In 2012-2013, 10 (10%) community patients had been referred urgently to mental health services by a GP in the 3 months prior to death.

Clinicians' views on prevention

232. In 2011-2013, clinicians indicated a number of factors related to acute care that in their view would have made suicide less likely. These included: less frequent use of agency/locum staff (3, 1% of all patients; 1 (3%) of in-patient suicides); better out-of-hours care (8, 2%); more psychiatric beds (20, 3%); and better crisis facilities (26, 5%).

Compulsory Treatment Orders in the community

233. There were 28 suicides in patients subject to a compulsory treatment order in the community between 2007-2013, 2% of all patient suicides, an average of 4 deaths per year. The highest number was in 2008 (8 patients).

234. 8 patients subject to a compulsory treatment order had been non-adherent with drug treatment in the month before death and 5 had missed the last appointment with services; 1 had been both non-adherent and missed the last appointment. Therefore, 43% of those who died were not receiving care as intended despite compulsory treatment order powers. 11 deaths under a compulsory treatment order occurred within 3 months of hospital discharge.

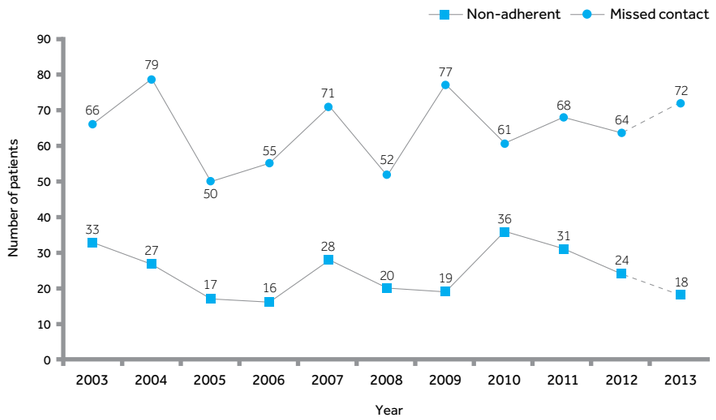
Non-adherence and missed contact

235. 269 (12%) patients had been non-adherent with drug treatment in the month before death, an average of 24 deaths per year.

236. 715 (29%) patients missed their final service contact before death, an average of 65 deaths per year.

237. There were fluctuations in the annual number of suicides in patients following non-adherence or missed last appointment, with no clear trends (Figure 64).

Figure 64: Patient suicide: number non-adherent with drug treatment or missed contact



HOMICIDE

238. In 2003-2013 the Inquiry was notified of 942 homicide convictions, an average of 86 per year. There were 966 victims, an average of 88 per year.

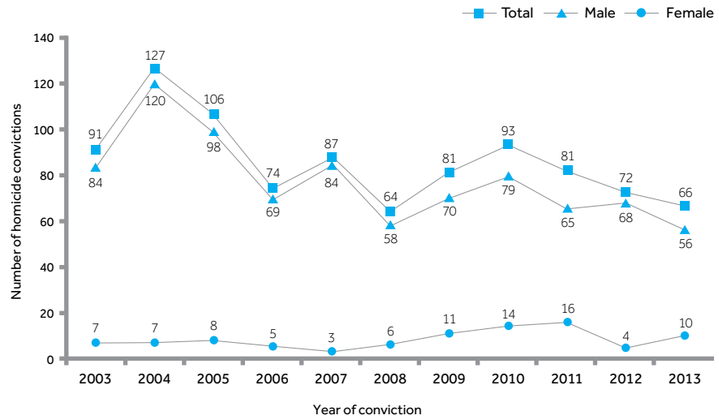
Homicide in the general population

239. The annual number of homicide convictions in the general population is shown in Figure 65. These figures are provided as context for our data on homicides by people with mental illness. More recent homicide statistics are published by the Scottish Government based on the number of offences recorded annually.[19]

240. There has been a fall in the number of homicide convictions over the report period since a peak in 2004 (Figure 65).

241. The most common method of homicide was the use of a sharp instrument (498, 56% of all homicides) followed by hitting and kicking (155, 17%).

Figure 65: Number of homicide convictions in the general population, by gender of offender

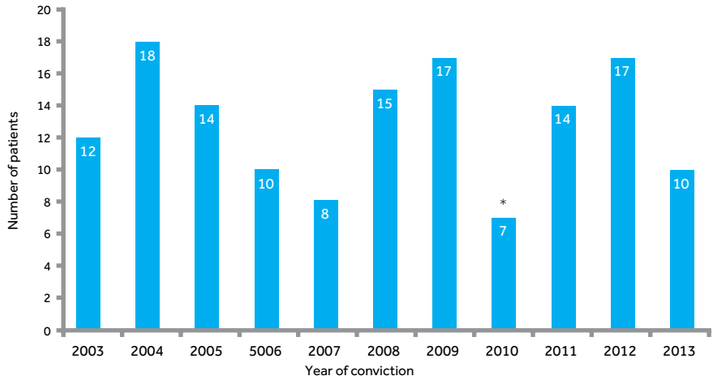


PATIENT HOMICIDE

242. The following analysis is based on the confirmed patient cases for 2003-2013 plus additional cases for 2010-2013 to take account of questionnaires not yet returned, a total of 142 (15% of all homicide convictions). This represents an average of 13 patient homicides per year. There were 146 victims, an average of 13 per year.

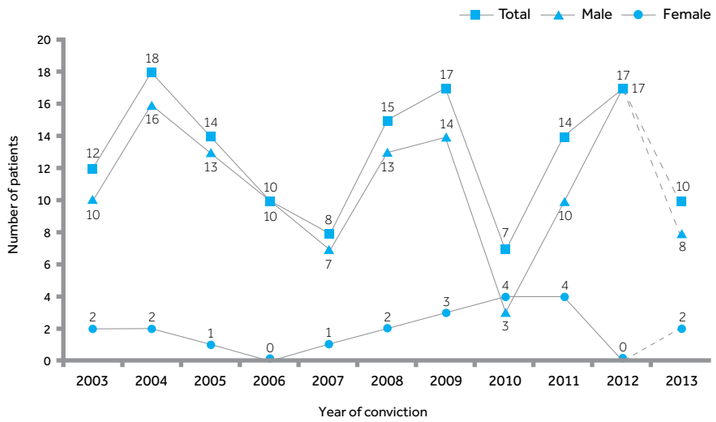
243. The numbers fluctuated over the period of the report, with no overall trend (Figures 66 and Figure 67).

Figure 66: Number of patient homicides



*Note: numbers for 2010 are an underestimate and will be revised when data become available

Figure 67: Number of patient homicides, by gender of offender



Mental health care

244. 2 were in-patients at the time of the homicide. There were 14 homicides within 3 months of discharge from in-patient care, 10% of all patient homicides. 5 (4%) patients had been under crisis resolution/home treatment teams (CR/HT) at the time of the homicide.

245. No patients were subject to a compulsory treatment order at last discharge or at the time of the offence.

Forensic and clinical history

246. Between 2003-2011, 55 (58%) had been convicted of a previous violent offence.† 68 (55%) had previously been in prison.

247.3 had a history of admission to a high, medium or regional secure unit. 8 (6%) patients had previously been involuntarily detained under mental health legislation.

†Note: Data on previous convictions were not available for 2012 and 2013, see paragraph 39.

Non-adherence and missed contact

248. 14 (11%) patients had been non-adherent with drug treatment in the month before the homicide.

249. 48 (36%) patients missed their final service contact before the homicide, an average of 4 per year.

250. In total, 56 (44%) were either non-adherent or had missed final contact with services and were therefore not in receipt of planned treatment just prior to the homicide.

Homicide and schizophrenia

251. There were 29 homicides by people with a history of schizophrenia (includes other delusional disorders), 3% of the total sample, an average of 3 per year.

252. Of these, 17 (77% excluding unknowns) had symptoms of psychosis (delusions and/or hallucinations) at the time of the offence.

