

## Response to the Department of Health New Horizons Consultation 15 October 2009

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## Summary

1. We agree with the aims and themes of New Horizons and the approach being taken, which is to improve the mental well-being of the population as a whole, and to improve the quality and accessibility of services for people with poor mental health.
2. However, suicide prevention is not adequately addressed within New Horizons. Given the high probability of an increase in suicides over the next few years in the context of the economic recession, this is a serious omission.

We understand New Horizons as mainstreaming suicide prevention into mental health promotion and mental health services. This can be a powerful approach. However, there are specific measures needed to prevent suicide that are not automatically included in general mental health policy and which must not be lost in the process of mainstreaming. In addition, mainstreaming should not mean the loss of the structures and resources needed for action to prevent suicide.

Suicide prevention must:

- Be high profile
  - Be funded
  - Have responsibility for implementation clearly allocated
  - Have accountability against defined targets and measures
  - Include proper monitoring and recording of suicide data, reported regularly.
3. There should be a proper review of the current suicide prevention strategy and how suicide prevention can be taken forward in the context of New Horizons. This review should include policy-makers, researchers, service users, and representatives from across relevant sectors.
  4. The vision of New Horizons and some of its themes could contribute to the development and strengthening of suicide prevention in the next 10 years, including local action, service user involvement, and a focus on recovery.
  5. We have identified the following areas in which suicide prevention could be strengthened, and believe these should be explored as part of the review of the suicide prevention strategy:
    - Community-wide and community-specific action to prevent suicide
    - Better involvement of service users and those groups affected by suicide prevention work, such as those bereaved by suicide or those who care for someone in crisis.
    - A focus on recovery for those who have experienced suicidal crisis, rather than just prevention of the act of suicide
    - Looking at the evaluation of impact beyond the national suicide rate, such as evaluating the component parts of the suicide prevention strategy
    - The provision of crisis intervention, support and assistance for those affected by a suicide.
  6. There are multiple different factors that lead to suicidal behaviour, including factors at individual, community and societal level. This means that work related to suicide must extend beyond mental health in the narrow sense, and include cross-sector collaboration. This was included in the approach of the current suicide prevention strategy, and New Horizons can enable this to be further strengthened going forward.
  7. We want to see a more powerful partnership between Samaritans and the statutory sector. In particular we would like to strengthen:

- Referrals between statutory services and our 24/7 emotional support service for people in distress or crisis.
- Partnerships at local level through our 201 branches.  
This is particularly important given that 75% of those who end their lives are not in contact with mental health services.

## 1. Samaritans approach to responding to the New Horizons consultation

Samaritans has engaged with the consultation document for New Horizons and the twelve consultation questions provided. The document and these questions are wide-ranging, relating to the values and themes that underpin the New Horizons' vision, including the universal promotion of mental well-being; transitions and a life-stage approach; personalisation of mental health services; enabling local action; addressing stigma, discrimination and inequalities; value for money; innovation and areas for research.

In responding to the New Horizons document Samaritans has chosen to focus our response specifically in the area of suicide prevention. This is in line with the focus of our 2009-2015 Strategy: *Taking the Lead to Reduce Suicide*.

We believe that suicide prevention should remain a national priority and that currently New Horizons does not adequately address suicide prevention.

While New Horizons in its current form is not sufficient for suicide prevention, its vision, themes and values has the potential to strengthen suicide prevention going forward. Our response considers what the themes and values of New Horizons could mean for the next stage of suicide prevention in England.

We believe this work of reviewing the current suicide prevention strategy and seeing how suicide prevention should be taken forward in the context of New Horizons involves bringing together a range of stakeholders, policy-makers, researchers, service users, people from across sectors, and preferably with links across the nations. Our primary concern in making this submission is to see that such a review takes place, and to offer to assist in this process.

We recognise that there is a useful interim period between the end of the current suicide prevention strategy (scheduled to end in 2010 and report in 2011) and the implementation of New Horizons, where work could be undertaken to maximise the extensive findings and learning from the current suicide prevention strategy; to ensure that New Horizons is able to maintain this legacy.

## 2. About Samaritans

### 2.1. Samaritans' strategic intent

Samaritans **Vision** is that fewer people die by suicide.

We work to achieve this Vision by making it our **Mission** to alleviate emotional distress and reduce the incidence of suicidal feelings and suicidal behaviour.

We do this by:

- **Being available 24 hours a day to provide emotional support** for people who are experiencing feelings of emotional distress or despair, including those which may lead to suicide
- **Reaching out to high risk groups and communities** to reduce the risk of suicide

- **Working in partnership** with other organisations, agencies and experts to achieve our Vision
- **Influencing public policy and raising awareness** of the challenges of reducing suicide.

