FACTSHEET SUICIDE

Every year, around 24 people living in Lambeth will die from suicide. There are also a significant number of suicide deaths that occur within the borough of people who are resident in other local authority areas.

To help understand who is dying from suicide, how this changes over time, we can analyse data that is available to us from the Primary Care Mortality Data (PCMD) dataset, as well as data published by Public Health England on their "Suicide Prevention Profile" webpages. The suicide profiles published there for each local authority area are publicly accessible and allow comparison both of suicide rates as well as of suicide risk factors. There may be further information available in the future from a full suicide audit, however there are currently data access issues for this data. This would allow us to understand in more detail the circumstances leading up to suicide deaths and provide additional demographic and risk factor information such as ethnicity.

The data summarised here is taken from the PCMD dataset covering a period from 2001-2017. As suicide numbers are very small for individual years the conclusions that can be drawn from analysing such a long time period are more meaningful. Another difficulty with interpreting suicide numbers is that fluctuate year-on-year and it can be misleading looking at numbers for individual years. Further information on understanding suicide statistics is available on the Samaritans' website (www.samaritans.org) and on the ONS website (www.ons.gov.uk).

DEFINITIONS

1. The WHO definition of suicide is "the act of deliberately killing oneself".
2. The Lambeth suicide data analysis uses the definition of suicide adopted by the Office of National Statistics (ONS), which reflects the coding used by WHO (ICD-10). This includes deaths from the ICD-10 groups "intentional self-harm" (for persons aged 10 years and over) as well as "injury/poisoning of undetermined intent" (for persons 15 years and over). Deaths from an event of undetermined intent in 10 to 14 year-olds are not included because the assumption cannot be made that in this age group the deaths were self-inflicted, and the possibility of unverifiable accidents, neglect or abuse cannot be excluded.
3. This definition will vary from a Coroner's verdict of suicide. Coroners record a verdict of suicide only when there is evidence beyond reasonable doubt that the injury was self-inflicted, and the deceased intended to take their own life. Including "events of undetermined intent" mitigates against the undercounting of suicide that is known to occur when relying on coroners' verdicts, as coroners record an open verdict when there is doubt about the deceased's intentions. Research has shown that most open verdicts are likely to be suicides.
4. Suicides are recorded by ONS only once an inquest has been completed. As inquests may not be conducted in the year of death there can be considerable delay until a death is recorded. Data used for analysis counts suicides in the year in which they were recorded rather than the year of death. This is consistent with ONS practice.
5. Self-harm is defined as an intentional act of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent (NICE 2011). Self-harm admission data analysed was provided by Secondary Uses Service (SUS) and reports on admissions to hospital for self-harm in patients for whom Lambeth CCG is responsible.

KEY STATISTICS FOR LAMBETH

NUMBER OF SUICIDE DEATHS EACH YEAR

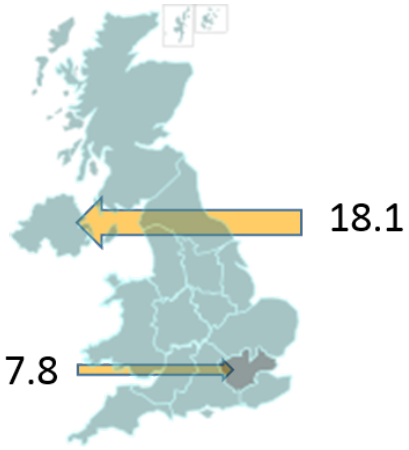
Over the 3-year period 2014-2016, on average 24 Lambeth residents died each year from suicide.

One quarter of these were female.

SUICIDE RATES

Highest age-standardised suicide rate: Northern Ireland 18.1 per 100,000 (2016)

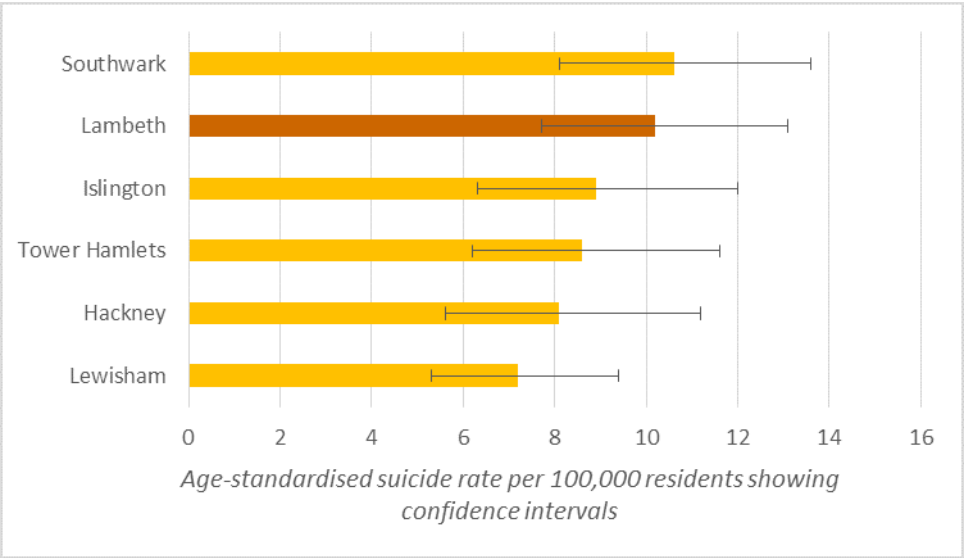
Lowest age-standardised suicide rate: London 7.8 per 100,000 (2016)



Highest and lowest age-standardised suicide rates in regions of the UK, 2016 (ONS), rate per 100,000 residents

Suicide rates vary significantly between the regions and countries of the UK. Northern Ireland has the highest rate, followed by Scotland, then Wales, with London having the lowest.

