Suicides and Undetermined Injuries

Headlines

- English suicide rates are low in comparison with other European countries.
- However, suicide remains a high priority in this country as it is the main cause of premature death amongst some vulnerable groups.
- Across England for the 3 year pooled period 2011-13, the mortality rate from suicide was 8.8 per 100,000, which is lower than in 2000, although it has not changed in the last 3 years.
- In North Lincolnshire, the equivalent rate for 2011-13 was 11.2 per 100,000. This represents an increase on the previous 3 years, and is higher than nationally, although not significantly so.
- The number of suicides in North Lincolnshire can fluctuate year to year from less than 10, to more than 20. This can result in quite significant fluctuations in published annual and 3 year pooled suicide rates, which may not be statistically significant.
- Males continue to have higher suicide rates than women, both locally and nationally.
- In 2011-13, suicide rates amongst men were three times that amongst women.
- The highest rates are amongst men in their middle years and older.

What’s the local picture and how do we compare?

The data in table 1 below are based on the year when the death was registered, which may not reflect the date of death, due to the time lag between the time of death, inquest verdicts and subsequent registration, which can take up to 6 months or more. For example, in 2013 there were 18 suicides which occurred in that year, of which half were registered in 2013 and the rest in 2014. In addition there were 4 suicides registered in 2013 which occurred in 2012. The published suicide rate for that year refers only to those that were registered within year, regardless of the date of death, ie the 13 suicides that were registered in 2013.

Provisional local data for 2014 suggests that the number of suicides registered in North Lincolnshire in that year was 10, of which 9 occurred in 2013. There may still be some verdicts pending for deaths which occurred in 2014.
Figure 1: No of suicides in North Lincolnshire and suicide rate (DSR), 1993-2013

Table 1: Annual suicide rates and numbers in North Lincolnshire (based on year of registration)

<table>
<thead>
<tr>
<th>Year</th>
<th>North Lincolnshire rate</th>
<th>North Lincolnshire nos.</th>
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<tbody>
<tr>
<td>1995</td>
<td>13.86</td>
<td>21</td>
</tr>
<tr>
<td>1996</td>
<td>8.16</td>
<td>14</td>
</tr>
<tr>
<td>1997</td>
<td>5.93</td>
<td>9</td>
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<td>1998</td>
<td>9.62</td>
<td>16</td>
</tr>
<tr>
<td>1999</td>
<td>9.18</td>
<td>15</td>
</tr>
<tr>
<td>2000</td>
<td>11.84</td>
<td>17</td>
</tr>
<tr>
<td>2001</td>
<td>9.78</td>
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<td>2002</td>
<td>6.87</td>
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<tr>
<td>2003</td>
<td>8.62</td>
<td>13</td>
</tr>
<tr>
<td>2004</td>
<td>7.27</td>
<td>20</td>
</tr>
<tr>
<td>2005</td>
<td>13.52</td>
<td>11</td>
</tr>
<tr>
<td>2006</td>
<td>6.60</td>
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<td>7.40</td>
<td>11</td>
</tr>
<tr>
<td>2010</td>
<td>4.02</td>
<td>16</td>
</tr>
<tr>
<td>2011</td>
<td>13.18</td>
<td>7.4</td>
</tr>
<tr>
<td>2012</td>
<td>11.4</td>
<td>22</td>
</tr>
<tr>
<td>2013</td>
<td>7.4</td>
<td>20</td>
</tr>
</tbody>
</table>

Source: ONS, and Public Health Intelligence Team, 2014

*Provisional local data
To avoid drawing undue attention to natural data fluctuations, suicides are generally monitored using three years’ worth of pooled data. These show that local rates fell between 2005 to 2010, although they have risen slightly in the last 4 years, although not significantly so. As in previous years, rates remain in line with the national average with no statistically significant differences between the local and national suicide rates, (see figure 2 below).

**Figure 2: Death rates from suicide, (DSR) and undetermined injury, England and North Lincolnshire 1994-2013**

Source: HSCIC, PHE, PCMD, 2014

**Why are these issues important?**

Despite being a leading cause of premature death, both in the UK and worldwide, there is little hard evidence to suggest why some people attempt or take their own lives.

The likelihood of a person taking their own life depends on a number of different factors, including physically disabling or painful conditions, severe mental illness, alcohol and drug misuse, as well as levels of emotional and social support. Stressful life events can also play a part, including bereavement, separation, family breakdown, unemployment debt and social isolation.

In 2012, the Coalition Government launched their Suicide Prevention Strategy, with a commitment to reduce suicides and to improve services for those bereaved by suicide.

A national implementation framework – ‘No Health Without Mental Health’ has been published which supports the implementation of the national suicide prevention strategy.

