agenda
Alliance for Women & Girls at Risk

Often Overlooked:

Young women, poverty and self-harm

A briefing by Agenda,
the alliance for women and girls
at risk, and the National Centre
for Social Research

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Summary

⇒ Since the year 2000, rates of self-harm[1] in England have increased across the population; and in young women they have tripled.

⇒ Self-harm is more common among people who face poverty and disadvantage. This seems to be particularly the case for women.[2]

⇒ Young women living in the lowest income households are five times more likely to self-harm than those in the highest income homes.

⇒ Most people who self-harm receive no medical or psychological help as a result, and this is particularly true for young people.

⇒ A cross-government response to prevention and support, that takes account of gender, poverty and disadvantage, is needed.

This briefing draws on new analysis of data from three major mental health surveys carried out in 2000, 2007 and 2014. Each survey drew on a random sample of around 6,000 16 to 74-year olds living in England.

Rates of self-harm have increased, particularly among women.

The 21st century has seen self-harm become more common. In 2000, 2.4% of people aged 16 to 74 reported self-harm, but by 2014 this had increased to 6.4%.

This rise is evident across the population but more recently it has become more pronounced in women (2.7% in 2010 to 7.9% in 2014) than men (2.1% to 5.0%).

This finding is consistent with recent survey work conducted by Addaction with 13 to 17-year olds which found girls were more likely to report having thought about hurting themselves than boys.[3]

Rates of self-harm are highest in young women

The rise was greatest for women aged 16 to 24, in whom the proportion having ever self-harmed tripled from 6.5% (in 2000) to 19.7% (in 2014). The rise was particularly steep between 2007 (11.7%) and 2014. **In 2014 one in five 16 to 24-year old women reported having self-harmed at some point in their life.**

It is probable that this is related to the increase in anxiety and depression in young women highlighted in the Women's Mental Health Taskforce report.[4]

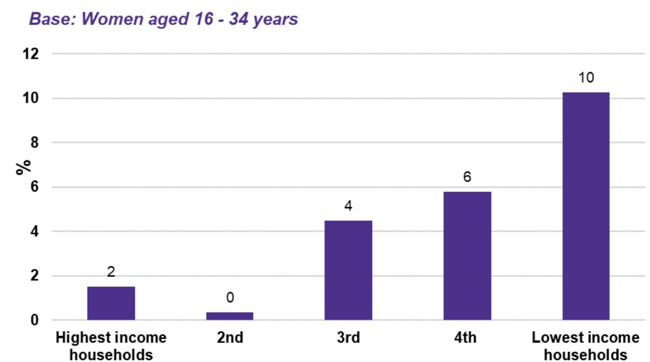
A quarter of young women (26%) have a common mental health condition like anxiety or depression – almost three times more than young men (9.1%).[5] Anxiety and depression are strongly linked with self-harming.[6]

Although self-harm is not necessarily an indicator of someone being at risk of suicide, those who die by suicide are more likely to have previously self-harmed. While young men are still more likely to take their own lives than young women, suicide rates for girls and young women (aged 10 to 24) have increased and in 2018 were the highest on record.[7]

Self-harm is associated with living in a low-income household

Media reports tend to link self-harm in young women with exam stress and social media. While it is right to acknowledge that these may play a role,[8] many other types of adversity associated with having self-harmed should also be recognised. These include: violence and abuse, poor health and pain, and debt and poverty.[9]

Self-harm in past year by household income, among 16-34-year old women in 2014

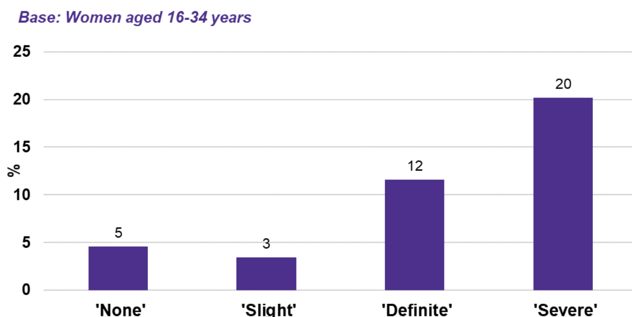


The proportion of young women (age 16 to 34[10]) to have self-harmed in the past year was five times higher among those living in the most deprived households, compared with those in the least.

The association between income and self-harm appears to be particularly strong in young women, compared with young men.

