Academic Health Science Network
North East and North Cumbria

NHS
North East Quality Observatory Service

Further analysis of self-harm in the North East and North Cumbria (NENC)

June 2023

Undertaken by:

North East Quality Observatory Service (NEQOS)

On behalf of:

AHSN NENC

BetterKnowledgeBetterCareBetterOutcomes

This report was created by NEQOS on behalf of the AHSN NENC.

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Report content

This report contains statistical analysis of suicides and of self-harm, including by method. Samaritans' guidelines were consulted during the preparation of this report.

1. Background

The cross-government Suicide prevention strategy for England was published in 2012, and five progress reports have subsequently been published. The latest highlights recent increases nationally in the number of registered suicides in England, with the suicide rate in 2019 being 10.8 per 100,000 people - a statistically significant increase compared to the 2016 rate of 9.5 per 100,000 people, affecting both males and females.

The suicide rate fell in 2020 in England and Wales, which ONS suggest was likely to have been driven by a decrease in male suicides at the start of the coronavirus pandemic, and delays in death registrations because of the pandemic. Although the 2021 suicide rate (10.7 per 100,000 population) was higher than 2020, it was lower than the rate in 2019 (11.0). ONS concluded that the suicide rate did not increase because of the coronavirus pandemic.

NICE defines self-harm as "when someone damages or injures their body on purpose, including taking an overdose of medication or other substances". NICE guideline [NG225] covers assessment, management and preventing recurrence for children, young people and adults who have self-harmed. It includes those with a mental health problem, neurodevelopmental disorder or learning disability and applies to all sectors that work with people who have self-harmed. Self-harm is an expression of personal distress and there is a significant and persistent risk of future suicide following an episode of self-harm.

Brennan et al.[1] identified two broad processes involved in reducing self-harm:

- 'Breaking the chain': strategies to manage immediate thoughts and feelings
- 'Building a new foundation for change': strategies that included longer-term mechanisms.

The authors concluded that work to reduce self-harm requires a move away from the predominance of clinical interventions to those with a more societal focus.

The NEQOS Population Health & Healthcare Surveillance report, delivered in March 2022, presented an analysis of suicide in the NENC. This was updated and expanded in the Analysis of suicide and self-harm across the NENC report, which incorporated an analysis of hospital admissions as a result of self-harm, including breakdowns by age, sex and level of deprivation of area of residence. This further analysis report builds on the existing NEQOS reports, providing more information on hospital activity as a result of self-harm in the NENC as well as other mental health care activity designed to prevent self-harm and suicide.

[1] Brennan, CA, Crosby, H, Sass, C, Farley, KL, Bryant, LD, Rodriquez-Lopez, R, et al. What helps people to reduce or stop self-harm? A systematic review and meta-synthesis of first-hand accounts. J Public Health. 24 Feb 2022. Available from: https://doi.org/10.1093/pubmed/fdac022

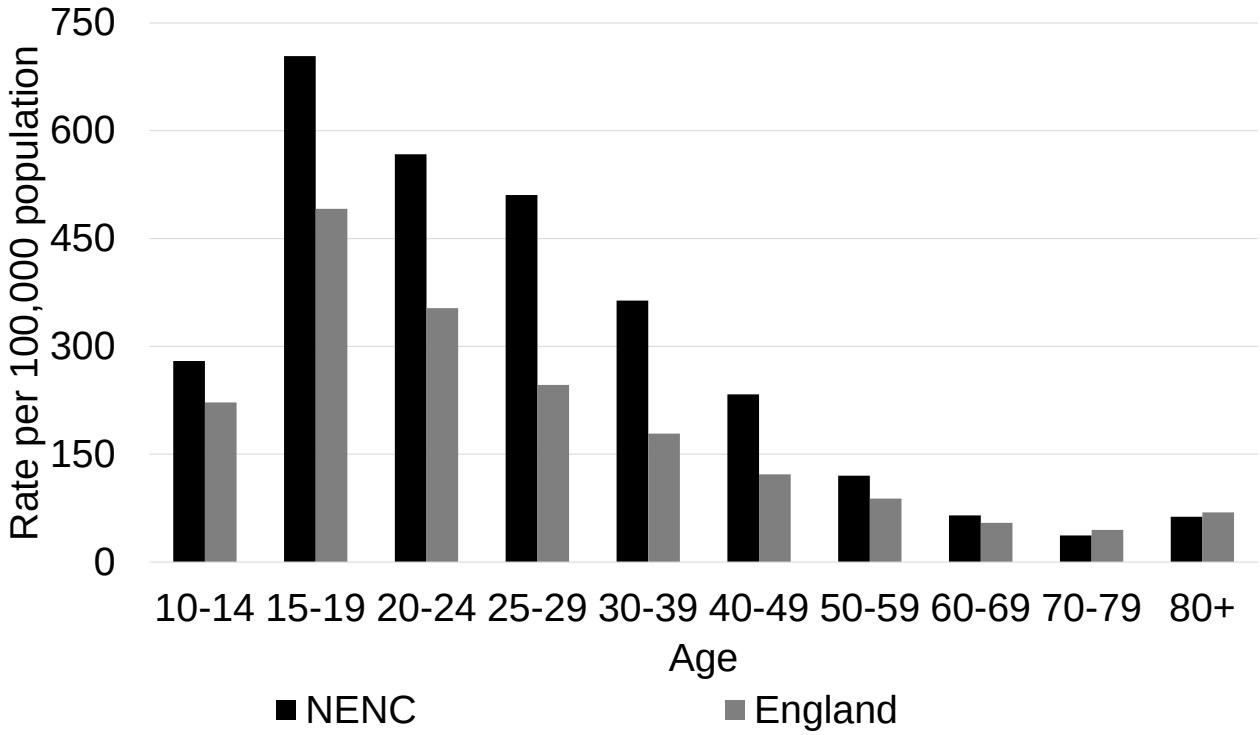
2. A&E attendances as a result of self-harm

In 2021/22 there were 6,815 A&E attendances by residents of the NENC as a result of self-harm. 19.7% of these arrived by ambulance, in comparison with 14.0% nationally for the same period. 20.9% of A&E attendances for all causes combined nationally arrive by ambulance[2].

2.1. A&E attendances by age

Figure 1 shows that the highest rates of A&E attendances in the NENC and in England are for those aged 15 to 19 years. Rates then fall as age increases, although those aged 80 and over have slightly higher rates of A&E attendances as a result of self-harm than those in their seventies. For every age band considered other than for those in their seventies, A&E attendance rates in the NENC are higher than rates in England as a whole.

Figure 1: A&E attendance rates by age band, 2021/22, NENC and England



Source: Hospital Episode Statistics (HES) datasets are accessed via the Data Access Environment, and re-used with the permission of NHS Digital. Copyright © 2023, NHS Digital. All rights reserved.

[2] Hospital Accident & Emergency Activity 2021-22, Official statistics, NHS Digital.

