MANCHESTER 1824
The University of Manchester

HQIP
Healthcare Quality Improvement Partnership

National Confidential Inquiry

into Suicide and Safety in Mental Health

EXECUTIVE SUMMARY

Annual Report 2022:
UK patient and general population data 2009-2019, and real-time surveillance data

ACKNOWLEDGEMENTS

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

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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During a difficult year for many, we would like to thank mental health staff and experts by experience for their invaluable contributions to our suicide prevention work.

We are aware that the content of this report, which includes some detail of methods of death, may be distressing for some readers.

EXECUTIVE SUMMARY

The 2022 annual report from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) provides findings relating to people aged 10 and over who died by suicide between 2009 and 2019 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 152,000 deaths by suicide in the general population, including over 38,000 patients. This internationally leading database allows NCISH to make recommendations for clinical practice and policy that will improve safety locally, nationally and internationally.

Within this report, the main findings are presented for the UK as a whole for the baseline year of 2009 and the subsequent 10 years, including the most recent year (2019) for which comprehensive data are available.

We have not received complete 2019 patient data from Northern Ireland but findings will be presented in future reports. Therefore, we present data on patient suicide deaths in Northern Ireland for the period 2009-2018 in the country specific and UK-wide sections of the report.

Data for individual UK countries are provided in the supplementary online information files, and key messages are also provided as an easy read report, an infographic, and an animated video.

In this year's report, though we present data from deaths occurring between 2009 and 2019, most of the themed findings relate to groups that we now know are likely to have been particularly vulnerable during the COVID-19 pandemic: patients with economic difficulties, those who have experienced domestic violence, and those with comorbid physical illness.

We also present some data from our pilot real-time surveillance of suspected suicide by people under mental health care in England.

KEY FINDINGS

General population suicide numbers and rates

- There were 66,991 suicides in the general population in the UK between 2009 and 2019, an average of 6,090 deaths per year. The rate of suicide increased by 8% in the UK in 2018-19 compared to 2017, and the increase was seen in both males and females.

- The rise in suicide rates in 2018-19 occurred in England, Scotland and Wales but not in Northern Ireland where a change in the coding of drug-related deaths has led to recording of lower figures.

- There has been a significant rise in deaths by hanging in 2018-19 and a small rise in deaths by self-poisoning, but no increase in deaths by jumping/multiple injuries. Among the less frequent methods of suicide, deaths by cutting/stabbing increased in 2018-19 while deaths from gas inhalation decreased.

Patient suicide numbers and rates

- Over 2009-2019, there were 18,268 suicide deaths in the UK by patients (i.e. people in contact with mental health services within 12 months of suicide), an average of 1,661 deaths per year, 27% of all general population suicides.

- In 2018-19, the number of patients who died by suicide rose significantly in England and there was a small increase in Scotland. However, the increase in England was not reflected in the rate of suicide among patients under mental health care, i.e. taking into account the total number of people under mental health care, where there has been little change.

- The number of deaths by hanging/strangulation has risen steeply in 2018-19, especially in female patients and in patients aged under 25. The number of deaths by self-poisoning also increased in 2018-19, but deaths by jumping/multiple injuries decreased.

Clinical characteristics

- The majority of patients who died had a history of self-harm (64%) and there were high proportions of those with alcohol (47%) and drug (37%) misuse, and comorbidity, i.e. more than one mental health diagnosis (53%).

- Nearly half (48%) lived alone. In 13%, the contact with mental health services was a one-off contact. 9% of patients were known to have died on or near an anniversary or significant date.

Clinical care

- Over 2009-2019, there were 5,218 (29%) patients who died by suicide in acute care settings, including in-patients (6%), post-discharge care (15%) and crisis resolution/home treatment (14%).

- Nearly half (46%) had been in contact with mental health services in the week before death. The majority (84%) of patients were viewed by clinicians as at low or no short-term risk.

- There were an estimated 67 suicides by mental health in-patients in the UK (excluding Northern Ireland) in 2019, around 4% of all patient suicides. Half of the in-patients were on agreed leave, 35% died on the ward, and 15% died off the ward without staff agreement or with agreement but failed to return. In 30%, the patients had been detained for treatment.

- There were an estimated 180 deaths by suicide in the 3 months after discharge from mental health in-patient care in the UK (excluding Northern Ireland) in 2019, 11% of all patient suicides, a small decrease since the previous year, maintaining 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.

Suicide by patients aged under 18

- There were 1,093 suicides in the general population by people aged under 18 in 2009-19, an average of 99 deaths per year. The number increased over the report period, mainly driven by an increase in girls aged 16 and boys aged 17, and by a rise in deaths by hanging/strangulation in the under 18s.

- There were 213 suicides by patients aged under 18, an average of 19 deaths per year. This represents 19% of general population suicides in this age group, a lower proportion than in older groups (27%). Recent numbers appear to be higher, reflecting the increase in general population suicides by people aged under 18.

- Patients under 18 were more likely to have died by hanging/strangulation and less likely to have died by self-poisoning. 13% were diagnosed with autism and 5% were diagnosed with eating disorders.

- Patients under 18 were more likely to have a history of self-harm. In 2011-19, 25% were known to have suicide-related online experience, more than other age groups.