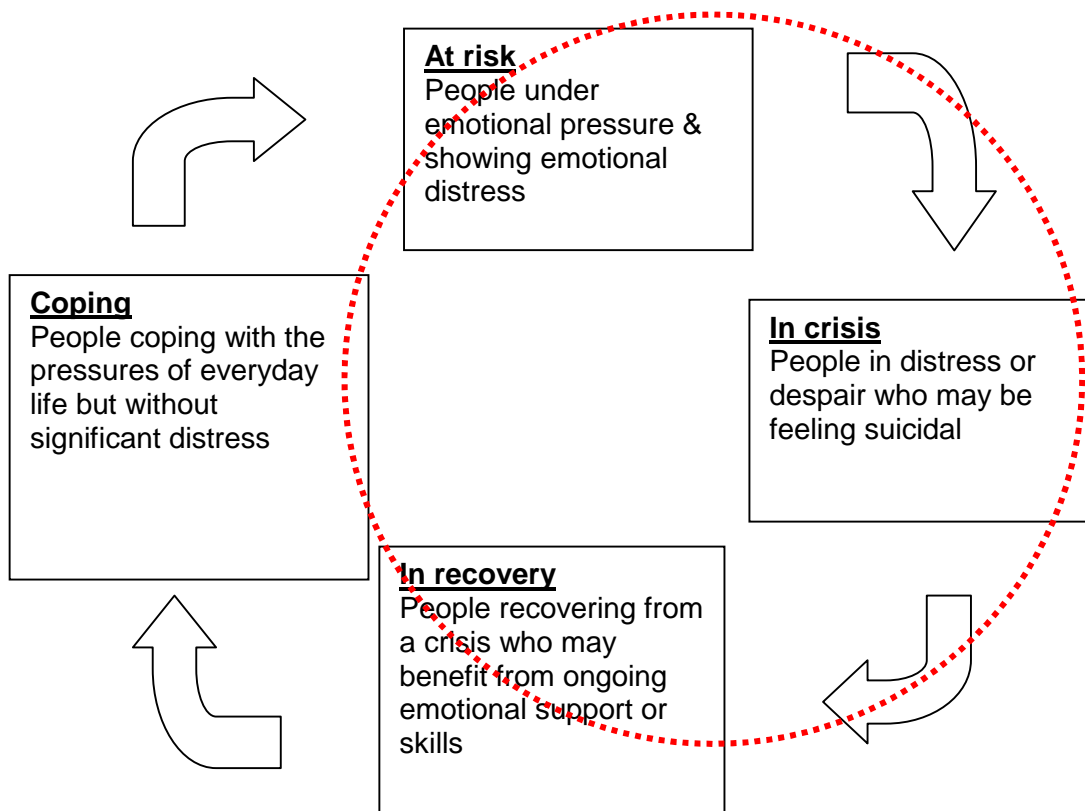
We are committed to:

- **Listening**, because exploring feelings alleviates distress and helps people to reach a better understanding of their situation and the options open to them
- **Confidentiality**, because if people feel safe, they are more likely to be open about their feelings
- **People making their own decisions** wherever possible, because we believe that people have the right to find their own solution and telling people what to do takes responsibility away from them
- **Being non-judgemental**, because we want people to be able to talk to us without fear of prejudice or rejection
- **Human contact**, because giving people time, undivided attention and empathy meets a fundamental emotional need and reduces distress and despair.

## 2.2. Samaritans approach to suicide prevention

In our strategy 2009-2015: *Taking the Lead to Reduce Suicide* we have committed that everything we do will be directed towards the risk of suicide. We are seeking a more powerful and coherent partnership with statutory services and agencies towards this end.

Our approach and priorities have been developed taking into account where people find themselves in the crisis cycle, with greatest (though not sole) emphasis on the risk, crisis and recovery phases (dotted area of the model):



We recognise that there are circumstances in which we will not prevent suicide; but we aim to provide emotional support, change attitudes, provide information and encourage healthy coping skills to ensure that everyone has the opportunity to recognise and explore the options available to them.

Importantly we will be placing greater focus on reaching out to individuals, communities, and groups, offering acceptable responses which reduce their level of risk.

## 2.3. Our service quantified: facts and figures for 2008

### *Numbers of contacts*

- In 2008 Samaritans received 5,159,698 contacts, by phone, email, text, letter, face-to-face at a branch, and at local and national festivals and other events.
- In 2008 Samaritans volunteers provided support in 2,715,226 dialogue contacts. Every 12 seconds Samaritans receives contact with someone who talks or writes about their feelings.
- Samaritans branches in the United Kingdom and Republic of Ireland (ROI) provided support to 168 prison establishments. Almost 1,500 Listeners (prisoners who provide emotional support to other prisoners) were trained in 143 establishments in England and Wales. The Listeners responded to approximately 100,000 contacts.
- Over 150,000 people were contacted through outreach and public awareness work by Samaritans branches.
- Since 2003 Samaritans External Training Services has trained over 5,000 people in handling difficult contacts, enhanced communication skills and managing stress in the workplace.

### *Who contacts us*

- Samaritans receives slightly more contacts from men (1,286,827: 47.4 percent) than from women (1,275,040: 47 percent). 5.6 percent (153,359) of contacts were unidentified.
- In 19.1 percent (517,335) of dialogue contacts to Samaritans, the caller expressed suicidal feelings at the time of the contact.
- In 35.6 percent (57,138) of email contacts to Samaritans, the caller expressed suicidal feelings at the time of the contact.

