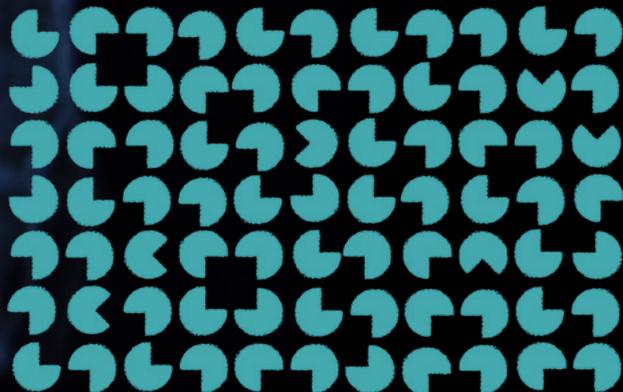




SAMARITANS

➤ **One year on:**
how the coronavirus
pandemic has
affected wellbeing
and suicidality

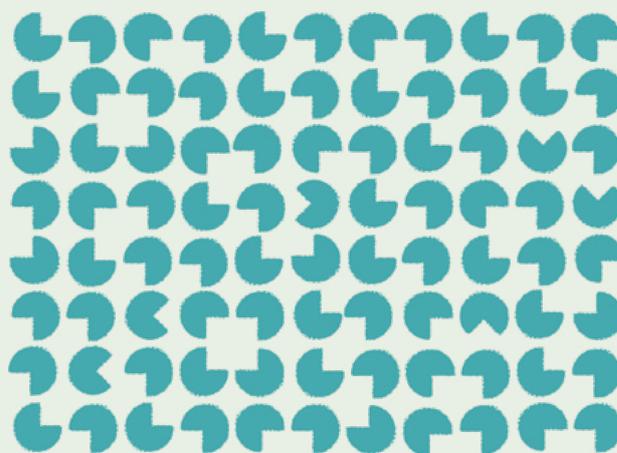
June 2021





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1. Foreword

We have lived through an extraordinary time. It's difficult to process how much our lives have been upended during the last year but I couldn't be prouder of the ways in which Samaritans' incredible volunteers have been there, ready to listen, every moment of every day.

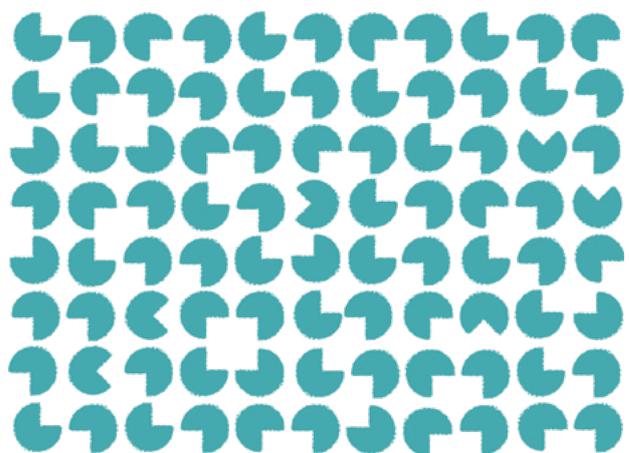
This report offers insights from what our callers have told us over the last year. There is clear evidence that the issues we were concerned about before the pandemic – such as middle-aged men feeling they need to cope alone with problems, or obstacles to young people who self-harm getting the right support – are more present than ever.

It's too soon to know for certain what the impact of the pandemic has been on suicide rates in the UK and Republic of Ireland. But during the year since restrictions began we have supported people who were struggling to cope 2.3 million times and coronavirus was specifically mentioned in one in five of those conversations. Our volunteers also told us it is affecting all callers in some way, even if it's not the direct reason for their call. So there's no room for complacency.

We are moving into a new phase of the pandemic with widespread vaccination programmes across the UK and Republic of Ireland and the easing of social distancing restrictions. Yet, we are far from being able to measure the mental health toll of the pandemic. It's likely that there will be further economic hardship for many people and we know that recessions, unemployment, low income and debt can all increase suicide risk.

There's no time to waste – governments across the UK and Republic of Ireland need to make sure that they put suicide prevention at the heart of our economic and social recovery. Suicide prevention is everyone's business.

