Suffolk County Council

Public Health & Communities

Population factors that affect mental health

Part of the Suffolk mental health needs assessment

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Suffolk County Council Public Health & Communities

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Contents

Five key points

1. The following groups are identified as being of high risk of poor mental health: ethnic minority groups, people living with physical disabilities, people living with learning disabilities, people with alcohol and/or drug dependence, prison population, offenders and victims of crime, LGBT+ (lesbian, gay, bisexual and transgender) people, carers, people with sensory impairment, homeless people, and refugees, asylum seekers and stateless persons. (See the section below on Population demographics and people at risk)

2. Excess weight and obesity are also considered a risk factor for mental ill health. More than 3 in 5 (62.9%) adults in Suffolk are classified as overweight or obese, similar to the national average (63.5%). (See the section below on Health behaviours)

3. On average, men with severe mental illness (SMI) die 20 years earlier, and women die 15 years earlier, than the general population. (See the section below on Data sources - comorbidity)

4. In 2020/21, Suffolk had the highest rate of self-harm in 15-19 year olds in the East of England region and was the only county/unitary authority within the region with a statistically significantly higher rate than England. (See the section below on Data sources – suicide and self-harm)

5. There were 394 people in drug treatment in Suffolk in 2020/21 with an identified mental health need who were receiving treatment for their mental health; this is 81.1% of all people in drug treatment with an identified mental health need. This is statistically higher/better than the national average, and the highest of any county/unitary authority in the East of England. (See the section below on Population data sources)

Context

Type of report

This report is part of a mental health needs assessment in the Suffolk Joint Strategic Needs Assessment. "A health needs assessment is a systematic approach to understanding the needs of a population that can be used as part of the commissioning process to ensure that the most effective support is provided for those in greatest need"[1].

Background - geography

The report covers the Suffolk County Council geography.

Clinical Commissioning Groups (CCGs) ceased to exist on 1 July 2022, when Integrated Care Boards (ICBs) were legally established. "Sub-ICB areas" match the geography of CCGs for data analysis. Suffolk is covered by two ICBs: Suffolk and North East Essex (West Suffolk and Ipswich and East Suffolk CCGs or sub-ICB areas), and Norfolk and Waveney (ICB or CCG). These areas are different sizes in terms of geography and population (March 2023)[2]:

- 1,088,258 Norfolk and Waveney CCG/ICB
- 1,058,560 Suffolk and North East Essex ICB
- 422,283 Ipswich & East Suffolk CCG/sub-ICB
- 265,688 West Suffolk CCG/sub-ICB

Where possible, health information on the Waveney part of Suffolk (including Lowestoft) is given at Primary Care Network (PCN) level. PCNs are groups of GP practices that cover smaller areas than an ICB or CCG.

Note: East Suffolk Lower Tier Local Authority (LTLA) includes the Lowestoft and Waveney area, which is in the Norfolk and Waveney ICB.

Overview

Population demographics and people at risk

The age and gender structure of the local population is an important driver of health need and demand for health services. Allocation of NHS resources for mental health (including dementia) is based on modelling mental health condition prevalence against known factors, such as acute mental health need being greatest among working age adults and dementia being more prevalent among older age groups[3]. Further weighting is included for ethnicity and socio-demographic factors.

Avoidable, systematic inequalities between groups are unfair. Some groups are at higher risk of unfavourable social, economic, and environmental circumstances which can increase the risk of mental illness. Some people may belong to more than one group at risk of poor mental health, for example their ethnicity, sex, and age.

The following groups are identified as being of high risk of poor mental health[4,5]:

- ethnic minority groups
- people living with physical disabilities
- people living with learning disabilities
- people with alcohol and/or drug dependence
- prison population, offenders, and victims of crime (see the section on crime, safety, and violence in the chapter on environmental factors and mental health)
- LGBT (lesbian, gay, bisexual, and transgender) people
- carers
- people with sensory impairment
- homeless people (see Housing and homelessness in the chapter on environmental factors and mental health)
- refugees, asylum seekers and stateless person

High rates of people moving home within and between areas can disrupt social ties and community networks and is related to higher levels of stress and mental ill health[6]. This can include people in life transitions such as students.

People who have recently arrived from abroad to live in an area – for example those from Ukraine fleeing the war in their country - may face barriers to accessing mental health services. Refugees are more likely to have experienced trauma and are therefore likely to have higher prevalence of mental health conditions such as post-traumatic stress disorder (PTSD), depression and anxiety. People who do not speak English well might need specific help to enable them to access the mental health services.

More information and data about Population and Migration, Ethnicity, and Ethnic Group, national identity, language and religion can be found on the Census 2021 pages of the Healthy Suffolk website.

Other examples of people who are at increased risk of mental ill health are highlighted in the chapter on environmental factors and mental health. In particular, higher rates of mental ill health are associated with poverty and socio-economic disadvantage. Across the life course, examples of groups identified as high priority are:

- women who are pregnant or have a child aged under 12 months
- children living at a socio-economic disadvantage

- children with parents who have mental illness or use substances
- looked-after children
- adults with a history of violence or abuse
- people with poor physical health
- older people living in care homes
- isolated older people

Population data sources

Around 1 in 7 people in Suffolk had a long-term illness, disability or medical condition (such as diabetes, arthritis, allergy or cerebral palsy) diagnosed by a doctor by the age of 15[7]. Poor health in childhood/adolescence can have other longer-term impacts, including on overall life chances.

Table 1 shows the numbers of adults in the county with selected sensory and physical disabilities. These populations may be at higher risk of mental illness.

Table 1: Numbers of people with selected health conditions in Suffolk, 2020[8,9]

	Serious visual impairment (18-64 years)	Moderate or severe visual impairment (65 and over years)	Some hearing loss (18-85 years)	Severe hearing loss (18-85 years)	Impaired mobility (18-64 years)
Suffolk	279	21,650	158,574	24,415	25,203
Babergh	33	2,897	21,007	3,239	3,162
East Suffolk	87	8,342	58,948	9,263	8,446
Ipswich	54	2,724	21,941	3,206	4,342
Mid Suffolk	38	3,039	22,527	3,434	3,621
West Suffolk	67	4,630	34,152	5,255	5,638

Figures may not sum due to underlying methodology

The numbers in Table 1 do not take into account the size or characteristics of a district's population. For example, East Suffolk has the highest number of people aged 65 and over of all the Suffolk districts – almost double that of the next highest district, West Suffolk. It could therefore reasonably be expected to have larger numbers of people affected by the conditions identified in Table 1.

