



London Health Observatory



Suicide in London 2005-2007

An update

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Key findings

Trends

- **Suicide rates have continued to fall in London in recent years. In 2005-07 the rate of 7.5 suicides per 100,000 population represents a 17 per cent reduction since 1995-97.**
- **If current trends continue London will meet the Government's PSA target in 2010.**
- **Reductions have been unequally distributed across London's population with the biggest percentage decreases seen for women aged 65 and over, and young men aged 15-34. The rate for the latter almost halved between the mid 1990s and 2005-07.**
- **Although the rate has decreased for young men, suicides still accounted for one in five of all deaths of men in their twenties in London in 2005-07.**

Area differences

- **Inequalities in suicide rates across London remain large. In 2005-07 the rate was significantly higher in Inner London than Outer London. There was a more than three-fold difference between the boroughs with the highest (Camden) and lowest rates (Enfield).**

Methods

- **Hanging, strangulation and suffocation remains the most common method of suicide for men in London. Drug-related poisoning is the most common method for women, but the proportion of suicides committed that way has decreased substantially over time. This welcome change may be related to a number of changes in access to potentially lethal drugs.**

Access to mental health care for patients most at risk

- **London's performance on access to mental health services for seriously mentally ill patients after discharge from hospital is very good and continues to improve. For a number of primary care trusts this is now close to 100 per cent of their most vulnerable patients.**

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1. Introduction

1.1 Aims

This report has been produced as part of the joint Mental Health Intelligence Programme (MHIP) funded by the London Development Centre (LDC) and the London Health Observatory (LHO). Suicide prevention was identified as a priority area by the MHIP advisory group, and this work has been undertaken with the goal of supporting local suicide audits and regional and local delivery of the National Suicide Prevention Strategy for England¹. From 1st April 2009, the London Health Observatory and London Development Centre have been founding organisations of Commissioning Support for London (CSL), a new organisation which provides clinical and business support to London's NHS.

The aim of this short report is to present a brief overview of suicide in London in 2005-2007 and to provide an update on trends. Our full review of suicide in London was published in the 2005 report, *Deaths from suicide and undetermined injury in London*.² This contained data up to 2001-03 and was followed by a short update report in 2006 containing figures for 2002-2004.³ For a more comprehensive discussion of sources of data on suicides, see the 2005 report and the North East Public Health Observatory paper *Using information to support suicide prevention*.⁴

1.2 Policy Context

Mental health was identified as one of four key areas in the Government's White Paper, *Saving lives: our healthier nation (OHN)*.⁵ This set a target, included in the Government's Public Service Agreements, to reduce suicide rates by at least a fifth by the year 2010. The reduction needed to meet the target in London is shown in Box 1.

Box 1 – Government PSA target

London Baseline (1995-97) suicide rate = 9.0 per 100,00 population

Target = 20 per cent reduction by 2010

London target (2009-11) suicide rate = 7.2 per 100,000 population

The National Suicide Prevention Strategy for England aims to support this target through activity based on six goals:

1. To reduce risk in key high risk groups
2. To promote mental well-being in the wider population
3. To reduce availability and lethality of suicide methods
4. To improve reporting of suicidal behaviour in the media
5. To promote research on suicide and suicide prevention
6. To improve monitoring of progress towards the OHN target to reduce suicides.

Suicide prevention was one of the core programmes of the National Institute for Mental Health in England (NIMHE). It is expected that this will remain the case for the new National Mental Health Development Unit, as it does for the London Development Centre.

Box 2 – Defining suicide

The definition of suicide used in this report is deaths with an underlying cause of intentional self-harm or injury/poisoning of undetermined intent. It has been customary to assume in England and Wales that most injuries and poisonings of undetermined intent are cases where the harm was self-inflicted but there was insufficient evidence to prove that the deceased deliberately intended to kill themselves.^{6,7}

2. Results

2.1 Suicides 2005-07: the London picture

Using the definition contained in Box 2, the suicide rate in London in 2005-07 was 7.5 deaths per 100,000 population. This has reduced by 17 per cent since the rate of 9.0 per 100,000 in 1995-97 (the baseline for the Government target). In 2005-07 there were 1,757 suicides in London, an average of 586 a year. This number has also fallen since 1995-97, when there was an average of 657 suicides a year.

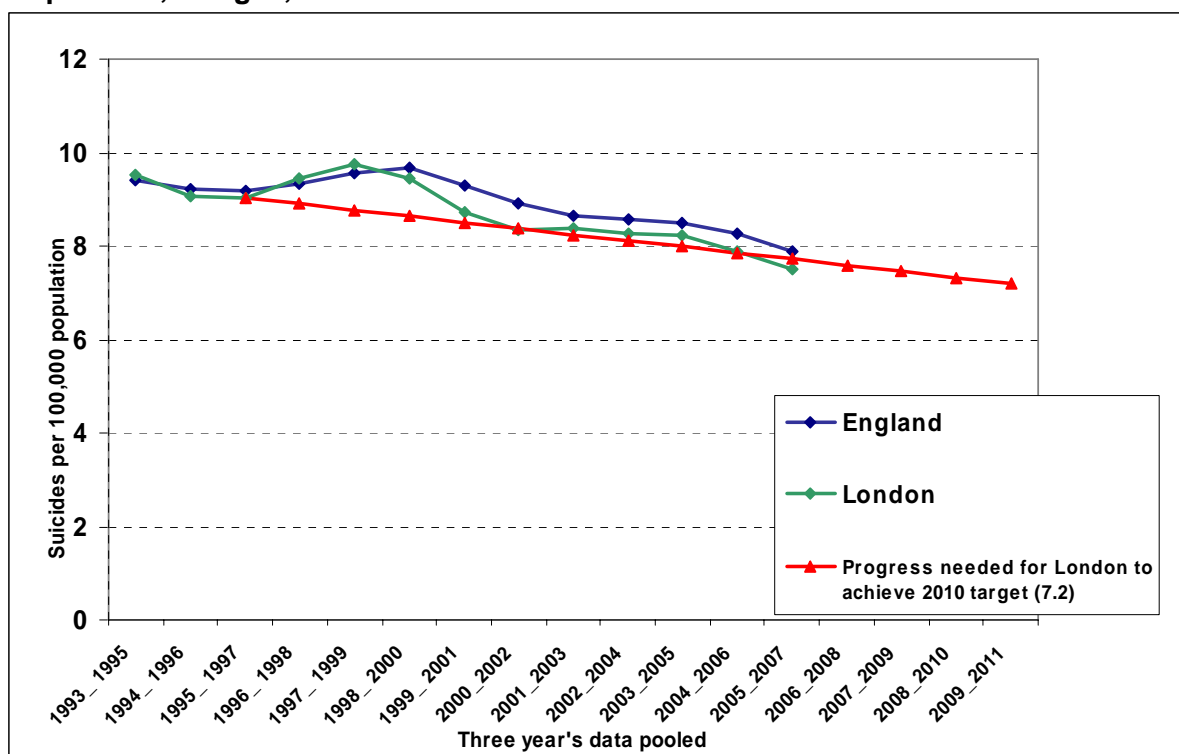
In 2005-07 the suicide rate in London was slightly lower than the rate in England (7.9 per 100,000). London's rate was significantly lower than in the North East and North West regions (8.7 and 9.3 suicides per 100,000, respectively). While the West Midlands and East of England had suicide rates which were slightly lower than London's, these differences were not statistically significant.

