National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)
In early 2013 NHS North West R&D commissioned a writer-in-residence, Charlotte March, to present key areas of local research as poetry. NCISH was one of the projects selected. The poem below refers to our studies on safer wards.

WE DON'T ACCEPT THE INEVITABILITY

We are the delay factors,  
the stumbling blocks.

We are the interventions,  
the vigilance.

We are the artwork on the walls  
of single rooms bright with colour  
and no curtain rails.

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www.charmarch.co.uk

Poems also available on our website:  
www.manchester.ac.uk/nci
WHO ARE WE?

- The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) was established at the University of Manchester in 1996. We are currently commissioned by HQIP.

WHAT DO WE DO?

- NCISH collects information on events leading to suicide, homicide or sudden unexplained death (SUD) in mental health patients and makes recommendations for prevention.

HOW DO WE DO IT?

- We collect mortality data from national sources (e.g. Office for National Statistics), identify mental health patients with the help of trusts, and send a questionnaire for completion to the clinical team responsible for the care of the patient prior to the incident.

- We also use other methodologies (e.g. case-control; psychological autopsy; data linkage) and use other large datasets (e.g. clinical practice register database) to identify specific antecedents of suicide, homicide and SUD.

WHAT IMPACT HAS OUR WORK HAD?

- Our work has impacted on mental health services in 4 key areas:
  1. providing new knowledge
  2. making recommendations for change
  3. identifying what changes work
  4. providing the tools for change

- We are recognised nationally and internationally for our expertise and leadership in the field of mental health and risk.

WHAT DO WE WANT TO DO IN FUTURE?

- We have 4 broad aims for our future work. We will:
  1. continue to identify safety priorities in mental health care
  2. monitor changes in key figures over time
  3. carry out more detailed themed projects on selected topics
  4. incorporate the lessons of the Francis and Berwick reports in how we approach safety.
How was NCISH established?

1.1 NCISH was awarded to the University of Manchester in 1996 following a competitive tendering process. Previously, from its establishment in 1991, it had been independently managed in association with the Royal College of Psychiatrists.

1.2 From 1996, NCISH developed a comprehensive system for identifying patient suicides and homicides. Around 95% of eligible cases are now identified; questionnaires are completed on 97% of identified cases.

1.3 In 1997, data collection was extended to the other UK countries. In 2004, sudden unexplained death in mental health in-patients (SUD) was added to the core NCISH work.

1.4 In 2011, NCISH was again awarded to the University of Manchester for a further 4 years (2011-2015) through a competitive tendering process.

What is the organisational structure of NCISH?

1.5 Our team combines academic skills and clinical experience – the latter is essential in maintaining the confidence of the clinicians who provide our data and in understanding safety issues most pertinent to day-to-day practice. The directors are leading clinical academics with a strong track record of health service research.

1.6 Our setting in a university department provides access to additional expertise, (e.g. in statistics and qualitative methods), and to administrative and technical support (e.g. HR and IT).

1.7 Our close links with the local NHS services, i.e. Manchester Mental Health and Social Care Trust (MMHSCT), along with our partner organisations, the Royal College of Psychiatrists, the Royal College of Nursing, the NHS Confederation, and the Manchester Academic Health Sciences Centre (MAHSC), ensures that our priorities and recommendations are important to clinical staff, patients and their families and that our publications are tailored to each of these audiences.

What are the key aspects of the NCISH core work programme?

1.8 There are 3 core strands to the NCISH work programme: suicide, homicide, and sudden unexplained death (SUD).

1.9 The overall aim of the research is to recommend changes to clinical practice and policy that will reduce the risk of suicide, homicide or sudden death in mental health patients.

1.10 NCISH meets the aims by:

- maintaining a national register of all suicides, homicides, and SUDs in the UK general population, and
- collecting detailed information directly from clinical teams on people who have been in contact with services in the previous 12 months.
1.11 NCISH is unique nationally and internationally in the scale and depth of information collected on individuals who die by suicide, commit homicide or die suddenly and unexpectedly while in mental health in-patient care (SUD).

