Brit. J. Psychiat. (1972), **120**, 79–84

A Comparison Between 'Samaritan Suicides' and Living Samaritan Clients

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Introduction

'The Samaritans' were founded in 1953 to help 'the suicidal and despairing'. As with similar lay agencies abroad, their growth in the past ten years has been vigorous; they now have more than 120 branches in the United Kingdom and these branches attracted over 50,000 clients in 1969. The Samaritans' aims have been described in detail by Fox (1968), but their most important aim is still the prevention of suicide. Their success in attracting the suicidal and preventing their subsequent death must therefore be the criteria of their effectiveness.

We have shown the suicide rate of Samaritan clients in Southern England to lie between 300 and 400 per 100,000, compared with a rate of 11 per 100,000 for a general population group of similar age and sex composition (Barraclough and Shea, 1970), demonstrating that the Samaritans do attract the suicide-prone person.

Do they also prevent suicide?

By comparing the suicide rate in County Boroughs before and after the introduction of a Samaritan service and controlling with ecologically similar county boroughs, Bagley (1968) demonstrated a relative reduction of nearly 25 per cent in the suicide rate of Boroughs where the Samaritans were operating. At first sight this suggests that they do prevent suicide, but the causal role of the Samaritans in this phenomenon must be conjectural. Social changes could just as well be responsible for both the drop in the rate and the founding of Samaritan branches.

Our published study (Barraclough *et al.*, 1970) showed that, although potential suicides were attracted to the Samaritans, 4 per cent of all the suicides in the area studied had been Samaritan clients; yet clients who committed suicide comprised only ½ per cent of all the clients seen. For the Samaritan worker on duty this means that one in every 200 or so of his clients will commit suicide; but he has no means of telling which one. As he cannot deploy all the helping forces at his disposal on every case, common sense rules of thumb seem to have developed to discriminate the client thought to be in danger from the others considered not at risk. We think that objective criteria would be of help to the Samaritan worker in this predicament, and to the psychiatrists and mental health workers who advise them. The findings may also be useful to the work of similar organizations in other countries.

Our enquiry, then, describes an attempt to derive these criteria by comparing Samaritan clients who committed suicide with a control group of living Samaritan clients. The aims are, firstly, to describe the major differences observed between the two groups and attempt to give them some general meaning, and secondly to derive the measures of practical value which discriminate most efficiently between suicides and living clients.

Method

(i) *Location of suicides and selection of controls*

The Samaritan suicides were identified by comparing the coroners' list of suicides with the Samaritans' register of clients in each of six towns in Southern England. In this way we identified 39 suicides; 6 more were found because although they had died outside the coroners' areas we examined, the Samaritan branches knew of their deaths, and newspaper cuttings of inquests provided proof of these suicides. There were therefore 45 Samaritan suicides available for study.

The towns examined were six County Boroughs in Southern England. We chose these places because they were close at hand and their coroners and Samaritan branches both agreed to help. Other nearby towns initially selected for inclusion had to be left out because either the Samaritan branch or the Coroner felt unable to take part in the study.

https://doi.org/10.1192/bjp.120.554.79 Published online by Cambridge University Press

The number of years the branches had been established was five (1), six (3), seven (1), and eight (1).

An unknown number of client suicides will have been missed because they died outside the coroners' areas we searched. Walk (1967) calculated that 10 per cent of suicides living in West Sussex died outside the coroners' areas in which they resided. We found 39 who committed suicide in their own coroner's area and 6 who killed themselves outside it—over 10 per cent. It seems likely that virtually all were located, if the West Sussex findings are general.

We also searched for clients whose deaths had been recorded as open verdicts, for suicides may be classified under this heading when evidence of intent is lacking. Two were found, fewer than expected, for the ratio of open verdicts to suicide verdicts in England and Wales is about one to five (Barraclough, 1970) and here it was one to twenty. The open verdict cases were not included in the analysis, for we wished to use the operational definition of the coroner's suicide verdict.

The population examined for suicides, and from which controls were drawn, comprised the 12,274 entries of new clients from 1961 to 1968 in the six branch registers. The period elapsing between last contact with a Samaritan worker and the suicide date was three months for 50 per cent of the suicides, one year for 80 per cent, and two years for 90 per cent. All the deaths took place within 40 months of the last Samaritan contact.

We selected the control group by taking the names of the two clients registered before and after each suicide's name in the cumulative alphabetical index of clients kept at each branch. The control group therefore numbers 90, twice the size of the suicide group.

The two groups are correlated for the surname's initial letter, a fact known to make for similarities rather than differences between populations, but as it will act against our findings of differences being true, it can be disregarded as a falsifying factor. The two groups are also correlated for area of residence at the time of registration with the Samaritans.

