Lincolnshire JSNA: Suicide

What do we know?

Summary

This JSNA section focuses on 3-year average data from 2008-2010 and specific data from the calendar year 2010, using the latest available information.

Nationally there has been a decrease in the overall rate of suicide over the last decade. In Lincolnshire, although the annual rate has dropped from 9.13 per 100,000 people in the year 2000 to 8.13 in 2010, the years in between give a fluctuating picture, with the death rate at its lowest in 2004 with 7.49 and at its highest in 2009 with 12.44. With regard to the actual number of deaths, this ranges from 53 to 90. The graph below represents the recent trend using a 3-year average death rate.

The majority of suicides continue to occur in middle aged men. With reference to gender and mortality rates across the districts, those which stand out are Lincoln City with a male death rate of 25.82 per 100,000; the worst ranking of 326 local authorities and East Lindsey with a female death rate of 12.41. (Compendium of Population Health Indicators - indicator.ic.nhs.uk)

Nationally and locally, the most common method of suicide for men and women is hanging, strangulation and suffocation with self-poisoning as the second most common method. With regards to the location of death, the local trend is approximately 2:1 Home: Elsewhere.

Within Lincolnshire, the City of Lincoln and East Lindsey have the first and second highest rates of suicide of their resident population per 100,000. There was a greater number and higher rate of suicide in the most deprived areas of the county. The majority of people who died were resident within urban areas.
The likelihood of a person dying from suicide appears to depend on several underlying factors. These include physically disabling or painful illness and mental illness; alcohol and drug misuse; and level of support. Stressful life events such as loss of job, imprisonment, a death or divorce can also play a part. For many people, it is the combination of factors which is important, rather than any single factor.

‘Preventing Suicide in England’ a cross-government strategy to save lives was published by the Department of Health in September 2012. This strategy sets out key areas for action, states what government departments will do to contribute, and brings together knowledge about groups at higher risk, effective interventions and resources to support local action.

A new strategy and action plan for Lincolnshire are currently being developed and due for completion in 2013. There are a number of local interventions in place to reduce suicide and self-harm.

With effect from 1 April 2013, suicide and self-harm prevention became part of the Public Health mental health responsibilities of Lincolnshire County Council (LCC).

**Facts, Figures and Trends**

3-year rolling averages are generally used for monitoring purposes, in preference to single year rates, in order to produce a smoothed trend from the data and to avoid drawing undue attention to year-on-year fluctuations.

The rate of suicide refers to the frequency with which suicide occurs relative to the number of people in a defined population. This age standardised rate takes account of differences in the size and age structure of the population to provide a comparable population across time and across different areas. It is important to note that national statistics are based on the registered date of death, which may be several months or occasionally years after the actual date of death due to coronial and other processes.

In 2010, there were 57 deaths by suicide and injury of undetermined intent registered in Lincolnshire, which gave an annual rate for 2010 of 8.1 and a three year pooled rate for 2008-2010 of 9.69 per 100,000 people.

**Death rate for District Authorities**

Using home postcode and local authority areas, combining male and female suicide in 2010, the City of Lincoln has the highest annual rate of 14.1 per 100,000, followed by East Lindsey with 11.2 and Boston with 10.4. As noted above, these combined rates can mask dramatic variation between parts of the population in the same area.

Using a 3-year rolling average for 2008-2010, Lincoln City and East Lindsey still have the first and second highest rates, with North Kesteven as the third highest. Between 2009 and 2010, Boston is the only authority to show an increase in rate, all other authorities show a decrease; an additional 3 deaths in Boston, doubled its death rate by suicide.
Gender

Significantly more men die by suicide than women and nationally in 2010, the majority of suicides continue to occur in adult males. In comparison to women of the same age, men are more likely to take their own lives, but the difference varies by age. Latest figures show the peak difference, both in terms of number and rate of suicide is in the 25-29 age-group where, there are more than four male suicides for each female suicide. The difference between male and female suicide rates is also noticeable in those aged 75+. Although a relatively low number of suicides occur for both males and females in this group, the low population makes the rate per 100,000 people relatively large, particularly for men1.

