LONDON BOROUGH OF BEXLEY
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London Borough of Bexley

Suicide Audit 2022

Non-disclosive version safe for sharing

Version 1.0

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Introduction

Suicide is a major issue for society and one of the leading causes of years of life lost. In England, one person dies from suicide every 2 hours, and it is the second largest cause of death in young people aged 15-29. Each death caused by suicide is a tragedy and has wide implications for the friends and families affected. Suicide, although complex, is entirely preventable and for this reason the implementation of a suicide prevention plan is of paramount importance.[1] [2]

There is substantial economic cost associated with suicide and its wider implications. Analysis estimates that every suicide costs the economy around £1.67 million (based on 2009 prices), although the exact costs are difficult to quantify. Around 60–70% of the cost of each suicide is attributable to the impact on the quality of life of those bereaved by suicide.[3]

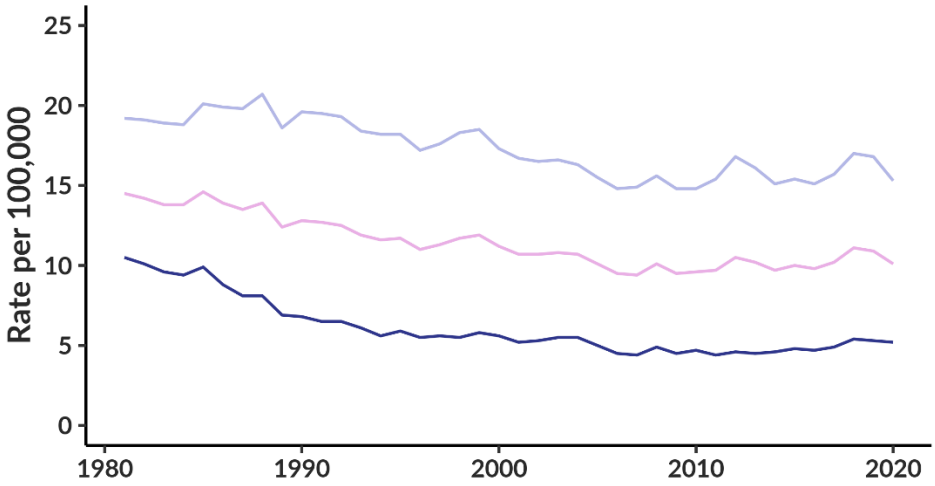
Reliable, timely, and accurate suicide statistics are the cornerstone of any suicide prevention strategy and of tremendous public health importance. As highlighted by the Government's 2012 document *Preventing Suicides in England*, national guidance is that local authorities are to carry out annual suicide audits. [2]

The aim of the Bexley Suicide Audit 2022 is to provide an overview of suicides in Bexley, comparing patterns and characteristics to national statistics and academic literature. The audit coincides with the formation of the Bexley Suicide Prevention Partnership, which will work in collaboration across the Local Care Partnership, with non-profit organisations, local authority departments, businesses and individuals to raise awareness of suicide and its contributing factors. The shared aim across the partnership is to become a zero-suicide borough, and the suicide audit aims to provide relevant recommendations from its findings.[4]

Background

Suicide prevention in 2022 must be understood in the context of the COVID-19 pandemic and the risk to mental health caused by anxiety, isolation, loss of support and disruption to care. Prior to the pandemic, there were already concerns of rising suicide rates seen in 2018 and 2019, although the longer-term trend in fact shows a decrease in rates:[5]

Fig 1. Age adjusted suicide rate (per 100,000), by sex
England & Wales, 1980 - 2020



Source: Office for National Statistics

Although the long-term trend is positive, there remain ongoing challenges. Mental health services for all ages have remained open throughout the pandemic, and plans for 24/7 all-age open access crisis services were accelerated so that anybody requiring urgent support could access those services rapidly. The delivery of services has been swiftly amended and improved to enable continuation of care, with many services embedding digital and remote working to assess people as they are referred, in the safest way possible. Suicide prevention strategies set out by the Department of Health and Social Care have been key to this rapid response taken on a national level.[6]

Policy Review

Preventing Suicide in England: A cross-government outcomes strategy to save lives, a national suicide prevention strategy published in 2012, outlined the policy direction for suicide prevention.[2] Following this, there have been regular progress reports to analyse the effectiveness of the policies set. The *NHS Five Year Forward View for Mental Health*, published in February 2016, set out the start of a ten-year journey for the transformation of mental health services. It included a commitment to reduce the rate of suicides in England by 10% by 2020 (compared to 2015 levels). As well as the above, the *NHS Long Term Plan* (published in 2019) outlines health care funding priorities over the next decade, reaffirmed the commitment to suicide reduction. This marked mental health as a vital area of focus, with a plan to transform mental health locally where £2.3 billion of funding had been allocated for mental health, of which £57 million is allocated specifically for suicide prevention and suicide bereavement.[7] [8]

The 5th policy review (most recent review) found that 2018 and 2019 saw increases in the number of registered suicides, with the suicide rate in 2019 being 10.8 per 100,000 people - a statistically significant increase compared to the 2016 rate of 9.5 per 100,000 people. A more significant rise was seen in men, suicides caused by strangulation, and women aged 10-24.[9]

The policy review also highlighted areas of possible vulnerabilities, especially in the light of the COVID pandemic. Data showed that the pandemic may have exacerbated existing illnesses or contributed to the development of new mental health issues across the risk groups of middle-aged men, people who self-harm, children and young people, and those with a prior mental health diagnosis. The *Covid-19 Mental Health and Wellbeing Recovery Action Plan*, published in March 2021, presented a cross-government approach to support people with mental health conditions, focusing on the general effects of the pandemic on people's mental health. The Government gave particular consideration to suicide by promoting suicide prevention awareness training to Government frontline workers and volunteers and by providing £5 million to support suicide prevention organisations in 2021/22.[10]

Cross-government actions to address the wider drivers of suicide and self-harm included action on key areas:[7]

- Job loss/Unemployment/Low-income jobs: extension of the Coronavirus Job Retention Scheme and Self-Employment Income Support Scheme until

September 2021; loan, grants and tax deferrals to businesses; enhanced welfare payments and statutory sick pay; job search support through Plan for Jobs.
    - Debt: provision of more debt advice and a new money guidance tool by the Money and Pensions Service; launch of the 'Stop the Debt Threat' campaign to make language in Default Notices more accessible and the 'Breathing Space Programme' to freeze interest, fees and enforcement action for people in problem debt, with more protections for people in mental health crisis treatment.
- Gambling: review of the Gambling Act 2005 by the Department for Digital, Culture, Media and Sport (DCMS); improvement of access and availability of services for treatment of gambling addiction.
- Social risk factors
    - Homelessness: £46 million award through the Changing Futures programme to help local areas deliver new interventions for individuals experiencing disadvantages such as homelessness; investment in targeted support for rough sleepers to improve access to professional help for substance dependency issues; delivery of over 6,000 new long-term homes over 4 years through the Next Steps Accommodation programme to provide secure accommodation to help those sleeping rough to engage in mental health support and reduce the impact of rough sleeping on mental health needs; mental health awareness training for housing officers, with a focus on how to work with those with mental health problems, including suicide prevention.
    - Loneliness/Social Isolation: a public campaign to encourage people to talk about loneliness, including guidance on supporting yourself and others safely, and a 'Tackling Loneliness Network' of high-profile charities, businesses and public figures working together to support social connection.
- Other
    - NHS/Social staff: implementation of a dedicated programme of work monitored by the Prevention of Nursing and Midwifery Suicide Oversight Group; development of suicide and deliberate self-harm prevention training modules for blue light staff; a comprehensive package of support for mental health and wellbeing of NHS staff; support for mental health and wellbeing of key frontline and social care staff.
    - Children and young people: funding for mental health advisers in each local authority to upskill education staff in responses to trauma; Mental

Health Support Teams; an online service developed by the Department of Education which includes resources to support teaching about mental wellbeing as part of Health Education; development of the University Mental Health Charter Award Scheme; the Student Space platform; the new 'Better Health - Every Mind Matters' campaign; the Online Harms White Paper; improved collection of LGBT self-harm and suicide data; collection of National Child Mortality Database data.

