Homicides Committed by Mentally Disordered Offenders: Do they Reflect their Media Stereotype?

In May 1994, the Department of Health published ‘Guidance on Discharge of Mentally Disordered People and Their Continuing Care in the Community, Health Service Guidance 94(27)’ (HSG(94)27). The guidance stated that independent inquiries must be undertaken in cases of homicide in which the perpetrator is, or was recently, a mental health service-user in England. This commission followed widespread concern within the public regarding the risk posed in the community by patients with mental disorders. This perceived danger is established across Britain and further afield, and is associated with a prevalent media attitude which pays particular attention to homicides involving mental health patients (patient homicides), drawing attention to acts characterised as particularly brutal, unprovoked and involving innocent strangers. For example, The Sun’s headline in October 2013 read: ‘1,200 killed by mental patients’, and was widely derided for inciting negative feeling against mental health patients due to its explicit link between mental health and homicide. Additionally, the intense reporting on high-profile cases, for example that of Christopher Clunis, serves as an example of a clear association between mental disorder and homicide. The intensity and detail of the reporting serves to emphasise the horror of the attack, ensuring it is memorable to the public. Portrayals of crazed murderers, both real and fictitious, are consistently hugely popular throughout the population, such as the hugely successful film ‘American Psycho’, based on Bret Easton Ellis’s novel. Such fictional depictions often feature mentally deranged protagonists attacking unsuspecting bystanders at random with alarming weaponry, or fulfilling an elaborate scheme of revenge. Brown et al. (2015) discuss the appearance of mentally-ill perpetrators in American TV cop shows who are portrayed as ‘deranged… walking time bombs’.

This sensationalised media depiction of mental illness has contributed to the stigmatisation of mental health patients, asserting that they are more likely than their mentally healthy counterparts to be involved in a homicide, that such a homicide is likely to have unusual characteristics, such as exotic weaponry, and involve stranger victims in public places. Such homicides, particularly those involving strangers, are important as when the perpetrator is reported as being a mental health patient they are thought to increase public opposition to patients living in the community. However, the perception that mental health patients are particularly involved in such killings is almost universally at odds with research on the subject. Yet the press selectively report homicides associated with mental disorder with these unusual characteristics and ignore all those with far more common characteristics – the homicide of a family member in a shared home with a kitchen knife – which are made ‘unnewsworthy’ by their sheer ordinariiness. In turn, this unjustified culture of fear has
propagated a public distrust of the ‘care in the community’ programme, and poses a significant obstacle to the effective rehabilitation of mental health patients. This paper looks to explore the literature regarding homicides perpetrated by mentally disordered offenders, and discuss relevant public health measures aimed at minimising such rates.

Do people with mental disorders commit homicide more frequently than those without mental disorders?

The 2015 National Confidential Inquiry into Suicide & Homicide by People with Mental Illness (NCISH) found that between 2003-2013, there were a total of 5835 homicide convictions in England, of which 630 (11%) were committed by ‘inquiry cases’ – people who had had any contact with secondary care mental health services in the 6 months prior to the homicide. The precise figure for the percentage of the population suffering from mental illness is extremely difficult to estimate, and therefore the proportion they should contribute to overall homicide rates (if mental health disorders were not associated with increased homicide rates) is impossible to accurately quantify. Much of this variation arises from different definitions of mental illness. Mind (the mental health charity) estimate that between 2014-2015, around 4% of the English population were in contact with mental health and learning disability services. In contrast, the World Health Organisation (WHO) estimate that 35-50% of serious mental health cases in high income countries go untreated, and the median delay in receiving treatment for a mental health issue is 10 years. Therefore, it may be unfair to state that people with mental disorders contribute to homicide statistics disproportionately more than would be expected by coincidence, as the number of mental health sufferers may be underestimated by using figures which only include those who have been identified as in need of treatment. NCISH figures also include those in contact only with substance abuse services.

If a more specific diagnostic group is studied – those with active psychotic symptoms (hallucinations and delusions) – increased rates of violence in the order of x3 to x5 have been shown in samples with careful controls, such as the Swanson et al. and Link et al. studies. But this does not necessarily mean homicides are more common in this group or that care in the community has had a bearing on homicide rates.