2.2 Trends in suicides rates – all ages

Suicide rates have been decreasing in London in recent years and this fall continued in 2005-07 (Figure 1 and Appendix Table 1). Although rates increased after 1995-97, they fell at the turn of the century. After several years when rates remained stable, falls have occurred again in the most recent two time periods. Suicide rates have also been falling in England, but the rate for London has been consistently lower than the national average since 1998-2000.

Figure 1 also shows the progress that needs to be made if the suicide rate in London is to be reduced by 20 per cent by 2010, to 7.2 deaths per 100,000. If recent trends continue, London will meet this target.

**Figure 1 - Directly age-standardised suicide rates, London and England
All persons, all ages, 1993-95 to 2005-07**



Source: ONS mortality data analysed by National Centre for Health Outcomes Development, chart by LHO

2.3 Suicide trends – broad age groups

In the mid-1990s, suicide rates for men in the age groups 15-34, 35-64 and 65 and over, were all similar, at around 20 deaths per 100,000 population (Figure 2). This has changed over time however, and rates for young men in London almost halved between 1993-95 and 2005-07. Rates in the two older age groups decreased, but not by the same extent.

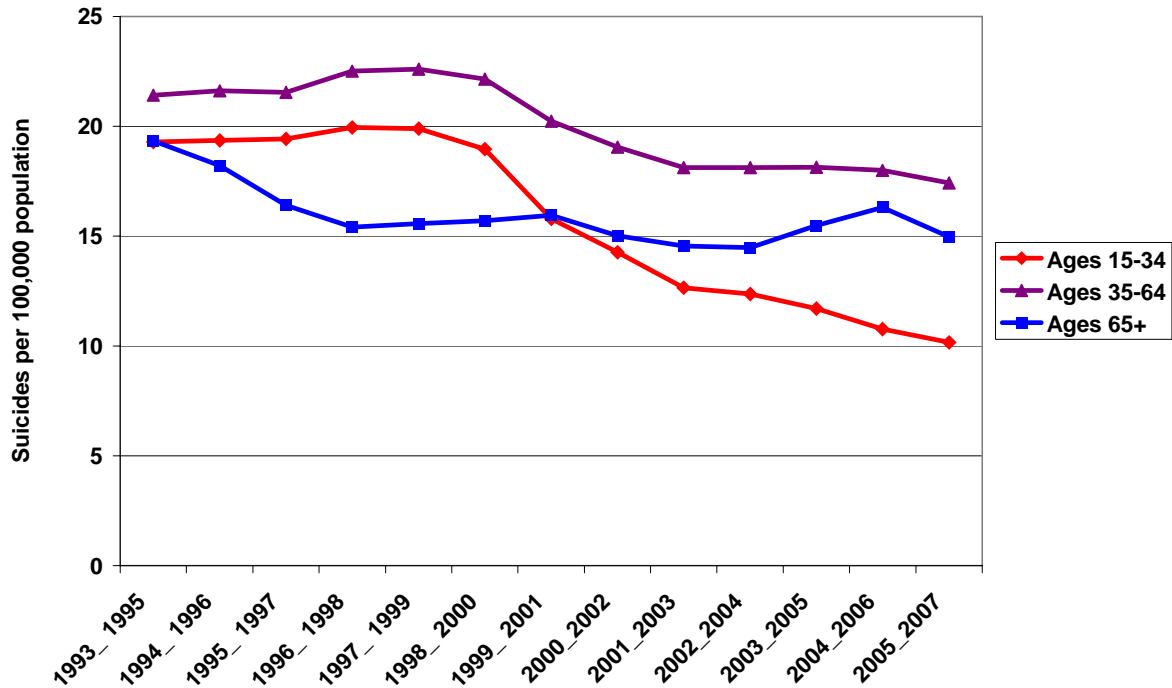
Unlike men, suicide rates for women throughout this period were consistently lowest for the youngest age group, 15-34 year olds (Figure 3). The biggest percentage decrease however, was for women in the oldest age group. Suicide rates for women aged 65 and over almost halved between 1993-95 and 2005-07, from 8.1 to 4.1 deaths per 100,000 population. In the most recent years, the highest rates therefore have been for women aged 35-64.

Suicide rates for men aged 15-34 were significantly lower in London than the national average for England in 2005-07 (Figure 4). Although rates for the other male age groups, and for females, differed from those for England, these differences were not significant.

Across the period 1993-95 to 2005-07, suicide rates for young men in London were consistently lower than for England as a whole (Appendix Table 2a). The rate in London also reduced by more than for England (reductions of 90 and 60 per cent respectively). For men age 35-64, rates in London remained similar to England across this time period. For older men aged over 65, however, suicide rates were higher in London than in England in every year since 1999-2001.

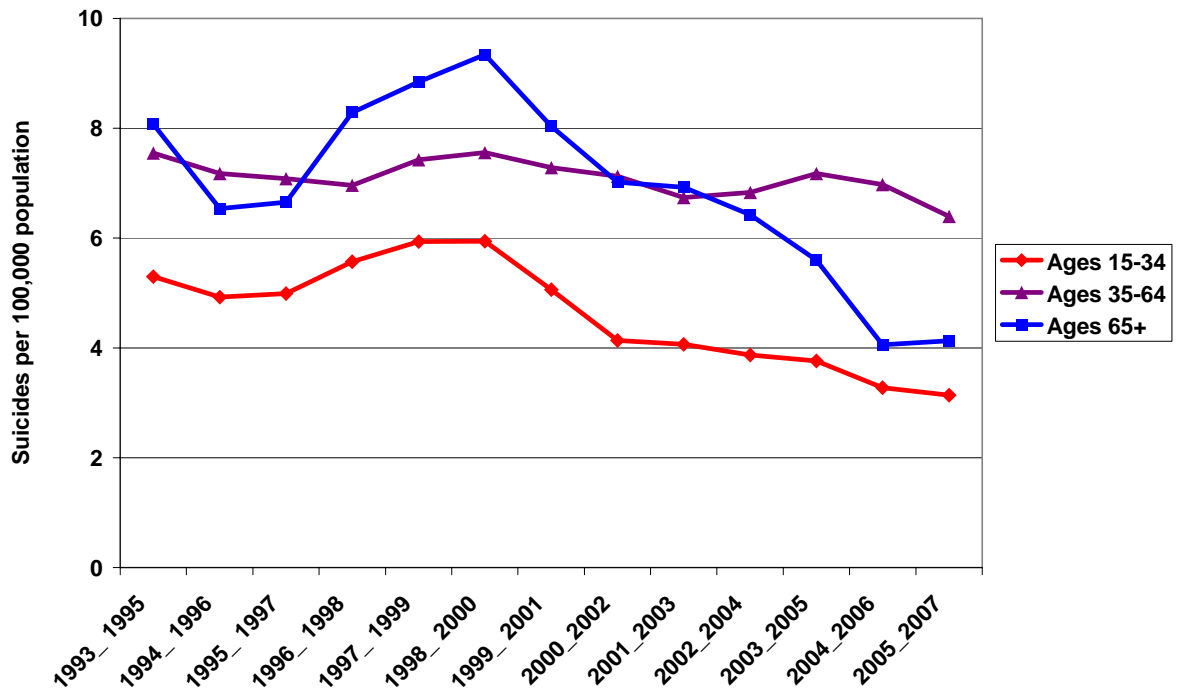
For women aged 35-64, suicide rates in London have been consistently slightly higher than for women in England. Older and younger women, however, do not present such consistent patterns (Appendix Table 2b).

