EVIDENCE REFERENCE GUIDE	
National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Annual Report: UK patient and general population data 2013-2023.	
1. What is the report looking at?	The 2026 NCISH annual report provides UK-wide and Jersey findings about people who died by suicide from 2013 to 2023, and detailed information on those people who were in contact with mental health services in the year before they died (26%). We also present information about patient groups that reflect some of the current priorities for suicide prevention or groups who may be at increasing risk: patients under crisis care settings, older (≥75 years) patients, patients with a primary diagnosis of anxiety disorders, and patients who were recent migrants to the UK.
2. What countries are covered?	UK-wide and Jersey. Data for England, Northern Ireland, Scotland, and Wales are provided in supplementary online information files.
3. The date the data is related to	1 January 2013 to 31 December 2023.
4. Links to NHS objectives	NCISH recommendations are cited in all UK countries' suicide prevention plans, in NICE guidelines, in Independent Reports, and in the NHS plan for Mental Health and guidance for commissioners. NCISH recommendations have informed Commissioning for Quality and Innovation (CQUINs), and the NCISH recommendation on early follow-up after discharge from psychiatric in-patient care is a target in the standard NHS contract. NCISH evidence and recommendations form the basis for the Personalised Approach to Risk element of the Culture of Care programme, which is part of NHS England's Quality Transformation Programme.

No.	Clinical Message	Intended audience for clinical message	Evidence in the report which underpins the clinical message *(including page number in the PDF version of the report)*	Guidance available	Any available comparison with previous NCISH reports
1	**Acute mental health care settings** There has been a change in the pattern of suicide among mental health in-patients, in that a rising proportion of deaths now occurs on the ward itself. This rise is particularly seen in in-patients under the age of 25 and in part it reflects an increase in strangulation as a method of suicide. In the last	Clinicians Commissions Regulators/groups with oversight Patients and carers	Over 2013-2023, there were 18,602 patient suicides, an average of 1,691 deaths per year, 26% of all general population suicides [pages 11-12, fig. 4]. There were 953 in-patient deaths by suicide in 2013-2023, 5% of all patient suicides [page 16, fig. 11].	• England: Suicide prevention strategy for England: 2023 to 2028 • Scotland: Creating Hope Together: suicide prevention	NCISH 2025 Annual Report: There were 18,670 suicide deaths by patients in the UK and Jersey in 2012-2022, 26% of all general population suicides, an average of 1,697 deaths per year. There were 1,004 in-patient deaths by suicide in 2012-2022 (5%). Over a third (353, 40%) had died on the ward.

	two decades wards have substantially reduced suicides by hanging and the clinical challenge now is to extend this to deaths in which ligatures but not ligature points are used, particularly by younger patients. There are also signs of a change in the pattern of suicides in the first week after in-patient discharge, with the peak risk occurring later in the week. This may reflect the recent requirement in England for follow-up within 72 hours and it raises a concern that early post-discharge suicides have been postponed rather than prevented. It is important that these early post-discharge contacts anticipate any imminent deterioration.		There was an increase in the proportion of in-patients who died on the ward in 2020-2023 compared to in 2013-2016 (47% v. 36%). The increase over these time periods was seen in men (57, 48% v. 78, 32%) and in those aged under 25 (19, 66% v. 15, 38%), especially women and girls aged under 25 (14, 74% v. 10, 43%) [page 16, fig. 11]. The majority (311, 91%) of deaths on the ward were by hanging/ strangulation/asphyxia. When separating hanging/strangulation/ asphyxia, there has been a rise in deaths by strangulation on the ward over the report period, from 25 in 2013-2016 to 32 in 2020-2023 [page 16]. There were 2,250 patients who died by suicide within 3 months of discharge from in-patient care, 13% of all patient suicide deaths, an average of 205 deaths per year [pages 16-17, fig. 12]. The number and rate of suicides by patients within 3 months of discharge have risen in 2021-2023 [pages 16-17, fig. 12].	strategy 2022 to 2032 • Wales: Understanding: a suicide prevention and self-harm strategy • Northern Ireland: Protect Life 2 – Suicide Prevention Strategy • Jersey: Connected in Hope - A Strategy for Suicide Prevention in Jersey 2025-2029 • NCISH Safer Services Toolkit • Acute inpatient mental health care for adults and older adults • NICE Quality Standard –	There was a 31% increase in the proportion of in-patients who died on the ward in 2019-2022 compared to in 2012-2015 (47% v. 36%). The increase was seen in those aged under 25 (20, 61% v. 17, 39%). There were 2,317 patients who died by suicide within 3 months of discharge from in-patient care, 13% of all patient suicides. Of patients who died in the first week after discharge, the highest number (63, 20%) occurred on day 3 after leaving hospital (day 1 = day of discharge) with higher numbers also occurring later in the week, i.e. days 4-6 compared to the first day of discharge (Fig. 14). In 2019-22 the highest number occurred on day 6 (20 patients, 22%).

