The University of Manchester

HQIP
Healthcare Quality
Improvement Partnership

National Confidential Inquiry

into Suicide and Safety in Mental Health

ANNUAL REPORT 2024:
England, Northern Ireland, Scotland and Wales

UK patient and general population data 2011-2021

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NCISH is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP).

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. The Clinical Outcome Review Programmes, which encompass confidential enquiries, are designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by systematically enabling clinicians, managers, and policy makers to learn from adverse events and other relevant data. 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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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.

CONTENTS

EXECUTIVE SUMMARY 4

KEY FINDINGS 5

CLINICAL MESSAGES 8

SCOPE OF THE REPORT 9

SUICIDE IN THE UK 10

PATIENT SUICIDE IN THE UK 13

THEMES IN THIS REPORT 26

SUICIDE BY AUTISTIC PEOPLE AND THOSE WITH ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) 26

SUICIDE BY IN-PATIENTS AGED UNDER 25 28

SUICIDE BY PATIENTS WHO WERE STUDENTS IN ENGLAND AND WALES 30

SUICIDE BY PATIENTS FOLLOWING A ONE-OFF ASSESSMENT 32

PATIENTS WHO DIED BY SUICIDE IN PUBLIC LOCATIONS 34

LINKS TO ADDITIONAL ONLINE DATA 36

EXECUTIVE SUMMARY

The 2024 annual report from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) provides findings relating to people aged 10 and above (in line with the Office for National Statistics) who died by suicide between 2011 and 2021 across all of the UK.

The NCISH database includes a national case series of suicide by patients under the care of mental health services over more than 26 years. The current suicide database stands at over 166,000 deaths by suicide in the general population, including over 41,900 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 2011 and the subsequent 10 years, including the most recent year (2021) for which comprehensive data are available. We have not received 2020 and 2021 patient questionnaire 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 2011-2019 in the country specific and UK-wide sections of the report. Data for individual UK countries are provided in the additional online information files. Key messages are also provided as an easy read report, an infographic, and an animated video.

In the report we also present data on specific topics, some of which are included because of current societal concerns or groups who may be at increasing risk. These include autistic people and those with attention deficit hyperactivity disorder, in-patients aged under 25, patients aged 18-21 who were students, patients with a one-off assessment, and those who died by suicide in public locations.

KEY FINDINGS

General population suicide numbers and rates

- There were 69,420 suicides in the general population in the UK between 2011 and 2021, an average of 6,311 deaths per year. The rate of suicide decreased by 4% in the UK in 2020 and 2021, the first years of the COVID-19 pandemic, compared to 2019 (see details on page 10). The decrease was particularly seen in men.

- In England and Wales in 2018 there was a lowering of the standard of proof required for a suicide outcome at inquest – this is likely to have contributed to the recorded rise in suicide rates in 2018 and subsequent years (see details on page 11). Rates have been lower in Northern Ireland since 2015 following a Review of Suicide Statistics subsequent to the identification of a classification issue in its suicide statistics (see details on page 9).

- There has been an overall rise in deaths by hanging/strangulation, although the number has fallen in 2020 and 2021 (see details on page 12). Deaths by self-poisoning also increased in 2018 but then fell in 2019-2021. There was no change in deaths by jumping/multiple injuries. Of the less common suicide methods, the number of deaths by cutting/stabbing has continued to increase since 2016.

Patient suicide numbers and rates

- Over 2011-2021, there were 18,339 suicide deaths in the UK by mental health patients (i.e. people in contact with mental health services within 12 months of suicide), an average of 1,667 deaths per year, 26% of all suicide deaths in the general population (see details on page 13).

- In 2020 and 2021, the first two years of the COVID-19 pandemic, the number of patients who died by suicide fell in England (see figures on page 14). There was a small increase in Scotland in 2020 but a fall in 2021. The patient suicide rate in England, i.e. taking into account the overall number of patients, has fallen over the report period but with little change in recent years.

- In the UK, the number of deaths by hanging/strangulation rose steeply in 2018-2021, especially in female patients and in patients aged under 25. The number of deaths by self-poisoning also increased in 2018-2020 but this appears to have fallen in 2021. The main substances taken in fatal overdose overall were opiates/opioids and the source (where known) was most often by prescription (see details on page 15).

Social and clinical characteristics

- Nearly half (48%) of all patients who died by suicide had lived alone (see details on page 17). 5% of patients were recent migrants, i.e. seeking permission to stay in the UK or resident in the UK for less than 5 years. 2% of female patients were pregnant at the time of suicide or died within a year of childbirth – further details on maternal deaths can be found in a recent report from the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE).

- The majority of patients who died by suicide had a history of self-harm (63%) and there were high figures for alcohol (47%) and drug (38%) misuse, and comorbidity, i.e. more than one mental health diagnosis (54%) (see details on page 17).

Acute mental health care

- Over the 11 years from 2011-2021, there were 4,767 (28%) patients who died by suicide in acute mental health care settings, namely in-patients (6%), post-discharge care (14%) and crisis resolution/home treatment (13%), an average of 433 deaths per year (see details on page 20). The proportion of patients dying by suicide under acute care has fallen over the report period.

- There were an estimated 74 suicides by mental health in-patients in the UK (excluding Northern Ireland) in 2021, around 4% of all patient suicides. The number and rate have not changed since a fall in 2016 (see details on page 21). Over a quarter (28%) died whilst under enhanced nursing observation*. Patients under enhanced observation were more likely to have been detained under Mental Health Act powers and to have died in the first week of admission (see details on page 22).

- There were an estimated 193 deaths by suicide in the 3 months after discharge from mental health in-patient care in the UK (excluding Northern Ireland) in 2021, 12% of all patient suicides. This was the same figure as for the previous two years (see details on page 24). The highest risk was in the first 1-2 weeks after discharge, with the highest number of deaths overall occurring on day 3 post-discharge (taking day 1 as the day of discharge). However, over the report period, the day of highest risk has shifted to later in the week.

**enhanced nursing observations are those beyond general or routine observations, including frequent (i.e. every 15-30 minutes) checks on a patient or being with them constantly.*

Suicide by autistic people and patients with attention deficit hyperactivity disorder (ADHD)

- In 2011-2021, there were 350 deaths by autistic people, 2% of all patient suicides, an average of 32 deaths per year. 159 patients had ADHD, 1% of all patient suicides, an average of 15 deaths per year. 29 patients had received a diagnosis of both autism spectrum disorder and ADHD. The number of autistic people and those with ADHD increased over the report period, likely a reflection of an increase in clinical recognition and diagnoses of these disorders (see details on page 26).

- The majority (76%) of autistic patients were male and 39% were aged under 25. They were more likely to identify as LGBT (13%) compared to other patients (5%), although numbers were small. A high proportion (37%) had experienced childhood abuse and most (70%) had a history of self-harm. A higher proportion had used the internet for suicide-related purposes (21% v. 7%), especially obtaining information on suicide method (16% v. 6%).

- Patients with ADHD were also more likely to be male (79%) and younger than other patients (31% were aged under 25 and 55% were aged 25-44). They had higher rates of key clinical risk factors, including self-harm (73%), drug misuse (62%) and childhood abuse (45%).

Suicide by in-patients aged under 25 years

- In 2011-2021, there were 117 deaths by suicide in in-patients who were aged under 25, 7% of all patients aged under 25 who died by suicide, an average of 11 deaths per year (see details on page 28). Twenty were aged under 18, although the final figure is likely to be higher as some inquests relating to deaths of young people in the report period are yet to be held. There was no fall in the total number of in-patients aged under 25 over the report period.

- The majority (61%) were female and they were more likely to have been given a diagnosis of personality disorder (39%) than in-patients aged 25 and over. Of 38 patients who died by hanging/strangulation on the ward, the majority (71%) appeared to use low-lying ligature points but 26% involved no ligature points, more than older in-patients (5%).

- In-patients under 25 who died showed high rates of clinical risk factors associated with suicide, including self-harm (86%), alcohol and/or drug misuse (59%), and childhood abuse (49%). Half (48%) had been detained under Mental Health Act powers. They were more often under enhanced nursing observation (40%), especially female in-patients (51%). In 43% the admission was at a non-local unit, a higher proportion than in-patients aged 25 and over (30%).

Suicide by students in England and Wales

- In 2011-2021, there were 869 deaths in England and Wales by those aged between 18-21 who were identified as students, an average of 79 suicides per year. 96 (11%) were mental health patients, a significantly lower proportion than other young people in the general population who died by suicide (25%), an average of 9 deaths per year (see details on page 30). The number increased between 2011 and 2020, which may reflect improved contact with health services, but fell in 2021.

- These deaths were most common in October and April, which may reflect arrival and exam times, and were less common in August/September.

- 60% of students who died by suicide were men and 23% were from an ethnic minority group. Over half (57%) lived at home with their parent(s) and 28% lived in shared accommodation. Students more often had depressive illness (36%) compared to other patients who died by suicide aged 18-21 (20%), while alcohol (27%) and drug misuse (31%) were less common.

Suicide by patients following one-off assessment

- Complete data on one-off assessments (both routine and crisis assessments) were available from 2016. In 2016-2021, there were 1,001 deaths by patients whose contact with mental health services was a one-off assessment, 12% of all patient suicides, an average of 167 deaths per year (see details on page 32). The number increased in 2016-2019 but was lower in 2020 and 2021, in line with overall patient numbers.

- 111 (13%) had missed their last appointment with services, of whom over a third (36%) were subsequently discharged without follow-up. In 254 (30%) the contact was after a recent (<3 months) routine or urgent GP referral of whom half (51%) had been assessed and discharged without follow-up.

- Those assessed only once were more likely to have a recent history of alcohol (39%) or drug (26%) misuse. The majority (71%) had experienced recent adverse life events, especially financial problems (20%) and relationship break-up (15%).

Patients who died by suicide in public locations

- Between 2011 and 2021, there were 3,894 patients who died by suicide in a public place, 29% of all patient suicides, an average of 354 deaths per year (see details on page 34). The number of these patients did not change over the report period.

- The most frequent locations were parks or woodland (24%) and railway networks (22%). There was an 87% increase in the number of patients who died in parks or woodland over the report period, driven by an increase in suicide by hanging/strangulation at these locations and by increased occurrence in patients aged under 25.

- Overall, patients who died in a public place were younger than those who died in private locations. They appeared to be more acutely unwell with high rates of schizophrenia and other delusional disorders (23%). Recent high-risk behaviours and stressors were common, including self-harm, drug misuse, relationship break-up and financial problems.

CLINICAL MESSAGES

1. Clinical care

Our reports have indicated how important it is to suicide prevention to address factors such as socioeconomic adversity, alcohol and drugs, physical health, clinical risk assessment, and suicide risk in children and young people, and in autistic people. The new national suicide prevention strategy for England and equivalent policies in other UK countries have highlighted these issues as priorities for safer care.

2. Acute mental health care settings

There is concern currently about safety in mental health in-patient services. To address this, services need to focus on: creating a therapeutic ward environment; the physical safety of the in-patient unit itself; safe transition from ward to community, pre- and post-discharge; early follow-up after in-patient discharge; and prompt access to crisis services.

3. Suicide by autistic people and those with ADHD

Diagnoses of autism spectrum disorder and ADHD are becoming a larger part of suicide prevention in mental health services, especially among young people. Clinicians may require specific training to recognise and support these patients. Awareness is needed of the high rates of suicide-related internet use prior to suicide among autistic people and drug misuse among patients with ADHD. Responding to self-harm and childhood trauma is crucial to both diagnostic groups.

4. Suicide by in-patients aged under 25

There has been recent concern over in-patient safety for young people. Services need to be aware that in-patients in this age group who die by suicide may have different clinical characteristics to adult in-patients, with proportionately more deaths on the ward and Mental Health Act detention, and with enhanced nursing observations being more frequent. Attention is needed to potential ligatures and ligature points used on the ward for this group, and to the importance of admission to local units where possible.

5. Suicide by young students

Promotion of a "whole university" approach to mental health is important to prevention, especially as high risk in students may be difficult to identify by conventional risk factors. Support should be enhanced at key times of risk, such as the start of the academic year and in the lead up to exams. There needs to be a clear pathway to NHS mental health services.

6. Suicide by patients with a one-off assessment

Care is needed when discharge is considered following a single assessment. In considering follow-up plans, clinicians should be aware of the potentially serious impact of recent adverse events such as financial difficulties and relationship break up. Alcohol and drug misuse add to risk and indicate a greater need for follow-up.

7. Suicide in public locations

The safety of the environment where mental health services are situated needs to be assessed. This should include how easy it is for patients to gain access to high risk locations such as the railway or parks and woodlands. Local suicide prevention plans should address this risk, reflecting joint working between clinical leaders and local authorities. Sensitive discouragement of personal memorials (e.g. floral tributes) and careful media reporting, including via social media, may contribute to prevention.

SCOPE OF THE REPORT

This report provides findings relating to people aged 10 and above who died by suicide in 2011-2021 across all UK countries.

The NCISH database includes a national case series of suicides by people who have been in contact with mental health services in the previous 12 months. The overall database now stands at over 166,000 suicides in the general population, including over 41,900 patients by this 12 month definition.

Complete details of the NCISH methodology are provided in our previous reports and on our website. In brief, we are notified by national mortality data providers of all deaths assigned a suicide or undetermined conclusion at coroner's inquest, or, for Scotland, deaths assigned an 'intentional self-harm' code on the basis of official sources. In 2021 the median time from the occurrence of a suicide to its registration was 180 days. We then determine which of these people had contact with mental health services in the year before they died, and request that the clinician responsible for their care complete our questionnaire.

In this report, findings are presented for the UK as a whole for suicide based on date of death. Our suicide figures therefore differ from official statistics from the Office for National Statistics (ONS) who present figures by date of death registration.

For the period 2011-2020, overall data completeness for patient suicide in the UK is 93%. Data completeness is lower in the final year reported, in this case 2021, at 67% (excluding Northern Ireland). This is, in part, because of the time associated with legal processes but also due to NCISH suspending data collection during the early months of the COVID-19 pandemic to support reducing burden and releasing capacity in clinical services. We therefore adjust estimates for the most recent years according to the number of unreturned questionnaires and the accuracy of the previous year's estimates. In Northern Ireland, we present actual figures but acknowledge these appear lower in more recent years and will be updated in future reports.

Information on some patient sub-groups may take longer to reach us - for example in-patient deaths can take up to four years to be registered. In these circumstances, we projected the figures in 2019-2021 using a more individualised approach, i.e. taking into account the proportion of all deaths in recent years in particular sub-groups. In analysing trends, the final year is not included because of these estimations.

Estimated numbers in the final year are presented as dotted lines in the figures. Changes in figures from previous annual reports occur as further information is received.

We have followed guidance from ONS on disclosure control to protect confidentiality within death statistics, and have omitted numbers less than three, including zero. The denominator in all estimates is the number of valid cases. All proportions are provided as valid percentages. We only report trends that are statistically significant.

Please note that in this report, "mental health diagnosis" relates to ICD-10 mental, behavioural, and neurodevelopment diagnoses provided by clinicians completing the questionnaire; this includes the diagnosis of autism spectrum disorder (referred to as "autism" hereon) and attention deficit hyperactivity disorder (ADHD). We have used the term "autistic people" rather than "people with autism" as guided by NHS-England, but we acknowledge that different terms can be used.

In this year's report we are not presenting findings on homicide or homicide-suicide as we have not received this data in 2020 and 2021 due to renewal of data-sharing agreements. We will therefore present this data in future reports.

