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The University of Manchester

National Confidential Inquiry

into Suicide and Safety
in Mental Health

ANNUAL REPORT 2023:

England, Northern Ireland, Scotland and Wales

UK patient and general population data 2010-2020



HQIP

Healthcare Quality
Improvement Partnership

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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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The National Confidential Inquiry into Suicide and Safety in Mental Health. Annual Report: UK patient and general population data, 2010-2020. 2023. University of Manchester.

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.

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EXECUTIVE SUMMARY

The 2023 annual report from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) provides findings relating to people aged 10 and above who died by suicide between 2010 and 2020 across all UK countries. Additional findings are presented on the number of people under mental health care who have been convicted of homicide, and those in the general population.

The NCISH database includes a national case series of suicide by patients under the care of mental health services over more than 25 years. The current suicide database stands at over 159,000 deaths by suicide in the general population, including over 39,500 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 2010 and the subsequent 10 years, including the most recent year (2020) for which comprehensive data are available.

We have not received 2019-2020 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 2010-2018 in the country specific and UK-wide sections of the report. However, we have information on the total number and age and sex of patients in Northern Ireland in 2019-2020 and these are included in the overall UK figures.

Data for individual UK countries are provided in the [additional online information files](#), and key messages are also provided as an easy read report, an infographic, and an animated video. We have not received data identifying homicides by patients in 2020 due to renewal of data-sharing agreements, therefore we present homicide patient data for the period 2010-2019.

In the report we also present data on certain themed topics, some of which are included because of current economic and societal concerns, including patients with economic adversity, those aged under 25, and suicide-related internet use.



KEY FINDINGS

General population suicide numbers and rates

- There were 68,357 suicides in the general population in the UK between 2010 and 2020, an average of 6,214 deaths per year. The rate of suicide decreased by 6% in the UK in 2020, the first year of the COVID-19 pandemic, compared to 2019, and the decrease was particularly seen in men.
- Suicide rates increased in 2018-19 compared to 2017 in all countries except Wales. All UK countries showed a fall in rates in 2020. Since 2014 rates have been lower in Northern Ireland due to a change in the coding of drug-related deaths (see details on page 9).
- There has been a change in the pattern of suicide method in recent years, including a rise in deaths by hanging/strangulation in all groups.

Patient suicide numbers and rates

- Over 2010-2020, there were 18,403 suicide deaths in the UK by patients (i.e. people in contact with mental health services within 12 months of suicide), an average of 1,673 deaths per year, 27% of all general population suicides.
- In 2018-19, the number of patients who died by suicide rose in England and there was a small increase in Scotland (see figures on page 14) but in 2020, the first year of the pandemic, the number did not increase. The overall increase in England over the report period was not reflected in the rate of suicide among patients under mental health care, i.e. taking into account the total number of people under mental health care, where there has been little change.
- The number of deaths by hanging/strangulation rose steeply in 2018-20, especially in female patients and in patients aged under 25. The number of deaths by self-poisoning also increased in 2018-20. The main substances taken in fatal overdose were opiates/opioids and the source (where known) was most often by prescription (see details on page 15).

Clinical and social characteristics

- The majority of patients who died had a history of self-harm (64%) and there were high proportions of those with alcohol (48%) and drug (37%) misuse, and comorbidity, i.e. more than one mental health diagnosis (53%) (see details on page 17). Nearly half (48%) of all patients lived alone. In 5% of cases overall, the patients were recent migrants, i.e. seeking permission to stay in the UK or resident in the UK for less than 5 years.
- In 13%, the contact with mental health services was a one-off contact. Around a third (32%) of these patients were employed and a fifth (20%) had a diagnosis of alcohol or drug dependence/misuse.

Clinical care

- Over 2010-2020, there were 5,103 (28%) patients who died by suicide in acute care settings, including in-patients (6%), post-discharge care (14%) and crisis resolution/home treatment (13%), an average of 464 deaths per year. The most common non-acute settings were community mental health services (14%), alcohol or drug services (13%), and older people's mental health services (8%).
- There were an estimated 70 suicides by mental health in-patients in the UK (excluding Northern Ireland) in 2020, around 4% of all patient suicides, continuing a fall since 2015 (see details on page 21). However, the fall in the number of in-patient suicides seems to have slowed in recent years. Over a third (37%) died on the ward, 50% were off the ward on agreed leave, and 13% had left the ward without staff agreement or left with agreement but failed to return. Patients who died on the ward were more likely to die within the first week of admission than other in-patients who died during a mental health admission. Most died by hanging/strangulation using low-lying ligature points.
- There were an estimated 186 deaths by suicide in the 3 months after discharge from mental health in-patient care in the UK (excluding Northern Ireland) in 2020, 11% of all patient suicides. This was the same figure as the previous year (see details on page 24). The highest risk was in the first 1-2 weeks after discharge, with the highest number of deaths occurring on day 3 post-discharge (taking day 1 as the day of discharge).

- There were an estimated 347 deaths by patients who missed their last contact with services (excluding Northern Ireland) in 2020, 23% of all patient suicides (see details on page 26). The number fell in 2014 but has not changed in recent years. These patients had higher rates of conventional risk factors for suicide including unemployment, living alone, previous self-harm, and alcohol and/or drug misuse than those who maintained service contact. Services had made contact with the patient’s family in only 25% of those who had missed their final contact.

Suicide by patients with economic adversity

- Complete data on economic adversity were available from 2016. In 2016–20, there were 373 deaths per year in patients who had experienced recent (within 3 months) economic adversity, namely serious financial problems or loss of job, benefits or housing, 27% of all patient suicides (see details on page 27). The number increased over this 5-year period.
- Patients who were not previously unemployed but who had experienced recent serious financial stress were characterised by divorce (33%), depression (39%) and recent (<12 months) illness onset (35%).
- Patients who were previously unemployed who had in addition experienced recent serious financial stress also had higher rates of key clinical risk factors, namely recent alcohol misuse (47%), drug misuse (41%) and self-harm (41%).

Suicide by patients aged under 25 years

- We are presenting data on suicide by people aged under 25 in the general population and those in contact with mental health services. There were 7,220 suicides in the general population by people aged under 25 (10–24 years) in 2010–20, an average of 656 deaths per year. 1,145 were aged under 18 years, an average of 104 per year. The number of suicides in people aged under 25 increased in 2017, mainly driven by an increase in females aged under 18, and by a rise in deaths by hanging/strangulation (see details on page 29).
- There were 1,619 suicides by patients aged under 25, an average of 147 deaths per year; 235 were aged under 18, an average of 21 per year. This represents around 20% of general population suicides in these young age groups, a lower proportion than in older groups (27%). The number of patients aged under 25 increased from 2015, particularly in females aged 18–24.

- Patients aged under 18 were more often female than those aged 18–24. The majority lived with their family and over a third were known to have experienced emotional, sexual and/or physical abuse. They had higher rates of anxiety and autism and most (76%) had a history of self-harm. Suicide-related internet use was more common (24% v. 15% of 18–24 year olds); 13% had experienced cyberbullying.
- Patients aged 18–24 had more clinical factors that are associated with suicide in adult patients than those aged under 18, i.e. a diagnosis of personality disorder (20% v. 3% of those aged under 18), schizophrenia and other delusional disorders (17% v. 4%), alcohol (49% v. 30%) and drug (56% v. 36%) misuse. More had a comorbid (i.e. additional) mental health diagnosis (56% v. 49%) and had missed their last service contact (29% v. 22%). 40% had a known history of childhood abuse.

Suicide by patients given a diagnosis of personality disorder

- There were 174 deaths per year in patients given a diagnosis of personality disorder (PD), including antisocial and emotionally unstable/borderline PD, 11% of all patient suicides. The number increased between 2010 and 2019 and we estimate a continuing rise in 2020 (see details on page 34). The majority (57%) were female, an average of 99 per year.
- Women given a diagnosis of PD were younger and more were living alone, unemployed and homeless. Many had experienced childhood abuse (71%) and domestic violence (41%). 10% identified as LGBT. The majority had a history of self-harm (97%) and alcohol and/or drug misuse (65%). More had missed their last appointment with services (28%).
- Male patients given a diagnosis of PD showed similar features to female patients with a diagnosis of PD, particularly in the high proportions with previous childhood abuse (59%), self-harm (89%), and alcohol and/or drug misuse (78%). Nearly half (47%) had a history of violence.

Suicide by patients who identified as lesbian, gay, bisexual or trans

- In 2016-20, there were 223 deaths by patients who identified as lesbian, gay or bisexual (LGB), an average of 45 per year; 4% of all patient suicides (see details on page 37). These figures are likely to be underestimates.
- A high proportion of LGB patients had experienced childhood abuse (55%) and they were more likely to have experienced domestic violence (18%). They were younger than other patients (18% were aged under 25) and 26% had been given a diagnosis of personality disorder and 69% had a history of self-harm.
- There were 37 patients within a trans group, 7 per year, 1% of all patient suicides. We are using "trans" as an umbrella term to include transgender, transsexual, or non-binary but we acknowledge that the terms people use to describe their own identity can be dynamic and we will be monitoring this in future reports.
- Trans patients were younger than other patients (35% were aged under 25). Over half (56%) lived alone. The majority (57%) had experienced childhood abuse, including emotional (46%), sexual (35%) and physical (31%) abuse.
- The most common diagnosis seen in this group was personality disorder (47%). 83% had a history of self-harm. Risk was less likely to be viewed by clinicians as low or not present in trans patients.

Suicide-related internet use

- Between 2011 and 2020, there were 73 deaths per year in patients with evidence of suicide-related internet use, 8% of all patient suicides. This included obtaining information on suicide method, visiting pro-suicide websites, and communicating suicidal intent online. The number has generally been increasing since 2011 though figures for 2019-20 suggest a recent fall (see details on page 39).
- Patients with evidence of suicide-related internet use were more likely to be employed (30%); half (52%) were single and 43% lived alone. They were most often aged 25-44 (42%) or aged 45-64 (33%); 18% were aged under 25. Those aged under 25 were more likely to communicate suicidal ideas online than older patients (11% v. 2%).
- The most common diagnoses were depressive illness (37%) and personality disorder (16%). 5% had a diagnosis of autism. Of those who had evidence of suicide-related internet use and who died by self-poisoning, the substance used was more often tranquillisers that are rarely prescribed and may have been bought online.

CLINICAL MESSAGES

1. Clinical care

Patient suicide numbers and rates in the UK are relatively stable. To bring these figures down in the face of sustained and growing pressures, clinicians should focus on common factors associated with suicide including living alone, self-harm and comorbid alcohol and drug misuse. Loss of contact is still common before suicide and services should actively re-establish care in this situation, involving family members where possible.



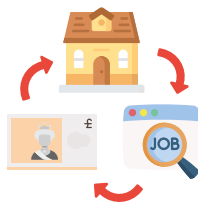
2. Acute care

In-patient admission and recent discharge from hospital continue to be periods of high risk. Services should improve patient safety at these times by (1) removal of low-lying ligature points and (2) ensuring pre-discharge leave and discharge planning address adverse circumstances the patient may be returning to. These recommendations form part of our ["10 ways to improve safety"](#). Our [previous work](#) has also highlighted the need to improve the in-patient experience and enhance the therapeutic relationship to reduce risk.



3. Economic adversity

We are entering a period of rising cost of living when patients are likely to be at additional risk. Our data show both the importance of long-standing socio-economic factors and, additionally, the potential impact of recent financial stress. Frontline staff should be aware of the risks of new problems of loss of job, benefits, housing, etc and should have the information to signpost patients to sources of financial support and advice, such as [Mental Health & Money Advice UK](#).



4. Patients aged under 25 years

The increase in suicide among young people in the general population is also reflected in the patient population. Patients under 18 and those aged 18-24 show different characteristics and risks relevant to prevention. For the under 18s, the role of family and educational settings, and the management of anxiety and autism, are especially important. In the older group, prevention should stress the treatment of severe mental illness and co-morbid substance misuse. Self-harm services are crucial to both groups.



5. Patients given a diagnosis of personality disorder

Suicides in this group appear to be increasing, particularly among women. Addressing these patients' needs is an essential component of prevention by services. Historically they have been excluded from services and better models of safe and compassionate care are now needed.



6. Patients who identify as LGB or Trans

Clinicians should be aware of the prejudice that patients in LGB and trans groups may have experienced and other factors that may add to suicide risk. They should ensure these are reflected in engagement, assessments and care plans. Many have a history of abuse and psychological therapies addressing previous trauma should be offered.



7. Suicide-related internet use

Clinicians should be aware that suicide-related internet use is a feature of suicide by mental health patients of all ages. It takes a number of forms, including information promoting suicide methods. Enquiry about exposure to internet risks should be a routine part of risk assessment.



SCOPE OF THE REPORT

This report provides findings relating to people aged 10 and above who died by suicide in 2010-2020 across all UK countries. Additional figures are presented on people convicted of homicide.

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 159,000 suicides in the general population, including over 39,500 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 2020 the median time from the occurrence of a suicide to its registration was 165 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), homicide (based on year of conviction) and homicide-suicide (based on date of offence, in England and Wales only).

Our suicide figures differ from official statistics from the Office for National Statistics (ONS) who present figures by date of death registration.

For the period 2010-2019, overall data completeness for patient suicide in the UK is 93%. Data completeness is lower in the final year reported, in this case 2020, at 61% (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.

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 2018-2020 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.

Changes to suicide death coding in Northern Ireland

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

NISRA recommends that until the review process is complete, to use figures from 2015 relating to registered deaths from self-inflicted injury only. This means the figures relating to date of death in Northern Ireland in 2015-2020, and to a lesser extent in 2013 and 2014, have fallen and cannot be compared with the number of suicides in earlier years. Our suicide figures also differ from NISRA who present figures by date of death registration.

UK-WIDE FINDINGS

SUICIDE IN THE UK

Between 2010 and 2020, NCISH was notified of 68,357 deaths in the general population that were registered as suicide or “undetermined”, an average of 6,214 per year. These are referred to as suicides throughout the report. Rates in the UK increased in 2018-2019 but fell overall in 2020 (Figure 1). Rates also increased between 2010 and 2012 but subsequently fell.

Suicide rates for each UK country are shown in Figure 2, presented by date of death. England and Scotland experienced higher figures in 2018-20, though the rates in Scotland remain lower than earlier in the report period.

Rates in Wales fell since an increase in 2017. Lower recent rates since 2014 in Northern Ireland reflect a change in how some drug-related 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 (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.

