

Frequently asked questions

Method

How do you define suicide and homicide?

General population suicides are defined as deaths by intentional self-harm and deaths of undetermined intent by individuals aged 10 and over. Homicide is a collective term used to describe unlawful killings. The Crown Prosecution Service (CPS) describes homicide as including murder, manslaughter, infanticide and offences involving causing or allowing the death or serious injury of a child or vulnerable adult. We have adopted this description in our work and collect data on all these outcomes. We also collect information on people who are charged with homicide but receive a verdict of not guilty by insanity or who are found unfit to plead. You can find more information about our homicide study, including frequently asked questions on our [Homicide and Mental Illness in England](#) website.

How do you define patient suicides?

Patients are those in contact with psychiatric, drug and alcohol, child and adolescent or learning disability services (if they are within mental health services) within 12 months of their death, with their care usually under a consultant psychiatrist. These include a range of patients, from those seen for one-off assessments to those who had been under the long-term care of services. Patients who were seen for a one-off assessment in a liaison setting with no follow-up arranged would not meet NCISH criteria for a patient suicide.

How do you collect suicide data?

Stage 1: National mortality data

Data on all general population suicide deaths and deaths of undetermined intent are obtained from the Office for National Statistics (ONS; for deaths registered in England and Wales), National Records of Scotland (NRS) and the Northern Ireland Statistics and Research Agency (NISRA).

Stage 2: Identification of mental health patients

We identify contact of those individuals with mental health services in the 12 months prior to the incident through administrative contacts at healthcare organisations and if contact is confirmed we:

Stage 3: Detailed data collection via questionnaire

Collect detailed clinical data via questionnaire from the consultant psychiatrist (or other senior professional) responsible for the patient's care.

[Further detail on the NCISH methodology is available on our website.](#)

NCISH has the following approvals:

- Section 251 support which is approved by the Secretary of State for Health and Social Care on the advice of the Health Research Authority's (HRA) Confidentiality Advisory Group (CAG) (reference: 23/CAG/0024). Section 251 support permits us to access confidential and identifiable patient information without consent in the interest of improving care.
- Approval from the Public Benefit and Privacy Panel for Health and Social Care (PBPP) (eDRIS ref: 2021-0114);
- Individual trust/Health Board approval with NHS mental health services providing data in England, Wales and Scotland.
- Data sharing agreement with Public Health Isle of Man and Manx Care.

How do you collect homicide data?

Stage 1

Obtain information on all homicide convictions from the Home Office Homicide Index (England and Wales) and the Management Information Analysis Team at the Scottish Courts and Tribunal Service (Scotland). We have historically obtained data from the Central Business Unit of Northern Ireland Courts and Tribunal Service (Northern Ireland).

Stage 2

Identify contact of those individuals with mental health services in the 12 months prior to the incident through administrative contacts at healthcare organisations – allowing us to record and report on the numbers of homicides by people in contact with mental health services.

You can find more information about our homicide study, including how we collect data on our [Homicide and Mental Illness in England](#) website.

How do you define homicide-followed by suicide and how do you collect these data?

Homicide followed by suicide is defined as when the perpetrator died by suicide within three days of carrying out the homicide. [Information on how this data is collected is outlined in our homicide followed by suicide methodology.](#)

How complete is the data you present?

Overall, the data completeness for patient suicide is high, but the figures for more recent years in any given report will be less complete. This reflects the time taken to process the data and is, in part, because of delays in legal processes. Data on homicide convictions provided by the Home Office are also incomplete for more recent years and are likely to vary between police force areas. We calculate how complete our data are by examining data patterns from earlier years and estimating how much more data we are likely to receive and the number of questionnaires this would generate.

Why is there a delay in the receipt of data from national sources?

Some deaths must be referred for a coroner's inquest into the cause of death; only then may the death be recorded as suicide or of undetermined cause on national registers. In England and Wales, the inquest process can take several months creating a delay in death registration and subsequently the notification of the death to the NCISH on our national mortality data extracts. In Scotland delays in registration are minimal as deaths are required to be registered within eight days. Similarly, the legal process of bringing a homicide to court, the trial itself, and any subsequent appeal against conviction introduces a time lag from when the homicide was committed to the offender being convicted and this outcome being recorded on national databases and notified to us.

Do you only collect case series data?

No. NCISH is a large, national case series of suicide and homicide by mental health patients. However, we also use other methods to address specific questions. We have:

- Carried out record linkage studies to identify patient suicides occurring in primary care and drug and alcohol services;
- Interviewed GPs and nurses to identify barriers to accessing secondary services, and difficulties with observation in in-patient settings;
- Conducted case control studies to investigate in-patient suicide, suicide in the post-discharge period and homicide by patients with a diagnosis of schizophrenia;
- Examined the association between local service delivery and changing suicide rates;
- Reviewed mental health care records to investigate the assessment and management of risk prior to suicide or homicide;
- Examined suicide in the general population using information from investigations by official bodies, mainly coroners;
- Reviewed independent investigations after homicide.