For 2008-2010 in England, the mortality rate for male suicide was 12.22 per 100,000 and 3.72 for female suicide. Within the boundaries of Lincolnshire Primary Care Trust, the male death rate was 14.53 per 100,000 people and 5.00 for females, so higher than the national rate and slightly less than the national average of more than 3 male to every female suicide. Numerically in the 3-year period there were 151 male and 57 female deaths, which includes 42 male and 15 female deaths in 2010.

The graph below shows a constant trend for male suicide and slightly increasing trend for female suicide over the last 10 years.

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2008-2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston</td>
<td>3.6</td>
<td>5.3</td>
<td>10.4</td>
<td>6.4</td>
</tr>
<tr>
<td>East Lindsey</td>
<td>12.5</td>
<td>17.8</td>
<td>11.2</td>
<td>13.8</td>
</tr>
<tr>
<td>Lincoln</td>
<td>15.9</td>
<td>15.7</td>
<td>14.1</td>
<td>15.2</td>
</tr>
<tr>
<td>North Kesteven</td>
<td>8.4</td>
<td>12.1</td>
<td>6.2</td>
<td>8.9</td>
</tr>
<tr>
<td>South Holland</td>
<td>6.0</td>
<td>9.3</td>
<td>2.4</td>
<td>5.9</td>
</tr>
<tr>
<td>South Kesteven</td>
<td>6.0</td>
<td>10.3</td>
<td>5.8</td>
<td>7.4</td>
</tr>
<tr>
<td>West Lindsey</td>
<td>8.2</td>
<td>12.3</td>
<td>5.0</td>
<td>8.5</td>
</tr>
</tbody>
</table>
With reference to district council areas, the highest rate for male deaths is for Lincoln City at 25.82 per 100,000 population and the highest female rate of 12.41 is for East Lindsey. It should be noted that suicide is recorded to place of residence rather than place of death.

2008-2010 DSR (The NHS Information Centre for health and social care - indicator.ic.nhs.uk)

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>All Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lincoln City</td>
<td>25.82</td>
<td>4.69</td>
<td>15.19</td>
</tr>
<tr>
<td>East Lindsey</td>
<td>15.03</td>
<td>12.41</td>
<td>13.85</td>
</tr>
<tr>
<td>North Kesteven</td>
<td>13.22</td>
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<td>8.89</td>
</tr>
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<td>8.48</td>
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<tr>
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<td>11.49</td>
<td>3.49</td>
<td>7.36</td>
</tr>
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<td>2.11</td>
<td>6.43</td>
</tr>
<tr>
<td>South Holland</td>
<td>10.62</td>
<td>1.03</td>
<td>5.89</td>
</tr>
<tr>
<td>Lincolnshire PCT</td>
<td>14.53</td>
<td>5.00</td>
<td>9.69</td>
</tr>
</tbody>
</table>

**Age**

Nationally, the highest suicide rate occurs in middle aged men. For 2008-10, the three-year average rate for 35-49 year old males was 20.8 per 100,000 people. For Lincolnshire, in the same 3-year period, the greatest number of male deaths was within the 35-54 age range and for female deaths, the greatest number were within the 35-44 and 55-64 age ranges. It is difficult to assess if there are any significant trends due to fluctuating and low numbers. However, this will continue to be monitored.

For Lincolnshire in 2010, the deceased ranged in age from 18 to 87 years of age. Due to small numbers, death rates per age-group are not available for Lincolnshire, however the greatest number of male deaths was in the 25-34 years age range, which is younger than in 2009 when the greatest number were aged 35-44 years. The greatest number of female deaths was in the 55-64 years age range, which is consistent with 2009.
Mortality from suicide and injury undetermined, age specific death rates for 2008-10 (January 2012)