1.12 Much of what we know about suicide, homicide and sudden unexplained death in patients under mental health care is a result of the NCISH work programme over the past 17 years.

1.13 There are 3 broad stages to data collection: 1) obtain individual data from national data sources (e.g. Office for National Statistics (ONS)), 2) identify contact with mental health services in the 12 months prior to the incident through administrative contacts at mental health trusts and 3) collect detailed clinical data via questionnaire from the consultant psychiatrist (or other senior professional) caring for the patient (Figure 1). Additional information is collected from the criminal justice and court service for homicide cases.

**Figure 1: NCISH data collection processes**

- Obtain national data
- Determine contact with mental health services
  - No contact with mental health services within 12 months
  - Contact with mental health services within 12 months
- Send questionnaire to consultant psychiatrist for completion

**Outputs**

1.14 NCISH produces a wide range of outputs, providing health professionals, policymakers, and service managers with the evidence and practical proposals they need to implement change effectively (Table 1).

1.15 We actively engage with the public, service users and carers through broadcast, print and social media, and public engagement events (Table 1).

**Table 1: Summary of outputs**

<table>
<thead>
<tr>
<th>Output type</th>
<th>Number &amp; description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual reports</strong></td>
<td>• 5 reports produced to date</td>
</tr>
<tr>
<td></td>
<td>• reports provide an update on numbers, rates and trends on key issues and patient groups</td>
</tr>
<tr>
<td><strong>Major UK and national reports</strong></td>
<td>• 5 reports produced to date</td>
</tr>
<tr>
<td></td>
<td>• these include comprehensive 5-year reports, and national reports for Northern Ireland and Scotland</td>
</tr>
<tr>
<td><strong>Independently commissioned reports</strong></td>
<td>• 2 reports on homicide investigations commissioned by Department of Health/NPSA</td>
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<tr>
<td></td>
<td>• 1 report commissioned by Northern Ireland on filicide</td>
</tr>
<tr>
<td><strong>Themed reports</strong></td>
<td>• 1 published</td>
</tr>
<tr>
<td></td>
<td>• 2 in preparation for 2013-14</td>
</tr>
<tr>
<td></td>
<td>• 3 forthcoming in 2014-15</td>
</tr>
<tr>
<td><strong>Academic publications</strong></td>
<td>Over 80 academic papers (1997-2013)</td>
</tr>
<tr>
<td><strong>Presentations</strong></td>
<td>Over 250 presentations to clinical, policy, service user, carer, and research audiences</td>
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<tr>
<td><strong>Print media</strong></td>
<td>Our media (print and online) coverage is monitored via the University media office. Examples below:</td>
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<tr>
<td></td>
<td>• Risk assessment report (launch June 2013): 11 online/print outlets reported our findings</td>
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<td></td>
<td>• Annual 2013 report (launch July 2013): over 40 online/print outlets reported our findings</td>
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<tr>
<td><strong>Website and use of social media</strong></td>
<td>Google analytics (from April 2013):</td>
</tr>
<tr>
<td></td>
<td>• Website hits: 8,116</td>
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<tr>
<td></td>
<td>• Unique visitors: 5,394</td>
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<tr>
<td></td>
<td>• New visitors: 36%</td>
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<tr>
<td></td>
<td>• Returning visitors: 64%</td>
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<tr>
<td></td>
<td>Twitter (from January 2013):</td>
</tr>
<tr>
<td></td>
<td>• followers:672</td>
</tr>
<tr>
<td></td>
<td>• posts: &gt;1,000</td>
</tr>
<tr>
<td></td>
<td>Podcasts:</td>
</tr>
<tr>
<td></td>
<td>• 2 (via website link and Youtube)</td>
</tr>
<tr>
<td></td>
<td>Facebook: 71 likes</td>
</tr>
<tr>
<td><strong>Public and professional engagement</strong></td>
<td>Toolkit for service development:</td>
</tr>
<tr>
<td></td>
<td>• 1,247 downloads</td>
</tr>
<tr>
<td></td>
<td>Survey: 135 participants (figure 10). NICE.HQIP/NPSA conferences and exhibitions</td>
</tr>
<tr>
<td></td>
<td>• Selected as research topic for writer-in-residence poetry competition (pages 2; 12)</td>
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<tr>
<td></td>
<td>• Awarded NHS Northwest R&amp;D funding for innovative dissemination project with Big Comedy workshop</td>
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<td></td>
<td>Public events:</td>
</tr>
<tr>
<td></td>
<td>• Stockport and District Mind Family Fun day stand</td>
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<td></td>
<td>(2012; 2013)</td>
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</table>
What new knowledge has NCISH contributed to our understanding of suicide, homicide and SUD?