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

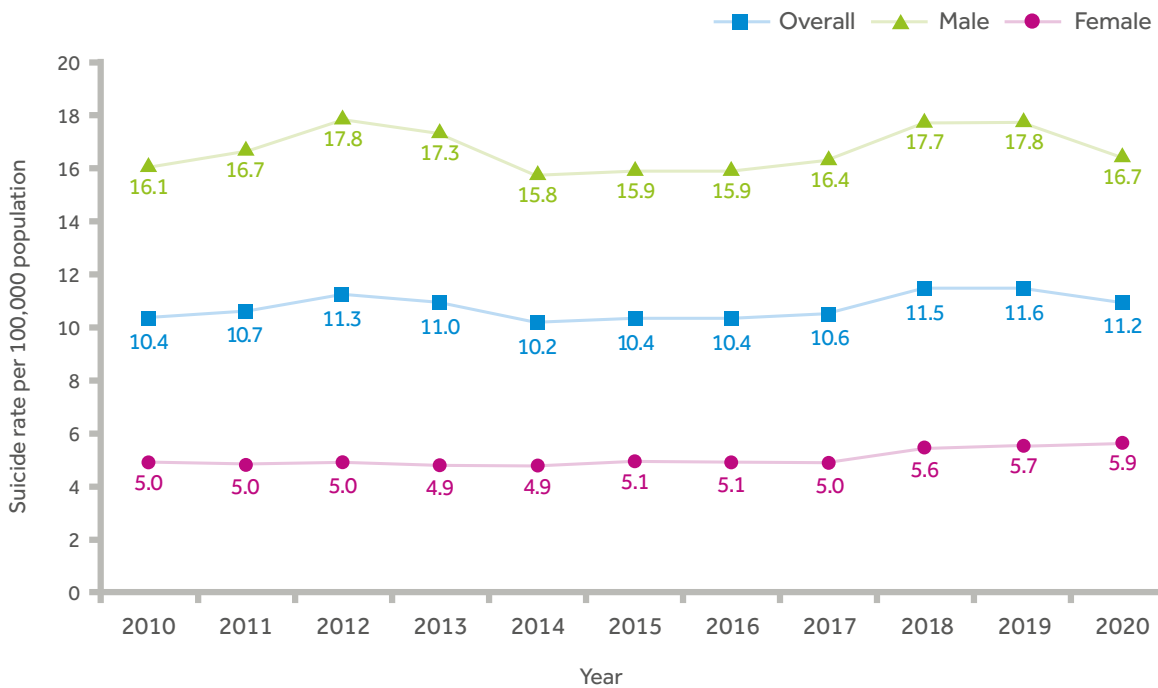
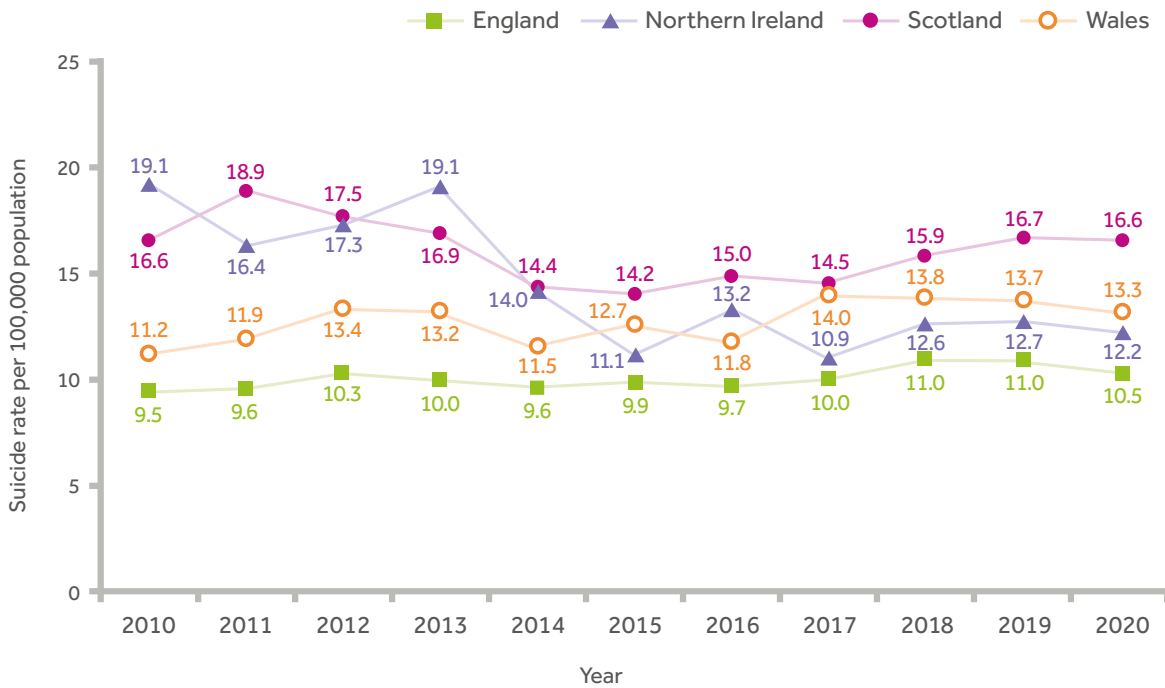
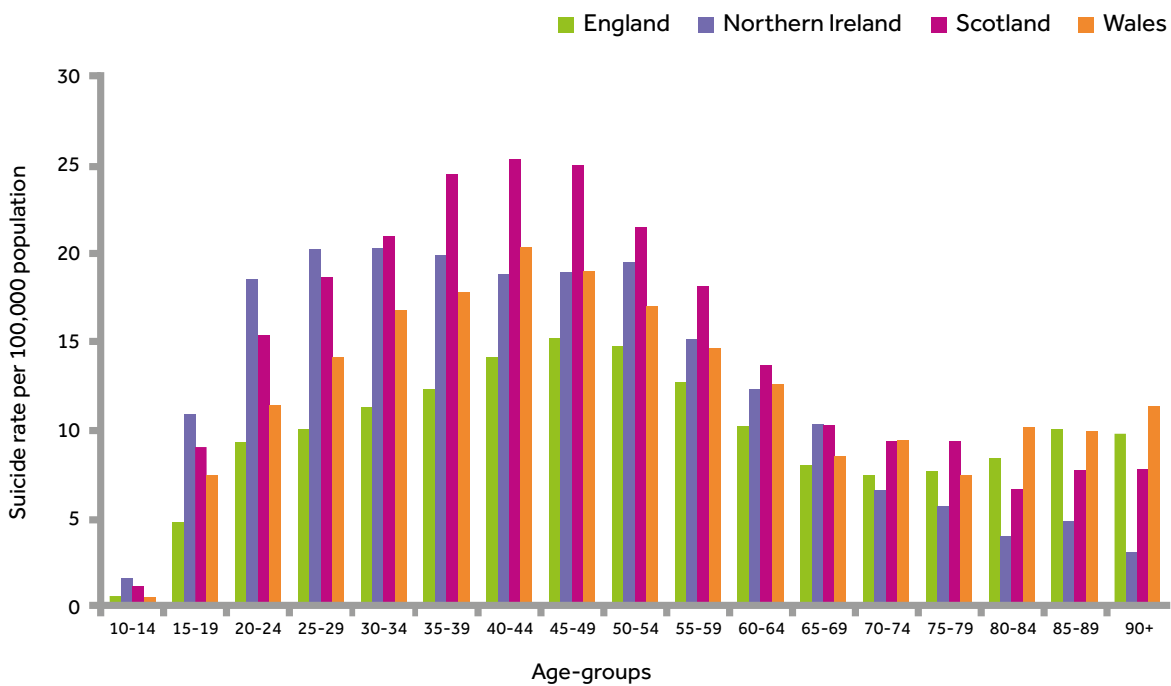


Figure 2: Suicide rates by year of death in the general population, by UK country



Note: The rates in 2015-2020 in Northern Ireland indicate the current guidance from 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 (2010-2020)



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 2018-20 but a lower number of deaths by jumping/multiple injuries (Figure 4). Deaths by hanging/strangulation have increased almost every year since 2010, with a 18% increase in 2019 compared to 2017, though there was a fall in 2020. This increase in hanging/strangulation was in men and women, and in all age-groups of under 25, 25-44, 45-64 and 65 and over.

Deaths from jumping/multiple injuries have continued to fall since 2014, while deaths by self-poisoning have recently increased following a decrease prior to 2015.

Of the less common methods, deaths from gas inhalation have fallen by 41% since 2015 following a previous increase, while deaths from cutting/stabbing have increased (Figure 5). Firearms remain a minor method, constituting less than 2% of all deaths, with a fall since 2012.

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

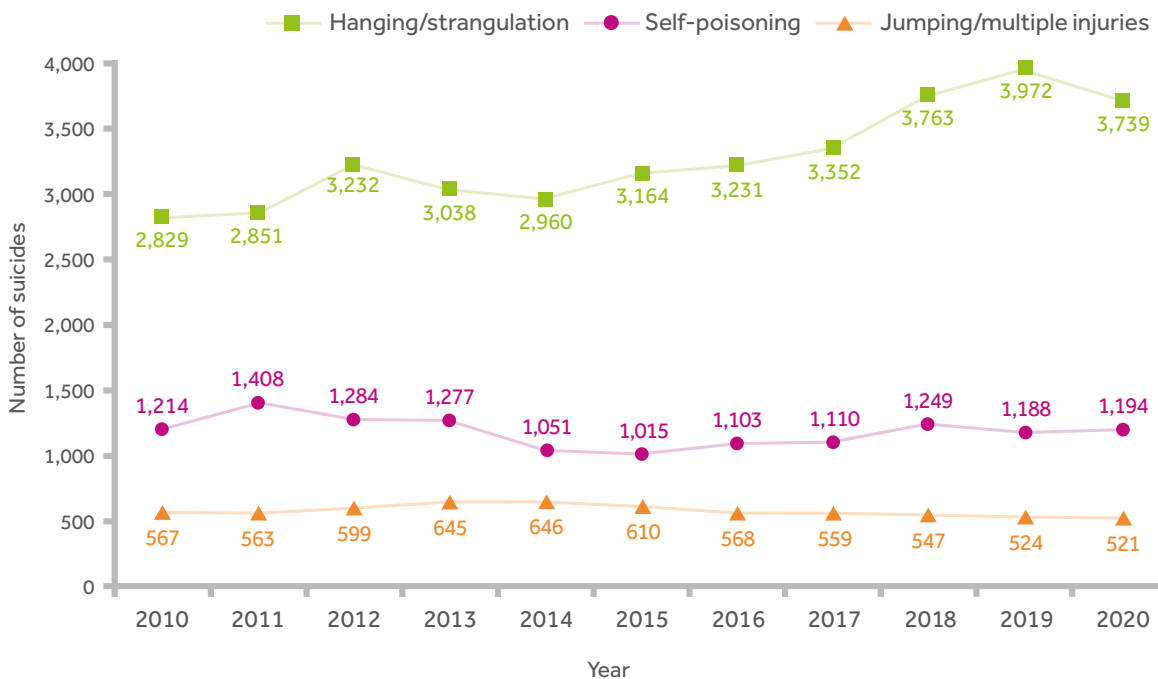
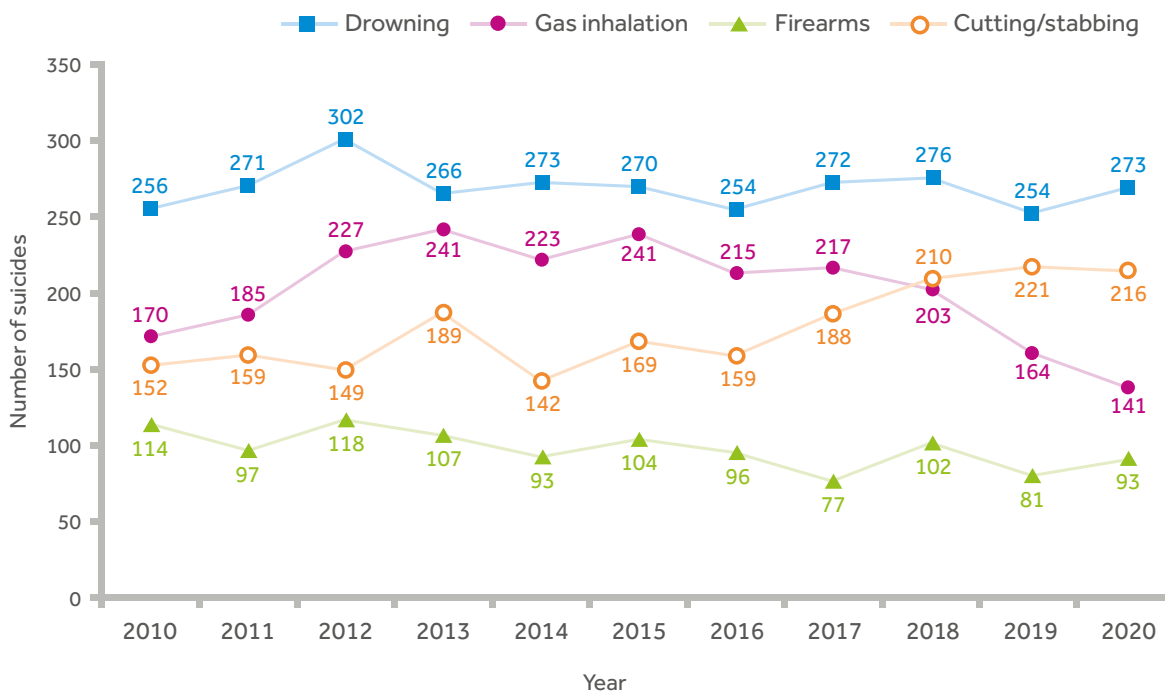


Figure 5: Suicide in the general population in the UK: other suicide methods



PATIENT SUICIDE IN THE UK

There were 18,403 suicide deaths by patients (i.e. people in contact with mental health services within 12 months of suicide) in the UK in 2010–2020, 27% of all general population suicides, an average of 1,673 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 2018–19, mostly driven by an increase in the number of female patients (Figure 6).

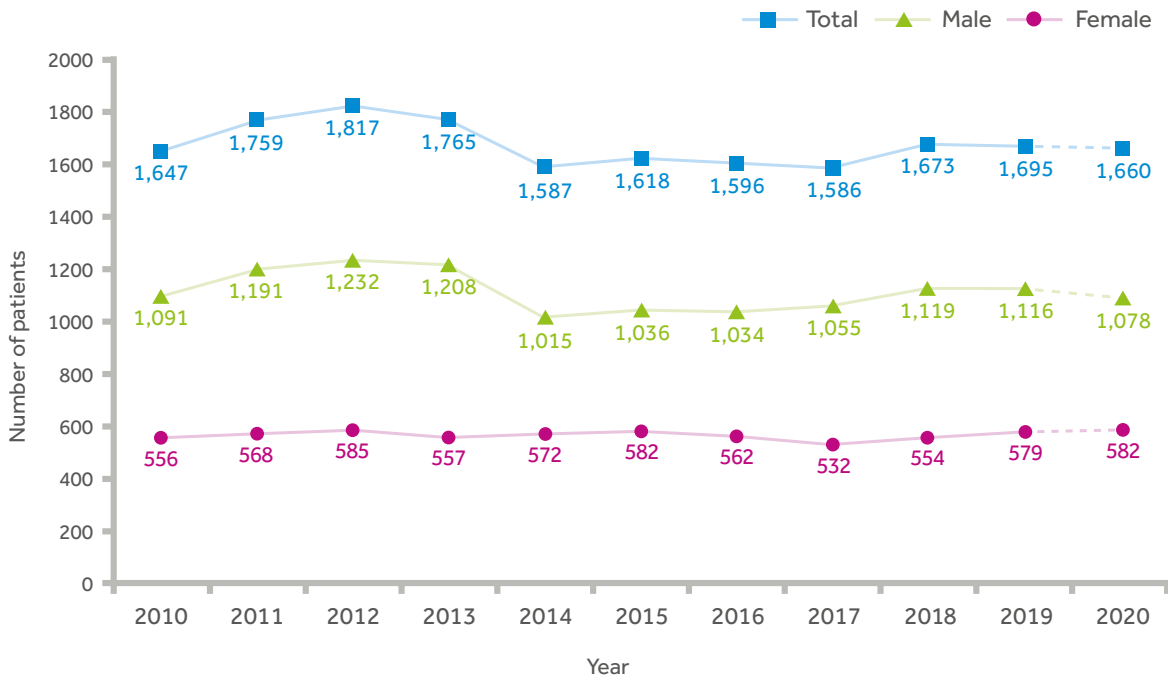
This is the first report where we can provide the number of patient suicides who died by suicide in 2020 following the onset of the COVID-19 pandemic – we have not seen an increase in 2020 overall or in vulnerable groups such as those aged under 25 or those aged 75 and over.

We are estimating an increase in England and Scotland in 2018–19 and a slight fall in 2020, though overall the highest figures were in 2011–12, with an apparent fall since then (Figure 7).

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 98.5 per 100,000 mental health service users in 2010 to 47.2 per 100,000 in 2020, though the most recent figures show little change (Figure 8).

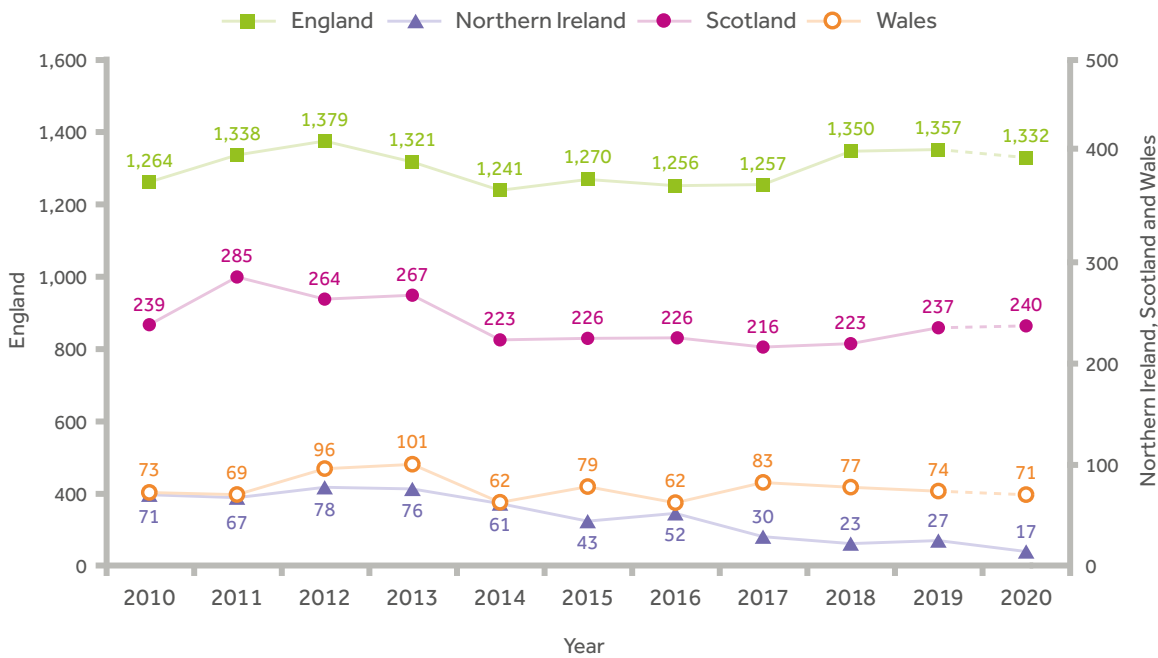
The Mental Health Services Data Set (MHSDS) was used to calculate rates. Changes in MHSDS methodology means rates between 2010–2011 and 2011–2020 are not directly comparable.

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



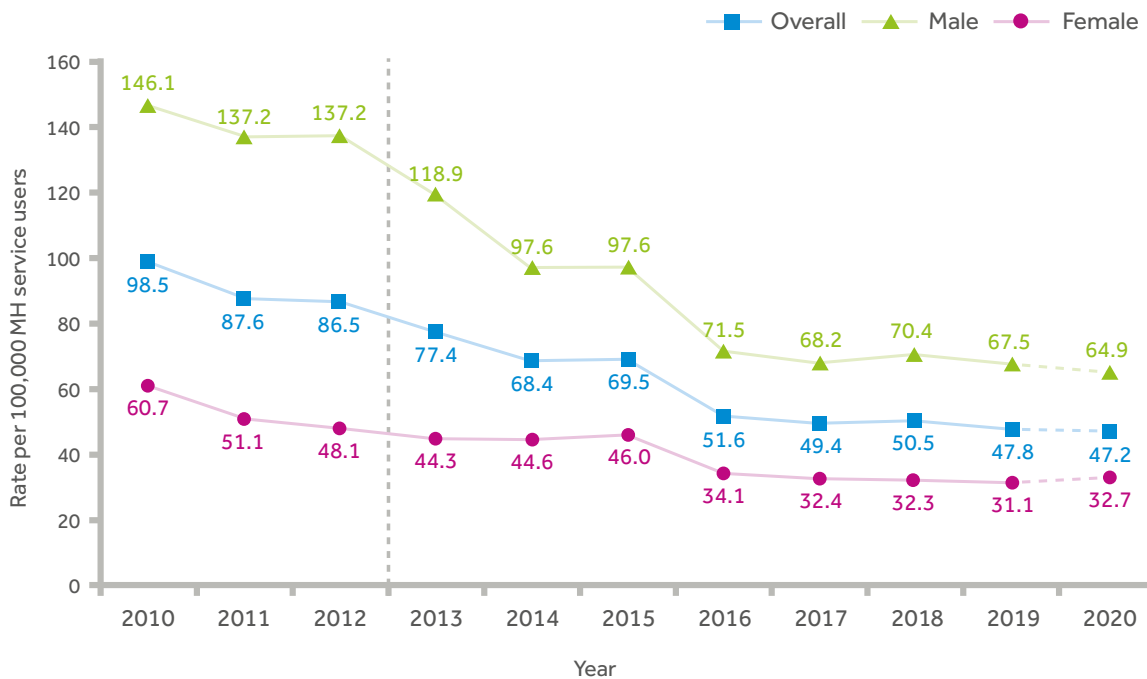
Notes: Male and female numbers in 2017 do not total the overall figure due to rounding.

