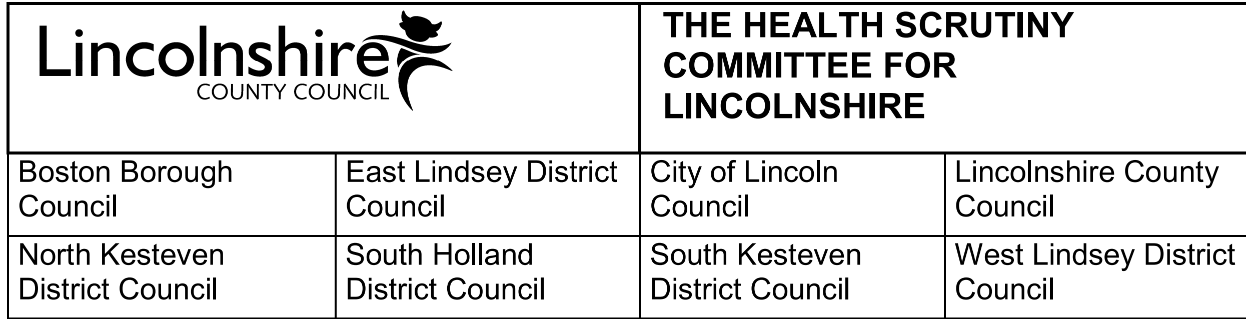


	THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE

Boston Borough Council	East Lindsey District Council	City of Lincoln Council	Lincolnshire County Council
North Kesteven District Council	South Holland District Council	South Kesteven District Council	West Lindsey District Council

Open Report on behalf of Dr Tony Hill, Executive Director of Community Wellbeing and Public Health

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**19 November 2014**
Subject:	**Annual Report on Suicide and Self Harm in Lincolnshire, authored by Public Health Lincolnshire**

Summary:

This highlight report by Public Health provides an overview of suicide and self-harm in Lincolnshire, with the purpose of demonstrating findings from the audit. The most up to date information is available from Health and Social Care Information Centre (HSCIC) and Public Health Mortality Files on suicides registered during 2013. More detailed information has been accessed via patient records and relates to those suicides registered in the calendar year 2011.

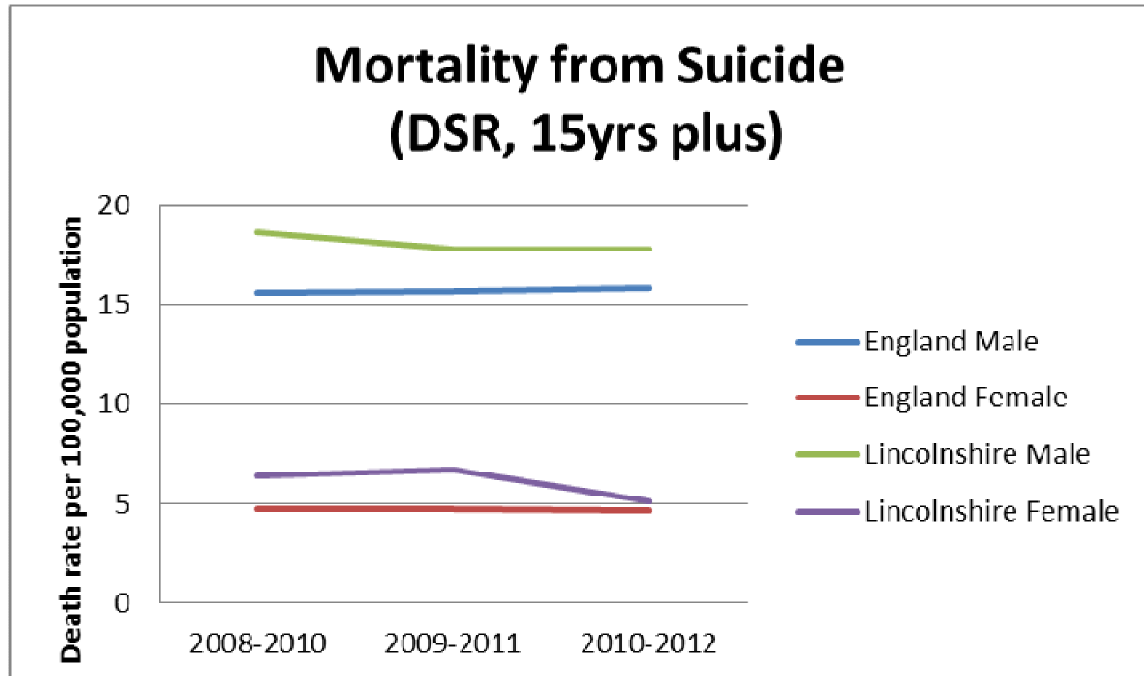
Actions Required:

