

(2008-2018)

1,601

suicides by people under mental health care in 2018

27%

who died by **suicide** had contact with **mental health services** in the **12 months** before death

Mental health **in-patient** and **post discharge** deaths continue to **fall**

Patients who lived alone

Patients under 25

746

deaths per year



More self-harm, drug and alcohol use

Higher rates of unemployment, physical and mental illness

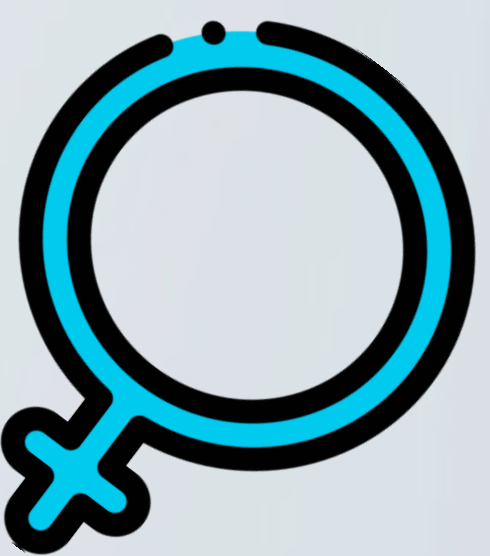


Services should address these clinical and social risks

134

deaths per year

Increasing numbers in 15-17 year olds and female patients



Personality disorder, eating disorders, drug misuse and self-harm more common

Improve skills to respond to clinical complexity

(2008-2018)

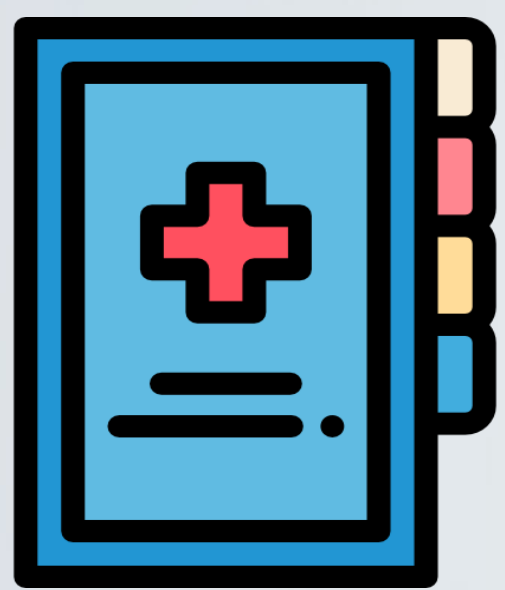
Patients from ethnic minority groups

107

deaths per year



Different prevention for severe mental illness, substance misuse and recent migration



Risk profile differs between ethnic groups



Services to be aware of diverse social and clinical characteristics

Suicide prevention during COVID-19

133

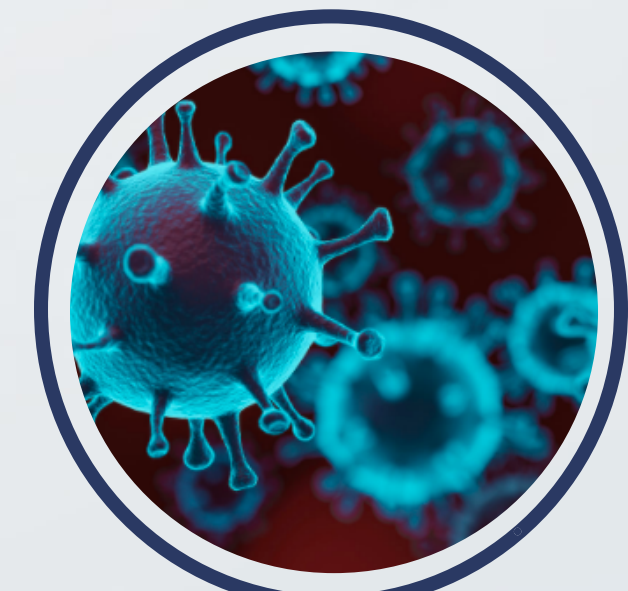
suspected suicide deaths



Increase in anxiety, loneliness & isolation



1/3 had reported disruption in regular support



2/3 reported adverse experiences related to the pandemic

Additional support may be needed for vulnerable groups

Suicide prevention in mental health services

Safer wards

Services for dual diagnosis

Early follow-up on discharge

Healthcare organisations can self-assess their services using our Safer Services toolkit

Low staff turnover

No out of area admissions

Outreach teams

24-hour crisis teams

Personalised management plans

Family involvement in 'learning lessons'

10 ways to improve safety

Guidance on depression