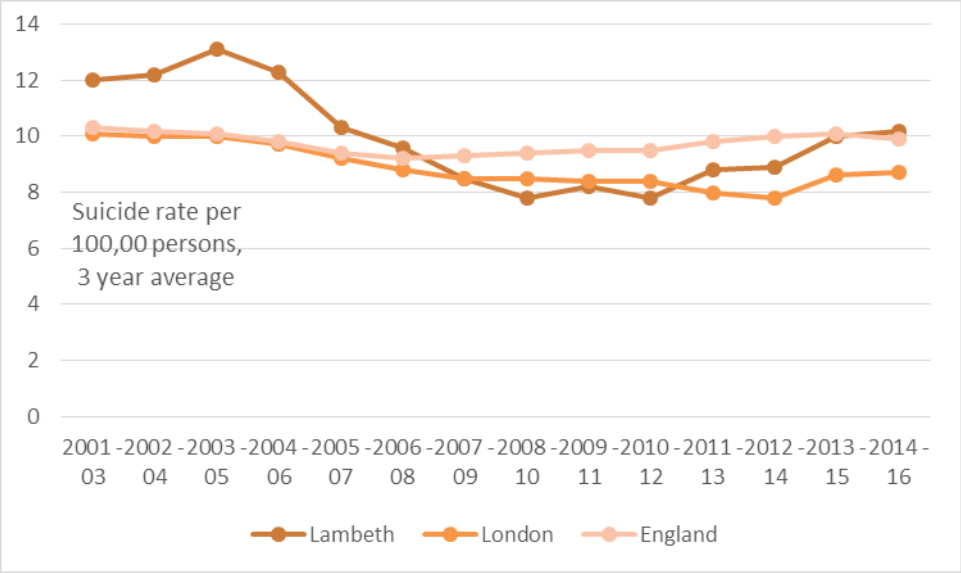
Within London, the boroughs' suicide rates have wide confidence intervals due to smaller numbers and there are no significant differences between the suicide rate in Lambeth and the rates in its statistical neighbours.



Age-standardised suicide rates per 100,000 per year, 2014-2016, for Lambeth and statistical neighbours (source: PHOF)

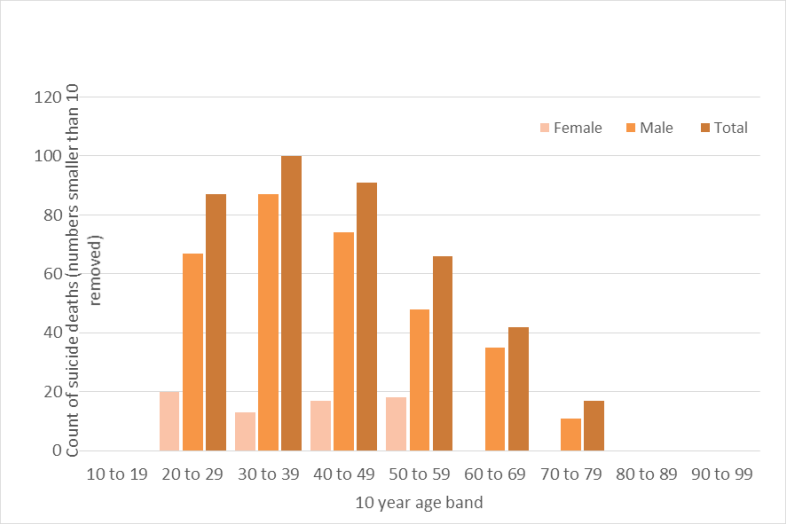
TRENDS

There has been a general decrease in suicide rates in Lambeth, London and England in the period 2001-2016.



Suicide rate in all persons showing 3-year averages, for Lambeth, London and England (source: PHE PHOF)

AGE

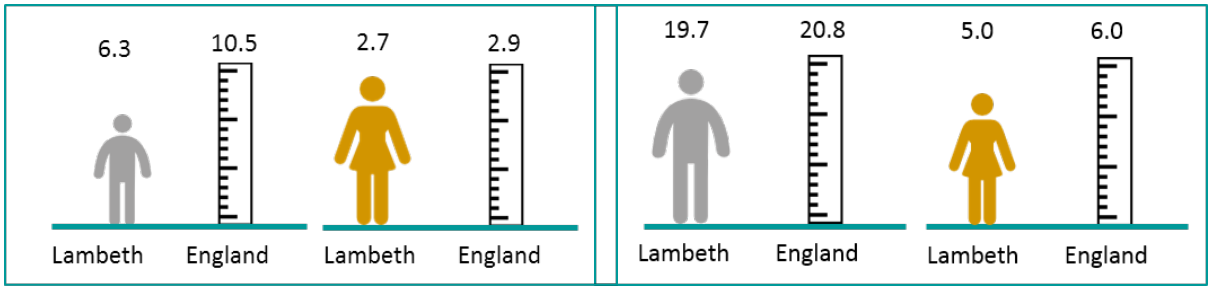


Count of suicide deaths in 10 year age bands for all persons, males and females, Lambeth residents, 2001-2017

Most suicides in Lambeth occur in people aged between 20-50 years.

In males, the most frequent age band is 30-39 year olds whereas in females it is 20-29 year olds.

