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HQIP
Healthcare Quality
Improvement Partnership

National Confidential Inquiry

into Suicide and Safety in Mental Health

Annual Report 2025:

UK patient and general population data 2012-2022*

* This report also includes data from Jersey

The National Confidential Inquiry into Suicide and Safety in Mental Health (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 and the Royal College of Nursing. Its aim is to promote quality improvement in patient outcomes. The Clinical Outcome Review Programmes, which encompass confidential enquiries, are designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by systematically enabling clinicians, managers, and policy makers to learn from adverse events and other relevant data. HQIP holds the contract to commission, manage, and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP), comprising around 40 projects covering care provided to people with a wide range of medical, surgical and mental health conditions. The programme is funded by NHS England, the Welsh Government and, with some individual projects, other devolved administrations and crown dependencies.

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

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We would like to thank mental health staff, experts by experience and the NCISH Project Board 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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NCISH Annual Report
UK and Jersey patient data (2012-2022)

HQIP Healthcare Quality Improvement Partnership

1,722 suicides by people under recent (within 12 months) mental health care in 2022

26% of all people who died by suicide in 2012-2022 had recent contact with mental health services

Acute mental health care settings

47% lived **alone**

17% had serious **financial problems**

31% had recent **self-harm**

Deaths **on the ward** have recently **increased**

Deaths **after discharge** from the ward have **risen** since 2017

Prevention should focus on ward safety, support after discharge, and recognition of risk following self-harm

Real-Time Surveillance of suspected suicides

67 in-patient and post discharge deaths reported

67% were **in-patients**; over **half** had been **detained**

Evidence of **suicide-related internet use**

All trusts contributing to real-time surveillance will provide early warning of safety concerns

NCISH Annual Report
UK and Jersey patient data (2012-2022)

Suicide in mental health patients with bipolar disorder

136 deaths per year

Mostly **female**, **middle-aged,** and **living alone**

39% were prescribed **lithium; 12%** received **psychological therapy**

Lithium treatment and psychological interventions should be provided in line with NICE guidelines

Suicide after missed contact and non-adherence with medication

347 deaths per year following **missed contact**

182 deaths per year following **non-adherence** with medication

Affective disorder common in both groups

Socioeconomic adversity was common in those who missed contact

Half of patients who were non-adherent were **prescribed antipsychotics**

Greater family involvement may help engagement efforts

Suicide and recent bereavement in mental health patients

119 deaths per year

More likely to be **female**, **older**, and **widowed** than other patients

7% died on or near the **anniversary** of a bereavement

Enquiring about significant dates should be a routine part of assessment

Contents

Introduction 6

Key findings 6

Clinical messages 8

Suicide in the general population 9

Mental health patient suicide 10

Real-time surveillance of mental health patient suicide 17

Themes in this report 18

Suicide in mental health patients with bipolar disorder 18

Suicide following missed contact and/or non-adherence with medication 19

Suicide and recent bereavement in mental health patients 21

Homicide in the UK 22

Links to additional online data 23

Introduction

The 2025 annual report from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) provides findings relating to people aged 10 and above (in line with the Office for National Statistics) who died by suicide between 2012 and 2022 across the UK (England, Northern Ireland, Scotland and Wales) and Jersey. 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 in the UK. Complete details of the NCISH methodology are provided in our previous reports and on our NCISH website.

The NCISH database has been established for more than 27 years and includes a national case series of suicide by patients who had been in recent (i.e. within 12 months) contact with mental health services. The current suicide database stands at over 171,700 deaths by suicide in the general population, including over 43,500 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 and Jersey as a whole for the baseline year of 2012 and the subsequent 10 years, including the most recent year (2022) for which comprehensive data are available. Data for individual UK countries are provided in the additional online information files. We adjust figures in 2020-2022 to account for lower data completeness levels in these years – further details are provided in the additional online information files. Estimated numbers in 2020-2022 are presented as dotted lines in the figures. Data collection on patient suicide deaths in Jersey was temporarily paused between 2020 and 2022. Therefore, we present detailed patient data in Jersey for the period 2012-2018 in the UK-wide sections of the report and will present data from 2019-2022 in future reports.

In the report we also present data on specific topics, some of which reflect current concerns in suicide prevention or groups who may be at increasing risk. These include patients with bipolar disorder, patients who have missed their last contact with services and/or were non-adherent with medication, and patients who have been recently (within 3 months) bereaved.

Our suicide figures differ from those presented by the Office for National Statistics (ONS), the National Records of Scotland (NRS) and the Northern Ireland Statistics and Research Agency (NISRA) because we base our figures on date of death rather than the date when the death was registered. Our NCISH website FAQs summarises how discrepancies may be explained.

Key messages are also provided as an easy read report, an infographic, and an animated video.

Key findings

Patient suicide numbers and rates

- Over 2012-2022, there were 18,670 suicides by patients in the UK and Jersey, an average of 1,697 deaths per year, 26% of all general population suicides (see details on page 10).
- The number of patient suicides increased in 2018 following a change in the standard of proof for suicide at inquest. In England and Wales, an increase in suicides registered in 2023, suggesting a possible rise in suicides occurring in 2022, has been reported by the Office for National Statistics. It is too early to say if this rise will be evident in our 2022 patient suicide figures.

Social and clinical characteristics

- A high proportion of patients who died by suicide showed evidence of isolation and social adversity; nearly half (47%) lived alone, and a sixth (17%) had recently experienced serious financial problems (see details on page 12). Suicide-related internet use was reported in 8% of patients.
- A history of alcohol (47%) or drug (38%) misuse was common. Over half (55%) had a comorbid (i.e. additional) mental health diagnosis. The majority (62%) of patients who died had a history of self-harm. The proportion who had recently (<3 months) self-harmed (31%) has increased over the report period (see details on page 12).

Clinical care

- There were 4,718 (27%) patients who died by suicide in acute care settings, including in-patients (5%), and post-discharge care (13%) or crisis resolution/home treatment (13%) (with overlap between these latter two groups), an average of 429 deaths per year (see details on page 14).

- There were an estimated 72 suicides by mental health in-patients in 2022, around 4% of all patient suicides in that year (see details on page 14). Of all in-patients, 40% died on the ward, 50% were off the ward on agreed leave, and 10% had left the ward without staff agreement or left with agreement but failed to return. The proportion of in-patients who died on the ward has increased by 31% between 2012-2015 and 2019-2022.
- There were an estimated 198 deaths by suicide in the 3 months after discharge from mental health in-patient care in 2022, 11% of all patient suicides (see details on page 15). The number and rate of post-discharge suicide has risen since 2017. Of all patients who died in the first week after discharge, the highest number occurred on day 3 (63 patients, 20%) post-discharge (taking day 1 as the day of discharge). However, in 2019-2022 the highest number occurred on day 6 (20 patients, 22%).

Real-time surveillance study

- We are establishing an additional method of patient suicide data collection through real-time surveillance (RTS) in England (see details on page 17). We ask all trusts to notify us of suspected suicides by in-patients or those recently discharged, without waiting for inquest.
- To date we have been notified of 67 suspected suicide deaths, the majority (44, 67%) by in-patients. Early themes include high proportions of in-patients being detained under the Mental Health Act (55%) and being admitted to wards outside of the patient's local area (35%).

Suicide and bipolar disorder

- In 2012-2022, there were 1,491 suicides by patients with bipolar disorder, 8% of all patient suicides, an average of 136 deaths per year. The average number in 2019-2022 increased by 19% compared to the average number in 2015-2018 (see details on page 18).
- Patients with bipolar disorder were more often female (47%), living alone (52%) and older, with more aged 45-64 (50%), than other patients who died by suicide.
- Overall, a minority (39%) were receiving lithium treatment and only 12% were receiving psychological treatment. More patients with bipolar disorder were non-adherent with medication (15%) and had experienced drug side effects (12%).

Suicide and missed contact and/or non-adherence with medication

- In 2012-2022, there were 3,817 suicides by patients who missed their last contact with mental health services, 22% of all patient suicides, an average of 347 deaths per year. There were 1,998 suicides by patients who were non-adherent with drug treatment, 12% of all patient suicides, an average of 182 deaths per year. Our estimates for 2022 show an increase in the proportion of patients with missed contact but a fall in those non-adherent with medication (see details on page 19).
- Missed contact was often accompanied by clinical morbidity (e.g. additional psychiatric diagnoses, self-harm, alcohol and/or drug misuse), and socioeconomic adversity (e.g. unemployment, financial problems, living alone). Services had made contact with the patient's family in 28% of those who had missed their last appointment.
- The majority (63%) of non-adherent patients had severe mental illness (see details on page 20). Half (47%) were prescribed oral antipsychotics. Reasons for non-adherence were reported to be the patient's impaired insight into their illness (31%), side effects (15%) and lack of effectiveness (13%).

Suicide and recent bereavement

- In 2012-2022, there were 1,312 suicides by patients who had been recently (<3 months) bereaved, 8% of all patient suicides, an average of 119 deaths per year. The number increased over two-fold in 2016-2022 compared to in 2012-2015, presumably due to better recognition by clinicians (see details on page 21).
- Patients bereaved were more often female (40%) than other patients who had not recently been bereaved and they were more likely to be older, widowed (20%) and living alone (54%). A third (34%) had a primary diagnosis of depression. More died on or near the date of a family member or friend's death anniversary compared to other patients (7% v. 1%). In 2020-2022, half (51% v. 35%) had reported suffering from insomnia and a third (35% v. 30%) had recently misused alcohol.

Clinical messages

The following clinical messages are intended for clinicians, mental health services, Integrated Care Boards (ICBs) and Health Boards.

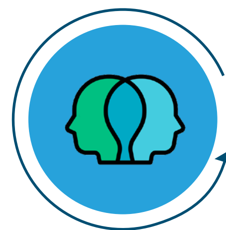
1. Clinical care and acute mental health care settings

Our findings on patient suicide highlight acute mental health settings where there appear to be changing patterns of suicide risk important to prevention. Specifically, the findings call for a greater focus on ward safety, on reversing the apparent increase in suicide amongst people recently discharged from in-patient care, and on recognition of risk after self-harm.

2. Real-time surveillance

Real-time surveillance of suspected in-patient and post-discharge suicides is being established nationally. We are asking all mental health trusts and clinical staff to take part. This new safety initiative will provide early warning of safety concerns.