Figure 2 - Directly age-standardised suicide rates by age band, London Men, 1993-95 to 2005-07



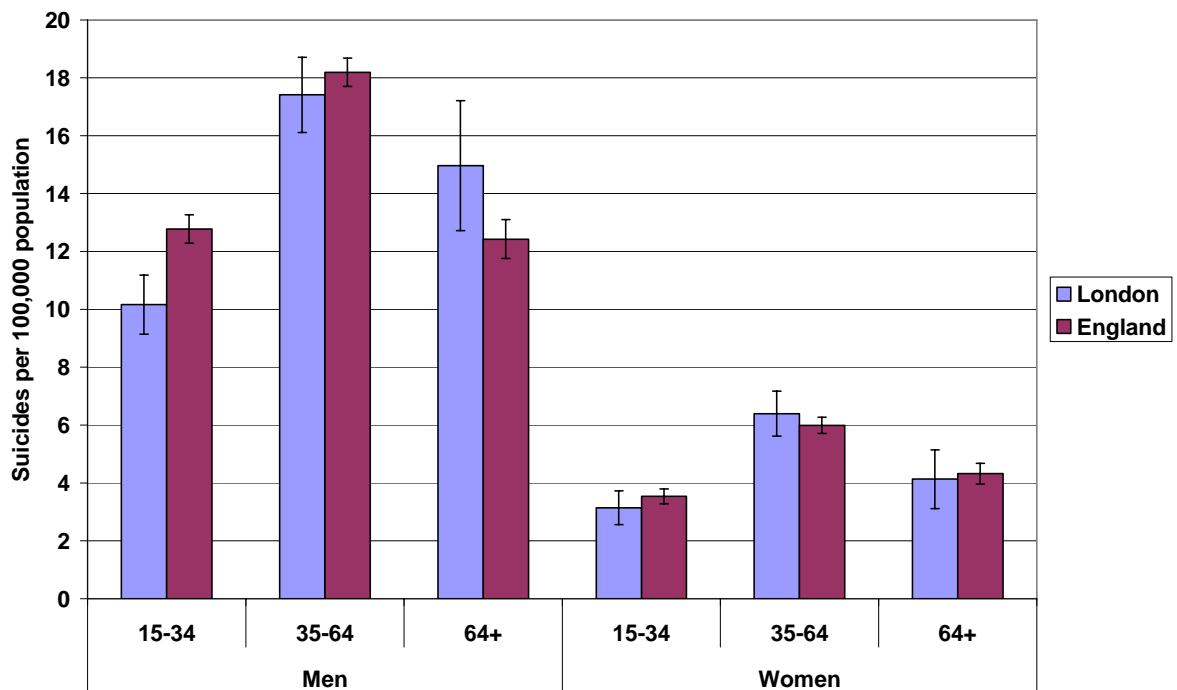
Source: ONS mortality data analysed LHO

Figure 3 - Directly age-standardised suicide rates by age band, London Women, 1993-95 to 2005-07



Source: ONS mortality data analysed LHO

Figure 4 - Directly age-standardised suicide rates by age band and sex England and London, 2005-07

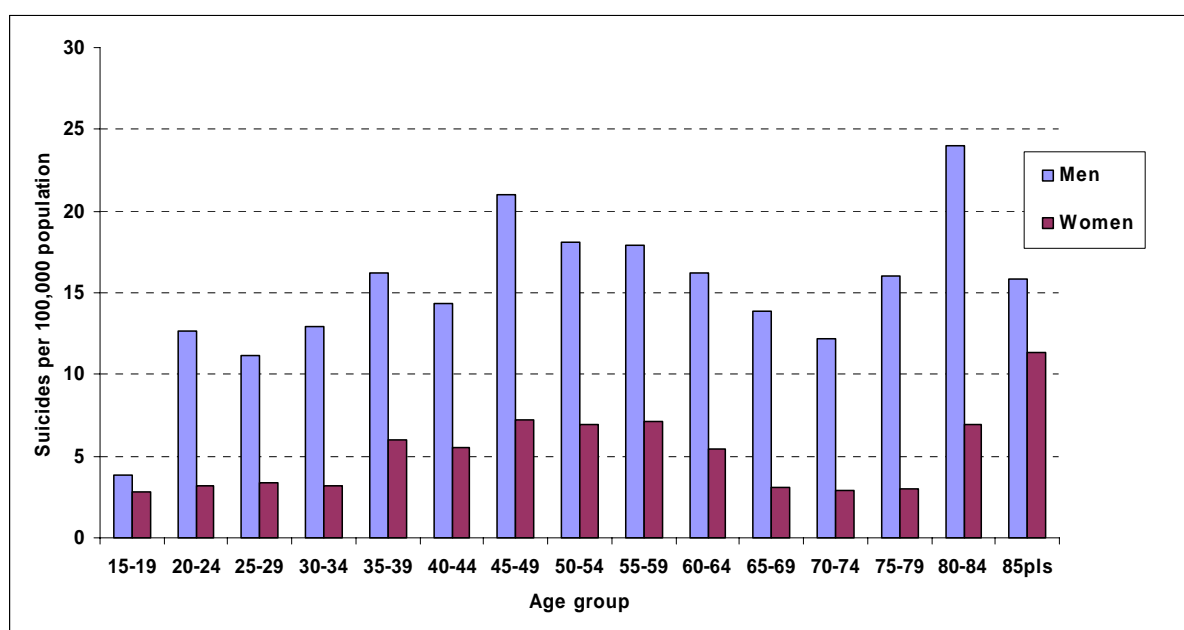


Source: ONS mortality data analysed LHO

2.4 Suicides by sex and five year age groups

The suicide rate for males was significantly higher than for females in London in 2005-07 and men accounted for just over seven out of ten suicides. Male suicide rates were higher than those for females at every age band (Figure 5 and Appendix Table 3). For both sexes, these age-specific rates followed a similar pattern, with peaks seen for those in their forties and fifties and then again in the oldest age groups. For women, the highest rate was in the final age band, 85 and over, but for men it was highest for those aged 80-84.

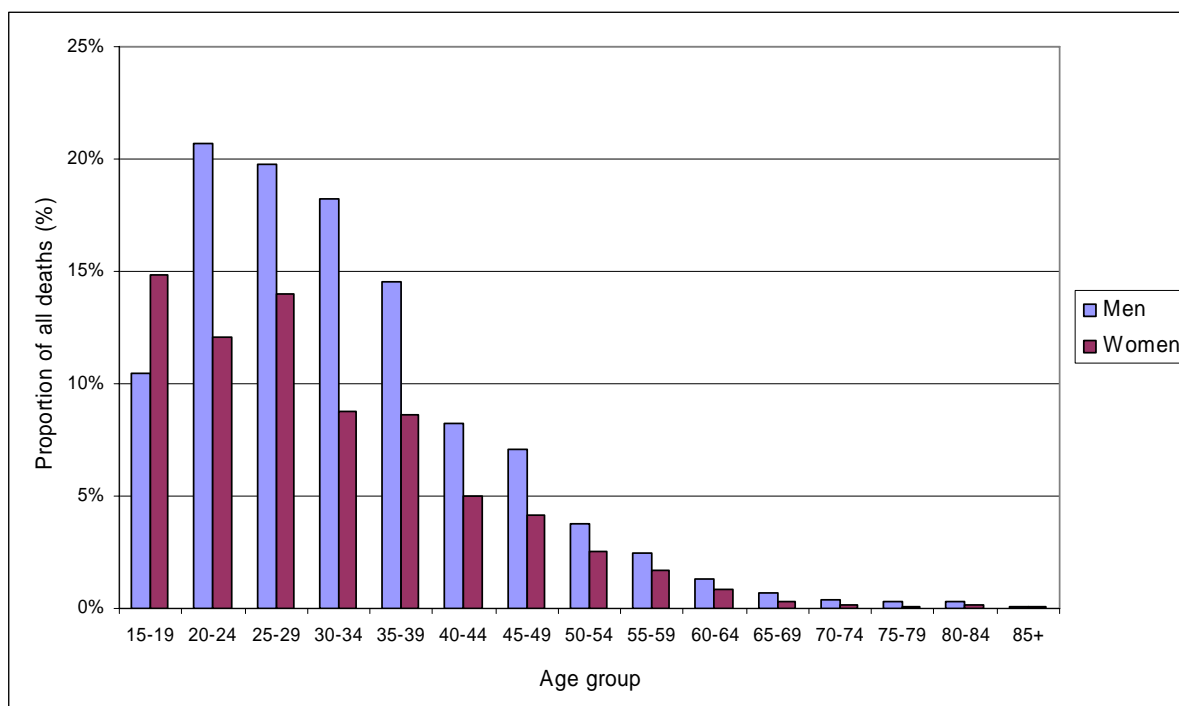
Figure 5 - Age-specific suicide rates per 100,000 population, London, 2005-07