- People in contact with Mental Health Services: Mental Health Safety Improvement Programme, National Quality Improvement Programme, Suicide Safety Plans.
- People in the criminal justice system: development of a new Health and Justice Information Service (HJIS) to link prison healthcare systems to healthcare systems in the community, and to prison systems; RECONNECT service for continuity of care post-release to help people in prison reconnect to community-based health services; development of a workstream to review policies and processes regarding deaths under supervision; implementation of a suicide and self-harm prevention system in Approved Premises; implementation of Roll-out of Assessment, Care in Custody and Teamwork; the Prisoner Listeners Scheme; delivery of a suicide and self-harm prevention campaign with staff working in prisons and probation services.[9]

Methodology

Definitions

Confirmed suicides were identified using the Office for National Statistics definition: "a suicide conclusion given by the coroner aged 10 and over and deaths from injury or poisoning where the intent was undetermined aged 15 and over".[11]

Suspected suicides were identified based on Real Time Surveillance records where police attending the scene suspected suicide.

Inclusion Criteria

It was important to be specific in the inclusion criteria before contacting our relevant data sources to simplify data collection which would be most timely in the audit process.

- Confirmed and suspected suicides as defined in the above section
- Ages 10+
- Sex – male and female
- All suicides of Bexley residents regardless of location of death, and all suicide deaths occurring within Bexley regardless of the deceased's residence
- Period: 30/06/2019 – 30/06/2022

Data items requested

Details surrounding the circumstances of each death or suicide attempt would also provide useful insight into areas we may be able to adapt to make suicide less likely. For this reason we requested data on:

- Location of death – as well as the type of area i.e. roadside, train, own home
- Alcohol / drug use at time of suicide attempt
- Further demographics including ethnicity
- Place of birth
- Occupation and employment Status
- Registered GP practice
- Any prior GP contact made leading up to death
- Known recent contact with any health service across primary care, mental health service, A&E, alcohol and drug service, smoking cessation service

- Known mental health disorder / contact with MH
- Previous suicide attempt / self-harm
- Physical health co-morbidities
- Marital status

It was understood that the all the desirable data requested may not be available but would be beneficial in making the recommendations following data analysis.

Data Sources

Publicly available aggregate data were drawn from the Office for National Statistics.[12]

Other sensitive disclosive data were accessed for the specific purpose of the suicide audit via Data Sharing Agreements with the relevant data controllers:

- Thrive Real Time Surveillance System (RTS): Thrive LDN is a London-wide mental health partnership. Thrive administer an RTS system for suspected suicides, used to join up multi agency response to suicides including the offer of bereavement support. Access to data from the system is made available to local authorities for audit purposes.
- Primary Care Mortality Database (PCMD): This is a database of death registrations managed by NHS Digital. This data is available to local authorities and NHS organisations for statistical purposes.[13]
- Additional data about Safeguarding Adults Reviews with suicides was obtained from the Bexley Safeguarding Adults Board.

Other potential data sources requested but not agreed within the timescale of the audit included:

- Coroner data
- Section 136 data: This is part of the mental health act that allows police to remove a person from a public place if there are concerns surrounding their mental health. There are Section 136 suites that are a place of safety for these individuals.
- Accident and emergency data for intentional self-harm and attempted suicide
- Oxleas: patients seen from primary care referrals and also in a secondary care setting where the indication involved suicide risk

The project also explored accessing these further data sources in a non-disclosive form via the South East London Integrated Care System, and this remains ongoing.

In addition to this we also invited each of the above (alongside a list of other non-profit organisations, local authority departments and businesses) to join the Bexley Suicide Prevention Partnership. This is with the aim of forming a partnership with the shared goal of becoming a zero-suicide borough, a programme with zero suicides being the key outcome measure which several boroughs nationally have adopted.[14]

Statistical Analysis

Only simple summary statistics were produced. Given the rare nature of suicide, small numbers had to be treated with care to avoid disclosure of the identity of individuals, and to avoid erroneous generalisations with large margins of uncertainty.

Summary of audit findings

Suicide Case Numbers

- Over 3 years, Bexley had an age adjusted (DSR[15]) suicide rate of 6.8 (95%CI 5.0-9.0) per 100,000 population: significantly lower than the England DSR of 10.4 (10.3-10.6) and not significantly different to London's DSR of 7.2 (6.9-7.6).[16]

Demographics

- Three quarters of suicides were in men
- The highest rate of suicide was seen in 45–49-year-olds: 14.7 (5.9-30.0)
- The highest rate of suicide among men was 35-39 years old: 23.1 (8.5-50.0)
- The highest rate of suicide among women was 55-59 years old
- 5 cases were aged 10-24 years old, all of which were male

Circumstances around death

- The most common method of suicide was asphyxiation (66%) and the second was overdose (14%), however for females both methods were equally frequent
- 10 cases had documented drugs and alcohol involved and all known cases of cocaine, narcotic and hallucinogenic use were in males

Employment status and occupation

- The most frequent employment status of those that died as a result of suicide was "employed" (41%), although 29% were unknown
- Where occupation was stated (57%), 40% worked in routine or semi-routine occupations

Marital Status

- Where status was known, a large proportion of those that had died as a result of suicide were single (48%), the next highest being widowed (27%).

Suicide place and residential address

- Most suicides took place in the individual's home (62%)
- People dying of suicide most commonly lived in the ward of Sidcup (7 out of 49). However, this was not significantly different to other wards.
- Based on its population, Sidcup had 15.5 (6.2-32.0) suicides per 100,000 population. This rate is not age standardised and therefore cannot be compared to London and England benchmarks.

Co-existing mental health disorders

- Of the 20 people with a mental health diagnosis, 65% were male
- Mood disorders including depression were the most common condition seen in 11 cases

Safeguarding Concerns

- 8 cases had a Safeguarding Adults Review (SAR)
- Most of the SARs were females
- The age range was 19 to 40 years old

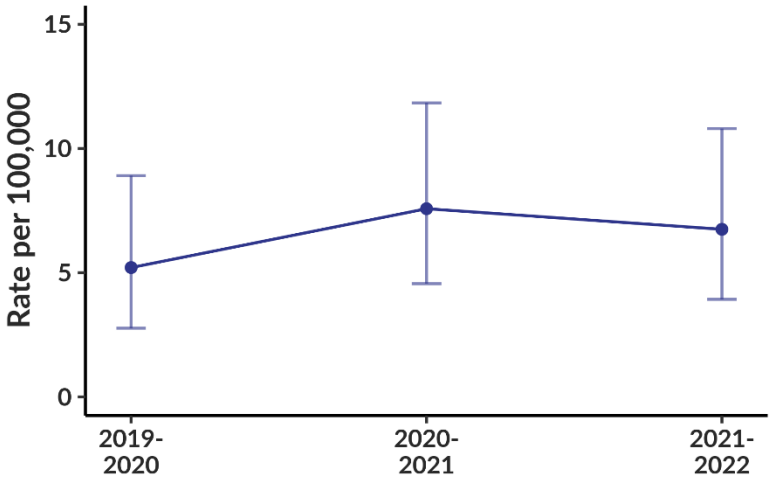
Results

Data were successfully obtained from PCMD and Thrive for the time period June 2019 to June 2022, identifying 49 deaths as a result of suicide occurring in Bexley or where the deceased lived in Bexley. There were 21 suspected suicides identified from Thrive, 24 confirmed suicides from PCMD, and 4 were found in both databases. No data were attained from coroners, Section 136 or A&E departments. Oxleas data were not available within the timeframe of the audit.