At the extremes of age (under 20 and over 79) suicide numbers are so small that they could not be shown (suicide numbers smaller than 10 cannot be reported).



Age 10-34 years

Suicide crude rates per 100,000, Lambeth residents, 5 year average (2011-15), male and female (source: PHOF) compared to benchmark (crude rate for England)

Age 35-64 years

Suicide crude rates per 100,000, Lambeth residents, 5 year average (2011-15), male and female (source: PHOF) compared to benchmark (crude rate for England)

The suicide rate for men in the age range 10-34 years is lower than the benchmark (England).

For women the rate is similar to the benchmark (though numbers have been combined for all female suicide deaths in London as they are too small to analyse by borough).

In the older age group (35-64), the rate in men is similar to the benchmark (England), whereas in women it is lower than the benchmark (again, the rate given for women is that for the whole of London).

COUNTRY OF ORIGIN

Ethnicity is not recorded in ONS data and was not available in the PCMD dataset analysed. The best available proxy was "country of origin" of the deceased.

At the time of the UK census 2011, 38% of the population of Lambeth was non-UK born.

Crude suicide rate in UK-born residents per year per 100,000 population (based on 2011 Census and PCMD from 2001-2017)

Crude suicide rate in non-UK-born residents per year per 100,000 population (based on 2011 Census and PCMD from 2001-2017)

Note on the data: overlapping confidence intervals

Deaths in UK-born residents 7.9 per 100,000 (CI 6.9 to 8.9)

Deaths in non-UK born residents 9.8 per 100,000 (CI 8.38 to 10.46)

Crude suicide rate in Lambeth residents by region of birth per 100,000 population (source: Census 2011 and PCMD 2001-2017).

Note: Apparent differences between regions of birth may not be significant due to small numbers

Key points

Local data suggests that there are differences in suicide rate linked to country of origin, with a particularly high rate in people born in North America and the Caribbean, however due to the small number of suicide deaths it is not possible to demonstrate a statistical difference.

LOCATION OF SUICIDE

47% of suicide deaths in Lambeth residents or occurring in Lambeth were certified in hospital. However most of these deaths had not occurred in hospital and were therefore excluded from the analysis of location. The data available recorded the location in which the deceased had been certified dead by a medical practitioner rather than the actual place of death, and in some instances the location stated did not reflect where the individual had died, particularly in relation to deaths by drowning in the Thames as bodies are generally retrieved some distance downstream.

59% of suicide deaths occurring in Lambeth or in Lambeth residents occurred in residential premises. These were also excluded from the analysis summarised in the figure as they are unlikely to be amenable to an intervention to the location.

Of the locations analysed for suicide deaths in Lambeth residents and suicide deaths occurring in Lambeth, the commonest locations were train stations and rail tracks, followed by the River Thames

Key points

59% of suicide deaths occurred in residential premises (excluding deaths were location was unknown)

Of known non-residential locations, the commonest were train stations and rail tracks, followed by the River Thames and parks, churchyards and cliffs.

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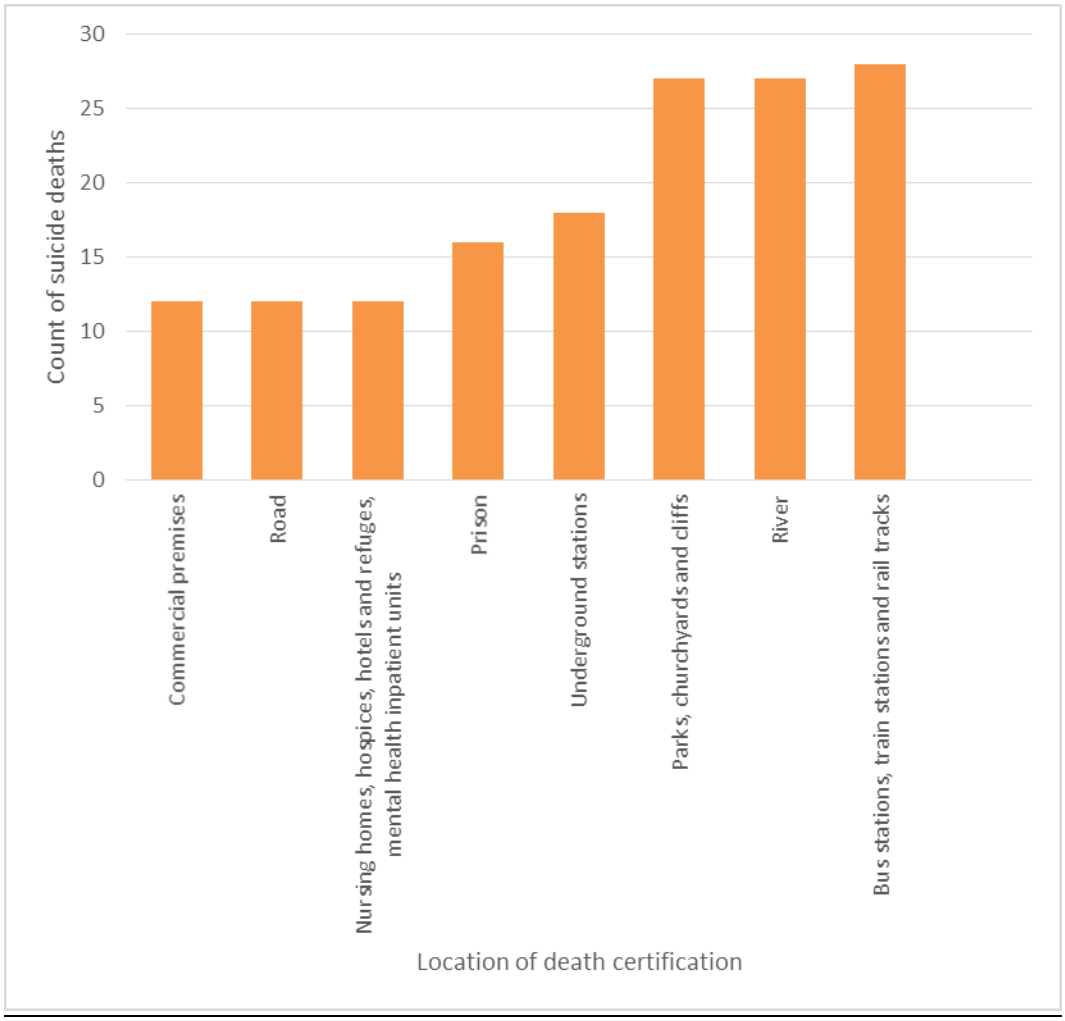


