Suicide and Self-Harm in Lincolnshire

Annual review 2018
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Produced by LCC Public Health Intelligence Team, January 2019
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1. Global and National Context

Estimated global suicide deaths each year (WHO)

800,000

World suicide prevention day

10 SEPT

Estimated global suicide rate per 100,000 population (WHO)

10.5

The number of suicides registered in Great Britain increased by 2.7% from 2016 to 2017 (ONS)

Three quarters of people who died from suicide in GB in 2017 were male (ONS)

'Five Year Forward View for Mental Health' report calls for 10% reduction in suicides by 2021

Some groups and occupations are associated with an increased risk of suicide (ONS)

Skilled and unskilled construction workers (males)

Culture media and sport occupations

Female health care workers

Carers
Suicide is defined as the intentional taking of one's own life. Prior to the late nineteenth century, suicide was legally defined as a criminal act in most Western countries. Currently however, suicidal behaviour is most commonly regarded and responded to as a psychiatric emergency. Suicide is considered to be a major public health problem, but is recognized as preventable with timely, evidence-based interventions.\(^1\)

In 2016 the World Health Organisation estimated that there were an estimated 793,000 suicide deaths worldwide. This indicates an annual global age-standardised suicide rate of 10.5 per 100,000 population. The UK age-standardised suicide rates are similar to some other Western European countries (like Portugal or Germany) but overall lower than France or some Scandinavian countries.\(^2\)

In the UK there were 5,821 suicides registered in 2017, which equates to an age-standardised rate of 10.1 deaths per 100,000 population—an increase of 2.7% compared to the previous year. Scotland had the highest suicide rate in Great Britain with 13.9 deaths per 100,000 persons, and England the lowest with 9.2 deaths per 100,000.\(^3\)

Males accounted for three-quarters of suicides registered in 2017 which has not changed since the mid-1990s, however the UK male suicide rate of 15.5 deaths per 100,000 population is the lowest since 1981. For females the rate was 4.9 deaths per 100,000 population and is consistent with rates from the previous 10 years.\(^3\)

The highest age-specific suicide rate was 24.8 deaths per 100,000 among males aged 45 to 49 years; for females, the age group with the highest rates was 50 to 54 years, at 6.8 deaths per 100,000 population. When compared with rates from the previous year, males aged 80 to 84 years demonstrate a significant decrease in the age-specific suicide rate, from 14.7 deaths per 100,000 in 2016 to 9.1 deaths per 100,000 in 2017, a decrease of 38.1%. There were no significant changes from 2016 to 2017 for any of the female age groups.\(^3\)

The most common suicide methods in UK in 2017 for both males and females were hanging, suffocation and strangulation (grouped together), accounting for 59.7% of all male suicides and 42.1% of females.\(^3\)

There is an apparent link to the socioeconomic factors and types of occupations people are involved in:

- Relationship breakdowns contribute to suicide risk, the greatest risk is among divorced men, who in 2015 were almost three times more likely to end their lives than men who were married or in a civil partnership.\(^5\)
- People who live in more deprived areas where there is less access to services, employment and education; are more at risk of suicide i.e. people among the most deprived 10% of society are more than twice as likely to die from suicide than the least deprived 10% of society.\(^5\)
- The lowest risk of suicide was found among corporate managers and directors, professionals including health professionals, and people working in customer service and sales.\(^4\)
- Males working in the lowest-skilled occupations had a 44% higher risk of suicide than the male national average. The risk of suicide among low-skilled male labourers, particularly those working in construction roles, was 3 times higher than the male national average.\(^4\)
- The risk among males in skilled trades was 35% higher than national average. The risk was especially high among building finishing trades; particularly plasterers and painters and decorators had more than double the risk of suicide than the male national average.\(^4\)
- The risk of suicide was elevated for those in culture, media and sport occupations for males (20% higher than the male average) and females (69% higher);\(^4\)
- For females, the risk of suicide among health professionals was 24% higher than the female national average; this is largely explained by high suicide risk among female nurses.
Male and female carers had a risk of suicide that was almost twice the national average.  