Taylor and Gunn (1999) analysed whether there had been a tangible increase in frequency of killings by mental health patients in England and Wales between 1957 and 1995, by studying the frequency of findings of ‘mental abnormality’ in Court statistics. They found that over the 38-year period there was in fact a 3% annual decline in their contribution to overall official homicide rates.
Szmukler et al. (1999) discuss steeply rising homicide convictions post-1965 in England and Wales, however this was not paralleled by a rise in diminished responsibility manslaughter convictions – in fact, they were shown to have significantly declined between 1987-1997. NCISH 2015 found that annual English patient homicides had continued to decrease annually between 2003-2009, and although figures for 2010 onwards remained lower than those seen in 2003, this downward trend has not been sustained, paralleling non-mentally disordered homicide rates. The absolute number of patient homicides is low in terms of statistical power, with 50 NCISH confirmed cases across England in 2012 – although of course every one is a personal tragedy. The low base rate of patient homicide makes it particularly difficult to study associated trends, as any apparently significant deviations may be artefact. Therefore, although the rate of patient homicides in England has recently plateaued, they have been shown to be uncommon events, especially when compared to the 6233 UK and Ireland suicides reported by the Mental Health Foundation in 2013. In 2013-14 1.7 million adults accessed mental health services in England – using NCISH figures the homicide rate was 29 homicides per million in mental health users compared to 12 per million in the general population. The consistently decreasing or plateaued rates of patient homicide combined with homicide rate comparison with the general public conflict with the perception of a failing care in the community approach to rehabilitation, and in fact serve to support the assertion that the programme is safe and well-suited to our mental health patient cohort.

Are patients with schizophrenic diagnoses more likely to be involved in homicide than patients with other mental health diagnoses?

Of interest is the particular attention schizophrenia receives in association with homicide. Arguably more than any other mental health diagnosis, schizophrenia receives the harshest media speculation and most detrimental stereotyping. It has been shown that people with least experience of schizophrenia sufferers tend to choose to maintain a greater social distance, and a greater knowledge of schizophrenia tends to be associated with a less-distancing attitude. Despite this, evidence suggests even those with an increased knowledge of schizophrenia tend to subscribe to its negative stigma: Llerena et al. (2002) studied the opinions of 274 medicine students and 70 nursing students in Spain, and found that although they reported high awareness of aspects such as risk factors and symptoms, 78% believed schizophrenics were or could be dangerous/violent. Angermeyer et al. (2005) found that the desire for social distance from people with schizophrenia increases with rising media consumption, particularly TV. These findings fit with the hypothesis that the public’s
perception of schizophrenia is largely influenced by its depiction in the media, particularly when no or little personal experience (which may conflict with media portrayal) is available to draw on.

NCISH 2015 found that between 2003-2013, 6% of all homicides in England were committed by people diagnosed with schizophrenia. When compared to schizophrenia’s prevalence within the population (around 1% in developed countries), this figure suggests that schizophrenics contribute to homicide rates more than would be expected. Douglas et al. (2009) conducted a meta-analysis on the subject, and found that psychosis was associated with a 49-68% increase in the odds of violence. Despite many studies demonstrating this link between schizophrenia and violence, the subtle network of causative factors behind this has never been fully untangled. This lack of clarity has resulted in a potentially spurious link between schizophrenia and violence becoming widespread, a subsequent focus on the minority of schizophrenics who are violent, and a resulting negative backlash on the vast majority who are not.

Fazel et al. (2009) found that most of the excess risk of violence and homicide in schizophrenia correlated with a substance abuse comorbidity, and the risk for offending in these patients was similar to that for substance abusers without a psychotic diagnosis. Laajasalo and Hakkanen (2006) looked at whether psychotic symptoms were associated with the nature of violence among schizophrenic homicide offender, and found that positive psychotic symptoms, including delusions, were not associated with acts of excessive violence, which was instead associated with cases in which the offender was not the sole perpetrator, or in cases in which the offender had a previous homicidal history. Large et al. (2009) echoed this finding, by showing that homicide rates by people with schizophrenia strongly correlate with the rate of all homicides in their geographical area, implying that more general influential factors (e.g. socioeconomic status and substance abuse) are a main driving force behind homicides. Joyal et al. (2004) examined whether homicide characteristics differed for offenders with schizophrenia, and offenders with schizophrenia and comorbid antisocial personality disorder (APD). They found that those with an additional diagnosis of APD were less likely to have been deemed to act on psychotic symptoms during the attack, and more likely to assault a non-relative. Therefore, factors which increase the risk and influence the characteristics of all homicides, such as substance abuse, disadvantaged social circumstances, a violent history and lethal weapon accessibility, are likely to have a large influence on homicides perpetrated by schizophrenics.

