



Bromley Clinical Commissioning Group

**BROMLEY JOINT STRATEGIC
NEEDS ASSESSMENT
2017
Adult Mental Health & Suicide**

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Adult Mental Health

Introduction

Improvements to mental health and wellbeing are associated with a wide range of better outcomes for people of all ages and backgrounds. These include; improved physical health and life expectancy, better educational achievement, reduced health risk and behaviours, such as smoking and alcohol misuse, improved employment rates and productivity and higher levels of social interaction and participation. Conversely, mental health problems can have a negative impact on all aspects of life and lead to; poverty, discrimination, relationship breakdown and addiction which in turn can contribute to a cycle of deteriorating physical and mental healthⁱ. People with severe and prolonged mental illness die on average 10 to 20 years earlier than other peopleⁱⁱ, largely as a result of poorer physical health and greater rates of long term conditions.

Mental Health problems are also calculated to be the largest single source of disability in the United Kingdom, with an estimate that they account for 23 per cent of the total 'burden of disease'ⁱⁱⁱ but only 11 per cent of spending on secondary health care^{iv}. Mental health problems are likely to occur alongside other chronic diseases (co-morbidities). The Kings Fund review of research in this area shows that people with long-term health conditions are two to three times more likely to experience mental health problems than the general population^v. However, mental health care is also often treated separately from other health interventions, in contrast to a whole person care approach which addresses mental health, physical health and social needs together^{vi}.

This chapter describes what we know about mental health in Bromley, focussing on rates of severe mental illness (SMI) and common mental health (CMH) conditions, and examining the physical health and lifestyle patterns of these groups compared to the average Bromley population. This will help identify what is contributing to the gap in life expectancy between people with an SMI and the general population in Bromley and assist service commissioners and providers in identifying the most effective action they can take to narrow this gap. This issue will be considered in a more in-depth mental health needs assessment for Bromley to be published in 2018. The final section of this chapter reviews the findings from a recent in-depth analysis of the trends in rates of suicide and self-harm in Bromley.

The social determinants of mental health and mental illness

The social determinants of health refer to the conditions in which people live, such as housing and employment, and the role they play in influencing health outcomes. For example, evidence suggests that poverty and unemployment often increase the duration of a Common Mental Health Disorder episode^{vii}. Understanding the social determinants of health can also help understand to why certain health conditions are more common in certain population groups than others. For example, the prevalence of severe mental illness and depression is higher in the more deprived areas of the Borough. This may be a consequence of the illness as well as a causative factor. The Healthwatch report *Exploring mental health in the London borough of Bromley*^{viii} (2015) identified a range of factors, through questionnaires and focus groups, which people in the area felt contributed to mental illness. These include employment status, education, housing conditions (specifically overcrowding), levels of social care, lone parenthood and lack of awareness of mental support services on offer. These factors can often bear a relationship to someone's socio economic status.

Public Health England uses indicators, such as those identified in the Healthwatch report, to create a mental health risk profile of a local area^{ix}. Bromley overall has a more favourable mental health risk profile when looking at these indicators compared to the England average. For example, its index of multiple deprivation score, calculated by using data from a number of domains including employment, income, housing, living environment and crime, is 15.2 which is lower than England's average of 21.8 (a lower score showing less overall deprivation). This pattern is the same for all the other risk indicators provided, including child poverty, older people living in poverty and the percentage of the population with a long-term health problem or disability. However, the number of people experiencing these risk factors in Bromley is still significant. For example, using 2011 Census data 15% of Bromley's population has a long-term health problem or disability which represents 46,323 people living in the borough.

What this means for residents in Bromley:

In order to address the difference in life expectancy between people with mental health conditions and the general population, it is important to look at how healthcare services can support physical health alongside mental health needs.

It is also important to understand how the population of Bromley experience the social factors that contribute to poorer mental health. This can provide intelligence on where and how best to target services and develop understanding as to how other areas of the local authority can play a role in protecting and promoting mental health and wellbeing.

A detailed assessment of the Physical Health Needs of people with Severe Mental Illness in Bromley will seek to answer many of these questions. This report is due in Spring 2018.

Severe mental illness amongst adults in Bromley

Severe mental illness (SMI) refers to a mental disorder that is persistent, can impair day to day functioning and may require high levels of care. The International Classification of Diseases^x includes the following under the term SMI:

- schizophrenic and delusional disorders
- mood (affective) disorders, including depressive, manic and bipolar forms
- neuroses
- behavioural disorders
- personality disorders

The QOF (Quality & Outcomes Framework) severe mental illness register (2016/17) records the prevalence of Severe Mental Illness in adults 18 years plus in each CCG. In Bromley CCG the prevalence of SMI in its registered population is 0.84%. This is slightly lower than the England average of 0.9%^{xi}. **Figure 1** shows a similar pattern for Bromley, London and England in terms of a steady increasing prevalence of SMI since 2006, though London's prevalence is higher than that for England and Bromley.

Figure 1

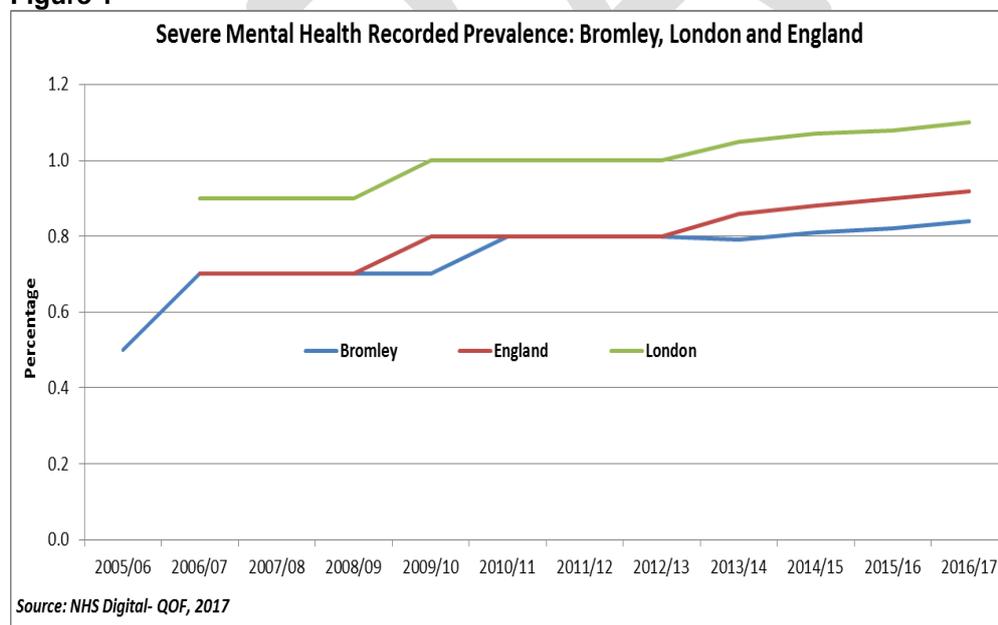


Table 1: Changes in the Severe Mental Illness register size and prevalence in Bromley: 2005/06 to 2016/17

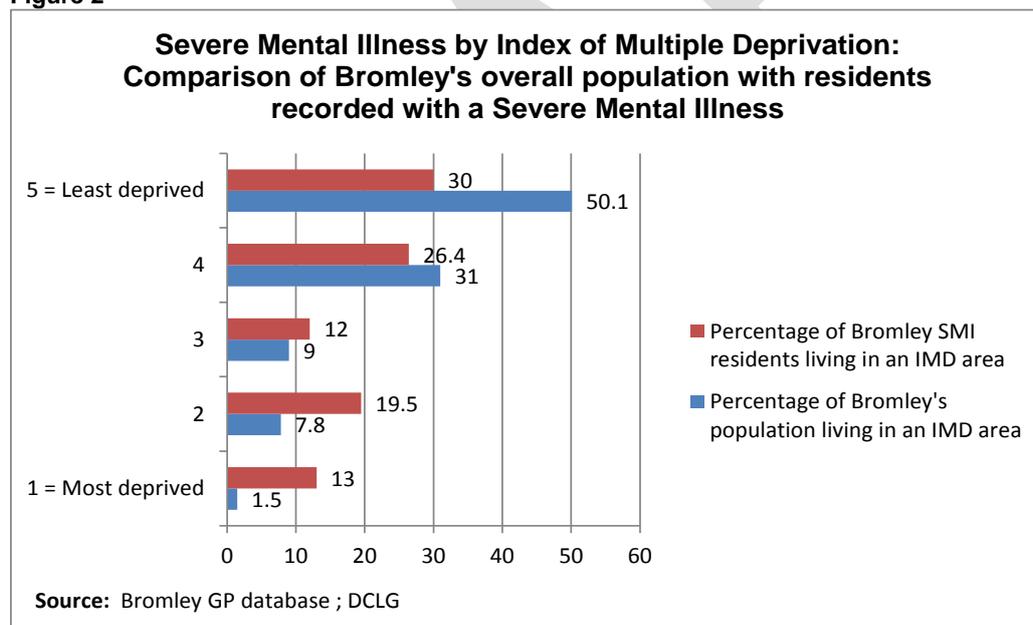
	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Severe Mental Illness Register Size	1667	2165	2265	2351	2389	2447	2544	2616	2667	2738	2808	2904
Severe Mental Illness Prevalence	0.50%	0.70%	0.70%	0.70%	0.70%	0.80%	0.80%	0.80%	0.79%	0.81%	0.82%	0.84%

Source: NHS Digital/QOF 2017

Analysis of Primary Care records in Bromley in 2016 found that there were 2,598 adults with a diagnosed severe mental illness registered with GPs in Bromley. This represents around 1% of the GP registered adult population. This is higher than the QOF prevalence data, which may be explained by primary care records also including patients in remission from a severe mental illness.