Change to the standard of proof for suicide in England and Wales

In 2018 in England and Wales there was a change to the standard of proof for coroners to conclude whether a death was by suicide. This was lowered from 'beyond reasonable doubt' to 'the balance of probabilities' and has resulted in an increase in the number of certain deaths registered as suicide.

Changes to suicide death coding in Northern Ireland

The Northern Ireland Statistics and Research Agency (NISRA) and the Coroners' Service reviewed deaths registered between 2015 and 2020 which were originally recorded as 'undetermined intent' and reclassified some of these to 'accidental' deaths, click here for details. These deaths would therefore no longer fall within our suicide definition.

NISRA have implemented a Series Break in the Northern Ireland Suicide Statistics Series following the Review of Suicide Statistics in Northern Ireland. This means that figures for years prior to 2015 can be used to indicate trend but are not directly comparable to figures from 2015 onwards.

UK-WIDE FINDINGS

SUICIDE IN THE UK

Between 2011 and 2021, NCISH was notified of 69,420 deaths in the general population that were registered as suicide or "undetermined", an average of 6,311 per year. These are referred to as suicides throughout the report.

Rates in the UK increased in 2018-2019 following the lowering of the standard of proof for suicide but fell overall in 2020 and 2021 (Figure 1). Suicide rates for each UK country are shown in Figure 2, presented by date of death. Rates in England, Scotland and Wales have followed a similar pattern, with higher rates from 2017-2018 and then a plateau. Figures in 2021 indicate a possible fall, but this is unconfirmed at this stage. Lower recent rates from 2015 in Northern Ireland will reflect a change in how some deaths are classified. As a result, rates in Scotland are currently the highest among UK countries.

In all countries except Northern Ireland the rates were highest in middle-aged groups, especially 40-44 and 45-49 year age groups (Figure 3). The biggest differences between UK rates were in the younger age groups, with higher rates in Northern Ireland and Scotland. In those aged 80 and above, rates were higher in England and Wales.

There were 7,313 suicides by people aged under 25, an average of 665 deaths per year. 1,208 were aged under 18, an average of 110 deaths per year. The number of deaths by people aged under 25 increased in 2017-2019 and has fallen in 2020 and 2021.

Figure 1: Suicide rates in the general population in the UK, by sex

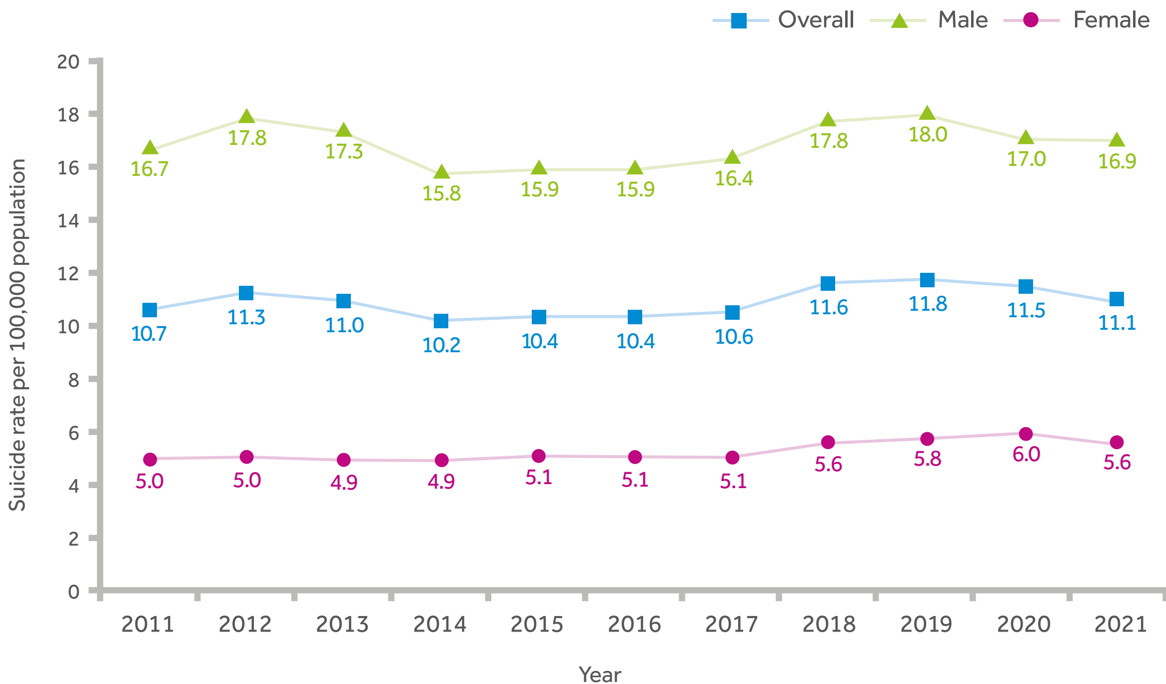
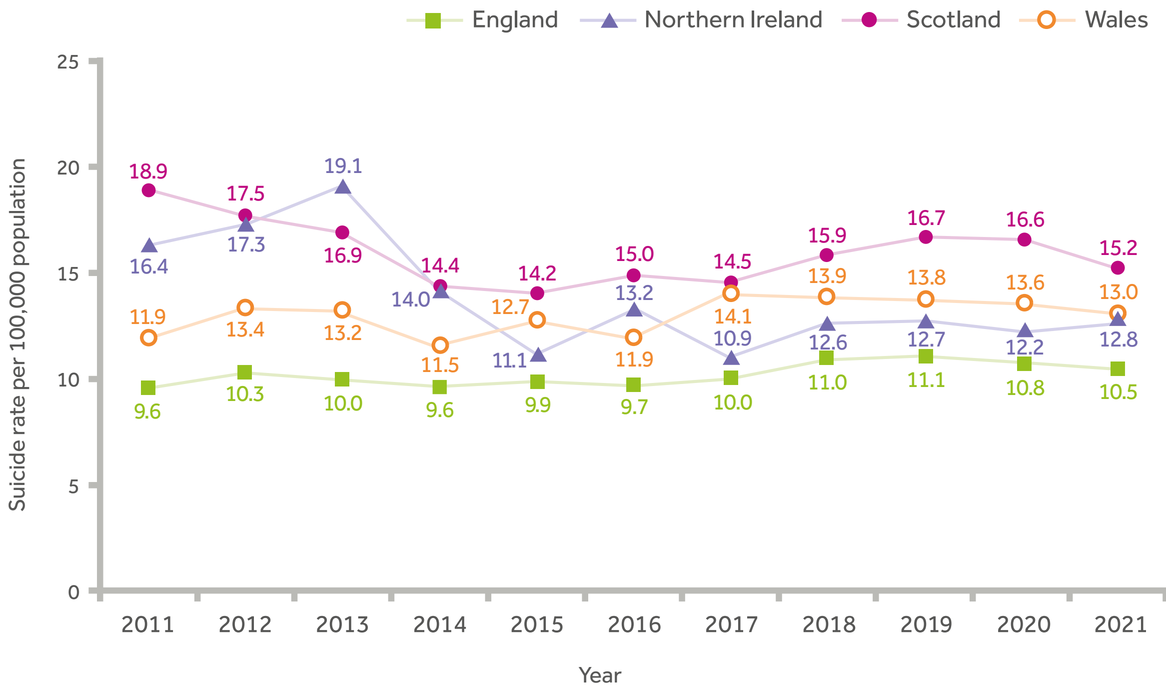
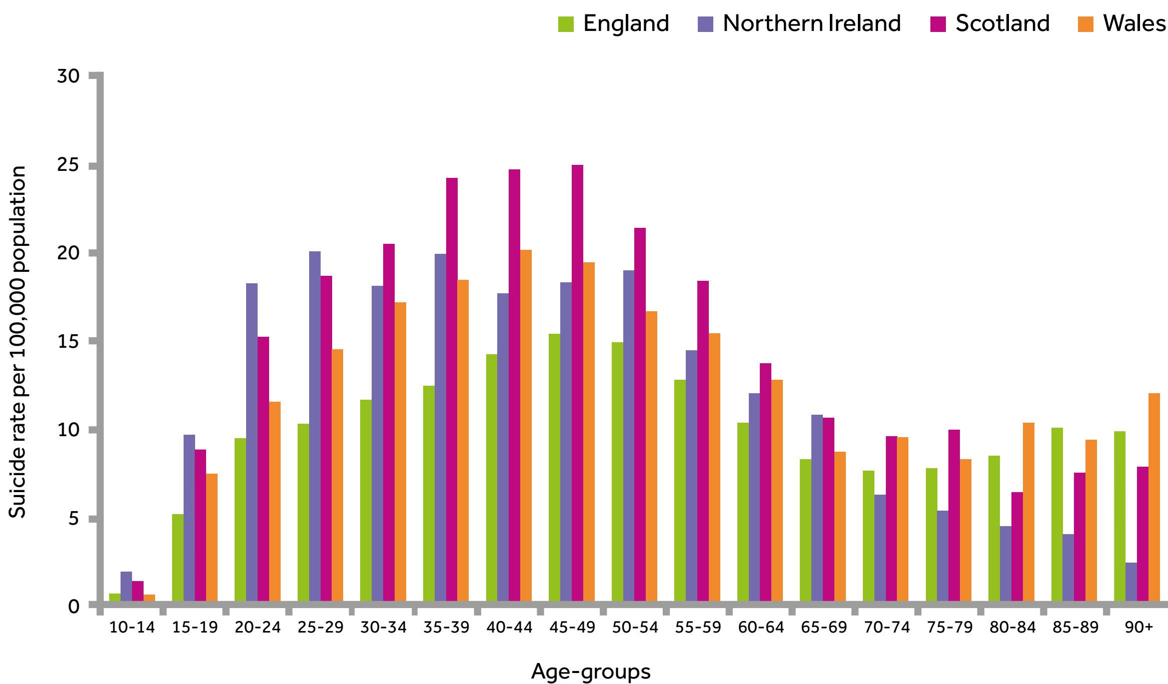


Figure 2: Suicide rates by year of death in the general population, by UK country



Note: The rates in 2015-2020 in Northern Ireland indicate the current guidance from Northern Ireland Statistics and Research Agency (NISRA) to include only registered deaths resulting from self-inflicted injury (see details on page 9).

Figure 3: Suicide rates in the general population by age-group, by UK country (2011-2021)



Method of suicide in the general population

There was a rise in the number of deaths by hanging/strangulation and, to a smaller extent, self-poisoning in 2018-2021 following the change to the standard of proof for suicide (see details on page 9), but no change in deaths by jumping/multiple injuries (Figure 4). Deaths by hanging/strangulation have increased almost every year since 2011, and the increase was seen in men and women, and in all age-groups, i.e. those aged under 25, 25-44, 45-64, and 65 and over. We were notified of the substances taken in 68% of deaths by self-poisoning, the most common being opioids (including opiates and paracetamol/opiate compounds) (n=3,515, 40%), paracetamol (716, 8%) and tricyclic antidepressants (579, 7%).

Of the less common methods, deaths from gas inhalation have fallen by 40% between 2015 and 2020 but increased in 2021, while deaths from cutting/stabbing have increased by 40% in 2011-2020 and continued to rise in 2021 (Figure 5). Firearms remain a minor method, constituting less than 2% of all deaths, with a fall over the report period.

Figure 4: Suicide in the general population in the UK: main suicide methods

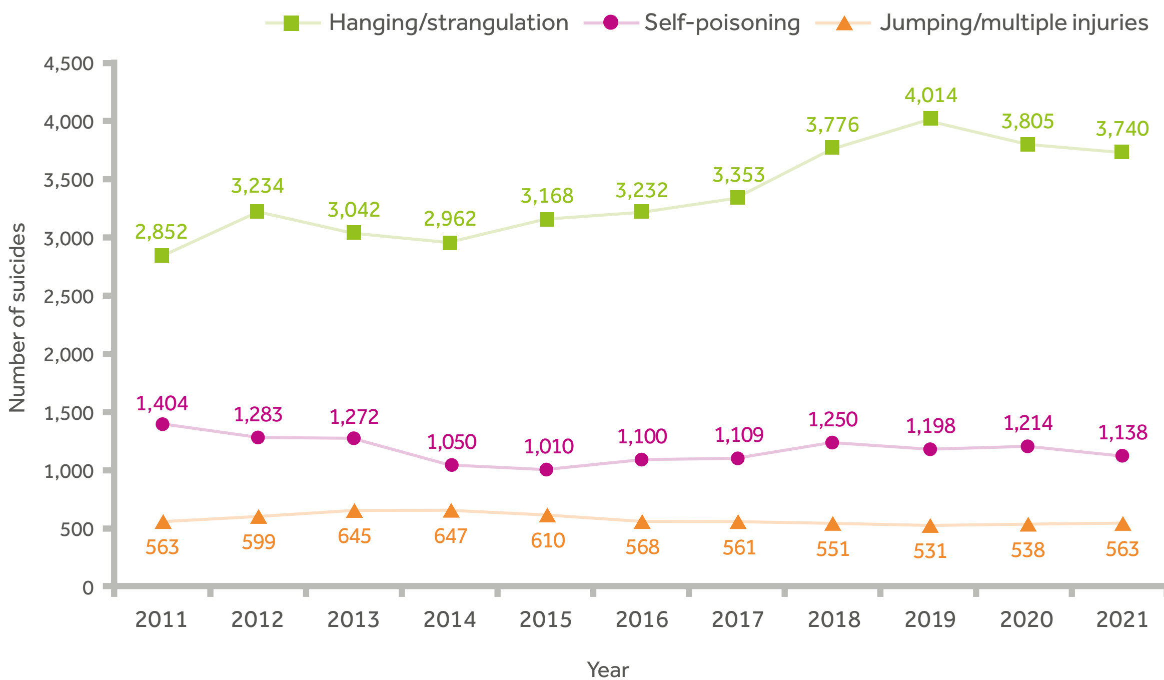
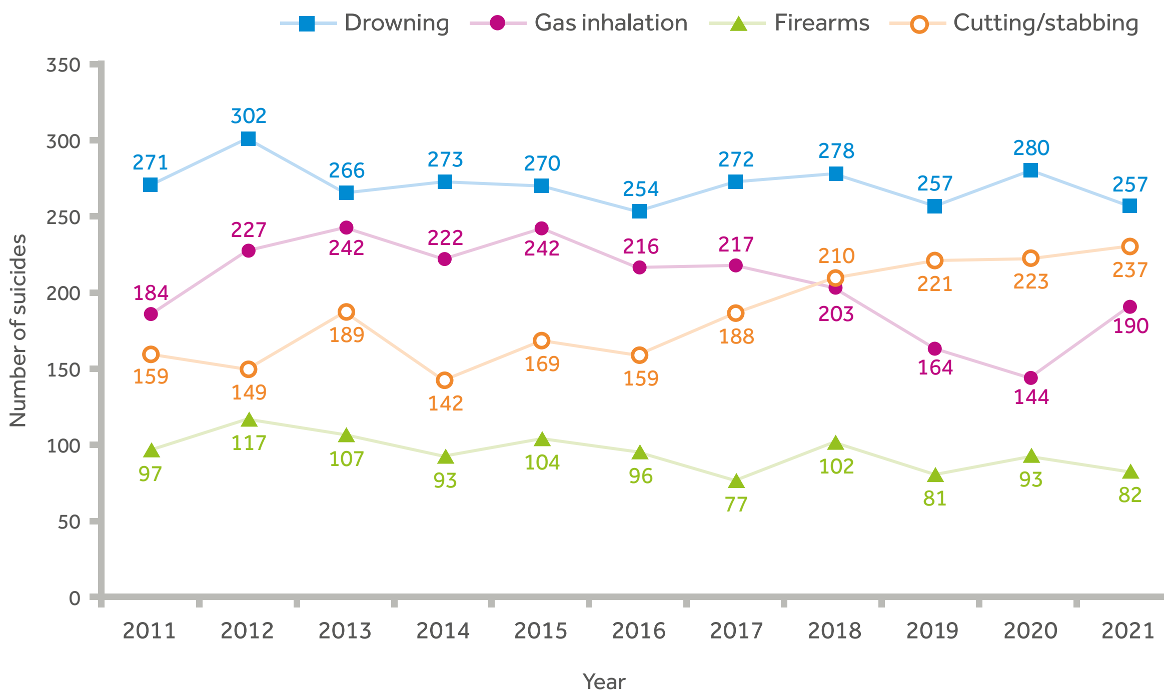


