Suicide Audit Annual Report

2022

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Bolton Council

Report providing the annual statistical update on suicide in Bolton

Chris Kirk
Munisha Savania
Shan Wilkinson

Public Health Directorate
Bolton Council
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1. Summary

Latest official data (2019-2021) shows that Bolton's suicide rate has slightly decreased (<0.02 decrease) and the gap between Bolton and the national rate may have reduced.

With relatively small numbers these changes are not statistically significant, and the Bolton rate remains similar to the England rate.

Over the longer term, Bolton has fallen from having the third highest suicide rate in the country in 2007/09 (of 152 authorities pre-April 2019) to a suicide rate that is around average in comparison to the rest of the country (176 of 302 lower tier authorities from April 2021).

Similar to the national picture, the majority of suicide cases were male; around 79% of local suicides and 75% of national suicides were among men.

Rates among the South Asian community were low; with small increases seen in 'Other' minority ethnic groups.

In terms of method of death by suicide, hanging/ strangulation accounts for just under half (45%) of all suicides and overdose or self-poisoning accounts for almost a third (30%).

Historically, hanging/ strangulation is generally associated with male suicides. Bolton follows this trend, with hanging/ strangulation accounting for around 49% of male suicides and 35% of female suicides. Self-poisoning was the most common method used for female suicides in Bolton.

In Bolton 77% of suicides occur at home, which is similar to national figures (76%). Locally, other locations include the home of a significant person, followed by outdoors in a field / park. Bolton data suggests we do not have any significant 'hotspots'[1].

Overall, twice as many suicides occur among people who are living in the most deprived areas of Bolton compared to the least deprived. This inequality gap is becoming more pronounced over time. This effect is seen much more strongly among women than men.

The average age of suicide in Bolton over the last twelve months is 42 years (over the last three years it is 47, and over the whole database it is 45). A relatively small number of suicides audited locally involved young people under 18 years of age.

In Bolton

77%

of suicides occur at home

[1]A particular site, usually in an easily accessible outdoor or public location where more than one suicide has occurred. North West Public Health Observatory (2009) Non-residential suicides in the North West, NWPHO, Liverpool.

However, Bolton Children's Safeguarding Board has carried out detailed investigation into such cases as a high priority.

Problematic alcohol use is associated with a quarter of all suicides in Bolton. Problematic alcohol use involves problems controlling your drinking, being preoccupied with alcohol or continuing to use alcohol even when it causes problems[2].

Drugs misuse is more closely associated with male suicides. Of those cases where substance misuse was evident, a significant proportion did not have contact with substance misuse services (misuse is when you drink or take drugs in a way that is harmful, or when you are dependent)[3].

Risk factors associated with local suicides include: living alone (40%); being unemployed (19%); having a history of mental health problems (48%); alcohol misuse (24%); drug misuse (14%); a history of violence (28%); and a history of self-harm (23%).

In Bolton, 42% of all people who died by suicide made their last primary care contact up to 12 months prior to their death.

In Bolton, over a quarter of all suicides had at least some lifetime contact with secondary mental health services.

'Trigger events' in a person's life immediately prior to suicide in Bolton cases have included: break-up of a serious relationship; redundancy/ recent unemployment; child taken into care; key points of interaction with secondary care mental health services such as being admitted onto caseload or discharged from services; bereavement; terminal diagnosis.

In Bolton,

42%

of all people who died by suicide made their last primary care contact up to 12 months prior to their death.

[2]https://www.mayoclinic.org/diseases-conditions/alcohol-use-disorder/symptoms-causes/syc-20369243#:~:text=Alcohol%20use%20disorder%20is%20a,even%20when%20it%20causes%20problems.
[3]https://www.nhs.uk/conditions/alcohol-misuse/

2.
Purpose of this report

The purpose of the annual suicide audit report is:

- **To understand Bolton's current position regarding suicides, comparing rates to other places and local trends**
- **To use the findings of the suicide audit to support coordinated multi-agency action on suicide prevention**

This report pulls together information on suicide in Bolton.

The two key data sources used were:

- **Local Suicide Audit information**
  Bolton Council's Public Health Department audits all coroners' files relating to suicide every six months. The audit data enables detailed examination of the circumstances surrounding suicides occurring in Bolton with a view to identifying trends and informing action on prevention. This report includes audit data for the period 2006 to 2021 and is for all ages.

- **Office for Health Improvement and Disparities (OHID)** directly standardised rate (DSR) for mortality from suicide and injury undetermined.

  This is a rolling three-year rate (due to relatively small numbers and significant random variation). The latest data available at the time of reporting is for 2019 to 2021 and is for all ages.

75%

of national suicides were among men

3. Background: why suicide prevention?

Suicide is preventable.

Suicide can have devastating impacts on those left behind – family members, partners, friends, colleagues and staff working in services who may have been in contact with the person before or at the time of their death.

The eventual outcome often extends to long-term psychological trauma, feelings of guilt, social isolation, reduced quality of life, ill health and premature mortality.

Furthermore, the role of adverse childhood experiences (ACEs) should not be underestimated when exploring the risk of suicide attempts. Evidence suggests that people who experienced ACEs are more likely to have attempted suicide in their lifetime compared to those who had not experienced ACEs.

Action to strengthen resources and collaboration in addressing ACEs and suicide prevention is crucial.

The economic impacts of suicide are also significant. The average cost of a completed suicide of a working age person in England is estimated to be £1.67m[4]. This includes intangible costs (loss of life to the individual and the pain and suffering of relatives), working time, public service time and funeral costs. For every year that an individual suicide is prevented, associated costs of £66,797 are averted[5].

Analysis of case studies in the UK found that known suicide attempts typically involve input from social services, police, mental health services and hospitals equating to an average of £50,000 per case.

Suicide is preventable. It is not inevitable. Preventing suicides can be complex and challenging, but there are proven effective solutions for many, and we know what factors can make a person vulnerable and contribute towards the risk of suicide.

Suicide prevention work is most effective and cost effective when we work in partnership and draw upon available evidence of what can work. Local government, the NHS, statutory services, the voluntary sector, local communities and families all have a role to play in a partnership approach to suicide prevention.

Evidence suggests that the most effective approach is to reduce those factors that increase risk and increase factors that promote resilience, at a population level[6].

[4]David McDaid, A-La Park, Eva-Maria Bonin (2014). Population-level suicide awareness training and intervention. PSSRU. https://bit.ly/3p3PYjX
[5]Parliament.uk (2016). Services to support people who are vulnerable to suicide. https://bit.ly/3BB9zga
[6]https://nspa.org.uk/wp-content/uploads/2021/04/Suicide-Prevention-using-a-population-health-approach-and-lived-experience.pdf

4. Introduction

National guidance[7] recommends that every local authority carries out an annual suicide audit, develops a suicide prevention action plan and establishes a multi-agency group to co-ordinate effective action within the local area.

Suspected suicide deaths will always be reported to a coroner, who will certify the death after an inquest. Coroners' inquests have an important role in establishing the who, how and where of these deaths.

In addition, the coroner's office will also be able to help bereaved families to find support from local and national organisations[8].

The council's Public Health department works closely with the coroner's office. Coroners work with health services and partner organisations and agencies to provide data that gives an early indication of emerging patterns, such as clusters or patterns of suicides, before data is compiled by the Office for National Statistics (ONS). Bolton has been undertaking suicide audits since 2006.

No single agency can deliver an effective, place-based suicide prevention programme alone. A strategy to reduce deaths by suicide relies on collaborative working to promote good mental health and build community resilience while also targeting people at heightened risk.

Based on key patterns and trends from the suicide audit findings, local practice and feedback from key stakeholders including those with lived experience, the Population Mental Wellbeing and Suicide Prevention Partnership aims to co-design an all-age suicide prevention strategy for Bolton.

This report details key findings from the 2022/23 suicide audit and key recommendations for local action.

[7] *Gov.uk (2012). Suicide prevention strategy for England. Department of Health and Social Care. https://bit.ly/3H6fF9B*
[8] *Gov.uk (2012). Suicide prevention strategy for England. Department of Health and Social Care. https://bit.ly/3H6fF9B*

5. Official suicide statistics[9]

The official suicide rate for 2019-2021 (inclusive) in Bolton was 9.8 per 100,000, based upon 72 suicides in that three-year period, equivalent to an average of 24 people dying by suicide each year.

This is similar to the comparative rate for England, which was 10.4 (per 100,000).

Table 1 and Figure 1 show that from 2004-2006 Bolton's suicide rate increased considerably, peaking in 2009-2011 (average 34 suicides per year) and falling from 2010-12 and beyond.

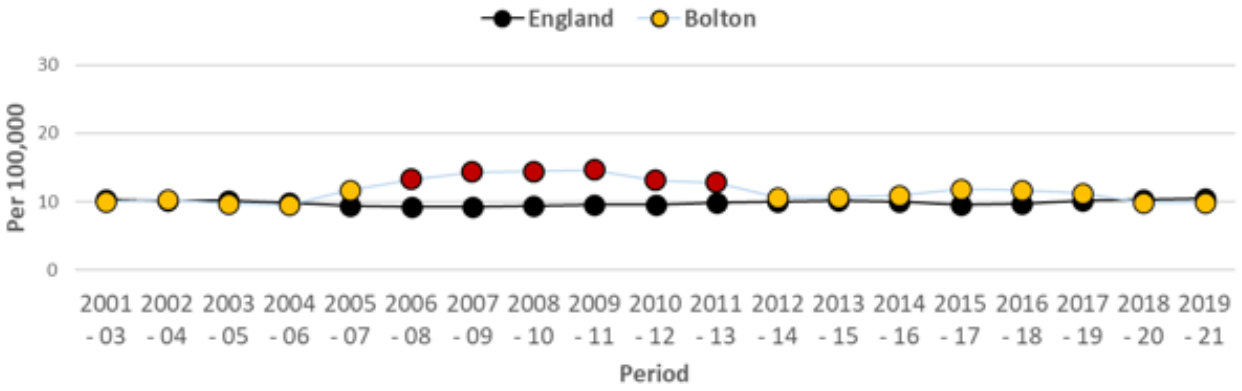
Up until the most recent release, the rate had increased slightly in each of the official releases since 2013-15. However, these increases are not statistically significant, and Bolton's rate remains similar to the national rate, despite Bolton being significantly more deprived than England generally. That said, there are indications that the gap between Bolton's and the national rate may be widening.

