



# BROMLEY SUICIDE AUDIT: A trend analysis 2024

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# National: Summary facts

10 things everyone should know about suicide prevention		
1	Suicide Remains a Major Concern	In England, suicide rates have been concerning, with approximately 4,500 deaths by suicide reported annually. While recent data shows a slight decrease, it remains a significant public health issue, necessitating ongoing attention and intervention.
2	Risk Factors	Understanding the risk factors associated with suicide is crucial. These include mental health disorders, substance abuse, history of trauma or abuse, social isolation, access to lethal means, and experiencing significant life events such as loss or relationship breakdown.
3	Suicides in Men and Intentional Self-harm in Women	Men are disproportionately affected by suicide, accounting for around three-quarters of all suicide deaths. Factors contributing to this disparity include traditional masculine norms, reluctance to seek help, and societal stigma surrounding mental health issues. While men have higher rates of completed suicide, women are more likely to engage in non-fatal self-harm behaviours. This demonstrates the importance of early intervention and support for individuals struggling with emotional distress.
4	Collaboration Between Stakeholders	Suicide prevention requires a collaborative effort between various stakeholders, including healthcare professionals, mental health organisations, policymakers, communities, and individuals. Developing comprehensive strategies that address risk factors and promote mental well-being is essential.
5	Strategies to Prevent Suicide	Effective suicide prevention strategies encompass a range of approaches, including improving access to mental health services, implementing crisis intervention programs, promoting mental health awareness, and reducing stigma associated with seeking help.
6	Whole Systems Approach	Adopting a whole systems approach involves integrating suicide prevention efforts across multiple sectors, including healthcare, education, social services, and criminal justice. This approach ensures a coordinated response to addressing risk factors and supporting those at risk.
7	Supporting People Bereaved by Suicide	The impact of suicide extends beyond the individual, affecting families, friends, and communities. Providing compassionate support and resources for those bereaved by suicide is essential for coping with grief and preventing further harm.
8	Responsible Media Reporting	Media reporting plays a significant role in shaping public perceptions of suicide. Responsible reporting guidelines aim to minimise sensationalism, avoid explicit details of methods, and provide information on available support services to prevent potential contagion effects.
9	Social and Economic Cost	Suicide imposes a significant social and economic burden, affecting individuals, families, and society. Investing in suicide prevention not only saves lives but also reduces healthcare costs, lost productivity, and the emotional toll on communities.
10	Local Government Suicide Prevention Strategies	Local governments play a critical role in implementing tailored suicide prevention initiatives that address the specific needs of their communities.  These strategies may include training for frontline workers, promoting mental health literacy, and establishing partnerships with local organizations to enhance support networks.

# Local

The number of suicides varies every year, with an average of about 21 people taking their own lives in Bromley annually.

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. 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.

In Bromley, the most common methods of suicide are consistent with those of the UK with hanging, strangulation or suffocation being the most common methods, followed by poisoning. The proportion of suicides by drowning has recently reduced and the overall proportion using this method remains low. The proportion of hospital admissions for intentional self-harm is highest in girls aged 0 to 18 years. However, it is worth noting that although there are fewer admissions of intentional self-harm in older residents, 65 years and over, research shows that older people who self-harm are three times more likely to die by suicide than the younger people who self-harm. Therefore, older adults and adolescent girls who intentionally self-harm should be a target group for services and support.

There is a strong relationship between deprivation and hospital admissions for intentional self-harm in Bromley but there is weak evidence for a relationship between suicide rates and deprivation. However, the difference seen in self-harm rates in the most and least deprived wards shows a high statistical significance. Further analysis at ward level shows that hospital admission rates are higher in the Penge and Cator and Cray Valley East wards, when compared to the rest of the borough.

# Introduction

When someone dies due to suicide, the effect on their family, peers, colleagues, healthcare staff, first responders, neighbours, broader community and beyond is devastating. The Department of Health estimates that a single person dying from suicide has an impact on approximately 135 people.<sup>1</sup> Globally, an estimate of 703,000 people take their own lives every year<sup>2</sup>, with 5,583 people dying from suicide in England in 2021.<sup>3</sup> A combination of distressing life events and a variety of risk factors often lead to suicidal behaviour. Factors such as gender, social and economic disparities contribute to the risk of suicide. As recommended by national directives<sup>4</sup>, this audit is conducted to provide guidance for Bromley's suicide prevention plan, based on comparisons between local and national statistics, which can then be used as a tool to reduce the local number of suicides, whilst addressing current inequalities.

According to the Office of National Statistics (ONS), suicide is defined as "death from deliberate self-harm among individuals aged 10 years and above" or "death by injury with an undetermined intent in individuals aged 15 years and above".<sup>5</sup> The first definition includes deaths which were explicitly labelled as suicide by the coroner or narrative conclusions on deaths which clearly indicate the deceased person's intention to end their own life. The second definition includes deaths with open or undetermined narrative conclusions from the coroner. The ONS' official statistics are based on the year in which a death was registered rather than the actual date of death.

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<sup>1</sup> [Layout 1 \(publishing.service.gov.uk\)](https://publishing.service.gov.uk)

<sup>2</sup> [Suicide \(who.int\)](https://www.who.int)

<sup>3</sup> [Suicides in England and Wales - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk)

<sup>4</sup> HM Government. (2021). Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives.

<sup>5</sup> Office for National Statistics. (2021, September). Suicides in the United Kingdom: 2020 registrations.

# National context

Suicide is a major, largely preventable, national public health issue with far reaching emotional, social, and economic implications for survivor family, friends & communities. It has been recognised as a priority area for national public health policy development and addressed through a series of national strategic documents.

Substantial progress has been achieved since the release of England's previous Suicide Prevention Strategy in 2012.<sup>6</sup> With nationwide implementation of local suicide prevention strategies and accessible bereavement services, bolstered by a £57 million allocation as part of the NHS Long Term Plan, notable progress has been made. Notably, suicide rates reached one of the lowest levels recorded in 2017.

Moreover, collaborative efforts to enhance patient safety have resulted in a significant 35% decrease in suicides within mental health inpatient facilities across England from 2010 to 2020. Despite these achievements, the current suicide rate, while not markedly higher than that of 2012, has plateaued, suggesting a pressing need for intensified efforts to prevent further loss of life.

The 2023 cross-government strategy for Preventing Suicide in England identified three principal objectives to:

- diminish the suicide rate within the upcoming five years, aiming for early signs of decline within two and a half years or less.
- improve support for individuals who have engaged in self-harm.
- improve support for people who have lost a loved one to suicide.<sup>7</sup>

These would be achieved by acting in eight priority areas:

1. improving the quality and availability of data and evidence to ensure that interventions remain effective, promptly adaptable and evidence based.
2. delivering tailored and focused support to priority groups, including those with heightened vulnerability, such as
  - children and adolescents, middle-aged men, individuals with a history of self-harm, individuals engaging with mental health services, individuals involved with the justice system, autistic individuals, pregnant women, and new mothers.
3. targeting common risk factors associated with suicide through early intervention and individualised support at a population level, including:
  - physical illness, financial hardship and economic challenges, problematic gambling behaviour, substance abuse, including alcohol and drug misuse, social isolation and feelings of loneliness and experiences of domestic violence.

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<sup>6</sup> [\[Withdrawn\] Suicide prevention strategy for England - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/101422/Withdrawn_Suicide_prevention_strategy_for_England.pdf)

<sup>7</sup> [Suicide prevention in England: 5-year cross-sector strategy - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/101422/Suicide_prevention_in_England_5-year_cross-sector_strategy.pdf)

4. promoting online safety and responsible media content to mitigate harm, enhance support resources, and provide constructive messaging regarding suicide and self-harm.
5. ensuring efficient crisis support services across various sectors to assist individuals who reach crisis point.
6. implementing measures to restrict access to means and methods of suicide as appropriate.
7. offering effective bereavement support to those affected by suicide.
8. fostering a collective responsibility towards suicide prevention, encouraging widespread engagement to maximise impact and efforts to support.

The 2024 report outlines the progress made against the original strategic objectives set in 2012 and 2023 and identifying key areas where further efforts are needed to accelerate the delivery of its aims at a local level, these are:

- Better and more consistent local planning and action by ensuring that every local area has a multi-agency suicide prevention plan, with agreed priorities and actions.
- Better targeting of suicide prevention and “help seeking” in high-risk groups such as middle-aged men, those in places of custody/detention or in contact with the criminal justice system and with mental health services.
- Improving data at national and local level and how this data is used to help act and target efforts more accurately.
- Improving responses to bereavement by suicide and support services.
- Reducing rates of self-harm as a key indicator of suicide risk.

The Office of Health Improvement and Disparities have published a series of Suicide Prevention Practice Resources to support local areas respond to the national strategy:

- Local suicide prevention planning (OHID 2022) v
- Support after a suicide: A guide to providing local services (OHID 2022) vi
- Preventing suicides in public places (OHID 2021) vii
- Identifying and responding to suicide clusters and contagion (OHID 2021)viii

# Purpose

The All-Party Parliamentary Group on Suicide and Self-harm Prevention recommends 3 elements essential to the successful local implementation of the national strategy:

- 1) Establishing a multi-agency suicide prevention group involving all key statutory agencies and voluntary organisations.
- 2) Completing a suicide audit.
- 3) Developing a suicide prevention strategy and/or action plan that is based on the national strategy and is informed by local data.

This audit report provides one element of the recommended tripartite local response. Suicide statistics provide an indicator of the mental health of a population, and it is important to monitor national and local trends in deaths resulting from intentional (and probable) self-harm.

The report aims to compare local and national rates, understand local trends, and make recommendations to reduce the number of local suicides in line with national strategies. It will form part of the local Mental Health Needs Assessment and Joint Strategic Needs Assessment and inform the Bromley Mental Health Strategy and the Bromley Suicide Prevention Plan.



# Changes in suicide in England, 1981-2021

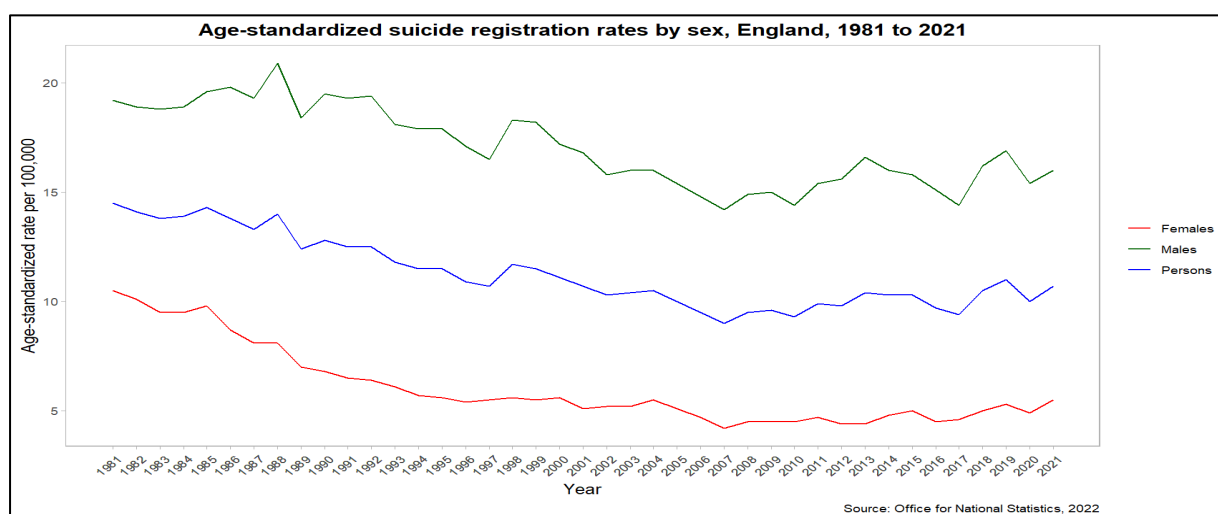
Overall, there has been a reduction in deaths from suicide in England from 1981 to the mid-2000s. After reaching a trough in 2007, suicide rates become relatively stable, followed by a slight increase, with periodic changes in the mid-2010s.

In 2021, the age-standardised suicide registration rate for persons in England was 10.7 deaths per 100,000 people. Although this is higher than the 10.0 deaths per 100,000 people seen in 2020, this is consistent with the rates observed in the pre-pandemic years of 2018 and 2019.

Gender differences in suicide rates are prominent throughout the observed period. Whilst both male and female suicide rates follow similar overall trends, with decreases in the early years and stability in the mid-2000s to mid-2010s, males consistently experience higher rates of suicide. In 1981, the male suicide rate was notably higher at 19.2 deaths per 100,000 people, while suicide rates for females stood at 10.5 deaths per 100,000 people. In 2021, the male suicide rate was 16.0 deaths per 100,000 people, while females recorded a rate of 5.5 deaths per 100,000 people in England. This is consistent with rates between 2018 and 2020. Women experience up to three times lower mortality rates than men (1,454 female deaths compared with 4,129 male deaths). In addition, the rates in women have declined at a faster and more consistent rate in comparison to the men as shown in Figure 1. The rate in women, from 1981 to 2021, has been nearly halved whilst the rate in men has reduced by 26% for the same period.

**Figure 1: Age-standardised suicide rates by sex, England, 1981 to 2021**

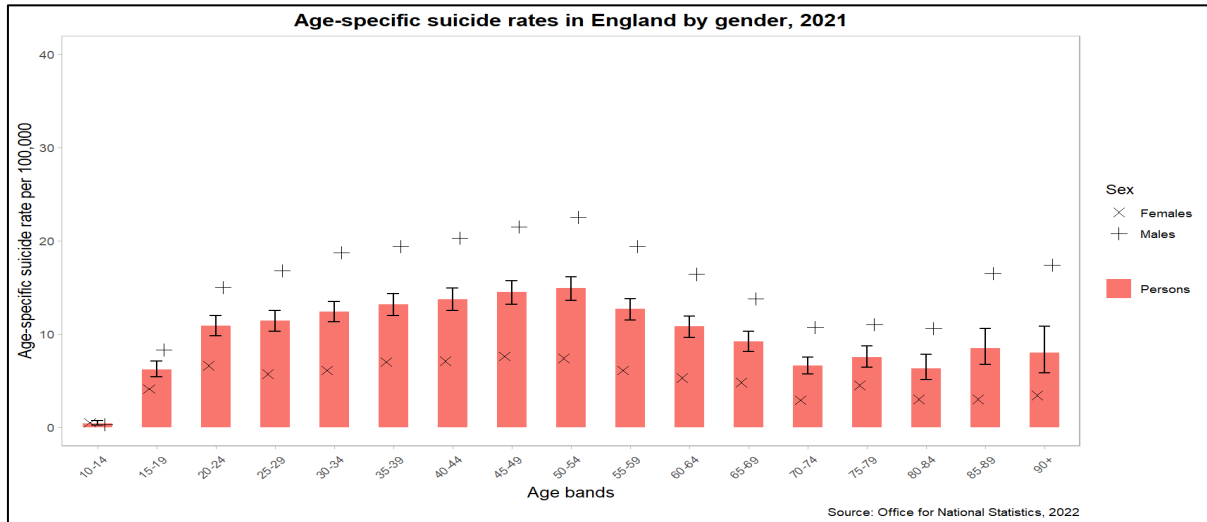
*Suicide definition: Deaths given an underlying cause of intentional self-harm or injury/poisoning of undetermined intent (in England people aged 15+). Deaths registered each year.*



Source: Office for National Statistics, 2022

Suicides rates in males increase with age up to 54 years and then reduces from 55 to 74 years of age before rising again. For women, the rates increase with age up to 54 years then reduces before rising again at 75 years (Figure 2).