Suicide by patients with recent economic adversity

- Complete data on economic adversity were available from 2013. In 2013-19, there were 281 deaths per year in patients who had experienced recent economic adversity, 18% of all patient suicides. These included serious financial problems, workplace problems, or homelessness. Recent figures were stable but there was an increase in 2018.

- Patients with recent economic adversity were more likely to be male (74%), middle-aged (45%), unemployed (55%), and divorced or separated (29%).

- They were more likely to have had a recent illness onset, most commonly affective disorder (depression or bipolar disorder), and also more likely to have alcohol and drug misuse. Despite recent acute illness, loss of contact with services (26%) and non-adherence with medication (15%) were more common.

Suicide by patients with comorbid physical illness

- There were 390 deaths per year in patients with a comorbid major physical illness, 25% of all patient suicides. The number has been increasing since 2014. Nearly half (47%) of patients aged 65 and over had a comorbid physical illness. The most common physical illnesses were cardiovascular diseases (24%) and musculoskeletal disorders (24%).

- Patients with physical comorbidity were older and more often men, but there was a higher proportion of women (37%) compared to in other patient groups (33%). They were less likely to have conventional risk factors, but living alone (52%) and having a long-term illness (especially depression) (58%) were more common and long-term risk was more often viewed as moderate or high (45%).

- In general, these patients more often died by self-poisoning (38%) and the drug type used was more often opioids (opiates or paracetamol/opiate compounds). In 76% the opioids had been prescribed for the patient.

Suicide by patients with a history of domestic violence

- Between 2015 and 2019, there were 532 patients who were known to have experienced domestic violence, 9% of all patients during this time period, 104 deaths per year. The average number in 2016-17 was 101 per year but in 2018-19 this had increased to 149 per year. The majority (73%) were female, an average of 76 per year.

- Women with a history of domestic violence were more likely to be younger than other women, and be single or divorced, living alone and unemployed. The majority (81%) had a history of self-harm and previous alcohol (61%) and/or drug (47%) misuse was common. Nearly a third (29%) had been diagnosed with personality disorder.

- Male patients who had experienced domestic violence showed similar features, particularly high proportions with personality disorder diagnosis (20%), previous self-harm (73%) and alcohol (75%) and/or drug (65%) misuse. They were more likely to also have a history of perpetrating violence (57%).

Real-time suicide surveillance

- We did not find a rise in suicide in the general population in England in the first year of the pandemic.

- Experiences of the pandemic, for example anxiety, isolation, disruption to care, may have contributed to some suicides by mental health patients.

CLINICAL MESSAGES

1. Clinical risk

Established risk factors for suicide – such as previous self-harm, alcohol or drug misuse, multiple mental health diagnoses, living alone – are common among patients who die by suicide, and should form the basis of risk management. Responding to loss of contact with services is an important prevention measure.

Assessment of risk should include significant dates and anniversaries which may then form part of safety planning.

2. Acute mental health care

People who die by suicide during in-patient care are not a uniform group. Prevention should address the ward environment (both physical and emotional), vigilance and the safety of leave arrangements before discharge. After hospital discharge, prevention should focus on the first two weeks, ensuring follow-up within 72 hours of discharge.

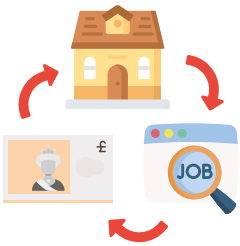
These recommendations are highlighted in our "10 ways to improve safety".

3. Suicide by patients aged under 18

The rise in suicide in young people is also seen in mental health patients. Prevention should focus on access to services, ensuring services have the skills to address multiple co-existing difficulties, preventing and responding to self-harm, and specific diagnoses such as autism and eating disorders.

Assessment of risk should include enquiry about online experience.

4. Suicide by patients with recent economic adversity



Clinicians should be aware of the features of those at suicide risk in the context of economic adversity: most often middle-aged men, unemployed, divorced or separated, with higher rates of alcohol or drug misuse. Onset of mental disorder, especially depression, may have been recent; some lose contact with services.

Working with organisations that support people facing debt or other financial problems is important to prevention.

5. Suicide by patients with physical illness

Physical illness is becoming a more frequent, or more frequently recognised, feature of suicide in mental health patients. The risk profile of these patients is not the same as for patients generally – they are older, common risk factors such as self-harm or alcohol/drug misuse, are less often present, a higher proportion are women.

Clinicians should be aware of the risk from opioids prescribed for pain. Safer prescribing in primary and secondary care is important to prevention.

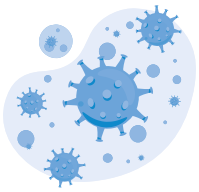
Assessment of risk should include access to opioids available at home, particularly among older patients.

6. Suicide by patients with a history of domestic violence

Clinicians should be aware of the risk associated with domestic violence, especially in female patients but also in men, often occurring with other risk factors such as self-harm or alcohol or drug misuse. Personality disorder diagnoses, more common in this group, may reflect previous trauma or abuse.

Assessment of suicide risk should include experience or threat of domestic violence.

7. Suicide prevention during COVID-19



Clinicians should be aware of the need to maintain support for patients under the care of mental health services, particularly for patients who are anxious, isolated, or have experienced disruption to care.

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