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



Note: Patient data shown in Northern Ireland in 2019 and 2020 are true figures

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 between 2010-2011 and 2011-2020 are not directly comparable.

Method of suicide by patients

The most common methods of suicide are shown in Figure 9. Hanging/strangulation increased by 16% during 2010-2020 (Figure 10). The increase was especially seen in women, from an average of 34% of all female deaths in 2010-2013 to 42% in 2017-2020, and in patients aged under 25, from an average of 54% in 2010-2013 to 63% in 2017-2020. The number of deaths by jumping/multiple injuries has fallen by 35% since 2013.

Overall the number of deaths by self-poisoning increased between 2010 and 2012 because of a rise in opiate deaths but has been lower since. However, we are estimating an increase in the number of self-poisoning deaths in 2019-20, continuing a rise since 2016.

Opiates (including opioid compounds) accounted for 34% of deaths by self-poisoning, though the number of deaths using opiates and opioids fell by 29% between 2010 and 2020. There was a 32% fall in the number of self-poisonings using paracetamol between 2010-2013 and 2017-2020. The number of deaths by psychotropic drugs fell by 45% between 2010 and 2020.

We have collected data on the types of opiates used since 2012, the most common being heroin/morphine (248, 38%), codeine (124, 19%), tramadol (106, 16%) and methadone (84, 13%). Information on the source of the opiates/opioids was available in 46% of those who died using these substances. In 218 (53%, excluding unknowns) these had been prescribed for the patient, an average of 24 deaths per year.

UK country differences: Northern Ireland (57%) and Wales (55%) had a higher proportion of suicide by hanging/strangulation compared to the UK average (47%).

The proportion of deaths by self-poisoning was higher in Scotland (34% v. 23%), with more patients using opiates and opioids (48% v. 31%), particularly methadone (19% v. 11%).

See additional online data for further details.

Figure 9: Patient suicide in the UK: suicide methods

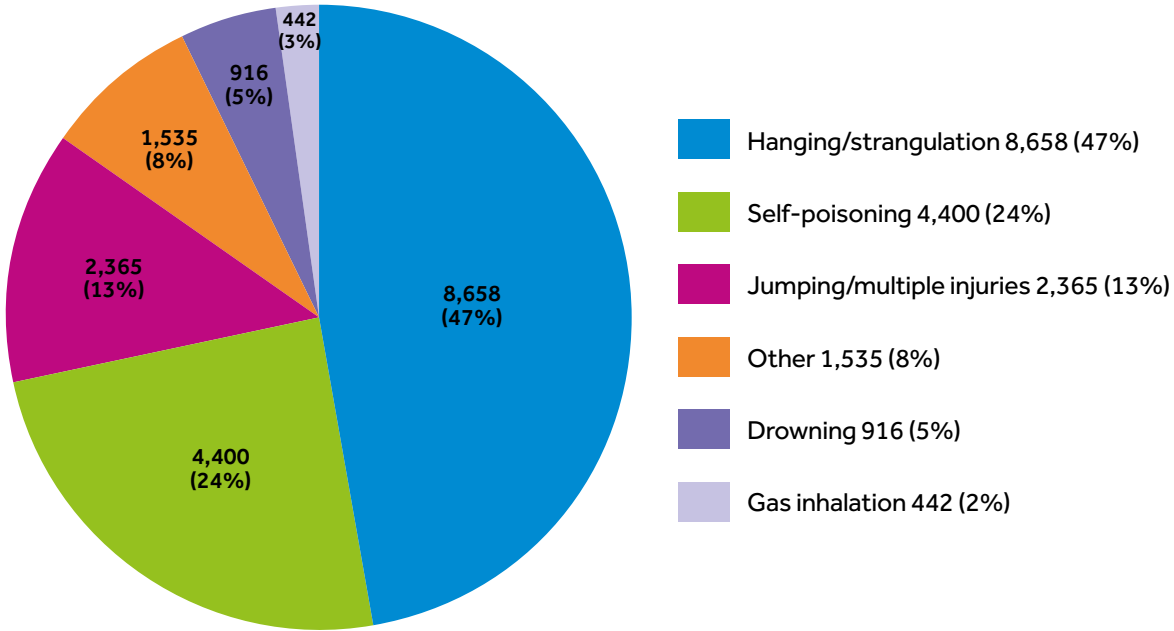
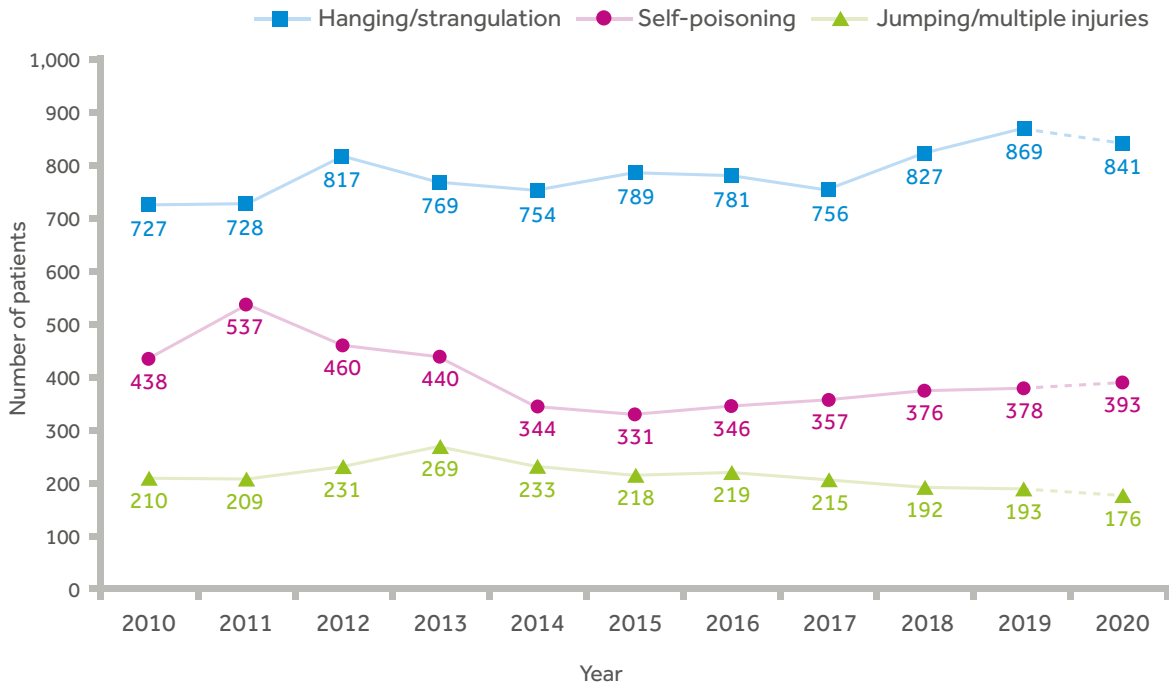


Figure 10: Patient suicide in the UK: main suicide methods



Patient data unavailable in Northern Ireland in 2019-2020.

Social and clinical characteristics

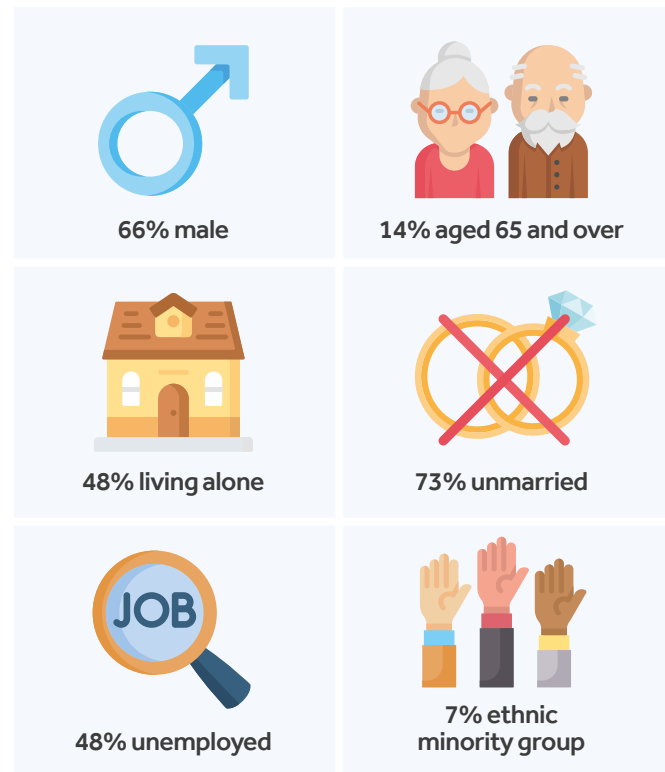
Box 1 shows some of the social features of patients dying by suicide in the UK. These patients had high rates of socio-economic adversity and isolation, indicated by unemployment and living alone. The majority (12,175, 66%) were male patients and 73% were unmarried. Nine percent were aged under 25 (see further details on page 29) and 14% were aged 65 and above. Since 2015 we have asked whether the patient was within a trans (including transgender, transsexual, non-binary) group and have identified 37 (1%) patients under this question (see further details on page 37).

Between 2011 and 2020, there were an estimated 756 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 76 deaths per year. The number has fallen by 24% over this period, from an average of 90 per year in 2011-2014 to 68 per year in 2017-2020. We have recently published a detailed study of suicide by migrants to the UK, which can be accessed at our [website](#).

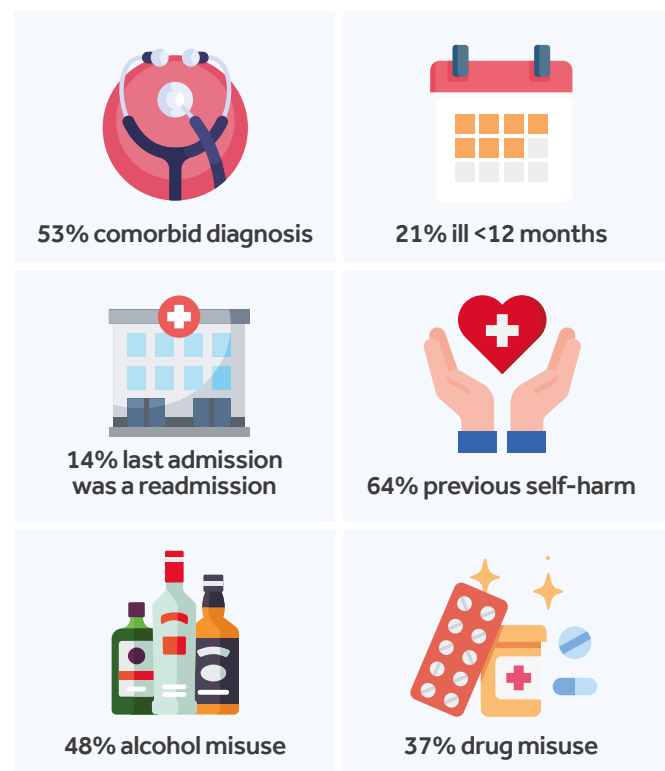
Around half had a comorbid (i.e. additional) mental health diagnosis, and rates of previous self-harm and alcohol misuse were high (Box 2). The proportion of patients with a history of self-harm decreased by 9% between 2010 and 2020. There was a 13% increase in the proportion of patients with a comorbid diagnosis, indicating increasing clinical complexity.

Since 2015, we have collected data on whether the contact with services was a one-off contact and this was the case for 759 (13% excluding unknowns) patients. They were more likely to be employed (193, 32% v. 1,006, 21%) and have a diagnosis of alcohol and/or drug dependence/misuse (141, 20% v. 481, 9%) than other patients. In nearly a fifth the contact was after a recent (<3 months) urgent GP referral (121, 18% v. 681, 13%).

Box 1: Socio-demographic characteristics of patients who died by suicide in the UK (2010-2020)



Box 2: Clinical and behavioural characteristics of patients who died by suicide in the UK (2010-2020)

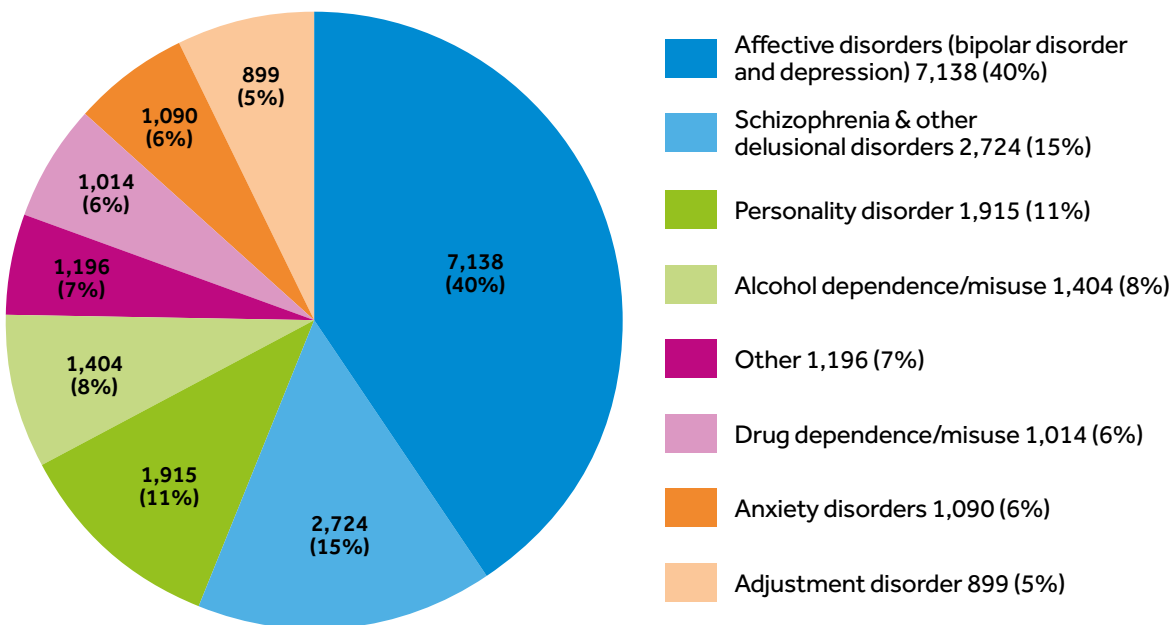


Diagnosis

The main primary mental health diagnoses are shown in Figures 11 and 12. Suicide by patients with affective disorder (bipolar disorder and depression) has generally been falling since 2012 and we are estimating a continued fall in 2020, with an average of 649 deaths per year during the report period (Figure 12). In patients with schizophrenia and other delusional disorders, the number in 2018-20 has continued to be lower than in earlier years of the report when there was a peak in 2013, with an average of 248 per year over the whole report period.

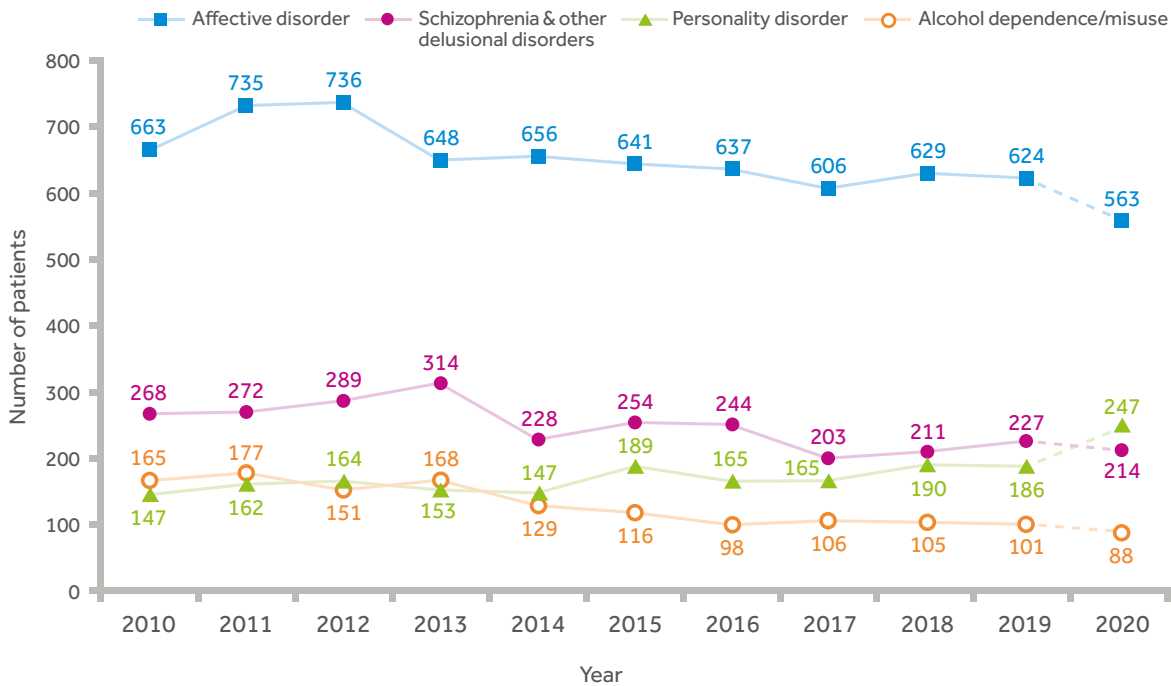
In patients given a diagnosis of personality disorder, the number increased in 2018-20, continuing a rise since 2010, with an average of 174 per year. The number of patients with alcohol dependence/misuse fell after 2011, with an average of 128 per year during the report period. Similarly, the number of patients with drug dependence/misuse has remained lower since 2013, with an average of 92 per year. The number of patients with anxiety disorders rose by 42% between 2010 and 2020, with an average of 99 per year.