### *Samaritans volunteers*

- In 2008 there were a total of 18,179 volunteers including 14,905 active listening volunteers in 201 branches across the UK and ROI.
- There were 9,050 applications to join Samaritans in 2008, from which 5,063 people were selected to undergo Samaritans training.
- If our listening volunteers were paid at an average wage of £11.87, the cost to Samaritans would be approximately £27.6m per year

## 3. General response to New Horizons, vision, values and principles

Samaritans agrees with the twin aims of New Horizons:

- To improve the mental health and well-being of the population
- To improve the quality and accessibility of service for people with poor mental health.

The *National Service Framework for Mental Health* (NSF-MH) was an organisational framework for providing and commissioning mental health services, setting out national standards and service models, accompanied by performance indicators. Samaritans agrees that what is needed now following the conclusion of the NSF-MH is more effort to promote whole population mental health and well-being, while continuing to improve services for

those experiencing problems. We believe the mental well-being approach is important for health and quality of life nationally, to prevent mental health problems and to reduce stigma and discrimination.

We support the vision of a society in which everyone enjoys good mental health and well-being, where people have the ability to cope well with problems and where everyone feels included and cared for. We share the vision of services working together to intervene early to prevent problems, to provide personalised care and enable recovery for those who experience mental health problems. We are in support of the key themes of personalisation, service user involvement, early intervention, recovery, local action, a life-stage approach, addressing inequalities, and cross-government and sector working.

However, we do believe that what will be important is providing a clearer conceptual framework for understanding mental well-being, how this is contributed to by different sectors and at societal, community or setting and individual level. There is some danger that mental well-being is conceptually so diffuse that everything can be seen as contributing or undermining mental well-being, making it difficult to bring about coherent action and measurement. Greater conceptual clarity will also help in getting the actions required from different actors and sectors. It is important also to make the 'story of mental well-being' something which everyone can understand and relate to.

Fundamentally what Samaritans sees in New Horizons is a call for a great effort of cross-government and sector working to join up and strengthen the many existing initiatives that contribute to mental health, mental well-being and quality of life. This we wholeheartedly support. But the call for joined up working is not new. The final section on New Horizons, entitled "How we will get there", says that a strategy is needed and enumerates the many agreements, structures and policies which already exist and which can be seen to contribute to promoting mental well-being and improving services. However, the detail of how these various things will be joined up and achieved in practice is thin. We are of the view that unless there is a clear and effective coordinating and mainstreaming mechanism, which enables different sectors of government as well as, very importantly, partners in other sectors, to make their contribution within a coherent framework, these different bits of work will continue to be fragmented and the vision of New Horizons will not be achieved.

We also note the repeated emphasis in the document that the current climate means there will be no increased investment: "All the aspirations expressed in New Horizons should be seen in the context of the financial constraints that the Department of Health and National Health Service will face of the next 3 – 5 years"<sup>1</sup>. We do believe that genuinely joined up working across sectors and government will make a difference. However, it is hard to see how by "2020 physical health and mental well-being will be seen as equal importance"<sup>2</sup> or how the significant extension and improvements to mental health services envisaged will be achieved with no increase in funding.

New Horizons is particularly non-committal with respect to practicalities. New Horizons is a beautiful vision, but one that will require leadership, conceptual clarity, coordination and resources or it will remain a vision. Government needs to commit to and resource a programme of short, medium and long term actions.

In the next section Samaritans indicates our specific concerns and issues related to suicide prevention and New Horizons.

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<sup>1</sup> New Horizons consultation – Towards a Shared Vision for Mental Health, 2009, DH. p. 8

<sup>2</sup> New Horizons consultation – Towards a Shared Vision for Mental Health, 2009, DH. p. 4

## 4. The importance of suicide prevention

The latest available data on suicide rates in England (a three year rolling average for the years 2005-07) shows a rate of 7.9 deaths per 100,000 which represents a 13.9 percent reduction from the 1995-97 figures used as a baseline for the existing *National Suicide Prevention Strategy for England*<sup>3</sup>.

The New Horizons consultation document indicates suicide prevention as one of the successes of the NSF-MH: “the suicide rate has fallen to the lowest on record, and is one of the lowest in Europe. Following a 25 year rise, suicide in young men has fallen for the past seven years, and suicide in mental health inpatients is down by 30 percent”<sup>4</sup>.

Despite the welcome downward trend in the suicide rate, this does not mean that suicide prevention need not be considered a priority in the years to come. Suicide remains a major public health issue and a significant cause of death in England with over 4,000 people taking their own lives in 2007<sup>5</sup>. The often sudden and traumatic nature of a death by suicide can have a devastating effect on the close relatives and friends of the individual and the impact is often also felt throughout the local community.