3. Suicide and bipolar disorder



Many patients with bipolar disorder who die by suicide appear not to be receiving optimal treatment. This should be provided in line with NICE guidance, including lithium treatment and consideration of psychological interventions, as a key suicide prevention measure.

4. Suicide and missed service contact and/or non-adherence with treatment

Non-receipt of planned care is a crucial precursor of patient suicide. Services should place priority on follow-up efforts for patients losing contact with services or who are non-adherent with medication. These patients have multiple clinical and social problems that are likely to add to risk and that need to be addressed in their care plan. Involvement of the patient's family or carers should form part of engagement efforts.

5. Suicide and recent bereavement

Clinicians should be aware that bereavement may add to suicide risk and be alert to symptoms such as insomnia and alcohol misuse. Enquiring about significant dates such as anniversaries of deaths should be a routine part of assessment. Services should make personalised bereavement support available.

Suicide in the general population

Between 2012 and 2022, NCISH was notified of 70,590 deaths in the general population in the UK and Jersey that were registered as suicide or "undetermined", an average of 6,417 deaths per year (Fig. 1). These are referred to as suicides throughout the report.

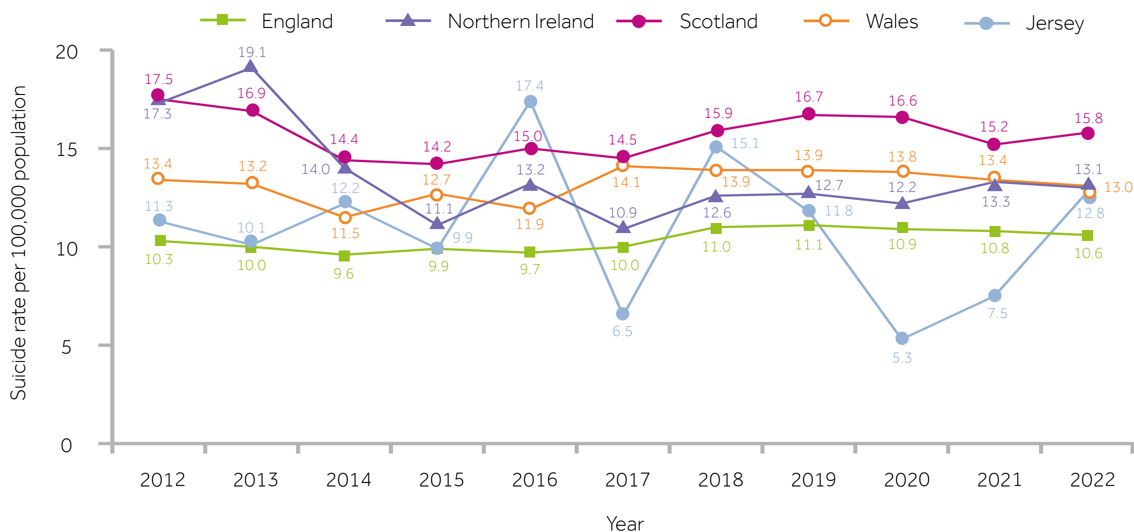
Fig. 1: Number of suicides in the general population and by mental health patients, by UK country

Note: There were 110 suicide deaths in Jersey; 45 (41%) were by patients

In England and Wales there were higher rates of suicide deaths occurring in 2017 and 2018 following the lowering of the standard of proof used by coroners that was introduced in 2018, and then a plateau (Fig. 2). However, figures in 2022 are expected to rise once late inquests are added.

In Scotland there were higher rates from 2018 compared to those in 2014-2017. Northern Ireland rates were lower from 2015 which reflect a change in how some deaths are classified (see details of the Review of Suicide Statistics in Northern Ireland). In Jersey the rates fluctuated, being based on small numbers.

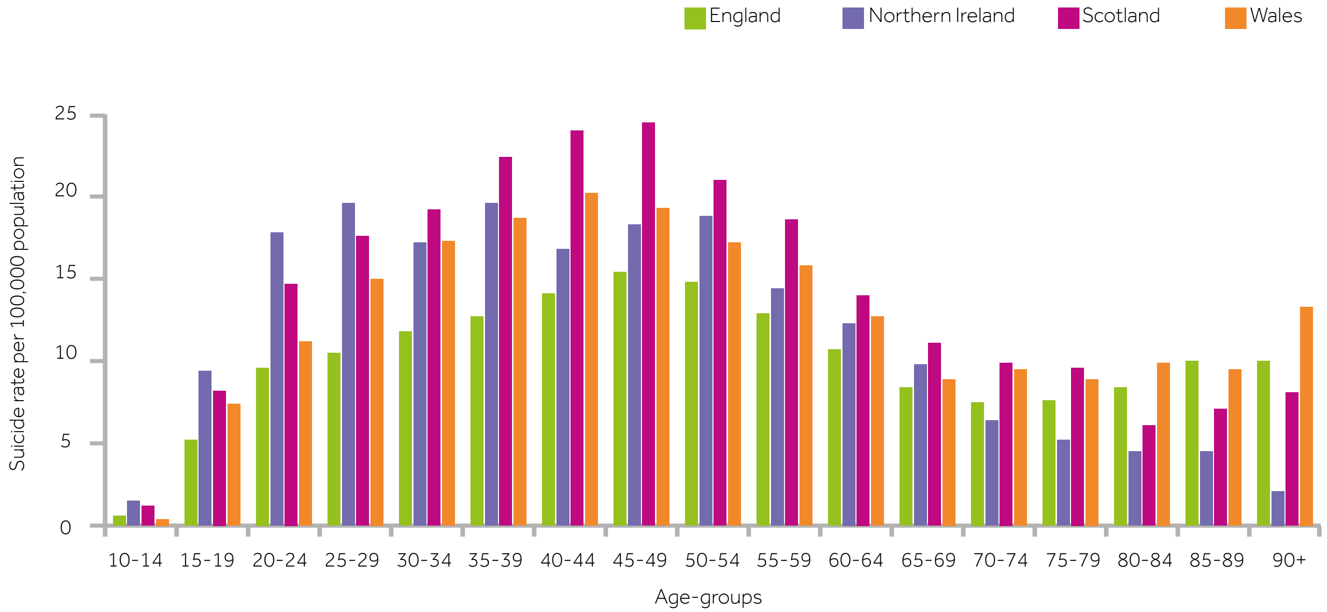
Fig. 2: General population suicide rates in the UK and Jersey



Note: In Northern Ireland data prior to 2015 are not directly comparable with those in 2015 onwards due to a review of suicide satistics by the Northern Ireland Statistics Agency (NISRA).

There was some variation in the peak age by UK country, but overall the pattern was equivalent, with highest rates in middle-aged groups, especially 40-44 and 45-49 year age groups (Fig. 3).

Fig. 3: Suicide rates in the general population by age-group, by UK country (2012-2022)



Note: Rates in Jersey not shown due to small numbers

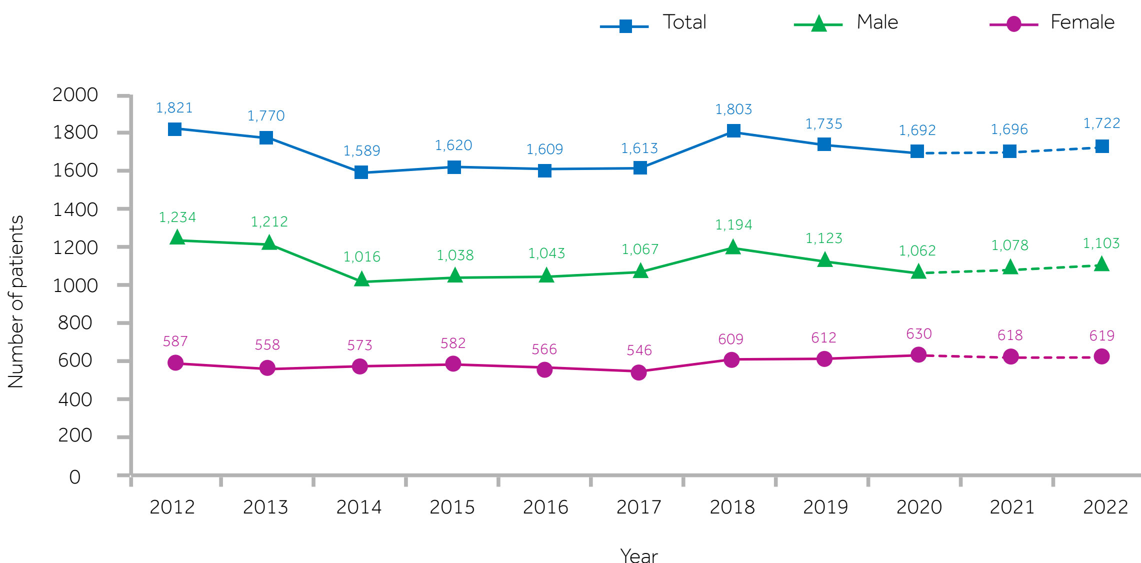
Mental health patient suicide

See clinical message 1

There were 18,670 patients who died by suicide (i.e. people in contact with mental health services within 12 months of suicide) in the UK and Jersey in 2012-2022, which represents 26% of all suicide deaths, an average of 1,697 deaths per year (see Fig. 1 on page 9).

There was an increase in the number of patient suicides occurring from 2018 in line with the change in the standard of proof for suicide that began in 2018. We did not see an increase during COVID-19 years and are currently estimating lower figures in 2020-2022 (Fig. 4). The number of suicides in England increased in 2018 and has been stable since, though this may yet increase in 2021-2022 following further inquests (Fig. 5). The number in Scotland has remained lower in 2014-2022 compared to figures in 2012-2013.