Autistic people and people with learning disabilities, and with autism, were identified above as at high risk of mental ill health.

Table 2 shows numbers of children in Suffolk with recorded learning disabilities (LD) or autism to estimate the size of these at-risk populations. In 2020, there were around 2,600 children known to Suffolk schools with either moderate, severe or profound and multiple learning difficulties; there were nearly 1,900 children with autism[10]. (See also the needs assessments for people with learning disabilities and for people with autism)

Table 2: Learning disabilities and autism in Suffolk[10]

Indicator Name	Period	Suffolk Trend	Suffolk count	Suffolk value	Children's services nearest neighbours	England	Compared to England	Compared to nearest neighbours
Adults (18 and over) with learning disability receiving long- term support from local authorities (per 1,000 population)	2019/20	Increasing	2,330	3.83	3.44	3.46	Higher	Higher
Children with Autism known to schools	2020	Increasing	1,870	18.1	15.2	18.0	Similar	Higher
Children with learning difficulties known to schools	2020	No significant change	2,597	25.2	34.4	34.4	Lower	Lower
Children with Moderate Learning Difficulties known to schools	2020	No significant change	2,022	19.6	29.1	29.1	Lower	Lower
Children with Profound & Multiple Learning Difficulty known to schools	2020	No significant change	68	0.66	1.02	1.29	Lower	Lower
Children with Severe Learning Difficulties known to schools	2020	Increasing	507	4.9	4.3	4.0	Higher	Higher
Learning disability: QOF prevalence (all ages)	2019/20	Cannot be calculated	4,285	0.5%	0.6%	0.5%	2nd highest quintile	Middle quintile

Table 2 identifies that Suffolk has statistically lower rates per 1,000 of children with moderate learning difficulties, and profound and multiple learning difficulties known to schools than both the national average and compared to its Children's Services nearest neighbours (other counties/unitary authorities that have similar socio-economic characteristics to Suffolk). The Suffolk rates are the lowest/among the lowest rates in the East of England region.

There were more than 2,300 adults with a learning disability supported by the local authority in 2019/20 (Table 2), representing a rate of 3.83 per 100,000 population, statistically higher than the national average[10].

Overall learning disability prevalence in the Suffolk population (0.5%) is similar to the national average, with around 4,300 registered patients in the county recorded as having a learning disability[10].

Mental illness in people with LD is often not recognised because[11]:

- carers may miss changes in behaviour
- symptoms of mental illness may be attributed to LD ("diagnostic overshadowing")
- co-morbidities may mean mental illness is missed or recognised 'late'
- the person may find it difficult to communicate new symptoms (or medication side effects)
- supervision and support may mean common signs of mental illness do not present. If a person has carers to support washing and dressing, then failure to maintain personal hygiene or cleanliness cannot be seen; help at mealtimes can mean there isn't weight loss[12]

Although not measuring the total number of people within Suffolk with mental illness who also use substances or alcohol, there were 394 people in drug treatment in Suffolk in 2020/21 with an identified mental health need who were receiving treatment for their mental health (Table 3); this is 81.1% of all people in drug treatment with an identified mental health need. This is statistically

higher/better than the national average, and the highest of any county/unitary authority in the East of England[13].

Table 3: Co-occurring substance use and mental illness, 2020/21, Suffolk compared to England[14]

Better 95% Similar Worse 95% Not applicable Data quality concerns

Recent trends: Could not be calculated; No significant change; Increasing & getting worse; Increasing & getting better; Decreasing & getting worse; Decreasing & getting better

Benchmark Value: Worst | 25th Percentile | 75th Percentile | Best

Indicator	Period	Suffolk			Region England	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
The proportion of clients entering drug treatment identified as having a mental health treatment need, who were receiving treatment for their mental health.	2020/21	–	394	81.1%	74.0%	71.0%	46.5%		3%
The proportion of clients entering alcohol treatment identified as having a mental health treatment need, who were receiving treatment for their mental health.	2020/21	–	400	92.4%	83.5%	80.4%	55.8%		96.4%

Source: Office for Public Health and Disparities (was Public Health England). Severe mental illness: Public Health Profiles (Fingertips)[15]

A similar number (400, 92.4%) were in alcohol treatment with an identified mental health need and receiving treatment for their mental health (Table 3). This is the 7th highest percentage of any county/unitary authority in England and is again statistically higher/better than the national average[13].

The chapter on environmental factors and mental health provides information on other at risk groups, such as people who are homeless.

Evidence and further information

The following documents and supporting materials are useful sources of further information on this topic:

- the Mental Health Foundation's Fundamental facts about mental health 2016 gives a summary of mental health research including needs of particular groups
- the National Institute of Mental Health has published Chronic Illness and Mental Health: Recognizing and Treating Depression (2021) which looks at the impact of long term physical conditions on mental health

Equity of access

Social characteristics, such as gender, disability, age, race and ethnicity, sexual orientation and cultural attitudes influence access to support and services.

It is a legal requirement that access to mental health services should not be discriminatory on the basis of protected characteristics as defined by the Equality Act 2010[16]. Protected characteristics are:

- age
- disability
- gender reassignment
- marriage/civil partnership
- pregnancy
- race
- religion or belief
- sex
- sexual orientation

It is also illegal to discriminate directly or indirectly against people with mental illness in public services and functions. Mental illness is defined as a disability characteristic if the 'mental impairment has a substantial and long-term adverse effect on a person's ability to carry out normal day to day activities'[16].

Research and equalities policy has given significant attention to the disparities in access to, and experience of, mental health services according to ethnicity. People from black African and Caribbean backgrounds are disproportionately seen in the 'hard end' of services (for example, at the point of arrest) and are more likely to receive harsher or more coercive treatments[17] due to the 'eurocentricity' of service design, people from some ethnic minority communities struggle to access services in ways meaningful to them[18].

