



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

Suicide and Homicide in Northern Ireland

JUNE 2011

MINISTER'S FOREWORD

Suicide is a highly complex issue and continues to present a growing challenge for our society despite strenuous efforts across the statutory, community and voluntary sectors together with inspirational support from bereaved families. The individual circumstances for each person represented in the statistics presented in this report are unique. Nevertheless, to reduce the risk of suicide it is important, where possible, to identify common themes and patterns.

We are all aware that people are now facing increasing pressures that can threaten their mental health and wellbeing. Substance misuse is a more common feature of modern life, particularly in areas of social and economic disadvantage; secure employment opportunities are not as plentiful; personal debt is rising; the gap in educational attainment remains; and stable family life is not as dominant a feature in society as it once was.

This report demonstrates the link between mental ill health and suicide with the finding that 29% of people who died by suicide had been in contact with mental health services in the previous 12 months. However, this figure also indicates that many people who are suicidal, and therefore likely to have mental health difficulties, are not accessing statutory mental health services.

Covering a nine year period from January 2000 to December 2008 during which there were 1,865 suicides and probable suicides in Northern Ireland, the report presents detailed data that looks behind the headline statistics. By presenting a better understanding of these deaths, the report will assist in fine tuning policy and practice for the care of people within mental health services and help to prevent deaths.

The remit of the Inquiry also covers homicide by people who have been in contact with mental health services and the report notes that 15% of perpetrators of homicide were confirmed to have been in contact with mental health services in the 12 months before the offence. As with homicide in the general population, in most of these cases the perpetrators and victims were known to each other and, more importantly, none of the "stranger homicides" over the review period were committed by a mental health patient. Perceptions around the issue of serious violence by mental health patients can increase the fear and stigma that mentally ill people encounter. The evidence from this report reinforces the important point of the low risk to the general public from mental health patients which should be highlighted in initiatives to combat stigma.

The report highlights areas where practice can be improved and presents a series of recommendations covering policy and practice. Work is already progressing that will help put many of the recommendations in place. This includes: the development of updated policy on suicide prevention and the promotion of positive mental health; the development of the second action plan for implementation of the Bamford Review of Mental Health and Learning Disability; ongoing implementation of the "Card Before You Leave" protocol at Emergency Departments; and work with the Department of Justice to improve support for people with mental illness in the criminal justice system.

Overall, the report increases our understanding of the risks of suicide in people with mental illness and of how to respond more effectively to those risks. This will help in taking further action to reduce suicide by people who use mental health services in Northern Ireland.



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STEERING GROUP MEMBERSHIP 2010

The Inquiry Steering Group during the period of this report includes representatives of the Royal College of Psychiatrists (including members of the Northern Ireland Section), representatives from the devolved governments of Scotland and Wales, social services, mental health service users, user support groups and lay members of the public.

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SUMMARY OF KEY FINDINGS AND RECOMMENDATIONS

Suicide and homicide in the general population

Overall, 1,865 suicides occurred in Northern Ireland in the period 2000-2008, 207 per year, giving a general population annual suicide rate of 13.9 per 100,000 people. This rate is higher than in the United Kingdom as a whole, though lower than in Scotland. The suicide rate in Northern Ireland rose in the later part of the report period, in contrast to the rest of the United Kingdom. This period includes the first two years after the publication of the *Protect Life* suicide prevention strategy, though it is too early to comment on the effectiveness of the strategy.

We identified 142 homicide convictions during 2000-2008, 16 per year, though this is likely to be an underestimate. The equivalent annual homicide rate is 10.6 per million people, similar to the rate in England and Wales but lower than the rate in Scotland.

Recommendations

1. The suicide rate in the general population and in the main demographic sub-groups should be monitored closely as evidence of the effectiveness of the *Protect Life* strategy.
2. The causes of the higher rate of suicide in Northern Ireland in comparison to England and Wales should be investigated.

Suicide and homicide in mental health patients

In the period 2000-2008, there were 533 suicides in current mental health patients, defined as having contact with mental health services in the previous 12 months. This was 29% of all suicides and corresponds to 59 patient deaths per year. The number of patient suicides rose during the report period, in line with the rise in general population suicides.

We identified 21 current mental health patients in people convicted of homicide during 2000-2008, corresponding to approximately 2 per year and 15% of all homicides. There were 6 homicides by people with schizophrenia of whom 3 were current patients.

Recommendation

3. The forthcoming mental health strategy for Northern Ireland should highlight the importance of risk management and include specific measures to tackle risk of suicide and serious violence.

Suicide in young people

The largest difference between suicide rates in Northern Ireland and other UK countries was in young people and they should be a priority for suicide prevention. 332 suicides occurred in people under 25 during 2000-2008, 37 per year. Young people who died by suicide were more likely than other age-groups to be living in the poorest areas and they had the lowest rate of contact with mental health services (15%). Young mental health patients who died by suicide tended to have high rates of drug misuse (65%), alcohol misuse (70%) and previous self-harm (73%).

Recommendations

4. Policy-makers and services should develop youth mental health services spanning the age range up to 25 years, with the skills and capacity to address substance misuse and self-harm.
5. Services for self-harm, substance misuse and mental illness should jointly review how they collaborate in the care of young people, particularly in deprived areas.

Alcohol and drug misuse

High rates of substance misuse and dependence run through this report and, as we rely on information known to clinicians, our figures are likely to underestimate the problem. Alcohol misuse, in particular, was a common feature of patient suicide (60%), and appears to have become more common. Alcohol dependence was the most common clinical diagnosis (52%) in patients convicted of homicide and, in homicide generally, alcohol misuse was a more common feature in Northern Ireland than in the other UK countries. Dual diagnosis (severe mental illness and alcohol or drug misuse) was found in 1 in 4 patient suicides. Clinicians regarded better services for dual diagnosis as an important step towards reducing risk.