Suicide counts by location of death certification, Lambeth residents and suicide deaths occurring in Lambeth, 2001-2017

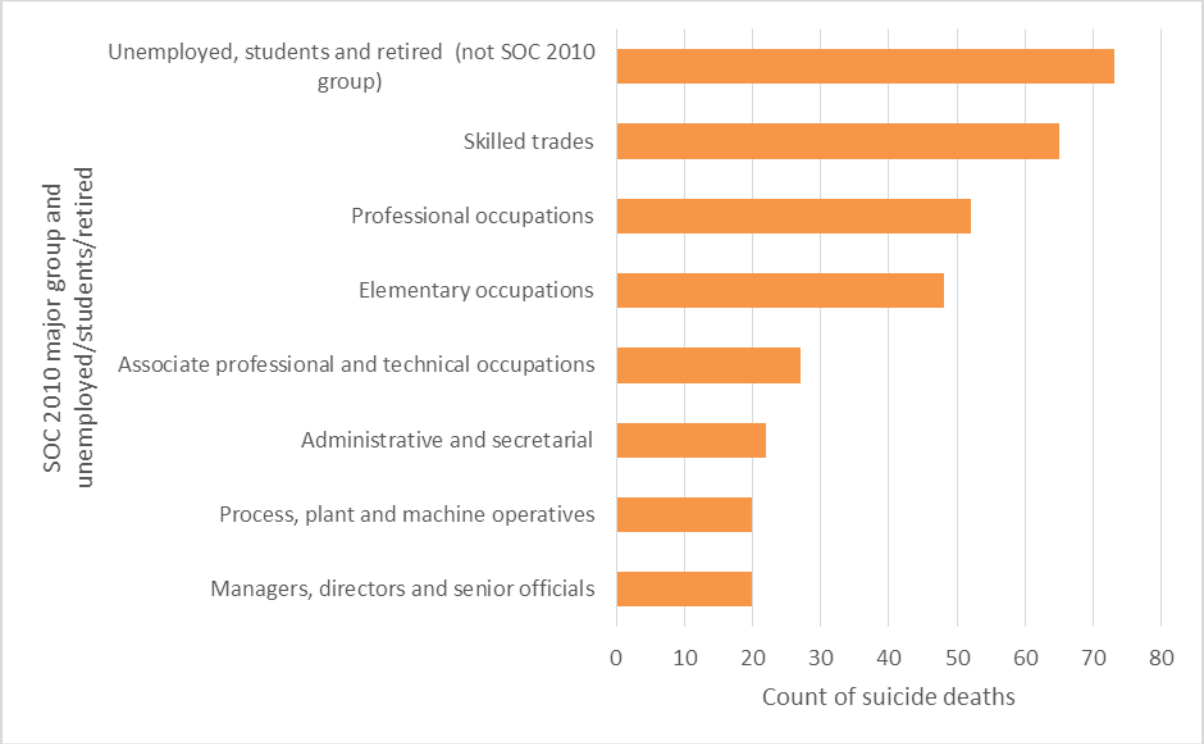
OCCUPATION

Occupations were recorded in Primary Care Mortality data and were converted to SOC 2010 codes (the current standard occupational classification for the UK).