Detailed consideration of mental illness among ethnic minority groups will require local action. This is likely to include local community engagement work and assessing the use of local support services by ethnic group through direct contact with providers (social care, CQC, advocacy services, specialist mental health, IAPT).

For information on how the Equality Act 2010 relates to mental ill health and employment, please see the chapter on environmental factors and mental health.

Data sources - equity

Data on access to drug and alcohol treatment services by age, gender, ethnic group, religion, sexual orientation and disability can be found in the Drug and Alcohol Needs Assessment.

Evidence and further information - equity

The following documents and supporting materials are useful sources of further information on this topic:

- Public Health Matters: local action on health inequalities amongst ethnic minorities (2018) discusses understanding how ethnicity relates to inequality and health inequality and taking action to reduce ethnicity-based inequality.
- Race equality foundation and mental health providers forum: better practice in mental health for Black and minority ethnic communities (2015) gives examples of best practice from organisations and projects promoting and addressing issues around mental health in ethnic minority communities.
- Chief Medical Officer annual report: public mental health (2013) includes chapters on parity of esteem and on ethnic inequalities and social inclusion.

Health behaviours

Positive health behaviours, such as not smoking, a balanced diet, and engaging in physical activity, can encourage wellbeing, improve physical and mental health, and support recovery among people who are unwell. In addition to supporting individuals to make healthy choices, interventions should focus on providing environments which support adopting healthy behaviours.

Smoking remains the single biggest cause of preventable death and illness in England.

Alongside smoking, there are a number of other links between health behaviours and poor mental health[19]:

- poor mental health in childhood predicts unhealthy behaviours in adolescence

- eating healthy food, particularly fruit and vegetables, can positively affect mental as well as physical health
- physical activity can positively affect stress, self-esteem, anxiety, dementia and depression and is recommended in the treatment of depression[20]
- rates of obesity are higher among people with a mental health condition

Health behaviour, physical health and mental health are closely related. Each is a determinant and consequence of the other and all are underpinned by wider social factors. Mental health affects risk behaviours, including smoking, alcohol and drug use, higher-risk sexual behaviour, lack of exercise, unhealthy eating and obesity[21].

Risk behaviours cluster in particular groups. For example, low income and economic deprivation are associated with obesity and with smoking. This same population has the highest prevalence of anxiety and depression. Such clustering can lead to greater lifetime risk of poor mental health, as well as social, behavioural, financial, and general health problems[21].

Public health action to support healthy behaviour needs to recognise the wider role of social determinants. People's behaviour choices are highly influenced by the opportunities and influences within their living environment and social setting. Access to public parks and green space can support people to be physically active. Ensuring there is access to a diverse range of food in the local

Data sources – health behaviours

1 in 8 (13.2%) adults in Suffolk smoke. The percentage of adults smoking across different districts varies from 9.8% in Babergh to 22% in Ipswich, the latter of which is statistically significantly higher than the national average[22].

In Suffolk, smoking is associated with 1,280 hospital admissions and 178.9 deaths per 100,000 population every year (both statistically significantly better/lower than England)[22]. Smoking related illness kills 3 people every day in Suffolk[22].

Smoking rates in adults with depression are approximately twice as high as among adults without depression. In addition, people with depression can have particular difficulty when they try to stop smoking and have more severe withdrawal symptoms during attempts to give up[23]. Almost half of all tobacco is now consumed by people with a mental illness[24].

Suffolk has one of the lowest smoking rates amongst adults with a long term mental health condition in the East of England region (20.5%). Within the county, rates range from 14.7% in West Suffolk – the only district with a rate statistically significantly lower than the England average – to 22.9% in East Suffolk (similar to the national average)[25].

Excess weight and obesity are also considered risk factors for mental ill health. More than 3 in 5 (62.9%) adults in Suffolk are classified as overweight or obese, similar to the national average (63.5%)[25].

Ipswich has a statistically higher proportion of adults classified as overweight or obese (68.2%) than the England average[25], and in addition has the lowest percentage of physically active (at least 150 minutes a week) adults (49.4%; down from 58.6% in 2019/20) of all Suffolk districts[26]. In contrast, two thirds of adults in Babergh are physically active (67.1%)[26]. For additional information on physical activity, please see the chapter on environmental factors and mental health.

Evidence and further information – health behaviours

The following documents and supporting materials are useful sources of further information on this topic.

Mental Health Foundation's Physical health and mental health (2022) includes a summary of the relationship between health behaviours and mental health.

The National Institute for Health and Care Excellence (NICE) guidance (2021) Tobacco: preventing uptake, promoting quitting and treating dependence covers support to stop smoking for everyone aged 12 and over, and help to reduce people's harm from smoking if they are not ready to stop in one go. It also covers ways to prevent children, young people and young adults aged 24 and under from taking up smoking. It covers nicotine replacement therapy and e-cigarettes to help people stop smoking or reduce their harm from smoking.

Public Health England's (PHE) Smoking cessation in secondary care: mental health settings (2018) provides guidance and self-assessment framework for NHS mental health trusts to develop local action to reduce smoking prevalence and the use of tobacco.

National Centre for Smoking Cessation and Training (NCSCT)'s Smoking cessation and smokefree advice including mental health (2018) provides support, guidance and advice on smoking cessation and smokefree policies, including a number of briefings specific to mental health.

PHE's Vaping in England: an evidence update (2019) provides the latest evidence on the prevalence of vaping in adults and young people and the use of e-cigarettes in stop-smoking services.

UK Faculty of Public Health's Better mental health for all – relationship with physical health and healthy lifestyles (2022) provides evidence and information about the links between physical health, mental health and healthy lifestyles

Alcohol use and drugs

Harmful use of alcohol or drugs often contributes to or co-exists with mental ill health and leads to poorer outcomes. When people have co-existing conditions, it is important that they access relevant treatment in line with NICE and other national guidance. They should not be excluded based on their mental health or alcohol/drug use ('no wrong door' principle). It is important that people experiencing mental health crisis are not turned away from services due to intoxication.[27]

People with co-occurring mental health and alcohol/drug use conditions often have multiple needs, with poor physical health alongside social issues such as debt, unemployment, or housing problems. They are also more likely to be admitted to hospital, to self-harm, or die by suicide[28].