253. 19 (66%) were patients.

254. 3 (17%) patients had been non-adherent with drug treatment in the month before the homicide. 5 (31%) patients with schizophrenia missed their final service contact before the homicide.

Homicide and personality disorder

255. There were 36 homicides by people with a history of personality disorder in 2003-2013, 4% of all homicide convictions, an average of 3 per year. 12 (33%) offenders with personality disorder were patients.

Patients with alcohol and drug misuse

256. 110 (87%) patients had a history of alcohol misuse. This was an average of 10 patient homicides per year. 115 (88%) patients had a history of drug misuse, an average of 10 per year. There were 127 patients who had a history of either alcohol or drug misuse or both, 94% of patients, an average of 12 homicides per year.

WALES

SUICIDE

257. Between 2003-2013, the Inquiry was notified of 3,508 deaths in the general population that were registered as suicide or "undetermined", an average of 319 per year. These are referred to as suicides throughout the report.

Suicide in the general population

258. The number and rate of suicide in the general population have risen since 2009 and are now at the highest level since 2003 (Table 4; Figure 68). Similarly the male numbers and rates have risen since 2008 (Figure 68). In 2013, the male: female ratio was 4.2:1.

259. Some deaths are not registered for several months or longer which means that our figures for the most recent years underestimate the true (final) figures. We therefore calculate figures that take this delay into account for 2013 (Table 4). However, improvements in registration delays may have contributed to increased rates in Wales in 2013.[20]

260. The rate in men aged 25-34 has fallen since 2003 (Figure 69). Rates have risen from 2007 in men aged 45-54 and 55-64. The rise in suicide in men aged 45-54 since 2007 is 74%, in men aged 55-64 it has been 75%. The fall in men aged 25-34 from 2003 to 2011 was 48%. There has been no change in the suicide rate in any age-group in women.

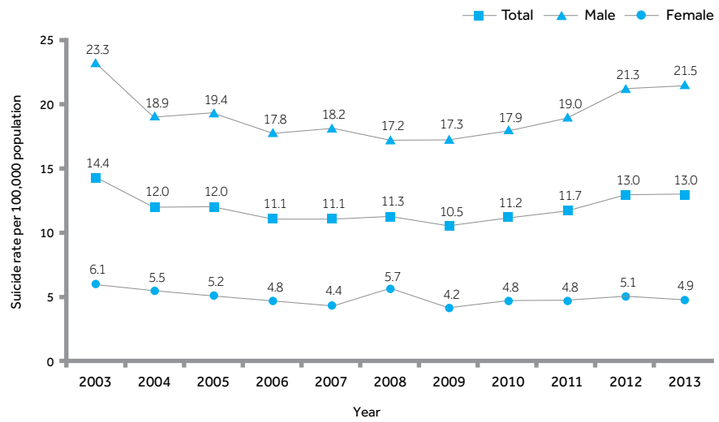
Table 4: Number of suicides in the general population, by gender

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Male	291	239	247	228	236	225	227	237	252	284	281 287†
Female	82	75	70	65	60	79	58	67	67	71	67 68†
Total	**373**	**314**	**317**	**293**	**296**	**304**	**285**	**304**	**319**	**355**	**348** **355†**

† indicates the estimated final number based on delays recorded in previous years, i.e. a 2% increase in 2013.

THERE HAS BEEN AN INCREASE IN THE RATE OF MALE SUICIDE SINCE 2007, PARTICULARLY IN THOSE AGED 45-54 AND 55-64.

Figure 68: Rates of suicide in the general population, by gender



Note: rates in 2012 and 2013 are estimated to take into account delays in data collection

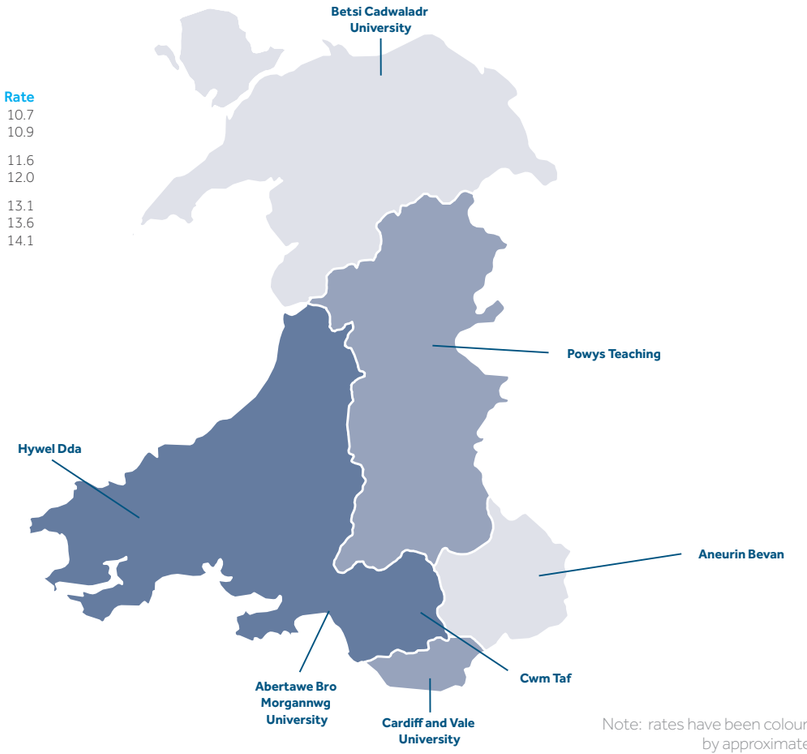
Figure 69: Male suicide rates in the general population in those aged 25-34, 45-54 and 55-64

Variation in suicide rates by area of residence (Health Board)

261. There was some variation in suicide rates by area of residence (by Health Board) at the time of death (average rate 2011-2013). The highest rate of suicide was in Cwm Taf, at 14.1 per 100,000 population, and the lowest in Betsi Cadwaladr University, at 10.7 per 100,000 population (Figure 70).

Figure 70: Rates of suicide per 100,000 population, by Health Board of residence (average rate 2011-2013)

Area	Rate
Betsi Cadwaladr University	10.7
Aneurin Bevan	10.9
Cardiff and Vale University	11.6
Powys Teaching	12.0
Hywel Dda	13.1
Abertawe Bro Morgannwg University	13.6
Cwm Taf	14.1



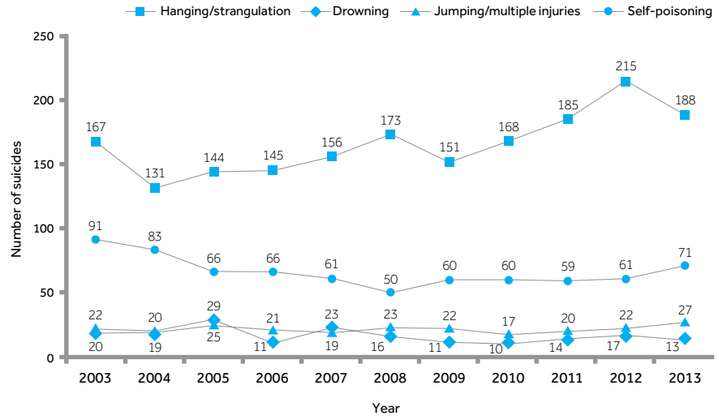
Note: rates have been colour coded by approximate tertile

Method of suicide

262. The most common methods of suicide were hanging and strangulation (referred to as hanging in the remainder of this report) (1,823, 52%) and self-poisoning (overdose) (728, 21%). Less frequent methods were jumping and multiple injuries (mainly jumping from a height or being struck by a train) (238, 7%), drowning (183, 5%), carbon monoxide (CO) poisoning (132, 4%), cutting and stabbing (97, 3%), and firearms (75, 2%).

263. Deaths by hanging have increased while deaths by self-poisoning have decreased overall, despite a rise since 2008 (Figure 71). Of the less common methods, deaths by CO poisoning, drowning, and firearms decreased.

