Suicide Audit Annual Report 2021

Population Mental Wellbeing and Suicide Prevention Partnership

Bolton Council

Report providing the annual statistical update on suicide in Bolton

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January 2022

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1. Summary

The latest official data shows that Bolton's suicide rate has slightly decreased 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 people who died by suicide 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 the 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 35% of female suicides and 49% of male 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 at death by 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 involved anyone under 18 years of age. However, Bolton Children's Safeguarding Board has carried out detailed investigation into such cases as a high priority.

The average age of suicide in Bolton over the last twelve months is

42yrs

[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.

Problematic alcohol use is associated with a quarter of all suicides in Bolton. 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.

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 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 – admitted onto caseload, discharge 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.

The report suggests that there are opportunities to intervene and further reduce the risk of suicide within Bolton. The report notes the significance of the following factors and thus areas for consideration in relation to reducing deaths caused by suicide:

a) **The significance of alcohol at time of death** – more than half of all those who died by suicide in Bolton had consumed alcohol.

b) **Almost half of cases had some form of history relating to a mental illness,** although only a small proportion of these had been recently diagnosed (circa 5%) within the last month.

c) **One in ten had a history of violent offending** within one year of death and had links to the justice system.

d) **Significant life events such as bereavement** (particularly those bereaved by suicide), relationship breakdown and redundancy pose significant risks for vulnerable individuals.

e) **Previous suicide attempts** were evident in a fifth of cases and thus this could be seen as a marker of increased risk.

f) **Contact with primary care** within the week prior to death was evident in 40% of cases, which may indicate further opportunities to intervene.

g) **There are no geographical 'hotspots'** noted currently, although this is continuously monitored, as is any emerging clustering of cases.

h) **Given the dispersed nature of the causes** and means of suicide within Bolton a multi-component and multi-agency strategy to reduce suicides is supported by the evidence set out within this report.

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 coroner's 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 2020 and is for all ages.
- Public Health England's 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 2018 to 2020 and is for all ages.

75%

of national suicides were among men

3. Background: why suicide prevention?

Every suicide represents a potentially preventable loss of life.

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 were 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 individual in England is estimated to be £1.67m[2]. 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[3].

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 a complex and challenging issue, 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.

The average cost of a completed suicide of a working age individual in England is estimated to be

£1.67m

[2]Parliament.uk (2016). Services to support people who are vulnerable to suicide. https://bit.ly/3BB9zga
[3]David McDaid, A-La Park, Eva-Maria Bonin (2014). Population-level suicide awareness training and intervention. PSSRU. https://bit.ly/3p3PYjX

4. Introduction

National guidance[4] 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 have an important role in establishing via inquest proceedings 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[5].

The council's Public Health Department works closely with coroners. 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 are compiled by the Office for National Statistics (ONS). Bolton has been undertaking suicide audits since 2006.

Suicide prevention is an important priority for Bolton and a statutory responsibility of the Director of Public Health, which requires an annual suicide audit to be produced.

In 2017, Bolton launched its latest evidence-based prevention strategy, No More Suicides in Bolton: Bolton's suicide prevention partnership strategy, 2017-20.

Prior to July 2020, Bolton Suicide Prevention Steering Group met quarterly as a standalone suicide prevention strategy group. More recently, the Suicide Prevention Steering Group was merged with the recently developed Population Mental Wellbeing Steering Group. The new group is named the Population Mental Wellbeing and Suicide Prevention Steering Group.

It is recognised that 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 but also target groups of people at heightened risk.

The Population Mental Wellbeing and Suicide Prevention Steering Group will oversee the suicide audit, its findings and a multi-agency approach to identifying key priorities for Bolton based on the findings from the audit.

This report details key findings from the 2020/21 suicide audit and key recommendations for local action.

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

5. Official suicide statistics[6]

The official suicide rate for 2018-2020 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, but these changes are not statistically significant and Bolton's rate remains similar to the national rate, despite Bolton being significantly more deprived than England generally. However, there are indications that the gap between Bolton's and the national rate may be widening.

The most recent data (2018-2020) shows Bolton to have the fourth highest suicide rate in Greater Manchester, which places us higher than average, but not significantly so. Figure 2 shows Bolton within the context of the whole of the North West, where we rank slightly lower than average (17th of 40). 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.

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.

An average of

24

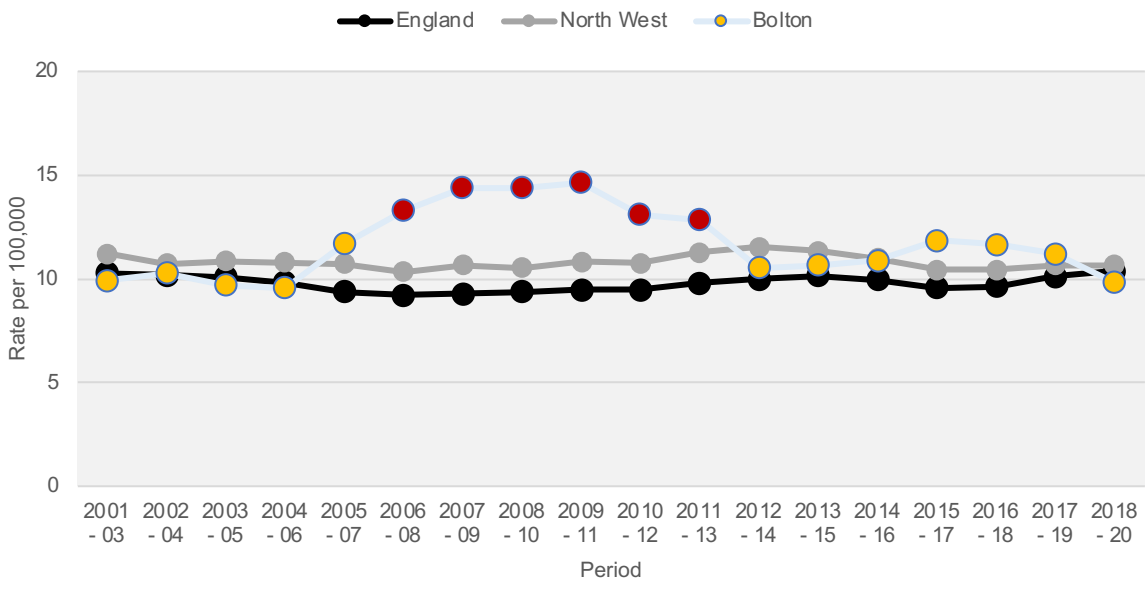
people die by suicide each year in Bolton

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

Table 1: Trend of the suicide rate in Bolton compared to England and the North West over time (2001 to 2020)

Period	Bolton Value	Bolton Count	North West	England
2001 - 03	9.9	68	11.2	10.3
2002 - 04	10.3	70	10.7	10.2
2003 - 05	9.7	66	10.9	10.1
2004 - 06	9.6	65	10.8	9.8
2005 - 07	11.7	80	10.7	9.4
2006 - 08	13.3	93	10.3	9.2
2007 - 09	14.3	101	10.7	9.3
2008 - 10	14.4	101	10.5	9.4
2009 - 11	14.6	103	10.8	9.5
2010 - 12	13.1	94	10.8	9.5
2011 - 13	12.8	93	11.3	9.8
2012 - 14	10.5	77	11.5	10.0
2013 - 15	10.7	78	11.3	10.1
2014 - 16	10.9	81	11.0	9.9
2015 - 17	11.9	88	10.4	9.6
2016 - 18	11.7	87	10.4	9.6
2017 - 19	11.2	82	10.6	10.1
2018 - 20	9.8	72	10.7	10.4

Figure 1: Trend of the suicide rate in Bolton compared to England and the North West over time (2001 to 2020)