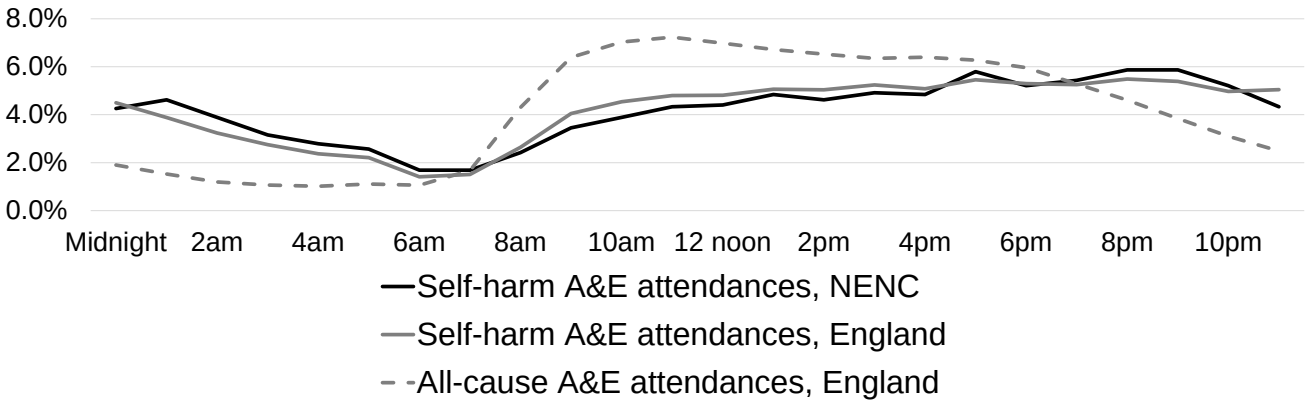
2.2. A&E attendances by day of week

In 2021/22, the most common day of the week for A&E attendances as a result of self-harm was Monday: 15.3% of NENC attendances and 15.9% of attendances nationally were on a Monday. This was also the case for A&E attendances for all causes combined, where 15.8% of all attendances were on a Monday, the most common day[2]. The least common day for attendances as a result of self-harm was Friday: 12.9% of NENC and 13.4% of the national attendances. Saturday was the least common day for A&E attendances for all causes combined.

2.3. A&E attendances by time of day of arrival

In 2021/22, between 5pm and 10pm was the most common time of day to attend A&E as a result of self-harm. 28.2% of all NENC attendances and 26.9% nationally were during this time. Between 4am and 9am were the least common times. Figure 2 shows A&E attendances as a result of self-harm by time of day, in comparison with A&E attendances for all causes combined, and shows that A&E attendances as a result of self-harm were more likely than A&E attendances for other reasons to be during the evening and the night.

Figure 2: Proportion of total A&E attendances by hour of arrival, 2021/22, NENC and England



Sources: (1) Self-harm A&E Attendances: Hospital Episode Statistics (HES) datasets are accessed via the Data Access Environment, and re-used with the permission of NHS Digital. Copyright © 2023, NHS Digital. All rights reserved. (2) All-cause A&E attendances: Hospital Accident & Emergency Activity 2021-22, Official statistics, NHS Digital.

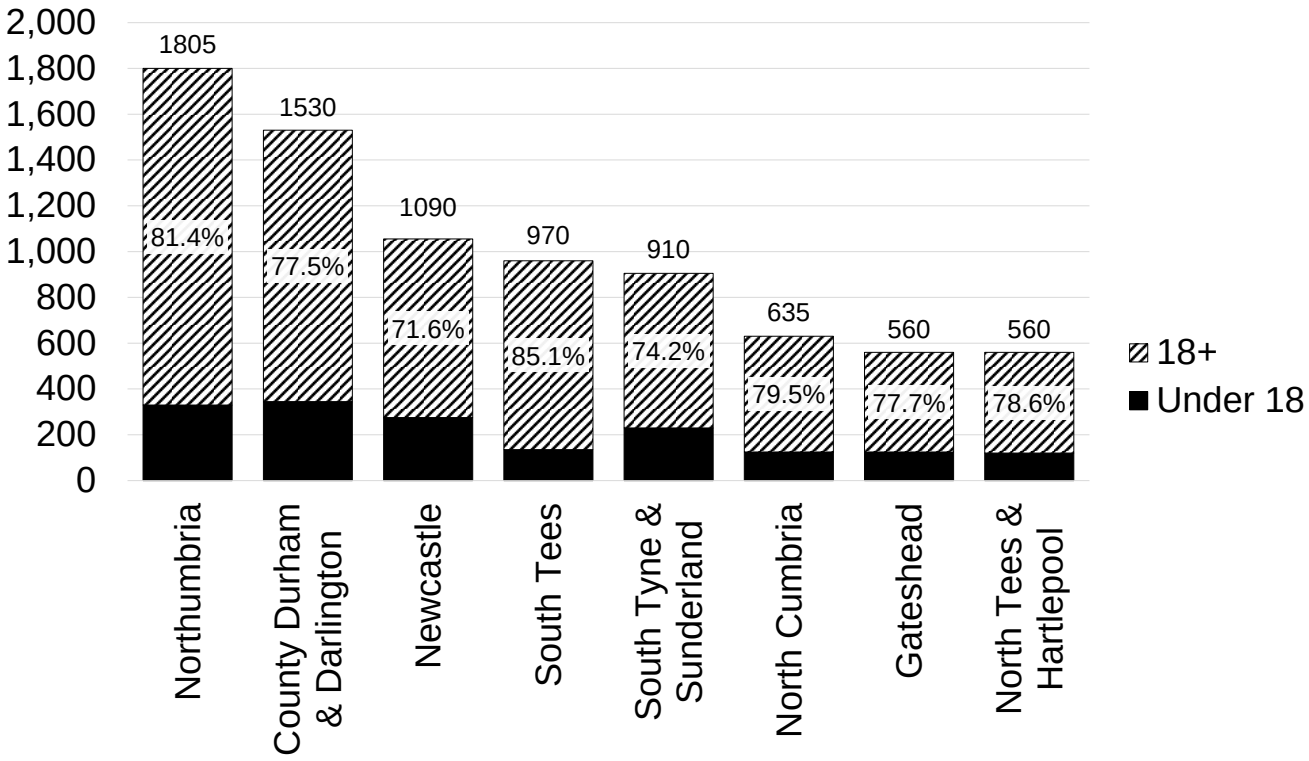
3. Hospital admissions as a result of self-harm

Hospital admissions as a result of self-harm are used in this section as a proxy of the prevalence of severe self-harm, but do not represent the full burden of self-harm. Any indicator based on hospital admissions may be influenced by local variation in referral and admission practices as well as variation in incidence or prevalence. In 2021/22 there were 7,600 admissions as a result of self-harm for residents of the NENC, and the North East region has the highest rates of all English region.

3.1. Hospital admissions (counts) by admitting trust

Figure 3 shows the number of emergency admissions as a result of self-harm to each NENC acute trust. Northumbria admitted the most patients following self-harm in 2021/22. However, Newcastle had the highest proportion of admissions of under 18s, with 28.4% of its 1,090 admissions being of children and young people.

Figure 3: Self-harm hospital admissions (counts), 2021/22, by admitting acute trust*, NENC



Source: Hospital Episode Statistics (HES) datasets are accessed via the Data Access Environment, and re-used with the permission of NHS Digital. Copyright © 2023, NHS Digital. All rights reserved.