**Figure 2: Age-specific suicide rate by age and gender, England, 2021**



Source: Office for National Statistics, 2022

# Simulated age-standardised rates

To assess the impact of narrative verdicts on suicides rates, simulated age-standardised suicide rates are discussed below. Monitoring simulated age-standardised suicide rates, especially when considering hard-to-code narrative conclusions, is crucial for understanding the impact of narrative coding on overall rates. According to the Office of National Statistics, hard to code narrative conclusions refers to the deaths from accidental hanging or poisoning, where the alternative underlying cause of death could not be assigned based on the information provided in the coroner's inquest conclusion. Unfortunately, there is no local data for Bromley at that granularity, so we are looking at the regional and national picture.

The lack of indication of intent makes it difficult for ONS to assign an underlying cause of death. The rules for coding cause of death mean that in the absence of a record of intent by the certifier, a death from injury or poisoning must be coded as accidental.

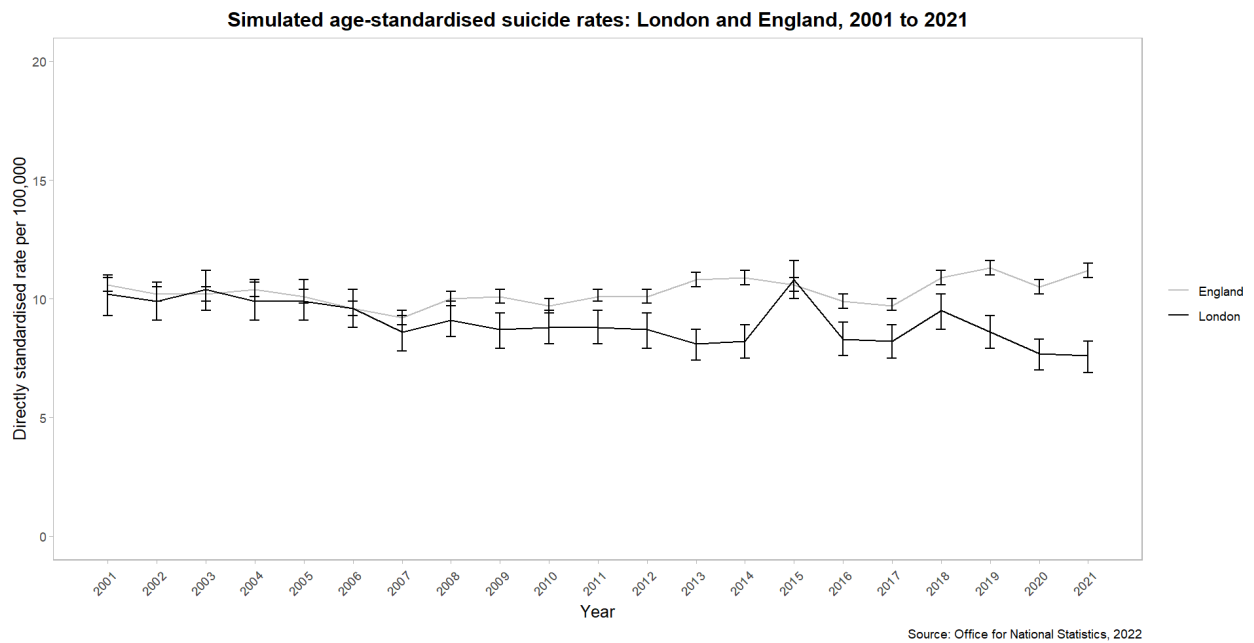
Assuming all deaths where a hard-to-code narrative verdict, due to coding rules, meant the death has been coded as accidental, were intentional self-harm. For instance, accidental hanging (ICD-10 codes W75–W76) or accidental poisoning (ICD-10 codes X40–X49) and count those deaths as intentional self-harm-hanging (ICD-10 codes X70) or intentional poisoning (ICD-10 codes X60-X69).

These “assumed” intentional deaths are then added to the number of suicides to calculate the simulated suicide rates. This allows us to further understand the impact of hard-to-code narrative verdicts on suicides.

Simulated age-standardised suicide rates for both England and London showed a relatively stable trend in 2021 compared to 2020. When comparing simulated age-standardised rates to directly age-standardised rates, simulated rates, which include hard-to-code narrative conclusions, tend to be slightly lower than directly age-standardised rates. This suggests that the inclusion of hard-to-code narratives might have a moderating effect on the overall rates (Figure 3).

London maintains a consistent pattern of lower suicide rates, both in simulated and directly age-standardized rates, indicating the presence of fewer suicides per 100,000 persons compared to the national average for England (Figure 3).

**Figure 1: Simulated age-standardised suicide rates: London and England, 2001 to 2021**

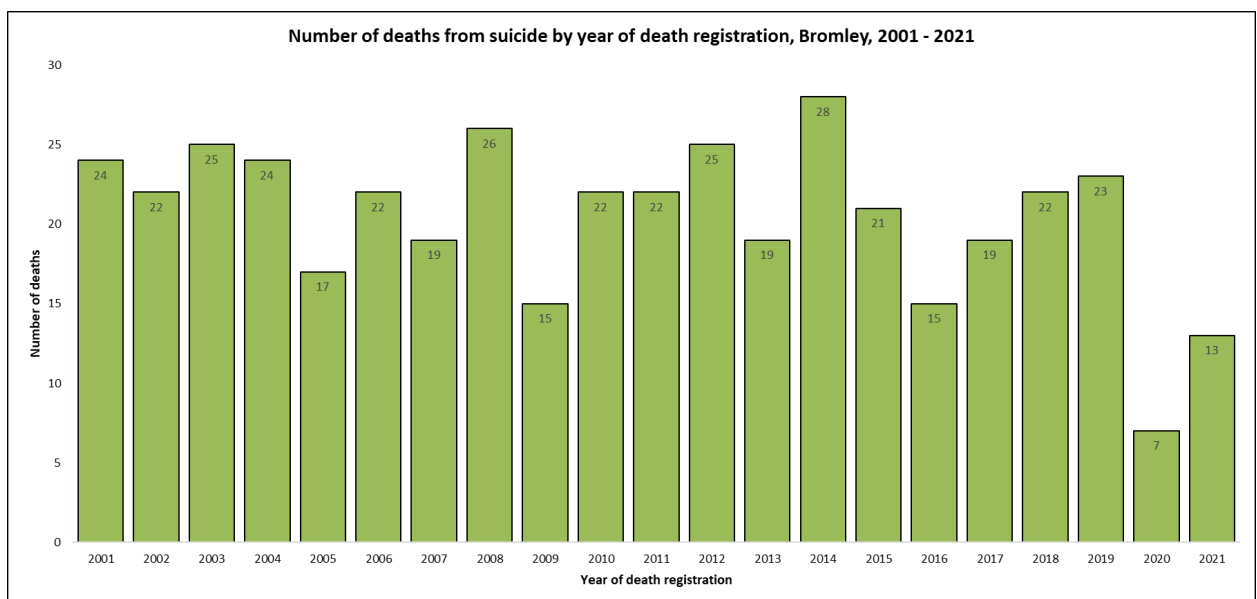


Source: Office for National Statistics, 2022

### Bromley

Bromley experiences a relatively small number of deaths from suicide each year. On average, twenty-one people die of suicide each year. However, every death from suicide is a tragedy which is potentially preventable and one which can have devastating and far-reaching impacts. The Office of Health Improvement and Disparities recommends that every local area, whether its suicide rate is high or low should make suicide prevention a priority.

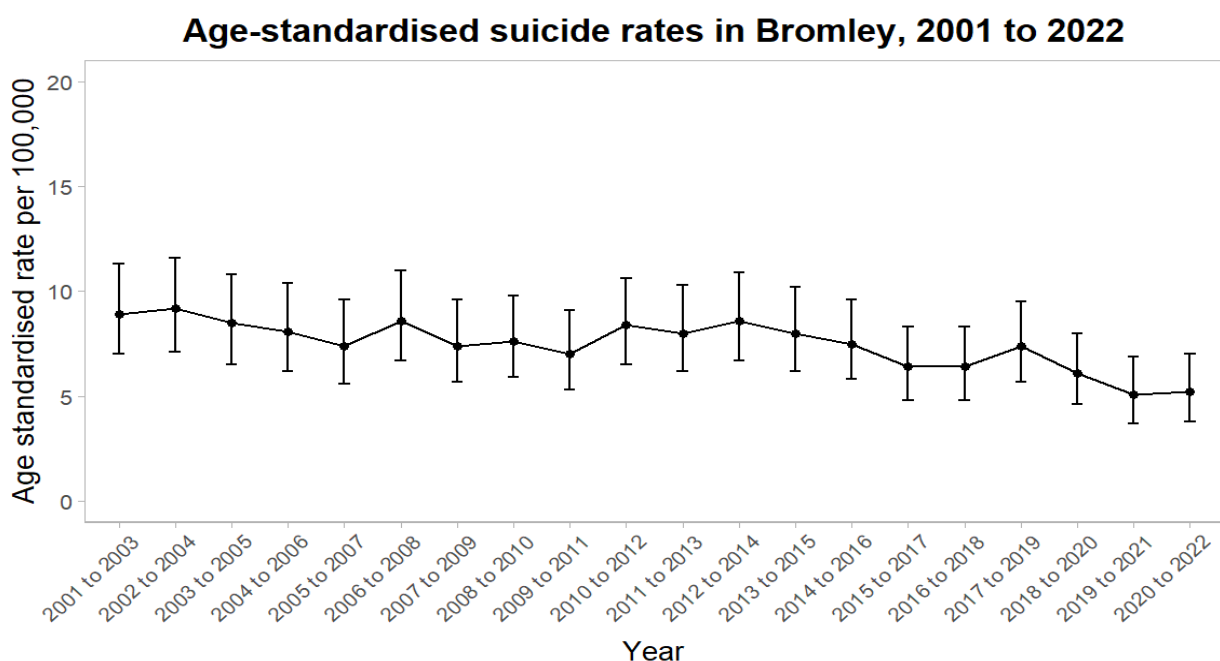
**Figure 4: Number of deaths from suicide by year of death registration, Bromley, 2001 to 2021**



Source: Primary Care Mortality Database

There is some fluctuation in age-standardised suicide rates in Bromley, with a slight decline over the years. In recent years, the suicide rates have gone from 7.4 deaths per 100,000 people in pre-pandemic years (2017 to 2019) to 5.1 deaths per 100,000 people in post-pandemic years (2019 to 2021). The trend in suicide rates slightly increased in the most recent years (2020 to 2022) to 5.2 deaths per 100,000 people. However, it is a very small difference, and it is unclear if this trend is likely to continue in future years. The wide range in confidence limits provide some uncertainty in estimating the true suicide rates due to the overall small number of suicides in Bromley’s population. Therefore, it is advised to interpret these findings with caution.

**Figure 5: Age-standardised suicide rates in Bromley, 2001 to 2022. Rates are calculated at 3 year intervals**



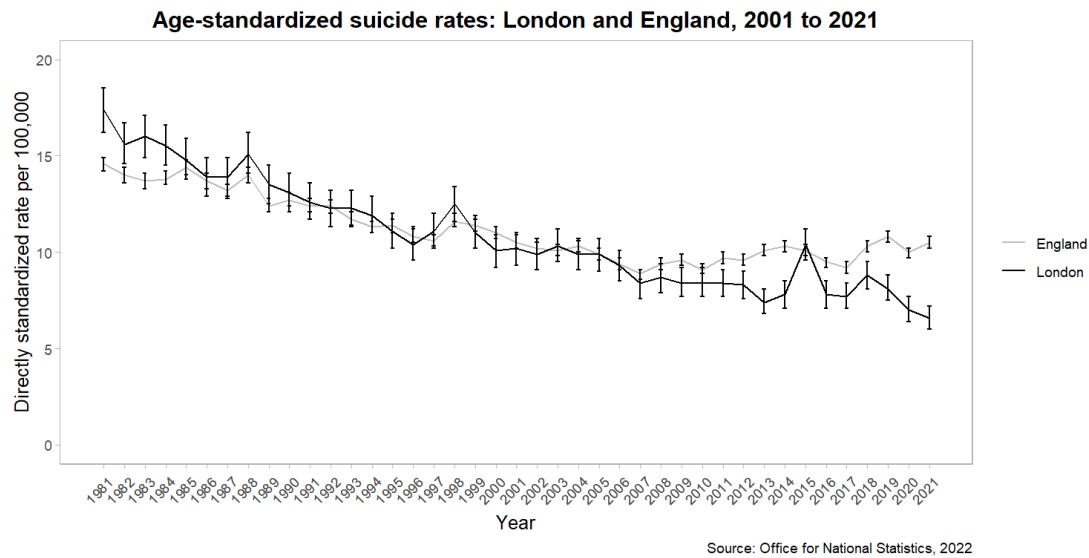
Source: Office for National Statistics, 2023

Source: Office for National Statistics, 2023

The regional rates have also decreased, to 6.6 deaths per 100,000 people in 2021 from 7.0 deaths per 100,000 people in 2020. The upper confidence limit (UCL) for London in 2021 was 7.2 deaths per 100,000 people, indicating a relatively low level of uncertainty. Contrastingly, the age-standardised suicide rate for England in 2021 was 10.5 deaths per 10,000 people, which was considerably higher than the regional rate for the same year. This rate also exhibited a slight decline compared to 10.0 deaths per 100,000 people in 2020. The UCL for England in 2021 was 10.8, suggesting a stable trend.

Both London and England have experienced fluctuations in age-standardised suicide rates over the years. For London, the rates have generally decreased at a much faster rate than England since 2015. In contrast, England has seen relatively stable rates with slight fluctuations, but have remained higher than London.