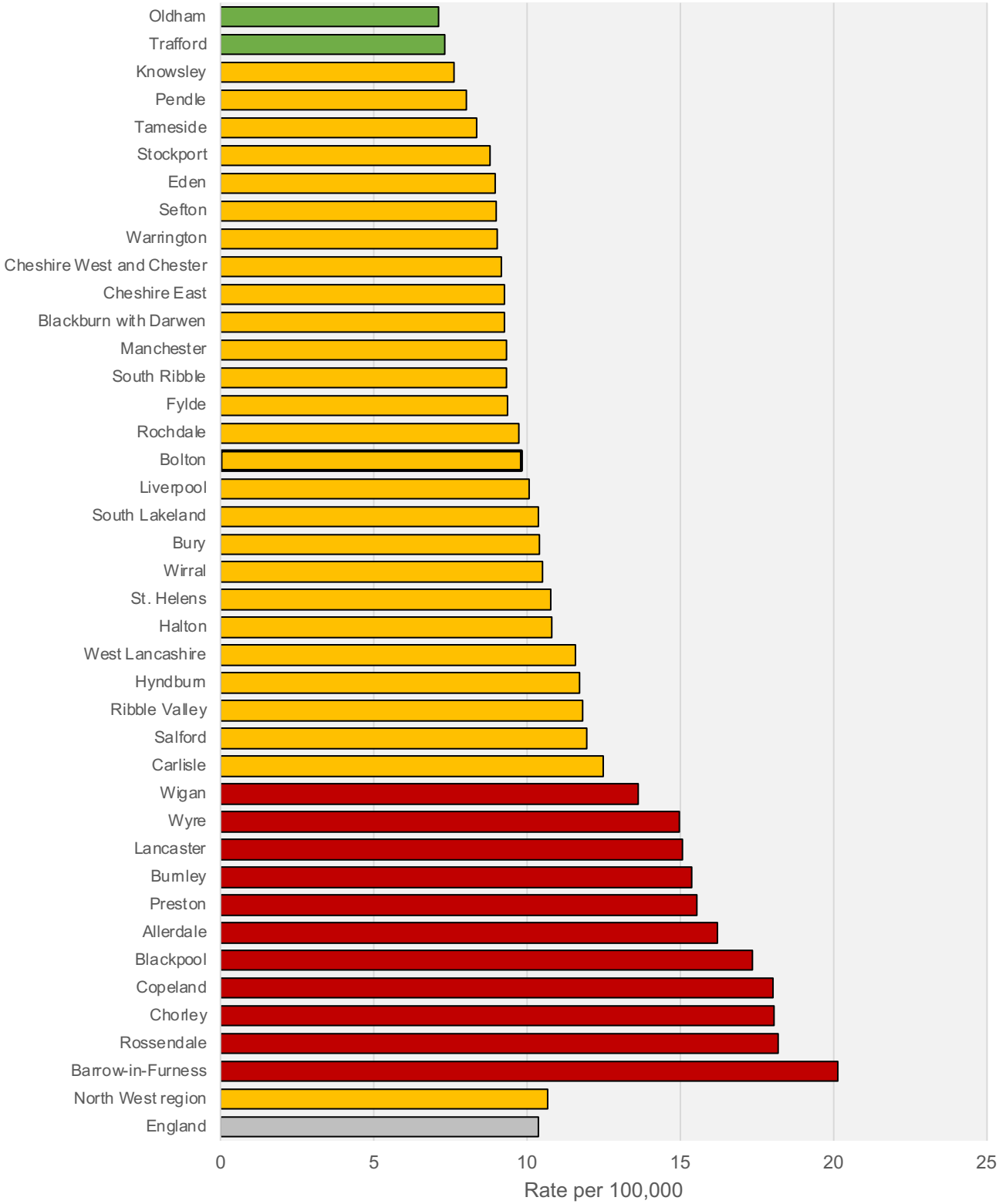


***Red** = significantly worse than England, **amber** = no significant difference from England*

Table 2: Suicide rates across the North West (2018-2020)

Area name	Time period	Value
England	2018 - 20	10.4
North West region	2018 - 20	10.7
Oldham	2018 - 20	7.1
Trafford	2018 - 20	7.3
Knowsley	2018 - 20	7.6
Pendle	2018 - 20	8.0
Tameside	2018 - 20	8.3
Stockport	2018 - 20	8.8
Eden	2018 - 20	9.0
Sefton	2018 - 20	9.0
Warrington	2018 - 20	9.0
Cheshire West and Chester	2018 - 20	9.1
Cheshire East	2018 - 20	9.3
Blackburn with Darwen	2018 - 20	9.3
Manchester	2018 - 20	9.3
South Ribble	2018 - 20	9.3
Fylde	2018 - 20	9.3
Rochdale	2018 - 20	9.7
Bolton	2018 - 20	9.8
Liverpool	2018 - 20	10.1
South Lakeland	2018 - 20	10.4
Bury	2018 - 20	10.4
Wirral	2018 - 20	10.5
St. Helens	2018 - 20	10.8
Halton	2018 - 20	10.8
West Lancashire	2018 - 20	11.6
Hyndburn	2018 - 20	11.7
Ribble Valley	2018 - 20	11.8
Salford	2018 - 20	11.9
Carlisle	2018 - 20	12.5
Wigan	2018 - 20	13.6
Wyre	2018 - 20	15.0
Lancaster	2018 - 20	15.1
Burnley	2018 - 20	15.4
Preston	2018 - 20	15.6
Allerdale	2018 - 20	16.2
Blackpool	2018 - 20	17.4
Copeland	2018 - 20	18.0
Chorley	2018 - 20	18.1
Rossendale	2018 - 20	18.2
Barrow-in-Furness	2018 - 20	20.2

Figure 2: Suicide rates across the North West (2018-2020)

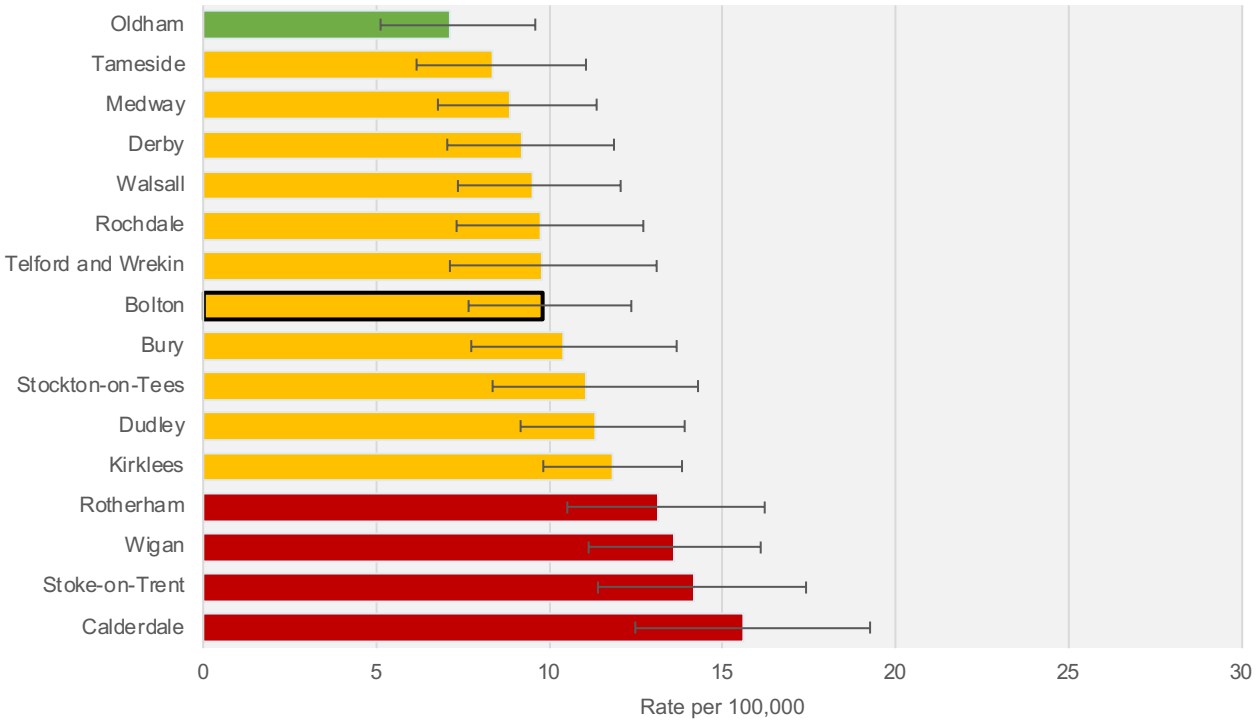


***Red** = significantly worse than England, **amber** = no significant difference from England*

Table 3: Suicide rates (2018-2020) among Bolton's CIPFA statistical neighbours[7]

