



# Suicidal thoughts, suicide attempts, and self-harm

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## Summary

- Suicide prevention is a major goal for local authorities and central government. Between 2007 and 2013, suicide registration data showed a broadly upward trend among men and stability among women, although in 2014 and 2015 the male rate declined and the female rate increased.
- Self-reported suicidal thoughts, suicide attempts and self-harming (without suicidal intent) are associated with great distress for the people who engage in them, as well as for the people around them. They are strongly associated with mental illness, and help to identify people at increased risk of taking their own life in the future.
- The Adult Psychiatric Morbidity Survey (APMS) included questions on these in both the face to face and the self-completion parts of the interview. For reasons of comparability, trends over time draw on face to face reports, which tend to be lower. A variable combining face to face and self-completion data was used for examining differences in rates between groups.
- The proportion of the population who reported having self-harmed increased from 2.4% and 3.8% of 16 to 74 year olds in 2000 and 2007, to 6.4% in 2014. This increase is evident in both men and women and across age-groups. Greater awareness of self-harming is probably a factor in the increased reporting.
- One in four 16 to 24 year old women (25.7%) reported having self-harmed at some point; about twice the rate for men in this age group (9.7%) and women aged 25 to 34 (13.2%). The gap between young men and young women has grown over time.
- Self-harm in young women mostly took the form of self-cutting. The majority reported that they did not seek professional help afterwards.
- 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. For women, the increase occurred between 2000 and 2007; for men it took place later, between 2007 and 2014.

- Since 2000 there has been a slight increase in the reporting of suicide attempts, but only among women (0.5% in 2000, 1.0% in 2007).
- Particular subgroups have experienced more pronounced increases over time. For example, people aged 55 to 64 suicidal thoughts (2.1% in 2000; 4.9% in 2014) and suicide attempts (0.1% in 2000; 0.6% in 2014) at least doubled in rate since 2000. This was evident both in men and women.
- Some groups in the population were more likely than others to report these thoughts and behaviours, such as those who lived alone or were out of work (either unemployed or economically inactive). Benefit status identified people at particularly high risk: two-thirds of Employment and Support Allowance (ESA) recipients had suicidal thoughts (66.4%) and approaching half (43.2%) had made a suicide attempt at some point.
- Overall, half of people who attempted suicide sought help after their most recent attempt (50.1%). About a quarter sought help from a GP, a quarter went to a hospital or specialist medical or psychiatric service, and a fifth tried to get help from friends or family.
- Men and women were equally likely to seek help after a suicide attempt. Older people were more likely to seek help from a hospital or specialist medical or psychiatric service than younger people; the latter were more likely to turn to family and friends. Using GPs as a source of support following a suicide attempt was equally common across age-groups.

## 12.1 Introduction

In 2015, England's Department of Health (DH) published its second annual report on the cross-government outcomes strategy to save lives: *Preventing suicide in England: Two years on* (DH 2015). Between 1990 and 2007 the suicide rate in England fell, and in 2007 reached its lowest recorded level in men (at 13.9 per 100,000). The male suicide rate then saw an upward trend, reaching 16.1 per 100,000 in 2013 (a return to about the level it was in 2001) before falling in 2014 and 2015. In 2015 it was highest in men aged 40 to 59 (ONS 2016). Economic

and employment context has been identified as a factor in trends in male suicide; those areas of England worst affected by recent unemployment experienced greater increases in suicide (Barr et al. 2012). Rates in women are lower and have stayed relatively constant since 2007, although increasing from 4.3 to 5.0 deaths per 100,000 between 2013 and 2015 (ONS 2016).

Among its key objectives, the English National Suicide Prevention Strategy includes the development of epidemiological evidence concerning suicide and self-harm (DH 2015). Such knowledge is needed to plan services and target interventions at the most relevant groups. A prior attempt is a key risk factor for suicide (WHO 2014), and so measuring suicide attempts and self-harm can help profile people at increased risk of suicide. However, it is important to note that the relationship between suicidal ideas, self-harm and suicide is not straightforward. The profile of people reporting suicidal thoughts, attempts and self-harm is very different, in terms of age and sex, from that of people who take their own life, and the great majority of people who engage in these thoughts and behaviours do not go on to die by suicide.

Suicidal thoughts and suicidal behaviours are, in their own right, associated with high levels of distress, both for the people engaging in them and in those around them. They frequently co-occur, but are distinct. While much research on self-harm has combined suicide attempts with non-suicidal self-harming, Adult Psychiatric Morbidity Survey (APMS) data can be used to examine these behaviours separately as it includes some indication of self-reported intention.

Among those who engaged in non-fatal self-harming (with suicidal intent or not) many do not consult health services and, if they do, they may not be identified as being suicidal. Data collected routinely for administrative health datasets provides a unique understanding of patterns of service use but provides a different understanding to community prevalence studies. Studies of people attending health services will be affected by the factors associated with clinic and hospital attendance (Geulayov et al. 2016). Official statistics on recorded suicides (official suicides and undetermined deaths) provide a profile of people who have taken their own life, but not systematically coded detail about their life and socioeconomic circumstances. While this can be obtained from surveys, survey

samples exclude those people, mostly male, who take their own life at the first attempt (Isometsä and Lönnqvist 1998). There is therefore a need to look across a range of data sources, and at suicidal thoughts and self-harm as well as attempts.

This chapter provides nationally representative estimates of the prevalence of suicidal thoughts, suicide attempts and self-harm, and trends in these since 2000. Their relationship to age, sex and other characteristics is described alongside findings on the methods and reasons reported for self-harming. Finally, results are presented on the help-seeking behaviour of people who have made a suicide attempt, and on the types of professional help received by those who have self-harmed.

## 12.2 Definition and assessment

### **Suicidal thoughts, suicide attempts and self-harm**

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (APA 2013) includes two types of self-harming behaviour as conditions for further study: non-suicidal self-injury (NSSI) and suicidal behaviour disorder (SBD). While intentionality can be difficult to establish (Kapur et al. 2013), this is broadly the approach that has also been adopted in the APMS series, with a separate focus on thinking about suicide; making a suicide attempt with the intention of taking one's own life; and harming oneself without the intent to die.

### **Measuring suicidal thoughts, suicide attempts and self-harm**

#### *Face to face questions*

As in APMS 2000 and 2007, all participants were asked in the face to face section of the interview a number of questions about suicidal thoughts, suicide attempts, and self-harm without suicidal intent.<sup>1</sup> These questions form part of the revised Clinical Interview Schedule (CIS-R). For the purposes of the analysis in this chapter, suicidal thoughts, attempts and self-harm were assessed using the following questions:

<sup>1</sup> These questions were also asked in the 1993 APMS survey, but only of a subgroup of respondents (those who had been depressed in the previous week). Therefore trends are only presented for 2000, 2007 and 2014.

- Have you ever thought of taking your life, even though you would not actually do it?
- Have you ever made an attempt to take your life, by taking an overdose of tablets or in some other way?
- Have you ever deliberately harmed yourself in any way but not with the intention of killing yourself?

A positive response to each was followed up with a question on whether this last occurred in the past week, the past year, or longer ago.

### *Self completion questions*

While questions about suicidal thoughts, attempts and self-harm were asked face to face in order to retain comparability with the previous APMS surveys, it was recognised that some participants might choose not to report them if asked face to face. For this reason, in the 2007 and 2014 surveys, some questions were also asked of all respondents a second time, later in the interview, using laptop self-completion. In 2007 this consisted of the three lifetime prevalence questions listed above (a subset of the full section administered face to face). In 2014, most of the questions on suicidal thoughts, attempts and self-harm were administered in the self-completion section, with some retained in the face to face section for trends and for use in scoring the CIS-R.