Figure 11: Patient suicide in the UK: primary diagnoses



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

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



Patient data unavailable in Northern Ireland in 2019-2020.

UK country differences: More patients in England (42%) and Wales (39%) had affective disorder (bipolar disorder and depression) 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 (14%).

Alcohol and drug dependence/misuse were more common in patients in Northern Ireland (20% and 9% respectively) and Scotland (13% and 13%) compared to England (6% and 4%) and Wales (9% and 7%).

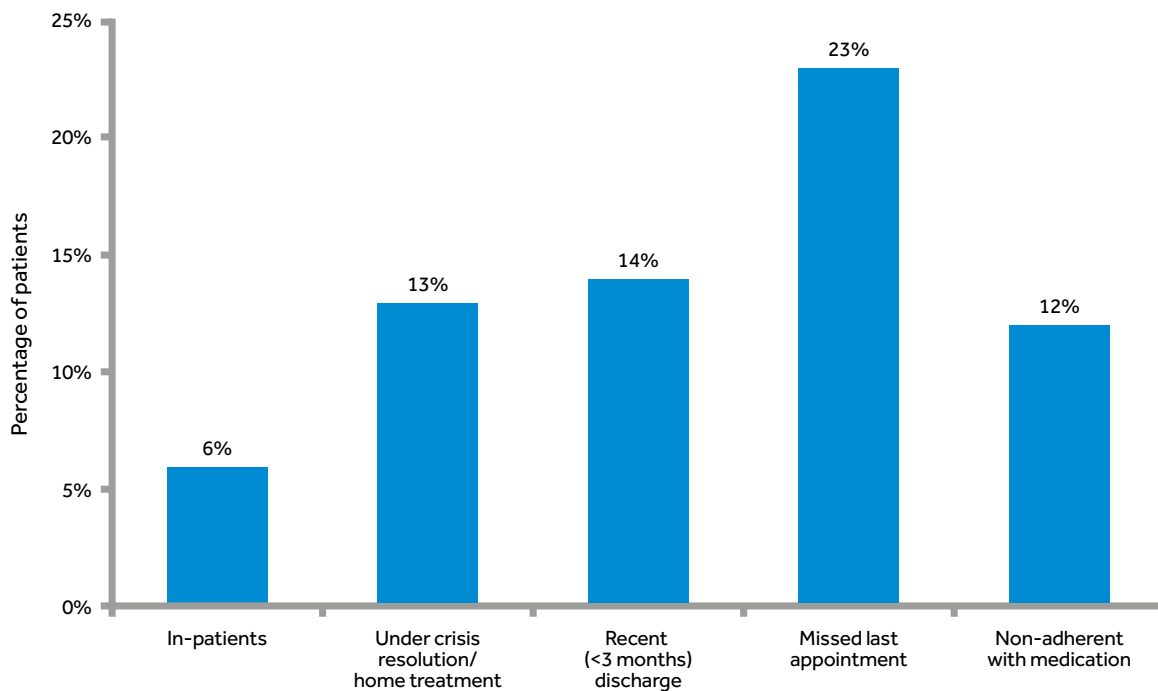
See [additional online data](#) for further details.

MENTAL HEALTH CARE

During 2010–20, 5,103 patients (28%) who died by suicide were in acute care settings (in-patients, under crisis resolution/home treatment (CRHT), recently discharged from in-patient care) (Figure 13). A quarter (3,937, 23%) had missed their last appointment with services and 2,042 (12%) had not taken medication as prescribed.

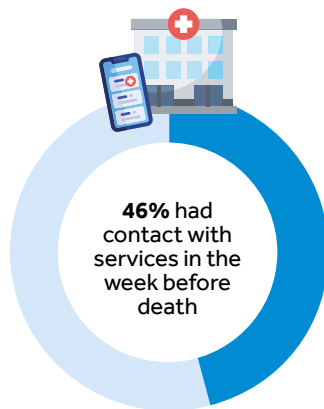
The most common non-acute settings were community mental health services (14%), alcohol or drug services (13%), and older person’s mental health services in the community (8%). Nearly half of all patients (7,693, 46%) had been in recent (<7 days) contact with mental health services.

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 (83%) of patients who died by suicide. In our report [“The assessment of clinical risk in mental health services”](#) we examined current practice on risk assessment and recommended that risk assessment tools should not be seen as a way of predicting suicidal behaviour. Rather, the management of risk should be personal and individualised.



UK country differences: There were fewer patients in Northern Ireland (8%) and Scotland (7%) receiving care under crisis resolution/home treatment services compared to England (15%) and Wales (11%).

More patients in Northern Ireland (37%) 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

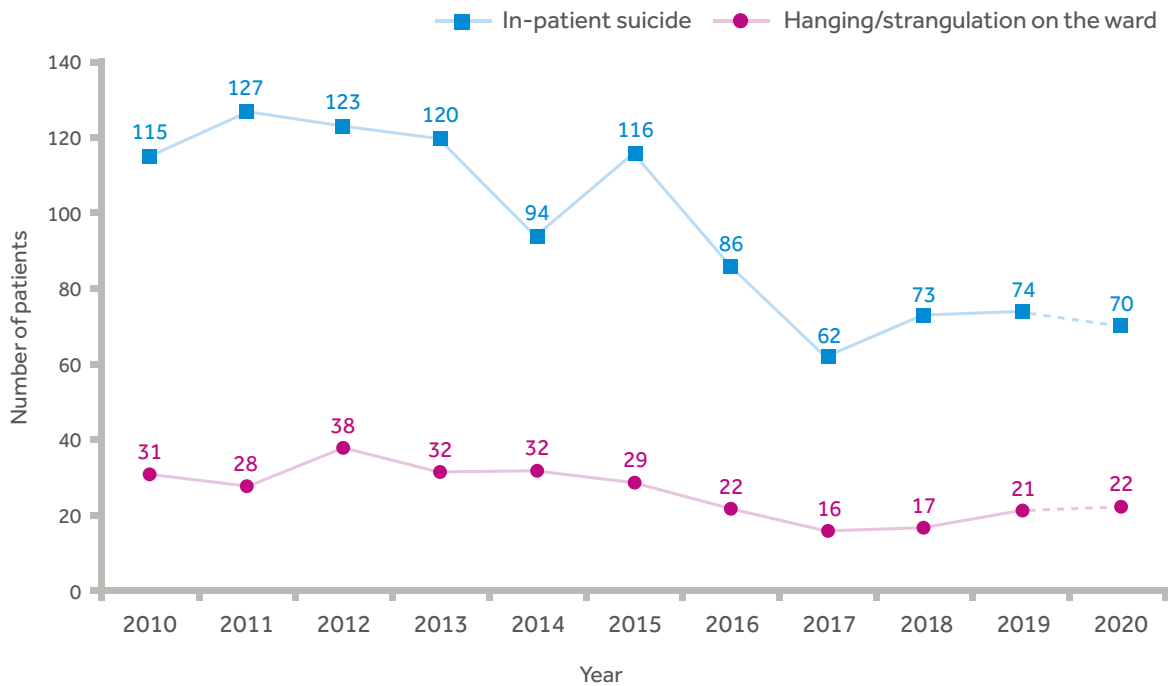
There were 1,060 in-patient deaths by suicide in 2010-2020, representing 6% of patient suicides overall during this time period, but with a lower figure since 2016 (4% in 2020). Sixteen (2%) were aged under 18.

From 2010 to 2020, there was a 39% fall in the number of in-patient suicides, though figures in 2017-20 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 2018-2020 using the average proportion of all patient suicides that were in-patients in recent years and adjusting for expected questionnaire returns.

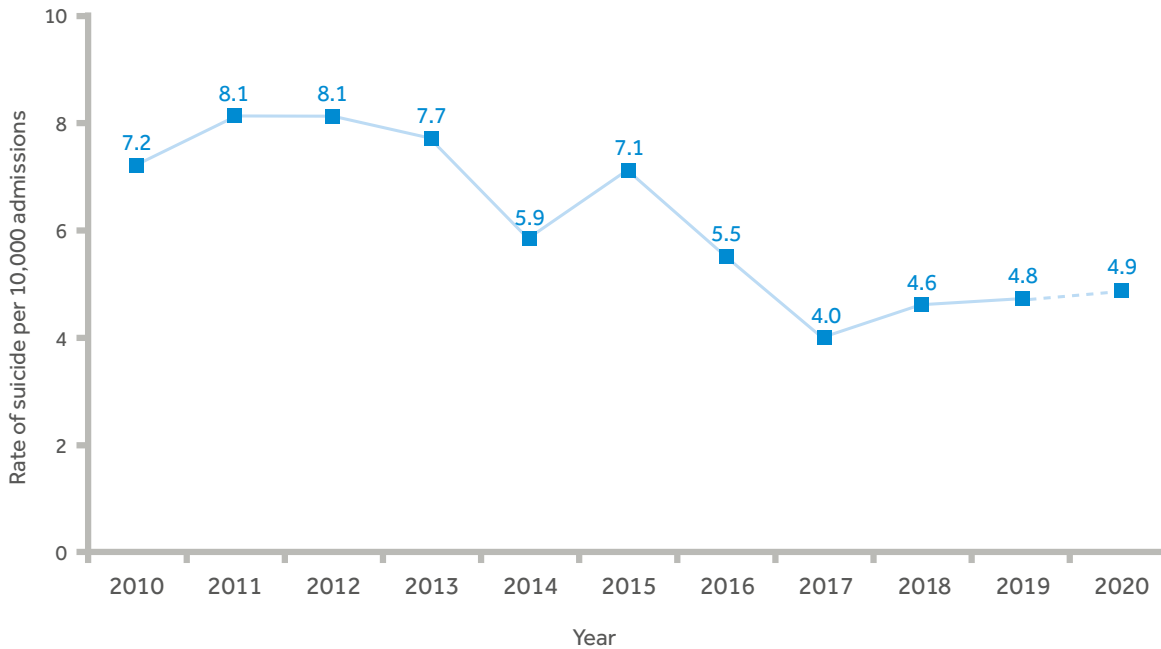
In-patient suicide numbers may be affected by changes in the number of admissions. Nonetheless, we found rates of in-patient suicide per 10,000 admissions still fell by 32% in 2010-2020 (Figure 15). Our figures since 2015 appear to be lower, although at this stage this includes a degree of estimation and so should be treated with caution.

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



Patient data unavailable in Northern Ireland in 2019-2020.

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



Patient data unavailable in Northern Ireland in 2019-2020.

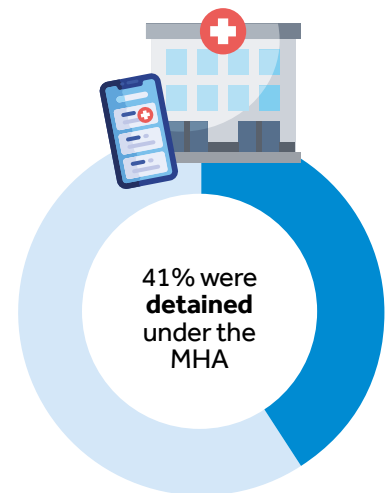
In-patients who died on the ward

There were 337 patients who died on the ward, 37% of in-patient suicides, an average of 31 deaths per year. Six (2%) were aged under 18. From 2010 to 2020, there was a 34% fall in the number of in-patients who died on the ward, in line with the fall in overall in-patient suicides.

The majority (80%) died by hanging/strangulation. Between 2010 and 2014 there were on average 32 deaths per year by hanging/strangulation on the ward but since 2015 the number has fallen to an average of 19 deaths per year (Figure 14). Many (216, 94%) are from low-lying ligature points (i.e. strangulation) but also include deaths by strangulation with no ligature point (i.e. self-strangulation). The majority died in a single bedroom (164, 63%) or a toilet/bathroom (74, 28%).

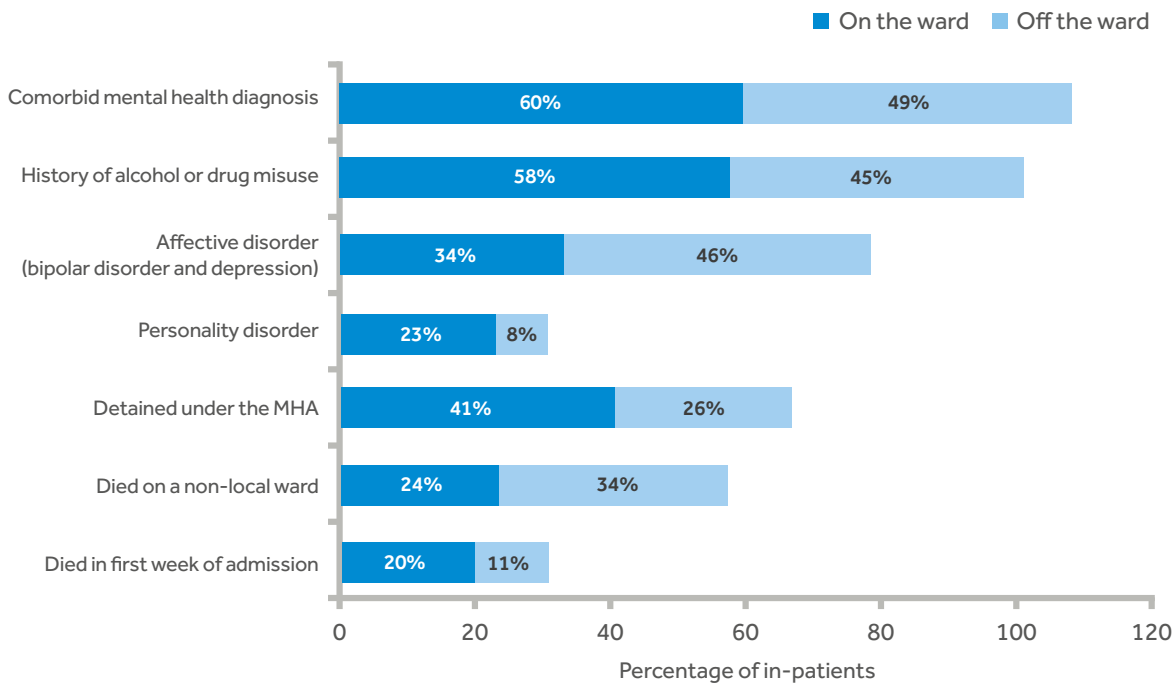
The most common ligature points were doors (119, 50%) or windows (21, 9%). The most common ligatures were a belt (72, 28%), sheets/towels (65, 26%) or shoe laces (289 11%). Overall, 155 (65%) patients used a ligature relating to an item of clothing or a personal object (e.g. clothing, belt, shoe laces, bag strap, etc).

Figure 16 shows the key differences between in-patients overall who died on the ward and other in-patients, which includes patients who left the ward on agreed leave (461, 50%) or absconded from the ward (124, 13%).



Those who died on the ward were more likely to have been given a diagnosis of personality disorder, comorbidity (i.e. additional mental health diagnosis) and alcohol and/or drug misuse. Fewer died on a non-local in-patient unit but more were detained under the Mental Health Act 2007. A fifth died in the first week of admission. Over a third (119, 37%) were under a medium or high level of observation.

Figure 16: In-patient suicide in the UK: characteristics of those who died on the ward



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

In Scotland there were more in-patients who died in the first week of admission (22% v. 12%) or who died off the ward without staff agreement (37% v. 18%).