Source: ONS mortality data analysed LHO

Although the highest rates are found in these older age bands, suicide at younger ages represents a far greater proportion of the total number of deaths (Figure 6 and Appendix Table 4). For men in their twenties, for example, suicide accounted for a fifth of all deaths in 2005-07. For women, it made up around 1 in 8 deaths in this age group. These proportions generally decrease with age.

Figure 6 - Suicides as a proportion of total deaths, London, 2005-07



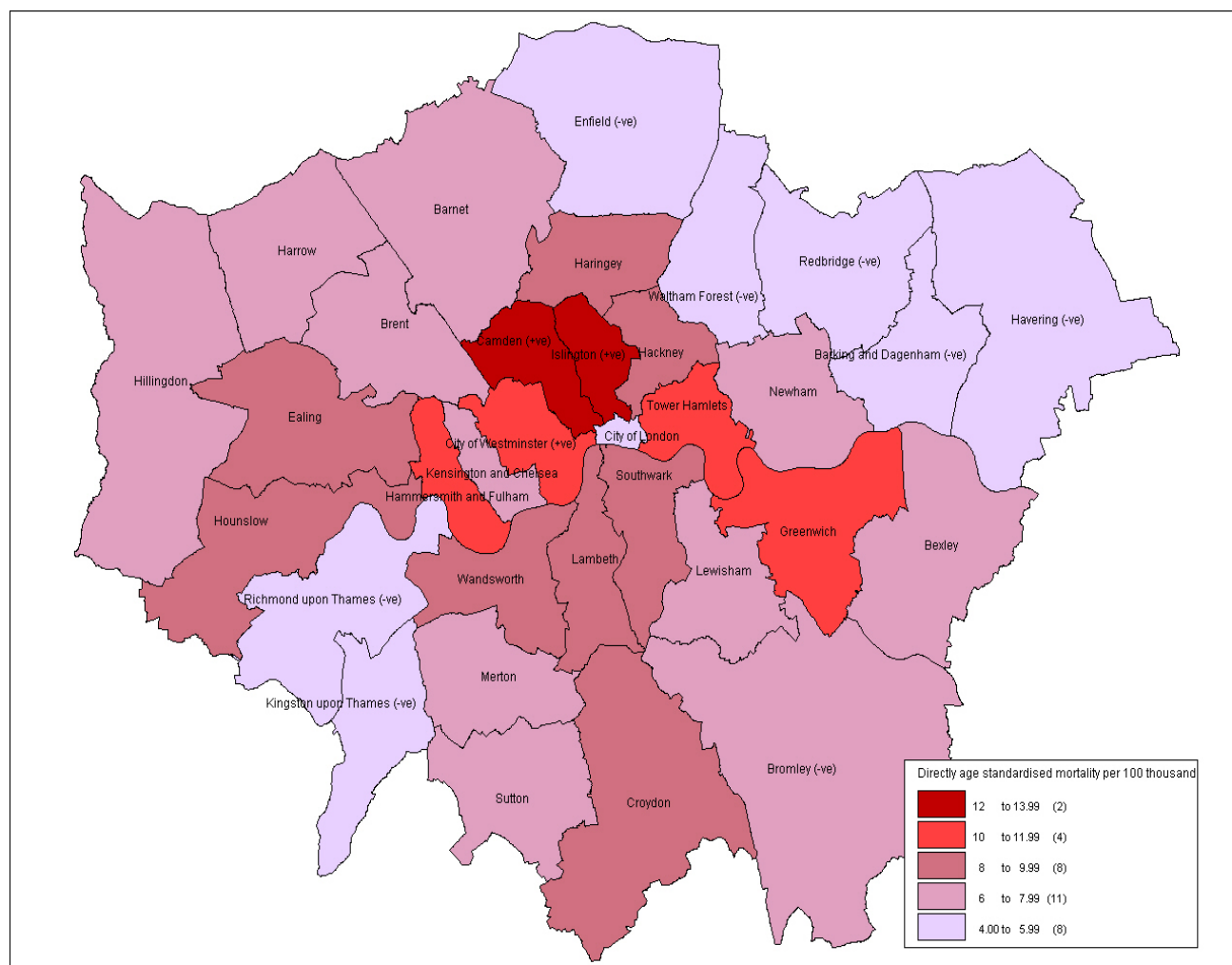
Source: ONS mortality data analysed LHO

2.5 Inequalities in suicide within London

Suicide rates varied considerably across the capital in 2005-07. While the rate in Outer London (6.5 deaths per 100,000 population) was significantly lower than the England average, the rate in Inner London, at 9.3, was significantly higher. Eight out of the nineteen boroughs in Outer London had rates significantly lower than the national average (Map 1 and Appendix Table 5a). Three Inner London boroughs (Camden, Islington and Westminster), had suicide rates which were significantly higher than for England. The rate in Camden was over three times higher than that in Enfield, the borough with the lowest rate in London (13.2 and 4.0 per 100,000 respectively).

These differences were also reflected in sex-specific suicide rates for London boroughs (Appendix Tables 5b and 5c). For males, the highest rates were in Islington, Greenwich and Tower Hamlets. As for all persons, there was a more than three-fold difference between the highest and lowest rates (18.7 in Islington, 5.3 in Enfield). The highest rate for females was in Camden (10.8 suicides per 100,000) while the lowest, at just 1.0 per 100,000, was in Redbridge.

**Map 1 - Directly age-standardised suicide rates per 100,000 population
London boroughs, all ages, persons, 2005-07**



Source: ONS mortality data analysed by National Centre for Health Outcomes Development, mapped by LHO
Based on Ordnance Survey material. (c) Crown Copyright 2008. All rights reserved. Department of Health 100020290 2008
(+ve) Significantly higher than the England average
(-ve) Significantly lower than the England average