2.1 NCISH has generated key findings and figures that were not previously known but are now established and widely quoted by professionals, mental health charities and government reports.

2.2 Recent key findings from our 2013 Annual Report include:

- suicide findings:
  - patient suicides have recently risen,
  - trends in in-patient suicides - and in-patients who were detained or absconded prior to suicide, have continued to fall,
  - patient suicides under crisis resolution/home treatment service have increased (figure 2),

25% (1,200 people) of all people who die by suicide are in contact with mental health services in the previous 12 months; of this group half are in contact with services in the week before death.

- Of perpetrators convicted of homicide, 10% were mental health patients.

- 4% of suicides are by people who had been the lone carers of young children.

- Approximately one in ten patient suicides occur during an in-patient admission; the commonest cause of death is by hanging.

- The highest risk period is the first week after discharge, particularly the first 1 to 3 days (figure 4).

- Although stranger homicides increased between 1969-97, there was no increase in homicides by mentally ill patients. Accurate knowledge about homicide by patients with mental illness helps to fight against stigma.

Figure 2: Patient suicide rates and crisis resolution/home treatment

Figure 3: Patient suicide: drugs taken in fatal overdose
hanging as a method of death has increased in the patient population,
opiates are now the second most common cause of death in patient suicides (see figure 3).

- **homicide findings:**
  - homicides by mental health patients have fallen substantially since a peak in 2006,
  - figures for the most recent confirmed years are the lowest since we began data collection in 1997 – 33 cases reported in 2010 (England),
  - in 2001-2010 an average of 74 patients per year were convicted of homicide in the UK. When non-patient perpetrators with symptoms of mental illness are added, the total rises to an average of 115 per year.

- **SUD findings:**
  - there were 355 SUD cases over the report period, an average of 32 per year,
  - there were 5 deaths within 1 hour of restraint over the 10-year report period.

### Figure 4: Weeks between discharge from in-patient unit and suicide

3.3 The **Quality of Risk Assessment** study was carried out to examine the 'low risk' paradox. That is, although the risk factors associated with suicide and serious violence are well known, clinicians often report risk as having been low prior to the incident.

3.4 Key findings included:

- overall quality of risk assessments was considered unsatisfactory in 36% of patient suicides, and 41% of patient homicides, and
- risk formulation and management plans were the domains most likely to be judged unsatisfactory in suicides and homicides.

3.5 Key messages for services are that risk assessment and management:

- **should:** 1) be individual and personalised, 2) assess current risk factors and past history, and 3) include management plans that are consistent with risk assessment.
- **should not:** 1) equate the completion of a checklist with good risk formulation and management, and 2) rely on a generic plan of clinical management.

3.6 The **Models of Service Delivery** study was carried out to identify what aspects of service provision are most effective in reducing patient suicide.

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### What themed project work is NCISH undertaking?