Julie Bentley
CEO, Samaritans





2. Summary

There is no doubt that the coronavirus pandemic has had a huge impact on people's lives. Samaritans is seeing the direct impact on people's wellbeing in the UK and the Republic of Ireland.

In the year since restrictions began in the UK on Monday 23 March 2020, Samaritans provided emotional support over 2.3 million times to people struggling to cope, by phone and email. One in five of these contacts were from people who were specifically concerned about coronavirus.

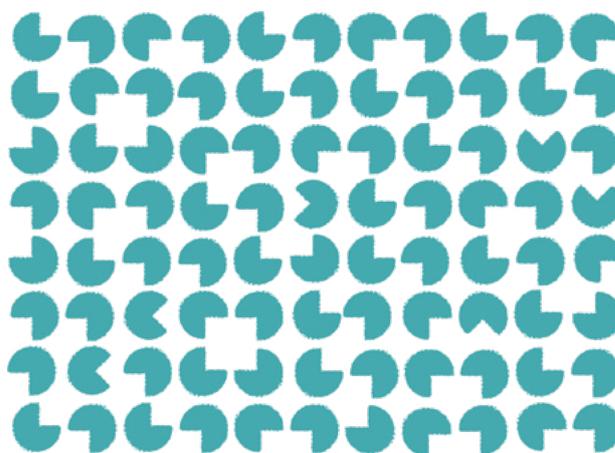
This report brings together analysis of anonymous Samaritans' service data from calls and emails, and primary research with our listening volunteers, which took place at 7 different points during the year since restrictions began. The report also includes secondary analysis of findings from focus groups with Samaritans volunteers on the dedicated helpline for NHS and social care workers in England and Wales, as well as analysis of a subset of data collected as part of the *UK COVID-19 Mental Health & Wellbeing study*, which was part-funded by Samaritans and led by researchers at the University of Glasgow ([MHWS](#)).

At the time of writing, official statistics on suicide rates during the pandemic have not been released. This report identifies that while data so far has found no evidence that national suicide rates increased, it is too soon to be sure. Data so far has not captured differences in local areas or particular groups, nor does it tell us what might happen longer term as a result of the economic disruption.

This report shows that people struggled to access support for self-harm and suicide attempts during the pandemic, with reduced hospital and GP contacts in the early months of restrictions, which was not matched by a reduction in self-harm rates. Some evidence points to an increase in suicidal thoughts over the course of the pandemic, but this is uncertain.

Coronavirus has affected the lives of people contacting Samaritans in many ways. We found that:

- Concerns about coronavirus in contacts to Samaritans peaked in April 2020 and have generally mirrored the timing of UK lockdowns, with coronavirus a more common concern in times of tighter restrictions.
- Since restrictions began, there was a 12 per cent increase in calls between the hours of 2am and 6am, compared to the previous year.
- Calls about coronavirus lasted an average of 24 minutes, which was 40 per cent longer than other calls (average of 17 minutes).
- There was a rise in calls lasting 30 minutes or longer in the first months of restrictions in the Republic of Ireland, especially 1am - 6am.





2. Summary

The knock-on effects of coronavirus also impacted on people's wellbeing in many ways. We found that:

- **Mental ill-health** was the most common concern during the year since restrictions began, and increased slightly compared to last year. The mental health of people with pre-existing mental health conditions appears to have been affected most.
- **Contacts about loneliness and isolation** were most strongly linked to coronavirus, being more than twice as likely to be about coronavirus than other contacts. The protracted nature of restrictions appears to have had a cumulative effect on people's feelings of loneliness.
- **Contacts about family** concerns were 50 per cent more likely to involve specific concerns about coronavirus, with people's concerns ranging from worries about being separated from loved ones to the negative impact of living in close quarters.
- **Finance and work concerns** were strongly associated with concerns about the pandemic, with concerns about potential and actual job loss strongly linked to fears about the future.