While these figures are not evidence of prevalence, there is some power in citing numbers from our own service. Every 60 seconds, Samaritans receives a contact from someone who has suicidal feelings. Every 30 minutes Samaritans receives a contact from someone who has self-harmed in a life-threatening way.

There is extensive evidence to demonstrate that economic recession, especially when it is sudden and severe, can lead to an increased risk of suicide. This is not only because more people become unemployed and, as a result, more psychologically vulnerable, but also because those in employment feel threatened too. A negative life change such as redundancy comes with a whole raft of implications. There are the obvious financial knock-on effects but there can also be feelings of low self-esteem and guilt at what someone perceives as their failure to provide for their family. Financial difficulty can contribute to the breakdown of even the strongest relationships with friends and family. People may rely more heavily on alcohol and drugs as a coping mechanism and it is well established that excessive alcohol consumption and drug misuse increase suicide risk. Research shows that people who are unemployed are two to three times more likely to die by suicide than people in employment<sup>6</sup>, with unemployed men particularly at risk<sup>7</sup>. Even in cases where no serious mental health has been recorded, there is a 70 percent greater chance of an unemployed person dying by suicide<sup>8</sup>.

The New Horizons consultation document acknowledges the significance of this risk stating that “suicide tends to rise at times of unemployment and economic problems, and the current recession will require the vigilance of many frontline agencies to advise and support people who are facing debts or who are in emotional crisis”<sup>9</sup>.

The NSF-MH included a specific standard on suicide prevention and was also complemented by the *National Suicide Prevention Strategy for England* which launched in 2002 and is due to expire in 2010. The consultation document for New Horizons summarises

<sup>3</sup> *National Suicide Prevention Strategy for England - Annual Report on Progress 2008*, NMH DU, p.13

<sup>4</sup> New Horizons consultation – Towards a Shared Vision for Mental Health, 2009, DH. p. 9

<sup>5</sup> ONS figures cited in *National Suicide Prevention Strategy for England - Annual Report on Progress 2008*. NMH DU, p.18

<sup>6</sup> Platt, S., Suicide and Work, in *Suicide in Specific Populations*. 2003, The Medicine Publishing Company p.25-28

<sup>7</sup> Platt, S. and K. Hawton, Suicidal Behaviour and the Labour Market, in *The International Handbook of Suicide and Attempted Suicide*, K.Hawton and K. Van Heeringen, Editors. 2000, John Wiley & Sons, Ltd: Chichester, West Sussex. p.309-384

<sup>8</sup> Platt, S. 2009, Keynote address, Irish Association of Suicidology, Annual Conference.

<sup>9</sup> New Horizons consultation – Towards a Shared Vision for Mental Health, 2009, DH. p. 56

briefly the existing strategy for suicide prevention and states that “suicide prevention will remain a vital aim for public health and mental health services in the years ahead”<sup>10</sup> but does not provide substance as to what this will mean in practice.

Samaritans believes that the “new era” for mental health policy heralded by New Horizons needs to include specific suicide prevention measures, or the gains made under the current strategy will be eroded. Whether this is as a strategy that links into New Horizons, or the proper inclusion of suicide prevention within New Horizons, what is essential is that suicide prevention is high profile, funded, with responsibility for implementation clearly allocated, and with accountability against defined targets and measures.

## 5. Suicide prevention and New Horizons

While New Horizons does not adequately address suicide prevention in its current form, Samaritans believes that the vision, values and themes of New Horizons could contribute to strengthening suicide prevention. In the next section Samaritans provides some themes or issues which we would like to see taken forward in suicide prevention in the next 10 years. We believe these issues should be part of the wider review of suicide prevention in the context of New Horizons, including the full range of role-players.

### 5.1.1. Addressing the multiple factors and pathways that lead to suicide

Samaritans concurs with the general understanding of suicide, that there are multiple factors and multiple different pathways that lead to suicidal behaviours; and further that suicide is a multi-determined event, meaning that it is generally not the consequence of a single issue but the combination of several issues in a person’s life<sup>11</sup>. While there are several models for pulling these factors apart, the following is a useful model taken from the New Zealand Suicide Prevention Strategy 2006 – 2016. This is captured in Figure 1 below<sup>12</sup>.

1. Wide-ranging factors contribute to suicidal behavior. These include individual factors, such as genes and personality, family experiences, life events, exposure to trauma, cultural beliefs, social isolation, income, education and housing and wide macro-social trends such as unemployment rates.
2. These factors can contribute to suicidal behaviours directly, but they can also contribute indirectly by influencing individual susceptibility to mental health problems. A vast amount of evidence shows that:
  - The majority of those dying by suicide or making suicide attempts have a recognisable mental health problem
  - Mental health disorders (including in particular mood disorders, substance abuse disorders, psychotic disorders and antisocial behavior disorders) account for up to 70 percent of suicides and suicide attempts.