[See additional online data for further details.](#)

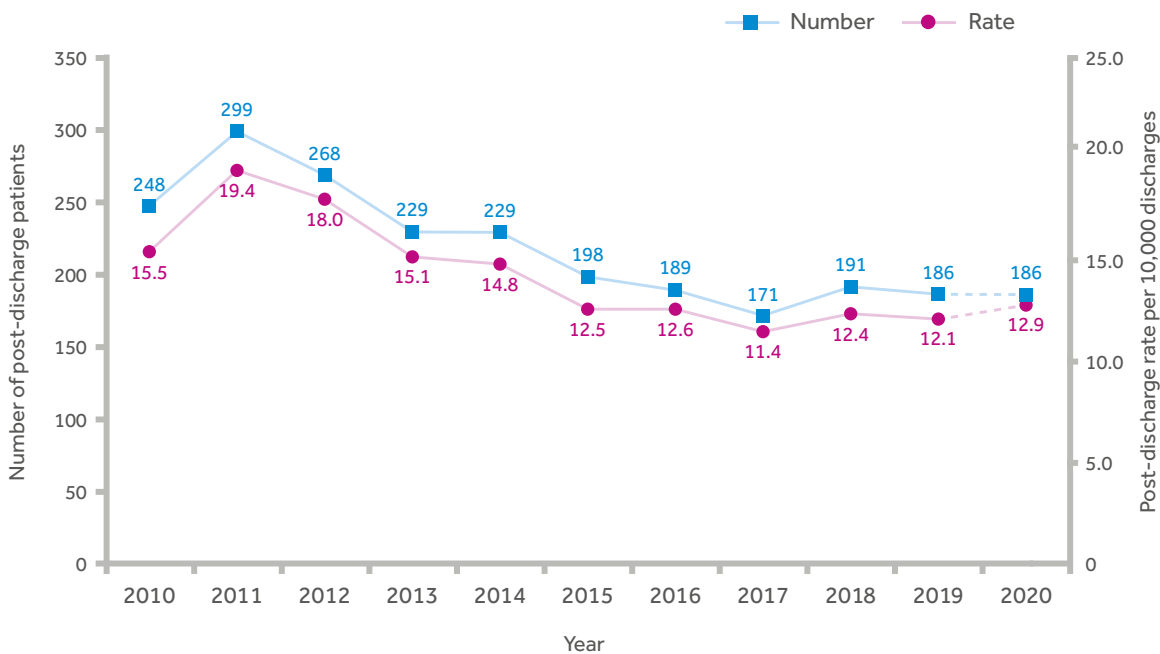
Patients under a Community/Compulsory Treatment Order (CTO)

There were 229 patients who died by suicide having been subject to a CTO in 2010-2020, 1% of all patient suicides, an average of 21 per year. Around a third (83, 36%) 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 2,394 suicides within 3 months of discharge from in-patient care, 14% of all patient suicides, an average of 218 deaths per year. 15 (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 2010-14 being 255, and for 2016-20 being 185 (Figure 17). The average rate of suicide was 14.3 per 10,000 discharges (Figure 17).

Figure 17: Patient suicide in the UK: number who died within 3 months of in-patient discharge and rate of suicide per 10,000 discharges



Note: Patient data unavailable in Northern Ireland in 2019-2020

The figures for 2018-2020 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.

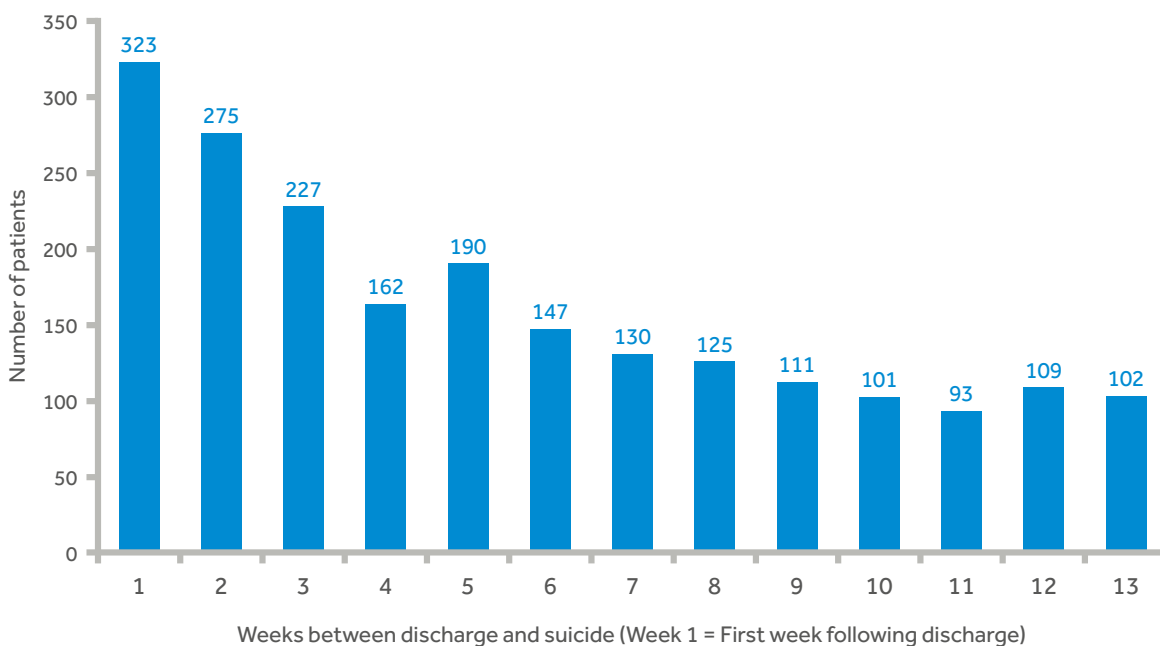
Post-discharge suicides were most frequent in the first 1-2 weeks after leaving hospital when 598 deaths (29% excluding unknowns) occurred (Figure 18). Of the 323 deaths in the first week after discharge, the highest number (67, 21%) occurred on day 3 after leaving hospital (day 1 = day of discharge). Over half (172, 55%) of those who died in the first week post-discharge had experienced recent adverse life events, with family problems (11%) more commonly reported than in other post-discharge patients (6%). Our recommendation that all patients are followed up within 72 hours of discharge from in-patient care is now included in the standard NHS contract by NHS England.¹

Since 2015 we have collected data on the circumstances the patient was discharged to. In 2015-2020, 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).

229 (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 (28%). The number of patients who died before the first follow-up fell by 43% over the report period, from an average of 35 per year in 2010-11 to 20 per year in 2019-20.

203 (9%) died after being discharged from a non-local in-patient unit. In 2020 there were 10 (9%) suicides after discharge from a non-local unit.

Figure 18: Patient suicide in the UK: number per week following discharge (2010-2020)



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/nhs-standard-contract/22-23/>

Patients who had missed their last appointment with services

There were 3,937 suicides by patients who had missed their last service contact, 23% of all patient suicides, an average of 358 deaths per year. 43 (1%) were aged under 18. The number who missed their last contact fell in 2014 and has since remained stable, though we are estimating an increase in 2019-20 (Figure 19).

Those who missed their last appointment were younger than patients who had not missed their last contact, the majority being aged under 45 (54% v. 44%). They had high rates of social adversity and isolation, e.g. unemployment (57% v. 45%) and living alone (56% v. 46%). Their clinical profile differed with higher rates of personality disorder diagnosis (12% v. 10%), alcohol (11% v. 7%) or drug (8% v. 5%) dependence/misuse. The majority had a comorbid (i.e. additional) mental health diagnosis (59% v. 52%) and in a higher proportion, medication was not taken as prescribed (19% v. 11%).

These patients showed traumatic histories, with more self-harm (67% v. 61%) and violence (25% v. 19%). Around a quarter had experienced recent economic adversity including loss of job, benefits or housing (24% v. 19%) and serious financial problems (22% v. 15%).

Overall, services had made an attempt to follow up with the patient in 93% of patients, most often sending a further appointment (56%), calling the patient (54%) or informing the GP (49%). In only 25% the family was contacted regarding the missed appointment.

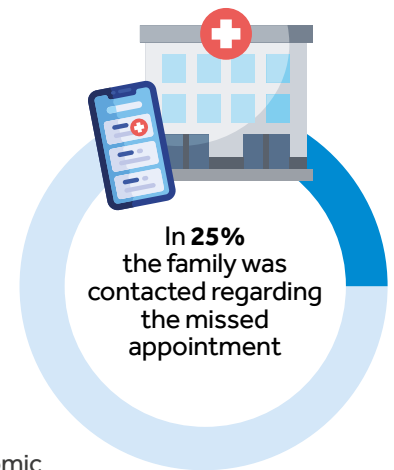
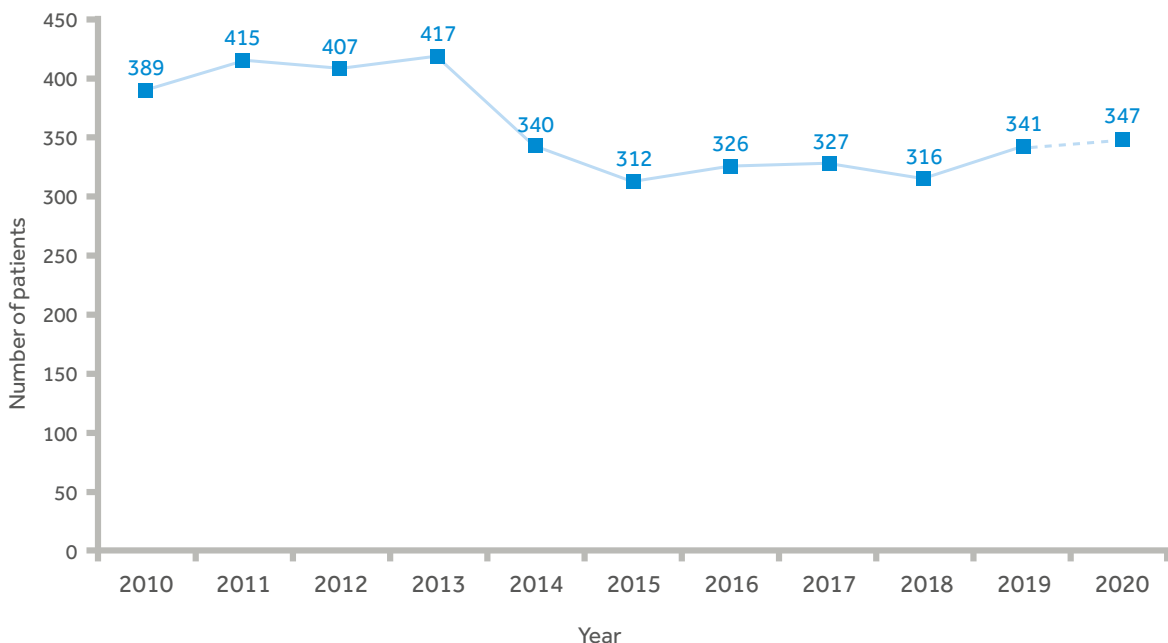


Figure 19: Patient suicide in the UK: number who missed their last appointment with services



Note: Patient data unavailable in Northern Ireland in 2019-2020

THEMED TOPICS

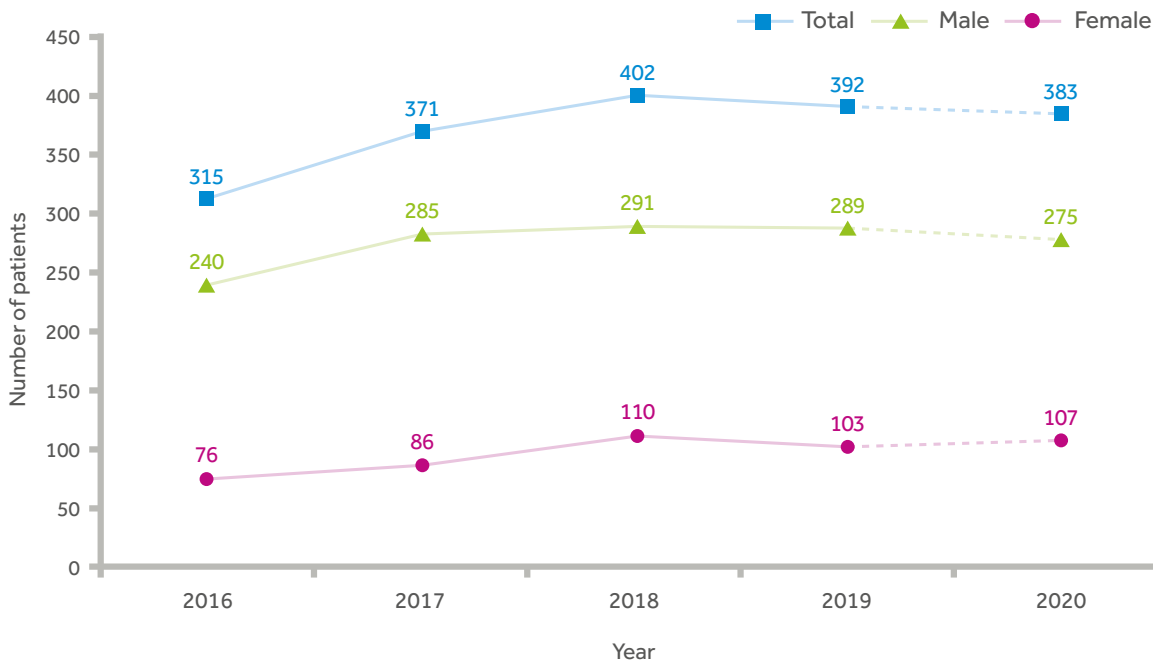
In this section we provide more detailed data on particular themed topics. Some of the groups below reflect those who may be vulnerable to current societal concerns, including patients with financial difficulties, children and young people, and suicide-related internet use. For the first time we have also described the common characteristics of patients who identified as lesbian, gay, bisexual or trans (including transgender, transsexual, or non-binary). We have combined lesbian, gay and bisexual patients due to small numbers but we acknowledge that they are not a homogeneous group.

SUICIDE BY PATIENTS WITH RECENT ECONOMIC ADVERSITY

In the UK, there were 1,864 suicides in 2016-2020 by patients who experienced recent (within previous 3 months) economic adversity. This was defined as patients who experienced: i) serious financial difficulties or ii) loss of job, benefits or housing. The average number of patient suicides was 373 per year over this time period, 27% of the overall number.

There was an increase in the number of patients with economic adversity overall and in women (Figure 20). The increase was driven by those with loss of job, benefits or housing, from an average of 226 patients per year in 2016-17 to 277 per year in 2019-20. Characteristics of those with recent economic adversity are shown in Box 3.

Figure 20: Suicide by patients who experienced recent adverse economic factors (serious financial difficulties or loss of job, benefits or housing) in the UK



Notes: Male and female numbers in some years do not total the overall figure due to rounding. Patient data unavailable in Northern Ireland in 2019-2020.

Below we describe 3 different sub-groups of patients with economic adversity to compare recent and long-standing economic hardship: (1) those unemployed without recent serious financial problems or loss of job, benefits or housing; (2) those unemployed with recent serious financial problems or loss of job, benefits or housing; and (3) those not unemployed but with recent serious financial problems or loss of job, benefits or housing.

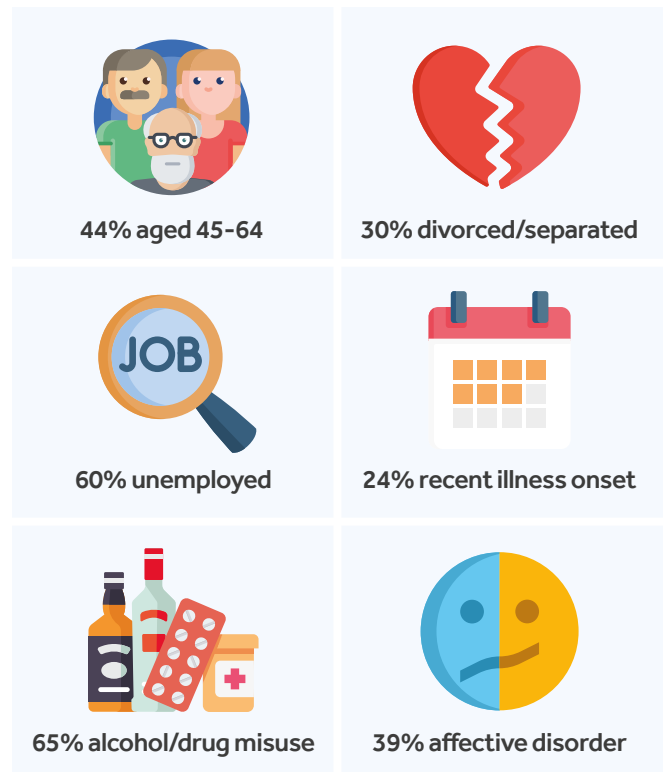
Patients who were unemployed without recent serious financial stress

There were 1,681 (31%) suicides by patients who were unemployed and who had not recently experienced financial difficulties or loss of job/benefits/housing in 2016-2020, an average of 336 per year. These patients were less likely to be divorced (311, 19% v. 404, 30%) or married (232, 14% v. 285, 21%) and more likely to be single (1,035, 64% v. 627, 46%) than patients with financial stress. Fewer were homeless (22, 1% v. 92, 7%), had a diagnosis of depression (324, 19% v. 433, 31%), a recent (<12 months) illness onset (167, 11% v. 294, 24%) or a recent (<3 months) history of alcohol misuse (544, 34% v. 555, 42%) or self-harm (501, 31% v. 507, 37%).

Patients who were unemployed with recent serious financial stress

There were 862 (16%) suicides by patients who were unemployed and who had recently experienced serious financial difficulties or loss of job/benefits/housing in 2016-2020, an average of 172 per year. These patients were more likely to be divorced (225, 28% v. 490, 23%), living alone (479, 58% v. 1,168, 53%) or homeless (82, 10% v. 32, <1%) compared to patients who were not unemployed and/or with no financial stress. More had a comorbid mental health diagnosis (580, 70% v. 1,328, 60%), recent (<3 months) self-harm (332, 41% v. 676, 31%), alcohol (376, 47% v. 723, 34%) or drug misuse (334, 41% v. 575, 27%).

Box 3: Characteristics of patient suicides in the UK with recent economic adversity (2016-2020)



Patients who were not unemployed with recent serious financial stress

There were 570 (10%) suicides by patients who were not unemployed but who had recently experienced serious financial difficulties or loss of job, benefits or housing in 2016-2020, an average of 114 per year. They were more likely to be divorced (179, 33% v. 536, 22%) or married (166, 30% v. 350, 14%) and less likely to be single (178, 32% v. 1,484, 61%) compared to unemployed patients with or without financial stress. Fewer were living alone (237, 44% v. 1,410, 57%), had a recent (<3 months) history of drug misuse (115, 21% v. 794, 33%) or a long-term history of alcohol misuse (239, 45% v. 1,341, 55%) or self-harm (275, 51% v. 1,520, 63%).

More had a diagnosis of depression (215, 39% v. 542, 22%) and a recent (<12 months) illness onset (174, 35% v. 287, 13%). 64 (12%) had a one-off contact with services, more than other patients (201, 9%).

