MANCHESTER 1824
The University of Manchester

HQIP
Healthcare Quality Improvement Partnership

NATIONAL CONFIDENTIAL INQUIRY

into Suicide and Safety in Mental Health

Annual Report 2018
Executive Summary

ANNUAL REPORT:
ENGLAND, NORTHERN IRELAND, SCOTLAND AND WALES
OCTOBER 2018

EXECUTIVE SUMMARY

INTRODUCTION

i. The 2018 annual report from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) provides findings relating to people who died by suicide or were convicted of homicide in 2006-2016 across all UK countries. Additional findings are presented on sudden unexplained deaths under mental health care in England and Wales.

ii. The NCISH database is a national case series of suicide, homicide and sudden unexpected death (SUD) by mental health patients over 20 years. The current suicide database stands at almost 127,000 suicides in the general population, including over 33,500 patients. This large and internationally unique database allows NCISH to examine the circumstances leading up to and surrounding these incidents and make recommendations for clinical practice and policy that will improve safety in mental health care.

iii. As with previous annual reports, the main findings are presented here by country for the baseline year of 2006 and the subsequent 10 years, including the most recent year for which comprehensive data are available (2016). A UK-wide section provides selected findings from the UK as a whole.

METHODOLOGY

iv. The NCISH method of data collection is equivalent across all UK countries and consists of three stages:

- National data used to identify individuals in the general population who die by suicide or are convicted of homicide.
- Those who have been in contact with specialist mental health services in the 12 months before the incident are identified with the help of mental health providers.
- Detailed clinical information obtained for individuals via questionnaires completed by clinicians.

v. Co-operation from front-line professionals is excellent - the questionnaire response rate is around 95% overall. In the final year of a report period - 2016 in this report - the completeness figures are lower and we therefore estimate final figures taking into account the number of outstanding questionnaires and the accuracy of our estimates in previous years.

ANALYSIS

vi. The main findings of the report are presented in a combination of figures, maps and tables. These show changes in key figures in patient safety over the report period.

vii. General population and patient rates for suicide are calculated using the Office for National Statistics (ONS) mid-year population estimates and, where available, denominators based on patient activity obtained from NHS Digital (England).

viii. We examine for statistically significant time trends over the report period. However, because 2016 figures are partly estimates, these are not included in the analysis of trends.

KEY FINDINGS

Suicide numbers and rates

ix. Suicide rates in the general population in UK countries have shown a recent downward trend, though this is less clear in Northern Ireland which continues to have the highest rate.

x. The highest rates during the report period (2006-2016) were in people in middle age except in Northern Ireland where young adults had higher rates. Similarly, the largest differences in rates between UK countries - higher rates in Northern Ireland and Scotland - were in young adults.

xi. There were 1,612 patient suicides in the UK in 2016, this figure having fallen in recent years. During 2006-2016, there were 17,931 suicides by mental health patients, 28% of suicides in the UK general population, although this percentage was slightly higher in Scotland and slightly lower in Wales. In England the number of patient suicides in 2016 was similar to the previous two years but the patient suicide rate fell as patient numbers increased.

Method of suicide

xii. The commonest method of suicide by patients continued to be hanging/strangulation, accounting for 776 deaths UK-wide in 2016, almost half of all patient suicides, though there were variations in methods between UK countries.

xiii. The second commonest suicide method among patients was self-poisoning, accounting for 365 deaths in 2016, almost a quarter of patient suicides. The previously-reported[1] fall in self-poisoning deaths has not continued. The main substances taken in fatal overdose were opiates and the main source (where known) was by prescription.

Clinical care

xiv. There were 106 suicides by in-patients in the UK in 2016, around 7% of all patient suicides, continuing a long-term downward trend. However, the fall has been slower in recent years, reflecting the pattern in England.

xv. There were 227 suicides in the 3 months after hospital discharge in 2016, 17% of all patient suicides, a fall since 2011. The highest risk was in the first 2 weeks after discharge and the highest number of deaths occurred on day 3 post-discharge.

xvi. During 2006-2016 there were 909 suicides per year on average by patients who had a history of alcohol or drug misuse, 56% of all patients who died - this percentage was higher in Scotland and Northern Ireland. Only a minority were in contact with specialist substance misuse services.

