MANCHESTER 1824
The University of Manchester

NCISH Annual Report

UK patient data (2011-2021)

HQIP
Healthcare Quality Improvement Partnership

1,597 suicides by people under recent (within 12 months) mental health care in 2021

26% of all people who died by **suicide** in 2011-2021 had **recent** contact with **mental health services**

Clinical care

48% lived **alone**

47% had **alcohol misuse**

54% had more than one **mental health diagnosis**

Clinical prevention should target these common risk factors

Acute mental health care settings

433 deaths per year

28% In-patients died under **enhanced nursing observation**

Highest risk **1-2 weeks** after discharge

Prevention should focus on ward environment and careful transition to community

Autistic people or those with ADHD

44 deaths per year

Younger and more likely to identify as **LGBT**

Suicide-related internet use common

Services should be aware of risks of online experience

National Confidential Inquiry into Suicide and Safety in Mental Health (2024)

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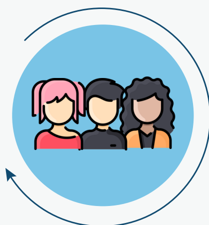
In-patients under 25

11 deaths per year

Mostly **female**; almost half had experienced **childhood abuse**



More **died on the ward** than in-patients aged 25+

Attention is needed to potential ligatures and ligature points

Students aged 18-21 under mental health care (England and Wales)

9 deaths per year

Fewer students under **mental health care**

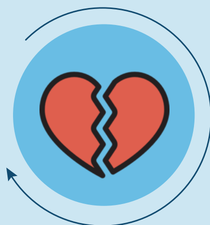
More **depression** than other young patients

A clear pathway to NHS services is needed

Patients with a one-off assessment

167 deaths per year

Recent adverse **life events** common



Many had **no further follow-up**

Awareness of risk needed after single assessments

Patients who died in public locations

354 deaths per year

Younger, more **acutely unwell**

Increased use of **parks/woodland**

Local suicide prevention plans should address high risk locations

National Confidential Inquiry into Suicide and Safety in Mental Health (2024)