Local authority	Period	Rate per 100,000
Calderdale	2018 - 20	15.6
Stoke-on-Trent	2018 - 20	14.2
Wigan	2018 - 20	13.6
Rotherham	2018 - 20	13.2
Kirklees	2018 - 20	11.8
Dudley	2018 - 20	11.3
Stockton-on-Tees	2018 - 20	11.0
Bury	2018 - 20	10.4
Bolton	2018 - 20	9.8
Telford and Wrekin	2018 - 20	9.8
Rochdale	2018 - 20	9.7
Walsall	2018 - 20	9.5
Derby	2018 - 20	9.2
Medway	2018 - 20	8.8
Tameside	2018 - 20	8.3
Oldham	2018 - 20	7.1

Figure 3: Suicide rates (2018-2020) among Bolton's CIPFA nearest neighbours[8]



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

[7]*Public Health Outcomes Framework (2021). Suicide Prevention Profile. Office for Health Improvement and Disparities. https://bit.ly/3p7cDM3*
[8]*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[9]

Surveillance of suicide is carried out locally with the Suicide Audit established as part of the National Suicide Prevention Strategy for England[10] 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[11]. If evidence does not point towards this legally required standard then an 'open' verdict is returned. However, during 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)[12].

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[13] 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 **2020**

15 cases

- The last three years **2018 to 2020**

53 cases

- The full audit database **2006 to 2017**

337 cases

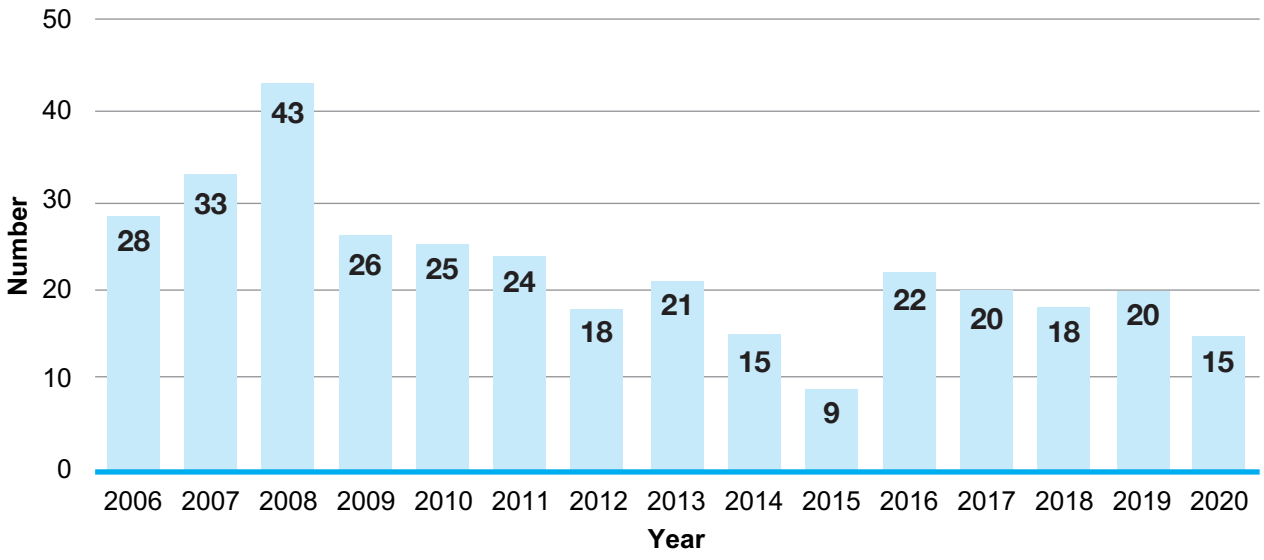
[9]Source: Bolton Suicide Audit, undertaken by Bolton Council from Coroner's records.
[10]Department of Health (2002) National Suicide Prevention Strategy for England, DoH, London.
[11]Department of Health (1999) Saving Lives: Our Healthier Nation, DoH, London.
[12]Samaritans (2018). High Court Ruling. https://bit.ly/3JMdCZT
[13]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 2020).

Figure 4: Number of case files audited by year of death for Bolton[14]



[14]*Source: Bolton Coroner's Court suicide cases, (2006-2020)*

8.
Age, gender, ethnicity and sexuality

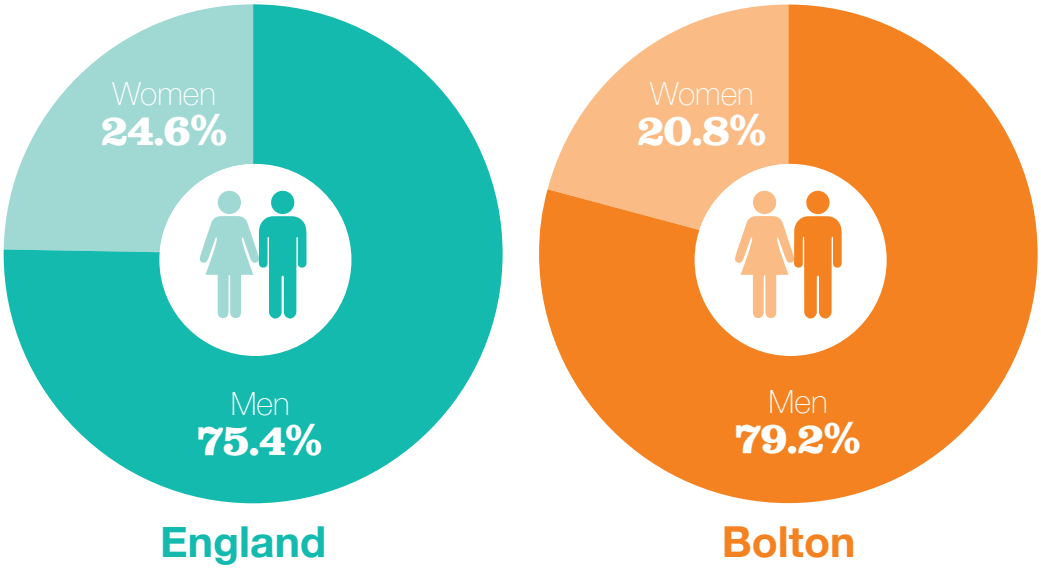
Over the last three years (2018-2020) there were 53 suicides audited.

For the most recent year (2020), 80% of people who died by suicide were male, which compares to 79% for the last three years and 72% in the whole database (2006-2020). Overall, this gender balance is similar to the national picture, where 75% of suicides are among men.

The average age of suicide in Bolton over the last year was 42. Over the previous three years it is 47, and over the whole database it is 45 years. (See Figure 6)

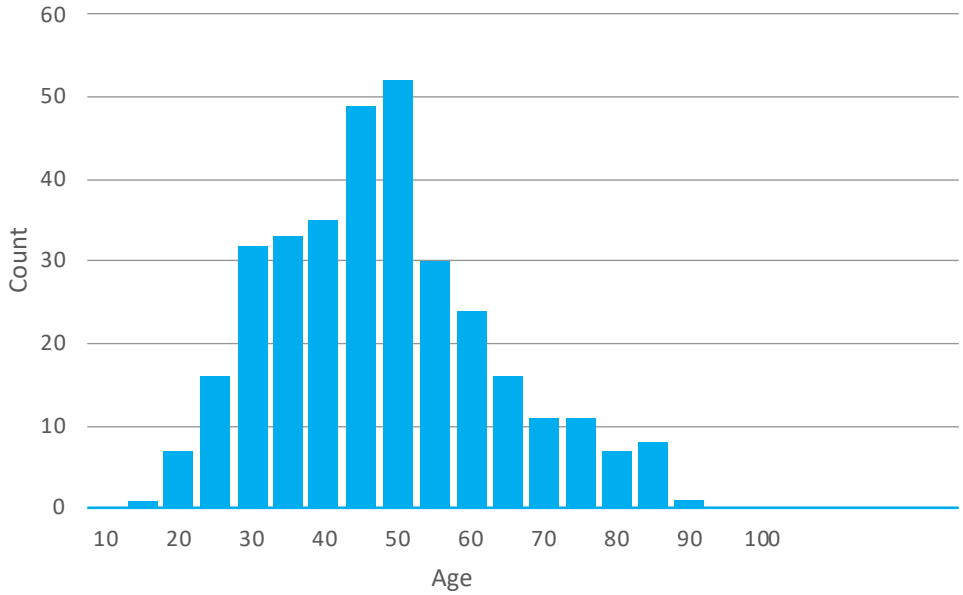
Regarding ethnicity, 83% of all people who die by suicide in Bolton are from the White British ethnic group. Among people from minority ethnic groups who die by suicide, the largest number are generally from the South Asian community and in recent cases of 'Other' ethnicity. The South Asian community 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.

