Suicide Prevention

Annual Public Health Report 2024

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Welcome to Bromley's Annual Public Health Report 2024

Foreword

I am pleased to present Bromley's Annual Public Health Report for 2024.

Every year Directors of Public Health produce a report which reflects on the health and wellbeing of local communities and reviews the services currently available to support the health of residents.

In previous years our reports have focussed on complex, emerging public health issues which have had profound effects both locally and nationally.

This year is no different. The focus of this report is Suicide Prevention, a subject which can be difficult to discuss yet must be addressed.

Often referred to as 'the silent killer', suicide remains one of the leading causes of death for men in England. The effects of suicide are both long-lasting and far-reaching, felt by families, friends and throughout wider communities.

This report will explore the prevalence of suicide, both nationally and locally, and will highlight some of the support services and interventions that are currently available to Bromley residents and those in need. We hope that by raising awareness of suicide and openly discussing how it may be prevented, we can build upon the broader work we have undertaken in the past and, in particular, the work we have jointly undertaken with colleagues and external partners, to develop a more effective suicide prevention plan.

We hope you will find this report useful and interesting.

Dr Nada Lemic
Director of Public Health
London Borough of Bromley

This report contains sensitive content about suicide and suicide prevention. We have included contact details of services and organisations on pages 16-19 for those seeking support or further information in relation to these issues.

With special thanks to colleagues from the Public Health Department who jointly authored and produced this report.

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Introduction

The purpose of this Annual Public Health Report is to inform and raise awareness about suicide and suicide prevention. We hope that healthcare and local authority professionals can use the information contained within this document to inform future suicide prevention efforts.

This report will use a variety of data to determine the prevalence of suicide and its impact, both nationally and locally, and will consider risk factors and those who are most at risk. This document will explore some of the strategic plans and interventions which have been implemented for suicide prevention and will signpost readers to sources of further advice and support.

The information detailed within this report will be used to inform our next Suicide Prevention Plan for Bromley. This work will be led by the Bromley Suicide Prevention Strategy Steering Group, a multi-agency group, whose members include those who have been personally affected by suicide. The group have been meeting on a quarterly basis since 2018 and developed the first Suicide Prevention Plan and Action Plan for Bromley in 2019. A review of the Suicide Prevention Plan is due in 2025 and work is currently underway to prepare for this, including the publication of a Suicide Audit, an analysis of trends in suicide and self-harm in the Borough of Bromley.

Background

How do we define suicide?

The Office of National Statistics (ONS) defines suicide in two ways. For people aged 10 and above, it includes deaths from deliberate self-harm where it is clear the person intended to end their life[1]. For those aged 15 and above, it also includes deaths from injuries where it is unclear if the person meant to harm themselves. The first instance covers cases where the coroner has clearly identified the death as a suicide or where the circumstances show the person's intention. The second instance includes cases where the coroner's conclusions are open or undetermined. It is important to note that the ONS records these statistics based on the year the death was officially registered, not the actual date of death.

The suicide definition uses the International Classification of Diseases, Ninth Revision (ICD-9) for the years 1981 to 2000[2] and the Tenth Revision (ICD-10) from 2001 onwards[3]. For the specific cause of death codes included in the National Statistics definition of suicide, please refer to Table 1 in the ONS' Quality and Methodology document[4].

Global burden

According to the World Health Organisation (WHO), around 726,000 people die by suicide each year, with many more attempting it[5]. Each suicide is a devastating event that impacts families, communities and nations, leaving long-lasting effects on those left behind. Suicide can occur at any age and was the third leading cause of death among 15-29-year-olds globally in 2021. Addressing suicide as a serious public health issue requires a public health response. Timely, evidence-based and often low-cost interventions can prevent suicides. Effective national responses need a comprehensive, multi-sectoral suicide prevention strategy.

Epidemiology of suicide

Suicide rates vary significantly across different regions and populations. Factors such as age, gender, socioeconomic status and mental

health conditions play a crucial role in the epidemiology of suicide. In 2023, there were 6,069 registered suicidal deaths in England and Wales, an age-standardised mortality rate of 11.4 deaths per 100,000 people (Figure 1). This marks a 7.6% increase, or 427 additional deaths, compared to the total in 2022, which had 5,642 deaths (10.7 deaths per 100,000 people). In 2023, the male suicide rate was 17.4 deaths per 100,000 people, while females recorded a rate of 5.7 deaths per 100,000 people in England - the highest rates seen since 1999 for men and 1994 for women. Whilst both male and female suicide rates follow similar overall trends, with decreases in the 1980s, to early 2000s and stability in the mid-2000s to mid-2010s, males consistently represent around three-quarters of suicide deaths. The rates in women have declined at a faster and more consistent rate in comparison to the men. The rate in women, from 1981 to 2023, has been nearly halved whilst the rate in men has reduced by 21% for the same period.