**Figure 6: Age-standardised suicide rates: London and England, 2001 to 2021**

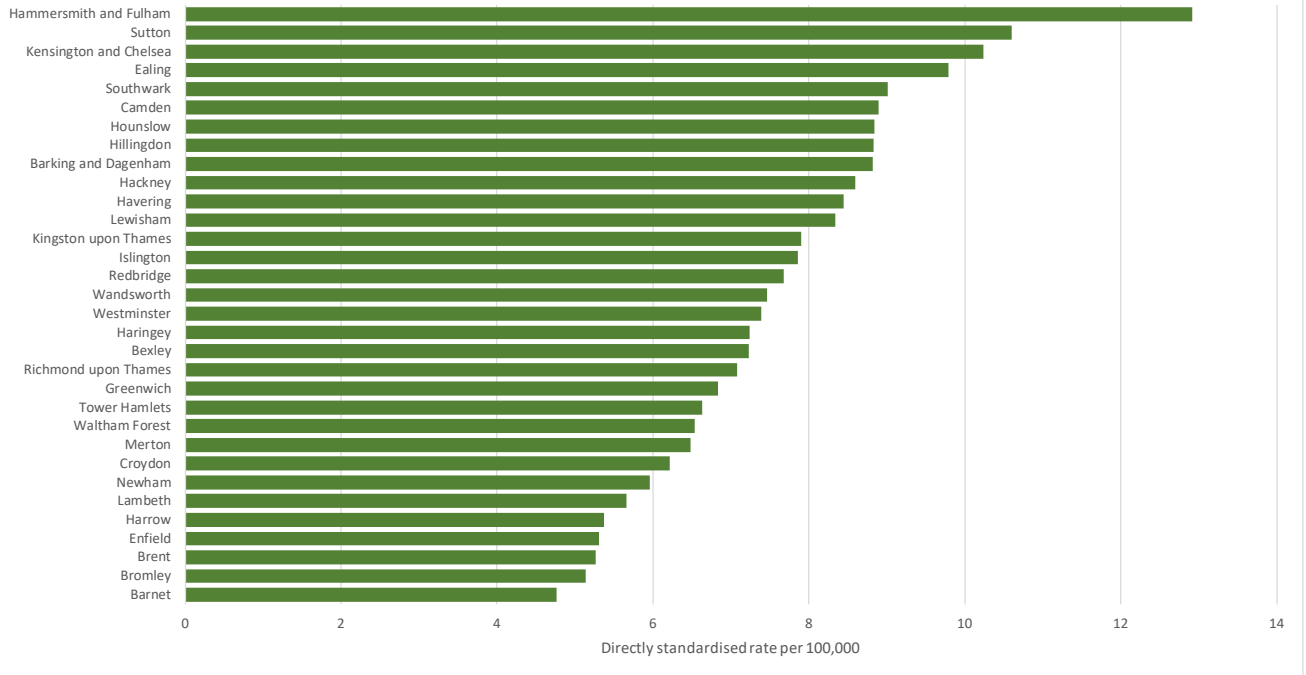


*Source: Office for National Statistics, 2022*

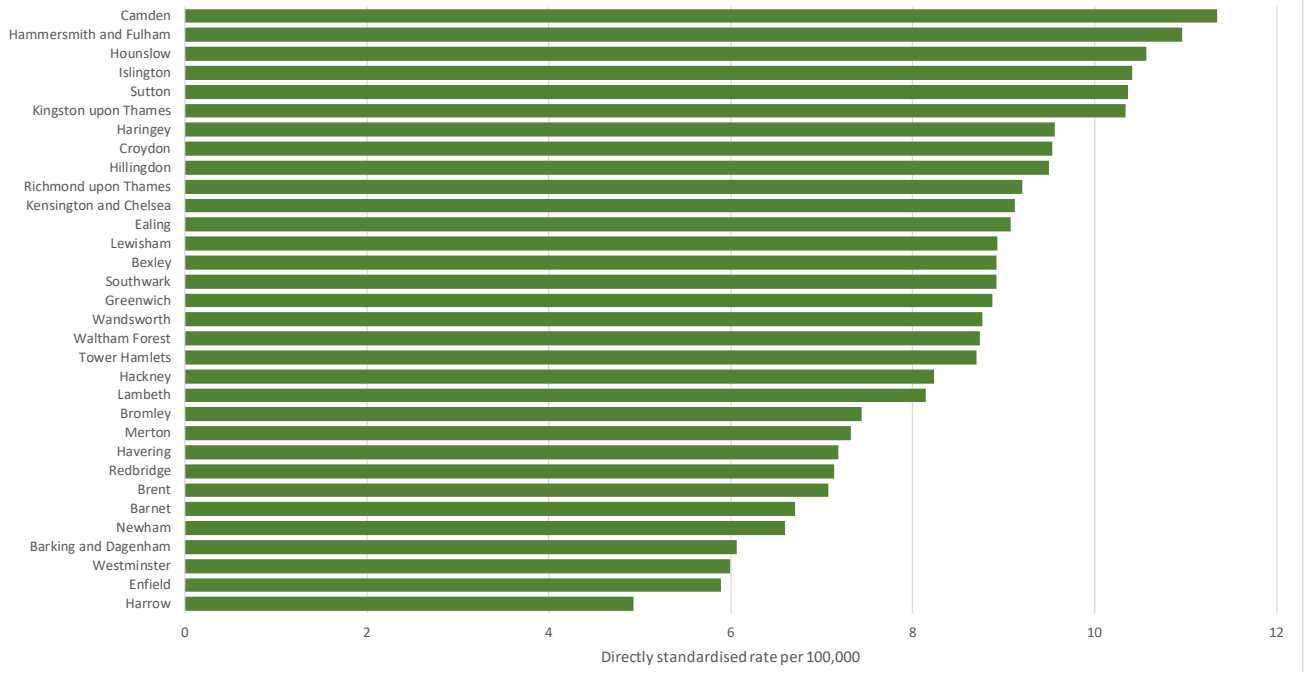
To gain further understanding on suicide rates in Bromley, the estimates can be compared with other London Boroughs. Bromley has a lower age-standardised suicide rate compared to London, making it one of the boroughs with lower rates in 2019-2021. This is consistent with the rates observed in the pre-pandemic years of 2017-19. Bromley ranks 31st out of the 33 London boroughs on suicide rates (where 1 is highest) in 2019-21 but there is a slight difference in Bromley’s ranking in comparison to other boroughs in 2017-19, when Bromley ranks 22nd. The lower rates recorded in the pandemic era may have been influenced by lower suicide registrations or worsened registration delays, due to lockdown restrictions. 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 7: Age-standardised suicide rates per 100,000 population, 2019 to 2021 and 2017 to 2019, persons 10+ years**

Age-standardised suicide rates per 100,000 population, 2019 to 2021 in persons 10+ years



Age-standardised suicide rates per 100,000 population, 2017 to 2019 in persons 10+ years



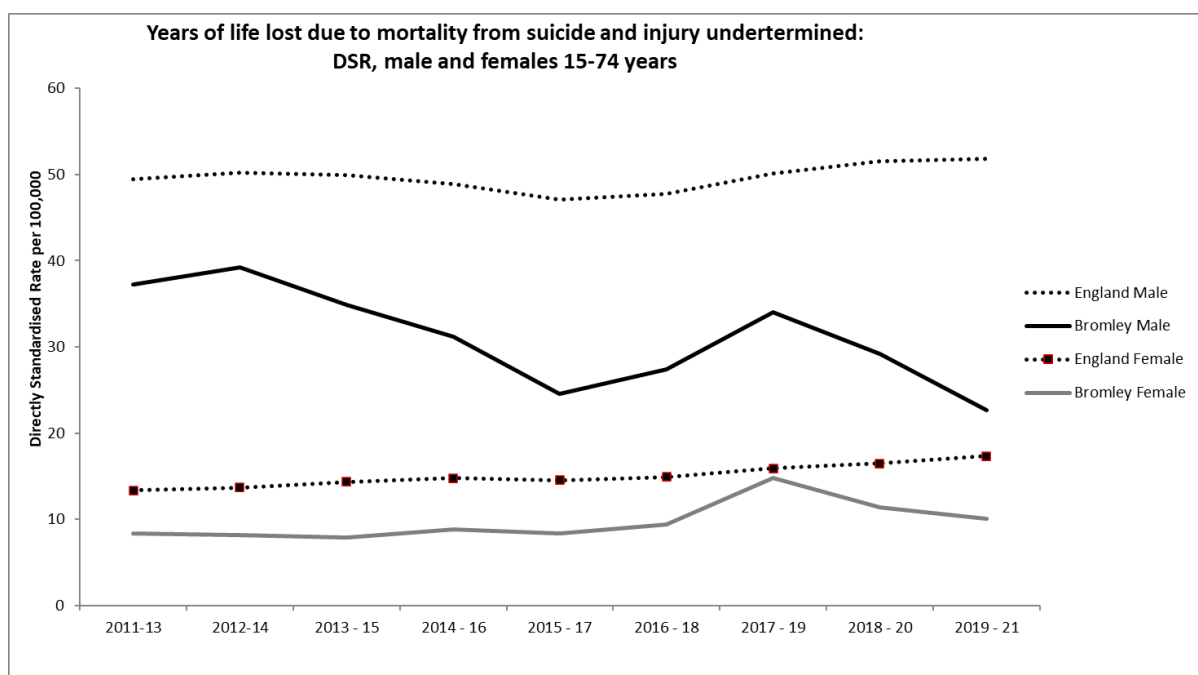
Source: OHID Fingertips

# Burden of suicide

Years of life lost is a population measure of premature mortality, estimating the length of time a person would have lived had they not died prematurely. Years of life lost due to mortality from suicide and injury of undetermined intent is an attempt to better quantify the burden on society.

The years of life lost to suicide is much higher in men than women. In Bromley specifically, the burden of suicide is consistently lower than the national average for England. While the years of life lost to suicide for Bromley shows a decline with some variability over the years, Bromley women show a relatively stable trend. There is a peak in Bromley men (34 deaths per 100,000 people) and women (12 deaths per 100,000 people) in 2017 -19. The mortality burden from suicide for Bromley men has recently decreased to approximately 21 deaths per 100,000 people in 2019-21. It should be noted that this mortality burden from suicide is wider than the premature life lost to the individual, having far reaching and long-term impact for family, friends and wider society.

**Figure 8: Years of life lost due to mortality from suicide and injury undetermined: Directly Standardised Rates, Bromley males and females, 15-74 years.**



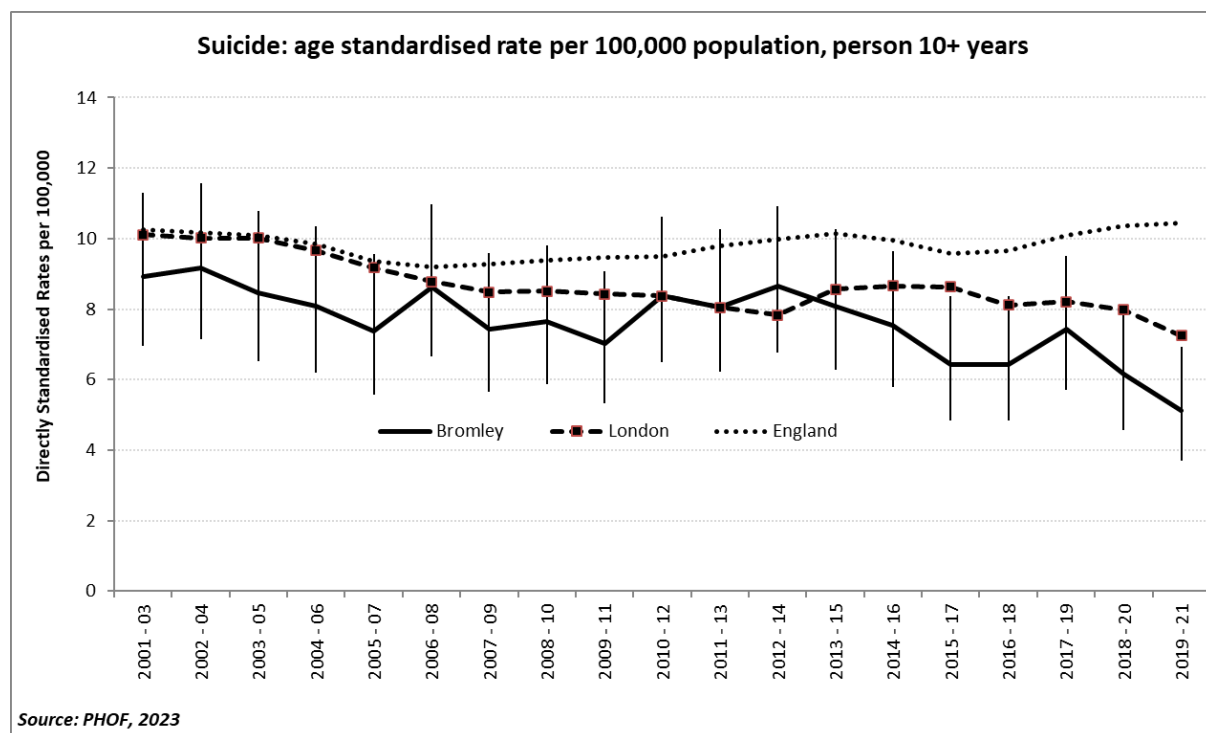
Source: Suicide Prevention Profile, 2023



### Trends in suicide mortality rates

Suicide rates in Bromley are lower than both England and London until 2010-12, where increases in Bromley suicide rates go above the regional average until 2013-15 when rates in Bromley dip below the regional average again. There are limitations to determining if any of these regional or national differences are statistically significant. There seems to be a declining trend in Bromley's suicide rates, notably in recent years (2019 - 2021). The rate in 2019-21 stands notably lower than previous years, showing a possible decreasing trend. However, these observations should be interpreted with caution, due to the potentially reduced number of registrations impacted by the COVID-19 lockdown restrictions. There are also considerably low numbers, which would impact the variability in Bromley rates, as well as the wide confidence intervals. There is some likelihood that the changes seen are not a precise estimate of the true underlying value (Figure 9).

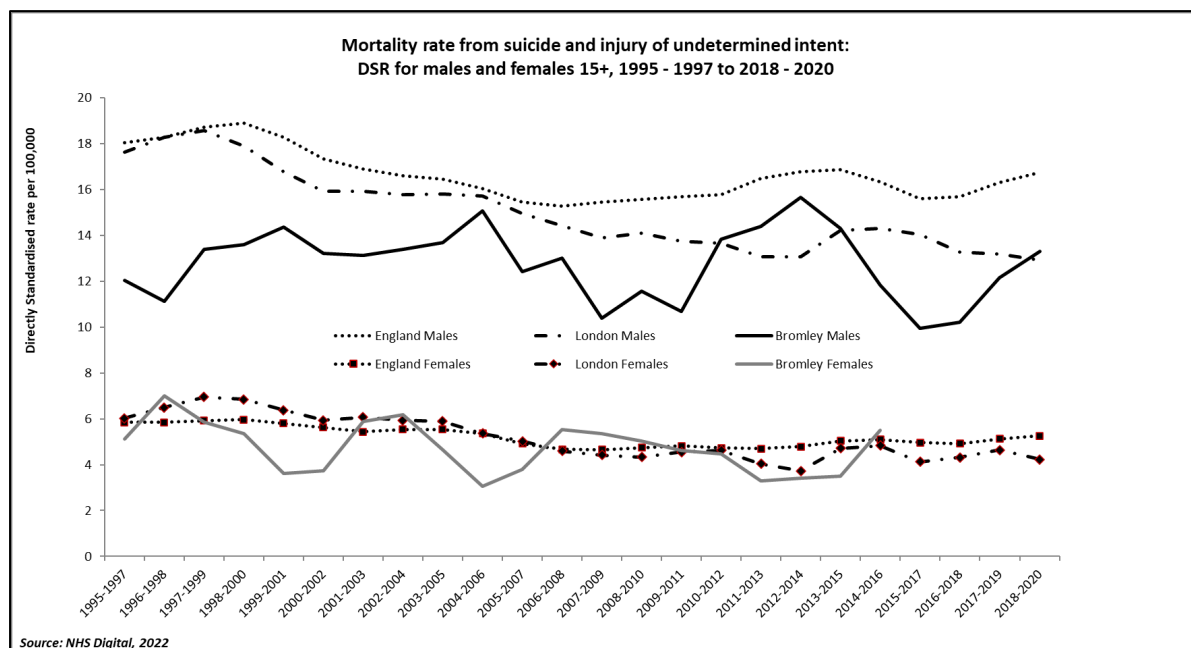
**Figure 9: Intentional self-harm included for persons aged 10 years plus and injury/ poisoning of undetermined intent included for persons aged 15+**



Source: Public Health Outcomes Framework, 2023

Both male and female suicide rates in Bromley have shown variability, with the most recent years indicating slight fluctuations. The male suicide rate in Bromley initially had a slight decrease from around 15.05 deaths per 100,000 people in 2004-2006, which was followed by a modest increase in the latest years reaching approximately 13.3 deaths per 100,000 people in 2018 - 2020. For Bromley females, there's an absence of data for recent years (2015 - 2020), making it challenging to discern current trends accurately, but there are considerable fluctuations ranging from 3.30 to 5.51 deaths per 100,000 people in the observed period.

