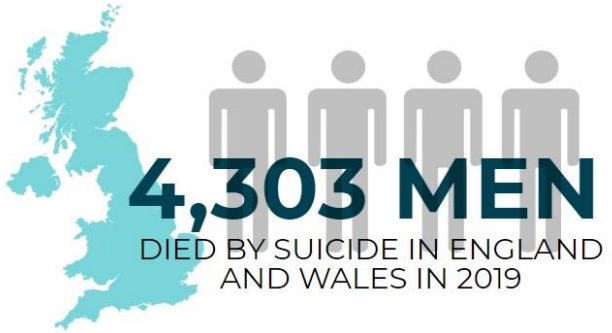
Male Suicide

Introduction

Data on the rates of suicide across the UK suggest that there is a gendered dimension to suicide. Male suicides accounted for around three quarters of the total in England and Wales in 2019.

In light of this, and in the context of the Welsh Government's wider suicide prevention work, the First Minister asked the Wales Centre for Public Policy to explore what is known about the factors that contribute to the trends.

This note provides an overview of male suicide rates and some of the causes, at both the UK and Wales level.



What is suicide?

Since 2016, the National Statistics definition of suicide for the UK includes all deaths from intentional self-harm for persons aged ten years and over, and deaths where the intent was undetermined for those aged 15 years and over. Deaths from an event of undetermined intent in ten to 14 year olds are not included, as it is not always clear whether the assumption that the harm was self-inflicted is appropriate. The previous definition of suicide only included intentional and undetermined deaths for those aged 15 years and above.

Suicide statistics at the UK-level

The ONS annually analyses registered deaths in the UK from suicide by sex, age, area of usual residence of the deceased and suicide method and releases this in a statistical bulletin. Most of the analysis is only done at the UK level. Figures for 2019 were done for England and Wales

The ONS reports that in 2019, there were 5,691 suicides registered in England and Wales, corresponding to an age-standardised rate of 11.0 deaths per 100,000 population.

Table 1: Comparison of suicide statistics between the UK and Wales *(analysis of Welsh data is only available until 2017)*

	England and Wales		Wales	
	All	Males	All	Males
2018 suicide rate (per 100,000)	10.5	16.2	12.8	19.1
2019 suicide rate (per 100,000)	11.0	16.9	12.2	18.8
2019 group with highest suicide rate (per 100,000)	45 – 49 males 25.5		Not available	
2017 hanging, suffocation and strangulation (%)	58.0	61.7	Not available	

Source: *ONS data (2018, 2019, 2020)*

Of the 5,691 suicides registered in England and Wales in 2019, males accounted for three quarters of these (4303). This equates to a male suicide death rate of 16.9 per 100,000, compared with 5.3 deaths per 100,000 for the female suicide death rate in 2019 (table 1). This

represents an increase from the 2018 rate of 16.2 per 100,000 and is significantly higher than rates seen between 2014 and 2017.

The ONS reports that the highest specific suicide rate in England and Wales is among males aged 45-49 at 25.5 per 100,000 in 2019. This group has had the highest rates of suicide in the UK since 2013 and are also the generation which had the highest suicide rate from 1991-2011, when they were aged 30-44.

In 2019, the most common method of suicide for both males and females in England and Wales was hanging, suffocation or strangulation, which accounted for 61.7% of suicides among males and 46.7% of all suicides among females. For males, the proportion of suicide by method in England and Wales in 2019 include poisoning (16.0%); other (6.8%); drowning (3.9%); and fall and fracture (3.6%).

In 2019, there was an increase in the suicide rate among the under 25s, particularly for females aged 10-24. In 2019, the suicide rate for this group in England and Wales was 3.1 deaths per 100,000 representing a 93.8% increase from the 2012 rate of 1.6 deaths per 100,000. However, this can't be seen in the Welsh data.

Suicide statistics at the Welsh-level

Previously, the ONS only included Welsh statistics in their UK-level statistical bulletin. This was because relatively small numbers of suicides in Wales, meant there was large amounts of fluctuation year to year; however, in 2019, the ONS released their first statistical bulletin on suicide in Wales (ONS, 2019).

Between 1981 and 2017, there were 11,500 deaths by suicide in Wales, an average of 300 deaths per year, of which 76% were male (8715). In 2017, there were 360 deaths by suicide, corresponding to 13.2 deaths per 100,000. This is statistically significantly higher than that of the UK and England, but comparable to Scotland (figure 1). This trend is also reflected for male suicide rates. There has been a general downward trend in the Welsh suicide rate. In 2019, there were 330 deaths by suicide in Wales, corresponding to 12.2 deaths per 100,000 population.

Males aged 25-44 have had the highest age-specific rate since the early 1990s, with a 3-year moving average of 28.3 deaths per 100,000. This group has seen a substantial increase with the suicide rate being 16.3 deaths per 100,000 in 1981-1983.

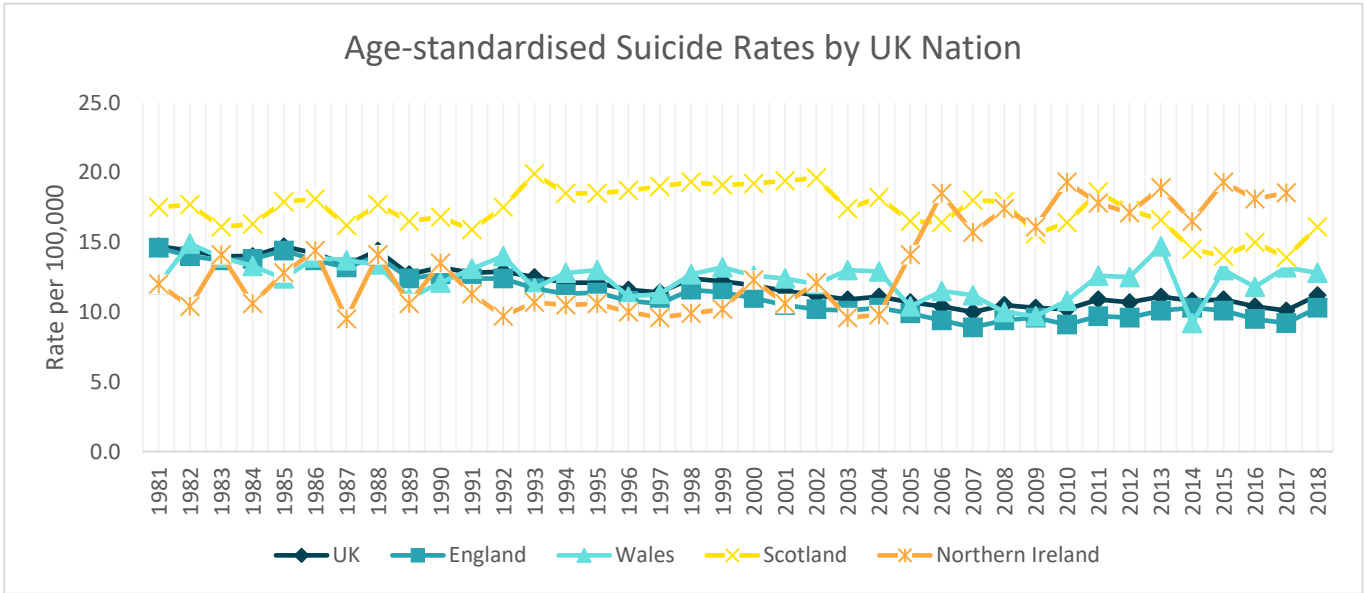


Figure 1: *Age standardised suicide rates by UK nation*
Source*: ONS data (2017)*
Note*: The ONS does not report on Northern Ireland statistics; instead, this is collected by the Northern Ireland Research and Statistic Agency website*

In 2017, the most common method of suicide was by hanging, strangulation or suffocation, accounting for 66% of male deaths by suicide in 2015-2017. The proportion of suicides from this cause decreases by age, with the proportion of male suicides by poisoning generally increasing with age.