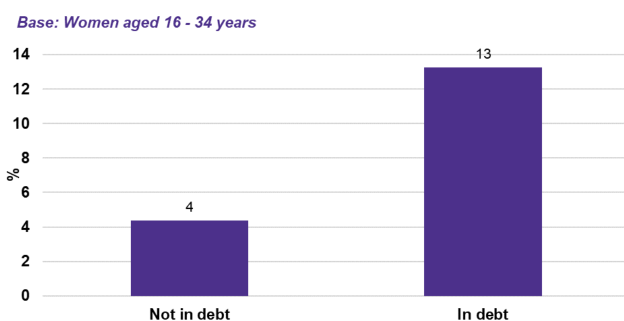
A fifth of young women reporting 'severe' money problems and one in ten reporting 'definite' problems had self-harmed in the past year.

Self-harm in past year by reported level of money problems, among 16-34 - year old women in 2014



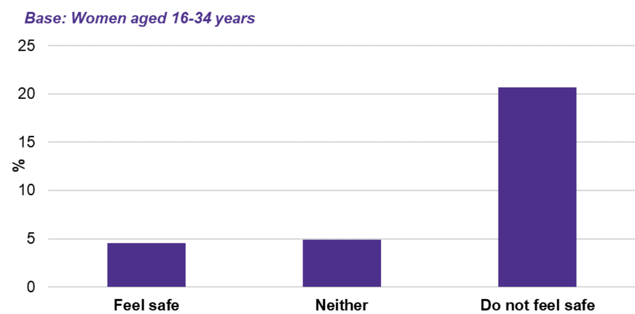
This same pattern was also evident in relation to debt: those seriously behind with payments or who have had utilities disconnected were three times more likely to have self-harmed in the past year than other women.

Self-harm in past year by debt and dis-connection, among 16-34 - year old women in 2014



The area where young women live seems to matter too. Self-harm in the past year was four times more common among young women who did not feel safe in their neighbourhoods in the day.

Self-harm in past year by whether feel safe in local area in the daytime, among 16-34-year old women in 2014



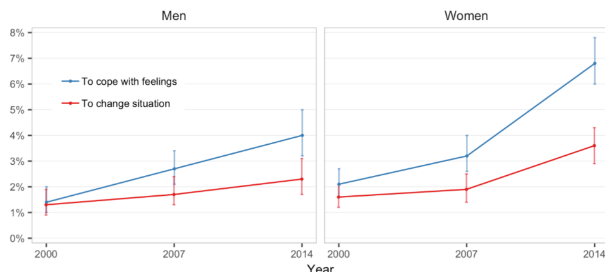
While this data does not establish a causal relationship between poverty and self-harm,[11] the results do indicate that the young women who are self-harming are much more likely to be found in low income homes, among those struggling with money problems, and potentially in contact with debt collection services.

People increasingly report self-harming to cope with stress

The proportion of people saying that they self-harmed in order to cope with or relieve feelings of tension, anxiety, anger, or depression tripled from 1.8% in 2000 to 5.4% in 2014.

The absolute increase was greatest for 16 to 24-year old women: from 5.8% to 17.7%, compared with 3.4% to 5.8% in men of the same age.

Reported reasons for self-harm, among 16 to 74-year olds in 2000, 2007, and 2014



Most people who self-harm do not receive support

Overall, most people (59%) who self harmed received no medical or psychological services as a result, although women were more likely than men to get treatment following self harm.[12] This lack of support has been the case for many years: the results show that over the past decade there has been no increase in the proportion of people who self-harm accessing treatment, such as medication or psychological therapy.

The research also shows that younger people (aged 16 to 34) who self -harm are less likely than older people (aged 35 to 74) who do so to get services.

Previous analyses have also found that young people with poor mental health were less likely to receive mental health treatment than older people.[13] However, this was not for want of asking. Initial analyses of the survey data this paper is based on indicate that one in ten young people with poor mental health had asked for – but had not got – mental health intervention.

Implications for society, services and policy

People self-harm for a number of reasons, including to cope with difficult feelings or states of mind.[14] There can be lifelong implications for those who self-harm, especially if it becomes a long -term coping strategy. For example, those with scars from self-harming can experience stigma and negative attitudes from others.[15]

While self-harming does not necessarily mean a person wants to take their own life, those who do self-harm are at higher risk of suicide,[16] so increasing rates of self-harm may in time contribute to a higher suicide rate.

It is of great concern that increasing numbers of young women are turning to self-harm as a way to cope. Taken in the context of other evidence showing deterioration in mental health in women and girls,

with young women experiencing especially high levels of mental distress, this evidence should act as a further impetus for action for policy and service providers.

Despite increased rates of self-harm service contact following self-harm has not increased over time. Some groups, including men and younger people, are particularly under-served.