Figure 5: Male/female split for England and for Bolton between 2018-202[15]



[15]*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

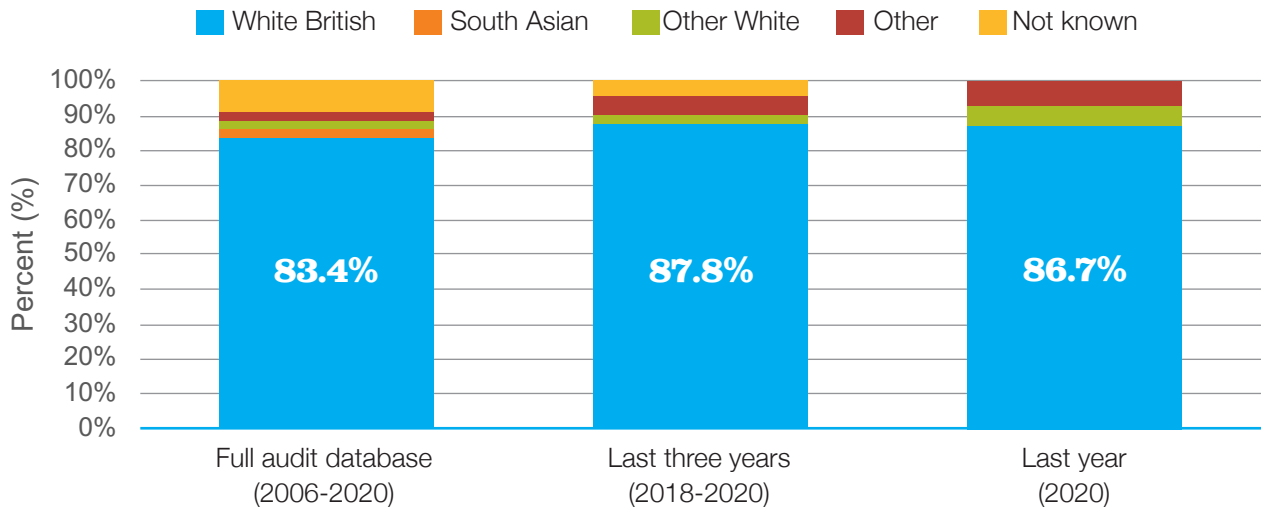


If the ethnicity of a person is not stated within the suicide file, then ethnicity will be recorded as 'not known'. Recording of ethnicity has improved since the audit was initially started, which may explain the high number of unknown ethnicity in the full audit database.

Over the last three years, 7% of people who die by suicide were born outside the UK, which is lower than seen across the full audit database (8%). In general, across years, and though small to begin with, suicides by those born outside the UK have been reducing over recent years.

Though poorly recorded, it would appear virtually all individuals in the suicide audit were recorded as heterosexual. Unless documented in family testimonies, a person's sexuality rarely appears.

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



9. Method of suicide

The main methods of suicide in the UK are hanging / strangulation or self-poisoning with psychotropic or analgesic drugs. This is true in Bolton also: in the whole suicide audit dataset, hanging / strangulation accounts for 42% of all deaths by suicide, with overdose accounting for over a quarter (28%). Over the last three years the proportion of self-poisoning or overdose has increased to 62% while the proportion of hanging / strangulation remains consistent. Historically, hanging / strangulation is generally associated with male suicides. In the whole dataset, hanging / strangulation occurred in 35% 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. More violent suicides in Bolton (impact with trains, jumping from a height, self-immolation, cutting / stabbing) are still more often associated with men, accounting for 12% of male suicides and 8% of female suicides. (Figure 8, Table 4)

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

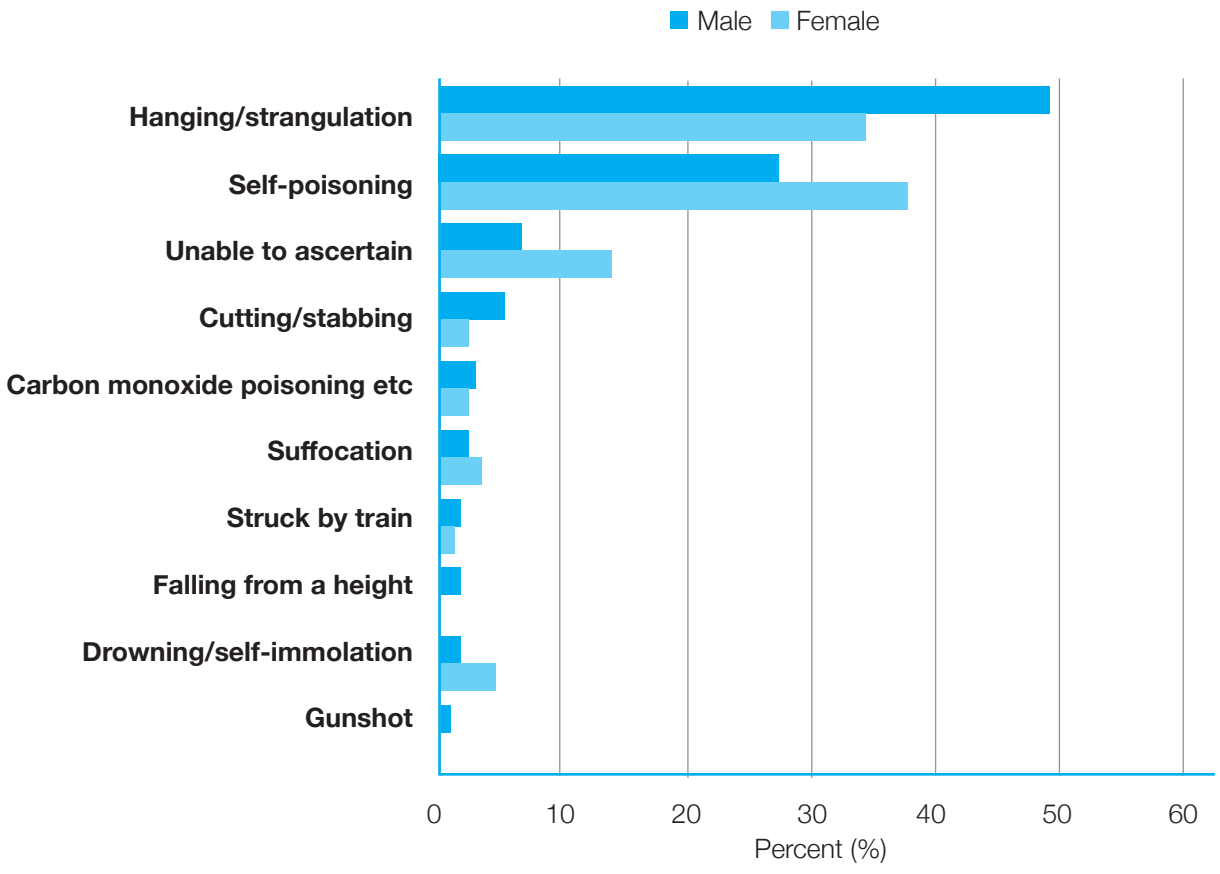


Table 4: Breakdown of suicide method by gender (2006-2020)

Method	Male (%)	Female (%)
Hanging / strangulation	49.3	34.5
Self-poisoning	27.5	37.9
Unable to ascertain	6.6	13.8
Cutting / Stabbing	5.2	2.3
Carbon monoxide poisoning etc	3.1	2.3
Suffocation	2.2	3.4
Drowning / self-immolation	1.7	4.6
Falling from a height	1.7	0.0
Struck by train	1.7	1.1
Gunshot	0.9	0.0
Total	**100.0**	**100.0**

Regarding self-poisoning, the drugs most commonly used in Bolton suicides were (in order):

1. **Paracetamol/paracetamol opiate compound**
2. **Opiates (heroin, methadone etc.)**
3. **Tricyclic antidepressants**
4. **Anti-psychotic drugs**
5. **SSRI/SNRI antidepressants**
6. **Benzodiazepine**

10. Location

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

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[16]. 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 North West, high risk non-residential areas and features have been identified, including waterways, railways, motorways, urban centres and parks and other open areas[17].