Number of Deaths

There were a total of 49 deaths over a 3 year period. The directly standardised suicide rate for the period was 6.8 (95%CI 5.0-9.0) per 100,000 population: significantly lower than the England DSR of 10.4 (10.3-10.6) and not significantly different to London's 7.2 (6.9-7.6).[17] 13 deaths occurred between June 2019 - May 2020, 19 between June 2020 – May 2021, and 17 between June 2021 – May 2022. There was no significant difference between the crude annual suicide rates per 100,000 population:

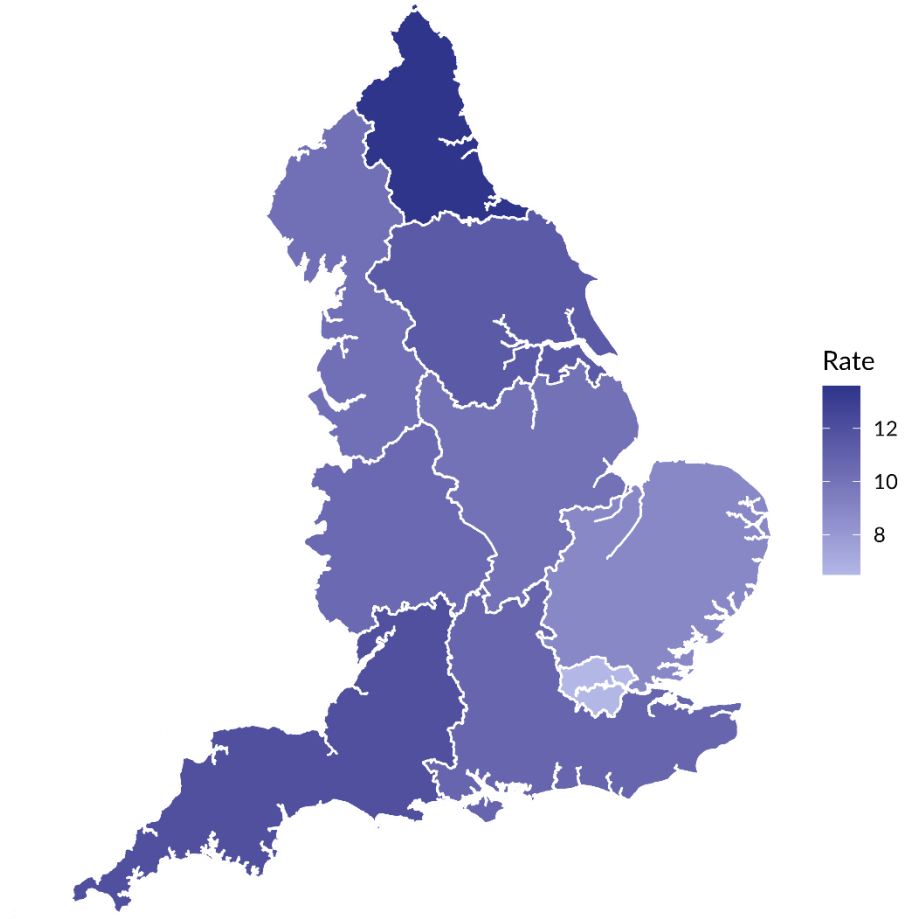
Fig 2. Crude suicide rate (per 100,000)
Bexley, June 2019 - June 2021



Source: PCMD, Thrive

ONS data in Figure 3 shows that in 2021 there were 5,219 suicides registered in England and a directly age standardised rate of 10.5 deaths per 100,000 people; this increase was not statistically significant compared with 2020 and is consistent with the pre-coronavirus (COVID-19) pandemic rates in 2019 and 2018.[5]

Fig 3. Age adjusted suicide rate (per 100,000), by region
Persons, 2020



Source: Office for National Statistics

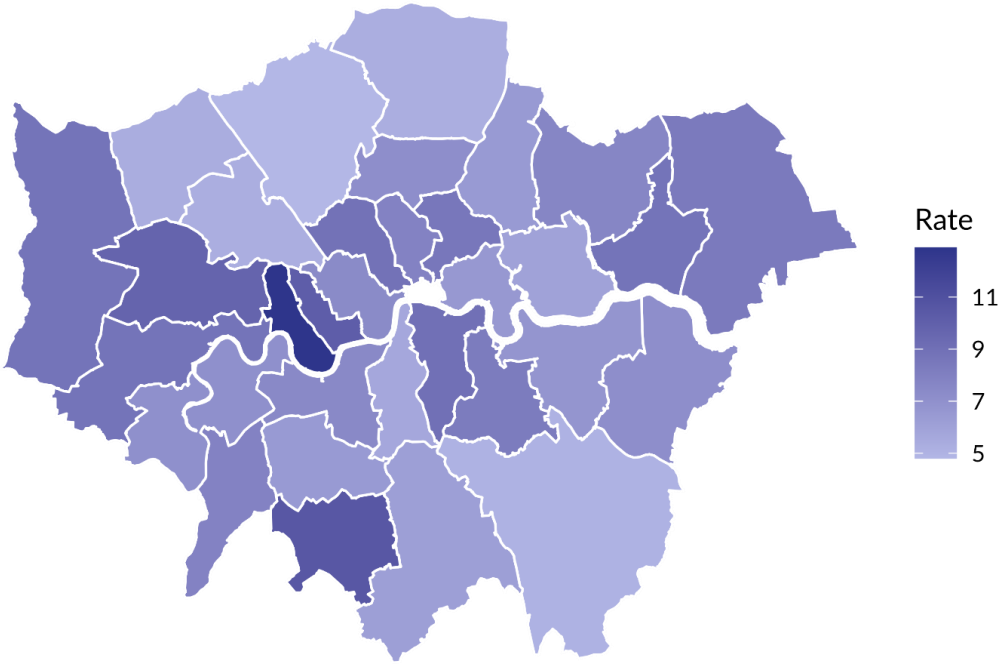
In 10 of 11 previous years, London had the lowest suicide rate of any region of England (DSR 6.6 deaths per 100,000), while the highest rate was in the Northeast of England with a DSR of 14.1 deaths per 100,000 in 2021. In Bexley, the directly standardised suicide rate for the reporting period was 6.8 (95%CI 5.0-9.0) per 100,000 population: significantly lower than the England DSR of 10.4 (10.3-10.6) and not significantly different to London's 7.2 (6.9-7.6).[18]

Historically London once had the highest suicide rates in England, however a generation later now has the lowest. In 1981, during the Thatcher era recession, London had a suicide rate of 17.9 per 100,000 population, by far the highest in the UK. The change in recent years is thought to be possibly linked to the growth of various

ethnic groups in London, as suicide rates are particularly low among some ethnic groups such as South Asians.[19] [20]

Despite the slight fluctuations between 2019 and 2021 in Bexley, no significant annual difference was observed, and any annual change may be due to natural variation. Furthermore, it is thought that there were delays in death registrations during the COVID pandemic which may affect the distribution of registrations across the time period.

Fig 4. Age adjusted suicide rate (per 100,000), by borough
Persons, 2019-21



Source: Office for National Statistics

At a sub-regional level within London, inner London boroughs had a slightly higher rate in 2019-2021 (DSR 7.9 per 100,000) than outer boroughs (DSR 7.0 per 100,000 population). ONS data shows that for the calendar years 2019 – 2021 Bexley had an age adjusted 7.2 deaths per 100,000 population, higher than some of its neighbouring boroughs in South London such as Greenwich (6.8 per 100,000) and Bromley (5.1 per 100,000). Kent, which also neighbours Bexley, has a significantly higher rate at 11.1 per 100,000 population. Across the 32 Boroughs, Bexley ranked 19th, where first is the highest rate. While various factors are likely to play a role in the differences across the London boroughs including socioeconomic causes and demographics, Bexley as an outer Borough has a slightly higher rate than both the outer London boroughs and