While coronavirus has changed everyone's lives, evidence suggests the pandemic may impact some groups' suicide risk more than others. The report identifies five key groups that we are particularly concerned about:

- **People with pre-existing mental health conditions** have increased suicide risk, and our research shows the extra challenges of accessing support, whether from mental health services, friends and family, or community services, have been a key cause of distress.
- **Young people** have faced rising self-harm and suicide rates in recent years, and during the restrictions our research shows they have struggled with family tensions, a lack of peer contact and negativity about their future prospects.
- **Middle-aged men** have faced the highest suicide rates for decades and our research shows key risk factors for this group, such as relationship breakdown and unemployment, alongside a perceived need to cope alone, is affecting this group's wellbeing.
- **Healthcare workers** have experienced a significant and direct impact on their life and work as a result of the pandemic. Our research finds that stress and burnout, fears of infecting family members and anxiety about attending work have all been common features of Samaritans contacts.
- **People in prison** faced much higher suicide rates than the general population before the pandemic began, and our findings show that increased cell time, reduced activities and a lack of family visits resulting from the pandemic have impacted on their wellbeing.

There is no room for complacency about suicide rates, which were rising even before the pandemic. As we move to a new phase of the pandemic with the rollout of vaccinations and social distancing restrictions easing, governments need to put suicide prevention at the heart of efforts to rebuild.



3. Research context

The coronavirus pandemic has had profound social, psychological and economic impacts all over the world. In this report we explore how the pandemic has affected the lives of Samaritans callers and people in emotional distress, and the way people use our services.

Samaritans is seeing the direct impact of coronavirus on people’s wellbeing in the UK and Republic of Ireland. Restrictions began in Republic of Ireland on 12 March 2020, before a full lockdown on 27 March. A UK-wide lockdown started on 23 March. In the year since these restrictions began in the UK, we provided emotional support over 2.3 million times to people struggling to cope, by phone and email.

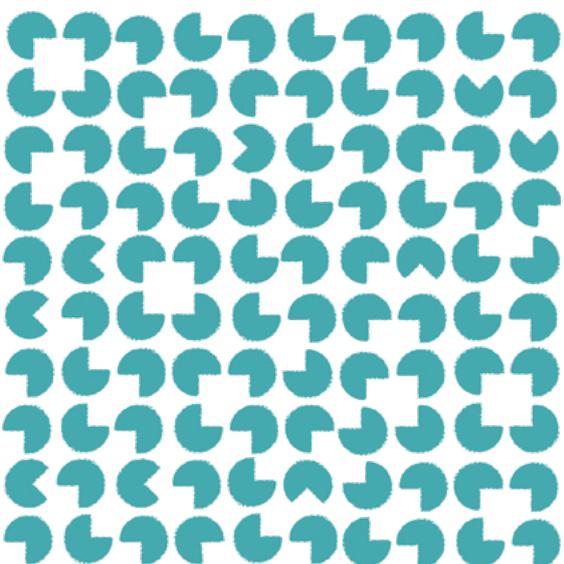
Even before coronavirus, suicide rates had been rising across the UK¹. Trends are less clear in the Republic of Ireland, where the most recent final data is from 2018. However, across the UK and Republic of Ireland, middle-aged men remain at highest risk, a fact which has persisted for decades. But rates have also been rising among women, with, for example, the rate among women under 25 in England and Wales rising to the highest rate on record in 2019. Against this backdrop, the impact of the pandemic on wellbeing and suicide risk is of great concern.

Suicide rates during the pandemic

It is still too early to know what effect the coronavirus pandemic has had on suicide rates. This is because it takes a long time to register, analyse and report on suicide data at a national level, and this has been further delayed due to the pandemic².

Fortunately, provisional suicide registrations for 2020 in England suggest that rates haven’t risen so far³, and early data from ‘real-time surveillance’ systems in several parts of England found no change in suicide trends following the first national lockdown (between April-October 2020)². There were more suspected suicides in this period compared to the same period in 2019, but this was considered in line with the longer-term trend of rising suicide rates, rather than the impact of the pandemic. Real-time data from other nations in the UK and Republic of Ireland is not available as surveillance systems are not currently widespread, though some are under development, including work to improve real time data in Scotland.

These findings are mirrored in international research, which found no increase in suicide in the early months of the pandemic in 21 high or upper-middle income countries⁴ based on suspected suicides via real-time data systems. There was an increase in female suicide in Japan from July to November and men from October to November, but this may have been related to two high-profile celebrity suicides, and has since returned to expected levels⁵.





There is still reason to be cautious. Research suggests the early months of the pandemic saw a 'pulling together' effect, with an increase in some protective factors against suicide, such as social connectedness and mutual support⁶. This may not have extended later into the pandemic, and no data on suicide rates for the later months of the pandemic is currently available.