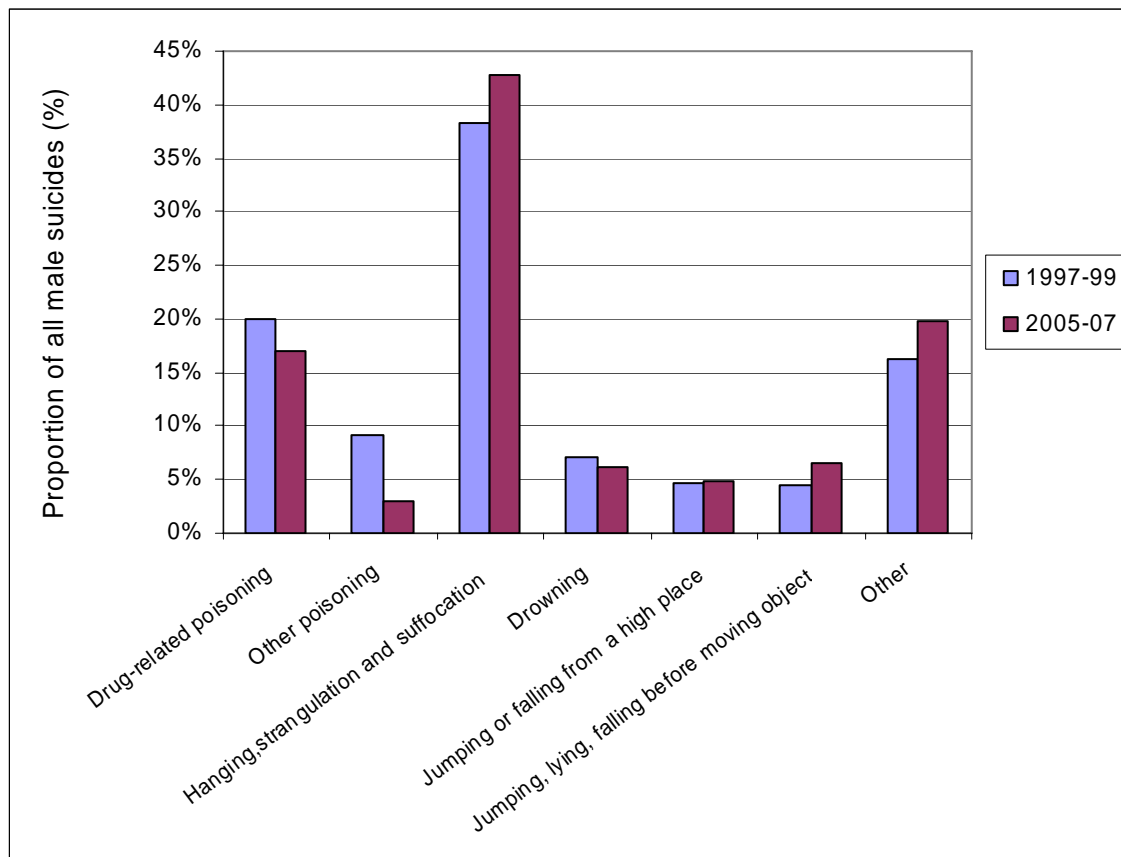
2.6 Methods used to commit suicide

The third goal of the National Suicide Prevention Strategy is to reduce the availability and lethality of suicide methods. Evidence suggests that impulsive acts of suicidal behaviour may be delayed or prevented if a person does not have immediate access to lethal methods.¹ Therefore monitoring the underlying cause of death may be useful in identifying opportunities for reducing availability of potentially lethal methods of self-harm. (See the 'Data sources and definitions' section for details of how methods of suicide were extracted).

In men, deaths as a result of hanging, strangulation or suffocation made up the largest proportion of suicides in London in 2005-07 (43 per cent - Figure 7 and Appendix Table 6). The second highest category, 'Other', contains methods such as self-harm with firearms or sharp objects and the crashing of motor vehicles. These results have changed somewhat in recent years, with drug-related and other poisonings accounting for a smaller proportion of suicides in 2005-07 than they did in 1997-99.

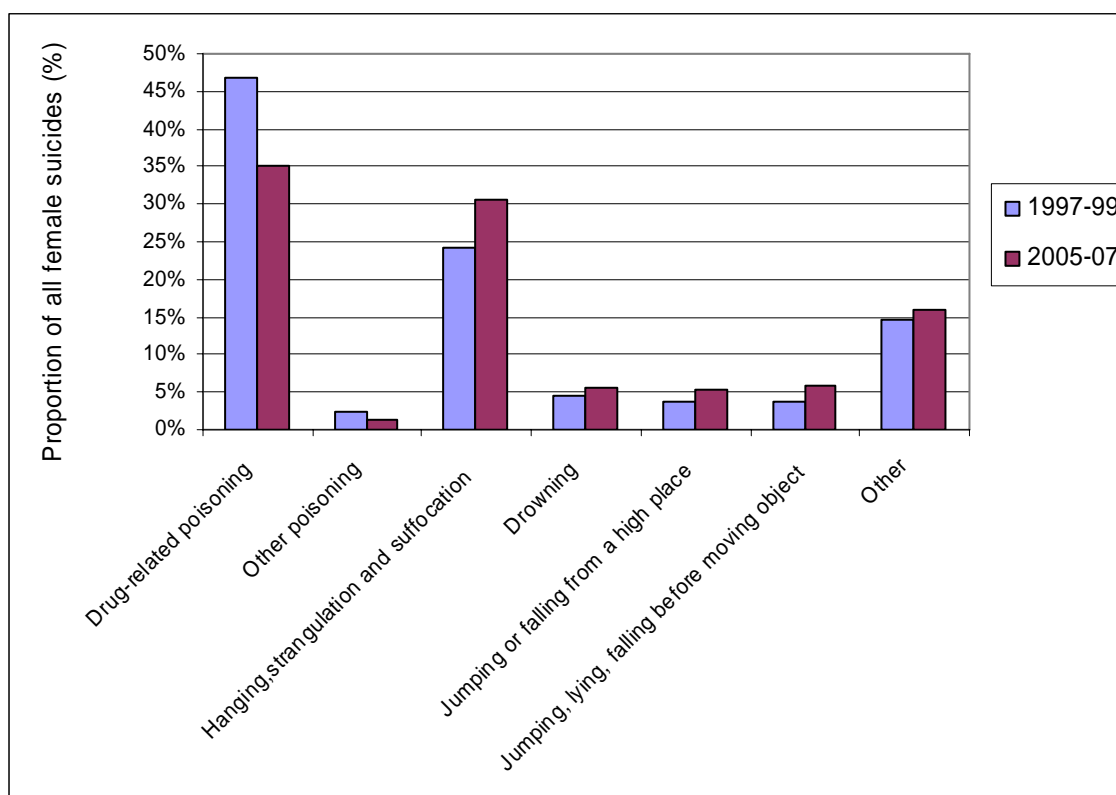
The same is true for women, although drug-related poisonings still represent the main method for female suicide in London (Figure 8 and Appendix Table 6). The proportion fell from 47 per cent in 1997-99 to 35 per cent in 2005-07, however. Death as a result of hanging, strangulation and suffocation was the second most common method of suicide for women in 2005-07, making up 31 per cent of the total.

Figure 7 - Percentage of suicides by method, men aged 15+ London, 1997-99 and 2005-07



Source: ONS mortality data analysed LHO

Figure 8 - Percentage of suicides by method, women aged 15+ London, 1997-99 and 2005-07



Source: ONS mortality data analysed LHO

2.7 Follow-up of discharged patients with severe mental illness

The first goal of the National Suicide Prevention Strategy is to reduce risk in key high risk groups. The five year report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness found that a quarter of all people who died by suicide had been in touch with mental health services within the previous year.⁸ The highest number of those who died within three months after discharge from an inpatient unit, took their lives within the first one to two weeks. The report concluded that many of these suicides might have been prevented if there had been sufficient contact between services and service users soon after discharge. The implementation plan for the Government's National Suicide Prevention Strategy for England¹ therefore recommends that "all discharged in-patients who have severe mental illness or a recent (less than three months) history of deliberate self-harm should be followed up within one week".

Table 1 shows performance by London PCTs for this measure. The figures show an average improvement between 2006-07 and 2007-08, from 86.7 to 93.4 per cent. By the latter time period a majority of PCTs reported that they achieved over 95 per cent follow-up within seven days.

