MRC/CSO Social and Public Health Sciences Unit
Consultation Response

Title of consultation
Consultation on the Scottish Health Survey questionnaire content

Name of the consulting body
Scottish Government

Link to consultation
https://consult.scotland.gov.uk/population-health/scottish-health-survey

Why did the MRC/CSO Social and Public Health Sciences Unit contribute to this consultation?
A sizeable number of SPHSU researchers utilise the Scottish Health Survey (SHeS) as a key data resource.

Our consultation response
The Unit’s response to the consultation on the future content of the SHeS from 2018 onwards was submitted in two parts: a core one and separate one with a dedicated focus on self-harm.

In relation to the following topics:
- General health
- Anxiety and depression
- Mental Wellbeing and Symptoms of psychiatric disorder
- Strengths and Difficulties (children aged 4-12)
- Respiratory health including asthma
- Cardiovascular Disease and Use of Services
- Blood Pressure
- Prescribed Medicines
- Parental history
- Adult and child physical activity
- Fruit and vegetable consumption
- Eating habits
- Vitamins including Vitamin D (see Annex A)
- Dietary salt intake (urine sample)
- Smoking and e-cigarettes
- Cotinine levels (saliva sample)
- Alcohol consumption and drinking experiences
- Body Mass Index / Obesity (height and weight measurements)
- Waist Circumference measurements
- Accidents and
- Contraception

We expressed the necessity of retaining the questions without any changes and for
the information to be gathered annually. Annual data collection means more favourable sample sizes are available for the purpose of research conducted to inform policy. Annual data collection allows for closer inspection in trends over time. It also means that comparable information is available in both SHeS and the Health Survey for England (HSE) for making national comparisons.

The impact on our work in these areas if these data were not collected in the SHeS would be major. Reducing the content and frequency of data collection would lead to a reduction in the number of outcomes that can be studied for research purposes as well as making it more difficult to monitor trends over time. Further, a reduction in content would also make it more difficult to control for confounding variables meaning we couldn’t be sure of the validity of any established associations between exposure and outcome. Some examples follow:

- In one project, SHeS data for 16-24 year olds from the 2010-12 surveys was merged with similar data from the Health Survey for England (HSE) as part of a Cancer Research UK (CRUK) grant to conduct research informing on whether young people not in education, employment or training (NEET) were more likely to exhibit unhealthy behaviours associated with cancer (smoking, drinking, low fruit and veg consumption, no participation in sport/exercise, unhealthy BMI) than ‘non-NEETs’. These associations were investigated before and after adjustment for a wide range of socio-demographic confounders available in the survey. Merging of SHeS and HSE data also allowed for cross-national comparisons of behaviours. Findings were presented at a showcase event which included CRUK employees and external stakeholders. Findings have also been submitted peer-reviewed publication in order to increase the evidence base, which is currently lacking, on whether NEETs are at greater risk of cancer development by increased participation in unhealthy behaviours.

- There is particular interest in smoking and e-cigarettes data. Previous smoking data-based work has shown that whilst active smoking may be associated with reduced risk of being overweight among some older adults, there was no evidence to support the belief among young people that smoking protects them from weight gain. Making this point in educational campaigns targeted at young people may help to discourage them from starting to smoke. This work has been presented as evidence to Action on Smoking and Health (Scotland) (ASH Scotland) Scottish Tobacco Control Alliance (STCA) Research Group and The Scottish Government’s Research and Evaluation Sub-Group of the Ministerial Working Group on Tobacco Control.

- The alcohol consumption data are valuable and have been used to examine social patterning of consumption and other health-related behaviours. Data on amount consumed during the heaviest drinking day are particularly informative: these data are a rare means of determining national, age, sex and deprivation-specific estimates of binge drinking for Scotland. Given concerns regarding alcohol use and its importance for policy, we believe that the item on amount consumed during the heaviest drinking day should be retained to avoid severe impeding the ability to monitor prevalence of this important public health metric.

- Both GHQ12 and WEMWBS are other important priorities. Reduced ability to
estimate these mental health measures would make tracking of trends and evaluating and informing policy very challenging. This is paramount since these are national statistics and mental health is an evermore important public health priority, not least because of concerns of the impact of austerity and cuts.

- Since diet and physical activity should certainly be monitored on the basis of their informing on determinants of obesity, we believe that both fruit and vegetable consumption and physical activity modules should be retained.

We said we require data at subnational level, namely NHS Health Board region and smaller geographies where possible. We also said it is also important to link information on these topics to age, sex and household characteristics in SHeS annually in order to fit multilevel models to account for the clustering of individuals within households and areas.