**3.1 In addition to the core NCISH work (i.e. patient suicides, homicides, sudden unexplained deaths), themed project work is selected through an annual open topic selection process managed by HQIP.**

**3.2 Five projects were selected by the Independent Advisory Group (IAG) to be completed between 2011/12 and 2014/15. Three are completed or near completion.**
This study is an extension of our previous study in England looking at the uptake and impact of recommendations on mental health trust suicide rates (Lancet, 2012)\(^1\) (see pg. 10-11 for findings).

Preliminary findings from the new study show:

- up-take of recommendations was high, ranging from 66% to 91%
- there was an increase in the number of recommendations implemented over time
- the magnitude of the fall in suicide rates was greatest in trusts that implemented recommendations, compared to trusts that did not.

Key messages for services are:

- adopting NCISH recommendations is linked to lower patient suicide rates
- lower suicide rates were particularly associated with:
  - crisis resolution/home treatment,
  - removal of low lying ligature points, policy on information sharing, and
  - assertive outreach.

The *Suicide in Primary Care* study is examining:

- healthcare utilisation in relation to suicide in primary care patients
- recognition and treatment of mental health problems, and
- the effects of co-morbid physical health problems.

Although the majority of people are in contact with primary care services prior to suicide, there is currently little evidence to inform clinical and management practices in primary care to reduce suicide.

For the first time, NCISH is using the Clinical Population Registered Datalink (CPRD), a national primary care dataset with individual level data for each contact between a patient and their general practice.

Analysis is currently under way. The study dataset has 2,384 cases of suicide and 46,899 controls who had visited their GP in the 12 months prior to suicide or index date.

Preliminary findings show (figure 5):

- the risk was higher in patients who never visited their GP in the year before suicide, and in patients who visited their GP frequently
- 8% of people dying by suicide had been referred to secondary mental health services.

**Figure 5: Risk of suicide and number of GP visits**

Key messages for services are:

- patients who do not attend are at increased risk of suicide. This is important because they account for over 1/3 of patients in the current study. Prevention strategies in primary care need to include engaging at risk patients who do not attend, as well as managing the needs of frequent attenders.
- this study showed only 8% of patients who died had been newly referred to secondary mental health services during this same time period. GPs may be under-referring patients to secondary mental health services

In addition, 2 studies are in the early phases of data collection:

- The *In-patient Observation* study is examining how psychiatric in-patients die by suicide while under intermittent or constant observation. Novel methods of data collection and data sources will be used to take account of the views of patients and professionals on the use of

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\(^1\) Lancet, Vol. 379, No. 9820, pp. 1005-1012.
in-patient observation, including on-line data collection and review of serious untoward incident reports.

- The Risk and Organisational Health study is examining the association between organisational factors and reduction in suicide rates in mental health trusts. This study will link publicly available data to examine the association between suicide rates and the following domains: patients (e.g. complaints), staff (e.g. sickness), and service configuration.

THE IMPACT OF NCISH: DRIVING CHANGE IN MENTAL HEALTH SERVICES

Recommendations for change

4.1 NCISH make recommendations about what services might do to prevent suicide, homicide, and SUD, and reduce stigma, particularly in relation to homicide and mental illness.

4.2 Our work forms the basis of sections of the national suicide prevention strategy for England (2012).

4.3 Our work forms the basis of much of the high risk sections of the National Suicide Prevention Strategy for England (2012). As a result of our work on ward safety, the National Patient Safety Agency (NPSA) made hanging from non-collapsible curtain rails on NHS wards a “never event”.

4.4 In 2001, NCISH published 12 points to a Safer Service, a summary of our recommendations, which was influential in changes to clinical practice and mental health policy.

4.5 There has been a focus on in-patient safety as a result of our work, and follow-up upon discharge from in-patient care. Increasingly, NCISH recommendations have focussed on suicides occurring under community teams, reflecting the changing nature of how mental health services are delivered.

Tools for change

4.6 We have developed a toolkit for local audit and quality improvement, based on NCISH findings.

4.7 Since its launch in May 2013, it has been downloaded 1,247 times. The toolkit includes:
   - information about the quality standards that we recommend,
   - a chart for trusts to note whether they meet each of the quality/safety standards,
   - the NCISH data that support the standards,
   - and the data source (i.e. report or other publication).

