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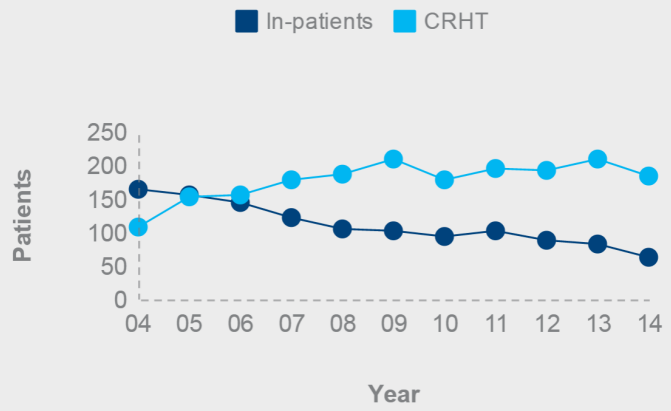
# Making Mental Health Care Safer:

20 Years of the National Confidential Inquiry

## 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**

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# 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

## 10 ways to improve safety

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