Executive summary

- The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) holds a UK-wide dataset of people who have died by suicide who were current or recent mental health patients. The dataset for England currently stands at over 21,000 patient suicides.
- There are over 1300 patient suicides per year in England. Current areas of concern include: rising suicides by middle-aged male patients; safety of crisis resolution teams; suicide following discharge from hospital; lack of services for alcohol and drug misuse.
- We have shown an association between specific clinical initiatives and decreased patient suicide rates - these should be adopted by all mental health trusts. They are: removal of ward ligature points; early follow-up on hospital discharge; 24 hour crisis teams; services for patients with both mental illness and substance misuse; outreach teams for patients who may disengage; implementation of NICE guidance for depression.
- We have also shown lower patient suicide rates linked to organisational factors such as reduced staff turnover and, as a marker of a learning culture, case review involving the family following patient suicide.
- The most common type of drug taken in fatal overdose by mental health patients is opiates. We support further measures to improve safe prescribing of these drugs and antidepressants.
- Our studies of primary care highlight the recognition and treatment of depression as the crucial intervention in this setting. However, a third of people who die by suicide have not seen their GP for at least a year. They are mainly young and male and for them treatment on-line and in non-clinical settings should be widely available.
- Our studies of self-harm have shown that the subsequent risk of suicide is high and that specialised psychosocial assessment is a key determinant of future risk. Self-harm care should be a commissioning priority.
- Our recent report on suicide by children and young people has highlighted common themes including exam stress, bullying, physical health conditions and bereavement, especially by suicide. Internet use related to suicide was common. Over half had previously self-harmed. 43% were not in contact with any specialist agency. Our
findings suggest that schools, primary care, social services and youth justice all have a role to play in suicide prevention for young people.

- Every local area should develop a suicide prevention plan based on the substantial evidence now available.

Introduction

1. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) collects detailed clinical information on patients of mental health services who have died by suicide. NCISH research is based on a UK-wide, comprehensive, internationally unique database; in England this currently consists of 78,000 general population suicides and 21,000 patient suicides. We provide definitive figures on suicide to clinical services and governments, produce data-driven safety recommendations, and demonstrate that these recommendations reduce suicide. NCISH has been based at the University of Manchester since 1996, and its work in England is currently commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. The senior academics overseeing NCISH are Prof Louis Appleby, who also chairs the National Suicide Prevention Strategy Advisory Group, and Prof Nav Kapur who has chaired the NICE clinical guideline development groups on self-harm and depression.

2. Our core work is therefore on suicide by people under mental health services - we publish annual reports highlighting current concerns. We have also conducted equivalent studies in other settings, specifically primary care and A&E departments, and on suicides by other groups such as children and young people. These studies and their implications for prevention are summarised below.

Summary of key NCISH findings

Current safety concerns

3. The number of mental health patient suicides in England has recently risen and is currently over 1300 per year. However, this increase has occurred at a time when the number of people under mental health care has risen rapidly - it is not in itself evidence that services are becoming less safe. It does mean that the potential impact of mental health services on suicide prevention in the population as a whole is increasing.
4. This rise in patient suicide is particularly striking in male patients in middle age, especially in the 45-54 years age group. Our data suggest that the factors behind this rise are alcohol, economic pressures and social isolation.

5. Over half the patients who die by suicide have a history of drug or alcohol misuse, around 670 deaths per year. However, only 11% of patients are receiving treatment from drug or alcohol services.

6. The commonest methods of suicide by mental health patients are hanging, followed by overdose. The commonest type of drug taken in fatal overdose is opiates, including prescribed analgesics. There has been a levelling off in the number of fatal antidepressant overdoses after a fall 10 years ago, thought to be the result of safer prescribing.

7. There has been a large fall - of around 70% - in the number of suicides by mental health inpatients in the last 10 years, though the figure is still 60-70 deaths per year. This fall was initiated by a requirement to remove ward ligature points to prevent hanging, although there are also fewer suicides off the ward and by other methods.

8. There are now around 200 suicides by patients under crisis resolution/home treatment (CRHT) teams, three times the number among inpatients. 37% have been under the CRHT team for less than a week at the time of death. 43% live alone. These features suggest the patient may not have been suitable for CRHT.

9. Around 200 patient suicides occur in the three months after discharge from hospital and the time of highest risk is the first two weeks post-discharge. These deaths are linked to short preceding admissions and lack of care planning. Around 10% of post-discharge suicides, 19 deaths per year, occur after admission to an out-of-area bed.

**Mental health service recommendations**

10. Each report we publish carries recommendations to mental health and other services on improving safety. We have carried out a series of studies examining whether mental health trusts have implemented recommendations from NCISH and other national bodies, and whether there is any subsequent impact on safety. We found that implementation of recommendations has been good and has been followed by fewer patient suicides.
11. The key service features linked to reduced suicide in our studies are listed in box 1 - these largely reflect recommendations to clinical services but they also include organisational factors, i.e. lower non-medical staff turnover and multidisciplinary review of patient suicides involving families, as a marker of a learning culture within a trust. We estimate that these recommendations were associated with 200-300 fewer patient deaths per year, with a potential saving of £450 million annually.