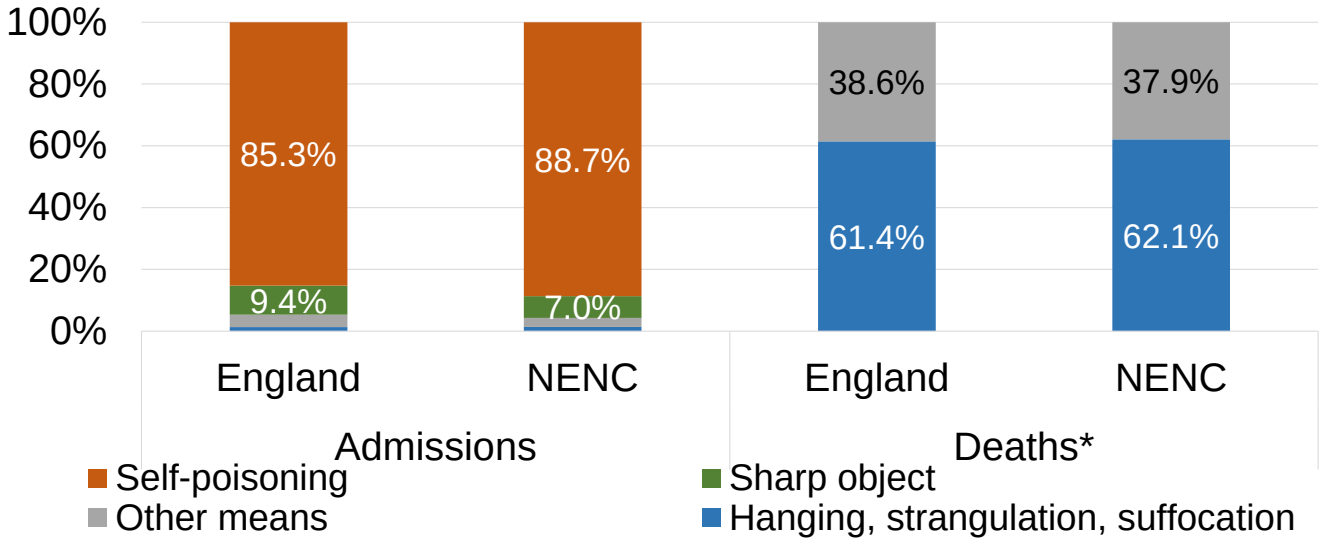
**Note: Admissions will vary based on local population and variations in pathways and thresholds. Chart shows all admissions to the acute trusts, not limited to residents of the NENC.*

3.2. Hospital admissions by method of self-harm

Figure 4 shows the proportion of emergency admissions as a result of self-harm, for the main methods of self-harm, in comparison to deaths as a result of suicide. The most common method for those admitted to hospital as an emergency is self-poisoning, with 88.7% of all self-harm admissions in NENC and 85.3% of all self-harm admissions in England as a result of self-poisoning[3], with a very small proportion as a result of hanging, strangulation or suffocation. However, when considering deaths by suicide, hanging, strangulation or suffocation are the most common methods, with 62.1% of all suicides in NENC and 61.4% of all suicides in England as a result of these causes.

Numbers were too small to show deaths by any cause other than 'hanging, strangulation, suffocation' for NENC, so these are combined with 'Other' in Figure 4 (detail for England is shown in Table 1).

Figure 4: Self-harm hospital admissions (2021/22) and deaths (2021), by self-harm method, NENC and England



Sources: (1) Self-harm hospital admissions: Hospital Episode Statistics (HES) datasets are accessed via the Data Access Environment, and re-used with the permission of NHS Digital. Copyright © 2023, NHS Digital. All rights reserved. (2) Deaths as a result of self-harm: Life events dataset, mortality statistics. Nomis - Official Labour Market Statistics.

** Deaths as a result of self-poisoning, sharp object and other means combined.*

[3] Please note that these findings relate only to those admitted to hospital as a result of self-harm; other methods of self-harm may be more common in the general population or in specific subgroups but not commonly require hospital admission. In addition, certain self-harm behaviours such as alcohol misuse may be less likely than others to be recognised and recorded as self-harm in hospital records.

Table 1: Self-harm hospital admissions (2021/22) and deaths (2021), by self-harm method, NENC and England

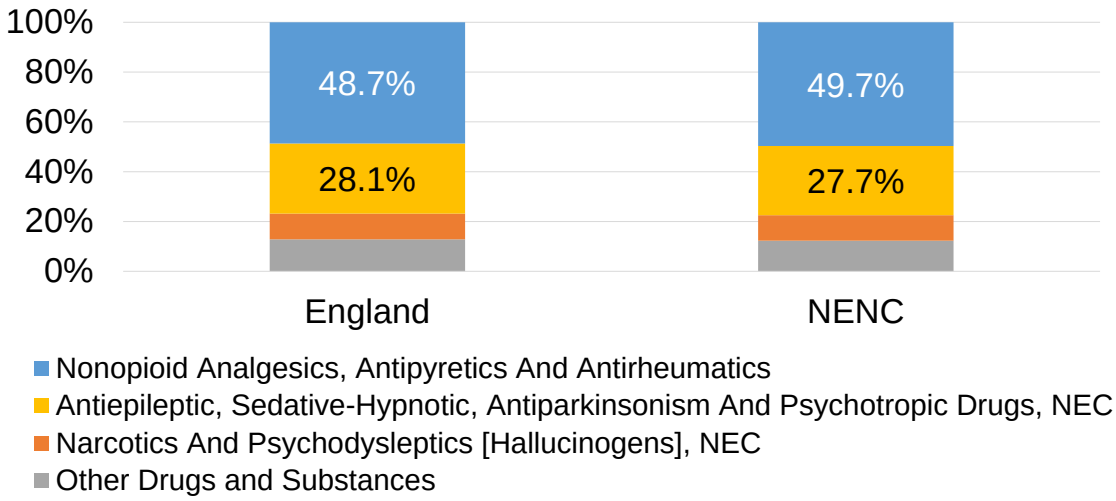
Method	Admissions		Deaths	
	England	NENC*	England	NENC
Self-poisoning	80,566	6,740	921	130
Sharp object	8,892	535	165	
Other means	3,790	220	718	
Hanging, strangulation, suffocation	1,244	105	2,874	213

Sources: (1) Self-harm hospital admissions: Hospital Episode Statistics (HES) datasets are accessed via the Data Access Environment, and re-used with the permission of NHS Digital. Copyright © 2023, NHS Digital. All rights reserved. (2) Deaths as a result of self-harm: Life events dataset, mortality statistics. Nomis - Official Labour Market Statistics.

** Note: admissions for NENC are rounded to the nearest 5*

As shown in Figure 4 and Table 1, self-poisoning is the most common method of self-harm when considering hospital admissions. Figure 5 shows self-poisoning by substance, and shows that for England and for the NENC, just under half of all self-poisonings which lead to hospital admission are from nonopioid analgesics, antipyretics and antirheumatics, and just over one quarter are from antiepileptic, sedative-hypnotic, anti-parkinsonism and psychotropic drugs.