Similarly, while these figures suggest a universal effect on suicide rates is unlikely, overall trends may disguise increases among certain groups or those experiencing certain risk factors. For example, data from the National Child Mortality Database suggests that deaths by suicide among under 18s may have increased during the first phase of lockdown in the UK, but numbers are too small to reach conclusions⁷. Previous epidemics have resulted in increased suicide rates among particular groups, for example, evidence suggests that suicide increased among older adults in Hong Kong following the SARS virus epidemic⁸, and there were increases in the USA during the 1918-19 influenza pandemic⁹.

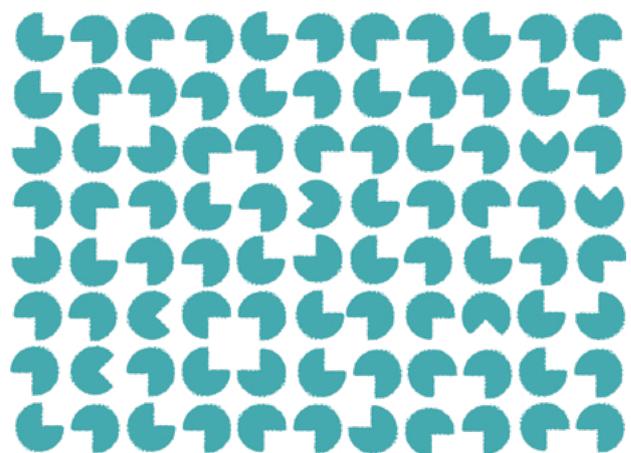
Self-harm and suicide attempts

Rates of self-harm appear to have remained stable throughout the pandemic. A survey of 70,000 people (the *UCL Covid-19 Social Study*) which has run weekly throughout the time since restrictions began, consistently found that around 2 per cent of people report self-harming in the past week¹⁰. Some charities have reported a high number of contacts about self-harm during the pandemic, but it is unclear if this is an increase. Shout, a text mental health service, reported that self-harm was one of its texters top concerns, mentioned in 15 per cent of all conversations since the pandemic began, with higher rates among younger texters and female texters¹¹.

Over the year since restrictions began, the *UCL Covid-19 Social Study* found that self-harm was higher amongst younger adults (aged 18-29), people with lower incomes and people with a diagnosed mental health condition. This does not seem to be a change since the pandemic, as self-harm rates were already higher among these groups¹².

Even before the pandemic, people who self-harmed could struggle to access support – with only 38 per cent of people in England who self-harmed receiving medical and/or psychological support¹³. Unfortunately, coronavirus has made it harder still for some to access support. Following the first lockdown, a lower proportion of people who had self-harmed or attempted suicide in the UK received medical care in both hospital and GP settings¹⁴. This raises significant concerns about how people who self-harm have coped during the past year.

The reduction in hospital presentations appears to have been greater among women than men, with GP presentations for self-harm and suicide attempts reducing most among women and under 45s. By September 2020, primary care presentation rates were back to expected levels¹⁵, likely reflecting the easing of restrictions and reducing fears of burdening healthcare services during the summer months.





4. Methodology

The research in this report brings together:

- a) Analysis of anonymous service data that is routinely collected about Samaritans calls and emails
- b) Primary research with our listening volunteers through regular surveys
- c) Secondary analysis of findings from focus groups with health and social care helpline volunteers
- d) Analysis of a subset of data collected as part of the *UK COVID-19 Mental Health & Wellbeing study (MHWS)*.

Further details about the data and the analyses for each are detailed below.

a) Analysis of Samaritans service data

This analysis was carried out to understand trends in contacts to Samaritans, including callers' most common concerns and changes to our service compared to the previous year.