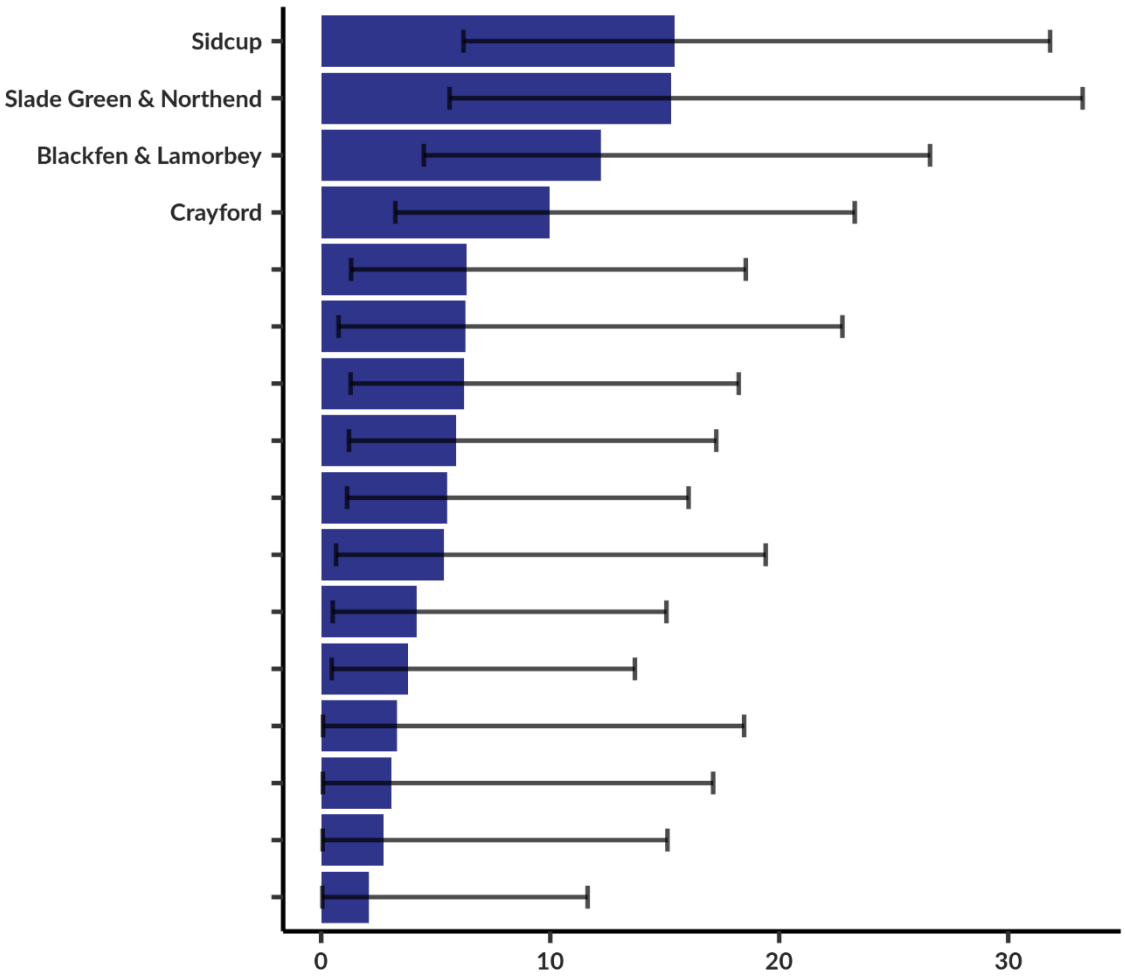
London average. There is room for improvement in reducing this figure and matching lower rates seen in other boroughs such as Bromley, Barnet and Enfield.

Ward of Residence

Although the rate of suicide varied by ward of residence, from 2.1 (0.1-11.6) per 100,000 in the lowest incidence ward to 15.5 (6.2-31.8) in Sidcup, no significant differences were found and the pattern of incidence may be due to natural variation. Other than Sidcup, Slade Green & Northend, Blackfen & Lamorbey, and Crayford, the number of suicides in each ward was less than 5, therefore identifiers have been redacted:

Fig 5. Crude suicide rate (per 100,000), by ward

Bexley, June 2019 - June 2021



Source: PCMD, Thrive

Age

The mean age for deaths as a result of suicide was 47.2 (upper quartile 59, lower Quartile 35, median 46). Age-specific rates are broadly comparable between England and Bexley where local numbers are large enough to include (rates based on numbers less than 5 are redacted):

Table 1. Age-specific suicide rate (per 100,000), England 2021, Bexley 2019-21

	Crude suicide rate per 100,000	
Age	**England 2021 (ONS)**	**Bexley (Audit)**
10-14 years	0.4 (0.2-0.7)	*
15-19 years	6.2 (5.4-7.1)	*
20-24 years	10.9 (9.8-12)	*
25-29 years	11.4 (10.3-12.5)	*
30-34 years	12.4 (11.3-13.5)	*
35-39 years	13.2 (12-14.3)	12.8 (5.1-26.4)
40-44 years	13.7 (12.5-14.9)	*
45-49 years	14.5 (13.2-15.7)	14.7 (5.9-30.2)
50-54 years	14.9 (13.6-16.1)	*
55-59 years	12.7 (11.5-13.8)	*
60-64 years	10.8 (9.6-11.9)	*
65-69 years	9.2 (8.1-10.3)	*
70-74 years	6.6 (5.7-7.5)	*
75-79 years	7.5 (6.4-8.7)	*
80-84 years	6.3 (5.1-7.8)	*
85-89 years	8.5 (6.7-10.6)	*
90 plus years	8 (5.8-10.8)	*

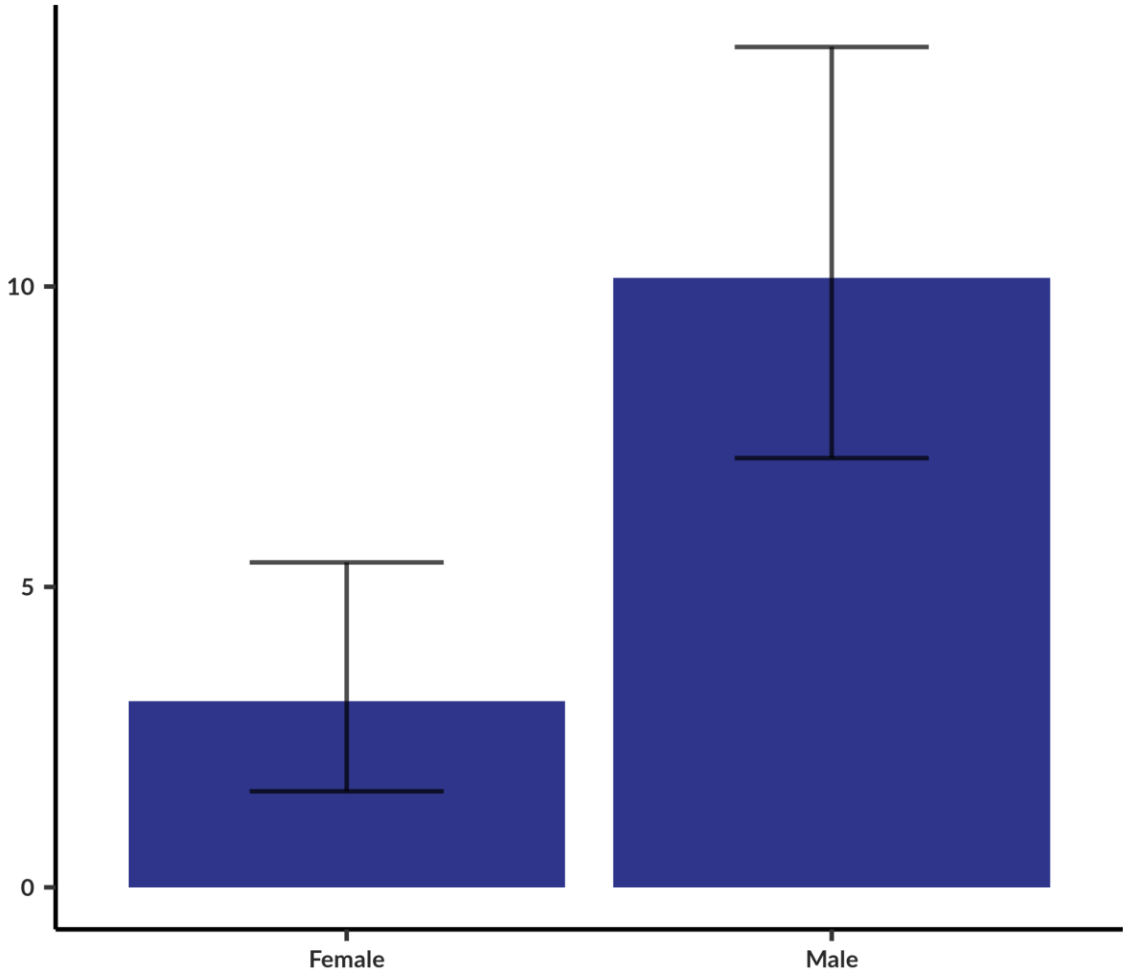
Sources: ONS, PCMD, Thrive

The highest age-specific rate of death by suicide was noted in 45-49 year olds. Similarly across England, rates were highest for 45-49 year olds and 55-54 year olds. Bexley has a slightly different age profile to that of London, with less working age people and more children and older people. 65% are aged 18-64 in London compared to 60% in Bexley. Bexley has a larger older aged population over 65, 16.5% compared to 12% in London.[21] Comparing England to Bexley by age group is difficult given the low number of cases in Bexley and very large ranges of uncertainty around the age-specific rates.