Recommendations outlined in the 'The Five Year Forward View for Mental Health' states that 'the Department of Health, PHE and NHS England should support all local areas to have multi-agency suicide prevention plans in place by 2017, contributing to a 10 per cent reduction in suicide nationally. These plans should set out targeted actions in line with the National Suicide Prevention Strategy and new evidence around suicide, and include a strong focus on primary care, alcohol and drug misuse. Each plan should demonstrate how areas will implement evidence-based preventative interventions that target high-risk locations and support high-risk groups (including young people who self-harm) within their population, drawing on localised real-time data. Updates should be provided in the Department of Health’s annual report on suicide.'

1 http://www.who.int/mediacentre/factsheets/fs398/en/
2 http://www.who.int/gho/mental_health/suicide_rates/en/
3 ONS, Suicides in Great Britain: 2016 registrations, September 2017
4 ONS, Suicide by occupation, England: 2011 to 2015, March 2017
5 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/whoismostatriskofsuicide/2017-09-07
2. Suicide and deaths of undetermined intent in Lincolnshire

- 63 suicides were recorded in Lincolnshire in 2017.
- The number of suicides increased slightly between 2016 and 2017.
- Year on year increase was related to increase in female deaths.
- 2 in 3 suicides in Lincolnshire were male deaths in 2017.

- 60.2% of male deaths
- 39.6% of female deaths

- Hanging remains the most frequent method of suicide between 2015-17.

- Age groups with the highest rates of suicide deaths in Lincolnshire:
  - 40-44 years males
  - 45-49 years females

- The suicide rates in the most deprived areas of Lincolnshire were nearly 2 x the national average and nearly 3 x those in Lincolnshire's least deprived areas.
This section provides analysis on the deaths from suicide and undetermined injury of residents in the County of Lincolnshire that were registered up to 2017.

Numbers and rates of suicide include deaths of undetermined intent. These deaths are classified by having an underlying cause of death recorded as ICD10 codes X60-X84 (age 10+ only), Y10-Y34 (ages 15+ only), registered in the respective calendar years.

2.1. Key findings:

- In the calendar year 2017 there were 63 deaths due to suicide among Lincolnshire residents. The number has increased compared to previous years (58 in 2016), but lower than in 2015 (75). This increase was mainly due to an increase in female deaths.
- As a result of the increase in female suicides in 2017, the gender gap has narrowed compared to 2016 and is comparable to 2015. Among 63 suicide deaths registered in 2017, 21 were female (33%).
- Rates of suicide in the Lincolnshire population appear stable over time and are currently not significantly different from national rates for both male and females.
- Similarly, in the previous 3-year period; suicide rates for 2015-2017 in Lincolnshire were highest in East Lindsey and Lincoln and lowest in South Kesteven.
- In the 3 year period 2015 to 2017; the highest rates of suicide and undetermined injury occurred in the age group 45-49. This is in comparison to previous years, when the highest rate in the period 2014-16 was the 55-59 age group, in 2013-15 50-54, and for the previous 6 consecutive 3-year periods ages 40-44.
- Hanging/strangulation remained the most frequent method of suicide among males (60.2% in the period 2015 to 2017). For females there were 2 dominant methods of suicide: hanging (39.6%) and poisoning (43.4%).
- In Lincolnshire, the suicide rate in the areas classed as most deprived in England is nearly twice the national average and nearly 3 times as high as in the least deprived areas.

2.2. Change over time

In the calendar year 2017 there were 63 deaths due to suicide among Lincolnshire residents. This number has increased compared to previous years (58 in 2016), but is lower than in 2015 (75) (Figure 1); and mainly attributable to an increase in female deaths.