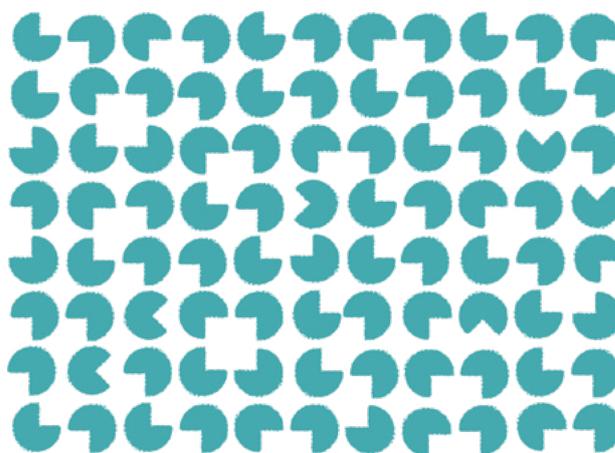
Data

After every contact, Samaritans' volunteers complete a log about the nature of the contact. This provides data to help us understand how people use our service and to some extent who they are, which can help us understand their needs.

Over the year since restrictions began, people could contact Samaritans by phone call, email, letter, online chat when pilots were running or face-to-face when branches are open. Throughout the report we use the term 'contacts' to refer to conversations with people by any of these methods.

However, this data is somewhat limited, and is more focused on the conversations we have with callers, rather than our callers themselves. Our volunteers do not specifically gather data about callers, and callers are not required to disclose details about themselves. This means that volunteers can focus on the caller's concerns and data collection doesn't get in the way of providing support to people when they need it. Therefore, volunteers only record the information that is voluntarily disclosed during the natural course of the conversation. For instance, while we record a caller's gender when it is known, in 7 per cent of all contacts this remains unknown.

In certain circumstances, such as a safeguarding issue, identifiable information may be recorded, but no identifiable information is ever used for research purposes.





This research involved the analysis of three sets of Samaritans service data, described below.

Helpline and email dataset

For the purpose of this research, we used a dataset of over 4 million anonymous contact records. This included contacts where emotional support was provided, by telephone and email, across a two-year period (23 March 2019 to 22 March 2021). The data set included the following variables:

- Broad topics that were raised by the caller as a concern during the contact (eg, loneliness)
- Method of contact
- Gender of caller, where known
- Age of caller, where known
- If suicidal feelings or behaviours were expressed during the contact
- If self-harm was discussed during the contact

Healthcare workers dataset

We used a subset of the 'Helpline & email dataset' above of over 17,000 anonymous contact records where:

- Emotional support was provided by telephone and email
- The contact was in the period (3 April 2020 - 22 March 2021)
- The volunteer logged the contact as having been from a 'NHS Worker'.

The dataset includes most answered calls to the dedicated NHS and social care helpline in England and Wales, as well as calls to the main helpline where the caller mentioned that they were an NHS worker.

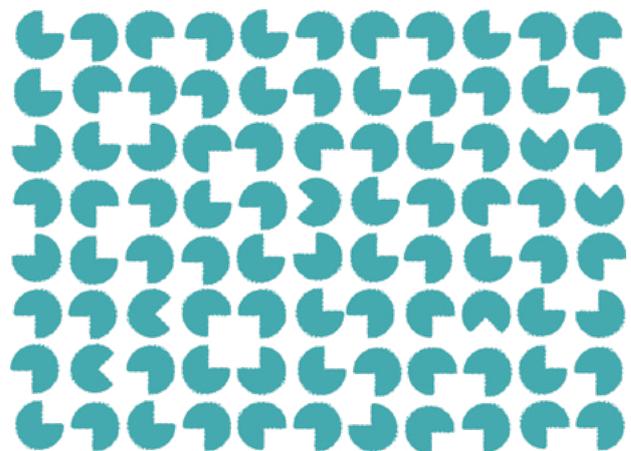
Prison contacts dataset

We used a dataset of over 120,000 anonymous contact records. This included contacts where emotional support was provided by telephone or face-to-face within prisons over a two-year period (23 March 2019 to 22 March 2021), across two sources of support:

- Contacts to the dedicated Samaritans helpline in England and Wales which were known to be from a prison setting (a subset of the 'Helpline and email dataset' above)
- Face-to-face contacts within prisons settings across England, Wales, Northern Ireland and Republic of Ireland, delivered by a peer support Listener

In Scotland, the prisoner Listener scheme was suspended as soon as Coronavirus restrictions were introduced and began gradual reinstatement from August 2020. In August 2020, mobile phones were given to every prisoner in Scotland with free, unlimited access to the Samaritans main 116 123 number. However, it is not possible for Samaritans to disaggregate this caller data from Scottish people in prison from other calls to our helpline. The Scottish Prison Service holds data on the number of calls made from these mobiles, but no information on caller concerns is recorded. As data for Scotland is not comparable, it is not included in this report.