Table 1: Trend of the suicide rate in Bolton compared to England and the North West over time (2002 to 2021)

Period	Bolton Value	Bolton Count	North West	England
2002 - 04	10.3	70	10.2	10.7
2003 - 05	9.7	66	10.1	10.9
2004 - 06	9.6	65	9.8	10.8
2005 - 07	11.7	80	9.4	10.7
2006 - 08	13.3	93	9.2	10.3
2007 - 09	14.3	101	9.3	10.7
2008 - 10	14.4	101	9.4	10.5
2009 - 11	14.6	103	9.5	10.8
2010 - 12	13.1	94	9.5	10.8
2011 - 13	12.8	93	9.8	11.3
2012 - 14	10.5	77	10.0	11.5
2013 - 15	10.7	78	10.1	11.3
2014 - 16	10.9	81	9.9	11.0
2015 - 17	11.9	88	9.6	10.4
2016 - 18	11.7	87	9.6	10.4
2017 - 19	11.2	82	10.1	10.6
2018 - 20	9.8	72	10.4	10.7
2019 - 21	9.8	72	10.4	11.4

[9]*Public Health Outcomes Framework (2021). Suicide Prevention Profile. Office for Health Improvement and Disparities. https://bit.ly/3p7cDM3*

Figure 1: Trend of the suicide rate in Bolton compared to England and the North West over time (2001 to 2021)



***Red** = significantly worse than England, **amber** = no significant difference from England*

The most recent data (2019-2021) shows Bolton is around mid-table when looking at the suicide rate across Greater Manchester, which places us lower than average, but not significantly so.

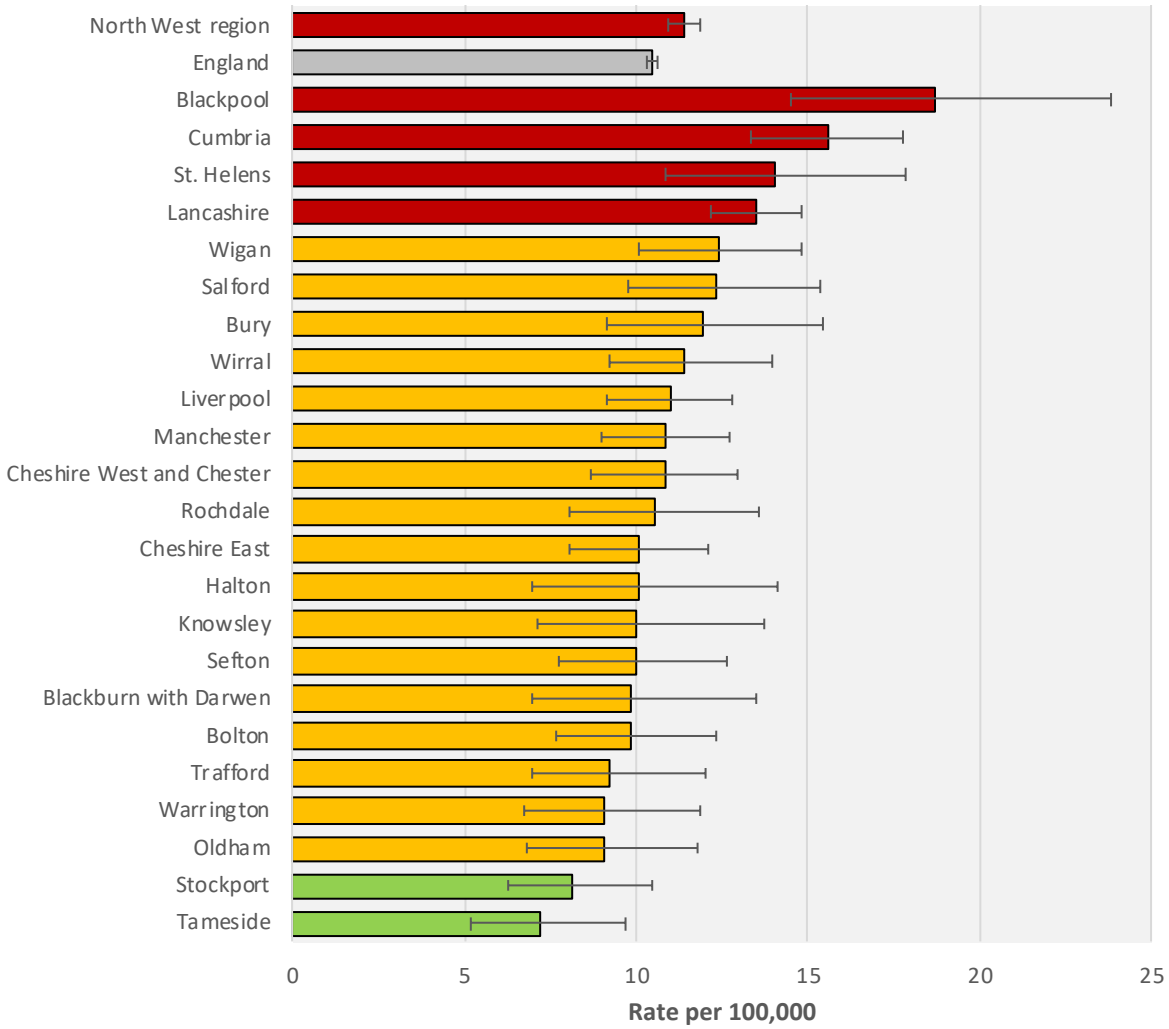
Figure 2 shows Bolton within the context of the whole of the North West, where we rank lower than average (33 out of 39).

Figure 3 shows much the same in comparison with the Chartered Institute of Public Finance and Accountancy (CIPFA) nearest neighbours for Bolton, i.e., most similar in terms of population makeup.

Table 2: Suicide rates across the North West region (2019-2021)

Area name	Time period	Value
England	2019 - 21	10.4
North West region	2019 - 21	11.4
Blackpool	2019 - 21	18.7
Cumbria	2019 - 21	15.5
St. Helens	2019 - 21	14.0
Lancashire	2019 - 21	13.5
Wigan	2019 - 21	12.4
Salford	2019 - 21	12.3
Bury	2019 - 21	12.0
Wirral	2019 - 21	11.4
Liverpool	2019 - 21	11.0
Manchester	2019 - 21	10.8
Cheshire West and Chester	2019 - 21	10.8
Rochdale	2019 - 21	10.5
Cheshire East	2019 - 21	10.1
Halton	2019 - 21	10.1
Knowsley	2019 - 21	10.0
Sefton	2019 - 21	10.0
Blackburn with Darwen	2019 - 21	9.8
Bolton	2019 - 21	9.8
Trafford	2019 - 21	9.3
Warrington	2019 - 21	9.0
Oldham	2019 - 21	9.0
Stockport	2019 - 21	8.1
Tameside	2019 - 21	7.2

Figure 2: Suicide rates across the North West region (2019-2021)



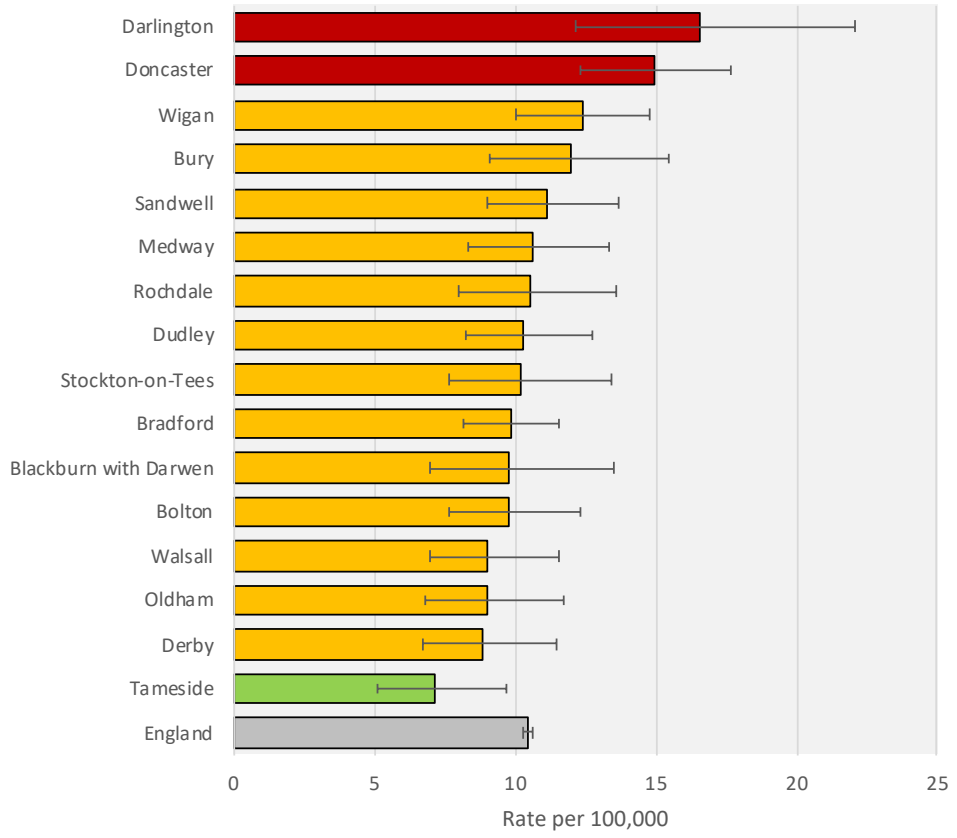
***Red** = significantly worse than England, **amber** = no significant difference from England*

During the 2007/09-2009/11 peak, Bolton was the highest of our statistical neighbours and ranked third highest in the country. We have since come into line with our peer average, but this is still too high. However, the confidence intervals are wide due to relatively low numbers and the differences are not statistically significant.

Table 3: Suicide rates (2018-2020) among Bolton's CIPFA nearest neighbours[10]

Local authority	Period	Rate per 100,000
Darlington	2019 - 21	16.6
Doncaster	2019 - 21	15.0
Wigan	2019 - 21	12.4
Bury	2019 - 21	12.0
Sandwell	2019 - 21	11.2
Medway	2019 - 21	10.6
Rochdale	2019 - 21	10.5
Dudley	2019 - 21	10.3
Stockton-on-Tees	2019 - 21	10.2
Bradford	2019 - 21	9.8
Blackburn with Darwen	2019 - 21	9.8
Bolton	2019 - 21	9.8
Walsall	2019 - 21	9.0
Oldham	2019 - 21	9.0
Derby	2019 - 21	8.8
Tameside	2019 - 21	7.2

Figure 3: Suicide rates (2019-2021) among Bolton's CIPFA nearest neighbours[11]



***Red** = significantly worse than England*

***Amber** = no significant difference from England*

[10]*Public Health Outcomes Framework (2021). Suicide Prevention Profile. Office for Health Improvement and Disparities. https://bit.ly/3p7cDM3*
[11]*Public Health Outcomes Framework (2021). Suicide Prevention Profile. Office for Health Improvement and Disparities. https://bit.ly/3p7cDM3*

6.
Suicide in Bolton: insight from local suicide audit data[12]

Surveillance of suicide is carried out locally with the Suicide Audit established as part of the National Suicide Prevention Strategy for England[13] in 2002.