Adults diagnosed with severe mental illness are not evenly distributed across the borough. This can be observed when comparing levels of SMI and deprivation based on patients' area of residence. **Figure 2** presents the percentage of patients with SMI by IMD quintile (1 is most deprived and 5 the least deprived) compared to the spread of Bromley's overall population. Adults with an SMI are over-represented in the most deprived areas. 13% of people with an SMI in Bromley live in the most deprived areas of the borough whereas only 1.5% of the total population of Bromley live in these areas. Conversely, whilst over 50% of people diagnosed with an SMI live in the two most affluent areas of Bromley, this is lower than the proportion of the total Bromley population living in those areas which is just over 80%, suggesting that the proportion of adults with a severe mental illness is actually lower than expected in these areas.

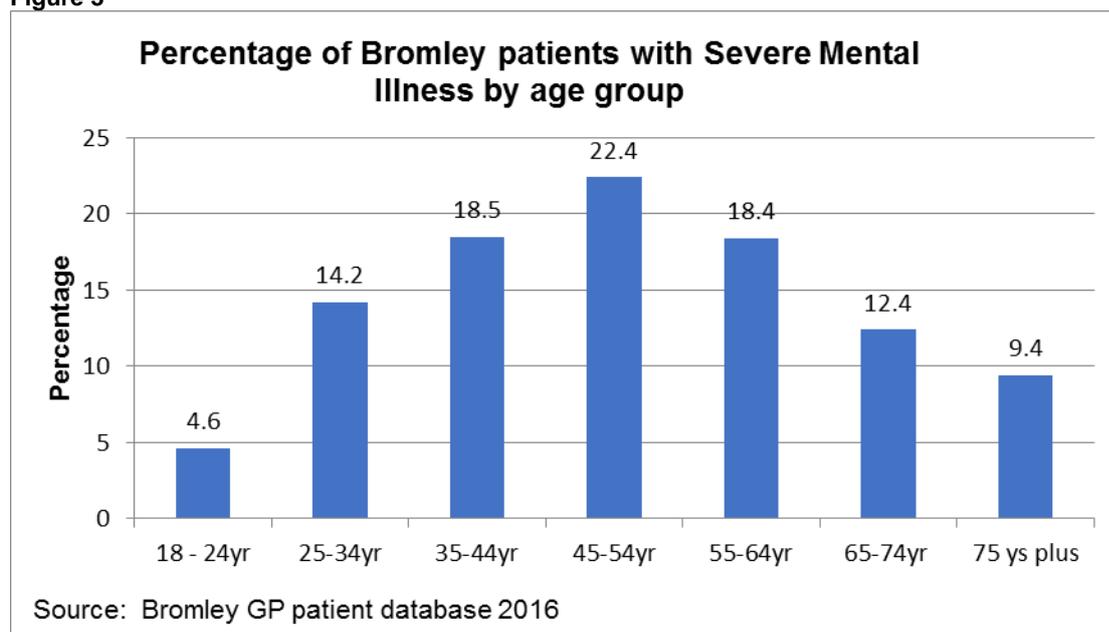
Figure 2



SMI by age

The highest proportion of Bromley patients with diagnosed Severe Mental Illness are between 45 and 54 years old (22.4%) (see **Figure 3**). The majority, nearly 60%, of adults with an SMI in Bromley are between 35 and 64 years of age.

Figure 3



Severe mental illness by type

Analysis of the type of SMI experienced by adults in Bromley is presented in **Table 2**, with its findings summarised below:

- Schizophrenia is the most common form of severe mental illness in Bromley, closely followed by all psychosis (accounting for 31% and 29% of all SMI respectively).
- More men than women are affected by schizophrenia, but women have a higher recording for the other three classified disorders. As a point of comparison, GLA (Greater London Authority) population estimates for 2015 calculate that 48% of Bromley's population are men and 52% women^{xii}. Psychosis is the only SMI that closely follows this population split, with 49% men and 51% women diagnosed.
- Black and ethnic minority (BME) groups¹ are over represented in terms of schizophrenia, psychosis and severe depression compared to Bromley's overall BME population (estimated at 19%^{xiii}).

20% of people diagnosed with a SMI in Bromley are from a BME group, compared to BME estimates in the local population of 19%^{xiv}. The broad umbrella category of 'BME' makes it challenging to identify any specific ethnic groups which may be over represented in these statistics. In general people from ethnic minority groups are more likely to be diagnosed with poor mental health and admitted to hospital. The

¹ The Black and ethnic minority category was identified as any different ethnic group to 'White British' or 'White'. Fifty-nine patient records had a blank field for ethnic group, so the numbers below may reflect an underestimate.

reasons for this are complex and may reflect higher rates of poverty amongst these communities and challenges in accessing culturally appropriate treatment^{xv}. Recent analysis published in the Lancet did not show evidence that excess mortality from a SMI was higher in any one ethnic group than another^{xvi}.

Table 2: Severe mental illness by type:

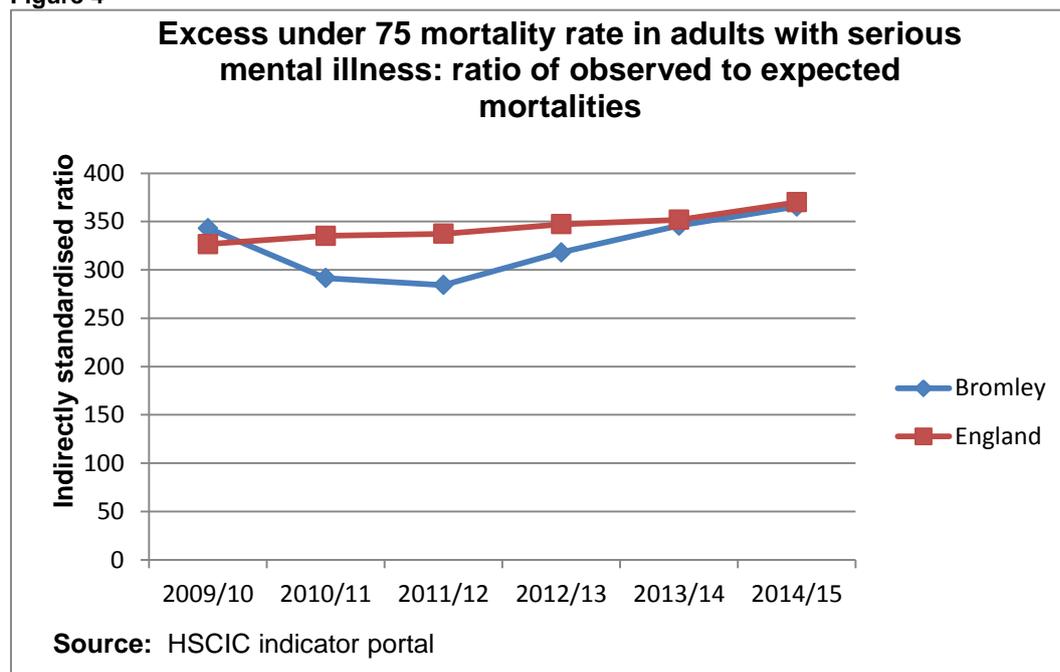
Mental health diagnosis	Number of adults aged 18 years plus			
	Total count	Men	Women	BME
Schizophrenia	797 (31%)	463 (58%)	334 (42%)	194 (24%)
All psychosis	742 (29%)	367 (49%)	375 (51%)	133 (18%)
All bipolar disorder	635 (25%)	251 (40%)	384 (60%)	96 (15%)
Severe depression	96 (3.7%)	35 (36%)	61 (64%)	37 (39%)
Other	328 (12.2%)	-	-	-
Total	2,598	1,116 (49%)	1,154 (51%)	460 (20%)

Source: Bromley GP Primary Care Database, 2016

Severe Mental Illness: Life expectancy

Deaths under the age of 75 are considered premature. Comparing the rates of premature deaths in those with SMI to those without SMI provides a measure of the extent adults with a severe mental illness die younger than adults in the general population. The excess under 75 mortality rate for adults with SMI in Bromley is 366, meaning that those with an SMI in Bromley have a 366% increased risk of death under the age of 75 years than those without an SMI in the borough. This is higher than the average rate for London (327) but lower than the England national rate of 370. **Figure 4** shows the trends in excess under 75 mortality for people with SMI in Bromley compared to England over the last 6 years. Looking both nationally and locally there has been an overall upward trend in excess premature mortality for people with an SMI over the last 3 years. The relatively small numbers of people with an SMI in Bromley in comparison with the total number in England may account for the fluctuation in rates seen at a local level compared to nationally.

Figure 4



What contributes to this gap in life expectancy will be considered below.

Severe mental illness: Physical health needs

Severe mental illness is linked to physical health conditions, such as heart disease and obesity. In addition, having a chronic physical condition is associated with having a lower level of mental wellbeing. This pattern is the same for men and women^{xvii}.

The table below shows the prevalence of physical illness alongside a diagnosis of severe mental illness or co-morbidity (as noted in the Bromley Primary Care data set 2016). There is also a comparison with the level of disease recorded across the overall Bromley CCG population using QOF data for 2015-16². The list sizes between the two datasets do vary, which can account for differences in the number of cases of illness. Yet despite this, a strong difference is observed in the majority of these disease categories in terms of the higher number of cases (prevalence) recorded for patients with an SMI.

