Making Mental Health Care Safer:

Key Findings from NCISH Annual Report & 20-year Review 2016

**Acute Care**
CRHT is now the main setting for suicide prevention


Post-discharge deaths are falling less than in-patients, with a peak in the first 1-2 weeks

- **3 times** as many deaths in CRHT as in in-patient care
- **Around 200 per year**
- **1/3** were under CRHT for less than a week

**Substance misuse**
access to specialist services should be more widely available

- Around half of patient suicides had a history of alcohol misuse
- Many had a history of drug misuse

**Economic problems**
are becoming more common in patient suicide

- **13%** serious financial difficulties
- **47%** unemployed
- **87** recent migrants deaths per year
- **137** homeless - deaths over 3 years
Changing pattern of patient suicide

**Isolation**
Living alone has become a more common feature

**Substance misuse**
Alcohol & drug misuse more frequent in patients who die by suicide

**Economic adversity**
Increasing unemployment, debt and homelessness

**Self-harm**
More patients who die by suicide have recently self-harmed

10 ways to improve safety

- Safe wards
- Early follow-up on discharge
- No out-of-area admissions
- 24 hour crisis teams
- Family involvement in 'learning lessons'
- Guidance on depression
- Dual diagnosis service
- Low staff turnover
- Outreach teams
- Personalised risk management