[Find out more about our projects.](#)

How many of the questionnaires that you send out are returned?

Response rates refer to the completion and return of NCISH questionnaires by clinicians and are expressed as a percentage. For example, 95 out of 100 questionnaires sent to clinicians within a trust/health board that are returned complete would equate to a 95% response rate. In 2023, response rates were 95% or better in almost all trusts.

What has been the effect of the ICD-10 coding changes to the recording of drug-related deaths?

Following an update to the International Classification of Diseases and Related Health Problems (ICD-10) in 2011, new rules for coding certain drug-related deaths were introduced. Some drug-related

deaths previously coded as due to 'mental and behavioural disorders due to psychoactive substance misuse' are now coded as suicide or undetermined deaths. Both the [Office for National Statistics](#) (ONS) and the [National Records of Scotland](#) (NRS) have implemented these changes to coding practice. Analysis by ONS has shown these new coding rules have had no significant impact on the suicide figures in England. However, they have affected numbers in Scotland. More information on the change in coding rules can be found in the ONS statistical bulletin [Suicides in the UK, 2011](#).

What has been the effect of 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. 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.

How does NCISH classify homicide cases?

Homicide is a collective term used to describe unlawful killings. The Crown Prosecution Service (CPS) describes homicide as including murder, manslaughter, infanticide and offences involving causing or allowing the death or serious injury of a child or vulnerable adult. We have adopted this description in our work and collect data on all these outcomes. We also gather information on individuals who are charged with homicide but receive a verdict of not guilty by reason of insanity, are found unfit to plead or died by suicide following a homicide.

Why are there differences between the rates of suicide you calculate and those calculated by other agencies?

Discrepancies may arise between national numbers and suicide rates presented in our annual reports and those presented by other agencies, like ONS, due to differences in measurement of suicide and how the rates of suicides are calculated. We:

- Calculate the number of suicides based on the **date of death**;
- Collect data on suicide from age 10 years and over;
- Include a small number of deaths occurring outside the country and deaths of people who were not residents of the country. For example, for Wales we include all those deaths that occurred within Wales (residents and non-residents of Wales) and the deaths of Wales residents who died in other countries;
- Calculate the overall rate of suicide based upon the number in the general population aged 10 years and over.

- Calculate crude suicide rates.

Other agencies sometimes report the rate of suicide:

- Where the number of suicides reported are based on **date of registration of death**;
- Using deaths from age 15 and over.
- That have been standardised using the European Standard Population.

How do NCISH mental health patient figures compare to official statistics from the Office for Health Improvement & Disparities (OHID)?

The 2026 report [Suicide in people with severe mental health problems](#) by the Office for Health Improvement & Disparities (OHID) presented findings on suicide by people in England who were referred to mental health services. Their statistics complement the NCISH data but are not directly comparable. For example, OHID include earlier mental health service contact of up to five years prior to suicide; open referrals rather than confirmed contact with services; and people aged 18 to 74 years rather than 10 years and over. They also report suicide rates based on date of death registration, and which are age-standardised (see details on suicide rates in FAQ above).

Obtaining data

Can I request data from the NCISH?

Yes. Individuals submitting data, audit teams and commissioners of services can access data through bespoke [data requests](#). Currently, data requests must be initiated by the Medical Director of the healthcare organisation. Data requests provide individual trusts with benchmarking data for their trust in the context of the national data. [Our annual reports](#) provide some data on a regional basis, where appropriate. Annually, we provide a Safety Scorecard to the Medical Director of each mental health trust in England. This Scorecard provides benchmarking data to support quality improvement. All our outputs and information about our work programme are available via our website – including PowerPoint [data slides for download](#). We actively engage with clinical, commissioning and policy stakeholders through presentations at professional meetings and training days. We inform the public of our work through events, presentations, print and social media. However, we are bound by the conditions stated in the data sharing agreements we have with our data providers which are intended to safeguard the identifiable clinical information that they share with us and therefore it may not always be possible to respond to a request if it risks breaching these agreements. See our [privacy notice](#) for further information.

What happens to the information I provide?

We publish annual reports which include analysis of the most recent year of national data on patient suicides, as well as trends over time. In addition to annual reports, we publish project reports investigating specific patient sub-groups.

We recommend changes to clinical practice and policy to reduce the risk of suicide and improve the safety of mental health patients. We only publish aggregate figures, and we follow Office for National Statistics guidance about small numbers – we don't publish low counts, and we never share information about an individual.