The audit aims to support local suicide prevention intelligence and identify local trends, patterns and suicide hotspots to inform multi-agency action on prevention.

Legally, a verdict of 'suicide' must involve proof beyond reasonable doubt that death has occurred as a result of a deliberate act by the deceased, performed with the intention to cause their own death[14]. If evidence does not point towards this legally required standard, then an 'open' verdict is returned.

However, in July 2018 a new ruling was passed by the High Court that the civil standard of proof (on the balance of probabilities) should now be used by coroners in reaching a conclusion of suicide at inquest rather than using the criminal standard (beyond all reasonable doubt)[15].

This legal change has not resulted in any significant change in the reported suicide rate in England and Wales; recently observed increases in suicide among males and females in England, and females in Wales, began before the standard of proof was lowered[16], and since Bolton already audits open verdicts, a minimal impact is expected.

The remainder of this report summarises the common themes and trends from suicides in Bolton from the data in relation to:

- The most recent year **2021**

16 cases

- The last three years **2019 to 2021**

57 cases

- The full audit database **2006 to 2022**

363 cases

At the time of the audit, there were four cases where the year of death was recorded as 2022. This was due to the timings of the audit being towards the end of the year (2022). These values are included when referring to the full dataset; values that are given and referred to as 'the most recent year' or 'the last three years' indicate the periods of 2021 and 2019-2021 respectively.

This year's report will also include three-year rolling averages, to help calculate trends over shorter periods of time.

[12]*Source: Bolton Suicide Audit, undertaken by Bolton Council from Coroner's records.*
[13]*Department of Health (2002) National Suicide Prevention Strategy for England, DoH, London.*
[14]*Department of Health (1999) Saving Lives: Our Healthier Nation, DoH, London.*
[15]*Samaritans (2018). High Court Ruling. https://bit.ly/3JMdCZT 13ONS (2020). Change in the standard of proof used by coroners and the impact on suicide death registrations data in England and Wales*
[16]*ONS (2020). Change in the standard of proof used by coroners and the impact on suicide death registrations data in England and Wales -*

7. The audit

Figure 4 shows the number of case files audited according to the year in which the individual died.

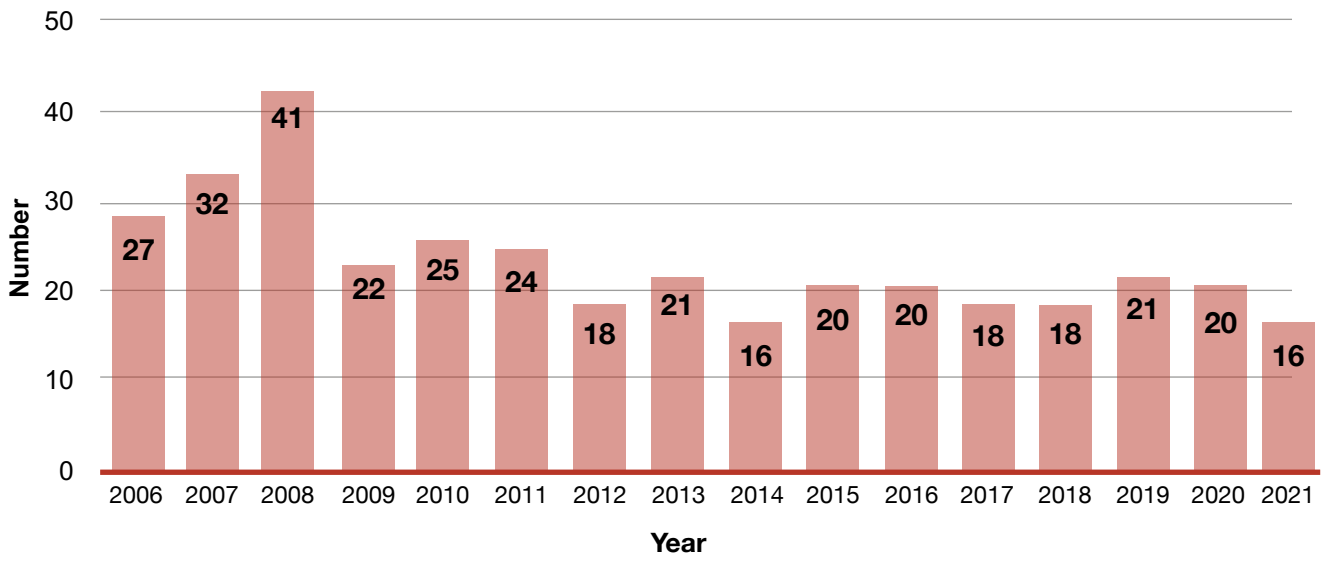
These totals will never exactly match the official statistic for each year because the definitions used are different. The official statistic includes suicide and injury of undetermined intent, classified by underlying cause of death recorded using a set of ICD10 codes.

The local audit includes files relating to inquests resulting in a verdict of suicide and some open and narrative verdicts, on a case-by-case basis.

Deaths that are clearly not suicide, but say misadventure or accidental drug overdose, but have been given an open verdict, are excluded from the audit. This is because the aim of this work is to assess and quantify the issues pertinent to those individuals who have determined to take their own life.

In addition, given the time taken to reach a verdict, some cases that are certainly suicide may not have reached a verdict at the time of audit and may be delayed in consequence (these will primarily relate to later 2021).

Figure 4: Number of case files audited by year of death for Bolton[17]



[17]*Source: Bolton Coroner's Court suicide cases, (2006-2021)*

8.
Age, gender, ethnicity and sexuality

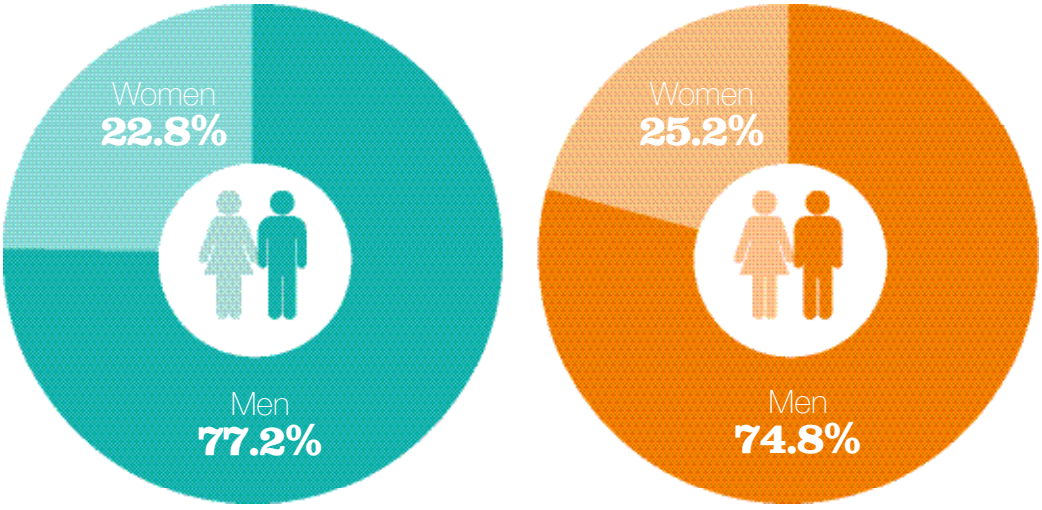
Over the last three years (2019-2021) there were 57 suicides audited.

Gender

For the most recent year (2021), 81% of people who died by suicide were male, which compares to 77% for the last three years and 73% in the whole database (2006-2021).

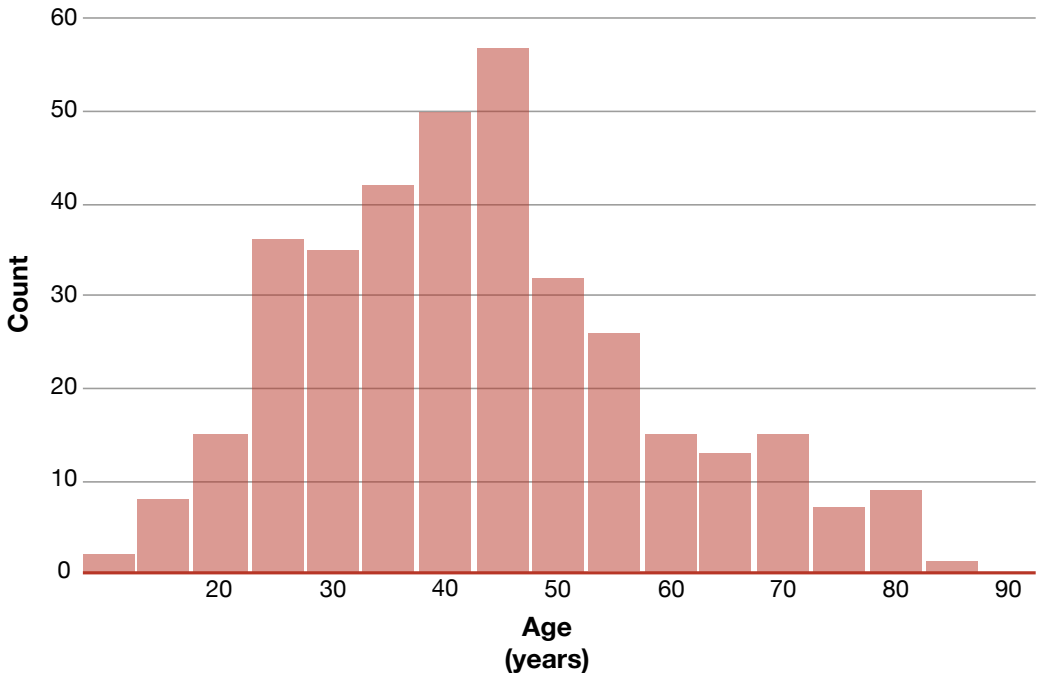
Overall, this gender balance is similar to the national picture, where 75% of suicides are among men.