This information is recorded within the London Mental Health Scorecard, developed by LHO on behalf of the London Development Centre to provide accessible information on the

delivery of mental health and wellbeing services and initiatives across London and at PCT level.⁹

Table 1 - Percentage of service users on the Care Programme Approach that were contacted within 7 days of discharge from an inpatient unit.

PCT	2006/07	2007/08	Percentage point change
London average	86.7	93.4	6.7
Barking and Dagenham	80.0	98.9	18.9
Barnet	98.5	74.5	-24.0
Bexley	74.0	100.0	26.0
Brent	92.2	85.2	-7.0
Bromley	77.7	97.1	19.4
Camden	79.4	94.6	15.2
City and Hackney	93.9	99.7	5.8
Croydon	92.6	91.6	-1.0
Ealing	70.1	89.0	19.0
Enfield	97.0	99.4	2.4
Greenwich	79.1	97.4	18.3
Hammersmith and Fulham	73.8	88.3	14.5
Haringey	87.9	99.0	11.1
Harrow	88.4	78.1	-10.2
Havering	92.3	98.1	5.8
Hillingdon	82.3	93.4	11.1
Hounslow	100.0	95.8	-4.2
Islington	73.7	92.9	19.1
Kensington and Chelsea	81.3	96.5	15.2
Kingston	82.0	91.4	9.4
Lambeth	80.1	82.7	2.6
Lewisham	89.4	79.4	-10.0
Newham	100.0	100.0	0.0
Redbridge	85.6	100.0	14.4
Richmond and Twickenham	97.9	97.8	-0.1
Southwark	90.7	96.5	5.9
Sutton and Merton	93.2	98.6	5.4
Tower Hamlets	89.7	95.3	5.6
Waltham Forest	81.1	100.0	18.9
Wandsworth	94.3	88.7	-5.5
Westminster	89.4	96.4	7.0

Source: London Health Observatory, Mental Health and Wellbeing Scorecard

3. Understanding the picture

3.1 Explaining geographical inequalities

Substantial inequalities persist in the geographical distribution of suicides in London. The rate in 2005-07 was significantly higher for people who lived in Inner London compared to those in Outer London. There was also a more than three-fold difference between the boroughs with the highest and lowest rates. The persistent geographical inequalities in suicide in the capital may partly be explained by socio-economic factors. In England and Wales, suicide rates have been found to be twice as high for those living in the most deprived areas compared to those living in the least deprived.¹⁰ Inner London includes some of the most deprived areas in England. The LHO's 2005 report noted how deprivation has been shown to affect use of mental health services, particularly inpatient services which may be used as an indicator for the mental health needs of a population.² The MINI2K (Mental Illness Needs Index Score 2000) provides predicted rates of admissions based on population characteristics such as deprivation. In the MINI2K schizophrenia index,⁹ based on expected admission rates for schizophrenia and major mental illnesses, the highest score in London was for Camden, which also had the highest suicide rate in London in 2005-07.

There may be other demographic reasons for the distribution of suicides across London. For example, Durkheim in the 1890s postulated that marriage reduced the risk of suicide by increasing the social integration of married people.¹¹ In England and Wales suicide rates for single and divorced people have been shown to be around three times higher than for married people.¹² Data from the last census show that in 2001, in Outer London 46 per cent of adults were living in a married couple, compared to 30 per cent in Inner London.¹³

3.2 Methods used to commit suicide

Results for 2005-07 show how the methods used by Londoners to commit suicide have changed over time. These are likely to be associated with national-level interventions which have reduced the lethality of certain methods. The fall in the proportions of deaths from 'Other poisoning' for example, is related to the introduction of catalytic converters in motor vehicles, reducing the number of deaths from carbon monoxide poisoning. The fall in the proportion of deaths from drug-related poisoning, particularly evident for women, may be related to a number of factors. The introduction of legislation governing pack sizes for paracetamol has been much discussed regarding its impact on suicide.¹⁴ The recent withdrawal of co-proxamol does appear to have had an effect on the total number of deaths involving paracetamol and its compounds. Numbers in England and Wales reduced from 653 in 1997¹⁵ to 242 in 2007.¹⁶ There has also been a national reduction in deaths involving tricyclic antidepressants.¹⁶ These factors together have probably made key welcome contributions to reducing access to lethal methods - an objective in the national suicide strategy.

3.3 Unemployment

Figures presented in this report are based on latest available mortality data up to 2007. The recent entry of the country into an economic recession, however, raises questions about the impact this may have on future suicide trends. The question of how economic circumstances, particularly unemployment, may be related to patterns of suicide has been the subject of much research. Gunnell *et al*, for example, looked at the association between unemployment and suicide in men and women aged 15-44 in England and Wales between 1921-1995.¹⁷ For both sexes they found significant associations, i.e. suicide rates tended to rise in periods of high unemployment. Similar results have been found in other countries. A study in Australia, which looked at the relationship between unemployment and suicide between 1907-1990, also found that peaks in suicide rates coincided with periods of high unemployment.¹⁸ Such studies, which look at trends in population-level data, cannot provide firm evidence that unemployment is a cause of suicide, and trends may vary for reasons unrelated to socio-economic factors. Evidence can however also be drawn from cohort studies which record employment status at a baseline and then follow the same people over time. Such a study in the USA in the 1980s found that after three years of follow-up, unemployed men were twice as likely to commit suicide as their employed counterparts. Unemployed women also had a much higher risk of suicide than the employed.¹⁹ Such studies have their own limitations however, as mental health problems, which may lead to suicide, may also be a cause of unemployment.

4. Learning from suicide audits

A survey in 2008 by the London Development Centre, of how suicide audits are being undertaken by London Primary Care Trusts, received eight responses.²⁰ Although a limited sample, PCTs reported that use of the suicide audit toolkit produced by the National Institute for Mental Health in England,²¹ had been used to amend suicide prevention strategies, consider suicide hot spots, improve mental health services and identify training requirements.

Some PCTs mentioned the valuable role of coroners in contributing to suicide audits and partnership working. Lack of collaboration from local coroners, however, was also identified as a barrier to implementation of the suicide audit toolkit. London PCTs are continuing to engage with local coroners to obtain information not available to them through the system of death registration.

Links to examples of suicide audits which have been carried out in London, can be found in the References and Resources section of this report. The report from Ealing, for example, highlights the high proportion (40 per cent) of male suicides who were unemployed.²⁴ It also notes that White males were the most vulnerable ethnic group for suicides in Ealing. While this was determined through local audit, the lack of ethnicity recording in the national system of death registration remains a barrier to analysis of suicide by ethnic group. Collecting ethnicity at death registration would require a change in primary legislation and would clearly not be the deceased's own assessment of their ethnic group. The Office for National

Statistics is, however, currently working with the Department of Health to consider alternative methods of data collection.

5. Conclusions

Suicide rates in London, which had been relatively stable in the periods 2000-02 to 2003-05, had more substantial decreases in recent years. In 2005-07 the rate fell to 7.5 suicides per 100,000 population, a 17 per cent reduction since 1995-97. If current trends continue, London will meet the Government's PSA target in 2010. These falls have not been even across London's population however, with the biggest percentage decreases since the mid 1990s seen for young men aged 15-34 and women aged 65 and over.

Although suicide rates have decreased for young men, suicides accounted for one in five of all deaths of men in their twenties in London in 2005-07.