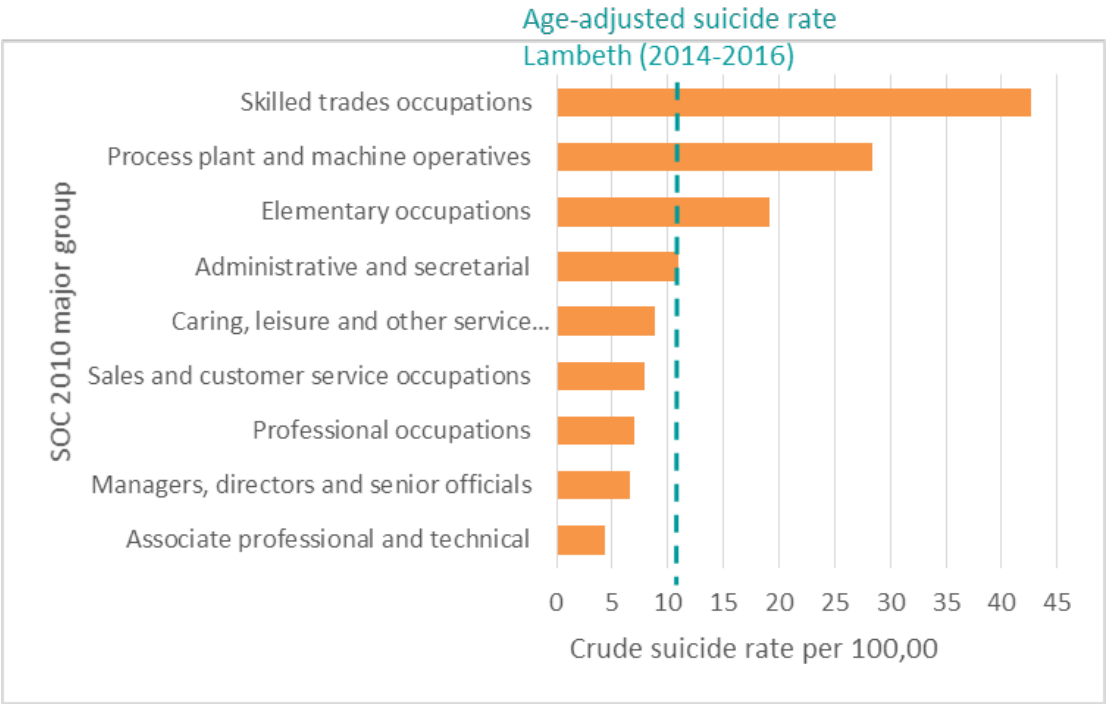
Key points

The largest number of suicide deaths occurred in people who were unemployed or students or retired.

In people recorded as having an occupation, the largest number were working in skilled trades, followed by professional occupations.



Suicide deaths in Lambeth residents, 2001-2017, by SOC 2010 major occupational group and for unemployed/students and retired, excluding those with no record of occupation.

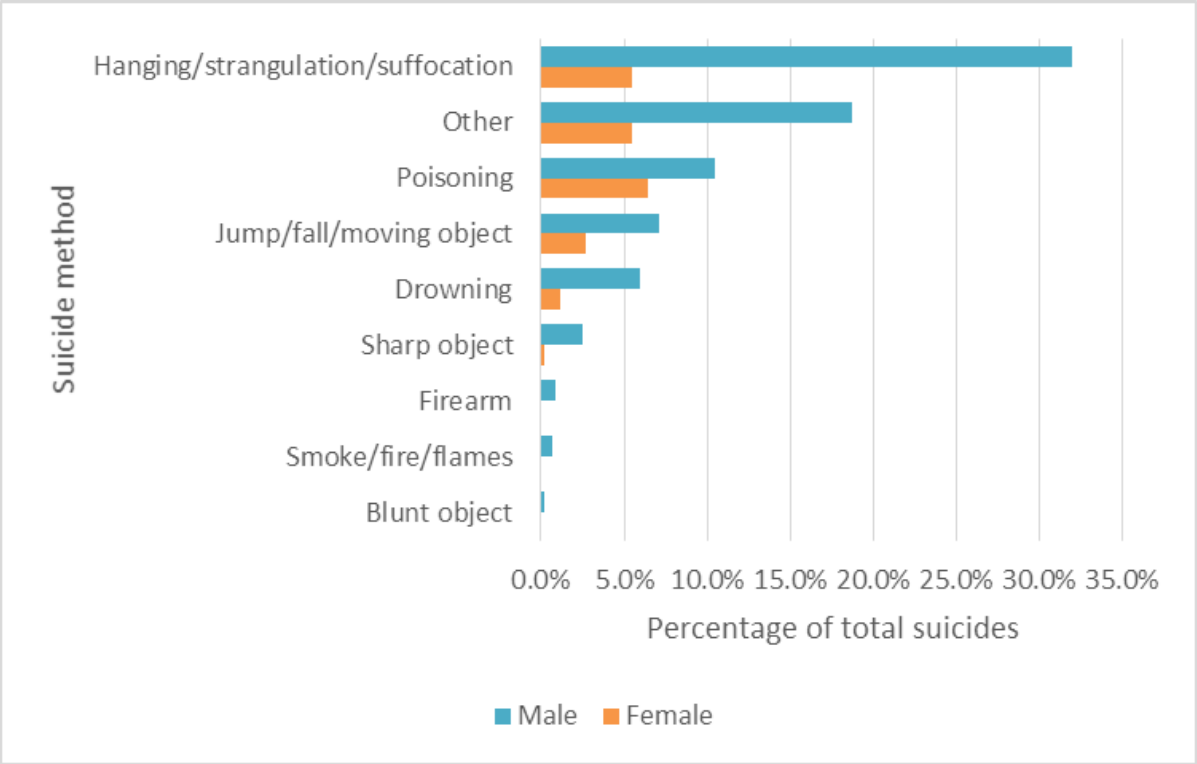


Crude suicide rates for SOC 2010 major occupational groups, per 100,000 population, in Lambeth residents (2001-2017; using 2010 as approximate midpoint for size of occupational groups in Lambeth, source: NOMIS). Dashed line shows age-adjusted suicide rate for Lambeth (2014-2016) as benchmark.

Key points

Local data suggests that people working in certain occupational groups are at significantly increased risk of suicide. The group with the highest rate is those working in skilled trades occupations (predominantly, in Lambeth, those in skilled metal, electrical and electronic trades, textiles, printing and other skilled trades, and skilled construction and building trades). The second highest rate is in those working as process, plant and machine operatives (predominantly transport and mobile machine drivers and operatives).