Figure 5: Chart showing male/female split for England and for Bolton between 2018-2020[18]



[18]*Office for Health Improvement and Disparities (2022). Suicide Prevention Profile. PHE. https://bit.ly/3payuSW*

Figure 6: Age distribution of people dying by suicide in Bolton



Age
The average age of suicide in Bolton over the last year was 50. Over the previous three years it was 47, and over the whole database it was 45 years. (See Figure 6)

Ethnicity
Regarding ethnicity, 83% of all people who die by suicide in Bolton are from the White British ethnic group.

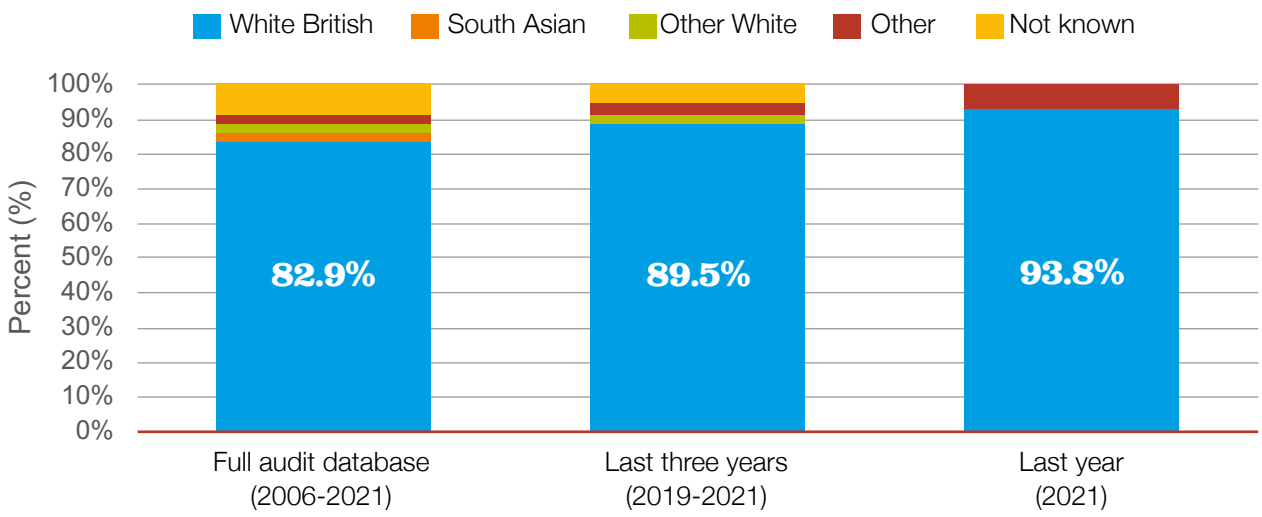
Among people from minority ethnic groups who die by suicide, the largest number are generally from the South Asian community and in recent cases of 'Other white' and 'Mixed/ multiple' ethnicity. The South Asian community is the largest ethnic minority group in Bolton, but the number is still lower than expected given Bolton's population makeup, suggesting low incidence in this group.

Ethnicity is poorly recorded and so does not allow for detailed analysis.

Ethnicity is now more commonly recorded compared to when the audit initially started.

However, if the ethnicity of a person is not stated in the suicide file, then it will be recorded as 'not known'. This may explain the high number of people recorded as being of unknown ethnicity in the full audit database.

Figure 7: Ethnic breakdown of people dying by suicide in Bolton



Over the last three years, 2% of people who die by suicide were born outside the UK, which is lower than seen across the full audit database (7%). In general, across years, and though small to begin with, suicides by those born outside the UK have been reducing over recent years.

Sexuality

Though poorly recorded, it would appear virtually all individuals in the suicide audit were recorded as heterosexual. Less than 3% across the full dataset had documented evidence that their sexual orientation was homosexual or bisexual. Unless documented in family testimonies, a person's sexuality rarely appears.

9. Method of suicide

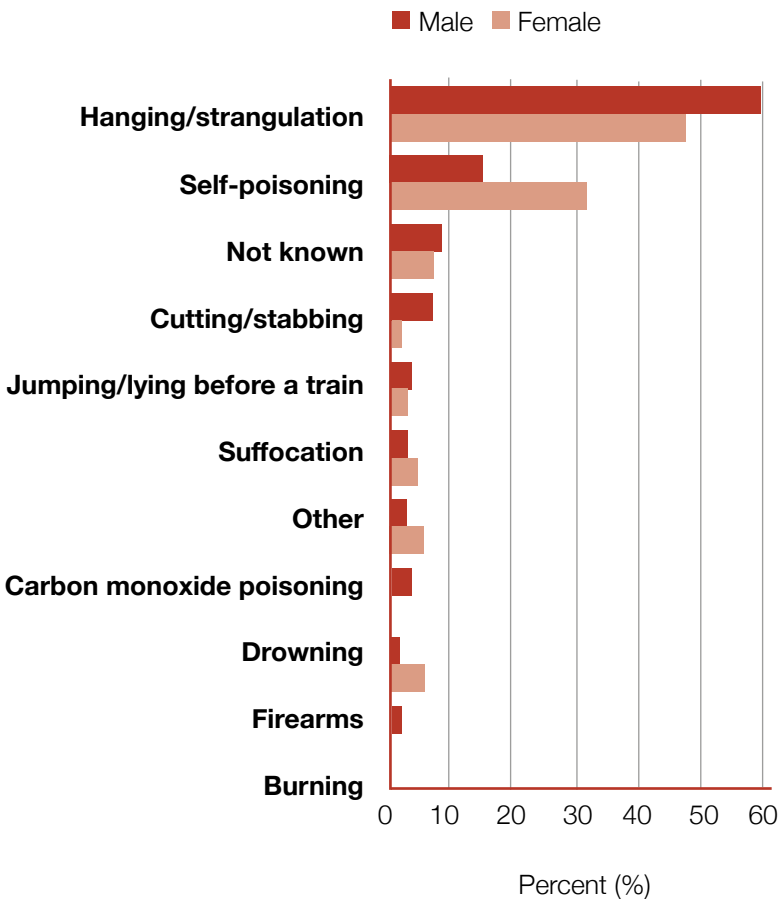
The main methods of suicide in the UK are hanging/ strangulation or self-poisoning with psychotropic or analgesic drugs.

In the whole suicide audit dataset, hanging / strangulation accounts for 56% of all deaths by suicide, with overdose accounting for 20%. Over the last three years the proportion of self-poisoning or overdose reduces to 14%, while the proportion of hanging / strangulation remains consistent at around 59%.

Historically, hanging / strangulation is generally associated with male suicides, with self-poisoning or overdoses linked more closely with female suicides.

In the whole dataset, hanging / strangulation occurred in 47% of female suicides; in recent years the proportion of women who died by this method may be becoming more similar to the proportion of men, but it is difficult to say as numbers are small.

Figure 8: Method of death by suicide by gender (2006-2020)



More violent suicides in Bolton (impact with trains, jumping from a height, self-immolation, cutting / stabbing, firearms) are still more often associated with men, accounting for 10% of male suicides and 2% of female suicides. (Figure 8, Table 4)

Table 4: Breakdown of suicide method by gender (2006-2021)

Method	Male (%)	Female (%)
Hanging / strangulation	59.8	47.4
Self poisoning	15.0	32.0
Not known	7.9	7.2
Cutting or stabbing	5.3	1.0
Jumping/lying before a train	2.3	1.0
Carbon monoxide poisoning	1.9	2.1
Other	1.9	3.1
Suffocation	1.9	2.1
Drowning	1.5	4.1
Jumping from a height	1.5	0.0
Firearms	0.8	0.0
Burning	0.4	0.0

10. Location

The majority of suicides in the UK occur in the home, with research showing that 76% of suicides nationally occur indoors – in the home, the home of a significant person, or in the workplace[19].

The proportion of suicides in Bolton that take place at home has remained steady over time, accounting for around 75% of suicides in Bolton.

Numbers are too small to break it down to specific location, but in Bolton other key settings have included outdoor areas (parks, railways, waterways, quarries etc.), home of a significant other, and place of work.

'Hotspot' describes a particular site, usually in an easily accessible outdoor or public location. A site where more than one suicide has occurred is labelled a 'hotspot' as this shows the location to have the means and opportunity for suicide.

In the Northwest, high risk non-residential areas and features have been identified, including waterways, railways, motorways, urban centres and parks and other open areas[20].

Several suicides have occurred on Bolton's railways and at car parks, but no two suicides have yet occurred at the same location. Several suicides have occurred at Bolton's quarries, but none in exactly the same locations. As such there are no clear hotspots identified in Bolton.

The proportion of suicides that take place at home is steady over time, accounting for around

75% **of suicides in Bolton.**

[19]*Giles, S. and D. Canter (2007) The Final Farewell: Using a Narrative Approach to Explore Suicide Notes as Ultra-Social Phenomena (Unpublished Doctoral Thesis), University of Liverpool, Liverpool.*
[20]*North West Public Health Observatory (2009) Non-residential suicides in the North West, NWPHO, Liverpool.*

11.
Socioeconomic deprivation

Deprivation quintiles divide the population of Bolton into five equal groups based upon the socioeconomic status of their home address.

If there was no difference by deprivation, suicides would be split evenly with 20% in each quintile. However, over the full dataset, 48% of suicides occurred in the most deprived population group; more than four times as many suicides occur in the most recent Suicide Audit Annual Report 2021 deprived quintile compared to the least deprived.

Figure 9 shows this strong inequality gradient, which has widened in recent years (Figure 10).

The risk of suicide is particularly concentrated in the most deprived quintile of Bolton. Although Bolton does contain a higher number of deprived areas than the average across England, the proportion of suicides that occur in the most deprived quintile is overrepresented.

In Bolton, the inequality gradient for women is stronger than for men; almost 40% of female suicides are from the most deprived group, compared with 33% of male suicides.