Figure 5: Suicide in the general population in the UK: other suicide methods



PATIENT SUICIDE IN THE UK

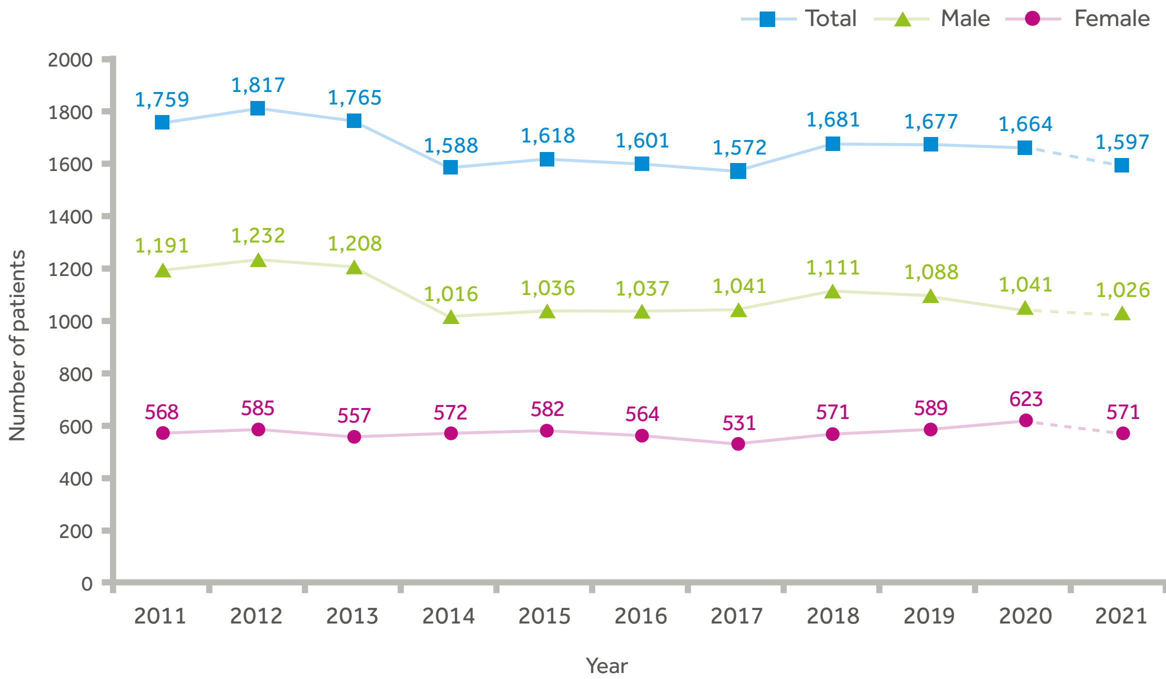
There were 18,339 suicide deaths by patients (i.e. people in contact with mental health services within 12 months of suicide) in the UK in 2011-2021, 26% of all general population suicides, an average of 1,667 deaths per year. This figure was slightly higher in Scotland (31%) and lower in Wales (22%) (see additional online data). There was an increase in the number of patient suicides in 2018-2019, particularly among female patients, but we are estimating a fall in 2020 and 2021 (Figure 6).

Following the onset of the COVID-19 pandemic in 2020, we have not seen an increase in 2020 and 2021 overall or in groups of concern such as those aged under 25 or those aged 75 and over. However, the number of female suicides increased in 2020, driven by an increase in the number of suicides by hanging/strangulation.

The number in England increased in 2018 and has been stable since, with a possible decrease in 2020 and 2021 (Figure 7). The number in Scotland has remained lower in 2014-2019 compared to figures in 2011-2013, although may have increased in 2020 and 2021.

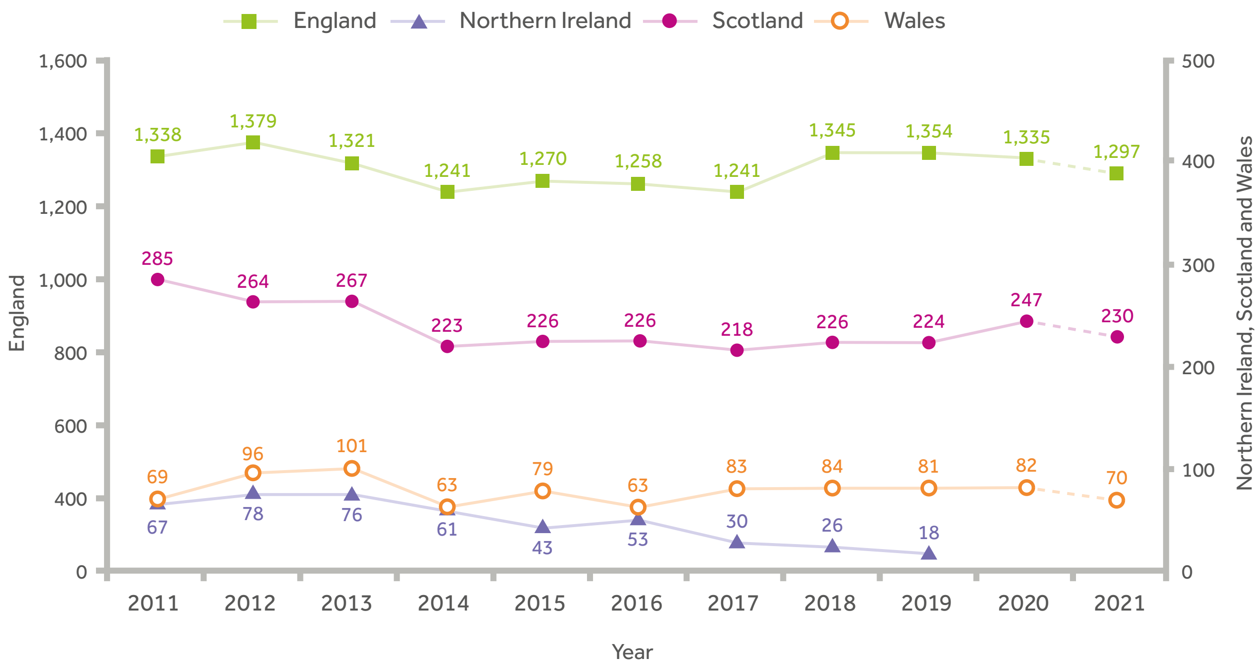
Rates of patient suicide (England only), taking into account the rising number of patients under mental health care, show a fall over the report period, from 87.6 per 100,000 mental health service users in 2011 to 41.3 per 100,000 in 2021, although the most recent figures show little change (Figure 8). The Mental Health Services Data Set (MHSDS) was used to calculate rates. Changes in MHSDS methodology means rates in 2011 and 2012-2021 are not directly comparable.

Figure 6: Patient suicide: numbers by sex in the UK



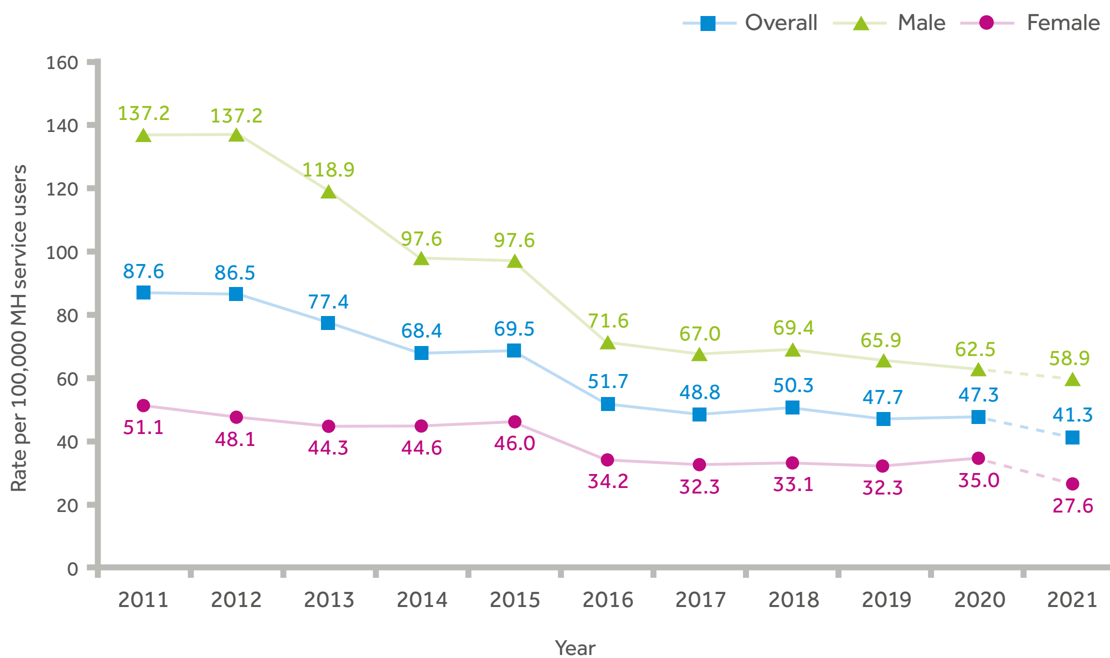
Notes: Patient data unavailable in Northern Ireland in 2020 and 2021.
Male and female numbers in 2018 do not total the overall figure due to rounding.

Figure 7: Patient suicide: numbers by year in each country of the UK



Note: Patient data unavailable in Northern Ireland in 2020 and 2021.
Figures in Northern Ireland also appear lower in more recent years but will be updated in future reports.

Figure 8: Rates of suicide per 100,000 mental health service users† in England



† The Mental Health Services Data Set (MHSDS) was used to calculate rates.
Changes in MHSDS methodology means rates in 2011 and 2012-2021 are not directly comparable.

Method of suicide by patients

The most common methods of suicide are shown in Figure 9. Hanging/strangulation increased by 13% during 2011-2021, especially after 2018 (Figure 10). The increase was especially seen in women, from an average of 36% of all female deaths in 2011-2014 to 44% in 2018-2021, and in patients aged under 25, from an average of 53% in 2011-2014 to 61% in 2018-2021. The number of deaths by jumping/multiple injuries has fallen by 31% in 2013-2020 but we are estimating an increase in 2021.

The number of self-poisoning deaths has risen by 22% between 2015 and 2020, although we are estimating a fall in 2021 (Figure 10). Opiates (including opioid compounds) accounted for 34% (n=1,259) of deaths by self-poisoning, although the number of deaths using opiates and opioids fell by 52% between 2011 and 2021. There was a 25% fall in the number of self-poisonings using paracetamol between 2011-2014 and 2018-2021. The number of deaths by psychotropic drugs fell by 51% between 2011 and 2021.

We have collected data on the types of opiates used since 2012, the most common being heroin/morphine (n=279, 38%), codeine (145, 20%), tramadol (114, 16%) and methadone (97, 13%). Information on the source of the opiates/opioids was available in 44% of those who died using these substances. In 238 (53%, excluding unknowns) these had been prescribed for the patient, an average of 24 deaths per year.

UK country differences: Northern Ireland (58%) and Wales (53%) had a higher proportion of suicide by hanging/strangulation compared to the UK average (48%).

The proportion of deaths by self-poisoning was higher in Scotland than other UK countries (32% v. 22%), with more patients using opiates and opioids (48% v. 30%), particularly methadone (18% v. 11%).

See additional online data for further details.

Figure 9: Patient suicide in the UK: suicide methods

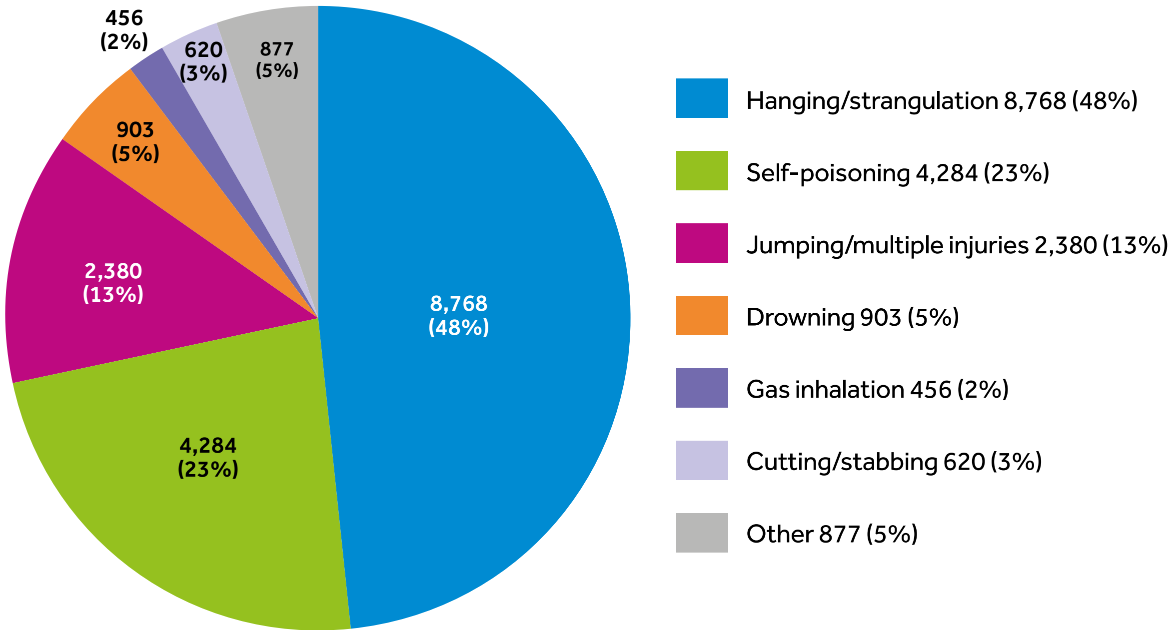
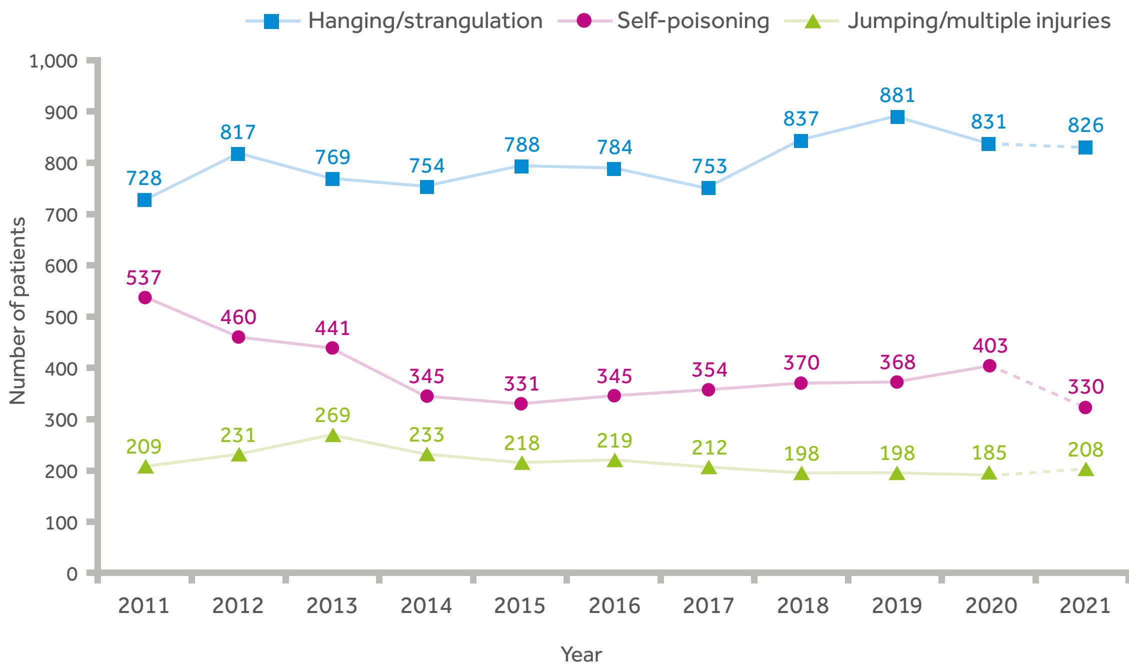


Figure 10: Patient suicide in the UK: main suicide methods



Note: Patient data unavailable in Northern Ireland in 2020 and 2021.