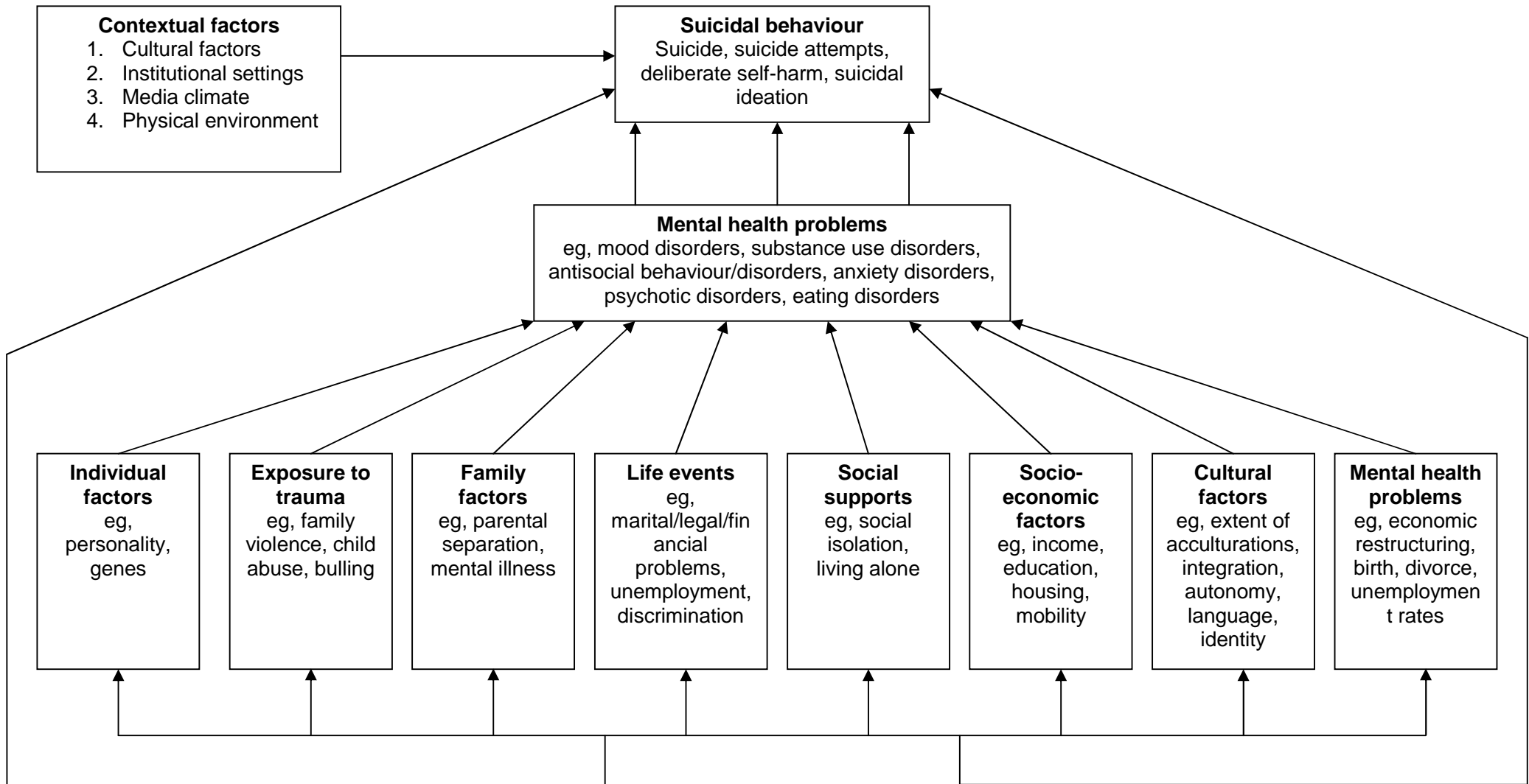
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<sup>10</sup> New Horizons consultation – Towards a Shared Vision for Mental Health, 2009, DH. p. 56

<sup>11</sup> Hawton, K. & van Heering, K. 2009. Suicide, *Lancet*, 373: p1372-81; Mann, J.J., Apter, A., Bertolote, J. et al. 2005. *Suicide Prevention Strategies: A Systematic Review*, 294(16): p 2064-2074.

<sup>12</sup> This is adapted from the New Zealand Ministry of Health, New Zealand Suicide Prevention Strategy 2006 – 2016, p 15-16, available at [http://www.moh.govt.nz/moh.nsf/pagesmh/4904/\\$File/suicide-prevention-strategy-2006-2016.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/4904/$File/suicide-prevention-strategy-2006-2016.pdf), accessed 1 October 2009.

Figure 1: Pathways to suicide behaviour



3. Contextual factors influence the extent to which exposure to these factors translates into suicidal behavior. Contextual factors include:
  - Cultural factors that may modify the effects of risk and protective factors of suicidal behaviour
  - Institutional settings such as schools, universities, workplaces, hospitals and prisons whose climate, organisation and practices may influence the extent to which exposure to risk is translated into suicidal behaviours
  - Media that may influence the extent and expression of suicidal tendencies
  - Physical environments that may influence the availability of suicide methods

This model enables the pulling apart of the various factors, from large societal trends, to community, to individual issues that impact on suicidal behaviour and the creation of interventions to impact at these different levels. Thinking about suicide in this way as the consequence of multiple factors and different pathways means that a broad multi-sectoral approach to suicide prevention is important with interventions at various levels from the individual to society as a whole<sup>13</sup>.