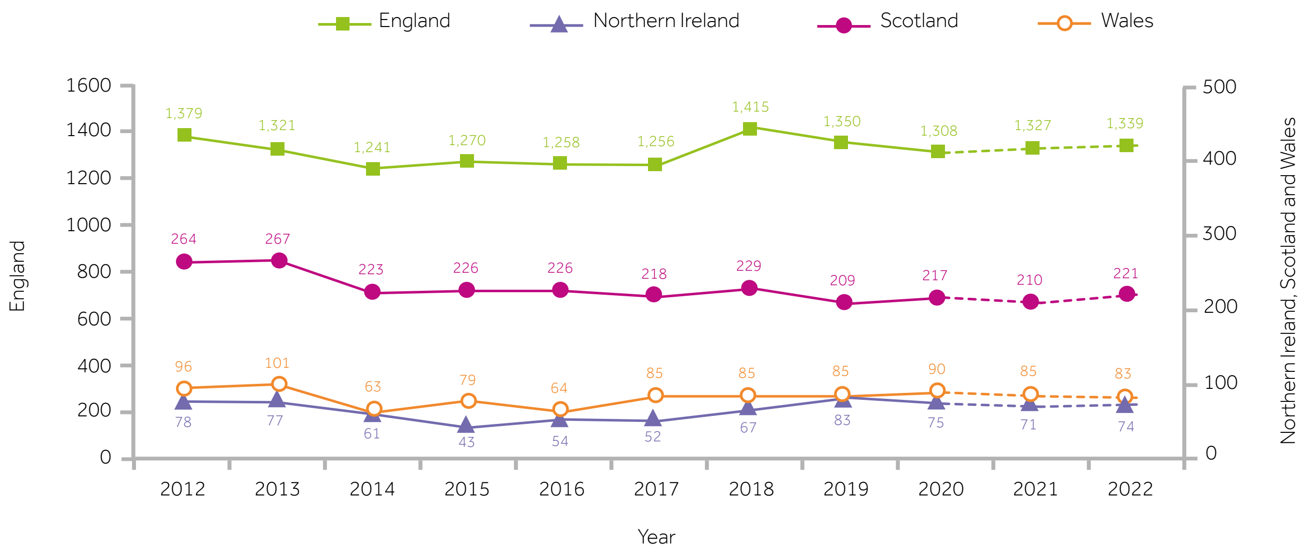
Fig. 4: Number of mental health patients who died by suicide, by sex in the UK and Jersey



1,697 patient suicide deaths per year

26% of all suicide deaths

Fig. 5: Number of mental health patients who died by suicide, by UK country



Note: In Northern Ireland data prior to 2015 are not directly comparable with those in 2015 onwards due to a review of suicide statistics by Northern Ireland Statistics Agency (NISRA). Data from Jersey are not shown due to the low number of patient deaths by suicide.

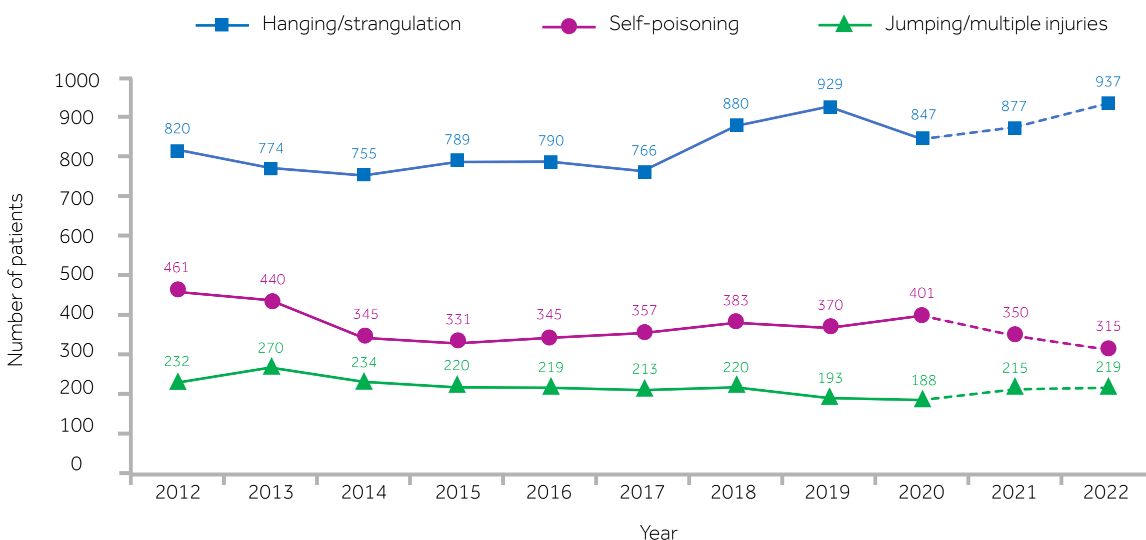
Method of suicide by mental health patients

The most common methods of suicide were hanging/strangulation (9,164, 49%), self-poisoning (4,098, 22%), and jumping/multiple injuries (2,423, 13%).

Hanging/strangulation increased by 14% during 2012-2022, especially after 2017 when the standard of proof for suicide was lowered (Fig. 6). The increase was especially seen in women, from an average of 39% of all female deaths in 2012-2015 to 46% in 2019-2022. The number of deaths by jumping/multiple injuries has fallen by 30% in 2013-2020 but we are estimating an increase in 2021-2022.

The number of self-poisoning deaths fell in 2014 but has risen by 21% between 2015 and 2020, though we are estimating a fall in 2021-2022 (Fig. 6). Overall, opiates (including opioid compounds) were the most common substances used, accounting for a third (1,123, 33%) of deaths by self-poisoning, though the number of deaths using opiates or opioids fell by 44% between 2012 and 2021.

Fig. 6: Main suicide methods by mental health patients in the UK and Jersey



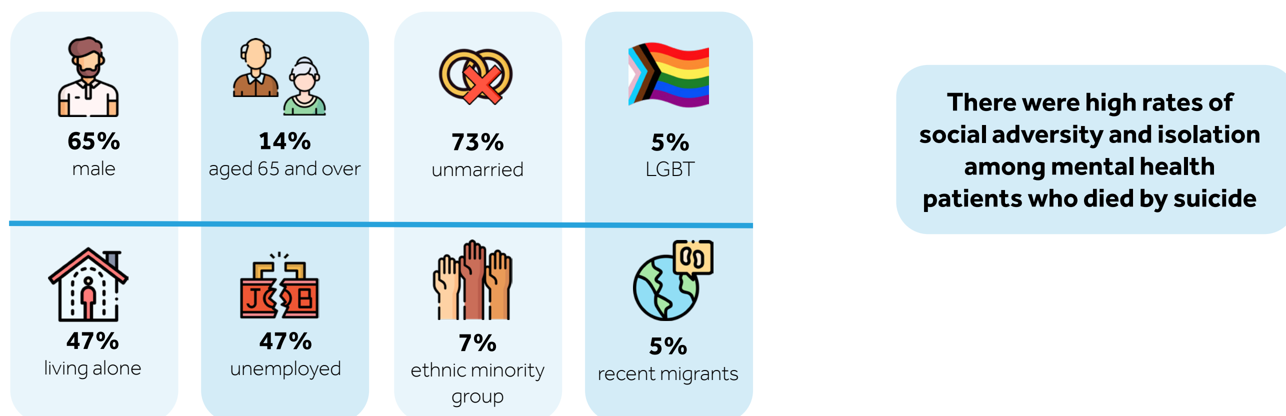
Note: Patient data unavailable in Jersey in 2019-2022

Social and clinical characteristics of mental health patients who died by suicide

Box 1 shows some of the social features of patients dying by suicide. The majority were male patients (12,170, 65%) and unmarried (11,795, 73%) and nearly half (7,752, 47%) lived alone (see additional online data for further information).

1,652 (9%) were aged under 25 (including 266 (2%) aged under 18 and 1,386 (8%) aged 18-24); 2,470 (14%) patients were aged 65 and above. 1,194 (7%) were from an ethnic minority group. In 2016-2022, 367 (5%) of all patients were known to identify as lesbian, gay or bisexual and 84 (1%) were within a trans (including transgender, transsexual, non-binary) group. 800 (5%) patients were migrants to the UK (either seeking permission to stay in the UK or resident in the UK for less than 5 years).

Box 1: Socio-demographic characteristics of mental health patients who died by suicide (UK and Jersey, 2012-2022)



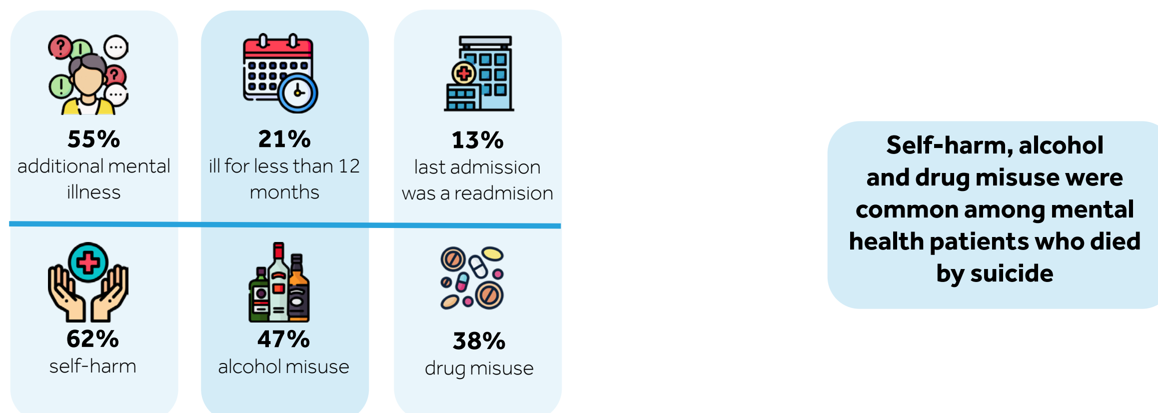
See additional online data for frequencies

There were 2,101 (17%) patients who had recently experienced serious financial problems. Suicide-related internet use (e.g. visiting pro-suicide websites) was reported in 813 (8%) of all patients. There were 138 (1%) patients who had died on or near the date of a family member or friend's death anniversary.

Over half of patients who died by suicide had a comorbid (i.e. additional) mental health diagnosis, and rates of previous alcohol and/or drug misuse were high (Box 2; see additional online data for further information). The proportion of patients with a comorbid mental illness increased by 16% over the report period.