### *Questions used for results in this chapter*

In 2014, a new question was added on when the participant had last self-harmed. In previous surveys in the series, participants were asked if they had ever self-harmed, but not when this had last happened. Trends in self-harm, therefore, are based only on reports of lifetime experience. Also to retain comparability of method with the 2000 and 2007 surveys, only data collected in the face to face interviews were used to assess change over time. The other analyses of suicidal thoughts, attempts and self-harm in this chapter draw on derived variables that combine positive responses in the face to face interview with positive responses in the self-completion section, as we believe this approach to be

the most accurate. Generally, reporting in the self-completion was higher than reporting face to face, but not all participants did the self-completion.

### **Measuring methods of self-harming**

In the self-completion section of the interview, participants who reported that they had self-harmed at some point were asked which of a list of methods (cutting, burning, swallowing something, or some other way) they had used. It was possible to give more than one response.

*Did you... (You may give more than one response)*

1. Cut yourself
2. Or burn yourself
3. Or swallow anything
4. Or harm yourself some other way

### **Measuring reasons for self-harming**

Participants who reported in the self-completion that they had self-harmed were also asked two questions about their motivation. It was possible to endorse neither, one, or both of these reasons:

- Did you do any of these things to draw attention to your situation or to change your situation?
- Did you do any of these things because it relieved unpleasant feelings of anger, tension, anxiety or depression?

The issue of intent is very complex; these questions are reductive and the reasons given by participants for self-harming may reflect subsequent rationalisations (Kapur et al. 2013). The data presented on this should be treated as only indicative.

## 12.3 Results

### Suicidal thoughts, suicide attempts and self-harm by age and sex

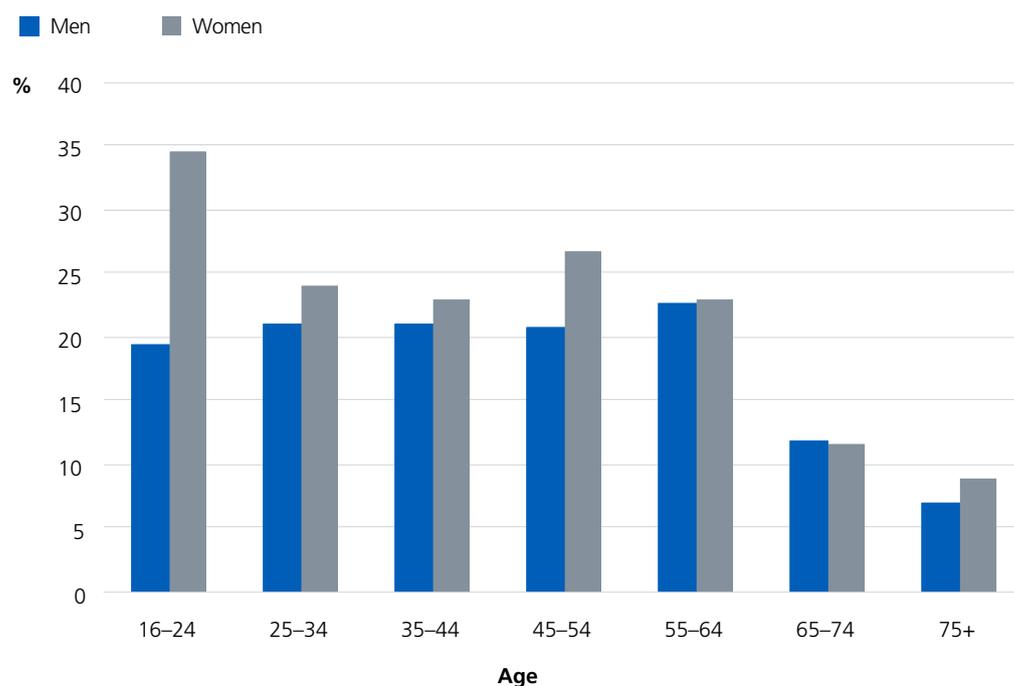
#### *Prevalence of suicidal thoughts*

A fifth of adults (20.6%) reported that they had thought of taking their own life at some point. If all adults in the wider population had been asked about this it is likely that the proportion agreeing would be between 19.5% and 21.7% (95% confidence interval (CI)). This was more common in women (22.4%) than men (18.7%), and in people of working-age than those aged 65 or more.

The survey questions related to suicidal thoughts across the lifetime. The higher reporting in people aged less than 65 might be explained by generational differences, with young people now being more likely to have suicidal thoughts than their counterparts in the past. However, age group variations in recall, perception and willingness to report, together with healthy-survivor effects,<sup>2</sup> may explain some of this association with age.

#### **Figure 12A: Suicidal thoughts ever, by age and sex**

*Base: all adults*



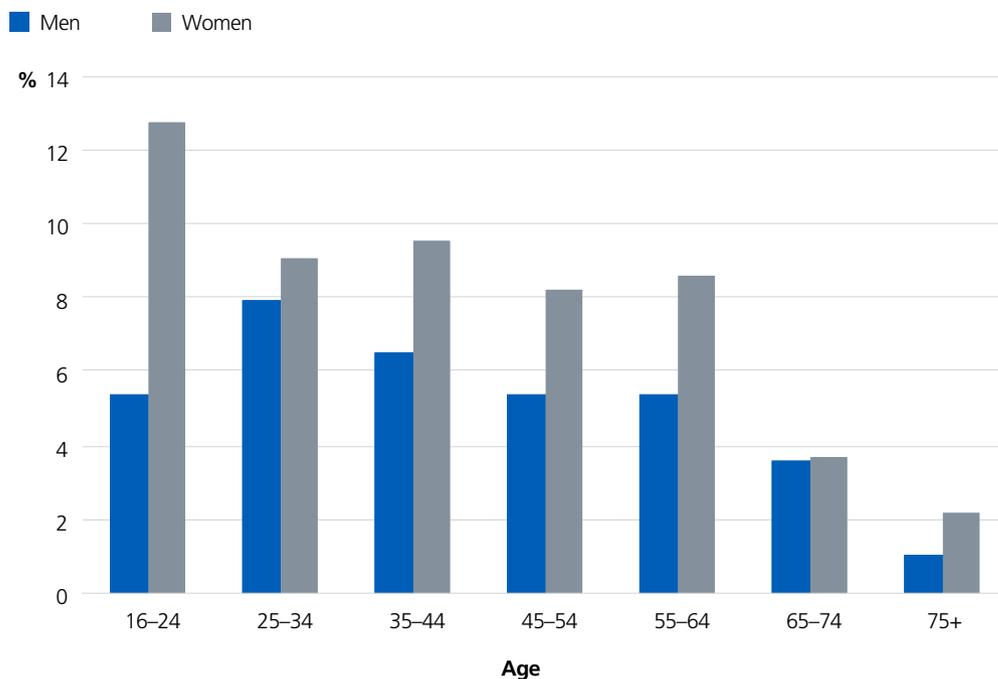
<sup>2</sup> 'Healthy survivor effect' is a type of selection bias. People who face adversities on average die younger than those who do not. This means that those who survive into late old-age will not be representative of their birth-cohort in terms of level of exposure to adversity.