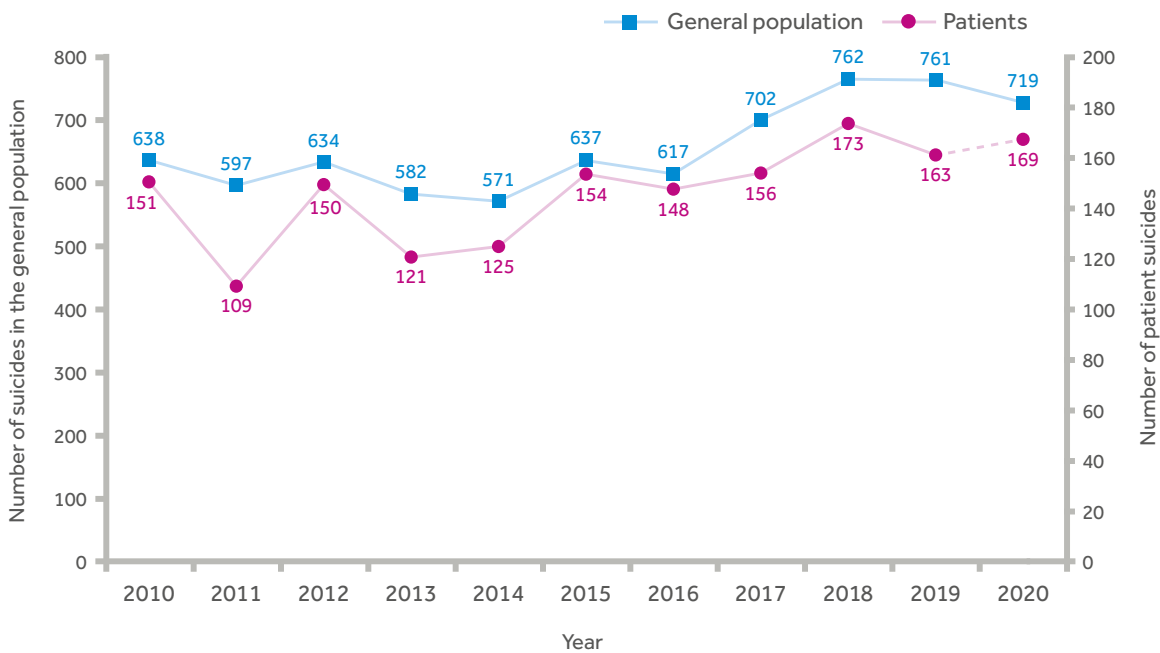
SUICIDE BY PEOPLE AGED UNDER 25

In the UK in 2010-2020, there were 7,220 suicides in the general population by people aged under 25, an average of 656 deaths per year. 1,145 were aged under 18, an average of 104 deaths per year. The number of deaths by people aged under 25 increased in 2017 and has remained higher than earlier years (Figure 21).

Overall, there was an increase in the number of suicides in females aged under 15, aged 18-19 and aged 20-24, and in males aged 15-17. There was an increase in deaths by hanging/strangulation in the under 25s, from an average of 374 deaths per year in 2013-2016 to 497 per year in 2017-2020, a 33% increase.

1,619 (22%) were suicides by patients, i.e. people who had been in contact with mental health services in the previous 12 months, an average of 147 per year (Figure 21). This proportion in contact with services is lower than in other age groups (27%). The majority (1,383, 85%) were aged 18-24, an average of 126 deaths per year; 235 (15%) were aged under 18, an average of 21 per year (Figure 22). Overall, the number of patients aged under 25 who died increased in 2015 and has since remained above the average for the report period (Figure 21). This rise was driven by a 61% increase in female patients aged 18-24, from 134 in 2010-2013 to 216 in 2017-2020. The number of suicides increased steadily with age, particularly in young men (Figure 23).

Figure 21: Suicide by people aged under 25 in the UK



Note: the scales for the two groups are not the same but are presented to allow comparison of trends in those aged under 25 in the general population and in patients.

Figure 22: Suicide by people aged under 18 in the UK

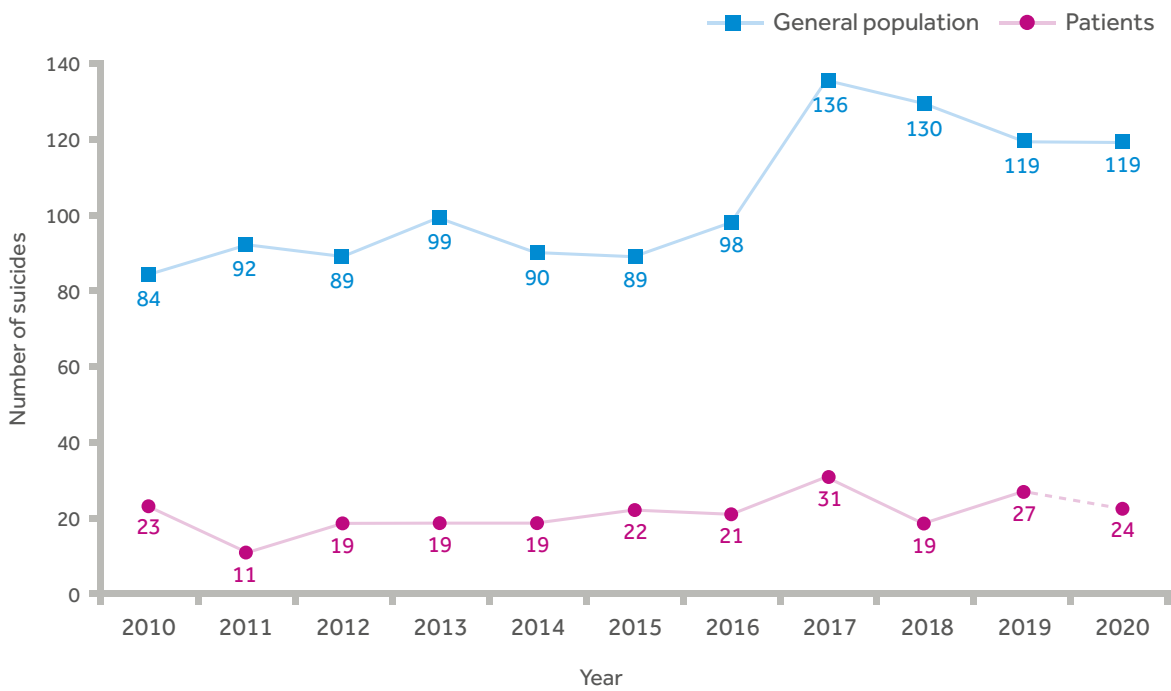
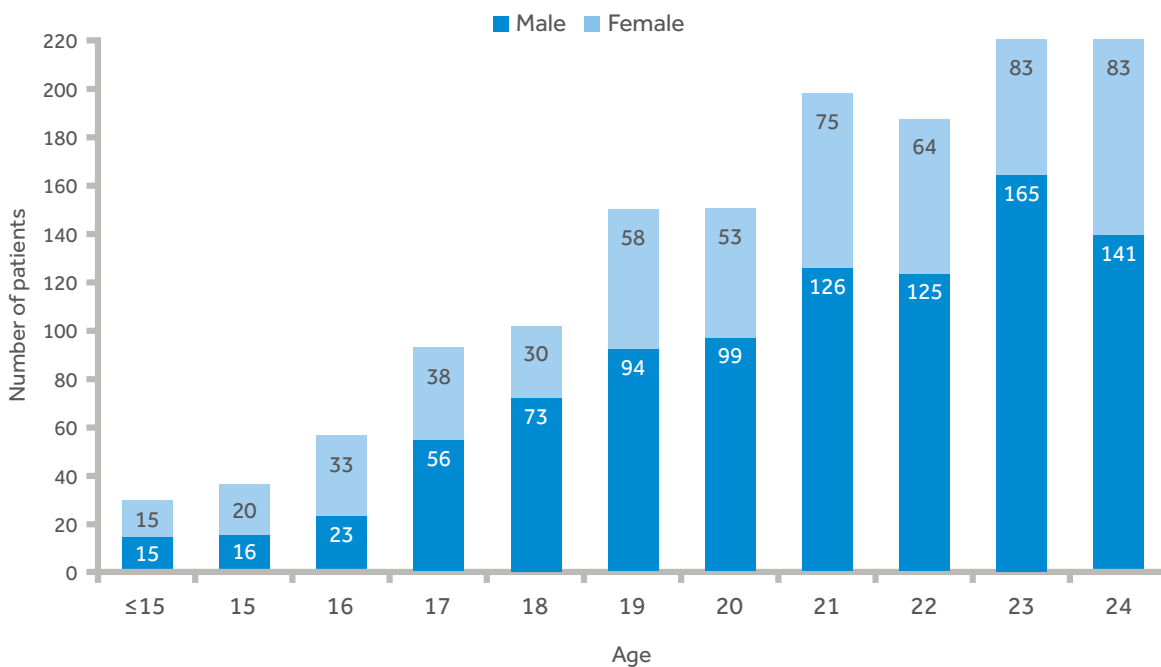


Figure 23: Patient suicide: number by age and sex in the UK (2010-2020)



Note: the numbers presented are actual figures and not projected

Key characteristics of patients aged under 25 are shown in Box 4. 552 (37%) were female, a higher proportion than other age groups (33%) and more were from an ethnic minority group (168, 12% v. 921, 6%). 320 (24%) were full-time students. The number of suicides among students who were patients increased by 52% over the report period, from an average of 25 per year in 2010-2013 to 38 per year in 2017-2020. In 2016-2020, 46 (11%) were known to identify as lesbian, gay, bisexual or trans (LGBT), more than older patients (200, 4%).

Characteristics of patients aged under 18 and aged 18-24

Comparisons between patients aged under 18 and aged 18-24 are shown in Table 1. Those aged under 18 were more likely to be female, living with their parents, and be in education than those aged 18-24. They were more often diagnosed with anxiety disorder or autism and to have been ill for less than 12 months.

A similar proportion of both young age groups had a history of self-harm (around 75%) and had experienced childhood abuse (40%). More of the under 18s had reported recent problems with their family or friends. Suicide-related internet use was also more common in the under 18s, including searching for information on suicide method (15, 18% v. 59, 10%) and visiting pro-suicide websites (11, 14% v. 33, 6%). More under 18s had experienced online bullying (6, 13% v. 9, 4%).

Patients aged 18-24 were more likely to have been given a diagnosis of personality disorder or schizophrenia and other delusional disorders than those aged under 18. The proportion given a diagnosis of personality disorder increased from 16% in 2010-2013 to 25% in 2017-2020. More had died within 3 months of discharge. 40% had recently (<3 months) misused drugs compared to 29% of those aged under 18, and the most common drugs were cannabis (286, 42% v. 39, 36%) and stimulants (177, 27% v. 20, 19%).

Overall they showed more clinical complexity, for example a third (33%) had a combination of previous self-harm, comorbidity, and alcohol or drug misuse compared to 18% of the under 18s. Despite this, short-term risk of suicide was viewed as low or not present for 81% of these patients.

Box 4: Sociodemographic characteristics of patients aged under 25 in the UK (2010-2020)

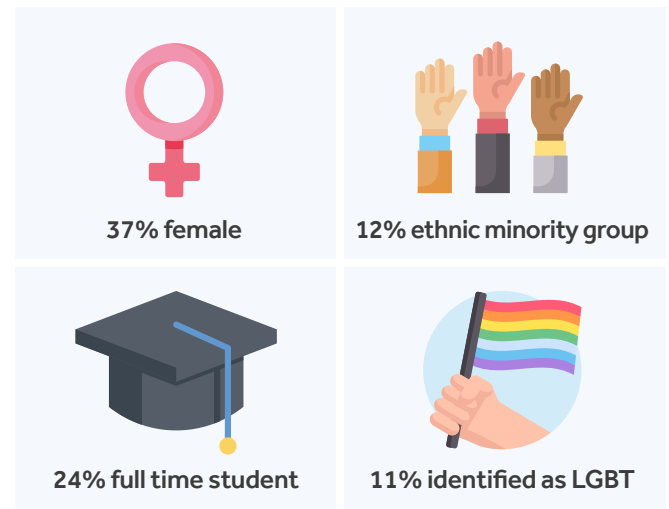


Table 1: Patient suicide in those aged under 18 compared to 18-24 years

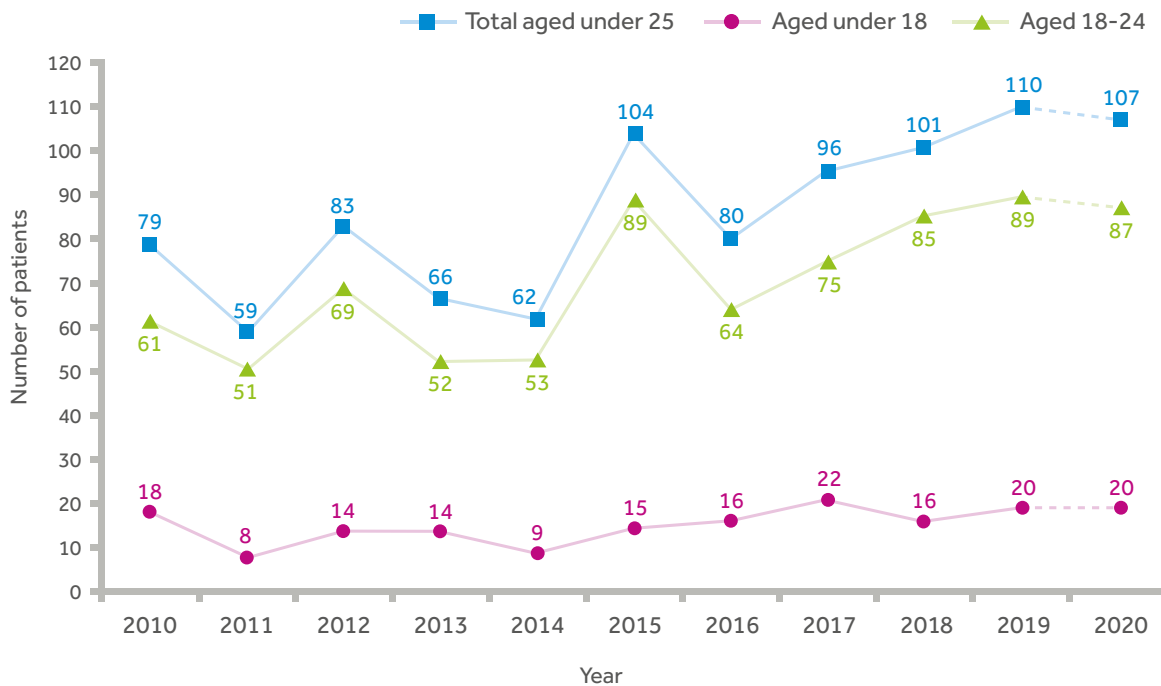
	Aged under 18 Total = 235	Aged 18-24 Total = 1,383
	Number (%)	Number (%)
Sociodemographic factors:		
Female	106 (49%) **	446 (35%)
Living with parent(s)	175 (83%) **	530 (46%)
Full-time student	147 (72%) **	173 (15%)
Identified as LGBT	9 (16%)	42 (10%)
Ethnic minority group	19 (9%)	149 (12%)
Clinical factors:		
<i>Mental health diagnosis:</i>		
Affective disorder (bipolar disorder and depression)	64 (31%)	314 (26%)
Schizophrenia and other delusional disorders	9 (4%)	208 (17%) **
Alcohol or drug dependence/misuse	12 (6%)	148 (12%) **
Anxiety disorder†	20 (10%) **	52 (4%)
Personality disorder	6 (3%)	251 (20%) **
Primary or secondary diagnosis of autism	29 (14%) **	71 (6%)
Primary or secondary diagnosis of eating disorder	10 (5%)	49 (4%)
Comorbid (i.e. additional) diagnosis	97 (49%)	684 (56%)
Recent (<12 months) history of illness	58 (38%) **	260 (24%)
Suicide within 3 months of discharge	15 (8%)	162 (14%) *
Missed last appointment with services	43 (22%)	330 (29%)
Estimation of short-term risk: low or not present	148 (80%)	893 (81%)
<i>History of:</i>		
Self-harm	159 (76%)	916 (75%)
Violence	34 (17%)	289 (25%)*
Alcohol misuse	62 (30%)	586 (49%)**
Drug misuse	73 (36%)	684 (56%)**
Social factors:		
Victim of childhood abuse (emotional, sexual and/or physical)	68 (40%)	376 (40%)
Recent (<3 months) family problems	25 (14%) **	65 (6%)
Recent (<3 months) friend/peer problems	12 (7%) **	14 (1%)
Suicide-related internet use	26 (24%) *	92 (15%)

† includes phobia, panic disorder, obsessive compulsive disorder, post-traumatic stress disorder

** significance $p < 0.01$; * $p < 0.05$

Suicide by hanging/strangulation was the most common method, particularly in patients aged under 18 (73% v. 56% of 18-24 year olds). Self-poisoning was more common among patients aged 18-24 (17% v. 7%). Overall, the number of patients aged under 25 who died by hanging/strangulation increased over the report period (Figure 24), driven by females aged 18-24 (from 49 in 2010-2013 to an estimated 129 in 2017-2020).

Figure 24: Suicide by hanging/strangulation in patients aged under 25 in the UK (2010-2020)



Notes: The numbers by age group in some years do not total the overall figure due to rounding. Patient data unavailable in Northern Ireland in 2019-2020.

