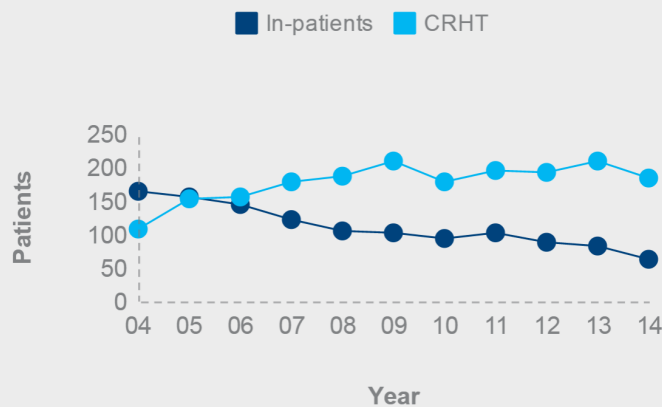


# Making Mental Health Care Safer:

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

### Acute Care

CRHT is now the main setting for suicide prevention



62%

decrease in in-patient suicide in England (2004-2014)

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

13%



serious financial difficulties

47%



unemployed

87



recent migrants deaths per year

137



homeless - deaths over 3 years

### Economic problems

are becoming more common in patient suicide

# Making Mental Health Care Safer:

## Key Findings from NCISH Annual Report and 20-year Review 2016

### 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

### Safer wards

Early follow-up on discharge



Dual diagnosis service



No out-of-area admissions



10 ways to improve safety

Low staff turnover



24 hour crisis teams



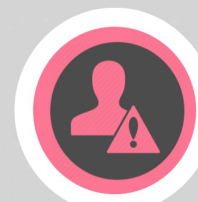
Outreach teams



Family involvement in 'learning lessons'



Personalised risk management



Guidance on depression