The Committee is asked to consider and comment on the content of the report.

1. Background

Demographics Information

As can be seen from the graph below, Lincolnshire has a higher rate of death from suicide for both males and females than in England.



Ref HSCIC Mortality from Suicide and Injury Undetermined, directly standardised rate, 15+ years, 3 year average.

Nationally, the majority of suicides continue to occur in adult males, accounting for approximately three quarters of all suicides. Latest information for Lincolnshire shows 64 deaths were registered in 2013, of which 52 (81%) were male. This represents a change in the gender bias for the county, with an increasing proportion of male deaths, as shown below:

	2008	2009	2010	2011	2012	2013
Male	46 (78%)	62 (69%)	42 (74%)	42 (69%)	64 (82%)	52 (81%)
Female	13 (22%)	28 (31%)	15 (26%)	19 (31%)	14 (18%)	12 (19%)
All Persons	59	90	57	61	78	64

Actual figures

In Lincolnshire, the majority (56%) of male deaths were of those aged 35-44 and 45-54 years, which is consistent with recent years. Historically, the majority of female suicide has been within the 55+ age group, but for 2013, Lincolnshire data shows a more even distribution across all age groups. Child suicides are uncommon in Lincolnshire, reflecting the national picture. However, there has been an increase in the number of suicides with four confirmed suicides in children and young people under 18 years and two suspected suicides since September 2011. In the same time

period there has been an increase in the number of children admitted to hospital with self-harm[1]. All the confirmed and suspected suicides were male; they were aged between 11 and 17 years.

A review of these confirmed and suspected suicides is underway; a final report will be presented to the Child Death Overview Panel in September 2014.

Method

Hanging, strangulation and suffocation continues to be the most common method of suicide for men, accounting for 63% in 2013. Along with drug-related poisoning, hanging is also a common method amongst women. For Lincolnshire in 2013, hanging was the method used in 33% of female suicides and 50% of deaths were due to drug-related poisoning.

Location

For 2013, 64% of suicides occurred at the home of the individual, consistent with the 2:1 ratio of Home to Elsewhere of previous years in the county. The remainder were recorded to a variety of locations, including hospitals, alternative addresses, rivers, roads and level crossings.

Contact with Mental Health Services

2011 patient records showed 43% males and 63% females had some previous contact with mental health services. A history of depression was evident in 33% male and 56% female records. Lincolnshire Partnership NHS Foundation Trust (LPFT) has confirmed that 33% of individuals were in contact with services within the 12 months prior to death. This represents an increase from 25% for 2010.

Self-Harm

People who self-harm are at increased risk of suicide, although many people do not intend to take their own life when they self-harm. Self-harm is an expression of personal distress, not an illness, and there are many varied reasons for a person to harm him or herself. Risk is particularly increased in those repeating self-harm and in those who have used violent or dangerous methods of self-harm. The number of self-harm referrals from GPs in 2013 increased by nearly 13% compared to the previous year and 44% compared to 2011. Proportionally, the highest referrals rate was from Lincolnshire West CCG and the lowest from South Lincolnshire CCG.

Physical Health

Some long-term physical health conditions are associated with an increased risk of suicide. 41% of 2011 Lincolnshire records identified long term physical ill health, which included back injuries and pain, osteoarthritis, epilepsy, asthma and cancer.

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[1] Admissions to hospital due to self-harm in Lincolnshire are similar to the England average; admissions in under 25 year olds per 100,000, 2012/13, Child Health Profile 2014.