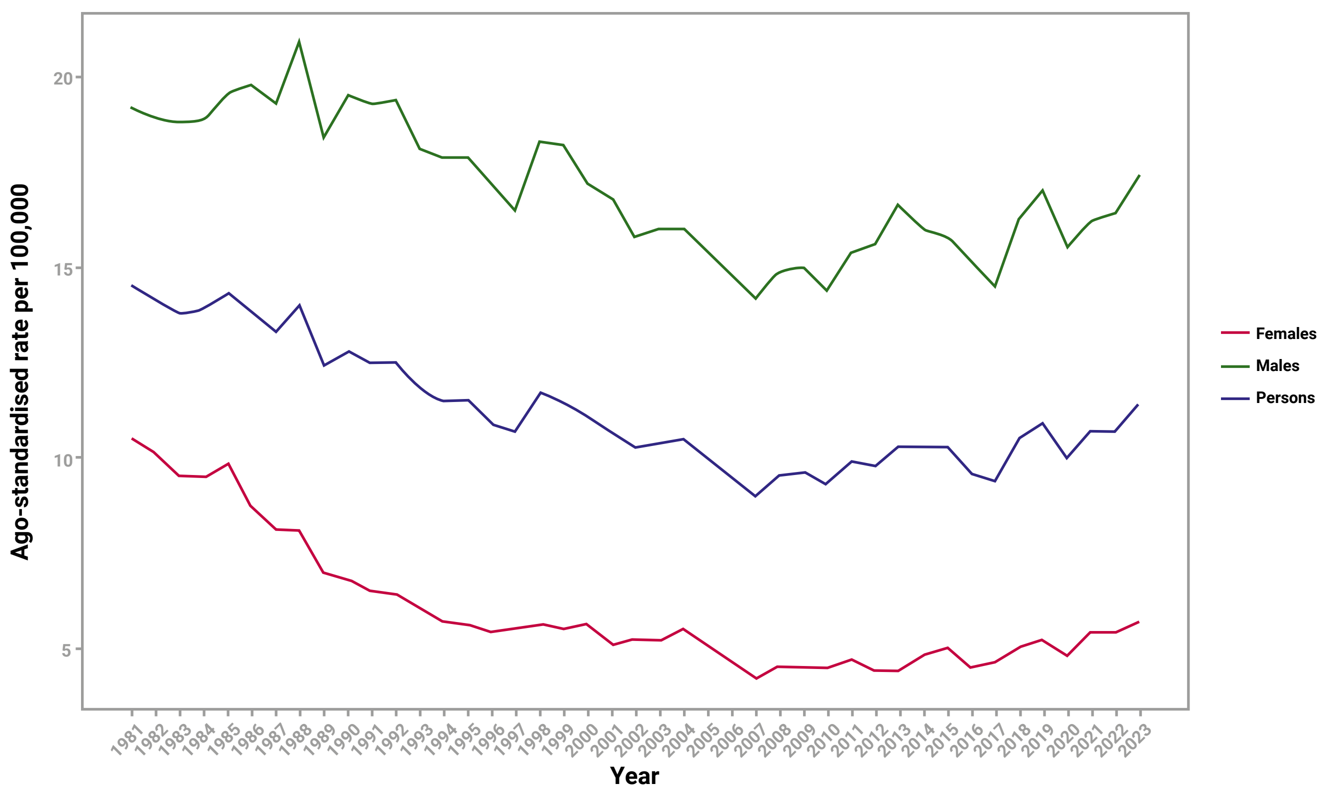

Figure 1: Age-standardised suicide rates by sex, England and Wales, 1981 to 2023. Source: ONS, 2024

In 2023, London had the lowest suicide rate among all regions in England, with 7.3 deaths per 100,000 people, while the North West had the highest rate at 14.7 deaths per 100,000. The highest suicide rates were observed in individuals aged 50 to 54 years. The age-specific suicide rate was highest for males aged 45 to 49 years, at 25.5 deaths per 100,000, and for females aged 50 to 54 years, at 9.2 deaths per 100,000. Since 2010, men aged 45 to 64 years have consistently had the highest suicide rates among broad age groups, and since 2005, women in the same age range have had the highest rates.

The most common method of suicide in England and Wales in 2023 was hanging, strangulation, and suffocation, accounting for 58.8% of all suicides (3,569 deaths). The proportion of suicides by hanging has increased over time. In England and Wales, all suicides are certified by a coroner and cannot be registered until an inquest is completed, leading to a delay between the occurrence and registration of the death.

People living in the most deprived areas of England face a higher risk of suicide compared to those in the least deprived areas. Between 2017 and 2019, the suicide rate in the most deprived 10% of areas was 14.1 per 100,000 people, nearly twice the rate of 7.4 per 100,000 in the least deprived 10% of areas[7].

