



The National Confidential Inquiry
into Suicide and Homicide by People
with Mental Illness

Lessons for mental health care in Scotland

JUNE 2008

FOREWORD

Every death under mental health care is a tragedy, inevitably raising the question of whether more could have been done. This report by the National Confidential Inquiry examines the details of individual cases of suicide and homicide by people with mental illness, asking: How many cases are there? What are the common themes? Can we learn from them about risk and how to reduce it?

In the time covered by the report – six years for suicides, five years for homicides – there were around 5,000 suicides and around 500 homicides in Scotland. However, the Inquiry found that only 28% of the people who died by suicide and 12% of those who committed a homicide had recently been mental health patients. Their first recommendation is therefore that we should recognise that the potential for prevention by mental health services is limited to these cases – in other words, other agencies must also play their part.

Yet mental health services can strengthen their management of risk in a number of ways. The report does not present a long list of instructions to clinical staff. Instead, it highlights the key areas of clinical practice where improvement is needed and suggests what changes could be made. In the end however, it will be up to local clinicians and services to turn these findings into actions.

The report makes a number of recommendations. Of particular interest are the suggestions to strengthen training and services for the management of drug and alcohol misuse, including a focus on “dual diagnosis” patients; and to improve outreach services for patients at risk of losing contact with care.

The report tackles the sensitive issue of serious violence by mental health patients, aware that this topic can increase the fear and stigma that mentally ill people encounter. Two points are emphasised. One is the low risk to the general public from mental health patients; the other is that people who need mental health care are at times imprisoned by the courts. Further study of why mentally ill people are sent to prison is recommended.

There are several positive findings – progress on in-patient suicide, for example. But a fundamental message is that Scotland has high rates of both suicide and homicide, in the general population and in patients. The report recommends definitive studies of the reasons.

Scotland has a number of national policies that are intended to improve the mental health of the community and the safety of mental health services. We also have a new Mental Health Act and a national strategy to reduce suicide. The National Confidential Inquiry report is a call to do more. It reminds us that mental illness carries risks, that mental health services cannot be risk-free, and that safety must be at the heart of good care.

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STEERING GROUP

The Inquiry Steering Group is currently chaired by Professor Sheila Hollins of the Royal College of Psychiatrists and includes members of the College (including the Scottish Section) in general adult and forensic psychiatry, representatives from the devolved governments of Wales and Northern Ireland, service users, user support services and lay members of the public.

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SUMMARY OF KEY MESSAGES

SUICIDE RATES

There has been a welcome recent fall in the general population suicide rate. Despite this, the most striking feature of rates in Scotland is how much higher they are than in England and Wales, almost twice as high. Although this is not a recent development, it remains unexplained.

Possible explanations include:

- differences in how deaths are investigated and how cause of death is determined
- more widespread social adversity
- higher rates of key risk factors such as alcohol and drug misuse
- a combination of these and other factors.

Research should now examine the causes of high suicide and homicide rates.

The degree to which Scottish rates are higher varies with age, being greatest in teenagers. Age patterns like this raise the possibility of a “cohort effect,” i.e. that young people who are currently at high risk will carry this risk with them as they get older, raising future suicide rates for the population as a whole.

The higher general population rate is also reflected in the number of patient suicides, which is proportionally higher than in England and Wales. For example, the number of suicides by patients with schizophrenia – around 35 per year – is higher than would be predicted from equivalent figures from England and Wales – around 200 per year – in a population around tenfold higher, assuming similar population rates of schizophrenia. However, it is not possible to draw conclusions about the overall safety of mental health services from these figures. It may be that the causes of the higher population rate affect all sub-groups, including people with severe mental illness.

One point about prevention by services is clear, however. Twenty-eight percent of suicides nationally are by current or recent patients. The potential for prevention by mental health services is limited to this group.

For others, action will be needed on public health, in primary care, by other agencies such as social care and probation and by society as a whole. Nevertheless, the figure of 28% translates into 233 patient suicides per year on average. The findings in this report refer primarily to these people and the measures that could reduce their number.

The difference between general population suicides rates in Scotland and in England and Wales is greatest in young people – in their teens and early twenties. This is also the age group with the lowest rate of contact with specialist mental health care. It seems likely that there is a problem in recognising the presence or seriousness of mental disorder in young people.

A major initiative is now needed to develop mental health services for young people, that can offer prompt access to care and early intervention.

HOMICIDE RATES

Similarly, the homicide rate in Scotland is substantially higher than in England and Wales. In contrast to suicide rates, national homicide rates are high because of particularly high rates in certain areas of the country – Greater Glasgow, and Clyde and Argyll.