There are many factors associated with suicide and self-harm. While it has long been recognised that socioeconomic context is strongly linked with suicidal behaviour, the evidence for its role in non-suicidal self-harm has been more mixed and received less attention.[17] **The evidence presented in this briefing of an association between poverty and self-harm is important but has often not been recognised**. These results are based on cross-sectional data, and cannot establish that poverty causes self harm. The relationship is likely to be bi-directional - that is, that people who self-harm may also be more likely to enter poverty. However, the results do make clear that rates of recent self-harming are far higher in those living in the lowest income homes.

Taken in the context of cuts in public services and welfare spending, which have hit women especially hard, it is clear that living in poverty can cause distress. Women disproportionately depend on local government services. These have experienced significant reductions, and women's unpaid work often fills the gaps these services leave behind. Women are also more likely to work in local authorities and schools, so are hit harder when jobs are cut.[18]

Women and girls on low incomes may be in contact with a range of services, from education, housing or homelessness, to criminal justice, addiction treatment, social services or domestic abuse support. Those with mental health problems will not always present to health services, so it is imperative that all the professionals and providers they do come in to contact with are able to recognise and respond appropriately to self-harm.

This research has also highlighted the importance of having specialist mental health surveys, drawing on the voices of a random sample of the general population, to shine a light on the specific connections between people's circumstances and experiences and their mental health. Treatment and service use data do not cover those who receive no support and provide little information on their wider lives. Relying on these datasets alone risks overlooking groups of the population who do currently access services, but need support.

Recommendations

In response to the trends in self-harm highlighted in this briefing, Agenda recommends the following changes be implemented across policy, practice and wider society.

- A cross-government strategy to improve the outcomes of women and girls facing poverty and disadvantage in order to tackle the major risk factors linked with self-harm. This should come with a central government funding pot to support relevant and joined-up responses to tackling these disadvantages and support the provision of gender and trauma-informed services that respond to the wide range of challenges women and girls may face.

- National and local suicide prevention strategies and action plans must acknowledge and respond to self-harm among young women and girls, with poverty considered as a central factor.

- Policy initiatives to tackle women and girls' risk of poverty and disadvantage must be developed and delivered. This includes tackling in-work poverty, addressing the gender pay gap, supporting young women in training and employment and addressing insecure and zero hours contracts. In addition, sustained in vestment in the public services that women and girls in poverty disproportionately rely on is needed to improve the quality of their lives.

- Professionals that come into contact with those living in poverty must be aware of the increased rate of self-harm among girls and young women on low incomes. A wide range of agencies beyond health, education and social care, including job centres, debt management agencies and social housing landlords, should be aware that women in poverty are an at-risk group for self-harm. Department of Health and Social Care have a central role to play in upskilling professionals and providing them with training and information to enable them to respond appropriately to women and girls who self-harm.

- Population-wide survey data, which spans poverty, mental health, self-harm and violence and abuse, are needed in both England and Wales to understand the factors that drive inequalities in health. Such survey's

should cover experiences of poverty, debt, and violence and abuse, alongside assessing mental health. This should include continuing the Adult Psychiatric Morbidity Survey (APMS) series in England, and an equivalent survey being commissioned in Wales. It is important that future survey samples are large to support ethnic and gender disaggregated analysis and a specific focus on young women, and that people experiencing homelessness and who are in the criminal justice system are included in specific surveys of those populations.

About the research

This briefing has been produced by researchers at the National Centre for Social Research, in partnership with Agenda, the alliance for women and girls at risk. It draws on three major surveys of the general population, carried out with 20,000 people in England. The datasets covered people living in households but not those in custody, living in refuges, mental health service inpatients, or those who were homeless when the survey was done. The sample was also too small to examine minority ethnic groups, highlighting the urgent need for data collection that reaches specific – potentially vulnerable - groups. Findings are summarised here, with details of the full reports listed at the end of this briefing.

Methods

For this analysis we examined data from the 2000, 2007 and 2014 Adult Psychiatric Morbidity Surveys (APMS). Each survey included a large, representative sample of women and men aged 16 to 74 living in England. Trained interviewers visited a random sample of addresses and conducted detailed interviews. Participants answered detailed questions about their mental health and any self-harm behaviours, including their motivations and whether they had medical attention or psychological support as a result. Self-harm was defined as self-inflicted injury without suicidal intent. Some trends are presented for those aged 16 to 24. However, where subgroups are compared some analyses are based on those aged 16 to 34, to ensure the sample was large enough for analyses to be robust.

Comparisons highlighted in the text have been tested and found to be statistically significant at the 95% confidence level.

Previous research into trends self-harm rates have been based on those people who present to hospital. This only gave a partial picture, as most people who self-harm do not get treatment. The sample was too small to examine the needs of young black and minoritised women in depth but previous research has found profound ethnic inequalities in access to mental health treatment and support.

