

SAFER SERVICES

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

Report 1999: Summary

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SUMMARY: KEY FINDINGS AND RECOMMENDATIONS

Key findings: Suicide

Suicides under mental health services

1. 24% of suicides had been in contact with mental health services in the year before death; this represents over 1,000 cases per year (findings below refer to these cases).
2. The commonest methods of suicide were hanging (men) and self poisoning by overdose (women).
3. The commonest drugs used in overdose were those prescribed to treat mental disorder (psychotropic drugs); suicides who had previously harmed themselves were more likely to commit suicide with psychotropic drugs.
4. The commonest diagnoses were depression, schizophrenia, personality disorder and alcohol or drug dependence.
5. Around half also had a second (co-morbid) diagnosis, indicating more complex treatment needs.
6. Suicides clustered in the first year after the onset of illness, when 22% occurred.
7. There were high rates of alcohol and drug misuse; 17% were misusing both alcohol and drugs.
8. 63% had a history of self-harm; 19% had a history of violence.
9. Around half the suicides occurred in patients with a history of self-harm and either substance misuse or previous admission to hospital; combinations of risk factors such as these indicate priority groups for mental health services.
10. Following suicide, the mental health team had contact with the family of the deceased person in just over half the cases.

Last contact with services

11. Half the suicides had been in contact with mental health services in the week before death.
12. At final contact, immediate risk of suicide was estimated to be low or absent in 85% of cases.

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13. When suicide risk was estimated to be moderate or high, this information was usually passed on to other members of the mental health team, but in a minority (14%) it was either recorded in the case notes only, or not communicated.
 14. In 10% of suicides, the care plan was not altered at final contact because the patient's current problem was thought to be the result of alcohol, drugs or personality rather than illness.
 15. When patients were seen by two services prior to suicide, key points of information known to one service were frequently not known by the other.

Preventability

16. Mental health teams regarded 22% of the suicides as preventable but in around two-thirds they believed that more could have been done to reduce risk.
17. Mental health teams identified improved patient compliance and closer supervision as the factors that would have reduced risk in the largest number of cases.
18. If a new Mental Health Act prevented non-compliance or non-attendance by severely mentally ill patients whose last admission was under the Act, up to 30 suicides per year could be prevented.

In-patient suicides

19. 16% of cases (4% of all suicides) were psychiatric in-patients.
20. Around one third of in-patient suicides occurred on the ward itself.
21. In-patient suicides, particularly those occurring on the ward, were most likely to be by hanging.
22. Suicide on and off the ward followed different patterns, suicide on the ward being more common in the evening and night.
23. Around one quarter of in-patient suicides were under special observation (constant or intermittent).
24. In almost a quarter of in-patient suicides, there were difficulties in observing patients because of ward design.

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25. In a quarter of in-patient suicides, there were nursing shortages on the ward.

Suicides in the community

26. 28% of patients in the community who committed suicide were currently out of contact with services, usually following discharge at the patient's request or against medical advice.
27. In around a third of community suicides who had lost contact with services, no further action was taken; when action was taken this was usually to offer an appointment by letter rather than a home visit.
28. Less than half of community suicides were regarded as receiving any form of psychological intervention, including psychological support.
29. 14% were taking benzodiazepines for anxiety; almost half of these had a diagnosis of major psychiatric disorder.

Post-discharge suicides

30. 24% of suicides occurred within three months of discharge from in-patient care.
31. These post-discharge suicides were at a peak in the first week after leaving hospital; within the first week, the highest number occurred on the day after discharge.
32. 41% of post-discharge suicides occurred before the first follow-up appointment.
33. Post-discharge suicides were associated with final admissions lasting less than 7 days, re-admissions within 3 months of previous admission and "patient-initiated" discharge.

Suicides and the Care Programme Approach

34. Forty-two per cent of suicides were subject to the Care Programme Approach (CPA) at a level requiring multi-disciplinary review.
35. In most of these, the main provisions of the CPA were in place, i.e. key worker, follow-up appointment, date for next case review.
36. These CPA suicides had a higher rate of non-compliance but a lower rate of being out of contact with services.

Non-compliance with treatment

37. 26% of suicides were known to be non-compliant with drug treatments in the month before death; 30% of these had also missed their final appointment with services.
38. Non-compliant suicides had higher rates of schizophrenia, hospital admission and drug misuse.
39. Non-compliant suicides had a higher rate of distressing medication side-effects, most often related to oral anti-psychotic drugs.

Disengagement from services

40. 24% of suicides did not attend their final appointment with services in the community.
41. This disengaged group showed a general pattern of weak ties to society as a whole (i.e. high rates of unemployment and living alone) as well as to mental health services.
42. When this disengaged group committed suicide as in-patients, this was more likely to occur following absconding, indicating continuing disengagement from services.