Sex

Fig 6. Crude suicide rate (per 100,000), by sex

Bexley, June 2019 - June 2021



Source: PCMD, Thrive

Crude rates of death per 100,000 population were 10.2 (7.2-14.0) for males and 3.1 (1.6-5.4) for females: a statistically significantly higher rate for males. Three quarters of suicide deaths were seen to be in men, 37 cases in males compared to 12 in females. This is close to the 73% average across England. There is little influence from cohort proportion of male and females in Bexley which are almost equal (51% male, 49% female).[22]

The male sex is an established risk factor for suicide. The circumstances surrounding suicides in males in Bexley and what specific struggles they may have been going through are discussed later in this report.

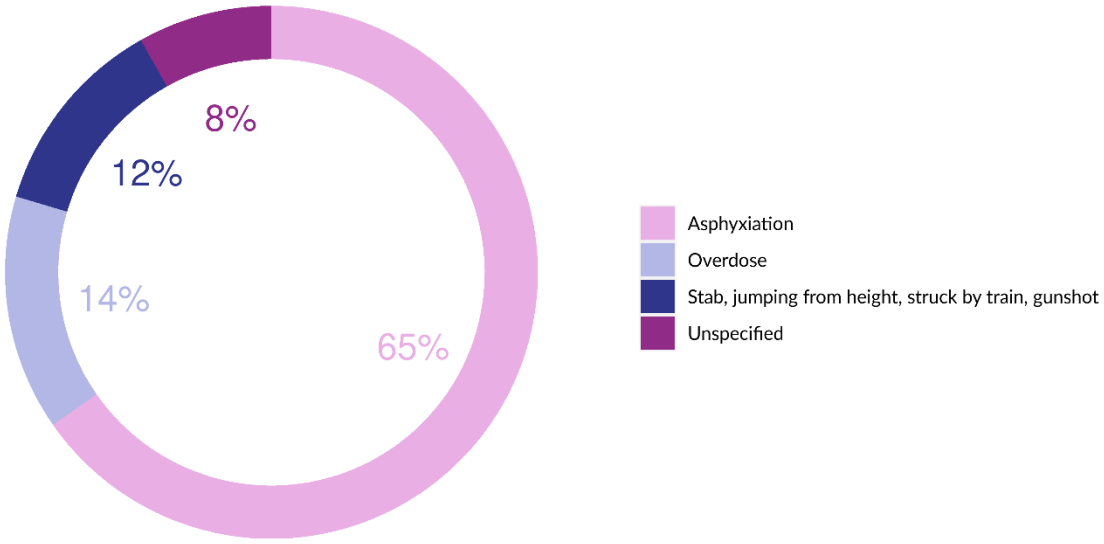
Looking into age group and sex, females aged 35-59 have the highest numbers, mirroring the age profile of female suicides across England. For males, ONS statistics show that in England since 2010, men aged 45 to 64 years had the highest age-specific suicide rates. In Bexley, the highest rate in males was seen in the 35-39 and 45-49 year age groups.

The age and sex profile of cases in Bexley may be linked to the COVID pandemic, job loss and financial stress and other factors discussed further in the later occupation analysis. There were a number of cases in the 19 and under age group. This is a known risk factor, as stated by the Royal College of Paediatric and Child Health, acknowledging that young males are at higher risk of suicide but also noting a trend of increasing suicide in young people more generally. The RCPCH published data showing an increase in referrals to ChildLine for suicidal concern leading up to 2018, from 200 cases in 2010 up to 3500 in 2018. Issues that children may be facing include poor mental health; self-harm; academic pressures or worries; bullying; social isolation; family environment and bereavement; relationship problems; substance misuse; or neglect.[23]

Suicide method

In Bexley, asphyxiation including hanging, strangulation and suffocation was the most common method of suicide by a large margin, covering 66% of all suicide cases. Overdose was second to this at 14%. Other methods of suicides were low in comparison, including jumping from height, self-inflicted stab wound and being struck by a train:

Fig 7. Proportion (%) by method of suicide
Bexley, June 2019 - June 2021



Source: PCMD, Thrive

While the method was asphyxiation for over three quarters of males (77%), this accounted for less than half of females (42%) – the same proportion as the overdose method for females. Males used a larger variety of methods compared to females, however this may be a function of the higher numbers of male suicides overall.

The ONS *Suicides in England and Wales: 2021 registrations* revealed the most common method of suicide in England and Wales for both males and females continued to be hanging, strangulation and suffocation (as a group).[5] This method accounted for 58.4% of all suicides in England and Wales in 2021 (3,258 out of 5,583 registered deaths). The second most common method continued to be poisoning and accounted for 20.5% of all suicides in 2021 (1,147 out of 5,583 deaths). Bexley data mirrored this distribution with suicide by hanging/asphyxiation accounting for 66% of all suicides.

Reasons for this are not yet fully understood but national commentary has suggested that hanging appears to be more socially accepted. Before it was abolished as a method of judicial execution in 1965, hanging was stigmatised as dishonourable, however the

change of law has since seen cases increasing. This trend is not seen in females, something also reflected in Bexley.

Data from European studies show that the rate of completed suicides is generally much higher for men. Traditionally, women have selected suicide methods that are less lethal, and men have chosen techniques that are more violent and whose consequences are irreversible. Hanging is universally available and methods to cause asphyxiation are numerous which explains its high count, as is seen across Europe, however other countries have counts as low as 18% in the United States and 32% in Australia. The reasons as to why are not fully understood but may be associated with firearm availability. In Bexley, an equal proportion of females use overdose and hanging, highlighting the suggestion that females use less violent methods. This could be an area of focus.[24]