With specific regard to stranger homicide, Nielssen et al. (2009) conducted a meta-analysis of 7 studies incorporating data on stranger homicide by patients with psychotic disorders across a number of developed countries, and found that such murders are so rare (pooled estimate of 1
stranger homicide per 14.3 million people per year), comparison of characteristics with other schizophrenia subgroups was impossible. Therefore, it would appear that much of the perceived danger from people with schizophrenia, particularly by those who do not know any sufferers personally, is unwarranted and exaggerated.

However, such relationships are multifactorial, and treatment of the underlying schizophrenia is imperative, both for the wellbeing of the patient and to minimise risk of violent adverse events. Meehan et al. (2006) found that within a group of schizophrenic homicide offenders in England and Wales, 56% had shown a clear change in the ‘quality, intensity, or conviction of or emotional response to their delusions’ in the month preceding the homicide, and 28% had no previous contact with mental health services. Montanez (2000) compared homicidal and non-homicidal schizophrenics, and found that homicidal schizophrenics were more likely to have experienced a late-onset illness, and delayed diagnosis, and found that homicide appeared to occur as a consequence of losing control due to intense episodes of psychosis or withdrawal from intoxicants.

Clearly, early identification of those with schizophrenia and changes in their presentation and circumstances with appropriate treatment may prevent a dramatic escalation of the patient’s symptoms or surrounding issues, and ultimately preclude a successive violent climax. However, the literature suggests that other socioeconomic factors have a potentially greater influence over a patient’s propensity to commit homicide, and therefore bring into question the widespread causal association between schizophrenia and violence. The intensely rare nature of homicide involving a patient with schizophrenia provides an inherent difficulty to teasing out particular characteristics which increase a patient’s risk of being involved in a homicide, and therefore hugely limits risk assessment.

Do mentally disordered homicide offenders tend to commit more stranger homicides than homicide offenders without mental disorders?

The archetypal fictional image of a homicidal mental patient often involves a predatory serial killer, stalking the streets to snatch unsuspecting strangers, only to satisfy the killer’s own urges. This type of killer is well exemplified by a number of high profile murderers with well-known psychiatric problems: for example, Ian Brady of the prolifically reported ‘Moors Murders’, who has spent over 30 years in Ashworth Psychiatric Hospital under a diagnosis of psychopathy/antisocial personality disorder, and Ed Gein, who confessed to killing two women but was found legally insane, and on whom the cannibalistic character Leatherface is reportedly based in the popular film ‘The Texas Chainsaw
Massacre’. This focus on mental health issues and sadistic, bizarre stranger homicide is widespread throughout both popular fiction and non-fiction media, and clearly fuels negative perceptions of mental health sufferers.

NCISH 2015 found that only 7% of all stranger homicides across the UK between 2003 and 2013 were committed by mentally-ill perpetrators. Not only is this far lower than the proportion that stranger homicide makes up of overall homicides in England over the same timeframe (25%), it is also lower than the percentage of overall homicides committed by patients (11%). Crichton (2011)xvi analysed the 236 HSG(94)27 inquiries published between 1994 and 2010, and his findings on stranger homicide echoed that of NCISH (15% of the total victims were strangers, vs. 32% of all victims in England and Wales 2009-2010). Although hugely tragic, the data strongly suggests that stranger homicides committed by mentally disordered offenders are extremely rare events, and are more likely to be perpetrated by someone without a mental health issue than with.

Within the 1994-2010 HSG(94)27 inquiries, domestic homicide (involving family members at home) was far more prolific than in general homicide statistics (46% of total involved family and partners/ex-partners, compared to 38% of all homicides in England and Wales 2009-2010). Ross and Crichton (2016)xvii went on to analyse the 170 HSG(94)27 inquiries published between 2011 and 2015, and found that in 88% of cases the victim was known to the perpetrator prior to the homicide, versus only 57% of cases within homicide in the general population between 2014-2015xviii. Therefore, studies of patient homicides using different methodologies not only refute the stereotype of the stranger victim but support the conclusion that the typical mentally disordered homicide has domestic characteristics.