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The views expressed in this publication are those of the authors and not necessarily those of the NIHR or the DHSC.

Further information

McManus S, Gunnell D, Cooper C, Bebbington P, Howard L, Brugha T, Jenkins R, Hassiotis A, Weich S, Appleby L. Prevalence non-suicidal self-harm and service contact in England, 2000-14: repeated cross-sectional surveys of the general population. Lancet Psychiatry 2019 6; 7: 573-581. https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(19)30188-9/fulltext

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McManus S, Scott S, Sosenko F (2017) Joining the dots: the combined burden of violence, abuse, and poverty in the lives of women. Agenda: London. https://weareagenda.org/wp-content/uploads/2015/11/Joining-The-Dots-Report_Final_b_Exec-Summary.pdf

McManus S, Gunnell D. (2019) Trends in mental health, self-harm and suicide attempts in 16 to 24-year old students and non-students in England, 2000-2014. Social Psychiatry and Psychiatric Epidemiology.

About the National Centre for Social Research

Britain's leading centre for independent social research, with 50 years' experience of listeing to the public and making sure their voice is heard. www.natcen.ac.uk.

About Agenda

Agenda, the alliance for women & girls at risk, is working to build a society where women & girls can live free from inequality, poverty & violence. www.weareagenda.org

Sources of support

In the UK, Samaritans can be contacted on 116 123 or email jo@samaritans.org

1. Used here to indicate self-harm without suicidal intent, also known as non-suicidal self-harm (NSSH).

2. The data analysed was of 16 to 74-year olds, so here 'women' refers to those 16 years and over.

3. Addaction (2018) Youth in Crisis? A survey of wellbeing and self-harm among 13 to 17 year olds.

4. Department of Health and Social Care (2018) The Women's Mental Health Taskforce Final Report- https://www.gov.uk/government/publications/the-womens-mental-health-taskforce-report.

5. McManus S, Bebbington P, Jenkins R, Brown L, Collinson D, Brugha T (2019) *Data Resource Profile: Adult Psychiatric Morbidity Survey*. International Journal of Epidemiology.

6. Mars B, Heron J, Crane C, et al. *Differences in risk factors for self-harm with and without suicidal intent: findings from the ALSPAC cohort*. Journal of affective disorders. 2014 Oct 15;168:407-14.

7. Office for National Statistics (2019). *Suicides in the UK.* Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesintheunitedkingdomreferencetables (Table 8).

8. McManus S, Gunnell D. (2019) Trends in mental health, self-harm and suicide attempts in 16 to 24-year old students and non-students in England, 2000-2014. *Social Psychiatry and Psychiatric Epidemiology*.

9. Scott S & McManus S. (2016). *Hidden Hurt: Violence, abuse and disadvantage in the lives of women.* Agenda, London; and 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. http://natcen.ac.uk/our-research/research/suicide-and-self-harm-in-britain-researching-risk-and-resilience/.

10. While we wanted to focus this analysis on 16 to 24 year old women, the sample was too small to produce rates for household income quintiles, so comparisons are based on women aged 16 to 34.

11. This dataset is cross-sectional: it provides a picture at one point and does not follow individuals over time, so it cannot be used to make definitive conclusions about causal relationships.

12. Both before and after controlling for other factors, women's odds of receiving treatment after self-harming were more than twice those of men (adjusted odds ratio

2.49 95% confidence interval 1.43-4.25, p=0.001).

13. McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) (2016) *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital.

14. https://weareagenda.org/wp-content/uploads/2019/01/PR-Report-Final.pdf

15. Burke TA, Piccirillo ML, Moore-Berg SL, Alloy LB, Heimberg RG.

16. Hawton K, Harriss L, Zahl D. *Deaths from all causes in a long-term follow-up study of 11 583 deliberate self-harm patients*. *Psychol Med* 2006; 36: 397–405.

17. Mars B, Heron J, Crane C et al. *Differences in risk factors for self-harm with and without suicidal intent: findings from the ALSPAC cohort*. Journal of Affective Disorders 2014.

18. https://wbg.org.uk/analysis/reports/triple-whammy-the-impact-of-local-government-cuts-on-women/.

19. Participants were asked face-to-face: 'Have you ever deliberately harmed yourself in any way but not with the intention of killing yourself?' those reporting self-harm were also asked about motivations (e.g. 'Did you do any of these things because it relieved unpleasant feelings of anger, tension, anxiety or depression?'), and subsequent service contact: 'Have you received medical attention for deliberately harming yourself in any of these ways?' and 'Have you ever seen a psychiatrist, psychologist or counsellor because you had harmed yourself?'.