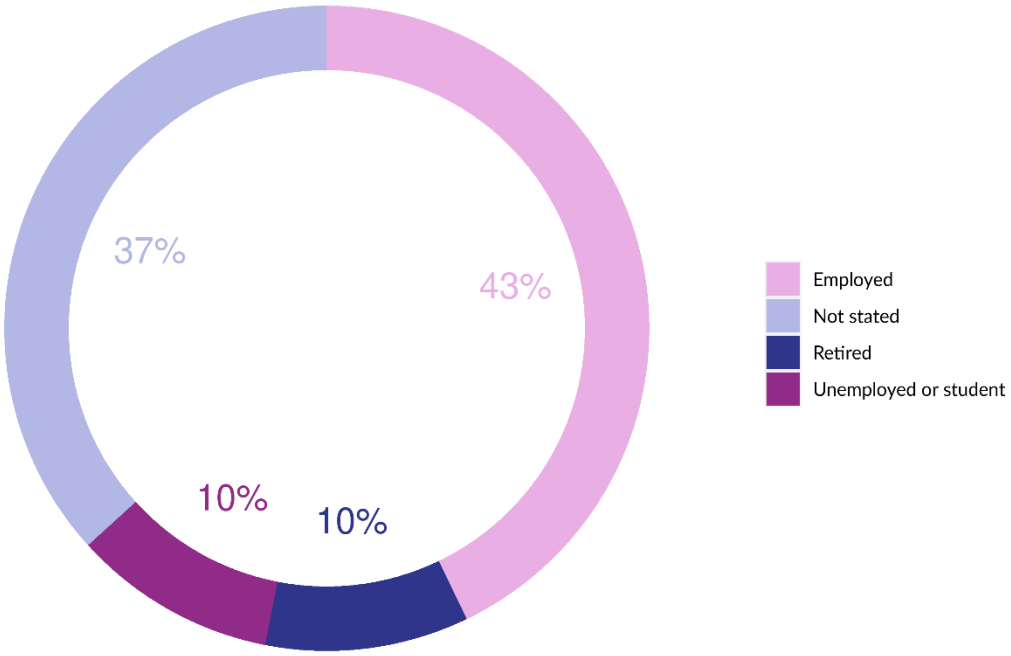
The use of drugs and alcohol alongside suicide was also assessed, with 10 cases out of 49 with a recorded use of alcohol or drugs, either documented as part of the death certificate, as part of the person's treatment history, or where evidence was found at the scene. It is important to note that the lack of documented use for the other 39 cases may be due to incomplete recording, either due to no evidence from the coroner's inquest, still awaiting a verdict, and/or no history of substance misuse known or no evidence of use when the body was found.

Of the few cases of substance use alongside suicides in females, all were isolated use of alcohol. Males were seen to use other substances such as cocaine, narcotics or hallucinogens. Themes across countries with similar patterns of suicide method reveal similar patterns of high alcohol consumption, high rates of alcohol dependence and abuse among individuals aged 30–35, and high overall suicide rates - areas which could be looked into further.

Employment Status

Of all suicides audited, 18 (37%) did not have a complete or defined employment status recorded. The largest group, 21 (43%), were recorded as employed; with 5 (10%) retired, and 5 (10%) either unemployed or in academic study:

Fig 8. Proportion (%) by employment status
Bexley, June 2019 - June 2021



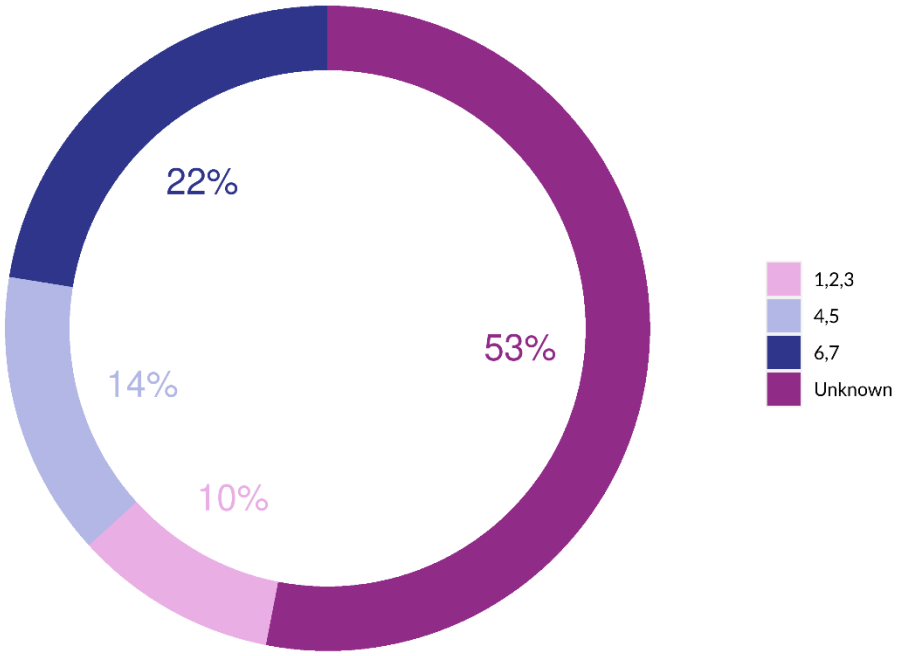
Source: PCMD, Thrive

London Borough of Bexley, an economic assessment[25] states that Bexley residents have a higher employment rate than both London and Great Britain, although over time this has been decreasing. In 2017 80.4% of males were employed and 69.6% of females – a higher proportion than represented in the audit. This may indicate that employment is a protective factor for suicide, although with over a third of employment statuses missing in the audit, this pattern may be artefactual.

Occupation

Using the ONS National Statistics Socio-economic classification (NS-SEC), the known occupations of the deceased were classified in a socio-economic hierarchy from 1 (highest seniority) to 7 (routine):[26]

Fig 9. Proportion (%) by ONS Socio-economic classification
Bexley, June 2019 - June 2021



Source: PCMD, Thrive

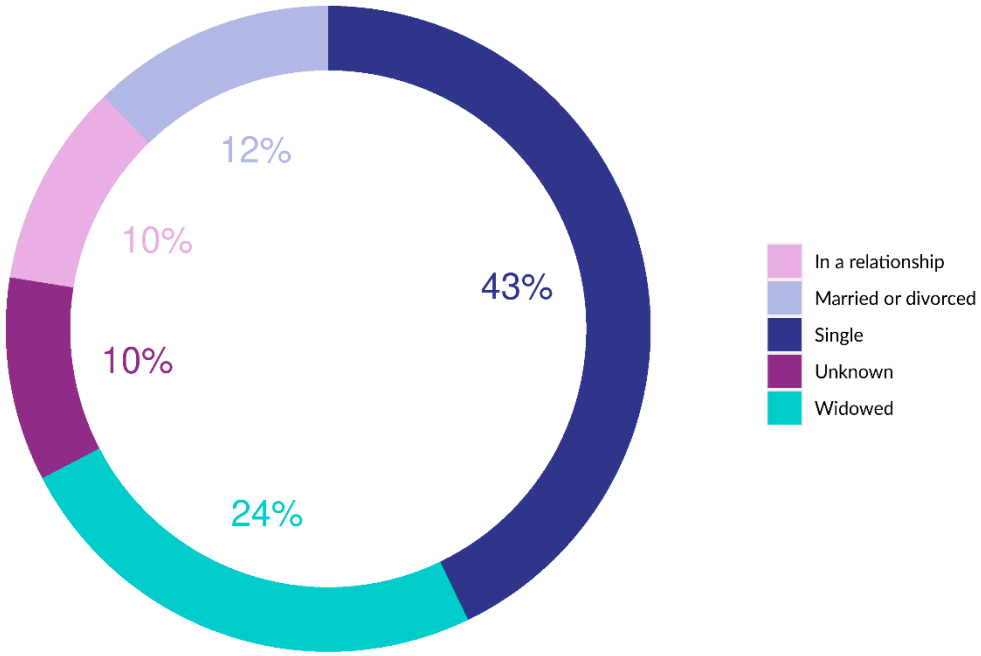
More than half (53%) of the records audited did not include an occupation. The largest group after this was the routine and semi-routine occupations (classifications 6 and 7), at 22% - more than twice the size of the senior group of classifications (1, 2 and 3) at 10%. This may indicate a correlation between routine occupation and suicide risk, or may be an artefact of the largely incomplete data, for example it could be that more senior occupations were less likely to be recorded. Similarly it is of interest that more than 70% of the suicides in the routine and semi-routine occupation were clustered in the first year of the reporting period, however the completeness of occupational data in the first year is almost twice that of the other two audit years, indicating that this too could be a data quality issue.

Marital Status

Marital status was well recorded in the audit records, with a completeness of around 90%. The largest group was single with 21 cases (43%), and the next largest widowed

with 12 (25%). 5 (10%) were in a relationship, and 6 (12%) were either married or divorced:

Fig 10. Proportion (%) by marital status
Bexley, June 2019 - June 2021



Source: PCMD, Thrive

Males were most likely to be single (51%), whereas females were most likely to be married or divorced (42%), however the very small number of females overall makes such comparisons problematic.