This understanding of suicide is part of the current suicide prevention strategy. However, New Horizons can enable us to significantly strengthen suicide prevention by joining it up more coherently with efforts to address factors such as social isolation and socio-economic deprivation and mental well-being.

The current suicide prevention strategy includes the goal to “promote well-being in the general population”. However, the strategy targets its work in this area to specific vulnerable groups in relation to suicide, and leaves the general promotion of mental health and well-being to the work carried out under Standard One of the NSF-MH. The suicide prevention strategy is very careful in defining vulnerable and at risk groups. While not exclusively, but to a significant extent the interventions for the risk groups are clinical, in the area of improved clinical identification and management of risk. The careful and focused nature of the current suicide prevention strategy is valuable, and the suicide rates for the defined risk populations have decreased.

Yet one figure has remained largely constant. The suicide prevention strategy states that “around three quarters of people who commit suicide are not in contact with mental health services”<sup>14</sup>. New Horizons states that “around 75 percent of the 4,000 people who take their own life each year in England are not in contact with mental health services”<sup>15</sup>. This supports the need to widen our interventions.

## **5.2. Mainstreaming suicide prevention and making sure specific suicide prevention measures remain in place**

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<sup>13</sup> While this is a model specific to suicide prevention, such a model which pulls apart the levers of mental well-being looking at individual, community or setting and societal issues would be useful in understanding the different levels of intervention, and where sectors and organisations fit in and contribute. New Horizons provides several models (for example, Figure 1: Framework for developing well-being, p 13; or Figure 3: The Guiding principles, p 20) but none of these pull apart the framework at societal, community and individual level.

<sup>14</sup> Safety First: *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*, cited in Department of Health, 2002. *National Suicide Prevention Strategy for England*, p 9.

<sup>15</sup> University of Manchester. 2006. *Avoidable Deaths: Five Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*, cited in *New Horizons consultation – Towards a Shared Vision for Mental Health*, 2009, DH. p. 55. Appleby, L., et al. 2001.

While New Horizons is not explicit in this regard, our reading of the document is that it suggests the mainstreaming of suicide prevention into mental health promotion, and mental health services. Suicide in New Horizons currently sits in the chapter on “Better Mental Health and Well-being for Adults”, in which one of the key messages is “multi-sector approaches can be taken at a wider population and community level to promote mental well-being”. Samaritans believes mainstreaming suicide prevention could be a powerful approach which allows far better integration between fostering mental well-being, engagement with the vulnerable, early intervention, management of risk and prevention of suicide.

However, importantly, there are some specifics to the prevention of suicide and to dealing with suicidal behavior which are not automatically present in a general mental health programme. Suicidal behavior can be understood as a particular category and kind of human behavior with particular features, knowledge of which is increasing. Just as there are specifics to the engagement with other kinds of mental health problems, there are specifics to the prevention of suicide. Such measures include:

- Training frontline staff, such as police, GPs and teachers and others to improve their understanding of suicide risk. Samaritans has various training programmes that increase the knowledge and skills of key practitioners and others in dealing with people in distress and allows them to better provide support and signpost to Samaritans. We have developed DEAL (Developing Emotional Awareness and Learning), a teaching resource for 15 to 16 year olds.
- Limiting availability and access to lethal means
- Good media practice: research shows that media portrayal of suicide may result in an overall increase in suicide and/or an increase in uses of particular methods. Samaritans uses its well-known and well-respected *Media Guidelines for Reporting Suicide and Self-harm* as the basis for encouraging the press to report suicide responsibly. In 2006, Samaritans successfully lobbied the Press Complaints Commission for a new sub-clause to be introduced into Editor’s Code of Practice. This sub-clause – 5ii) When reporting suicide, care should be taken to avoid excessive detail about the method used – is used alongside Samaritans’ Media Guidelines to further encourage responsible reporting of suicide and mitigate the risk of copycat suicides occurring.
- Improving care for those with mental health disorders with high suicide risk
- Follow-up care after suicide attempts
- Support for families and communities affected by suicide
- Promotion of research into suicide and suicide prevention
- Monitoring and collation of suicide related data
- Education and awareness programmes

All of these things require funding, allocated responsibility and overt presence in any framework to ensure they take place. While we believe the mainstreaming of suicide prevention work could be immensely powerful, the specifics required to prevent suicide must not be lost. Mainstreaming should not mean that suicide prevention becomes so diffuse as to disappear.

### **5.3. National strategy and local action**

Two significant themes in New Horizons are cross-government and sector work; and enabling action at local level. While the current suicide prevention strategy commits to

multi-sector work, Samaritans believes New Horizons gives us the opportunity to strengthen this approach - creating more powerful partnerships between sectors (public, private and third sector), as well as across sectors such as health, community development and justice, and community-wide approaches at local level.

