The University of Manchester

HQIP
Healthcare Quality Improvement Partnership

National Confidential Inquiry

into Suicide and Safety in Mental Health

EXECUTIVE SUMMARY 2021

ANNUAL REPORT: ENGLAND, NORTHERN IRELAND, SCOTLAND AND WALES

Patient and general population data 2008-2018, and NCISH COVID-19 related work

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 and NHS Improvement, the Welsh Government and, with some individual projects, other devolved administrations, and crown dependencies.

More detailed information can be found at: **www.hqip.org.uk/national-programmes**

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Service users and patients	For many people with mental ill-health the pandemic has brought new stresses and disruption to daily life and the availability of care. In our work on patient safety we will continue to listen to their experiences and to reflect these back to services. In such difficult times we want to acknowledge the contribution of experts by experience throughout our work programme.
Mental health staff	This has been a gruelling period for all health staff, including those in mental health services. We would like to thank clinical and social care staff for continuing to support our work during the pandemic. The need to strengthen our suicide prevention effort is as great as ever. The cooperation from staff remains invaluable.
This report	COVID-19 is dominating care across the NHS. Some of those most affected by the pandemic - young people, ethnic minorities, people who live alone - have also been a concern in suicide prevention. Their mental health will be an important feature of society's recovery. In this report we do not yet have data from 2020 but our findings highlight key issues in patient safety in these groups.

EXECUTIVE SUMMARY

Introduction

The 2021 annual report from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) provides findings relating to people who died by suicide between 2008 and 2018 across all UK countries. Additional findings are presented on the number of people under mental health care who have been convicted of homicide, and those in the general population.

The NCISH database includes a national case series of suicide by patients under the care of mental health services over more than 20 years. The current suicide database stands at over 144,000 deaths by suicide in the general population, including over 36,000 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 2008 and the subsequent 10 years, including the most recent year (2018) for which comprehensive data are available. A UK-wide section provides themed findings for all countries combined. In this year's report, though we present data from deaths occurring between 2008 and 2018, most of the themes presented relate to groups that we now know are likely to have been particularly vulnerable during the COVID-19 pandemic: patients who live alone; those aged under 25; those from an ethnic minority group; and those who have died by hanging/strangulation. This year we also present information on our work to support clinicians working through the pandemic, as well as some data from our pilot real-time surveillance of suspected suicide by people under mental health care in England.

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 the report period – 2018 in this report for the core data – figures are incomplete, in part because of the time associated with legal processes, but also due to NCISH suspension of data collection during the early months of the COVID-19 pandemic to support reducing burden and releasing capacity in clinical services. 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 2018 figures are partly estimates, these are not included in the analysis of trends.

We have not received complete 2018 patient data from Northern Ireland as a result of the new GDPR regulations and COVID-19-related disruptions in data collection but findings will be presented in future reports. Therefore, we present data on patient suicide deaths in Northern Ireland for the period 2008-2017 in the country specific and UK-wide sections of the report. This report follows current guidance from the Northern Ireland Statistics and Research Agency (NISRA) to include only deaths resulting from self-inflicted injury registered between 2015 and 2018. This means the figures relating to date of death in Northern Ireland in these years, and to a lesser extent in 2013 and 2014, have fallen and cannot be compared with the number of suicides in earlier years. We no longer present information relating to homicide in Northern Ireland as we are unable to obtain conviction data.

KEY FINDINGS

Suicide numbers and rates

I. Suicide rates in the general population in the UK show a recent rise in most countries since 2016 or 2017, the exception being Northern Ireland where a change in the coding of drug-related deaths has led to lower figures. Differences in suicide rates remain between the UK countries, though recent rates in Northern Ireland are not comparable due to changes in the death coding process. The largest between-country differences in rates over the 11-year report period were in young adults; and in Northern Ireland the highest rates were in this group. In the other UK countries, the highest rates were in middle aged groups but in Scotland rates were highest in people in their late 30s and 40s while in England and Wales rates were highest in people in their 40s and early 50s.