Due to the small numbers there is relatively wide variation year on year. Therefore 3 year rolling averages have been used to allow smoothing of random variation and to investigate the longer term trend, as shown in figure 1.
Directly age standardised rates are calculated to compare Lincolnshire figures to the national ones. Direct standardisation allows accounting, not only for the difference in population size but also for the age profile of the different population groups.

The most recent data, calculated as 3 year rolling averages (2015-17), shows that Lincolnshire rates (9.78 per 100,000 population) are currently very similar to the England rates (9.57 per 100,000 population). Whilst male suicide rates in Lincolnshire (14.75 per 100,000 population) during the same time period are also similar to national male suicide rates (14.69 per 100,000 population). Despite the female suicide rate (5.17 per 100,000 population) in Lincolnshire being higher than the national female suicide rate (4.69 per 100,000 population) in 2015-17, they are not significantly different from national levels.

Previously, rates in Lincolnshire have been higher than nationally for the majority of the 2000s as shown in figure 2. The higher rates in the periods 2005-07, 2007-09 and 2008-10 were statistically significant. National rates have been steadily increasing over the last 5 years, while Lincolnshire rates decreased slightly in the last 3 year period.

Source: NHS Digital Indicator Portal; 2015 - 2017 NHS Digital Primary Care Mortality Database, December 2018
Due to the increase in female suicide deaths in 2017, the gender gap has narrowed on the previous year. Among 63 suicide deaths registered in 2017, there were 21 females (33%). This is higher than the 11 female suicides in 2016, yet comparable to 2015 when there were 23 female suicides (the highest level since 2009), which accounted for 31% of all suicide deaths. It is important to note however that low numbers are very susceptible to random fluctuation year on year due to individual circumstances rather than whole population change.

2.3. Geographical variation

Similarly as in the previous 3-year period, suicide rates in 2015-2017 in Lincolnshire were highest in East Lindsey and Lincoln and lowest in South Kesteven. Differences in rates between Lincolnshire districts and between these districts and England are not statistically significant. Table 1 provides rates, counts and confidence intervals for Lincolnshire districts and comparators.
Table 1: Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2015-2017 rolling average by district of residence

<table>
<thead>
<tr>
<th>Area Name</th>
<th>Value</th>
<th>Lower CI</th>
<th>Upper CI</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston</td>
<td>8.23</td>
<td>4.58</td>
<td>13.60</td>
<td>15</td>
</tr>
<tr>
<td>East Lindsey</td>
<td>11.72</td>
<td>8.33</td>
<td>15.99</td>
<td>43</td>
</tr>
<tr>
<td>Lincoln</td>
<td>11.49</td>
<td>7.68</td>
<td>16.46</td>
<td>32</td>
</tr>
<tr>
<td>North Kesteven</td>
<td>8.27</td>
<td>5.31</td>
<td>12.28</td>
<td>25</td>
</tr>
<tr>
<td>South Holland</td>
<td>10.59</td>
<td>6.94</td>
<td>15.46</td>
<td>27</td>
</tr>
<tr>
<td>South Kesteven</td>
<td>7.41</td>
<td>4.89</td>
<td>10.74</td>
<td>28</td>
</tr>
<tr>
<td>West Lindsey</td>
<td>9.21</td>
<td>5.92</td>
<td>13.65</td>
<td>25</td>
</tr>
<tr>
<td>Lincolnshire</td>
<td>9.78</td>
<td>8.44</td>
<td>11.26</td>
<td>195</td>
</tr>
<tr>
<td>England</td>
<td>9.57</td>
<td>9.41</td>
<td>9.73</td>
<td>13,846</td>
</tr>
</tbody>
</table>


2.4. Age and gender profile

In the 3 year period 2015 to 2017 the highest rates of suicide and undetermined injury occurred in the 45-49 age group (16.1 per 100,000 population or 25 deaths in 3 years). This is a change compared to previous years: the 50-54 age group had the highest rate in the period 2013-15, and the 40-44 age group for the previous 6 consecutive 3-year periods. The increase in the suicide rate in people aged 45-49 relates to 10 deaths in this age group registered in 2015 (compared to 6 in 2016 and 9 in 2017). At the same time, between 2015 – 2017 nearly one in 5 people (19%) who died from suicide were less than 30 years old, with the 25-29 age group having the second highest rate for suicide and undetermined injury (15.0 per 100,000 population or 19 death in 3 years). Figure 3 compares the age specific rates of suicide in 3 year periods 2014-16 and 2015-17.