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 and 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.**

[16]*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.*
[17]*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 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.

The inequality gradient for women is stronger than that seen in men – 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, 2006-2020)

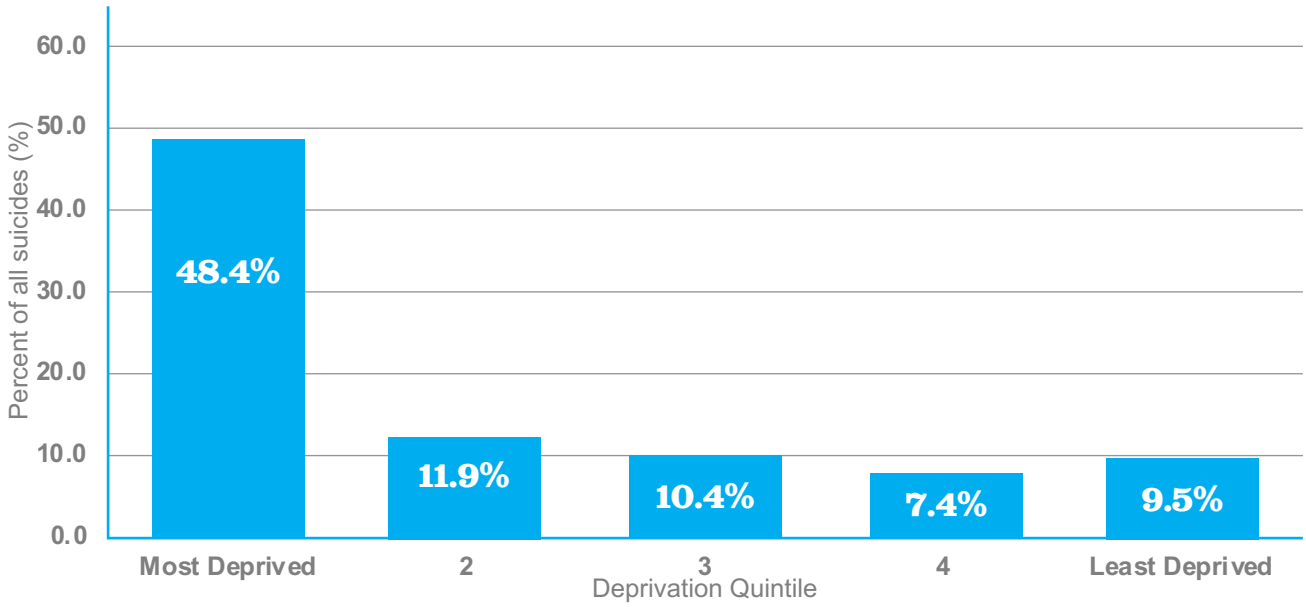


Figure 10: Socioeconomic gradient in deaths by suicide (Bolton, 2018-2020)

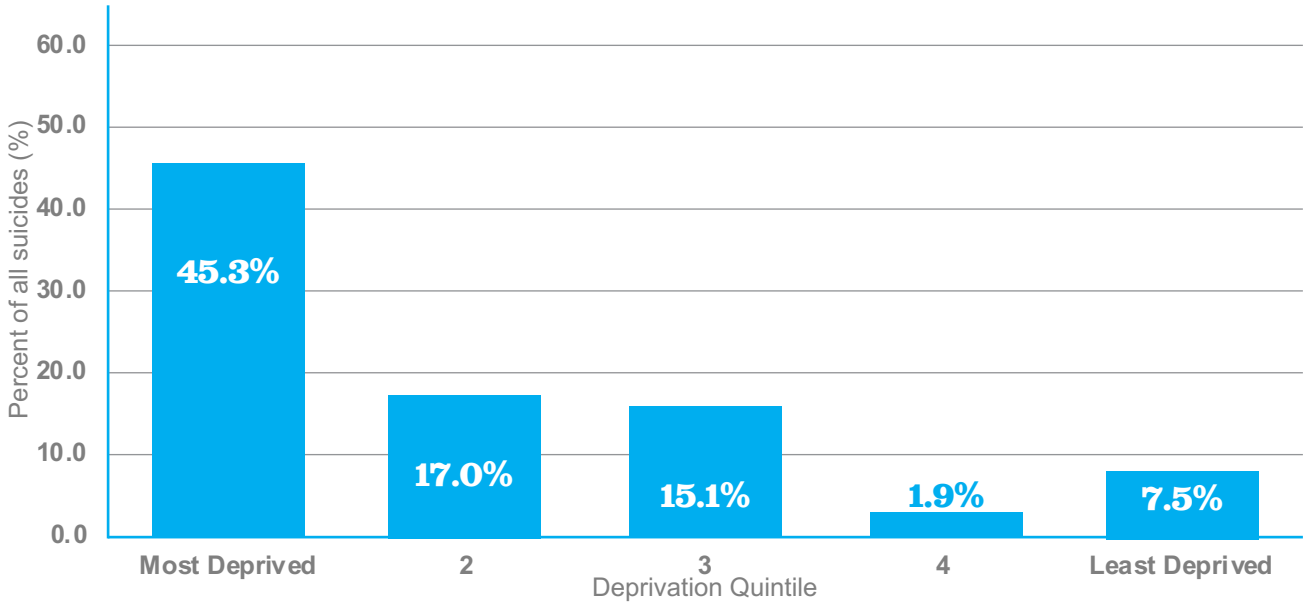


Table 5: Deprivation gradient for deaths by suicide by gender (2006-2020)

Socioeconomic status	Male (%)	Female (%)
Most deprived	47.5	50.5
2	13.1	8.6
3	9.8	11.8
4	8.2	5.4
Least deprived	8.6	11.8

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 less than their deprivation would suggest, as low numbers of suicides occurred in those communities. However, people die from suicide throughout the borough.