II. There were 1,601 suicides by people under mental health care in the UK in 2018, this figure having fallen in recent years. Over the whole report period 2008-2018, there were 18,029 patient suicides, 27% of all suicides in the general population, although this percentage was higher in Scotland and lower in Wales. In 2018 the number of patient suicides rose in England. However, the increase was not reflected in the rate of suicide among patients under mental health care, where there has been a continued fall since 2011, i.e. taking into account the total number of people under mental health care.

Method of suicide

III. The commonest method of suicide by patients was hanging/strangulation, accounting for 825 patient deaths UK-wide in 2018 (excluding Northern Ireland), over half (52%) of all patient suicides. Over the report period, the number of deaths by hanging/strangulation increased, most markedly in female patients and those aged under 25.

IV. The second commonest suicide method among patients was self-poisoning, accounting for 335 deaths in 2018, almost a quarter (22%) of patient suicides. The number of deaths by self-poisoning among patients has fallen over the report period. The main substances taken in fatal overdose were opiates/opioids and the main source (where known) was by prescription.

V. Suicides by methods resulting in multiple injuries (jumping from a height or in front of a train) accounted for an average of 222 patient deaths per year. The number of deaths by jumping/multiple injuries has fallen since 2013.

Clinical care

VI. There were 74 suicides by mental health in-patients in the UK (excluding Northern Ireland) in 2018, around 4% of all patient suicides, continuing a downward trend since 2011. The lower number of in-patient suicides in the last few years has mostly been due to reductions in England. Over the report period around a third of in-patient suicides took place on the ward itself. Many ofthese deaths were by hanging/strangulation from low-lying ligature points.

VII. There were 179 deaths by suicide in the 3 months after hospital discharge in the UK (excluding Northern Ireland) in 2018, 13% of all patient suicides, a small increase since the previous year, in the context of an overall downward trend. The highest risk was in the first 1-2 weeks after discharge and the highest number of deaths occurred on the second full day after discharge.

Suicide by patients who lived alone

VIII. There were 746 deaths per year on average by patients who lived alone over the period 2008-2018, nearly half (48%) of all patient suicides. The number fell over the report period, though figures in 2017 and 2018 show a rise in men.

IX. These patients were more likely to be aged over 45, unemployed, on long-term sick leave, and single or widowed than those who did not live alone. More had experienced recent financial difficulties and relationship break-up.

X. These patients had more conventional risk factors for suicide including previous self-harm and alcohol and drug misuse than those who did not live alone. They also had higher rates of psychiatric and physical co-morbidity, most commonly musculoskeletal disease, cardiovascular disease, and chronic pain.

Suicide by patients from ethnic minority groups

XI. There were 107 deaths per year in patients from ethnic minority groups, 7% of all patient suicides. There was no overall trend over the report period.

XII. There were differences between ethnic groups in social and clinical characteristics that could be important to suicide prevention. Patients from a South Asian background were less likely to be unmarried or living alone and they had high rates of affective disorder. Black Caribbean and Black African patients were more likely to live alone and had the highest rates of schizophrenia and other delusional disorders and previous violence. Black Caribbean patients also had higher rates of alcohol and drug misuse. Chinese patients were more often female and had a short history of psychiatric illness. Patients from a multiple/mixed ethnic background had higher rates of personality disorder, co-morbidity and previous self-harm and substance misuse.

Suicide in children, young people, and young adults

XIII. There were 626 deaths per year on average in people aged under 25 (10-24 year) in the general population, though the number was higher in 2017 and 2018. Around a fifth (21%) were patients under the care of mental health services. The number of young patients who died by suicide increased over the report period, particularly in those aged 15-17 and in female patients.

XIV. Compared to older patients, children and young people who died by suicide were more likely to die by hanging/strangulation and jumping/multiple injuries and less likely to die by self-poisoning. The number of deaths by hanging/strangulation in this group increased over the report period.

XV. Diagnoses of personality disorder, drug dependence/misuse and eating disorders were more common. A third had a combination of previous self-harm, co-morbidity and a history of substance misuse.

Suicide by hanging/ strangulation

XVI. There were 3,080 deaths per year by hanging/strangulation in the general population; 746 were by patients under mental health care. There was an increase in the number of deaths by hanging/strangulation in both the general and patient populations. The increase was seen in those aged under 25, particularly in women.