In 2022, the suicide rate in England, Wales, Northern Ireland and Scotland combined was 7.9 per 100,000 people. This rate is relatively low compared to other similar high-income European countries[8]. For instance, Germany had a suicide rate of 9.2 per 100,000 people, while France's rate was higher at 12.1 per 100,000 people. Sweden reported a suicide rate of 13.0 per 100,000 people, and Finland had one of the highest rates among these countries, at 13.4 per 100,000 people.

Prevention and control

Suicide prevention can be addressed at population, sub-population, and individual levels. WHO's LIVE LIFE initiative recommends key evidence-based interventions:

- Limiting access to means of suicide (e.g. pesticides, firearms, certain medications)

- Engaging with the media for responsible reporting of suicide.
- Promoting socio-emotional life skills in adolescents.
- Early identification, assessment, management, and follow-up of individuals affected by suicidal behaviours.

These interventions should be supported by foundational pillars: situation analysis, multi-sectoral collaboration, awareness raising, capacity building, financing, surveillance, and monitoring and evaluation. Effective suicide prevention requires coordinated efforts across multiple sectors, including health, education, labour, agriculture, business, justice, law, defence, politics and media. Given the complex nature of suicide, these efforts must be comprehensive and integrated.

National policies and strategies

Suicide is a significant and potentially preventable public health issue in the UK, with profound emotional, social, and economic impacts on families, friends, and communities. Recognised as a priority for national public health policy, it has been addressed through various strategic documents.

Since the release of England's Suicide Prevention Strategy in 2012, substantial progress has been made. Local suicide prevention strategies and accessible bereavement services have been implemented nationwide, supported by a £57 million investment from the NHS Long Term Plan[9]. This has led to notable achievements, including one of the lowest recorded suicide rates in 2017. Collaborative efforts to improve patient safety have resulted in a 35% reduction in suicides within mental health inpatient facilities from 2010 to 2020. However, the current suicide rate has increased in both males and females since 2020, indicating the need for intensified prevention efforts (Figure 1).

The 2023 cross-government strategy for preventing suicide in England has three main goals:

1. To reduce the suicide rate within the next five years, with early signs of decline within two and a half years.
2. To enhance support for individuals who have self-harmed.
3. To improve support for those who have lost a loved one to suicide.

National priority areas of action

The cross-government's strategic goals would be achieved by acting in eight priority areas:

1. Improving data quality and availability to ensure effective, adaptable, and evidence-based interventions.
2. Providing tailored support to vulnerable groups, including children, adolescents, middle-aged men, individuals with a history of self-harm, those in mental health services, the justice system, autistic individuals, pregnant women, and new mothers.
3. Addressing common risk factors such as physical illness, financial hardship, gambling, substance abuse, social isolation, and domestic violence through early intervention and individualised support.
4. Promoting online safety and responsible media content to reduce harm and provide constructive messaging about suicide and self-harm.
5. Ensuring efficient crisis support services across various sectors.
6. Implementing measures to restrict access to means of suicide.
7. Offering effective bereavement support to those affected by suicide.
8. Encouraging collective responsibility for suicide prevention through widespread engagement.

Bromley data

1. In line with national figures, suicide rates in Bromley have increased from 5.2 deaths per 100,000 in 2020-2022 to 7.3 deaths per 100,000 in 2021-2023. The number of suicides in Bromley fluctuates annually, with an average of approximately 23 suicides per year.
2. 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.

3. From 2018 to 2023, most suicides locally were in men aged 25 to 59 years, with the highest numbers being in the 40–44 year-old age group.
4. Hanging, strangulation, or suffocation are the most common methods of suicide in Bromley, consistent with national trends, followed by poisoning.
5. Nearly 40% of suspected suicides involved individuals with a known mental health condition or a history of drug or alcohol misuse. Approximately 38% of suspected suicides were linked to social problems such as unemployment, homelessness, or relationship difficulties. A significant proportion of individuals who died by suicide had previously attempted suicide or left a suicide note. 67% of suspected suicides occurred at home.
6. There is a strong positive association between higher deprivation and higher self-harm rates in Bromley, supported by significant statistical evidence and a well-fitting regression model.
7. Penge and Cator and Crystal Palace show the highest concentrations of suicides. Other notable areas include Bromley Common and Keston, Mottingham and Chislehurst North, and Cray Valley East.
8. The proportion of hospital admissions for intentional self-harm is highest in girls aged 0 to 18 years.
9. Bromley's Standardised Admission Ratio (SAR) for emergency admissions due to self-harm is 45.6. This means Bromley has fewer emergency admissions for self-harm compared to England (which is 100).
10. Compared to the London average SAR of 42.7, Bromley's SAR is slightly higher. This means Bromley has a slightly higher rate of hospital stays for self-harm than the average across London.
11. 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.