Alcohol is the third leading preventable cause of ill health after tobacco and hypertension[5], and in England, among people aged 15 to 49 years, it is the leading cause of ill health, and disability[29].

Drinking more than the low risk guidelines can harm mental and physical health. It can also lead to social problems, such as unemployment, divorce, domestic abuse, and homelessness[30].

Regular consumption of alcohol has been shown to cause mental ill health including depression, anxiety. People who use alcohol may be more likely to self-harm and have a higher risk of suicide[31]. Poor mental health can cause people to drink more, particularly as people may drink alcohol as a form of 'self-medication'.

People treated in the community for substance use may present with poor mental health. There are many factors associated with harmful alcohol and drug use. Drug use can cause social disadvantage, and social disadvantage may lead to drug use and dependence. Many are social factors, such as deprivation. Prevention and treatment interventions aiming to influence and treat drug and alcohol use should therefore consider the root causes of health and social harms. They must aim for broader interventions on the social determinants.

Alcohol and drug use contributes to wider social harms such as absenteeism, unemployment, domestic violence, family breakdown, child maltreatment, and public disorder.

Data sources - alcohol use and drugs

Nationally there is an estimated 589,000 people dependent on alcohol, with around a quarter of them anticipated to be taking medication for mental ill health, such as for anxiety, depression, sleep problems, bipolar disorder or psychosis[32]. Around half of individuals with a severe mental health disorder are affected by substance use, and 53% of substance users have at least one serious mental illness[33].

Local Data - - alcohol use and drugs

The Drug and Alcohol Health Needs Assessment was published in May 2022, covering a broad range of sources about substance use in the county, including a section on the mental health of substance users.

Evidence and further information - alcohol use and drugs

The following documents and supporting materials are useful sources of further information on this topic:

- NICE's Coexisting severe mental illness and substance misuse: community health and social care services (2016) "covers how to improve services for people aged 14 and above who have been diagnosed as having coexisting severe mental illness and substance misuse". The aim is to provide a range of coordinated services that address people's wider health and social care needs, as well as other issues such as employment and housing.
- PHE's Better care for people with co-occurring mental health, and alcohol and drug use conditions (2017) gives guidance on commissioning and providing better care for people with co-occurring mental health and alcohol and drug use conditions.
- PHE's JSNA support packs for alcohol, drug and tobacco use (2018) will help local areas to develop JSNAs and local joint health and wellbeing strategies, which effectively address public health issues relating to tobacco, drug and alcohol use.

Comorbidity in mental and physical illness

Mental and physical health is totally linked. Mental health and physical health are both determinants and consequences of each other.

There is a strong argument to integrate physical and mental health. There are 4 related challenges[34]:

- high rates of mental health conditions among people with long-term physical health conditions
- poor management of 'medically unexplained symptoms' which lack an identifiable organic cause

- reduced life expectancy among people with the most severe mental health conditions, largely attributable to poor physical health
- limited support for the wider psychological aspects of physical health and illness

On average, men with severe mental illness die 20 years earlier, and women die 15 years earlier, than the general population[21]. Compared with the general population people in contact with specialist mental health services have[21]:

- nearly 4 times the rate of deaths from diseases of the respiratory system
- just over 4 times the rate of deaths from diseases of the digestive system
- nearly 3 times the rate of deaths from diseases of the circulatory system

Much of the extra burden of poor physical health among those with mental ill health is linked to health behaviours such as smoking and alcohol. Other factors also play a part such as barriers to receiving adequate physical healthcare; less than a third of people with schizophrenia in hospital received the recommended assessment of cardiovascular risk in the previous 12 months[21].

NHS England is leading work to ensure that it meets the physical health needs of 280,000 more people living with severe mental illness by 2020 to 2021. This will be achieved by increasing early detection and expanding access to evidence based physical care assessment and intervention each year. Collaboration between public health, primary care and secondary care mental health services is crucial to realising this aim. This commitment was reaffirmed in the NHS Long Term Plan pledging £2.3 billion a year by 2023 to 2024 to invest with the ambition to increase the number of people receiving physical health checks.

It is important to also consider the mental health needs of people with long-term physical health conditions. Integrated care for physical health should include provision of psychological support, as failure to do so is associated with poorer outcomes and faster disease progression[34]. People with long term chronic conditions should receive psychological therapy support to improve their recovery[21].

The close relationship between mental health and physical health is strongly underpinned by the underlying social determinants of health, such as social deprivation. This is an important way in which inequalities are perpetuated[34] and a broad public health strategy should consider the role of these social determinants for the whole population.