What works

4.8 We have been able to demonstrate that service changes based on NCISH recommendations on clinical practice and policy can reduce suicide rates. Evidence linking services to suicide prevention was previously lacking.
4.9 There was a 58% decrease in the number of inpatient suicides in 2010 compared to 2001, approximately 112 fewer in-patient suicides, a 70% decrease in suicides since 1997 (England) (figure 6). This followed our recommendations on ward safety.

4.10 There has also been a substantial reduction in in-patient suicides who were detained under the Mental Health Act and who absconded prior to suicide (Figure 7, Figure 8).

Figure 6: In-patient suicide

<table>
<thead>
<tr>
<th>Year</th>
<th>In-patient Suicide</th>
<th>Hanging/Strangulation on the Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>200</td>
<td>20</td>
</tr>
<tr>
<td>2002</td>
<td>150</td>
<td>10</td>
</tr>
<tr>
<td>2003</td>
<td>100</td>
<td>5</td>
</tr>
<tr>
<td>2004</td>
<td>50</td>
<td>2</td>
</tr>
<tr>
<td>2005</td>
<td>20</td>
<td>1</td>
</tr>
</tbody>
</table>

Figure 7: Number of suicides by patients formally detained

4.11 Suicide by tricyclics has also decreased following our recommendation for vigilant prescribing of specific drug classes.

4.12 In a key paper published in the Lancet (2012), our findings showed:

- our recommendations had been increasingly implemented by mental health services,
- trusts that implemented most of our recommendations had lower suicide rates than trusts that implemented fewer,
- implementation of 24-hour crisis teams, dual diagnosis policies, and multi-disciplinary reviews following a patient suicide were associated with a 9-20% fall in suicide rates,
- overall, adopting our recommendations had led to between 200 and 300 fewer patient deaths per year,
- NCISH recommendations designed for specific patient sub-groups (e.g. mental health in-patients; patients recently discharged into the community following an in-patient stay) reduced suicide rates in those specific patient sub-groups (ranging from 11% to 32%) (Figure 9),
- suicide rates did not decrease in services that did not implement NCISH recommendations.
Figure 9: Specific impact of targeted recommendations

<table>
<thead>
<tr>
<th>RECOMMENDATION</th>
<th>TARGET GROUP</th>
<th>% FALL IN SUICIDE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ligature points</td>
<td>In-patients</td>
<td>24%</td>
</tr>
<tr>
<td>Assertive outreach</td>
<td>‘Non-compliant’ community patients</td>
<td>32%</td>
</tr>
<tr>
<td>Assertive outreach</td>
<td>‘Missed appointment’ community patients</td>
<td>11%</td>
</tr>
<tr>
<td>24-hour crisis team</td>
<td>In-patients</td>
<td>29%</td>
</tr>
<tr>
<td>7-day follow-up</td>
<td>Patients within 3 months of discharge</td>
<td>21%</td>
</tr>
<tr>
<td>Non-compliance policy</td>
<td>‘Non-compliant’ community patients</td>
<td>25%</td>
</tr>
</tbody>
</table>

4.18 Around 2/3 of respondents thought NCISH addressed important safety issues, influenced service development and clinical practice (Figure 10).

4.19 Our work is used for local audit and service improvement. We have been asked by trusts to work with them to develop their local suicide prevention strategies, informed by NCISH work (Figure 11).

4.20 Our work has informed similar surveillance schemes in Ireland and Norway.

Figure 10: Survey 2013 results

National and international reputation

4.13 NCISH is highly regarded among mental health professionals.

4.14 Our reputation is reinforced by our partnership with key professional organisations: The Royal College of Psychiatrists, The Royal College of Nursing, the NHS Confederation and the University of Manchester Academic Health Sciences Centre.