### Prevalence of suicide attempts

One person in fifteen had made a suicide attempt at some point (6.7%, CI 95%: 6.1% to 7.4%). Despite men being more likely than women to take their own life (ONS 2015), women were more likely to report an attempt (5.4% of men, compared with 8.0% of women). As for suicidal thoughts, lifetime suicide attempts were more likely in working-age adults than in those who were older. While the overall pattern by age was not significantly different in men and women, the rate of suicide attempts reported by young women (aged 16 to 24) was notably high. This fits with their particularly high levels of suicidal thoughts, self-harm, and wider psychiatric morbidity, as captured in other chapters of this report.

**Figure 12B: Suicide attempts ever, by age and sex**

Base: all adults



### Prevalence of self-harm without suicidal intent

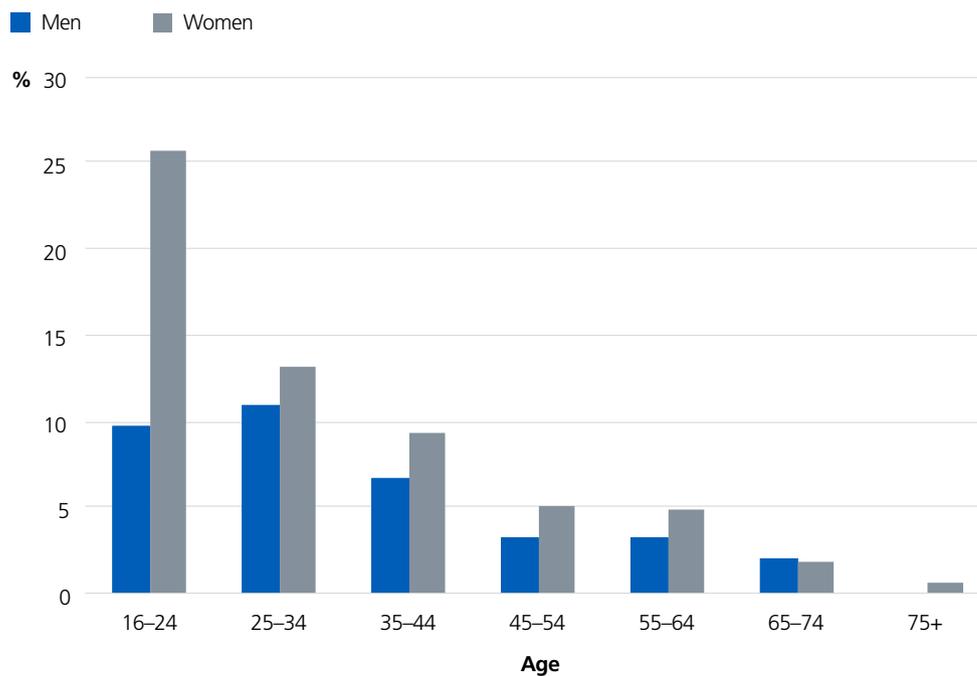
The overall rate of self-harm in the adult population (7.3%, CI 95%: 6.7% to 8.0%) was comparable to that for suicide attempt (6.7%), with rates higher in women (8.9%) than in men (5.7%). However, the age gradient for self-harm was more pronounced, and this was particularly evident in women. One in four women aged 16 to 24 (25.7%) report having self-harmed, compared with one in a hundred women aged 75 or over (0.6%).

Young women were also much more likely than young men to self-harm: 25.7% of women aged 16 to 24 reported this, compared with 9.7% of men in the same age group. Such variation by sex was not evident in older age groups.

**Table 12.1**

**Figure 12C: Self-harm without suicidal intent ever, by age and sex**

*Base: all adults*



## Suicidal thoughts, attempts and self-harm; 2000, 2007 and 2014

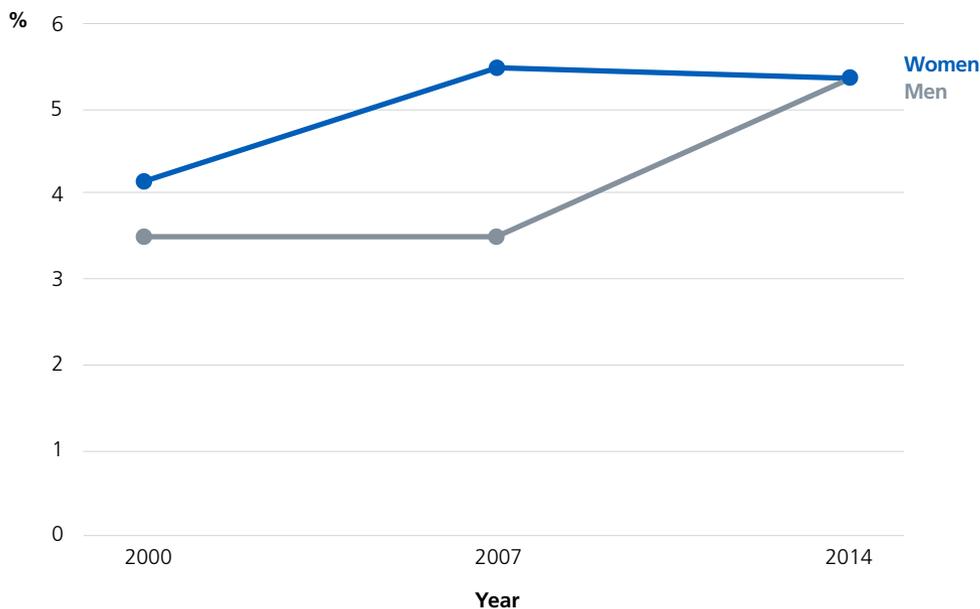
Note that the trend data in this chapter are based only on face to face reports. In 2007 and 2014 self-completion data on this topic was also collected, this tends to elicit higher reporting.

### *Trends in suicidal thoughts*

In 2014, 5.4% of 16 to 74 year olds reported suicidal thoughts in the past year when asked in the face to face part of the interview, a significant increase on the 3.8% reporting this face to face in 2000. For women, the increase occurred between 2000 and 2007; for men it took place later, between 2007 and 2014.

### **Figure 12D: Suicidal thoughts in the past year (reported face to face) by sex; 2000, 2007 and 2014**

*Base: adults aged 16–74 and living in England*

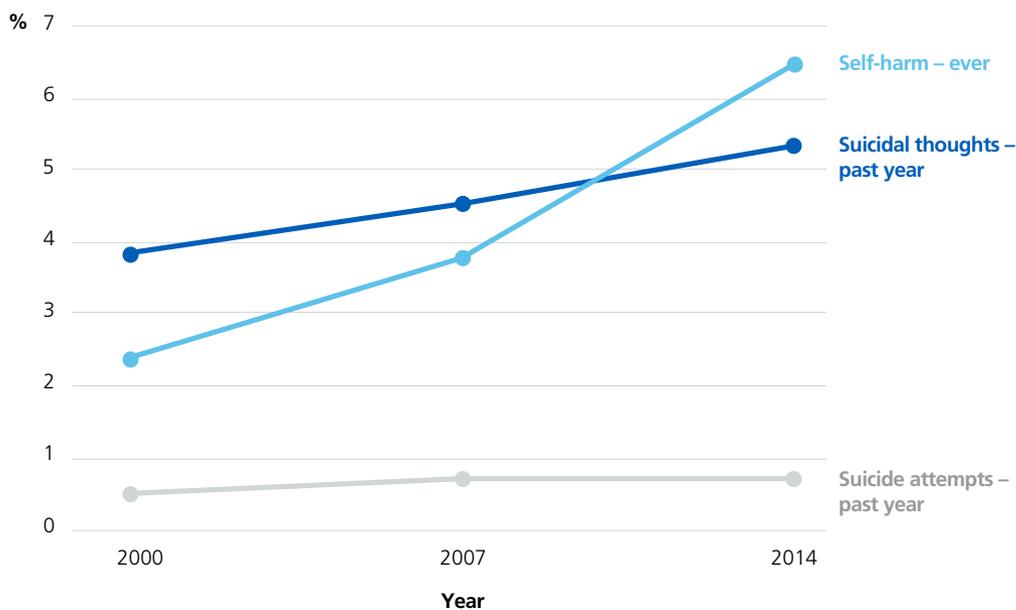


### *Trends in suicide attempts*

Between 2007 and 2014, reporting of a suicide attempt in the past year remained stable at 0.7% of 16 to 74 year olds. Since 2000 there has been a slight increase, but only among women (0.5% in 2000, 1.0% in 2007).