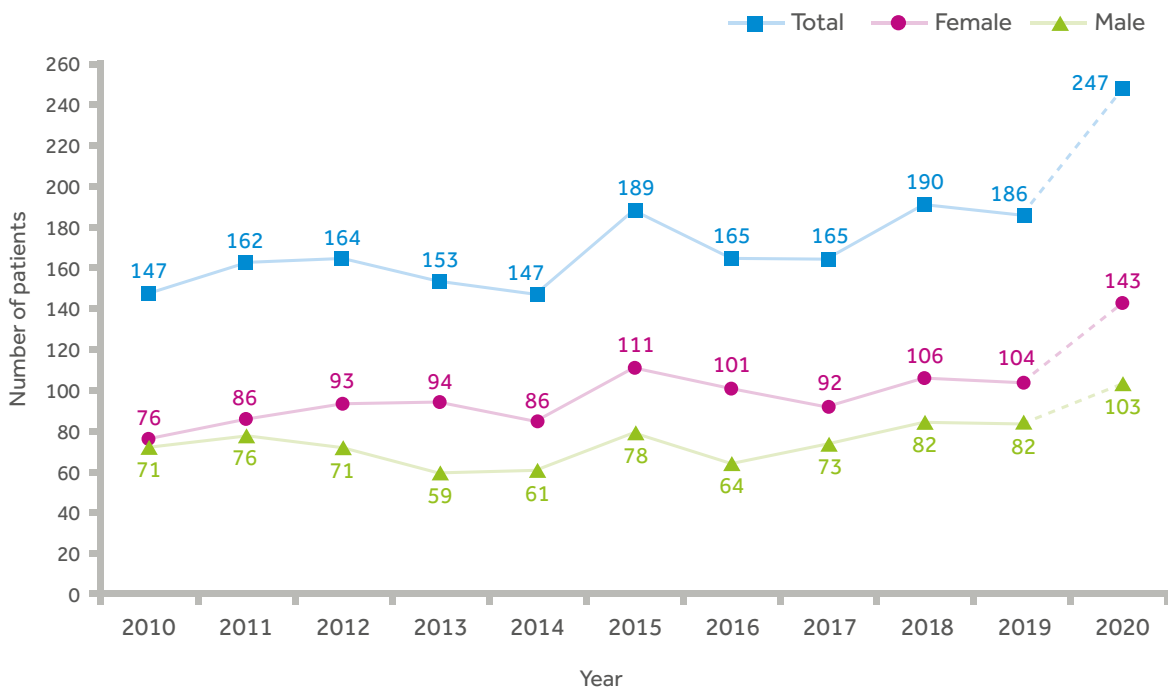
UK country differences: There were significantly more patients aged under 25 in Northern Ireland (11%) than the national average (9%). More young patients died by hanging/strangulation in Wales (77%) compared to England (57%) and Scotland (55%).

SUICIDE BY PATIENTS GIVEN A DIAGNOSIS OF PERSONALITY DISORDER

In the UK in 2010-2020, there were 1,915 suicides by patients given a diagnosis of personality disorder (PD), 11% of all patients, an average of 174 deaths per year. We began collecting data on the type of personality disorder in 2016, the most common being emotionally unstable or borderline PD (586, 87%).

The number has increased by 27% between 2010 and 2019 and we are estimating a further increase in 2020 (Figure 25). Over half (1,092, 57%) were women, 18% of all female patients, an average of 99 deaths per year. These female patients are described in more detail below.

Figure 25: Suicide by patients given a diagnosis of personality disorder in the UK



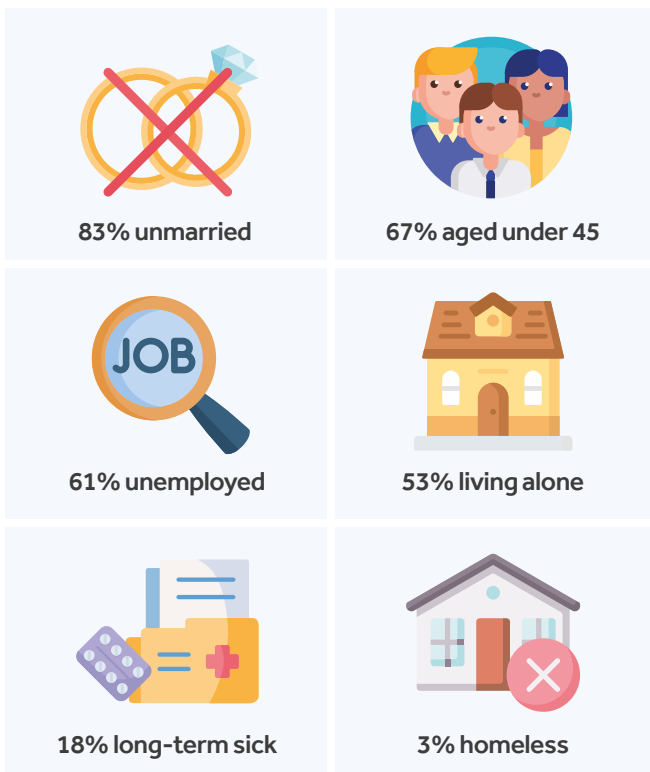
Notes: Male and female numbers do not total the overall figure due to rounding. Patient data unavailable in Northern Ireland in 2019-2020.

Female patients given a diagnosis of personality disorder

The number of female patients given a diagnosis of personality disorder increased by 37% between 2010 and 2019 and we are estimating a further increase in 2020 (Figure 25). Between 2016-2020, in the majority (383, 95% excluding unknowns) the diagnosis was of emotionally unstable or borderline PD. Women given a diagnosis of PD were younger than other women, the majority being aged under 45 (666, 67% v. 1,838, 39%). Four (1%) were aged under 18. They were more often single, living alone, unemployed, on long-term sick leave, or homeless (Box 5). In 2016-2020, 33 (10%) were known to identify as lesbian, gay, bisexual or trans (LGBT), more than other women (49, 4%).

The majority had experienced childhood abuse (558, 71% v. 980, 30% of other female patients) and in 2016-2020, 129 (41%) had experienced domestic violence, more than other women (268, 21%). Nearly all had a history of self-harm (947, 97% v. 2,957, 66%) and over a third had been seen in the emergency department for self-harm in the previous 3 months (292, 35% v. 739, 19%).

Box 5: Socio-demographic characteristics of female patients given a diagnosis of personality disorder in the UK (2010-2020)

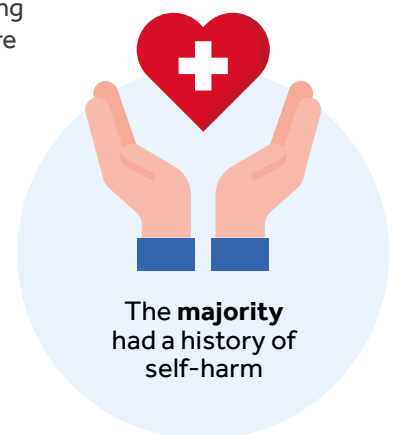


Other factors commonly associated with suicide such as alcohol misuse (522, 56% v. 1,595, 36%), drug misuse (409, 43% v. 1,045, 24%) and violence (203, 23% v. 440, 10%) were more common. A higher proportion had previously been in prison (58, 6% v. 121, 3%). Overall, 416 (43% v. 1,029, 23%) had a combination of previous self-harm, a comorbid diagnosis (mostly depressive illness) and a history of alcohol or drug misuse, indicating clinical complexity. Over a quarter had missed their last contact with services (245, 28% v. 912, 21%).

Most (748, 78%) had a diagnosis of PD for longer than 5 years. 95 (10%) were in-patients at the time of death, 59 (63%) of whom died on the ward, more than other female in-patients (94, 31%). A higher proportion also died within 3 months of hospital discharge (170, 19% v. 636, 15%).

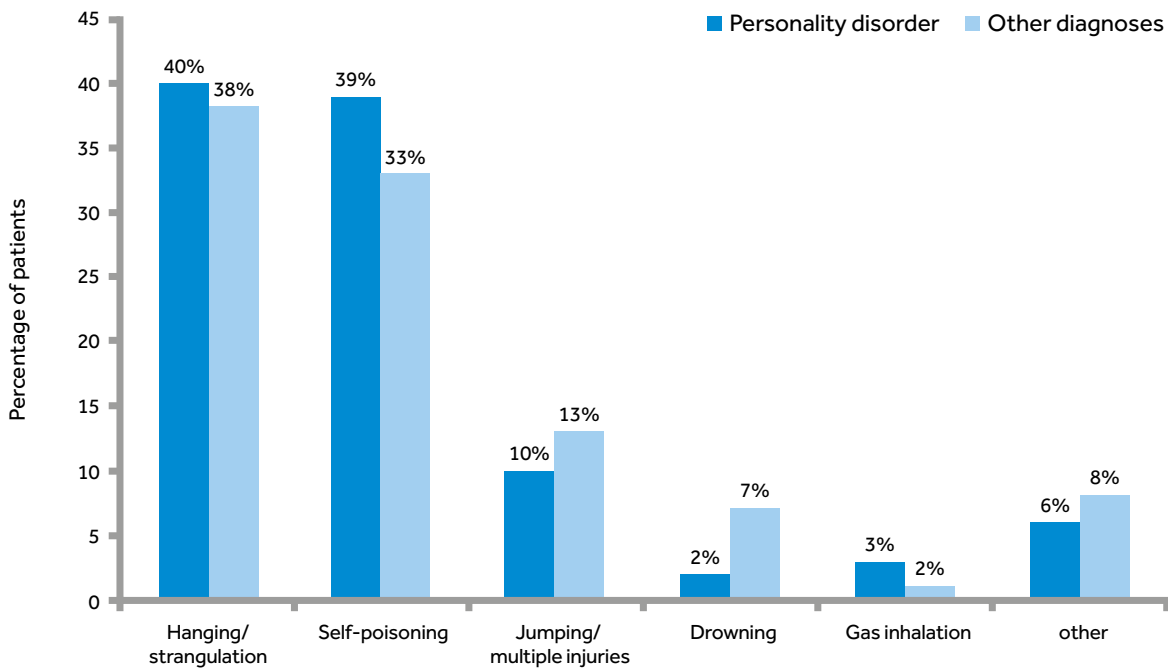
Over half had been in recent (<1 week) contact with services (548, 56% v. 2,313, 50%). Overall, 48 (12%) were seen under specialist personality disorder services, 65 (9%) alcohol services, and 43 (6%) drug services. More women with a diagnosis of PD were receiving antidepressants (719, 77% v. 3,092, 72%), antipsychotic medication (439, 47% v. 1,861, 43%) or some form of psychological therapy (279, 30% v. 747, 18%) compared to other women. Fewer were viewed by clinicians as at low or no short-term risk (621, 71% v. 3,439, 83%).

Suicide by self-poisoning was proportionally more common in women given a diagnosis of PD compared to other women, while jumping/multiple injuries and drowning were less common (Figure 26).



The most common substances used in self-poisonings were opiates/opioids (including paracetamol/opioid compounds) – these drugs were used in 115 (34%), similar to other female patients (417, 31%). For the majority (38, 61% excluding unknowns), the opioids had been prescribed for the patient.

Figure 26: Method of suicide in female patients diagnosed with personality disorder in the UK (2010-2020)



Male patients given a diagnosis of personality disorder

There were 820 suicides by male patients given a diagnosis of PD, 7% of all male patients, an average of 75 deaths per year. Overall the number did not change over the report period, though the number has risen since 2016 and we are estimating an increase in 2020 (Figure 25). In the majority the diagnosis was emotionally unstable or borderline PD (224, 77%) and in 18 (6%) antisocial PD.

Compared to other male patients, those given a diagnosis of PD were younger (median age 39 v. 46 years) and more were unmarried (85% v. 73%), unemployed (69% v. 49%) and living alone (59% v. 49%).

Over half had a history of childhood abuse (59% v. 21%) and more had experienced domestic violence compared to other men (12% v. 4%). They had high proportions of previous self-harm (89% v. 57%), violence (47% v. 24%), alcohol and/or drug misuse (78% v. 62%). More had previously been in prison (27% v. 14%) and in 2016-2020, 18% had recently (<3 months) been charged with a criminal offence.

The majority had a comorbid (i.e. additional) mental health diagnosis (74% v. 52%) and had been ill for longer than 5 years (75% v. 50%). Over a quarter had missed their last service contact (28% v. 24%). More were receiving some form of psychological therapy (20% v. 14%) compared to other men. Clinicians were less likely to view male patients with a diagnosis of PD as at low or no immediate (80% v. 84%) or long-term (41% v. 60%) risk.

Our report "[Safer care for patients with personality disorder](#)" examined the treatment and pathways into care for patients given a diagnosis of personality disorder. We found that patients were not receiving care consistent with NICE guidelines and recommended that an examination of personality disorder services is needed.

SUICIDE BY PATIENTS WHO IDENTIFIED AS LESBIAN, GAY, BISEXUAL OR TRANS

We have collected data on whether the patient identified as lesbian, gay or bisexual (LGB) or was within a trans (including transgender, transsexual, or non-binary) group since 2016. In 2016-2020, there were 223 (4% excluding unknowns) LGB patients, an average of 45 deaths per year. This included 178 (4%) lesbian or gay patients and 45 (1%) bisexual patients. There were 37 (1%) patients within a trans group, 7 deaths per year. The number did not change in LGB or trans patients over this period. As these figures are based on clinical reports, they are likely to be underestimated.

Patients within a trans (including transgender, transsexual, non-binary) group

Sex/gender was recorded by the clinician as male in 25 (68%) patients within the trans group. This included 3 males who were recorded by the Office for National Statistics as female based on their birth certificate. However, we are unable to determine if any trans patients had officially changed their gender on their birth certificate. Trans patients were significantly younger than other patients, with more aged under 25 (13, 35% v. 531, 10%). They were more likely to be unmarried (31, 97% v. 3,713, 72%) and a full-time student (5, 17% v. 138, 3%). 18 (56%) lived alone (Box 6).

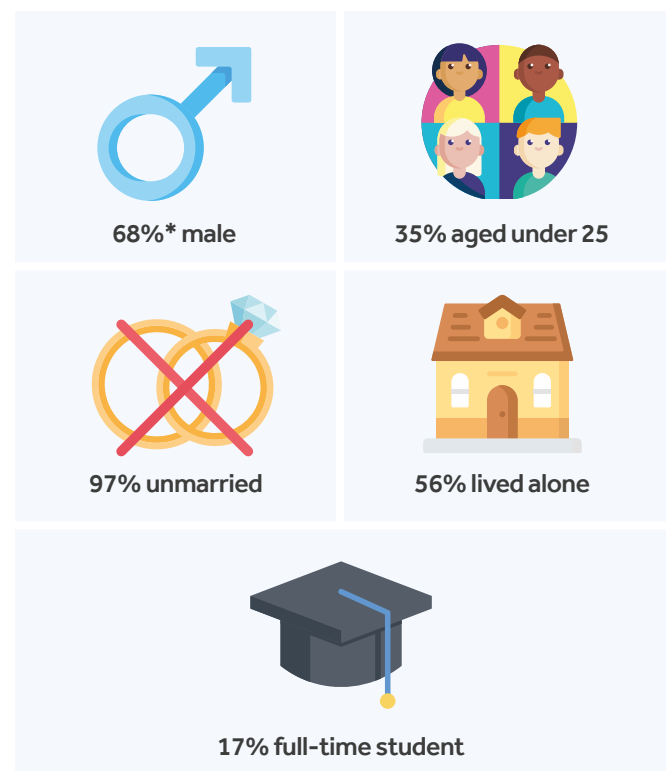
Over half had experienced childhood abuse (17, 57% v. 1,455, 36%), including emotional (13, 46% v. 1,160, 31%), sexual (9, 35% v. 629, 17%), and physical (8, 31% v. 691, 19%) abuse. The majority had a history of self-harm (29, 83% v. 2,883, 56%) and a higher proportion had recently (<3 months) attended the emergency department for self-harm compared to other patients (13, 42% v. 1,187, 25%).

The most common diagnoses were personality disorder (17, 47% v. 615, 11%) and affective disorder (bipolar disorder and depression) (10, 28% v. 2,142, 40%). While numbers were small, a diagnosis of autism (5, 14% v. 123, 2%) and eating disorder (3, 8% v. 75, 1%) were more common than in other patients.

Over half (17, 53%) had been ill for longer than 5 years. A fifth (7, 20%) were receiving care under crisis resolution/home treatment services; 3 (10%) were under specialist personality disorder services. Clinicians were less likely to estimate short (18, 64% v. 3,849, 81%) and long-term (11, 37% v. 2,480, 56%) risk of suicide as low or not present in trans patients compared to other patients.

Hanging/strangulation (46%) and self-poisoning (38%) were the most common methods, with more patients dying by self-poisoning (22%).

Box 6: Socio-demographic characteristics of trans patient suicides in the UK (2016-2020)



*gender as officially recorded on the birth certificate

LGB patients

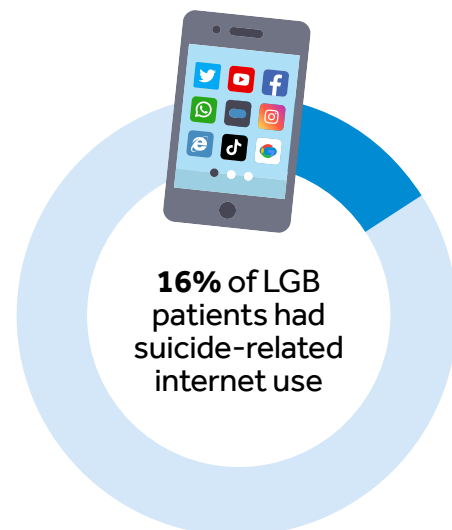
We have combined the overall number of LGB patients due to small numbers but acknowledge this is not a homogenous group. LGB patients were younger than other patients, and more likely to be aged 25-44 (106, 48% v. 1,651, 35%), aged under 25 (40, 18% v. 392, 8%) and aged under 18 (7, 3% v. 45, 1%). A similar proportion were male (141, 63% v. 3,091, 65%). They were more likely to be unmarried (173, 83% v. 3,065, 68%) and a full-time student (18, 9% v. 92, 2%). Half (100, 50%) lived alone.