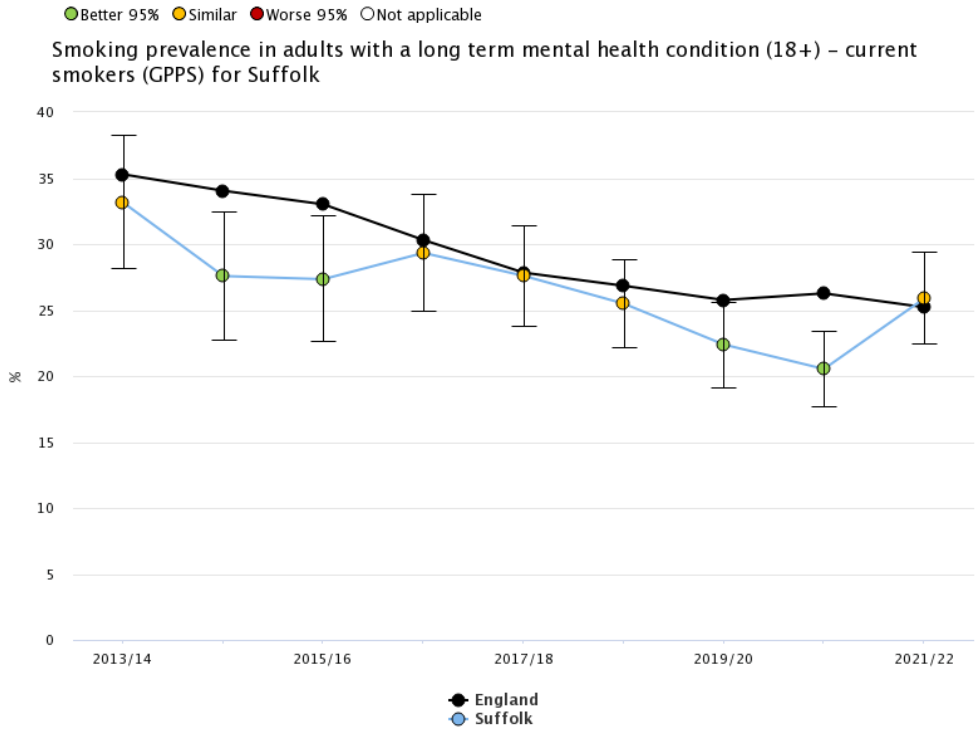
Data sources - comorbidity

Smoking was identified as a risk factor for mental ill health in an earlier section. Data from the Office for Health Improvement and Disparities (OHID) Mental Health and Wellbeing JSNA profile (Figure 1)[25] shows that a fifth (20.5%) of adults (aged 18 and over) with a long term mental health condition smoke (2020/21). This figure is statistically significantly lower than the national average (26.3%) and the second lowest proportion in the East of England region. Luton had the highest percentage in the region (33.3%)[25].

Compared to its CIPFA nearest neighbours (authorities that have been identified as similar) Suffolk had the lowest rate of rate of adults with a long term mental health condition that smoke. CIPFA nearest neighbours are groups of local authorities created by the Chartered Institute of Public Finance and Accountancy based on statistical similarity in 40 socio-economic measures. These comparisons can be more informative than comparisons with all authorities in England, for example where rurality may have an impact.

Since 2013/14 the proportion of adults in Suffolk with a long-term mental health condition who smoke has been falling (Figure 1)[25].

Figure 1: Smoking prevalence in adults with a long-term mental health condition, Suffolk and England, 2013/14 - 2020/21



Source: Office for Public Health and Disparities (was Public Health England). Severe mental illness: Public Health Profiles (Fingertips)[15]

Within Suffolk, proportions range from 14.7% in West Suffolk (statistically lower than England average) to 22.9% in East Suffolk (similar to the national average).

People with SMI, such as schizophrenia and bipolar disorder, are at a greater risk of poor physical health and have a higher premature mortality than the general population. People with SMI in England[35]:

- die on average 15 to 20 years earlier than the general population
- have 3.7 times a higher death rate for ages under 75
- experience a widening gap in death rates over time

It is estimated that 2 in 3 deaths in people with SMI are from physical illnesses that can be prevented. Major causes of death in people with SMI include chronic physical medical conditions such as cardiovascular, respiratory, diabetes and hypertension. In addition to chronic physical medical conditions, suicide is also an important cause of death in the SMI population (see section on Self-harm and suicide below)[35].

In 2018-20, 1,235 adults in Suffolk with a severe mental illness died prematurely, equivalent to a directly standardised rate of 71.1 per 100,000. This is the lowest rate in the East of England region and statistically significantly lower than the national average (103.6 per 100,000)[25]. Excess mortality in people in Suffolk aged under 75 years and with a severe mental illness is similar to the national average, with a flat trend in this measure over the last four years[36].

Evidence and further information - comorbidity

The following documents and supporting materials are useful sources of further information on this topic.

- NHS RightCare's Physical ill health and CVD prevention in people with severe mental illness toolkit was developed in collaboration with Public Health England. This toolkit provides expert practical advice and guidance to support system wide improvement to help improve physical health for people with severe mental illness and reduce health inequalities.
- NHS toolkit Improving the physical health of people with a serious mental illness: a practical toolkit includes detailed case studies at pilot sites, short examples and supporting documents.
- King's Fund's report Bringing together physical and mental health (2016) calls for integrated physical and mental healthcare. Provides examples of innovative service models and identifies areas where there is scope for improvement.
- PHE's Commissioning cost-effective services for promotion of mental health and wellbeing and prevention of mental ill health includes information on interventions to protect the mental health of people with poor physical health.
- PHE's Wellbeing in mental health: applying all our health (2017) gives examples to help healthcare professionals make interventions to encourage physical health and wellbeing in mental health.
- Health Matters: reducing health inequalities in mental illness (2018) is a professional resource focusing on some of the actions local areas can take to reduce physical health inequalities experienced by people living with mental illness.
- World Suicide Prevention Day 2019 is a study by the National Cancer Registration and Analysis Service exploring data in the risk of suicide after cancer diagnosis in patients, and the risk between the types of cancers which are considered preventable.

Suicide and self-harm

Every suicide should be seen as preventable. Gaining an understanding of local populations can aid development of an effective suicide prevention plan. For example, people with a history of self-harm are a high-risk group for suicide.

Suicide and self-harm are linked to mental distress[4]. Suicide is preventable, yet suicide rates in England have generally increased since 2007. Suicide is the biggest killer of men under 50 as well as a leading cause of death in young people and new mothers. On average, 13 people kill themselves nationally every day. The death of someone by suicide has a devastating effect on families, friends, workplaces, schools and communities, as well as an economic cost[37].

The cross-government prevention strategy identified 7 important areas for action[37]:

- reduce the risk of suicide in 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 those bereaved or affected by suicide
- support the media in taking a sensitive approach to suicide and suicidal behaviour
- support research, data collection and monitoring
- reduce rates of self-harm as a major indicator of suicide risk

People with a history of self-harm are a high-risk group and a priority for prevention. Some groups have higher rates of self-harm, including young people, particularly looked after children and care leavers, and lesbian, gay and bisexual people.

People who self-harm are at increased risk of suicide, although for many people self-harm is a coping mechanism and not a suicide attempt. Risk of suicide is particularly increased in those repeating self-harm and in those who have used violent/dangerous methods of self-harm[37].

Other groups identified as high risk for suicide are:

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

Data sources – suicide and self-harm

Data from the Office for Health Improvement and Disparities (OHID) Public Health Profiles show that hospital admissions as a result of self-harm in 15-24 year olds were particularly high in Suffolk, with Suffolk rates statistically significantly higher than the East of England average (Figure 2;Figure 3).