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Box 1: Service features linked to lower patient suicide rates

- Removal of potential ligature points on inpatient wards, including non-collapsible curtain rails
- Community services to include assertive outreach team that provides intensive support for people with severe mental illness who may disengage from standard services
- Crisis teams, available 24 hours a day
- Follow-up of patients within 7 days of discharge from inpatient care
- Written policy on the management of patients with mental illness and alcohol or drug misuse
- Implementation of NICE guidance on depression
- Multidisciplinary review and information sharing with families after a suicide
- Low turnover of non-medical staff

Suicide in primary care

12. We have also studied primary care patients who died by suicide. Just over a third of people who died by suicide had not been in contact with their GP in the previous year; suicide risk was increased by 67% in those who did not attend, who were mainly male and young or young middle-aged. Suicide risk was also higher in those who were frequent attenders - the number of GP consultations was particularly increased in the 2-3 months prior to death. In those who attended more than once every two weeks over a year, risk was increased 12-fold. Depression and suicide risk were often unrecognised, with 37% of those who died having no mental health diagnosis recorded. These findings suggest that a key suicide prevention measure in primary care is the detection and treatment of depression. However, for those who do not attend their GP, especially men, services that offer support on-line or in non-clinical settings, e.g. linked to sport, should be developed.

Self-harm in A&E departments

13. A related study in our research centre, the Multicentre Study of Self-Harm examines trends in self-harm and its management in A&E departments in three cities in England (Manchester, Oxford, Derby). Self-harm differs from suicide in being more common in females and in teens and early 20s but it is one of the most important risk factors for suicide. Although self-harm patients attending A&E are often treated unsympathetically, their suicide risk in the following year is raised 50-fold and the risk of death from accident and natural causes is also high. The Multicentre Study has
shown that specialist psychosocial assessment is a crucial determinant of outcome after self-harm and can reduce the risk of further self-harm by 40%. However, a study of 31 hospitals in England found that the proportion of self-harm episodes receiving a psychosocial assessment varied widely with an overall figure of 58% showing no improvement over 10 years despite national guidance on the management of self-harm.

**Suicide by children and young people**

14. We have conducted the first study of all suicides by children and young people under 20 years of age in England. We collected data from a range of investigations by official bodies, e.g. coroners, and identified relevant antecedents prior to suicide. Suicide rates rose sharply in the late teens, and several factors appear to contribute to this (box 2). For many, long-standing family adversity seemed to be followed by difficulties in other areas of life, and complicated by mental health problems. This pattern of cumulative risk may then lead to a “final straw” event, often a broken relationship or exam stress.

**Box 2: Ten common themes in suicide by children and young people**

<table>
<thead>
<tr>
<th>Family factors such as mental illness and domestic violence</th>
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<tbody>
<tr>
<td>Abuse and neglect</td>
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<tr>
<td>Bereavement and experience of suicide in family or friends</td>
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<td>Bullying, including on-line bullying</td>
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<td>Suicide-related internet use, e.g. searching for suicide methods, postings on social media</td>
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<td>Academic pressures, especially related to exams</td>
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<tr>
<td>Social isolation or withdrawal</td>
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<td>Physical health conditions that may have social impact, especially acne and asthma</td>
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<tr>
<td>Alcohol and illicit drugs</td>
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<tr>
<td>Mental ill health, self-harm and suicidal ideas</td>
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</tbody>
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15. Over half the young people had previously self-harmed. 43% had no contact with children's services or agencies. Improved services for self-harm and access to
CAMHS are therefore crucial to addressing suicide risk but the antecedents identified in this study make clear the vital role of schools, primary care, social services, and youth justice.

**Summary of key measures in local areas**

16. There is a substantial amount of evidence on suicide and suicide prevention from our research and other academic units in the UK. On the basis of this evidence, we believe that local authorities and the NHS in every part of the country should develop a joint strategy for suicide prevention. This should include:

- specific measures to reduce suicide risk in men, particularly in middle age, including services that are available on-line and in non-clinical settings
- high quality services for self-harm, ensuring psychosocial assessment and follow-up
- safer mental health care, as described above (box 1), with an emphasis on crisis teams and care following hospital discharge
- specialist services for people with drug or alcohol misuse and those with both mental illness and substance misuse
- improved treatment of depression in primary care, following NICE guidance
- measures to reduce isolation for people at risk, including community-based supports and transport links
- a multi-agency approach to young people's mental health, including self-harm care, CAMHS, primary care, social care, schools and youth justice
- a system of reviewing and learning from suicide deaths, with input from the family of the person who has died.

**References**