SUICIDE METHOD

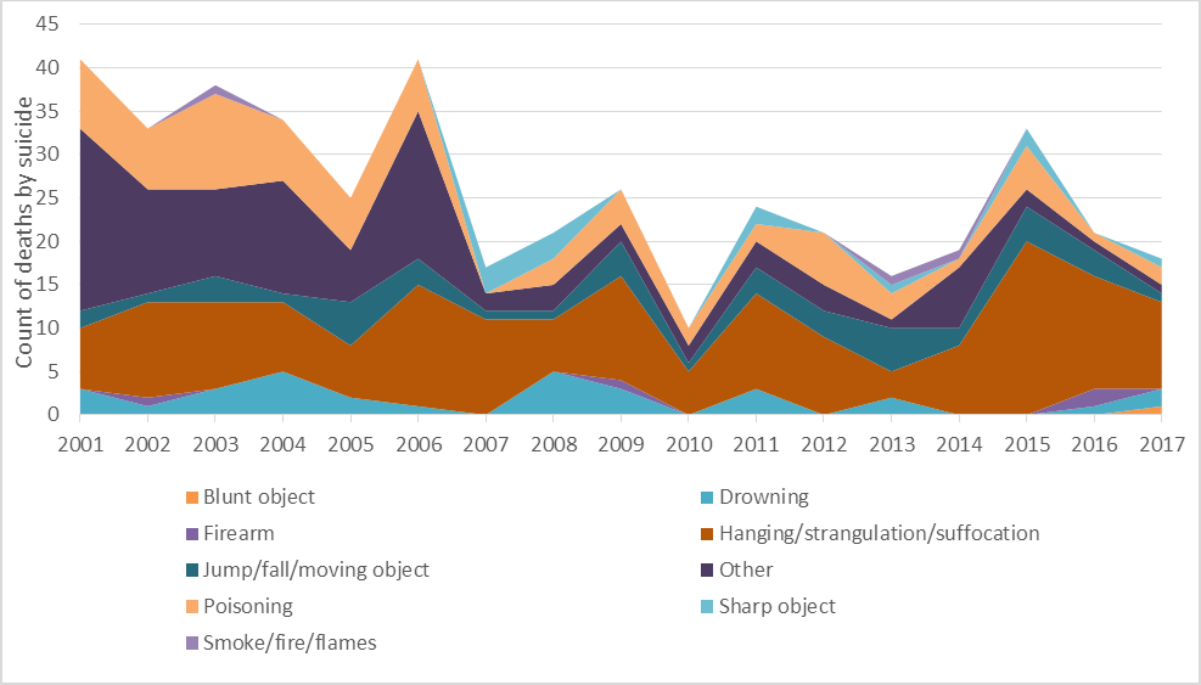


Proportion of total suicide deaths occurring by different methods, showing male and female deaths, Lambeth residents, 2001-2017

Key points

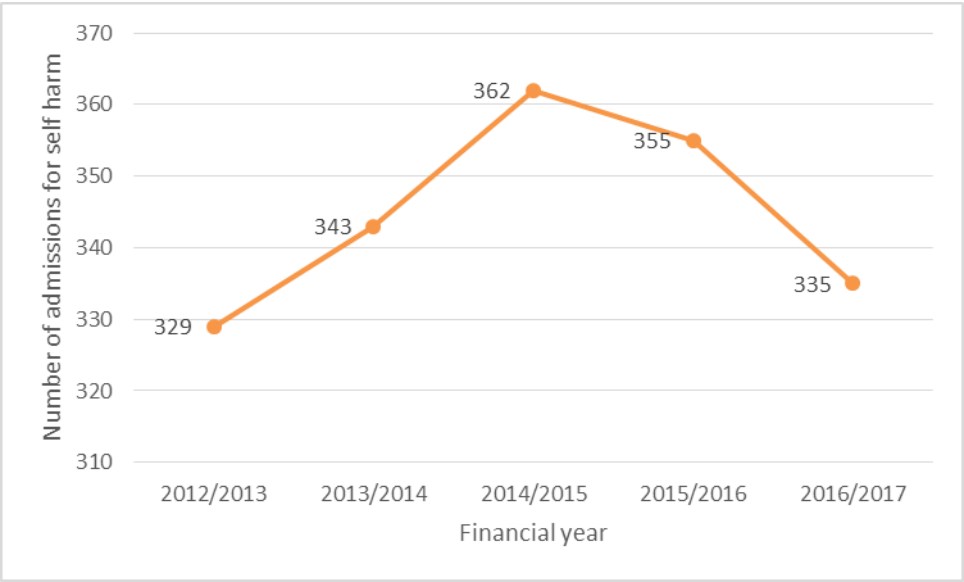
Hanging, strangulation and suffocation are the commonest suicide method overall and the commonest in males, whereas in females death by poisoning is marginally more common than hanging.

Poisoning has become less common over the time period analysed (2001-2017), while there has been a slight increase in the proportion of suicides occurring as the result of hanging/strangulation/suffocation. There has been little change over time in the proportion of deaths occurring by jumping or falling.