Substantial inequalities persist in the geographical distribution of suicides in London. The rate in 2005-07 was significantly higher for people who lived in Inner London compared to those in Outer London, although rates have decreased in both areas. There was a more than three-fold difference between the borough with the highest rate (Camden) and the area with the lowest rate (Enfield).

Hanging, strangulation and suffocation remained the most common means of suicide for men in London. Drug-related poisoning was the most common method for women, but the proportion of suicides committed that way has decreased substantially over time.

The National Suicide Prevention Strategy represents the best of current knowledge of what strategies are most effective in preventing suicides and continued implementation of this should be encouraged across the capital with the focus of preventative action being widened to all population groups at risk of suicide.

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The LHO team, for their help in reviewing drafts.

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7. Data sources and definitions

Information on cause of death is processed by the Office for National Statistics. Data in this report are based on annual mortality files provided by ONS to the Public Health Observatories, based on deaths registered in each calendar year. ONS also provides data to the National Centre for Health Outcomes Development (NCHOD) which reports on suicide rates in its Clinical and Health Outcomes Knowledge Base, the source of some of the results included here.

Data were selected using the International Classification of Diseases (ICD). From 1979-2000, deaths in England and Wales were coded using the Ninth Revision of the ICD (ICD-9). The Tenth Revision has been used since 2001 (ICD-10). The change in revision had no impact on the coding of suicides, as this cause of death is determined by coroners' verdicts. The ICD codes used to identify suicides are included in Box 3 and the codes used to extract suicides by method are in Box 4.

As numbers of suicides may fluctuate annually, results are presented using data which have been pooled for three years. Except for the age-specific rates presented in Figure 5, death rates have been directly age-standardised using the European Standard Population. This makes allowances for differences in the age structure of populations.

Rates for London boroughs are based on the deceased's place of normal residence, not where the suicide was committed.

Box 3 – Definition of suicide

ICD codes used to select identify suicides

<u>ID-10</u>	<u>ICD-9</u>	<u>Description</u>
X60-X84	E950-E959	Intentional self-harm
Y10-Y34*	E980-E989**	Injury/poisoning of undetermined intent

*Excluding Y33.9

**Excluding E988.8

Deaths assigned to codes Y33.9 and E988.8 are excluded, as these codes were used by ONS in cases where the coroner adjourns an inquest awaiting prosecution in a higher court. The coroner is able to register these deaths before legal proceedings have been completed (accelerated registration). As a large proportion of these cases are subsequently found to be homicides, these deaths are not included in the definition of suicide used here.

Box 4 - Method of suicide

ICD codes used to identify suicides by method

Method	ICD-9	ICD-10
Drug-related poisoning	E950.0-E950.5,E980.0-E980.5	X60-X64,Y10-Y14
Other poisoning	E950.6-E950.9,E951-E952,E980.6-E980.9,E981-E982	X65-X69,Y15-Y19
Hanging, strangulation and suffocation	E953,E983	X70,Y20
Drowning	E954,E984	X71,Y21
Jumping or falling from a high place	E957,E987	X80,Y30
Jumping, lying, falling before moving object	E958.0,E988.0	X81,Y31

8. Appendix Tables

Table 1 – Data underlying Figure 1

Directly age-standardised suicide rates per 100,000 population, 1993-95 to 2005-07
All Persons, All ages

	1993_1995	1994_1996	1995_1997	1996_1998	1997_1999	1998_2000	1999_2001	2000_2002	2001_2003	2002_2004	2003_2005	2004_2006	2005_2007	2006_2008	2007_2009	2008_2010	2009_2011
England	9.41	9.23	9.16	9.32	9.56	9.66	9.30	8.90	8.65	8.56	8.48	8.25	7.89				
London	9.53	9.08	9.03	9.44	9.75	9.46	8.74	8.33	8.37	8.28	8.21	7.88	7.49				
Progress needed for London to achieve 2010 target (7.2)			9.03	8.90	8.77	8.63	8.50	8.37	8.24	8.11	7.98	7.85	7.72	7.59	7.46	7.33	7.20

Source: National Centre for Health Outcomes Development, analysed by LHO

Table 2a - Data underlying Figures 2 and 4

**Directly standardised suicide rates by age band, England and London, 1993-95 to 2005-07
Men**

	London			England		
	15-34	35-64	65+	15-34	35-64	65+
1993_ 1995	19.3	21.4	19.3	20.4	20.5	17.9
1994_ 1996	19.4	21.6	18.2	20.8	20.2	17.3
1995_ 1997	19.4	21.5	16.4	20.5	19.8	16.4
1996_ 1998	19.9	22.5	15.4	21.3	19.9	15.8
1997_ 1999	19.9	22.6	15.6	21.6	20.5	15.8
1998_ 2000	19.0	22.1	15.7	21.7	21.0	15.8
1999_ 2001	15.8	20.2	16.0	19.5	20.0	15.8
2000_ 2002	14.3	19.1	15.0	17.9	19.0	14.6
2001_ 2003	12.7	18.1	14.6	16.1	18.4	13.9
2002_ 2004	12.4	18.1	14.5	15.4	18.4	13.7
2003_ 2005	11.7	18.1	15.5	14.5	18.5	13.8
2004_ 2006	10.8	18.0	16.3	13.5	18.5	13.4
2005_ 2007	10.2	17.4	15.0	12.8	18.2	12.4

Source: ONS mortality data analysed by LHO

Table 2b – Data underlying Figures 3 and 4

**Directly standardised suicide rates by age band, England and London, 1993-95 to 2005-07
Women**

	London			England		
	15-34	35-64	65+	15-34	35-64	65+
1993_ 1995	5.3	7.6	8.1	4.7	6.8	7.8
1994_ 1996	4.9	7.2	6.5	5.0	6.7	7.1
1995_ 1997	5.0	7.1	6.7	5.0	6.9	6.9
1996_ 1998	5.6	7.0	8.3	5.4	6.7	6.8
1997_ 1999	5.9	7.4	8.8	5.3	6.7	6.9
1998_ 2000	5.9	7.6	9.3	5.5	6.7	6.9
1999_ 2001	5.1	7.3	8.0	5.0	6.6	6.3
2000_ 2002	4.1	7.1	7.0	4.7	6.4	5.8
2001_ 2003	4.1	6.7	6.9	4.1	6.1	5.3
2002_ 2004	3.9	6.8	6.4	4.2	6.2	5.7
2003_ 2005	3.8	7.2	5.6	4.1	6.4	5.4
2004_ 2006	3.3	7.0	4.1	3.9	6.3	5.0
2005_ 2007	3.1	6.4	4.1	3.5	6.0	4.3

Source: ONS mortality data analysed by LHO

Table 3 - Data underlying Figure 5

Age-specific suicide rates per 100,000 population, London, 2005-07

Age band	Men	Women
15-19	3.8	2.8
20-24	12.7	3.2
25-29	11.2	3.4
30-34	13.0	3.2
35-39	16.3	6.0
40-44	14.3	5.5
45-49	21.0	7.2
50-54	18.1	6.9
55-59	17.9	7.1
60-64	16.2	5.5
65-69	13.9	3.1
70-74	12.2	2.9
75-79	16.0	3.0
80-84	24.0	6.9
85+	15.9	11.3

Source: ONS mortality data analysed by LHO

Table 4 - Data underlying Figure 6

Suicides as a proportion of total deaths, London, 2005-2007

	Men	Women
15-19	10.5%	14.9%
20-24	20.7%	12.1%
25-29	19.8%	14.0%
30-34	18.3%	8.8%
35-39	14.5%	8.6%
40-44	8.3%	5.0%
45-49	7.1%	4.2%
50-54	3.8%	2.5%
55-59	2.5%	1.7%
60-64	1.3%	0.8%
65-69	0.7%	0.3%
70-74	0.4%	0.2%
75-79	0.3%	0.1%
80-84	0.3%	0.1%
85pls	0.1%	0.1%