<table>
<thead>
<tr>
<th></th>
<th>15-34yrs</th>
<th>35-64yrs</th>
<th>65-74yrs</th>
<th>75+yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>England - Male</td>
<td>12.4</td>
<td>19.0</td>
<td>10.5</td>
<td>13.8</td>
</tr>
<tr>
<td>East Midlands - Male</td>
<td>12.0</td>
<td>17.0</td>
<td>6.8</td>
<td>12.6</td>
</tr>
<tr>
<td>England - female</td>
<td>3.5</td>
<td>5.7</td>
<td>4.1</td>
<td>4.4</td>
</tr>
<tr>
<td>East Midlands - female</td>
<td>4.0</td>
<td>5.6</td>
<td>3.3</td>
<td>4.5</td>
</tr>
</tbody>
</table>

**Method of suicide**

Death by hanging, strangulation and suffocation and is the most common method for male and female suicide. For males, approximately half of male suicides are due to this method. Self-poisoning accounts for approximately a quarter of all suicide deaths in England. It is the second most common method of suicide in both men and women and was, until 2008, the most common method among women.

For 2010 in Lincolnshire, hanging, strangulation and suffocation remains the most common method with 33/57 (58%); other methods used include poisoning 12/57(21%), firearm discharge, exposure to smoke, fire and flames, drowning and submersion, contact with sharp object and jumping from a high place.

Looking at each gender, 62% of male deaths were due to hanging, strangulation and suffocation (63% in 2008, 50% in 2009) and 14% due to poisoning (12% in 2008, 32% in 2009). Other methods used include firearm discharge, exposure to smoke, fire and flames, drowning and submersion, contact with sharp object, jumping from a high place and unspecified events.

Prior to 2009 in Lincolnshire, women were more likely to self-poison, however 2009 was the first year when hanging was equally common (39%) as the cause of death in women and appears to be an increasing trend. In 2010, 47% female deaths were due to hanging, strangulation and suffocation and 40% due to poisoning (64% in 2008 and 39 % in 2009); other methods include drowning and submersion, exposure to smoke, fire and flames. An inference may be made that the increasing trend in hanging is due to greater controls of medicines that are toxic at overdose levels.

**Overdose drug type**

In Lincolnshire, the proportion of deaths by self-poisoning has decreased from 33% in 2009 to 21% in 2010 with comparatively less use of analgesics especially opioids for self-poisoning. There were
no deaths relating to Co-proxamol which is no longer licensed due to safety concerns, particularly
toxicity in overdose, although Co-proxamol tablets (unlicensed) may still be prescribed for patients
who find it difficult to change, because alternatives are not effective or suitable so there is some
supply available.

Location of death

With regards to the location of death, distinction is made between those that occur at home or
‘elsewhere’. It is still more common for people to die by suicide in their own home than in public
places or public buildings. The recent trend has been approximately 2:1. However over the last 3
years, there has been a slight tendency for more deaths to occur ‘elsewhere’. In 2010, 38 (67%)
deaths occurred within the home and 19 (33%) occurred ‘elsewhere’. In 2009 there was an
increased proportion of deaths occurring ‘elsewhere’ - 56 home: 34 elsewhere (62%:38%).

With reference to the 19 deaths that occurred outside the home, 9 occurred in hospital. It should
be noted that the place of death may differ from the location of the suicidal act if the individual is
transferred and dies in hospital. The majority of these deaths were through self-poisoning. The
remaining 10 deaths occurred elsewhere, the majority through hanging; locations included
farmland, fields, wooded and play areas.

Targets

Up until 2010, there has been a national target to reduce the death rate from suicide and
undetermined injury by at least 20%, from a baseline of 9.2 deaths per 100,000. For Lincolnshire
this target was a reduction in the rate from 8.5 per 100,000 in 2008 to 6.41 per 100,000 in 2010.

For the 3 years 2008-2010, data shows a national rate of death by suicide and injury of
undetermined intent of 7.92; and for Lincolnshire, a rate of 9.69 deaths per 100,000.