Figure 71: Suicide in the general population: main causes of death



PATIENT SUICIDE

Patient suicide: numbers and rates

264. During 2003-2013, 806 deaths (23% of general population suicides) were identified as patient suicides, i.e. the person had been in contact with mental health services in the 12 months prior to death. This represents an average of 73 patient suicides per year.

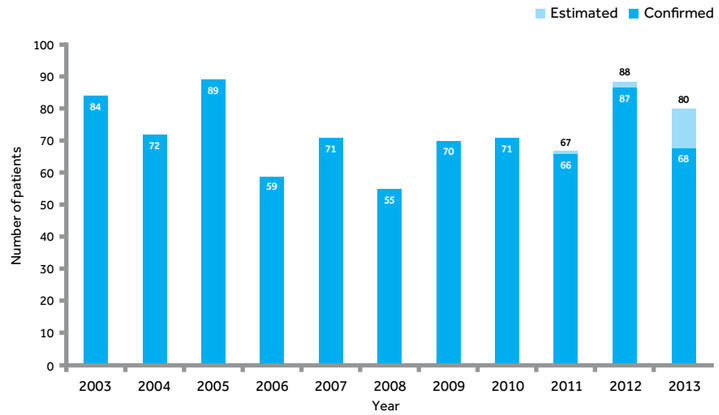
265. There was no overall change between 2003 and 2012 in the number (Figure 72 and 73) or the rate of patient suicide (using a general population denominator; Figure 74). However, the number has risen since a low figure in 2008.

266. Similarly, the number and rate of male suicides have increased since 2008 (Figures 73 and 74). The rate of female suicide has fallen in 2003-2012.

267. Numbers and rates for individual age-groups by gender fluctuated with no overall trend. However, there has been a 27% increase in the number of male suicides in those aged 55-64 since 2011.

268. In 232 (32%) the suicide occurred within a year of mental health service contact; in 318 (44%) it was over 5 years.

Figure 72: Number of patient suicides



MALE PATIENT SUICIDES HAVE INCREASED SINCE 2008. THERE HAS BEEN A 27% INCREASE IN THOSE AGED 55-64 SINCE 2011.

Figure 73: Number of patient suicides, by gender

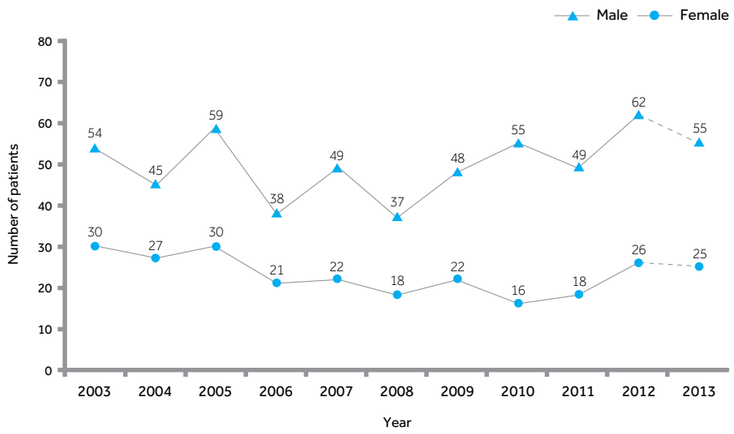
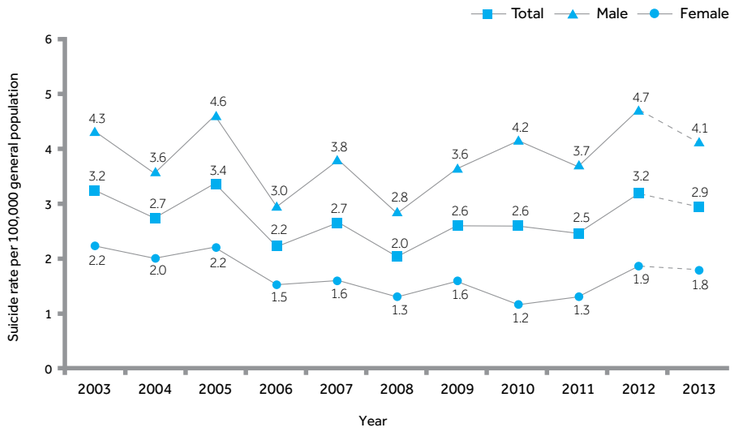


Figure 74: Rates of patient suicide, by gender



Method of suicide by patients

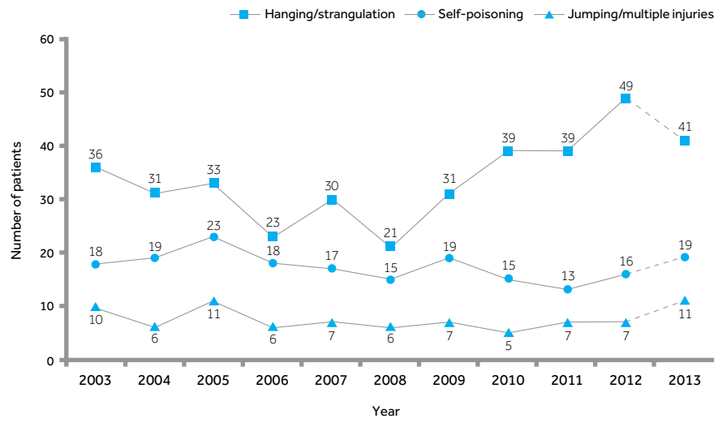
269. The most common methods of suicide by patients were hanging (373, 46%), self-poisoning (192, 24%) and jumping (83, 10%).

270. Hanging has increased since 2003 (Figure 75). Deaths by other methods have not changed.

271. The most common substances used in deaths by self-poisoning were opiates (43, 25%), anti-psychotics (21, 12%) and tricyclic antidepressants (20, 11%).

272. Since 2009, there have been 15 deaths, including 1 patient death, which followed inhalation of helium gas, 3 of which occurred in 2009-2010 and 12 in 2011-2013.

Figure 75: Patient suicide: main causes of death



Suicides in people aged under 25

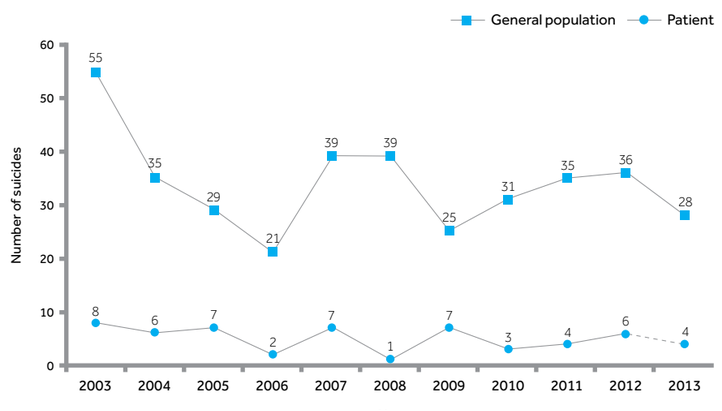
273. During 2003-2013, there were 373 suicides in the general population in those aged under 25, 11% of all suicides, an average of 34 per year. 134 were aged under 20 and 64 were aged under 18.

274. 55 of those under 25 were patients, 7% of patient suicides and 15% of all suicides in this age-group. This represents an average of 5 deaths per year. 18 were aged under 20 and 13 were aged under 18.

275. There has been no overall change in the number of general population or patient suicides aged under 25 over the report period since a peak in 2003 (Figure 76).

276. We are currently carrying out a detailed study investigating suicide in this age group and will be publishing preliminary findings in 2017.