Some data of interest are collected in other national surveys: for instance, a question on cigarette smoking is present in the Scottish Household Survey. However, the breadth of health information collected in SHeS are not available in the same detail elsewhere.

Further, we made a plea for the retention of the sexual orientation question and suggested that it is broadened to include a transgender category. Despite the small numbers, SHeS is among the very few sources of such data and the significant health inequalities justify their inclusion.

There is a belief that topic inclusion should be considered using some more objective criteria than simply whether there appears to be user demand. There should be regard for the importance of the topic for policy and research as well as whether there are already readily available data (with relevant covariates).

Specifically in relation to:
- Self-harm
- and associated topics:
  - General health
  - Anxiety and depression
  - Social capital
  - Discrimination and harassment
  - Stress at work
  - Mental Wellbeing and Symptoms of psychiatric disorder
  - Strengths and Difficulties (children aged 4-12) and
  - Accidents

We would like the self-harm questions to be retained with some suggested changes. Given the unprecedented rise in self-harm over the past 2-3 decades among Scottish youth, combined with the lack of effective treatment for the problem the SHeS is a vital nationwide indicator regarding national patterning of self-harm. We would suggest adding a few simple or open answer questions to try and understand the underlying reasons for both onset and reduction or cessation in self-harm. This may help in targeting NHS resources and treatments to those most vulnerable and those most likely to gain benefit from existing services. Given that the majority of older
participants do not self-harm these questions will be primarily answered by the youngest participants.

**Potential follow-on self-harm question.**
Following the question [DSH5SC]: *Have you ever deliberately harmed yourself in any way but not with the intention of killing yourself?*

**QA: What method(s) have you used to self-harm from the following list:**
cutting (on the arm or wrists)
cutting (elsewhere on the body)
scratching or scoring
taking dangerous tablets or pills
hitting or punching self; slamming hands in door
burning (with cigarettes, lighter, etc)
other way (please specify)

**QB: At what age did you first self-harm? Age_____**

**QC: What are/were the reasons for self-harming? Pick from the following list:**
to upset others
☑ relieve anxiety
☑ relieve anger
☑ forget about something
☑ make someone else take notice
others in my social circle were doing it
I was curious
☑ punish myself
☑ kill myself
☑ not sure why
☑ other reason (please specify) ____________________

**QD: At what age did stop Self-harming? Age______ [0 = self-harmed in last year]**

If no longer self-harming...

**QD: Why did you stop or what helped you stop? Pick from the following list:**
☑ It was one off or temporary phase (e.g. `only happened once)
☑ I found a better way to cope What? ____________________
☑ I found a purpose in life (child, marriage, university, job, etc.) What? __________
☑ Got professional help (e.g. `went to see psychiatrist, nurse, etc.'); Who? ______
☑ Got help from family; Who? ______
☑ Got help from friends; Who? ______
☑ Realised how much it hurt my family and friends.
☑ Realised self-harming did not help me cope.
☑ Other reason; What? ____________________

We said we require self-harm information to be gathered annually by the survey. This enables the detection of temporal trajectories, time trends and cultural shifts in self-harm rates and behaviours. Currently the younger generation (16-25) show a twenty to thirtyfold increase in the rates of self-harm compared to the older cohort. Tracking the increase in this major risk for suicide and future psychiatric problems is key.

The impact on our self-harm work if data were not collected in the SHeS would be major. Mental health is an area of strategic importance. Based on the SHeS results thus far we appear to be measuring a huge rise in self-harm among young people. This information may be vital in understand the underlying social causes of self-harm. More importantly it is useful tool to gauge the effects of future public policy and local interventions designed to reduce population rates of self-harm. This is also a vital instrument for international comparisons in rates of self-harm/self-injury.

We said we require data at subnational level, namely NHS Health Board region and smaller geographies where possible since they are needed to contrast local interventions and policies designed to reduce self-harm. It is important to link information on these topics in SHeS to social and demographic factors and link to hospital records vital annually. Given the secretive nature of self-harm behaviours the ability to contrast self-report with official hospital records is a critical tool to help calculate the level of unmet need. It is also a potential proxy to gauge if service changes within the NHS are engaging self-harming individuals to seek and receive medical treatment.

Some self-harm information is available from other sources but not systematically and nationwide with links to hospital records.

When was the response submitted?
17 October 2016

Find out more about our research in this area
http://www.sphsu.mrc.ac.uk/research-programmes/in/

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