Please note that these findings are available in the Executive Summary of the Bromley 2024 Suicide and Self-Harm Audit, published on our website. The full Audit report can be made available upon request.

Risk factors / at risk groups

In England, approximately 4,500 people die by suicide each year. making suicide a significant public health issue and necessitating ongoing attention and intervention to prevent these deaths. The causes of suicide are complex, encompassing biological, clinical, psychosocial and environmental factors. A key factor in addressing suicide mortality is understanding the risk factors for suicide. This review aims to provide an overview of recent literature examining risk factors for suicide (or suicide attempts) in the general adult population globally. The search strategy and methodology are detailed in Appendix 1.

This review found several risk factors for suicide, including demographic, clinical and psychosocial risks. The most frequently cited risk factor is history of any mental health conditions, including affective disorders, post-traumatic stress disorder (PTSD), anxiety and panic disorders, schizophrenia, personality disorder and eating disorders. Those who self-harm, have previously attempted suicide, or have suicidal ideation are also at increased risk. Other risk factors identified include substance misuse (including smoking, alcohol and illicit drugs), social exclusion or low social support, physical health problems, family and relationship issues, trauma, acute stress, and childhood adversity or abuse. Cultural factors may be important in providing context to the adverse experiences in a person's life that may increase their risk of suicide.

The age group at highest risk varied between studies, with some studies finding the risk higher in middle age, and some higher in youth. In England and Wales in 2023,

risk of suicide in England and Wales was highest among people aged between 45 and 54 and lowest among people aged under 20[10].

Two reviews identified female gender as a risk factor for suicide, however data from the UK indicates men[11] are much more at risk, with over 75% of suicides in men. Data from England

and Wales has shown that highest rates of suicide between 2011 and 2021 were in men aged 40 to 50 years. In this group the highest rates of suicide were in disabled people, those who have never worked or are in long-term unemployment or are single (never been married or in a civil partnership). As this review included global studies, this highlights the issues in generalisability when comparing between countries and regions, for example when considering gender and marriage status. Further work should be done to understand region-specific risk factors for suicide, as these may be more representative of the population in Bromley when compared with the world.

The impact of ethnicity as a risk factor varies depending on each region's demographics, therefore it would be inappropriate to apply the findings from these reviews to the UK. However, in both reviews where ethnicity was cited as a risk factor, ethnically minoritised groups were more at risk. Data from the UK between 2011-2021 showed that rates of suicide were highest in the white and mixed/multiple ethnic groups for both men and women[12]. Further research should be done to further understand these disparities and their implications for suicide prevention strategies for the population of Bromley.

This review identified lack of religious affiliation as a risk factor. This is in line with data from the UK, where the ONS has reported people belonging to any religious group generally had lower rates of suicide, compared with those who reported no religion (however, rates were higher in Buddhists and "Other" religious groups)[13].

Care must be taken when interpreting risk factors, as they do not predict risk of suicide at a single point in time, but instead indicate increased risk of a whole population over its lifetime. The BMJ found that current suicide risk assessment tools mainly use demographic risk factors and have largely been developed without a solid empirical basis[14]. Therefore it will be important to consider evidence base when making policy, and further research will be needed into risk factors in the population.

Many of the risk factors identified in this review are reflected in the list of priority risk factors in the DHSC 5-year

cross-sector strategy for suicide prevention in England[15]. These priority areas are: physical illness, financial difficulty and economic adversity, harmful gambling, substance misuse, domestic abuse, social isolation and loneliness. This reflects a priority from the government to support marginalised and most at-risk populations.

Interventions for prevention

Suicide remains a significant public health issue both in the UK and internationally. As local authorities increasingly recognise the role they play in mitigating suicide risk, it is essential to examine the effectiveness of interventions delivered at the local level. This literature review, drawing on recent studies (2006–2024), focuses on the role of local authorities, public health interventions, and the integration of sociodemographic, economic, and systemic factors in reducing suicide rates. It aims to inform Bromley's approach to suicide prevention by identifying evidence-based strategies, successful models, and areas for improvement. The search strategy and methodology are detailed in Appendix 1.

The findings from this literature review emphasise the importance of a multifaceted approach to suicide prevention, combining interventions across individual, community, healthcare, and policy levels.

Restricting access to means

Restricting access to lethal means is one of the most consistently effective strategies in suicide prevention. Studies across countries like the United States, Australia and the UK have shown that restricting access to firearms, pesticides, and other lethal means significantly reduces suicide rates[16]. The effectiveness of these interventions is particularly pronounced in high-income countries where access to means can be more easily regulated. However, in lower-resource settings, particularly in rural areas or low-income countries, restricting access to means can be a

more challenging task, and the absence of sufficient infrastructure may impede the success of such measures[17].