In Scotland, as elsewhere, homicide is a crime committed by young men, with young men their likeliest victims. In the cases we studied alcohol or drugs had often been taken, and the homicides were most often committed with what our data sources call “sharp instruments.”

The policy response to these deaths should focus on alcohol and drug abuse in young people, and on the carrying of knives by young men. Drugs and knives are a dangerous mix.

As with suicide, the high population risk is reflected in the number of homicides by mental health patients. The number of patient homicides is proportionally greater in Scotland, mainly because of the number committed by patients with alcohol or drug dependence. The risk of a person with schizophrenia committing a homicide appears no higher than in England and Wales.

The rise in homicide in recent years is the result of an increase in killings by young people, mainly men under 25. Most, however, are not mentally ill. A public health approach to homicide would target alcohol and drug use before mental illness.

Our homicide findings also raise an important concern about the way that courts deal with cases in which the convicted person has a severe mental illness, and this needs further investigation.

Of the patients committing homicide, 88% were sent to prison. Although most had disorders such as alcohol and drug dependence, patients with mental illness were also imprisoned. And, of all those with schizophrenia (patients and non-patients), almost half (7 of 15) were given prison sentences. This seems inappropriate and inhumane.

PREVENTION BY MENTAL HEALTH SERVICES

The potential for mental health services to prevent suicides is a sensitive subject. Anyone who has been in clinical practice is aware of how difficult it can be to manage risk, to get the balance right between patient autonomy and intervention. Clinicians often feel that the public does not understand the complexities of clinical care or recognise the large number of cases that are managed successfully. They see a “culture of blame” in which the press, the public and the government, often examining a single tragic case with hindsight, blame the clinician rather than the true culprit, the illness itself. They are likely to point to the findings in this report showing that most patient suicides and homicides happen without obvious warning – they occur when risk seems low.

On the other hand, patients’ families and the wider public see mental health professionals as over-defensive. They see aspects of care going wrong and a tragedy occurring and are perplexed when clinicians appear to dispute whether they could or should have acted differently, or claiming that managing the risk of patient violence is not their job. They are likely to point to the views of clinicians in most of the cases in this report – that the death could not have been prevented – as evidence that professionals are reluctant to accept their responsibility for patient and public safety.

This is an important debate, to which these findings can contribute. None of the tragedies in this report should be seen as inevitable, but many happened despite care which in crucial ways was satisfactory, e.g. when efforts were made to encourage compliance with treatment.

Prevention is difficult and prediction – identifying the highest risk patient from the many who are at risk to some degree – unreliable. But, the management of risk can always be improved.

Clinicians, if they are to persuade the public to be realistic about what can be achieved in caring for high-risk patients, need to show that they accept the need to strengthen clinical care. In any case, most of the measures that can be taken to reduce risk are about the quality of care more broadly – closer follow-up or contact with patients’ families, for example.

The public, as well as advocates for patients and their families, need to accept that when tragedies happen, they are not necessarily someone’s fault, even if care could have been different. Without this shared understanding of risk and its management, the kind of scrutiny of clinical care that is necessary to improve it will not take place. Attitudes to prevention can be a positive, practical influence on safety itself.

ALCOHOL AND DRUGS

Alcohol and drug misuse runs through these findings. It appears to be a major contributor to risk in mental health care and in broader society. It is likely that alcohol and drugs lie behind Scotland's high rates of suicide and homicide.

Alcohol and drug misuse are already known to be risk factors for both suicide and violence. Even so, the frequency with which they occur as antecedents in the cases described here is striking.

Of the 1,373 patient suicides in this report, there was a history of alcohol misuse in 785, an average of 131 deaths per year, and a history of drug misuse in 522, an average of 87 deaths per year. A quarter of patient suicides had "dual diagnosis" – a combination of severe mental illness and drug or alcohol dependence/misuse – 343 in total, an average of 57 deaths per year.

Of the 58 patient homicides in this report, 41 had a history of alcohol misuse and 45 a history of drug misuse. Thirteen, just under a quarter, had "dual diagnosis." Among all perpetrators, whether patients or not, drug dependence and alcohol dependence were the most common diagnoses. In both suicide and homicide, most were not under the care of addiction services.

Addictions are difficult to treat; mental health and addiction services can not tackle on their own the serious problems posed by the widespread misuse of alcohol and drugs.