Figure 5: Self-poisoning hospital admissions, 2021/22, by substance, NENC and England



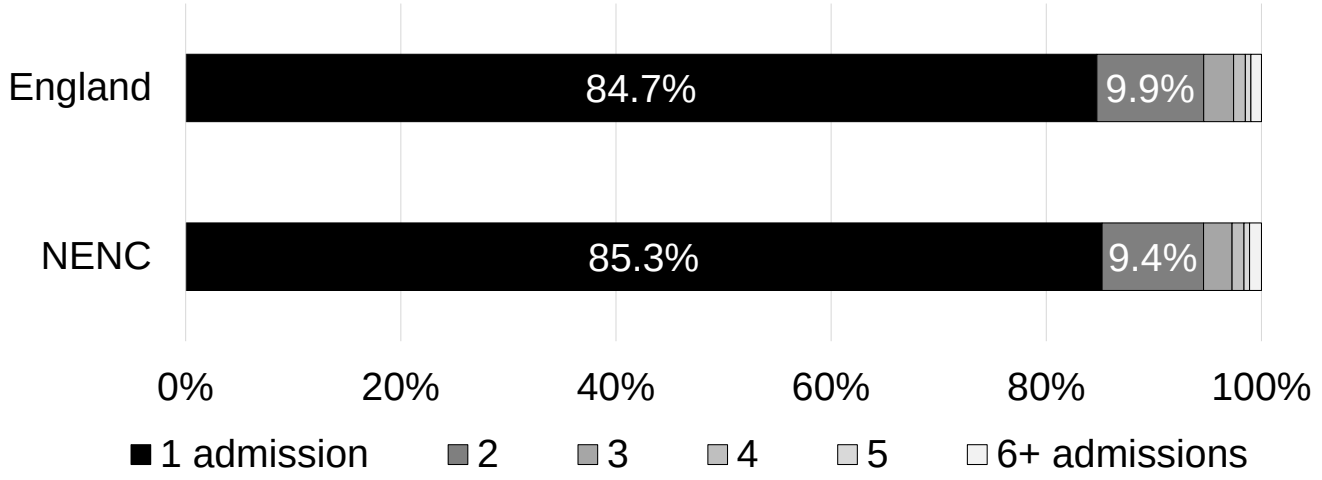
Source: Hospital Episode Statistics (HES) datasets are accessed via the Data Access Environment, and re-used with the permission of NHS Digital. Copyright © 2023, NHS Digital. All rights reserved.

3.3. Frequency of admissions

In 2021/22 there were 7,600 admissions as a result of self-harm in the NENC relating to 5,835 individuals: those admitted at any point in the year had an average of 1.3 admissions in the year.

Figure 6 shows that the majority (85.3%) of people admitted as a result of self-harm in the NENC were admitted only once in the year, and this is similar for England as a whole.

Figure 6: Frequency of self-harm admissions in 2021/22, for those admitted at any point in the year, England and NENC



Source: Hospital Episode Statistics (HES) datasets are accessed via the Data Access Environment, and re-used with the permission of NHS Digital. Copyright © 2023, NHS Digital. All rights reserved.

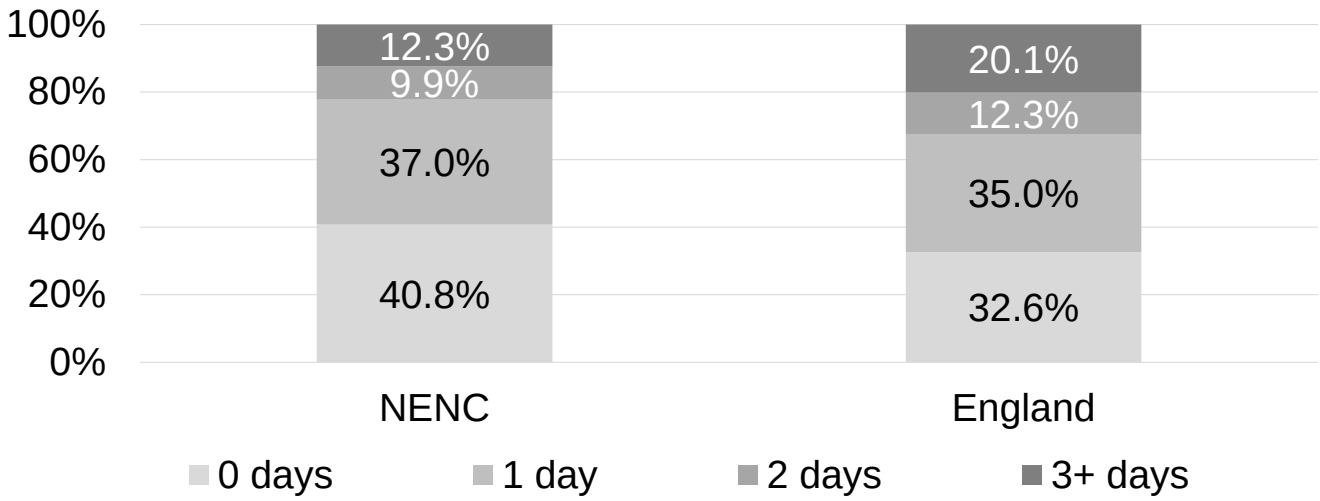
3.4. Time between admissions

As shown in Figure 6, the majority of admissions as a result of self-harm in 2021/22 were of people who were admitted only once in the year. However, of the small group admitted more than once (shown in the shades of grey on Figure 6), most were admitted exactly two times in 2021/22. For this group who had two admissions, 31.3% had their second admission before 30 days of discharge from the first admission in NENC and 27.0% nationally. A further 14.3% in the NENC and nationally had their second admission between 30 and 59 days following discharge, suggesting an opportunity for intervention following any self-harm admission.

3.5. Length of stay following admission as a result of self-harm

40.8% of those admitted as a result of self-harm in the NENC were discharged on the same day, compared with only 32.6% nationally. Only 12.3% of those admitted as a result of self-harm in the NENC were in hospital for three days or longer, compared with 20.1% of those nationally.

Figure 7: Length of stay following admission as a result of self-harm in 2021/22, England and NENC



Source: Hospital Episode Statistics (HES) datasets are accessed via the Data Access Environment, and re-used with the permission of NHS Digital. Copyright © 2023, NHS Digital. All rights reserved.

Note: there is likely to be variation in management and recording of activity between different trusts

3.6. Admissions of patients with a long-term condition

Singhal et al.[4] studied the association between chronic physical illnesses and self-harm, using linked hospital records from 1999 to 2011. They found significantly increased risk of self-harm was associated with epilepsy (with a risk ratio of between 2.8–2.9), asthma (1.8–1.9), migraine (1.7–1.8), psoriasis (1.5–1.7), diabetes mellitus (1.5–1.6), eczema (1.3–1.5) and inflammatory polyarthropathies (1.3–1.4). Risk ratios were significantly low for cancers (0.93–0.97), congenital heart disease (0.8–0.9), ulcerative colitis (0.7–0.8), sickle cell anaemia (0.6–0.8) and Down's syndrome (0.1–0.2). They also found that epilepsy, asthma,

[4] Singhal A, Ross J, Seminog O, Hawton K, Goldacre MJ. Risk of self-harm and suicide in people with specific psychiatric and physical disorders: comparisons between disorders using English national record linkage. J R Soc Med. 2014 May;107(5):194-204. doi: 10.1177/0141076814522033. PMID: 24526464; PMCID: PMC4023515.

eczema and cancers had a statistically significant increase in risk of suicide compared to the reference cohort.