² To note, this analysis took place before 2016/2017 QOF data became available.

Table 3: People with Severe Mental Illness in Bromley with a recorded physical health condition compared to overall borough prevalence: QOF 2015/16

Physical health condition	Number	Condition prevalence for people recorded with SMI	Recorded disease prevalence, Bromley CCG
Hypertension (blood pressure)	519	20%	13.6% (46,526)
Chronic Obstructive Pulmonary Disorder	163	6.3%	1.3% (4,420)
Diabetes	141	5.4%	**5.4% (14,493)
Chronic Kidney disease	139	5.4%	*3.6% (9,560)
Coronary heart disease	109	4.2%	2.9% (9,846)
Cancer	91	3.5%	2.5% (8,455)
Epilepsy	96	3.7%	*0.62% (1,672)

Source: Bromley Primary Care database, 2016

Key

*List size 18 years plus

** List size 17 years plus

The lifestyle behaviours of both groups (those with SMI and the general population) were also compared. As a means to improve the physical health of people with SMI, NICE recommends monitoring weight and cardiovascular indicators of this population group such as blood pressure and cholesterol, as well as offering lifestyle change management programmes^{xviiiix}. This means that there is relatively recent and comprehensive recording of data in the Bromley Primary Care database with which to analyse how measurements such as obesity and lifestyle behaviours such as smoking and drinking compare between the population with SMI and the general population average. The following can be summarised from the findings:

- The Public Health Outcomes Framework 2016 estimated that 63.8% of Bromley's population are either overweight or obese^{xx}. According to Bromley Primary Care

records, 72.5% of patients categorised with Severe Mental Illness are overweight or obese (measured as having a BMI of over 25kg/m²).

- Around 37% of people with an SMI in Bromley are current smokers. This is over double the estimated smoking rate in the general population in Bromley which is 14.2%.

What this means for residents in Bromley:

Most people diagnosed with Severe Mental Illness in the borough are middle aged and live in the most deprived areas of the borough.

More women are recorded as having an SMI than men and there is a higher proportion of cases recorded amongst people from a black and minority ethnic group than the overall population estimate for the borough.

Bromley sees an excess in its under 75 mortality rate in adults with serious mental illness and this rate is higher than the London average.

People in Bromley with severe mental illness have higher rates of obesity and smoking than the general population and higher levels of chronic ill health, particularly heart and respiratory disease.

Improving the physical health of people with an SMI therefore is a logical step to reduce differences in life expectancy between this group and the general population.

Common mental health disorders

A common mental disorder (CMD) describes types of depression and anxiety. These disorders can disrupt the ability to carry out daily activities but differ from severe mental illness in usually not affecting insight or cognition. Their high prevalence in the population (with a recent study estimating that depression affects more than 4 in 10 people^{xxi}) results in a high cost to society if the condition is untreated. For example:

- a loss in workplace productivity
- a breakdown in personal relationships
- Uptake of risky lifestyle behaviours such as high consumption of alcohol and/ or drug taking.

Common mental health disorders can be difficult to quantify as people do not always seek treatment when they experience an episode of mental ill health. **Box 1** defines the different ways depression is classified in addition to the different theories in terms of the causes of this illness.

Box 1

What is depression?

Depression is generally classified at three levels, according to the extent it impacts on daily activities:

- Mild depression describes some impact on daily life
- Moderate depression describes significant impact on daily life
- Severe depression can make carrying out daily activities almost impossible. A small proportion of people with severe depression may have psychotic symptoms.

Causes of depression can include an adverse life event, such as unemployment or divorce (referred to as reactive depression). Depression is also accompanied by physical changes, for example a change in levels of chemicals in the brain. This can be influenced through hormone change, such as depression associated with pregnancy or childbirth. Family history also plays a part, with a family history of depression increasing its likelihood. Studies are also investigating different versions of a gene (5-HTT) and its links to depression.

Prevalence of common mental health disorders in Bromley

There are various sources of prevalence measures for common mental health disorders in Bromley.

For example, NHS England estimates the prevalence of common mental health disorders amongst Bromley residents aged 16 to 74 years of age as 14.9% (compared to the London average of 16.4% and an England average of 15.6%). This is based on historic Primary Care Trust prevalence data published to help inform provision of psychological therapy services, and is therefore likely to be out of date (for example, it does not take into account changes in overall population size or age distribution). In the Adult Psychiatric Morbidity Survey (APMS) of 2014, one in six (17%) people aged 16 years and over were identified with a CMD the week before interview. The APMS is a household sample survey of treated and untreated mental health conditions in the English adult population.

QOF 2016/17 data for Bromley shows that 8.5% of Bromley registered patients have been diagnosed with **depression**. This places Bromley as the third highest London borough for recorded depression (see **Figure 5**). The prevalence of depression in Bromley is higher than the London average of 6.63% but its prevalence is lower than the England average at 9.09%. The range across London boroughs is 4.92% in Redbridge to 9.03% in City and Hackney borough.

Figure 5

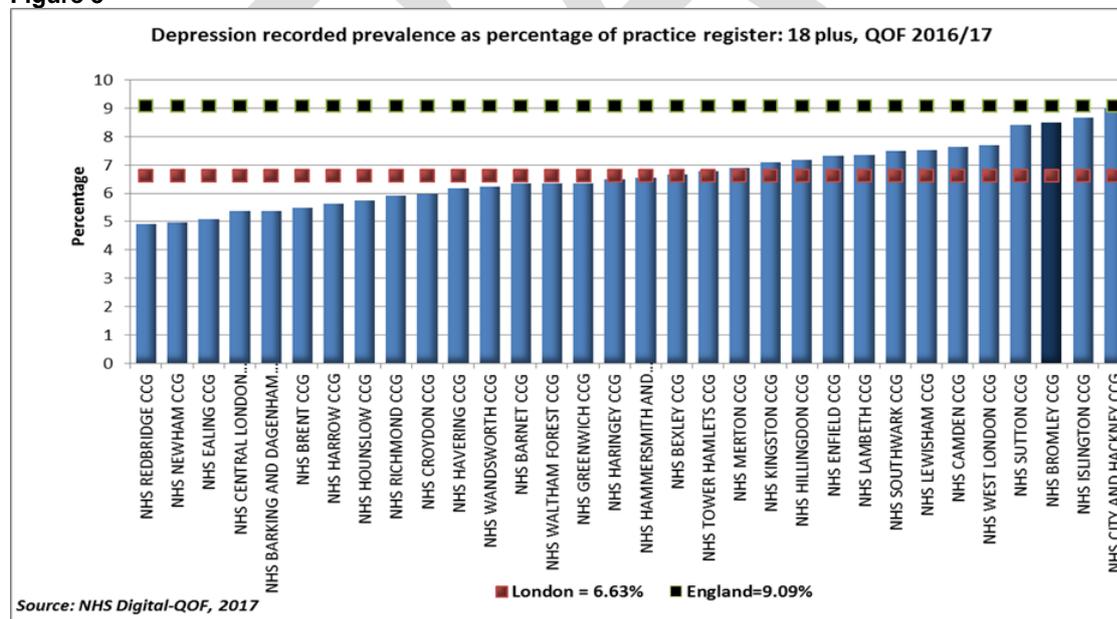


Figure 6

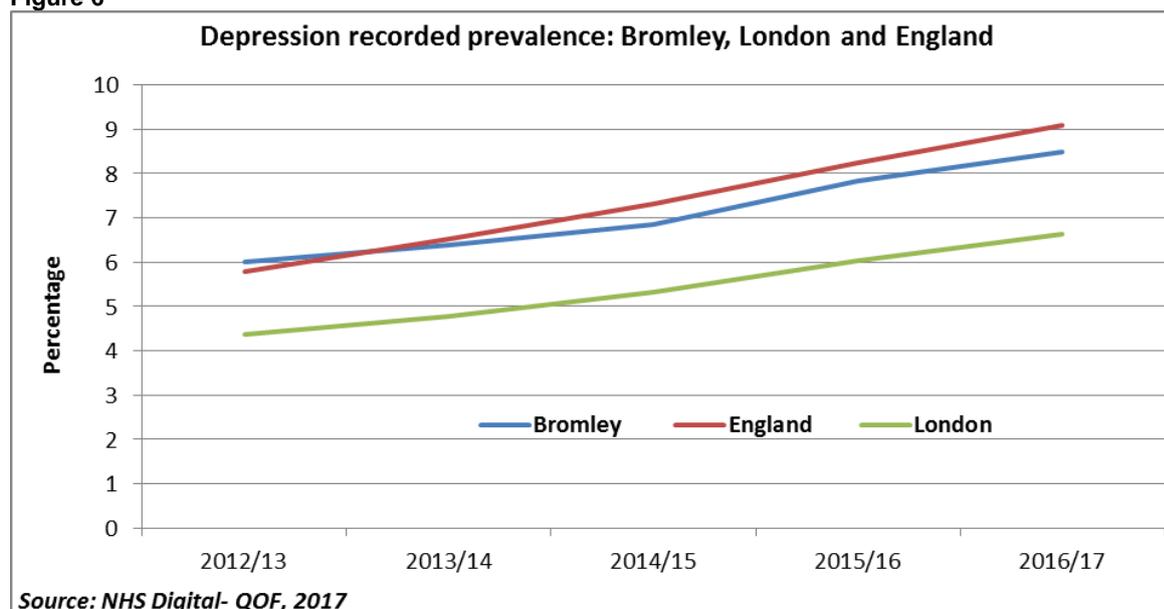


Table 4: Changes in the prevalence of people with depression as recorded by GP practice in Bromley from 2012/13 to 2016/17