**Figure 12E: Suicidal thoughts, suicide attempts and self-harm (reported face to face); 2000, 2007, 2014**

*Base: adults aged 16–74 and living in England*

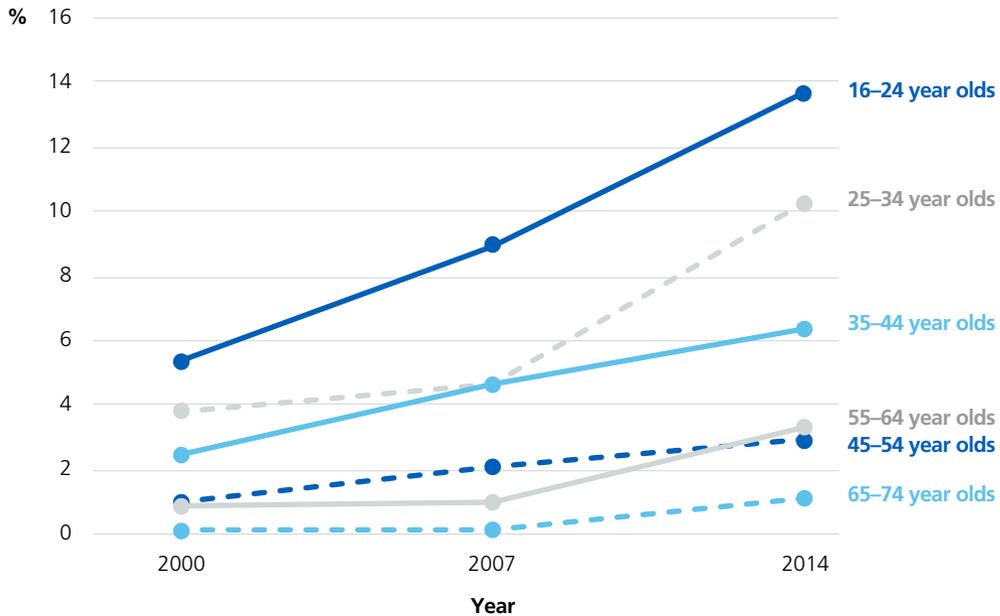


### *Trends in self-harm*

Reporting of lifetime self-harm in the face to face part of the interview has seen sustained increases over time, from 2.4% in 2000, 3.8% in 2007, to 6.4% in 2014. This increase is evident across age-groups, in all of which rates have more than doubled since 2000. In some age-groups (25 to 34 year olds, and those aged 55 to 74) reporting of lifetime self-harm has doubled since 2007.

**Figure 12F: Self-harm ever (reported face to face)  
by age; 2000, 2007 and 2014**

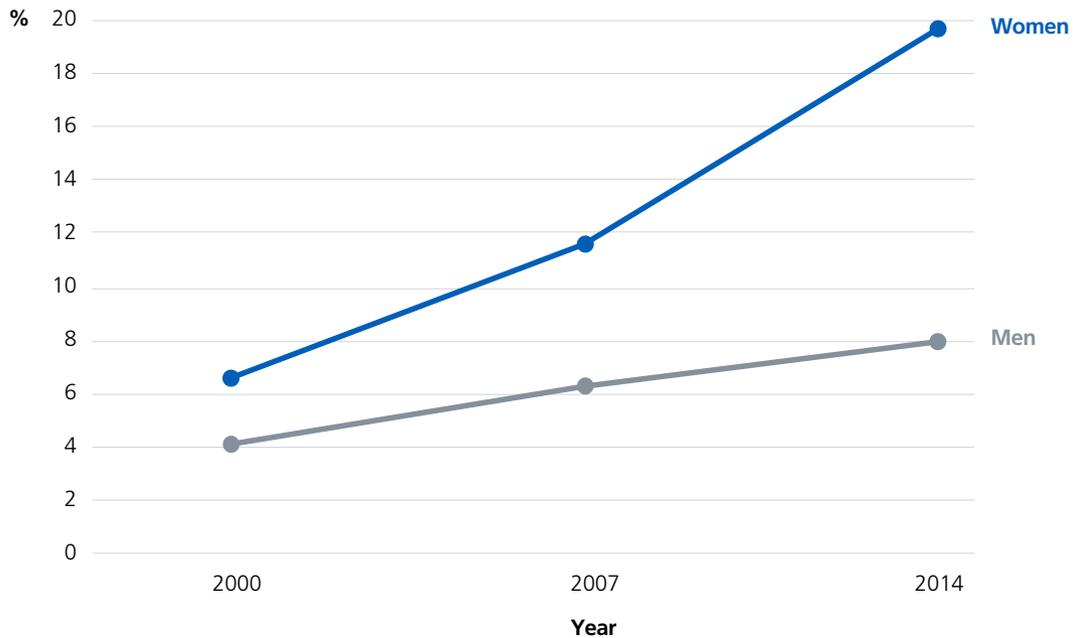
*Base: adults aged 16–74 and living in England*



Among women aged 16 to 24 years in 2000, one in fifteen reported having ever self-harmed (6.5%); this increased to one in nine in 2007 (11.7%) and to one in five in 2014 (19.7%). In 2000, rates of self-harm were similar in young men and women. By 2014, young women were more than twice as likely to report it as their male counterparts (19.7%, compared with 7.9% of 16 to 24 year old men). [Table 12.2](#)