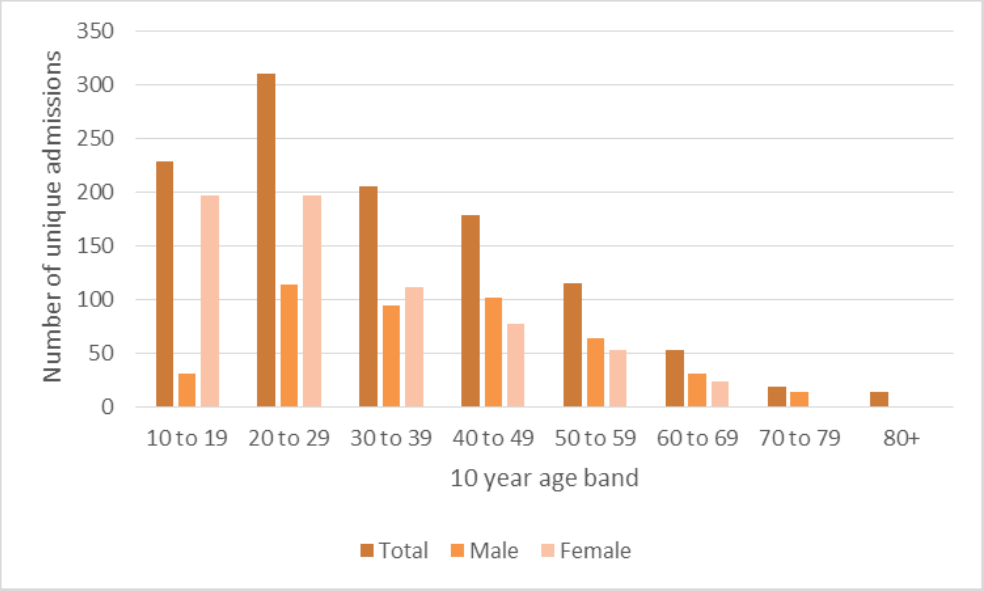


Trends in suicide methods shown as size of coloured area corresponding to proportion of deaths occurring by that method. Lambeth residents, 2001-2017.

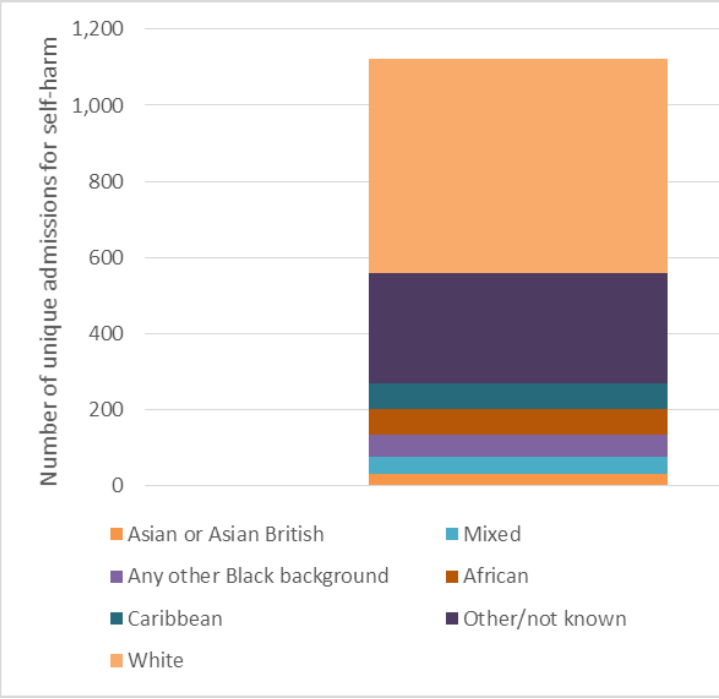
SELF-HARM



Number of emergency admissions due to self-harm, for Lambeth CCG responsible patients, for period 2012/2013-2016-2017 (source: Lambeth CCG, 2017)



Unique admissions for self-harm, by 10 year age bands, for males, females and all persons, Lambeth CCG, 01/04/2012-31/10/2017



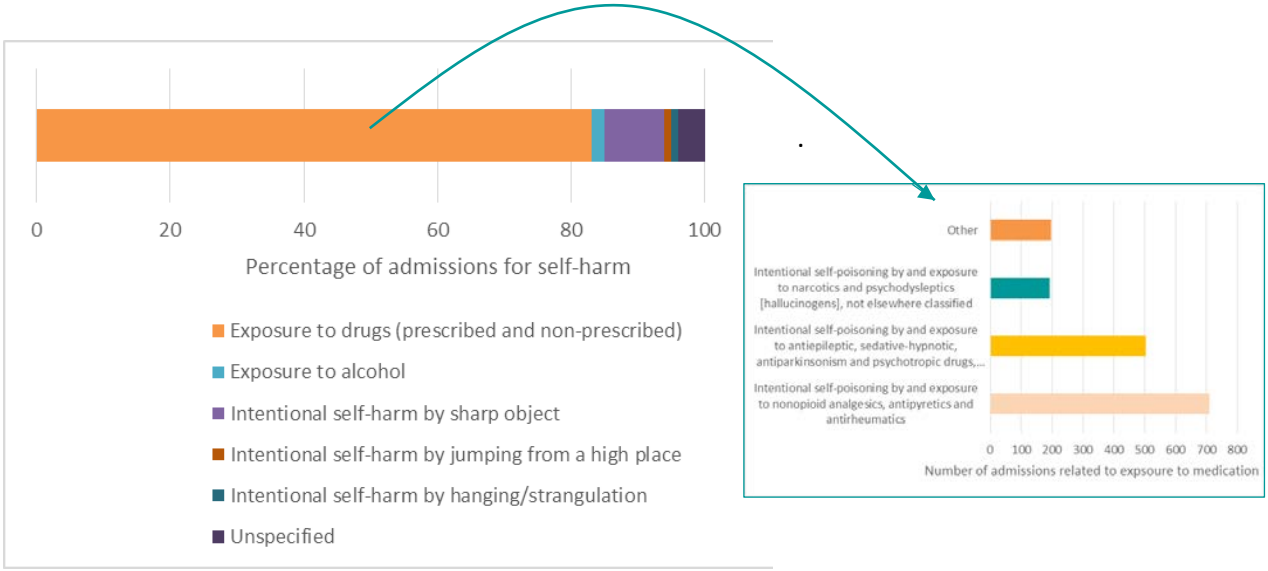
Unique admissions for self-harm, by ethnicity, Lambeth CCG responsible patients, 01/04/2012-31/10/2017