Suicides in ethnic minorities

43. 5% of suicides were from an ethnic minority. Suicides among ethnic minorities usually had severe mental illness.
44. Suicides in ethnic minorities had a high rate of non-compliance with drug treatments in the three months before suicide.

Homeless patients

45. 3% of suicides were homeless.
46. Homeless suicides tended to be young unemployed males with alcohol dependence or schizophrenia.
47. 46% of homeless suicides were under the CPA at a level requiring multi-disciplinary review.
48. Homeless suicides had high rates of non-compliance with treatment and loss of contact with services.
49. A high proportion of homeless suicides died as in-patients.

Diagnosis

50. Suicides in people with schizophrenia showed high rates of non-compliance and distressing drug side-effects although the main reason for non-compliance was thought to be lack of insight into illness.
51. Suicides with alcohol or drug dependence or personality disorder had the most disrupted pattern of care, including high rates of loss of contact with services.

Key findings: Homicide

Homicides in the general population

52. The majority of homicides in the general population were committed by young men who were unmarried and/or unemployed. Alcohol and drug misuse were common.
53. Six per cent of people convicted of homicide were committed to psychiatric hospital; this outcome was more common in women.
54. Of perpetrators whose psychiatric court reports were obtained, 44% had a diagnosis of mental disorder based on life history; the majority of diagnoses were alcohol or drug dependence, personality disorder or affective disorder. Most did not have severe mental illness.
55. 6% of people convicted of homicide (for whom psychiatric reports were available) had a history of schizophrenia.

Mental illness at the time of homicide

56. 14% of people convicted of homicide (for whom reports were available) had symptoms of mental illness at the time of the offence (“mentally ill homicides”)
57. In these mentally ill homicides, previous convictions for violence were less common.
58. In these mentally ill homicides, alcohol and drugs were less likely to have played a part in the offence.
59. Mentally ill homicides were most likely to kill a family member or spouse; the proportion of victims who were strangers was lower than in those without current symptoms of mental illness.
60. Only 20% of mentally ill homicides had been in contact with mental health services in the previous year.

Homicides and mental health services

61. 8% of all homicides had been in contact with mental health services in the year before the offence: this represents around 40 cases per year. At least 14% had been in contact with services at some time (findings below refer to these 14%).
62. The most common diagnoses were personality disorder and schizophrenia; the majority did not have severe mental illness.
63. More than half also had a second (co-morbid) diagnosis, indicating more complex treatment needs.
64. There were high rates of alcohol and drug misuse.
65. In a third of cases in which contact had occurred with two hospitals, no written details had been passed between hospitals.

Previous violence (those with mental health service contact)

66. The majority of patients who committed homicide had a recorded history of previous violence.
67. Previous convictions for violence were frequently not documented in the mental health case notes.
68. In 14% there was a history of previous violence occurring during episodes of psychosis; the majority of these patients were either non-compliant with treatment or out of contact with services at the time of the homicide; just over half were subject to the higher levels of the CPA.
69. Most cases in whom service contact had been recent had committed an aggressive act (including threatening) in the year before homicide.

Contact with services

70. Only 17% of patients convicted of homicide were subject to multi-disciplinary review under the CPA.
71. 71% of patients convicted of homicide were out of contact with services at the time of the offence, usually following “patient-initiated” discharge.
72. 23% of patients were not compliant with their treatment prior to homicide.

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73. Homicides tended to have lower rates of recent contact with services than suicides, 14% having been in contact with services in the week before the offence.
 74. At final service contact risk was estimated to be low or absent in 88% of cases.
 75. Most of the homicides were not regarded as preventable by the mental health teams involved; however in around half, mental health teams were able to identify factors which could have made homicide less likely, most often improved patient compliance.
 76. If a new Mental Health Act prevented non-compliance or non-attendance by severely mentally ill patients whose last admission was under the Act, around 2 homicides per year could be prevented.
 77. There were 15 patients with schizophrenia among the Inquiry cases; most had a history of previous violence; only 9 were subject to the higher levels of the CPA.

Training and policies

78. Most trusts in England and Wales provide training for staff in the use of the Mental Health Act, but only half provide training on the assessment of suicide risk and risk of harm to others.
79. Only a minority of trusts have written policies on responding to non-compliance or non-attendance, or the communication of risk estimations.