	2012/13	2013/14	2014/15	2015/16	2016/17
Depression Register Size	15645	16789	18140	20970	23,073
Depression Prevalence	6.00%	6.38%	6.85%	7.83%	8.50%

Source: NHS Digital/QOF 2017

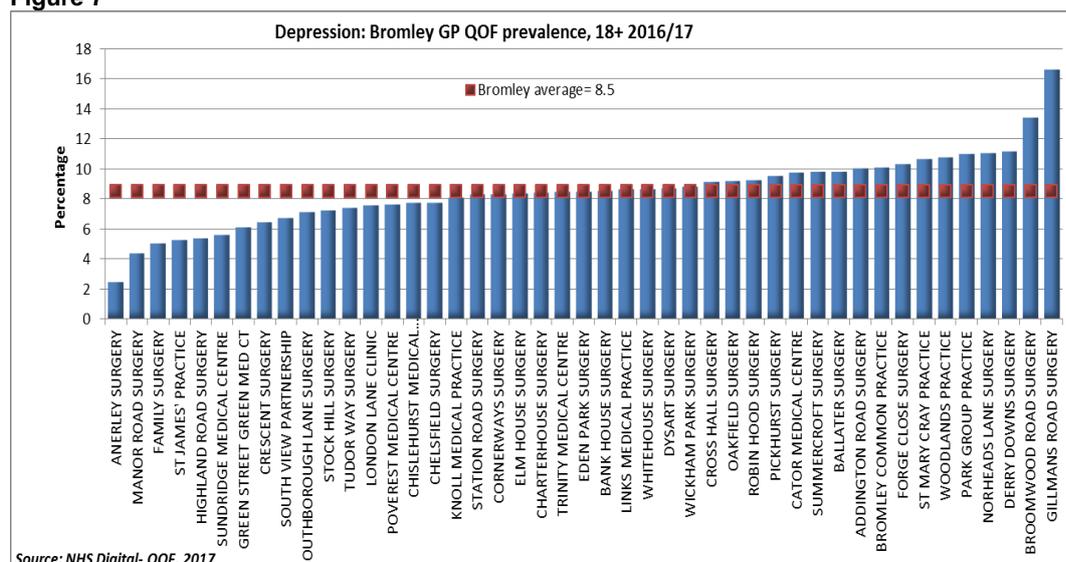
Figure 6 and **Table 4** show a steady increase in the number of existing cases (prevalence) of depression in Bromley. For example, the depression register size in Bromley has increased by 7,428 cases over a 4-year period, averaging around 1,800 new cases each year. This could be due to better data recording and/ or an increase in the number of people presenting themselves to primary care with depression. This increase also seems to follow a regional and national trend (see **Figure 6**).

Prevalence of depression by GP practice and levels of deprivation

The prevalence of recorded depression varies substantially across GP practices in Bromley from just over 2% of the registered population to over 16% of the registered population. This information is presented in **Figure 7**.

This range may indicate under presentation or under diagnosis of depression in certain GP practice areas. However, it also suggests that the number of cases of depression can be influenced by place (for example, relative deprivation of the area as seen in the analysis of the Primary Care database below).

Figure 7



Prevalence of depression: Bromley Primary Care database

According to data captured from the Bromley primary care database in 2016 the prevalence of patients recorded with a depressive term (a proxy for common mental health disorders) is 13.9% (a total of 37,063 or 1 in 7 patients). This is higher than the QOF average of 8.5%. As with severe mental illness, the differences in these estimates may be explained by the primary care records including patients now in remission.

65% of patients registered with a depressive term are women (compared to population estimates that women make up 52% of Bromley's population^{xxii}) and 13% are recorded as being from a Black and Minority Ethnic Group (19% of Bromley's population is estimated to be from an ethnic minority group^{xxiii}). In terms of a representation of ethnic minority groups this is likely to reflect an underestimate of need. For example, Bromley's Mind recovery works service records 24% of clients from a BME background and IAPT services (talking therapies) recorded 28.5% of referrals from a BME background in the first quarter of 2017/18^{xxiv}. The greater proportion of depressive terms recorded for women may be a true reflection of a greater number of depressive incidents amongst women, but might also be explained by the greater tendency by woman to seek medical help for depression.

Table 5: Number and proportion of people on Bromley GP register with depression term: Men, women and Black and Minority ethnic group

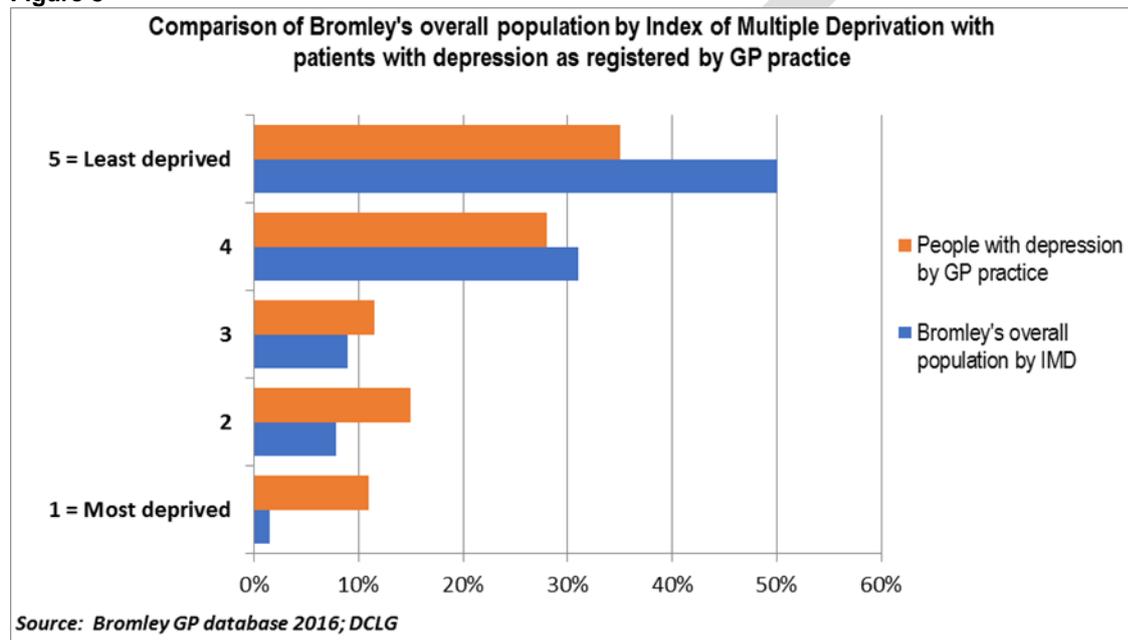
Men	Women	BAME
12,879 (35%)	24,184 (65%)	4,953 (13%)

Source: Bromley GP register, 2016

The Adult Psychiatric Morbidity Survey (APMS, 2014) showed nationally a slight but steady increase in the proportion of women with symptoms of common mental health disorders (CMD) compared to 2009, but no noticeable increase for men^{xxv}. The national survey also noted that the increase in prevalence for women was mostly at the severe end of the scale.

As with SMI, more patients with a depressive term (proxy for CMD) live in areas of higher deprivation. For example, 11% (4,052) of patients with depression live in the most deprived areas of the borough compared to 1.5% of Bromley's overall population (see **Figure 8**).

Figure 8



In terms of the age distribution of people recorded with a depressive term, the distribution is fairly similar to what is observed for Severe Mental Illness, with the highest prevalence in the 45-54 year age range (23.2%) and then 17% and 19% for the age groups 35 to 44 years old and 55 to 64 years old. 9.3% of this population group is over 75 years old. Bromley's IAPT service noted the high needs they see in the younger adult age group (18 to 25 years old) which can be observed in **Figure 9**. To note, this is based on only 3 months of referral data and analysis over at least a year is required to establish if this is a true reflection of the age profile of the population presenting to this service.