The majority (10,353, 62%) of all patients had a lifetime history of self-harm; the proportion fell by 12% from 67% in 2012-2015 to 59% in 2019-2022. However, the proportion who had self-harmed in the 3 months before suicide (4,877, 31%) increased by 10% from 29% to 32% between 2012-2015 and 2019-2022, driven by a higher number of patients who self-harmed in 2020 (497, 37%). This increase in 2020 was seen in both male and female patients. In 3,325 (24%) instances, the patient had been seen by the emergency department for self-harm.

Box 2: Clinical characteristics of mental health patients who died by suicide (UK and Jersey, 2012-2022)



Self-harm, alcohol and drug misuse were common among mental health patients who died by suicide

See additional online data for frequencies

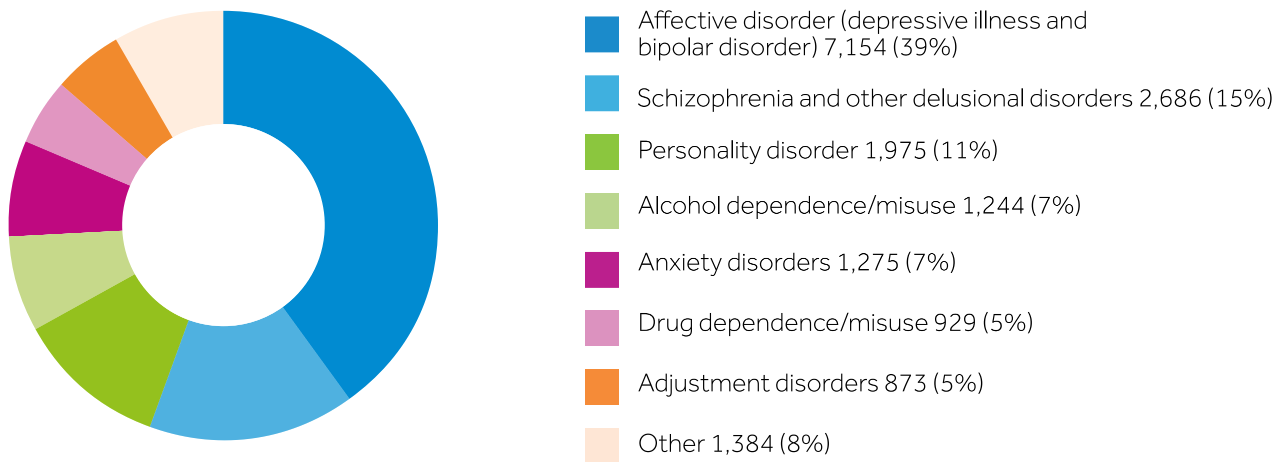
Diagnosis of mental health patients who died by suicide

The main primary mental health diagnoses are shown in Fig. 7. Suicide by patients with affective disorder (bipolar disorder and depressive illness) has generally been falling, although we estimate an increase in 2021-2022 (Fig. 8). The number of patients with schizophrenia and other delusional disorders has been lower since 2017 than in earlier years of the report.

The number of suicide deaths in patients given a diagnosis of personality disorder increased in 2018-2020 but may have fallen in 2021-2022. Suicide by patients with anxiety disorders rose by 59% between 2012 and 2022; the increase was seen in those aged 25-44 and those aged 45-64. The number of patients with alcohol or drug dependence/misuse who died by suicide fell after 2013 and has continued to fall.

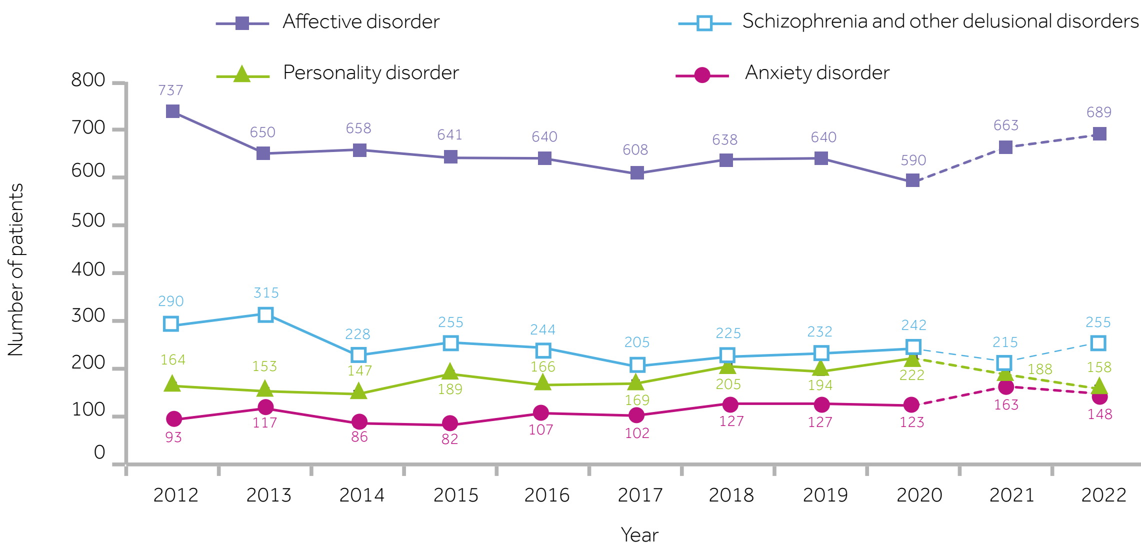
There were 386 (2%) patients with any diagnosis (primary or secondary) of autism spectrum disorder and 207 (1%) with attention deficit hyperactivity disorder (ADHD) who died by suicide; these numbers have increased since 2018 and recent figures show they account for approximately 60 and 40 deaths respectively each year. There were differences in the younger age groups. In patients aged 18-24, 8% had a diagnosis of autism spectrum disorder and in those aged under 18 this was 18%; 3% of those aged 18-24 had a diagnosis of ADHD compared to 7% of those aged under 18.

Fig. 7: Primary diagnoses of mental health patients who died by suicide (UK and Jersey, 2012-2022)



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

Fig. 8: Main primary diagnoses of mental health patients who died by suicide in the UK and Jersey

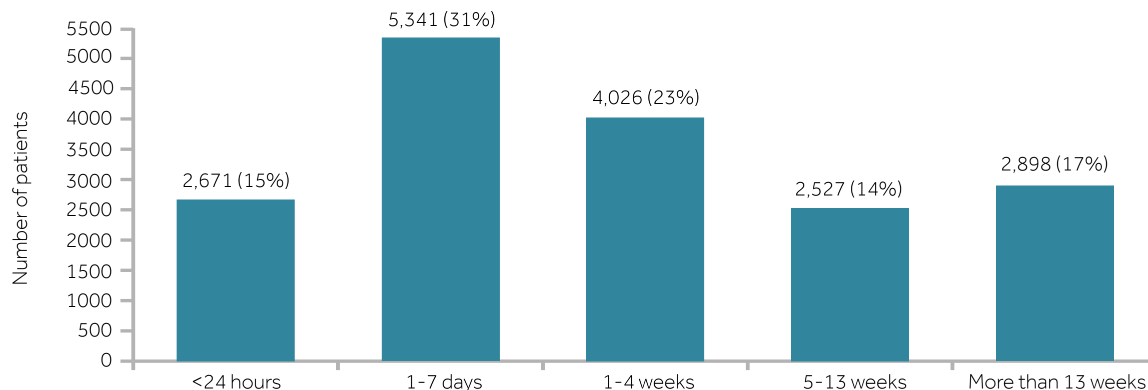


Note: Patient data unavailable in Jersey in 2019-2022

Contact with services by mental health patients who died by suicide

Nearly half (8,012, 46%) had been in contact with services in the week before death (Fig. 9). At the final service contact, the immediate risk of suicide was viewed as not present or low in the majority of patients (12,124, 81%).

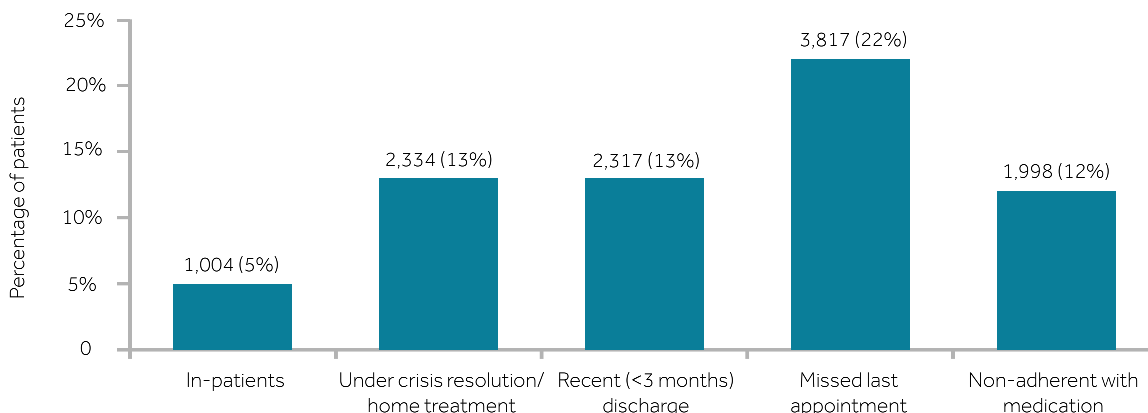
Fig. 9: Timing of last contact with mental health services by patients who died by suicide (UK and Jersey, 2012-2022)



Clinical settings of mental health patients who died by suicide

During 2012-2022, there were 4,718 patients (27%) who died by suicide in acute care settings (in-patients, under crisis resolution/home treatment, recently discharged from in-patient care), an average of 429 deaths per year (Fig. 10). The proportion under acute care has fallen in 2019-2022 (25%) compared to 2012-2015 (30%).

Fig. 10: Service characteristics of mental health patients who died by suicide (UK and Jersey, 2012-2022)



Note: these categories are not mutually exclusive.

There were 250 patients who died by suicide having been subject to a Community/Compulsory Treatment Order (CTO) at some time in 2012-2022. This accounts for 1% of all patient suicides, an average of 23 deaths per year. Around a third (86, 35%) were no longer under the CTO at the time of suicide.

There were 310 patients under the care of an assertive outreach service, 2% of all patient suicides, an average of 28 deaths per year.