The inclusion of suicide as an indicator within the public health outcomes framework reflects the importance attached to this issue and is a means of tracking progress on the national objective to reduce the suicide rate. [http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000044/pat/6/ati/102/page/1/par/E12000003/are/E06000013](http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000044/pat/6/ati/102/page/1/par/E12000003/are/E06000013)
The national cross government strategy on suicide prevention identifies six key areas for action:

- Reduce the risk of suicide in key high risk groups
- Tailor approaches to improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to the bereaved and those affected by suicide
- Support media in delivering sensitive approaches to suicide
- Support research, data collection and monitoring

Which groups are most affected by this?

The cross government strategy on suicide identified the following high-risk groups as priorities for suicide prevention:

- young and middle-aged men
- people in the care of mental health services, including inpatients
- people with a history of self-harm
- people in contact with the criminal justice system
- specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers.

However, other groups who may be at higher than average risk of suicide and suicide attempts include:

- people who are gay, lesbian or transgender
- war veterans
- people who are homeless, or at risk of homelessness
- people with severe depression
- people with a family history of suicide
- people with few close relationships
- people who are socially isolated through bereavement, separation, discrimination or bullying
- people who have suffered trauma or abuse, including sexual abuse
- people who are terminally ill, have a long term disability or who suffer chronic pain

Nationally, men are at three times greater risk of suicide than women. Most suicides are amongst working age men, with men aged 35-49 year olds being at greatest risk.

In the 11 years between 2003-2013, there were 156 registered deaths from suicide or undetermined injury in North Lincolnshire, of these 76% were men.
Older men also have higher suicide rates than older women, with men aged 75+ being at highest risk. This may reflect the impact of social isolation, illness, depression and bereavement in older age.

Periods of high unemployment and severe economic recession have been shown to have a significant impact on people’s mental health and have been associated with an increased risk of suicide. For many people it is a combination of complex factors, rather than one single reason.

National data for 2012 suggest that hanging, strangulation and suffocation continue to be the most common methods of suicide for men, along with drug poisoning, which is the most common method amongst women.
In North Lincolnshire, the most common methods of suicide are hanging, followed by drug poisoning, drowning and carbon monoxide poisoning.

**Where is this causing most concern?**
Geographical areas that are known to be areas where people have repeatedly attempted suicide or completed suicide are known nationally as Hotspots. This might include bridges, railway lines, cliffs, rivers and woods.

The majority of deaths by suicide in North Lincolnshire are by residential hanging which is difficult to prevent. However, much could be done to raise awareness, recognise distress and support families.

**What’s changed since 2012?**
As of April 2013, the responsibility for coordinating and implementing local work on suicide prevention lies with the local authority, as an integral part of their new responsibilities for public health and health improvement.

Whilst the national strategy provides some guidance, it will be up to local agencies to identify, adapt and agree the best ways forward in their area.

North Lincolnshire has developed a Suicide Prevention Action Plan with service providers, health services and agencies with an interest or concern.

**What are the views of local people?**
The latest National Strategy recommends the inclusion of those bereaved by suicide to be included in local suicide prevention developments/action. Members of the SOBS group are included in North Lincolnshire’s Suicide Prevention Action Plan group.

The Samaritans receive feedback from their outreach, public facing work. Feedback is also received from Facebook.

**What are our key strengths/assets?**
- Suicides are monitored routinely in North Lincolnshire and investigated thoroughly by a multi-agency steering group of partner agencies to identify how they might have been prevented. This group is currently refreshing the local Suicide Prevention Strategy and Action Plan.
- RDASH the specialist mental healthcare service provides specialist training e.g. Storm to members of staff.
- RDASH have opened the Talking Shop which is an open access shop in the town centre offering a range of support, including 'Stressbusters’ in the evening.
- North Lincolnshire has award-winning Primary Mental Healthcare which offers access to Improving Access to Psychological Therapies to the general population.
- Multi-agency commitment to Suicide Prevention.
What are the 3 key issues for commissioners and service providers to consider?

- Promote general population awareness raising, sensitise people to the subject.
- Train frontline professionals e.g. local authority, support staff, GP’s, teachers, jobcentre plus staff in a range of interventions at different levels as appropriate.
- Supporting the Samaritans work to support local presence, reduce stigma, preventative work.

What are our future needs?

- Collaborative prevention.
- Recognition of suicidal tendency/risk and prevention to be integrated across service areas e.g. Drugs/Alcohol/Crime
- Learn lessons, promote best practice across primary care, secondary care and wider, universal services.

Links to evidence base

- [www.suicideprevention.org.uk](http://www.suicideprevention.org.uk)
- [www.depressionalliance.org](http://www.depressionalliance.org)
- [www.mhfaengland.org.uk](http://www.mhfaengland.org.uk)
- [www.uk-sobs.org.uk](http://www.uk-sobs.org.uk)
- [www.samaritans.org](http://www.samaritans.org)
- [www.sane.org.uk](http://www.sane.org.uk)
- [www.youngminds.org.uk](http://www.youngminds.org.uk)

References


Department of Health, *Statistical Update on Suicide* DoH Publications, 2014

Department of Health, *Prompts for local leaders on Suicide Prevention*, DoH, 2012

Samaritans, *Men & Suicide*, 2012

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