In the NENC, 3.9% of those who had ever been admitted with epilepsy[5] between April 2017 and November 2022 also had a record of admission as a result of self-harm during that period, compared with 3.2% of those in England as a whole.

Considering the group of patients who had ever been admitted with epilepsy, asthma or diabetes[6] as a whole during the period, 2.0% of those in NENC also had a record of admission as a result of self-harm. In England, this was 1.6%.

Please note the figures shown relate to hospital admissions where the long-term condition was recorded on the patient's record, however:

- There may be individuals admitted as a result of self-harm who have these conditions, but have not required a hospital admission during which their long-term condition was included on their record.
- There may be self-harm in groups of patients with these long-term conditions which does not result in hospitalisation, and are therefore not reflected here.
- Conversely, there may be **no** significantly increased self-harm rates in those patients with the long-term conditions considered that are able to be well-controlled and therefore do not require hospitalisation.

3.7. Admissions of patients as a result of self-harm with mental and behavioural disorders due to psychoactive substance use

35.9% of those admitted as a result of self-harm in the NENC in 2021/22 also had a diagnosis of a mental and behavioural disorders due to psychoactive substance use on their hospital record[7]. This was the case for 31.6% of patients nationally.

[5] A diagnosis of G40: 'Epilepsy' or G41: 'Status epilepticus' in any diagnosis position on admission records during the period for any reason.

[6] A diagnosis of epilepsy, as above, or J45: 'Asthma', J46: 'Status asthmaticus', E10: 'Insulin-dependent diabetes mellitus' or E11: 'Non-insulin-dependent diabetes mellitus' in any diagnosis position on admission records during the period for any reason.

[7] A diagnosis of F10-F19 'Mental and behavioural disorders due to psychoactive substance use' in any diagnosis position on the self-harm admission record.

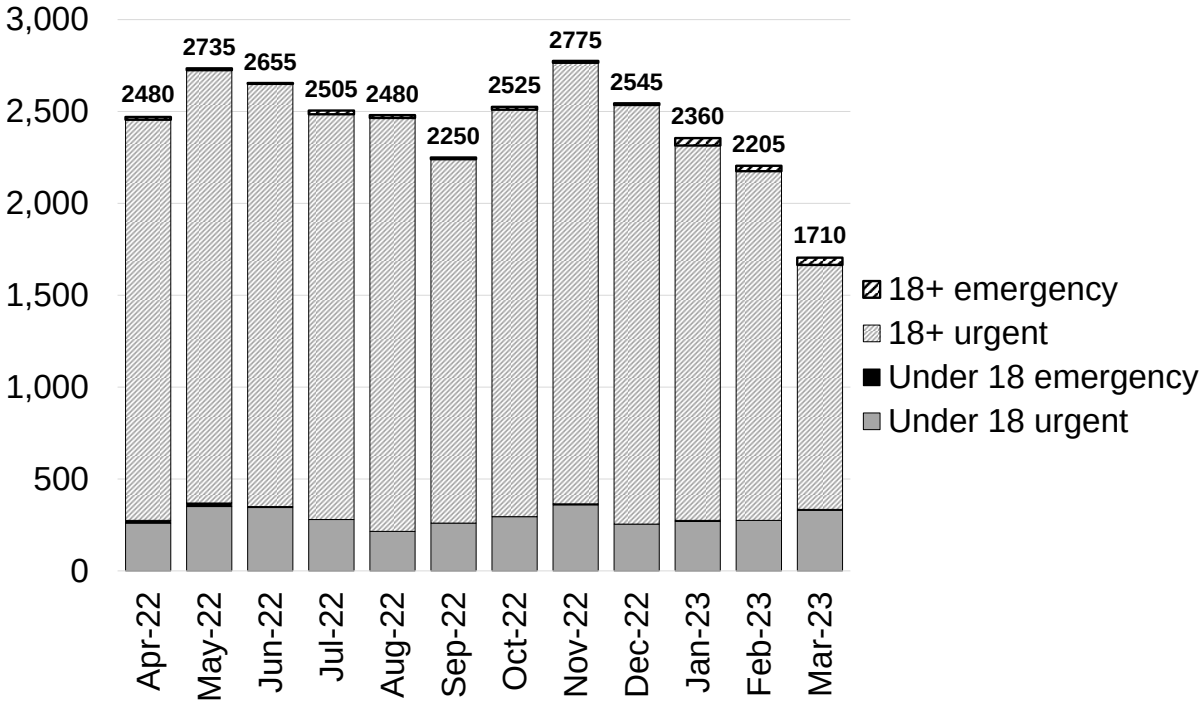
4. Referrals to crisis care teams

The NHS Long Term Plan sets an ambition for more comprehensive crisis pathways in every area that are able to meet the continuum of needs and preferences for accessing crisis care, whether it be in communities, people's homes, emergency departments, inpatient services or transport by ambulance.

4.1. Referrals received by mental health trusts

In March 2023, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust received 1,710 urgent or emergency referrals to crisis care; Tees, Esk and Wear Valleys NHS Foundation Trust received 1,905. Figures 8 and 9 show the numbers of referrals monthly for the two mental health trusts in the NENC.

Figure 8: Count of urgent and emergency referrals to mental health crisis care, April 2022 – March 2023, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