Female patients

xvii. In previous reports we have focused on suicide by male patients. In this report we present findings on female patients who died by suicide during 2006-2016. During this period there were 6,016 suicides by female patients in the UK, 38% of suicides by females in the general population, a higher figure than in males. The number per year has risen in England but the rate, i.e. taking into account the rising number of patients, has fallen. Almost half were aged between 35 and 54 years.

xviii. Over a third of female patients died by self-poisoning, most commonly with opiates, antidepressants or antipsychotics. Women were more likely than men to take antidepressants and paracetamol in self-poisoning, and less often used opiates, though these were still common. Hanging/strangulation was also common, particularly in young patients - accounting for 50% of suicides in female patients under 25.

xix. A history of self-harm was especially common, occurring in 74% of female patients overall and 89% of those under 25. We identified suicides by a group of female patients, often younger, with a complex clinical picture including self-harm, additional diagnoses and alcohol or drug misuse.

xx. The most common primary diagnoses for females were affective disorders, followed by personality disorder, and personality disorder was more common in females aged under 45 compared to those aged 45 and over.

xxi. More women had been in contact with services in the week before death compared to men, and risk of suicide was more likely to be viewed by clinicians as moderate/high.

Young people

xxii. We have concluded our study of suicide by young people, presented in previous reports[2,3] and papers[4]. An updated summary of main findings is included here, based on 595 suicides by people under 20 in the general population in the UK during 2014-2016.

xxiii. Key features of suicides in the under 20s were:

- the number of suicides rose rapidly during the late teens
- common antecedents included family problems, bullying, physical health conditions, self-harm, exam stresses, relationship problems
- a quarter had experienced a bereavement and in 9% this was by suicide
- around a quarter had used the internet in a way that was suicide-related, i.e. searching for suicide methods, online bullying, suicidal posts on social media
- 60% had been in contact with services for children or young people at some time, 41% in recent contact.

Students

xxiv. We have examined suicides by students aged 18-21 in England and Wales (as recorded by ONS). During 2006-2016 there were 577 suicides in this group, with numbers rising during the study period. These deaths were more common in January and April, less common in August.

xxv. 69 (12%) were mental health patients, lower than in the general population. Compared to other patients in this age group dying by suicide, they were more likely to be suffering from depression, more often of recent onset, and less likely to have a history of alcohol or drug misuse.

Self-harm as an antecedent of patient suicide

xxvi. We have previously reported [1,5] a rise in recent self-harm (in the previous 3 months) as an antecedent of suicide in mental health patients - self-harm presents an indication of risk and a chance to intervene. In this report we have examined patients who died within 3 months of self-harm. During 2006-2016 there were 4,776 suicides in this group.

xxvii. There was a clear association with age and gender. Half of female patients and one third of male patients under 25 who died by suicide had self-harmed in the previous 3 months.

xxviii. Suicide was more likely to occur by hanging/strangulation than in those with no history of self-harm, suggesting an escalation in intent.

xxix. Most were thought to be at low risk at their final service contact, including those who were seen in the week before they died.

Patient homicide

xxx. During 2006-2016, 11% of homicide convictions in the UK were in mental health patients, a total of 785 patient homicides over the report period, an average of 71 homicides per year. 6% were by people with schizophrenia, an average of 37 per year, including both patients and non-patients. In England, the number of patient homicides since 2009 has been lower than in previous years. Our estimate is for 38 patient homicides in 2016.

xxxi. Our detailed analysis of patient homicide since 1997 has highlighted:
- the victim is most likely to be an acquaintance and less likely to be unknown to the perpetrator than in homicides by non-patients
- most patients had a history of alcohol or drug misuse; homicide in the absence of comorbid substance misuse is unusual
- around half of patients were not receiving care as intended, either through loss of contact or non-adherence with drug treatment
- patients are also at high risk of being victims of homicide.