Do mentally disordered homicide offenders tend to use unusual murder weapons?

Within homicide in general, it has been shown that a substantial number involve the use of sharp weapons. The Office for National Statistics found that the proportion of homicides using a sharp instrument has consistently remained the highest compared to other methods (36% of all homicide weapons in 2014-2015xxvii). Kitchen knives have been identified as making up a significant proportion of sharp weapon homicide across the population due to their accessibility and lethality (e.g. Hern et al., 2005xxix). Hughes et al. (2012)x found that use of sharp instruments was relatively much higher in mentally-disordered offenders: 57% of homicides which underwent HSG(94)27 inquiries between 1994 and 2010 involved a sharp instrument. Crichton (2011)xvi found that a large proportion of the sharp objects used by mentally disordered perpetrators were kitchen knives – he stated that the
HSG(94)27 inquiries generally ‘describe men in their twenties or thirties stabbing with a kitchen knife a family member (often in a caring role) in their shared house’. Much of this domestic homicide is thought to be unplanned (65% of homicides within 2011-2015 HSG(94)27 inquiries\textsuperscript{xxvi}).

Hughes et al. (2012)\textsuperscript{xxx} hypothesised that there was an association between unplanned homicide and use of kitchen knives. They found that the weapon in unplanned homicides within the 1994-2010 independent inquiry cohort was significantly more likely to be a kitchen knife than any other type of knife, however there was no association between knife type and, independently, the relationship between the perpetrator and victim, or whether the homicide occurred in a domestic or public setting. Ross and Crichton (2016)\textsuperscript{xxvii} found that within the 2011-2015 HSG(94)27 inquiries, knives accounted for 53% of all murder weapons (vs. sharp objects making up only 36% of weapons for all homicides committed in England from 2014-2015\textsuperscript{xxviii}). Kitchen knives were significantly more likely to be used than any other knife type, however again an association could not be found between knife use and domestic homicide. This lack of association between kitchen knives and unplanned homicide could be due to the inherently low sample size (a type II error), or the widespread use of kitchen knives across all groups of homicide offenders, which would require a huge sample to be able to demonstrate a significant difference in usage in certain situations. Further work is ongoing to examine the characteristics of weapon use across homicide subgroups.

The literature explored provides evidence against the use of ‘exotic’ weapons by mental health patients, and in fact supports the hypothesis that they are likely to use easily accessible weapons, particularly kitchen knives, possibly due to the generally unplanned nature of their attacks. Whilst comparison of planning between mentally disordered and non-mentally disordered homicide offenders is limited by lack of data on planning in the general population, it is clear that the majority of cases involving mental health service users were unplanned, utilised an ordinary weapon to hand and occurred in a domestic setting.

**What factors could predict whether a mental health patient will commit a homicide?**

NCISH 2015\textsuperscript{iv} identified a number of characteristics which may be important in the risk assessment of a patient to determine their likelihood of committing a homicide: previous forensic history, previous admission to a secure unit or involuntary detention, non-adherence with planned treatment, and specific psychiatric diagnoses, particularly alcohol/drug misuse. 51% of patients who had committed a homicide in England had a historical conviction for a violent offence, and 48% had previously been in prison. 17% of patients had been non-adherent with their drug treatment in the
month leading up to the offence, and 39% missed their last service contact before the attack: a combined total of 49% not receiving their planned treatment (due to non-adherence, missed service contact, or both) just prior to the murder. NCISH also identified personality disorders as being particularly associated with homicide, with 40% of patient homicides involving a person with a personality disorder diagnosis. 75% and 78% of patients had a history of alcohol and drug misuse respectively, with a total of 89% having an abuse history of one or both.

A number of the risk factors and behaviours discussed above can be extended to non-mentally disordered homicide, and indeed many of the patterns evident in patient homicides can also be seen in general homicide statistics: the vast majority are committed by males (in 2012, 84% of stranger homicides and 88% of total English homicides were committed by men\textsuperscript{iv}), and they have both followed a generally downward trend in recent times (NCISH show decreases of 29% in patient homicide and 32% in overall English homicide between 2003-2012\textsuperscript{iv}). This suggests that at least some of the measures put in place to decrease overall homicide have a similar effect on patient homicides, and that therefore both groups of homicide are governed by common influential factors.

