



Summary

**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

Summary report

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Summary

Background

Since the early 1990s national UK surveys have sensitively collected information from large, probability samples of the general population about experiences of nonsuicidal self-harm, 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 nonsuicidal 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 consolidate, 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.

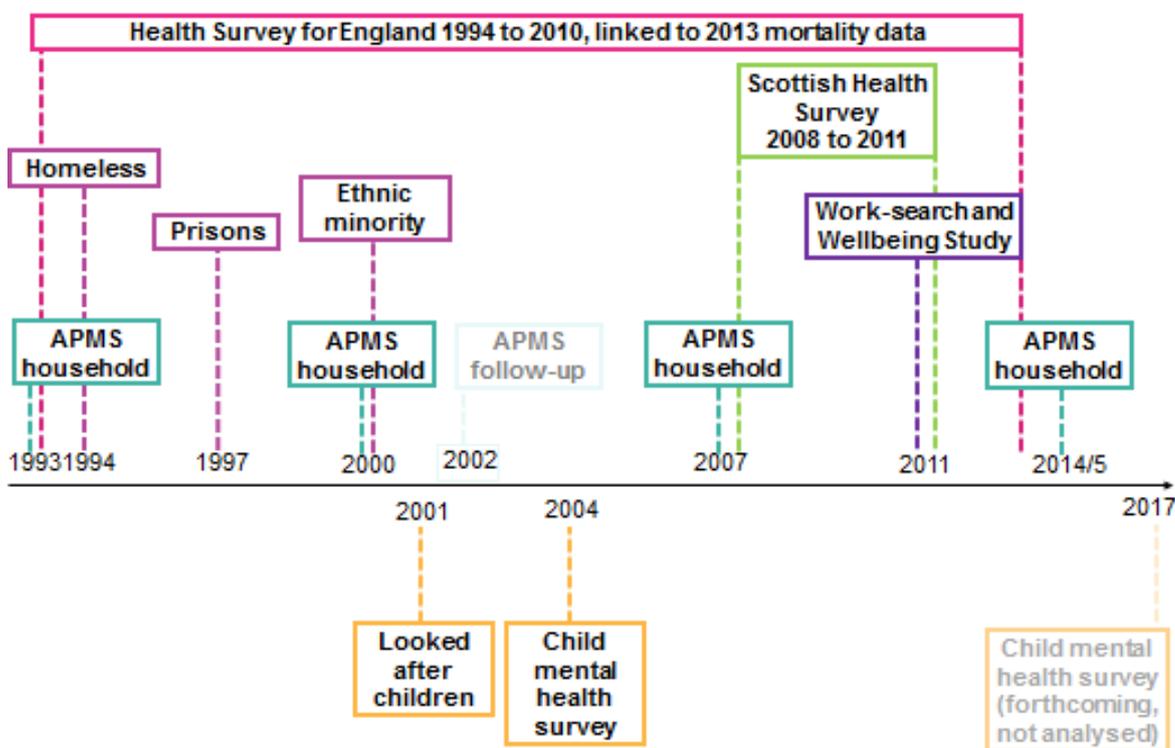
Methods

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 nonsuicidal self-harm. The datasets were analysed using descriptive analyses, multiple logistic regression modelling, and latent class analysis to identify common factors that predict suicidal thoughts, attempts and nonsuicidal 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. Over 140,000 participants consented to data linkage, 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). Multiple regression analyses were undertaken to identify longitudinal predictors of subsequent suicide.

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, and 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

People with lived experience 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 framework¹ and a focus on the social determinants of health, including mental health.² An aim of the research was to identify subgroups in the population at elevated risk of suicidal thoughts, attempts and nonsuicidal self-harm. The statistical analysis involved examining variation by sex, ethnicity, age, sexual identity, relationship status, health status, disability, and subgroups

¹ 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>

² 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>

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, 2000-2014

Analyses of three waves of the Adult Psychiatric Morbidity Survey (APMS) show that people have become more likely to report nonsuicidal 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 is also evident in suicidal thoughts, from 3.8% in 2000 to 5.4% in 2014. The results are striking, but consistent with other research.³

While a number of factors may account for some of this upward trend, such as changes in likelihood to report, it does seem clear that at least some of this increase reflects real changes in behaviour. The prevalence of self-harm was highest in young women, with around one in five (19.7%) reporting this face-to-face and one in four reporting this by self-completion in 2014. Individuals who start to self-harm when young may be more likely to go on to 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.

Trends are examined in more detail in a separate, forthcoming report.

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 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.

³ 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).



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 crisis⁴ 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 greater 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.

⁴ Defined on the surveys as the equivalent of the sudden loss of three or more months' income.

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 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.