In this regard Samaritans believes:

- It is important to maintain suicide prevention as a national priority and to have national coordination to provide a strong lead and prevent fragmented.
- There should be a standing national reference group including the Department of Health, other government departments, representatives of local government, third sector organisations and representatives of target groups and service users.
- There must be responsibility for suicide prevention in statutory authorities at local level.
- A community-specific and community-wide approach at local level should be entrenched.

The factors that are most pertinent with respect to suicide often have particular configurations at local level, so national strategies need to enable community-specific action to deal with what is important locally. A community-wide approach involves bringing together local organisations and community members, with statutory services and representatives across the local authority, to plan and implement a specific plan for the local area. For example, in an area where homelessness is a particular problem and a risk for suicide, involving organisations working with the homeless can lead to better reaching out and mental health support to this group. Including the parts of the local authority dealing with housing and communities rather than just mental health would enable wider socio-economic issues to be addressed as well<sup>16</sup>. With our 201 branches across the UK and ROI and our considerable experience in working with local communities to reduce suicide, we believe we can make an important contribution in this area. This community-wide approach can be important for fostering mental well-being as well, and community-wide promotion of mental health and suicide prevention could usefully be joined up.

Suicide prevention strategies have now been established in Scotland, Wales and Northern Ireland and we believe that this UK-wide framework for suicide prevention needs to be maintained and strengthened. There should be more coordinated and coherent sharing of knowledge across the nations. As an organisation working across nations we believe we also have a contribution to make in this area.

#### **5.4. Targets and impact measures**

Samaritans understands that the decision has been taken not to create a new national target for suicide reduction. While we believe such a target has been useful for focusing effort, we understand that it is a rather blunt measure of the success of a suicide prevention strategy, particularly given the impact of large macro-social trends on suicide levels.

However, as with mental well-being, or any area of work, it is important that there are targets and impact measures in order to assess and understand the impact of suicide

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<sup>16</sup> Ashdeed, F., Hahne, S., Leibowitz, J. & Seymour, L. 2004. Supporting implementation of the National Suicide Prevention Strategy: A public mental health approach. *The Mental Health Review*, 9:3, p 24 – 27.

prevention action. With the removal of the overall national target we would like to see the exploration of other kinds of targets and impact measures:

- This could be suicide rate reduction targets for specific vulnerable groups, or local suicide reduction targets.
- It is also important to look at other impact measures beyond just suicide rates. At the moment progress in suicide prevention is measured by looking at rates overall, in different groups and by method. The different component parts of the suicide prevention strategy must be evaluated; for example, the actual impact of improvements in clinical management for service users, the impact of public health initiatives, community level actions or any other part.
- We would like to see the inclusion of measures focused on the actual experiences of people in distress and crisis, such as the extent to which interventions enable recovery, or service users' views of clinical risk identification and management. New Horizons commits us to the involvement of service users in the development and evaluation of our interventions.

While reports on actions undertaken as part of the current national suicide prevention strategy have been published annually, we believe the work of reviewing the strategy and evaluating its impact needs to be done. It should include researchers and policy-makers, cross-sector stakeholders, as well as service users and affected groups, such as those bereaved by suicide and those caring for others in crisis.

The mainstreaming of suicide prevention through mental health promotion and services entails looking at targets and measures for suicide prevention and mental health and well-being in a more integrated way.

## **5.5. Data and research**

The national target may have been dropped, but the ongoing collection and monitoring of data related to suicide and suicide-related behavior must continue, to inform suicide prevention and as an indicator of the mental health of the population.

Further, the data on suicide numbers and rates should be improved. It should be:

- Better coordinated
- More accessible
- More detailed.

The UK figures are finalised 12 months after the period to which they relate. The data released is usually for the year in which the death was registered (when the inquest finishes) rather than the year in which the death occurred. Information about trends in suicide during the year is not routinely available. Some provisional data is released and then amended and it would be useful to have the final information much earlier.

Although this data is available via the Office for National Statistics it is often not presented in a clear and easily accessible way and this can be further complicated by the different times at which data is released (ROI data in May, Scotland in August, England and Wales and Northern Ireland in December).

Some local data is also available, but from the NHS Information Centre rather than the Office for National Statistics and Samaritans has had to pay for local data.

Data is available about the numbers and rates of suicide by nation and with detail by sex and age group. Information about method of suicide is also produced. More detailed information about ethnicity, occupation or other characteristics is not routinely available and can only be investigated through specific research studies.

Research needs to move beyond analysis of epidemiology and more to looking at what is effective in reducing suicide. There needs to be more money available for 'action research' where services which show promise can be systematically evaluated by credible researchers. We need to break down the barriers between research, policy and practice and this is another reason for the creation of a forum where people involved in suicide prevention can share knowledge and ideas.

### **5.6. A focus on recovery**

Samaritans greatly appreciates the New Horizons theme of 'recovery and hope' and 'living a life beyond illness' and believes this emphasis should be incorporated into suicide prevention work.

