NCISH is commissioned by the Healthcare Quality Improvement Partnership (HQIP)

The Healthcare Quality Improvement Partnership (HQIP) is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices. Its aim is to promote quality improvement in patient outcomes, and in particular, to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality in England and Wales. HQIP holds the contract to commission, manage and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP), comprising around 40 projects covering care provided to people with a wide range of medical, surgical and mental health conditions. The programme is funded by NHS England, the Welsh Government and, with some individual projects, other devolved administrations and crown dependencies.

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EXECUTIVE SUMMARY

INTRODUCTION

The 2019 annual report from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) provides findings relating to people who died by suicide in 2007-2017 across all UK countries. Additional findings are presented on the number of people convicted of homicide, and those under mental health care.

The NCISH database includes a national case series of suicide by mental health patients over 20 years. The current suicide database stands at over 136,000 suicides in the general population, including over 35,000 patients. This internationally unique database allows NCISH to make recommendations for clinical practice and policy that will improve safety locally, nationally and internationally. As with our previous annual reports, the main findings are presented by country for the baseline year of 2007 and the subsequent 10 years, including the most recent year (2017) for which comprehensive data are available. A UK-wide section provides selected findings for the UK as a whole.

METHODOLOGY AND ANALYSIS

The NCISH method of data collection is provided in our previous annual reports and on our website. The main findings of the report are presented in a combination of figures, tables and maps. These show changes in key figures in patient safety over the report period.

In the final year of a report period – 2017 in this report – figures are incomplete, in part because of the time associated with legal processes. We therefore estimate final figures for the most recent years taking into account the number of outstanding questionnaires and the accuracy of our estimates in previous years. We examine for statistically significant time trends over the report period. However, because 2017 figures are partly estimates, these are not included in the analysis of trends.

KEY FINDINGS

Suicide numbers and rates

I. Suicide rates in the general population in UK countries show that the lower figures of recent years have been broadly maintained during the report period,[1] although in Wales there appears to have been a rise in 2017. Previously all countries experienced a rise after the 2008 recession and a fall after 2013.

II. Difference in suicide rates remain between the UK countries, with the highest rate in Northern Ireland. The largest differences in rates over the report period were in young adults. In Northern Ireland the highest rates were in people in their 20s whereas in England, Scotland and Wales rates were highest in people in their 40s.

III. There were 1,517 suicides by people under mental health care in the UK in 2017, this figure having fallen in recent years. Over the whole report period 2007-2017, there were 18,024 patient suicides, 28% of suicides in the population, although this percentage was higher in Scotland and lower in Wales. In Wales the number of patient suicides rose in 2017, in line with general population figures.

IV. In England there was a small fall in the number of patient suicides and a significant decrease in the rate, i.e. taking into account the total number of people under mental health care.

[1] Recent ONS figures suggest an increase in 2018

Method of suicide

V. The commonest method of suicide by patients was hanging/strangulation, accounting for 714 patient deaths UK-wide in 2017, almost half (47%) of all patient suicides. Over the report period, deaths by hanging/strangulation increased, most markedly in female patients.

VI. The second commonest suicide method among patients was self-poisoning, accounting for 348 deaths in 2017, almost a quarter (23%) of patient suicides. The main substances taken in fatal overdose were opiates/opioids and the main source (where known) was by prescription.

VII. Suicides by methods resulting in multiple injuries (jumping from a height or in front of a train) accounted for over 200 patient deaths per year. Individual locations often become known locally because they are frequently used.

VIII. New methods of suicide continue to appear in our figures. Inhalation of gases now accounts for 3% of patient suicides, 43 deaths per year.

Clinical care

IX. There were 92 suicides by in-patients in the UK in 2017, around 6% of all patient suicides, continuing a long-term downward trend after a rise in 2015-16. Over the report period around a third of in-patient suicides took place on the ward itself. Many of these deaths were by hanging/strangulation from low-lying ligature points.

X. There were 206 suicides in the 3 months after hospital discharge in 2017, 14% of all patient suicides, a small fall since the previous year, continuing an overall downward trend. The highest risk was in the first 1-2 weeks after discharge and the highest number of deaths occurred on day 3 post-discharge.

XI. In 2017 there were 866 suicides by patients who had a history of alcohol or drug misuse, 57% of all patient suicides UK-wide, higher in Scotland. Only a minority were in contact with specialist substance misuse services.

Suicide in patients aged 75 and over

XII. There were 425 deaths per year in people aged 75 and over. The number increased during the report period, driven by a rise in suicide by older males, although the rate decreased, i.e. taking into account rising patient numbers. 20% of people in this age group who died by suicide were mental health patients, lower than in other age groups.

XIII. These patients were more likely to have depression than other age groups and a higher percentage had been ill for less than a year.

XIV. They were less likely to die by hanging/strangulation. Self-poisoning was more likely to be by paracetamol or paracetamol/opioid compounds.

XV. Conventional risk factors such as self-harm or substance misuse were less common. Living alone, physical illness and bereavement were more common.