XVII. Patients who died by hanging/strangulation were more likely to be male, employed and married than patients who died by other methods. Affective disorder (bipolar disorder and depression) and adjustment disorders were common and they were more likely to have been recently diagnosed with psychiatric illness. More had been seen in an Emergency Department for self-harm in the preceding 3 months.

XVIII. These patients more often reported recent financial problems, relationship break-up, and workplace problems.

Suicide prevention during COVID-19

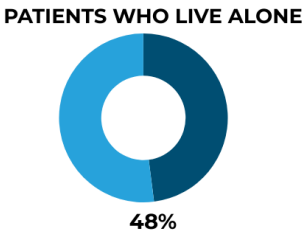
XIX. There were 133 suspected suicide deaths that mental health trusts in England told us about between 23rd March and 30th September 2020. This is not a representative case series, being based on deaths notified to us voluntarily in a pilot data collection of "real-time" surveillance of suspected suicides.

XX. Most deaths notified to us occurred in community (i.e. CMHT) rather than in acute or crisis care settings.

XXI. Two thirds of the patients who died had reported adverse experiences related to the pandemic, particularly feelings of anxiety, isolation, and loneliness.

XXII. Over a third had experienced disruption to their usual mental health care.

CLINICAL MESSAGES



1. Suicide by patients who live alone

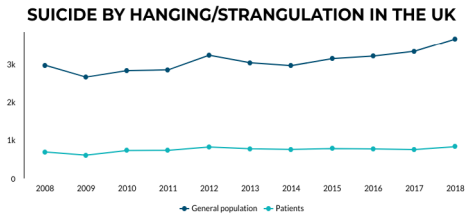
Clinicians need to be aware of the vulnerability of patients living alone, who represent approximately half of all patient suicides. Their increased risk arises both from their mental and physical ill-health and from factors weakening their ties with society, such as a lack of employment, recent relationship breakdowns and financial difficulties. Care packages devised by clinical services and other agencies for patients who live alone should address these clinical and social risks.

2. Suicide by patients from ethnic minority groups

Clinical services should be aware that the suicide risk profile of patients differs between ethnic groups. Different suicide prevention approaches will be needed, in relation to severe mental illness or depression, alcohol or drug misuse, likely suicide method, or recent migration.

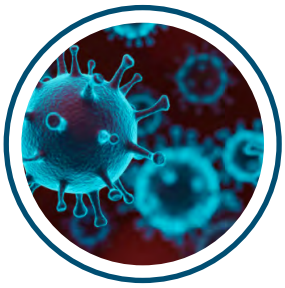
3. Suicide in people aged under 25

Clinical services should ensure that services for children, young people, and young adults have the skills to respond to the clinical complexity of many younger patients, including combinations of personality disorder diagnosis, eating disorder, self-harm and alcohol or drug misuse. These co-morbidities add to suicide risk but can act as a reason for non-acceptance by services designed for single conditions.



4. Suicide by hanging/strangulation

Clinical services should be aware of a continuing increase in suicide by hanging/strangulation among patients under mental health care. This is a difficult method to prevent outside institutional settings. Clinicians assessing risk should consider the factors associated with this method; recent risk factors such as self-harm, adverse life events and diagnosis of depression; apparent protective factors such as employment and marriage.



5. Suicide prevention during COVID-19

People under mental health care may be at risk during the pandemic. Some groups who have been especially vulnerable to the acute pandemic may need additional mental health support, as described above. Suicide prevention measures for services should particularly support those who are anxious, isolated or lonely. There should be a focus on patients who are receiving care under community services as well as in acute settings. It is important to minimise disruption to usual care where possible, making use of digital technology where this is appropriate.

6. Suicide prevention in mental health services

Healthcare organisations can use our NCISH toolkit 'Safer Services' to self-assess their services against our 10 key elements of safer care for patients. We recommend that responses be based on recent local audit data or equivalent evidence, and that each element is reviewed annually. Our toolkit has been updated to reflect the key findings and clinical messages within this report.

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