Aims of recommendations

- to improve the skills of “front-line” staff in the recognition, assessment and management of suicide risk
- to simplify the administrative component of clinical care
- to strengthen the CPA by increasing its focus on people at risk
- to specify high-risk groups who should be the priority for safer services
- to ensure that information related to risk is passed between components of services
- to reduce non-compliance with treatment in people at risk by improving both the acceptability and the acceptance of effective treatments

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- to improve the ways in which services maintain contact with disengaged patients at risk, including homeless people
 - to promote the development of services for people with mental illness who also misuse alcohol and drugs
 - to make it easier for families to gain access to health professionals as partners in care
 - to prompt an extensive review of the physical structure of in-patient facilities, and of observation procedures on in-patient wards
 - to improve integration of in-patient and community services at the time of in-patient discharge
 - to specify the legal powers that will be required to achieve greater engagement and compliance with treatment
 - to reduce access to means of suicide
 - to establish good practice on dealing with the aftermath of suicide and homicide
 - to highlight the need for new policies on personality disorder
 - to reduce the stigma of mental illness arising from the high public profile of homicides by psychiatric patients
 - to reduce the “culture of blame” in mental health services

Recommendations

Training

1. All staff in contact with patients at risk of suicide should receive training in the recognition, assessment and management of risk, of both suicide and violence, at intervals of no more than three years.
2. The content of training should reflect many of the points highlighted by this report: indicators of risk, high-risk periods, managing non-compliance and loss of contact, communication, the Mental Health Act.

Documentation/information

3. A new, simplified, universal system of documentation (patient passports) should be developed, to be used for three purposes:
 - Clinical risk assessment, by the recording of key indicators of risk.
 - Allocation to care under the CPA according to evidence of risk, and subsequent monitoring.
 - Transfer of information between services.
4. Unified systems of case notes for all professional disciplines should be developed.
5. All patients with a history of violence in the context of mental illness should receive the highest level of care under the CPA.
6. Information on previous convictions for violent offences should be readily available to mental health services on request.
7. Risk-related information, e.g. rates of co-morbidity and staff training, should be collected and used in determining resources and monitoring performance.

Treatments and non-compliance

8. Modern drug treatments such as “atypical” anti-psychotic drugs and newer antidepressants should be offered to all patients with severe mental illness who are non-compliant with treatment because of side-effects.
9. Family and psychological interventions should be available to all high-risk patients with severe mental illness.
10. Trusts should have a written policy on non-compliance, based on these recommendations, which is made known to staff, patients and families.

Disengaged patients

11. In all patients with severe mental illness who have a history of disengagement from services, a comprehensive social and clinical care plan should be devised which includes satisfactory housing and occupational activities.

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12. Services should have the capacity for assertive outreach in response to loss of contact with patients with severe mental illness, including those who are homeless.
 13. These recommendations should be part of a written policy on disengagement which should be made known to staff, patients and families.

Co-morbidity

14. Services should make provision for patients with severe mental illness and alcohol or drug misuse as part of mainstream mental health services.
15. Training of staff in general psychiatry services should include the management of alcohol and drug misuse.

Families

16. “Points of access” to mental health teams should be provided for families who are concerned about a patient’s risk.

In-patient suicides

17. All services should review the physical structure of wards to identify
 - (1) any obstructions to the observation of high-risk patients and
 - (2) structures which could be used in suicide by hanging. Wards in which these cannot be removed should not be used for the admission of acutely ill patients.
18. Alternatives to intermediate level observations should be developed for patients at risk.
19. Services should increase and monitor the observation of patients in the evening and at night.
20. Risk assessment should always be carried out prior to granting leave in patients who are recovering from illness.

Post-discharge suicides

21. There should be follow-up within 48 hours for all patients who have been at high risk and who are discharged from in-patient care, and follow-up within one week for all discharges, including those who discharge themselves.

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22. Health authorities and trusts should make provision to accommodate all acutely ill patients in local catchment area services, ending transfers to in-patient care in other districts.
 23. Prior to discharge from in-patient care, in-patient and community teams should conduct a joint case review, including assessment of risk.
 24. CPA documentation should include more intensive provisions for the first three months after discharge from in-patient care, and specific reference to the first post-discharge week.

Mental Health Act

25. Mental health legislation should allow the enforced treatment of high-risk patients with severe mental illness who become non-compliant with treatment or who show indications of increasing risk, even in the absence of clear signs of relapse.

Access to means of suicide

26. Patients at risk of suicide, including all patients with a recent history of self harm, who are treated with psychotropic drugs should receive modern, less toxic drugs and/or supplies lasting no more than 2 weeks.

Aftermath of suicide or homicide

27. Following a suicide or a homicide, mental health teams should hold a multi-disciplinary review of the case.
28. Following a suicide or homicide, information on what happened should be provided promptly and openly to families.

Personality disorder

29. Clear policies on the clinical management of personality disorder should be disseminated by the Department of Health.

Stigma

30. Information in this report should be used by the Royal College of Psychiatrists to inform the public on the risks posed by people with severe mental illness, both to themselves and others.

Culture of blame

31. The Department of Health should assess the purpose and value of local inquiries into serious untoward incidents, and consider changes to the current requirement for full-scale inquiries in all cases.

Copies of the full report can be obtained from:
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