Sudden unexplained death

xxxii. During 2006-2016, we identified 270 sudden unexplained deaths of mental health in-patients in England and Wales, an average of 25 per year.

xxxiii. We are concluding our study of sudden unexplained death in mental health in-patients. Our detailed analysis of these deaths since 1999 has highlighted:
- sudden unexplained death was often linked to physical health problems; most had a history of cardiovascular or respiratory disease
- polypharmacy with psychotropic drugs was relatively uncommon, occurring in around 9%
- around a quarter were aged under 45; in this group physical illness was less common, polypharmacy more common and this group was also more likely to be male, from a black and minority ethnic group, and to have a diagnosis of schizophrenia
- In the total study period since 1999, there were 32 deaths following restraint, 1-4 deaths per year. It is not possible to say that restraint was related to the deaths.

CLINICAL MESSAGES

xxxiv. Our "10 ways to improve safety" continue to reflect the evidence we have collected over several years on the features of clinical services that are associated with lower patient suicide rates. These include safer wards, personalised risk management and low staff turnover (see fig 1).

xxxv. A renewed emphasis on reducing suicide by in-patients is needed, in particular by (1) improving the physical safety of wards, with the removal of potential ligature points (2) care plans at the time of agreed leave (3) development of nursing observation as a skilled intervention.

xxxvi. The evidence in this year's report also emphasises key measures that services should take to reduce patient suicide risk:
- follow up within 2-3 days after hospital discharge
- safe prescribing of opiates and psychotropic drugs
- reducing alcohol and drug misuse.

xxxvii. Female patients who die by suicide have a unique risk profile and require a particular focus on:
- treatment of depression, following NICE guidance[6]
- developing services that meet quality standards for self-harm care
- improving services for people with a diagnosis of personality disorder, in line with our recent report
- care of females with complex problems including self-harm, additional diagnoses and alcohol or drug misuse.

xxxviii. Recent self-harm is increasingly common as an antecedent of suicide in mental health patients and is particularly associated with younger patients. An episode of self-harm is a strong risk factor for suicide but risk can be under-estimated at assessment. Protocols for managing self-harm patients who are under mental health care should highlight the short term risk.

xxxix. Suicide in people aged under 20 is rising. A broad range of stressors appear to play a part, reflecting the lives of young people in general. Many young people who die are not known to children's services. Prevention includes bereavement support, improved online safety and measures to tackle bullying. A wide range of professionals have a role in prevention including those working in self-harm, mental health, social care, primary care, youth justice, education and the voluntary sector.

xl. Preventing suicide in students requires specific measures, including:
- prevention, through promotion of mental health on campus
- awareness of risk, including the fact that conventional risk factors, e.g. alcohol or drug misuse, may be absent
- availability of support especially at times of risk, e.g. exam months
- strengthened links to NHS services, including mental health care.

xli. The risk of homicide by mental health patients is strongly linked to other factors in the clinical picture, namely the additional use of drugs or alcohol, and the loss of contact with services. Clinical measures most likely to prevent patient homicides and by implication reduce the risk of interpersonal violence are therefore:
- reducing alcohol and drug misuse
- maintaining treatment and contact in patients at risk of disengaging from services.

Figure 1: NCISH "10 ways to improve safety"

Box 1: NCISH methodology

1. NCISH is a comprehensive national project collecting data on all patient suicides and homicides in the UK, with a response rate from clinicians of around 95%.

2. Suicide and homicide are defined legally, e.g. inquest conclusion or determination by a court. This provides consistency of definition but may under-estimate because of the high standard of evidence required.

3. Patients are defined by recorded contact with specialist mental health services in the 12 months prior to suicide/homicide - this omits some contacts, e.g. those seen in A&E but not referred to mental health.

4. NCISH is not a risk factor study but examines in detail circumstances in which deaths occur, e.g. the number of deaths in certain patient groups or settings, and how common remediable factors are. Findings describe the deaths that must be prevented to achieve a major reduction in suicide and homicide.

5. The comprehensive nature of the NCISH database spanning over 20 years gives the opportunity to analyse large numbers, allowing the monitoring of changes in figures over time, including in patient sub-groups.

6. Additional NCISH studies use a range of methodologies, e.g. case control, evaluations, and triangulation with qualitative methods.[1-4, 7,8]

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