(ii) *Recording of data*

The information recorded on each client's case sheet was transferred by one of the authors (M.S.), who is a Samaritan worker, on to our own data sheets without any alterations, judgements or ratings being made.

The information taken from the branch records was in three broad categories; firstly biographical, clinical, social and economic; secondly the details of the contact with the branch, mode of referral, duration of contact, action taken; and thirdly the measurable aspects of the client-worker contact, particularly their congruity with regard to age, sex and social class.

There are sources of error in the original collection and recording of these facts arising out of the worker-client interview and the workers' method of recording information, over which we had no control and which we now have no means of estimating. As the variables used are relatively simple and 'hard', we are assuming that the error is not great, probably affects the two groups of clients equally, and is largely of a clerical nature, for over 100 workers were responsible for completing the records and systematic bias is therefore unlikely. Further, the interviewers could not have known which clients were to kill themselves and which not.

A word needs to be said about the definitions we used of social class and previous psychiatric treatment. The social class of occupations was decided by referring to the Registrar General's 'Classification of Occupations, 1966'. Previous psychiatric treatment was rated 'Yes' when there was unequivocal evidence of a period of in-patient, out-patient or day-patient care at a psychiatric hospital, a general hospital psychiatric unit or from a psychiatrist privately.

Results

(i) *The major differences between the two groups*

The suicides among Samaritan clients do in fact constitute a distinct group among the general client population, as an inspection of Table I, which summarizes the differences, will show. The picture of the suicide group which emerges is one of a history of psychiatric treatment and suicide attempts, phases of depression and present social isolation, in predominantly middle-aged people with disrupted marriages who are already in touch with other 'helping' agencies.

The groups are markedly different even in their age and sex composition. The suicides are concentrated in the older age groups and especially in later middle age. The sexes are fairly evenly represented in the suicide group, while the control group is predominantly female.

An examination of marital status shows that the suicide group is characterized by a disrupted marital relationship; a further difference and one related to this fact is seen in the living conditions, where more of the suicides are found to be living alone or in non-private

https://doi.org/10.1192/bjp.120.554.79 Published online by Cambridge University Press

TABLE I

*The major differences between suicides ($N = 45$) and controls ($N = 90$)**

Feature	Suicides		Controls		Chi squared
	N	%	N	%	
Age					
25	4	9	19	21	$\chi^2 = 15{\cdot}87$
25–44	14	31	33	37	d.f. = 3
45–64	19	42	26	29	$p < 0{\cdot}01$
65+	8	18	1	1	
N.K.	0	0	11	12	
Sex					
Male	24	53	29	32	$\chi^2 = 4{\cdot}76$; d.f. = 1
Female	21	47	61	68	$p < 0{\cdot}05$
Marital Status†					
Single	11	24	26	29	$\chi^2 = 7{\cdot}12$
Married	15	33	41	46	
Married but living apart	9	20	8	9	d.f. = 2
Divorced	4	9	5	6	$p < 0{\cdot}05$
Widowed	6	13	4	4	
N.K.	0	0	6	7	
Living conditions					
Living alone, hotel, institution, N.F.A.	25	56	32	36	$\chi^2 = 3{\cdot}91$; d.f. = 1
Multi person household	17	38	50	56	
N.K.	3	7	8	9	$p < 0{\cdot}05$
Previous suicide attempts					
Yes	13	29	10	11	$\chi^2 = 5{\cdot}51$
No	32	71	80	89	d.f. = 1; $p < 0{\cdot}02$
Previous psychiatric treatment					
Yes	23	51	24	27	$\chi^2 = 6{\cdot}86$
No	22	49	66	73	d.f. = 1; $p < 0{\cdot}01$
Subject in touch with another agency					
Yes	38	84	38	42	$\chi^2 = 20{\cdot}05$
No	7	16	52	58	d.f. = 1; $p < 0{\cdot}001$
Type of agency‡					
Medical only	23	61	13	34	$\chi^2 = 6{\cdot}08$
Medical plus non-medical	7	18	8	21	d.f. = 2
Non-medical only	8	21	17	45	$p < 0{\cdot}05$

* Those cases falling into the Not Known category have not been included for the calculation of Chi squared.

† Married but living apart, divorced and widowed have been aggregated in calculating Chi squared.

‡ 'Medical Agencies'—General Practitioners, Mental Hospitals, Nursing Homes; 'London Specialist', Psychiatrist, Homeopath, General Hospitals; 'Doctors', Hospital Social Worker, Mental Welfare Officer, Mental Welfare Departments.

'Non-medical Agencies'—Ministry of Social Security, Other Samaritan Branches, Minister of Religion, Police, Probation Officers, Labour Exchange, National Society for Prevention of Cruelty to Children, Naval Pay Office, Housing Department, Marriage Guidance Council, Children's Committee, Solicitor, Welfare Departments, Sisters of Bethany, Women's Voluntary Service; 'Courts', Parish Worker, Alcoholics Anonymous.

households. The suicide group also tend to be clustered in Social Classes I, II and III but not to a significant degree.