In 2021/22, Suffolk had the second highest rate of self-harm in 15-19 year olds in the East of England region (Figure 2) and was only one of three counties/unitary authorities within the region with a statistically significantly higher rate than England. There were 325 admissions in 15-19 year olds for self-harm in Suffolk in 2021/22.

Figure 2: Hospital admission rates as a result of self-harm in 15-19 year olds in East of England by local authority in 2021/22, compared to East of England average

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	20,675	641.7	633.0	650.5
East of England region	–	2,030	584.5	559.6	610.8
Peterborough	–	115	900.2	750.3	1,089.1
Suffolk	–	325	816.5	732.5	912.9
Cambridgeshire	–	290	758.3	673.5	850.8
Norfolk	–	325	694.5	623.0	776.5
Central Bedfordshire	–	90	595.7	490.9	746.8
Luton	–	80	524.7	410.2	645.8
Bedford	–	55	522.9	393.9	680.7
Thurrock	–	50	472.6	334.5	601.5
Hertfordshire	–	320	471.2	423.8	528.9
Southend-on-Sea	–	40	426.8	295.9	568.9
Essex	–	340	420.0	374.2	464.5

Source: Office for Public Health and Disparities (was Public Health England). Mental Health, Dementia and Neurology: Public Health Profiles (Fingertips)[38]

Compared to its CIPFA neighbours, Suffolk had the fifth highest rate of self-harm admissions in this age group: Somerset, Devon, Wiltshire, Gloucestershire, Derbyshire and Cambridgeshire also had rates that were statistically significantly above the national average.

Figure 3 shows hospital admission rates for self-harm in 20-24 year olds across the East of England region. Compared to the national average, Suffolk had a similar rate (only Southend on Sea had a statistically significantly higher rate than the national average) but as Figure 3 shows, Suffolk was

one of three counties than had a statistically significantly higher rate than the regional average. There were 140 admissions in 20-24 year olds for self-harm in Suffolk in 2021/22.

Figure 3: Hospital admission rates as a result of self-harm in 20-24 year olds in East of England by local authority in 2021/22, compared to East of England and England

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	11,615	340.9	334.7	347.1
East of England region	–	1,065	310.8	292.4	330.0
Southend-on-Sea	–	55	587.2	442.3	764.3
Norfolk	–	195	380.9	327.5	436.2
Thurrock	–	35	367.1	273.2	534.9
Suffolk	–	140	366.5	313.1	438.1
Bedford	–	35	350.7	261.0	511.1
Luton	–	50	324.4	252.0	442.4
Essex	–	235	301.8	263.2	341.6
Central Bedfordshire	–	40	285.8	198.2	381.0
Peterborough	–	30	258.0	188.2	388.5
Cambridgeshire	–	110	250.9	208.2	304.8
Hertfordshire	–	130	210.8	179.1	253.9

Source: Office for Public Health and Disparities (was Public Health England). Mental Health, Dementia and Neurology: Public Health Profiles (Fingertips)[38]

- These higher Suffolk rates were mostly as a result of increased levels of admissions coming from Ipswich and East Suffolk local authorities.
- Most of the higher rates of hospital admissions as a result of self-harm seen in children and young adults in Ipswich and East Suffolk come from ICD-10 codes associated with self-poisoning.
- Although the Waveney area of East Suffolk has higher rates than the area that was previously Suffolk Coastal, the rates are not statistically significantly higher.
- Not all drugs used in self-poisoning will have necessarily been prescribed (for example, aspirin, ibuprofen, and paracetamol).
- Suffolk Police have raised concerns about misuse of gabapentin and pregabalin.
- Note that these data only refer to hospital admissions and therefore will not show the whole picture of self-harm/injuries for those incidents where people are not admitted to hospital (that is dealt with in the community/primary care or where emergency attendances do not lead to admissions).

The findings of this analysis to some extent mirror trends in deaths from drug poisoning in Suffolk[39]:

- In 2021 Suffolk recorded its highest number of deaths from drug poisoning (n= 57) since records began in 1993.
- Compared to adjacent counties, only Suffolk recorded an increase in deaths (+13.1%) from drug poisoning between 2018-20 and 2019-21.

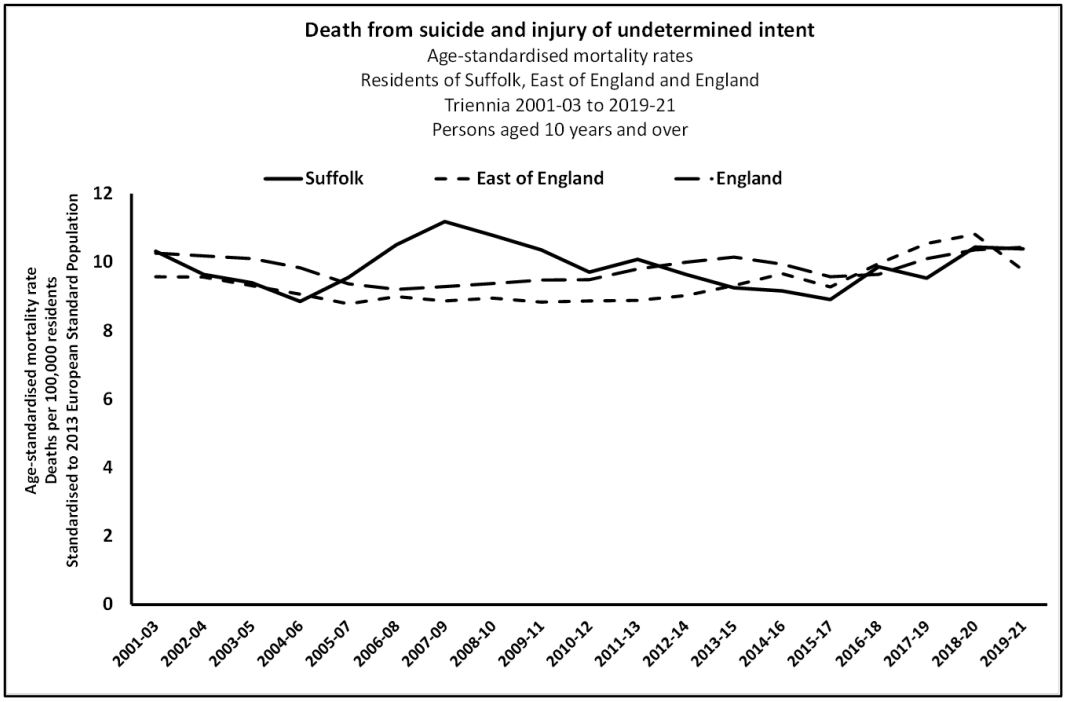
Findings of a study published in 2022[40] investigating "life problems" experienced by self-harming children and adolescents found that:

- Young people who self-harm face a range of life problems
- Detailed understanding of the nature of the problems faced by children and younger adolescents who self-harm is limited
- Family problems are significant for children and young people who self-harm
- Common life problems for young people who self-harm are social or interpersonal in nature
- Life problems vary by age, gender and whether self-harm is repeated
- Clinical supports and services for children and young people who self-harm should be embedded in community settings

- Life problems differ between children and younger adolescents compared with older adolescents, which should be accounted for in psychosocial assessments and recommended interventions

In 2019-21 Suffolk had a suicide rate of 10.4 per 100,000. This was not statistically different to the regional (9.8) or national averages (10.4) (Figure 4). This is also true of the suicide rate for both males (15.1 per 100,000) and females (6.0 per 100,000)[41].

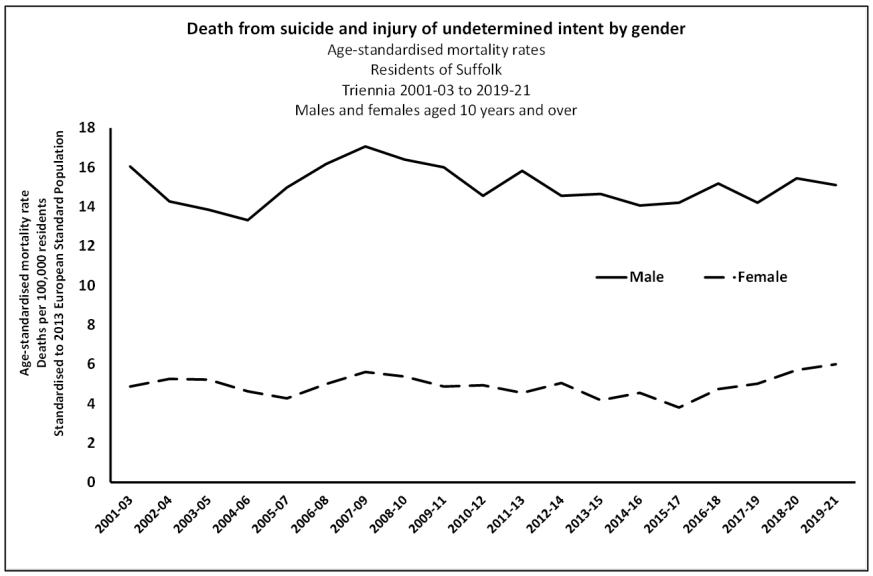
Figure 4: Deaths from suicide and injury of undetermined intent, age-standardised mortality rates, 2001-03 to 2019-21



Source: analysis of the Primary Care Mortality database[42]

However, Suffolk has the second highest suicide rate for females in the East of England region. In 2015-17 Suffolk's female suicide rate was 3.8 per 100,000, compared to 6.0 per 100,000 in 2019-21[41].

Figure 5: Deaths from suicide and injury of undetermined intent by gender, age-standardised mortality rates, 2001-03 to 2019-21



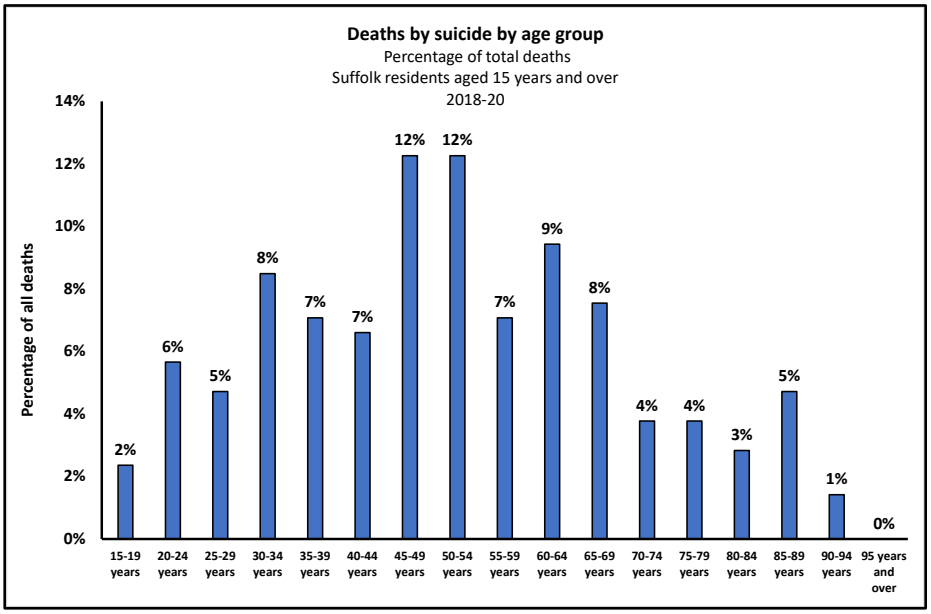
Source: analysis of the Primary Care Mortality database[42]

Local Data – suicide and self-harm

Data and trends on deaths by suicide in Suffolk can be found in the latest annual Suicide Audit, with some of the key points noted below:

- There were 210 deaths by suicide of Suffolk residents between 2018 and 2020; the average number per year over this period was 71 (68 between 2017 and 2019).
- The average age at death between 2018 and 2020 was 51 years (48 years in 2017-19). Almost two thirds of all deaths by suicide in 2018-20 were of people aged 45 years and over (Figure 6).

Figure 6: Deaths by suicide by age group, percentage of total deaths, Suffolk residents aged 15 and over, 2018-20



Source: analysis of the Primary Care Mortality database [42]

- Nearly three quarters (73%) of deaths from suicide in this same period were of males and just over a quarter (27%) were females.
- Rates of death by suicide at district and Integrated Neighbourhood Team (INT) level were similar to the county average. Saxmundham and North East INT had the highest age-sex standardised rate (20.9 per 100,000 population aged 15 and over).

