

## Annual Report 2017 Key messages

# Evidence of improved patient safety:

#### Patient suicide down overall, and..

- ..in in-patient suicides
- ..following hospital discharge
- ..after non-adherence to treatment

but...

0

.slowing of longstanding downward trend in in-patient suicides:

39%



2005-2010

**10%** 

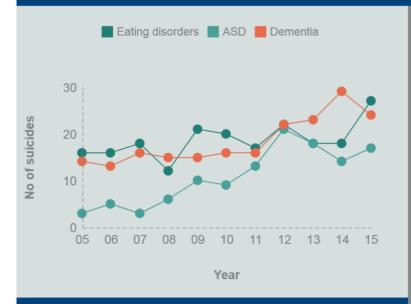


2010-2015



..the first week
post-discharge
period remains a time
of high risk

### Vigilance in specific diagnostic groups



#### Eating disorders

2/3

ill for >5 years

contact with specialist services

Autism spectrum disorder

Self-harm

more common than in other patients



rise likely to reflect increasing diagnoses access to specialist support needed in these conditions

Dementia

18

deaths per year

16%

ill for < 1 year



# **Annual Report 2017 Key messages**

# Reducing suicide by overdose:

safer prescribing of opiate & opiate-containing analgesics





self-poisoning deaths per year



opiates most frequent type of drug in fatal overdose



however, figures have fallen in England, Scotland, Wales



Most patients convicted of homicide have a history of alcohol or drug

misuse

#### Alcohol & drug misuse:

specialist substance misuse & mental health services to work together in risk management





Risk from mental health patients is related to co-existing substance misuse

#### **Health and justice:**

concern over prison sentences for people with severe mental illness

Patients with schizophrenia convicted of homicide offence:



Many are sent to prison rather than hospital



Further understanding needed of sentencing decisions

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness