



**Suicide and self-harm in Britain
-researching risk and resilience**

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Suicide and self-harm in Britain

researching risk and resilience using UK surveys

Main report

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McManus S, Lubian K, Bennett C, Turley C, Porter L, Gill V, with Gunnell D, Weich S.
(2019) *Suicide and self-harm in Britain: researching risk and resilience using UK surveys*. NatCen: London.

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This report is independent research funded by the National Institute for Health Research Policy Research Programme ('Risk and resilience: Self-harm and suicide ideation, attempts and completion among high risk groups and the population as a whole', 023/0167). The views expressed in this publication are those of the authors and not necessarily those of the National Institute for Health Research or the Department of Health and Social Care.



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Contents

| | |
|---|----|
| Executive summary | 5 |
| Acknowledgments | 13 |
| 1 Aims..... | 14 |
| 2 Background | 16 |
| 3 Methods | 20 |
| 4 Key findings: Trends in self-harm 2000-2014 | 27 |
| 5 Key findings: Risk factors | 30 |
| 5.1 Mental illness and wellbeing | 30 |
| 5.2 Physical health and health behaviours | 31 |
| 5.3 Relationships | 32 |
| 5.4 Acute and chronic stressors | 32 |
| 5.5 Economic adversity and insecurity | 33 |
| 5.6 Demographics and identity | 34 |
| 5.7 Formal service contact | 35 |
| 5.8 Further information | 35 |
| 6 Consultation: Context for midlife men | 37 |
| 7 Consultation: Support..... | 51 |
| 7.1 Introduction..... | 51 |
| 7.2 Mapping support received | 51 |
| 7.3 Facilitators to accessing support | 58 |
| 7.4 Barriers to accessing support | 59 |
| 8 Key findings, recommendations and next steps..... | 64 |
| 8.1 Summary of key findings from the survey analysis | 64 |
| 8.2 Context provided by the participant consultation | 65 |
| 8.3 Recommendations from the participant consultation | 66 |
| 8.4 Limitations, considerations and next steps | 67 |

See the separate Technical Appendices for detailed methods and analysis, tables of results, and full recommendations.

Figures

| | | |
|------------|--|----|
| Figure 3:1 | Timeline of datasets included in the Strands 1 and 2 analyses | 21 |
| Figure 4:1 | Ever self-harmed (without intent) among 16 to 74 year olds by age and sex, 2014..... | 27 |
| Figure 4:2 | Ever self-harmed (without intent) among 16 to 24 year olds by sex, 2000, 2007, 2014..... | 28 |



Executive summary

Background

Since the early 1990s national UK surveys have sensitively collected information from large, probability samples of the general population about experiences of non-suicidal self-harm¹, suicidal ideation, and suicide attempts. These surveys are available to researchers for further analyses, and the opportunity to link the responses of survey participants to their subsequent mortality outcomes and other routinely collected data has been developing.

Study aims

In this study we support further suicide prevention research by identifying resources and developing methods. We have revisited a range of datasets, linked survey participants to mortality outcomes, and analysed data to identify common themes from across the surveys. We have worked alongside people with lived experience to find out whether results resonated with them, and what they saw as the implications for policy and practice. The aim has been to elicit methodological and substantive insight, within a framework of consultation.

Our research questions were:

- What survey datasets are available that provide insight into who self-harms, has suicidal thoughts or makes a suicide attempt in the UK?
- Across these datasets, what common factors predict non-suicidal self-harm, suicidal thoughts, suicide attempts, or suicide?
- How do statistical findings produced in analyses like these resonate with the lived experience of people affected by suicidal distress? What implications do they see arising from the statistics?

The primary objective was to draw out, from multiple sources, consistent patterns in trends, prevalence, subgroup variation and risk. Given that poor mental health has long been established one of the strongest risk factors for self-harm and suicide we situated this study in a mental health research context.

Methods

The study consisted of three linked strands of work.

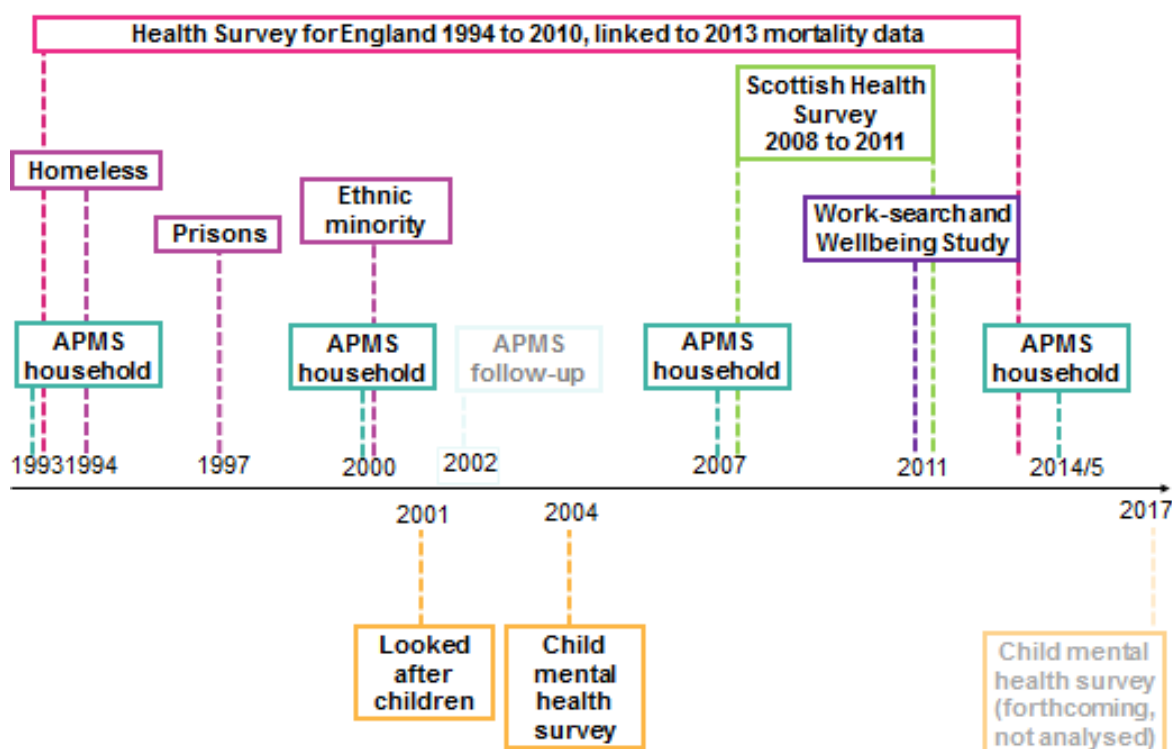
Strand 1 involved identifying and reviewing the content and scope of cross-sectional, national surveys from the past two decades that have asked people about suicidal thoughts, attempts and non-suicidal self-harm. The datasets were analysed using descriptive analyses, multiple logistic regression modelling, and latent class analysis to a) produce trends in the nature and extent of non-suicidal self-harm between 2000 and 2014/5, and b) to identify common factors that predict suicidal thoughts, attempts and non-suicidal self-harm.

Strand 2 consisted of pooling waves of Health Survey for England (HSE) data from 1994 to 2010. Only waves including the General Health Questionnaire (GHQ-12) were retained, to ensure all cases had data on mental health. The combined sample was linked to participants' mortality outcome (that is: whether they were alive in 2013 and whether they had taken their own life) where participants had consented to data

¹ In general, in this report the term 'self-harm' is used to refer to behaviours reported by participants in response to questions on 'non-suicidal self-harm'. Intentionality, of course, is complex and may not always be clear to participants.

linkage at the time of interview. Multiple regression analyses were undertaken to identify longitudinal predictors of subsequent suicide.

Figure 1.1 Timeline of datasets included in the Strands 1 and 2 analyses



Strand 3 involved depth interviews with twenty people carried out in a location of their choice, facilitated by experienced qualitative researchers. Participants in the consultation were midlife men who had experienced self-harm or suicidal crisis, family members bereaved by male suicide, or professionals working to support men in crisis. Topic guides were developed and interviews began with discussion of the Strand 1 statistical findings. Interviews were audio-recorded (with participants' permission), transcribed verbatim and managed using the Framework approach for thematic analysis.

Public involvement in the research

Central to this study was this involvement of people with lived experience. They have informed how the statistical findings have been prioritised, presented and interpreted and they have led on formulating policy implications. The study also involved working with third sector and survivor-led organisations, to guide the findings towards addressing the information needs of those sectors. A complete list of participants recommendations is provided in the separate Technical Appendices.

Equality and diversity

We started with a health inequalities framework² and a focus on the social determinants of health, including mental health.³ An aim of the research was to identify subgroups in the population at elevated risk of suicidal thoughts, attempts and non-suicidal self-harm. The statistical analysis involved examining variation

² The Marmot Review. (2010) *Fair Society: Healthy Lives*. UCL Institute of Health Equity.

<http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review>

³ World Health Organization and Calouste Gulbenkian Foundation. (2014) *Social determinants of mental health*. Geneva, World Health Organization. <http://www.instituteofhealthequity.org/projects/social-determinants-of-mental-health>

by sex, ethnicity, age, sexual identity, relationship status, health status, disability, and subgroups characterised by economic disadvantage and poverty. In addition to protected characteristics, groups exposed to particular types of adversity were also addressed. The Strand 3 consultation work focused on some of the groups highlighted as experiencing particular disadvantage. To ensure sufficient numbers to address issues in a meaningful way, we focused the consultation on those who were male and in midlife, and ensured inclusion of men with a non-heterosexual identity. This was done in part to address policy need to understand these under-researched, high-risk groups.

Results: Trends in self-harm, 2000-2014

Analyses of three waves of the Adult Psychiatric Morbidity Survey (APMS) show that people have become more likely to report non-suicidal self-harm. The proportion of the population aged 16 to 74 reporting this increased from 2.4% in 2000 and 3.8% in 2007, to 6.4% in 2014. The increase was evident in both men and women and across age groups. An upward trend since 2000 is also evident in suicidal thoughts. These results are striking, but consistent with research based on people in contact with services indicating an increase in self-harming behaviours in England since 2000.⁴

Results: Risk and context

Analyses of the surveys and mortality linked data, spanning more than 230,000 people, identified features common in many of the lives of people affected by suicidal thoughts and self-harm behaviours. Because most of the surveys analysed were cross-sectional, conclusions are drawn about associations and context, but not causality.



Mental health was confirmed as one of the most pervasive contextual factors for suicidal thoughts, suicide attempt and nonsuicidal self-harm. This held true for the population as a whole and for specific subgroups. Both depression and anxiety disorders each had an independent association. The more severe the symptoms of mental illness, the stronger the association was with suicidal thoughts and self-harm

⁴ For example, Geulayov G, Kapur N, Turnbull P, Clements C, Waters K, Ness J, Townsend E, Hawton K. Epidemiology and trends in non-fatal self-harm in three centres in England, 2002–2012: findings from the Multicentre Study of Self-harm in England. *BMJ Open*. 2016; 6(4).

behaviour. Deterioration in mental health over time and low levels of mental wellbeing were also both isolated as independent risk factors. This association was expected, especially given that suicidal thoughts can be a feature of depressive disorders.

A range of other factors, spanning many aspects of people's lives, emerged in the survey analyses:

Physical health and health behaviours including both self-perceptions of poor general health and having specific, diagnosed conditions. Physical illness was especially key if it was felt to limit ability to work or to participate socially, or where it meant someone experienced pain. Those with problematic patterns of alcohol use or smoking were also identified as higher risk groups for suicidal thoughts, attempts and self-harm.

Relationships emerged as important, both in relation to social network size (living alone, or not having a partner or children in the household), and in terms of quality of social relationships (for example, lacking closeness to others or being subject to violence or abuse).

Stressful events or trauma across the life course, such as a bereavement, divorce, police contact, and financial crisis⁵ were all linked to self-harm outcomes. Rather than any one of these being prominent, it was the accumulation of multiple stressors that presented the greatest risk.

Employment and financial insecurity were associated with self-harm, with debt emerging more consistently as a predictor than low income, although both mattered. Living in rented accommodation was also a significant risk factor. Employment context was relevant both in terms of job insecurity and loss, and also in terms of job quality. Chronic precarity as well as sudden economic shocks were significant.

Identity and demographics - associations with age and sex varied by outcome measures. While the analyses of mortality-linked survey data confirmed that suicide is most common in midlife men, nonsuicidal self-harm rates peaked in young women. Identifying with a non-heterosexual identity was strongly associated with both nonsuicidal self-harm and suicidal thoughts and attempts.

The statistical analyses demonstrated that:

- **Many different factors** have independent associations with suicidal thoughts and self-harm
- **There is a dose relationship** (with more exposure to a factor often linked with increased risk)
- **Risks are cumulative** (exposure to multiple factors was linked with increased risk).

The survey data was limited for developing deeper understanding of the particular experiences of midlife men, the demographic most likely to take their own life. The facilitated consultation therefore focused on the needs of this group.

Consultation: context and support

Midlife men with lived experience of suicidal distress, family members bereaved by male suicide, and professionals working in the field responded to the statistical results. They talked about whether these resonated with their experiences, and made recommendations for responding to suicidal distress in midlife men in terms of: (1) recognising need, (2) facilitating access, and (3) adjusting delivery.

(1) Recognising need: who is 'ill enough'?

Permission: People were keenly aware that public resources are limited and required to meet competing demands. Some felt that their own needs were less deserving of support and services than others. The

⁵ Defined on the surveys as the equivalent of the sudden loss of three or more months' income.

men we spoke to realized that, especially early in their journeys, they had lacked insight into the fact that they were not well and needed help. They articulated a need for people, but especially men, to be informed that they are *entitled* to help, even where they manage to present the outward appearances of coping.

Appearances: Sometimes a doctor, an employer, a friend or family member assumed a man who was 'functioning', working, dressed presentably, and able to joke could not be suicidal. The people we spoke to stressed: don't assume from by appearances, it is necessary to ask.

Persistence: There was also talk about the need to be persuaded to accept support. Men described how they had avoided and deflected initial approaches, or ignored and pushed other people away. Some told us they wished friends and colleagues had persisted with them – called or even just texted support – and not settled for their initial response of 'everything's fine'.

(2) Facilitating access: the right words, time and place

What is available: Two levels of essential support were highlighted by the people we spoke with: to manage chronic, ongoing stress, and to address acute tipping points and crises. Many people had little idea what support was available, some had looked for support and couldn't find any. Calls for better signposting and clear sources of information are a familiar mantra, but the issues remain. In particular it was stressed that information needs to be in the places where men feel comfortable.

Finding the words: After realising that they needed help and finding help that was available: some men said that they lacked the words to ask for it, especially when they were low. They wanted to know: what do I say to my employer, or to a debt collect service? How do I explain to the GP what I am feeling? They suggested testimonials from others would help, with examples of specific ways to ask for help. Some stressed the need to develop insight and resilience from an early age.

Allowing time: Another theme to emerge was allowing more time. Short counselling sessions were described as inadequate, and struggles with employers who expected recovery to be swift were clear. Men described feeling rushed to come off medications before they were ready or were discharged from services they still felt a need for. Debt collection letters were described as threatening. Part of our wider awareness around men, mental health and suicide needs to include messaging that acknowledges that these processes can take time.

(3) Adjusting delivery: equal engagement

Power: Some of the men interviewed described a power dynamic in health service interactions which they found uncomfortable. It was felt to be hierarchical, assumed knowledge about what 'was best', and was disempowering. Men said it took a lot to reach out for help. One negative or seemingly dismissive contact could have long-lasting impact. It put some off returning or seeking help again. It was clear that every contact counted, and that negative contacts could, inadvertently, count the most.

Varied forms: In facilitated peer-support groups some men found a model that provided them with training in how to talk and find connections with others who shared similar experiences. Safe spaces for men may be different from what women need. What felt safe varied: some men expressed a preference for the support of women and others felt more comfortable with peer support alongside other men with similar experiences to them. Gay and bisexual men in particular highlighted how A&E could feel threatening.

Space: Across the interviews with men with lived experience of suicidal distress, with bereaved family members, and with professionals working in the field there were calls for longer-term respite. The Maytree Centre, a charity providing residential sanctuary for people in suicidal crisis in a non-medical setting, is

such a service. Secure spaces were called for - physical, emotional and temporal - and were described as hard to find.

Recommendations for survey research

In addition to the substantive recommendations made by people with lived experience, this study also reviewed the scope of existing survey data and identified gaps and issues.

Ask everyone: **Surveys of the mental health of prisoners, the homeless population, minority ethnic and migrant groups, and looked after children are needed.** The UK has a rich tradition of health and social survey data collection, with high quality studies conducted using comparable methods since the 1990s. However, this review found that many surveys of specific populations have never been replicated, despite great change in their prevalence and composition. Routinely collected data provide some types of insight, especially for comparing regions, but do not tell us about undiagnosed symptoms, treatment gaps, and individual circumstances. We need to ask people directly about subjective experiences, and in sufficient numbers to monitor subgroup trends.

Ask the right questions: **Survey questions need regular review** There can be a trade-off between maintaining comparability over time and ensuring questions are meaningful in the current context. For example, the 2017 Mental Health of Children and Young People Survey asked about suicide attempts and self-harm using a single combined question, as this was how it was asked on the 2004 survey. Too often, follow-up questions are not asked of participants reporting self-harm. These are needed to provide context and meaning. For example, while the Millennium Cohort Study asked participants 'have you hurt yourself on purpose in any way?', without further questions to understand the nature of what was being reported.

Cover the right topics: **Wider engagement from practitioners, policy makers and people with lived experience** should continue to be promoted with representation on advisory groups and consultations like those run by NHS Digital and other research commissioners and contractors. Facilitated, qualitative consultation including at least some numeration - like that which informed this study - should also be resourced and undertaken to inform the interpretation and presentation of statistical analyses.

Longitudinal and cross-sectional: **Both types needed** Longitudinal data and analyses are needed to investigate the long-term consequences of non-suicidal self-harm and suicide attempts. Following up sample from cross-sectional surveys would provide an invaluable resource. The inclusion of a self-harm question in the Millennium Cohort Study is positive, and provides a baseline for later research. However, longitudinal surveys should not be used to estimate prevalence and trends over time, these require repeat cross-sections of the population.

Make data accessible: **The latest child and adult mental health survey datasets are important resources that need to be accessible to researchers.** For forty years, the UK Data Service has been an expertly curated central repository for health and social survey data covering all UK countries, with data freely available to research institutes for immediate download.⁶ Since 2016 permission from the NHS Digital Data Access Request Service (DARS) has been required before some health survey datasets could be accessed. It is crucial that this permission for data use be granted in a timely manner to all appropriate researchers and institutions working for the public good and pace of data access should be monitored. Samples from APMS 2000, 2007 and 2014 can be pooled, enabling trends to be updated and smaller subgroups and specific types of suicidal thoughts or behaviours to be examined. Initial APMS 2014

⁶ Since 1967, the UK Data Service has provided unified access to the UK's most comprehensive collection of social, economic and population data. Funded by the ESRC, they are the experts in survey curation and streamline archiving of regional, national and international survey. It is a significant part of the UK data infrastructure and designated a Place of Deposit by the National Archives.

reporting has identified a recent, steep upturn in the proportion of young women self-harming. This urgently warrants further investigation.

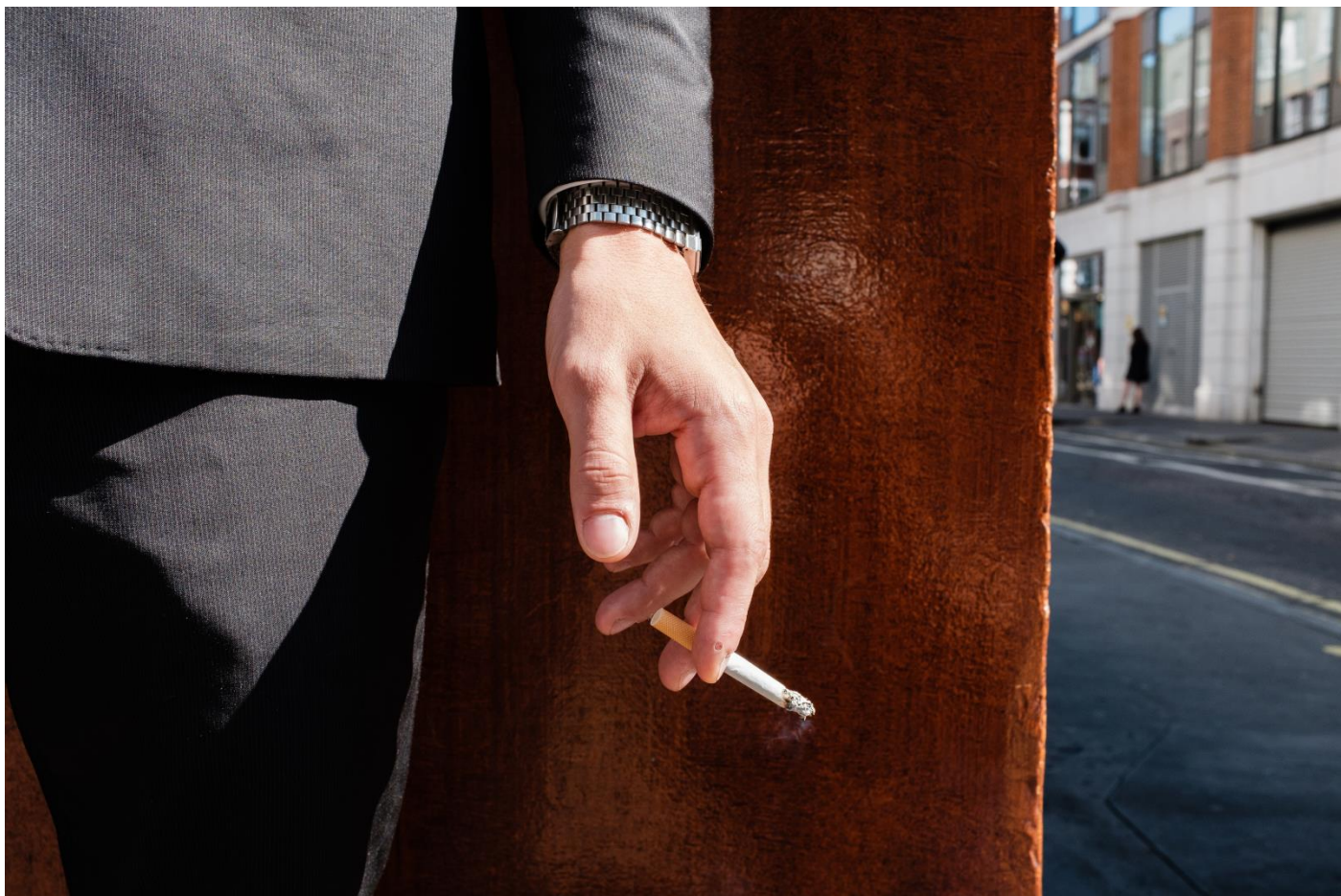
Facilitate linkage: The value of linked survey data is increasingly being realised but will remain underdeveloped in England (compared to, for example, Scotland) unless permission processes are streamlined. The linkage of survey and mortality data undertaken for this study took two years to get approval, this is not uncommon. Informed permission for data collection can be routinely requested from all survey participants, and it is important that such permissions are respected. It could be argued that not using data that people have provided specifically for research purposes is in itself unethical.

Triangulate: Many questions can be better examined using data from service and administrative sources, in isolation or when linked with survey data, including addressing the urgent need to better understanding local area and regional variations. Qualitative and other forms of research are needed to better understand meanings and intentions.

Descriptive and complex: Use the right analyses Patterns of population change and inequality can be clearly communicated with simple descriptive analyses, and these have their place. This study also highlighted the scope there is for much more innovative analytic methods. For example, for greater use of latent class analyses to profile populations patterns in new ways or for studies that examine links with biological and genetic data. Computational advances further facilitate working with ever larger datasets.

Address gender: The experience of self-harm and suicidal crisis, in terms of prevalence, trends, nature and context, is gendered. We recommend that research funders and commissioners require gender to be considered in all mental health research from the start, including ensuring that there is investigation into gendered risk factors (such as violence and abuse), that analyses are stratified by gender, and that evidence is generated on gender sensitive treatment and care.⁷

⁷ See Howard L, Ehrlich A, Gamlen F, Oram S. Gender neutral mental health research is sex and gender biased. *The Lancet*. 2017 4:1;9-11. [https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366\(16\)30209-7/abstract?code=lancet-site](https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(16)30209-7/abstract?code=lancet-site)



Acknowledgments

First and foremost, we thank the men and women with experience of suicidal thoughts or self-harm or who have been bereaved by suicide who contributed as part of this study. They are not named, but their words are here. They gave generously of their time and insight. We also interviewed people actively working in this field, and their views are also part of this study.

Our advisory group gave of their extensive expertise and several members provided invaluable assistance with participant recruitment. We are indebted to Natalie Howarth from Maytree, Martin Todd and Peter Baker from the Men's Health Forum; Dr John Larsen from Rethink; Elizabeth Scowcroft and Hazel Nunn from the Samaritans; Andy Bell from the Centre for Mental Health; and Leila Woodhouse from Mind.

We thank the hundreds of thousands of people from across the UK who have taken part in surveys over the years. Without people giving their time and personal information in this way, Britain would not have the strong social science resource that it does.

We are very grateful to the programme managers at the National Institute of Health Research, particularly Olena Myronova, Olena Vinareva and Cassie Zwier, who have been patient, pragmatic and understanding despite significant project delays. Alison Tingle and Helen Steele at the Department of Health and Social Care, brought policy relevance and overarching programme co-ordination. Without the support of NHS Digital, the Health Survey for England mortality data linkage and the analysis of the 2014 Adult Psychiatric Morbidity Survey would not ultimately have been possible. This study drew on advice and/or publications from established academics in the field, including Louis Appleby, Louise Howard, Keith Hawton, Nav Kapur, Rory O'Connor, and others. David Gunnell and Scott Weich provided particular advice during the project.

This study was carried out by a team of qualitative and quantitative researchers based at the National Centre for Social Research, several of whom have since moved on (including several core team members: Claire Bennett, Lauren Porter and Valdeep Gill, the last of whom came up with the original idea for this study). We were further assisted by Gemma Lewis, Stephen Sharman, Tanya Crowther and Jane Kerr, who helped with aspects of analysis, drafting, and charting transcripts. Many of the researchers running Britain's national survey programmes provided invaluable advice. We would particularly like to thank Rachel Craig (former Director of the Health Survey for England) and Lisa Rutherford (former Director of the Scottish Health Survey). Cathy Coshall undertook the extensive task of combining sample from two decades of the Health Survey for England and linking this to mortality outcome data.

*Sally McManus, Klaudia Lubian, Claire Bennett, Caroline Turley, Lauren Porter, Valdeep Gill
with David Gunnell and Scott Weich*

1 Aims

1.1 Overall study aims

Since the early 1990s several national surveys have sensitively collected information from random samples of the population about their experience of non-suicidal self-harm, suicidal thoughts, and suicide attempts. This study brings together these existing data sources, and re-analyses them using consistent statistical methods. A main aim has been to consolidate national self-harm and suicidal behavior survey data in terms of common findings on trends, prevalence, subgroup variations, and risk and protective factors.

Central to this study has been the involvement of men with lived experience of self-harm or suicidal crisis, and people who have been bereaved. They have shaped how the statistical findings are discussed, situated them in the context of their own experiences, and led on formulating practical implications. This study has also involved working with third sector and survivor-led organisations, to ensure that the analyses address their information needs.

Throughout, our aims within each strand of work have been twofold: firstly, to highlight data availability and develop methodological approaches, and secondly to consolidate the substantive evidence base and place it in the context of lived experience.

1.2 Strand 1 aims: survey review and analysis

The first strand of work sought to:

- **Review:** Identify the range of national, cross-sectional, probability sample UK surveys from the last 20 years that have asked adults or children about suicidal thoughts, suicide attempts or non-suicidal self-harm, including both surveys of the general population and surveys of specific subgroups (for example, prisoners, looked after children, or variation by ethnic group).
- **Analyse:** Profile who is at greatest risk of suicidal thoughts, attempts, and non-suicidal self-harm through application of comparable analysis techniques.

Our hypothesis was that some risk factors would be common across the population, while others would be salient for specific subgroups and of most relevance to targeted suicide prevention.

1.3 Strand 2 aims: mortality linked data

The aims behind the analysis of mortality linked survey data were to:

- **Review:** Consider the feasibility and potential applications of this data linkage methodology for suicide epidemiology in an English context.
- **Analyse:** Use regression analyses to identify whether there are early predictors of subsequent suicide that would extend the knowledge base in this area.

Our predictions were that while pooled survey samples linked to mortality outcomes present challenges to interpretation, this approach will be important to develop further as data linkage techniques become increasingly sophisticated. It will be key to ensure that data use permission processes can be streamlined for timely analysis.

1.4 Strand 3 aims: participatory consultation

The reasons for conducting exploratory, depth interviews with midlife men, bereaved family members, and professional stakeholders working with men in the community mental health field were to:

- **Provide context** for the statistical results, helping them to be grounded, meaningful, comprehensive, and to resonate with people's lived experiences.
- **Allow exploration** of people's experiences, understandings and views about how support should be tailored, located and delivered.
- **Work collaboratively** to formulate recommendations grounded in both statistical findings and lived experiences, which can be applied to real world policy and practice.

While we initially proposed interviewing men and women with lived experience, our sampling strategy was responsive to Strand 1 findings and to policy information needs, and so was adapted to focus on midlife men, family members bereaved by midlife men, and professionals involved in support provision for midlife men.

1.5 Report coverage

The report consists of two documents: a separate and extensive set of Technical Appendices, and this main report covering:

- **Chapter 2: Background**, including ethical considerations
- **Chapter 3: Methods** and project structure
- **Chapter 4: Trends** in self-harm in England 2000 to 2014
- **Chapter 5: Risk factors** for suicidal thoughts, suicide attempts, non-suicidal self-harm 1993-2014
- **Chapter 6: Consultation views on context** of suicidal distress in midlife men
- **Chapter 7: Consultation views on support** for men experiencing suicidal crisis
- **Chapter 8: Recommendations** for further research, policy and practice.

The separate, and extensive, **Technical Appendices** consists of further chapters detailing:

- **Public engagement**
- **Equality and diversity issues**
- **Background, methods, analysis, data tables and interpretation for each of the nine surveys**, including results of the latent class analysis and the mortality linked survey data analysis
- **Detailed recommendations** for service improvements suggested by consultation participants listed in full
- **Fieldwork documents** used in the qualitative consultation.

A brief **Summary Report** is also available.

2 Background

2.1 Suicide and self-harm epidemiology and data sources

Suicide is a major public health issue and epidemiological methods have long been used to identify population risk factors.⁸ Many risk factors for suicide are well established. For example, most people who end their own life experience mental illness, with depression usually present and psychosis, personality disorder, or substance dependence often evident.^{9 10} The issue is that while the majority of people who take their own life is mentally ill, a small minority of mentally ill people die by suicide.¹¹

One of the challenges for suicide prevention is identifying those at greatest risk. Previous research has revealed significant risk factors for suicide, such as occupation,¹² incarceration,¹³ and perfectionism.¹⁴ Among the most common risk factors identified is a history of self-harm and previous suicide attempts,^{15 16} present in approximately 40% of completed suicides.¹⁷ Self-harm requiring emergency hospital treatment has been found to be present in about 15% of those who take their own life.¹⁸ There remains debate about the role that suicidal intent in previous attempts plays. While much of the research on self-harm combine suicide attempts with non-suicidal self-harming, this study included datasets that attempted to separate these.^{19 20} However, sample size limitations often prevented examining them separately. While attempts to predict, in a treatment context, which individuals may go on to take their own lives have faced challenges – with even detailed risk classification scales having poor sensitivity and poor specificity²¹ – there is still great value in understanding trends and patterns at the population level, to inform national, regional and local policy and practice, informing prioritisation and targeting. The findings support existing clinical guidance not to use risk classification scales alone to determine treatment or predict future risk.

The stigma attached to suicidal thoughts and self-harming behaviours - and mental illness more generally - often prevents people from telling others how they feel and seeking help. This complicates accessing information on this group, who are often invisible to services.²² The national prevention strategies and their

⁸ Moscicki, EK. (1997) Identification of suicide risk factors using epidemiologic studies. *Psychiatric Clinics of North America*, 20, 499-517.

⁹ McLean J, Maxwell M, Platt S, Harris F, Jepson R. (2008). *Risk and Protective factors for suicide and suicidal behavior: A literature review*. Scottish Government Social Research.

¹⁰ The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. (2017) Annual Report: England, Northern Ireland, Scotland and Wales. University of Manchester.

¹¹ Kaminer DB. (2012) Can suicide be prevented? *BMJ* 345:e7557.

¹² Roberts SE, Jaremin B, Lloyd, K. (2013) High-risk occupations for suicide. *Psychological medicine*, 43(06), 1231-1240.

¹³ Hawton K, Linsell L, Adeniji T, Sariaslan A, Fazel S. (2014) Self-harm in prisons in England and Wales: an epidemiological study of prevalence, risk factors, clustering, and subsequent suicide. *The Lancet*, 383(9923), 1147-1154.

¹⁴ Flett, GL, Hewitt PL, Heisel MJ. (2014) The destructiveness of perfectionism revisited: Implications for the assessment of suicide risk and the prevention of suicide. *Review of General Psychology*, 18(3), 156.

¹⁵ Andover MS, Morris BW, Wren A, Bruzzese ME. (2012) The co-occurrence of non-suicidal self-injury and attempted suicide among adolescents: distinguishing risk factors and psychosocial correlates. *Child and adolescent psychiatry and mental health*, 6 (11).

¹⁶ Cooper J, Kapur N, Webb R, Lawlor M, Guthrie E, Mackway-Jones K, Appleby L. (2005) Suicide after deliberate self-harm: a 4-year cohort study. *American Journal of Psychiatry*, 162(2), 297-303.

¹⁷ Hawton K, van Heeringen K. (2009) Suicide. *The Lancet*, 373:1372-81

¹⁸ Olfson M, Marcus SC, Bridge JA. (2014) Focusing suicide prevention on periods of high risk. *JAMA*, 311(11), 1107-1108.

¹⁹ Although the validity of these distinctions have been questioned, e.g. Kapur N, Cooper J, O'Connor, RC, Hawton K. (2013) Non-suicidal self-injury v. attempted suicide: new diagnosis or false dichotomy? *The British Journal of Psychiatry*, 202(5), 326-328.

²⁰ Mars, B, Heron, J, Crane, C, Hawton, K, Kidger, J, Lewis, G, et al. Differences in risk factors for self-harm with and without suicidal intent: findings from the ALSPAC cohort. *J Affect Disord* 2014; 168: 407–14.

²¹ Steeg S, Quinlivan L, Nowland R, Carroll R, Casey D, Clements C, Cooper J, Davies L, Knipe D, Ness J, O'Connor RC, Hawton K, Gunnell D, Kapur N (2018) Accuracy of risk scales for predicting repeat self-harm and suicide: a multicentre, population-level cohort study using routine clinical data. *BMC Psychiatry*. 18:113.

²² Geulayov G, Casey D, McDonald KC, Foster P, Pritchard K, Wells C, Clements C, Kapur N, Ness J, Waters L, Hawton K. Incidence of suicide, hospital-presenting non-fatal self-harm, and community-occurring non-fatal self-harm in adolescents in England (the iceberg model of self-harm): a retrospective study *The Lancet Psychiatry*, 2017, 5, (2), 167-174.

updates highlight the role research plays in identifying at risk groups and informing targeted support.²³ The Strategy focuses on analysis of mortality statistics, coroners' records and self-harm data held by health services as key monitoring sources. The National Suicide Prevention Alliance (NSPA) is implementing a data improvement work-stream as part of its strategic framework, which includes establishing a 'data hub'.

While official statistics on recorded suicide (official suicides and undetermined deaths) provide a profile of people who have taken their own life, unless linked to survey data these tend not to provide systematic detail about their lifetime experiences or precise social demographic circumstances. Psychological autopsy approaches have been developed to address this to some extent. Research with people who have attempted suicide can also provide more in-depth data on this, but excludes people, mostly men, who take their own life on a first attempt. There is, therefore, a need to look at suicidal thoughts as well as attempts.

Furthermore, many people who self-harm (with suicidal intent or not) either do not consult health services or may not be identified as suicidal when they do. Data collected routinely for administrative health datasets, therefore, can provide great insight into the nature of health service contact but only partial coverage of the population who self-harm. General population surveys provide a different picture of the epidemiology of suicidal thoughts, attempts and self-harm from studies including only those identified by health services. Patterns of survey response however do pose limitations: some people who are ill are less likely to take part²⁴ and sample sizes are often relatively small.

Monitoring can be supported by including research with people who have experienced suicidal crisis, whether they sought help from formal services or not. This study was designed with this in mind to demonstrate how statistical results can be interpreted and contextualized by those with lived experience.

2.2 Framework for this research

Making the best use of existing data

The survey samples drawn on here collectively exceed 230,000 people, many linked to details of mortality outcomes, and span over two decades. They provide researchers with an amazingly rich resource. The UK Data Service facilitates the sharing of survey datasets, and many funding organisations - such as the Economic and Social Research Council (ESRC) - actively encourage further secondary analysis of existing, high quality datasets like these.

We see our role, and one objective of this study, being to raise awareness of these existing resources in relation to suicide and self-harm epidemiology; to promote their suitability for addressing a range of questions using evolving methods; and to support and advise researchers who choose to revisit these datasets. As part of this study we have also been looking forward to upcoming opportunities, in relation to new datasets and approaches that will be available soon.

Processing for accessing research data have changed radically, further since the 2018 General Data Protection Regulation (GDPR) legislation came into effect. It is important that these processes are transparent and realistic to ensure that appropriate and responsible research for the public good is not delayed or prevented.

Situating in a whole population context

²³ Preventing suicide in England: Third progress report on the cross-government outcomes strategy to save lives (2017) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/582117/Suicide_report_2016_A.pdf

²⁴ Knudsen AK, Hotopf M, Skogen JC, Øverland S, Mykletun A. (2010) The Health Status of Nonparticipants in a Population-based Health Study: The Hordaland Health Study. *Am. J. Epidemiol.* 172 (11): 1306-1314.

Patients are a key group and the Mental Health Services Dataset is a key resource for many working in this field.²⁵ However, since local authorities and local communities took on much of the cross sector co-ordination of suicide prevention measures, it is more important than ever before that research draws on the whole general population, situated in families, households and local communities. *Healthy Lives, Healthy People: Our strategy for public health in England*²⁶ (2010) gave an enhanced role to local government and local partnerships. Using general population datasets provides an evidence base for councillors, local authorities, health and wellbeing boards, local organisations and Public Health England for demonstrating how suicide prevention reaches far beyond patients, health services and treatment.

This study provides context and benchmarking for other suicide prevention research by enabling:

- People in contact with primary care, secondary care or community psychiatric services to be compared with those who are not
- People who have experienced suicidal crisis to be compared with those who have not
- People who self-harm and have thought about or attempted suicide to be compared with people who self-harm and have not
- People belonging to particular groups to be compared with the rest of the population
- People with particular adverse experiences to be compared with the rest of the population.

Risk and protective factors as complex, interrelated and situated in context

The Strategy highlights suicide as the end point of a complex history of risk factors and distressing events. It states that for many people it is the combination of factors that is important. The general population datasets we draw on do not focus on single risk factors in isolation, but allow for the role of cumulative exposure and the interrelation of different kinds of factors to be examined, including positive models of social support and participation and negative experience of discrimination, harassment and bullying. The participant consultation was key to this, with a major focus of this work being on people's perceptions of how the different aspects of their lives interact and link with their suicidal thoughts and behaviours.

Finally, recession and austerity may have contributed to an end in the long term decline in the suicide rate. It is more important now than ever before that research incorporates good and multiple socioeconomic indicators. As well as income, employment status, occupation, and tenure, data on problem debt, housing conditions, job insecurity, and workplace demands are available on general population surveys, with particular salience to tailoring support at men. Collecting information on intra-household access to resources is also needed, alongside other gendered risk factors such as exposure to violence and abuse.

2.3 Ethical considerations and data disclosure risks

Ethical approval was successfully sought from NatCen's Research Ethics Committee (REC) which complies with the requirements of the ESRC²⁷ and Government Social Research Unit Research Ethics Frameworks.²⁸

Strands 1 and 2 involved secondary analysis of existing datasets, and because this analysis involved sensitive and low prevalence behaviours, it presented a theoretical risk of participant confidential data disclosure to be managed. Archived datasets were used for all the analyses except for that which involved linkage to mortality data. Archived datasets have personal identifiable information removed and a condition of data access is agreement that no attempt is made to identify individuals through reviewing data in combination. All datasets analysed were stored on NatCen's secure networks and not on personal laptops

²⁵ <http://content.digital.nhs.uk/mhsds>

²⁶ <https://www.gov.uk/government/publications/healthy-lives-healthy-people-our-strategy-for-public-health-in-england>

²⁷ <http://www.esrc.ac.uk/funding/guidance-for-applicants/research-ethics/>

²⁸ http://www.civilservice.gov.uk/wp-content/uploads/2011/09/ethics_guidance_tcm6-5782.pdf

or directories. NatCen has a Data Release Panel that advises on data analysis plans to avoid risk of data disclosure. NatCen is registered under the Data Protection Act 1998 and fully accredited to ISO 27001 (Information Security). The linkage of survey data to mortality outcomes was reviewed by NHS Digital (then the Health and Social Care Information Centre, HSCIC). NatCen's procedures in this area are closely monitored by NHS Digital. In March 2018, the Data Access Request Service (DARS) team at NHSD granted formal approval for the research team to analyse APMS 2014.

Given the Strand 3 focus on interviewing people with experience of self-harm and suicide attempts, our methods of recruitment, communication, interview conduct, ongoing contact and information storage and presentation had to be conducted to the very highest standards and at every stage prioritized the needs of our participants.²⁹ We recruited only through service user organisations to ensure participants had ready access to support if needed following the interview, and made clear that taking part was voluntary. Our consideration of ethical issues in relation to the participant consultation is detailed in Section 3.3.2 and also in the Technical Appendices.



²⁹ Set by the British Psychological Society (2007).

3 Methods

3.1 Strand 1 methods: survey review and analysis

Analysis of national general population survey data can be used to profile prevalence, patterns, and associations with non-suicidal self-harm, suicide ideation and suicide attempts in the population as a whole and in specific subgroups, at different points in time. We reviewed government-funded surveys using probability sampling and high quality data collection, which collected information, usually via self-completion, about non-suicidal self-harm, suicide ideation and suicide attempts.

Survey review

General population samples include people without contact with health and social services, and enable people with and without experience of suicidal crisis to be compared. Questions administered sensitively by self-completion mean some people report experiences they have never told anyone - service provider or friend: people invisible to other forms of research.

This study drew on large, national, survey series from the past two decades which collected data on suicidal thoughts, attempts and/or non-suicidal self-harm alongside contextual factors. We searched the catalogues held by the UK Data Service and spoke widely to researchers working in the field to identify whether we had missed survey datasets suitable for inclusion. Our inclusion criteria were that the surveys were:

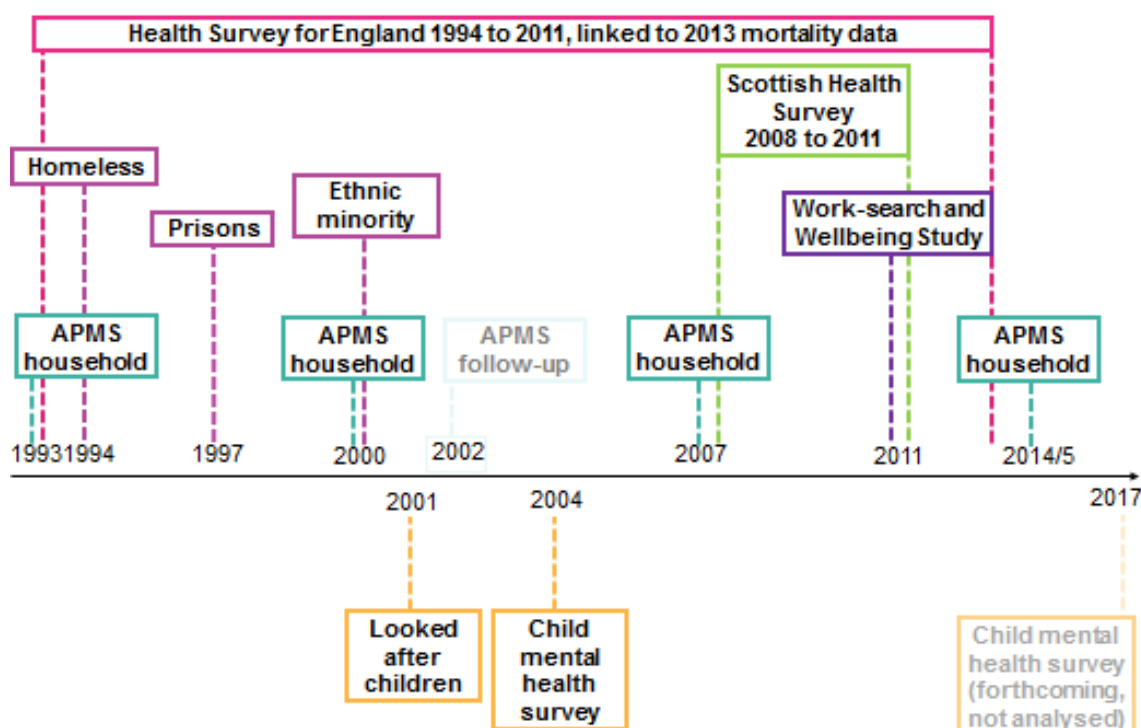
- National in scope (either covering Britain or England, Scotland, or Wales)
- Used high quality probability sampling
- Cross-sectional (and therefore suitable for prevalence estimates and generating trends over time)
- Conducted since 1993
- Included questions on at least one of: self-harm, suicidal thoughts, suicide attempts
- Included questions on social, economic and health factors
- Available to researchers through the UK Data Service archive.

The following datasets were accessed:

- **Adult Psychiatric Morbidity Survey (APMS)** 1993, 2000, 2007, 2014
- **Scottish Health Survey (SHeS)** 2008-2011
- **Ethnic Minority Psychiatric Morbidity Illness Rates in the Community (EMPIRIC)** 2000
- **National Study of Work-search and Wellbeing (NSWW)** 2011
- **Adult Psychiatric Morbidity Among Prisoners in England and Wales (Prisons)** 1997
- **Survey of Psychiatric Morbidity among Homeless People (Homeless)** 1994
- **Mental Health of Children and Young People (CMHS)** 2004
- **Mental Health of Looked After Young People (LACS)** 2001-2003
- **Health Survey for England (HSE)** 1994-2011 linked to data on cause of death.

Permission to analyse **APMS 2014** was granted in March 2018, and that dataset was added to the report at the end. The strengths and limitations of each of these surveys are discussed in detail the separate Technical Appendices. The Northern Ireland Young Life and Times survey was considered but ultimately not included, to avoid duplication of other work underway.

Figure 3:1 Timeline of datasets included in the Strands 1 and 2 analyses



Stages of analysis

Analyses were weighted and controlled for complex survey design. The analysis plan varied between datasets, according to data and sample availability. Key to Strand 1 was keeping methods broadly consistent, aiding read-across between studies. Each dataset analysed included at least some (but not all) of the following stages:

- Accessed, managed, and familiarised with datasets in SPSS, identified appropriate weighting variables to use, re-derived variables as appropriate depending on sample size and comparability.³⁰ All analyses were run on weighted data and adjusted for complex survey design where possible.³¹
- Latent class analysis (LCA), using Latent GOLD,³² was undertaken on the APMS dataset to identify how different types of non-suicidal self-harm, and different types of suicidal thoughts and suicide attempts might co-occur in the population as a whole. Population typologies of non-suicidal self-harm and suicide behaviour were derived. (Although the best fit solutions were ultimately not felt to be informative. Therefore, the subsequent regression analyses used the existing self-harm, suicidal thoughts and suicide attempt variables.)
- Ran weighted frequencies for the self-harm and suicide typology and for past week, past year and lifetime prevalence of self-harm, and suicidal thoughts and attempts for population as a whole, and for each population subgroup supported by the data.
- Ran weighted cross-tabulations of outcome variables (non-suicidal self-harm and suicidal thoughts

³⁰ IBM Corp. (2012) *IBM SPSS Statistics for Windows, Version 21.0*. Armonk, NY: IBM Corp.

³¹ Some of the earlier datasets did not contain variables that allowed for stratification and clustering to be controlled for.

³² Statistical Innovations. (2013) *Latent GOLD Version 5.1*. Belmont, MA.

and attempts) by risk and protective factors to produce a profile of people with a history of each in the past year (for the most appropriate time frame, depending on the given dataset).

- Generated unadjusted odds and tested significance of association with self-harm and suicide outcomes with risk and protective factors using multiple logistic regression analysis in SPSS (v21) or Stata (v12 and v14).³³
- Multiple logistic regression analyses were produced, with self-harm and suicide behaviour as outcome measures, identifying predictors that remained significant when other factors are controlled for.
- Where appropriate, regression modelling testing for interactions between factors and subgroups to identify factors associated with further elevated or reduced risk in particular subgroups. Where sample was sufficient (for example in the analysis by ethnic group using the EMPIRIC dataset), regression modelling was undertaken within each subgroup sample.
- Multiple logistic regression was also undertaken to identify factors that predict: self-harm with suicide attempts; self-harm without suicide attempts; and suicide attempts without self-harm.

3.2 Strand 2 methods: mortality linked analysis

All the Health Survey for England (HSE) datasets from 1994 to 2011 were accessed and their content reviewed. Comparable variables for a wide range of candidate predictors were located in each dataset. These included a wide range of social, economic, health, and demographic factors collected as part of the core interview (and therefore available for every wave). Content of rotating modules was left out as was not available for all waves. Variables were renamed to be consistent across the combined dataset and recoded to ensure comparable categories where possible (as categories sometimes changed across years, for example to fit with changes resulting from revisions by ONS to their recommended harmonized survey questions).³⁴

Consent to link the information collected during the survey interview with health records was asked of HSE participants at the end of their initial interview (before the nurse visit). Permission was requested specifically for linkage to Hospital Episode Statistics (HES), cancer diagnoses and mortality data. Profiling was undertaken to compare those providing permission for data linkage with those who did not to check for biases. Reassuringly, the profiles of the two groups were very similar. Those participants who did not provide consent for data linkage were removed from the combined dataset for these analyses.

Access to the mortality data required for this project was requested by the research team, who submitted a data request form first to NatCen's Data Release Panel. Once approved, liaison took place with NHS Digital (formerly Health and Social Care Information Centre, HSCIC), including the submission of a formal application to their data disclosure review commission. Due to a major moratorium on processing data linkage applications, this strand of the project was delayed by approximately 18 months. Approval was eventually granted to link survey responses from HSE participants to mortality records.

For each survey year of HSE, the identifying information for those who consented to linkage was securely transferred to NHS Digital. The mortality data for these participants were flagged and extracted, and securely returned to NatCen. The data included date of death, age at death and detailed main cause of death. Cause of death was grouped into a derived variable to reduce the risk of disclosure. The resulting

³³ Stata Corp. (2011) *Stata Statistical Software: Release 12*. College Station, TX: StataCorp LP.

³⁴ ONS (2011) *Harmonised Concepts and Questions for Social Data Sources Introduction to Harmonised Standards Version 4*.

dataset was prepared and managed by a NatCen Data Manager and the required subset of HSE variables were matched onto the mortality data. Linked data was accessed in NatCen's data enclave, which provides secure storage and access to highly confidential data.

We are very grateful to NHS Digital for persisting with and facilitating the whole approval and linkage process, which took in excess of two years. A range of different analytical approaches were considered and these are detailed in the Technical Appendices.

3.3 Strand 3 methods: participatory consultation

3.3.1 Qualitative participatory methods: depth interviews

The third strand of the study was not designed to be qualitative research, but rather to use qualitative methods to facilitate the involvement of people with lived experience to inform the interpretation of the statistics and to develop recommendations drawing on their insight and expertise.

Depth interviews were conducted with people selected to reflect some of the risk factors that emerged in the Strand 1 analysis. The Strand 2 analysis was also supposed to have informed the sampling design, but due to delays with permission for the mortality linkage, this strand of work was delayed.

We initially proposed involving both men and women with lived experience of suicidal thoughts, suicide attempts or self-harm, but in response to the profile of registered suicides, in recognition of gaps in the existing research, and to meet expressed policy needs at the Department of Health and Social Care, we adapted our sample design to focus on men in midlife.³⁵ We were especially concerned that survey data may underestimate suicidal thoughts and attempts in this group, relative to women and younger people.

Depth interviews (rather than, for example, focus groups) were used for this sensitive topic as it allowed for one-to-one discussions, whereby participants' individual narratives about their views and experiences of suicide risks and support services could be discussed in a private and confidential setting. Furthermore, participants had greater control within depth interviews to cover topics of particular resonance to their unique and often complex lived experiences. Researchers also benefited from hearing the language participants used to describe suicidal distress.

The research was made as accessible as possible. Participants were given the choice of a face-to-face or telephone interview, carried out at a time and place of the participant's choosing. Interviews were conducted by an experienced qualitative researcher and generally lasted 1-1.5 hours (some interviews were longer, if the participant preferred that). Breaks were offered during the interview as required.

Three topic guides were developed, one for each participant group - men with lived experience, family members bereaved by male suicide, and professional service providers. Each topic guide broadly covered the same areas, to ensure consistency of discussions across interviews, but the wording was tailored so that they were relevant to each group. The following topics were covered:

- **Risk factors:** discussion of the statistical findings and resonance with their experience.
- **Support:** discussion of support encounters and gaps, types of support and settings, facilitators and barriers to men seeking help, and positive and negative examples of support.
- **Recommendations:** suggestions to help men feel supported and empowered, and to reduce male suicide.

³⁵ Samaritans (2012) *Men, Suicide and Society: Why disadvantaged men in mid-life die by suicide*. London.

Alongside the topic guide, a number of additional tools and visual aids were designed, for example a timeline sheet to assist men and bereaved family members to map their experiences, as these could be difficult to explain and recall. Furthermore, show cards listing types of support were used to prompt participants to consider types that they may not have had experience of, and to consider 'support' in its fullest sense, including the wider social and informal context and encounters beyond health-related service provision. These tools were only used when necessary to help open up or focus in discussions. A copy of each topic guide is provided in the Technical Appendices.

3.3.2 Ethical considerations in participant consultation

Men and bereaved family members were recruited via community and voluntary organisations (CVOs) that specialise in supporting people affected by suicide and self-harm. While this does mean that we did not include people not in touch with services - who may have very different experiences - it did ensure a level of safety for participants. A requirement of participating was that people with lived experience were in current contact with a relevant support service. Gatekeepers within CVOs approached individuals they believed would be able to participate in the research safely. CVOs could also support individuals following interviews, should the interview have triggered difficult thoughts or other support needs.

At the recruitment stage, individuals were given an information leaflet explaining the research and describing what participation would entail. A full explanation was also given to recruited participants both in writing and verbally prior to the interview. This information included an overview of the topic areas likely to be discussed, the voluntary nature of participation, and that participants could withdraw from the research at any time before the point of analysis.

Participants were reassured about the confidential nature of taking part. It was emphasised that they would not be required to share any personal or sensitive information that they did not wish to. At the start of the interview, participants were informed of the NatCen disclosure policy; whereby researchers may breach participant confidentiality if they believe the participant is at risk to themselves or anybody else around the time of the interview.

Consent to take part in the research was sought prior to the start of the interview. Interviews were audio recorded on an encrypted device so that an accurate record of the discussion was made; permission to audio record the discussion was obtained prior to the start of the interview. If an individual did not want to be audio-recorded, detailed notes were taken with the participant's permission.

At the end of the interview men and bereaved family members were offered a leaflet with details of national support organisations. They were also offered a £25 cash token of appreciation as a thank you for their time; participants were also given the option to donate this to a charity of their choice. Professional interviewees were offered a £25 donation to their place of work in recognition for their time.

The research team who conducted the interviews were skilled qualitative researchers, with extensive experience in interviewing on sensitive topics; enabling them to draw on their skills and experience to manage the interview pace and dynamic, being led by the participant as far as possible, and ensuring the wellbeing of the participant was always the priority. All researchers conducting the interviews had enhanced Disclosure Barring Service (DBS) clearance. The project was carried out in accordance with data security standards as set out by ISO 27001 (Information Security).³⁶

³⁶ A quality management system which establishes the terms and definitions as well as the service requirements for organisations and professionals conducting market, opinion and social research.

3.3.3 Consultation recruitment

The research team worked closely with CVOs across England to recruit research participants. CVOs that specialise in working with people affected by self-harm and suicide were identified by advisory group members and desk-based internet searches. Initial contact was made by email, and then followed with a telephone conversation with a relevant contact (from now on, referred to as the gatekeeper) to discuss the purpose of the research, interview content, and potential recruitment via their service.

If an organisation agreed to support the research, the recruitment process was discussed verbally and confirmed within an email. Each gatekeeper was best placed to approach recruitment in the most ethical and appropriate way within their particular service. Gatekeepers were provided with study information leaflets to assist their recruitment efforts.

Potential participants could register an interest in participating by contacting the gatekeeper or the research team. The research team had a short telephone conversation with each potential participant prior to arranging an interview. This call involved screening potential participants for eligibility to take part, ensuring they understood what participation involved, including the content of the depth interviews, and what participants could expect in terms of anonymity and confidentiality. Verbal consent to participate was always sought from individuals during recruitment and then again prior to the interview. Participant characteristics were monitored throughout the recruitment process to ensure that participants were eligible to take part, and that a range of experiences were included.

3.3.4 Consultation sample

The qualitative element of this consultation aimed to include people with lived experience of self-harm and suicide, as well as professionals from CVOs working within the field. Suicide statistics identify men in their middle years as at higher risk of suicide than other demographic groups. Being gay or bisexual presented an additional risk factor identified in the survey analysis. These findings informed the sample strategy for this qualitative consultation, highlighting:

- **Men aged between 30 and 60**, with lived experience of self-harm, suicidal thoughts or who had made an attempt to take their own life
- **Adults bereaved by male suicide**, where the man was aged 30 to 60 years
- **Professionals** working for CVOs supporting men (especially men in midlife) with experience of suicidal distress.

Twenty depth interviews were conducted, comprising nine men with lived experience, six bereaved family members and five interviews with professionals. Fieldwork was carried out with people living across England, to capture localism of views and diversity of research participants.

The intention was not to recruit a strict purposive sample representative of the different characteristics evident among people who self-harm, as is typical within qualitative research sampling, but rather to work with stakeholders with different types of experiences of self-harm and suicide among midlife men, to develop meaningful policy relevant findings and outputs founded on personal experience and expert knowledge. Nevertheless, the sample did capture a diversity of views, experiences and circumstances.

The achieved sample had limitations. Firstly, for reasons of participant safety, all men and bereaved family members interviewed for this research were or had been in contact with formal specialist support services for suicide prevention and bereavement. We therefore were unable to represent the views of those who had never accessed formal support provision (although some of the men discussed by the bereaved family members had not, to their knowledge, accessed formal support). Secondly, despite recruitment efforts, all

the bereaved family members interviewed were female. The perspectives of male bereaved family members, therefore, are not included. All bereaved family participants were mothers of the deceased, with the exception of one daughter. We therefore did not capture the perspectives of partner relationships.

3.3.5 Consultation analysis

Verbatim transcripts of all recorded discussions (or fieldwork notes) were used to manage and analyse the data using the Framework approach.³⁷ Framework is a thematic approach to analysing qualitative data, embedded in NVivo 10 software. This involved developing an analytical matrix framework following familiarisation with the interview data, with different column headings for the key themes and sub-themes identified and a row for each participant. Data from each interview was then summarised into the appropriate column heading to allow for systematic comparison of themes between participants. This approach helped to reduce the large volumes of data obtained while ensuring comprehensive analysis. It also facilitated systematic between-case (looking at what different participant groups - men, bereaved families and service providers - said on the same issue) and within-case (looking at how an individual's views and experiences on one topic relate to their views on another) investigation of the data.

Through reviewing the summarised data, the full range of views and experiences described by participants were systematically analysed, and the accounts of different participants, or groups of participants, were compared and contrasted. The use of the Framework approach ensured that the consultation analysis was fully documented and conclusions could be clearly linked back to the original source data. Verbatim interview quotations and case illustrations are provided in Chapters 6 and 7 to highlight themes and findings where appropriate. Case illustrations drew on the experiences of multiple participants and details have been amended to prevent disclosure.



³⁷ Ritchie J, Lewis J, McNaughton Nicholls C, Ormston, R. (2014) *Qualitative Research Practice*. London: Sage.

4 Key findings: Trends in self-harm 2000-2014

This chapter briefly highlights evidence on the changing prevalence of self-harm in England, focusing on the proportion of people to report having self-harmed without suicidal intent at some point in their life. Data from the 2000, 2007 and 2014 Adult Psychiatric Morbidity Surveys (APMS) were analysed. The prevalence of self-reported non-suicidal self-harm has increased steeply in England since 2000. These trends are examined in more detail in a separate, forthcoming report.

4.1 Methods

Participants aged 16 to 74 and resident in England were selected for analysis from the three cross-sectional surveys. See the separate Technical Appendices for details of the methods used and a discussion of strengths and limitations. The APMS 2014 survey report also covered these trends.

Non-suicidal self-harm: In 2000, 2007, and 2014, participants were asked face-to-face: 'have you ever deliberately harmed yourself in any way but not with the intention of killing yourself?' Those responding affirmatively were classified for these analyses as having ever engaged in nonsuicidal self-harm.

4.2 Results

Data tables with all results are presented in Chapter 4 of the Technical Appendices.

Prevalence of nonsuicidal self-harm in 2014

In 2014, 6.4% of 16-74 year olds reported that they had self-harmed without suicidal intent at some point in their lives. Rates were higher in women (7.9%, CI: 6.9-9.0) than men (5.0%, CI: 4.0-6.1). There was a strong linear association with age, with self-harm rates highest among those aged 16-24 (13.7%, CI: 11.2-16.7) and lowest in the oldest age group (1.1% of 65-74 year olds, CI: 0.7-2.0). There was no significant overall association with ethnic group ($p=0.743$), although the sample was underpowered to examine this.

Figure 4:1 Ever self-harmed (without intent) among 16 to 74 year olds by age and sex, 2014

Base: 16-74 year olds, APMS 2014

%

25

20

15

10

5

0

■ Men ■ Women

16-24

25-34

35-44

45-54

55-64

65-74

Age

19.7

10.0

10.6

7.9

2.1

3.8

2.6

4.0

0.9

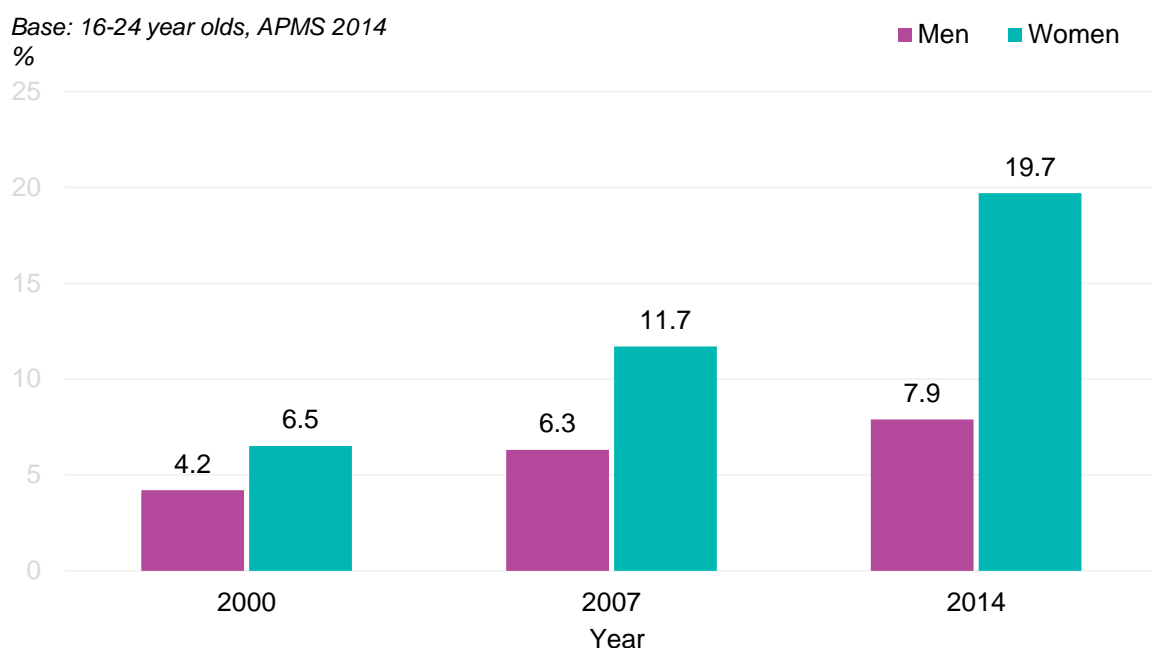
1.3

Prevalence of non-suicidal self-harm in 2000, 2007 and 2014

The proportion of the population reporting self-harm increased from 2.4% (95% CI: 2.0-2.8) in 2000 and 3.8% (95% CI: 3.3-4.3) in 2007, to 6.4% (95% CI 5.8-7.2) in 2014. The increase since 2000 has been significant both in men (2.1%, CI: 1.6-2.7 in 2000; 5.0% CI: 1.6-2.7 in 2014), and in women (2.7% CI: 2.2-3.4 in 2000; 7.9% CI: 6.9-9.0 in 2014).

The demographic group with the highest rate of self-harm without suicidal intent was young women. One in five (19.7%, CI: 15.7-24.5) women aged 16 to 24 reported this in 2014, up from 6.5% (CI: 4.2-10.0) in 2000 and 11.7% (CI: 8.4-16.0) in 2007.

Figure 4:2 Ever self-harmed (without intent) among 16 to 24 year olds by sex, 2000, 2007, 2014



The trends presented here are based on face to face reports as these were available every wave. Self-completion reports are also available for 2014 and indicate higher rates. When self-completion rates are also considered, one in four (25.7%) 16 to 24 year old women in 2014 reported having self-harmed.

Prevalence of suicidal thoughts and suicide attempts in 2000, 2007 and 2014

In 2014, 5.4% of 16 to 74 year olds reported suicidal thoughts in the past year, a significant increase on the 3.8% reporting this in 2000 and 4.5% reporting this in 2007. For women, the increase in suicidal thoughts occurred between 2000 and 2007; for men it took place later, between 2007 and 2014. Since 2000 the reporting of suicide attempts in the past year has remained largely stable.

4.3 Discussion

People in England have become more likely to report non-suicidal self-harm. The proportion of the population to report this increased from 2.4% in 2000 and 3.8% in 2007, to 6.4% in 2014. This increase was evident across the population as a whole: in both men and women and across age groups.

These results support other research indicating an increase in self-harming behaviour in England between 2000 and 2014.^{38 39} While a number of factors may account for some of this upward trend, such as changes in likelihood to report certain behaviours, it does seem clear that at least some of this increase must reflect real changes in behaviour. The increase is evident in men and women, and across age groups. However, the prevalence in young women, of around one in four, is notably high. Individuals who start to self-harm when young might adopt the behaviour as a long-term strategy for coping; there is a risk that the behaviour will spread to others; and also that it may lead in time to a higher suicide rate.

A report is forthcoming with further and more detailed analyses of the nature and extent of changes in the reporting of self-harm, in particular non-suicidal self-harm, and consequent use of services.



³⁸ Geulayov G, Kapur N, Turnbull P, Clements C, Waters K, Ness J, Townsend E, Hawton K. Epidemiology and trends in non-fatal self-harm in three centres in England, 2002–2012: findings from the Multicentre Study of Self-harm in England. *BMJ Open*. 2016; 6(4):e010538

³⁹ Morgan C, Webb R, Carr M, Kontopantelis E, Green J, Chew-Graham CA, Kapur N, Ashcroft D. 'Incidence, clinical management, and mortality risk following self harm among children and adolescents: cohort study in primary care.' *BMJ*. 2017. 359: j4351.

5 Key findings: Risk factors

Seven consistent themes emerged from the analyses of the survey datasets undertaken in Strands 1 and 2. Nine different survey series were analysed, covering more than 230,000 people between 1993 and 2015. These are detailed in the separate Technical Appendices, and only the overarching themes are synthesised and summarised here. These themes were:

- Mental illness and wellbeing
- Physical health and health behaviours
- Relationships
- Acute and chronic stressors
- Economic adversity and insecurity
- Demographics and identity
- Formal service contact.

These areas are not surprising. They are consistent with what has been identified before and they are well supported by the wider theoretical and empirical literature. However, by looking across and linking up findings from the different surveys – which looked at these topics in slightly different ways or with different population subgroups – important patterns emerge.

Survey questions are often kept consistent over waves and across survey series to enable comparison, but this can mean consistency is prioritised over validity. In these analyses we sometimes combined reports of suicide attempts with those of self-harm without intent. However, where the sample was sufficient to examine these behaviours separately we found many predictors to be common to both, the correlations between them to be very high, and clear distinctions in their profiles not to emerge in (flawed) population segmentation analysis. Some researchers have queried the ability of brief survey questions to meaningfully capture intentionality at all in this context. A key difference in the profile of those who reported having made a suicide attempt and those who reported having self-harmed (without suicidal intent), is that the latter group is more likely to be younger and female.

5.1 Mental illness and wellbeing

Mental health context: Consistent with previous analyses, mental illness was consistently the strongest risk factor for suicidal thoughts, suicide attempts and self-harm (without intent) to emerge across the multiple analyses.

Both anxiety and depression: Some datasets contained not just one measure of mental illness, but several. The results found independent effects for each. For example, anxiety and depression were both significant predictors of suicide attempts and self-harm in multiple regression models. This pattern was true both for adults and children. There were indications that the aspects of mental illness to most strongly predict self-harm and suicide attempts varied by ethnic group. For some groups it was depressive ideas, others fatigue, and in others anxiety or worry. Sample size limitations mean these patterns must be treated with caution, but they also indicate that suicide risk may present differently in different groups. GPs and others needing to recognize the signs should be aware of this variation.

Deterioration: Irrespective of starting point, an increase in symptoms of mental illness was associated longitudinally with increased risk of subsequent suicidal thoughts. This demonstrates that mental health is dynamic and highlights that a decline should be regarded by health services and support providers as a potential risk. Prior symptoms or diagnosis of mental illness also emerged as important.

Severity: Not surprisingly, datasets with dimensional measures of mental illness showed that the more severe the current symptoms of mental illness were, the more likely it was that the person also reported suicidal thoughts, suicide attempts or self-harm.

Low wellbeing: While uncommon, some people with relatively mild symptoms of mental illness, as assessed by the standard survey measures used, also reported suicidal thoughts, attempts and self-harming. Even where presence of mental disorder was controlled for, low mental wellbeing (as measured by the Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)⁴⁰) and reporting a lack of optimism about the future, were both predictors.

5.2 Physical health and health behaviours

Specific conditions: Several general health surveys ask people what physical conditions they have. The conditions to significantly predict suicide attempts and self-harm were different for men and women. For example, digestive disorders were linked with suicidal thoughts and attempts in women but not men; this association in women may stem from a physical manifestation of distress rather than a prior risk factor.⁴¹ In mortality-linked data, terminal conditions may not have significantly predicted suicide as an outcome because people sometimes died from the physical condition (or circumstances associated with it).

Multiple conditions: More than specific conditions, comorbidity emerged as a risk factor. This fits with a theme of cumulative effect evident throughout the analyses. The more conditions that someone had, the stronger the associations were with suicidal thoughts and self-harm.

Perceptions of health: Even after controlling for the presence of health conditions that have been diagnosed by a professional, people's *perceptions* of their general health remain a significant predictor. This suggests that not only may the underlying condition and its symptoms be relevant, but how 'well' people feel, and how they view themselves and their health, matter too.

Impairments that limit work: Surveys often include questions about whether people have a condition, and then whether it limits the amount of work that they can do. Work-limiting conditions are far more strongly associated with suicidal thoughts than conditions which were not reported as limiting.

Impairments that limit life: A standardized measure that covers a number of instrumental activities of daily living is widely used to capture the presence of functional limitations affecting the capacity to live independently. Similar to comorbid conditions, the more activities of daily living that someone needed assistance with, the more likely it was that they reported suicidal thoughts or attempts. This highlights disabled people as a subgroup at elevated risk.

Substance use: Smokers are more likely than non-smokers and ex-smokers to report suicidal thoughts, attempts and self-harm. The datasets in these analyses are mostly cross-sectional; smoking could be a way of coping with stress or it may induce stress, for example through stigma and by contributing to poorer physical health. It is likely that there are multiple causal pathways. The finding that suicide behaviour risk increases with number of cigarettes smoked suggests that attempts to reduce cigarette consumption are worthwhile, and that cessation effort could be sensitively tailored towards those experiencing distress. Data

⁴⁰ Warwick-Edinburgh Mental Well-Being Scale; <http://www2.warwick.ac.uk/fac/med/research/platform/wemwbs/>

⁴¹ Previous analyses have found digestive disorders to be strongly linked with low wellbeing in women (and not in men). Chanfreau J, Lloyd C, Byron C, Roberts C, Craig R, De Feo D, McManus S (2013) *Predicting Wellbeing*. DH: London. <http://natcen.ac.uk/media/205352/predictors-of-wellbeing.pdf>

from the 1990s indicated that as young children in care grow into young people in care, drug use emerged as a predictor of self-harm.

5.3 Relationships

Data: We lack nuanced survey data on people's social worlds. The data that we do have indicates that relationships and the lack of them, both positive and negative – are critical to suicide and self-harm risk.

Quantity: Recurrent across the analyses was the impact of being alone. Measures that are commonly available – and were significant in several models – included living alone, an increasing trend in the wider population with the growth of single occupancy households. Living with children in the household clearly and consistently emerged as protective.

Loss: Having but then losing a primary relationship emerged as a risk factor, including both bereavement and marital breakdown in the form of divorce or separation.

Quality: After controlling for being physically alone, different aspects of the quality of social relationships continued to be critical. In adults the lack of relationships that were felt to be 'close' predicted self-harm and suicide attempts. In children, not being 'attached' to at least one adult had a similar association. The survey datasets analyzed did not have good coverage of more qualitative experiences of social isolation and withdrawal, and inclusion of more detailed questions on these would be welcome in future data collections.⁴² These were, however, key keys to emerge in the participant consultation. Significant protective factors included feeling 'accepted' by other people.

Damaging: Alongside relationships where support and acceptance were lacking, were social interactions that were explicitly harmful. Different manifestations of bullying, violence and abuse were significant in many of the models, both in terms of individual or past traumatic events (including abuse in childhood) and chronic or ongoing situations (such as domestic violence or workplace bullying). While child sexual abuse has been widely recognized as a major self-harm and suicide predictor, abuse from a partner in an adult domestic violence situation is much less acknowledged by mental health and other services.

5.4 Acute and chronic stressors

Crisis and shock: Specific types of stressful 'events' were sometimes significant in the models. These included occurrences such as a serious illness or assault, bereavement, police contact, or sudden financial crisis.

Cumulative: However, again number of traumatic events proved to be a much stronger predictor of self-harm and suicide attempt. We recommend that further analyses seek to include indices or counts to try to capture the dimensional nature of pervading stress.

Sustained adversity: These datasets confirm the very high prevalence of suicidal thoughts, suicide attempts and self-harm in particular population subgroups characterised by exposure to sustained stress: people with experience of adversity in both childhood and adulthood, people who are homeless, have very

⁴² For a review of social isolation measures to use in mental health research see: Wang J, Lloyd-Evans B, Giacco D, Forsyth R, Nebo C, Mann F, Johnson S (2016) *Social isolation in mental health: a conceptual and methodological review*, *Scoping Review 14*. <http://www.sscr.nihr.ac.uk/PDF/ScopingReviews/SR14.pdf> The review highlights a current gap around measures that capture online social relationships.

high levels of caring responsibilities, have been involved in armed conflict, live in prison custody, or are being or have been brought up in local authority care. Within these populations, the risk factors appear to follow a similar pattern, but are intensified due to the higher prevalence of exposure to risk.

5.5 Economic adversity and insecurity

Debt more than income: Many surveys collect estimates of household income (albeit problematically, with inaccurate reports, considerable missing data and little on distribution of resources within households), but fewer cover individual and household debt. Our analyses suggest that for mental health epidemiology, debt is at least as important as income, and probably much more so.

Scale and nature of debt: Following the established pattern of cumulative impact, the more problem debts someone has, the greater the suicide risk. It is possible that combining problem debts into a single repayment programme could therefore be helpful in reducing stress. We do not tend to have good data on size of debt, only on number of debt, as size of debt is problematic to collect in a meaningful way. This is an area which would be important to explore in qualitative research, and where better survey questions are needed to quantify the extent of debt burden.

Employment: Different aspects of employment context predicted suicidality – such as job loss, length of unemployment, and working in routine or manual employment. However, what consistently emerged in the data was how much more strongly each of these predicted suicidal thoughts in men compared with women. Data which focused on the recently unemployed population found predictors of suicidal thoughts in this subgroup included markers of economic insecurity (persistent unemployment, multiple debts, health impairment or disability affecting the amount of work one can do, low job security among those who did return to work); coupled with social insecurity (bullying and relationship breakdown).

Housing insecurity: Rates of current suicidal thoughts and feeling that life is not worth living were high in the homeless population, and this varied with the type of homelessness someone experienced. People who had at least a consistent base – even a bed and breakfast where they were able to stay longer term – were doing better than those staying in shorter term hostels. Being a renter was associated with suicidal thoughts and attempts; alongside increasing housing unaffordability and changes to housing benefit levels and entitlements, this risk factor has become more prevalent in the population.

Reflecting current context: Series such as the Scottish Health Survey (SHeS), using data from 2008-2011, also found being a renter (as opposed to an owner occupier), not in a managerial or professional occupation, and not having access to a car or van, all strongly and independently linked with increased odds of reporting self-harm or a suicide attempt. Similar patterns emerge in datasets collected before the 2008 recession, such as APMS 2007. Initial analyses of the 2014 APMS reveal extremely high rates of suicidal thoughts, suicide attempts and self-harm among benefit recipients, especially those in receipt of Employment and Support Allowance (ESA) aimed at people unable to work due to health or disability. Recession may have had particular impact on specific population subgroups, and further analyses of more recent datasets (such as APMS 2014) will be key to understanding these trends.



5.6 Demographics and identity

Lesbian, gay, bisexual: While the individual survey samples were too small to look separately at people who identify as lesbian, gay or bisexual, a combined 'non-heterosexual' group was associated with particularly high rates of suicidal thoughts and attempts. Issues for people who are transgender were also highlighted by the people in our consultation, but this is a group that is generally too low prevalence to be analysed in quantitative surveys of the general population. Representative quantitative data on this group would require an approach such as the inclusion of a question on the 2021 Census.

Ethnicity and migration status: Key indicators of suicide risk may differ by ethnic group. While sample size limited robust analysis of these patterns, for the Irish and Pakistani groups at least it appears that migration status is key, with those born abroad appearing to be less likely to have suicidal thoughts than those born in the UK.

Age and sex: Much of the cross-sectional survey data on risk factors for suicidal thoughts, attempts and self-harm highlight women and young people as at greatest risk. While these groups had higher rates of self-harming without intent, the analyses of linked mortality data confirmed the patterns we observe in mortality statistics, with higher rates of suicide in men and at midlife.

5.7 Formal service contact

People with a higher level of service contact often have high levels of need: Requesting and accessing services of various types - from educational specialists through to being a patient or in treatment - was associated with suicidal thoughts, attempts and self-harm. These are cross-sectional analyses and so this association is not unexpected and suggests that thresholds for service access may be high as many of those who use services seem to have particularly complex needs. It is clear that not everyone who needs services get them, for example children who self-harmed had only slightly increased odds of teachers having requested specialist support for them than other children. Adult prisoners who self-harmed are much more likely than those who did not to have had lifelong contact with care systems, specialist schools and institutional settings, even in childhood, indicating that their vulnerability has been longstanding and pervasive.

Getting help inside: There was some indication that people were more likely to get support inside prison than before they went in, although this may in fact reflect deterioration in their mental health and an increase in support need since starting their sentence.

5.8 Further information

These themes are detailed in the extensive Technical Appendices, which includes a separate chapter focusing on each of surveys analysed, with full data tables.

Participant responses to these topics are described in Chapters 6 and 7, and the findings are drawn together and implications are discussed in Chapter 8 of this report.



6 Consultation: Context for midlife men

6.1 Introduction

This chapter examines risk factors for suicide and self-harm in men at midlife from the perspective of people with lived experience: men, people bereaved by the suicide of a man in midlife, and professionals who support men in suicidal crisis. The interviews started with presentation of results from the survey analysis, using a handout (included in the separate Technical Appendices) and summarized in the box below.

Risk factors identified in survey analysis and reviewed with participants

- **Demography and identity:** Being male, aged 35-59, not heterosexual.
- **Mental illness:** Anxiety, depression, persistent worries, deterioration in mental health, substance dependence.
- **Physical illness:** General poor health, physical conditions that limit ability to work, being a patient, disability.
- **Financial insecurity:** Debt, struggling to manage financially, renting or living in insecure housing, job worries or unemployment.
- **Relationships:** Living alone, not having children in the household, bullying, abuse and violence, lacking a supportive or close relationship.
- **Stressful events:** Including divorce or separation, financial crisis, contact with police, being attacked.

Participants described what these factors meant to them in the context of their wider lives, what relevant factors were missed by the survey analysis, and how these factors had contributed to their own – or their loved one's - suicidal thoughts or self-harm.

Experiences and perspectives of formal and informal support were also covered in the interviews and are described in the next chapter (Chapter 7). The views presented here reflect circumstances for midlife men with experience of suicidal distress; while some experiences may resonate for women and other age groups it should not be assumed that they are generalisable.

6.2 Overarching responses

6.2.1 Risks in combination

Across the participant consultation interviews, men, bereaved family members, and professionals recognised several - and sometimes all - of the risk factors identified in the survey analysis. Their views of each of these are discussed individually below. In the interviews, however, none of these emerged as the main or singular factor in suicide risk. Participants emphasized how it was the combination of more than

one type of risk, experienced in parallel or close succession, which they felt led to feelings of helplessness, entrapment and isolation, and brought on feelings of suicide.



6.2.2 Risks over time

The men who talked to us had a range of different life histories, and their experiences of suicidal distress were also diverse. But a common theme was that suicidal thoughts were not described as a one-off occurrence: reoccurring periods of suicidal crisis were typical, although with varying levels of intensity.

Men talked about their experience of suicidal thoughts in a number of ways. While some had had suicidal thoughts or made attempts only in the past, for others these were still persistent or recurring. Some men had their first thoughts of not wanting to live during their teenage years and these had continued throughout their lives.

‘[For some people suicidal thoughts might be] more of an impulsive thing like a reaction to a stressful time; for me, I feel like it’s like a tug or a pull or something that nags me every day.’

(Midlife man with experience of suicidal thoughts)

The men typically described a ‘lead up time’ over a period of months before the onset of feeling actively suicidal. During this time, they increasingly felt unable to ‘cope’, ‘out of control’ or ‘trapped’. Feeling isolated was also a strong theme in the lead-up to feeling suicidal and was described in two ways:

- **Being alone:** for example not being in a relationship or having a limited social network (detailed more in Section 6.7)
- **Feeling alone:** with problems and stress, or feeling disconnected from people and things around them.

When faced with multiple stresses, while also feeling lonely, with reduced resilience and low confidence, suicidal thoughts were described by some men as ‘taking back control’. They were perceived to be a ‘solution’ to a set of problems or as a source of ‘comfort’ or ‘order’.

Men identified personal triggers that they felt contributed to their feeling suicidal. These were realised with hindsight, either by themselves (through self-reflection) or through guidance from or interaction with others (for example, with self-help books or peer support). Some cited obvious trigger points such as exposure to a stressful event (the death of someone close or an abusive experience) without adequate aftercare. Others cited the build-up of difficulties across a number of areas, such as the combination of relationship breakdown, work-related stress, financial insecurity and worsening health.

At the time of the interview, participants tended to feel that they currently had greater insight into their stress and personal triggers for worry, depression and suicidal thoughts than they had had previously. They had not had this awareness during their first experiences of suicidal distress. With each new period of feeling suicidal, some men described having developed greater insight about their own triggers, improved self-assessment of suicide risk and developed personal coping strategies. However, although men were able to objectively identify risk factors and triggers, they also described struggling to fully understand their reasons for feeling suicidal.

'I think...it's easier to explain perhaps why you're depressed, or why you feel anxious, but I think it's really difficult to understand how you can want to so completely destroy yourself, persistently. That doesn't make sense, you know? It doesn't - like, where does it come from?'

(Midlife man with experience of suicidal thoughts)

There were men who believed it was unlikely that they would act on their suicidal thoughts, whereas others believed death by suicide was inevitable for them. It was difficult for participants to explain why men were in one group or the other; but views focused on differences between:

- Men who had developed – or believed they could develop – coping strategies and those who did not feel that they could develop such strategies
- Men who were confident that they would be able to access support when they needed it and those who could not rely on support being available
- Men who felt that their life had potential to improve (for example, the prospect of better employment, relationships, and financial stability) and those who anticipated the same or worsening circumstances (including a chronic or deteriorating health condition).

It is important to note that how men were feeling around the time they were interviewed for this research could also have influenced how they thought about their future risk.

The rest of this chapter discusses the individual risk factors for suicide and self-harm.

6.3 Demography and identity

Demography and identity: Being male, age 35-59, not heterosexual

While secondary analysis of survey data allowed a profile of who has suicidal thoughts or attempts (but does not take their life) to be produced, the profile of those who do take their own life is different. For some years, the suicide rate in England has been highest in men in their middle years. The survey data also identified being gay or bisexual (or rather, due to sample sizes limitations, not identifying as heterosexual) as a strong risk factor for suicidal thoughts and self-harm. These findings informed the sample strategy for the Strand 3 consultation: it was decided to focus on men in midlife, families bereaved by a man in midlife and professionals working to support such men to address these gaps in the survey analysis. A particular

effort was made to recruit men who did not identify as heterosexual and community and voluntary organisations (CVOs) specialised in supporting non-heterosexual men.

Self-identity and 'fitting in' were strong themes throughout the interviews. Personal and societal expectations were felt to place pressure on men, setting standards they felt they ought to live up to. Perceptions of what these were varied between individuals, but broadly included beliefs about how to be a man, body image, expectations about happiness, income and work achievements, and relationship status. Not meeting 'standards' in these areas could prompt men to question their role and purpose in life. Feelings of failure in any life area could be a source of embarrassment and shame. Admissions of failure were described as particularly difficult to disclose to others and as important contributors to suicidal thoughts.

Self-identity as a man

Expectations of what a man 'should be' included being physically and mentally strong, being able to deal with problems (their own and other people's), and being a (financial) provider.

Particular stigma was perceived as attached to men experiencing depression. Men also described how it was more acceptable for women to be open and emotional. These gendered expectations about men and how they ought to respond to problems informed men's coping strategies. For example, professionals working in support provision and some bereaved family members described how men 'put on a brave face' and hide that they are not coping behind a 'jovial manner'.

'Yes we get callers with mental health problems. We get callers with financial insecurities or work stress, or loneliness. Loneliness is a huge thing. Relationships, stressful events, these things happen to women too...so what's different between those two? I think the difference between those two is around how society expects you to deal with them...for men society expects men to grit their teeth, carry on, don't look weak.'

(Professional)

'I think for him to have to stand there and say to somebody else... 'I'm struggling' would have taken massive courage and it's something that I'll admit now he never would have done. And I think that's the big barrier when it comes to men who take their own life; they don't know it's ok not to be ok. To them they have to be ok all the time because of the stereotype of what a man should be, what a man should do.'

(Bereaved family member)

Social constructs of 'being a man' were felt to be internalised from a young age and continually reinforced, for example, in the media's portrayal of men and in the behaviour of family and peers. These constructs were felt to be ubiquitous and so difficult to challenge. One man described being praised by relatives for being strong and not crying or showing emotion following the death of a parent. He recounted how this subtle re-enforcement of how a man should respond to a highly stressful and emotive situation was a factor in him not fully grieving at the time of the death.

Professionals stressed that there may be particular pressures on certain subgroups of men. Young Asian men were highlighted as sometimes facing family expectations around career paths or marriage. Some bereaved family members felt that there was greater pressure on men living in the north of England to be 'masculine'. Professionals working with gay and transgender clients (specifically those transitioning to female) highlighted their increased suicide risk. Social isolation after disclosure of being gay or transgender was reported. In addition, experiences of homophobia and transphobia - including verbal or physical abuse - were traumatic and humiliating. Such instances reinforced men's feelings of low self-worth, and could

trigger other risk factors for suicide, such as being scared to leave home and feeling isolated. Furthermore, participants did not feel the police were always supportive when abuse was reported by men.

Having experiences that are typically thought to affect women were described as difficult for men to disclose and raised questions about their identity as a man; such as being a survivor of sexual abuse, domestic violence or having an eating disorder. To deviate from expected norms could bring about a sense of shame and feelings of 'failing at being a man'. One participant described it as having 'a deep psychological impact' and 'emasculating'.

'The idea of being a man is paramount...if for some reason your status as a man is in doubt or is shaken at all, it kind of means, yeah, I guess there's no point or, you know, they've failed as, as a human. Yeah, so I think - I think taking that for granted is a mistake...it's gonna shatter your world if you don't live up to these standards.'

(Midlife man, with experience of suicidal thoughts)

The importance of 'being a man' was not salient to all men interviewed.

'I don't buy into the thing that men pretend to be the strong one and all that nonsense. I think that's rubbish. I think it's just that mental health issues still have a stigma.'

(Midlife man, with experience of suicidal thoughts)

Self-identity during midlife years

Men, family members, and professionals all discussed the pressure on men to achieve age-related goals in terms of career, partner and family.

'That pressure to be the strong man is massive...their role in life is to be the great man, the provider, and not show any kind of weakness, as they see it. You know, you can't earn the money you want to earn - and if you are sad, where do you go? You can't go to the wife or the girlfriend because you've got to be strong for her, you've got to be strong for the children, so where do they actually go? And there isn't particularly anywhere to go.'

(Bereaved family member)

The men interviewed were aged between 35 and 59, and described these years as a stage when expectations are confronted, leading to a sense of disappointment and that things will not improve. Other risk factors – such as onset of poor physical health, financial stress, marriage breakdown, workplace demands, and caring responsibilities for both parents and children – were also felt to coincide around this time. For some men who had first experienced suicidal thoughts when young described how chronic despair, by midlife, had worn them down and led them to believe it was inescapable.

'It would just be such a long time to actually get my life back to a reasonable level again...when I had depression for the first time, you think it may be a one-off but knowing that it's happening again, and the likelihood is, even if you get better, that you're likely to have it again...just the thinking that there wasn't a possibility of life being, in inverted commas: 'okay' in the future.'

(Midlife man, with experience of suicidal thoughts)

Self-identity and sexuality

Not fitting in or not feeling accepted or safe were key themes among the gay men interviewed. Those men who did not feel comfortable with their sexuality felt that being gay was a central factor to their suicidal thoughts.

'I hate being gay.'

Other gay men described stresses linked to being gay. Being gay in a heteronormative society was described as a vulnerability, especially the experience of discrimination and homophobia. 'Coming out' was identified as a period of increased stress, due to anxieties and worry about how people may react and then dealing with social isolation following disclosure, in instances where friends and family objected. Gay men also described how media portrayals of gay men set unrealistic expectations of them, such as having a toned physique, a successful career and disposable income. Not measuring up to these expectations led some to feel inadequate. The gay men interviewed also felt that health and other services did not address their specific needs or rendered them more vulnerable (see Chapter 7).

6.4 Mental illness

Mental illness: Anxiety, depression, persistent worries, deteriorating mental health, substance dependence

Poor mental health as a precursor to suicidal thoughts was a common experience across the sample. It was not always diagnosed by a doctor. Observing a decline in one's own mental health was a source of worry in itself, as was the onset or intensification of suicidal thoughts.

Depression, anxiety and/or worry were described by men independently of suicidal thoughts, but were highlighted as worsening during the lead up to being actively suicidal. The sample included men with diagnosed mental health conditions such as post-traumatic stress disorder, bipolar disorder, borderline personality disorder and eating disorder. Some reported experiences or traits associated with autism, or described having delusions or psychotic episodes. In addition, the professionals interviewed who worked with men in crisis expressed concern about gambling behaviours and excessive use of pornography.

Bereaved family members mentioned substance use by men in discussions about triggers and risk factors for suicide, such as alcohol, cannabis, Valium and methadone. However, use of cannabis and alcohol was not necessarily considered problematic by family members.

'I think that looking back [he] had terrific anxiety. He started using first marijuana and then other things as self-medication and that it then got out of hand and then he was later diagnosed with bipolar and possible personality disorder but, you know, whether that was brought on by the drugs or not, I don't know. Plus the trauma of his dad dying when he was little but again - you see, it's hard to know.'

(Bereaved family member)

Age of onset for poor mental health varied for men in the sample, but they broadly fell into three groups:

- Those who had been living with poor mental health from their early teens and not disclosed this to anyone until later in life
- Those who had poor mental health and been in contact with mental health professionals and services since their early teens and had a medical diagnosis, and
- Those who had not experienced poor mental health until their late teens/early twenties.

Men's first experience of suicidal thoughts happened at different ages too, linked with the types of life experiences they had encountered.

Men described a wide range of implications which they associated with poor mental health, particularly during 'low' episodes, and which they felt fed into thoughts of suicide. These included:

- Low energy
- Poor self-care including problems with getting out of bed, washing, dressing and eating
- Limited social activities
- Diminished ability to focus or perform well in work or education
- Increased negative self-thoughts
- Loss of confidence
- Disrupted sense of self-identity.