Data from 2011-2015, shows that three major occupations had elevated risks of suicides for males:

- Elementary low-skilled occupations (71% higher risk)
- Caring, leisure and other service occupations (70% higher risk)
- Skilled trades occupation (41% higher risk)

Notes on the statistics

Alongside their analysis, the ONS also suggests some explanations for suicidal trends (ONS, 2017, 2019). They suggest that:

- One of the factors contributing to the latest increase in suicide statistics could be related to improved reporting from coroners in narrative conclusions, and the improved coding of narrative conclusion since 2011.
- The increase in the proportion of suicides from hanging in the UK, maybe related to the restrictions on the availability of other methods and a misconception that hanging is a quick and painless way to die. For example, a study shows that following UK legislation to reduce the size of paracetamol packages, there was a significant reduction in the number of deaths due to paracetamol overdose (Hawton et al., 2013).
- Suicide rates differ across occupations because of job-related features, such as low pay, low job security and risk to injury; selection effects; access to, or technical knowledge about highly lethal methods of suicide.

Why is there a higher suicide rate for males?

Particularly in more developed countries, there is a gender disparity between those dying by suicide, with men three times more likely to take their own lives than women on average (Hunt et al., 2017). A number of factors have been identified which contribute to this gender disparity, including:

- Men having more lethal means than women (Beautrais, 2002; Smith, 2017)
- The idea of masculinity and traditional gender roles (Möller-Leimkühler, 2003)
- The reluctance of males to seek help (Möller-Leimkühler, 2003)
- Men being more likely to abuse alcohol and drugs (Möller-Leimkühler, 2003)
- The effect of relationship breakdown being more severe for men (Scourfield et al., 2012)

> **…suicide is the consequence of health and gender inequalities, with mental health problems being the biggest driver for those dying by suicide.**

Gunnell et al. (2003) identify that the increase in the male suicide rate (particularly for those aged 25-34) in the late 20th century, paralleled with rises in a number of risk factors. These included increases in divorce, unemployment, income inequality, alcohol and drug abuse, and declines in marriages.

In 2012, the Samaritans commissioned five academics to review the evidence and theory of disadvantaged mid-life males dying by suicide (Wyllie et al., 2012). The key messages from the report are that suicide is the consequence of health and gender inequalities, with mental health problems being the biggest driver for those dying by suicide. The report identifies

factors which contribute to the development of suicidal thoughts and suicide in disadvantaged males, including

- Some personality traits and mind-sets, such as the belief that you must always meet the expectations of others; self-criticism, brooding; having no positive thoughts about the future and reduced social problem-solving ability.
- The idea of masculinity, which particularly affects working class men.
- Relationship breakdown, due to the reliance men place on their partners for emotional support and from being separated from their children
- The emotional lives and social disconnectedness of males, sure to men's peer relationships dropping away after the age of 30.
- Social change: the report refers to men currently in their mid-years as the 'buffer' generation, who are "caught between the traditional silent type of their fathers and the more progressive, open and individualistic generation of their sons" (p2).
- Socio-economic inequalities in jobs, class, education, income and/or housing.

Overall, the literature emphasises that the factors leading to someone dying by suicide is multi-faceted.

What is the role of policy in reducing (male) suicide?

While placing gender-based restrictions on accessibility to lethal means would dramatically reduce the suicide rate, this is not viable and may even lead to perverse outcomes.

Controlled studies have identified that a stronger continuum of care across services within hospital, and between hospitals and the community is a successful approach for reducing the risk of suicide attempts (e.g. Knesper, 2011).

An important measure to reduce suicide among particular demographic groups is to reduce the stigma of mental disorder within that group, educating them about suicidal behaviour and making services more accessible to working men, which utilise language and approaches that are relevant and comprehensible to them (McKenzie, 2006).

Some academics also argue that tackling male suicide requires co-operative working between not just health and social services, but also community facilities, support groups, health facilities, etc. in order to have a more integrated approach (Sayers, 2010).