For more information on how we use the sensitive information that we collect in our work, and the rights you have if you think that we hold information about you as a data subject please refer to our [privacy notice](#).

Involvement

How do you involve service users, carers and their representative organisations?

We recognise how important it is for us to listen to the experiences and opinions of patients, and their family members, friends or carers, who have been involved with mental health services. We work closely with service users and carers in the design and development of our studies, including with our dedicated patient and public involvement group – [Mutual Support for Mental Health -Research \(MS4MH-R\)](#). A Project Board provides independent external oversight of our work and includes representatives from key stakeholder groups, and lay members with user and carer experience. Previously, we have asked about experiences of risk and safety assessment and have gathered views on personality disorder and psychiatric in-patient services ([see our projects page](#)). Our work seeking the experiences and views of patients of mental health services is also published on our [website](#) and on our social media accounts ([X](#), [LinkedIn](#), [Bluesky](#)). We speak about our work to service user groups and other healthcare organisations, and we attend public events (e.g. local markets and other community activities) with information about our findings.

[Our Patient and public involvement and engagement strategy](#) describes our approach to involving, engaging, and informing patients, and their family members, friends or carers who have been involved with mental health care throughout our work.

Where can I obtain advice and support?

Sources of help and support can be found on [our support page](#). The [Support after Suicide Partnership \(SASP\)](#) has put together a library of support guides for those bereaved or affected by suicide for each country of the UK on their website.

Online data collection

From June 2024, we are asking clinicians to complete our NCISH questionnaire using a new online platform called REDCap. The following FAQs provide more information about why this step was taken and how to access this new platform.

Why did NCISH decide to change online data collection systems?

All NHS Trusts in England, Health Boards in Scotland and Wales, and Health and Social Care Trusts in Northern Ireland moved from the completion of paper NCISH questionnaires to an online system for the collection of questionnaire data in January 2018. We developed a secure platform for this online data collection system with the help of The University of Manchester's IT Services.

Recent feedback from clinicians has increasingly described the platform developed in 2018 as difficult to use, visually unappealing, and time consuming. To help reduce clinician burden, we decided to move to a different online data collection system called REDCap. REDCap is a secure web platform for building and managing online surveys.

Who has approved the change of online data collection system to REDCap?

We have obtained approval to use REDCap as our online system for the collection of NCISH questionnaire data from the North–West Research Ethics Committee (reference: ERP/96/136), the Health Research Agency (HRA) Confidentiality Advisory Group (reference: 23/CAG/0024), and the Public Benefit and Privacy Panel for Health and Social Care (reference: 2021-0114).

How secure is REDCap?

REDCap has been approved by The University of Manchester Information Governance Office to store data classified as 'highly restricted'. Although REDCap does not hold patient identifiable information, it is crucial high levels of security are maintained due to the sensitive nature of the data we collect.

REDCap undergoes annual penetration testing at The University of Manchester by an external CREST-certified supplier, which covers the application and hosting infrastructure. The REDCap web server runs Microsoft Defender Endpoint for Linux with real-time protection enabled. Full server scanning is also performed nightly. REDCap was pen tested in January 2024.

What browsers are recommended to use REDCap?

REDCap is accessible from almost any device with internet access, including most modern browsers found on any smart phone or tablet. Javascript will need to be enabled.

We do not anticipate any difficulties in accessing REDCap. However, should you require any help, please contact the NCISH office by phoning 0161 275 0700 or email ncish@nhs.net.

How do I access a questionnaire on REDCap?

The letter you receive requesting completion of a NCISH questionnaire will include a unique link to REDCap (or an access code if you receive the letter by post). Further details on how to use your link or access code will be included in an information sheet sent alongside your invitation letter. There is no need to register on REDCap.

Should you start completing the questionnaire on REDCap and choose to return to it later (using the 'Save and Return Later' button), you will be prompted to enter your email address. An email with instructions for returning to the questionnaire will then be sent to you from The University of Manchester's 'REDCap Administrator' email address (its-redcapadmin@listserv.manchester.ac.uk).

Will REDCap hold any identifiable information?

As with the previous online data collection system, REDCap does not hold any patient identifiable information. Each record is comprised of three unique identifiers representing (i) the service user; (ii) the consultant; (iii) the Trust or Health Board. It is not possible to identify an individual, a consultant, or the organisation in which a consultant is based from these identifiers. The key is held on the NCISH's independent server which is not connected to The University of Manchester's IT infrastructure.

What do I do if I have concerns about REDCap or am unable to use it?

If you are experiencing difficulties accessing REDCap or have any feedback, please email ncish@nhs.net.