**Figure 10: Mortality from suicide and injury undetermined (ICD-10 X60 – X84, Y10 – Y34 equivalent to ICD-9 E950 – E959, E980 – E989 excluding E988.8): directly standardised rate, 15+ years**



Source: NHS Digital, 2022

## Local mortality data

### Methodology

To get a more in-depth perspective of suicides at the local level, the Primary Care Mortality (PCMD) and Thrive London databases are used. The PCMD data is filtered to include only Bromley residents, date of death from January 2018 to October 2023 and the underlying cause of death for suicides refers to ICD10 codes X60-X84 (Intentional self-harm) and Y10-Y34 (Event of undetermined intent). The Thrive data includes all records of Bromley residents from 2020 onwards. Thrive data had known data quality issues in the first year of operation and data is significantly more dependable and complete from 01/03/2021 onwards. Thrive data only includes date of death. Deaths from the Thrive database are suspected suicides and are awaiting coroner inquests.

The records from Thrive data where the date of birth and postcode match the records in the PCMD data have been removed. Thrive data has been combined with PCMD data for Figure 11. Thrive data does not include a date of registration. Please note that Thrive data is more complete from March 2021 onwards. This should be considered when interpreting data on year totals.

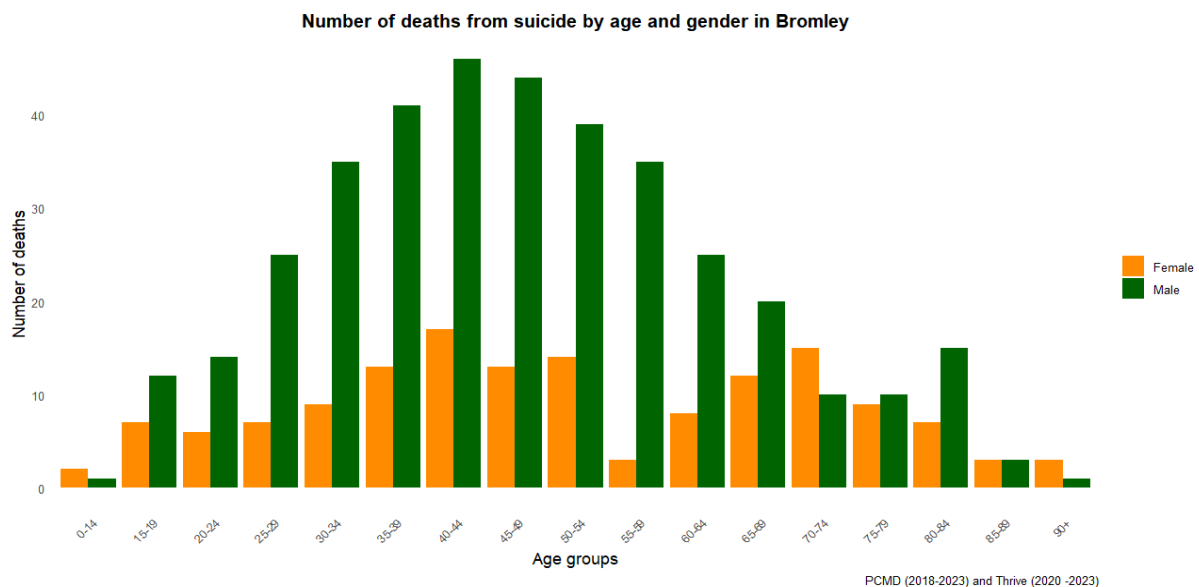
The small number of observed deaths locally is an additional reason to treat the data with caution. The data in figure 11 has been aggregated to three year rolling averages or 5 year rolling averages to increase events to levels which are more meaningful statistically and allows for easier illustration of underlying trends.

From 2018 to 2023, there were 524 suicides in Bromley. Majority of suicides locally were in people aged 30-59 years. Given that suicide rates in men are about three times higher than women, one can conclude that targeting interventions for males 30-59 years of age would dramatically reduce intentional self-harm that culminates in death in Bromley.

Without access to Coroner’s records data on ethnicity is limited; it is not fully available from death certificates. Place or country of birth as a proxy indicator for ethnicity does not consider the changing demographics where relatively large numbers of people from ethnic groups other than White British were born in the UK.

National evidence has shown that there is an increased risk of suicide among the unemployed<sup>89</sup> and that certain occupation groups have an elevated risk of suicide xiv (such as those in professions with easy access to means)<sup>10</sup>. The recording of occupation details over the years has improved however, without the coroner reports, there is no way of knowing the full social circumstances surrounding each suicide e.g., job losses, family losses etc. Research suggests that association between macroeconomic conditions and suicide vary according to occupation roles<sup>11xv</sup>. A range of other stressors such as austerity measures, loss of home, debt, strains on relationships and reduction in mental health services, alongside job losses, contribute to suicides<sup>12</sup>.

**Figure 11: Number of deaths from suicide by age and gender in Bromley**



Source: PCMD (2018-2023) and Thrive (2020-2023)

<sup>8</sup> [Work and Suicide: An Empirical Investigation | The British Journal of Psychiatry | Cambridge Core](#)

<sup>9</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1732539/>

<sup>10</sup> <https://pubmed.ncbi.nlm.nih.gov/24297788/>

<sup>11</sup> [Socioeconomic disadvantage and suicidal behaviour - Full.pdf \(samaritans.org\)](#)

<sup>12</sup> [Socioeconomic disadvantage and suicidal behaviour - Full.pdf \(samaritans.org\)](#)

## Method used

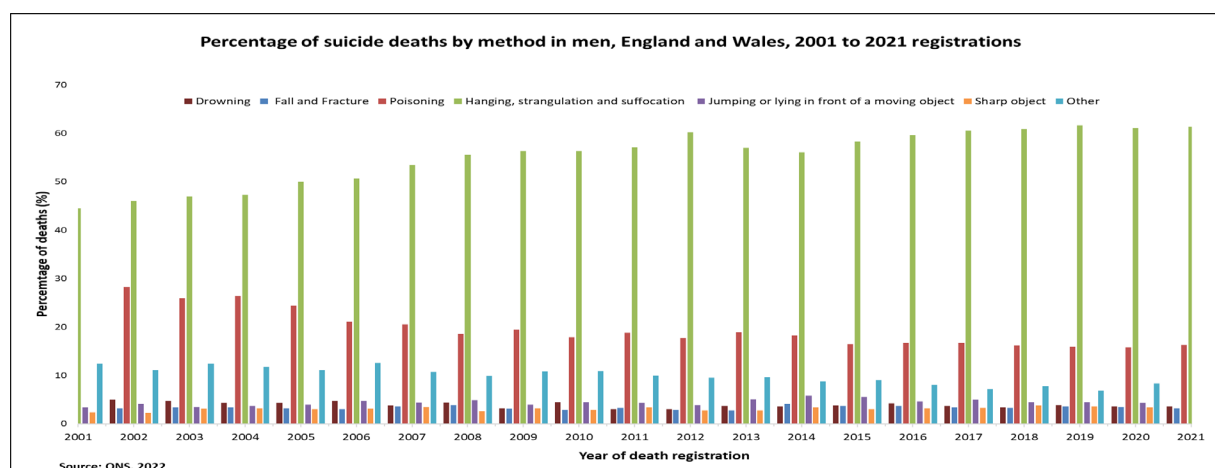
The method of suicide is recorded to identify the most employed causes of suicidal deaths, which can provide insights into potential targeted suicide prevention interventions. Mental health professionals and caregivers can assess an individual's risk of suicide and take the necessary preventative measures. It is important to note that different methods may have varying levels of lethality, and knowledge of the method used can help in determining the level of risk for individuals exhibiting suicidal behaviours.

The determination of the cause of death relies on the International Classification of Diseases, Tenth Revision (ICD-10) codes, detailed in the Appendix. The "Other" category encompasses suicide methods such as the use of firearms, inhalation of smoke, involvement with fire and flames, and events that are unspecified. Please also note that the method of suicide recorded at the local level is for Bromley residents only and does not include deaths that happened to have Bromley as the location at the time of death.

At the national level, hanging, strangulation, and suffocation are consistently the most common methods of suicide in males, ranging from 44.5% to 61.7%, with slight increases over the years. Poisoning is the most common method in females in the early 2000s (2001 – 2007) but became the second most common method for both genders, with a decreasing trend over the years. Similar patterns are observed in Bromley, where hanging by suffocation or strangulation is the most common method of suicide, with a slight increase over the years. Poisoning also follows a similar pattern as the second most common method and fluctuating decreases in the use of this suicide method.

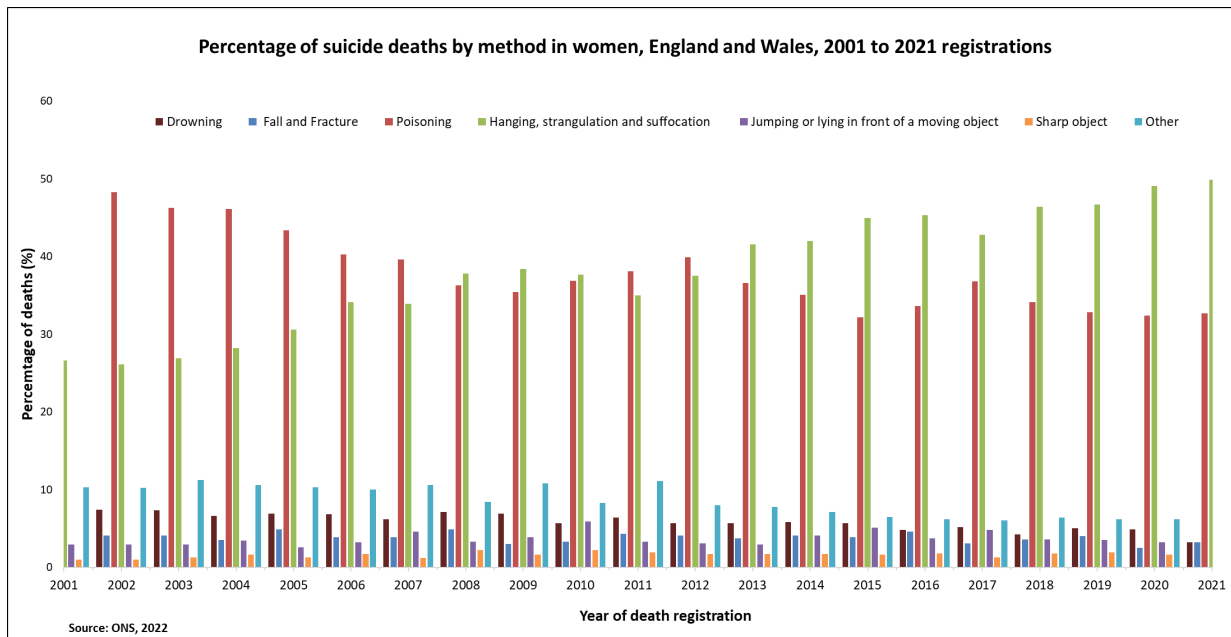
Fall and fracture, as well as jumping or lying in front of a moving object, show some variation but no consistent trend at the national level. Jumping or lying before a moving object is the most common method of suicide death by jumping (Figure 15), but there is no consistent trend, both at the national and local level.

**Figure 12: Percentage of suicide deaths by method in men, England and Wales, 2001 to 2021 registrations**



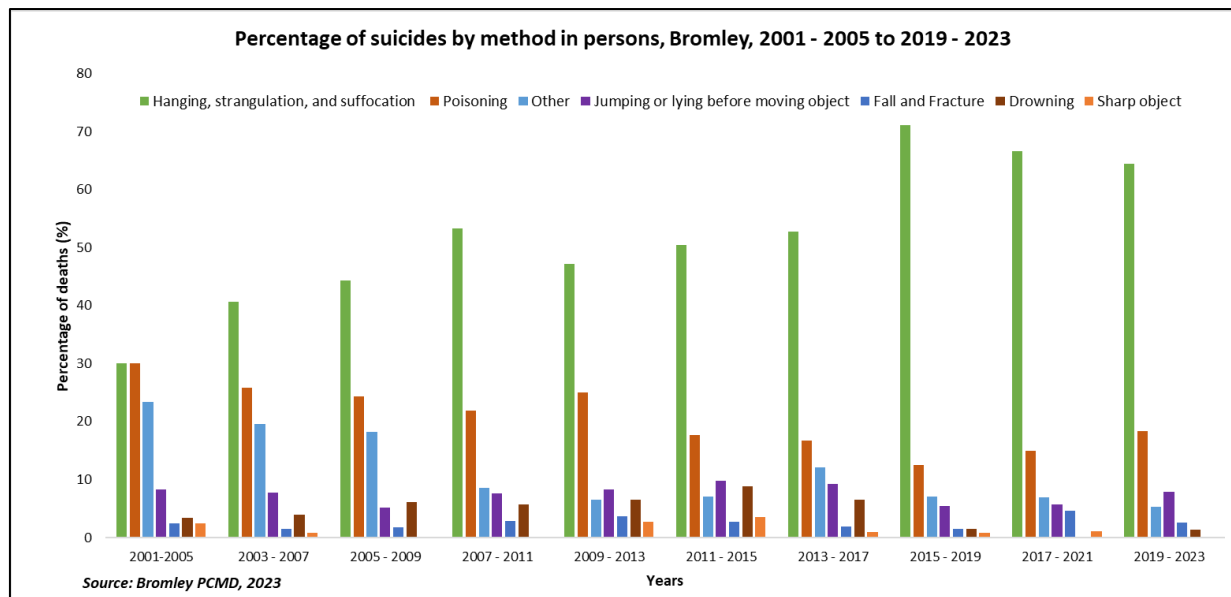
Source: ONS, 2022

**Figure 13: Percentage of suicide deaths by method in women, England and Wales, 2001 to 2021 registrations**



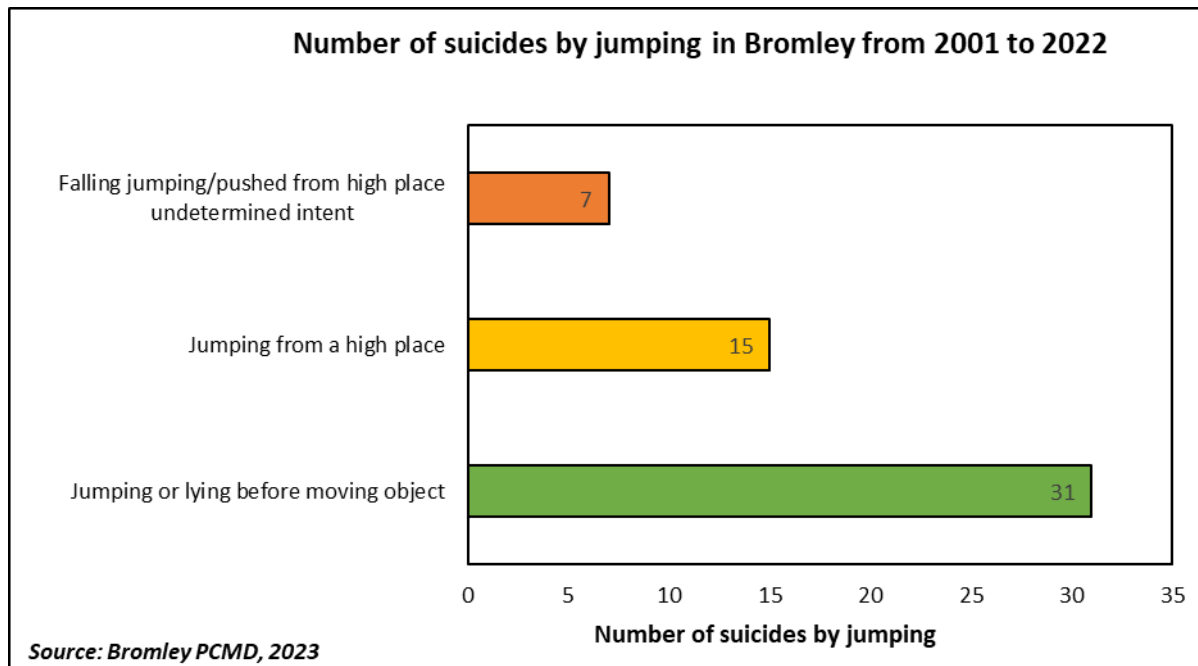
Source: ONS, 2022

**Figure 14: Percentage of suicides by method in persons, Bromley, 2001 – 2005 to 2019 - 2023**



Source: Bromley PCMD, 2023

**Figure 15: Number of suicides by jumping in Bromley from 2001 to 2022**



Source: Bromley PCMD, 2023

### Registration delays

Deaths should be registered within 5 days of the death occurring. Deaths considered unexpected, accidental or suspicious will be referred to a coroner. Due to the nature of recording such sensitive deaths, there can be a significant delay in obtaining figures caused by delayed coroner’s inquests which exacerbate death registration delays. Knowing the length of registration delays can provide an insight into the influence of long registration delays on the yearly fluctuations in suicide numbers. The complexity of certain cases may result in prolonged death registrations, and potentially also lead to lower observed suicide rates.