Figure 9

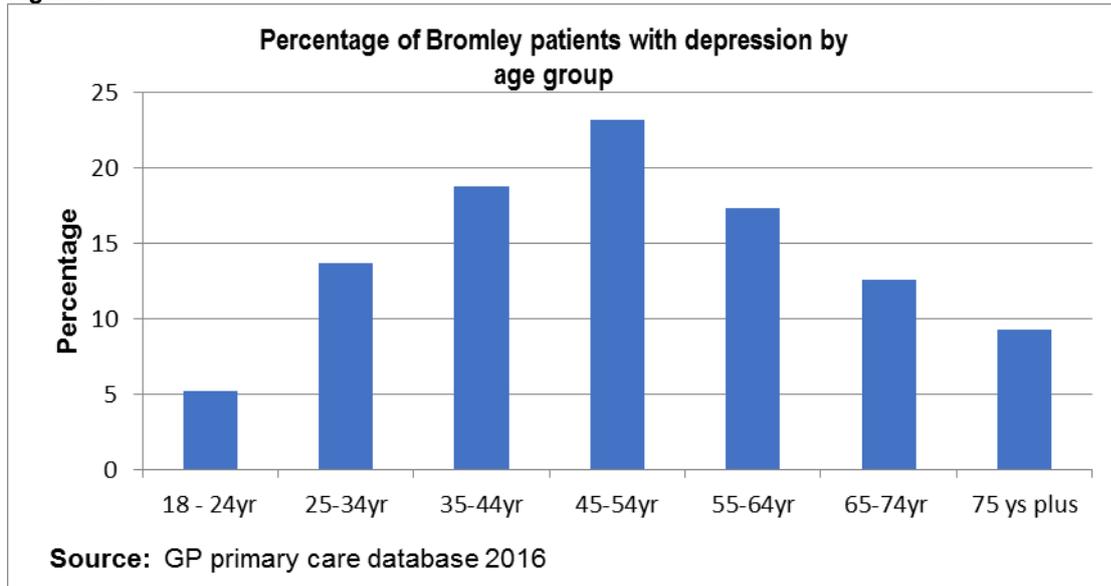
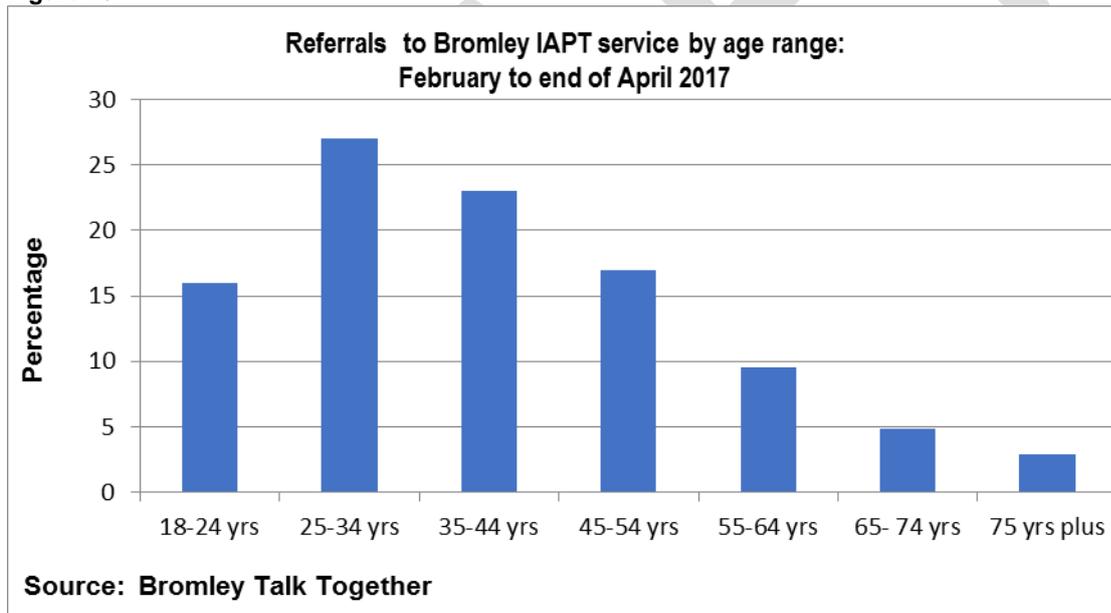


Figure 10



Common mental health disorders and physical health needs

As with severe mental illness, the prevalence of physical health conditions in those with a recorded depressive term can be compared to the prevalence of these conditions in the overall Bromley registered population. These results are set out in **Table 6**. This shows the prevalence of physical illness alongside a diagnosis of depression (as noted in the Bromley Primary Care data set 2016). It is then compared with the level of disease recorded across the overall Bromley CCG population using QOF data for 2015-16.

Table 6: Physical health condition for people with a depressive term: QOF data 2015/16

Physical health condition	Number	Percentage	Recorded disease prevalence – CCG level
Hypertension	7258	20%	13.6% (46,526)
Coronary heart disease	1767	4.8%	2.9% (9,846)
Chronic Obstructive Pulmonary Disorder (COPD)	2265	6.1%	1.3% (4,420)
Diabetes	1273	3.4%	**5.4% (14,493)
Chronic Kidney disease	1517	4.1%	*3.6% (9,560)
Cancer	1681	4.5%	2.5% (8,455)
Epilepsy	729	2%	*0.62% (1,672)

Source: Bromley Primary Care database, 2016

Key

*List size 18 years plus

** List size 17 years plus

Similarly to Severe Mental Illness, physical health conditions show a greater prevalence in people with a depressive term, with the exception of diabetes. This correlates with the higher prevalence of certain lifestyle behaviours amongst people with depression, for example higher smoking rates may explain some of the difference in COPD. Just over half the total population of people with COPD at the CCG level have depression as a co-morbidity. However, it is likely that managing a chronic health condition such as COPD can also contribute to depression. A similar association is likely for the other listed physical health conditions, such as coronary heart disease, chronic kidney disease and cancer.

The condition which is unusual in terms of its lower prevalence amongst people with a depressive term is diabetes, which differs from national trends where there is a higher recording of depression amongst people with diabetes compared to the general population^{3 xxvi}. This may indicate that levels of depression are being underestimated within this patient group in Bromley.

Patients with a depressive term and lifestyle factors

As with Severe Mental Illness, people with common mental health disorders often exhibit lifestyle behaviours that can worsen physical health. For example, the Adult Psychiatric Morbidity Survey 2014 found that CMDs were more prevalent in people who smoked cigarettes. This does not suggest a causative relationship (for example, it may be that social disadvantage is a stronger link between both smoking and poor mental well-being). However, it does mean that lifestyle behaviour factors need to be considered in patients with common mental health disorders.

The points below summarise analysis exploring Bromley patients with a depressive term with regards to weight, smoking habits and alcohol use.

- 32% of patients diagnosed with a common mental health disorder had their weight recorded in the past two years, this is similar to the proportion of people with any long term health condition who have had their weight monitored over the same period. Of these patients, 68.1% had a BMI value of over 25 (defined as excess weight). This compares to an estimated rate of excess weight of 63.8% of Bromley's general population.
- Of the patients with CMD with a smoking status recorded (29% of the total), 37.4% (13,880) are recorded as current smokers. This compares to a Bromley population estimate of 14.2% (a 14.8% difference).

Dual Diagnosis: Mental Health & Substance Misuse

Mental health problems are common among those needing treatment for substance misuse and substance misuse is common among those with a mental health problem. Particular population groups may be more affected by this dual diagnosis, for example alcohol dependence in combination with poor mental health is frequent in homeless people and prisoners^{xxvii}.

³ NHS Digital cites that there is a 24 per cent lifetime prevalence of co-morbid depression in individuals with diabetes mellitus, which is three times higher than the prevalence rate in the general population³.

An analysis of the profile of patients with co-occurring mental health and drug misuse issues, both nationally and locally, is presented in the JSNA section on Drug Misuse in Adults

What this means for residents in Bromley:

The profile of people living with a common mental health disorder (CMD) in Bromley is similar to that of the population living with severe mental illness in terms of their age and deprivation profile.

The number of people from a BME group with a CMD is lower than expected based on data from total population estimates. This could be due to data recording issues or patterns in how people from BME groups with CMD present to services.

People in Bromley with common mental health disorders have higher rates of higher levels of chronic ill health, particularly heart and respiratory disease, than the general population. Surprisingly the level of diabetes is lower amongst people recorded with a CMD than the population average, which goes against evidence collated at a national level. This may benefit from further investigation.

Better recording of data on the lifestyle behaviours of people with CMD in Bromley would help to establish how health promotion messages could be best delivered to this patient group to improve physical health and wellbeing and reduce the risk of developing co-morbidities.

Suicide Audit, 2017

This section provides a summary of the Bromley Suicide Audit 2017 a copy of the full report is available on request from: susan.mubiru@bromley.gov.uk

The report aims to compare local and national rates of suicide and self-harm, understand local trends and make recommendations to reduce the number of local suicides in line with national strategies.