Discharge destination	% of discharges after self-harm admission
High security psychiatric accommodation	1%
Penal establishment or police station	1%
Patient died	1%
General hospital ward	4%
Mental health inpatient unit	6%
Permanent or temporary place of residence	87%

Discharge destinations from self-harm emergency admissions, Lambeth CCG, 01/04/2012-31/10/2017

Key points

- The number of emergency admissions for self-harm is much larger than suicide counts each year; and those admitted for self-harm represent only a proportion of those who self-harm as many people do not present to hospital after a self-harm episode
- The peak age group overall and in males is 20-29 year olds; in females the peak spreads across the 10-19 and 20-29 year age bands.
- Just over half of admissions for self-harm are in people of white ethnicity, about 17% are in black ethnicities (about a third each African, Caribbean and other Black background).
- 6% of those admitted due to self-harm are discharged to a mental health inpatient unit, and a further 1% to a high security psychiatric unit.



Reason for emergency admission after self-harm, Lambeth CCG, 01/04/2012-31/10/2017

Key points

- The majority of self-harm admissions occur as a consequence of exposure to drugs (prescribed and non-prescribed)
- The second most frequent reason (9%) is intentional self-harm by a sharp object.
- The most common type of drugs used in self-harm are non-opioid analgesics, antipyretics and antirheumatics: 37% of all admissions (this groups includes paracetamol and ibuprofen).

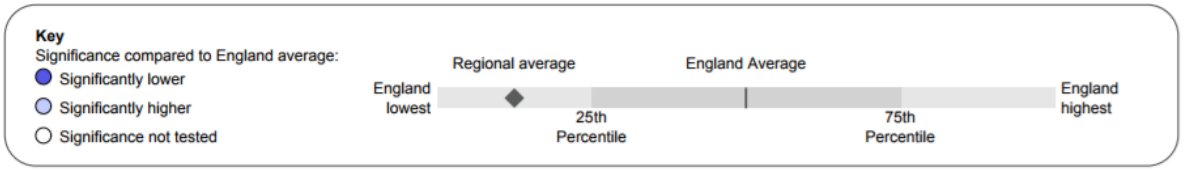
Deprivation

Analysis of suicide rates by IMD (Index of Multiple Deprivation) decile band shows that there is a far larger burden of suicide deaths in the 5 most deprived deciles compared to the 5 least deprived.

The life expectancy gained if the most deprived quintile in Lambeth had the same mortality from suicide as the least deprived quintile would be 0.14 years in males, and 0.02 years in females (PHE 2015).

RISK FACTOR PREVALENCE

Lambeth has a higher prevalence than the benchmark value (the average for England) and the regional average in the following, which are all known to be risk factors for suicide (Source: PHE Fingertipsreports):



1. Substance misuse

	Period	Local count	Local value	Region value	England value	England lowest	Range	England highest
Estimated prevalence of opiates and/or crack cocaine use: rate per 1,000 population aged 15 - 64	2011/12	3,074	13.4	9.6	8.4	1.9		20.8
Alcohol-related hospital admission (Broad): directly age standardised rate per 100,000 population (Persons)	2014/15	3,199	1572	1252	1258	833		2100

2. Children in the care system

	Period	Local count	Local value	Region value	England value	England lowest	Range	England highest
Looked after children: rate per 10,000	2014/15	485	78.0	52.0 ~	60.0	20.3		157.9
Children leaving care: rate per 10,000	2014/15	325	52.3	31.1 ~	26.8	10.9		64.2

3. Contact with the criminal justice system

	Period	Local count	Local value	Region value	England value	England lowest	Range	England highest
Children in the youth justice system: rate per 1,000 aged 10 - 18	2014/15	286	10.8	7.0	6.5	2.3		14.1

4. Severe mental illness

	Period	Local count	Local value	Region value	England value	England lowest	Range	England highest
Severe mental illness recorded prevalence (QOF): % of practice register (all ages)	2015/16	4,836	1.28	1.09 ~	0.90	0.52		1.52

5. Loneliness

	Period	Local count	Local value	Region value	England value	England lowest	Range	England highest
People living alone: % of all households occupied by a single person	2011	44,691	14.9	12.8	12.8	8.0		23.4

Key points

Lambeth has a higher than average prevalence (as compared to England as well as to London) for the following risk factors for suicide:

1. Substance misuse (both alcohol and opiates and/or crack cocaine use)
2. Severe mental illness
3. Contact with the criminal justice system (in children/young people aged 10-18)
4. Loneliness (as measured by % of households occupied by a single person)
5. Children in care/care-leavers

CURRENTLY UNKNOWN

The following characteristics of individuals who died from suicide and other additional details are not available from current data but would be very valuable in understanding suicide patterns and local issues in Lambeth:

- Ethnicity and protected characteristics
- Chronic ill health/disability/terminal illness
- Substance misuse
- Engagement with mental health services and other services
- Local context (e.g. large-scale local redundancies by a single employer)
- High-frequency locations (as almost half of deaths certified in hospital, location information is missing for almost half of all suicide deaths)
- Immigration status and refugee status