One professional remarked that the term 'anger' was the one most searched for on their website.

Changes to the type or dose of psychotropic medications were commonly experienced by men reporting worsening mental health. In some cases, these changes in medicine were described by men as exacerbating low mood and feelings of suicide.

Men who had experienced mental health problems for a number of years, either continuously or periodically, described feeling 'worn down' by them. Men who had experienced a number of 'breakdowns' explained that with each episode, they had to deal with the subsequent 'fall-out' such as returning to work, re-establishing social networks and rebuilding self-confidence. The thought of having to cope with mental illness for the rest of their life coupled with the sense that nothing would alleviate or improve their illness, were cited as factors in wanting to end their life. Mental illness was raised as a reason for lacking the energy or motivation to investigate how or where to get help. Not receiving support, or receiving ineffective support, for mental illness was seen as fueling men's feelings of hopelessness about living.

6.5 Physical illness

Physical illness: General poor health, physical conditions that limit ability to work, being a patient, disability.

Participants described how having a chronic illness or disability raised the risk of feeling suicidal, especially if it restricted a person's social activities or limited their ability to go to work. Men highlighted conditions that were difficult to manage or were unlikely to improve as particularly problematic. Conditions that men were embarrassed about, or felt were stigmatised, also presented particular risk. Professionals specialising in supporting gay men highlighted that an HIV diagnosis had featured in the reasons their clients gave for considering suicide.

Physical health problems with recurrent pain and experiencing a sudden and frightening 'health scare' (for example, undergoing medical investigations to test for cancer) were both cited as having exacerbated men's stress and reduced their feelings of being able to cope. Similarly, chronic conditions in close family and friends, in the context of wider demands, were also felt to erode feeling able to cope.



6.6 Employment and financial insecurity

Financial insecurity: Debt, struggling to manage financially, renting or living in insecure housing, job worries or unemployment.

Employment status and financial circumstances were seen as closely related. Financial concerns were described as a catalyst and a consequence for a host of other stresses, such as housing insecurity, relationship breakdown and feeling a loss of control. In particular, employment status was linked to men's self-identity and feelings of self-worth. The interviewed men essentially fell into two groups: those in employment and those not. Suicidal thoughts and behaviours were present within both groups; and the groups were not static: most of the men had moved in and out of work at different stages of their adult life.

6.6.1 Men in work

For men who generally enjoyed their job, employment was described as a source of 'therapy' as it provided a distraction from negative thoughts and an incentive to get out of bed and leave the house when feeling low and lacking in energy. These men talked about how being out of work would have negative implications for their mental health and make them feel worse about themselves.

However, employment was also described as a source of stress and a trigger for feeling unable to cope with life. Men who had experienced work-related stress, due to demanding workloads, unsupportive management and colleagues, a work grievance, or fears of job loss felt that these factors brought about or

exacerbated depression, anxiety and suicidal thoughts. Changes in employment, such as the lead-up to job loss, starting a new job or relocating, being promoted and having new responsibilities, or working under a new manager, were key times at which men described feeling particular work-related stress. Men feeling devalued after not getting a sought after promotion, or feeling unappreciated at work was also raised by bereaved family members.

Conversely, having depression or suicidal thoughts (independent of work-stress) could affect concentration at work and reduce feelings of competency; which was described as further lowering self-esteem and reinforcing negative thoughts. In addition, men described having to hide their poor mental health from employers, due to worry about the possible consequences of disclosure, including being treated differently by managers and colleagues.

‘The employer was willing to keep his job open for a month whilst he got better. But he felt that if he went back and the other people discovered that he'd had depression he would've been teased remorselessly or, you know, he'd have felt a lesser person. So therefore he would hide it and he changed his job which was a pity because it was a well-paid job.’

(Bereaved family member)

Men talked about how they stayed in stressful jobs to avoid financial insecurity, or because they felt they ought to be able to meet work demands. In hindsight, these experiences were felt to have been detrimental to men's mental health at the time. However, men who took a period of sick leave (and reduced income through statutory sick pay) discussed the financial pressure this then placed on them.

6.6.2 Men out of work

Financial insecurity, which especially affected those out of work, was a major factor cited by men considering suicide. Professionals associated the financial recession and wider economic downturn with increased suicide risk. The threat of - or actual - financial insecurity was viewed as a contributor to stresses experienced by their service users. Men and bereaved families echoed this, and stressed that employment circumstances and financial insecurity could act as a catalyst for a range of social and financial difficulties.

‘So, he had this vast loan against his name...the split up came, nowhere to live, finances against him, no way of getting social housing. They'd only offer him hostel accommodation although he had his son three days a week overnight, couldn't get that. I think the paranoia set in when we then get these wonderful debt collectors. Oh, and I'll just throw in the other part about his work, he couldn't even get dole money because they hadn't put in their tax return. So, if we look at one element of that, I think that's enough to tip you. So, basically, he had numerous problems.’

(Bereaved family member)

Being out of work was not only related to financial insecurity, but also closely linked to men's feelings of self-worth. For men recently out of work, the transition to being unemployed was a significant moment in their narratives of reaching a point of suicidal crisis. Job loss was a major source of stress itself and adjustments to being unemployed opened men up to new and additional problems. These included men questioning their personal identity and how other people may perceive their unemployed status, as well as practical concerns, such as applying for out-of-work benefits, adjustment to a lower income, and in some cases, housing insecurity and debt. Men listed social isolation as a wider impact of being unemployed, due to less disposable income and interacting with colleagues.

Unsuccessful job searches were described as demotivating and adding to feelings of rejection; this was echoed by bereaved family members. Those who did not feel able to work, but faced pressure to job-seek in order to qualify for out-of-work benefits, found this to be an added source of stress.

Men said they felt – from themselves and others - stigma attached to being of working age but unemployed, particularly in relation to receiving out-of-work benefits. Men in receipt of these benefits felt they were perceived as ‘scroungers’; a view felt to be reinforced by the media. Men in receipt of other benefits such as Disability Living Allowance (DLA) and Employment Support Allowance (ESA) described how changes to eligibility criteria, as a part of wider governmental austerity measures, were a source of worry. Professionals echoed this; they explained that the potential for benefit awards to be reduced or cut completely was a concern among affected service users, and particularly those with disabilities.

Professionals and bereaved family members noted that financial concerns could negatively affect relationships, such as with partners, and in some cases lead to relationship breakdown. This was described as creating further financial and emotional difficulties, such as isolation, feelings of failure, as well as practical adjustments such as moving house and separation from children. In acknowledgement of the link between financial insecurity and its impact on wellbeing, one stakeholder organisation worked closely with foodbanks to sign-post people to sources of emotional support.

‘It looks like an increase in suicide since the recession...and how much is to do with financial insecurities and how much is to do with how roles in kind of society are changing, you know the role of men in society... men in midlife who find themselves suddenly, suddenly unemployed having you know been quite well-paid jobs and kind of losing their identity.’

(Professional)

Wider financial circumstances

Participants also raised wider financial issues that could negatively affect men’s mental health. These included financial hardship following an unexpected cost; being in debt; or relationship breakdown which led to housing insecurity, reduced income or acquiring the debt of an ex-partner. Professionals also worked with men who had financial difficulties as a result of problem gambling. One of the men interviewed talked of the all-pervading fear and desperation he felt at being ‘hounded’ by bailiffs and money lenders, and how his financial situation removed all ‘control’ he felt over his life, forcing him to be trapped in a job he hated. When talking about debt, several of the men used the word ‘spiraling’ to convey how inescapable and threatening they found the situation. Some bereaved family members described how they knew their sons were in debt and struggling financially, but their sons would not talk about it.

6.7 Relationships

Relationships: Living alone, not having children in the household, bullying, lacking a supportive or close relationship

Being alone or feeling alone with problems were both connected to suicidal thoughts; a distinction and a link articulated by professionals, men and bereaved families. The lack of a close supportive relationship – be it with a partner, parent or friend – was identified as a trigger that could lead to suicidal thoughts.

‘Isolation is a really big a problem for lots of our people too, and certainly as we, as GBT men - lots of people that use our services and talk to us about being isolated, not feeling connected to a community, not feeling connected to other people, having no family. I mean, quite often people

when they come out, sometimes people lose their families along the way, or don't have a very supportive kind of relationship, and people's social capital isn't particularly great, maybe not having any friends, poor housing, not working, not very much money. And of course as we get older we can feel more and more isolated as well.'

(Professional)

The breakdown of a partner relationship represented a tipping point at which several men started to actively consider suicide. This was also true for one man who had exited an abusive relationship, where he was the victim/survivor. Men and bereaved family members recounted the time leading up to and directly after relationship breakups as particularly stressful. Alongside grieving the loss of a relationship, breakups could bring about wider life changes to financial and housing circumstances and social support networks. Separation from children following a relationship breakdown was mentioned as a factor in the subsequent isolation of fathers. Breakups were a prompt for self-reflection, negative thoughts and worries about the future; they were linked to feeling alone and reasons for contemplating suicide.

Similarly, men talked of the loss of any significant relationship as a trigger for poor mental health, such as the death of a close relative or friend, or loss of a friendship group. Suicidal feelings may not be triggered immediately after such losses but play a notable role in reasons for not wanting to live. Equally, difficult relationships with significant individuals like parents, teachers, managers, peers and colleagues were discussed as presenting challenges for men.

Conversely, a period of depression was described as leading men towards social isolation. Men withdrew from social networks because they felt too unwell. Or, family, friends and acquaintances were felt to keep their distance, which men perceived was due to people not knowing how to react to someone experiencing long-term depression, articulating suicidal thoughts, or following a suicide attempt.

Men described how living alone could compound feelings of loneliness during 'low' periods, giving individuals more time to ruminate on negative thoughts.

'I think the biggest issue was the living alone. I think that really - there was no support there. You just sit in a room...all you're left with is your thoughts...Yeah and then you'd end up getting really upset and then you'd just think what's the point?...What's the point of waking up every morning to this? You know I didn't sleep and then when I did sleep I'd wake up and I'd wait for the postman to bring me another letter demanding money or I'd wait for another phone call from my ex-partner saying I couldn't see the children...So I just sat in the house and it just seemed to spiral more and more out of control to the point where you know you'd just be in tears in the house by yourself, but too scared to tell anyone.'

(Midlife man, with experience of suicidal thoughts)

Wanting close relationships but being unable to achieve these was raised. Some men had struggled to form friendships and close relationships throughout their life. For some single men who wanted a partner-relationship, the prospect of growing old alone was a source of worry and feelings of hopelessness.

6.8 Stressful life events

Stressful events: Including a divorce or separation, financial crisis, contact with police or being attacked.

Men talked about encountering different stressful events over their life. Some events overlapped with issues also discussed in this chapter, for example, being diagnosed with a health condition or experiencing a financial crisis. Participants highlighted three other types of stressful events that they felt had lasting impacts on them and increased suicide risk.

- **Traumatic childhood experiences**, such as difficulties with parents and care givers, being bullied at school and the experience of childhood neglect and abuse.
- **Crime and antisocial behaviour** such as sexual abuse in adulthood, homophobic encounters or attacks, or disputes with neighbours; and any subsequent police investigation or legal proceedings.
- **Times of transitions**, where individuals had to re-establish themselves in a new area, job, or household after a relationship breakdown or bereavement.

It should be noted that the men we interviewed had also experienced traumas and stressful events that they did not wish or feel able to disclose.



6.9 Additional factors identified

Participants were asked what other factors, not identified in the survey analysis, they felt also presented risk for men's suicidal thoughts and behavior. They highlighted:

- Geographic location, especially local community attitudes and living in areas of high deprivation
- Use of social media.

Case illustration A: James

James is 47, single and gay. James can't remember a time when he didn't feel low. He first had suicidal thoughts from age 14; he doesn't know what the trigger was. He describes himself as being a 'loner' during his school years and remembers feeling alone at home too, like he didn't fit in anywhere. He was severely bullied at school; he felt the teachers knew about the bullying but never stopped it. James knows this is in the past now, but he still can't shake off these feelings.

His mum and dad are good parents, but they are just not a very communicative family. James supports them by shopping and taking them to hospital appointments. He worries about their health and who would look after them if he wasn't around. He hasn't 'come out' to them, nor do they know about his depressive episodes. He is concerned about their reaction, but at the same time feels he is living a lie.

In many ways he feels accomplished; he has a 'good job', owns his own flat, has a couple of good friends and a network of acquaintances. Yet, he has periods of feeling extremely low and experiences crippling anxieties, when he can't leave his bed, wash, eat or dress for days on end. Most of the time, however, he 'performs' functioning well.

In terms of support James feels he has tried everything; the NHS, support from the third sector, alternative therapies - but hasn't found anything that helps in the long term. Each time an approach doesn't work, he feels as though another door shuts in his face.

James has had some relationships, but finds it hard to trust people. He also feels it's unfair to start a relationship while he's in and out of depressive episodes - who would want him like that anyway? He worries he will be alone forever and often wonders what the point of it all is. He experiences suicidal thoughts and urges daily and has done so for many years. He feels worn down by life. He has a suicide plan, which is a source of comfort for him.

Case illustration B: Adam

Adam is 35, single and straight. He describes his early years as idyllic. At age 17, his mum was diagnosed with breast cancer and was ill for two years before she died. Adam felt he never dealt with this; it wasn't discussed in the family, and he felt he had to be strong for his dad and younger siblings. He was praised for 'staying strong' by other relatives.

Adam did well at university and generally felt fine but had periods of feeling down and 'empty', which he put down to stress at the time. At university he was part of a group of 'mates'; they played football, computer games and went drinking, but didn't talk much. He had a girlfriend, but often felt worried she would leave him. He didn't really talk about it, and sometimes got angry with her for no real reason. After university he found work that he liked.

Adam and his girlfriend bought a flat together and had a baby boy. He found this overwhelming. Having a child triggered thoughts of his mum, which surprised him. He worried about whether he would be a good dad. They struggled financially moving from two incomes to one and neither coped well with the stress. Their relationship broke down and he moved out of the flat. He had lost contact with his university mates years earlier and gave up football in his twenties. Adam increasingly struggled to focus at work and felt stressed, but didn't know who to speak to. His employer was supportive and reduced his workload and hours to 80%, after which he was offered sick leave. When he returned to work, Adam felt that his colleagues were 'different' and distant with him. He decided to leave his job, but struggled to find another one. Adam moved back in with his dad and has occasional contact with his ex-girlfriend and son.

Adam feels ashamed he is in this position in his thirties and doesn't want to burden his dad. He has called helplines from his mobile in the park once or twice but it doesn't really help; he doesn't feel he can explain what he is feeling, and never provides his real details. It has been the longest period he has ever felt so low. He can't picture what his future will be, or how things could be different. He starts to have impulses to jump in front of a train. Thoughts go round his head and he worries he is going mad. He doesn't want his child to grow up without a father, but he feels a failure and a burden.

Adam has tried to speak with his ex-girlfriend about how he is feeling, but he doesn't know how to explain it. She has suggested he speaks to his GP, but he hasn't yet. He doesn't know what help he would get from a GP as he doesn't want medication and he can't find the words to explain how he feels.

7 Consultation: Support

7.1 Introduction

This chapter explores issues around support for men at midlife raised by people with lived experience: men, people bereaved by the suicide of a man in midlife, and professionals who support men in suicidal crisis. ‘Support’ in this context includes formal support, including statutory and third sector services. Participants also considered support more widely, including that provided by friends, family, colleagues, employers, non-health related services and other contexts. The interviews explored not only what support people had accessed or understood to be available, but also what they would like to see provided. After mapping out the types of support highlighted in the interviews, the facilitators and barriers participants raised in accessing support are described.

7.2 Mapping support received

As a safeguarding measure, the men interviewed for the consultation had to be in contact with some form of support in order to take part. As participants were recruited through community and voluntary organisations (CVOs), this could have biased findings towards support provided by CVOs. While we did not engage directly with men who were not currently supported, some bereaved family members described how their father or son had not, to their knowledge, accessed positive support. Men also described the journey they took in getting help and periods of their life when they were not supported.

The importance of support was highlighted throughout the interviews. Participants talked about accessing support at different stages and for different reasons; during long periods of depression, at times of acute crisis, while recovering after a suicide attempt, and to help them manage ongoing suicidal thoughts. The types of support identified by participants as relevant to them included: primary health care; mental health services, accident and emergency (A&E) departments; crisis teams; social workers; respite and rehabilitation centres; gay, bisexual and transgender (GBT) specific support; peer support groups; online sources and forums; telephone helplines; self-help literature; family, partners and friends; and colleagues, human resources personnel and line managers.

7.2.1 Health services

Primary care

Contacting mental health services was considered a significant step by participants. As many of these services were seen to require a medical referral, a visit to the GP was regarded as the first stage, and this was also advised by family and friends. Inevitably, a range of experiences were discussed. Some men detailed how a GP had listened to them, found sufficient time, and provided information, prescriptions and/or referrals. Men and family members spoke of how specific GPs had shown ‘such care’ and sensitivity, and sustained regular contact, particularly during times of extreme stress. This was considered invaluable and felt as an indication that ‘somebody cared’. However, some men and family members described occasions where they felt their GP lacked understanding of mental health, did not respond with the sympathy or urgency required, or had insufficient time to understand the complexity and depth of their situation. Some described a ‘tick box’ process, which was frustrating to men and their families.

‘But the actual meeting with the GP...wasn’t really any help...You usually get a form from them that says, “Rank how you’re feeling in all these various ways.” And that doesn’t seem like...the

greatest thing, kind of rating how depressed you are. You know, just kind of like a formality...It doesn't really seem to work that well...It would have helped me if they did have time; they'd be able to talk more and stuff.'

(Midlife man, with experience of suicidal thoughts)

'[I wanted to say to the GP] I am not doing a shopping list, I am talking about [my son's] life.'

(Bereaved family member)

A&E

Health services were also sought at times of acute crisis. Participants described experiences in Accident and Emergency (A&E) departments as well as with crisis teams⁴³. A&E was felt to be chaotic and under resourced; it was described as heightening pre-existing feelings of confusion and vulnerability. In particular, A&E was not felt to be a 'safe' place for GBT people.

'When we talk to people about their options and about where they can find help and support...we do talk about A&E of course, and...I think generally for going there for mental health support, can feel like a difficult thing to do. People haven't had the best kind of responses there, have been left waiting for a very long time, felt quite dismissed and quite judged...There's quite a large problem for LGBT people going to A&E. I mean, presenting at A&E at three o'clock on a Saturday morning if you're feeling suicidal...when most of A&E's full of quite - well, I was going to say sort of drunk, rough, fighting men...can be a very difficult thing to do if you're very visibly trans, or if you're with a same sex partner...it can feel quite risky. It doesn't feel particularly safe or inviting for LGBT people...certainly if you're already vulnerable.'