**Figure 12G: Self-harm ever by sex among 16-24 year olds; 2000, 2007 and 2014**

*Base: adults aged 16–24 and living in England*



### Variation in suicidal thoughts, attempts and self-harm by other characteristics

#### *Ethnic group*

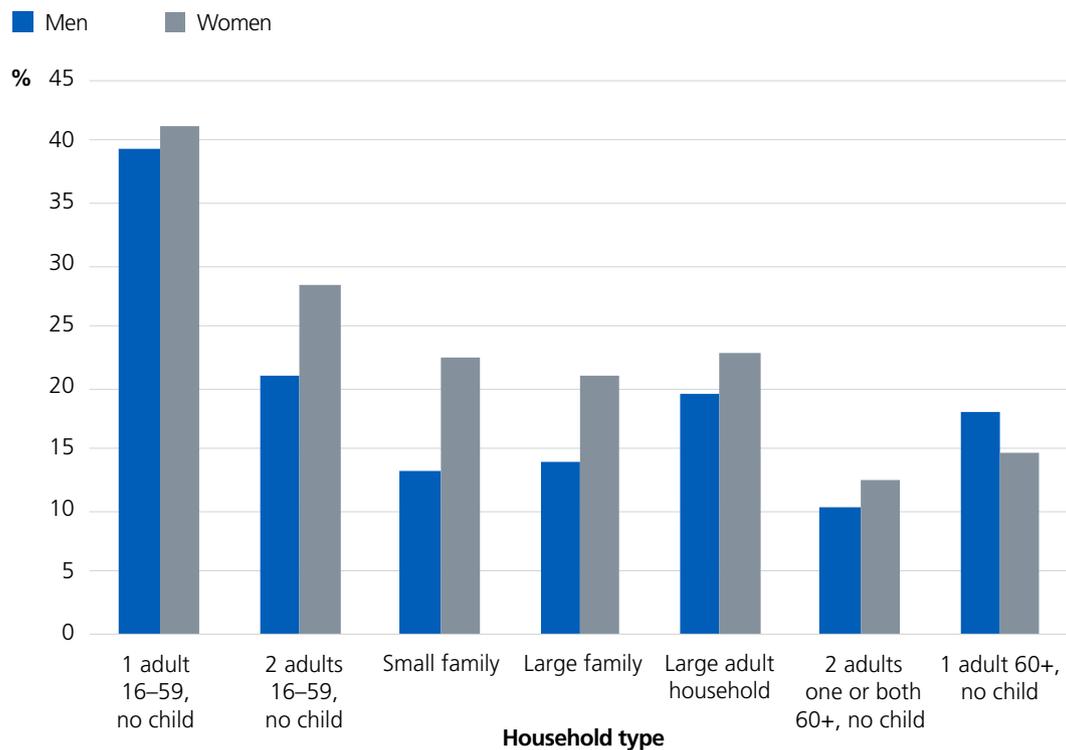
Lifetime suicidal thoughts, attempts and self-harm were evident across all ethnic groups. Rates did not differ significantly by ethnic group after age-standardising the data. It should be noted however, that due to sample size limitations the ethnic group categories are both small and heterogeneous. It is possible that this might mask real differences. [Table 12.3](#)

### Household type

People under 60 who lived on their own were more likely to have suicidal thoughts than those of the same age living with others. This was also true of having made a suicide attempt and of having self-harmed. Of people living in such circumstances, 40.2% had suicidal thoughts, compared with 24.8% of people who lived with another adult. This pattern was also evident in people aged 60 and over: those living alone were more than twice as likely to have made a suicide attempt as those living with another person (6.4%, compared with 2.5%). [Table 12.4](#)

**Figure 12H: Suicidal thoughts ever, by household type and sex**

*Base: all adults*

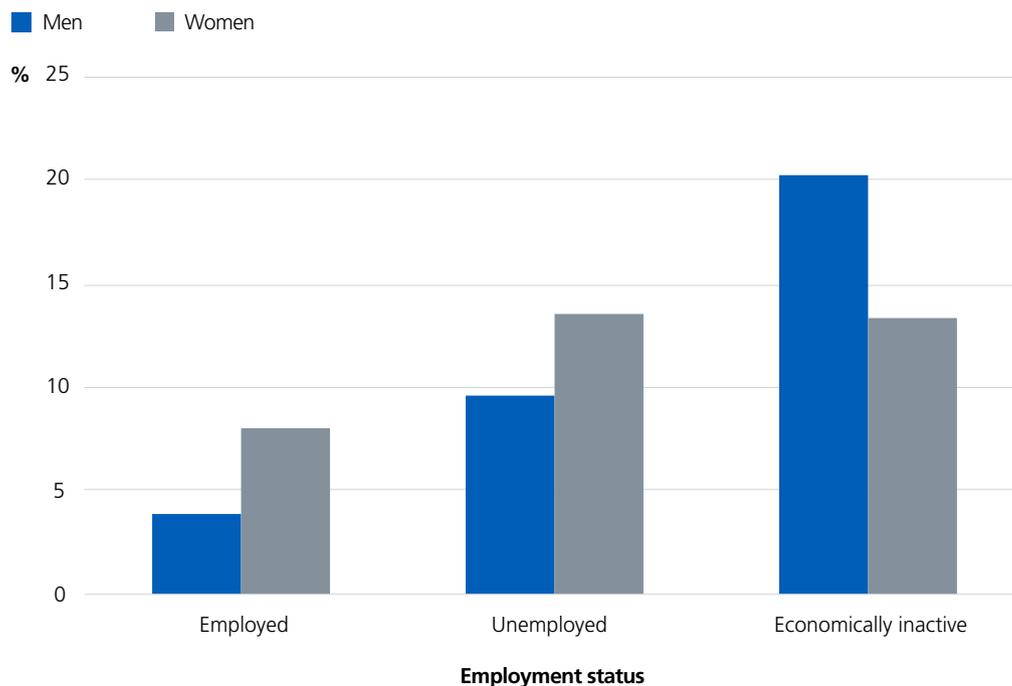


### Employment status

Employment status was associated with suicidal thoughts, attempts and self-harm in the working-age population (16 to 64 year olds). Among men, the associations were strong, with rates of each lowest among the employed and highest in the economically inactive. In women the differences were less marked, with similar rates in the unemployed and those who were economically inactive. [Table 12.5](#)

**Figure 12I: Suicide attempt ever, by employment status (age-standardised)**

Base: aged 16–64



### Benefit status

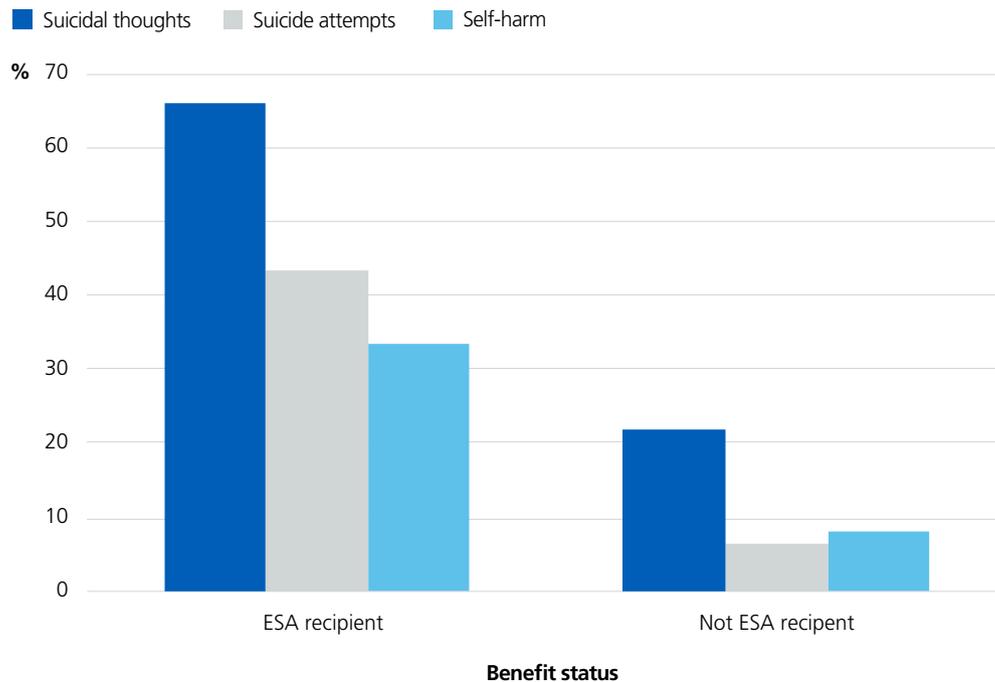
Age-standardised associations of suicidal thoughts and attempts, and self-harm with the receipt of out-of-work benefits were examined for people aged 16 to 64. Links with housing benefits are reported for the whole population.