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Summary facts

National^{xviii}

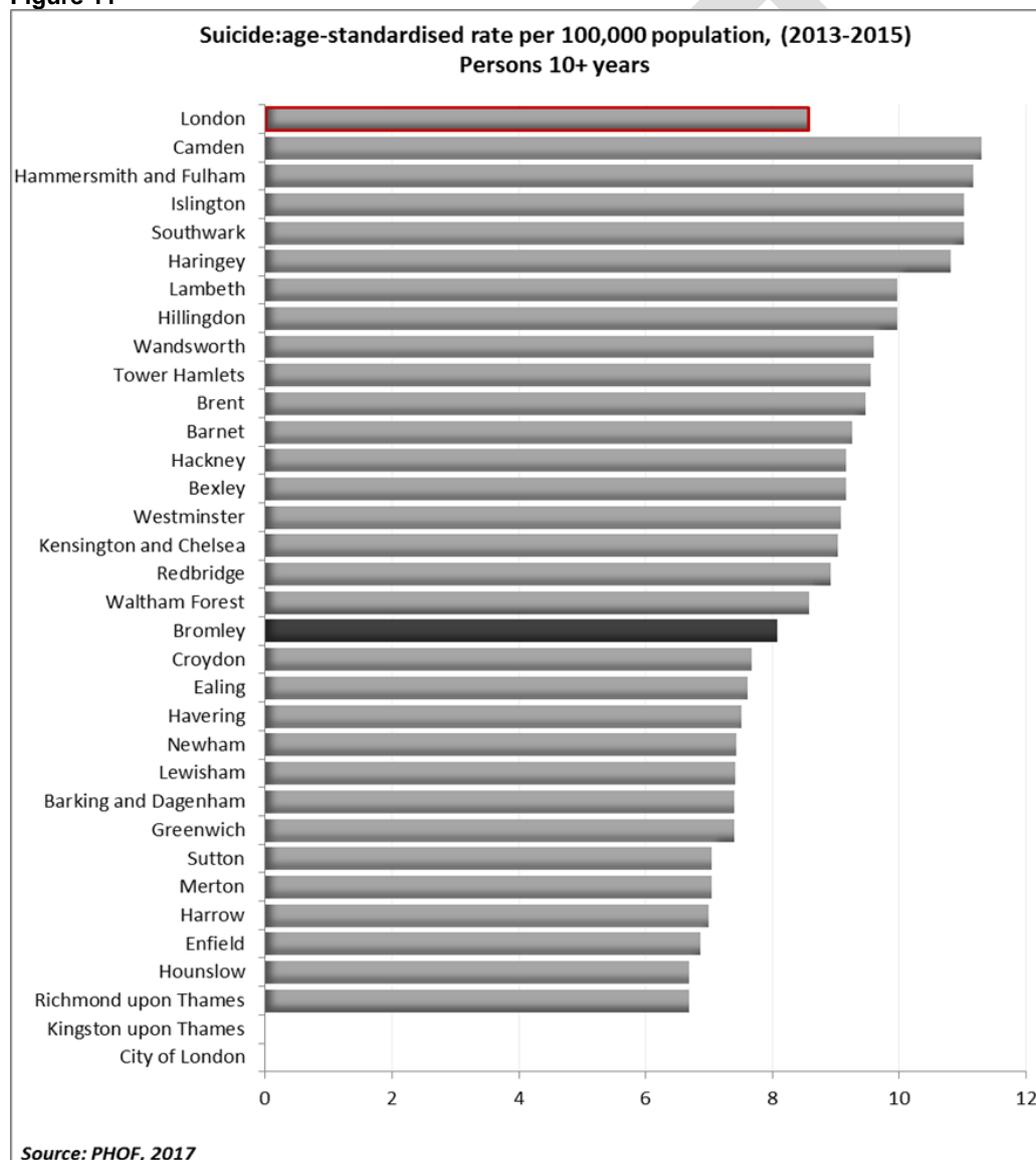
10 things that everyone needs to know about suicide prevention:	
1 - Suicide takes a high toll	There were 4,880 deaths from suicide registered in England in 2015. For every person who dies at least 10 people are directly affected.
2 – There are specific groups of people at risk of suicide	<p>Three in four deaths by suicide are by men.</p> <p>The highest suicide rate in England is among men aged 45-49.</p> <p>People in the lowest socio-economic group and living in the most deprived geographical areas are 10 times more at risk of suicide than those in the highest socio-economic group living in the most affluent areas.</p>
3 – There are specific factors that increase the risk of suicide	<p>The strongest identified predictor of suicide is previous episodes of self-harm.</p> <p>Mental ill-health and substance misuse greatly contribute to suicides.</p> <p>Suicide prevention strategies must consider and link to programmes of early identification and effective management of self-harm, mental ill-health and substance misuse.</p>
4 – Preventing suicide is achievable	<p>The delivery of a comprehensive strategy is effective in reducing deaths by suicide through combining a range of integrated interventions that build community resilience and target groups of people at heightened risk of suicide.</p> <p>The involvement of directors of public health and health and wellbeing boards is crucial in co-ordinating local suicide prevention efforts and making sure every area has a strategy in place.</p>
5 – Suicide is everybody’s business	<p>A whole system approach is required, with local government, primary care, health and criminal justice services, voluntary organisations and local people affected by suicide having a role to play.</p> <p>Suicide prevention can also be part of work addressing the wider determinants of health and wellbeing.</p>
6 – Restricting access to the means for suicide works	This is one of the most evidenced aspects of suicide prevention and can include physical restrictions, as well as improving opportunities for intervention.
7 – Supporting people bereaved by suicide is an important component of suicide prevention strategies	Compared with people bereaved through other causes, individuals bereaved by suicide have an increased risk of suicide and suicidal ideation, depression, psychiatric admission as well as poor social functioning.
8 – Responsible media reporting is critical	Research shows that inappropriate reporting of suicide may lead to imitative or 'copycat' behaviour.
9 – The social and economic cost of suicide is substantial and adds to the case for suicide prevention work	<p>The economic cost of each death by suicide of someone of working age is estimated to be £1.67 million.</p> <p>This covers the direct costs of care, indirect costs relating to loss of productivity and earnings, and the intangible costs associated with pain, grief and suffering.</p>
10 – Local suicide prevention strategies must be informed by evidence	Local government should consider the national evidence alongside local data and information to ensure local needs are addressed.

Local

Suicide

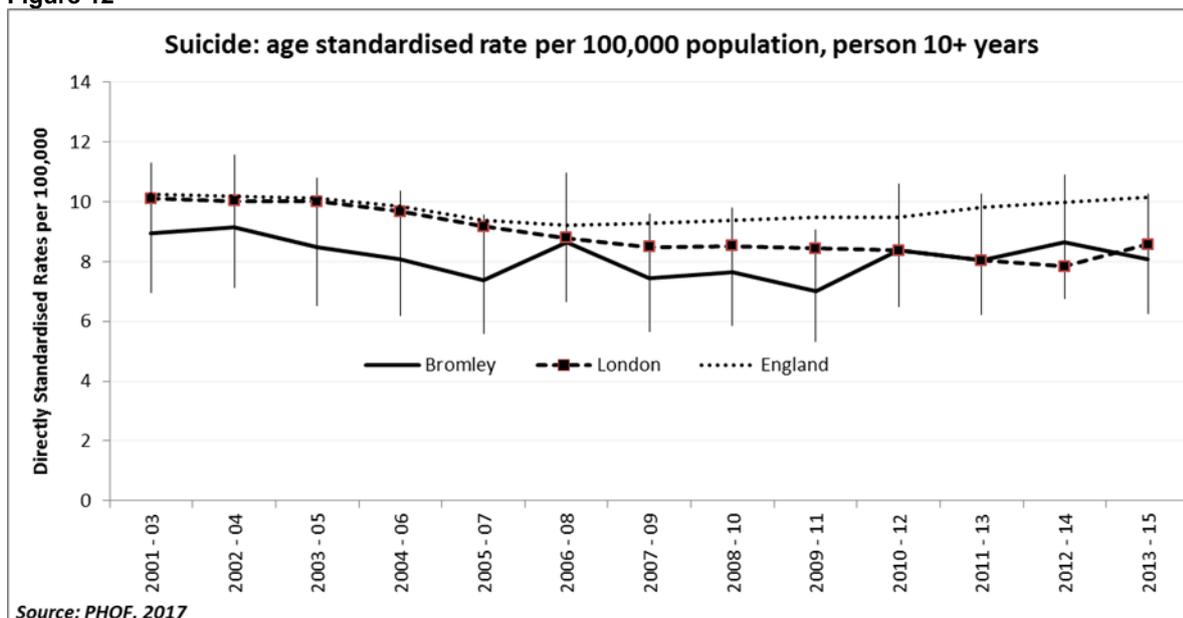
Bromley experiences a relatively low number of deaths from suicide each year; on average about 20 people. In 2013-2015 the suicide rate in Bromley was 8.08 deaths per 100,000 population aged 10 years and over. This rate is lower than the 2012-2014 rate at 8.65 deaths per 100,000 (Figure 12). Bromley ranks 16th out of the 33 London boroughs on suicide rates (where 1 is lowest) as shown in Figure 11. The borough wide rates mask local community variation; however the small numbers behind the rates affect the ability to further investigate links to wider determinants locally.

Figure 11



Intentional self-harm is included for persons aged 10 years plus and injury/ poisoning of undetermined intent is included for persons aged 15+

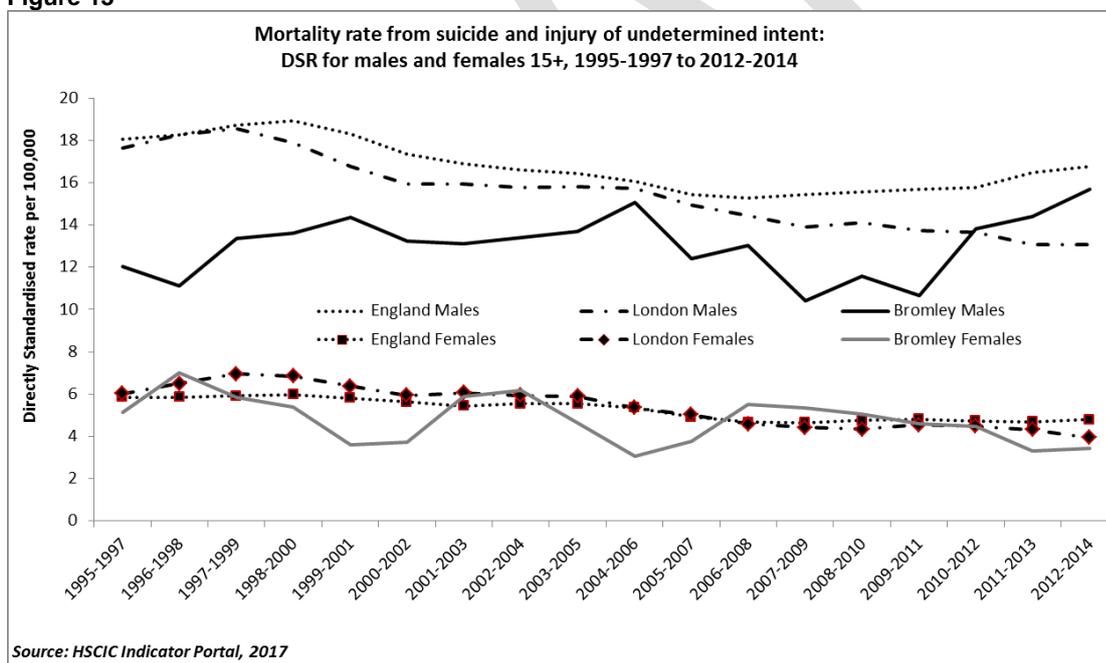
Figure 12



Intentional self-harm is included for persons aged 10 years plus and injury/ poisoning of undetermined intent is included for persons aged 15+

Figure 13 shows that nationally, regionally and locally suicides continue to be **more prevalent in males**, up to three times the rate in females.