Figure 11: Map showing geographical spread of suicide across Bolton

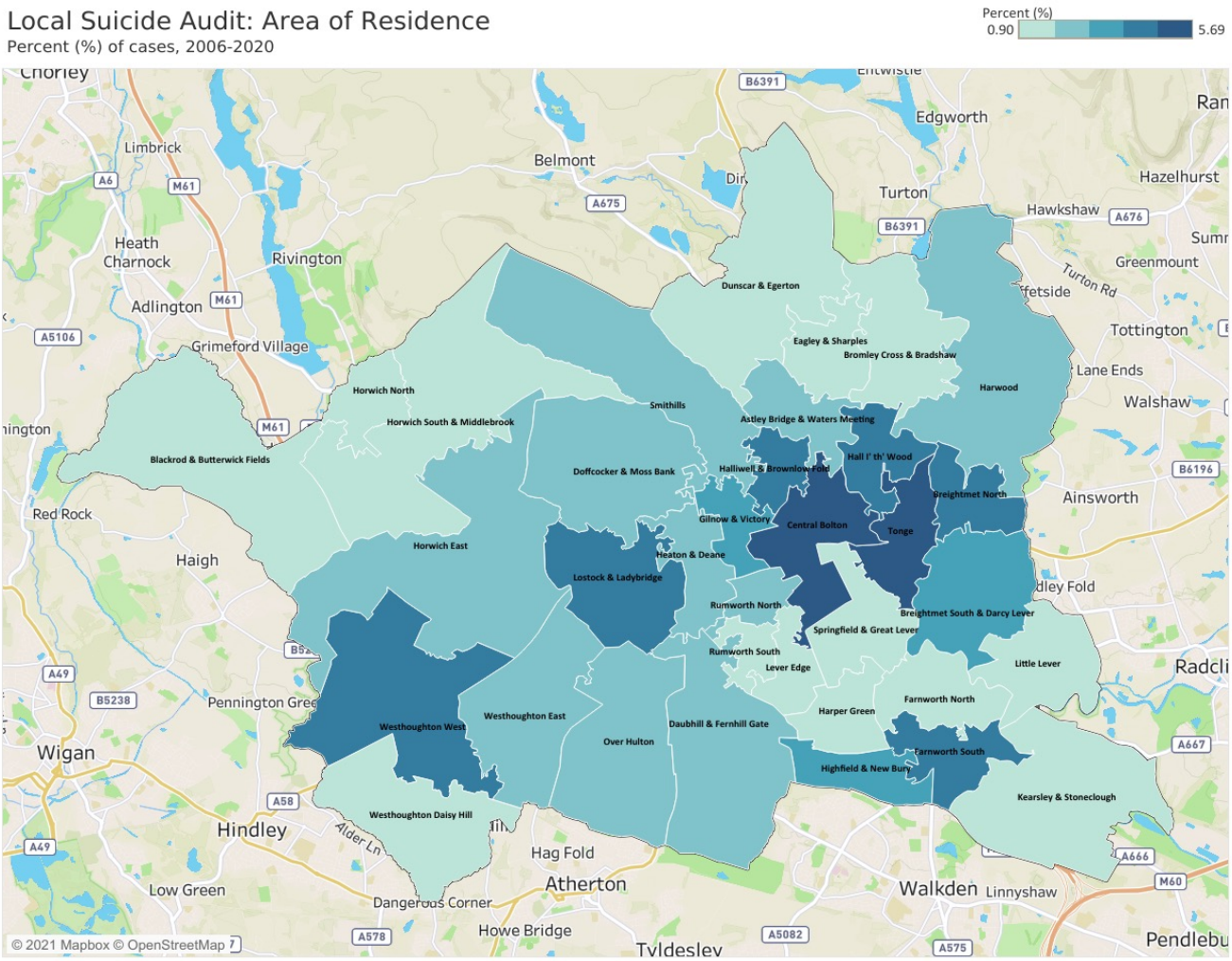
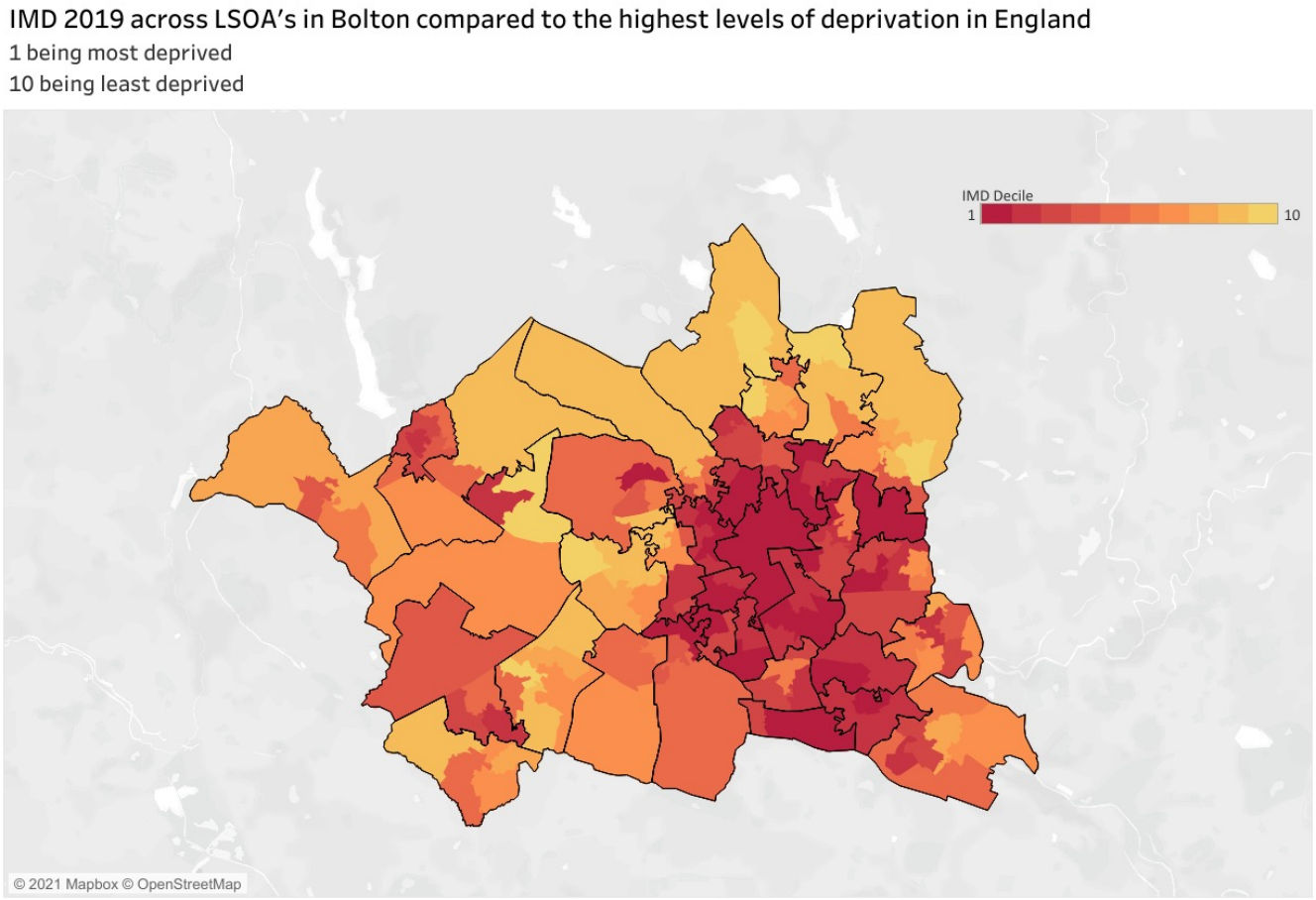


Figure 12: Map showing Index of Multiple Deprivation (IMD) 2019 across Bolton



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

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 2020).

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, it is considered to be 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[18]**
- **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 data). With COVID-19 having such a significant impact on our daily lives, this will no doubt place a burden on the mental and physical health of people, and we are yet to see the full impact that the pandemic has had on suicide rates.

[18]*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 status

In total 40% of people who die 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 2020.

Of all suicides recorded in the database, 23% of individuals were married, 9% were co-habiting and 14% were divorced. Around a third (34%) were single at the time of death. These proportions remain consistent over recent years.

Table 6: Living status split by gender for Bolton residents (2006-2020)

Living situation	Male (%)	Female (%)
Alone	41.7	34.4
Spouse/partner	20.2	22.6
Parents	12.0	5.4
Spouse/partner and children under 18	5.8	10.8
Other family	5.4	3.2
Not known	3.7	1.1
Spouse/partner and children 18+	3.3	7.5
Adults (non-family)	2.9	4.3
Other	2.1	2.2
Other shared	2.1	2.2
Child(ren) under 18	0.8	3.2
Child(ren) 18+	0.0	3.2
Total	**100.0**	**100.0**

Table 7: Relationship status split by gender (2006-2020)

Living situation	Male (%)	Female (%)
Co-habiting	7.8	14.0
Divorced	13.9	12.9
In a relationship not living together	5.3	1.1
Married	22.1	25.8
Separated	8.2	7.5
Single	34.8	30.1
Unknown	2.5	4.3
Widowed	3.7	3.2
Other	1.6	0.0
Total	**100.0**	**100.0**