Alcohol and Drug Misuse

20% of Lincolnshire patient records for 2011 indicated a history of alcohol problems, representing 20% of males and 19% of females, which is lower than previous years. 11% indicated a history of drug misuse; again this percentage is lower than previous years.

Dual Diagnosis

Co-morbidity of drug and alcohol misuse and mental ill health is associated with increased risk of suicide and suicide attempts. 72% patient records with alcohol abuse also had history of contact with mental health services. 83% patient records with substance misuse also had a history of contact with mental health services. This includes four records which identified both alcohol and substance misuse with a history of mental health contact.

Childhood Experience

As stated in the National strategy, adverse and abusive experiences in childhood are associated with an increased risk of suicidal behaviour. 14% of 2011 records investigated suggest child abuse or difficult childhood experiences; an increase from 2009 and 2010.

The investigation identified common themes, including death, abandonment or separation from parent, abuse, taken in to care or fostered, alcoholic parent or parent with mental ill health, and special educational needs. The majority had a history of self-harm.

Criminal Justice System

People in contact with the criminal justice system have been identified as a high-risk group for suicide. From patient records accessed for Lincolnshire in 2011, 20% had a history of contact with the Criminal Justice System, none of which referred to recent release from police custody.

Bereavement and Relationships

Bereavement and relationship breakdown or difficulties feature in more than a third of records, with 23% of records making reference to bereavement, which includes suicide and attempted suicide of family members.

Special Educational Needs

16% of 2011 records suggest some form of special educational need, which include problems with literacy, mild learning disability, autism and Attention Deficit Hyperactivity disorder.

Contact with Primary Care

Of the 56 patient records accessed for 2011, there was no information regarding GP contact for 14 records. Of the remaining 42 records, nine indicated zero appointments in the last 12 months. Where information was available, nine indicated contact regarding mental health, 14 indicated contact for medication or medication review; other contact included new patient registration, blood test, monitoring and physical health.

Contact with Other Services

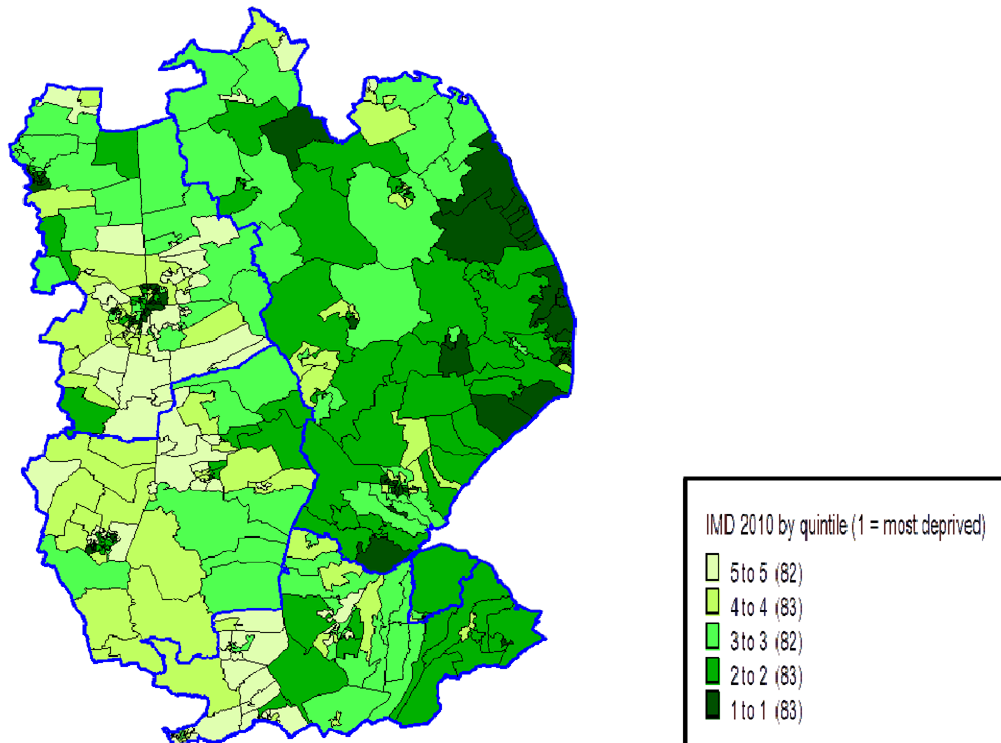
In addition to primary care and mental health services, patient records indicate contact with a range of other services. These include housing and benefits, Police and courts, alcohol and drug treatment services, occupational health and a range of secondary care including gastroenterology, ear nose and throat and physiotherapy. All potentially have a role in suicide prevention.