(Professional)

Crisis teams

Views of the support received from crisis teams varied greatly. Bereaved family members talked with despair about teams that had failed to meet urgent demands placed on them, and a perception of a service unable to cope. Key benefits cited were the ability to access *informed* expertise (in contrast to more general health care providers), in a critical timeframe (where this was met), and in safer spaces (such as at home). Participants described how crisis team members were not only about managing an immediate crisis, but could be important in establishing an initial direction for recovery. They were well networked with other providers and helped people develop the confidence to leave the home and reestablish familiarity with outside spaces, for example by arranging meetings in coffee shops. However, the limited availability and resources of crisis teams and the restricted length of time they can work with their clients for (described as a few weeks maximum) were major sources of concern.

7.2.2 Talking therapies

The talking (or psychological) therapies referred to in the interviews included contact with a cognitive behavioural therapist, psychotherapist, counsellors and psychiatrists. Participants had experienced both one-to-one and group settings. Talking therapy had been provided through the NHS (usually with a GP referral) or via the third sector, but was also sought and paid for privately. There was a range of experiences of such support and its perceived usefulness. For example, participants described how their experiences of cognitive behavioural therapy (CBT) did not disentangle the complexity of their situation;

⁴³ Crisis teams are part of mental health services. They can support people in the community who are having a mental health crisis (for example, in their own home). Crisis teams take different forms and are also known as home treatment teams, crisis resolution teams, crisis and assessment teams, rapid response services and psychiatric emergency services.

was offered for too few weeks; and was sometimes delivered by practitioners who they felt were inexperienced.

'CBT...tends to be the cheap option 'cause the government have ploughed lots of money into that...It does work for some people, but in my case the lady who was doing the CBT said, "You've got too many issues. You've got too many complex issues for me to deal with this". So you could turn up on day one and issue x could be the problem and next week you turn up and issue y is the problem; the next week issue z is the problem. So there's no consistency whereas most people...that use CBT have one issue...whereas I might turn up one day feeling desperately unhappy because the depression is back. And then the next session it could be anxiety. And that's why CBT failed for me and I've relayed that to the NHS time and time again and I may as well have told the chair.'

(Midlife man, with experience of suicidal thoughts)

The opportunity to talk to an independent and qualified practitioner about suicidal thoughts was considered beneficial. The participants who described the most positive experiences were those who had accessed therapy for months or years with a consistent therapist. These men spoke of meaningful progress and attributed their recovery to positive relationships with that therapist. Ongoing care was considered essential, not just in understanding suicidal thoughts and moments of crisis, but in learning to understand their context and to live with ongoing mental health conditions. For other participants however, access to talking therapy was more sporadic. Regional variations in mental health provision were felt to limit options and availability. Participants wanted a broader range of talking therapies, more promptly and widely available, and available for longer periods of time.

7.2.3 Peer support

Recovery-focused peer support was perceived to have increased in availability. Professionals cited wider views that the approach could promote an increase in self-esteem, confidence and the self-management of individual difficulties.⁴⁴ The professionals interviewed spoke positively about peer support; their organisations facilitated peer support groups or encouraged individuals to attend known peer support groups outside of their service. The men identified the following benefits of peer support:

- Feelings of comfort, safety and being understood due to speaking to people with similar experiences and thoughts to them. To this end, the importance of GBT-specific peer support was emphasised by gay men and professionals with GBT clients. Such support was felt to enable honest discussion and the sharing of experiences (including homophobia, biphobia and transphobia) as well as alleviating worries about having to reveal their sexuality and the issues surrounding it to an unknown audience.
- An opportunity to relate to others at a time when men felt disconnected and isolated.
- A source of information about other local services, particularly within the third sector.
- An opportunity to make friends and be involved in social activities such as exercise classes, trips to art galleries and music events. This was considered a crucial part of recovery.

'It [peer support group] has given me confidence to carry on and it's a constant support. You know if I'm having a really down time and not feeling well and I know that...on the last Thursday of the month there's something to look forward to and that's meeting other people who understand if you go along and you're a bit subdued then they won't immediately say, "Oh come on, brighten up" and all the rest of it. You go along and they understand. But you feel better. You come away with a smile because...being with people who understand because they themselves have been either in that situation or are going through that situation, it helps

⁴⁴ Basset T, Faulkner A, Repper J, Stamou, E. (2010) *Lived Experience Leading the Way: Peer Support in Mental Health*, Together. <http://www.together-uk.org/wp-content/uploads/downloads/2011/11/livedexperience.pdf>

enormously.’

(Midlife man, with experience of suicidal thoughts)

Family members also spoke of the value of peer support groups and the role that they had played in helping them to cope with their bereavement.



7.2.4 Online support

The professionals who provided online forums and web chats as part of their support provision considered these to be in 'high demand' and an expanding part of their remit. The perceived benefits they cited included:

- Their ease of access and use.
- The availability of men-only forums.
- Being a source of up to date information, signposting and support, for men themselves and those concerned about someone else. The men interviewed recalled searching for and reading posts to understand how others experienced depression, anxiety and suicide ideation. Bereaved families spoke of how they had accessed websites and forums to feel better equipped to support their loved one as well as to signpost them to particular sites that they thought might help.

However, the men interviewed for this research did not contribute to online discussions directly and expressed frustration about finding the 'right' groups with more closely aligned experiences. The interviews also revealed how going online in moments of crisis could pose considerable risk. Men spoke of how, while looking for support online, they had inadvertently found information on how to take their own life. The availability of such information at a time when men were feeling confused, distressed and socially isolated had risked exacerbating their suicidal thoughts. A bereaved family member described how she attempted to have specific websites taken down after discovering her son had accessed them during a suicide attempt.

7.2.5 Helplines

The benefits of telephone helplines were felt to be their accessibility, immediacy, and for some men, that they avoided the need for face-to-face contact. Some men described keeping a helpline number with them to provide a sense of reassurance and security. Experiences of calling helplines were particularly positive during moments of crisis. However, dissatisfaction stemmed from some helplines not being available 24 hours a day or seven days a week, and the perceived absence of free phone numbers. Both factors were seen as barriers to access (discussed further in the next section). In addition, while helplines were considered beneficial during moments of crisis, the men interviewed did not regard them as a source of ongoing support.

'It's premium rate...It's not manned 24 hours a day. A lot of suicides are early morning...in the middle of the night and I think that's when most people are at their lowest ebb. So, even though that's focused on men, there's no access 24/7 and if you've got no mobile or you've got no money on your mobile or you've got no access to a phone, you know, you're stuffed really.'

(Bereaved family member)

The professionals who offered support via a helpline described them as being in high demand and, perhaps unsurprisingly, raised concerns around the availability of funding to maintain and expand helpline services to meet the need.

Bereaved family members also highlighted their desire for helplines to provide information to family and friends who want to learn more about how to support someone experiencing suicidal thoughts or distress.

7.2.6 Respite and rehabilitation centres

Having a safe physical location to retreat to for a prolonged period of recuperation was a concept that was enormously attractive to participants and valued by those men who had accessed this form of support. Such provision, whether provided by the private or third sector, not only offered a physical space but also opportunities for psychological intervention, practical help and peer support. However, this form of support was felt to be highly limited in its availability (especially subject to regional variations), lacking funding, and in the case of private rehabilitation centres, perceived to be prohibitively expensive.

7.2.7 Self-help literature

Self-help literature emerged as a convenient and meaningful way of accessing support. Examples were given where it had encouraged men to reflect on their thoughts and feelings and develop their own strategies to help them acknowledge, live with, or avoid suicidal thoughts. One participant described how reading about mindfulness strategies was one of the most 'useful' things he did to help him look after himself and his wellbeing. Literature on addictions (especially alcohol) had also provided men with a space to understand why they had developed their dependences, the links with their depression, and how to address them.

'I kind of locked myself in my room and read a lot of Alcoholics Anonymous literature and a lot of mindfulness literature and worked on myself. I went through about two of these inside three weeks.'

(Midlife man, with experience of suicidal thoughts)

7.2.8 Family and friends

The emotional and practical support provided by family members, including a spouse or partner, was cited as invaluable by men. Key elements of this support at its best included: unconditional love; honesty; being non-judgmental; and the time and energy dedicated to sourcing help for their loved one. One family member spoke of how she attended numerous support groups about men with addictions and suicidal thoughts, in order to understand the complexity of her son's condition and find ways to help him. Family members also expressed feelings of anger and guilt that they had 'failed' in the support of their son.

'I didn't know how to ask for help. I think that's really what it was. And you know...I'm not the type to push and shake the boat, that's my fault as a mother...Maybe I could've done more.'

(Bereaved family member)

Men also raised the importance of talking to siblings and cousins, with whom they sometimes shared experiences of traumatic childhoods. For men who had lost their parents, either because of bereavement or estrangement, that loss of connection was felt to add to their susceptibility to suicidal thoughts.

The importance of having one particular, motivated friend for support and advocacy also emerged as hugely beneficial. A friend who: continued to make contact; recognised when men were starting to feel low; offered comfort and sympathy; planned social activities; and provided perspective on their situation, proved critical. Female friends were described as easier to approach and talk to in comparison to male friends by some participants. Here, gendered differences between men and women were given as explanations for this.

'One friend, I slept on her floor for three days and she took me into work and picked me up from work because...I was basically going in there to be somewhere, so I didn't hurt myself. And then she looked after me and she [found a respite centre] she took me to the doc and she basically was my carer for a few days and I think that helped me. I couldn't have imagined doing that with any of my male friends at all. Like I remember chatting to one guy on the phone...I was walking down the road...and he was like, "Oh, how are you doing?", and I was like, "Oh, I'm fine, yeah, yeah, fine", and, and he knew I wasn't, and I knew I wasn't, but we just let it slide.'

(Midlife man, with experience of suicidal thoughts)

The role of friends in providing support was not, however, straightforward. There were instances where men felt they could not disclose their circumstances or a condition to their friends. In addition, during times of depression and suicidal thoughts, men spoke of how they may have pushed their friends away and given the impression that they did not want them around. This added to feelings of isolation.

‘It would have been useful if some friends had, even though they didn’t think I wanted to be in contact with them, but they had still been in contact with me and come and visited me. I couldn’t ask for them to because I just didn’t have that within me but it would have been helpful for them to have done that.’

(Midlife man, with experience of suicidal thoughts)

7.2.9 Work: managers, human resources, colleagues

Communication with employers during times of stress was described as complicated and having a mixed impact. Men said they were cautious about talking at work about their mental health. They feared being judged, felt that their work prospects would be damaged (in the short and long term), or that there would be no benefit to disclosing due to a lack of understanding about mental health and adjustments. This was echoed in the accounts of bereaved families too.

Some men did talk to individuals at their workplace, usually a line manager or human resources manager. Responses included an acknowledgement of stress, reallocation of certain tasks and responsibilities, being given some time off work, and being referred to a telephone counsellor through an employee wellbeing scheme or advised to go to the GP. Such support was broadly regarded as positive.

Broader concerns were not expressed so much about the initial response of employers, but more with awareness of suicidal distress as long term, and with managing the return to work after a period of leave. Men felt they were expected to return to work quickly and to return to their usual hours and responsibilities straightaway, and that there was a lack of preparation for their return and support available. There was some lack of trust in workplace confidentiality, compounded by a sense that being identified with stress meant a label, stigma, and introduced an awkward dynamic with colleagues:

‘He [my son] said, “They [the employer] told me to go to the doctors” and, of course, he was then put on antidepressants and, you know, he felt that he was then tarred with depression in capital letters across his paperwork. You know, that that was gonna be a stigma to him, no matter what he did and where he went.’

(Bereaved family member)

7.2.10 Financial services

As discussed in the previous chapter, feeling trapped by ‘spiraling’ or chronic financial pressures was identified by men as a key trigger for suicidal thoughts. For example, one man described how the pressure of new targets and conditionality associated with his income support exacerbated his anxiety and panic. Alongside this, he felt his employment coach at the Jobcentre did not understand depression and the impact it could have on job seeking.

Men described how debt collection agencies (such as bailiffs and bank and utility company departments responsible for dealing with late payments) and debt advice agencies and helplines lacked understanding about how incapacitating periods of mental illness and crisis could be. Although participants acknowledged that these organisations ‘had a job to do’, some of the methods used were felt to heighten stress. Men talked about how organisations needed ways of managing customers’ stress in their communications, and that they could have a role to play in reaching out to people showing signs of crisis. Professionals suggested that such organisations could even fund local or national projects focusing on supporting people dealing with mental illness.

‘Maybe you’ve lost a business or you’re losing your house, you’ve got a financial crisis on your hands which is gonna devastate you. And then you’ve got a company that are like...just ringing you up, “We want money, we want money, we want money.” And, you know, what you gonna do? It’s not helping to sort out the problem...They could give you more advice, you know, they could

give more advice about what you could do to get help and support...maybe the banks and the utilities companies could be funding some of this work that, you know, Citizens Advice Bureau and those organisations do to support people through these times. Maybe they should have some more kind of like social responsibility.'

(Midlife man, with experience of suicidal thoughts)

7.3 Facilitators to accessing support

The next section explores how men learnt about what services and support were available, and who or what facilitated access. Men talked about how all attempts to seek support required them to know: that the support was available; they were entitled to it; what the process was to access it; and that they could speak honestly and without fear of judgement.

7.3.1 Informal support as a gateway to more formal provision

The emotional and practical support provided by family and friends was not only a support in itself, but was a primary facilitator to accessing more formal provision. Examples included family and friends identifying appropriate services (including groups, respite centres, and counsellors); making appointments; getting men out and driving them to and from appointments. One man described how he printed an email from a friend which explained why he needed support and gave the email to his GP to read, because he felt his friend was able to provide the words to articulate his crisis in a way that he could not. Men also spoke of the connections made with other men in peer-support and other group settings as useful sources of information about what they were entitled to, what was available, and how to access it.

7.3.2 GP referral to other forms of support

For some services, especially statutory, a GP assessment and subsequent referral was felt to be the only 'route in'. As such, GPs were seen as both a 'gateway' and a gatekeeper to other forms of support. Men described being referred on to other services by a GP as 'getting into the system', and as a starting point to reaching other linked support. This included both short-term assistance offered by crisis and occupational health teams, as well as longer term support such as psychiatry and other forms of counselling. Men spoke positively about entering such 'networks' of provision. Men also mentioned the leaflets and posters in GP surgeries.

7.3.3 Community and voluntary organisations

Community and voluntary organisations (CVOs) were widely cited as key hubs, signposting to other services. Men described their websites as useful and trustworthy sources of information, both in terms of understanding their own condition and for accessing local support groups. For some, this was the first time they had heard about support of this nature. Third sector staff also encouraged men to access different types of support as well as developing self-help techniques, which were seen as an important part of learning to live with mental illness. For example, men discussed how they had learnt to carry the telephone numbers of helplines, supportive friends or a counsellor with them in case of crisis. This strategy was also described as comforting, and reassured people that there was someone they could contact if necessary.



7.4 Barriers to accessing support

Participants explored the different factors that they felt made accessing support more difficult, and which could particularly affect men when they were feeling at their lowest and most overwhelmed.

7.4.1 Perceived stigma

The difficulty people have in talking about suicide in general as well as an individual's own suicidal thoughts was raised by all participant groups, and Western society's reluctance to openly discuss death and bereavement more generally was felt to exacerbate this. Concerns about being judged and a 'burden' to others meant that deciding who to disclose their suicidal thoughts to was an important and often difficult decision. Media portrayals of suicide that were negative, lacking compassion, judgemental and moralistic further fed into men's feelings of guilt and shame, and discouraged them from talking or seeking help.

'It [suicide] isn't a selfish act and yet we're told that it is and that just adds to the guilt and that just makes you feel worse.'

(Midlife man, with experience of suicidal thoughts)

There were also fears around medical 'labelling', being officially diagnosed with a 'mental disorder', and being seen as a 'mental health patient'. These concerns were prominent among men who had been sectioned in the past and who were anxious about returning to a psychiatric ward.

'Mental health means something to mental health professionals. It means a label for the rest of the world. And it's not a label that people would normally identify with.'

(Professional)

7.4.2 Perceptions of masculinity

As discussed in the previous chapter, beliefs about masculinity were identified as risk factors for suicidal thoughts. They were also raised as barriers to seeking support. Ideals surrounding men's self-sufficiency were felt to be reinforced through the media, social interactions, and values, as well as language. For example, phrases such as 'man-up' were felt to have been internalised by some men who felt they were 'weak' because they had suicidal thoughts.

'I think it's...the idea of someone judging you and thinking that you're not - it sounds really pathetic - but you're not a man. You're somehow weak. I think that's for me where the...biggest [barriers to support] are.'

(Midlife man, with experience of suicidal thoughts)

Men described how it was more acceptable for women to display emotion and ask for help, and how people generally did not know how to respond to a man who was visibly upset. Forums such as 'agony aunt' pages in magazines targeted at women, media portrayal of women talking to female friends, and a social acceptance of women crying in public were all felt to encourage women to talk and share feelings and experiences. These gendered expectations about men and women's roles and how they 'should' respond to problems informed men's help seeking behaviour. Men, bereaved families and professionals felt men used distancing techniques – like joking and denial – to avoid 'exposure'.

Not all participants agreed with this however. Some men argued that perceptions of masculinity were not a barrier to accessing support but rather an unhelpful stereotype. These men, and some professionals, felt that men like and want to talk.

'Men don't like to talk? So who the fuck is phoning our helpline? Every time we expand capacity we get more calls. You know I beg to differ...I think we could times our service by ten and we still wouldn't take enough calls.'

(Professional)

7.4.3 Awareness, availability and accessibility

A recurring theme, especially when men talked about early episodes of suicidal thoughts, was confusion regarding what support was available. Men spoke of the difficulties they experienced booking appointments with their GP, especially in busy surgeries. In addition, men who worked full-time found it difficult to take time off to attend medical appointments, and some mental health services (as well as some helplines) were only available on weekdays and during working hours. As a consequence, some men had been taken off programmes or felt they had to manage their condition without support.

Some participants also felt that men and women have different needs with regards to service provision, and that most support is inadvertently designed for or directed towards women. For example, some peer support groups are predominantly attended by women and this discouraged some men from joining.

'Men are not necessarily going to always feel comfortable coming and sitting in a support group for example that's predominantly women, and because they don't necessarily open up in the same way.'

(Professional)

Moreover, the 'marketing' of mental health, depression and suicide was seen as problematic. One professional noted that images of men 'looking depressed' was not encouraging. Creating specific male spaces and targeting places men occupy such as pubs, and music and sporting venues were suggested by men and bereaved families.

Bereaved family members spoke about their exasperation at not knowing what support was available and how they could engineer access on their loved one's behalf. Some described 'fighting' for mental health services over many years from the 'outside'. For example, one bereaved mother spoke of phoning helplines, speaking to doctors, and contacting organisations about support for her son but was told that he had to contact them directly. Mothers also felt they had received limited advice from professionals about techniques and communication strategies that they could use, and were unhappy at having been excluded from discussions between their sons and professionals.

'I could've gone off and done training. I would've done it, you know, when [my son] was alive because it could've been the rephrasing of words to give, [that would] lift him up a little bit, you know, and to let them talk about suicide more you see, because I gather the more they [talk about it] the less they do it, you know...All these things I've learnt since.'