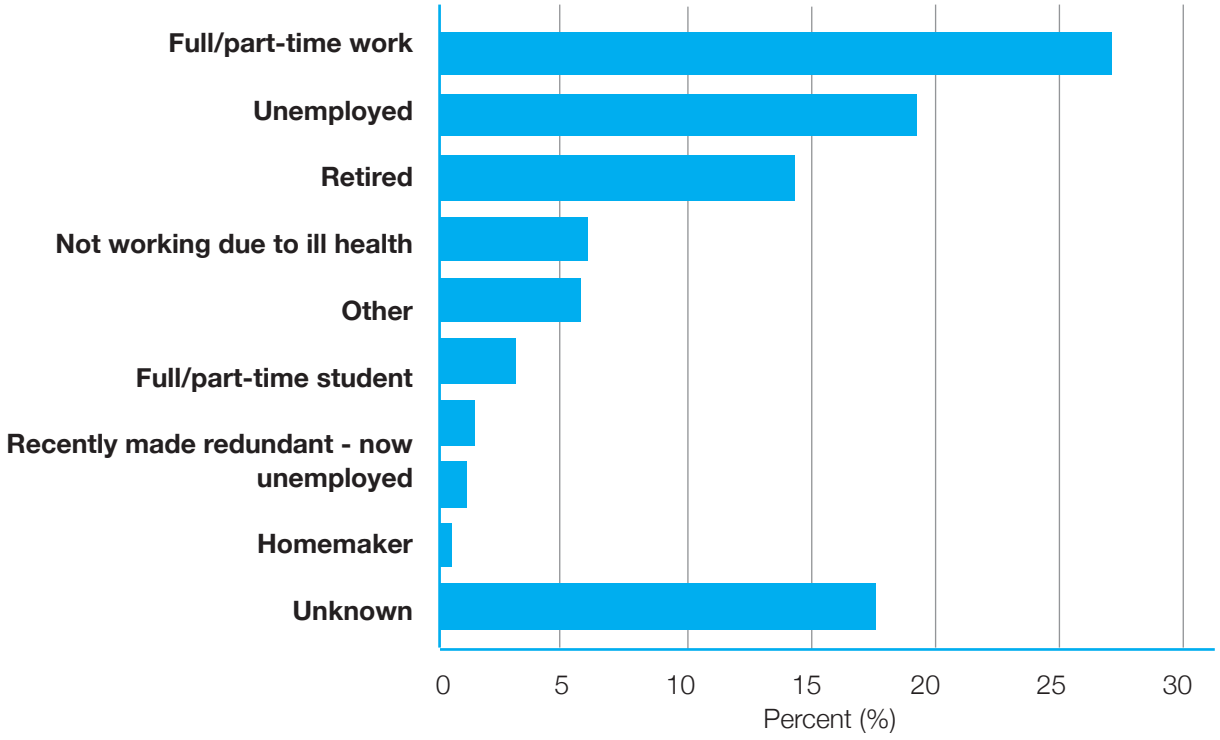
16.
Employment status

Of those suicides audited, over a quarter were in full / part-time work (28%). Ten percent were either employed and on sick leave or were not working due to ill health. Almost a fifth (18%) were classed as unemployed.

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

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

Figure 13: Employment status among those who died by suicide (Bolton, 2006-2020)



From narrative accounts in the audit, if a person has regularly worked, the time immediately following unemployment/ 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.

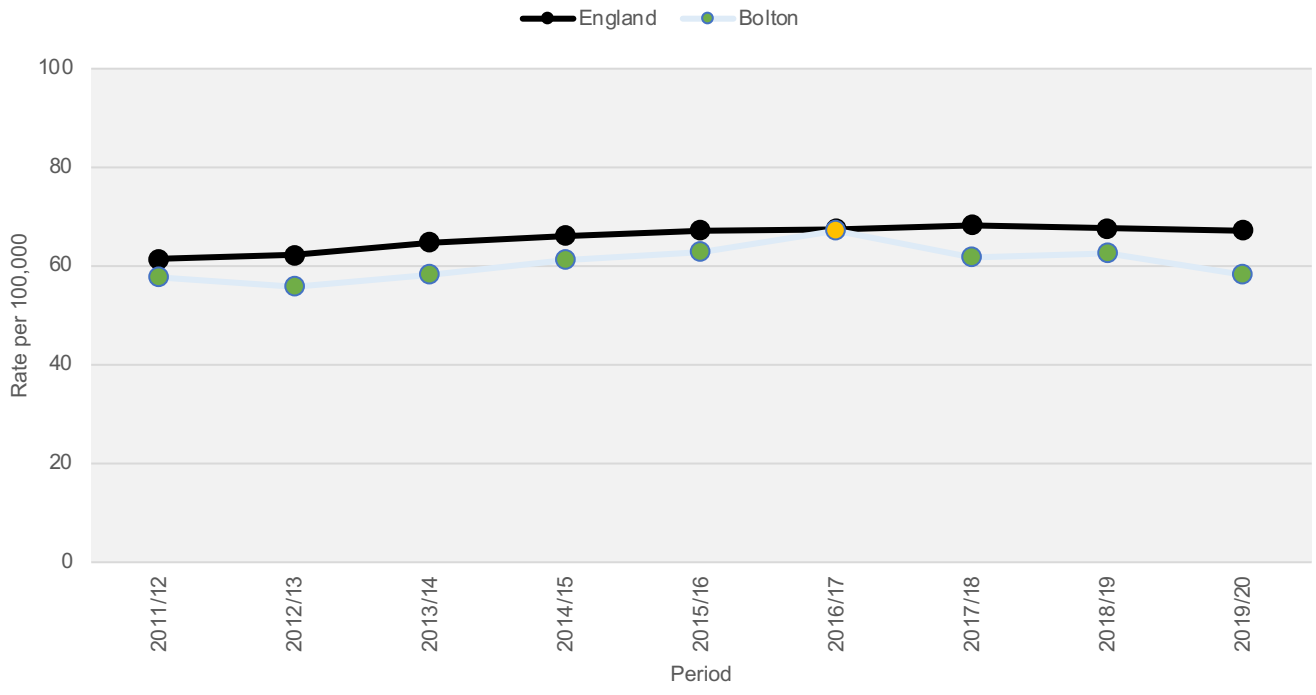
The 2006 evidence review, Is Work Good for Your Health and Wellbeing?[19], concluded that work was generally good for both physical and mental health and wellbeing.

In Bolton there is a 58 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

Figure 14: Gap in the employment rate for those in contact with secondary mental health services[20]



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

17. Mental health

Almost half (48%) of those people audited had a history of mental health problems.

This is far greater than in the general population (17-25%)[21]. A relatively small proportion (8%) 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 (42%). This was followed by those with anxiety / phobia / panic disorder / obsessive compulsive disorder (18%), and alcohol misuse (11%) and drug misuse (8%).

Illnesses such as schizophrenia (5%) and personality disorder (5%) 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. It has been acknowledged that 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[22]. 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 25% 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 diagnosis history split by gender (2006-2020)

Mental health diagnosis	Male (%)	Female (%)
Immediately preceding death	0.4	0.0
Lifetime history	41.4	51.6
Never	25.8	23.7
Unknown / other	14.8	14.0
Within one month prior to death	5.7	3.2
Within one year prior to death	11.9	7.5
Total	100	100

[21]*Mental Health Foundation (2016) Fundamental facts about mental health 2016, MHF.*
[22]*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 2020 Bolton data, 60% of individuals had made their last primary care contact in the previous month to one year; 85% of which were with a GP (Figure 15).

For 30% 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 2018 and 2019 than earlier years, which 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[23]. Previous suicide attempts were recorded in primary care records in 19% of all cases.