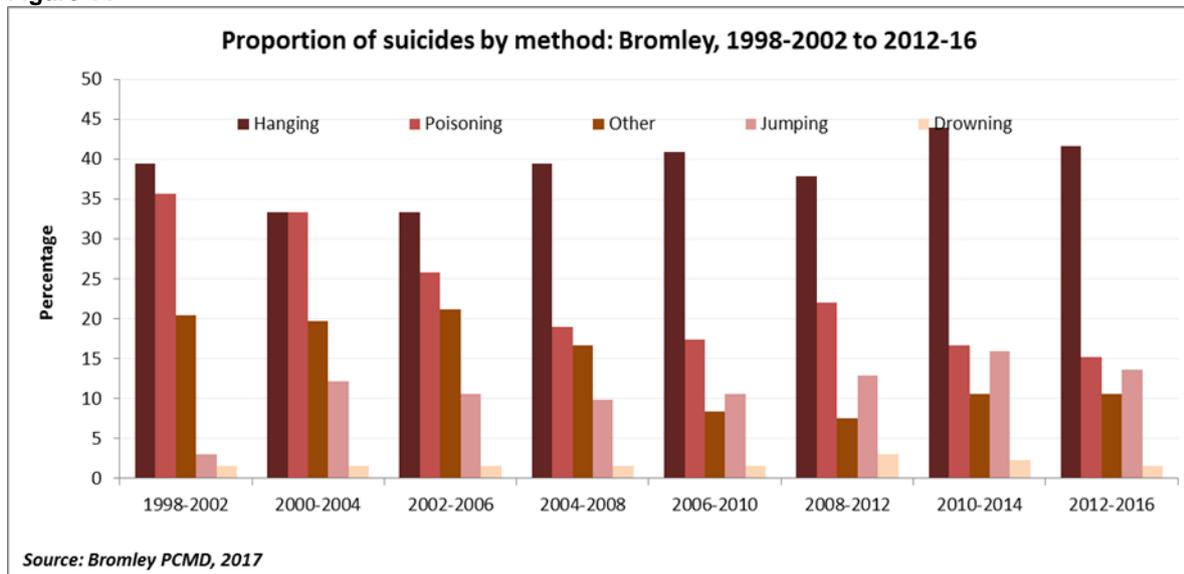
Figure 13



In Bromley, the **most common methods of suicide** are similar to the UK with **hanging, strangulation or suffocation** being the most common methods, followed by poisoning (**Figure 14**). The proportion of **suicides by self-poisoning is reducing**, whilst the proportion of suicides by jumping from a height or in front of a

moving object is generally increasing, although the overall proportion using this method remains low.

Figure 14



Social context and prior contact with health and care services

The National Suicide Strategy 2012^{xxix} identified the following groups at high risk of suicide:

- 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
- People with a history of self-harm

It was not possible to analyse the social circumstances or patterns of prior contact with services of the people who took their lives in Bromley in the current audit but previous suicide audits in Bromley have showed that:

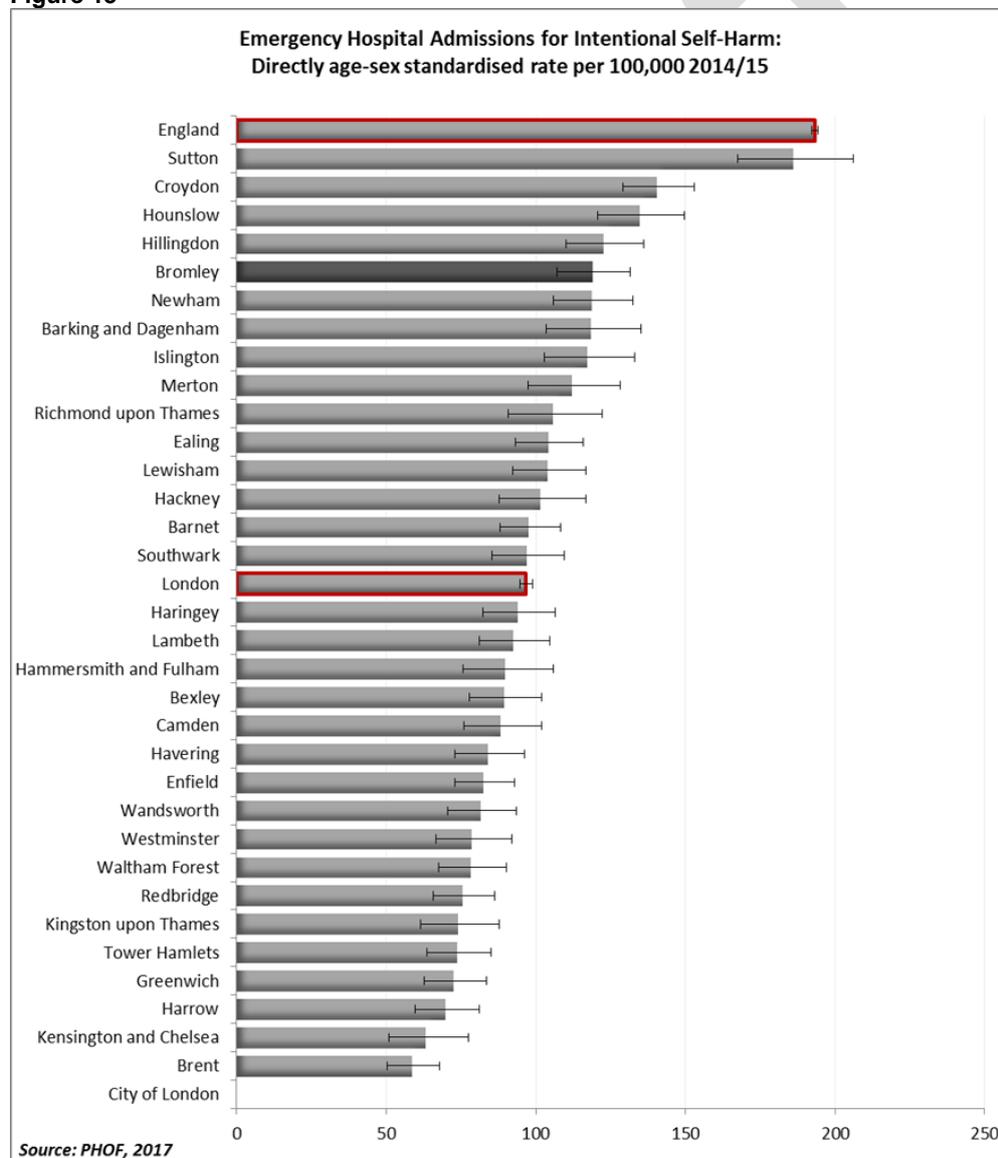
- many people had a documented suicide risk
- there was history of poor physical health and a mental illness diagnosis
- there was history of self-harm and a previous suicide attempt
- contact with Primary Care within 12 months prior to death
- previous contact with mental health services and some had a diagnosis of mental illness 12 months prior to the death, including depressions

Self-harm

Self-harm is presented alongside suicide because suicide is a form of self-harm. Self-harm with no suicidal intent is more common than suicidal behaviour and its outcomes cause less physical harm. The difference between self-harm and suicide lies in the intent. Research shows that repeated behaviour of self-harm increases the risk of a completed suicide by between 50-100 times (Royal College of Psychiatrists, 2010). In many cases of suicide there is an episode of self-harm shortly before someone takes their own life.

Bromley has the **5th highest** intentional self-harm rates in the region (**Figure 15**).

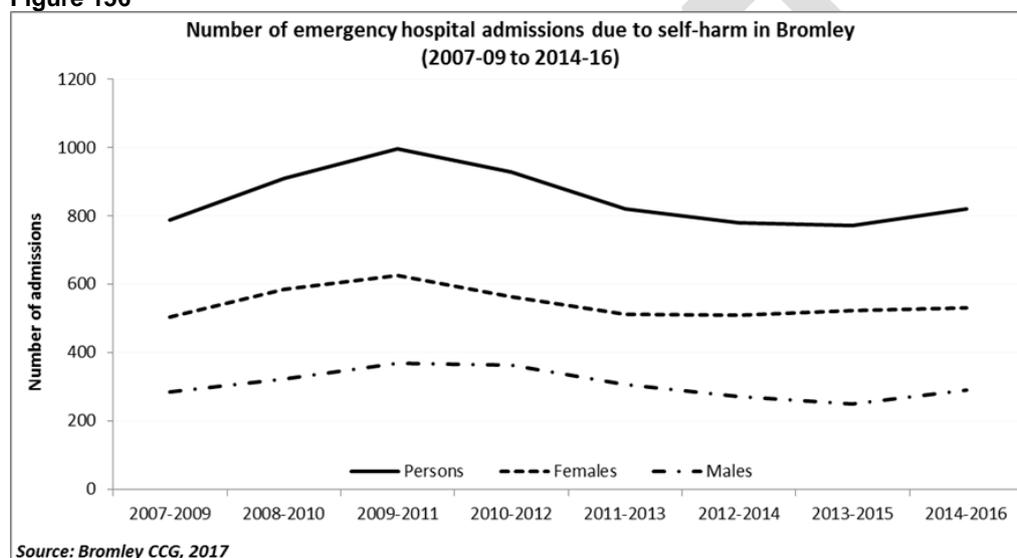
Figure 15



The age standardised admission rate for intentional self-harm in 2014/15 in Bromley was 118.83 per 100,000 population compared with 96.79 in 2013/14. The 2014/15 rate is significantly higher than London but significantly lower than England at 96.65 and 193.23 per 100,000 respectively. The figures are subject to reporting and recording bias. The practice of recording intent is variable across NHS Trusts and practitioners.