Source: NHS Digital, Primary Care Mortality Database, December 2018
There are differences in age profiles between males and females who died from suicide during the period between 2015 and 2017 (Figure 4). Males in Lincolnshire during that period were 2 and half times more likely to commit suicide than females during that period.

The highest rates for females were observed in the age group 45-49 (12.47 per 100,000 population or 10 death in 3 year period) and 50-54 (11.8 per 100,000 population or 10 death in the 3 year period), accounting for 37% of all females deaths in that period.

Death rates of males are the highest in people aged 40-44 (25.53 per 100,000 population or 16 death in the 3 year period), accounting for 11% of all male deaths.

Figure 4: Age and gender specific mortality rates due to suicide and injury undetermined (ICD10 X60-X84, Y10-Y34) per 100,000 population, 2015-2017

Source: NHS Digital, Primary Care Mortality Database, December 2018

In the three year period 2015 to 2017, most deaths due to suicide and undetermined causes were caused by hanging/strangulation (54%) and by poisoning (24%), accounting for 78% of all suicides during that period. There is a noticeable difference between male and female causes. Figure 5 shows that among males hanging/strangulation was the most frequent method of suicide in Lincolnshire (60.2%). In females there were 2 dominating methods of suicide: hanging (39.6%) and poisoning (43.4%).
2.5. Deprivation

The Index of Multiple Deprivation 2015 (IMD 2015) is an overall measure of multiple deprivation experienced by people living in an area and is calculated for every Lower-layer Super Output Area (LSOA), or neighbourhood, in England. The English Indices of Deprivation 2015 are based on 37 separate indicators which measure income, employment, education and other factors affecting peoples’ living conditions. All the areas in England are ranked according to their deprivation scores.7

Many health inequalities are associated with deprivation measured by IMD. Figure 6 shows the rates of mortality from suicide in Lincolnshire calculated for each decile of deprivation. For example, '1 - most deprived' contains all the areas in Lincolnshire which are classed as in the 10% most deprived in England. These rates have been aged standardized to account for the differences in population age profiles between areas.

In Lincolnshire, suicide rates are the highest among people from areas classed as the most deprived in England: 17.09 per 100,000 population which is nearly twice the national average (9.6 per 100,000 population) and nearly 3 times as high as in the least deprived areas.

Figure 6: Mortality from suicide by quintile of deprivation (residence based), directly age standardized rate per 100,000 population, calendar years 2015-2017, Lincolnshire

Source: NHS Digital Primary Care Mortality Database, December 2018
3. Findings from coroner's data

The review of 90 cases of suicide deaths in Lincolnshire revealed that:

- 67% had known mental health issues
- 39% had known family or relationship issues
- 40% had known suicidal tendencies or previous suicide attempts

- 2/3 of people died in their own homes
- 70% of the cases were concluded to be premeditated suicides
- Over half had left a suicide note (53%)
- Half of the cases were in employment, over a quarter retired, 1 in 7 was unemployed
- The majority accessed health care provision within a year prior to their deaths. Many in the last week or day of their life.

Multiple issues and risk factors were identified in some of the cases.
- Mental Ill health
- Previous suicide attempts / tendencies
- Harmful drinking
- Financial concerns
- Family/relationship issues
As part of a programme to improve intelligence provision and inform suicide prevention measures, Lincolnshire Coroners Service has provided information to Lincolnshire County Council's Public Health Intelligence team for analysis. Data relating to 90 deaths has been provided to date, for deaths where inquests concluded during 2016, 2017 and early 2018, including confirmed suicides as well 'open verdicts', where the underlying cause of death was recorded as 'self-harm, undetermined intent', (ICD10 codes Y10-Y34).

