

MANCHESTER
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HQIP

Healthcare Quality
Improvement Partnership

National Confidential Inquiry

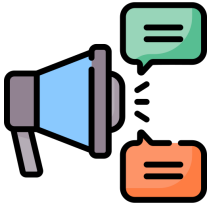
into Suicide and Safety in Mental Health

Annual Report 2022:
Easy Read

About this document



This report uses easy words and pictures



This report will tell you about our work and what this means for you

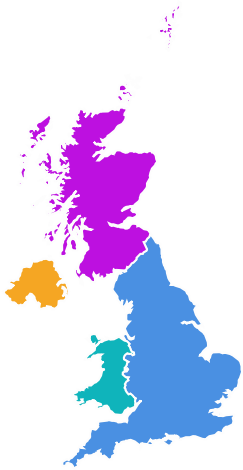


This report is about suicide and you may find it upsetting. You may want to read this report when someone else is with you

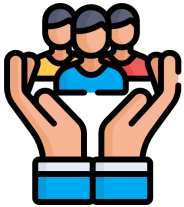


It tells you about people who died by suicide between 2009 and 2019

Introduction



We collect information about all people in the UK who die by suicide when they have been cared for by mental health services



This information helps us understand what was happening in people's lives, and what care they had from mental health services before they died



We collect this information so we can make services safer for people who are cared for by mental health services



Every year we write a report about people who died by suicide and were cared for by mental health services before they died. We call these people patients

What we did

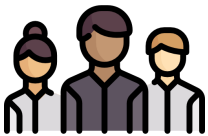


We collected information on people who died by suicide between 2009 and 2019 and who had been cared for by mental health services in the year before they died



This information came from the people in mental health services who cared for the patient

What we found



Every year in the UK about 6,000 people die by suicide

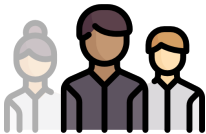


In 2018 and 2019 the number of people who died by suicide went up

Suicide by patients



More than a quarter of people who died by suicide were cared for by mental health services in the year before they died



2 in every 3 people who died were male



Many patients had depression



Nearly half of the patients who died by suicide lived alone



Most had harmed themselves before, and had used alcohol and drugs



Nearly 1 in 10 patients died on or near to an anniversary or important date

Mental health care

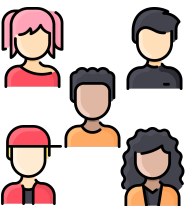


More than a quarter of patients who died by suicide had been staying in hospital, had recently left hospital or were being seen by a home treatment team

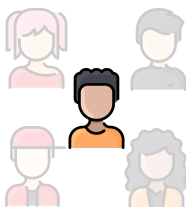


We found the risk of suicide is higher very soon after returning home, or being on leave from hospital

Young patients



There were 19 deaths a year by patients aged under 18



Only 1 in 5 were in contact with mental health services and three-quarters had harmed themselves before

Patients with money, work or housing problems



Almost 1 in 5 patients who died by suicide had recently lost their job, had money or work problems, or a problem with where they were living

Patients with physical illness



A quarter of patients who died by suicide also had a physical illness, like heart disease



Patients with a physical illness who died by suicide were older than patients who did not have a physical illness

Patients who had been victims of domestic violence

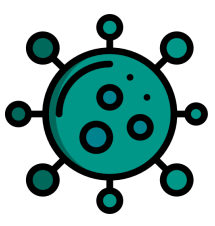


There were 104 deaths a year by patients who had been victims of domestic violence. Most were women but over a quarter were men



A diagnosis of personality disorder, self-harm and using alcohol and drugs were more common than in other patients

Suicide prevention during the COVID-19 pandemic



There was not an increase in the number of deaths by suicide during the first year of the pandemic, compared to other years



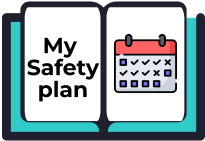
We found that anxiety, isolation and disruption to care were often reported for patients who died by suicide during the pandemic

What these findings mean for you

If you are cared for by mental health services



People who care for you in mental health services should ask about **anniversaries** and **dates** that are important to you



These dates might be talked about when you are **safety planning**

If you have been staying in hospital



If you are staying in hospital the ward you are staying on should be a **safe place**



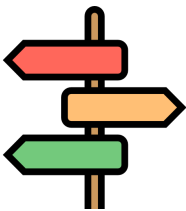
When you go home from hospital you should be seen by someone from your mental health team within **3 days**

If you are a young person



You might feel like you have a lot of problems. You should be encouraged to **use services** that will be able to help you

If you have money, work or housing problems



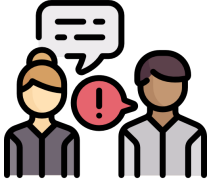
You should be told about organisations that can **help** you with your problems (e.g. money you owe, problems with your job or where you live)

If you have a physical illness



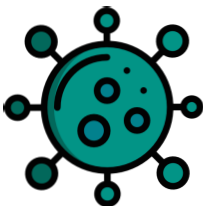
You might be asked about your **physical health** and what **medications** you or someone else you live with have at home

If you have been a victim of domestic violence



Talking about any violence or risk of violence against you is an **important part** of your **care**

Your care during the COVID-19 pandemic



If you are feeling **anxious, isolated** or **lonely** you should be able to get support. You should receive your usual care as much as possible

More information



You can read the non-easy read report [here](#)



You can watch a short video about the report [here](#)



If you any questions you can email us at ncish@manchester.ac.uk



Keep up to date with us by following us on Twitter @NCISH_UK