Psychiatric illness predominates among the suicide group, as do previous suicide attempts. The importance of these two factors is underlined by the record of the interviews with Samaritan workers. The words 'depression' and 'suicide' appear significantly more frequently on the reports of the interviews with the suicide group than with the controls. The mention of suicide by clients can be analysed further into reports of previous attempts and complaining of present suicidal feelings. The suicide group complained more frequently of suicidal thinking or intention.

A further point recorded on the Samaritans' reports is the presence of another 'agency'

https://doi.org/10.1192/bjp.120.554.79 Published online by Cambridge University Press

attempting to help the client. The agencies vary from medical practitioners to the Women's Voluntary Service. A complete list of them is given in footnote (‡), Table I.

We thought it likely that more controls than suicides would be in contact with other agencies because their problems were of a more practical nature, whereas the suicides' difficulties were predominantly 'psychological', using the terminology of the reports. The reverse was found. Over 80 per cent of the suicides were in touch with other agencies compared with 42 per cent of controls, suggesting a greater amount of intractable problems among the suicides.

Of the 38 suicides and the 38 controls who were in touch with other agencies, it was the suicides who were in contact more with medical as opposed to non-medical agencies, indicating that their problems were more often medical-psychological while the controls' difficulties were of a practical character. There is however a considerable overlap, and about one-fifth of each have been seeing both medical and non-medical people.

The details of the clients' transactions with the branch, such as the duration of contact, the number of interviews and the action taken do not show any significant differences.

The month and day of contact and month and day of death are also statistically insignificant, but there is a tendency for the first contact by the suicide group to reach a peak in spring—in this respect similar to suicides as a whole—and to a lesser extent in mid-summer, indications, possibly, of the part played by depressive illness.

Our examination of the congruity of 'client' and 'worker' shows no important difference with regard to sex or social class, but significantly more of the suicides had workers of the same or younger age-group. This phenomenon is accounted for by the suicide group being older than the client group, not by the excessive youth of the suicide group's counsellors.

We think, therefore, that the factors differentiating a client who is going to kill himself from one who will not are primarily those of differences between individual clients rather than the 'treatment' they receive from the Samaritans, or the characteristics of the Samaritan worker, though there may be branch differences affecting mortality, as our first paper (Barraclough *et al.*, 1970) showed, or possibly important worker or treatment characteristics which we have not been able to evaluate.

(ii) *A discrimination between suicides and controls*

We want to turn now to the question of discriminatory measures of practical value; items of information about a client, easily obtained from him by the Samaritan worker, likely to be valid, and which taken together could distinguish with some confidence the suicidal from the other clients or alternatively the definitely non-suicidal from the remainder.

Two items when combined provide this discrimination: a history of 'previous psychiatric treatment' and contact with 'other agencies'. Table II shows that by combining these two nearly 50 per cent of the controls have neither feature and only one suicide has neither feature. In practical terms it means that by using these two features virtually half of all the clients attending might have been disregarded as serious suicide risks.

TABLE II
Distinguishing the non-suicidal client

		Suicides (N = 39)* Previous psychiatric treatment		Controls (N = 83)† Previous psychiatric treatment	
		Yes	No	Yes	No
In contact with other agencies	Yes	18	16	20	20
	No	4	1	3	40

* N.K. = 6. † N.K. = 7.

However, there are reservations. As the information was not available for 6 suicides and 7 clients, we do not know into which category these would have fallen; secondly our conclusions are based on sampling the clients and are therefore subject to sampling error; and thirdly we have ignored the suicide-prone clients whose suicide may have been prevented by their Samaritan contact and whose characteristics are unknown to us.

With these qualifications in mind we still feel that this finding is a contribution to the practical side of the Samaritan's work.

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Discussion

The aim of this investigation was to distinguish the suicidal from the non-suicidal. But the data have compelled us to approach the problem from both aspects; on the one hand to find the characteristics more commonly found in the suicidal client, and on the other to discover those features distinguishing the non-suicidal from the remainder. The two approaches have not been equally successful. There are no sets of features which clearly mark the client or group of clients who subsequently killed themselves. There are, though, a number of individual features which do occur significantly more often among the suicides as a group than among the controls. These should provide some help to the Samaritan worker in detecting the suicide-prone client.

When we looked for features characteristic of the non-suicidal client two became apparent immediately. Although these have less practical value for the Samaritan worker than if they had unequivocally characterized the suicidal client, a great saving in time and a relief of worry can be achieved if the worker has a good reason to believe that certain clients are not serious suicide risks. We think the findings of both these approaches have a part to play in the day to day work of the Samaritan branches, but with sensible qualifications.