In-patient suicide

There were 1,004 in-patient deaths by suicide in 2012-2022, representing 5% of patient suicides overall during this time period. This percentage has decreased since 2016, dropping to 4% in 2022. 22 (2%) were aged under 18 and 92 (10%) were aged 18-24.

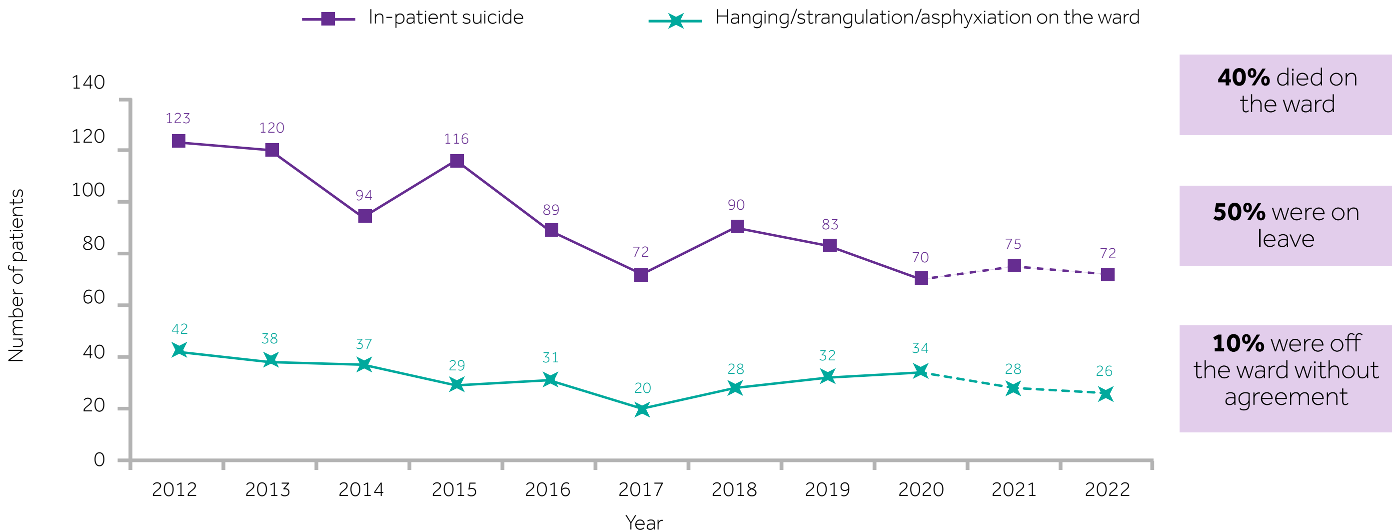
There was a 41% fall in the number of in-patients who died by suicide between 2012 and 2022, although figures in 2020-2022 have not fallen (Fig. 11). We also found rates of in-patient suicide per 10,000 admissions fell by 33% in 2012-2022, i.e. taking into account the total number of in-patient admissions in the UK.

Over a third (353, 40%) died on the ward; half (432, 50%) had left the ward with staff agreement; and 87 (10%) had left the ward without staff agreement or left with agreement but failed to return. There was a 31% increase in the proportion of in-patients who died on the ward in 2019-2022 compared to in 2012-2015 (47% v. 36%). The increase was seen in those aged under 25 (20, 61% v. 17, 39%). The majority (316, 90%) were by hanging/strangulation/asphyxia; the number of these deaths fell in 2012-2017 but have since remained stable and account for an average of 30 deaths per year (Fig. 11).

In-patient deaths include those that occur physically on the ward and those that occur off the ward (e.g. during authorised or unauthorised leave)

Overall, a third (301, 34%) had been detained under Mental Health Act powers, half (152, 51%) of whom died on the ward compared to a third (198, 33%) of voluntary in-patients.

Fig. 11: Number of mental health in-patients who died by suicide and number who died by hanging/strangulation/asphyxiation on the ward in the UK and Jersey



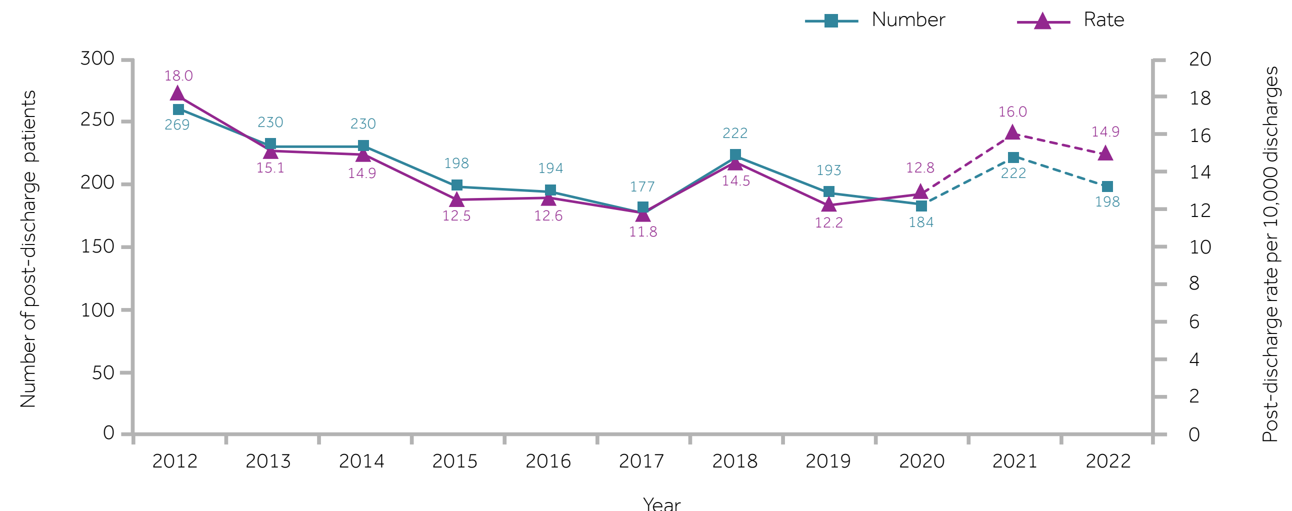
Note: Patient data unavailable in Jersey in 2019-2022

Mental health patients who died by suicide after recent discharge

There were 2,317 patients who died by suicide within 3 months of discharge from in-patient care, 13% of all patient suicide deaths, an average of 211 deaths per year. 13 (1%) were aged under 18 and 165 (8%) were aged 18-24.

The number and rate of suicides by patients within 3 months of discharge fell in 2013-2017 but have since risen (Fig. 12). In the UK, the average rate of suicide over the report period was 14.1 per 10,000 discharges.

Fig. 12: Number and rate of mental health patients who died by suicide within 3 months of in-patient discharge in the UK and Jersey



Note: Patient data unavailable in Jersey in 2019-2022; rates of suicide exclude Jersey due to unavailable denominator data

Post-discharge suicide deaths were most frequent in the first 1-2 weeks after leaving hospital (Fig. 13). Of patients who died in the first week after discharge, the highest number (63, 20%) occurred on day 3 after leaving hospital (day 1 = day of discharge) with higher numbers also occurring later in the week, i.e. days 4-6 compared to the first day of discharge (Fig. 14). In 2019-22 the highest number occurred on day 6 (20 patients, 22%).

Fig. 13: Number of mental health patient deaths by suicide per week following discharge (UK and Jersey, 2012-2022)

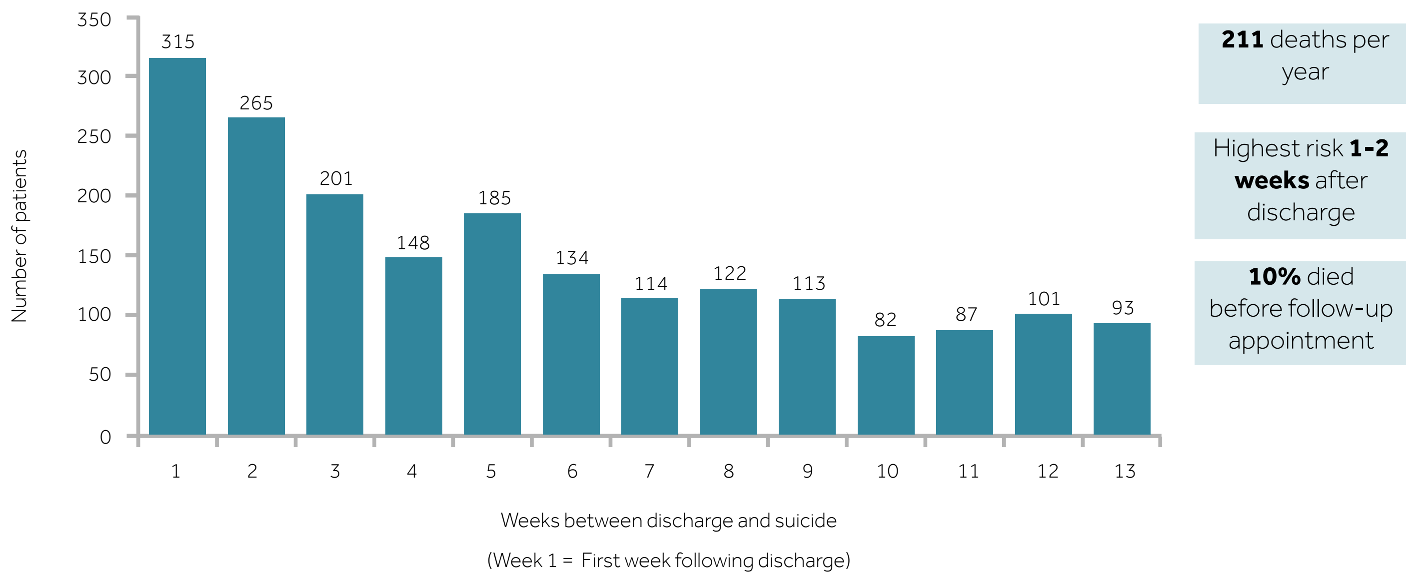
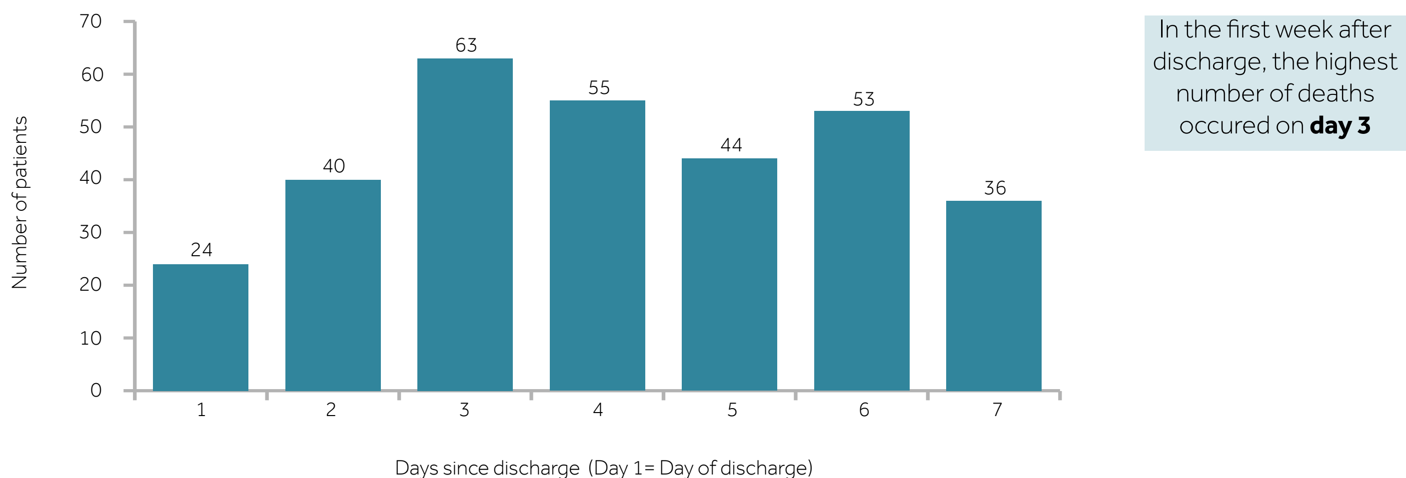