(Bereaved family member)

7.4.4 Not feeling well enough to access support

Men's emotional and physical state during periods of crisis also emerged as a barrier to seeking support. For example, a participant described how he felt unable to leave the home and was consumed by feelings of helplessness and confusion at the times when he needed support most, without the energy to physically move or attend appointments.

7.4.5 Others' perceptions of their wellbeing

Men spoke of their depression and suicidal thoughts not being taken seriously. A recurrent example – which tended to be especially impactful when it did occur – was when a medical professional was dismissive and this was a man's first point of contact. This made him reluctant to seek help again, or delayed any further attempt. Some men also discussed how they felt they were susceptible to others' perceptions. For example, one man described how his doctor told him he was better and reduced his dosage of antidepressants. Although at the time he did not feel better, he felt he must be if a medical professional had told him so. A few weeks later his suicidal thoughts increased and he attempted to take his own life.

A common theme among men who were working full-time was that others – including medical professionals – assumed that because of this they must be coping and so could not be suicidal or in need of support. Men talked about not 'looking' ill, especially if they appeared to be 'functioning' in conventional ways. Bereaved families similarly gave examples of where their loved one's appearance seemed to affect whether they were offered support. They emphasised that outward appearances in terms of dress and manner did not necessarily indicate coping.

'What does suicide look like? And that's been my question ever since [my son died]...We've always got this perception of somebody lying in a heap all over the floor, pulling their hair out, looking a bit odd, you know [laughs], strange looking colour or whatever but...my son had his going out clothes on...He looked highly trendy, you know...his shoes, his trousers, his smartest shirt, he looked fabulous, and lays on the bed and died.'

(Bereaved family member)

Similarly, there was felt to be a lack of understanding about the long-term effects and impacts of suicidal crisis. Men described disparities between their own and other people's expectations of their recovery, such as feeling pressurised by employers to return to work before they felt ready with remarks like 'are you better?' and 'you must be over it by now?'.

7.4.6 Men's own perceptions and understanding

Understanding and managing suicidal thoughts appeared to be something that the interviewed men, with support, had learned to develop over time. A key barrier to recovery from early episodes of suicidal crisis was their own knowledge and understanding of their condition, including whether or not they saw themselves as 'ill enough' to warrant help. While discussing these instances, men recalled the confusion and anxiety that arose from lacking perspective on the severity of their own needs and not being able to recognize intensification in their symptoms. The view that resources for mental health were limited was felt to influence this; even at times when men felt actively suicidal, some questioned whether their needs were sufficient to be prioritised.

7.4.7 Past experiences

The types of services men had accessed in the past and the nature of these experiences also affected whether they would seek this support again in future. Examples of negative experiences with service providers that acted as a barrier to continuing service provision included services: losing their personal records; offering contradictory advice; lacking continuity of care; and discharging people without notifying them. Moreover, delays in being referred and the perceived inappropriateness of some of the support received were barriers to pursuing this type of assistance again. These experiences appeared to have exacerbated the view held by some men and bereaved families that 'nothing would be done' if they were to disclose to a professional that they were suicidal. Underpinning this perspective was an acute awareness of a lack of funding and resources for service provision.

'As somebody who has been in the thick of the services I can vouch that they have been hugely unhelpful to me and...they tend to ignore the fact that I will turn up and say "I'm suicidal. I'm really feeling suicidal". Nothing will be done. It will just be "Oh, see you next week then". Just ridiculous.'

(Midlife man, with experience of suicidal thoughts)

Case illustration D: Tarek

Tarek is in his mid-forties and divorced. After he developed emphysema he stopped playing five-a-side football and found it harder to sustain the contract work he had been doing in local accounts departments. As his physical health deteriorated, he became increasingly isolated with limited access to resources. While his medical treatment for emphysema was ongoing, his deteriorating mental health was not recognised.

Tarek stopped leaving the house. He no longer attended appointments for his physical health and only communicated with his family. His mother became increasingly worried and visited regularly to cook and help with cleaning the house. As Tarek's depression worsened, he started to think about taking his own life. He did not want to burden his family with how he was feeling and so did not talk to anyone about them.

When Tarek had barely left the house for two months, his mother insisted that he visit his GP and made him an appointment, but Tarek had a panic attack at the prospect of going outside.

Tarek called a national telephone helpline. He found this experience quite difficult as he did not like talking to a stranger that he could not see. He looked on the internet for support forums that could help him, but he felt overwhelmed and was distracted by websites he felt were destructive.

Reflecting on this time, Tarek felt that having a professional come to his home to assess him and his situation was what he needed, but did not know if such a service existed.

Case illustration C: Gary

Gary went to see his GP about his depression and suicidal thoughts; he found her to be 'very understanding'. As well as doubling the length of his appointment and listening to his circumstances as fully as possible in the time available, she discussed and prescribed him appropriate medication and also referred him to a counsellor based at the surgery. At his first appointment with the counsellor, Gary described how his suicidal thoughts had intensified and the counsellor referred him to a psychiatrist from the local crisis team who visited Gary at his home.

Gary was in contact with the crisis team for two months and he described the experience as a 'turning point'. He spoke positively about the relationships that he built with the crisis team and how they supported him with practical exercises to help get him out of the home. During this time the crisis team also referred him to a community mental health worker to help build his confidence with being around other people.

As Gary's suicidal thoughts reduced and he began to feel better, he was keen to go back to work. The community mental health worker referred him to occupational health support as well, who advised on a staggered return to work plan.

Throughout this time, he was still in regular contact with his counsellor at the GP surgery.



8 Key findings, recommendations and next steps

8.1 Summary of key findings from the survey analysis

Results: Trends in non-suicidal self-harm, 2000-2014

People have become more likely to report non-suicidal self-harm. The proportion of the population to report this increased from 2.4% in 2000 and 3.8% in 2007, to 6.4% in 2014. The increase was evident in both men and women and across age groups.

These results support other research indicating an increase in self-harming behaviour (with and without suicidal intent) in England in recent decades (Geulayov et al. 2015; Morgan et al. 2016). While a number of factors may account for some of this upward trend - such as changes in likelihood to report certain behaviours – it does seem clear that at least some of this increase must reflect real changes in behaviour.

Results: Risk and context

Mental health was confirmed as one of the clearest risk factors for suicidal thoughts, suicide attempts and self-harm. This held true for the population as a whole and for specific subgroups. Both depression and anxiety disorders each had an independent association. The more severe the symptoms of mental illness, the stronger the association was with suicidal thoughts and behaviour. Deterioration in mental health over time and low levels of mental wellbeing were also isolated as independent risk factors. This association was expected given that suicidal thoughts are one symptom of depression.

A wide range of other risk factors, spanning many aspects of people's lives, emerged in the analysis of survey data:

Physical health and health behaviours including both self-perceptions of general health and having specific, diagnosed conditions. Physical illness was especially key if it was felt to limit ability to work and participate. Smoking and harmful patterns of alcohol use were associated with suicidal thoughts, attempts and self-harm.

Relationships relating to social network size (living alone, or not having a partner or children) as well as to quality of social relationships (for example, lacking closeness to others or being subject to violence or abuse).

Stressful events such as a bereavement, divorce, police contact, and financial crisis were all linked to self-harm outcomes. Rather than any one of these being key, it was the accumulation of multiple stressors that presented the greatest risk.

Economic adversity and financial insecurity were confirmed as a key risks. This was more evident for debt than low income. Living in rented accommodation also emerged as predictive. Employment context was relevant both in terms of job insecurity and loss, and also in terms of job quality.

Identity and demographics associations with age and sex varied for different outcome measures: while completed suicide is most common among men in midlife, self-harming rates peak in young women. Identifying as lesbian, gay or bisexual remained predictive of self-harm across the datasets examined.

The statistical analyses demonstrated that:

- **Many different factors** have independent associations with suicidal thoughts and self-harm
- **There is a dose relationship** (with more exposure to a factor often linked with increased risk)
- **Risks are cumulative** (exposure to multiple factors was linked with increased risk).

The survey data was limited for developing deeper understanding of the particular experiences of midlife men, the demographic most likely to take their own life. The facilitated consultation therefore focused on the needs of this group.

8.2 Context provided by the participant consultation

Men with lived experience, bereaved family members, and professionals working in the field responded to the statistical results. They talked about how these did or did not resonate with their experiences, and made recommendations for responding to suicidal distress in midlife men in terms of: (1) recognising need, (2) facilitating access, and (3) adjusting delivery.

(1) Recognising need: who is 'ill enough'?

Permission: People were keenly aware that public resources are limited and must meet competing demands. The men we spoke to realised that, especially early in their journeys, they lacked insight into the fact that they were not well. They expressed a need for people, but especially men, to be informed that they are *entitled* to help, even if they manage to present the outward appearances of coping.

Appearances: Sometimes a doctor, an employer, a friend or family member assumed a man who was 'functioning', working, dressed presentably, and able to joke could not be suicidal. The people we spoke to stressed: don't judge by appearances, ask.

Persistence: Men needed persuading; they described how they had avoided and deflected, or ignored and pushed people away. Some told us they wished friends and colleagues had persisted with them – called or even just texted support – and not settled for their 'yeah, everything's just fine'.

(2) Facilitating access: the right words, time and place

What is available: In all the interviews, two levels of support need were highlighted: to tackle or manage chronic, ongoing stress, and to address acute tipping points and crises. Many people simply had no idea what types of support were out there. Calls for better signposting and clearer, consistent sources of information are a familiar mantra, but the battle has not been won. Information needs to be in the places where men feel comfortable and will take note.

Finding the words: After realising that they needed help and that help was out there: some men simply lacked the words to ask for it. They wanted to know: what do I say to my employer? How do I explain to the doctor what I am feeling? They wanted testimonials from others, and examples of ways to ask for help. Many also stressed the need to develop self-insight and resilience from an early age.

Allowing time: Many men found short six-week counselling sessions inadequate and struggled with employers who expected recovery to be swift. Some felt rushed to come off medications before they were ready or were discharged from services they still felt a need for. Part of our wider awareness around men, mental health, and suicide needs to include messaging that acknowledges that these processes can take time.

(3) Adjusting delivery

Power: There is a power dynamic in much formal and clinical service provision that some men felt uncomfortable with. It was hierarchical, assumed knowledge about what ‘was best’, and disempowering. Some men we spoke with found in facilitated peer-support groups a model that provided them with training in talking and with connections with others who understood.

Every service contact counts: Men said it took a lot to reach out for help. One negative or seemingly dismissive contact often had long-lasting impact. It would put them off returning or seeking help again. It was clear that every contact counted, and that negative contacts could, inadvertently, count the most.

Safe spaces: Safe spaces for men may be different from what women need. What feels safe varies; some men preferred the support of women and others felt more comfortable with peer support alongside other men with similar experiences to them. Gay and bisexual men, in particular, described A&E as a threatening place. Long-term respite, like that provided by Maytree, is needed more widely.

8.3 Recommendations from the participant consultation

The people who engaged with us made recommendations for different groups:

| Target groups | Recommendations |
|-------------------|---|
| Service providers | <ul style="list-style-type: none">• Avoid assuming someone is well because they are functioning• Ask directly, and again, about suicidal thoughts• Every contact counts, negative contacts can count most |
| Commissioners | <ul style="list-style-type: none">• Extend community-based provision• More ongoing (e.g. peer) support models needed• Alongside properly resourced crisis response |
| Employers | <ul style="list-style-type: none">• Returns to work needs more and careful management• Recognising that recovery can take time• Give colleagues the skills and awareness to be supportive |
| Community | <ul style="list-style-type: none">• We are all responsible for the people around us• Reach out: call, text, write, persist• Be mindful of the language you use |
| Information | <ul style="list-style-type: none">• More online support• Wider range of support available• More testimonials and personal strategies provided e.g. walking, pets etc. |
| Media | <ul style="list-style-type: none">• Avoid images and narratives of suicide as ‘selfish’• Talk about masculinity and mental illness• Provide examples of positive individual and community responses |

See the separate Technical Appendices for a full list of participant recommendations.

8.4 Limitations, considerations and next steps

In carrying out this work we have encountered limitations and identified upcoming opportunities.

New opportunities for research

This report comes at an exciting time as we are on the cusp of:

- Improvements in data linkage opportunities and in computational power for analyses means that new techniques are becoming possible, for example for improved handling of rare events such as suicide.
- Major new survey data releases, including the combined 2013-2016 Scottish Health Surveys (SHeS) and the most recent SHeS 2017, Adult Psychiatric Morbidity Survey (APMS) 2014/15; and the Mental Health of Children and Young People Survey (MHCYPS 2017), available 2019.

Pooling survey waves for improved sample sizes

- These releases present a new opportunity to pool samples, achieving a larger combined sample than has been possible before. This means that there should be sufficient samples for looking at specific, low prevalence outcomes (such as suicide attempt in the last year) and subgroups (for example young women or people with particular disorders or conditions). A larger sample would enable greater exploration of the role of intentionality, but enabling comparison of reporting of suicide attempts and self-harm robustly and within a more recent time frame. Our latent class analysis indicated that intentionality may be a problematic dichotomy.
- With the availability of the new survey datasets mentioned above there will be scope for researchers to examine trends, for example across APMS 2000, 2007 and 2014, and SHeS 2013-2016. For example, further analyses being undertaken as part of this study will examine whether changes in the risk factors for self-harm in young women can explain the steep increases in rates.

Capturing current context

- A strength of these datasets is that they have used consistent methods over many years and cover a range of economic, social, health and mental health risk and protective factors. The datasets drawn on span two decades, but they mostly predate the 2008 onset of recession, and so do not directly examine the most recent economic context. The update from APMS 2014 reflects relatively recent economic context and warrants further analysis.
- The datasets examined provide a picture of specific populations, such as children, specific ethnic groups, or people who are homeless or in prison, were mostly carried out in the 1990s. There is urgent need for surveys of the homeless, prison population, and looked after children to be carried out again and recognition that administrative data sources cannot capture their suicidal thoughts, the majority of their self-harming behaviours, or the social and economic context of their lives across the life course.

Life-course patterns

- These datasets are cross-sectional, which are required for the best estimates of prevalence and trends over time. However, there is a need for longitudinal surveys to include more questions on these themes (although they too are restricted by sample size). The inclusion of questions on self-harm in the Millennium Cohort Study is positive.

Population segmentation and typologising

- Alongside descriptive analyses, we have explored statistical techniques that look to population data for naturally occurring latent classes of related behaviours. Population segmentation approaches can have particular salience for policy and the tailoring of interventions. The attempts outlined here for segmentation analysis are initial, and there is scope for these to be replicated with different datasets and using different approaches.

Broad brush pictures

- In this study we have sought to be as comprehensive as possible, and to revisit many different datasets using comparable approaches. A limitation of this approach is that very specific topics will not be examined with the level of nuance and detail that a study focused exclusively on that topic would bring. However, we hope that by reviewing the data available we can encourage others to focus in on specific areas.

Covering protective factors

- Many protective factors were identified in the research; strong, accepting relationships; supportive working environments; financial stability. However, coverage of other potential protective factors remains underdeveloped in many survey series. The collection of data on the positive aspects of people's lives needs to be seen as part of the developing wellbeing agenda. What are the positive aspects of people's lives that we can should be asking about on UK surveys to better generate an evidence base for reducing suicide risk?

Ask the questions

- These surveys provide plentiful evidence that we can ask these questions. Others have found that asking about suicide does not increase risk that people will act.⁴⁵

Data linkage has growing potential

- These surveys capture suicidal thoughts, suicide attempts, and self-harming behaviour, rather than suicide. The profile of people who make an attempt is very different from the profile of those who do take their life.
- The linkage of survey data with administrative records and mortality outcomes will be vital in future population public health research. Every year the approach becomes more refined, as issues of administrative data quality are improved and more surveys record permission from participants for their data to be linked. Rightly, the process of linkage remains under scrutiny, ensuring confidentiality, ethical practice and informed consent. We still have some way to go before these processes are sufficiently streamlined: momentum for this to happen requires the continued engagement of policy makers and for the case to be made to the public of the value of such research.
- Permission from survey participants for data linkage has been gained since the 1990s, and with each new wave of the annual Health Survey for England (HSE), the sample available for linkage to mortality data, and the number of new mortality outcomes, increases. Thus this resource is just now coming into its own for suicide epidemiology. Our analysis of pooled HSE data with mortality

⁴⁵ Dazzi T, Gribble R, Wessely S, Fear NT. (2014). Does asking about suicide and related behaviours induce suicidal ideation? What is the evidence? *Psychol Med*; 7:1-3.

outcomes demonstrated that this approach is feasible and powerful, and will become within the next few years even more powerful with developments in computational power, increases in sample size, and improvements in the data linkage process.

- Linkage of survey responses to healthcare datasets such as Hospital Episode Statistics or the Clinical Practice Research Database, or benefit datasets held by DWP, might enable investigation, for example, of temporal relationships in physical illness, between diagnosis, important related events like treatment changes or hospital admission, illness-related unemployment and receipt of benefits, and self-harm or suicide. This could lead to a more productive approach to targeted screening for mood disorder in the physically-ill. All such work depends on there being a streamlined and efficient review process.

Participant perspectives

- Research ‘respondents’ or participants often lack power in the research process. The widely used term ‘respondents’ implies that participation in studies is passive. We therefore advise talking about ‘participants’, to reflect the active engagement of people taking part.
- We sought here to use a ‘participatory consultation’ approach to involve people with lived experience in the contextualising of the statistical data, and leading on generating substantive recommendations for practice. The depth interviews were conducted flexibly using a topic guide, to facilitate coverage of the issues that participants felt were most relevant to them.
- There is often a trade-off between specificity and generalisability when designing research. In this study we have aimed to generate broad and generalisable insights from survey statistics, but honed the recommendations developed through the participatory consultation in on the specific circumstances for men in midlife.
- It has been nearly twenty years since the last survey of minority ethnic mental health. Such studies are needed, but costly and time consuming to undertake. In the meantime, a qualitative participant consultation like that undertaken here focusing on the meanings and manifestations of suicidal thoughts and self-harming behaviours in different ethnic groups is urgently needed. Without this, models for identifying people at elevated risk remain based on understandings of how suicidal thoughts and behaviours manifest in the White British population.

Gendered perspectives

- The experience of self-harm and suicidal crisis, in terms of prevalence, trends, nature and context, is gendered. Research funders and commissioners should require gender to be considered in all mental health research from the start, including ensuring that there is investigation into gendered risk factors such as violence and abuse, that analyses are stratified by gender, and that evidence is generated on gender sensitive treatment and care.⁴⁶
- Several participants highlighted a need to better understand the prevalence and nature of self-harm among people who are transgender.

⁴⁶ See Howard L, Ehrlich A, Gamlen F, Oram S. Gender neutral mental health research is sex and gender biased. *The Lancet*. 2017 4:1;9-11. [https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366\(16\)30209-7/abstract?code=lancet-site](https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(16)30209-7/abstract?code=lancet-site)