Media guidelines

Research has shown that responsible media reporting can reduce the likelihood of suicide contagion, a phenomenon where media coverage of suicides leads to imitative behaviours, especially among vulnerable individuals[18]. In contrast, sensationalist or graphic portrayals of suicide can contribute to higher rates of suicide in the community. Evidence suggests that media guidelines that emphasise respectful, non-sensational reporting can have a significant impact on reducing suicide rates[19]. However, these guidelines are not universally followed, and the increasing influence of social media complicates efforts to control the narrative around suicide[20].

Web-based programmes

Web-based programmes have gained attention as an accessible and scalable form of suicide prevention. These platforms provide individuals with anonymous and immediate access to mental health resources and crisis support. For instance, online intervention programmes like "LivingWorks Start" and "The Trevor Project" have been shown to reduce suicidal ideation and increase help-seeking behaviours[21,22]. A key advantage of web-based interventions is their accessibility, particularly for individuals in rural areas or those hesitant to seek in-person help due to stigma[23,24]. However, while these programmes hold promise, they are not a panacea, and their effectiveness varies depending on factors such as engagement and the quality of support provided[25].

Community-based programmes

Community-based programmes have proven to be highly effective in preventing suicides by providing local, peer-driven support networks. Programmes that focus on training community members as "gatekeepers" to identify at-risk individuals and connect them with mental health services have been widely successful. In particular, the "SafeTALK" and "QPR (Question, Persuade, Refer)" training programmes have been linked to improved suicide prevention outcomes in communities[26,27]. Peer support groups, especially those in

culturally specific communities, also help in reducing stigma and providing an environment where individuals can discuss their struggles with mental health. The challenge with community-based programmes, however, lies in their reliance on local resources and volunteers, which can lead to challenges in sustainability and consistent quality[28].

Healthcare system interventions

In the healthcare system, integrating mental health services into primary care settings is crucial for early detection and intervention. A study by Turmane et al. demonstrated that integrating suicide screening into routine healthcare visits significantly improved identification of at-risk individuals and helped connect them to appropriate treatment[29]. Crisis intervention services, such as suicide prevention hotlines and emergency response teams, are also critical for providing immediate support. Research suggests that services like the National Suicide Prevention Lifeline (1-800-273-TALK) in the United States have been effective in decreasing suicide rates in areas with high call volumes[30]. Despite their success, the healthcare system often faces resource constraints, and mental health services remain underfunded, especially in low- and middle-income countries where the need is most acute[31].

Postvention support

Providing psychological support to families and communities after a suicide can help mitigate the risk of contagion and prevent additional suicides. Studies indicate that postvention programmes that offer grief counselling, peer support, and mental health resources for survivors significantly reduce the emotional and psychological burden of suicide and reduce the risk of suicide contagion[32]. However, postvention efforts are often underfunded and may not be implemented systematically across all affected communities.

Policy and legislation

National strategies that prioritise mental health and create public health frameworks for suicide prevention have proven effective in reducing suicide rates. For example, countries like Norway and Japan have implemented comprehensive national suicide prevention policies that focus

on mental health literacy, means restriction, and public awareness campaigns[33]. However, the lack of consistent implementation of these policies, especially in lower-income countries, remains a significant challenge. Further, while legislation around mental health and suicide prevention has been strengthening in many high-income countries, it remains inconsistent in low- and middle-income regions[34].

What is available currently in Bromley and where to access support

Bromley Local Suicide Prevention Plan 2019 – 2024

Our Suicide Prevention Plan was developed by a multi-agency group, including those who have been personally affected by Suicide. The Suicide Prevention Strategy Steering Group oversees the implementation of this plan and is led by the consultant in public health for the London Borough of Bromley. The aim of the Steering Group is to understand and address the local challenges around suicide, identifying and working together on areas to make the biggest difference for our population. The Bromley Suicide prevention plan has adopted the six key priority areas from the National Strategy to develop priorities for Bromley:

1. Reduce the risk of suicide in key high risk groups.
2. Tailor approaches to improve mental health in specific groups.
3. Reduce the means of suicide.
4. Provide better information and support to those bereaved or affected by suicide.
5. Supporting safe and effective communication around suicide and suicidal behaviour.
6. Support research, data collection and monitoring.