The reduction of suicide is one of the indicators in the 4th domain of the Public Health Outcomes
Framework (PHOF) - ‘Healthcare public health and preventing premature mortality’ with the
objective of reduced numbers of people living with preventable ill-health and people dying
prematurely, while reducing the gap between communities. Further indicators related to suicide
prevention include PHOF 2.10 Hospital admission as a result of self-harm, 2.7 Hospital admissions
caused by unintentional and deliberate injuries in under 18s, plus the NHS Outcome Framework
Indicator NHS 1.5 Reducing premature death in people with serious mental illness.

Performance

Nationally there has been a decrease in the overall rate of suicide over the last decade. In
Lincolnshire the rate has dropped from 9.13 in 2000 to 8.13 in 2010. However the years in
between give a fluctuating picture with the death rate at its’ lowest in 2004 with 7.49 and at its
highest in 2009 with 12.44. In terms of the number of deaths, this ranges from 53 to 90.

Further work is required to develop our targeting of prevention work and we must expect some
upward pressure on rates to be evident as a result of worsening overall economic conditions.
Latest information from Office of National Statistics (ONS) indicates 61 deaths registered in 2011 and 76 registered in 2012 which gives an updated death rate for 2010-2012 of 9.08 per 100,000 population.

What is this telling us?

Summary

The Lincolnshire Primary Care Trust area has a higher than national and regional average death rate. This rate fluctuates and peaked in 2009. Lincoln City has the highest rate for male suicide of all local authorities in England. A new Lincolnshire suicide and self-harm prevention strategy is currently being developed, based on the National Suicide Prevention Strategy published in September 2012.

It is clear from local audit and engagement with stakeholders that further targeted work on understanding suicide and developing prevention tactics is required, for example, the factors influencing suicide in certain areas of work and the extraordinary rate in the City of Lincoln.

There are some clear risk factors that increase the likelihood of suicide and these include on-going mental illness and substance misuse, serious and long term debilitating illness and adverse life events like the ending of a relationship and bereavement. Whilst individual factors are important a more useful predictor of risk for individuals is the coincidence of more than one factor.

A key factor to note from the nature of some of the key risks is that many people who die by suicide are known to and in contact with services in the run up to their decision and action. However many are not and methods of getting essential information or an immediate response when someone is seriously contemplating suicide needs to be considered carefully.

There are some anecdotal indications from Coroners and Coroners Officers that are worthy of consideration. One is around the impact of media reporting on suicides, especially where details of the 'successful' method is published, with Coroners suggesting 'copy-cat' deaths rise in the wake of such reporting. The second important factor is around the number of cases where Coroners judge that the individual did not mean to kill themselves. It seems clear that a number of deaths occur each year because the person either did not know how fast and effective their chosen method was (for example, hanging and strangulation) or underestimated how long it would be before they were discovered following overdose, and how quickly the substances used would irreversibly harm them.

Local views

There is a quarterly Suicide and Self Harm prevention group ‘Choosing Life’, which includes representatives from those with lived experience of suicide and self-harm.

It is intended to form a new Mental Health Alliance late in 2013, consisting of partners from a wide range of statutory and non-statutory organisations, third sector, service users and those with an interest in mental health. The Mental Health Alliance will deliver the Mental Health Promotion Strategy (currently being consulted upon) and identify areas for future activities.
National and local strategies

‘Preventing Suicide in England’ a cross-government strategy to save lives was published by the Department of Health in September 2012. This strategy sets out key areas for action, states what government departments will do to contribute, and brings together knowledge about groups at higher risk, effective interventions and resources to support local action.

The overall objectives set out in the strategy are a reduction in the suicide rate in the general population in England; and better support for those bereaved by suicide. Six key areas are identified – these are:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring.

In response to the national strategy, a working group is to prepare a new Lincolnshire Strategy and action plan. This will replace the current ‘Reasons to Live - Lincolnshire Suicide and Self-Harm prevention strategy 2010-2013’, which was produced by the countywide suicide and self-harm prevention group (a multi-agency countywide group led by the NHS Lincolnshire commissioning lead for mental health). This was based on the three life stages of pre-work, work and retirement. A new mental health promotion strategy is also being developed, which will enable better coordination and contribute to reducing suicide and self-harm.