			Of patients who died within the first week of discharge, the highest number occurred on days 3 (54, 18%) and 4 (55, 18%) after leaving hospital (day 1 = day of discharge). Over the report period, the peak days of suicide after discharge have become later in the week, e.g. in 2013-2016 the highest number were on days 3 (30, 24%) and 5 (22, 17%) and in 2020-2023 they were on days 4 (20, 21%) and 6 (19, 20%) [pages 16-17, fig. 14].	Transition between inpatient mental health settings and community or care home settings	
2	**Suicide under crisis care settings** The features of patients who die by suicide under crisis teams point to an area of future priority: depressed, a short history of illness, living alone, adverse life events and recent self-harm. Crisis services should review how well they are able to support this group. Similarly, these are the patients at risk for whom the new mental health emergency departments, as outlined in the recent 10-year health plan for England, should be designed.	Clinicians Commissioners Regulators/groups with oversight Patients and families	In 2013-2023, there were an estimated 2,465 suicides by patients receiving treatment under crisis care settings, including crisis resolution home treatment services and other crisis care teams (e.g. crisis houses), 14% of all patient suicides, an average of 224 deaths per year [page 19, fig. 15]. The number of patients under crisis care has not changed in recent years following a peak in 2018 and a subsequent fall. In 2019-2023, there were also 207 patients (6%) whose last contact was under liaison psychiatry services, an average	• Royal College of Psychiatrists Practice Guidelines for Crisis Line Response and Crisis Resolution and Home Treatment Teams • NICE Depression in adults: treatment and management • NICE Depression in	In previous reports we have provided figures on patients who were specifically under crisis resolution/home treatment teams. For example, in the NCISH 2025 report: There 2,334 patients (13%) who died by suicide under crisis resolution/home treatment. In the NCISH 2024 report: 13% of patients who died by suicide were under crisis resolution/home treatment. In the NCISH 2023 report: 13% of patients who died by suicide were under crisis resolution/home treatment.

			of 41 deaths per year [page 19]. Patients under crisis care were older than other patients, with more aged 45-64 (1,079, 45% v. 5,589, 38%). Around a third were married (736, 32%)and 655 (29%) were employed 1,006 (44%) patients under CRHT lived alone [page 19]. The most common primary diagnosis was depressive disorder (42%) and a third had been ill for less than a year (34%). A quarter (25%) died within 3 months of discharge from in-patient care [page 19]. Recent (<3 months) self-harm was common (40%) as were adverse life events (58%) including serious financial difficulties (21%) and relationship breakup (14%) [page 19].	adults Quality Standard • NICE Self-harm: assessment, management and preventing recurrence • NICE self-harm Quality Standard	
3	**Suicide by people aged 75 and above** The risk profile of older patients who die by suicide is one in which depression, physical illness, isolation and bereavement are prominent and these factors should be the target of prevention. Recent self-harm in older patients	Clinicians Commissioners Regulators/groups with oversight Patients and families	In 2013-2023, there were an estimated 5,184 suicides by people aged 75, 7% of all suicides in the general population, an average of 471 deaths per year. There was an increase overall, driven by those aged 75-79 and by men aged 90 and above [page 20].	• Royal College of Psychiatrists - Guidance for commissioners of older people's mental health services	We previously reported on this patient group in the 2019 NCISH Annual Report: There were 425 deaths per year in people aged 75 and over. The number increased during the report period, driven by a rise in suicide by older males, although the rate decreased, i.e. taking into account rising patient numbers. 20% of people in this age