Social and clinical characteristics

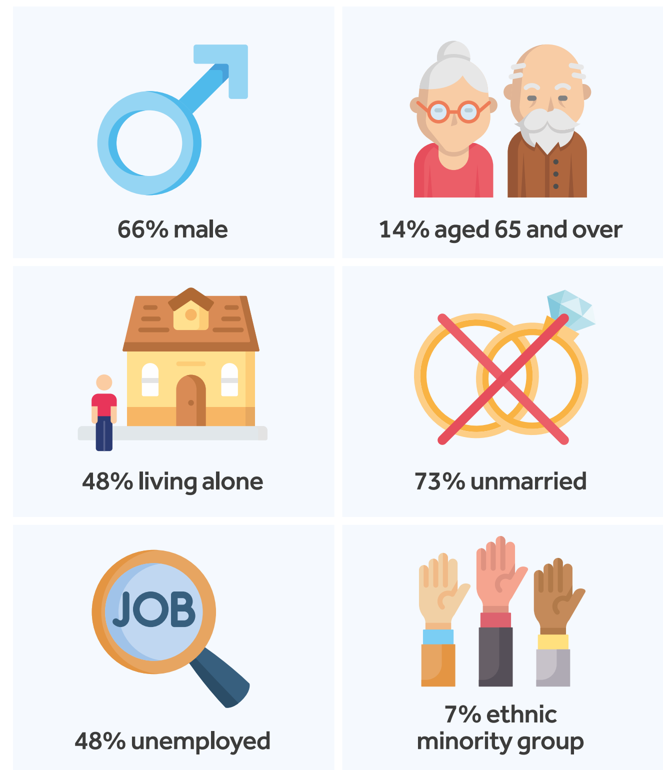
Box 1 shows some of the social features of patients dying by suicide in the UK. These patients had high rates of socio-economic adversity and isolation, indicated by unemployment and living alone. The majority (n=12,027, 66%) were male patients and 73% were unmarried. 1,552 (9%) were aged under 25 and 237 (1%) were aged under 18; 14% were aged 65 and above. In 2016-2021, 305 (5%) of all patients were known to identify as lesbian, gay or bisexual and 53 (1%) were within a trans (including, transsexual, non-binary) group.

There were 89 (2%) women who were either pregnant at the time of the suicide or died within a year of childbirth – further details on maternal deaths can be found in a recent report from the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE).

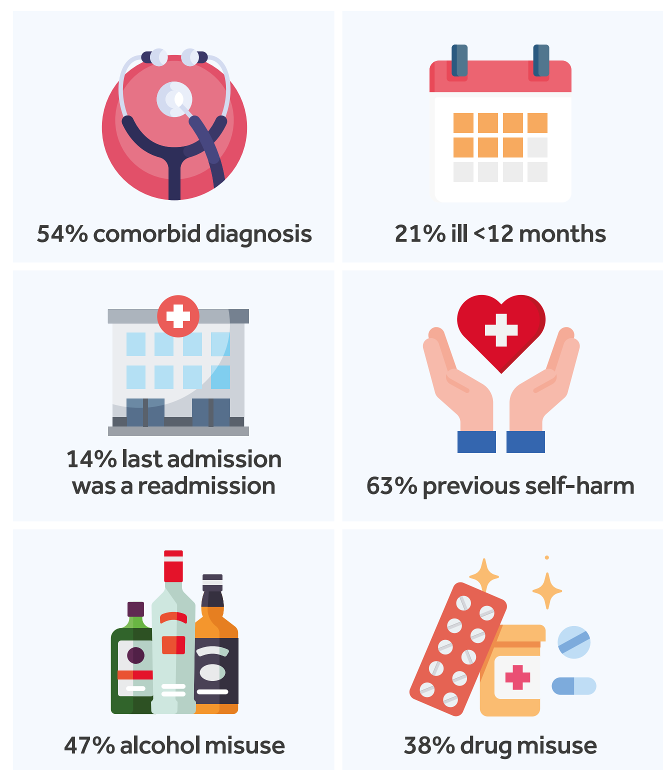
There were an estimated 842 suicides by patients who were migrants to the UK (either seeking permission to stay in the UK or resident in the UK for less than 5 years), 5% of all patients, an average of 77 deaths per year. The number has fallen by 17% over this period, from an average of 90 per year in 2011-2014 to 75 per year in 2018-2021. We have published a detailed study of suicide by migrants to the UK, which can be accessed at our website.

Around half had a comorbid (i.e. additional) mental health diagnosis, and rates of previous self-harm and alcohol misuse were high (Box 2). The proportion of patients with a history of self-harm decreased by 13% between 2011 and 2021. There was a 19% increase in the proportion of patients with a comorbid diagnosis, indicating increasing clinical complexity.

Box 1: Socio-demographic characteristics of patients who died by suicide in the UK (2011-2021)



Box 2: Clinical and behavioural characteristics of patients who died by suicide in the UK (2011-2021)

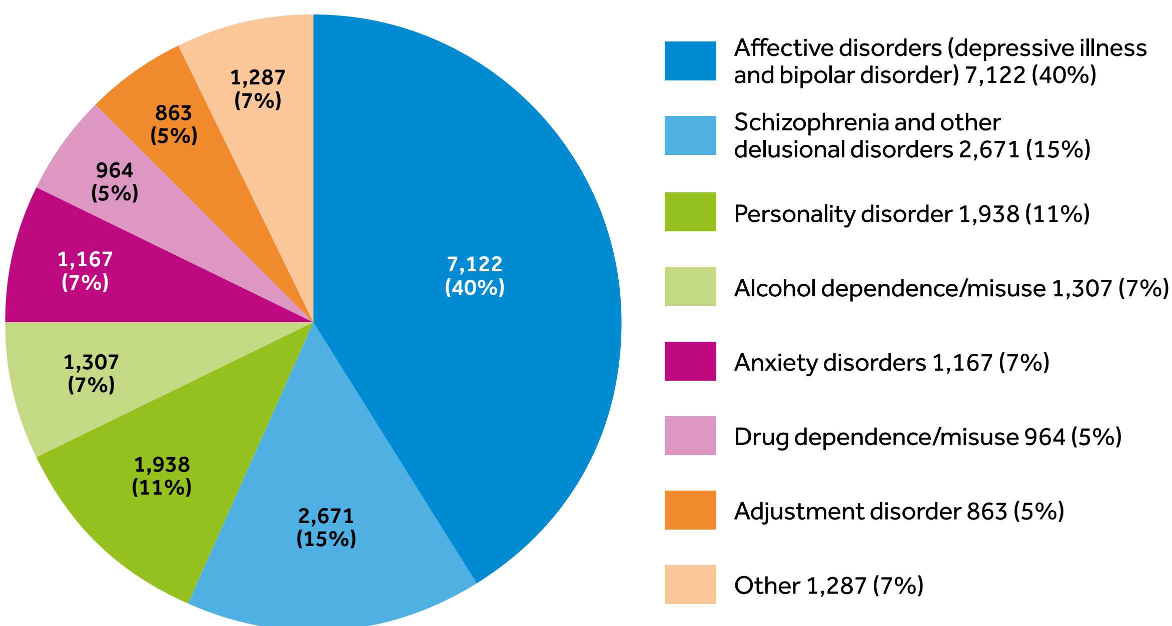


Diagnosis

The main primary mental health diagnoses are shown in Figures 11 and 12. Suicide by patients with affective disorder (including bipolar disorder (n=1,473, 8%) and depression (5,646, 32%)) has generally been falling since 2012, with an average of 647 deaths per year during the report period (Figure 12). The number of patients with bipolar disorder has increased in 2019-2021 following a fall in 2015-2018. A similar proportion of patients with bipolar disorder died by self-poisoning compared to other patients (25% v. 23%) but the substances used were more likely to be psychotropic drugs (44% v. 29%). In 7% the substance taken was lithium/mood stabilisers, more than other patients (1%).

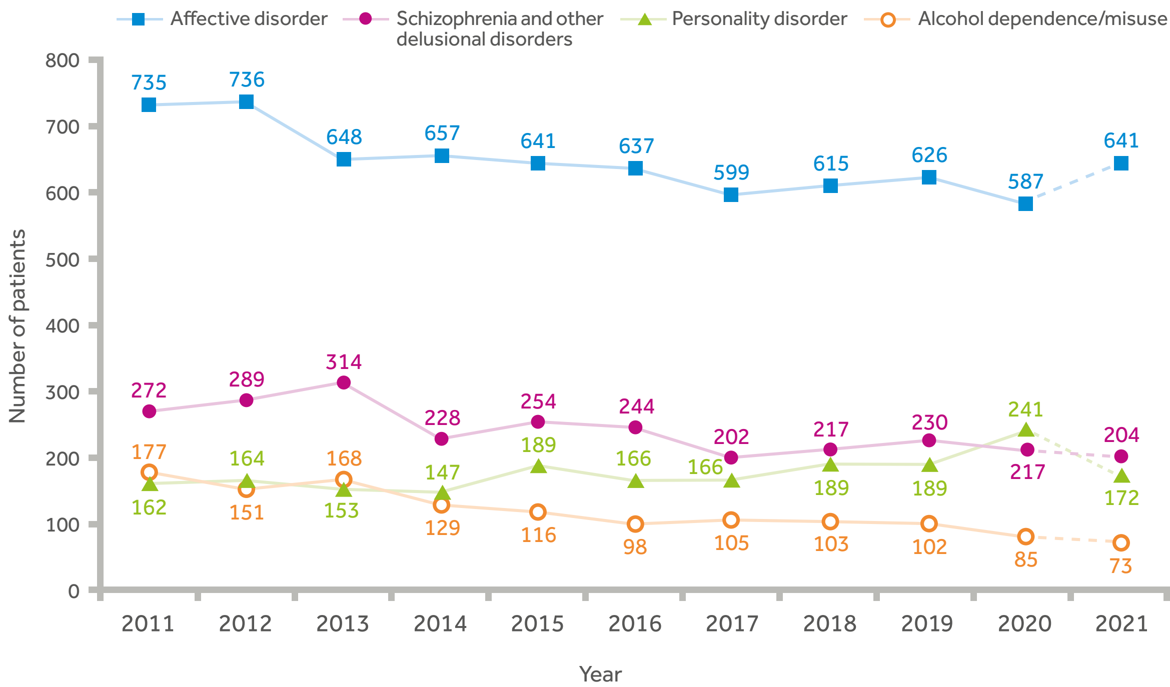
In patients with schizophrenia and other delusional disorders, the number in 2019-2021 has continued to be lower than in earlier years of the report when there was a peak in 2013, with an average of 243 per year over the whole report period. In patients given a diagnosis of personality disorder, the number increased in 2018-2021, continuing a rise since 2014, with an average of 176 per year. The number of patients with alcohol dependence/misuse fell after 2011, with an average of 119 per year during the report period. Similarly, the number of patients with drug dependence/misuse has remained lower since 2013, with an average of 88 per year. The number of patients with anxiety disorders rose by 90% between 2011 and 2021, with an average of 106 per year.

Figure 11: Patient suicide in the UK: primary diagnoses



*"other" diagnoses include eating disorders, learning disability, conduct disorder, autism spectrum disorder, somatisation disorder, ADHD, organic disorder, drug induced psychosis, dementia and other specified.

Figure 12: Patient suicide in the UK: most common primary diagnoses



Note: Patient data unavailable in Northern Ireland in 2020 and 2021.

UK country differences: More patients in England (42%) and Wales (38%) had affective disorder (depressive illness and bipolar disorder) compared to Northern Ireland (32%) and Scotland (30%).

Schizophrenia and other delusional disorders were more common in England (16%) compared to Northern Ireland (12%) and Scotland (13%).

Alcohol and drug dependence/misuse were more common in patients in Northern Ireland (19% and 9% respectively) and Scotland (13% and 12%) compared to England (6% and 4%) and Wales (8% and 7%).

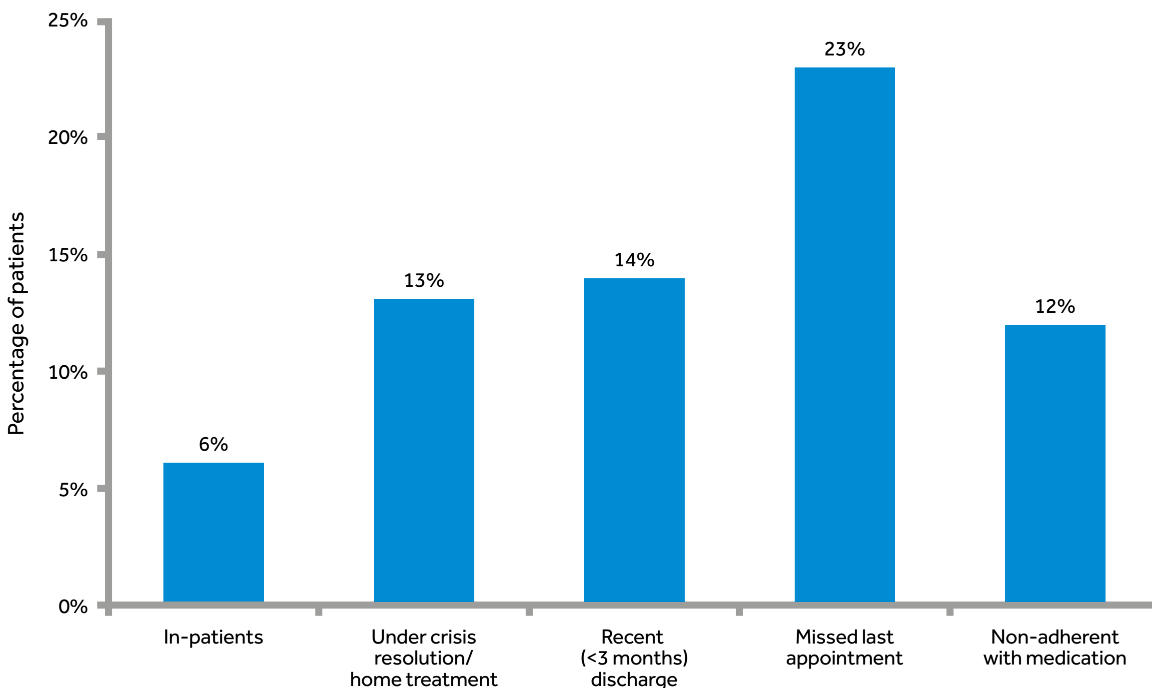
See additional online data for further details.

