

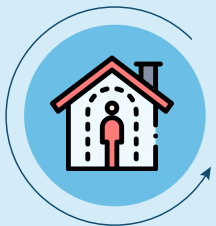
1,597

suicides by people under recent (within 12 months) mental health care in 2021

26%

of all people who died by **suicide** in 2011-2021 had **recent** contact with **mental health services**

Clinical care



48%
lived **alone**



47% had
alcohol misuse



54% had more
than one
**mental health
diagnosis**

Clinical prevention should target these common risk factors

Acute mental health care settings

433

deaths per
year

28%

In-patients died
under **enhanced
nursing
observation**



Highest risk
1-2 weeks
after
discharge

Prevention should focus on ward environment and careful transition to community

Autistic people and patients with ADHD

32

deaths per
year
autistic people

15

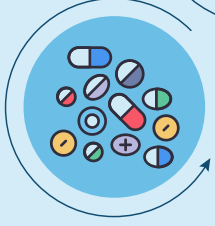
deaths per
year
ADHD



**Self-harm and
childhood
abuse** common
in both groups



**Suicide-related
internet use** common
in autistic people



Drug misuse
common in patients
with ADHD

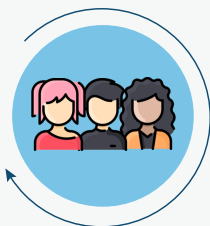
Services should recognise and respond to the safety needs of both these groups

In-patients under 25

11

deaths per year

Mostly **female**; almost half had experienced **childhood abuse**



More **died on the ward** than in-patients aged 25+

Attention is needed to potential ligatures and ligature points

Students aged 18-21 under mental health care (England and Wales)

9

deaths per year

Fewer students under mental health care



More **depression** than other young patients

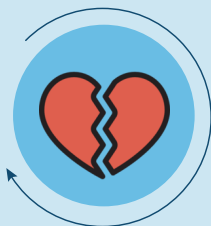
A clear pathway to NHS services is needed

Patients with a one-off assessment

167

deaths per year

Recent adverse **life events** common



Many had **no further follow-up**

Awareness of risk needed after single assessments

Patients who died in public locations

354

deaths per year

Younger, more acutely unwell



Increased use of **parks/woodland**

Local suicide prevention plans should address high risk locations