**Figure 16: Registration delays in Bromley and England from 2001 to 2021**

Bromley Registration Delays in Days				Compared to England	England Registration Delays in Days			
Year of registration	Median	Lower Quartile	Upper Quartile		Year of registration	Median	Lower Quartile	Upper Quartile
2001	81	62	130		2001	102	66	159
2002	90	75	112		2002	102	68	157
2003	72	53	113		2003	115	73	173
2004	101	76	119		2004	126	80	194
2005	97	82	114		2005	130	84	198
2006	101	90	143		2006	137	93	207
2007	144	129	219		2007	145	96	219
2008	149	114	199		2008	153	101	234
2009	129	77	198		2009	155	104	241
2010	137	112	194		2010	156	101	241
2011	144	120	178		2011	159	105	248
2012	124	93	162		2012	156	106	239
2013	107	70	168		2013	168	109	263
2014	127	98	247		2014	150	102	246
2015	131	116	164		2015	144	103	216
2016	186	151	308		2016	149	103	208
2017	161	131	231		2017	152	105	209
2018	158	130	176		2018	159	111	228
2019	120	89	173		2019	166	119	238
2020	169	112	212		2020	165	113	254
2021	206	153	333		2021	180	123	300

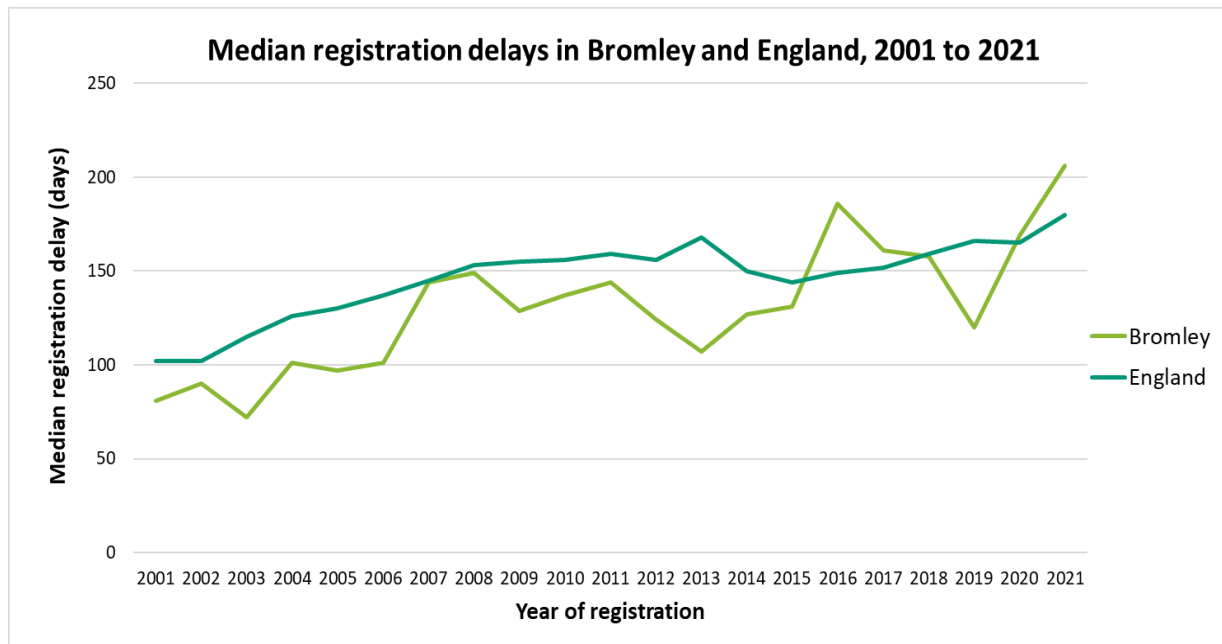
Shorter

Longer

Source: PCMD, 2022 and ONS 2022

Figure 16 shows that Bromley, when compared to England, generally has shorter registration delays. However, Bromley data is subject to random variability due to small numbers and any outliers are likely to skew the data.

**Figure 17: Median registration delays in Bromley and England, 2001 to 2021**



Source: Office for National Statistics

#### Social context and prior interactions with health and care services.

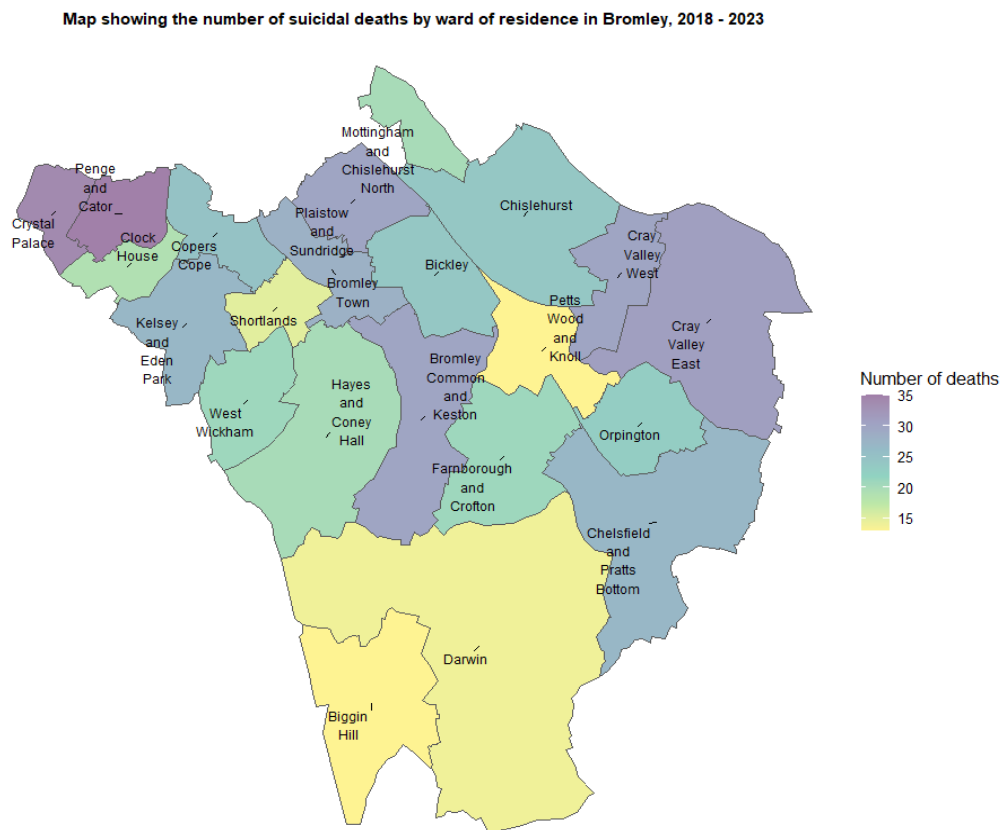
The National Suicide Strategy 2012 highlighted specific demographics at heightened risk of suicide, including young and middle-aged men, individuals under mental health care, those involved with the criminal justice system, and certain occupational groups like medical professionals, veterinary workers, farmers, among others. However, in this audit for Bromley, a comprehensive analysis of the social circumstances and service contacts of individuals who died by suicide has been impeded due to limitations: the unavailability of coroner’s reports and GP clinical notes, and insufficient clinical expertise and workforce to analyse extensive records spanning 1997-2016 for meaningful insights. Previous Bromley suicide audits, covering shorter timeframes, revealed crucial patterns, including documented suicide risk, instances of poor physical health and mental illness diagnoses, prior incidents of self-harm and suicide attempts, interactions with Primary Care within the year before death, and previous engagements with mental health services, including diagnoses of mental illness such as depression within the year before their passing.

#### Ward of residence

The map depicting suicides in Bromley reveals distinct variations in the distribution of the number of deaths from suicide across different electoral wards. Penge and Cator show the highest concentrations of suicides, followed by Crystal Palace. Other pockets within the borough with elevated occurrences compared to others include, Cray Valley East, Bromley Common and Keston and Plaistow and Sunbridge and Cray Valley West. These areas of darker shading suggest localised clusters of suicidal incidents. Such geographical clustering could imply the presence of specific

local factors or conditions, primarily in the north of Bromley which contribute to increased vulnerability within these regions. Further examination of the Bromley wards exhibiting higher densities of suicides would offer valuable insights into the underlying causes.

**Figure 18: Map showing the number of suicidal deaths by ward of residence in Bromley, 2018 - 2023**

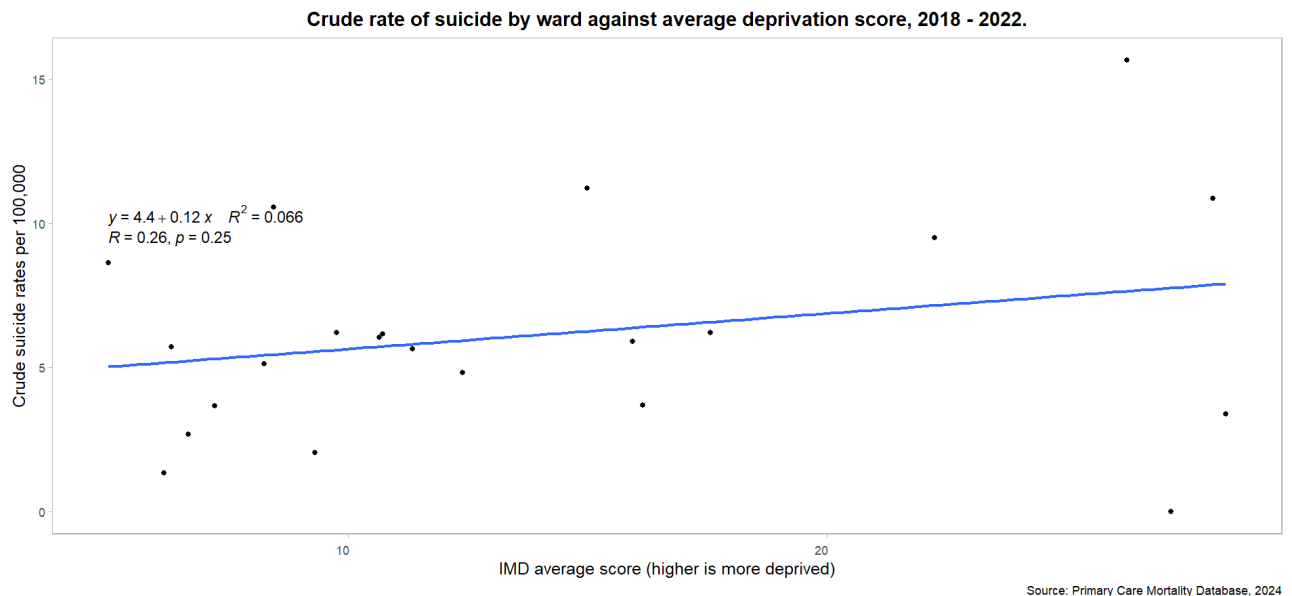


Source: PCMD and Thrive, 2018-2023

Source: PCMD and Thrive, 2018 – 2023



**Figure 19: Crude rate of suicide by ward against average deprivation score, 2018 - 2022**



Source: Primary Care Mortality Database, 2024

Figure 19 presents suicide rates by deprivation score across different wards in Bromley. Each dot represents a ward and the IMD score is a measure of deprivation, with higher scores indicating higher levels of deprivation.

There is some variability in suicide rates across different wards, with some evidence for a general trend of higher self-harm rates in wards with higher IMD scores, suggesting a potential association between deprivation and self-harm rates. The regression equation,  $y = 4.4 + 0.12x$ , implies that for every unit increase in the deprivation score ( $x$ ), the self-harm rate ( $y$ ) increases by 0.12 units, with an intercept of 4.4. The p-value of 0.25, suggests low statistical significance in the relationship between the deprivation score and suicide rates. Upon further evaluation, an R-squared value of 0.066 and an adjusted R-squared value of 0.26, indicate that approximately 0.6% of the variance in self-harm rates can be explained by the linear regression model. Therefore, these statistics suggest there is weak evidence for a positive association between deprivation and suicide rates in Bromley. This is likely due to small numbers of suicide in Bromley and the possibility that not all suicides are effectively captured in the PCMD database alone.

# Assessing the risk factors from suspected suicides

While the factors leading to an individual taking their own life often involve a variety of intricate circumstances, research on suicides across wider populations indicates a relationship between social determinants of health and a higher risk of suicide<sup>13</sup>. Key factors associated with suicide in men include depression, especially when it is untreated or undiagnosed, alcohol or drug misuse, unemployment, family and relationship problems (including marital breakup and divorce), social isolation and low self-esteem. Therefore, recognising shared risk factors, whilst acknowledging people's individual circumstances can facilitate the creation of specific intervention strategies. The identified risk factors relevant to Bromley residents are outlined below.

The risk factors presented in this analysis were gleaned from qualitative data from summary texts sourced from Thrive London's surveillance data and coded on N VIVO.<sup>14</sup> This qualitative approach delves into the intricacies and contextual nuances surrounding mental health, drawing insights from interviews, observations, and diverse narratives. Through this qualitative exploration, Thrive London's surveillance data captures a broad spectrum of experiential insights, perspectives, and personal accounts, allowing for a deeper understanding of the multifaceted factors contributing to mental health challenges and associated risk factors. Drawing from qualitative methodologies, would facilitate a more nuanced examination of the social, psychological, and environmental dimensions influencing mental health, providing a rich foundation for identifying and understanding the multifaceted risks that individuals face in Bromley.

Understanding the risk factors helps in identifying individuals who may be at higher risk of suicide, which would in turn, enable, timely interventions, support, and preventive measures to reduce the likelihood of suicidal behaviour. Please note that the identified risk factors were extrapolated from summary texts and coded on a thematic basis.

Mental health conditions are often associated with an increased risk of suicide due to the emotional distress and challenges they may pose to an individual's well-being. Individuals noted to have had a mental health condition had a diagnosed mental health disorder or condition, such as depression or anxiety, bipolar disorder, schizophrenia, anxiety disorders, or other psychiatric conditions. Substance abuse can also exacerbate mental health issues, impair judgment, increase impulsivity, and

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<sup>13</sup> Turecki, G., Brent, D. A., Gunnell, D., O'Connor, R. C., Oquendo, M., Pirkis, J., & Stanley, B. H. (2019). Suicide and suicide risk. *Nat Rev Dis Primers* 5, 74 (2019). *Nature Reviews Disease Primers*, 5, 74.