Current activity and services

Local intervention into the prevention of suicide and self-harm includes suicide awareness training in the form of ASIST and SafeTalk; mental health first aid training, website based information resources, the provision of Crisis Houses, support for the farming community through the work of the Rural Support Network, which includes mental health screening and debt counselling, books and exercise on prescription, a self-harm pathway for children and young people, and emotional health and wellbeing for children through the Healthy Schools Enhancement programme.

Nationally the Samaritans have a partnership with Network Rail and deliver training on emotional health for station staff and people who work on the railways. This training has been going for 2 years and in the first year there has been an 11% decrease in the number of suicides on the railways. The training is to be rolled out in Lincolnshire in 2013. The Samaritans also deliver programmes to primary schools and secondary schools, advising how they might be able to access help, who they might be able to talk to.

Each year, an annual report has been produced with information gathered from Office for National Statistics, the NHS Information Centre for health and social care (indicator web site) and patient records. When looking at information for the deaths registered in the calendar year 2010, 44/57 patient records were available. These records vary in completeness and depth of information. As with the national statistics, suicides and deaths of undetermined intent are combined for the analysis. Due to the sensitive nature of suicide and the small numbers involved, confidentiality and data protection were important issues when gathering and presenting the data for this report.
Investigation by the Clinical Risk team within Lincolnshire Primary Care Trust into those cases which involved both inpatient and community service users of LPFT included 19 cases whose deaths occurred within the 2010 calendar year. Further actions were identified in 12/19 cases. These include policy around DNA’s (did not attend) and discharge; sharing information with teams out of area and mechanisms for notifying new GPs across county borders; review of suicide rates per specialist LPFT teams; secure GP involvement in future RCA (root cause analysis); reference to the need for a crisis and contingency plan for service users on CPA (Care Programme Approach) within one month of acceptance on caseload; record and review risk in prescribing records at time of request for holiday prescribing.

Key inequalities

To help analyse risk factors, a risk matrix was developed which included data for the period 2008-2010. This data was obtained from patient records. It was found that 63(31%) of the people who had died through suicide lived within the most deprived quintile in Lincolnshire. 21(33%) of these people had a history of alcohol abuse. 29(46%) of the people who lived in the most deprived quintile and died through suicide had a history of depression.

This section looks at inequalities that have been identified from patient records. The following areas have been examined:

Deprivation

Between January 2010 and December 2012 there were 194 registered deaths by suicide. In order to consider whether people from deprived areas are more likely to commit suicide the following analysis was carried out. Using the Indices of Multiple Deprivation 2010 Lower Level Super Output Areas was mapped according to the most deprived quintiles to the least deprived. The 194 victims as mentioned above were mapped and the quintile in which they lived in was identified.

The map below shows the location of the most and least deprived quintiles in Lincolnshire.
The Suicide and undetermined injury – mortality rates by deprivation quintile was calculated. The results are shown on the graph below.

Mortality rate from suicide in Lincolnshire by quintile of deprivation, 2010-12 crude rate per 100,000 population.

Source: ONS Primary Care Mortality Database files & DCLG IMD 2010
The graph above shows there was a higher rate of suicides in the most deprived areas.

An inference can be made that further analysis into the risk factors of those living within the most deprived quintiles would be beneficial to defining forthcoming local strategy and action plan.

**Urban/rural areas**

Further analysis was completed to ascertain if living in an urban or rural area had an impact on the risk of suicide. This is difficult to measure as it does not consider the actual characteristics of the individual and instead focuses primarily on the location.

In terms of numbers, the table below shows the number of deaths by suicide that were within either an urban or rural area between January 2008 and December 2010.