MENTAL HEALTH CARE

During 2011-2021, 4,767 patients (28%) who died by suicide were in acute care settings (in-patients, under crisis resolution/home treatment, recently discharged from in-patient care), an average of 433 per year (Figure 13). The proportion under acute care has fallen in 2018-2021 (25%) compared to 2011-2014 (30%).

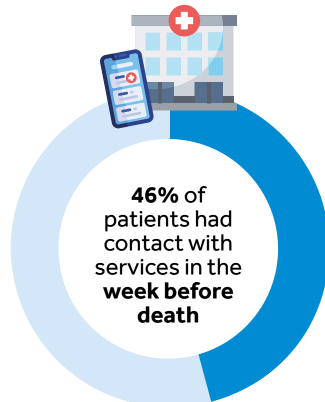
The most common non-acute settings reported were community mental health services (14%), alcohol or drug services (13%), and older person's mental health services in the community (8%). Around a quarter (n=3,628, 23%) had missed their last appointment with services and 1,898 (12%) had not taken medication as prescribed. Nearly half of all patients (7,873, 46%) had been in recent (<7 days) contact with mental health services.

Figure 13: Service characteristics of patients who died by suicide in the UK



Note: these categories are not mutually exclusive

The immediate risk of suicide at the time of final service contact was judged by clinicians to be low or not present for the majority (82%) of patients who died by suicide. In our report "The assessment of clinical risk in mental health services" we recommended that management of risk should be personalised and that risk assessment tools should not focus on predicting suicidal behaviour.



UK country differences: There were fewer patients in Scotland (7%) and Northern Ireland (9%) receiving care under crisis resolution/home treatment services compared to England (15%) and Wales (10%).

More patients in Northern Ireland (36%) and Scotland (27%) had missed their last contact with services compared to England (22%) and Wales (22%).

See additional online data for further details.

In-patient suicide

There were 1,052 in-patient deaths by suicide in 2011-2021, representing 6% of patient suicides overall during this time period, but with a lower figure since 2016 (5% in 2021). Twenty (2%) were aged under 18. From 2011 to 2021, there was a 42% fall in the number of in-patient suicides, although figures in 2018-2021 have not fallen (Figure 14). Information on in-patient deaths often takes longer to reach us – up to 4 years. We have therefore estimated the overall figures in 2019-2021 using the average proportion of all patient suicides that were in-patients in recent years and adjusting for expected questionnaire returns.

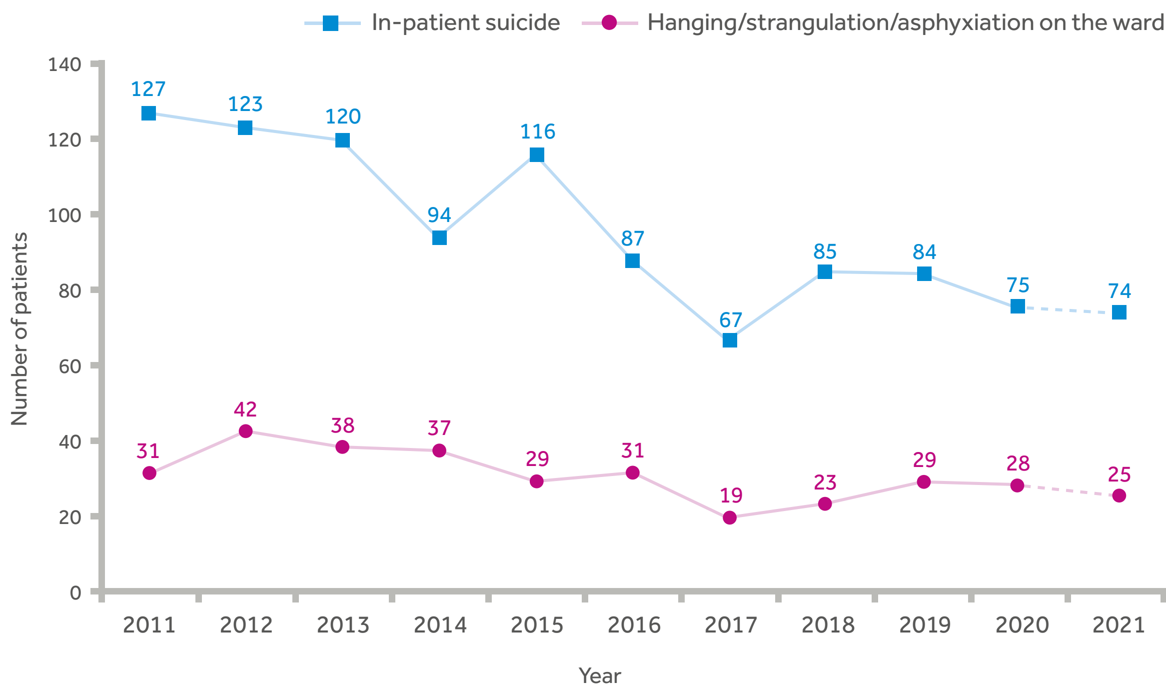
In-patient suicide numbers may be affected by changes in the number of admissions. Nonetheless, we found rates of in-patient suicide per 10,000 admissions still fell by 33% in 2011-2021 (Figure 15). Our figures since 2015 appear to be lower, although at this stage this includes a degree of estimation and so should be treated with caution. We have recently published a more detailed study of in-patient suicide rates in England, which can be accessed at our website.

Over a third (n=342, 38%) died on the ward, 51% were off the ward on agreed leave, and 11% had left the ward without staff agreement or left with agreement but failed to return.

Of the 342 patients who died on the ward, 37 (11%) were by asphyxiation and 272 (80%) were by hanging/strangulation, i.e. by using a ligature; 207 (92% excluding unknowns) appear to have used a low-lying ligature point and in 18 (8%) there was no ligature point. Between 2011 and 2015 there were on average 35 such deaths per year but since 2016 the number has fallen to an average of 23 deaths per year (Figure 14). The most common ligature points were doors (116, 51%) or windows (18, 8%).

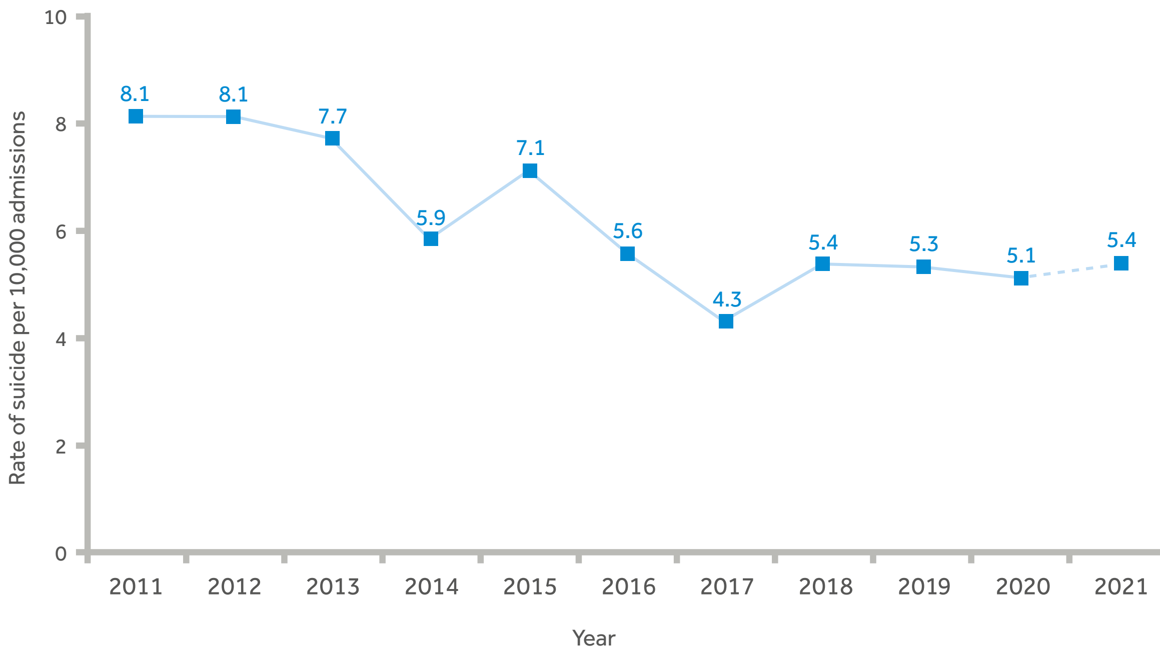
The most common ligatures were a belt (78, 32%), sheets/towels (60, 25%) or shoe laces (25, 10%). Overall, 167 (64%) patients used a ligature relating to an item of clothing or a personal object (e.g. clothing, belt, shoe laces, bag strap, etc). The majority died in a single bedroom (189, 64%) or a toilet/bathroom (87, 29%).

Figure 14: Patient suicide in the UK: number of mental health in-patients; number who died by hanging/strangulation/asphyxiation on the ward



Note: Patient data unavailable in Northern Ireland in 2020 and 2021.

Figure 15: Patient suicide in the UK: rate of in-patient suicide per 10,000 admissions

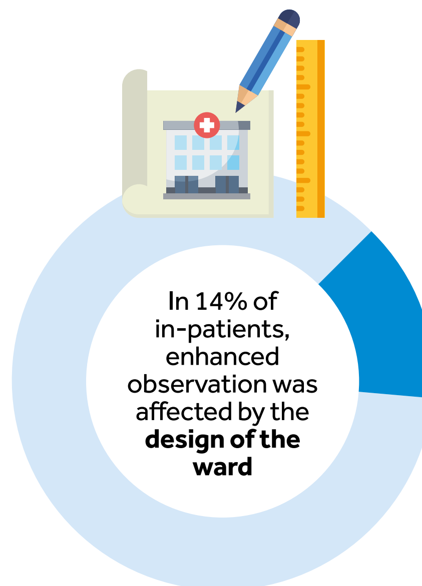


Note: Patient data unavailable in Northern Ireland in 2020 and 2021.

In-patients under enhanced nursing observation

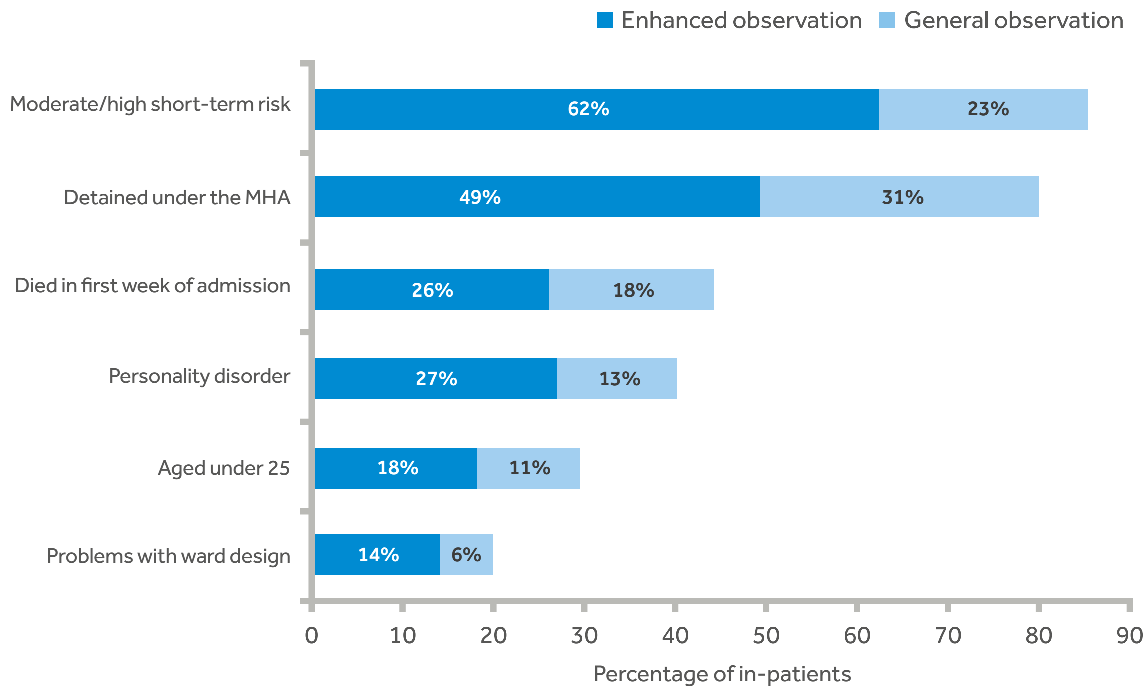
There were 166 patients who were under enhanced nursing observation*, 28% of in-patient suicides, an average of 15 deaths per year. Nine (5%) were aged under 18. From 2011 to 2021, there was a 40% fall in the number of in-patients under enhanced observation, in line with the fall in overall in-patient suicides.

Figure 16 shows the key differences between in-patients under enhanced observation and other in-patients. Those under enhanced observation were more likely to be aged under 25 and to have been given a diagnosis of personality disorder. More were detained under Mental Health Act powers and a quarter died in the first week of admission. In 20 (14%) there were problems in observation due to ward design, and in 2015-2021, there were problems in observation of 10 (18%) patients due to staff problems. Short-term risk was viewed as moderate or high in most (62%) patients under enhanced observation.



*enhanced nursing observations are those beyond general or routine observations, including frequent (i.e. every 15-30 minutes) checks on a patient or being with them constantly.

Figure 16: In-patient suicide in the UK: characteristics of those under enhanced observation



Note: MHA = Mental health Act

UK country differences: There were fewer in-patient suicides in Northern Ireland (3%) compared to the rest of the UK (6%).

In Scotland there were more in-patients who died in the first week of admission (24% v. 13%) or who died off the ward without staff agreement (34% v. 15%) compared to the rest of the UK.

See additional online data for further details.