The current NSPC Goal 1 is to reduce risk in key high risk groups. The objective in this section – for all the risk groups – is “to reduce the number of suicides”. We would like this to be reframed to include concern for the quality of care and recovery of those who experience suicidal behavior.

### **5.7. Postvention - support for those affected by the suicide of another**

Postvention – the provision of crisis intervention, support and assistance for families, loved ones or communities affected by a completed suicide – is an underdeveloped area of the current national suicide prevention strategy. The provision of appropriate crisis intervention can serve not only to mitigate the devastating effect of a completed suicide on families, friends and communities<sup>17</sup> but also to reduce the risk of contagion which is thought to lead to the formation of suicide clusters<sup>18</sup>. Support to families bereaved by suicide continues to be inadequate. It is important that postvention be included in a national strategy for coherent work in this area.

Samaritans is developing a suicide and self-harm response service for schools to do this postvention work. With the adolescent population considered to be the group most at risk of contagion, the response to completed or attempted suicide within a school community is of particular importance. Schools may lack understanding of the complex issues surrounding suicide and without the development of an appropriate protocol which can be used to respond to a crisis situation they risk inadvertently exacerbating the problem by hindering pupils' emotional recovery and inadvertently promoting suicide. Through support from a Samaritans' coordinator, the school can respond to and recover from a suicide, thereby minimising the risk of contagion and mental health problems, including depression and post traumatic stress disorder. The service includes:

- Appropriate procedures for notifying staff, family and friends about a death by

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<sup>17</sup> Brock SE (2003). Suicide Postvention, paper presented at the DODEA Safe Schools Seminar

<sup>18</sup> Robbins *et al*, 1983; Davidson *et al*, in press, cited in Centre for Disease Control (CDC), Recommendations for a Community Plan for the Suicide Prevention and Containment of Suicide Clusters (1988).

- suicide
- Guidelines for disseminating facts and dispelling rumours about the suicide
- Procedures for identifying individuals who may be at risk and referring them to appropriate support services
- The formation and training of a team in crisis intervention techniques

## 6. The value of our emotional support helpline

The role of helplines in supporting people in distress or crisis is often either ignored or seen as a 'nice to have'. By 2014, we will be answering 6 million calls a year from people seeking emotional support. We are available 24 hours a day, 365 days a year. Although our vision is to reduce suicide, we don't just offer support to people who are suicidal. Our services also reach people who are experiencing less acute emotional distress. 55 percent of our callers do not express suicidal feelings. The majority of people call us because they are feeling sad, lonely or anxious. A significant number experience mental health problems or self-harm. Many have experienced abuse or trauma. But importantly, people don't need to have an assessment or a diagnosis to gain access to our helpline. 40 percent of those contacting Samaritans are not using other services. It is a large scale, accessible service providing support to people in distress or crisis, whenever they need it.

The European Commission decided that certain numbers of social value should be contactable by the same memorable telephone numbers in all the member states to make it easy for people to find the correct telephone number for a service when they need help, assistance or advice, prefixed with the same code 116. This is referred to as the Harmonised European Short Code (HESC). The process of awarding the numbers in the United Kingdom was managed by the Office of Communications (Ofcom), advised by the Contact Council in the Cabinet Office. It is hoped that Samaritans will be awarded the number for emotional support 116123.

Ofcom defined the emotional support number as a service of "extreme social value": "Services of 'extreme social value' will generally meet a vital and/or extremely urgent need at a time of emotional distress or threat to welfare. The situation where a call to one of these numbers is likely to be needed is one in which it is crucial that the caller can make the call for reasons of their own safety or well-being of others. In other words, they provide a lifeline for people in distress"<sup>19</sup> Ofcom specified that services of "extreme social value" must be free to callers.

We are pleased that the extreme social value of emotional support helplines has been recognised and that this service is being made accessible to all by being free to callers. But there is currently no statutory funding associated with HESC. Samaritans can deliver this service more cost-effectively than anyone else because we have 18 000 trained volunteers. However, implementing 116123 will cost Samaritans an addition £3.16 million over the next five years.

More must be done to facilitate referrals and partnerships between statutory services and Samaritans, particularly given that 75 percent of those who end their lives who are not in contact with mental health services. Samaritans currently has several formal and

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<sup>19</sup> Office of Communications. 2009. *Harmonised European Numbers for Services of Social Value: Allocation and charging arrangement for the 116 numbers in the UK*, 20 February 2009, p 56.

informal referral partnerships, and is busy strengthening this work across the organisation.

In addition, there continues to be duplication of service in the provision of helplines, across the statutory and voluntary sector and this does not constitute value for money.

## **7. Conclusion**

We reiterate our call:

- That suicide prevention should remain a priority
- For a proper review of suicide prevention in the context of New Horizons including all role-players
- For a more powerful partnership between Samaritans and the statutory sector given the large scale, accessible emotional support service we provide, and our ability to work at community level through our 201 branches.