There was evidence of self-harm in the primary care records of 22% 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

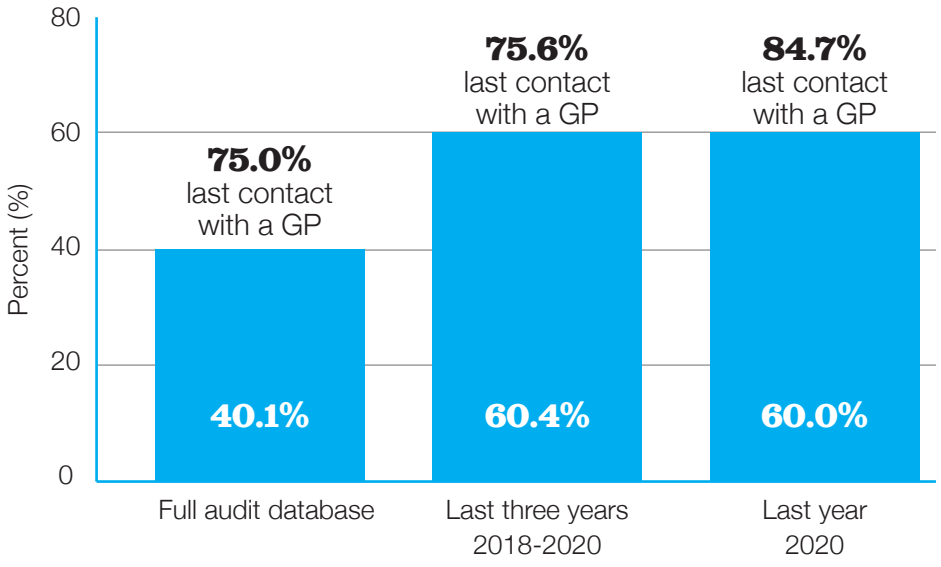


Table 10: Evidence of self-harm and previous suicide attempts found in the primary care records (2006-2020)

Primary care history	Male (%)	Female (%)	Full audit (%)
Evidence of self-harm in the primary care records	21.3	22.7	21.7
Evidence of suicide attempts in the primary care records	19.4	18.2	19.1

[23]*Bandolier (2010). September 1994 issue. https://bit.ly/3t5UUGd*

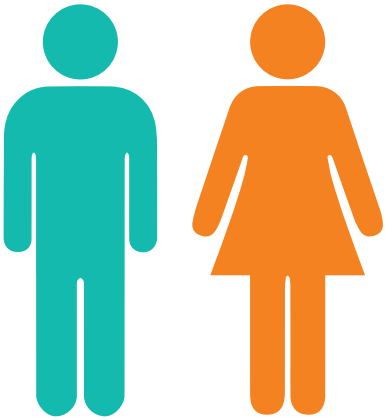
19. Secondary care mental health services

Across the whole audit database 27% had any lifetime contact with secondary mental health services. Of these, there is evidence of previous self-harm in the secondary care records of almost a quarter of cases (24%).

Where there was secondary care contact, 30% of individuals had evidence of previous suicide attempts in their secondary care record; when split into gender, 28% of males and 35% of females had previous suicide attempts recorded. Around 23% of males and 26% of all females in contact with secondary care had a history of self-harm recorded (Table 11).

Table 11: Evidence of self-harm and previous suicide attempts found in the secondary care records (2006-2020)

Secondary care history	Male (%)	Female (%)	Full audit (%)
Evidence of self-harm in the secondary care records	22.7	25.6	23.5
Evidence of suicide attempts in the secondary care records	28.0	34.5	29.9



Around 23% of males and 26% of all females in contact with secondary care had a history of self-harm recorded

20.
Drug and alcohol problems

Problematic alcohol use is associated with a quarter of male and over a fifth of female suicides in Bolton, while drug misuse is more associated with male suicides. A quarter of those who die by suicide in Bolton have a history of alcohol problems, and a fifth have a history of drug problems. (Table 12).

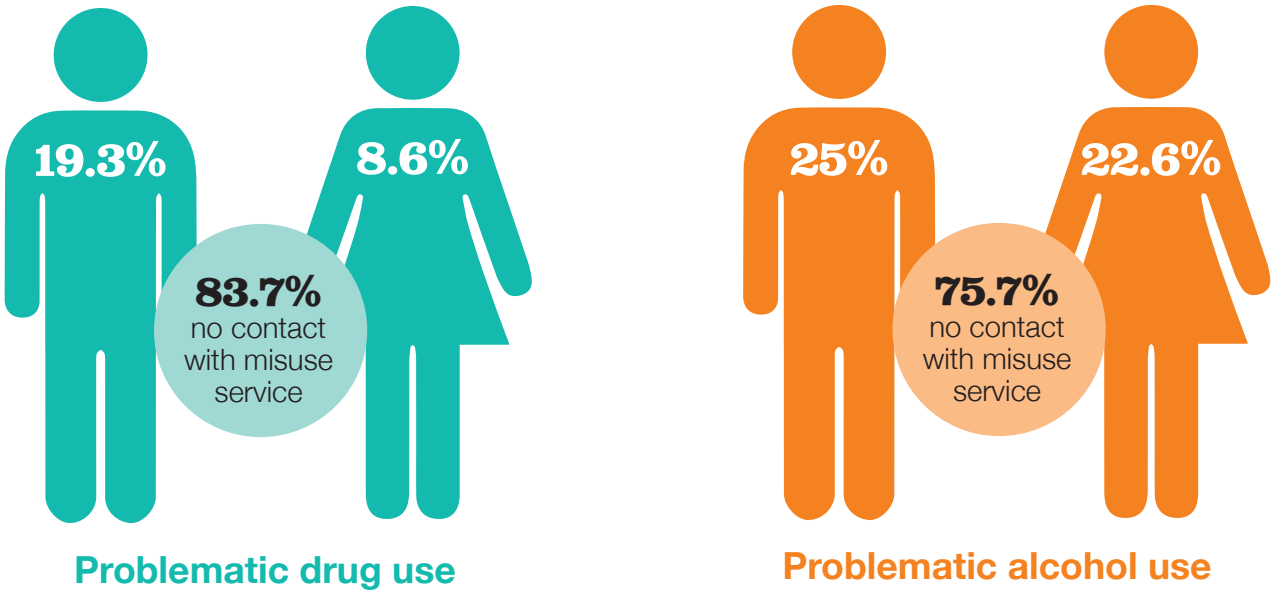
Around 76% of those with evident lifelong alcohol problems had no history of contact with alcohol services. Similarly, 84% of those with evident lifelong drug problems had no history of contact with drugs services (Figure 16, below).

Almost half (45%) of all those who die by suicide in Bolton were recorded as having consumed some form of alcohol at the time of death. This has increased to 52% over the last three years and 56% over the last twelve months.

Table 12: Proportion experiencing problematic drug and alcohol problems, split by gender (2006-2020)

Drug and alcohol use	Male (%)	Female (%)
Problematic drug use	19.3	8.6
Problematic alcohol use	25.0	22.6

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



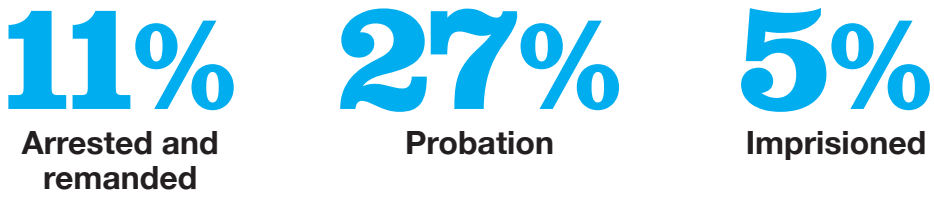
21.
Reporting of crime and violence

When looking at perpetrators of violent crime and offending, around 9% 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 (Figure 17). There are few women in the database with a longer-term history of violent offending, but nearly 20% had committed violent offences against partners etc. 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, 11% of Bolton suicides had a recorded history of being arrested and remanded or bailed in their lifetime; 27% had served probation within their lifetime, 5% 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 (31%), none over the last three years had had experience with Youth Offending Services.

Figure 17: History of violent offending split by 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[24]. 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 diagnosis**

A similar proportion of male and female suicides are associated with problematic alcohol use.

Key differences by gender are as follows.

Breakdown of relationship and redundancy / job loss is 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.

Evidence states that 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

23.
Serious untoward incidents

Over the audit period there was greater use (or greater sharing) of Significant Event Audit (SEA) / Serious Untoward Incident Review (SUI) information 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 (2020).

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.

Suicides can be complex, with wide and varied risk factors.

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 / action plan based on the findings of the codesign workshop, aligned to the population mental wellbeing and suicide prevention programme
- Disseminate the strategy / action plan and ways in which wider stakeholders can get involved in preventing suicides
- Monitor and evaluate key actions
- Undertake an annual suicide audit for 2021/22, including a refresh of the strategy / action plan

Population Mental Wellbeing
and Suicide Prevention Partnership

Bolton Council