It is almost certain that further suicides will take place among the population of clients we studied. How will this affect our results? Future suicides might differ from the 45 we located and thereby invalidate our findings, that is later suicides might differ from earlier suicides, for all the clients had a follow-up of six months or more. To check on this possibility we compared the suicides which occurred within six months with suicides occurring more than six months after last contact, on all the variables cited in Table I. The group of later suicides contained more people with previous histories of psychiatric treatment. This was the only variable which distinguished them at the 5 per cent probability level. Future suicides may be similar to this later group, and if they were included would have no effect beyond increasing the dissimilarity of controls and suicides with respect to a past history of psychiatric treatment.

Would future suicides affect the control group in such a way as to invalidate the findings? The answer depends on how many people are likely to be lost from the control group in this way. About ½ per cent of Samaritan clients killed themselves during the study period; fewer will disappear from the control group because of suicide, for most of them have already passed the period of maximum risk, the first year following self-referral. That means a probable loss through suicide of less than 0·5 of a person from the 90 controls. This would not affect the present findings.

The varying follow-up period for the clients is not therefore likely to affect our conclusions.

One surprising point is the large degree of overlap between the two groups, suicides and controls, on such features as a history of psychiatric treatment, a history of attempted suicide, being in contact with other agencies and a record of suicidal feelings at the time of first contact. These facts are recorded as being present in the control group many times more frequently than in the general population, indicating a high degree of psychological morbidity and social disability in Samaritan clients as a whole. It raises the interesting question of why people go to the Samaritans with their worries and practical problems when there are professional bodies to deal with them? Our data do not answer the question. Certainly referral by a psychiatrist was not mentioned as the reason.

A further point of interest is the resemblance of Samaritan suicides to populations of both attempted suicides and completed suicides. Samaritan suicides stand in some respects midway between the two. And of course the control group also has similarities with attempted suicides.

The confidentiality of their clients' records is rightly emphasized by the Samaritans. One of us (M.S.) is a Samaritan worker and it was therefore possible to preserve this important principle while at the same time subjecting the Samaritan service to scientific scrutiny.

We hope in future studies to look at other aspects of Samaritan work. These are, firstly,

https://doi.org/10.1192/bjp.120.554.79 Published online by Cambridge University Press

a comparison between Samaritan suicides and a consecutive series of suicides to identify the characteristics of those suicides not drawn to the Samaritans. Alterations might then be made to the Samaritan advertising programme to attract the suicide-prone they are at present missing. Secondly we will examine in more detail the characteristics of the typical Samaritan client as represented by our control group. Thirdly we intend to review critically the existing evidence as to whether the Samaritans really do prevent suicide.

Finally a word needs to be said about the operational definition of a suicide we have used in this study. We have shown that changing the coroner does not affect the suicide rate of County Boroughs to a detectable degree, and that there is some evidence that coroners use a standard definition of what a suicide is (Barraclough, 1970; Sainsbury and Barraclough, 1968). Therefore what is true of coroners' suicide verdict cases now is likely to be true of them in the recent past, elsewhere in England and Wales, and probably in the future if the system remains unchanged. Of so-called 'missed suicides' who is to call them suicides, or agree with such decisions? We feel that sticking to this operational definition—the coroner's suicide verdict—is the most useful approach at present, for 'making the best the enemy of the good is a sure way to hinder any statistical progress. The scientific purist who will wait for medical statistics until they are nosologically exact is no wiser than Horace's rustic waiting for the river to flow away.'

Summary

Forty-five suicides, formerly Samaritan clients, have been compared with a control group of 90 living Samaritan clients. The suicides were older, more frequently male, had disrupted marriages, were living alone or in hotels, had more histories of previous psychiatric treatment and attempted suicide, and presented more often with psychological as opposed to practical problems. Measures of the treatment received and the characteristics of Samaritan counsellors were the same for suicides and controls.

The best discriminating measures between the two groups were the presence at the time of self-referral of a previous history of psychiatric treatment, and being in contact with other agencies. Nearly half the control group had neither of these characteristics compared with only one of the 45 suicides. These findings are of practical value in assessing firstly the Samaritan client who is a high risk for suicides and secondly the client who is a low risk.

Acknowledgements

The enquiry would have been impossible without the co-operation of H.M. Coroners and the Directors of the Samaritan branches in the six County Boroughs studied; both generously made their records available to us. The Samaritan Research Advisory Committee provided valuable advice and support. Mr. Peter Fayer of the Medical Research Council Statistical Research and Services Unit made the statistical analysis.

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A synopsis of this paper was published in the October 1971 *Journal*.

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(*Received 6 May 1971*)

https://doi.org/10.1192/bjp.120.554.79 Published online by Cambridge University Press