<table>
<thead>
<tr>
<th>Type</th>
<th>No. Of suicides</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban &gt;10K</td>
<td>116</td>
</tr>
<tr>
<td>Village</td>
<td>41</td>
</tr>
<tr>
<td>Town and Fringe</td>
<td>27</td>
</tr>
<tr>
<td>Hamlet &amp; Isolated Dwellings</td>
<td>19</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>203</strong></td>
</tr>
</tbody>
</table>

It can be seen that the majority of deaths by suicide were by people living within an urban area. However this would be expected as there is a higher population within these areas. This can also be linked to the previous findings with a higher rate of suicide in more deprived areas.

**People in the care of mental health services.**

People with severe mental illness remain at high risk of suicide, both while in inpatient units and in the community. Inpatients and people recently discharged from hospital and those who refuse treatment are at highest risk. In 2010, information from the 44 records available shows 28/44 (64%) had a previous history of contact with mental health services, (20 male & 8 female patients) which includes 15/44 (34%) having contact within the 12 months prior to death. This compares to 2009 when 63% had a previous history of contact with mental health services and 28% within the previous 12 months.

Figures provided by Lincolnshire Partnership Foundation Trust (LPFT) indicate that 14/57 (25%) of people had contact with Lincolnshire mental health services in the 12 months prior to death, 10/14 (71%) within a month. This represents 19 % (8/42) of males and 40% (6/15) of females. An inference can be made that there is a need for mental health services to engage more with the male population.

With reference to the NEPHO Mental Health toolkit, which shows that Lincolnshire is significantly worse with regards to levels of mental ill health and disability and yet is significantly lower than England in a number of treatment indicators such as ‘Numbers of people using adult and elderly NHS secondary mental health services, rate per 1000 population’, ‘Numbers of people on a Care Programme Approach, rate per 1000 population’ and ‘Number of total contacts with mental health services, rate per 1000 population’. ii
From the 2008-2010 risk matrix (referred to previously), there was evidence for 100/203 (49%) of the people who died through suicide to show there was a history of contact with mental health services. This figure may be higher as patient records were not available for all of the deceased.

**People in contact with the criminal justice system**

From the information available, 8/44 (18%) records indicated previous contact with the criminal justice system, including reference to court cases, probation and imprisonment. The majority of this contact took place at least 2 years prior to death. For 6/8 cases, there was also previous contact with mental health services.

**Specific occupational groups**

Details around the occupation of those who have died by suicide are included within the death registration of the deceased and this is included within the Public Health Mortality (PHM) file. Occupation is based on the last gainful occupation of the deceased if they were retired or unemployed. Looking at the information available for Lincolnshire, occupations were listed for 45/57 (79%) and 9/45 (20%) were listed as retired.

Using ONS Standard Occupational Classification (2010), the groups with the highest numbers were from ‘Skilled Trades’ and ‘Managers, Directors & Senior officials’, both exclusively male. The highest number of females were in the ‘Caring, Leisure & Other Service’ occupations.

In recent years there has been both national and local concern around the suicide rates within agriculture. When investigating the figures locally, there has been 10/208 (in the period 2008-2010) suicides representing a wide range of agriculture-related occupations. This figure may be higher as the occupation given may be generic and does not always give an indication of the area of industry such as agriculture.

**Ethnicity**

Ethnicity and country of origin is not routinely recorded in ONS data or patient records. There is a need for further analysis to ascertain if the number of deceased of BME origin is significantly different compared to the Lincolnshire population in order to shape and target future interventions for suicide prevention.

**People with a history of 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. At least one in two people who take their own life have a history of self-harm, and one in four have been treated in hospital for self-harm in the preceding year. Around one in 100 people who self-harm take their own life within the following year. Risk is particularly increased in those repeating self-harm and in those who have used violent/dangerous methods of self-harm.

From the information available in the patient records, 18/44 (41%) indicated previous self-harm. 14 refer to multiple previous incidents. The majority were more than 12 months prior to death, however 6 (14%) cases took place within the 12 months prior to death. This data is similar to 2009, when 46% made reference to history of self-harm, with 16% in the previous 12 months.
14/44 of those with a history of self-harm were also associated with a history of either alcohol and/or drug abuse; this is a higher proportion than the previous two years.