Figure 76: General population and patient suicides in those aged under 25

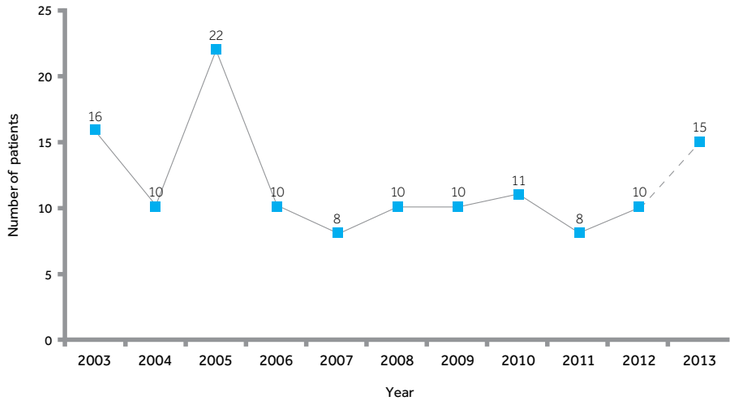


Patients with schizophrenia

277. There were 130 suicides in patients with a primary diagnosis of schizophrenia (includes other delusional disorders), 16% of the total sample, an average of 12 deaths per year.

278. Following a peak in 2005, there has been no change though we estimate an increase in 2013 (Figure 77).

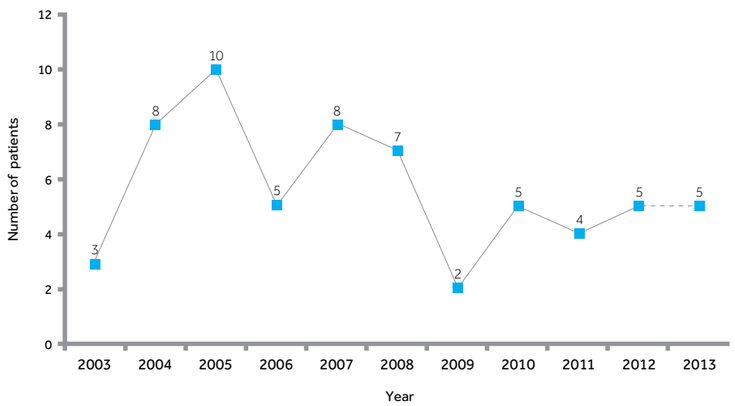
Figure 77: Patient suicide: number with a primary diagnosis of schizophrenia and other delusional disorders



Patients with personality disorder

279. There were 62 suicides in patients with a primary diagnosis of personality disorder, 8% of the total sample, an average of 6 deaths per year. The number has fallen since a peak in 2005 (Figure 78).

Figure 78: Patient suicide: number with a primary diagnosis of personality disorder



Patients with alcohol and drug misuse

280. There were 375 patients with a history of alcohol misuse, 48% of the total sample, an average of 34 deaths per year (Figure 79).

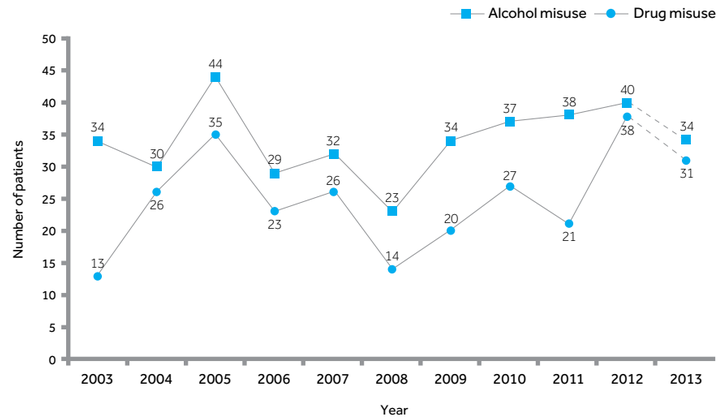
281. 274 had a history of drug misuse, 35% of the total sample, an average of 25 deaths per year (Figure 79).

282. 453 patients had a history of either alcohol or drug misuse or both, 57% of patient suicides, an average of 41 deaths per year.

283. Numbers have risen since low points in 2008, though we estimate falls in 2013.

284. Between 2011-2013, 20 (10%) patients were under drug services and 16 (8%) were under alcohol services.

Figure 79: Patient suicide: number with a history of alcohol or drug misuse



Socio-economic factors

285. Between 2012-2013, there were 17 (25% excluding unknowns) suicides in patients who had experienced serious financial difficulties in the 3 months before death.

286. In 2008-2012, a similar proportion of patients were unemployed (140, 41%) compared to the pre-recession years of 2003-2007 (139, 38%). 37 (5%) patients were homeless, living in bed and breakfast, or hostels, i.e. 'unstable housing'. This proportion did not change over the report period.

Websites promoting suicide

287. Between 2011-2013 there were 4 (2%) patients who died by suicide after visiting a "pro-suicide" internet site, i.e. providing information on methods or encouraging suicide. As these figures are based on clinical reports, they may underestimate how often this occurs.

Significant dates

288. According to clinician knowledge, in 7 the suicide occurred on a significant date, representing 3% of all suicides during 2011-2013.

MENTAL HEALTH CARE

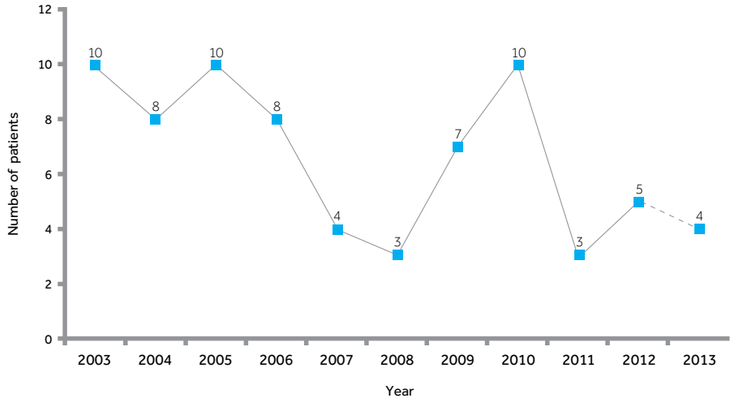
In-patient suicide

289. There were 72 in-patient deaths by suicide between 2003-2013, 9% of patient suicides, an average of 7 per year.

290. Figures have fluctuated with no overall trend, and have been low since a peak in 2010 (Figure 80).

291. There were 17 patients who died on the ward by hanging over the 11-year period. There were 13 suicides in detained in-patients, 19% of all in-patient suicides. 15 in-patients died after absconding from the ward, 21% of all in-patient suicides. The number has fallen since 2003.

Figure 80: Patient suicide: number of mental health in-patients



Crisis Resolution/ Home Treatment

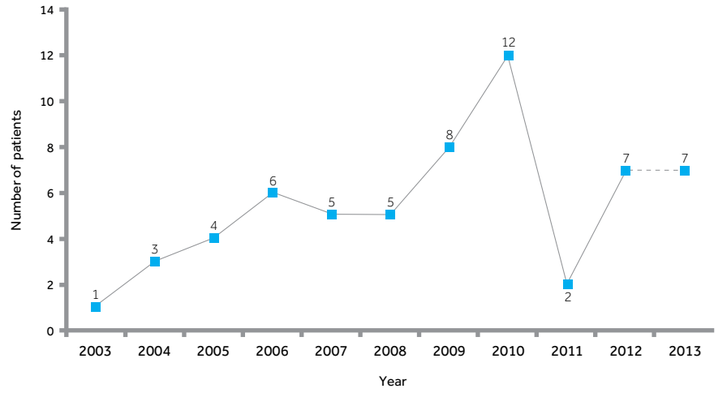
292. There were 60 suicides in patients under crisis resolution/home treatment (CR/HT) teams, 8% of the total sample, an average of 5 deaths per year.

293. There has been an increase in the number of suicides under CR/HT, with a peak in 2010 (Figure 81). Since 2007 there have been more patient suicides under CR/HT than in in-patient care, reflecting a change in the nature of acute care.