However, our findings support the view that alcohol and drugs are the most pressing mental health problems in Scotland and mental health services can play their part by:

- **Ensuring that front-line clinical staff are skilled and confident in assessing and managing misuse**
- **Developing dedicated services for dual diagnosis**
- **Establishing close links with addiction teams covering joint care plans, information sharing, referral criteria and consultation.**

IN-PATIENT CARE

Suicides by in-patients appear to have fallen since our data collection began in 1998. The fall is most clearly seen in deaths by hanging but it is not confined to this method – the findings suggest an improvement in ward safety generally, affecting both numbers and rates.

Despite these positive changes, in-patient care remains a key area for improved risk management. Risk of suicide is one of the main reasons for hospital admission; in-patient wards provide the best opportunities for close supervision and regular assessment. As a result in-patient care has arguably the greatest potential for prevention – clinicians themselves saw these deaths as more often preventable.

Our findings draw attention to differences between deaths that occur on and off the ward and that have therefore, different priorities for prevention. Thirty percent of in-patient deaths occurred on the ward itself. They were more likely to occur by hanging – especially from hooks, handles and pipes – and to occur in the first week of admission. The patients tended to have schizophrenia and co-morbid disorders including alcohol and drug misuse.

These findings suggest that prevention should focus on the care and supervision of acutely disturbed patients in the days after admission, and on removing ligature points.

Twenty-three percent of in-patient suicides occurred in patients who had left the ward without the agreement of staff. In fact, a third were, or were intended to be, under special observation. Their clinical and social profile was different to that of the first group – they more often had affective disorder and lived alone.

Prevention should focus on absconding – special observation alone is not enough. This may be done by improving the patient’s experience of the in-patient environment. A disturbed ward can be a frightening and isolating place. Without support and recreation, patients can feel frustrated and restless. Controlling entry and exit points should also make absconding more difficult.

Forty-five percent of in-patient suicides occurred in patients who were off the ward with the permission of staff. These deaths occurred later in the admission, when discharge was being planned, presumably a time of apparent clinical recovery. Their clinical profile too was characterised by affective disorder and living alone, as well as compliance with care.

Prevention should focus on careful assessment of risk during the period leading to discharge, including the patient’s reaction to his/her return to the stresses that may have triggered the admission.

COMMUNITY CARE

Two aspects of community care stand out in the report, and in both there are signs of improving risk management, as well as a need for more emphatic measures.

One in five of all patient suicides occurred in the first three months after discharge from hospital; one in thirty occurred in the first week. These patients are similar in clinical profile to the in-patients who die while discharge is being planned (see above).

Prevention should similarly focus on close supervision and careful assessment of risk in the period leading up to and after discharge, and on early follow-up.

Almost a quarter of these deaths occurred before the first follow-up appointment, though this figure appears to be improving. The number of post-discharge suicides may also be decreasing, though a clear trend cannot yet be confirmed.

Twenty-six patient homicides (47%) and 375 patient suicides (27%) were preceded by “missed contact,” a sign in this study of disengagement from care. Despite an unexplained fall in suicide cases in 2005, “missed contact” was a far more frequent antecedent than non-compliance with drug treatment, which occurred in 13% of homicides and 13% of suicides. Loss of contact with services is a critical issue in these tragedies,

whether or not it is causal. It is seen as a failure of community care, with the likely effect that public confidence in mental health services is damaged.

However, many of the “missed contact” cases in our sample, particularly in the case of homicide, had alcohol or drug dependence rather than severe mental illness and it cannot be assumed that more effective follow-up would have picked up warning signs, e.g. symptoms of relapse. Even so, there is a strong case for more intensive community support for patients at highest risk and greatest need, backing up the recent introduction of a community treatment order.

Based on these findings, community care linked to risk should be designed around: 1) follow-up after hospital discharge, working closely with in-patient teams, and 2) patients who drift out of services, particularly those with severe mental illness. This means highly specialised services at the heart of community mental health care, building on recent “outreach” developments.

SUMMARY OF ACTIONS

This report recommends:

- better training and services for the management of drug and alcohol misuse, including dedicated services for “dual diagnosis” patients
- specialist community mental health teams providing an outreach service for patients who are at risk of losing contact with care
- early follow-up following hospital discharge, requiring joint risk management by in-patient and community teams
- more intensive supervision of patients recently admitted to hospital
- removal of ligature points from in-patient wards
- prevention of absconding from wards through improvements in the ward environment and tighter control of exits
- careful assessment of risk during periods of leave leading up to hospital discharge
- improved mental health services for young people, providing better access and early intervention
- positive clinical attitudes to the management of risk as part of a more understanding dialogue with the public
- further study of the causes of higher suicide and homicide rates in Scotland
- examination of reasons for imprisonment of offenders with severe mental illness.

For further information about this publication contact:

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The full report is available on our website:
<http://www.manchester.ac.uk/nci>



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