Figure 9: Socioeconomic gradient in deaths by suicide (Bolton, 2006-2021)

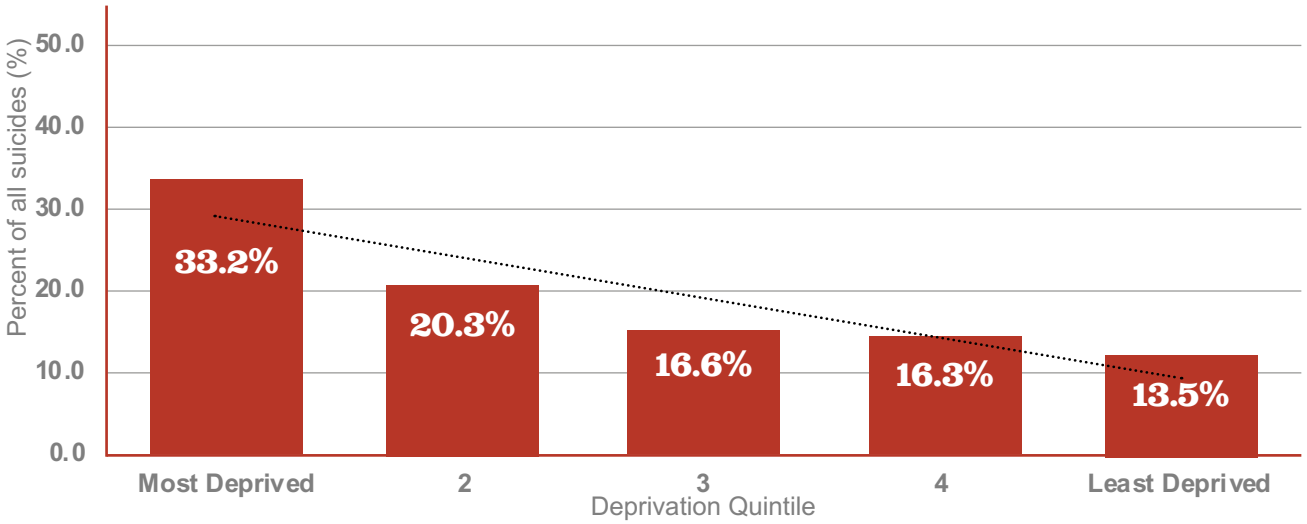


Figure 10: Socioeconomic gradient in deaths by suicide (Bolton, 2019-2021)

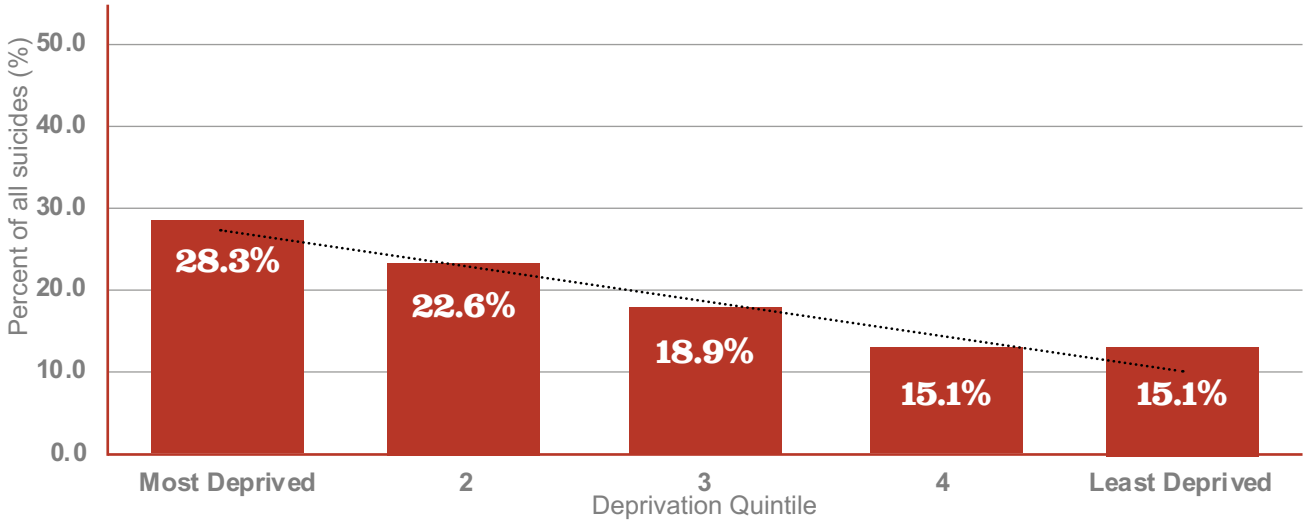


Table 5: Deprivation gradient for deaths by suicide by gender (2006-2021)

Socioeconomic status	Male (%)	Female (%)
Most deprived	31.8	33.8
2	20.5	20.3
3	15.9	16.9
4	17.0	16.0
Least deprived	14.8	13.1

12.
Geography: the influence of deprivation

The influence of deprivation is demonstrated geographically across the borough. Figure 11 shows the proportion of all suicides in Bolton by small area, showing the spread across the borough.

Higher incidence of suicide is seen in some of the most deprived parts of the borough, including around the town centre such as Tonge and Crompton, as well as Farnworth to the south, Westhoughton to the west and Breightmet to the east.

However, the deprived areas (Figure 12) around the town centre with large South Asian communities (Rumworth, Great Lever, etc.) account for fewer suicides than their deprivation would suggest, as low numbers of suicides occurred in those communities.

Even so, people die from suicide throughout the borough.

Figure 11: Map showing geographical spread of suicide across Bolton

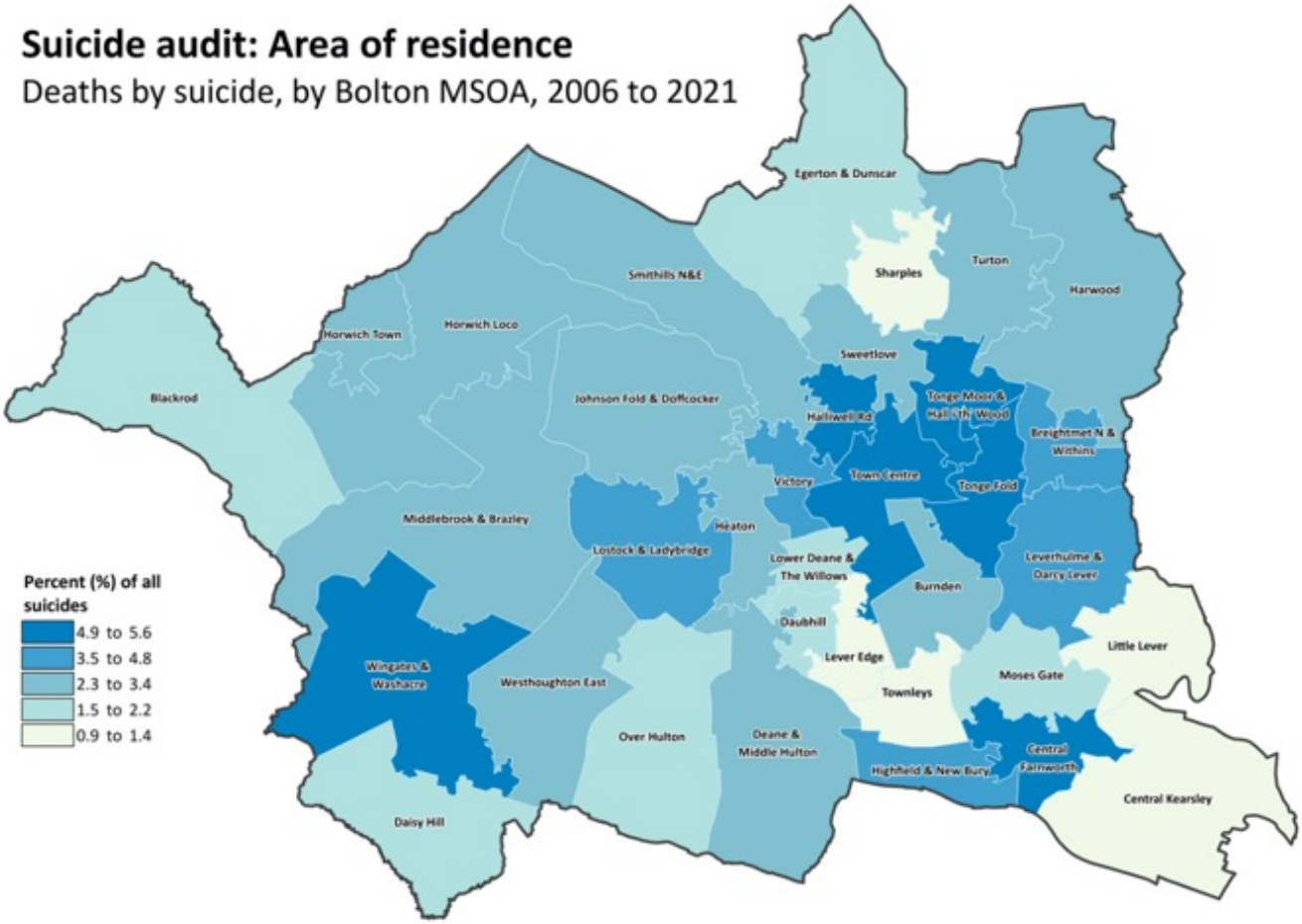
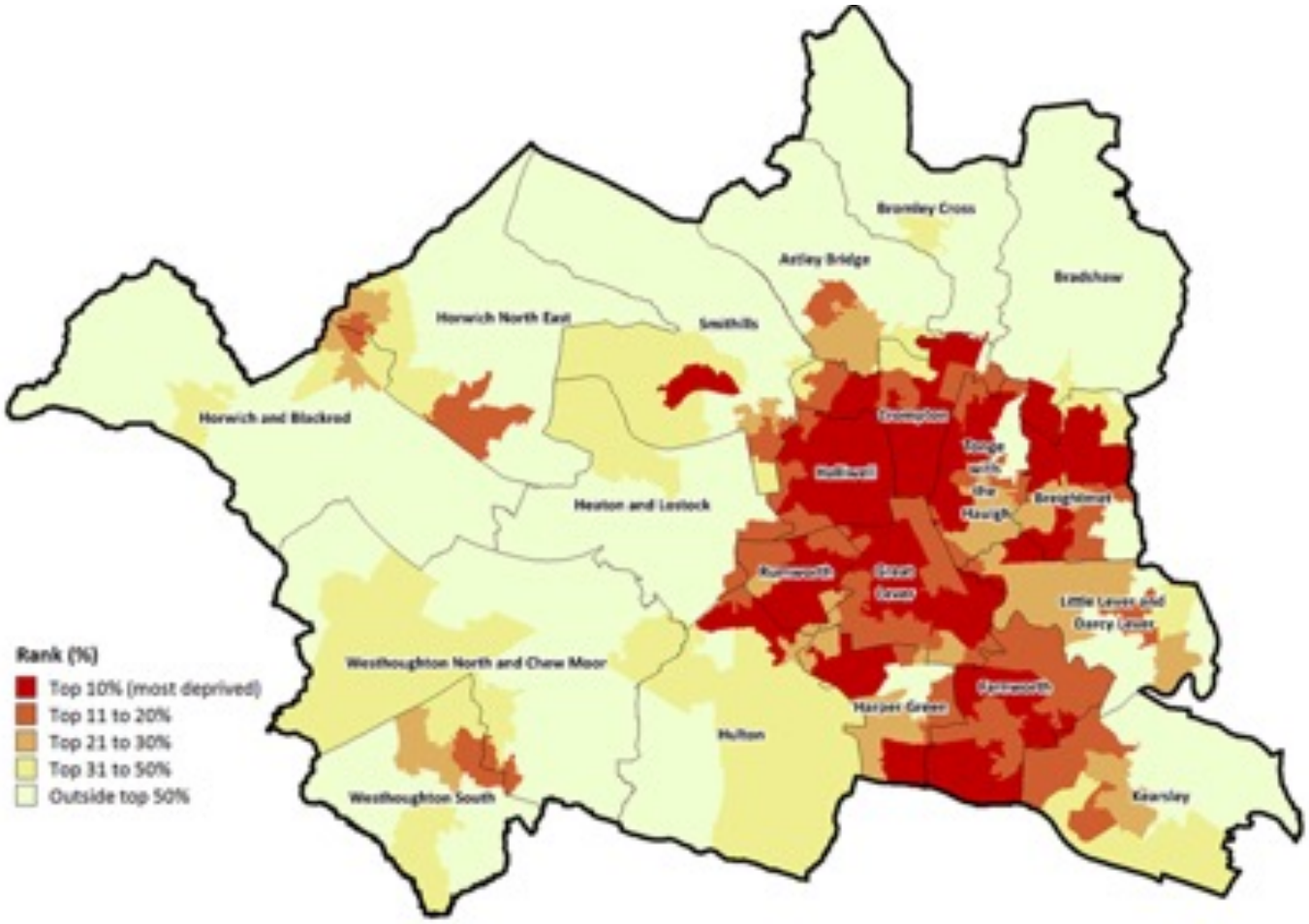