This information provides a much greater understanding of the factors and characteristics which may lead an individual to take their own life. While there is a great overlap between the cases analysed in the previous chapter (based on the Primary Care Mortality Database (PCMD) data) and those provided by coroner's office. It is important to note however, that this does not exactly represent the same cohort of people.

3.1. Key Findings:

- Two thirds of people who died from suicide were known to have mental health issues.
- Many had suicidal tendencies or had previously attempted to take their own life (40%).
- The majority of people who died from suicide has some form of contact with health services within a year prior to their deaths; many (30 out of 90 cases) within a week.
- Many people were found to have had multiple issues; for example mental ill health alongside family or relationship, substance misuse and financial concerns.

3.2. General characteristics

- 71 of the 90 deaths were male (79%) and 19 (21%) were female;
- There were 9 deaths of people aged under 25 (10%), 54 deaths of people aged 25-64 (60%) and 27 deaths of those aged 65+ (30%); similar to the relative proportions of the Lincolnshire population in these age bands.
- 63 of the 90 (70%) were found to be premeditated suicides, and 22 impulsive (24%);
- Around two-thirds of suicides died within their own homes (58 out of 90 – 64%);
- Over half (48 out of 90) left a suicide note (53%);
- 33 lived alone (37%), 30 with partners (33%), and 10 with partner and child/children (11%);
- 46 (51%), were in employment (including self-employment), 25 retired (28%) and 12 were unemployed (13%);

3.3. Risk factors

Table 2 shows the identified risk factors most commonly found. Some people had multiple factors recorded so the sum exceeds the total of cases reviewed.
3.3.1. Mental Ill health

Mental health issues were the most common risk factor identified, appearing in two thirds of the reviewed cases. Of the 60 cases identified as having mental ill-health, nearly half of these (40%) had contact with mental health services at some point during the year preceding their death. Most (48) had visited a GP in the year before their death (for any reason) and 33 were hospitalized during that period (again, for any reason).

More than half of those with mental health issues had known suicidal tendencies (38 cases, 63%) or previous suicide attempts (35 cases, 58%). People with mental health issues are often susceptible to additional risk factors, such as family or relationship issues (25 cases, 42%), disability or health concerns (22 cases; 37%), harmful drinking (20 cases; 33%), financial concerns (15 cases; 25%) or experience of bereavement (13 cases, 22%).

12 records for those with an indication of mental ill-health suggested that the deceased had some form of unmet need. Examples of these needs include issues such as homelessness, lack of a hospital bed or access to GP or no follow up after a suicide attempt.

3.3.2. Physical health

In 30 records (33%) there was an indication of the deceased having some form of physical health issue. The majority of these individuals were from older age groups, and often had additional risk factors such as mental ill-health (22 cases, 73%), recent bereavement (8 cases, 27%), or known suicidal tendencies (12 cases, 40%) or attempts (11 cases, 37%). None of the cases indicated that the medical condition or disability had a direct link with death.

3.3.3. Occupations

Those who died were most frequently working in (or previously worked in) occupations relating to skilled trades (22 cases; 24%) and professional occupations (12 cases; 13%). The proportion of cases where people were in skilled trades appears high compared to labour market data which suggests that 12.3% of employed people are estimated to work in those occupations. Examples of 'skilled trades' include agricultural, construction (and related occupations such as electricians and plumbers), metal working and vehicle trades. Examples of professional occupations include engineering, IT, teaching or legal professionals.
3.3.4. People born outside the UK

There were 15 suicides by people known to have been born outside the UK (mainly EU countries), 17% of all cases. These deaths were mostly (but not entirely) concentrated in the south of the county (e.g. South Holland, South Kesteven), and more frequently related to people aged 25-29 years old or 45-49 years old. To some extent, this reflects the percentage of non-British nationals living in Lincolnshire, with the majority living in South Holland (13% non-British nationals), Boston (27% non-British nationals), South Kesteven (6% non-British nationals) and Lincoln (8% non-British nationals). As the numbers are very small it is currently difficult to establish if there is a significant difference between people committing suicide born outside the UK and UK nationals.