A history of childhood abuse (97, 55% v. 1,248, 36%) was more common, including emotional (44% v. 31%), sexual (32% v. 16%) and physical abuse (26% v. 18%). They were also more likely to have experienced domestic violence (18% v. 12%). LGB patients had a higher prevalence of previous self-harm (69% v. 56%) and drug misuse (46% v. 35%). The type of drugs used were more likely to be stimulants (65% v. 54%) and new psychoactive substances ('legal highs') (29% v. 11%) compared to other patients. More LGB patients had used the internet for suicide-related purposes (18, 16% v. 246, 9%), particularly communicating suicidal ideas or intent online (6, 6% v. 61, 3%).

In our previous report on [Suicide by Children and Young People](#) in the general population, we also found higher rates of bullying, abuse, and suicide-related internet use among those reported as LGBT.

LGB patients more often had a diagnosis of personality disorder (26% v. 11%), autism (4% v. 2%) and eating disorder (3% v. 1%). Where the type of personality disorder was known, this was more often emotionally unstable/borderline personality disorder compared to other patients (96% v. 86%). More had a comorbid (i.e. additional) mental health diagnosis (68% v. 59%). Short-term risk of suicide was viewed as low or not present in 76% of LGB patients. Suicide by hanging/strangulation and self-poisoning were the most common methods, similar to heterosexual patients.

While method of suicide was more often by self-poisoning compared to other patients (30% v. 22%), a similar proportion used opioids (including paracetamol/opiate compounds) as the main substance (17, 35% v. 226, 29%).



SUICIDE-RELATED INTERNET USE

We have collected data on whether there was evidence of suicide-related internet use since 2011. In 2011-2020, there were 728 (8%) patients with evidence of suicide-related internet use, an average of 73 deaths per year. The types of internet use are shown in Box 7. As these figures are based on clinical reports, they are likely to underestimate how often this occurs. We will soon be collecting data on the use of social media by patients and findings will be presented in future reports.

The overall number has increased since 2011 though we are estimating a fall in 2019-20 (Figure 27). This increase was mostly driven by women aged under 25 and aged 25-44.

There was no change in the number of patients who obtained information on how to die by suicide, but the proportion significantly increased from 4% in 2011-12 to 6% in 2019-20.

There was a 70% fall in the average number of patients who visited websites that may have encouraged suicide between 2011-12 (n=33) and 2019-20 (n=10).

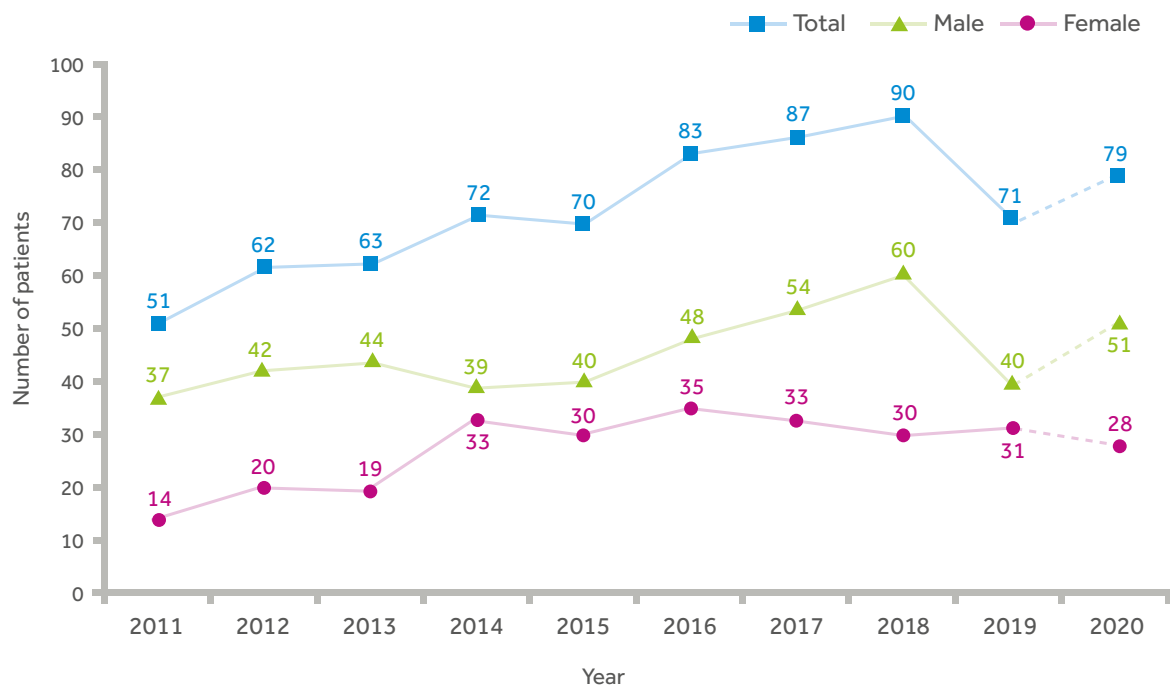
Those aged under 45 were more likely to obtain information on suicide method (256, 7% v. 206, 4%) and to have visited pro-suicide websites (144, 4% v. 93, 2%) compared to older patients. Communicating suicidal ideas online was particularly common among patients aged under 25 (29, 11% v. 62, 2%).

Box 7: Types of suicide-related internet use

	Total = 728	
	Number	%
Obtained information (e.g. method details) on how to die by suicide	503	6%
Visited websites that may have encouraged suicide	245	3%
Communicated suicidal ideas or intent online	107	3%
Other type of suicide-related internet use	66	2%

Note: the numbers do not total 728 as there was evidence of more than one type of suicide-related internet use for some patients

Figure 27: Suicide in patients with suicide-related internet use in the UK



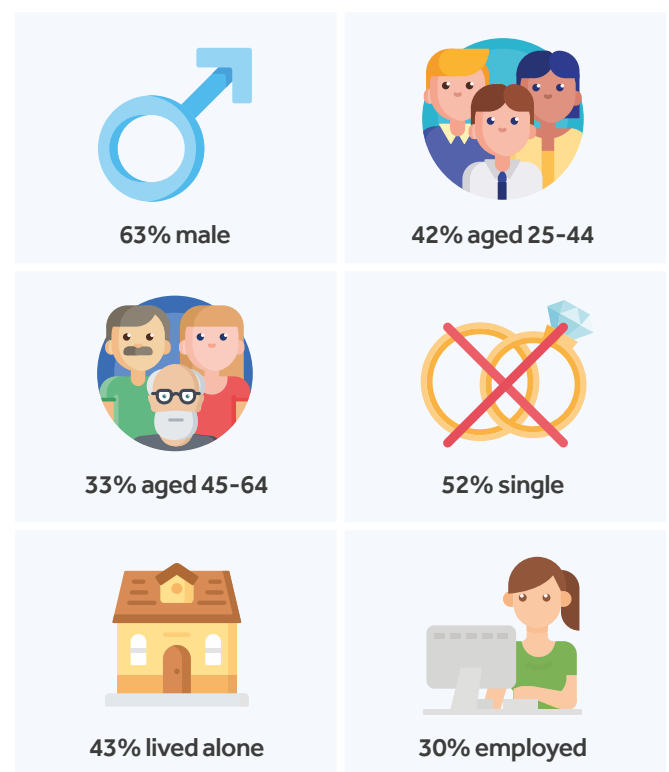
Patient data unavailable in Northern Ireland in 2019 and 2020.

Box 8 shows the main social features of patients with suicide-related internet use. 63% were male, similar to the total sample (66%). The majority were aged between 25 and 44 (276, 42%) or aged 45-64 (218, 33%); 117 (18%) were aged under 25, including 26 who were aged under 18. They were more likely to be employed (194, 30% v. 1,488, 19%), a full-time student (40, 6% v. 148, 2%) and single (335, 52% v. 3,375, 42%) compared to other patients. Fewer were living alone (279, 43% v. 3,873, 48%).

Patients with evidence of suicide-related internet use were more likely than other patients to have been given a diagnosis of depressive illness (241, 37% v. 2,651, 33%), personality disorder (105, 16% v. 859, 11%), autism (30, 5% v. 120, 1%) or eating disorder (19, 3% v. 99, 1%).

Over a quarter had been ill for less than a year (157, 26% v. 1,638, 22%) and they were more likely to have not taken medication as prescribed (106, 17% v. 965, 12%) and be receiving care under crisis resolution/home treatment services (131, 21% v. 1,233, 16%). A higher proportion had previous self-harm (442, 69% v. 5,006, 63%) and a history of childhood abuse (192, 34% v. 1,768, 25%) compared to other patients.

Box 8: Socio-demographic characteristics of patients with suicide-related internet use in the UK (2011-2020)



The majority had reported recent adverse life events (400, 63% v. 3,937, 50%), most often serious financial problems (22% v. 15%), relationship break-up (13% v. 9%) and work problems (6% v. 4%). Clinicians were less likely to estimate short- (392, 65% v. 5,995, 80%) and long-term (202, 35% v. 3,907, 54%) risk of suicide as low or not present.

Suicide by hanging/strangulation and self-poisoning were the most common methods, similar to other patients (Figure 28). Method of suicide was more often by gas inhalation and suffocation and less likely by jumping/multiple injuries, drowning, and cutting. The most common substances used in fatal overdose were older tranquilliser drugs which are rarely prescribed, indicating they may have been bought online; these were used in 25% of all deaths by self-poisoning, significantly more than other patients (<1%).

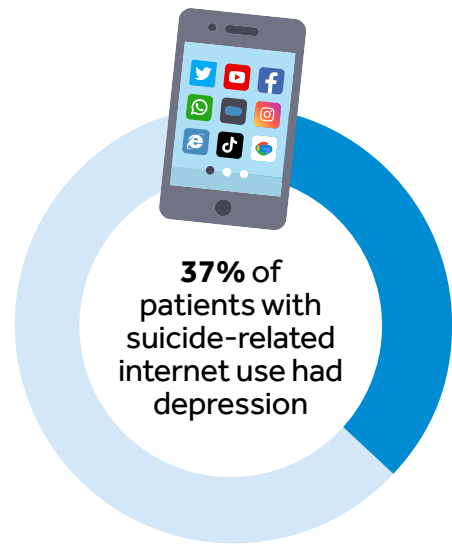
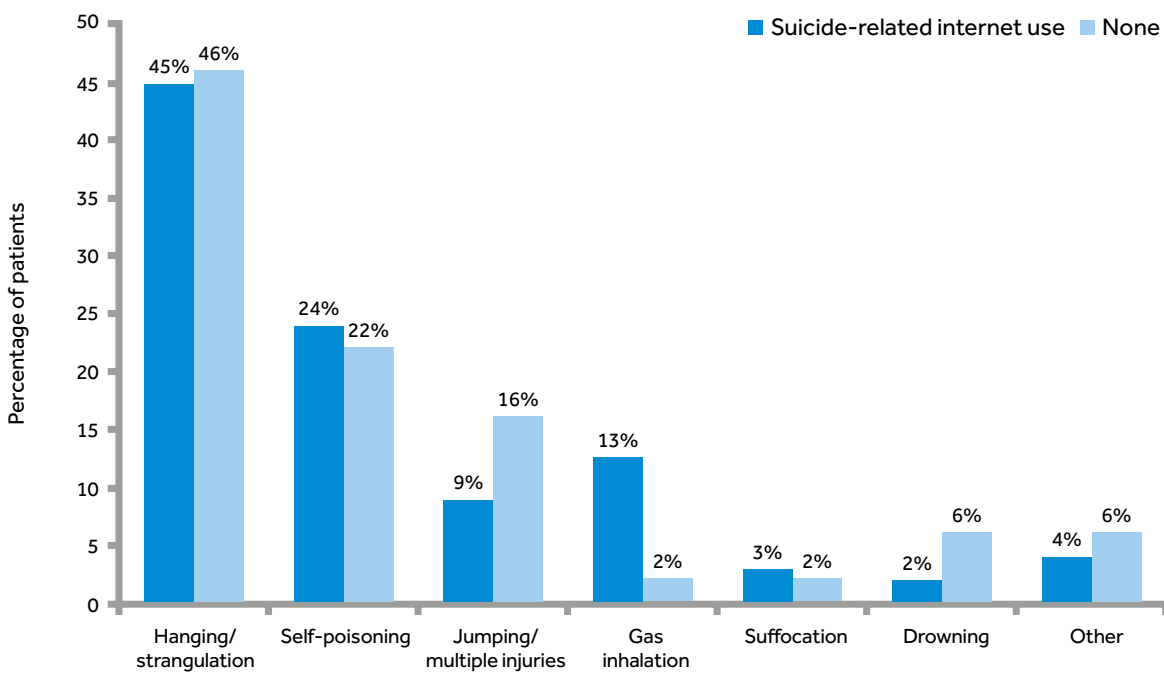


Figure 28: Method of suicide in patients with suicide-related internet use in the UK (2011-2020)



UK country differences: More patients in England (8%) had evidence of suicide-related internet use compared to the rest of the UK (5%).

HOMICIDE IN THE UK

In 2010-2020, NCISH was notified of 5,876 homicide convictions, an average of 534 per year. There were 6,112 victims, an average of 556 per year. Due to the COVID-19 pandemic there has been a fall in the number of homicide convictions in 2020. The fall has been around 38% (N=324) compared to the number of convictions in 2019 (N=521). There were 2,165 (37%) homicides by people aged under 25 and 497 (8%) by those aged under 18. In 2010-2019, there were 610 patients under the care of mental health services convicted of a homicide offence, an average of 61 per year. The number of convictions has fallen steadily over this period but has been constant in the most recent years (Figure 29).

There were 633 victims, an average of 63 per year. A fifth of patients convicted of homicide were aged under 25 (135, 22%) and 28 (5%) were aged under 18.

Across the UK, 11% of people convicted of homicide were patients under mental health care (Table 2). This figure remained higher in Scotland and Wales and where the general population homicide rates are also higher. More information taken from independent investigations following homicides committed while perpetrators were under the care of mental health services can be found in [An Independent Review of the Independent Investigations for Mental Health Homicides in England](#).

Figure 29: Patient homicide in the UK: numbers by year

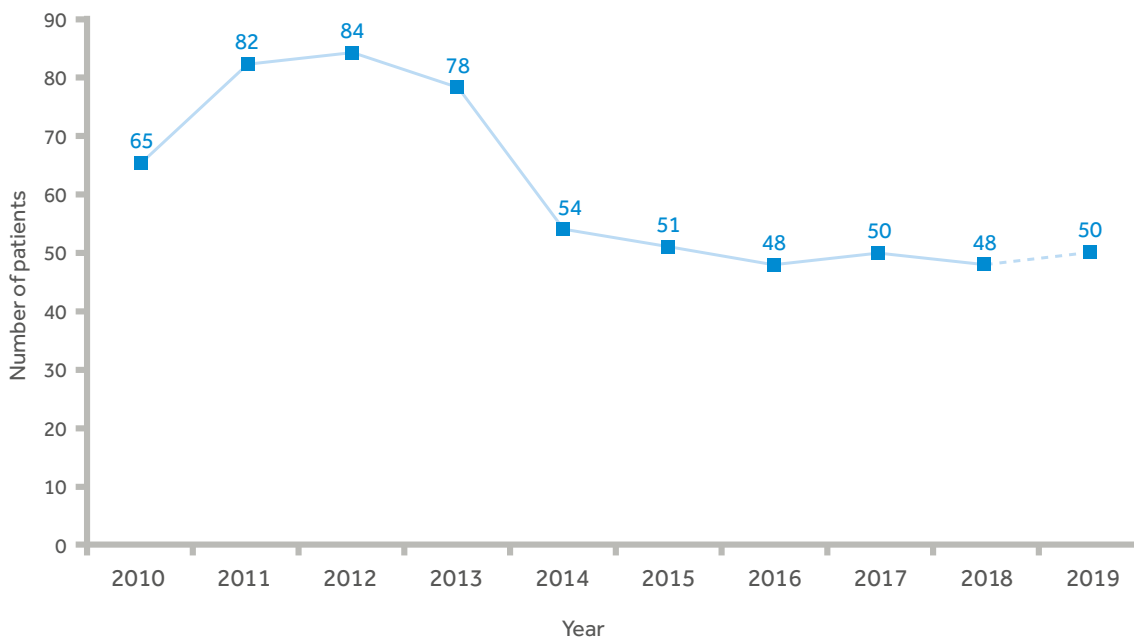


Table 2: Number of homicide offenders by UK country (2010-2020)

	England N (%)	Northern Ireland* N (%)	Scotland N (%)	Wales N (%)	UK N (%)
General population	4,930	100	601	245	5,876
Patients under mental health care^	484 (10%)	8 (8%)	87 (15%)	31 (13%)	610 (11%)

* Northern Ireland data between 2010-2014

^ Patient data between 2010-2019

HOMICIDE FOLLOWED BY SUICIDE IN ENGLAND AND WALES

Homicide followed by suicide is defined here as when the offender dies by suicide within 3 days of committing homicide. As there is no conviction for homicide, these cases are not included in the homicide analysis.

We were notified of 154 homicide-suicide incidents between 2010 and 2020, an average of 14 per year. Most offenders were male (131, 85%) and their median age was 45 (range 16-92). There were 221 victims in total, of which three-quarters were female (76%).

The relationship of victim to offender (principal victim if there was more than one victim) was most commonly a spouse/partner (current/ex) (104, 68%), followed by a son/daughter (26, 17%), then an acquaintance (8, 5%). The majority of all the victims who were a spouse/partner were female (98%). 10 (6%) of those who carried out homicide-suicides were identified as patients.

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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