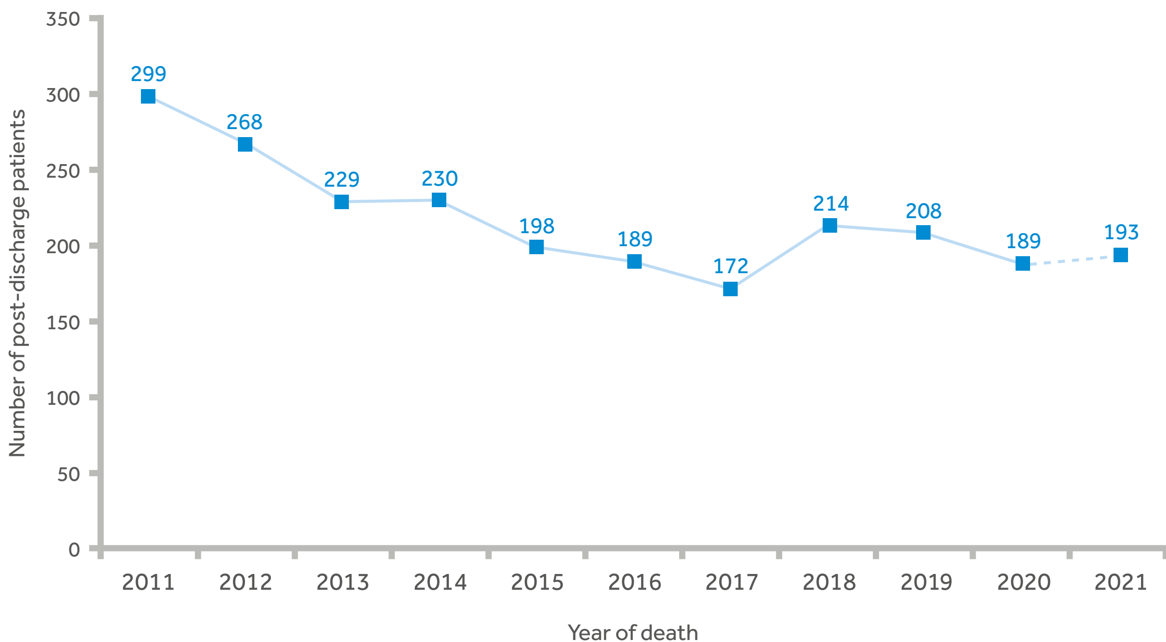
Patients under a Community/Compulsory Treatment Order (CTO)

There were 246 patients who died by suicide having been subject to a CTO in 2011-2021, 1% of all patient suicides, an average of 22 per year. Around a third (n=82, 34%) were no longer under the CTO at the time of suicide. We have published a study of suicide by patients under CTO, which can be accessed at our website.

Patients recently discharged from hospital

There were 2,389 suicides within 3 months of discharge from in-patient care, 14% of all patient suicides, an average of 217 deaths per year. Fourteen (1%) were aged under 18. The number of suicides by patients within 3 months of discharge has not changed in recent years but has fallen over the report period - the average for 2011-2015 being 245, and for 2017-2021 being 195 (Figure 17). The average rate of suicide was 14.5 per 10,000 discharges, and fell from 16.0 in 2011-2015 to 13.3 in 2017-2021.

Figure 17: Patient suicide in the UK: number who died within 3 months of in-patient discharge



Note: Patient data unavailable in Northern Ireland in 2020 and 2021.

The figures for 2019-2021 above contain a degree of estimation to take into account information on some patient groups that takes longer to reach us. The remaining figures in this section will present the actual figures.

Post-discharge suicides were most frequent in the first 1-2 weeks after leaving hospital when 608 deaths (29% excluding unknowns) occurred (Figure 18). Of the 325 deaths in the first week after discharge, the highest number (59, 18%) occurred on day 3 after leaving hospital (day 1 = day of discharge). However, over the report period, the day of highest risk has shifted to later in the week.

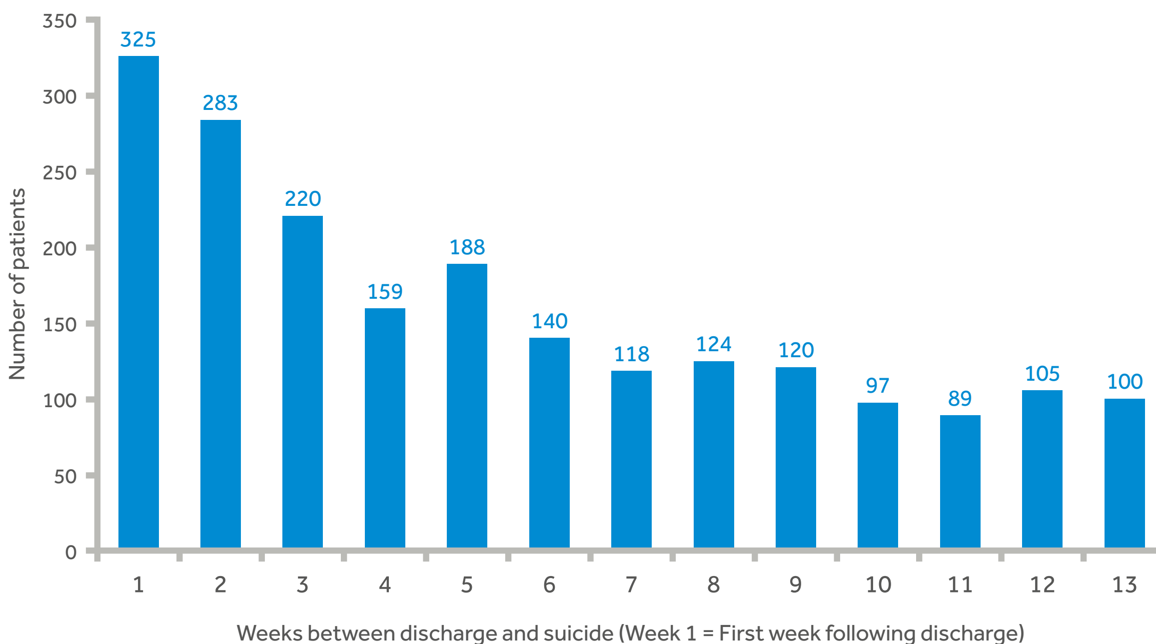
Over half (n=180, 58%) of those who died in the first week post-discharge had experienced recent adverse life events, with family problems (10%) more commonly reported than other post-discharge patients (6%). Our previous recommendation that all patients are followed up within 72 hours of discharge from in-patient care is now included in the Commissioning for Quality and Innovation (CQUIN) guidance and the standard NHS contract by NHS England.[1-2]

Since 2015 we have collected data on the circumstances the patient was discharged to. In 2015-2021, a quarter (25%) of patients who died within 3 months of discharge were known to have been discharged to housing, financial or employment problems, and 19% discharged to poor social support, more than other post-discharge patients (17% and 14% respectively).

231 (11%) of deaths post-discharge occurred before the first follow-up appointment. This proportion was higher for those who died within 2 weeks of discharge (26%). The number of patients who died before the first follow-up fell by 50% over the report period, from an average of 34 per year in 2011 and 2012 to 17 per year in 2020 and 2021. 176 (8%) patients had initiated their own discharge; those who died within a week of discharge were more likely to have self-discharged compared to other post-discharge patients (42, 13% v. 124, 7%).

213 (10%) died after being discharged from a non-local in-patient unit. In 2021 there were 19 (14%) suicides after discharge from a non-local unit.

Figure 18: Patient suicide in the UK: number per week following discharge (2011-2021)



UK country differences: More post-discharge suicides in Scotland (19%) died before the first follow-up appointment compared to the national average (11%).

[1] https://www.england.nhs.uk/publication/commissioning-for-quality-and-innovation-cquin-guidance-for-2019-2020/
[2] https://www.england.nhs.uk/nhs-standard-contract/22-23/

THEMES IN THIS REPORT

In this section we provide more detailed data on specific topics. Some of the patient groups below reflect those who may be vulnerable to high or increasing risk, including autistic people and those with attention deficit hyperactivity disorder, in-patients aged under 25, students aged 18-21, patients with a one-off assessment, and patients who died by suicide in public locations.

SUICIDE BY AUTISTIC PEOPLE AND THOSE WITH ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

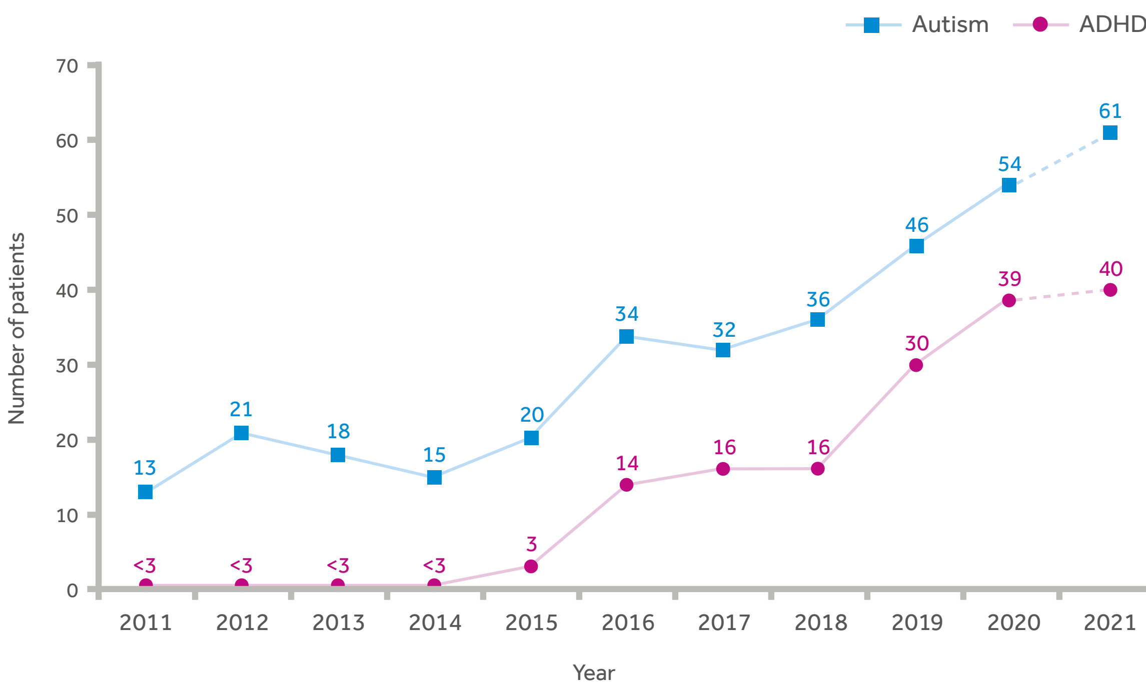
In the UK, there were 350 people who had received a primary or secondary diagnosis of autism spectrum disorder (ASD) (hereafter 'autism'), 2% of all patient suicides, an average of 32 deaths per year. There were 159 patients with ADHD, 1% of all patient suicides, an average of 15 deaths per year. 29 patients had been diagnosed with both autism and ADHD.

The number of autistic people who were patients and died by suicide has increased almost threefold, from an average of 17 per year in 2011-2014 to 49 per year in 2018-2021 (Figure 19).

The increase was seen in patients aged under 25 (including those aged under 18), and those aged 25-44 and 45-64. The number increased in both males and females.

The number of patients with ADHD has also increased from an average of 15 deaths per year in 2016-2018 to 36 per year in 2019-2021 (Figure 19) and increased in males and females and those aged under 25 and 25-44. These increases are likely a reflection of the increased clinical recognition and application of autism and ADHD diagnoses.

Figure 19: Patient suicide in the UK: number who received a diagnosis of autism and ADHD



Note: Data collection on ADHD began in 2016. Patient data unavailable in Northern Ireland in 2020 and 2021.

Autistic people

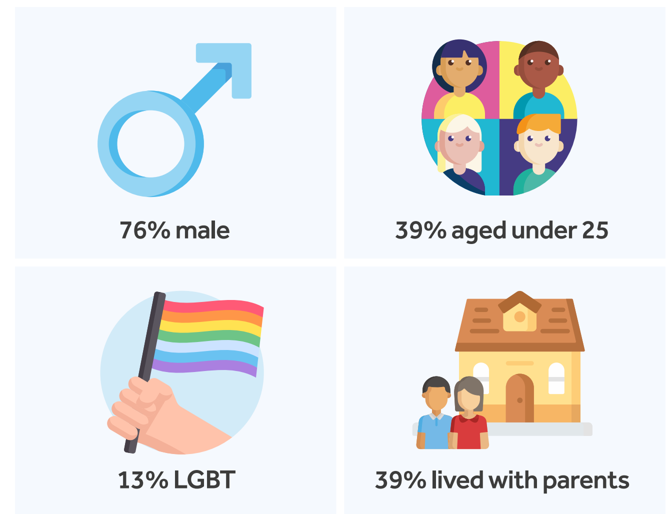
Compared to other patients (i.e. those without a diagnosis of autism or ADHD), autistic people (n=350) were more likely to be male and younger, with more aged under 25 (39% v. 8%) including aged under 18 (7% v. 1%) (Box 3; see additional online data for further details). They were more likely to identify as LGBT (13% v. 5%) and, with the exception of those aged 65 and above, more were unmarried (93% v. 72%) and living at home with their parent(s) (39% v. 12%).

More autistic people had experienced childhood abuse compared to other patients (37% v. 30%), including emotional (27% v. 16%) and physical (17% v. 9%) abuse. More had used the internet for suicide-related purposes, particularly obtaining information on suicide method (25, 16% v. 486, 6%), visiting "pro-suicide" websites (17, 11% v. 231, 3%) and communicating suicidal ideas (8, 8% v. 110, 3%).

They were more likely to be an in-patient at the time of death and to have been non-adherent with medication. Immediate and long-term risk of suicide was less likely to be viewed as low or not present among autistic people.

Self-harm was more common among autistic people (70% v. 63%) but they were less likely to have a history of alcohol misuse (31% v. 47%). Around a third (33%) had a history of drug misuse, similar to other patients (37%).

Box 3: Patient suicide: socio-demographic characteristics of autistic people in the UK (2011-2021)



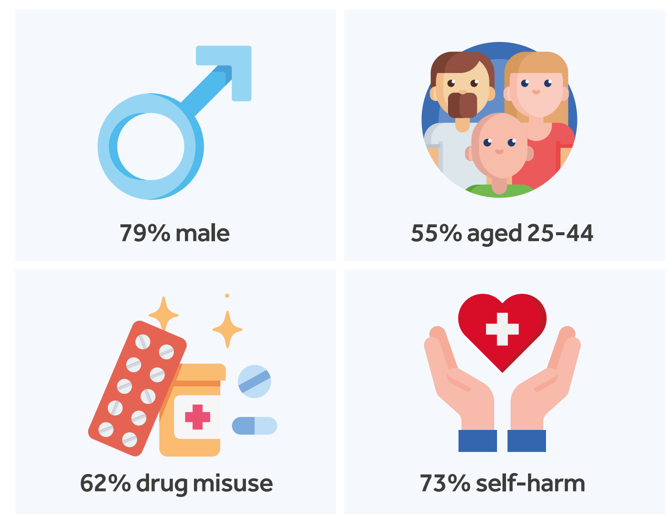
Patients with ADHD

Compared to other patients, those with ADHD (n=159) were more often male (79% v. 65%) and aged under 25 (31% v. 8%), including being aged under 18 (7% v. 1%), or aged 25-44 (55% v. 37%) (Box 4; see additional online data for further details). Over a quarter were living with their parents (29% v. 13%).

Nearly half (45% v. 30%) had experienced childhood abuse, including emotional (43% v. 16%), physical (33% v. 9%) and sexual (17% v. 9%) abuse.

Fewer patients with ADHD were under crisis resolution/ home treatment services (6% v. 14%). Long-term risk was more likely to be viewed as low or not present than other patients (70% v. 57%). They had a high proportion of previous self-harm (73% v. 63%) and the majority (62%) had a history of drug misuse compared to 37% of other patients. A similar proportion had a history of alcohol misuse (55% v. 47%).