Fig. 14: Number of mental health patient deaths by suicide per day in the week following discharge (UK and Jersey, 2012-2022)



Around a quarter (579, 27%) of patients who died within 3 months of discharge from in-patient care had been detained under the Mental Health Act (MHA) at their last admission; this proportion increased to 35% in 2019-2022. There were 262 (23%) patients known to have been discharged to housing, financial or employment problems.

198 (10%) patients died by suicide before their first follow-up appointment, especially those who died within 2 weeks of discharge (140, 25%). Overall, 184 (9%) had initiated their own discharge; higher in those who died within a week of discharge (47, 15%), and 227 (11%) died after being discharged from an in-patient unit which was out of their local area.

Real-time surveillance of patient suicide

See clinical message 2

We are currently developing a national real-time surveillance (RTS) of suspected suicide deaths (i.e. unconfirmed by inquest) by patients under the recent care of mental health services in England.

Our initial focus is on in-patients and those who died within 2 weeks of discharge, i.e. patients in close proximity to services.

The aim is to collect information early to support suicide prevention efforts. This includes information about:

- emerging novel suicide methods
- suicide related internet use
- travelling to a specific location
- potential clusters
- systemic problems in care, and
- particular problems that patients face.

We are taking a staged approach to establishing this real-time data collection. First we piloted the data collection in 8 NHS trusts in South East England. In April 2024 we expanded the data collection to all mental health trusts across England, asking for clinicians to notify us of any suspected suicide death of an in-patient or a patient recently (within 14 days) discharged from in-patient care, where the death occurred from 1 January 2024. Clinicians can therefore complete an online questionnaire without waiting for the inquest or a request from us.

Numbers of suspected suicide deaths by mental health patients

To date we have been notified of 67 suspected suicide deaths by patients under mental health care in England, the majority (44, 67%) by in-patients.

Between January 1 2024 and December 31 2024 we were notified of 42 suspected suicide deaths. Of these, around two-thirds (24, 65%) were men and most were aged between 25 and 44 (23, 55%) and 45-64 (10, 24%). The majority (28, 76%) were white.

The most common method of death was hanging/strangulation (21, 52%), followed by jumping/multiple injuries (7, 18%). Adverse experiences in the 3 months prior to death included isolation or loneliness (13, 31%) and workplace and/or financial problems (8, 19%).

Clinical characteristics

Most patients we were told about were psychiatric in-patients (32, 76%) with the remaining 10 (24%) patients dying within 2 weeks of discharge from in-patient care. The most common diagnoses were schizophrenia and other delusional disorders (11, 26%) and affective disorder (10, 24%).

In-patient deaths

6 patients (19%) waited up to 7 days in the community for an admission. Most patients (20, 65%) were admitted locally. At the time of death, over half (17, 55%) had been detained under Mental Health Act (MHA) powers and 14 (45%) had been admitted voluntarily. 15 (48%) patients self-harmed within a week prior to death. 12 (39%) patients died on the ward itself, and nearly half (15, 48%) were on agreed leave at the time of death. There was evidence of risk associated with internet use.

Post discharge patient deaths

For 6 (67%) patients who had been recently discharged, the last admission lasted less than a week. 4 patients had been detained under the MHA during this last admission. The majority (9, 89%) of patients had their first follow-up within 3 days of discharge; in most cases (6, 67%) this was face-to-face contact. 4 (40%) patients had experienced relationship problems following discharge.

Themes in this report

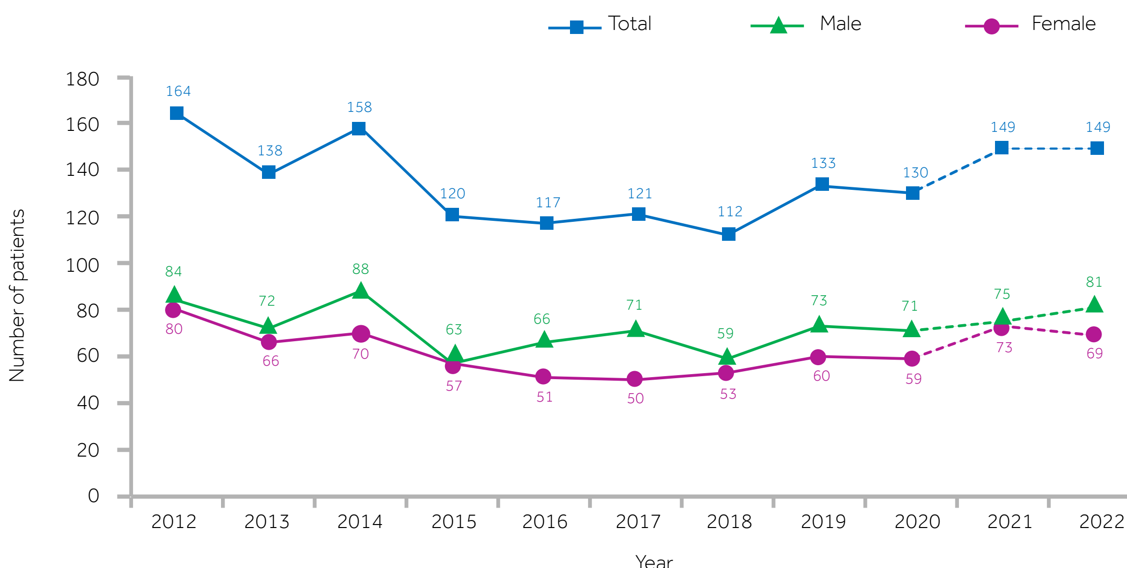
In this section we provide more detailed data on specific topics. The patient groups below reflect some people who may be vulnerable to high or increasing risk, including patients with bipolar disorder, those who had missed their last contact with services or were non-adherent with medication, and those recently bereaved.

Suicide in mental health patients with bipolar disorder

There were 1,491 patients who died by suicide who had received a primary diagnosis of bipolar disorder, 8% of all patient suicides, an average of 136 deaths per year. The average number in 2019-2022 increased by 19% compared to the average number in 2015-2018 (Fig. 15).

See clinical message 3

Fig. 15: Number of patients with a primary diagnosis of bipolar disorder who died by suicide in the UK and Jersey



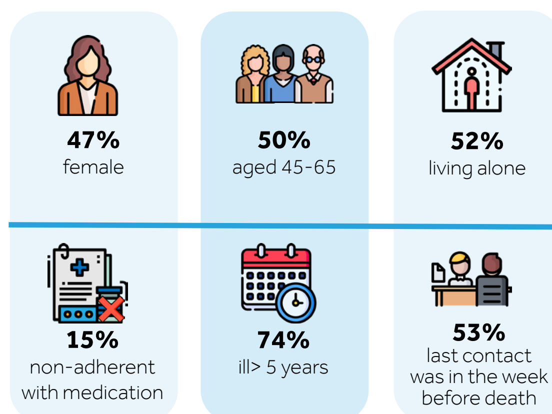
Note: Male and female numbers in 2021 and 2022 do not total the overall figure due to rounding. Patient data unavailable in Jersey 2019-2022.

Compared to other patients who died by suicide, those with bipolar disorder were more often female (694, 47% v. 5,351, 34%) and older, with more aged 45-64 (700, 50% v. 6,149, 39%). 68 (5%) were aged under 25 (the number aged under 18 was too small to report). Overall, more were living alone (695, 52% v. 6,943, 47%) (Box 3; see additional online data for further information).

The majority (1,017, 74%) had been ill for longer than 5 years, more than patients without bipolar disorder (7,254, 53%) but they were less likely to have a comorbid (i.e. additional) psychiatric (730, 52% v. 8,609, 55%) or physical illness (306, 23% v. 3,823, 26%). More had been recently (<3 months) discharged from in-patient care (210, 16% v. 1,943, 13%).

At the time of death, most (985, 73%) were receiving oral or depot antipsychotics, half (716, 53%) were receiving antidepressants, and over a third (527, 39%) lithium/mood stabilisers. The proportion of patients with bipolar disorder prescribed lithium/mood stabilisers increased over the report period from 31% in 2012-2015 to 44% in 2019-2022.

Box 3: Characteristics of mental health patients with bipolar disorder who died by suicide (UK and Jersey, 2012-2022)



See additional online data for frequencies

Of the 527 patients prescribed lithium/mood stabilisers, 147 (28%) died by self-poisoning, more than patients with bipolar disorder who were not prescribed lithium/mood stabilisers (169, 21%).