With reference to the 2008-2010 risk matrix, 69 (34%) of the people who died through suicide had a history of self-harm and 34 (49%) of these people also had a history of alcohol abuse.

Further analysis of data relating to self-harm injuries from a multi-agency perspective will be beneficial.

Other Risk Factors

The likelihood of a person dying from suicide depends on several factors. These include physically disabling or painful illness and mental illness; alcohol and drug misuse; and level of support. Stressful life events such as loss of job, imprisonment, a death or divorce can also play a part. For many people, it is the combination of factors which is important, rather than any single factor.

Many of these risks are addressed in the Joint Health and Wellbeing Strategy for Lincolnshire 2013-2018. And the cross-cutting issue of mental health is reflected throughout the five themes.

With reference to the first theme in the strategy of ‘Promoting Healthier Lifestyles’ with the outcome of people being supported to lead healthy lives; people with alcohol and or drug problems are considered at high risk of suicide. In 2010, 18/44 (41%) records indicate previous heavy drinking and alcohol abuse, the majority being male; 44% of these also referred to previous drug use. In comparison with previous years, there was evidence of heavy drinking or alcohol abuse in 27% records in 2007, 37% in 2008 and 28% in 2009.

12/44 (27%) records indicate a history of substance abuse, 11/12 were male, 8 also associated with alcohol abuse. This represents an increase from 12% in 2007, 22% in 2008 and 21% in 2009.

An inference can be made that there is a strong link between the use of alcohol and illicit substances and the level of suicide risk.

Theme three is to ‘Deliver High Quality Systematic Care for Major Causes of Ill Health and Disability’ - People are prevented from developing long term health conditions, have them identified early if they do develop them and are supported effectively to manage them. 17/44 (39%) records for 2010 refer to physical health conditions, including references to back and joint pain. This compares to 49% in 2009 and 63% in 2008. With reference to the 2008-10 risk matrix; where evidence from patient records was available, 88 (43.3%) of the people that died through suicide had long term health conditions or physical ill health, such as cancer and epilepsy.

29/44 (66%) records refer to history of depression to varying degree of severity, some alongside anxiety. With reference to the risk matrix for 2008-10; where evidence from patient records was available, 94 (46.3%) of the people that died through suicide had a history of depression. A small proportion of these people also had a history of anxiety, social phobias and work stress with depression. 11/44 (25%) records refer to a psychiatric diagnosis, which include affective disorder, schizophrenia, adjustment disorder, obsessive compulsive disorder and personality disorder. This is an increase from 10% of records identified in 2009.

Theme Four is to ‘Improve Health and Social Outcomes for Children and Reduce Inequalities’ - Ensure all children get the best possible start in life and achieve their potential. 5/44 (11%) records refer to abuse (12 % in 2009). This includes physical and sexual abuse by family members or being in abusive relationships, plus being aware of domestic violence towards family members.
15/44 (34%) records refer to difficult or complex family circumstances and childhood experience including the death of siblings at premature age, family history of psychiatric care, unsettled upbringing in different institutions, frequent changes of school, fragmented life as child, subject of child protection register, complex family relationships and accusations of child abuse, lack of family relationships & poor family dynamics. With reference to the risk matrix for 2008-10; where evidence from patient records was available, 30/203 (15%) records refer to abuse or a difficult childhood experience.

The fifth theme is 'Tackling the Social Determinants of Health - Peoples health and well-being is improved through addressing wider determining factors of health that affect the whole community. 6/44 (14%) records refer to financial difficulties, anxiety about money, tax returns and debt of family members.

9% of records refer to caring responsibilities including caring for elderly parents, sick spouse and family members with mental health problems.

Other risk factors include a military history, which for 2010, was identified in 7% of records. None were currently serving or recently retired. In 2009, this figure was 13%.

Bereavement and relationship breakdown or difficulties feature in many records. 8/44 (18%) refer to recent or premature death of spouse, siblings, parents and grandparents. In addition, there are also cases which refer to suicide and attempted suicide of family members.