Further detail on each dataset can be found in the Appendix.





Analyses

Descriptive analyses

We carried out a general, descriptive analysis of the variables listed above for the overall post-pandemic dataset (ie, the year since restrictions began). This provided weekly descriptions of the overall volume of contacts during this time, as well as the volume of specific types of contacts (ie, broad concerns, suicidal feelings or behaviours, and self-harm).

Comparisons with pre-pandemic periods

We carried out visual comparisons of graphs between the years pre-and post-pandemic (with 'pandemic' defined as 23 March 2020, when the UK went into lockdown for the first time) for the variables listed above. Any trends or differences were tested for statistical significance using chi-square tests. Analysis was conducted using RStudio.

We did this for all three datasets: telephone and email contacts, healthcare workers contacts, and prison contacts.

Healthcare worker status was not routinely collected until after lockdown began, so this data covers the period from 3 April 2020 - 22 March 2021 and we do not have comparison data from the previous year. Similarly, coronavirus was only recorded as a caller concern from 4 April 2020 onwards.

Comparisons between groups

We carried out visual comparisons of graphs between the following sub-groups for the variables listed above. We did this for both the pre-and post-pandemic years and explored differences in week-by-week trends during the post-pandemic year.

- a. Male and female contacts
- b. Contacts where self-harm was discussed and contacts where it wasn't
- c. Contacts where mental health was a concern and contacts where it wasn't

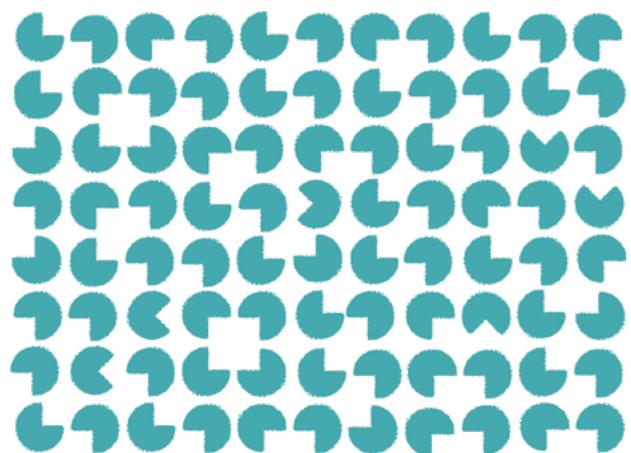
Any differences were tested for significance using chi-square tests. Analysis was conducted using RStudio.

Predicting coronavirus concerns

Analysis of helpline data was conducted by Dr Becky Mars at the University of Bristol to investigate factors that predict having a concern about coronavirus.

Calls with and without concerns about coronavirus were compared on a number of factors, including caller characteristics, features of the call, types of caller concerns, whether suicidal feelings or behaviours were expressed and whether self-harm was discussed.

Logistic regression was used to investigate how strongly these factors predict coronavirus concerns. Analyses first looked at each factor on its own, and then adjusted for all the other factors.





Across all Samaritans service data analyses, all reported data is significant to $p < .001$. Results that were not significant are not reported.

b) Volunteer surveys

Surveys of volunteers were collected regularly throughout the year since the pandemic began to deepen our understanding of the service data and how common concerns were changing in nature as the pandemic progressed.

Data

Qualitative data was collected through seven online surveys with Samaritans volunteers in the UK and Republic of Ireland throughout the year since restrictions began. The surveys were distributed through Samaritans' internal communications channels.

The surveys asked volunteers who had completed at least one listening shift in the relevant time period (eg, the month prior to the survey) to reflect on trends in what callers talk to us about and how this changed from month to month. We asked volunteers about:

- Discussion of suicidal thoughts and attempts
- The most common caller concerns and how these change over time
- The ways people used the Samaritans service
- Specific concerns of key groups, such as people with pre-existing mental health conditions, young people, men and healthcare workers.

We received 10,766 responses over the seven surveys, which contained a mixture of open and closed text responses.

More detail about the sample and data collected in each survey can be found in the Appendix.