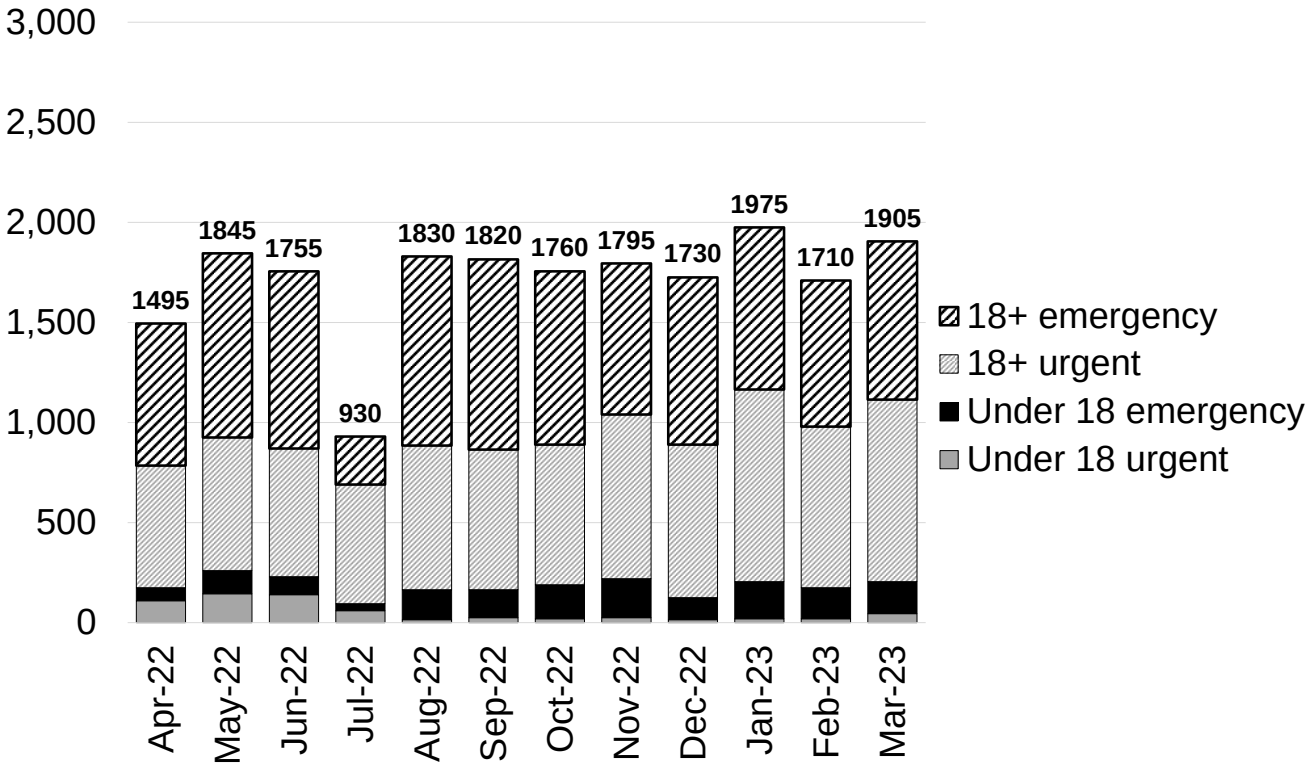


Source: Mental Health Services Monthly Statistics (indicators CCR70 and CCR71), NHS Digital. All rights reserved.

Note: figures are reported separately for urgent (CCR71) and emergency (CCR70) referrals and are rounded to the nearest 5 in the source. These rounded figures have been summed to provide the totals shown in the chart above.

Note the final recommendations on the mental health access standards were published in July 2021.

Figure 9: Count of urgent and emergency referrals to mental health crisis care, April 2022 – March 2023, Tees, Esk and Wear Valleys NHS Foundation Trust



Source: Mental Health Services Monthly Statistics (indicators CCR70 and CCR71), NHS Digital. All rights reserved.

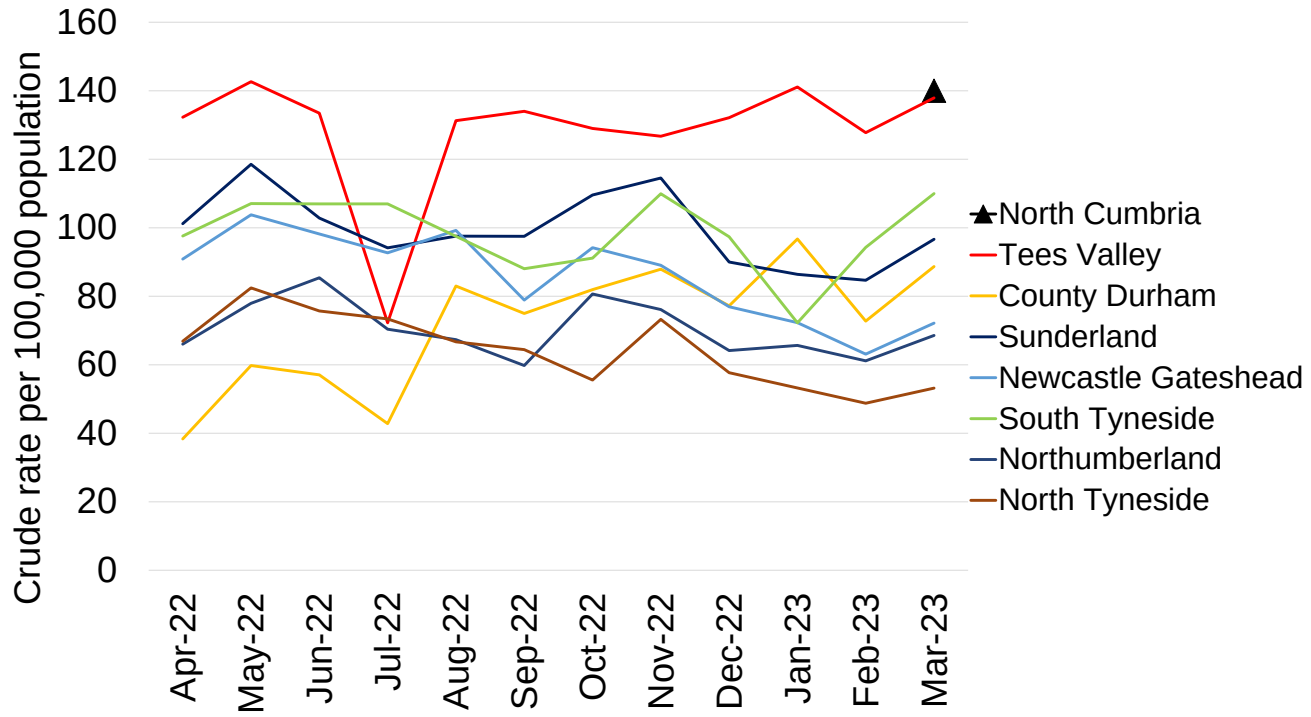
Note: figures are reported separately for urgent (CCR71) and emergency (CCR70) referrals and are rounded to the nearest 5 in the source. These rounded figures have been summed to provide the totals shown in the chart above.

Note the final recommendations on the mental health access standards were published in July 2021.

4.2. Rates of referrals of patients by sub-ICB locality

Figure 10 presents urgent and emergency referrals (combined) of residents of each sub-ICB locality in NENC by month, as a rate per 100,000 total population. It shows that the Tees Valley tends to have the highest rate of referrals (with North Cumbria appearing to have a similar rate in March 2023). In March 2023, the rates in the NENC localities varied from 53.2 per 100,000 population in North Tyneside in March 2023 to 137.9 per 100,000 population in Tees Valley and 140.0 per 100,000 population in North Cumbria.

Figure 10: Rate of urgent and emergency referrals to mental health crisis care, April 2022 – March 2023, sub-ICB locality in NENC



Source: Numerator: Mental Health Services Monthly Statistics, NHS Digital. All rights reserved. Denominator: Patients Registered at a GP Practice monthly statistics, NHS Digital.

Note: figures are reported separately for urgent (CCR71) and emergency (CCR70) referrals and are rounded to the nearest 5 in the source. These rounded figures have been summed for the chart. Data pre-July 2022 was reported for CCGs.

Figures for North Cumbria prior to March 2023 not shown as appeared anomalous. March 2023 shown by a black triangle.

5. Maternal mental health

NHS England defines perinatal mental health (PMH) problems as those which occur during pregnancy or in the first year following the birth of a child. Perinatal mental illness affects up to 27% of new and expectant mums and covers a wide range of conditions. If left untreated, mental health issues can have significant and long-lasting effects on the woman, the child, and the wider family. Specialist PMH services provide care and treatment for women with complex mental health needs and support the developing relationship between parent and baby. The NHS Long Term Plan builds on the commitments outlined in the Five Year Forward View for Mental Health to transform specialist PMH services across England, and NHS England aims to ensure that by 2023/24, at least 66,000 women with moderate or complex to severe PMH difficulties can access care and support in the community.