294. In 26 (43%) the patient lived alone.

THERE HAS BEEN AN INCREASE IN THE NUMBER OF SUICIDES UNDER CR/HT.

Figure 81: Patient suicide: number under crisis resolution/home treatment services



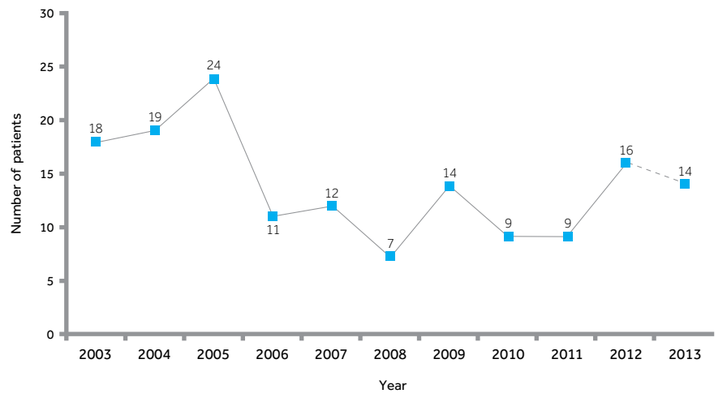
Patients recently discharged from hospital

295. There were 153 suicides within 3 months of discharge from in-patient care, 19% of all patient suicides and 21% of suicides in community patients, an average of 14 deaths per year.

296. The number of post-discharge suicides fell after a peak in 2005 but there has been no change since 2006 (Figure 82).

297. Post-discharge suicides were most frequent in the 2 weeks after leaving hospital when 53 deaths occurred, 37% of all suicides within 3 months of hospital discharge, an average of 5 deaths per year. There were 21 patients who died in the first week after discharge.

Figure 82: Patient suicide: number who died within 3 months of in-patient discharge



Section 136 of the Mental Health Act

298. In 2012-2013, 6 (9%) community patients had been conveyed to a hospital-based place of safety under Section 136 of the Mental Health Act within the preceding 3 months; 2 (3%) had been conveyed to a custody-based place of safety under this section.

Urgent referral

299. In 2012-2013, 6 (9%) community patients had been referred urgently to mental health services by a GP in the 3 months prior to death.

Clinicians' views on prevention

300. In 2011-2013, clinicians indicated a number of factors related to acute care that in their view would have made the suicide less likely. These included: better crisis facilities (11, 5%); better out-of-hours care (10, 5%); more psychiatric beds (7, 3%); and less frequent use of agency/locum staff (3, 1% of all patients; 1 (9%) of in-patient suicides).

Community Treatment Orders

301. There were 6 suicides in patients subject to a community treatment order in 2009-2013, 2% of all patient suicides in this time period.

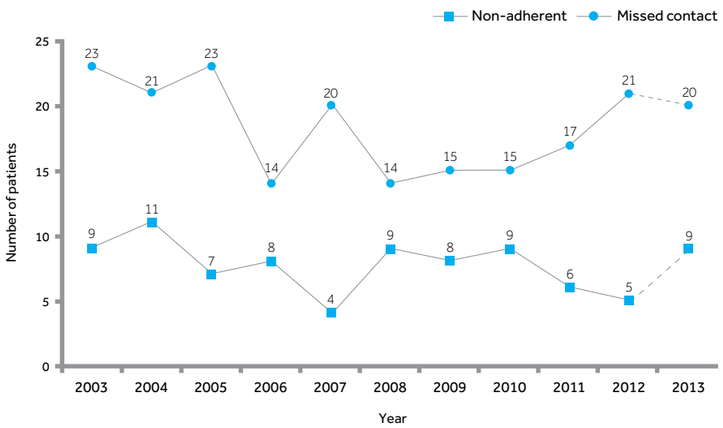
Non-adherence and missed contact

302. 85 (12%) patients had been non-adherent with drug treatment in the month before death, an average of 8 deaths per year.

303. 203 (28%) patients had missed their final service contact before death, an average of 18 deaths per year.

304. There was no overall change in 2003-2012 in the annual number of patient suicides following non-adherence or missed contact (Figure 83). However, figures for suicide following missed contact have risen since a low point in 2008.

Figure 83: Patient suicide: number non-adherent with drug treatment or missed last contact



HOMICIDE

305. In 2003-2013 the Inquiry was notified of 271 homicide convictions, an average of 25 per year. There were 285 victims, an average of 26 per year.

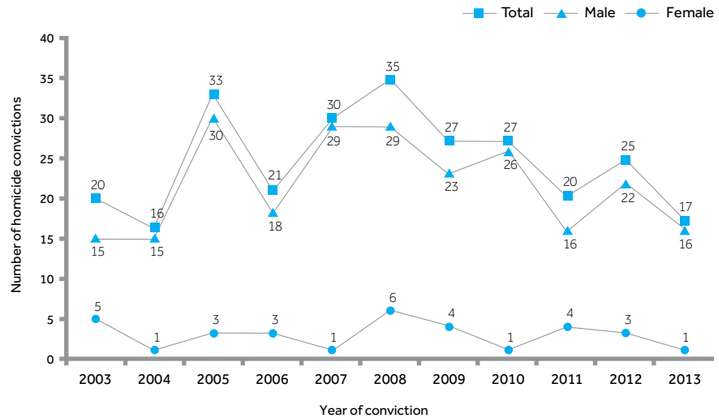
Homicide in the general population

306. The annual number of homicide convictions in the general population is shown in Figure 84. More recent data are published for England and Wales by the Office for National Statistics.[17]

307. The number of homicide convictions has fallen since a peak in 2008.

308. The most common method of homicide is the use of a sharp instrument (93, 35% of all homicides) followed by hitting and kicking (60, 23%).

Figure 84: Number of homicide convictions in the general population, by gender of offender



PATIENT HOMICIDE

309. During 2003-2013, 31 people convicted of homicide (11% of the total sample) were confirmed as patients, i.e. the person had been in contact with mental health services in the 12 months prior to the offence, an average of 3 per year. There were 37 victims, an average of 3 per year.

Acute care

310. There were no homicides committed by in-patients. There were 3 homicides within 3 months of discharge from in-patient care, 11% of all patient homicides. 1 patient was under crisis resolution/home treatment care (CR/HT) at the time of the homicide.

Forensic and clinical history

311. 14 (45%) had been convicted of a previous violent offence. 11 (44%) had previously been in prison. 2 people had a history of admission to a high, medium or regional secure unit. 8 patients had previously been involuntarily detained under mental health legislation.

Non-adherence and missed contact

312. 4 (17%) patients had been non-adherent with drug treatment in the month before the homicide. 5 (18%) missed their final service contact before the homicide. In total, 8 (32%) were either non-adherent or had missed final contact with services and were therefore not in receipt of planned treatment just prior to the homicide.

Homicide and schizophrenia

313. Of the total number of homicides, 22 were by people with schizophrenia (includes other delusional disorders) 8% of the total sample, an average of 2 homicides annually.

314. Of these, 20 (95%) had symptoms of psychosis (delusions and/or hallucinations) at the time of the offence. 11 (50%) people with schizophrenia were patients.

Homicide and personality disorder

315. 14 had a diagnosis of personality disorder, 5% of all homicide convictions. 5 (36%) were patients.

Patients with alcohol and drug misuse

316. 25 patients had a history of alcohol misuse, 83% of the patient sample. This was an average of 2 patient homicides per year. 23 patients had a history of drug misuse, 77% of the patient sample, an average of 2 per year. There were 28 (93%) patients who had a history of either alcohol or drug misuse or both, an average of 2 homicides per year.

HOMICIDE FOLLOWED BY SUICIDE

317. Homicide followed by suicide is defined here as when the offender dies by suicide within 3 days of committing homicide. As there is no conviction for homicide in these cases, they are not included in the previous analysis.

318. We were notified of 12 offences between 2003 and 2013. There were 14 victims in total. Two incidents involved 2 victims, in both of these cases all the victims were family members.