The most common occupation type amongst people born outside the UK was 'Process, plant and machine operatives' (6 out of 15 cases, 40%). The most common risk factors amongst those who were born outside of the UK were family/relationship issues (10 out of 15 cases), followed by harmful drinking (8 out of 15 cases) or financial concerns (7 out of 15 cases). Ten people were known to have mental health issues, but only one had contact with mental health services in the year preceding their death.

3.3.5. Multiple risk factors

Out of the 90 cases the majority had multiple risk factors identified (Table 3); 33 had five or more risk factors recorded. Of these 33 cases; 32 cases had a recognised mental illness, 30 had known suicide tendencies and previous suicide attempts; 21 had family/relationship issues, 18 had harmful drinking and 11 had financial concerns.

Table 3 on the next page lists the most frequent risk factors and the number of cases associated with each combined pair.
Table 3: Risk factors identified in people who died from suicide in Lincolnshire

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Source: LCC Coroners Service, (2016 to early 2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health</td>
<td>60</td>
</tr>
<tr>
<td>Known suicidal tendencies</td>
<td>38 42</td>
</tr>
<tr>
<td>Previous suicide attempt(s)</td>
<td>35 36 39</td>
</tr>
<tr>
<td>Family/Relationship issues</td>
<td>25 19 20 35</td>
</tr>
<tr>
<td>Health Concerns</td>
<td>22 12 11 6 30</td>
</tr>
<tr>
<td>Harmful drinking or alcohol misuse</td>
<td>20 15 16 18 5 30</td>
</tr>
<tr>
<td>Financial Concerns</td>
<td>15 11 10 14 3 11 23</td>
</tr>
<tr>
<td>Drug misuse</td>
<td>12 10 9 8 5 11 4 18</td>
</tr>
<tr>
<td>Bereavement</td>
<td>13 6 5 5 8 6 3 2</td>
</tr>
<tr>
<td>Unemployment/Employment concerns</td>
<td>11 8 8 9 2 7 5 1 3 13</td>
</tr>
<tr>
<td>Housing concerns</td>
<td>7 6 6 5 1 4 6 1 1 9</td>
</tr>
<tr>
<td>Previous self harm</td>
<td>7 7 7 4 0 5 1 4 0 7 0 7 9 9</td>
</tr>
<tr>
<td>Skilled trade</td>
<td>15 12 12 10 8 7 4 3 4 4 1 1 22</td>
</tr>
<tr>
<td>Born outside UK</td>
<td>7 3 3 10 1 6 7 4 2 2 3 1 2 15</td>
</tr>
</tbody>
</table>

**Key:**

<table>
<thead>
<tr>
<th>Highest value</th>
<th>Lowest value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>
4. Self-harm

Self-reported self-harm in adults is on the increase nationally (Adult Psychiatric Morbidity Survey, 2014)

- 1,034 self-harm emergency hospital admissions (2016/17), decreased compared to 2015/16
- Lincolnshire rates were significantly better than national level

Self-harm admissions by district

In comparison to England

Poisoning was the most common form of self-harm leading to the hospital admissions

23% of people admitted due to self-harm in Lincolnshire were aged < 20

In the youngest age groups (aged 10-19) four out of five admissions were female
Self-harm is an expression of personal distress and there are varied reasons for a person to harm themselves irrespective of the purpose of the act. It is important to note that the relationship between suicidal ideas, self-harm and suicide is complex. The profile of people reporting suicidal thoughts, attempts and self-harm is very different in terms of age and sex from that of people who take their own life, and the great majority of people who engage in these thoughts and behaviours do not go on to die by suicide.  