Figure 12: Map showing Index of Multiple Deprivation (IMD) 2019 across Bolton



The deprived areas (Figure 12) around the town centre with large South Asian communities (Rumworth, Great Lever, etc.) account for fewer suicides than their deprivation would suggest, as low numbers of suicides occurred in those communities.

13.
Children and young people

Suicide in children and young people is a particularly devastating event.

A minority of suicides audited were classed as involving anyone under 18 years of age (accounting for less than five cases between 2006 and 2022).

The Bolton Children's Safeguarding Board has conducted a detailed investigation into the nature of local suicides involving young people. However, due to the relatively small number of suicides in children, these are out of the scope of this report.

14.
Contributing factors to suicide

Many suicide risk factors are known from published research.

These include:

- **Being male**
- **Living alone**
- **Being unemployed**
- **Recent relationship breakdown**
- **Alcohol and drug misuse**
- **Mental illness[21]**
- **Having four or more adverse childhood experiences**

The audit shows that among the contributing factors for Bolton suicides there is a recurrence of: living alone, being unemployed, having a history of mental health problems, alcohol and drug misuse, and a history of violence and self-harm.

COVID-19 and the resulting lockdown(s) was frequently mentioned as a contributing factor in the most recent suicide audit conducted (2020 and 2021 data). With COVID-19 having such a significant impact on our daily lives, this no doubt placed a burden on people's mental and physical health. However, we are yet to see the full impact that the pandemic has had on suicide rates.

[21] *National Institute of Clinical Excellence (2004) Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care, NICE, London.*

15.
Living and relationship status

In total, 43% of people who died by suicide in Bolton were living alone at the time of death, which is consistent over time. However, there is a relatively even split with those living with their spouse / partner seen from 2006 to 2021.

Of all suicides recorded in the database, 22% of individuals were married, 9% were co-habiting and 13% were divorced. Over a third (36%) were single at the time of death. These proportions remain consistent over recent years.

Table 6: Living status split by gender for Bolton residents (2006-2021)

Living situation	Male (%)	Female (%)
Alone	44.2	37.5
Spouse/ partner	17.4	22.2
Parents	11.4	4.0
Other family	6.6	3.6
Spouse / partner and children under 18	4.5	13.5
Other	3.6	2.5
Spouse / partner and children 18+	2.8	2.8
Adults (non-family)	2.5	5.1
Child(ren) under 18	1.6	3.1
Not known	3.4	0.1
Other shared	1.2	1.3
Child(ren) 18+	0.7	4.2
Total	**100.0**	**100.0**

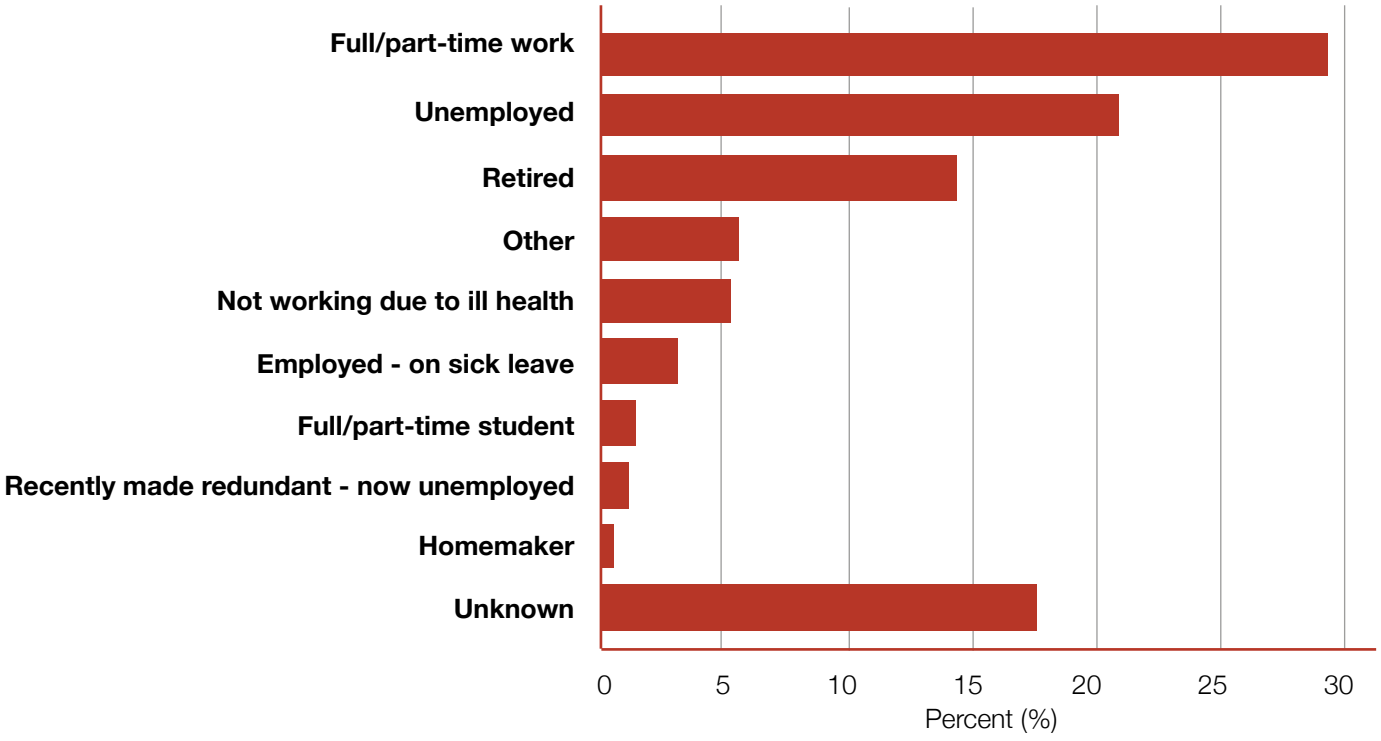
Table 7: Relationship status split by gender (2006-2021)

Living situation	Male (%)	Female (%)
Single	38.3	27.8
Married	20.7	28.9
Divorced	12.4	14.4
Separated	8.3	8.2
Co-habiting	6.8	13.4
In a relationship not living together	5.6	1.0
Widowed	3.8	3.1
Unknown	2.6	3.1
Other	1.5	0.0
Total	**100.0**	**100.0**

16.
Employment status

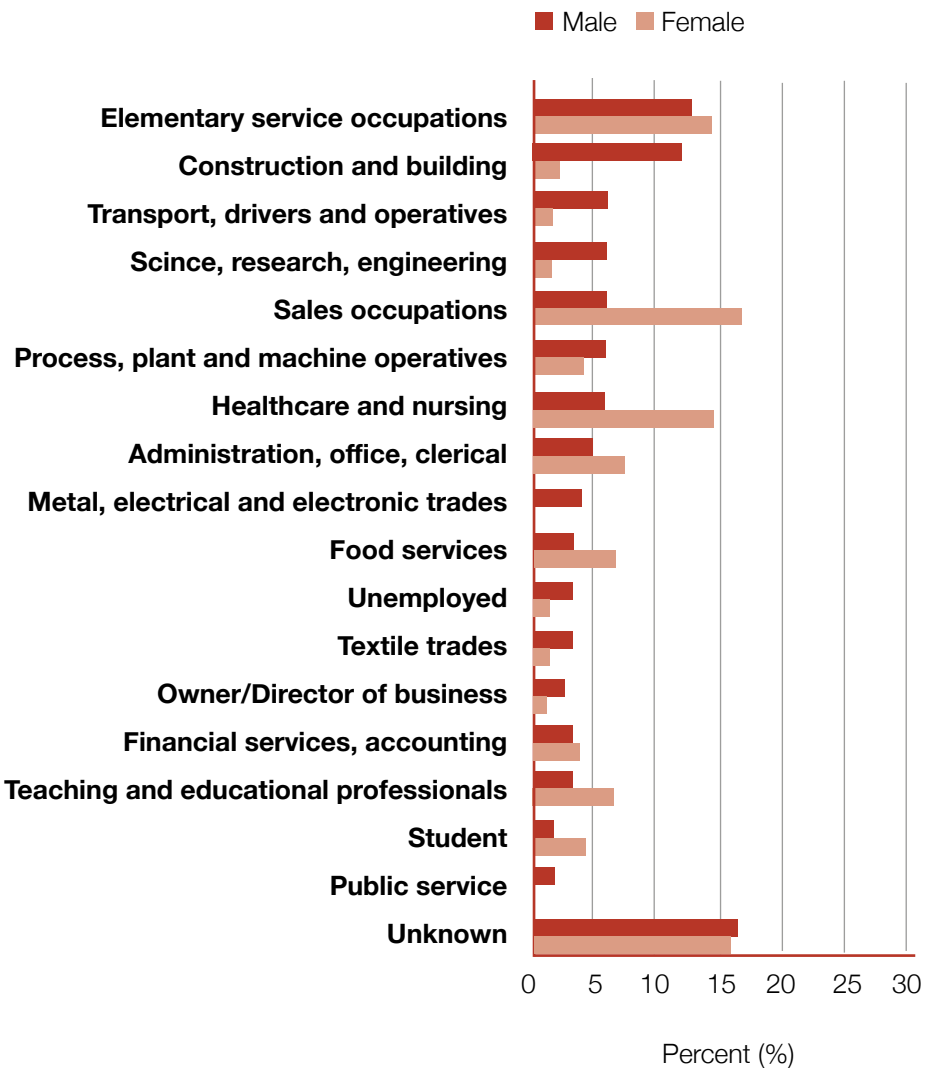
Of those suicides audited, a third were in full / part-time work (33%). Ten percent were either employed and on sick leave or were not working due to ill health. Almost a quarter (24%) were classed as unemployed.