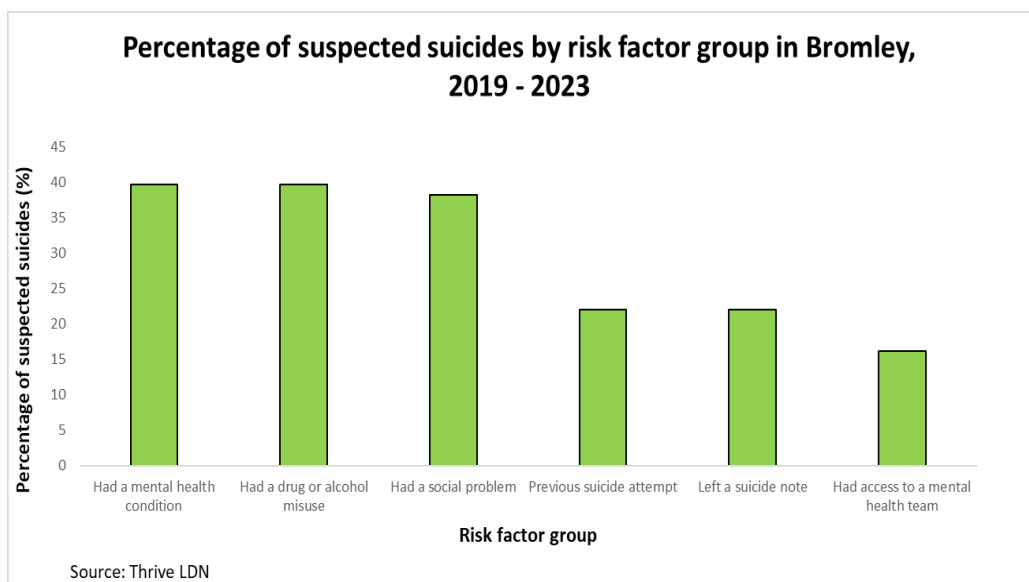
<sup>14</sup> <https://thriveidn.co.uk/about/our-activities/suicide-prevention/>

contribute to suicidal thoughts or behaviours. Reference to the drug or alcohol misuse risk factor suggests that the individual had a history of excessive drinking or misusing drugs such as prescription drugs, steroids, cocaine, heroin or other class A drugs.

Lack of access to appropriate mental health care can be a risk factor. While access to care does not necessarily eliminate the risk of suicide, it may serve as a protective factor when proper support and interventions are provided. Having access to a mental health team indicates whether the individual had access to mental health professionals or services. This support can vary from therapy and counselling to psychiatric care and medication.

Another risk factor is the experience of a social problem, which refers to the presence of significant social difficulties or stressors in the individual's life. Social problems could include relationship issues, family conflicts, grief, financial problems, unemployment, bullying, social isolation, previous arrest, being taken into custody or other challenging life circumstances that may contribute to emotional distress and feelings of hopelessness. The presence of a suicide note can also provide insights into the individual's mindset, reasons behind their decision, and may offer information to aid investigations. When someone leaves a written or verbal message expressing their intention to end their life, it's considered a suicide note. Finally, individuals who have made a previous suicide attempt are at a higher risk of attempting suicide again. A history of prior suicide attempts is considered one of the most significant risk factors for completed suicide.

**Figure 20: Percentage of suspected suicides by risk factor group in Bromley, 2019 - 2023**



Source: Thrive LDN

The data on suspected suicides by risk factor group in Bromley offers valuable insights into the contributing factors behind suicide. Nearly 40% of the cases involved individuals with a known mental health condition or a history of drug or alcohol misuse, emphasizing the critical role of mental health support and substance abuse intervention in suicide prevention efforts. This underscores the importance of

accessible and effective mental health services and substance misuse programs within the community to identify and support individuals at risk.

Additionally, social problems were identified in approximately 38% of suspected suicides, highlighting the impact of socioeconomic factors on mental well-being and suicide risk. Addressing social issues such as unemployment, homelessness, or relationship difficulties is crucial in preventing suicides and promoting mental resilience within the community. Furthermore, the data reveals that a significant proportion of individuals who died by suicide had previously attempted suicide or left a suicide note, indicating the importance of recognizing and responding to warning signs and providing appropriate follow-up care and support for those at risk. This underscores the need for comprehensive suicide prevention strategies that encompass mental health support, substance misuse interventions, social support services, and proactive identification and intervention for individuals with a history of suicidal behavior.

# Intentional Self -Harm

There exists no universally accepted definition of self-harm; however, for the context of this report, the definition put forth by NICE 2022 is employed<sup>15</sup>:

*Any act of self-poisoning or self-injury carried out by an individual irrespective of motivation.*

Notably, this definition excludes instances stemming from excessive alcohol or drug consumption, starvation due to anorexia nervosa, and accidental self-harm.

This report strictly adheres to the NICE 2011 definition and associates self-harm with suicide, highlighting that while suicide is a form of self-harm, most self-harm cases lack suicidal intent and result in less severe physical harm. The pivotal difference between self-harm and suicide lies in the intention behind the action. Research indicates that repeated instances of self-harm significantly elevate the risk of eventual suicide, increasing the likelihood by 50-100 times (Royal College of Psychiatrists, 2010). Often, cases of suicide are preceded by an episode of self-harm.

Detecting self-harm behaviour in individuals is challenging due to the secretive nature surrounding these actions. Data on self-harm outside of hospital admissions is scarce, except for that obtained from the Wellbeing service for children and young people commissioned in late 2014. Currently, there's no centralised reporting system for adults who intentionally self-harm outside hospital settings, and the identification and recording of intent may be prone to bias. It's important to note that hospital admissions do not fully represent the scope of intentional self-harm in Bromley; they merely scratch the surface of the problem.

Furthermore, hospital admissions count finished consultant episodes rather than the number of individuals, allowing for the possibility of multiple admissions for the same condition within a year, thus skewing the count.

To obtain further insights into the underlying causes, patterns, and associated risk factors of suicide, analysis of intentional self-harm episodes would help identify individuals at higher risk of suicide, allowing for targeted interventions and preventative measures. Not every individual that intentionally self-harms is successful in ending their own life. Thus, identifying the patterns in communities with the most risk of self-harming would provide deeper insights for timely suicide prevention measures.

Additionally, studying intentional self-harm data aids in assessing the effectiveness of the existing mental health support services provided in Bromley, as well as guiding improvements in interventions, treatments, and support systems tailored towards reducing the incidence of self-harm and preventing potential suicides. Ultimately, this analysis contributes to the overall enhancement of mental health care strategies,

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<sup>15</sup> [Overview | Self-harm: assessment, management and preventing recurrence | Guidance | NICE](#)

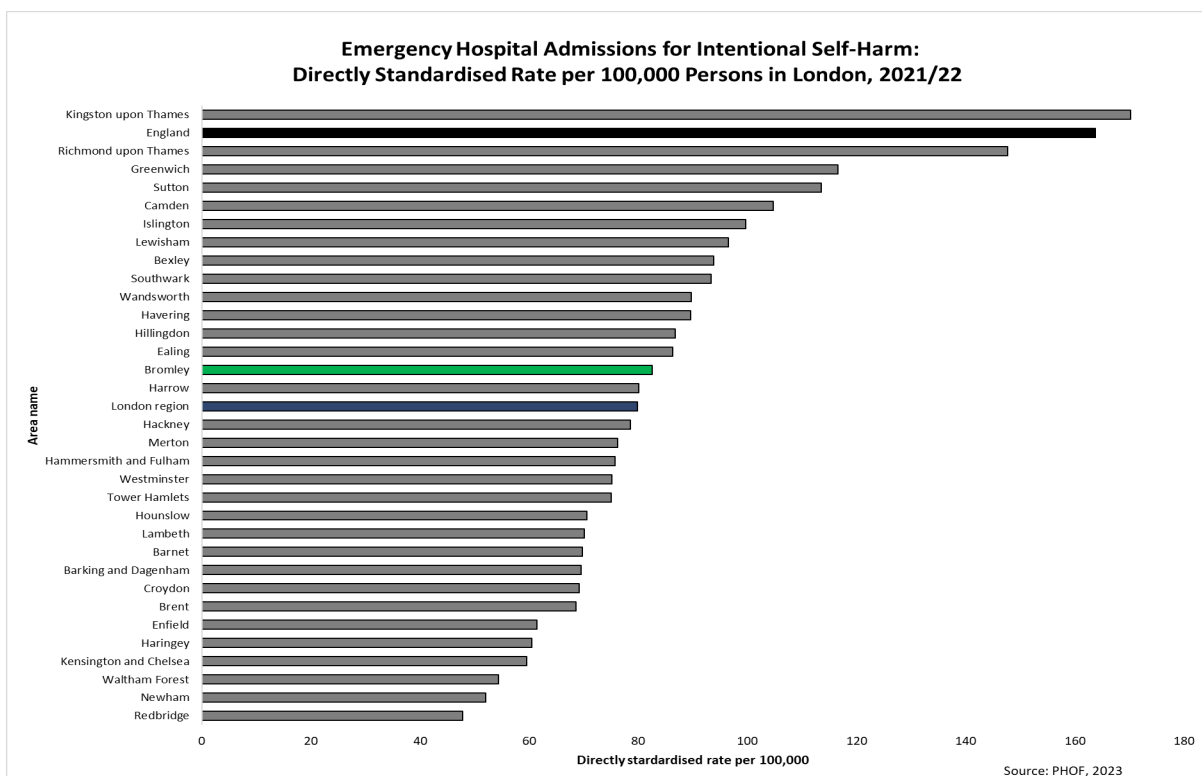
fostering a better understanding of vulnerable populations and facilitating the development of more targeted and effective suicide prevention initiatives.

Nonetheless, there are limitations to using hospital admissions data to reflect on intentional self-harm in Bromley. Hospital admissions do not accurately capture the full scope of intentional self-harm incidents, indicating a significant underestimation of the issue. This discrepancy arises from the fact that hospital admissions are tallied based on the number of finished consultant episodes, rather than unique individuals. Consequently, individuals may be readmitted multiple times within a year for the same condition, each instance being counted as a separate admission, further skewing the data.

To overcome some of these limitations, intentional self-harm incidents is evaluated from different data sources, including the Public Health Outcomes Framework (PHOF) and mainly the Hospital Episode Statistics (HES) database.

HES encompasses patient-level information from NHS hospitals in England, detailing hospital admissions, outpatient appointments, and Accident & Emergency visits. This dataset spans from 1997 to present and offers valuable insights into intentional self-harm incidents. However, there is still potential underreporting of self-harm cases due to reliance on hospital data, variations in coding practices, and the inability to capture non-hospitalised incidents or repeat occurrences outside of hospital settings.

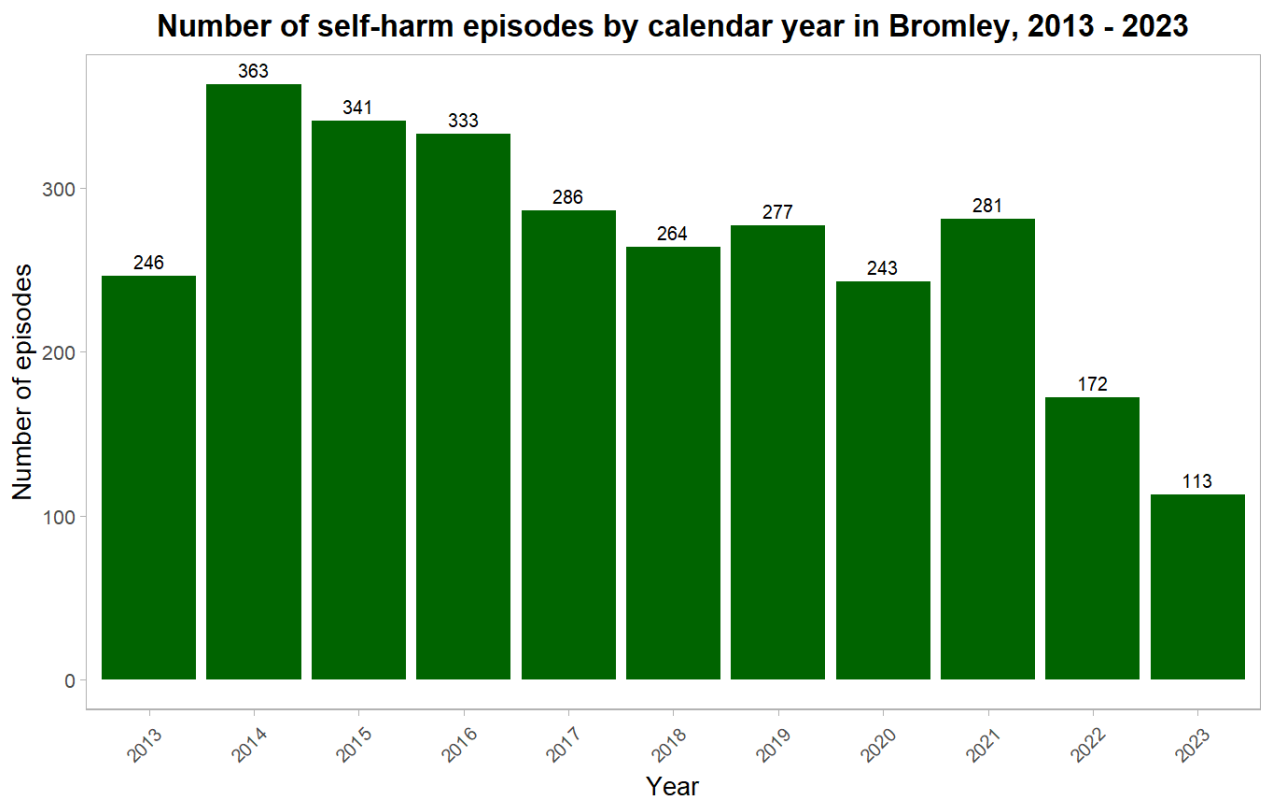
**Figure 21: Emergency hospital admissions for intentional self-harm: directly standardised rate per 100,000 persons in London, 2021/22**



Source: Public Health Outcomes Framework, 2023

The hospital admissions data shows that Bromley had the 14<sup>th</sup> highest rate of intentional self-harm in 2021/22, at 82.5 per 100,000 people. These rates are lower than the England rate of 163.74 per 100,000 population. The 2017 suicide audit highlighted that Bromley had the 5<sup>th</sup> highest intentional self-harm rates at 118.83 per 100,000 population in 2014/15. This suggests an improvement in intentional self-harm rates in Bromley in the recent years. Nonetheless, self-harm rates in Bromley remain higher than the overall rates in the London region at 79.81 incidents per 100,000 population. It is important to note that these figures are subject to reporting and recording bias and the practice of recording intent is variable across NHS Trusts and practitioners.