319. Most of the offenders were male (10, 83%), with a median age of 44 (range 29-81).

320. The relationship of victim to offender (as a principal victim if there was more than one victim) was most commonly spouse/partner (current/ex) (7, 58%); parent or step parent (2, 17%); son or daughter (1, 8%); other family member (1, 8%) and acquaintance (1, 8%).

321. 2 cases of homicide-suicide involved patients under the care of mental health services prior to the offence.

UK-WIDE DATA AND UK COMPARISONS

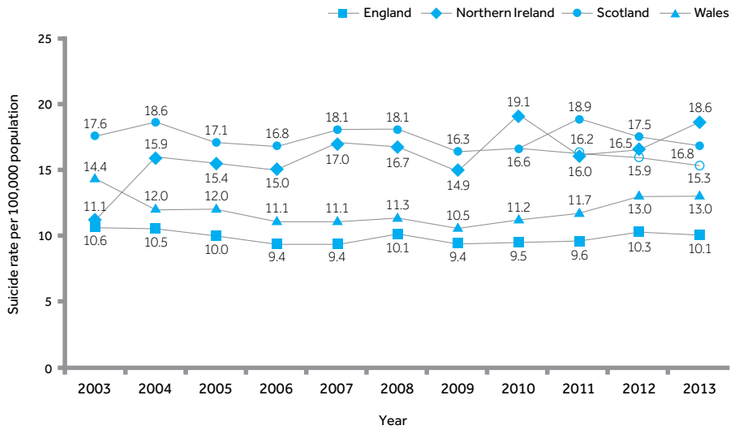
SUICIDE IN THE GENERAL POPULATION

322. Suicide rates for each UK country are shown in Figure 85. Scotland and Northern Ireland continue to have the highest general population suicide rates, though the rate in Scotland has fallen.

323. There has been an increase in the rate of suicide in men since relatively low figures for 2006 in England, Northern Ireland and Wales but a fall in Scotland (Table 5). Rates have increased in all countries in males aged 45-54 (Table 5) and have also increased in males aged 55-64 in England and Wales.

SUICIDE IN MEN HAS RISEN IN THE UK SINCE 2006-2008. THE RISE IS MOST MARKED IN MEN AGED 45-54.

Figure 85: Suicide rates in the general population, by UK country



Note: unfilled markers in 2011-2013 indicate rates using the old death coding rules in Scotland

Table 5: Male suicide deaths and those aged 45-54 in the general population, by UK country

	ENGLAND	N. IRELAND	SCOTLAND	WALES
Males **Suicide rate (per 100,000 population)‡**	16.1	26.6	26.7	21.4
Change post-2006†	10%	13%	-10%	20%
Males aged 45-54 **Suicide rate (per 100,000 population)**	24.6	33.0	37.8	29.7
Change post-2006†	37%	9%	20%	32%

‡Average rate in 2012-2013; †percentage change between the rate in 2006 and the average rate in 2012-2013; Figures in Scotland are based on the new death coding rules

PATIENT SUICIDE

324. There were 18,220 suicides by patients in the UK in 2003-2013. We were also notified of 10 patients in Jersey, of a general population total of 21 in 2012-2013. UK figures show a rise in the annual number of patient suicides since 2006 (Figure 86 and Table 6). The number of patient suicides is influenced by the number of people under mental health care which has also risen, and by changes to death coding (see page 12).

325. The number of male patient suicides in all UK countries has risen since comparatively low figures in 2006 (Table 7), particularly in England and Wales where the increase is much greater than the corresponding rise in the general population. There has been a 73% increase in suicides in male patients aged 45-54 in the UK since 2006 (Table 7), as well as rises in those aged 55-64 in England and (since 2011) Wales.

THERE HAS BEEN A RISE IN THE UK IN PATIENT SUICIDE SINCE 2006. WITH THE EXCEPTION OF NORTHERN IRELAND, THE NUMBER OF MALE PATIENT SUICIDES HAS INCREASED.

Figure 86: Number of patient suicides in the UK

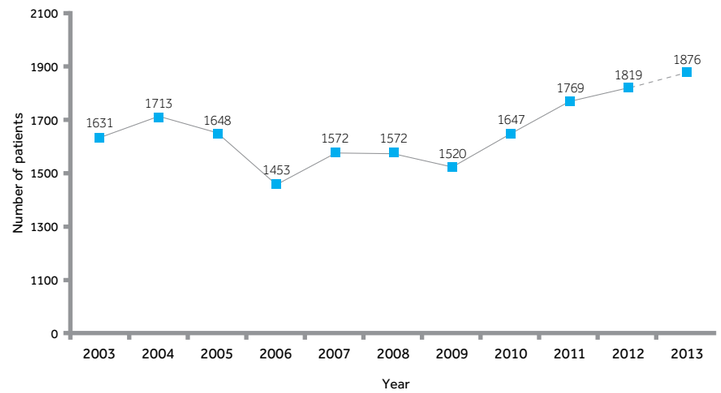


Table 6: Patient suicide: numbers by year and UK country (2003-2013)

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
England	1256	1317	1277	1124	1143	1211	1165	1263	1351	1396	1469
N. Ireland	45	73	64	61	76	76	64	74	67	73	68
Scotland	246	251	218	209	282	230	221	239	284 †231	262 †224	259 †227
Wales	84	72	89	59	71	55	70	71	67	88	80

Note: Figures from 2009 include estimates based on late notifications. †indicates the number of suicides in Scotland using the old death coding rules

Table 7: Patient suicide: male suicide deaths and those aged 45-54, by UK country

	ENGLAND	N. IRELAND	SCOTLAND	WALES	UK
Males Number of suicides‡	989	47	170	59	1,239
Change post-2006†	33%	7%	6%	55%	29%
Males aged 45-54 Number of suicides	271	11	47	12	333
Change post-2006†	86%	*	*	*	73%

‡Average number in 2012-2013; †percentage change between the number in 2006 and the average number in 2012-2013;
*No calculation due to the small number of suicide deaths; Figures in Scotland are based on the new death coding rules

PATIENT HOMICIDE

326. In 2003-2013 there were 830 (11%) homicides by patients in the UK, an average of 75 per year. The figure of 51 in 2013 is incomplete (and further cases, especially in England, are expected).

327. Patient homicide numbers in the UK have fallen over the report period (Figure 87 and Table 8), though there has been no continued fall after 2010.

Figure 87: Number of patient homicides in the UK

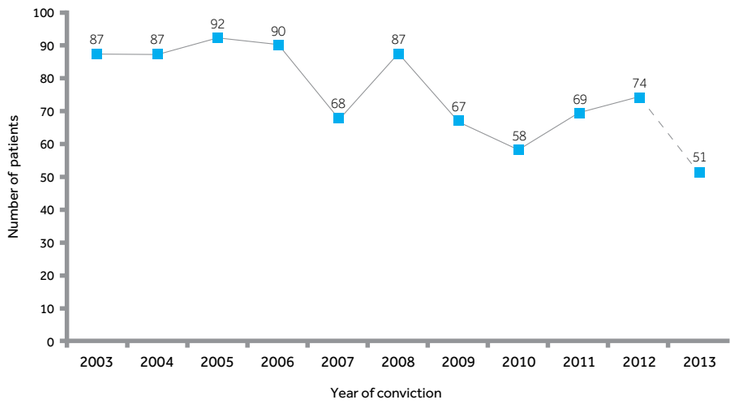
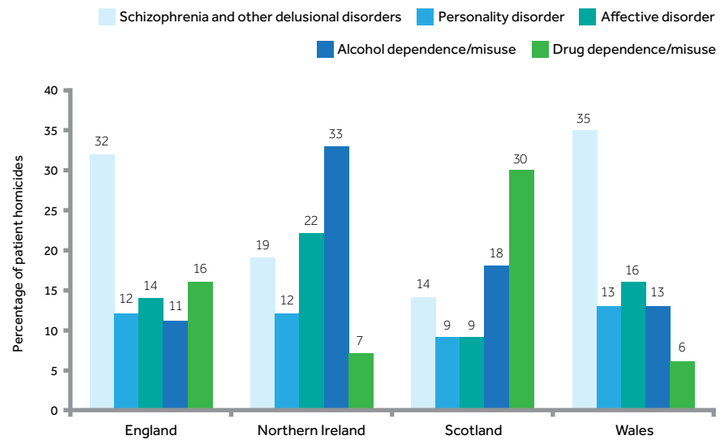