To date the following has been achieved through the implementation of the Bromley Suicide Prevention Plan:

- A real time suicide surveillance system has been established
- Suicide awareness training has

been provided for social care colleagues
- Suicide prevention training provided in schools
- Supporting schools to develop suicide prevention plans
- Promotion of the Zero Suicide Alliance training to Local Authority staff and the public
- Regular Health Promotion and awareness raising with the public
- Working with rail network colleagues to prevent suicides on the rail network
- Undertook a Suicide Audit, a review of suicides and trends in the borough

https://www.bromley.gov.uk/downloads/file/1759/bromley-suicide-prevention-plan-2019-24

Support and local services

Find support:

- **Samaritans** – Call 116 123 for support available 24 hours a day. *https://www.samaritans.org*
- **Papyrus** – a national charity dedicated to the prevention of young suicide. If you or a young person you know is struggling with life you can get confidential support from Papyrus' **Hopeline** on 0800 068 4141 (9am – 12am midnight) every day of the year. *https://www.papyrus-uk.org* *https://www.papyrus-uk.org/contact-us*
- **Oxleas** – The Mental Health Crisis Line on 0800 330 8590 is a 24-hour telephone service for those who may be experiencing a mental health crisis. This line provides opportunity to speak with a mental health professional about your mental health crisis & can provide information and advice for carers, family, and friends. *https://oxleas.nhs.uk/contact-us*
- **Shout 85285** is a free and confidential text messaging service that is available 24/7. Text 85285 at anytime if you are struggling to cope and need immediate support to start a conversation with a trained volunteer who will listen and help you to get to a calmer and safe place. *https://giveusashout.org*
- **Switchboard LGBT+ helpline** – Switchboard provides a one-stop listening service for LGBT+ people on the phone, by email and through instant messaging. Call 0300 330 0630 (available from 10am – 10pm, every day). *https://switchboard.lgbt*

Support if you are worried about someone else:

- **Samaritans** – Call 116 123 for

support available 24 hours a day. *https://www.samaritans.org*

- **Zero Suicide Alliance (ZSA)** – provides free suicide prevention training that is accessible to all. ZSA helps people to learn how to identify when someone is presenting suicidal thoughts/behaviour, how to speak with them in a supportive manner, and how to help them find useful services and support. *https://www.zerosuicidealliance.com*
- **Charlie Waller Memorial Trust** – the charity provides mental health resources, support and training for parents and carers through school events and online webinars. *https://www.charliewaller.org*
- **Bromley Mental Health and Wellbeing Toolkit** – view this toolkit developed with local education settings that provides mental health and wellbeing resources for education staff and parents and carers to help better support children and young people. *https://new.express.adobe.com/webpage/A9SQIa0FTyg2R??*

Support for adults:

- **Bromley Talking Therapies** *https://www.bromleytalkingtherapies.nhs.uk*
- **Bromley Well** *https://www.bromleywell.org.uk*
- **South East London Mind (SEL Mind)** *https://selmind.org.uk*
- **Counselling - NHS** *https://www.nhs.uk/mental-health/talking-therapies-medicine-treatments/talking-therapies-and-counselling/counselling*
- **Oxleas NHS – How to get help in a crisis** *https://oxleas.nhs.uk/contact-us*
- **Every Mind Matters** *https://www.nhs.uk/every-mind-matters*
- **Good Thinking UK** *https://www.good-thinking.uk/youngpeople*

Support for young people:

- **Kooth** *https://www.kooth.com*
- **Bromley Y – Wellbeing Service** *https://www.bromley-y.org*
- **Bromley Well – Young Carers** *https://www.bromleywell.org.uk*
- **Oxleas Children & Adolescent Mental Health Service (CAMHS) - Bromley** *https://oxleas.nhs.uk*
- **SLAM (SE-London & Maudsley)** *https://slam.nhs.uk*
- **Every Mind Matters** *https://www.nhs.uk/every-mind-matters*

- **Good Thinking UK**
  https://www.good-thinking.uk

Suicide bereavement support:

South East London Suicide Bereavement Service offer free, confidential, and non-judgemental support. Staff specialise in bereavement by suicide and provide a service built around individual needs. Get in touch to have a chat and find out more about the service. You don't need a professional to refer you. Usually open from 9am to 5pm Monday to Friday, but can also offer out-of-hours appointments if needed:
Phone: 07933 393397
Email: *suicidebereavement@blgmind.org.uk*
Website: *https://blgmind.org.uk/home/suicide-bereavement-support/*

Get connected:

Simply Connect Bromley
https://bromley.simplyconnect.uk

Local Village Network
https://www.lvn.org.uk

All website links and contact numbers are operational at the time of publication, however please be aware these details may change over time. Please check the internet for updated contact details for organisations.