**Figure 22: Number of self-harm episodes by calendar year in Bromley, 2013 - 2023**



Source: Hospital Episode Statistics, 2024

Source: Hospital Episode Statistics, 2024

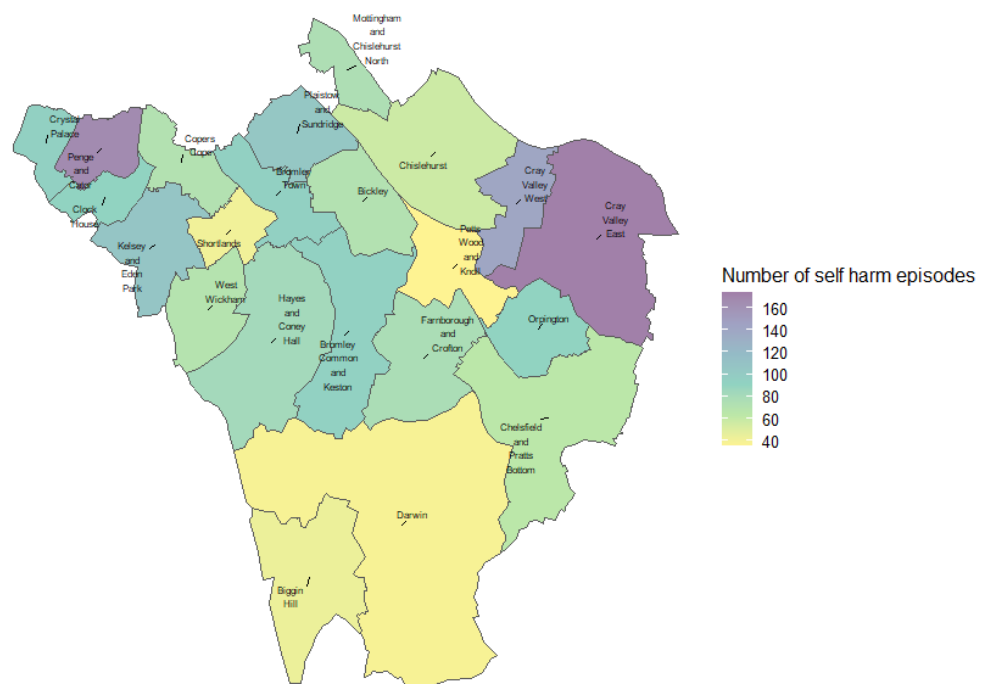
There is a slight variability in the number of self-harm episodes in Bromley over the last 10 years. The highest numbers of self-harm episodes observed are from 2014 to 2016. There is a slight decrease over the years, but these numbers should be interpreted with caution, due to the likelihood of repeated admissions in hospitals. The self-harm incidents in 2023 should also be interpreted with caution, as the data may not be completely up to date at the time of data extraction.

## Demographic differences

The map depicting self-harm in Bromley shows variations in the distribution of the number of self-harm episodes across different electoral wards. Cray Valley East shows the highest concentrations of self-harm, followed by Penge and Cator. Other pockets within the borough with elevated occurrences compared to others include Cray Valley West and Kelsey and Eden Park. These areas of darker shading suggest localised clusters of self-harm. Such geographical clustering could imply the presence of specific local factors or conditions, primarily in the north of Bromley which contribute to increased vulnerability within these regions. Further examination of the Bromley wards exhibiting higher densities of self-harm would offer valuable insights into the underlying causes.

**Figure 23: Map showing the number of self-harm episodes by ward of residence in Bromley, 2016 - 2023**

**Map showing the number of self harm Episodes by ward of residence in Bromley, 2016 - 2023**



Source: Hospital Episode Statistics, 2023

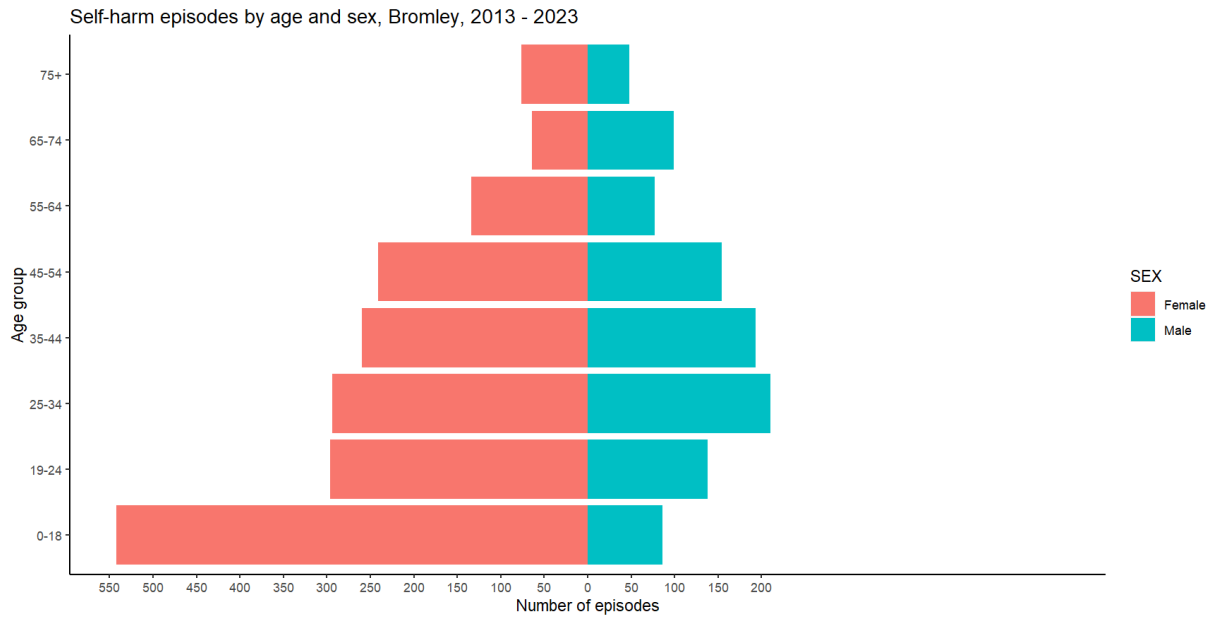
Source: Hospital Episode Statistics, 2023

Figure 24 shows that from 2013 to 2023, the number of self-harm episodes in Bromley females is higher than those in males across most age groups. There is a notably high number of self-harm incidents amongst the under 18 year old females, where we see 542 episodes, whereas the males in the same age category show 210 episodes. Self-harm incidents are relatively similar in those aged 35-44 and 45 – 54 years. The older age groups (64 -74 and 75+ years) show the lowest number of self-harm episodes in Bromley. Reasons other than changes in intentional self-harm patterns could have contributed to these numbers, for instance changes in coding



methods, treatment methods, community interventions and changes in reporting practices and patient management.

**Figure 24: Self-harm episodes by age and sex, Bromley, 2013 - 2023**

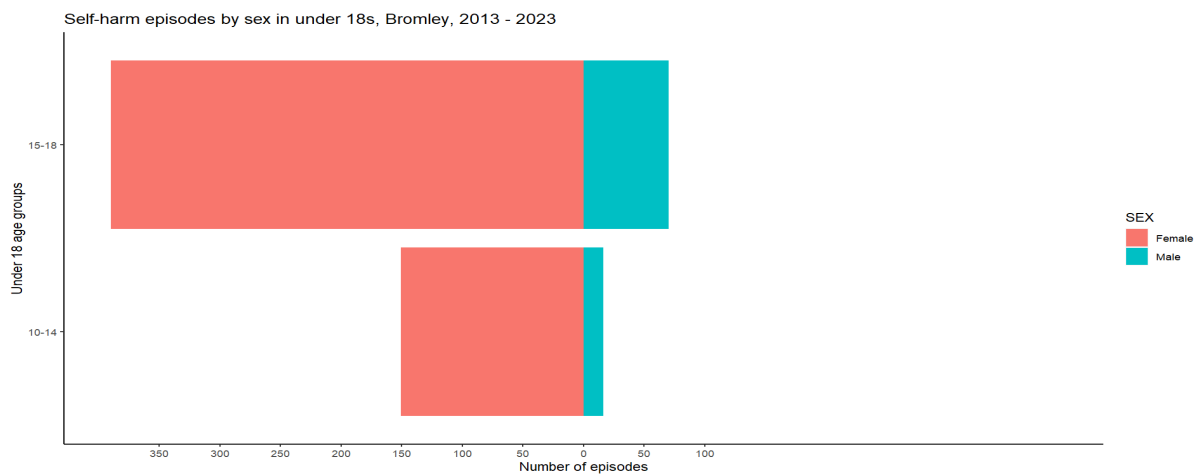


Source: Hospital Episode Statistics, 2024

Source: Hospital Episode Statistics, 2024

Figure 25 provides a closer observation of the under 18-year-olds to highlight if self-harm incidents are more common in children or teenagers. The chart suggests that young girls between the ages of 10-14 and 15-18 years have the highest number of self-harm episodes. Young girls aged between 15 and 18 years show the highest number of self-harm incidents, suggesting that secondary school girls are potentially more likely to self-harm.

**Figure 25: Self-harm episodes by sex in under 18s, Bromley, 2013 - 2023**



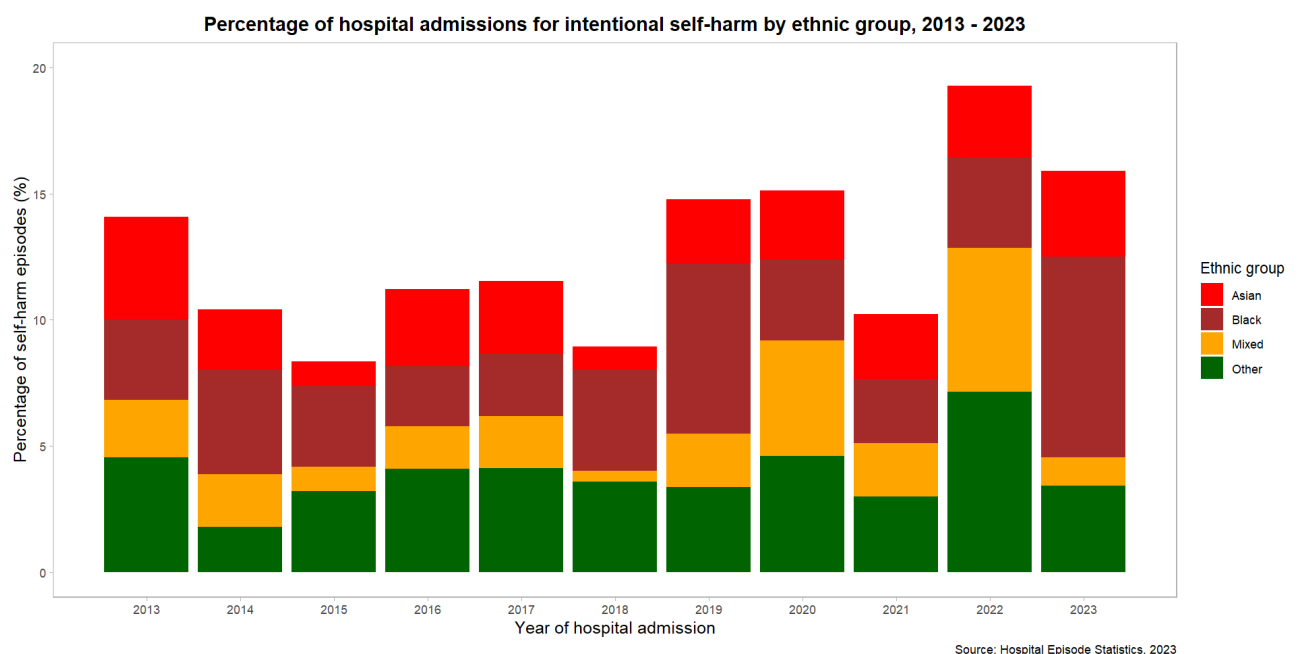
Source: Hospital Episode Statistics, 2024

Source: Hospital Episode Statistics, 2024

## Differences by ethnicity

Figure 26 shows the number of self-harm incidents by ethnic category over the years. The ethnic groups are categorised based on the codes provided in HES. Each ethnic category represents a broader grouping of ethnicities based on shared characteristics. The “Black” category comprises individuals of Caribbean, African, or other Black backgrounds. The “White” category includes individuals of British, Irish, or other White backgrounds. The “Mixed” category encompasses individuals of mixed heritage, such as White and Black Caribbean, White and Black African, White, and Asian, or any other mixed background. The “Asian” category includes individuals of Indian, Pakistani, Bangladeshi, or other Asian backgrounds. Finally, the “Other” category includes individuals from ethnic groups such as Chinese or any other ethnic group not covered by the previous categories. These categories provide a simplified way to analyse and understand the ethnic diversity within a population.

**Figure 26: Percentage of hospital admissions for intentional self-harm by ethnic group, 2013 - 2023**



Source: *Hospital Episode Statistics, 2023*

Discussion on self-harm episodes by ethnicity can be challenging due to the significant representation of individuals from white ethnic backgrounds, which introduces some discrepancy in the analysis. However, this overrepresentation is expected given that Bromley has a predominantly white population. To address this issue, Figure 26 excludes data for individuals from white ethnic backgrounds to better visualise differences within and between other ethnic groups. Interestingly, there has been a rise in intentional self-harm admissions among individuals from “Black” or “Other” ethnic backgrounds, while admissions from “Mixed” ethnic minority groups seem to have declined, despite the high number of admissions in 2022. Admissions for individuals from Asian or Asian British backgrounds are the lowest.

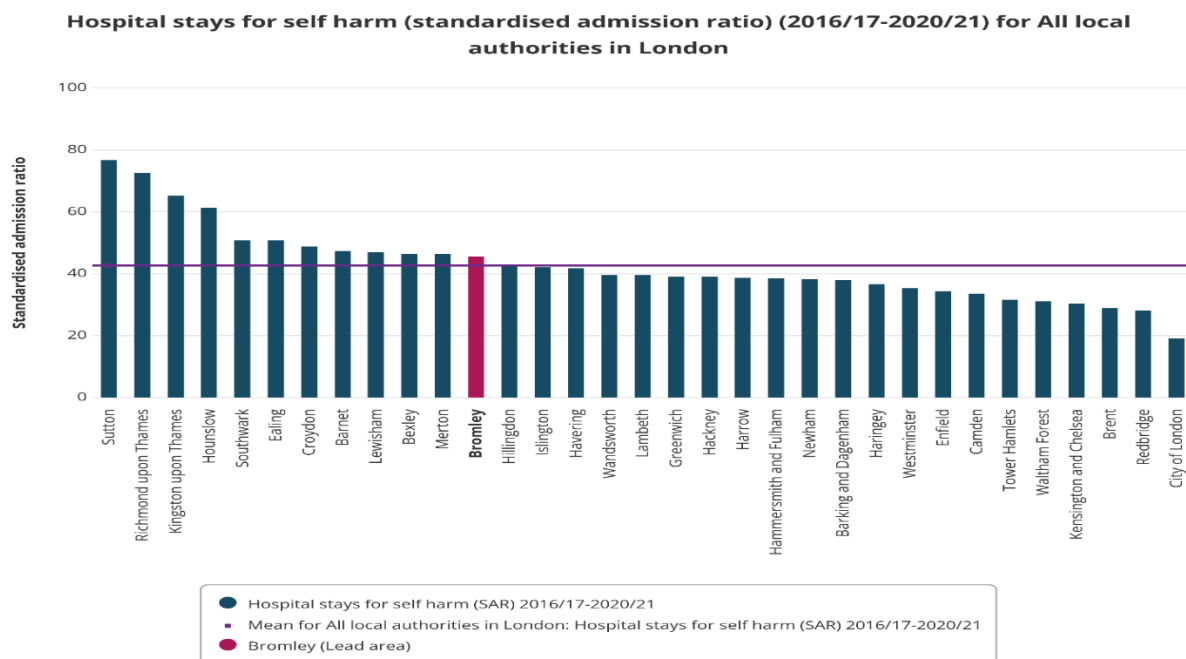
It is important to note that this analysis does not allow for standardised comparison, and further investigation is needed to ascertain the statistical significance of the observed differences. Additionally, HES may not have a high quality of ethnicity data available, due to the overall large proportion of individuals with unknown ethnicity in HES. Thus, these numbers should be interpreted with caution.