Source: ONS mortality data analysed by LHO

Table 5a – Data underlying Map 1

Directly age-standardised suicide rates per 100,000 population, London boroughs, 2005-07

All persons, all ages

London Boroughs	No. of suicides	All Persons		
		Suicides per 100,000 population	95% Confidence limits	
			Lower	Upper
England	12,607	7.89	7.75	8.03
London	1,757	7.49	7.13	7.85
Barking and Dagenham LB	26	5.35	3.27	7.42
Barnet LB	74	7.39	5.68	9.10
Bexley LB	49	7.07	5.05	9.09
Brent LB	51	6.35	4.57	8.13
Bromley LB	59	6.09	4.48	7.71
Camden LB	84	13.18	10.21	16.16
Croydon LB	88	8.17	6.45	9.90
Ealing LB	82	8.36	6.50	10.22
Enfield LB	36	4.04	2.70	5.38
Greenwich LB	72	10.51	8.00	13.01
Hackney LB	59	9.01	6.59	11.44
Hammersmith and Fulham LB	57	10.82	7.81	13.83
Haringey LB	59	8.36	6.12	10.59
Harrow LB	43	6.33	4.40	8.26
Havering LB	37	5.11	3.42	6.79
Hillingdon LB	51	6.64	4.79	8.49
Hounslow LB	58	8.59	6.34	10.84
Islington LB	71	13.01	9.78	16.23
Kensington and Chelsea LB	42	7.46	5.11	9.80
Kingston upon Thames LB	29	5.49	3.44	7.55
Lambeth LB	68	8.65	6.43	10.87
Lewisham LB	49	6.46	4.57	8.35
Merton LB	39	6.91	4.67	9.15
Newham LB	53	6.82	4.90	8.73
Redbridge LB	37	4.67	3.15	6.19
Richmond upon Thames LB	26	4.63	2.80	6.47
Southwark LB	70	8.63	6.49	10.76
Sutton LB	42	6.78	4.66	8.90
Tower Hamlets LB	66	10.46	7.59	13.33
Waltham Forest LB	38	5.21	3.51	6.92
Wandsworth LB	66	8.78	6.52	11.04
Westminster, City of LB	74	11.01	8.39	13.63

Source: ONS mortality data analysed by National Centre for Health Outcomes Development

Table 5b – Data not illustrated

Directly age-standardised suicide rates per 100,000 population, London boroughs, 2005-07
Males, all ages

London Boroughs	Males			
	No. of suicides	Suicides per 100,000 population	95% Confidence limits	
			Lower	Upper
England	9,441	12.09	11.84	12.33
London	1,296	11.29	10.65	11.92
Barking and Dagenham LB	20	8.53	4.75	12.30
Barnet LB	55	11.66	8.55	14.78
Bexley LB	37	11.21	7.55	14.87
Brent LB	42	10.79	7.44	14.13
Bromley LB	43	9.38	6.51	12.26
Camden LB	50	15.61	10.97	20.25
Croydon LB	67	12.95	9.83	16.08
Ealing LB	59	11.85	8.73	14.97
Enfield LB	23	5.26	3.09	7.42
Greenwich LB	59	18.20	13.45	22.95
Hackney LB	42	13.12	8.92	17.33
Hammersmith and Fulham LB	36	14.08	9.09	19.07
Haringey LB	48	14.30	10.00	18.60
Harrow LB	31	9.52	6.12	12.92
Havering LB	28	8.39	5.24	11.54
Hillingdon LB	38	10.20	6.93	13.47
Hounslow LB	45	13.23	9.27	17.19
Islington LB	50	18.68	13.09	24.26
Kensington and Chelsea LB	29	10.54	6.51	14.56
Kingston upon Thames LB	22	8.87	5.09	12.66
Lambeth LB	55	13.72	9.71	17.72
Lewisham LB	35	9.85	6.43	13.28
Merton LB	28	10.07	6.21	13.93
Newham LB	45	11.43	7.90	14.95
Redbridge LB	33	8.45	5.54	11.35
Richmond upon Thames LB	18	6.60	3.46	9.74
Southwark LB	54	13.18	9.41	16.95
Sutton LB	30	10.01	6.34	13.68
Tower Hamlets LB	52	16.23	11.18	21.28
Waltham Forest LB	25	7.16	4.24	10.09
Wandsworth LB	44	11.96	8.16	15.77
Westminster, City of LB	51	15.25	10.86	19.64

Source: ONS mortality data analysed by National Centre for Health Outcomes Development

Table 5c – Data not illustrated

Directly age-standardised suicide rates per 100,000 population, London boroughs, 2005-07
Females, all ages

London Boroughs	No. of suicides	Females Suicides per 100,000 population	95% Confidence limits	
			Lower	Upper
England	3,166	3.84	3.70	3.97
London	461	3.86	3.49	4.22
Barking and Dagenham LB	6	2.36	0.45	4.27
Barnet LB	19	3.36	1.78	4.95
Bexley LB	12	3.27	1.37	5.17
Brent LB	9	2.22	0.74	3.69
Bromley LB	16	3.13	1.49	4.76
Camden LB	34	10.78	7.00	14.56
Croydon LB	21	3.69	2.09	5.29
Ealing LB	23	4.78	2.78	6.77
Enfield LB	13	2.68	1.14	4.22
Greenwich LB	13	3.50	1.51	5.49
Hackney LB	17	5.18	2.57	7.79
Hammersmith and Fulham LB	21	7.81	4.28	11.33
Haringey LB	11	2.96	1.16	4.75
Harrow LB	12	3.56	1.50	5.61
Havering LB	9	2.16	0.65	3.66
Hillingdon LB	13	3.33	1.46	5.21
Hounslow LB	13	4.00	1.80	6.19
Islington LB	21	7.67	4.23	11.11
Kensington and Chelsea LB	13	4.53	1.99	7.07
Kingston upon Thames LB	7	2.49	0.59	4.38
Lambeth LB	13	3.52	1.48	5.56
Lewisham LB	14	3.35	1.51	5.19
Merton LB	11	3.90	1.52	6.28
Newham LB	8	2.10	0.59	3.60
Redbridge LB	4	1.02	0.01	2.02
Richmond upon Thames LB	8	2.81	0.78	4.84
Southwark LB	16	4.17	2.04	6.31
Sutton LB	12	3.84	1.56	6.13
Tower Hamlets LB	14	4.39	1.69	7.09
Waltham Forest LB	13	3.67	1.64	5.69
Wandsworth LB	22	5.88	3.27	8.49
Westminster, City of LB	23	6.96	3.99	9.93

Source: ONS mortality data analysed by National Centre for Health Outcomes Development

Table 6 - Data underlying Figure 7

Proportion of suicides by method, ages 15 years and over, London, 1997-99 and 2005-07

	Men		Women	
	1997-99	2005-07	1997-99	2005-07
Drug-related poisoning	20.1%	17.0%	46.9%	35.0%
Other poisoning	9.2%	2.9%	2.3%	1.3%
Hanging, strangulation and suffocation	38.2%	42.8%	24.3%	30.7%
Drowning	7.1%	6.1%	4.5%	5.7%
Jumping or falling from a high place	4.6%	4.8%	3.7%	5.4%
Jumping, lying, falling before moving object	4.5%	6.6%	3.7%	5.9%
Other	16.2%	19.8%	14.6%	16.1%

Source: ONS mortality data analysed by LHO