Key findings

- Suicide is a significant public health issue, with around 726,000 deaths worldwide each year. Bromley has an annual average of 23 deaths from suicide. The area has seen an increase in suicide rates since 2020, consistent with national levels. Males aged 25 to 59 are the most affected. The most common method of suicide is hanging, strangulation or suffocation, with a significant number of deaths linked to mental health conditions, substance misuse, and social issues. There are notable associations between deprivation and self-harm rates, with higher suicide rates in certain areas like Penge and Cator, and Crystal Palace.
- Risk factors for suicide include mental health conditions, substance misuse, social exclusion, and relationship issues. Specific at-risk groups include middle-aged men, individuals with a history of self-harm or suicide attempts, and those in socially deprived areas.
- Effective suicide prevention requires a multi-faceted approach, including restricting access to lethal means, responsible media reporting, web-based support programmes, community-based initiatives, and healthcare interventions. Providing postvention support to bereaved families and implementing robust policies are also key strategies.
- Bromley's Suicide Prevention Plan (2019-2024) focuses on reducing the risk of suicide in high-risk groups, improving mental health, restricting means of suicide, and providing better support for those affected by suicide. It aligns with the national suicide prevention strategy and aims to reduce suicides through coordinated efforts across sectors.
- Through the implementation of the Bromley Suicide Prevention Plan, a real-time surveillance system has been established and suicide awareness and prevention training has been provided. Other initiatives such as Zero Suicide Alliance training, health promotion activities, collaboration with rail networks and the development of a suicide audit have been undertaken.

- There are several local support services available for individuals in crisis or seeking mental health assistance. The Samaritans (116 123) offer 24/7 support, while Papyrus (0800 068 4141) provides help for young people at risk of suicide. The Oxleas Mental Health Crisis Line (0800 330 8590) and Shout (85285) offer crisis support through phone and text, and Switchboard LGBT+ Helpline (0300 330 0630) provides a listening service for LGBT+ individuals. Additional resources include Zero Suicide Alliance for prevention training, Bromley Talking Therapies, Kooth, and Bromley Y for young people. There's also Suicide Bereavement Support for those affected by suicide, as well as online resources like Every Mind Matters and Good Thinking UK.

Next steps

By understanding the epidemiology of suicide and what works in prevention, we can develop a comprehensive, multi-sectoral approach to reduce the incidence of suicide and its devastating impact on individuals, families and communities.

It is hoped that this edition of the Annual Public Health Report has helped to raise awareness of suicide prevention. The Public Health Team at Bromley will use this report to continue to build upon the work that has been undertaken previously with external partners and colleagues to promote suicide prevention strategies. This document will be shared with colleagues and members of Bromley's Health & Wellbeing Board (HWB), Integrated Care Board (ICB), Mental Health Partnership Board, and Bromley's Suicide Prevention Strategy Steering Group.

Glossary

APHR: Annual Public Health Report
BMJ: British Medical Journal
DHSC: Department of Health and Social Care
Embase: Excerpta Medica Database
Emcare: Nursing and Allied Health Database
HES: Hospital Episode Statistics
HWB: Health and Wellbeing Board
ICB: Integrated Care Board
ICD-9: International Classification of Diseases, Ninth Revision
ICD-10: International Classification of Diseases, Tenth Revision
IMD: Index of Multiple Deprivation
Medline: Medical Literature Analysis and Retrieval System Online
NSSI: Non-Suicidal Self-Injury
OECD: Organisation for Economic Co-operation and Development
OHID: Office for Health Improvement and Disparities
ONS: Office for National Statistics
PCMD: Primary Care Mortality Database
PHE: Public Health England
PRISMA: Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PsycInfo: Psychological Information Database
QPR: Question, Persuade, Refer
SAR: Standardised Admission Ration
Scopus: Abstract and Citation Database
WHO: World Health Organisation
ZSA: Zero Suicide Alliance

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Appendices

Appendix 1

Literature search strategy for section entitled *Risk factors/at risk groups*

Review methodology

Rapid reviews use modified systematic review methods to accelerate the review process while maintaining systematic, transparent, and reproducible methods.[35] There is increasing recognition worldwide for the need for timely knowledge synthesis to inform policymaking and decision-making in health, in both routine and emergency contexts. Rapid reviews are an efficient solution as they provide high-quality evidence in a timely and cost-effective manner.[36]

This review uses rapid review methods to swiftly identify and synthesise evidence. This review follows guidance by the Cochrane Rapid Reviews Methods Group on rapid review methods, which have been informed by systematic review methods.[35] There is not yet formal guidance on the reporting of rapid reviews, therefore this review adheres to the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidance.

Search strategy

Initial scoping searches were performed to refine the topic and selection of search terms. Three online databases were searched for peer-reviewed articles: MEDLINE, Embase and the Cochrane Library. The search strategy was developed and refined with the support of a Knowledge and Evidence Specialist.

The review aimed to identify the risk factors for suicide or suicide attempts in the general adult population globally. Search terms used were variations of the following string, edited depending on the database:

> ((“suicid*”[Title] OR “suicide, attempted”[MeSH Terms]) NOT (“assisted”[Title/Abstract] OR “euthanasia”[Title/Abstract])) AND (“risk”[Title] OR “risks”[Title] OR “cause*”[Title] OR “risk factors”[MeSH Terms]) NOT (“child*”[Title] OR “adolescent”[Title]) AND “review”[Title]

Articles were restricted to the last 5 years to identify the most up to date literature on the topic. There were no language restrictions applied.