Patients with bipolar disorder were more likely to be non-adherent with medication than patients without bipolar disorder (201, 15% v. 1,682, 12%) and more had experienced distressing side effects of medication (157, 12% v. 915, 7%), especially weight gain (29, 32% excluding unknowns v. 99, 18%). Fewer were receiving psychological treatment compared to other patients (162, 12% v. 2,296, 16%), though this was more commonly prescribed for patients aged under 25 (16, 28% v. 146, 12%).

There were 18 (1%) patients with bipolar disorder subject to a Community/Compulsory Treatment Order (CTO) at the time of death; 39 (3%) patients were under the care of an assertive outreach service.

Both immediate (975, 81% v. 10,904, 81%) and long-term risk of suicide (636, 56% v. 7,205, 57%) were viewed as not present or low in the majority of patients with bipolar disorder, similar to other patients.

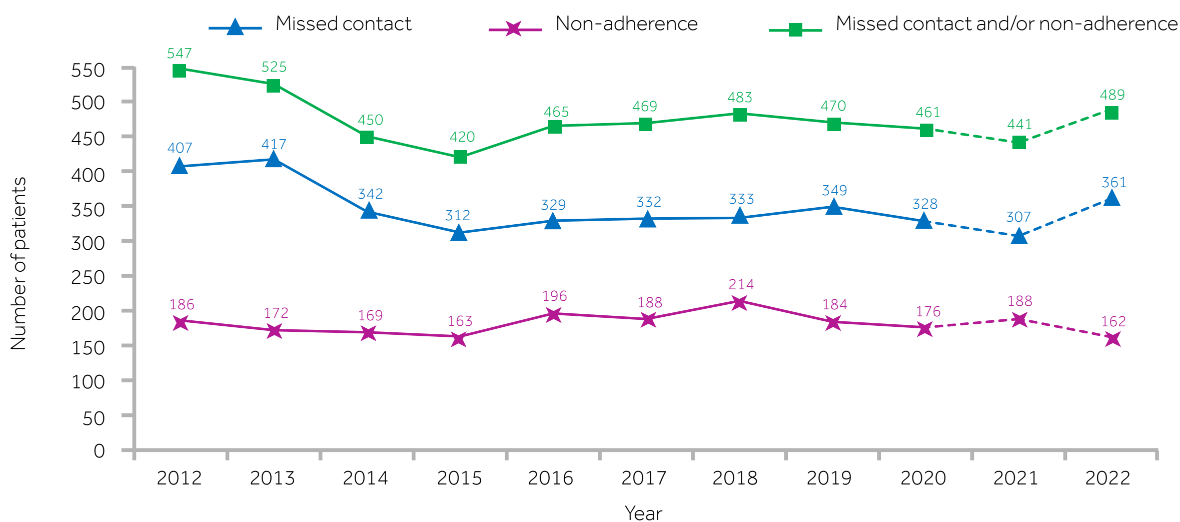
Suicide following missed contact and/or non-adherence with medication

See clinical message 4

An estimated 3,817 patients who died by suicide had missed their final contact with mental health services, accounting for 22% of all patient suicides, an average of 347 deaths per year. There were an estimated 1,998 patients who were non-adherent with drug treatment in the month before their death, representing 12% of all patient suicides, an average of 182 deaths per year. 5,220 patients had missed their last contact and/or were non-adherent to medication, accounting for 29% of all patient suicides, an average of 475 deaths per year. 593 patients fell into both categories - having missed their last contact and being non-adherent - making up 3% of all patient suicides, an average of 54 deaths per year.

The overall number of patients who died by suicide and had missed contact with services has decreased over the report period but we are projecting an increase in 2022; the number of patients who were non-adherent with drug treatment has been relatively stable and we project a fall in 2022 (Fig. 16).

Fig. 16: Number of mental health patients who died by suicide following missed contact and/or non-adherence with medication in the UK and Jersey



Note: Patient data unavailable in Jersey in 2019-2022

Missed last service contact

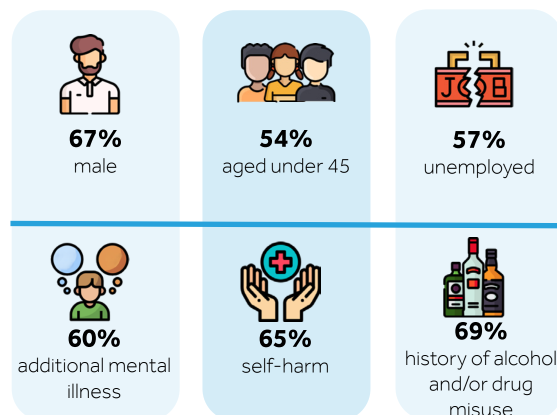
A higher proportion of patients who died by suicide and had missed their last service contact were men compared to other patients who had not missed their last contact (2,560, 67% v. 8,115, 65%) (Box 4; see additional online data for further information). 45 (1%) were aged under 18 and 330 (9%) were aged 18-24. Overall, they were younger, with more aged under 25 (375, 10% v. 1,098, 9%) and aged 25-44 (1,586, 44% v. 4,340, 35%). More were single (1,697, 51% v. 5,035, 43%), unemployed (1,877, 57% v. 5,022, 44%) and living alone (1,883, 56% v. 5,317, 45%) than other patients.

The most common primary diagnosis among patients who missed their last contact was affective disorder (bipolar disorder and depression; 1,239, 35%). A higher proportion had a primary diagnosis of alcohol (328, 9% v. 753, 6%) and drug (266, 8% v. 550, 5%) dependence/misuse and personality disorder (446, 13% v. 1,244, 10%) compared to other patients. More had a comorbid (i.e. additional) diagnosis (2,104, 60% v. 6,443, 53%) and a long (>5 years) history of illness (1,808, 57% v. 5,794, 54%).

A history of self-harm (2,236, 65% v. 7,143, 60%), violence (771, 24% v. 1,945, 17%) and alcohol and/or drug misuse (2,397, 69% v. 6,341, 54%) was more common among those who missed their last contact than other patients. More had experienced financial problems (541, 22% v. 1,415, 15%) and had previously been in prison (491, 15% v. 1,033, 9%).

There were 39 (1%) patients who missed their last contact with services who were subject to a Community/Compulsory Treatment Order (CTO) at the time of death. 72 (2%) patients with missed contact were under the care of an assertive outreach service.

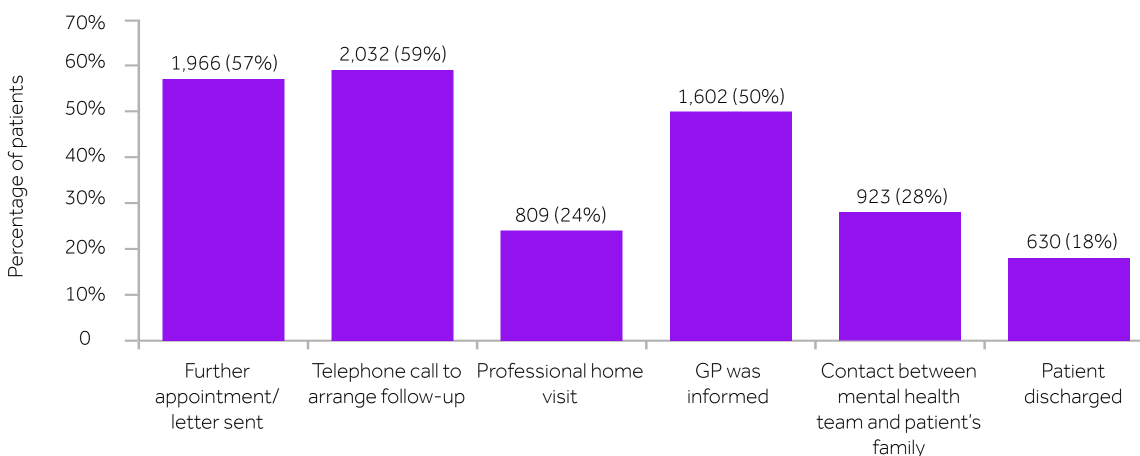
Box 4: Characteristics of mental health patients who died by suicide after missed service contact (UK and Jersey, 2012-2022)



See additional online data for frequencies

Services had attempted to re-engage the majority (3,332, 94%) of patients following missed contact. This was mostly a follow-up via telephone (59%) or letter (57%) to arrange another appointment; in half (50%) the GP was also informed and in 28% the patient's family was contacted. In 18% the patient was discharged from follow-up (Fig. 17).

Fig. 17: Follow-up by services following missed last contact of mental health patients who died by suicide (UK and Jersey, 2012-2022)



Non-adherence with medication

Patients who died by suicide and had been non-adherent to medication were younger than other patients (median age 44yrs v. 46yrs), with more aged 25-44 (766, 40% v. 4,951, 36%). 18 (1%) were aged under 18 and 179 (9%) were aged 18-24. A similar proportion were male (1,298, 65% v. 8,926, 65%) and from an ethnic minority group (158, 9% v. 921, 7%) but they were more likely to be single (942, 52% v. 5,741, 44%) and unemployed (937, 52% v. 5,878, 46%) (Box 5; see additional online data for further information).

A higher proportion had severe mental illness (schizophrenia or affective disorder) (1,180, 63% v. 7,439, 55%) and a comorbid (i.e. additional) psychiatric disorder (1,154, 62% v. 7,219, 54%).

There were 18 (1%) patients who had been non-adherent with drug treatment and were subject to a Community/ Compulsory Treatment Order (CTO) at the time of death and 36 (2%) patients under the care of an assertive outreach service.

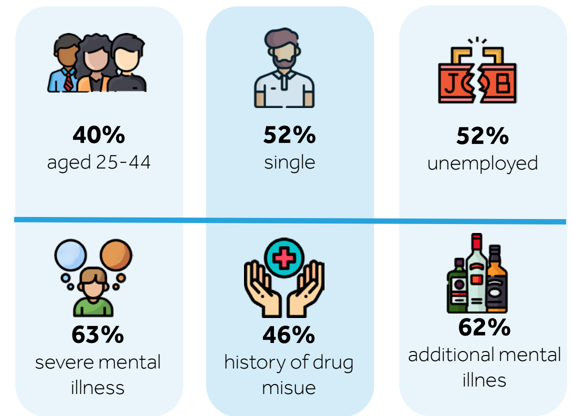
Overall, more patients who were non-adherent with drug treatment had been detained under the Mental Health Act (MHA) at their last admission compared to other patients (457, 26% v. 1,856, 15%).