Two thirds of people in receipt of Employment and Support Allowance (ESA) (66.4%) had thought about taking their life, approaching half had made a suicide attempt (43.2%), and a third reported self-harming (33.5%); indicating that this is a population in great need of support. People in receipt of other benefits also had

higher rates of suicidal thoughts, suicide attempts and self-harm than those who did not receive these benefits. [Table 12.6](#)

**Figure 12J: Suicidal thoughts, suicide attempts, and self-harm ever by receipt of Employment and Support Allowance (age-standardised)**

*Base: adults aged 16–64*



*Region*

Suicidal thoughts, suicide attempts, and self-harm occur in all regions of England, without significant variation in rate. This remained the case when the data were age-standardised to adjust for age-differences in the population of different regions.

[Table 12.7](#)

*Mental health*

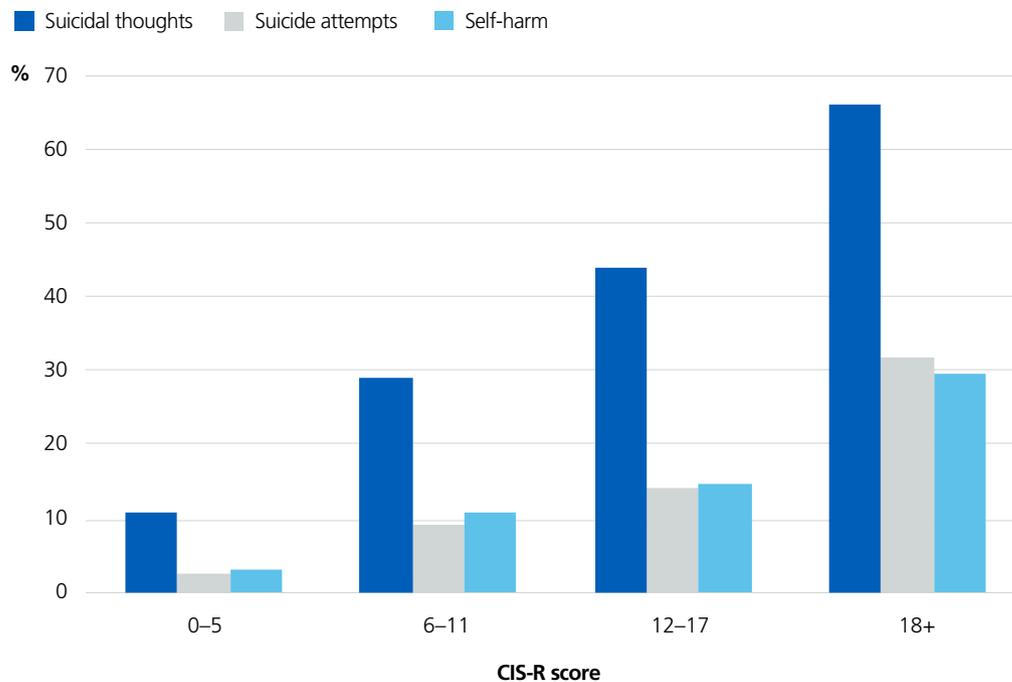
As described in Chapter 2, symptoms of common mental disorder (CMD) in the past week were assessed using the CIS-R. The total CIS-R symptom score was strongly associated with lifetime suicidal thoughts, suicide attempts, and self-harm.

Two-thirds of people with severe symptoms of CMD (CIS-R score 18+) (65.9%) had thought about taking their own life, compared with a tenth of those with no or few symptoms (10.7%). The association was stronger for men than for women.

**Table 12.8**

**Figure 12K: Suicidal thoughts, suicide attempts, and self-harm ever by severity of symptoms of CMD in the past week (CIS-R score)**

*Base: all adults*



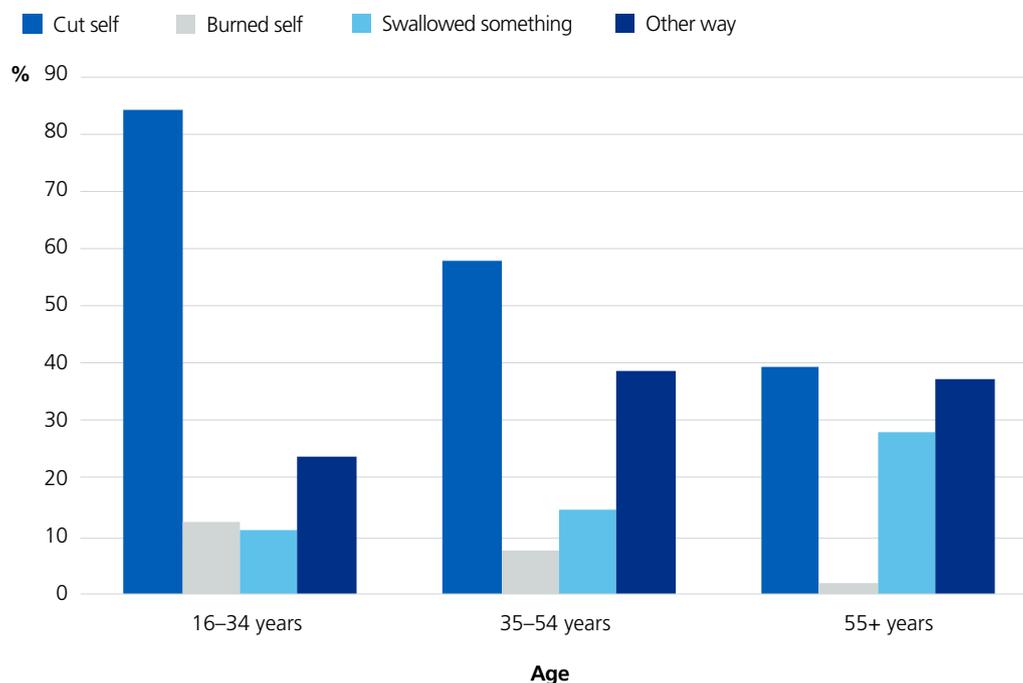
### Methods of self-harming

Overall, three-quarters of people who self-harmed had cut themselves (73.1%); around one in ten had burned themselves (10.2%); a similar proportion swallowed something (13.8%); and nearly a third had used some other method (29.1%). While women were more likely than men to report cutting (77.0%, compared with 66.2% of men), men were more likely than women to have burned themselves (16.8%, compared with 6.5% of women).