Identification of relevant risk factors pertaining to specific diagnoses (e.g. personality disorder, and schizophrenia) and frequent assessments of presentation and adherence to treatment are clearly relevant in the management and violent risk reduction of such patients. However, such risk factors are likely to be so widespread within mental health patients that the specificity of identifying only those who will go on to be violent or involved in a homicide is very low. General public health measures aimed at reducing the overall rates of violence (particularly from specific cohorts e.g. substance abuse and previous violent history) may be more effective, and allow targeted decreases in both general population and mentally disordered homicides.

**What are the implications of these findings for public health measures and risk assessment of psychiatric patients?**

Whatever the circumstances, a homicide is a tragic and emotionally painful event for the victim’s family, perpetrator and perpetrator’s family, and also for the healthcare team involved. The implementation of HSG(94)27 inquiries was partially aimed at increasing public confidence in our mental health services, however their publication leads to reinforcement of the stereotype of dangerous and violent mental health patients. They have served as a medium to increase media reporting on mentally disordered offenders, serving as an additional time point for further reflection on and repetition of the case, thereby emphasising the link between violence and mental illness.
The inquiries themselves are hampered by a number of inherent problems obstructing their quest to minimise, or even eradicate, patient homicide. Szmuckler (2000) discusses these limitations, which can be extrapolated to consider the restrictions that assumptions on mentally disordered homicides pose for the risk assessment of patients. The fact that homicide inquiries exist in the context of mentally disordered offenders suggests they are considered preventable, and the media and politicians tend to take on an attitude of complete intolerance. This is in spite of the fact that mentally disordered homicides have unfortunately been present across the globe throughout history. They seem to be an ugly part of the human condition, and although they can be minimised, completely stopping them is unfeasible, if not impossible.

If such homicides were predictable, such a stance would be understandable. Yet a huge proportion (if not all) of mental health patients – and the general public – carry at least one of the risk factors for homicide as discussed above. Indeed, a history of violence could be taken as proof that the patient was ‘capable’ of such crimes, and is therefore likely to reoffend. If all such patients were treated as at risk of committing a homicide, and their liberties restricted accordingly, many thousands of innocent people would be needlessly penalised with the outcome of possibly preventing one death. The Department of Health reported a substantial increase of 24% in the use of compulsory admissions between 1994-1995 – potentially as a response to the increased public perception of risk, and a resulting reluctance of mental health workers to allow patients into the community. Such a prescriptive approach to care may appear on the surface to minimise exposure of the public to potentially dangerous patients, yet the long-term outcomes are still unknown: will future patients, including the dangerous minority, be more likely to disengage with such a paternalistic, restrictive system? Such considerations suggest that skewing mental health legislation away from patient rights and towards potential public protection may cause more harm than benefit in the long run.

Additionally, inquiries tend to lessen the responsibility of others in the events surrounding the homicide. The perpetrator tends to lose his identity as an independent being capable of choice, and a history of violence preceding their mental health diagnosis due to personality or socioeconomic factors is overlooked. Their mental health diagnosis is seen as the root of all problems. The role of other actors is also minimised, for example if the victim took part in obvious risk-taking behaviours, or if other responsible bodies did not take opportunistic action, such as the police. The ultimate idea that the healthcare team should have full control over the patient’s behaviours is unusual and unrealistic, short of permanent detention and severe limitation of rights. Hindsight bias is also rife throughout inquiries, as when a logical progression of events towards an adverse end event is presented, the ultimate outcome appears inevitable and potential deviations from that outcome
unlikely. Additionally, the recommendation of management changes assumes that such changes would have avoided the end result, but it is extremely difficult to show that any such decision was significantly related to the final outcome. Therefore, although inquiries give the opportunity to reflect on a major event and identify areas in which the healthcare system is able to improve, they are inherently flawed by emphasising the capacity of the healthcare team to prevent such unpredictable occurrences, and therefore could also misdirect public policy on the subject. The engagement of other services, such as the police, as well as acknowledging the underlying observation that prediction of mentally disordered homicides is fraught with difficulty are important points to take from the study of homicide inquiries.