The Maternal, Newborn and Infant Clinical Outcome Review Programme found that women were three times more likely to die by suicide during or up to six weeks after the end of pregnancy in 2020 compared to the 2017 – 2019 report. Maternal suicide was also a leading cause of death in women between six weeks and a year of their pregnancies ending, accounting for 18% of the women who died between 2018 and 2020. At least half of the women who died by suicide and the majority from substance misuse had multiple adversity with a history of childhood and/or adult trauma frequently reported.

5.1. Mental health assessment and support in the perinatal period

5.1.1. Opportunities for mental health assessment and support in early pregnancy

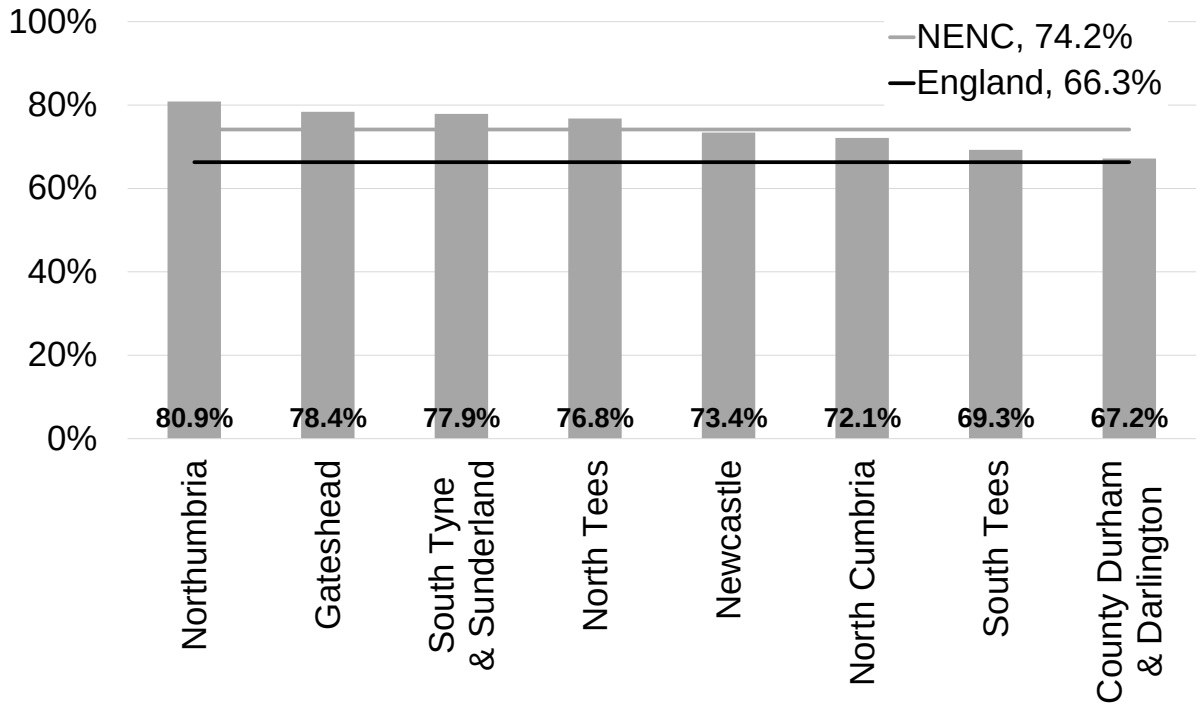
NICE guidance states that women should be offered a first antenatal (booking) appointment with a midwife to take place by 10 weeks of pregnancy. At the booking appointment, the women should be asked about previous or current mental health concerns such as depression, anxiety, severe mental illness, psychological trauma or psychiatric treatment[8], to identify possible mental health problems. Early identification of mental health risks enables women to be supported, and inadequate use of antenatal care has been shown to be strongly independently associated with increased odds of maternal death[9].

[8] The fact the questions were asked (but not their outcome) is required to be submitted to the Maternity Services Dataset, but is not reported nationally.

[9] Nair, M., et al. (2015). Factors associated with maternal death from direct pregnancy complications: a UK national case-control study. BJOG 122(5): 653-662.

Figure 11 shows that in the NENC, 74.2% of women had 'booked' by their 10th week of pregnancy. This ranged from 67.2% in County Durham and Darlington to 80.9% in Northumbria. In England as a whole, only 66.3% of women had booked by their tenth week of pregnancy.

Figure 11: Early access to maternity care: proportion of women giving birth whose first antenatal appointment with a midwife took place by 10+0 weeks of pregnancy, 2021/22, acute trust in NENC



Source: NHS Maternity Statistics, England - 2021-22, NHS Digital. All rights reserved.

There are known inequalities in early access to maternity care nationally[10], with the following groups of women less likely to book by 10 weeks of pregnancy:

- Women from minority ethnic groups
- Women living in more deprived areas
- Younger (under 25 years) and older (over 35 years) women
- Women with complex social factors[11]
- Women experiencing a subsequent (rather than their first) pregnancy

[10] Child and Maternal Health - Data - OHID (phe.org.uk)

[11] Complex social factors include alcohol or drug misuse, recent migrant or asylum seeker status, difficulty reading or speaking English, aged under 20, domestic abuse. Pregnancy and complex social factors [CG110]

5.1.2. Opportunities for mental health assessment and support in late pregnancy

Health visitors and their teams play a key role in supporting maternal and family mental health. The Healthy Child Programme includes five mandated visits, one antenatally, and four before the child turns 2½. At the antenatal and new baby mandated reviews, the health visitor will complete a holistic needs assessment, and ask screening questions for depression and anxiety in line with National Institute of Clinical Excellence (NICE) Quality Standard [QS115] Antenatal and Postnatal mental health. If required, health visitors can arrange access to other specialist services and voluntary sector agencies and working in partnership with these services. Despite mandation, coverage of these visits is not universal, and are subject to inequalities.

According to health visitor service delivery metrics official statistics (experimental), between April 2021 to March 2022, 16,536 pregnant women in the North East region had a face-to-face contact with a health visitor in the third trimester of their pregnancy (antenatal review). While the official statistics do not present this as a metric, it suggests that about 66% of those in the region who might be expected to be eligible[12] are receiving the antenatal review, with the North East being the highest of all English regions, and higher than England as a whole (approximately 34%). In Cumbria as a whole, 465 women had their antenatal review, suggesting only about 11% of those eligible received the review. There are inequalities in which groups receive antenatal reviews, and therefore inequalities in opportunities for mental health assessment and support antenatally. Characteristics of children receiving universal health visitor reviews uses experimental analysis of the Community Services Dataset (CSDS) to describe these inequalities, nationally and for NHS regions:

- Nationally, there are significantly decreased odds of receiving an antenatal review[13] associated with being in Asian or Black ethnic groups, and the same is true for the North East and Yorkshire region.
- Nationally, the receipt of an antenatal review is associated with deprivation (considering national deprivation deciles where 1 is the most deprived and 10 the most affluent). There are decreased odds of receiving a review[13] associated with living in more deprived areas, with the exception of those living in the most deprived areas (decile 1), where there appears to be a protective effect. This is not the case in the North East and Yorkshire region, where there appears to be no association with

[12] Using ONS maternities for 2021 as a denominator, see details below Figure 9.