Figure 13: Employment status among those who died by suicide (Bolton, 2006-2021)



For those employed at the time of death, the main occupation groupings were, in order of prevalence:

- Construction and building
- Elementary service occupations
- Sales occupations
- Healthcare and nursing
- Administration, office and clerical
- Process, plant and machine operatives
- Science, research and engineering
- Transport, drivers and operatives
- Food and catering services
- Teaching and educational professionals
- Metal, electrical and electronic trades
- Textile trades
- Financial services and accounting



From narrative accounts in the audit, if a person has regularly worked, the time immediately following unemployment or redundancy is a key point where additional support may need to be in place; as is coping with financial difficulties following a change in status, especially for men with families.

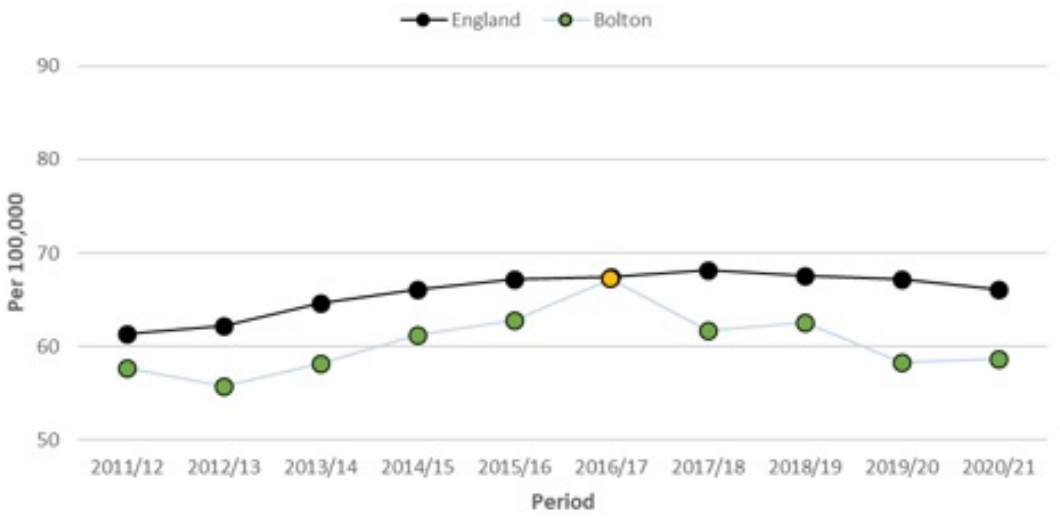
The 2006 evidence review, Is Work Good for Your Health and Wellbeing?[22], concluded that work was generally good for both physical and mental health and wellbeing.

In Bolton there is a 59 percentage point gap in employment between those in contact with secondary care mental health services and the overall rate. Despite Bolton's rate on this indicator showing better than the England average, this nevertheless reflects a 'double whammy' for these individuals.

Table 8: Gap in the employment rate for those in contact with secondary mental health services

Time period	Bolton	Greater Manchester	England
2011/12	57.7	59.6	61.3
2012/13	55.8	60.9	62.2
2013/14	58.2	63.4	64.7
2014/15	61.2	65.4	66.1
2015/16	62.8	64.6	67.2
2016/17	67.2	65.6	67.4
2017/18	61.7	66.7	68.2
2018/19	62.6	66.6	67.6
2019/20	58.3	66.6	67.2
2020/21	58.7	63.9	66.1

Figure 14: Gap in the employment rate for those in contact with secondary mental health services[23]



[22]*Department for Work and Pensions (2006). Is work good for your health and wellbeing? An independent review. https://bit.ly/3t14SIT*
[23]*Office for Health Improvement and Disparities (2022). Public Health Outcomes Framework. PHE. https://bit.ly/3LThtX8*

17.
Mental health

Almost half (44%) of those people audited had a history of mental health problems.

This is far greater than in the general population (17-25%)[24]. A relatively small proportion (12%) received a mental health diagnosis within one year prior to death.

The majority of those with a mental health diagnosis related to a depressive illness (51%). This was followed by those with anxiety / phobia / panic disorder / obsessive compulsive disorder (25%), and alcohol misuse (12%) and drug misuse (11%).

Illnesses such as schizophrenia (5%) and personality disorder (6%) are less common amongst those who die by suicide in Bolton.

The literature suggests that those with a mental health diagnosis are at generally higher risk of suicide. There are two potential peaks in the risk of suicide relating to those with a mental health diagnosis. These are soon after admission to psychiatric hospital and soon after discharge[25].

However, in more recent years suicides for those receiving mental health care and treatment have reduced significantly due to changes in the management of risk.

More than 30% of people who die by suicide in Bolton have never had a diagnosis of a mental health disorder, although the majority of people in the database have had some lifetime history contact with mental health services.

Table 9: Mental health history split by gender (2006-2021)

Mental health diagnosis	Male (%)	Female (%)
Lifetime history	46.4	58.4
Never	26.2	25.8
Within 1 year prior to death	13.3	9.0
Unknown / other	7.3	2.2
Within 1 month prior to death	6.5	4.5
Immediately preceding death	0.4	0.0
Total	100.0	100.0

[24]*Office for Health Improvement and Disparities (2022). Public Health Outcomes Framework. PHE. https://bit.ly/3LThtX8*
[25]*National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2008) Lessons for Health Care in Scotland, University of Manchester, Manchester.*

18. Primary care contact

Nationally, 25% of people who die by suicide have had some form of contact with a healthcare professional in the previous week (usually with a GP). Approximately 40% had some form of contact with a healthcare professional in the previous month, although this may not have been specifically in relation to suicidal ideation or mental health issues.

In the 2021 Bolton data, 88% of individuals had made their last primary care contact in the previous one year prior to their death; only 14% of which were with a GP (Figure 15). This decrease could be due to a number of reasons.

Nationally, evidence suggests that many patients chose not to visit their GP practices during the Covid-19 pandemic due to fear of increased risk of transmission[26]. Many people also stated the difficulty in getting an appointment due to demand on practices or mixed communication on how to access GP support during this time[27]. Local evidence is limited; therefore, no conclusions have been drawn to account for the decrease locally.

For 33% of suicides over the last three years there was evidence of previous suicide attempts in the primary care records.

This proportion seems to be higher for deaths in the latest three years than in earlier years. This may reflect better reporting (missing data is particularly high in the early years), but fluctuations are seen with the relatively small numbers.

Research suggests the average GP will experience suicide in one of their patients once every four or five years with a patient consulting before this episode only once every eight or nine years[28]. Previous suicide attempts were recorded in primary care records in 20% of all cases.

There was evidence of self-harm in the primary care records of 20% of all Bolton suicides (Table 10). Self-harm is a complex phenomenon to measure because many cases are never brought to the attention of and recorded by public services. Not all people who self-harm will be at increased risk of suicide.

Figure 15: Chart showing last contact (not necessarily mental health related) with primary care within one month to a year prior to death and the proportion made with a GP

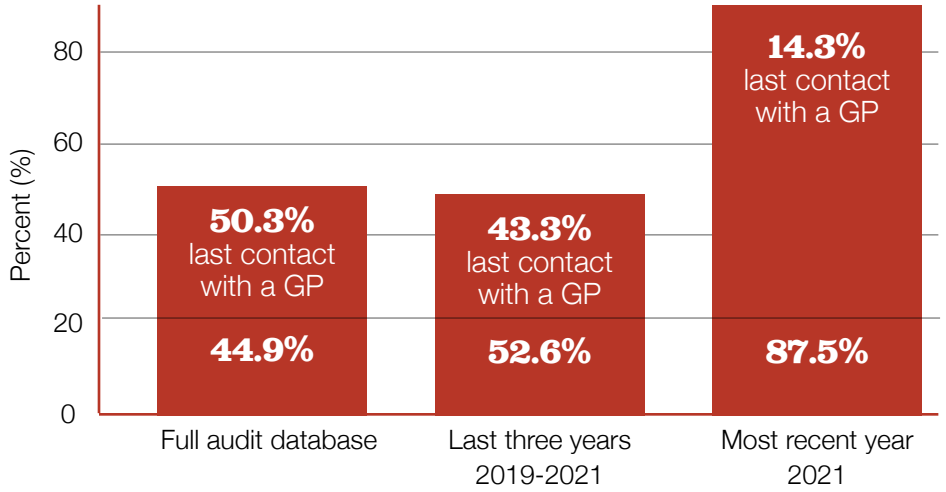


Table 10: Evidence of self-harm and previous suicide attempts found in the primary care records (2006-2020)

Primary care history	Male (%)	Female (%)	Full audit (%)
Evidence of self-harm in the primary care records	19.6	20.6	19.8
Evidence of suicide attempts in the primary care records	20.3	17.5	19.1

[26]*https://www.nuffieldtrust.org.uk/news-item/what-impact-has-covid-19-had-on-mental-health-services*
[27]*https://www.bmj.com/content/372/bmj.n798*
[28]*Bandolier (2010). September 1994 issue. https://bit.ly/3t5UUGd*

19. Secondary care mental health services

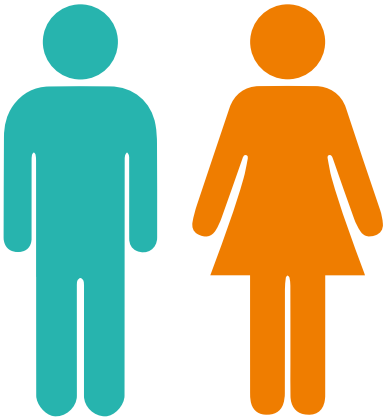
Across the whole audit database, 32% had any lifetime contact with secondary mental health services.