### Hospital stays due to self-harm

Whilst hospital admissions provide an overview of the rate of self-harm incidents, they do not capture the full scope of self-harm in Bromley, due to the potential for readmission and several other reasons. Hospital stays for self-harm can provide a more nuanced understanding of the impact and severity of incidents compared to solely looking at hospital admissions. Hospital stays indicate the length of time individuals require medical attention and monitoring following a self-harm incident. Longer hospital stays may suggest more severe cases or complications, as well as higher risk of repeated self-harm or suicide attempts. Analysing the duration of hospitalisation allows for risk stratification and tailored interventions to mitigate future incidents.

Moreover, examining hospital stays enables evaluation of the quality and effectiveness of care provided to individuals following self-harm. Factors such as access to mental health services, continuity of care, and discharge planning can influence the duration of hospitalisation and subsequent outcomes. Healthcare resources required to address self-harm incidents can also be assessed, including staff time, bed occupancy, and treatment modalities. This information can be crucial for resource allocation and planning within healthcare systems.

**Figure 27: Hospital stays for self-harm (standardised admission ratio) (2016/17 – 2020/21) for All local authorities in London**

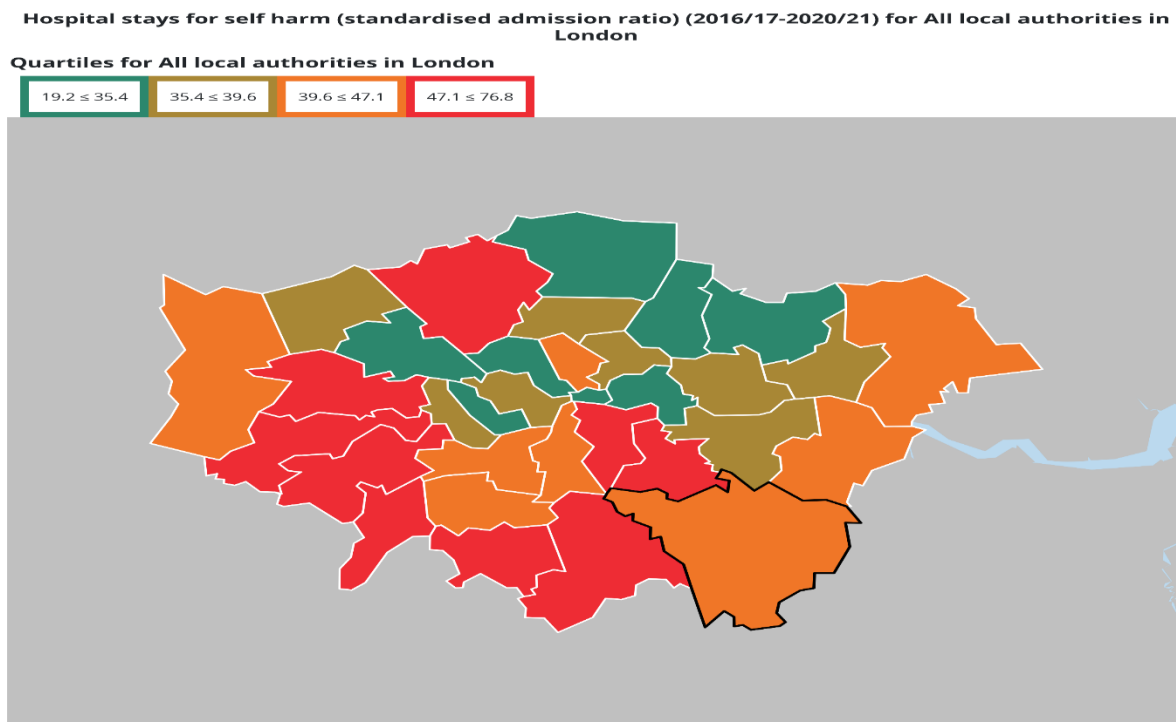


Source: Office for Health Improvement and Disparities (OHID)  
 Powered by LG Inform  
 Source: Office for Health Improvement and Disparities (OHID)

Figure 27 shows the hospital stays for self-harm in London local authorities from 2016/17 to 2020/21. The standardised admission ratio (SAR) indicates the likelihood that a Bromley resident would have an emergency admission to hospital compared to England, our standard reference population. This ratio compares the observed number of hospital admissions in Bromley, to the expected number in England. Bromley has a SAR of 45.6, which is below 100, indicating a lower-than-average emergency admission rate. However, when compared to all local authorities in London, Bromley is slightly above the mean SAR of 42.7. This suggests that Bromley has a higher rate of hospital stays for self-harm compared to the average across London. Nonetheless, Bromley still falls within a similar range as other local authorities. Overall, while Bromley's SAR is slightly elevated compared to the London average, it is within the range observed across various local authorities in the region.

The map indicates a moderate level of hospital stays for self-harm within Bromley compared to other London boroughs (SAR falls between  $39.6 \leq 47.1$ ). When compared to other regions on the map, we observe that some areas, such as Sutton and Kingston upon Thames, have higher SARs, suggesting a relatively higher incidence of hospital stays for self-harm in those regions compared to Bromley. Overall, while Bromley's SAR places it in the moderate range compared to other London boroughs, there are areas with both higher and lower incidence rates of hospital stays for self-harm, highlighting the variability across different regions within London.

**Figure 28: Hospital stays for self-harm (standardised admission ratio) (2016/17 – 2020/21) for All local authorities in London**



Source:  
Office for Health Improvement and Disparities (OHID)  
Powered by LG Inform

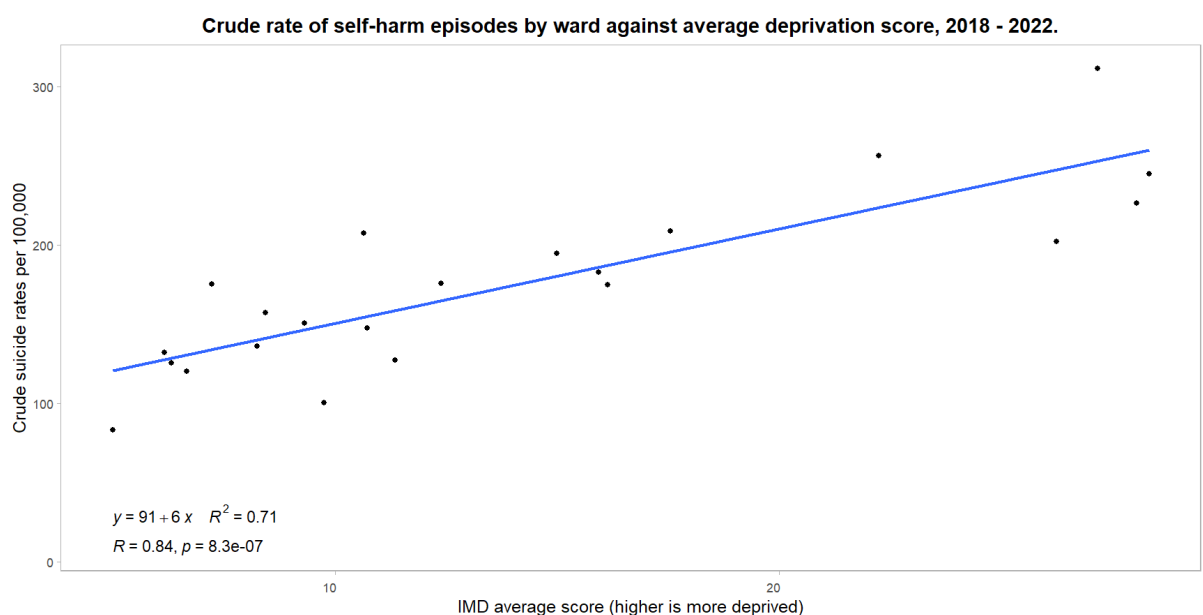
Source: Office for Health Improvement and Disparities (OHID)

## Deprivation and intentional self-harm

Figure 29 presents intentional self-harm rates by deprivation score across different wards in the Bromley area. Each dot represents a ward and the IMD score is a measure of deprivation, with higher scores indicating higher levels of deprivation.

There is strong variability in self-harm rates across different wards, with rates ranging from around 83 to over 311 incidents per 100,000 population. Additionally, there is evidence for a general trend of higher self-harm rates in wards with higher IMD scores, suggesting a potential association between deprivation and self-harm rates. The regression equation,  $y = 91 + 6x$ , implies that for every unit increase in the deprivation score ( $x$ ), the self-harm rate ( $y$ ) increases by 6 units, with an intercept of 91. This is supported with the p-value of  $8.3 \times 10^{-07}$ , suggesting that there is a statistically significant relationship between the deprivation score and self-harm rates. Upon further evaluation, an R-squared value of 0.71 and an adjusted R-squared value of 0.84, indicate that approximately 71% of the variance in self-harm rates can be explained by the linear regression model. The adjusted R-squared value of 0.84 suggests that this model is a good fit for the data. Therefore, these statistics suggest a strong positive association between deprivation and intentional self-harm rates in Bromley, as indicated by the regression model's performance and the significance of the coefficients.

**Figure 29: Crude rate of self-harm episodes by ward against average deprivation score, 2018 - 2022**



Source: Hospital Episode Statistics, 2024

# Conclusions and recommendations

Based on the findings of this audit, several conclusions can be drawn to enhance suicide prevention efforts:

- The number of suicides in Bromley fluctuates annually, with an average of approximately 21 suicides per year, emphasising the ongoing need for effective prevention strategies.
- Male individuals are disproportionately affected by suicide, with rates up to three times higher than females, while intentional self-harm rates are more prevalent among women and young people.
- Hanging, strangulation, or suffocation are the most common methods of suicide in Bromley, consistent with national trends, followed by poisoning, highlighting the importance of targeted intervention strategies.
- The proportion of hospital admissions for intentional self-harm is highest in girls aged 0 to 18 years.
- There has been a rise in intentional self-harm admissions among individuals from “Black” or “Other” ethnic backgrounds.
- Although fewer intentional self-harm admissions occur in older residents (aged 65 and over), research indicates they are at a significantly higher risk of subsequent suicide, necessitating tailored support services for this demographic.
- There is a notable association between deprivation and hospital admissions for intentional self-harm in Bromley, particularly evident in certain wards such as Penge and Cator and Cray Valley East.

The following opportunities for further development of action to prevent suicides in Bromley have been identified:

- Develop targeted interventions to address the specific needs of vulnerable populations, including older adults and adolescent girls who intentionally self-harm, focusing on early identification and support. This can be done by
  - establishing specialised support groups or counselling services and counselling services tailored to the needs of older adults who self-harm, providing them with a safe space to discuss their challenges and receive appropriate assistance.
- Implement school-based prevention programs focused on building resilience and coping skills among adolescent girls, equipping them with strategies to manage stress and emotional distress effectively.
- Strengthen collaboration between healthcare providers, social services, and community organisations to ensure a comprehensive approach to suicide prevention, with particular emphasis on addressing the underlying factors contributing to self-harm and suicidal behaviours.
- Implement community-based initiatives aimed at reducing stigma surrounding mental health and promoting help-seeking behaviours, particularly in areas with higher levels of deprivation. Encourage all members of the community to

attend suicide prevention training sessions such as the Applied Suicide Intervention Skills Training (ASIST) hosted by PAPYRUS, a charitable organisation dedicated to preventing suicide and promoting positive mental health in young people.<sup>16</sup>

- Enhance training programs for healthcare professionals and frontline workers to improve risk assessment and intervention strategies for individuals at risk of suicide or self-harm. This can be done by
- Offering specialised training workshops for primary care physicians and emergency room staff on suicide risk assessment and intervention techniques, incorporating evidence-based approaches such as the Columbia-Suicide Severity Rating Scale (C-SSRS) to improve accuracy and consistency in screening.
- Increase access to mental health services and crisis support resources, particularly in areas identified as having higher rates of intentional self-harm, to provide timely assistance and intervention to those in need.
  - For example, establishing outreach clinics or mobile mental health units in underserved areas of Bromley, would provide convenient access to counselling services and crisis intervention for individuals who may face barriers to accessing traditional healthcare settings.
- Review the Bromley Suicide Prevention Action Plan and action plan to reflect on the findings from this audit in the context of the Suicide prevention strategy published in 2023.
- Maximise the opportunities for sharing knowledge, intelligence and learning around effective suicide prevention strategies across the SEL STP ICS
- Continue to undertake an audit of suicides in Bromley at regular intervals to gather detailed knowledge about the epidemiology and risk factors of those taking their own life in the local population. A review of coroners' records should also be included in future audits.
- Explore wider sources of data on self-harm available at a national and local level to add insight to the hospital admissions data already available.
- Refresh the Bromley Suicide Prevention plan to reflect findings from this report and the new National Suicide Prevention Strategy published in 2023.
- Maximise the opportunities for sharing knowledge, intelligence and learning around effective suicide prevention strategies across the SEL ICS.
- Continue to undertake an audit of suicides in Bromley at regular intervals to gather detailed knowledge about the epidemiology and risk factors of those taking their own life in the local population. A review of coroners records should be undertaken in the next audit.
- Explore wider sources of data on self-harm available at a national and local level to add insight to the hospital admissions data already available.

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<sup>16</sup> [Upcoming Sessions | Papyrus UK | Suicide Prevention Charity \(papyrus-uk.org\)](https://www.papyrus-uk.org/)

# Appendix

International Classification of Diseases, Tenth Revision (ICD-10) codes

Method	ICD-10 Code
Drowning	X71, Y21
Fall and fracture	X80, Y30
Poisoning	X60-X69, Y10-Y19
Hanging, suffocation and strangulation	X70, Y20
Jumping or lying in front of a moving object	X81, Y31
Sharp object	X78, Y28
Other	X72-X77, X79, X82-X84, Y22-Y27, Y29, Y32-Y34

Source: ONS, 2022

## Technical notes

### Data sources and definitions

To understand suicides and intentional self-harm for Bromley, PCMD and Hospital Episodes Statistics extract have been used.

The Primary Care Mortality Database (PCMD) provides a list of all deaths recorded as suicides or open verdicts. PCMD collates deaths by place of death, CCG of residence and date of death. The underlying cause of death is recorded for all deaths in the PCMD using the World Health Organisation's (WHO) International Classifications of Diseases version 10 (ICD 10). The relevant codes are listed in a table in the appendix. It is worth noting the changes in coding deaths over the time period. From 1998-2000 deaths in England were coded using the Ninth Revision of the ICD (ICD-9), since 2001, the Tenth Revision of the ICD (ICD-10) has been in use.

Due to various organisation and regulation changes access to datasets (Coroner records and GP clinical records) that complement the PCMD extract is no longer possible. The absence of those datasets eliminates the soft intelligence around suicides which is vital in prevention strategies. The report specifically looks at profiling the population of people registered as having taken their lives.



Age-specific rates determine the frequency with which the event occurs relative to the number of people in a defined age group. The rate is limited to a particular age group compared to age-standardised rates which use the age-specific rates and adjust for population differences.

The Hospital Episodes Statistics (HES) extract pulls together inpatient and day patient hospital admissions for intentional self-harm. The underlying cause of admission is recorded for all admissions in the HES using the World Health Organisation's (WHO) International Classifications of Diseases version 10 (ICD 10). The relevant codes are listed in a table in the appendix.

### **Comparator data**

The comparator data is derived from the:  
Health and Social Care Information Centre Indicator Portal  
Public Health Outcomes Framework  
Data sources and definitions

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