Contributing Factors to Suicide

There are a number of known risk factors and it is often a combination of these that has led to suicide. Many of these factors are known from research – being male, living alone, being unemployed, alcohol and drug misuse, and mental illness. Up until 2013, access has been available to patient records to identify possible risk factors for Lincolnshire patients. However, since Public Health transferred to the local authority, permission to access patient records has not been granted. For deaths registered in 2011, this investigation identified evidence of the following contributing risk factors: history of mental health problems and depression, history of self-harm, physical ill-health, alcohol misuse, financial issues, abuse, bereavement and special educational needs. It is important to note that not all people exposed to these risk factors take their own life as, over the life course, a level of resilience and protective factors are developed.

Focus on the City of Lincoln

Given the high rate of suicide within the City of Lincoln 2008-2010, further investigation of the risk factors for this population has been initiated, which indicates the greatest number of deaths were of residents from Abbey, Park and Carholme wards; a greater proportion of deaths within the 25-34 age group, a greater proportion of those within 'Elementary Occupations' and lower proportion of those with 'Professional Occupations', 'Associate professional and technical occupations' and ' Skilled Trades'; a lower proportion with a history of contact with mental health services; slightly higher evidence of alcohol and substance misuse and greater proportion of those with a history of contact with the criminal justice system. Investigation of data for self-harm and identified hospital admission rates for self-harm were much higher among Lincoln residents than the rest of the county across all age groups. Geographically, the areas with the highest rates of admission for self-harm are based on the edge of Birchwood Ward and part of Abbey Ward. Amongst Lincoln residents, the correlation between deprivation quintiles and self-harm admission rates is even stronger than that found in the county as a whole.



Map showing deprivation status of areas across Lincolnshire

© Crown Copyright and database right 2013. Ordnance survey 100025370. *Source: Public Health Lincolnshire (LRO)*

2. Conclusions

1. Many individuals are in contact with a range of organisations and members of their local community leading up to their death, all of which potentially have a role in suicide prevention.

2. Self-harm is a known risk factor and one of the strongest known predictors of suicide. The increasing number of hospital admissions and referrals to LPFT emphasise the importance of engaging with and supporting individuals who self-harm and treating them with compassion. Emergency departments and primary care have an important role in the care of people who self-harm, specifically for those with repeated self-harm. There are some concerns over the accuracy of self-harm coding and data recording and therefore there is a need to be aware of this and for future work to improve robustness of self-harm data.

3. The number of deaths by suicide in Lincolnshire is relatively small, yet the impact of each suicide is vast and far-reaching. Family and friends bereaved by a suicide are at increased risk of poor mental health and emotional problems, and may be at higher risk of suicide themselves.

4. Since the transfer of Public Health to Local Authority, access to data and specifically to GP patient records, which have previously been used to inform suicide and self-harm prevention, has been restricted. There is a need to

develop information sharing agreements with partner organisations and explore alternative data sources, as collating numbers alone does not provide the quality of data to inform and target suicide prevention effectively.

5. There are a number of contributory factors towards the risk of suicide and self-harm, including deprivation and depression.

6. One of the most effective ways to prevent suicide is to reduce access to means and one of the suicide methods most amenable to intervention is self-poisoning.

7. Emotional resilience – as stated, not all people exposed to known risk factors have suicidal thoughts as through their life they have developed resilience and protective factors.

8. Improving the mental health of the population as a whole can also reduce suicide.

9. Fewer males have contact with mental health services, yet greater numbers die by suicide, indicating a need for increased awareness of mental health and support for males.

3. Consultation

There has been no public consultation necessary for this report, however many partners and organisations have provided information to feed into its formation.

4. Background Papers

The following background papers were used in the preparation of this report:

Public Health Suicide and Self-Harm annual Report 2014 (full report)

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