Table 8: Patient homicide: numbers by year and UK country (2003-2013)

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
England	70	64	72	74	55	68	43	47	51	50	36
N. Ireland	4	4	1	2	2	2	3	1	1	4	3
Scotland	12	18	14	10	8	15	17	7	14	17	10
Wales	1	1	5	4	3	2	4	3	3	3	2

328. The primary diagnoses for patients convicted of homicide varied by UK country (Figure 88). Many patients did not have severe mental illness and had a primary diagnosis of personality disorder or alcohol or drug dependence or misuse. The commonest diagnosis in England and Wales was schizophrenia. A primary diagnosis of alcohol dependence or misuse was more common in Northern Ireland while a primary diagnosis of drug dependence or misuse was more common in Scotland.

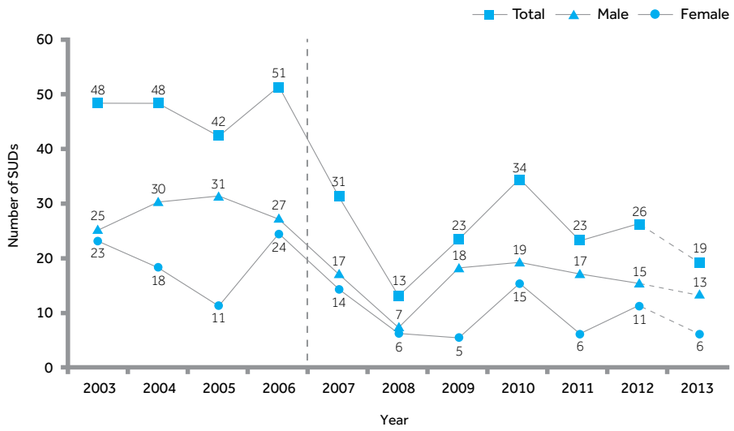
Figure 88: Number of patient homicides by primary diagnosis and UK country (2003-2013)



SUDDEN UNEXPLAINED DEATH (SUD) IN MENTAL HEALTH IN-PATIENTS (ENGLAND AND WALES)

329. During 2003-2013, there were 358 SUD cases in England and Wales, an average of 33 per year (Figure 89). There was an overall fall in the reported annual number of SUDs over the study period. However, due to a change in data provider, recent numbers are not comparable with previous data. There has been no change since 2007, the average number being 24 per year.

Figure 89: Number of sudden unexplained deaths, by gender



Note: between 2006 and 2007 data providers changed from the NHS-Wide Clearing Service (NWCS) to Hospital Episode Statistics (HES), therefore the numbers before and after 2006 are not strictly comparable.

AROUND 9 SUDDEN UNEXPLAINED DEATHS OCCUR EACH YEAR IN ENGLAND & WALES IN PATIENTS AGED UNDER 45

330. 163 (49%) had a history of cardiovascular disease; 89 (27%) had a history of respiratory disease; 43 (13%) had a history of cerebrovascular disease, and 27 (8%) had a history of epilepsy. 219 (66%) had a history of any physical illness.

331. 26 (8%) were receiving 2 or more anti-psychotic drugs (i.e. polypharmacy).

332. There were 44 (12%) SUD cases in patients from black and minority ethnic (BME) groups over the report period. The number of these deaths varied from 1-8 per year and showed no trend over time.

Restraint

333. There were 5 deaths within 1 hour of restraint in 2003-2013. We do not know whether restraint caused these deaths.

334. There were 22 deaths within 24 hours of restraint in 2003-2013, ranging from 0-4 per year. The number of post-restraint deaths is too small to identify a trend. There were 7 deaths within 24 hours of restraint in BME patients, one of which was within 1 hour.

Patients aged under 45

335. There were 96 (26%) patients under 45 years, an average of 9 per year. The annual number of these cases did not change over the report period.

336. 20 (24%) had a history of cardiovascular disease; 17 (20%) had a history of respiratory disease and 11 (13%) had a history of epilepsy. 48 (56%) had no history of these physical illnesses.

337. 14 (16%) patients were receiving 2 or more anti-psychotic drugs (i.e. polypharmacy).

338. Patients aged under 45 were more likely to be from a BME group (26 cases, 27% v. 17 cases, 6%).

SUICIDE BY SELF-POISONING USING OPIATES

OPIATES ARE THE MOST COMMON DRUG TAKEN IN FATAL OVERDOSE BY MENTAL HEALTH PATIENTS. THERE WERE 141 DEATHS USING OPIATES IN THE UK IN 2013.

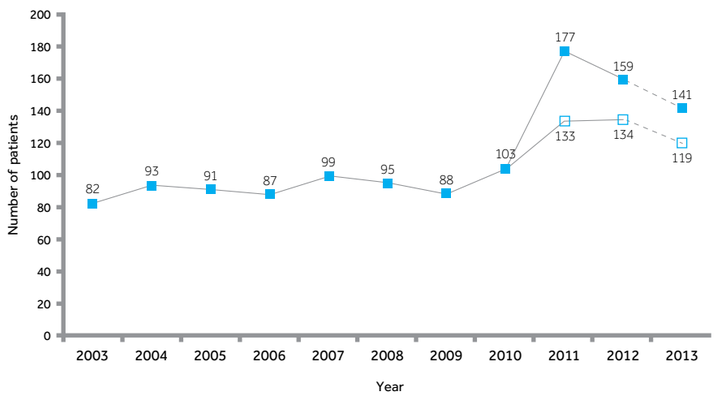
339. 1,215 deaths by opiate self-poisoning occurred in the UK during 2003-2013, an increase during the report period (Figure 90). There have been proportionately higher numbers in Scotland and Northern Ireland in recent years (Table 9).

340. We have collected data on the type of opiates used in self-poisoning deaths since 2012. The most common types identified were heroin/morphine (58, 38%), methadone (33, 21%) and tramadol (31, 20%). Methadone was more common in opiate overdose in Scotland than other UK countries (39% v. 15%). This is likely to reflect the increased availability of methadone and other opiate substitution therapies in Scotland.

341. In 194 (36% excluding unknowns) the opiates had been prescribed for the patient, in 42 (8%) they had been prescribed for someone else, and in 305 (56%) they had not been prescribed.

342. Those who died by self-poisoning using opiates obtained by prescription were older (median age 45 v. 36). They were also more likely to be female (103, 54% v. 102, 29%), have a major physical illness (103, 59% v. 64, 21%) and a primary diagnosis of affective disorder (63, 33% v. 68, 20%).

Figure 90: Patient suicide: number by self-poisoning of opiates



Note: unfilled markers in 2011-2013 indicate the number of suicides using the old death coding rules in Scotland.

Table 9: Patient suicide: number by self-poisoning of opiates by year and UK country

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
England	55	66	54	61	68	59	55	69	97	96	87
N. Ireland	1	3	6	3	2	5	7	4	8	9	10
Scotland	23	20	26	18	27	28	20	27	70 †26	49 †24	38 †16
Wales	3	4	5	5	2	3	6	3	2	5	6

†indicates the number of suicides in Scotland using the old death coding rules

SUICIDE IN PEOPLE WITH A PHYSICAL ILLNESS

AROUND A QUARTER OF PATIENTS WHO DIE BY SUICIDE HAVE A MAJOR PHYSICAL ILLNESS.

