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 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
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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

Safer wards
Early follow-up on discharge

Dual diagnosis service
Low staff turnover

No out-of-area admissions
24 hour crisis teams

Outreach teams
Personalised risk management

Family involvement in 'learning lessons'
Guidance on depression