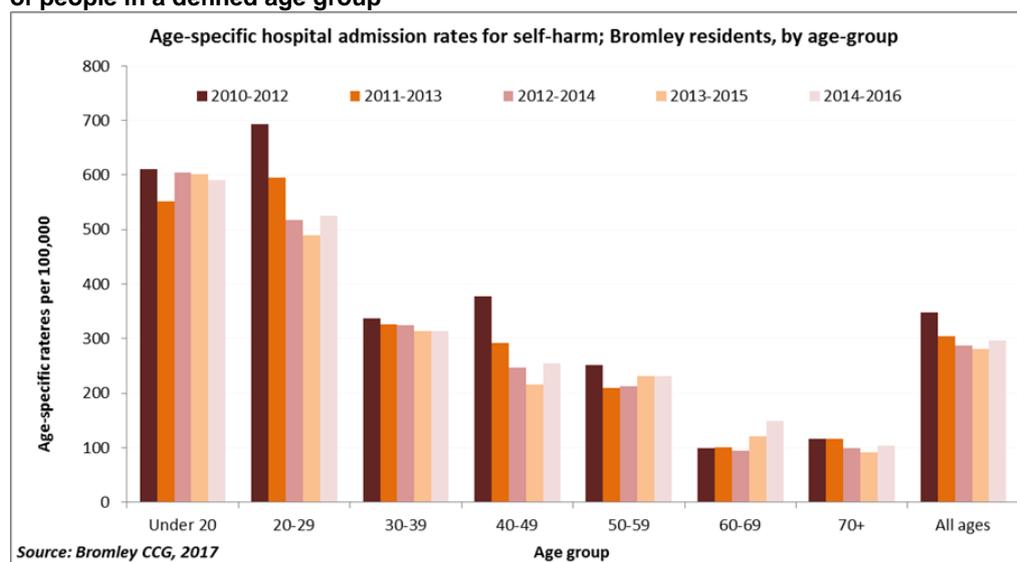
Rates of hospital admissions for intentional self-harm in both genders have fluctuated in Bromley over the last decade with a peak in 2009-11 (**Figure 16**). Although rates have declined since then there appears to be the **beginning of an upward trend**. Continued monitoring is required to assess if this upward trend is enduring.

Figure 156



More females are hospitalised year on year for intentional self-harm than men. In 2014/15, the female rate was 150 per 100,000 population compared to the male rate at 87 per 100,000. For every male hospitalisation for intentional self-harm there are nearly two female hospitalisations. There is need for work to identify further risk factors in people who intentionally self-harm in Bromley and tailor services for the affected local population.

Figure 167: Age-specific rates refer to the frequency with which self-harm occurs relative to the number of people in a defined age group



The proportion of hospital admissions **for intentional self-harm is highest in people aged 20-49**. Analysis of age –specific rates (**Figure 17**) also shows that people aged <30 are more represented in hospital for intentional self-harm than the general population. However it is worth noting that although there are fewer admissions of intentional self-harm in older residents, 60 years and over, research shows that **older people who self-harm are three times more likely to commit suicide** than the younger people who self-harm. Therefore older adults who intentionally self-harm should be a target group for services and support.

The relationship between deprivation and hospital admissions for intentional self-harm in Bromley is not linear and is marked by wide confidence intervals (**Figure 18**). However the difference seen in rates between women living in the most and least deprived deciles is significant. Analysis at ward level shows that **hospital admission rates are significantly higher in the Cray Valley wards and Penge and Cator** than the rest of the borough (**Figure 19**).

Figure 178: 5 years of data are aggregated to increase events in the deprivation deciles

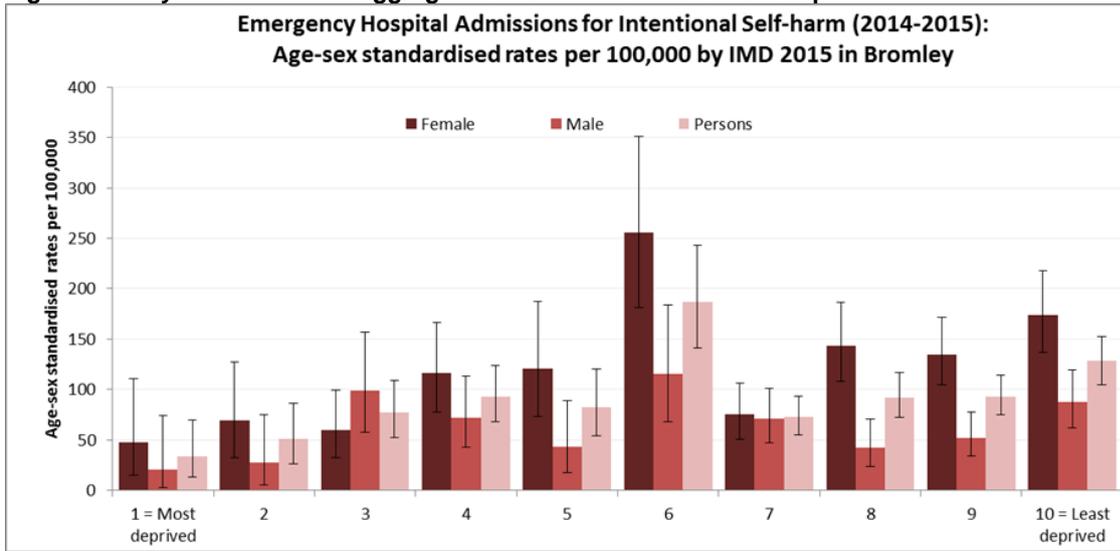
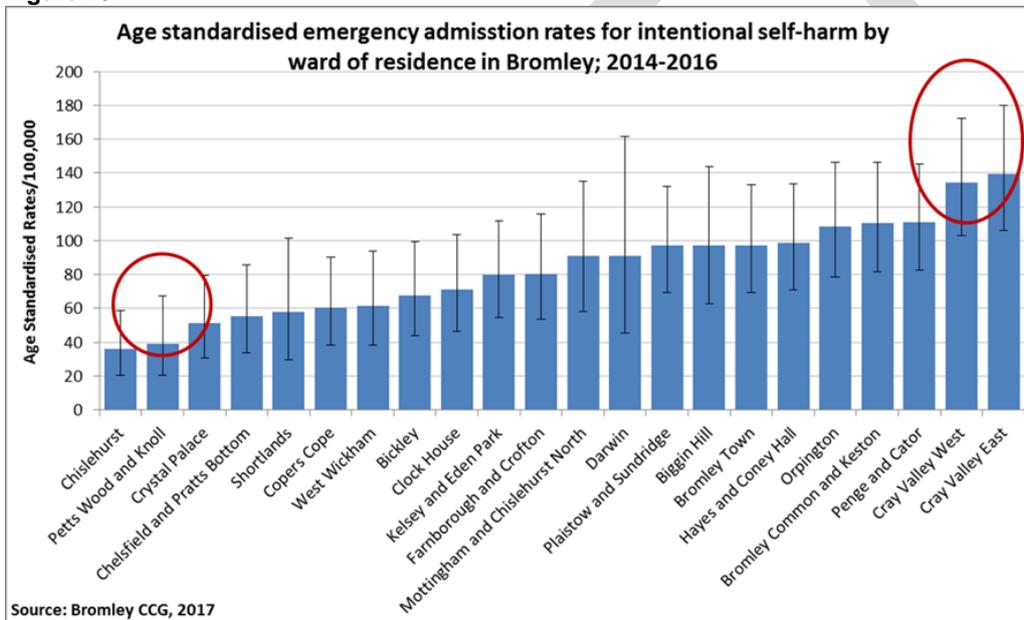


Figure 19



Source: Bromley CCG, 2017

What this means for residents in Bromley:

Bromley has the 5th highest intentional self-harm rates in the region and ranks 16th out of 33 London boroughs on suicide rates (where 1 is lowest).

Suicides continue to be more prevalent in males, up to three times the rate in females, whilst rates of admission for intentional self-harm continue to be more prevalent in women and young people.

The numbers of suicides in Bromley are very erratic year on year but on average about 20 people take their own lives in Bromley each year.

The most common methods of suicide in Bromley are hanging, strangulation or suffocation. The proportion of suicides by self-poisoning is reducing, whilst the proportion of suicides by jumping from a height or in front of a moving object is increasing.

Rates of hospital admissions for intentional self-harm have fluctuated in Bromley over the last decade with a peak in 2009-11. Although rates have declined since then there appears to be the beginning of an upward trend.

The proportion of hospital admissions for intentional self-harm is highest in people aged 20-49. Although there are fewer admissions of intentional self-harm in older residents, research shows that older people who self-harm are three times more likely to commit suicide than the younger people who self-harm.

The relationship between deprivation and hospital admissions for intentional self-harm in Bromley is not linear but analysis at ward level show that hospital admission rates are significantly higher in the Cray Valley wards and Penge and Cator than the rest of the borough.

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