Some evidence suggests that psychological treatments, such as cognitive behavioural therapy (CBT), reduce the number of repeated suicide attempts. However, there is limited evidence on its effect on men in particular.

Authors: Suzanna Nesom and Dan Bristow

Sources

Beautrais, Annette L. (2002). **Gender Issues in Youth Suicidal Behaviour.** Emergency Medicine, 14:35-42.

Gunnell, David, Nicos Middleton, Elise Whitley, Daniel Dorling and Stephen Frankel. (2003). **Why are suicide rates rising in young men but falling in the elderly? – a time series analysis of trends in England and Wales 1950-1998.** Social Science & Medicine, 57(4): 595-611.

Hawton, Keith, Helen Bergen, Sue Simkin, Sue Dodd, Phil Pocock, William Bernal, David Gunnel and Navneet Kapur. (2013). **Long term effect of reduced pack sizes of paracetamol on poisoning deaths and liver transplant activity in England and Wales: interrupted time series analyses.** British Medical Journal, 346.

Hunt, Tara, Coralie J. Wilson, Peter Caputi, Alan Woodward and Ian Wilson. (2017). **Signs of Current Suicidality in Men: A Systematic Review.** PLoS One, 12(3).

Knesper, David. J. (2011). **American Association of Suicidology, & Suicide Prevention Resource Center. Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from the Emergency Department of Psychiatry Inpatient Unit.** Newton, MA: Education Development Center, Inc.

McKenzie, Suzanne. (2006). **The Strong Silent Type.** Public Health News. 5 Jun:14-15.

Möller-Leimkühler, Anne Maria (2003). **The Gender Gap in Suicide and Premature Death or: Why are Men so Vulnerable.** European Archives of Psychiatry Clinic Neuroscience, 253:1-8.

O'Connor, Rory C. and Pirkis, Jane. (Eds.) **The International Handbook of Suicide prevention.** (2nd edition). Chichester: Wiley-Blackwell.

Office for National Statistics (2018, September 2019, September 2020). **Statistical Bulletin: Suicides in the UK: 2018 registrations.** Retrieved from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2019registrations

Office for National Statistics (2019). **Suicide in Wales since 1981.** Retrieved from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/suicideinwalessince1981/2019-06-27

Sayers, Pete. (2010) **Men and suicide.** In David Conrad and Alan White (Eds.) Promoting Men's Mental Health: 96-105

Scourfield, Jonathan, Ben Fincham, Susanne Langer and Michael Shiner (2012**). Sociological autopsy: An integrated approach to the study of suicide in men**. 74(4):466-473.

Smith, Evan (2017**) Suicide Rates as They Vary by Region, Sexuality and Gender.** Perspectives, 9(1).

Wyllie, Clare, Stephen Platt, Julie Brownlie, Amy Chandler, Sheelah Connolly, Rhiannon Evans, Brendan Kennelly, Olivia Kirtley, Graham Moore, Rory O'Connor and Jonathan Scourfield. (2012). **Men, Suicide and Society: Why Disadvantaged Men in Mid-Life die by Suicide.** Epsom: Samaritans. Retrieved from: https://www.samaritans.org/wales/about-samaritans/research-policy/middle-aged-men-suicide/

About the Wales Centre for Public Policy

Here at the Centre, we collaborate with leading policy experts to provide ministers, the civil service and Welsh public services with high quality evidence and independent advice that helps them to improve policy decisions and outcomes.

Funded by the Economic and Social Research Council and Welsh Government, the Centre is based at Cardiff University and a member of the UK's What Works Network.

For further information contact:

Dan Bristow

+44 (0)29 2087 0325

dan.bristow@wcpp.org.uk

Wales Centre for Public Policy

Cardiff University, 10/12 Museum Place, Cardiff CF10 3BG

www.wcpp.org.uk

029 2087 5345

info@wcpp.org.uk

@WCfPP

Cardiff University / Prifysgol Caerdydd

UKRI Economic and Social Research Council

Llywodraeth Cymru Welsh Government