opportunities and standards in the country, and it has circulated a questionnaire on the Membership to all those who sat the first examination. It is particularly anxious that overseas doctors working in British psychiatry should know of the Association in view of the special problems and disadvantages that many of them face.

The Association is particularly appreciative of the financial and vocal support given it by many senior psychiatrists throughout the country. This is sufficient evidence that the dissatisfactions expressed by trainees concerning training are not, as has been suggested, the manifestations of examination anxieties. The Association remains convinced that it is training rather than examinations that is the crucial problem, and that with adequate standards of training the emphasis on examinations and assessment becomes less important.

It would seem that standards of training in certain areas are in decline. There is a steady decrease in the number of British and Irish graduates entering psychiatry, and standards of professional care and responsibility in certain large mental hospitals have been the subject of serious public concern. The Association recognizes that the Royal College of Psychiatrists is not the only body with responsibility in this area, and intends making its views known to all those who are involved with the formation of adequate professional standards in the specialty. It believes that junior psychiatrists who carry a major share of responsibility in psychiatry, must begin to express their views on these issues, and it aims to provide them with a forum in which they feel free to do so.

For further details of the Association, write to Dr. John Hamilton, Secretary, Royal Edinburgh Hospital, Morningside Park, Edinburgh 10.

DOCTORS, SAMARITANS AND SUICIDE

The Samaritans *Newsletter* for September 1971 contains the following paragraph:

'If the decline of suicide in the United Kingdom is admitted, it is said that it must be due to better medical services. The Samaritans are the first to say that better diagnosis, poison treatment centres in hospitals, improved care of old people, etc., have played a part. But suicide is still increasing in Europe and the United States. Are we to assert that medical services in other countries have not improved? The decline is peculiar to Great Britain among Western countries. Britain is the only country with a national network of 24-hour advertised listening and befriending posts. More cogent still, there is a similar decline of suicide in certain places (Los Angeles and others in the U.S.A., Vienna in Austria) where similar posts exist, whereas the rate is still rising in the remainder of those countries—just as Christopher Bagley found that suicide decreased in British towns with a Samaritan Branch, but increased elsewhere.'

The *British Medical Journal*'s report on this paragraph ended, 'the conclusion drawn is that Britain's unique record of declining suicides is the result of its being the only country with a nationwide 24-hour Samaritan service' (1).

How are we to view the Samaritans' position among other contenders for the credit of having caused the suicide rate to drop? The short answer is that there is no proof that any specific agent is responsible, but there is some interesting evidence worth examination.

Samaritan clients in Southern England have a high suicide rate (2), 300 per 100,000, so it is clear that a proportion of those contemplating suicide are attracted to the service. But suicides among the clients amounted to only about 4 per cent of all suicides in the community served. Doctors also attract the suicidal, some 80 per cent of a sample of 100 being in medical contact. One could infer that Samaritans are far more successful than doctors at saving lives, such a small percentage of the total of suicides being their clients, but it may be that intending suicides do not make contact with them in large numbers. The Samaritans' power to attract the intending suicide would be more convincing if a greater proportion of the total of suicides had been their clients.

Parallel with the falling suicide rate has been a general increase in Samaritan activities measured in numbers of active branches, counsellors, clients and telephone calls. This correlation can be used to infer that the Samaritans have had a part to play in reducing suicide. But, of course, the medical services have changed over the same period. Psychiatric services have improved, the number of patients treated has increased, as have the psychiatrists to treat them; and mental hospitals have been changed from custodial institutions to open hospitals with community services, and the suicide rate of their in-patients has gone down. Similarly, general practitioners have become more aware of treatable mental illness, and parallel with the reduction in the suicide rate there has been increased prescribing of antidepressant drugs, known to be effective in the treatment of the illness associated with the majority of suicides. Moreover, barbiturates, potentially very lethal, are being replaced by less toxic hypnotics and sedatives. And lastly, improvements in the hospital treatment of acute poisoning, following the Atkins and Hill reports, have almost certainly had an effect.

https://doi.org/10.1192/S0007125072302564 Published online by Cambridge University Press

Of all the people dying from barbiturate poisoning, the cause of over 1,000 suicide deaths each year, 28 per cent died in hospital in 1959 but only 21 per cent in 1970, even though total admissions for poisoning had increased. The likely cause of this percentage drop is improved hospital care of the poisoned.