Methods of self-harming also varied with age (although caution in interpretation is required; there were only 55 people in the sample aged 55 and over who reported self-harm). Young people (16 to 34 years) were more likely than their older counterparts to report cutting or burning themselves, whereas older people were more likely to report swallowing something or some other method. It was also more common for 18 to 34 year olds to report more than one method, compared with those aged 35 or more. [Tables 12.9 and 12.10](#)

**Figure 12L: Method of self-harming, by age**

*Base: adults who had ever self-harmed*



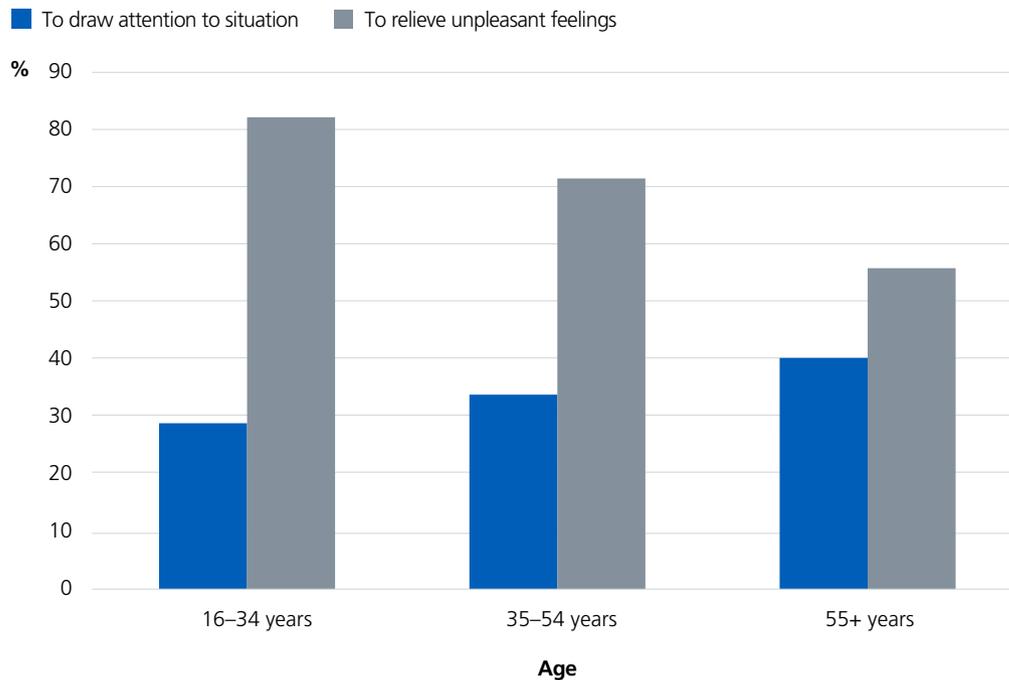
### Reported reasons for self-harming

Three-quarters of people who had self-harmed cited relieving unpleasant feelings of anger, tension, anxiety or depression as a reason for doing so (76.7%), while a third reported self-harming in order to draw attention to or to change their situation (31.0%). Women were more likely than men to agree with at least one of these reasons.

There was an association between reasons for self-harming and age. Younger people were more likely than older people to report that they self-harm in order to relieve unpleasant feelings, while older people were more likely than younger people to report self-harming in order to draw attention. [Tables 12.9 and 12.10](#)

### Figure 12M: Reasons for self-harming, by age

Base: adults who had ever self-harmed



### Help-seeking behaviour

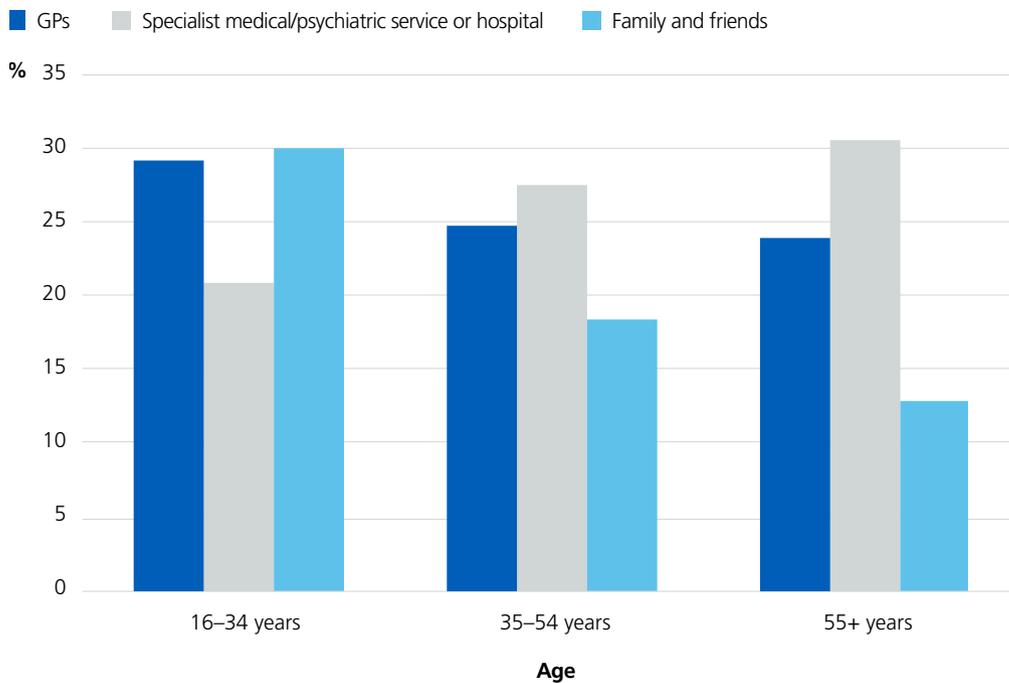
#### *Help-seeking following a suicide attempt*

Participants who reported in the self-completion section of the interview that they had made a suicide attempt were asked whether they had sought help following the most recent attempt. Overall, half reported that they had done so (50.1%). About a quarter of people sought help from a GP (26.4%), a quarter went to a hospital or specialist medical or psychiatric service (25.5%), and a fifth tried to get help from friends or family (21.7%). Very few mentioned other sources (1.8%).

Men and women were equally likely to seek help from each of these sources. However, there were differences by age-group. Older people were more likely to seek help from a hospital or specialist medical or psychiatric service than younger people; the latter were more likely to turn to family and friends. Using GPs as a source of support was equally common across age-groups. [Tables 12.11 and 12.12](#)

**Figure 12N: Help seeking after most recent suicide attempt, by age**

*Base: adults who had ever attempted suicide*



*Medical and psychological help for self-harming*

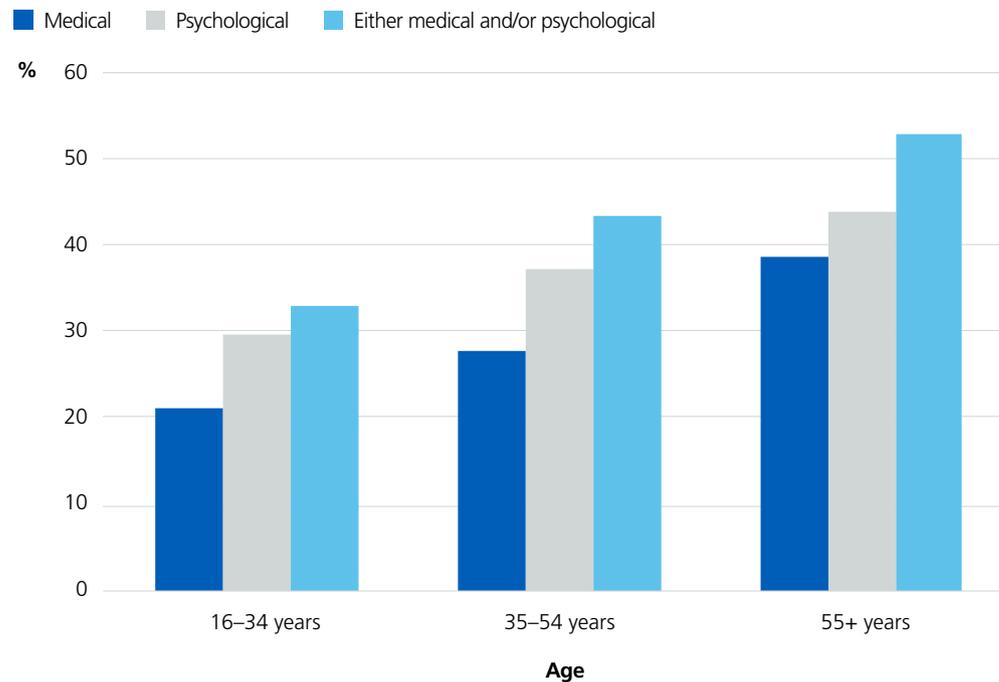
37.7% of people who self-harmed received medical or psychological help afterwards. A third of people who self-harmed reported psychological help (33.1%) and a quarter received medical attention (24.6%). 62.3% received neither.

Women were more likely than men to receive medical attention (29.2%, compared with 16.2% of men) or psychological help (38.1%, compared with 24.0% of men). There was also an age-gradient: half those aged 55 and over who had self-harmed obtained medical or psychological help at some point (52.9%),

compared with a third of those aged 16 to 34 (33.1%). It should be noted that this relates to self-harming and help received at any point; some younger people may go on to receive support in the future. [Tables 12.13, 12.14](#)

### Figure 120: Received medical or psychological help after self-harming, by age

Base: adults who had ever attempted suicide



## 12.4 Discussion

Two major implications for policy and practice emerge in the findings presented in this chapter. The first relates to self-harming, particularly self-cutting, in young women and the second relates to suicide risk among men in midlife.

### Young women and self-harm

Over the last fifteen years reporting of self-harm has more than doubled in the population as a whole; the step increase is evident in both men and women and

across ages. In 2000, one in fifteen 16 to 24 year old women reported in the face to face part of the interview that she had self-harmed (6.5%); this increased to one in nine in 2007 (11.7%) and one in five in 2014 (19.7%). When asked in the self-completion part of the interview one in four (25.7%) young women reported having self-harmed, twice the rate in men of the same age (9.7%) and of women aged 25 to 34 (13.2%). The great majority of the self-harm reported by young women involved self-cutting.

It is likely that this increase in reporting is due (at least in part) to changes in reporting behaviour, that minor self-injury which people had not included as self-harm in previous surveys has started to be labelled as such. It is also likely that people now feel more able to disclose self-harm. This might happen if self-harming has become more normalised and less stigmatised. Improvements in rapport between interviewers and participants could also elicit higher – and probably more accurate – reporting. Finally, it is possible that increased reporting of self-harm reflects a real increase in the behaviour. It is likely that a combination of these factors may be at play.

Evidence from other sources supports the view that there has been some real increase in self-harming behaviour. The Multicentre Study of Self-harm in England found an increase in self-injury since 2008 among men and girls presenting for medical care (Geulayov et al. 2016). Analyses of Hospital Episode Statistics (HES) have also shown increases in people presenting with self-harm, although data quality concerns have been raised (Clements 2016). Registration statistics show that the suicide rate in 15–19 year olds has risen since 2013 for three consecutive years, although they still have the lowest rate of any age group (ONS 2016). A growing gap in self-harm rates between young women and young men is consistent with trends in CMD described in Chapter 2, as well as findings from the Scottish Health Survey (Knudsen 2016) and other research (Hawton and Harriss 2008). Furthermore, a growing gender gap in mental illness and low wellbeing is consistent with the increases in rates of mental illness found in girls but not boys (The Children’s Society 2016; Lessof et al. 2016).

While it cannot be confirmed that the increase in self-harm is real, it may be appropriate for policy and practice to respond now. This matters because 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. There is also a need for responsible reporting of these figures: the way that this issue is discussed may influence future suicidal behaviour and risk in young people.<sup>3</sup>

If there is an upward trend in self-harming, with a particularly high rate in young women, there needs to be greater understanding of what is driving this. Some cite bullying on social media as one influence (Daine et al 2013), other sources highlight low self-esteem and anxiety (The Children's Society 2016). APMS data indicates that young people who self-harmed were more likely than older people who did so to report relieving feelings of anger, tension, anxiety or depression as a reason. It is important that alternative coping strategies are supported and that the right help is promoted, made available and accessible, including school-based mental health promotion programmes. Two-thirds of 16 to 34 year olds who self-harmed said that they got no medical or psychological support as a result (compared with around a half of older people). Younger people who made a suicide attempt described turning to family and friends or their GP. Recognition may be required of the additional burden that an increase in self-harm may mean for primary care, so that GPs are able to continue to provide this level of support.

### **Midlife men and suicide risk**

The proportion of men aged 55 to 64 who thought about suicide in the past year nearly tripled from 1.9% in 2007 to 5.3% in 2014. Other chapters in this report have identified deterioration in the mental health of this group, including Chapter 2 on trends in CMD. There was a steep rise in registered suicides among men in midlife between 2007 and 2014, and they have been highlighted as a priority in England's National Suicide Prevention Strategy. The data presented here supports existing evidence on links between male suicidal behaviour and indicators of recession (Coope et al. 2014), in particular, being unemployed, economically inactive, or receiving out-of-work disability benefits. Two-thirds of Employment and Support Allowance (ESA) recipients reported suicidal thoughts, four in ten had made a suicide attempt, and three in ten had self-harmed.

<sup>3</sup> For advice on the responsible reporting of suicide, see these guidelines produced by the Samaritans: [www.samaritans.org/media-centre/media-guidelines-reporting-suicide](http://www.samaritans.org/media-centre/media-guidelines-reporting-suicide)

Data presented here is also consistent with evidence showing that both mental illness and social context remain powerful risk factors for suicidal behaviour and self-harm. Two-thirds of people with severe CMD (CIS-R score of 18 or more) had thought about suicide, and people living alone are more likely to have suicidal thoughts, make a suicide attempt, and to self-harm than those who live with others. As lone-person households become more prevalent, the mental health associations with this secular change warrant investigation with longitudinal data.

## 12.5 Tables

### Prevalence and trends

- Table 12.1 Prevalence and recency of suicidal thoughts, suicide attempts and self-harm, by age and sex
- Table 12.2 Suicidal thoughts and suicide attempts in the past year and self-harm ever in 2000, 2007 and 2014 (face to face only), by age and sex

### Characteristics

- Table 12.3 Lifetime suicidal thoughts, suicide attempts and self-harm (observed and age-standardised), by ethnic group and sex
- Table 12.4 Lifetime suicidal thoughts, suicide attempts and self-harm, by household type and sex
- Table 12.5 Lifetime suicidal thoughts, suicide attempts and self-harm (age-standardised), by employment status and sex
- Table 12.6 Lifetime suicidal thoughts, suicide attempts and self-harm (age-standardised), by benefit status and sex
- Table 12.7 Lifetime suicidal thoughts, suicide attempts and self-harm (observed and age-standardised), by region and sex
- Table 12.8 Lifetime suicidal thoughts, suicide attempts and self-harm, by severity of current symptoms of common mental disorder and sex

## Methods and reasons

Table 12.9 Methods and reasons for self-harming, by sex

Table 12.10 Methods and reasons for self-harming, by age

## Treatment, service use and help seeking

Table 12.11 Sources sought help from following last suicide attempt, by sex

Table 12.12 Sources sought help from following last suicide attempt, by age

Table 12.13 Whether received medical and/or psychological help after self-harm, by sex

Table 12.14 Whether received medical and/or psychological help after self-harm, by age

## 12.6 References

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