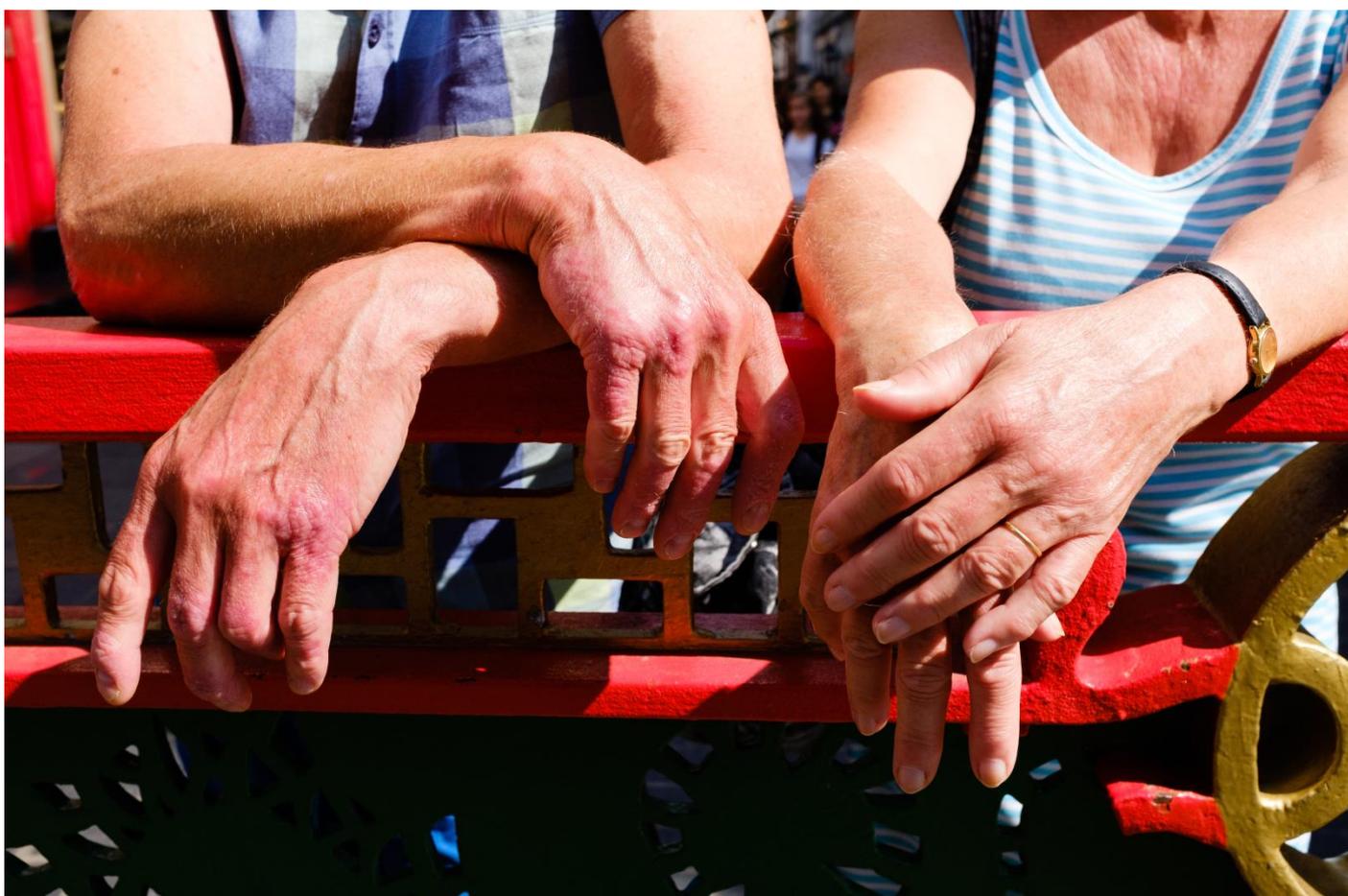
Allowing time: Another theme to emerge was allowing more time. Short counselling sessions were described as inadequate, and struggles with employers who expected recovery to be swift were clear. Men described feeling rushed to come off medications before they were ready or were discharged from services 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 cannot 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 remuneration - 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 nonsuicidal 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, although the inclusion of more detailed follow-up questions in future waves are needed, including questions about intent. Longitudinal surveys, however, 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 a central repository for health and social survey data, with data freely available to research institutes for immediate download.⁵ 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 reporting has identified a recent, steep upturn in the proportion of young women self-harming. This 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.

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.

⁵ 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.

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 and other segmentation analyses to profile population patterns 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 (including violence and abuse), that analyses are stratified by gender, and that evidence is generated on gender sensitive treatment and care.⁶



⁶ 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)