4.15 We have been selected by NHS Northwest R&D for novel methods of dissemination (see table 1).

4.16 We have been nominated for an award by HQIP in recognition of our innovative dissemination methods, including social media.

4.17 NCISH carried out a stakeholder survey in 2013; there were 135 respondents, of whom 70% were from an NHS trust.
How will NCISH meet the NHS patient safety priorities?

5.1 Our findings show 4 safety priorities for more detailed study:

- Patient suicides have recently increased
- Patient homicides are continuing to fall
- Self-poisoning by opiates has increased in recent years
- Suicides under crisis resolution/home treatment are now twice as common as in in-patient care.

5.2 We will address the 5 NHS patient safety themes, namely:

- Understanding
- Creating safety conditions
- Building safety capacity
- A whole system response to safety
- Tackle key safety concerns.

5.3 Our work will take account of the lessons learned from the messages in the Francis and Berwick Reports, reflecting the post-Mid-Staffordshire NHS environment.

5.4 This will include:

- Raising the profile of patients and carers in our governance, methods, topic selection, and dissemination
- Working towards a means of benchmarking to help trusts better understand their own safety record
- Examining the link between organisational health (e.g. staff absence, complaints) and patient suicide (see pg. 8-9)
- Promoting clinical skills and leadership by building safety capacity through working with our professional partners and trusts to influence clinical teaching and training; making it easier for clinicians to engage with NCISH via direct electronic data entry; continuing open calls for topics to reflect issues important to patients and clinicians

- Greater use of publicly available data and linking datasets to best effect
- Using NCISH questionnaires as a route for clinicians to raise safety concerns.

This poem is about how measures that delay a suicide may therefore prevent it.

The dialectic of prevention
No-one likes to wait, we hate delay. Trains running late, flights missing their slot, buses missed by milliseconds.

Our arms a whirling semaphore of fury. But to delay you – that is our idea. To give you pause – this is our aim.

We want to be like the wind that caught the crinolines of Sarah Ann Henley, that lovelorn barmaid on her Severn leap. We want to land her again safe in thick mud; fill her with strong tea in the railway refreshment room; load her bed covers with offers of matrimony; be at her marriage; see her through another 63 years of life.

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www.charmarch.co.uk

Poems also available on our website:
www.manchester.ac.uk/nci
### NCISH STAFF

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
</tr>
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<tbody>
<tr>
<td>Professor Louis Appleby</td>
<td>Director</td>
</tr>
<tr>
<td>Professor Navneet Kapur</td>
<td>Head of Suicide Research, Assistant Director</td>
</tr>
<tr>
<td>Professor Jenny Shaw</td>
<td>Head of Homicide Research, Assistant Director</td>
</tr>
<tr>
<td>Dr. Kirsten Windfuhr</td>
<td>Senior project manager, Research Fellow</td>
</tr>
<tr>
<td>Dr. Alyson Williams</td>
<td>Deputy project manager</td>
</tr>
<tr>
<td>Dr. Isabelle Hunt</td>
<td>Research Fellow</td>
</tr>
<tr>
<td>Dr. Sandra Flynn</td>
<td>Research Fellow</td>
</tr>
<tr>
<td>Dr. David While</td>
<td>Statistician</td>
</tr>
<tr>
<td>Ms. Cathy Rodway</td>
<td>Research assistant</td>
</tr>
<tr>
<td>Ms. Alison Roscoe</td>
<td>Research Assistant</td>
</tr>
<tr>
<td>Mrs. Rebecca Lowe</td>
<td>Administrative manager</td>
</tr>
<tr>
<td>Mr. James Burns</td>
<td>Administrative assistant</td>
</tr>
<tr>
<td>Mr. Phil Stones</td>
<td>Administrative assistant</td>
</tr>
<tr>
<td>Ms. Julie Hall</td>
<td>Administrative assistant</td>
</tr>
<tr>
<td>Ms. Huma Daud</td>
<td>IT officer</td>
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