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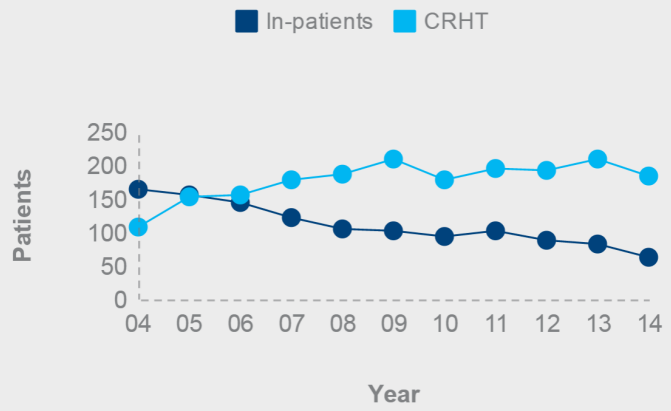
Making Mental Health Care Safer:

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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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