The introduction of a Real-Time Surveillance System (RTSS) in Suffolk from April 2022 is enabling the capture of information on suspected suicide cases to inform timely suicide prevention interventions.

Evidence and further information – suicide and self-harm

The following documents and supporting materials are useful sources of further information on this topic.

- Local Government Association: Suicide prevention a guide for local authorities (2017) is a guide for local councils on their role in suicide prevention, including a range of approaches and case studies to inform decision making.
- National confidential inquiry into suicide and homicide by people with mental illness (2022) provides the latest data and makes recommendations for improving clinical practice and service delivery to prevent suicide and reduce risk.
- NICE's Preventing suicide in community and custodial settings (2018) is a quality statement around self-harm includes aspects of suicide prevention advice, particularly in the resource section (with particular reference to the use of risk assessments).
- PHE's Suicide prevention – resources and guidance (2020) support local authorities and healthcare professionals to develop a suicide prevention strategy and implement action to reduce suicides and improve support for those bereaved or affected by suicide.
- Samaritans' suicide statistics report provides details of England suicide rates (along with Wales, Scotland and the Republic of Ireland) and helps to understand and interpret suicide statistics

References

1. NICE. Glossary (H). *Nice* 1–3 (2018).
2. NHS Digital. Patients registered at a GP practice. https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/general-practice-data-hub/patients-registered-at-a-gp-practice (2019).
3. Mental Health Foundation. *Fundamental Facts about mental health 2016*. https://www.mentalhealth.org.uk/publications/fundamental-facts-about-mental-health-2016 (2016).
4. Davies, S. C. & Department of Health. *Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence*. https://www.gov.uk/government/publications/chief-medical-officer-cmo-annual-report-public-mental-health (2014).
5. Joseph Rowntree Foundation. Population turnover and area deprivation 2007.
6. Vostanis, P. Meeting the mental health needs of refugees and asylum seekers. *Br. J. Psychiatry* **204**, 176–7 (2014).
7. Office for Health Improvement and Disparities. Local Health - small area Public Health data.
8. Institute of Public Care. PANSI - Projecting Adult Needs and Service Information.
9. Institute of Public Care. POPPI - Projecting Older People Population Information.
10. Office for Health Improvement and Disparities. Learning Disability Profile. *Public Health*

Profiles https://fingertips.phe.org.uk/profile/learning-disabilities.

11. NICE: National Institute for Health and Care Excellence. *Mental health problems in people with learning disabilities: prevention, assessment and management Guidance and guidelines*. https://www.nice.org.uk/guidance/ng54 (2016).
12. Royal College of Nursing. *Provision of mental health care for adults who have a learning disability*. https://www.rcn.org.uk/professional-development/publications/pub-004445 (2014).
13. Office for Health Improvement and Disparities. Co-occurring substance misuse and mental health issues. (2022).
14. Office for Health Improvement and Disparities. Vaccines and immunisations - Child and Maternal Health . https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/1/gid/1938133237/ati/302/cid/4/tbm/1.
15. Office for Public Health and Disparities (was Public Health England). Severe mental illness: Public Health Profiles (Fingertips). https://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness.
16. *Equality Act 2010*. 251 (2010).
17. Bhui, K. Brexit, social division and discrimination: Impacts on mortality and mental illness? *Br. J. Psychiatry* **209**, 181–182 (2016).
18. S. L. Hatch, B. Gazard, D. R. Williams, S. Frissa, L. Goodwin, Selc. S. T. & M. H. Discrimination and common mental disorder among migrant and ethnic groups: findings from a South East London Community sample. *Soc. Psychiatry Psychiatr. Epidemiol.* **51**, 689–701 (2016).
19. Royal College of Psychiatrists. No health without public mental health.
20. Royal College of Psychiatrists. *Smoking and mental health: a joint report by the Royal College of Physicians and the Royal College of Psychiatrists 2013*. (2013).
21. The Mental Health Taskforce. The Five Year Forward View for Mental Health. 81 https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf (2016).
22. Office for Health Improvement and Disparities. Local Tobacco Control Profiles. *2022*.
23. Mental Health Foundation. Smoking and Mental Health. (2015).
24. Faculty of Public Health. Better Mental Health For All. (2016).
25. Office for Health Improvement and Disparities. Mental Health and Wellbeing JSNA. (2022).
26. Sport England. Active Lives Survey. https://activelives.sportengland.org/ (2018).
27. 3. Mental health: population factors - GOV.UK. https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/3-understanding-people.
28. NHS. Alcohol misuse.
29. Royal College of Psychiatrists. Alcohol and depression.
30. NHS Digital. Statistics on drug misuse, England (November update). (2018).
31. Delgadillo, J., Godfrey, C., Gilbody, S., Payne, S. Depression, anxiety and comorbid substance use: Association patterns in outpatient addictions treatment. *Ment. Heal. Subst. Use* **6**, 59–75 (2013).
32. UK Health Security Agency. Alcohol dependence and mental health. (2017).
33. HelpGuide. Dual Diagnosis: Substance Abuse and Mental Health. (2023).
34. Naylor, C. & Ross, S. Bringing together physical and mental health A new frontier for

integrated care. (2016).

35. Public Health England. *Technical supplement: Severe mental illness and physical health inequalities*. (2018).
36. Office for Health Improvement and Disparities. Mental Health and Wellbeing JSNA.
37. HM Government. Cross-government suicide prevention work plan (2019). (2019).
38. Office for Public Health and Disparities (was Public Health England). Mental Health, Dementia and Neurology. *Public Health Profiles* https://fingertips.phe.org.uk/profile-group/mental-health.
39. Office for National Statistics. Deaths related to drug poisoning by local authority, England and Wales.
40. Townsend, E. *et al.* Life problems in children and adolescents who self-harm: findings from the multicentre study of self-harm in England. *Child Adolesc. Ment. Health* **27**, 352–360 (2022).
41. Office for Health Improvement and Disparities. Suicide Prevention Profiles.
42. NHS Digital. Primary Care Mortality Database. https://digital.nhs.uk/services/primary-care-mortality-database.