Patients at highest risk of suicide in first two weeks after leaving hospital

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Mental health patients are at their highest risk of dying by suicide in the first two weeks after leaving hospital - a report out today shows.

Around 3,225 patients died by suicide in the UK within the first three months of their discharge from hospital – 18% of all patient suicides, between 2002-2012.

The University of Manchester's National Confidential Inquiry into Suicide and Homicide by People with Mental Illness found that 526 patients died within the first week, the peak time of risk in England, Northern Ireland and Scotland; it is the first two weeks in Wales.

The Inquiry data, commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England, the Health Department of the Scottish Government, the Welsh Government, DHSSPS Northern Ireland and Jersey, was being presented to healthcare professionals and service users at a launch event in Manchester today.

Professor Louis Appleby, Director of the National Confidential Inquiry, who led the study said: "Our latest data shows the first three months after discharge remain the time of highest risk but especially in the first 1-2 weeks. This increased risk has been linked to short admissions and to life events so our recommendations are that careful and effective care planning is needed including for patients before they are discharged and for those who self-discharge.

"Early follow-up appointments should be strengthened and reducing the length of in-patient stay to ease pressure on beds should not be an aim in itself. Instead health professionals should ensure the adverse events that preceded the admission have been addressed."

The report also highlights 24 deaths in England and Wales in patients who had been restrained by ward staff in the previous 24 hours. 5 of these deaths occurred in 2012.

The research team call for suicides within 3 days of hospital discharge and deaths and serious injuries caused by restraint to be NHS 'never events'.

The National Confidential Inquiry at The University of Manchester presents data for England, Northern Ireland, Scotland and Wales from January 2002 to December 2012 based on date of death for suicide and date of conviction for homicide.

There were 18,017 patient suicides between 2002 and 2012 in the UK, 28% of suicides in the general population during this time.

Hanging remains a common method for suicide with an increase in this method. In 2012, there were 2,994 suicides by hanging in the UK, 813 in mental health patients.

Professor Nav Kapur, Head of Suicide Research at the National Confidential Inquiry, said: "The increase in hanging may be related to restrictions on the availability of other method and the misconception that hanging is a quick and painless way to die - but this is not the case and is also highly distressing for family members who discover the body.

"This method is difficult to prevent outside institutional settings but there is a broad responsibility for preventing suicide by this means. In

particular it would be helpful for the media to ensure that in avoiding the depiction of full details of suicides by hanging, they do not inadvertently make it appear to be a non-traumatic method."

The fall in homicides committed by mental health patients reported last year for England was sustained but there was no further fall. Between 2002-2012 828 people convicted of homicide in the UK have been confirmed as mental health patients, on average 75 per year. 66 homicides were recorded in 2012 in the UK.

19% of all homicides were intimate partner homicides, 13% of perpetrators were mental health patients similar to the 11% figure for all homicides.

Professor Jenny Shaw, Head of Homicide Research on the Inquiry, said: "Mental health services need to recognise their role in preventing domestic violence, working with other agencies. We need to improve the mental health of perpetrators to protect victims."

Provided by University of Manchester