343. There were 3,410 suicides in 2005-2013 by patients with a major physical illness, as recorded by clinicians (2005 was the first year we collected data on physical illness). This represents 24% of the total sample during this period, an average of 379 deaths per year.

344. Overall in the UK the annual number of these deaths has been rising (Figure 91 and Table 10), though this is mainly because of a rise in England.

345. In 2,876 (88%) cases, the illness was chronic, i.e. had lasted over 12 months. The most common categories of physical illness were neurological (629, 20%), endocrine (546, 17%) and rheumatological/ orthopaedic (524, 16%). 789 (44%) of those aged 65 and over had a major physical illness. In 664 (87%) cases, the illness was chronic.

346. We are supporting a study by NCEPOD on the mental health care of physically ill patients (**see www.ncepod.org**).

Figure 91: Patient suicide: number with a physical illness at the time of death

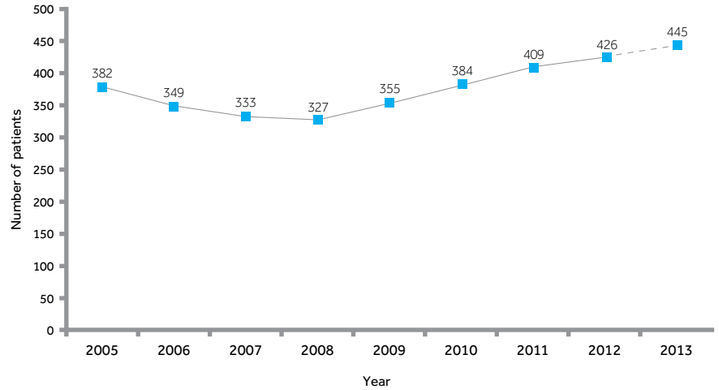


Table 10: Patient suicide: number with a physical illness by year and UK country

	2005	2006	2007	2008	2009	2010	2011	2012	2013
England	294	266	235	262	292	284	322	345	353
N. Ireland	17	10	14	20	13	20	18	18	13
Scotland	45	53	63	30	36	30	56	48	63
Wales	26	20	21	15	14	20	13	15	16

WORKING WITH FAMILIES

SERVICE CONTACT WITH FAMILIES COULD PLAY A GREATER PART IN SUICIDE PREVENTION. STAFF TOLD US THAT CLOSER CONTACT BETWEEN THE STAFF AND THE PATIENT'S FAMILY WOULD HAVE REDUCED SUICIDE RISK IN 14% OF CASES.

347. Closer contact with the patient's family was viewed by the mental health team as a factor that would have reduced the likelihood of suicide in 2,338 cases, 14% of all suicides, an average of 213 per year (Table 11). This number increased over the report period to 244 in 2011-2013.

348. The reason for the last contact was an urgent request by the patient or family in 1,001, 6% of all patient suicides (Table 11).

349. In 866 patients who missed their last appointment with services, the patient's family was contacted. This represents 22% of all patient suicides, an average of 79 per year (Table 11).

350. Following the patient's death, members of the mental health team made contact with relatives in 10,743 (66%). This number has increased over the report period, from 2,832 (63%) in 2003-2005 to 3,321 (68%) in 2011-2013. The contact was most often a face-to-face discussion (59%) or a telephone call (27%).

351. In patient homicides, 122 (18%) members of the mental health team considered the homicide would have been less likely if there had been closer contact with the patient's family.

Table 11: Patient suicide: family contact by UK country

	UK		ENGLAND		N. IRELAND		SCOTLAND		WALES	
	N	%	N	%	N	%	N	%	N	%
Contacted family after missed appointment	866	(22%)	708	(24%)	22	(11%)	94	(14%)	42	(22%)
Contact would have reduced risk	2,338	(14%)	1,979	(16%)	62	(9%)	197	(8%)	100	(13%)
Urgent request by patient/family	1,001	(6%)	822	(6%)	28	(4%)	112	(4%)	39	(5%)
Contact for review	10,743	(66%)	8,563	(69%)	429	(67%)	1,325	(53%)	426	(58%)

HOMICIDE BY STRANGERS

THE NUMBER OF STRANGER HOMICIDES BY PATIENTS HAS FALLEN OVER THE REPORT PERIOD

352. There were 1,563 convictions for homicide in the UK in which the victim and perpetrator did not know each other (stranger homicides), 25% of cases where the relationship was known, an average of 142 per year. The figure for 2013 was 109.

353. 7% of those convicted were mental health patients, 11 per year (Table 12). This is lower than the percentage of homicides overall that are committed by mental health patients (11%).

354. The number of stranger homicides by patients has fallen over the report period, especially after a peak in 2006 (Figure 92).

355. Most (88%) of these patients had a history of alcohol or drug misuse.

Figure 92: Number of stranger homicides by patients in the UK, by year of conviction

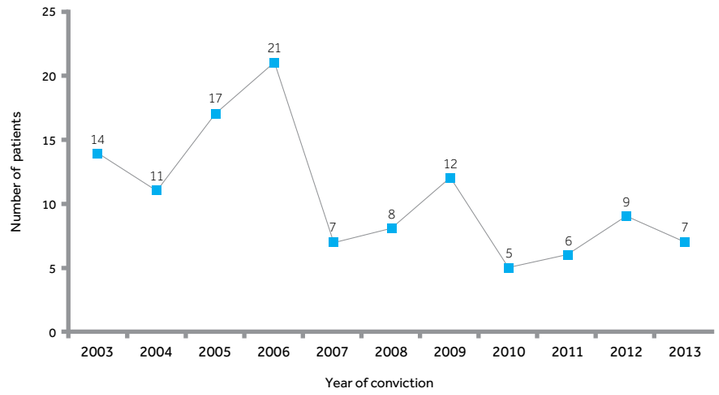


Table 12: Stranger homicide by UK country (2003-2013)

	UK	ENGLAND	N. IRELAND	SCOTLAND	WALES
	Number = 7,265	Number = 5,835	Number = 217	Number = 942	Number = 271
Stranger homicide: general population	1,563	1,264	74	178	47
Stranger homicide as a % of all homicides*	25%	26%	35%	20%	20%
Number of stranger homicide patient offenders	117	91	3	19	4
Patient stranger homicide as a % of all stranger homicides*	7%	7%	4%	11%	9%
Patient stranger homicide with a history of alcohol and/or drug misuse*	103	79	3	18	3

* The denominator includes only cases where the relationship between the victim and offender was known (i.e. this is a "valid" percent).

RECENT PUBLICATIONS FROM THE INQUIRY

A full list of Inquiry reports and publications can be found on the Inquiry website: **www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci - Publications**

Flynn S, Gask L, Shaw J (2015) Newspaper reporting of homicide-suicide and mental illness. BJPsych Bulletin, doi:10.1192/pb.bp.114.049676

Saini P, Chantler K, Kapur N (2015) General practitioners' perspectives on primary care consultations for suicidal patients. Health & Social Care in the Community, DOI: 10.1111/hsc.12198.

Oude Voshaar RC, van der Veen DC, Kapur N, Hunt IM, Williams A, Pachana NA (2015) Suicide in patients suffering from late-life anxiety disorders; a comparison with younger patients. International Psychogeriatrics, DOI: 10.1017/S1041610215000125.

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester (2015) In-patient suicide under observation. **http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/ipobsreport.pdf**

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester (2015) Healthy services and safer patients: links between patient suicide and features of mental health care providers. **http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/serv_features.pdf**

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester (2014). Suicide in primary care in England: 2002-2011. **http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/SuicideinPrimaryCare2014.pdf**

Rahman M & Kapur N (2014) Quality of risk assessment prior to suicide and homicide. Psychiatric Bulletin, 38, 46-7. DOI: 10.1192/pb.38.1.46b.

Saini P, While S, Chantler K, Windfuhr K, Kapur N (2014) Assessment and management of suicide risk in primary care. Crisis, 35, 415-25. DOI: 10.1027/0227-5910/a000277.

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