In some studies, both in Europe and US, divorced and separated persons were over twice as likely to commit suicide as married persons, and being single or widowed had no significant effect on suicide risk. Also divorced men were seen to be more at risk compared to women. Being married has been observed to be a protective factor, especially when involving children, but other factors also contribute including relationship satisfaction, same-sex marriage and most significantly relationship breakdown with divorce being seen to affect males more than females. [27] [28]

Whether this finding in Bexley is significant will need to be investigated further. A link between single males and loneliness could also be hypothesised, with findings from the Samaritans highlighting that loneliness was the second most highlighted issue

compared to fourth in females. It is also worth noting that inferring whether unmarried individuals were in a relationship was only partially possible, meaning it is unknown how many of those classified as single were in a relationship of some form. This, if possible, may well need to be investigated further as relationship issues and relationship dissatisfaction are equally as likely as loneliness to cause personal stress and effect mental health. [29] [30]

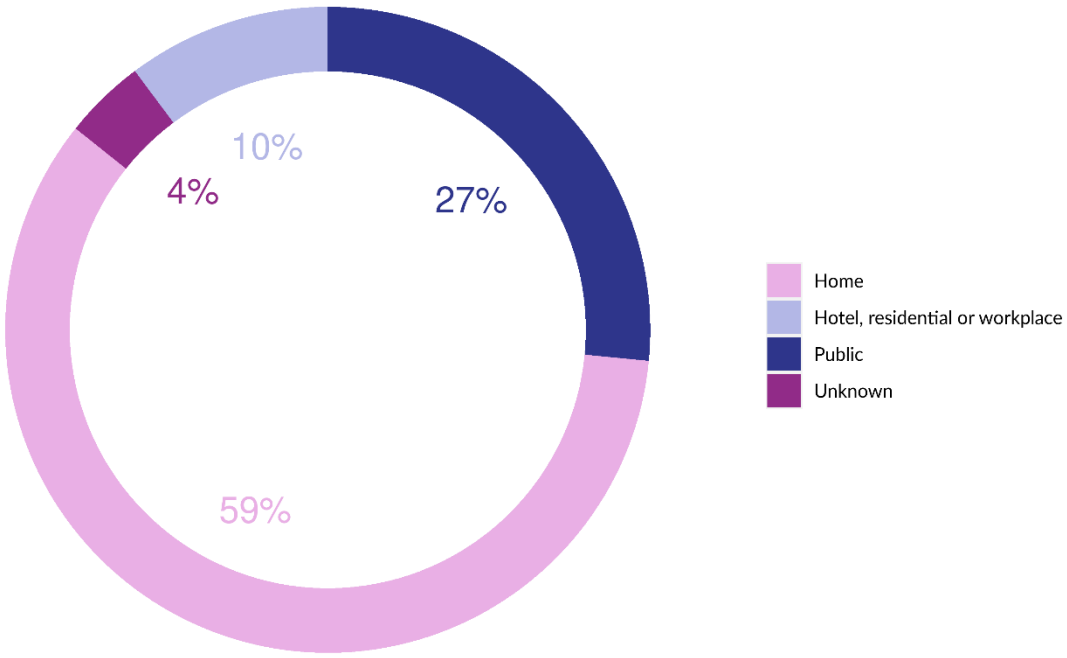
Ethnicity

Ethnicity was very poorly recorded, only being detailed on 23 (47%) of cases. Of those recorded, the majority were White – broadly reflecting Bexley's resident demographic.

Place of death

Place of death was well recorded, with only 2 cases incomplete. 29 out of 49 cases (59%) died in their own homes, with the next largest group of 13 (27%) in public places:

Fig 11. Proportion (%) by place of death
Bexley, June 2019 - June 2021



Source: PCMD, Thrive

There were no "suicide hotspots" to note, when defined as a specific location which has more than one suicide occurrence.

All female deaths occurred in their own homes and conversely all deaths occurring in public locations were male, which may be influenced by factors such as consideration of who will find the body, which can be involved in the thought process leading up to suicide.

Co-existing mental health disorders

Only 20 cases included details of a known mental health disorder. Further details such as the severity of the condition and whether they were on the mental health register were not available. Many cases also lacked specific diagnoses and only offered a combined category such as mood disorder, covering conditions such as depression and bipolar. As such, mood disorders were the most common co-existing condition seen in 11 cases. Female and male comparison showed that 7 out of 12 cases of female deaths (58%) had a recorded mental health disorder compared to 13 out of 36 (36%) in male cases. Twice the proportion of females having a mental health diagnosis compared to males could also be indicative of either males not presenting to seek help earlier; a lack of diagnosis due to sex norms, a factor for lack of presentation; or a a data completeness issue.

Depression is thought to be the most common mental health co-morbidity in those that commit suicide, given that it can affect all age groups. Its nature is complex and often co-exists with other disorders and can lack specificity as a predictor.[37] The literature also indicates sex-associated suicide risk related to certain mental health conditions, such as female cases of personality disorder and male cases of psychosis. Psychosis in men is a known risk factor for higher likelihood in resulting suicide.[31 32 33]

Previous suicide attempts were stated in only 6 cases, and it is difficult to discern where incomplete recording indicates no previous attempts or merely a lack of data. Of these 6, all had either a formal mental health diagnosis or mental health concerns. 5 of these cases had known mental health contact either from the community mental health team, the CRISIS team, counselling, previous treatment by Oxleas and Section 136 attendance. Current research suggests that most male and a substantial proportion of female suicides die in their first suicide attempt, with females making more non-fatal attempts prior.[34]

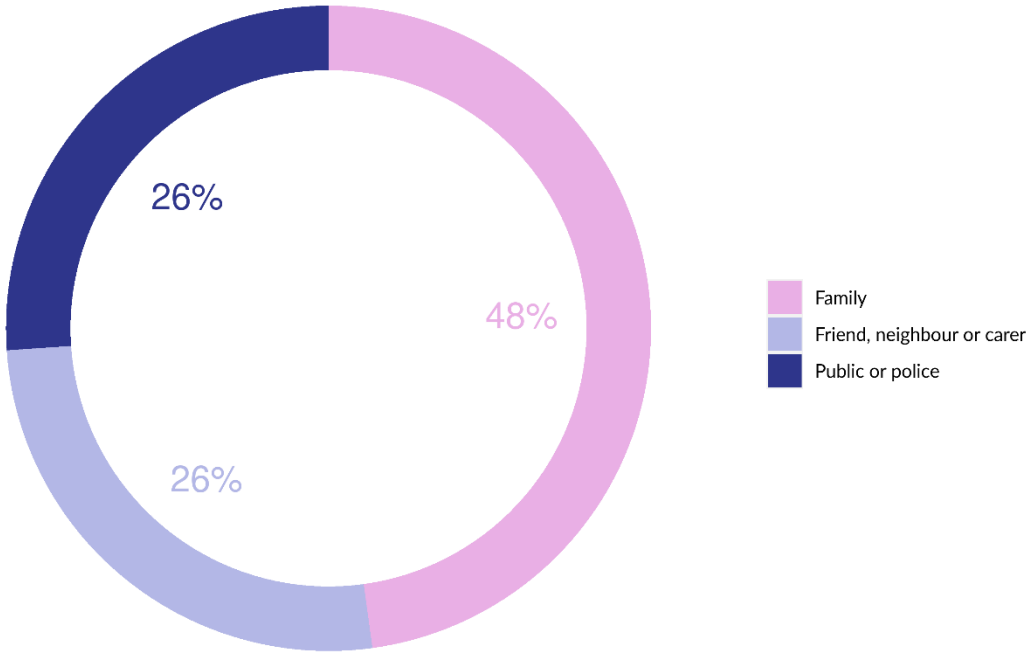
Suicide note

Information whether a suicide was left or not was available in 7 out of the 49 total cases in the audit. The most common themes in the notes were regarding finances and funeral arrangement. Other themes included reason for suicide, mention of other deceased relatives, possible paranoid beliefs/delusions and issues surrounding sexuality.

Discovery

23 cases (47%) included details of the individual who discovered the body. The most common individual to find the deceased body was usually the spouse or girlfriend/boyfriend. Family members, which included parents, spouses and adult children had a count of 11. Individuals that were not related to the deceased were often members of the public, neighbours and staff members (such as carers and cleaners).