The myth surrounding mentally disordered homicides impairs the design of public health approaches aimed at preventing homicide. One potential approach would be to consider parallels to interventions that have reduced suicide rates. The importance of access to harmful means is exemplified in situational crime reduction methods employed to decrease suicide methods. Interest in situational crime reduction stemmed from observation of the huge decrease in suicide rates following the transition from coal to natural gas. By preventing access to an effective and major means of suicide, both suicides by carbon monoxide inhalation and overall suicides fell. Therefore, not only were people dissuaded from committing suicide by a relatively pain-free method, they did not then substitute another lethal method of suicide – they were deviated from their original ultimate goal. This principle was applied when implementing the policy limiting the amount of paracetamol a consumer can buy at one time – an apparently trivial inconvenience forcing people set on overdose to visit numerous shops in order to buy a lethal dose both decreased paracetamol-related suicides, and suicides overall. Therefore, restriction of access to knives may be able to decrease overall homicides by a similar principle. Theoretically, this approach would have a greater effect on the mentally disordered homicide rate, due to their comparatively higher use of knives, and could be focussed on patients with a previous violent or weapon-carrying history.

Knife crime in general has been identified as an area requiring intensive effort in order to decrease levels. Much is made by both the media and by police groups regarding the prevalence of knife problems in society. In order to combat knife crime and respond to the public outcry, governments have employed a number of strategies to decrease both knife crime and knife carrying. In England and Wales, the Violent Crime Reduction Act was enacted in 2006, and increased the penalty for possession of a knife in a public place without lawful reason from 2 to 4 years imprisonment. It also increased the minimum age to buy a knife from 16 to 18 years, and gave greater powers to police officers and school staff to search school pupils for knives. Such measures have been
associated with a dramatic fall in homicide, particularly in Scotland. Hern et al. (2005)\textsuperscript{xxx} discuss the lethality conveyed to kitchen knives purely by their traditional long pointed style. The dagger style and length requires little force to penetrate the skin compared to blunt tipped knives, and allows easy penetration of vital organs. Following discussion with chefs and knife manufacturers, they found that this pointed knife type did not serve any unique culinary function, and was designed following long-standing tradition. They suggest the banning of long pointed knives in favour of a blunt-nosed style, which would lessen the likelihood of lethal injury (see www.newpointknives.co.uk). Hughes et al. (2012)\textsuperscript{xxx} discuss this in relation to the mentally-disordered homicide perpetrator cohort, in which a decrease in knife lethality could lead to an even greater effect on overall homicide. By adapting the lethality and restricting access to the weapon which is associated more than any other with homicide, the potential to influence a huge proportion of overall, but particularly mentally disordered, homicides would be harnessed.

**Conclusion**

Homicides in the UK associated with those who have had recent contact with mental health services are typically at the shared home of the victim and perpetrator, between family members, using a kitchen knife. Public health measures to reduce homicide in those with mental disorders are disadvantaged by a number of pervasive misconceptions, spread and maintained mainly by the media\textsuperscript{xxx}. Fictional depictions of mentally disordered homicides usually involve offenders taking part in lurid stranger homicides using bizarre weaponry. Such representations are both inspired by and fuel media attention towards such exceptional murders, and therefore add to public misconceptions in a self-fulfilling cycle\textsuperscript{iii}. The unremarkable homicides involving family members and easily accessible weapons characterising mentally disordered homicide are vastly underreported\textsuperscript{xxvi}. The stereotype of psychotic illness sufferers killing strangers using unusual weaponry is not upheld by the literature – in the UK, you are more likely to be a stranger victim of a homicide if the perpetrator has no mental illness\textsuperscript{iv, xxvi}.

Forensic psychiatry constantly treads the line between an obligation to protect the public, and the avoidance of discrimination against the patient. The inaccurate depiction of patient homicide in the media and subsequent public fear surrounding programmes such as care in the community serve to make this judgment even more difficult, and obstruct the implementation of effective public health measures. Factors involving the patient’s mental health diagnosis and more general socioeconomic factors, particularly a history of violence and/or substance abuse, are integral in assessing risk of and
predicting future violent acts, at the extreme end of which is homicide. Whilst attention must be paid to psychiatric markers of violent risk, and appropriate support offered, more general risk factors may be an even more effective target for public health legislation. The best way to reduce homicide in those with mental disorder may be to reduce the overall homicide rate, and the most effective way to do that initially may be to limit the immediate availability and lethality of potential weapons.
Bibliography


xi Mental Health Foundation. Suicide. Online resource accessed 07/10/2016 at: https://www.mentalhealth.org.uk/a-to-z/suicide