According to the 2014 Adult Psychiatric Morbidity Survey, the proportion of people aged 16 to 74 who reported having self-harmed increased from 2.4% of the population in 2000 to 3.8% in 2007 and 6.4% in 2014.

4.1 Key Findings:

- Emergency hospital admissions due to self-harm in Lincolnshire saw a marked reduction between 2015/16 and 2016/17, in line with national trends.
- At district level, admission rates continue to remain high in Lincoln, while Boston has seen a 47.5% reduction from 122 admissions in 2015/16 to 64 admissions in 2016/17.
- Based on hospital admissions, self-harm is especially prevalent in young females.
- Poisoning was the most common form of self-harm leading to the hospital admissions.

4.2 Hospital Episode Statistics (HES) data

Hospital episodes statistics capture cases of self-harm serious enough to result in hospital admission. In 2016/17 there were 1,034 emergency hospital admissions in Lincolnshire due to self-harm, which represents a decrease from 1,280 in 2015/16.

In contrast to mortality from suicide, self-harm hospital admissions affect more females than males. Self-harm admission rates among females have seen a reduction since 2013/14 both in Lincolnshire and nationally. In 2016/17, female self-harm admission rates in Lincolnshire (173.3 per 100,000 population) were significantly lower than the national rate (233.7 per 100,000 population) (Figure 7).

Self-harm admissions for males have also decreased since 2013/14 both in Lincolnshire and nationally. In 2016/17, male self-harm admission rates in Lincolnshire (121.1 per 100,000 population) were significantly lower than the national rate (138.8 per 100,000 population) (Figure 7).

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Figure 7: Emergency hospital admissions due to self-harm, directly age standardized rate per 100,000 population by gender


Figure 8 shows the level of emergency hospital admissions due to self-harm in Lincolnshire by district in 2016/17 in comparison to national rates.

The rates for individual districts have not changed significantly year on year. Lincoln had the highest level of admissions in 2015/16 (237.1 per 100,000 population) and 2016/17 (200 per 100,000 population). Admission rates in Boston have fallen from 190.4 per 100,000 in 2015/16 to 99.4 per 100,000 population in 2016/17 and are now significantly lower than the national rate. The admissions rates in East Lindsey, North Kesteven, South Holland and South Kesteven were significantly below the national level in 2016/17.
Self-harm affects more females as well as younger age groups. Figure 9 shows the rates of self-harm admission in Lincolnshire by age. Hospital admissions rates have seen a reduction between 2015/16 (181.7 per 100,000 population) and 2016/17 (147.2 per 100,000 population). Despite this decrease, self-harm admissions continue to be highest in people aged 15-19. In 2016/17, 23% of all the admissions due to self-harm affected people aged under 20, and rates for 15-19 year olds were particularly high (410.7 per 100,000 population).
In the youngest age groups (10-19) four out of five admissions were for young females. For the older age groups the gender split becomes more equal.

The main reason for hospital admissions due to self-harm in 2016/17 was poisoning (91% of admissions). The main three diagnoses were intentional self-poisoning by exposure to one of the following substances:

- Nonopioid analgesics, antipyretics and anti-rheumatics (ICD10 code X60)
- Antiepileptic, sedative-hypnotic, anti-parkinsonism and psychotropic drugs, not elsewhere classified (ICD10 code X61)
- Narcotics and psychodysleptics [hallucinogens], not elsewhere classified (ICD10 code X62)

Other reasons for hospital admissions due to self-harm in 2016/17, were using a sharp object (5%), hanging, strangulation and suffocation (1%) or others (2%) e.g. jumping from a high place or using a blunt object, crashing vehicle.

Produced by LCC Public Health Intelligence Team, January 2019
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