Of these, there is evidence of previous self-harm in the secondary care records in 21% of cases. Around 20% of males and 26% of all females in contact with secondary care mental health services had a history of self-harm recorded (Table 11).

Where there was secondary care contact, 28% of individuals had evidence of previous suicide attempts in their secondary care record; when split into gender, 25% of males and 35% of females had previous suicide attempts recorded.

Table 11: Evidence of self-harm and previous suicide attempts found in the secondary care records (2006-2021)

Secondary care history	Male (%)	Female (%)	Full audit (%)
Evidence of self-harm in the secondary care records	19.6	25.8	21.2
Evidence of suicide attempts in the secondary care records	25.2	35.1	27.8



Around 20% of males and 26% of all females in contact with secondary care mental health services had a history of self-harm recorded

20.
Drug and alcohol problems

In total, around 23% of people who die by suicide in Bolton have a history of alcohol problems, and 17% have a history of drug problems.

Breaking this down into male and female, problematic alcohol use is associated with around a quarter (24%) of male and over a fifth (22%) of female suicides in Bolton, while problematic drug use is more associated with male suicides.

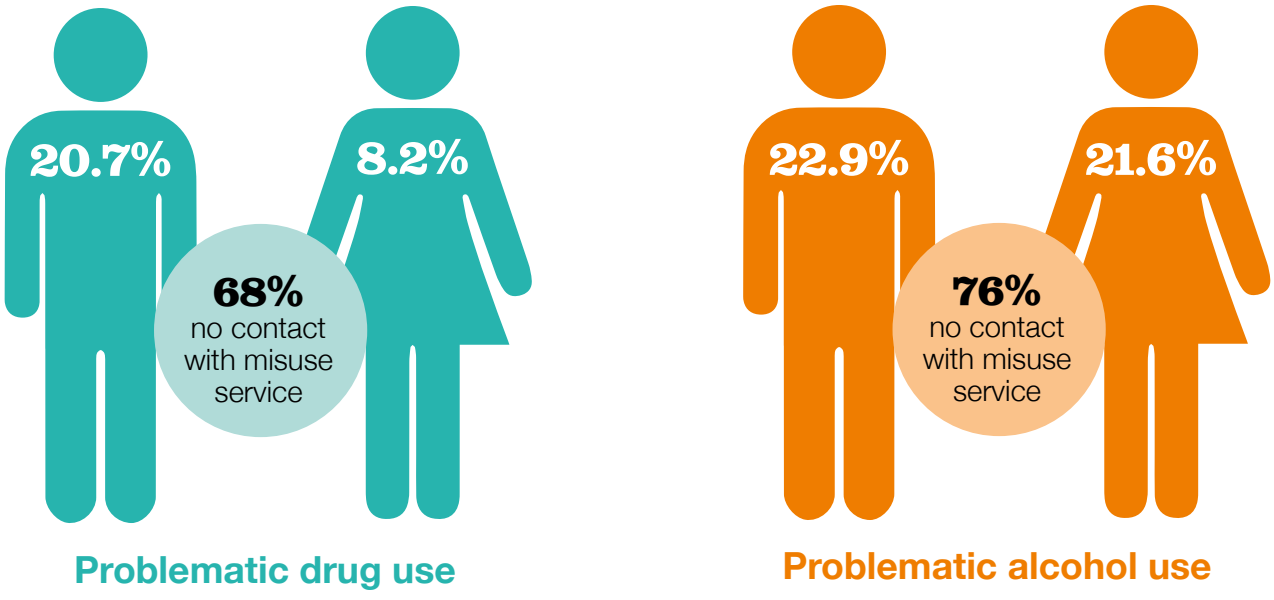
Around 76% of those with evident lifelong alcohol problems had no history of contact with alcohol services. The proportion of those with evident lifelong drug problems having no history of contact with drugs services was slightly lower (68%). (Figure 16, below).

Almost half (47%) of all those people who died by suicide in Bolton were recorded as having consumed some form of alcohol at the time of death (full audit). This has increased to 50% over the last three years, while the last twelve months shows 43%.

Table 12: Proportion experiencing problematic drug and alcohol problems split by gender (2006-2021)

Drug and alcohol use	Male	Female	Full audit
Problematic drug use	20.7	8.2	17.4
Problematic alcohol use	22.9	21.6	22.6

Figure 16: Problematic substance misuse and proportion having no contact with misuse services



21.
Reporting of crime and violence

When looking at perpetrators of violent crime and offending, around 7% of all people who died by suicide in Bolton had violent offending recorded more than a year prior to their death (domestic violence, assault, violent crime etc.).

This is consistent over recent years and is predominantly associated with men; over three-quarters (77.4%) of those appearing in the audit who had committed violent offences were male.

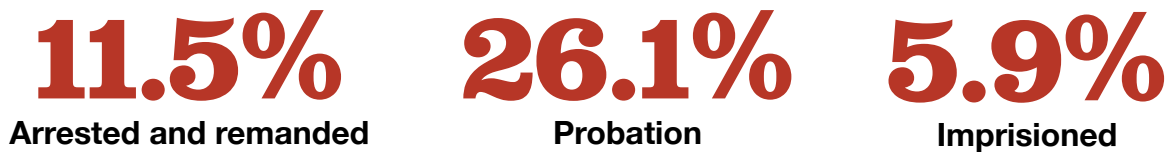
There are few women in the database with a longer-term history of violent offending (Figure 17). However, nearly 20% of females who had committed violent offences against partners etc. did so in the month before death (caution is advised here as numbers are small for females).

When looking at contact with the justice system across the whole database, 12% of Bolton suicides had a recorded history of being arrested and remanded or bailed in their lifetime; 26% had served probation within their lifetime, 18% had been arrested and released with fine or no charge, 6% had been imprisoned at some point in their past. Very few (<1%) people who die by suicide have contact with the criminal justice system within a year of their death.

Despite a higher prevalence over the whole database (24%), none over the last three years had had experience with Youth Offending Services.

Figure 17: Violent offending by time period and gender

Figure 18: Contact with the justice system



22.
Trigger events

Although specific risk factors have been identified, suicide occurs in all population groups and targeting one group cannot be expected to substantially impact upon the total number of suicides in a borough.

Many suicides are associated with being male and / or living in deprived circumstances.

The suicide audit collects information on contributory factors that are evident from coroners' files. The auditor must select factors from a list or by entering 'other factors' in a text box, which may then be subject to analysis.

From this we can identify certain trigger events that have occurred in a person's life immediately prior to suicide.

Examples of trigger events in Bolton's suicides include:

- **Break-up of a serious relationship**
- **Redundancy / recent unemployment**
- **Child taken into care**
- **Key points of interaction with secondary care mental health services – admitted onto caseload, discharge from services**
- **Bereavement**
- **Terminal illness diagnosis**

Many suicides are associated with being male and / or living in deprived circumstances.

Breakdown of relationship and redundancy or job loss are associated with a greater proportion of males than females for deaths by suicide, while the opposite is true for bereavement. A similar proportion of male and female suicides are associated with problematic alcohol use.

Adverse childhood experiences (ACEs) are a key risk factor for suicide attempts and should not be underestimated.

Although ACEs are not specifically recorded in coroners' suicide files, assumptions can be made with a degree of caution. Cases reviewed can be interpreted to have had some sort of adverse childhood experience, which is often reflected in the trigger events recorded.

The ACEs included in the study were:

1. **Psychological abuse**
2. **Physical abuse**
3. **Sexual abuse**
4. **Emotional neglect**
5. **Physical neglect**
6. **Witnessing violence against a mother or other adult female**
7. **Substance misuse by a parent or other household member**
8. **Mental illness, suicide attempt or suicide death of a parent or other household member**
9. **Incarceration of a parent or other household member**
10. **Parents' separation or divorce**

Researchers found that:

- Men who had experienced four or more ACEs and women who had experienced two or more ACEs had significantly increased risk of attempting suicide at least once, compared to members of each sex with no ACEs
- Men and women who reported having a parent or relative with mental illness were more likely to have attempted suicide than those who did not
- Men who had experienced childhood emotional neglect were more likely to have attempted suicide than those who had not
- Men and women who had experienced childhood sexual abuse were more likely to have attempted suicide multiple times compared to those who had not

Table 13: Key triggers before suicide split by gender (2006-2021)

Key triggers	Male (%)	Female (%)
Breakdown of relationship	38.7	28.4
Health issues	34.4	40.0
Problematic alcohol use	23.8	22.1
Problematic drug use	21.5	8.4
Finance issues	19.5	7.4
Bereavement	14.8	23.2
Social isolation	14.1	13.7
Job loss	13.3	7.4
Housing issue	5.1	2.1
Was a looked-after child	1.2	1.1
Child recently taken into care	0.8	3.2

23.
Serious untoward incidents

Over the audit period there was greater use (or greater sharing) of information from the Significant Event Audit (SEA) / Serious Untoward Incident Review (SUI) between mental health services and primary care.

Across the whole database, SEA / SUIs are available to audit for 4% of suicides. This figure increases to 8% for suicides over the last three years, although none were recorded for the most recent year (2021).

24.
Recommendations

To achieve real and sustainable improvement in suicide prevention, our recommendation is to align and embed opportunities to promote mental wellbeing and suicide prevention across key policies, programmes, strategies and plans in the borough. This requires a whole system approach.

However, it should be noted that, statistically speaking, the audit findings are based on small numbers and therefore drawing recommendations from this data alone comes with caution and requires a multi-agency approach.

Therefore, the following key recommendations have been identified:

- Undertake a multi-agency codesign workshop with key stakeholders and local residents to identify key priority actions based on evidence, audit findings and local experiences
- Develop a suicide prevention strategy and action plan based on the findings of the codesign workshop, aligned to the population mental wellbeing and suicide prevention programme
- Disseminate the strategy and action plan and ways in which wider stakeholders can get involved in preventing suicides
- Ensure alignment to the Bolton Mental Health Transformation Partnership
- Ensure alignment with the Greater Manchester Suicide Prevention programme, activating local action
- Ensure alignment with Bolton's Child Deaths Overview Panel (CDOP), ensuring key priorities take into consideration the needs of children and young people and transition into adulthood
- Ensure alignment with Bolton's Safeguarding Board, ensuring a preventive approach in supporting adults who are at high risk of suicide
- Undertake an annual suicide audit for 2023/24, including a review of the strategy and action plan

Public Health Directorate
Bolton Council
March 2023

Bolton Council