Annual report 2018: Key messages

Renewed emphasis on reducing suicide by in-patients

- Fall in in-patient deaths has slowed
  - 2006-2010: 31%
  - 2012-2016: 11%

- Improving physical safety on wards
- Care plans in place
- Strengthen nursing observation

Vigilance in specific patient groups

- Highest risk on day 3 post-discharge
- Safer prescribing
- Reducing alcohol & drug misuse

- Patients with substance misuse: 56%

Suicide prevention in young people

- Number of suicides rises in late teens
- Promoting mental health in education
- Shared role for front-line services
- Availability of support at times of risk, esp. exam months

- Suicides by students (aged 18-21) in England & Wales, per year: 52

National Confidential Inquiry into Suicide and Safety in Mental Health
Female patients

1/2 aged 35-54 years

74% self-harm especially common

15% diagnosis of personality disorder

Distinct risk profile compared to men

Recent self-harm

434 patients died within 3 months of self-harm, per year

1/2 rising in patients who died

1/2 were female patients aged under 25

Should be recognised as suicide warning

NCISH recommendations shown to reduce suicide rates

10 ways to improve safety

Services for dual diagnosis

Safer wards

Early follow-up on discharge

Low staff turnover

Outreach teams

No out-of-area admissions

24-hour crisis teams

Personalised risk management

Guidance on depression

Family involvement in ‘learning lessons’