	should be a warning sign for significant risk. The low rate of mental health service contact suggests the need for improvements in access for this age group.		An estimated 1,029 (20%) were suicides by mental health patients, i.e., people who had been in contact with mental health services in the previous 12 months, an average of 94 deaths per year [page 20, fig 16]. Half (51%) of older patients were living alone. 7% were in living in a nursing/care home. 12% had recently (<3 months) been bereaved [page 20]. The most common primary diagnoses were depressive disorder (49%) and dementia (14%). Over half (55%) also had a major physical illness. Overall, they had lower rates of common suicide risk factors such as self-harm (41%) and alcohol (12%) and drug misuse (2%) [page 20].	• NICE Depression in adults: treatment and management • NICE Depression in adults Quality Standard • NICE Depression in adults with a chronic physical health problem: recognition and management	group who died by suicide were mental health patients, lower than in other age groups. These patients were more likely to have depression than other age groups and a higher percentage had been ill for less than a year. They were less likely to die by hanging/ strangulation. Self-poisoning was more likely to be by paracetamol or paracetamol/opioid compounds. Conventional risk factors such as self-harm or substance misuse were less common. Living alone, physical illness and bereavement were more common.
4	**Suicide and anxiety disorders** A primary diagnosis of anxiety disorder is an increasing feature of patient suicide. This contrasts with a view of anxiety in clinical practice and in the wider public where it can be seen as a less severe condition, mainly affecting younger people. Our evidence indicates that for some it is a serious disorder	Clinicians Commissioners Regulators/groups with oversight Patients and families	In 2013-2023, there were an estimated 1,337 suicides by patients with a primary diagnosis of anxiety disorder, 7% of all patient suicides, an average of 122 deaths per year. The average number increased from 98 in 2013-2016 to 147 in 2020-2023. The increase was seen in men and women and in all age groups	• NICE Generalised anxiety disorder and panic disorder in adults: management • NICE Anxiety disorders:	We have previously reported on this patient group in the 2019 NCISH Annual Report: There were 86 suicides per year in patients with a primary diagnosis of anxiety disorder, 5% of all patient suicides. The figure has risen during the report period - this could reflect a change in patterns of referral or diagnosis, or an increase in risk.

	that carries significant risk despite fewer conventional risk factors such as self-harm and substance misuse. Services need to be alert to the risk, treat co-existing depression and make psychological therapies available.		except those aged under 18 [page 21, fig. 17]. Most patients with anxiety disorder were in the 45–64-year age group (41%). They were more likely than other patients to be married (38% v. 26%) [page 21]. The majority (68%) had an additional mental illness, most often depressive illness (39%). Previous self-harm (54%) and alcohol (35%) and drug (29%) misuse were all less common among patients with anxiety [page 21]. A quarter (25%) were receiving psychological therapy. Short-term risk of suicide was viewed as not present or low in 83% [page 21].	Quality Standard	They had a wide age range, with a median age of 47, with more women over 65, though overall the majority were male. They had fewer conventional social and clinical risk factors for suicide such as living alone or substance misuse. However, there was a rise in unemployment and financial difficulties over the report period. Most were receiving drug treatment and around a third were taking benzodiazepines. A quarter were receiving some kind of psychological therapy; 8% were under IAPT services at the time of death.
5	**Suicide and recent migrants** Our findings highlight social adversity in mental health patients who die by suicide after living in the UK for a relatively short time. Many face economic difficulties and have insufficient social support and this may exacerbate suicide risk, requiring multi-agency care planning at key points in the clinical pathway such as in-patient discharge.	Clinicians Commissioners Regulators/groups with oversight Patients and families	In 2013-2023, there were 838 suicides by patients known by clinicians to be recent migrants to the UK, 5% of all patient suicides, an average of 76 deaths per year. This included 33 patients seeking permission to stay in the UK (e.g. asylum seeker, refugee, or the visa had expired and the patient was seeking to continue living in the UK) [page 22, fig. 18].	• Office for Health Improvement and Disparities - Mental health: migrant health guide • British Medical Association - Refugee and asylum seeker	We have not previously reported on this specific patient group.

			The number has increased since 2017, overall and particularly in women. These figures are confirmed and not estimated and may increase substantially further in 2021-2023 as NCISH figures become more complete [page 22]. Overall, recent migrants were more likely to be younger than other patients who died by suicide, with most aged 25-44 (43% v. 36%). The majority (87%) were white and 46% lived alone [page 22]. Affective disorder was common (38%, including 28% with depressive illness, and 10% with bipolar disorder), followed by schizophrenia or other primary psychotic disorder (17%). A quarter had been ill for less than a year. Overall, they were more likely to have died after a recent (<3 months) in-patient discharge (17% v. 13%) and a higher proportion were discharged to socioeconomic adversity (housing, financial or employment problems) (34% v. 22%) and poor social support (28% v. 18%) [page 22].	patient health toolkit	