Fig 12. Proportion (%) by individual discovering deceased
Bexley, June 2019 - June 2021



Source: PCMD, Thrive

Thrive LDN, with the help of external partners, have developed London's first multi-agency information sharing hub, allowing vital information to be securely shared to enable effective bereavement support and the improvement of suicide prevention work throughout London. For this reason, it is important to consider the individual that found the deceased body given the trauma experienced by that person. The finding that partners, including spouses and girlfriend/boyfriends, were most likely to find the deceased body could be due to frequency of contact with the individual and insight into their personal life is higher than that of friends and sometimes family. Also, relationship issues and divorce being a known theme surrounding mental health is likely to be a contributor into this finding, although not exclusively the reason. Other factors to consider are those in the wider community that could be affected including staff members such as carers/warden staff, neighbours and police who commonly come across the deceased bodies.[35]

Circumstances surrounding suicide

Additional data were included in the Thrive data covering the circumstances surrounding the suicide, giving further information for 18 of the suicides, however it is unclear how much of this detail was circumstantial and/or inferred. Very little summary is possible due to the distinctive and identifiable details involved, however common themes were relationship issues, domestic abuse, bereavement, substance abuse, work issues and mental ill health. Of the cohort, males exclusively experienced work-related issues and issues involving prior police involvement.

Relationship issues were the most reported issue alongside the suicide, however this may be due to the high underlying prevalence rather than as a specific association with suicide. Research has found that high marital quality is associated with lower stress and less depression. However, single people were seen to have better mental health outcomes than unhappily married people. Given the above finding, more focus could potentially be targeted towards relationship issues and mental health.[36]

Finances and occupation were expected to occupy a larger proportion given the occupation demographics of Bexley alongside the effects of the COVID pandemic, and it may be that these issues are underreported due to incomplete data. Bereavement was also expected to be a more common theme than was evidenced, given the lives lost due to COVID.

Safeguarding

Data from the Bexley Safeguarding Adults Board showed there were 8 Safeguarding Adult Reviews between 2019 and 2022 that had suicide as outcome. From these the majority was female, and the age range was 19 to 40 years old. Due to a lack of identifiers in the datasets it was not possible to cross-reference the different sources, meaning it was not possible to ascertain whether all 8 Safeguarding Adult Review cases were included in the original dataset from RTS and PCMD.

Recommendations

Re-audit recommendations

There were limitations in the study, particularly missing responses from a few data sources, which could fill certain gaps in the current data set. Contacts for further data analysis includes: coroners, section 136, adult safeguarding board, accident and emergency department, GP surgeries and Oxleas.

Only a subset of the data had disclosed information on certain categories of information. This meant that that when analysing the data within this audit, it was difficult to draw conclusions from them at times. The incomplete data to be looked to include alcohol/drug involvement, place of birth, employment status, occupation, marital status, registered GP practice, ethnicity, known children, known mental health diagnosis, previous suicide attempt, physical health co-morbidity and suicide note.

Also, no information was found regarding previous GP contact and other health services such as drug and alcohol and smoking cessation. It may be worth investigating either from the GP Practices themselves if this data would be available and could provide insight into what services and how long before the actual suicide these individuals made contact. Oxleas may also be able to provide additional data into their level of contact with individuals that have committed suicide to assess any change of action from provision of mental health service to the user to help better protect high risk groups.

The majority of the THRIVE database had remaining coroners' inquests, for follow up purposes it would be worth chasing up the relevant coroners. As part of national recommendations, further suicide audits conducted by local authorities are advised and this should be continued to better understand how to tackle this issue in Bexley using accurate and up to date data. Future audits should seek to include data from coroners reports and section 136 as these would provide further contextual information relating to known risk factors, such as sex or ethnicity associated under-utilisation of clinical services. As well as completed suicide, attempted suicide may also be investigated in a similar way including self-harm in children.

Suicide prevention strategy recommendations

In regards to recommended actions that can be taken from findings of this audit, this can be assessed looking at the individual categories investigated. From this, risk factors can be identified that would be more specific to Bexley residents.

It might be helpful to conduct further studies of community-based initiatives that worked well in neighbouring areas. A small task and finish group could also be stablished to look into individual cases of suicide and wider implications for friends, family and carers, as this might help tailoring local suicide prevention strategies.

Suicide rates in other local boroughs

Given that there are 18 other boroughs with lower suicide rates per 100,000 population, reviewing suicide prevention strategies in other boroughs such as Bromley, Barnet and Brent could provide useful insight into preventative measures that are proving to be highly effective.

Age and sex

Focus should on the age range of 35-59, which had highest rate of deaths per 100,000 population in Bexley, and specifically for females, on the age range 45-59. Given the existence of cases in the 10-19 year old group, more focus on young people in school with mental health issues should be given attention with school based interventions. The male sex in general should be recognised as a risk factor for suicide.

Suicide Method

Given the ease of access to apparatuses with the potential to be used for hanging, a method-specific prevention strategy is difficult but can be enforced in controlled environments and institutional settings. In light of females having a higher propensity towards overdose, awareness could be raised with GPs and pharmacies on dispensing and prescribing medication to those at higher risk of suicide, including monitoring of antidepressants and opioids. It may also beneficial for GPs and pharmacies to internally audit cases where suicides have occurred as a result of prescription medication to investigate whether future occurrences could be prevented.

Collaboration with drug and alcohol services would be useful in substances misusers with a view to increasing referrals for mental health monitoring for at risk individuals.

Occupation

Where occupation was recorded, it was noted that routine and semi routine occupations were over-represented. Collaboration with certain employers could raise

mental health awareness for some of these individuals with more focus towards males who are employed.

Marital status

Both being single and having relationship issues are known to lead to poorer mental health outcomes. When risk stratifying individuals, single people should be identified, given the higher suicide counts seen in this group in Bexley. Loneliness could be a theme with these individuals and social prescribing may be of benefit. The risk to females under Safeguarding Adult Review should be discussed with the Bexley Safeguarding Adult Board.

Place of suicide

Although no clusters in suicide location or iconic spots were noted in the last 3 years, a wider time frame should be investigated to assess any repeat cases in certain outdoor locations. Preventative measures could focus on signage in outdoor environments used for suicide such as parks, wooded areas, bridges and highways.[37]

Place of residence

No significant difference was found in the rates of suicide for different wards of residence.

Co-existing mental health disorders

The high proportion of men with no formal diagnosis should prompt health care providers to seek alternative symptoms of depression in these individuals. There should be an approach to increase referrals for higher risk groups, talking therapies and follow up.

Circumstances surrounding suicide

A holistic approach should be tailored towards individuals with mental health diagnoses, with assessment of personal issues and redirection towards relevant services such as bereavement and relationship counselling.

Consistent with the purpose of THRIVE LDN, identifying those at risk of the consequences of identifying the deceased is also of importance, in particular spouses and boyfriends/girlfriends and staff members including police who commonly find deceased bodies.

Next Steps

- GPs to be informed of suicide audit findings and potentially training to be given with specific data findings
- Liaise with relevant teams from the Suicide Prevention Partnership to conduct action planning to implement recommendations including Adult Safeguarding Board, drug and alcohol services, GPs and schools
- Continue to audit suicide data in a continuous cycle, and expand to investigate self-harm

Conclusion

Rates of suicide in Bexley were lower than the national average and in keeping with London statistics, ranking 19th out all the London Boroughs. The demographic of the cohort was also in keeping with ONS suicide data, matching themes such as risks to young males and other statistics for ethnicity and age. No significant age trends were seen however it is worth noting the existence of suicides in children and young people aged 19 and less and also females aged 45-59.

Suicides committed via hanging are on the rise nationally and Bexley also reflected this. Specific interest should be taken in single males, and those in semi-routine occupations.

Given the rare nature of suicide, it is difficult to draw specific conclusions from very small unstable numbers, however as mentioned above, areas of focus have been indicated for further investigation, which may reveal risk-factors specific to residents in Bexley.

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