Box 4: Patient suicide: characteristics of people with ADHD in the UK (2016-2021)

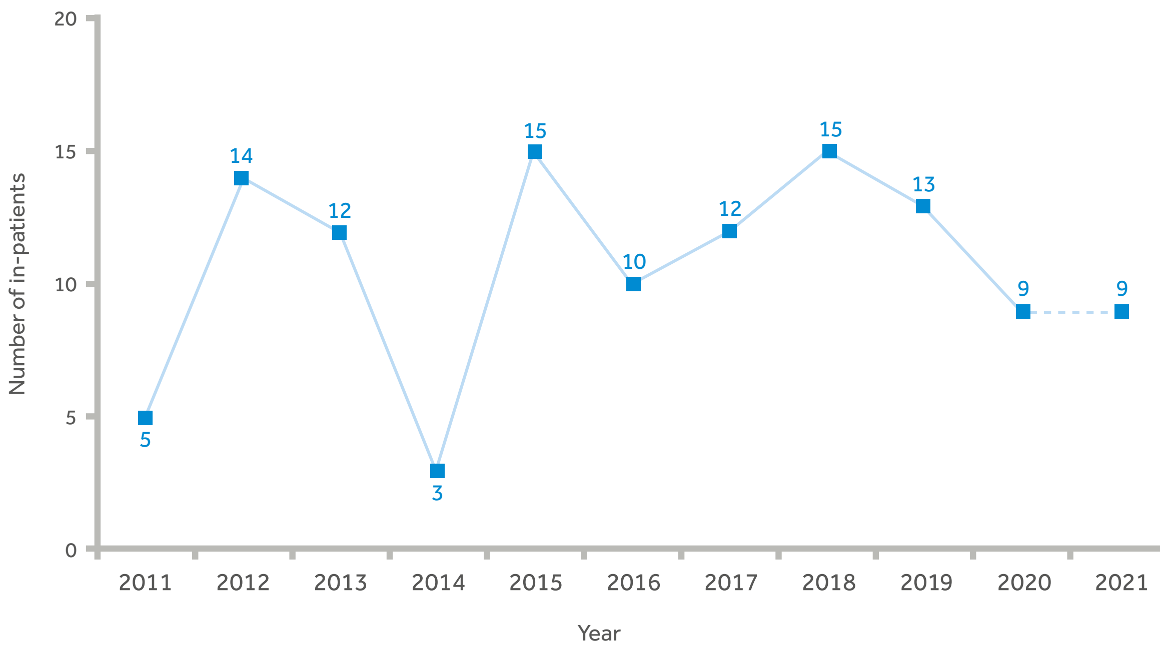


SUICIDE BY IN-PATIENTS AGED UNDER 25

In the UK in 2011-2021, there were an estimated 117 suicides in in-patients aged under 25, 7% of all patients aged under 25 who died by suicide, an average of 11 deaths per year.

Twenty were aged under 18, although the final figure is likely to be higher as some inquests relating to deaths of young people in the report period are yet to be held. The number of in-patients aged under 25 has fluctuated with no overall fall (Figure 20).

Figure 20: Patient suicide in the UK: number of in-patients aged under 25



Note: Patient data unavailable in Northern Ireland in 2020 and 2021.

The majority were female (n=66, 61%) and 12% were from an ethnic minority group. Most (59, 60%) were unemployed; overall they were more likely to be homeless than in-patients aged 25 and over (15, 14% v. 46, 5%) (Box 5).

In-patients aged under 25 were more likely to die by jumping/multiple injuries compared to patients in the community aged under 25 (26, 24% v. 235, 16%); a similar proportion died by hanging/strangulation (58% v. 59%).

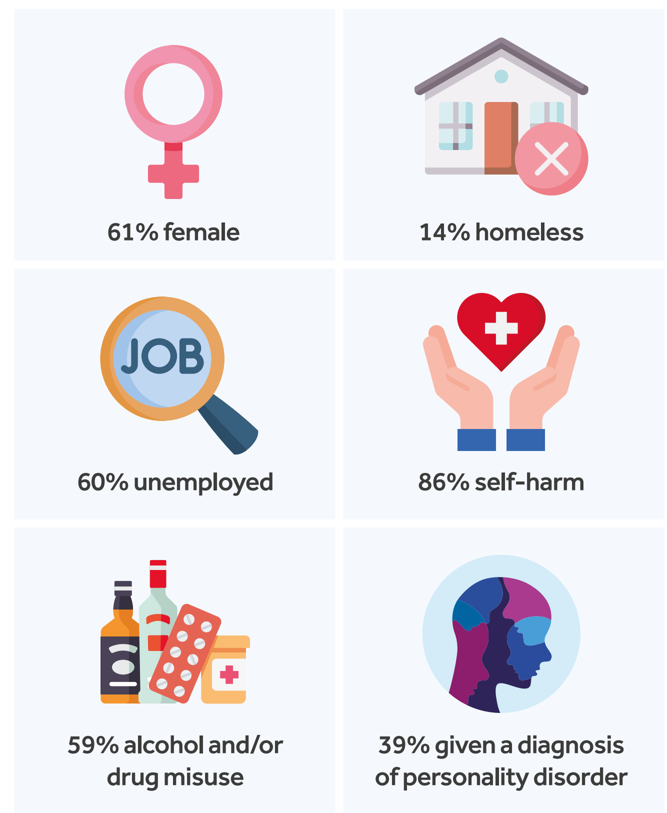
Of the 47 patients who died on the ward, 4 (9%) were by asphyxiation and 38 (81%) were by hanging/strangulation, i.e. by using a ligature; 22 (71% excluding unknowns) appear to have used a low-lying ligature point and in 8 (26%) there was no ligature point, more than in-patients aged 25 and over (10, 5%), although numbers were small.

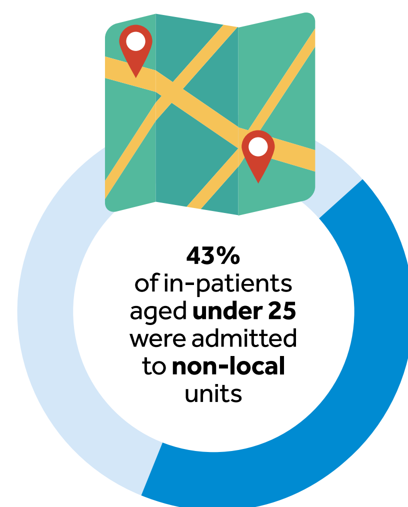
Compared to other in-patients, those aged under 25 were more likely to have been diagnosed with personality disorder (42, 39% v. 95, 11%) and less likely to have affective disorder (depressive illness and bipolar disorder; 17, 16% v. 365, 43%). More had a primary or secondary diagnosis of autism (13, 12% v. 21, 2%) and eating disorder (13, 12% v. 12, 1%). They had higher rates of previous self-harm (92, 86% v. 599, 72%) and alcohol and/or drug misuse (61, 59% v. 400, 48%), and were also more likely to have experienced childhood abuse (46, 49% v. 183, 27%).

Nearly half (n=47, 47%) died on the ward, 38 (38%) were on agreed leave and 15 (15%) were off the ward without staff agreement. Compared to other in-patients, those aged under 25 were less likely to have died in the first week of admission (8, 7% v. 130, 15%) but more likely to have been detained under Mental Health Act powers at the time of death (50, 48% v. 249, 30%). More were under enhanced nursing observation (30, 40% v. 136, 27%), especially female in-patients (24, 51% v. 55, 28%). 46 (43%) had died on a non-local in-patient unit, more than in-patients aged 25 and over (246, 30%).

Short-term risk was viewed as low or not present in 64% of in-patients aged under 25, similar to other in-patients (74%), but long-term risk was less likely to be viewed as low or not present in those aged under 25 (26% v. 41%).

Box 5: Characteristics of in-patients aged under 25 in the UK (2011-2021)





SUICIDE BY PATIENTS WHO WERE STUDENTS IN ENGLAND AND WALES

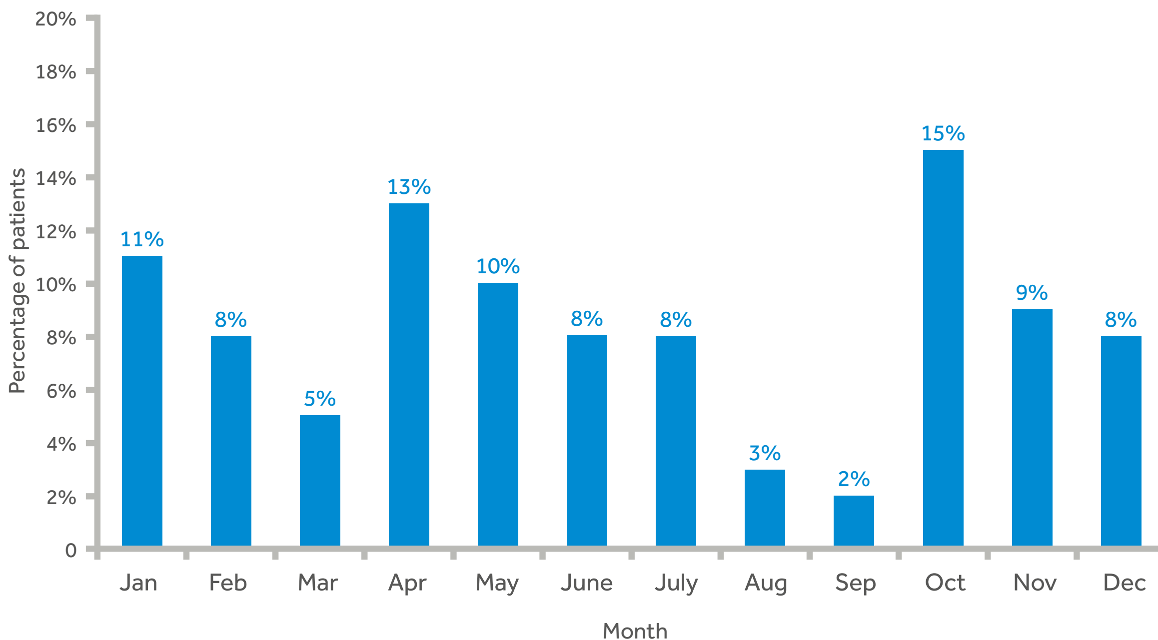
During 2011-2021 there were 869 deaths in England and Wales by those aged between 18-21 who were identified as students by ONS, an average of 79 suicides per year.

96 (11%) were mental health patients, lower than other young people in the general population who died by suicide (25%). This represented 1% of all patient suicides, an average of 9 deaths per year. There has been an increase in the number of deaths by students in contact with mental health services between 2011 and 2020, although we are estimating a fall in 2021.

The highest number of patient suicide deaths by students was in October (n=14, 15%) and April (12, 13%) and the lowest in August/September (5, 5%) (Figure 21). Suicide deaths were higher in October (15% v. 6%) and lower in August/September (5% v. 19%) compared to other patients aged 18-21.

Overall, hanging/strangulation (53, 59%) and jumping/multiple injuries (15, 17%) were the most common methods of suicide, similar to other 18-21 year olds (57% and 21% respectively).

Figure 21: Percentage of patient suicide deaths by students by month of death, England and Wales



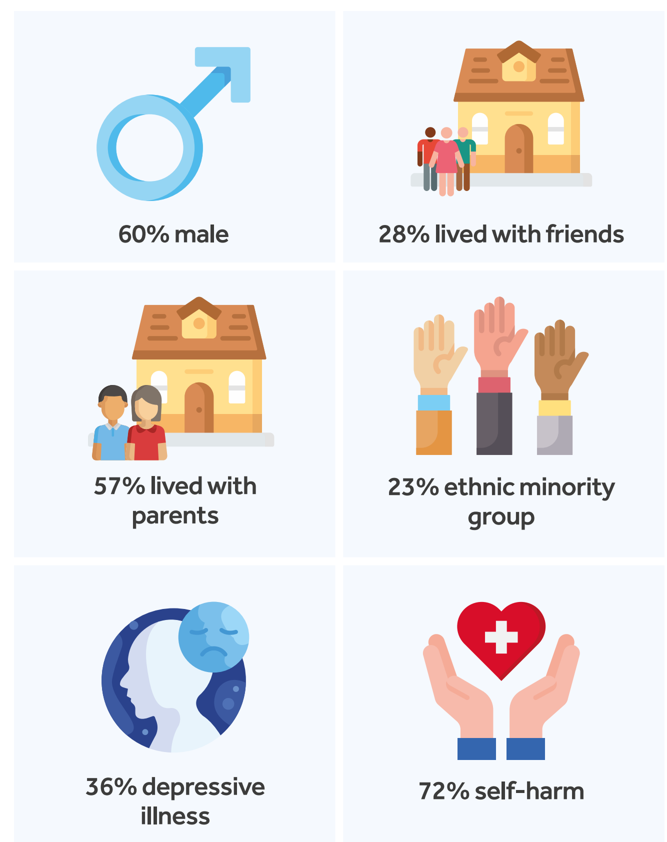
58 (60%) patient suicides by students were male, giving a male to female ratio of 1.5:1. Around a quarter (19, 23%) were from an ethnic minority group. A similar proportion of students lived with their parent(s) compared to other patients (50, 57% v. 187, 52%) but they were more likely to be living in other shared accommodation, i.e. with friends (25, 28% v. 44, 12%) (Box 6).

More students had a primary diagnosis of depressive illness (n=30, 36% v. 71, 20%) and fewer had schizophrenia and other delusional disorders (5, 6% v. 60, 17%) or personality disorder (10, 12% v. 79, 22%). A fifth had a primary or secondary diagnosis of anxiety, similar to other patients (16, 19% v. 63, 18%). Around half (39, 48%) had a comorbid mental illness.

Fewer students had a history of alcohol (23, 27% v. 150, 43%) or drug misuse (27, 31% v. 204, 57%). The majority (63, 72%) had a history of self-harm, and a third (27, 34%) had been seen at an emergency department for self-harm in the previous 3 months, similar to other patients (87, 29%).

Around a third (21, 31%) had been ill for less than 12 months. More students were receiving care under crisis resolution/home treatment services (18, 21% v. 35, 10%). Seventeen (24%) students had been subject to a routine or urgent referral by their GP in the preceding 3 months, similar to other young patients (52, 19%). Short-term risk was viewed as low or not present in a similar proportion of students and non-students (70% and 76% respectively).