Grey literature

To identify relevant grey literature, keyword searches were performed in Google Advanced Search engine and websites

of relevant governmental organisations, independent entities and charities, for articles meeting eligibility criteria published in the last 5 years. Institutions where website searches were performed included: Gov.uk, Office for National Statistics (ONS), Kings Fund, The Health Foundation, Samaritans, Mind, Zero Suicide Alliance and Grassroots Suicide Prevention.

Eligibility criteria

Eligibility criteria are outlined in Table 1. Eligible articles were reviews of either suicide or suicide attempts. Given that this is a rapid review, review articles were prioritised to limit unnecessary duplication, minimise resources needed to screen and summarise primary level evidence, and to minimize the potential bias and/or error which could be incurred by reviewing primary evidence rapidly.[37]

Articles were not eligible if the outcome was self-harm/non-suicidal self-injury (NSSI), suicide ideation or assisted suicide/ euthanasia. Suicide ideation and self-harm were excluded as, although they are risk factors for suicide attempts, the majority of instances of self-harm and suicidal ideation do not lead to suicide attempts.[38, 39] In fact a WHO study found that approximately two-thirds of individuals with suicidal ideation never make a suicide attempt.[40]

Articles that focused on discrete subpopulations, individual risk factors or genetic or biological markers were excluded. Studies focusing on specific time periods or events (e.g. the COVID-19 pandemic,

Table 1. Eligibility criteria

INCLUSION CRITERIA	EXCLUSION CRITERIA
Adults (>18 years)	Children (<18 years)
Suicide / attempted suicide	Assisted suicide / euthanasia
Any location globally	Self-harm / nonsuicidal self-injury (NSSI)
	Suicide ideation
	Discrete subpopulations e.g.: - Demographic groups - Specific professions - Specific diseases/medical conditions
	Analyse an individual factor (i.e. without comparison to another)
	Analyse only specific method(s) of suicide
	During specific events/timeframes
	Identifying genetic variants / biomarkers

other infectious disease outbreaks, natural disaster, war etc.) were not included as it was thought risk factors during these events may be specific to these time periods and would not be generalisable outside of these times (e.g. social distancing during the COVID-19 pandemic).

Literature search strategy for section entitled *Interventions for prevention*

Research question

What suicide prevention interventions have been delivered by local governments (authorities) in the UK and internationally?

Search strategy and methodology

The methodology for this review focused on identifying and synthesising relevant literature on suicide prevention interventions delivered by local governments (authorities) in the UK and internationally. A comprehensive search was conducted across multiple academic databases to ensure a broad and thorough collection of studies. The search strategy was designed to cover various facets of suicide prevention, including government-led initiatives, public health campaigns, and local authority interventions. Key databases searched included Medline, Embase, Emcare, PsycInfo, Google Scholar (for grey literature), and Scopus, using terms related to suicide, self-harm, prevention, and government intervention. The search process involved a two-step screening. First, duplicate records across databases were removed, and then studies were reviewed based on their titles and abstracts to ensure they met the inclusion criteria. The search yielded a total of 1223 results. After removing duplicates and conducting the title and abstract screening, 195 studies were retained for further review. Most studies were sourced from Medline, Embase, and Emcare, with a smaller proportion from Scopus. These studies were organised into thematic categories such as government-led interventions, public health media campaigns, and grey literature to facilitate the analysis and inclusion in the final report. The studies were evaluated for quality and relevance,

SOURCE	BEFORE REMOVING DUPLICATES	AFTER REMOVING DUPLICATES	AFTER SCREENING
Medline	167	167	67
Embase	356	258	66
Emcare	193	372	53
PsycInfo	454	0	0
Google Scholar	Not available	Not applicable	Not included
Scopus	53	21	9
Total	**1223**	**818**	**195**

with attempts made to access full texts where needed. Limitations of the search included its geographical focus on the UK and international studies, the use of grey literature which may lack peer review, and potential publication bias due to language constraints or unpublished studies. Despite these limitations, the search process resulted in a robust selection of studies that provided valuable insights into local government-led suicide prevention efforts worldwide, supporting the Bromley Annual Public Health Report on Suicide.

Rationale

This literature review synthesises the findings from a variety of studies that focus on different suicide prevention strategies. The review is structured according to key intervention categories, each of which plays a critical role in reducing suicide rates. These categories include restricting access to means, media guidelines, web-based programs, community-based programs, healthcare system interventions, crisis intervention services, postvention support, and policy and legislation.

Appendix 2

Technical notes

Data sources and definitions

To understand suicides and intentional self-harm for Bromley, PCMD, Thrive LDN 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. 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).

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