[13] Being classed as having received a review is subject to having received and accepted an offer of a review, attending the review, accurate local recording and accurate submission to the CSDS.

deprivation, with the exception of significantly decreased odds of receiving a review associated with living in the most affluent areas (decile 10). The reason for this finding is unclear, but may, for example, reflect women using private antenatal care.

5.1.1. Opportunities for mental health assessment and support postnatally

Coverage of the new birth visit is reported as a metric in the official statistics, using infants turning 30 days in the period as the denominator. In the North East region, 98.4% of infants received a new birth visit (97.4% in England), and only two areas (Hartlepool and Stockton-on-Tees) were below 95% (Hartlepool 93.9%, Stockton 92.2%). In Cumbria as a whole 97.1% of infants received a new birth visit.

However there are inequalities in which groups receive new birth visits, and therefore inequalities in opportunities for mental health assessment and support postnatally. Characteristics of children receiving universal health visitor reviews uses experimental analysis of the Community Services Dataset (CSDS) to describe these inequalities:

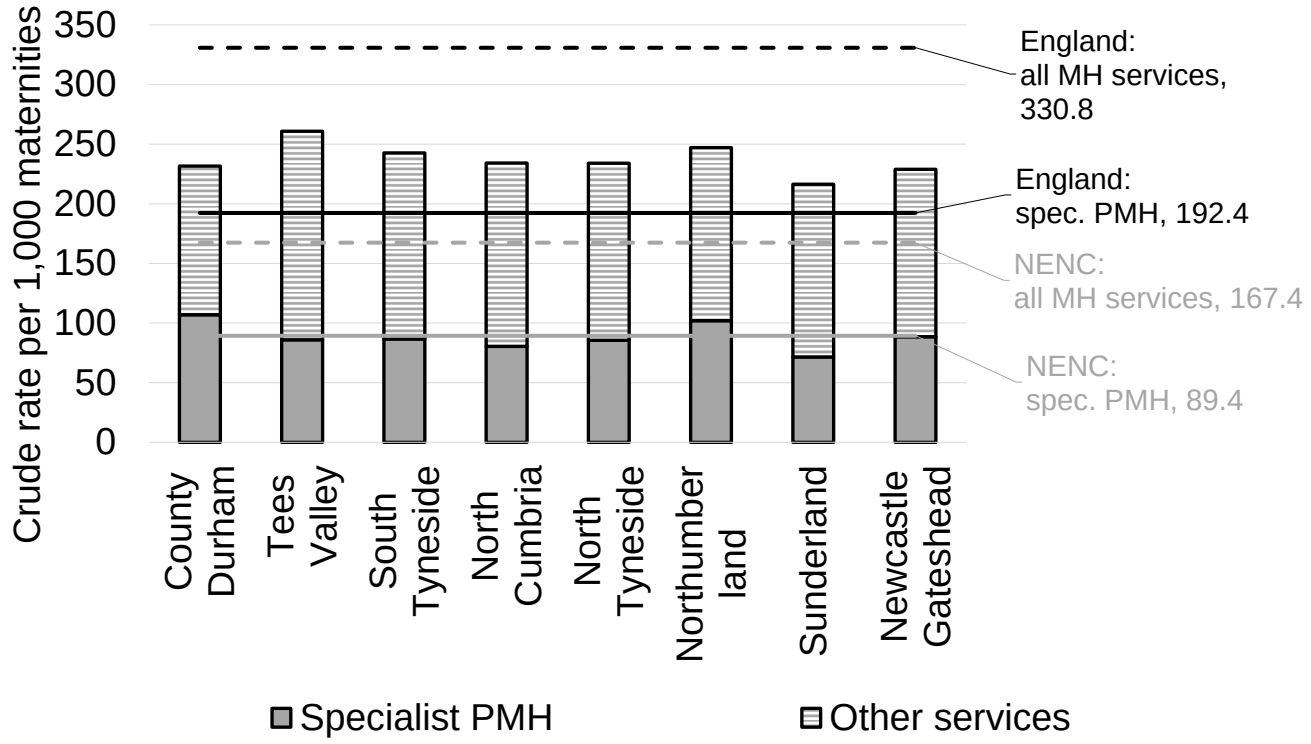
- Nationally there are significantly decreased odds of receiving a new birth review[13] associated with being in Asian or Black ethnic groups.
- In the North East and Yorkshire region, there are significantly decreased odds of receiving a new birth review associated with being in a Black ethnic group.
- There is a clear association with deprivation nationally and regionally, with increased odds of receiving a new birth review associated with living in more affluent areas.

In addition, the mother's six week postnatal check with the GP should contain a general discussion about her mental health and wellbeing, however no data is available on the uptake of these checks.

5.2. Mental health services in the perinatal period

Figure 12 shows pregnant women accessing mental health services in 2022 between their booking appointment (which is ideally before 10 weeks of pregnancy) and 12 months post-pregnancy, expressed as a rate of all maternities in 2021 (the latest available year). It shows that in the NENC as a whole, 89.4 pregnant or postnatal women per 1,000 were in contact with specialist PMH services, and the NENC rate is lower than the overall rate for England, of 192.4 per 1,000. In the NENC as a whole, 167.4 pregnant or postnatal women per 1,000 were accessing mental health services in general (including those accessing specialist PMH services), and this is lower than the overall rate for England of 330.8 per 1,000.

Figure 12: Rate of maternities of women (16+) in contact with perinatal mental health services between booking and twelve months post pregnancy (either inpatient or community services), January 2022 – December 2022, sub-ICB locality in NENC



Source: Numerator: Mental Health Services Monthly Statistics, NHS Digital. All rights reserved. Denominator: Maternities in 2021 (the latest available year) from Birth characteristics, ONS. Note maternities are published by local authority district[14].

Note: not all providers of NHS-funded mental health specialist secondary mental health services successfully submit data to the MHSDS, and the quality of submitted data varies.

[14] *The denominators for the following sub-ICB localities are made up of local authority districts combined:*

- *Tees Valley: Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton-on-Tees.*
- *Newcastle Gateshead: Gateshead and Newcastle upon Tyne.*
- *North Cumbria: Allerdale, Carlisle, Copeland and Eden.*

6. Conclusion

The NENC has higher rates of A&E attendance and of hospital admissions as a result of self-harm when compared to England as a whole. The majority of hospital admissions as a result of self-harm relate to self-poisoning, in the NENC and nationally, with almost half of self-poisoning admissions resulting from ingesting nonopioid analgesics antipyretics and antirheumatics. Evidence[4] suggests an association between chronic physical illnesses and self-harm hospital admissions, particularly for those with epilepsy, and data for the NENC appears to be in support. Over one third of patients admitted as a result of self-harm in the NENC in 2021/22 also had a diagnosis of a mental and behavioural disorders due to psychoactive substance use on their hospital record.

There are opportunities to assess maternal mental health both antenatally and postnatally and to intervene, however variation and inequalities in access to maternity services may also drive inequalities in maternal mental health. Fewer women in NENC in 2022 were in contact with mental health services in the perinatal period when compared with the average for England.