Box 6: Patient suicide: characteristics of students aged 18-21 in England and Wales (2011-2021)

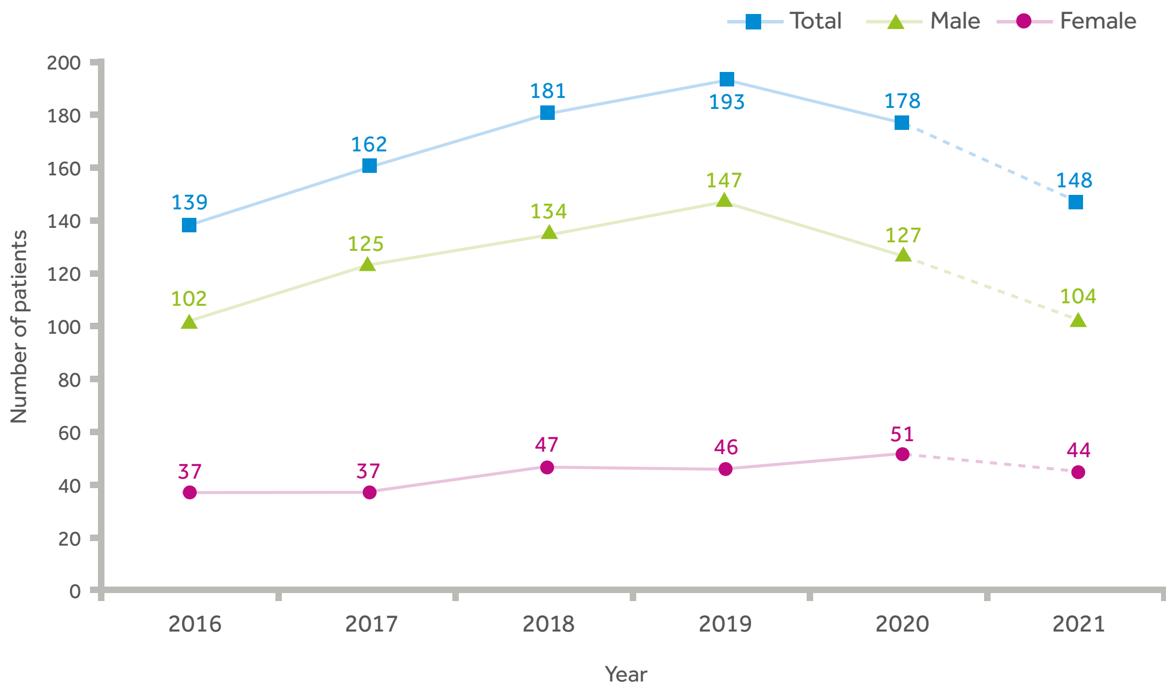


SUICIDE BY PATIENTS FOLLOWING A ONE-OFF ASSESSMENT

Complete data on one-off assessments (both routine and crisis assessments) were available from 2016. In the UK in 2016-2021, there were 1,001 suicides by patients in whom contact with services was a one-off assessment, 12% of all patient suicides, an average of 167 deaths per year.

The number has increased over the period but appears to have fallen since 2019 (Figure 22). The proportion of patients with a one-off assessment has remained steady, ranging between 10% and 13% per year.

Figure 22: Patient suicide in the UK: number following a one-off assessment



Note: Patient data unavailable in Northern Ireland in 2020 and 2021.

Compared to other patients, a higher proportion were aged between 25 and 44 (n=367, 41% v. 2,337, 35%) and more were married (230, 31% v. 1,649, 27%) and in paid employment (241, 33% v. 1,267, 21%) (Box 7).

In 234 (26%) deaths, the one-off contact was with a specialist or community mental health service (including assertive outreach, drug and alcohol services, Improving Access to Psychological Therapies (IAPT), acute day care services, child and adolescent mental health services, older people's mental health services, forensic community teams, probation services).

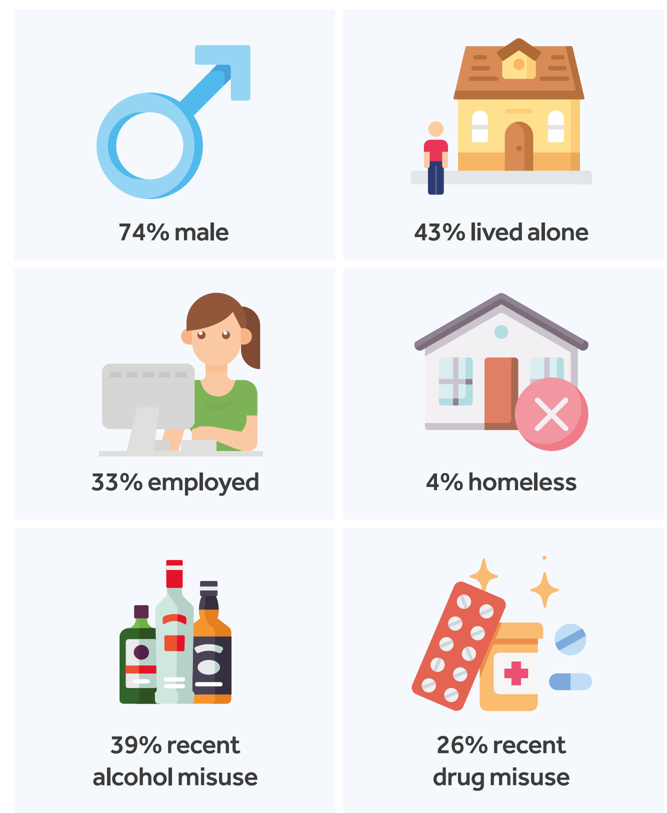
111 (13%) patients with a one-off contact had missed their last appointment with services, of whom over a third were subsequently discharged (38, 36%).

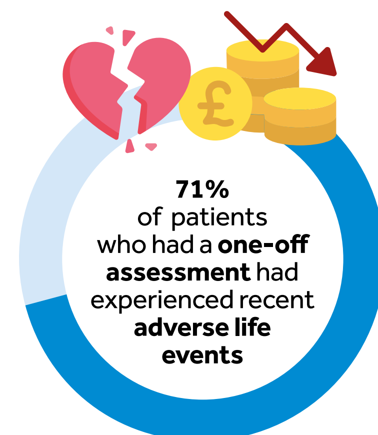
In 254 (30%) the contact was after a recent (<3 months) urgent or routine GP referral, more than patients without a one-off contact (1,315, 20%). Half (n=126, 51%) of these referred patients were assessed and discharged without any follow-up and 38 (15%) were referred to a mental health team but not seen.

Diagnoses of alcohol (97, 12% v. 330, 5%) or drug dependence/misuse (68, 8% v. 255, 4%) were more common and fewer had a severe mental illness (schizophrenia and other delusional disorders or affective disorder) (283, 34% v. 3,623, 55%) or a comorbid (i.e. additional) diagnosis (352, 44% v. 3,871, 60%). They were less likely to have a history of self-harm (375, 49% v. 3,586, 58%) but more had a recent (<3 months) history of alcohol (285, 39% v. 1,721, 29%) and drug (193, 26% v. 1,320, 22%) misuse.

The majority (n=506, 71%) had experienced recent adverse life events, with serious financial problems (117, 20% v. 850, 16%) and relationship break-up (98, 15% v. 588, 11%) more commonly reported than other patients. Short-term risk was more often viewed as low or not present in those with a one-off contact compared to other patients (663, 84% v. 4,493, 80%).

Box 7: Characteristics of patients who died by suicide following a one-off assessment in the UK (2016-2021)

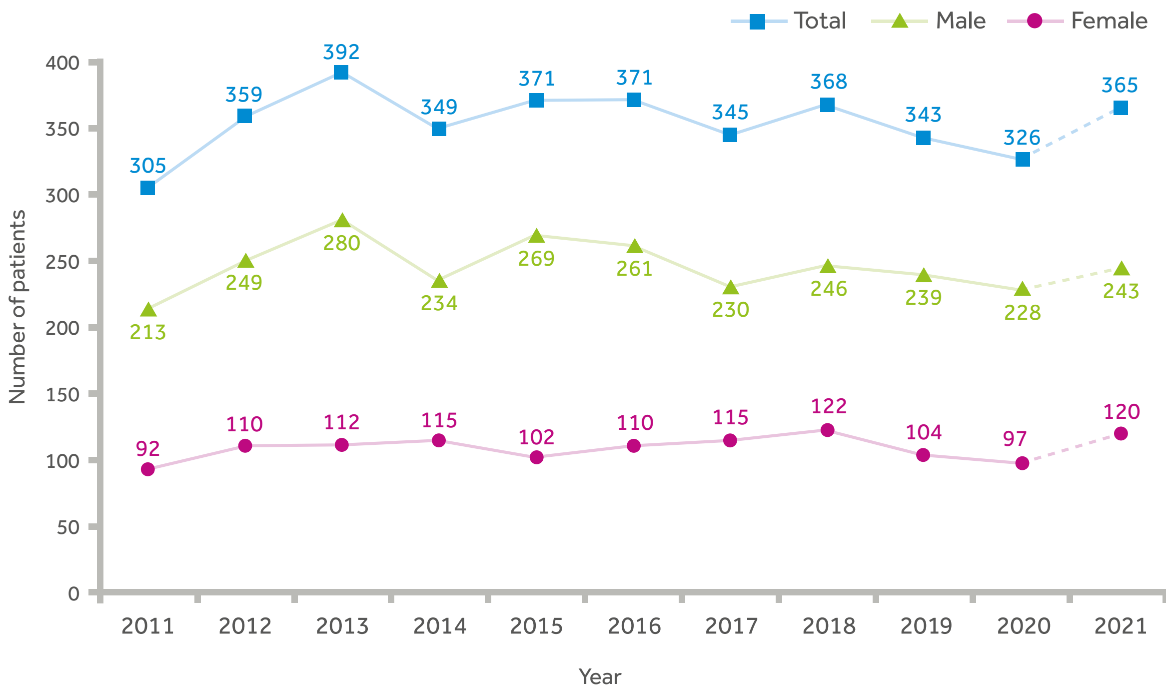




PATIENTS WHO DIED BY SUICIDE IN PUBLIC LOCATIONS

In 2011-2021, we received information on the location of the suicide in 13,535 (78%) patients. Of these, 3,894 (29%) died in a public location (defined as a place where an individual could be found by a member of public), an average of 354 deaths per year. This figure was lower in Northern Ireland (20%) and Scotland (25%) compared to England and Wales (28%). There has been no change in the number of suicides in public locations after an apparent peak in 2013 (Figure 23).

Figure 23: Patient suicide: number who died in a public location by sex in the UK



Notes: Male and female numbers in 2020 and 2021 do not total the overall figure due to rounding.
Patient data unavailable in Northern Ireland in 2020 and 2021.

Compared to patients who died in a private place, they were more likely to die by jumping/multiple injuries (1,690, 46% v. 271, 3%) and drowning (577, 16% v. 93, 1%) and less likely to die by hanging/strangulation (958, 26% v. 5,524, 56%) and self-poisoning (157, 4% v. 2,783, 28%).

More patients who died in public locations were male (2,692, 69% v. 6,458, 62%) and aged under 45 (1,838, 50% v. 4,302, 44%), including aged under 25 (464, 13% v. 782, 8%) and aged under 18 (95, 3% v. 117, 1%). They were more often homeless (159, 4% v. 133, 1%) (Box 8).

They were more likely to have schizophrenia and other delusional disorders compared to patients who died in private locations (821, 23% v. 1,438, 15%). A higher proportion died in acute mental health care settings, including in-patients (10% v. 6%), post-discharge care (18% v. 15%) and crisis resolution/home treatment (17% v. 15%).

The most frequent public locations were parks or woodland (24%) and railway locations (22%) (Figure 24). There was an 87% increase in the number of patients who died in parks or woodland, from an average of 60 per year in 2011-2014 to 112 per year in 2018-2021. This increase was especially seen in those aged under 25 and those aged under 18, and in the proportion who died by hanging/strangulation (from 68% in 2011-2014 to 76% in 2018-2021). There was no change in the number of patient suicides at other public locations.

Box 8: Socio-demographic characteristics of patients who died in public locations in the UK (2011-2021)

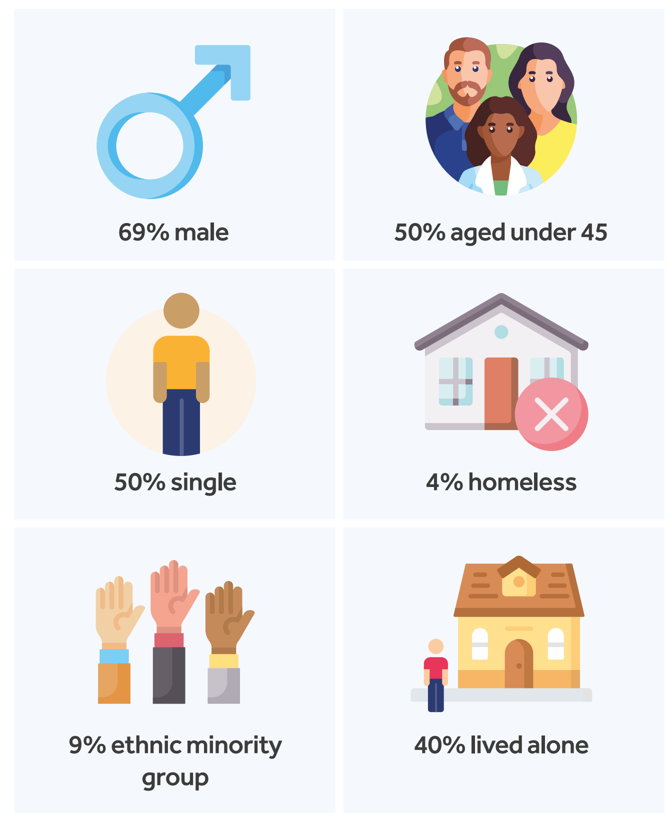
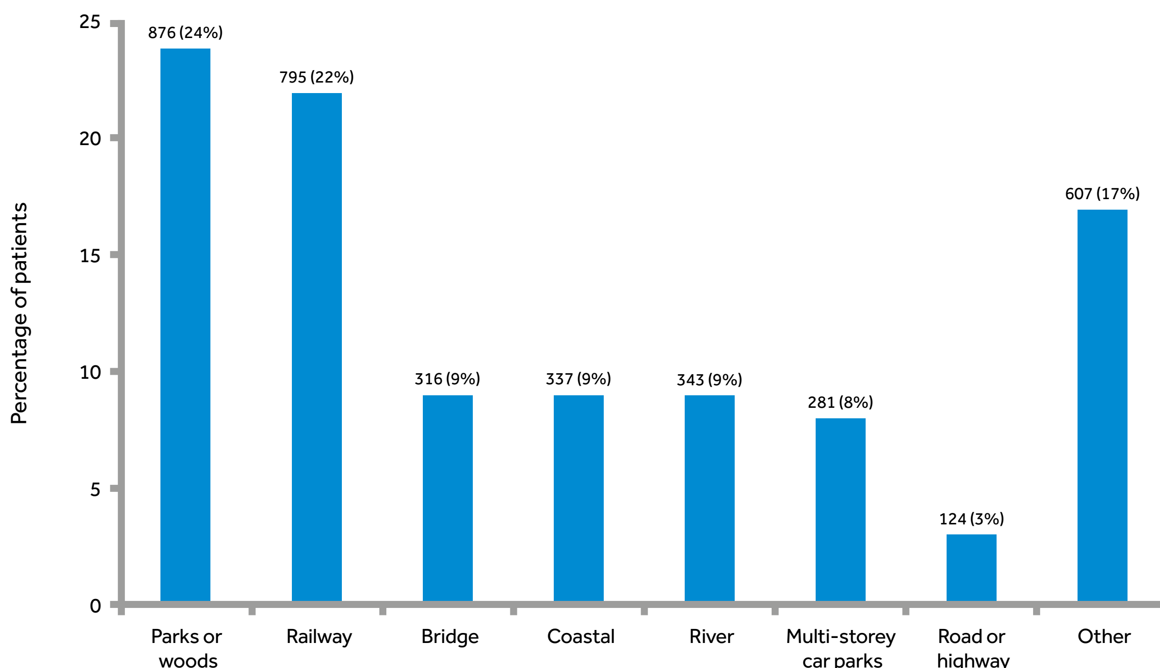


Figure 24: Patient suicide: type of public location in the UK (2011-2021)



LINKS TO ADDITIONAL ONLINE DATA

1. UK Additional Online Data
2. England Additional Online Data
3. Northern Ireland Additional Online Data
4. Scotland Additional Online Data
5. Wales Additional Online Data

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