However, the strongest evidence favouring the Samaritans is Bagley's (3) study. By comparing the suicide rate in 15 English county boroughs before and after the introduction of a Samaritan service, and controlling with ecologically similar boroughs, he showed a drop in the suicide rate of 5 per cent in the Samaritan boroughs and a rise of 20 per cent in the boroughs without a Samaritan branch. This use of controls was an attempt to eliminate all variables except the one under consideration, the Samaritan activity, and it made use of a classification of towns based on measurements of 57 demographic, health, social and economic variables. Each Samaritan town had a pair chosen objectively by this classification. To conclude that the Samaritans caused the drop in the suicide rate, we must assume that the pairs were identical in all relevant respects but the Samaritan activity, which is impossible. Bournemouth and Eastbourne, Halifax and Leeds, Derby and Preston, are convincing approximations to each other; but are Birmingham and Tynemouth, Hull and Merthyr Tydfil, Portsmouth and York? About half seem realistic pairs. This must reduce our confidence in conclusions drawn from using the controls. Another important dissimilarity lies in the unknown social factors which enabled sufficient people to come forward to found and staff a Samaritan branch. These social factors could themselves have been responsible for changes in suicide without the intervention of Samaritan activities.*

Evaluation of the effect of psychiatry on the suicide rate of defined areas are few, but two are worth attention. Following the introduction of modern mental hospital care at Dingleton (4), suicide decreased by nearly 50 per cent in the area served, and the rate also diminished among the elderly when community care was introduced in the Chichester area (5).

It is clear then that evidence exists pointing to both the Samaritans and the medical services as having influenced the incidence of suicide favourably.

Can we infer with any degree of certainty, from this brief outline of the evidence, that either the Samaritans or the medical services have caused the suicide rate to drop? The suicide rate, it must be remembered, has fluctuated in the past, before the Samaritans existed, before the development of modern psychiatric treatment.

It must be concluded that the evidence does not prove that either has been responsible, but the weight of the evidence favours the medical services as the more important, for most suicides are attracted to the medical services, and the medical services are well equipped to deal with the depressive illnesses that are common in suicide, and to resuscitate the poisoned when attempts are made. With the Samaritans, on the other hand, there is uncertainty about their ability to attract potential suicides in large numbers, and their befriending techniques appear unlikely at face value to alleviate the mental illness, personality disorder and social distress found in most cases of suicide, particularly as a large proportion of client contacts may receive only one or two visits from the Samaritan staff.

What the Samaritans have done is to underline the large number of unhappy people, people with personal, social and economic problems, some acute but many chronic or recurrent, arising from mental illness, personality disorder or social advertisity, who are not catered for by existing services and who have turned to the Samaritans for help. There were 68,000 new clients in 1970, about 0·1 per cent of the population.

B. M. BARRACLOUGH.

*'A Study of Suicide in Brighton', by Dr. S. Jacobson, to be published in this *Journal*, shows that the town's suicide rate was falling appreciably at a time when there was no Samaritan branch there. [Ed.]

REFERENCES

1. *British Medical Journal* (1971). **4**, 181.
2. BARRACLOUGH, B. M., and SHEA, M. (1970). *Lancet*, *ii*, 868.
3. BAGLEY, C. (1968). *Social Science and Medicine*, **2**, 1.
4. RATCLIFFE, R. W. (1962). *Lancet*, *ii*, 188.
5. WALK, D. (1967). *British Journal of Psychiatry*, **113**, 1381.

RESEARCH IN MENTAL ILLNESS SUPPORTED BY THE DEPARTMENT OF HEALTH AND SOCIAL SECURITY

During the current financial year the Department of Health and Social Security is supporting research in mental illness to the extent of rather more than £140,000. Expenditure by the Department is 50 per cent greater this year than last, and it is likely to continue to increase over the next few years.

The main Government agency for the advancement of medical research is the Medical Research Council. Very broadly, the research the Council supports is essentially basic research, whereas the research supported by the Department is mainly service orientated. This naturally limits the projects

https://doi.org/10.1192/S0007125072302564 Published online by Cambridge University Press