Suicide in women aged under 25

XVI. There were 144 deaths per year in females aged under 25, though the number increased over the report period. Around a third of suicides in women in this age group were by mental health patients.

XVII. Compared to older female patients they were more likely to die by hanging/strangulation and less likely to die by self-poisoning.

XVIII. The most common diagnosis was personality disorder; affective disorder (bipolar disorder and depression) was proportionately less common than at other ages, eating disorders more common.

XIX. Most had a history of self-harm and compared to older female patients who died, they more often had a history of alcohol or drug misuse. This clinical complexity - personality disorder, self-harm, substance misuse - was not reflected in risk assessment, the majority being seen as low risk at final contact.

Suicide in patients who are homeless

XX. There were 40 suicides per year in patients who were homeless, although in the last 3 years this figure has been lower.

XXI. Homeless patients who died by suicide were more likely to be male, to be unemployed, to have previously lived alone and to have a history of self-harm, violence and substance misuse.

XXII. They had a wide age range, with age-related differences. Those under 45 had higher rates of substance misuse, including new psychoactive substances, and self-harm. Those over 45 were more likely to have depression and financial difficulties.

Suicide in patients with anxiety disorders

XXIII. There were 86 suicides per year in patients with a primary diagnosis of anxiety disorder, 5% of all patient suicides. The figure has risen during the report period - this could reflect a change in patterns of referral or diagnosis, or an increase in risk.

XXIV. They had a wide age range, with a median age of 47, with more women over 65, though overall the majority were male.

XXV. They had fewer conventional social and clinical risk factors for suicide such as living alone or substance misuse. However, there was a rise in unemployment and financial difficulties over the report period.

XXVI. Most were receiving drug treatment and around a third were taking benzodiazepines. A quarter were receiving some kind of psychological therapy; 8% were under IAPT services at the time of death.

Suicide and the internet

XXVII. There were 65 suicides per year in patients known to have used the internet in ways that were suicide-related. This figure is likely to be an under-estimate. The commonest type of suicide-related internet use was searching for information on suicide method.

XXVIII. The suicide methods used were different from other patients. This group more often used gas inhalation and in deaths by self-poisoning, tranquillisers that are no longer in use were more frequent.

XXIX. Although they were more likely to be young, they were a diverse group in age and diagnosis, including severe mental illness. They were more often employed, less often living alone.

CLINICAL MESSAGES

1. In-patient and post-discharge care remain times of high risk for suicide. Key suicide prevention measures are:
— Safer wards, including removal of low-lying ligature points;
— Awareness of increased risk within the 1st week of admission;
— Comprehensive care planning for discharge and pre-discharge leave;
— Follow-up within 2-3 days of discharge from in-patient care.

2. Alcohol and drugs are common antecedents of suicide. Clinical measures that could help reduce risk are:
— Substance misuse assessment skills in frontline staff;
— Specialist substance misuse clinicians within mental health services;
— Joint working with local drug and alcohol services, with an emphasis on safety.

3. Measures that services can take to reduce risks associated with particular methods of suicide are:
— Safer prescribing in primary and secondary care, with particular attention on opiates/opioids prescribed to people with long-term physical illness;
— Working with local authorities to reduce risk at frequently used locations, i.e. high places and railways;
— Ensuring clinical staff are aware of suicide methods associated with internet use, as a result of information available online or by online purchases.

4. Several of these recommendations are highlighted in our "10 ways to improve safety", an important component of the NHS England and NHS Improvement suicide prevention programme:
— Safer wards;
— Early follow-up after in-patient discharge;
— Addressing alcohol and drug problems through services for "dual diagnosis" patients and outreach teams;
— Safer prescribing.

5. Patients aged 75 and over
Clinical services should be aware of (1) the lower rate of contact with specialist mental health services among those who die by suicide in this age group and the need to work with other agencies where people at risk may attend and (2) different patterns of clinical risk, with more depression, bereavement and physical illness, and lower rates of some common suicide risk factors such as self-harm and substance misuse.

6. Female patients aged under 25
Clinical services should (1) have the breadth of skills to respond to clinical complexity and comorbidities in this group, often including depression, a diagnosis of personality disorder, eating disorders, self-harm, and substance misuse, and in particular (2) be able to offer self-harm care that meets current quality standards, and (3) be aware of the recommendations of the Women's Mental Health Taskforce report.

7. Homeless patients
Clinical services should be aware of (1) different patterns of risk among homeless patients: younger people with self-harm and substance misuse including new psychoactive substances, and older men more likely to have depression and financial problems and (2) the need for specialist expertise in working with homeless people in areas where homelessness is a severe problem.

8. Patients with anxiety disorders
Clinical services should be aware of (1) the rise in suicide in patients with anxiety disorders, despite fewer conventional risk factors and (2) that suicide prevention in this group should include reduced prescribing of benzodiazepines, and access to IAPT services.

9. Internet risks
Clinicians need to be aware that (1) suicide-related internet use is a potential risk for all patients, especially but not only younger age groups and that (2) there is a need to enquire about online behaviour as part of assessing risk.

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