Recommendations

6. Reducing alcohol misuse and dependence should be seen as a key step towards reducing the risk of suicide and homicide, requiring a broad public health approach including health education and alcohol pricing.
7. Mental health services should ensure that they have full availability of services for alcohol and drug misuse, including dual diagnosis services.

In-patient suicide

There were 35 in-patient suicides during 2000-2008. This is 4 per year, 7% of all patient suicides. The number and rate fell during the report period and, although hanging was the most common method, there were no deaths by hanging in the later years of the report period. Twenty-eight in-patient suicides (80%) occurred off the ward and in 13 of these (46%) the patient had left without staff agreement. Eight deaths occurred while the patient was under observation - in 7 of these, observations were intermittent. Eight deaths were related to problems of observation because of ward design.

Recommendations

8. In-patient services should adapt or strengthen protocols for preventing and responding to absconding.
9. In-patient services should abandon the use of intermittent observation.

Post-discharge care

Overall, 125 patient suicides (24% of all cases) and 9 patient homicides (43%) occurred within three months of discharge from hospital. There was clustering of post-discharge suicides in the 1-3 weeks after leaving hospital and, although numbers were small, a similar clustering of post-discharge homicides appeared to occur. 24% of post-discharge suicides took place before first follow-up. Post-discharge suicides were associated with re-admissions within three months of a previous admission.

Recommendations

10. Services should ensure that comprehensive care planning takes place prior to hospital discharge as a key component of the management of risk.
11. Patients discharged from hospital should be followed up within seven days.

Missed contact

In 129 patient suicides (27%) and 10 patient homicides (53%), the patient missed their final appointment with services. Missed contact was an increasingly frequent antecedent of patient suicides during the period of study, in contrast to Scotland and England – both these countries have in recent years introduced assertive outreach services, in which there is an emphasis on maintaining contact and improving engagement with people with complex mental health problems and a history of treatment refusal. Although clinical teams in this study usually took some kind of follow-up action following missed contact, this was often simply a letter or a further appointment sent by post. More assertive attempts to re-establish contact by visiting the patient at home were unusual.

Recommendation

12. Services should introduce an assertive outreach function into community mental health services, through staff training, reduced case loads, and new team structures.

Risk recognition

In the majority of both patient suicides (90%) and patient homicides (81%), immediate risk at final contact with services had been seen as low. This is a finding that we have also reported in other parts of the UK. It is likely to be explained by one or more of the following:

- Risk factors are common and this can make it difficult to identify people at the highest immediate risk.
- Risk in patients can fluctuate rapidly.
- Staff may become desensitised to evidence of risk.

It is clear that a risk management strategy cannot have much effect in reducing suicides and homicides if it is based mainly on improved care for patients known to be at the highest levels of risk – there are too few of these, according to our sample. Risk management has to be improved for the majority of patients if the few who will otherwise die by suicide or commit a homicide are to be reached. This means comprehensive care plans addressing key clinical problems such as treatment refusal, missed contact and substance misuse.

It also means that risk assessment should not rely only on risk factor checklists. In this report, long term risk was likely to be judged as higher than immediate risk, and judgements were more often based on social risk factors and clinical history, suggesting that detailed history-taking can improve the accuracy of risk assessment.

The pessimism of staff about prevention is itself a potentially serious problem. Our figures show that it was unusual for staff to believe that the suicide or homicide could have been prevented - in only 9% of suicides and 7% of homicides (i.e. 1 case). In part this is likely to reflect a fear of being blamed when serious incidents occur in mental health care.

Recommendations

13. Mental health services should review their risk management processes to ensure that they are based on comprehensive assessment rather than risk factor checklists, and backed up by appropriate skills training and access to experienced colleagues.
14. Professional and policy leaders should ensure that, when serious incidents occur under mental health care, they strike an appropriate balance between identifying blame and recognising the complexities of clinical risk management, both in public statements and in how the incidents are investigated.

Stranger homicides

“Stranger homicides” are important in mental health because they are assumed to reinforce public prejudice against mentally ill people, the popular assumption being that the killing of a stranger is likely to be associated with mental illness. In this report, almost a third of homicides involved the killing of a stranger and the frequency of these cases appeared to have increased in the decade up to 2008. However, these were not associated with mental disorder. None of the stranger homicides were committed by a mental health patient or someone who was mentally ill at the time of the offence.

Recommendation

15. Initiatives to combat the stigma of mental illness should emphasise the low risk to the general public from mentally ill patients living in the community.

Sentencing

Prison is not a suitable place for people with severe mental illness. In this report, almost all people convicted of a homicide offence were sentenced to prison. This included 3 of 6 people with schizophrenia, 20 of 21 current or recent mental health patients and 12 of 15 people who were found to have been mentally ill at the time of the offence. In Northern Ireland, as we have also reported in other parts of the United Kingdom, there is an excessive use of prison in dealing with homicides and, by implication, other offences by mentally ill people.

Recommendation

16. Courts and mental health services should review the sentencing of mentally ill people with a view to establishing alternatives to imprisonment.



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and Public Safety**

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AN ROINN

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

MÁNNYSTRIE O

**Poustie, Resydènter Heisin
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**Public Health
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The full report and previous Inquiry reports and publications are available on our website: <http://www.manchester.ac.uk/nci>

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