The University of Manchester

Healthcare Quality Improvement Partnership

National Confidential Inquiry

into Suicide and Safety in Mental Health

EXECUTIVE SUMMARY

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

UK patient and general population data 2011-2021

ACKNOWLEDGEMENTS

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.

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

PLEASE CITE THIS REPORT AS:

The National Confidential Inquiry into Suicide and Safety in Mental Health. Annual Report: UK patient and general population data, 2011-2021. 2024. University of Manchester.

REPORT AUTHORS:

Louis Appleby, FRCPsych
Director

Nav Kapur, FRCPsych
Head of Suicide Research

Jenny Shaw, FRCPsych
Head of Homicide Research

Pauline Turnbull, PhD
Project Director

Isabelle M Hunt, PhD
Research Fellow

Saied Ibrahim, PhD
Research Fellow

Lana Bojanić, MSc
Research Assistant

Jane Graney, MSc
Research Nurse

Alison Baird, PhD
Research Fellow

Cathryn Rodway, PhD
Programme Manager and Research Associate

Su-Gwan Tham, MRes
Research Associate

Pauline Rivart, MSc
Research Assistant

James Burns, BA
Administration Manager

And all staff at NCISH:
Rebecca Lowe, Philip Stones,

Jodie Westhead, India Garry.

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 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. 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. 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.

- There has been an overall rise in deaths by hanging/strangulation, although the number has fallen in 2020 and 2021. 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.

- In 2020 and 2021, the first two years of the COVID-19 pandemic, the number of patients who died by suicide fell in England). 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.

Social and clinical characteristics

- Nearly half (48%) of all patients who died by suicide had lived alone. 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%).

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. 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. 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.

- 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. 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 dayof 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.

- 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. 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. 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. 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. 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.

CONTACT US:
The National Confidential Inquiry into
Suicide and Safety in Mental Health,
Centre for Mental Health and Safety,
Jean McFarlane Building,
University of Manchester,
Oxford Road,
Manchester
M13 9PL

E-mail: **ncish@manchester.ac.uk**

Visit us on our website: **www.manchester.ac.uk/ncish**

Follow us on X:

@NCISH_UK

Design by nectarcreative.com