The University of Manchester

NCISH Annual Report
(2008-2018)

HQIP
Healthcare Quality Improvement Partnership

1,601 suicides by people under mental health care in 2018

27% who died by **suicide** had contact with **mental health services** in the **12 months** before death

Mental health **in-patient** and **post discharge** deaths continue to **fall**

Patients who lived alone

746 **deaths per year**

More self-harm, drug and alcohol use

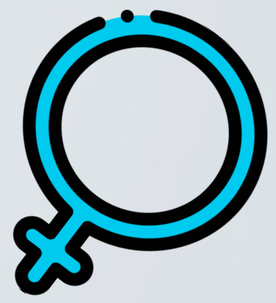
Higher rates of unemployment, physical and mental illness

Services should address these clinical and social risks

Patients under 25

134 **deaths per year**

Increasing numbers in 15-17 year olds and female patients



Personality disorder, eating disorders, drug misuse and self-harm more common

Improve skills to respond to clinical complexity

National Confidential Inquiry into Suicide and Safety in Mental Health (2021)

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Patients from ethnic minority groups

107 deaths per year

Risk profile differs between ethnic groups

Different prevention for severe mental illness, substance misuse and recent migration

Services to be aware of diverse social and clinical characteristics

Suicide prevention during COVID-19

133 suspected suicide deaths

1/3 had reported disruption in regular support

Increase in anxiety, loneliness & isolation

2/3 reported adverse experiences related to the pandemic

Additional support may be needed for vulnerable groups

Suicide prevention in mental health services

Healthcare organisations can self-assess their services using our Safer Services toolkit

National Confidential Inquiry into Suicide and Safety in Mental Health (2021)