Relationship breakdown or difficulties are indicated in 13/44 (30%) cases, which predominantly refer to breakdown of relationships with spouse/partner, difficult relationships with children including lack of access, poor or complex family relationships plus difficult relationships at work. With reference to the 2008-10 risk matrix; where evidence from records was available, 70 (34.5%) of the people that died through suicide had experienced bereavement or difficult or breakdown of relationships.

When looking at areas of intervention, it is useful to look at the services that have had prior contact with the deceased. For 2010, these organisations included a range of secondary health care including neurology, orthopaedics, urology, ophthalmology, pain management, ENT, podiatry plus physiotherapy, diabetic retinopathy screening, psychiatry, counselling, Accident and Emergency and Minor Injuries Unit. Other organisations include social services, debt counselling, benefits, probation, addiction services, job centre and training courses.

Most recent contact (within 1 month of death) included the Out of Hours Service, registering with a new GP, A&E, Podiatry, Diabetes Retinal Screening and Disablement Allowance application. Contact within 3 months of death included ENT, Phoenix Smoking Cessation, Minor Injuries Unit, Dietician, Cardiologist, Counsellor, Occupational Health, workplace physiotherapist and Addaction.

With regards to contact with a GP, 9/44 (20%) had contact with the GP within 2 weeks of death, with a further 7/44 (16%) cases within 2 months of death. The most common reason for patients’ last contact was for mental health reasons.

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**Key gaps in knowledge and services**
There is a need to improve targeting of interventions to support key ‘at risk’ populations. In certain areas, there is a lack of robust data to inform future intervention, such as self-harm, marital status, BME origin, ‘near miss’ incidents. It is hoped that improved partnership working and sharing of information will better inform suicide and self-harm prevention.

**Quality of data**

There are a number of issues regarding quality of data for this report. These include:

- There is a time delay between the actual date of death and the registered date of death, which need to be taken into consideration when drawing any conclusions.

- Numbers are relatively small and therefore it is not always possible to draw any conclusions.

- With regards the presence of suicide risk factors, source information for this report comes from patient records. The quality and availability of records varies and therefore caution should be taken when drawing conclusions. To increase the quality of the data, there is a need to make use of other data sources, such as Police, EMAS and A&E data. The percentage prevalence from the 2008-2010 risk matrix, uses all 203 records as the denominator, rather than just those where information is available and is therefore likely to be a low estimate of prevalence.

- With regards to occupation listed, this may be the last occupation known and the deceased may have not been working at the time of death. Also, the classification may be generic and may not give an indication to the industry concerned, for example, a ‘driver’ may be self-employed or work for an international haulage company, a factory worker may work in a number of different areas of industry.

**Risks of not doing something**

We will not achieve any further lowering of risk and incidence of suicide and self-harm for local people.

**What is coming on the horizon?**

Current economic pressures resulting in a reduction of services and support from public, private and third sector organisations, political priorities and poorer living conditions will have an effect on population wellbeing and increase the risk of suicide and self-harm.

**What should we be doing next?**

- Through the Choosing Life information sub group, undertake a confidential inquiry type of suicide audit focussing on Lincoln City and East Lindsey.

- Continue analysis into the risk factors of those living within the most deprived quintiles to define forthcoming local strategy and action plan.
• Further analysis may be carried out to ascertain if the number of deceased of BME origin is significantly higher compared to the Lincolnshire population.

• Further analysis of data relating to self-harm injuries from a multi-agency perspective will be beneficial.

• A strong link between the use of alcohol and illicit substances and the level of suicide risk has been found. It would be beneficial to understand the level of engagement from support services and the review of provision of alcohol and illicit substance services.

• To improve the holistic assessment of issues, link the key topic areas with the JSNA, for example, mental health, alcohol and unemployment.

• An overall conclusion for further work to look at Lincolnshire relative to regional and national averages in relation to certain risk factors to help formulate recommendations and actions for the local suicide and self-harm prevention strategy.

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i Statistical update on suicide DH (September 2012)