Previous violence (383, 22% v. 2,258, 18%) and drug misuse (832, 46% v. 4,612, 35%) were common, and more had recently (<3 months) experienced serious financial problems (278, 19% v. 1,649, 16%). Both immediate (1,191, 72% v. 9,708, 82%) and long-term risk (707, 45% v. 6,462, 57%) were less likely to be viewed as not present or low compared to other patients.

Those non-adherent were more often receiving oral antipsychotics (860, 47% v. 4,722, 35%). The most common reasons reported by clinicians for non-adherence were the patient's lack of insight into their mental ill health (460, 31%), medication side-effects (225, 15%) and the patient finding no positive effect from the treatment (192, 13%).

Overall, they were more likely to die by jumping/multiple injuries (314, 17% v. 1,826, 13%) and less likely to die by self-poisoning (327, 17% v. 3,055, 22%).

Box 5: Characteristics of mental health patients who were non-adherent with medication (UK and Jersey, 2012-2022))



See additional online data for frequencies

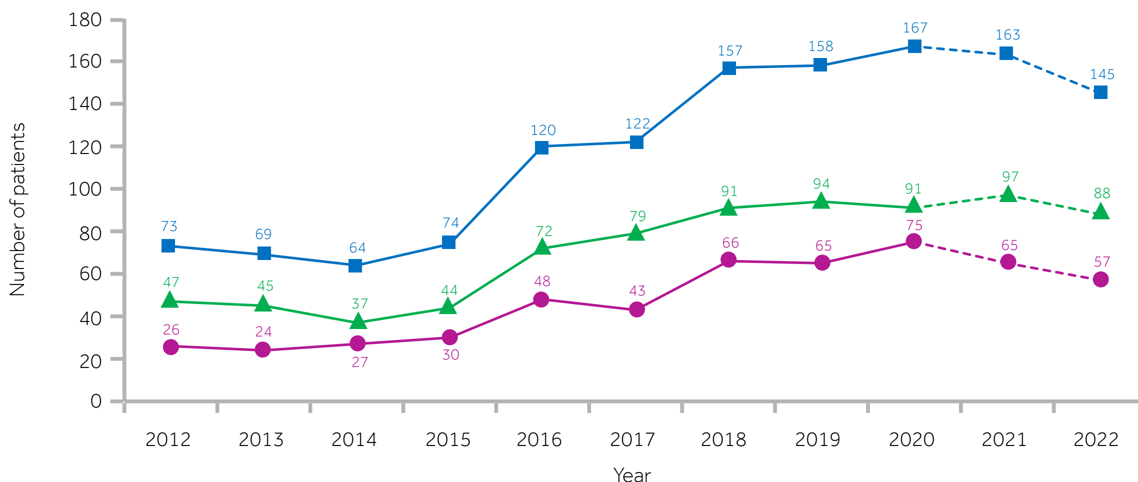
Of the patients who died by suicide and had either missed last contact and/or were non-adherent with medication, 52 (1%) were subject to a Community/Compulsory Treatment Order (CTO) and 94 (2%) were under the care of an assertive outreach service at the time of death.

Suicide and recent bereavement in mental health patients

See clinical message 5

In 2012-2022, there were 1,312 mental health patients who died by suicide and had been recently (i.e. within 3 months) bereaved, 8% of all patients, an average of 119 deaths per year. The number increased over two-fold in 2016-2022 compared to in 2012-2015, although we are estimating a fall in 2021 and 2022 (Fig. 18). The increase was seen in both male and female patients, and in those aged 25-44, 45-54 and 65 and above, but not in those aged under 25. The increase may be due to a greater awareness by clinicians of the impact of bereavement on mental health.

Fig. 18: Suicide by recently (<3 months) bereaved mental health patients in the UK and Jersey



Note: Patient data unavailable in Jersey in 2019-2022

Patients who died by suicide having been recently bereaved were more often female than other patients (526, 40% v. 4,689, 35%) and they were more likely to be older (median age 49yrs v. 46yrs), with more aged 65 and above (226, 18% v. 1,978, 14%). 19 (2%) were aged under 18 and 85 (7%) were aged 18-24. More were widowed (226, 20% v. 522, 4%) and living alone (629, 54% v. 6,239, 47%) (Box 6; see additional online data for further information).

The most common primary diagnosis among those recently bereaved was depressive illness, similar to other patients (405, 34% v. 4,354, 32%), but they were more likely to be diagnosed with adjustment disorder (108, 9% v. 630, 5%) and to have a short (<1 year) history of illness (276, 26% v. 2,681, 22%).

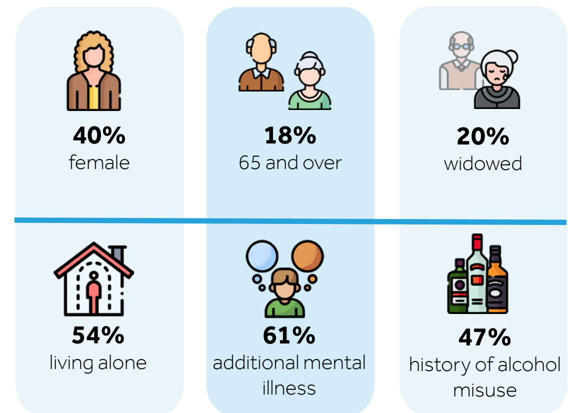
More recently bereaved patients had either a comorbid (i.e. additional) mental (720, 61% v. 7,300, 54%) or physical illness (320, 29% v. 3,333, 25%). In 2019-2022, half had reported suffering from insomnia (58, 51% v. 387, 34%). A history of alcohol misuse was common (539, 47% v. 5,763, 44%), including recent (<3 months) misuse (399, 35% v. 3,966, 30%).

The majority of recently bereaved patients were receiving antidepressants (777, 68% v. 8,722, 66%) and a fifth were receiving psychological therapy (209, 19% v. 2,102, 16%).

A higher proportion died by self-poisoning compared to other patients (314, 26% v. 2,929, 21%). They were also more likely to die on or near the date of a family member or friend's death anniversary (52, 7% v. 76, 1%). Nearly a fifth (178, 19%) had experienced recent (<3 months) serious financial problems, more than other patients (1,762, 16%).

More bereaved patients who died by suicide had missed their last appointment with services compared to other patients (290, 26% v. 2,650, 21%). Estimation of short-term suicide risk was less likely to be viewed by clinicians as not present or low compared to other patients (788, 75% v. 9,641, 81%).

Box 6: Characteristics of mental health patients who were recently (<3 months) bereaved (UK and Jersey, 2012-2022)



See additional online data for frequencies

Homicide in the UK

In 2012-2022, NCISH was notified of 5,794 homicide convictions in the general population, an average of 527 per year. There were 6,165 victims, an average of 560 per year.

There were an estimated 637 patients in recent (<12 months) contact with mental health services convicted of a homicide offence, an average of 58 per year; these are referred to as patient homicides. The number of these convictions fell after 2013 and remained steady in 2014-2019 (Fig. 19) but estimated figures in 2021-2022 show an increase which seems most likely due to delays in court prosecutions and outcomes due to COVID-19 in 2020 when there was a fall. However, these estimated figures should be treated with caution. There were 658 victims, an average of 60 per year. Around 1 in 5 patients convicted of homicide were aged under 25 (127, 22%), and 29 (5%) were under 18.

Across the UK, patients represented 11% of people convicted of homicide (Table 1). This figure continues to be higher in Scotland (17%) and Wales (14%) 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.

Fig. 19: Homicide by patients in recent (<12 month) contact with mental health services in the UK, by year of conviction and year of offence

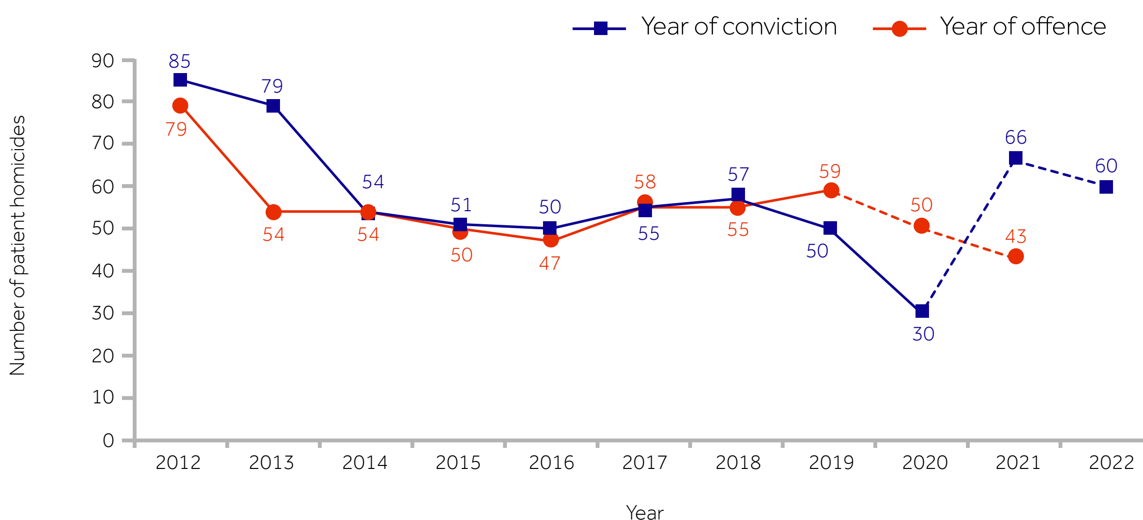


Table 1: Number of homicide offenders in the general population and by patients in recent (<12 month) contact with mental health services, by UK country (2012-2022)

	England N(%)	Northern Ireland* N(%)	Scotland N(%)	Wales N(%)	UK N(%)
General population homicide	4,967	56	522	249	5,794
Patients under mental health care	508 (10%)	6 (11%)	89 (17%)	34 (14%)	637 (11%)

* Northern Ireland data between 2012-2014

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