Analyses

Descriptive analysis of closed-text questions was completed in SurveyMonkey. Open-ended responses were analysed using thematic analysis, initially using a deductive coding approach.

Once a framework was established, an inductive coding approach was used to build on findings from each survey and gather a picture of trends throughout the year. More detail on the analysis approach can be found in the Appendix.

c) Qualitative research with volunteers of the NHS and social care worker helpline

As part of the internal evaluation of this new service, which is available in England and Wales, focus groups were conducted to identify early insights into how the helpline was working. The focus groups were carried out in November 2020 by Humankind Research on behalf of Samaritans. The topic guide for the focus groups was informed by a survey of 110 Samaritans volunteers who provided dedicated support through the helpline.

Data

This research used the briefings and reports summarising the findings from this internal evaluation activity to supplement the analysis of the healthcare workers dataset described above (a). The original qualitative research consisted of seven 90-minute online focus groups with volunteers on the helpline for NHS and social care workers (26 volunteers in total).

Analyses

Secondary analysis of the findings was triangulated with findings from of the quantitative service data (a).



d) Analysis of UK COVID-19 Mental Health & Wellbeing Study data

The *UK COVID-19 Mental Health & Wellbeing Study* (MHWS) is a national wellbeing tracker survey, which Samaritans has jointly funded and collaborated on with the Suicidal Behaviour Research Lab at The University of Glasgow and Scottish Association for Mental Health.

This survey involved a nationally representative baseline sample of 3,077 adults across the UK. It ran from 31 March 2020 throughout the year and is still running at the time of writing. Its purpose is to understand the impact the coronavirus pandemic is having on key psychological factors related to suicide risk.

Additional analysis was conducted for this report to explore help-seeking behaviours during the pandemic and between sub-groups.

Data

A subset of the data collected via the first six waves of this longitudinal survey were provided for analysis in this research. The data were originally obtained via a quota survey design and a sampling frame that permitted recruitment of a nationally representative sample. A total of 3,077 adults in the UK completed the first wave of the survey through an existing online UK panel (Panelbase.net), dropping to 2,283 adults by wave six. Drop-off in participation was greatest among younger adults (aged 18-29 years) and participants from Black, Mixed and Asian backgrounds.

The variables within this dataset were related to sociodemographic characteristics (age, gender, sociodemographic status) and whether, and how often, individuals had sought help from:

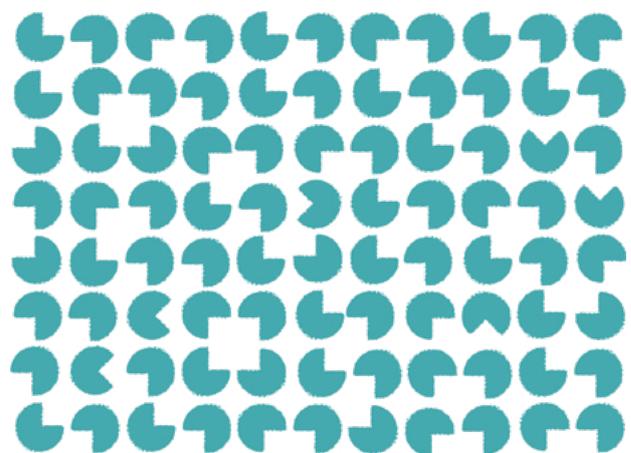
- Friends or family
- Samaritans by telephone
- Other helplines or voluntary support services
- Professional counselling or therapy
- Community groups/clubs
- Social media/online

Analyses

Analysis was conducted by Heather McClelland from the Suicidal Behaviour Research Lab at The University of Glasgow using Stata MP 16.

- Data was recoded as follows: all help-seeking answers were recoded to 'ever' vs 'never', gender was coded into binary data (male=1, female=2), age was grouped into three categories (18-29, 30-59, 60+ years), socio-economic status was divided into high/ low income.
- Adjusted odds ratios (ORs) with 95% confidence intervals (95% CI) were used to report binary sociodemographic characteristics (gender, socio-economic status)
- Chi-square was used to report differences between categorical age groups.
- Bonferoni adjustments were used to report post-hoc analysis of chi-square data.

More detail about the sample and data collected in each survey can be found in the Appendix.





5. How has coronavirus affected our callers' lives?

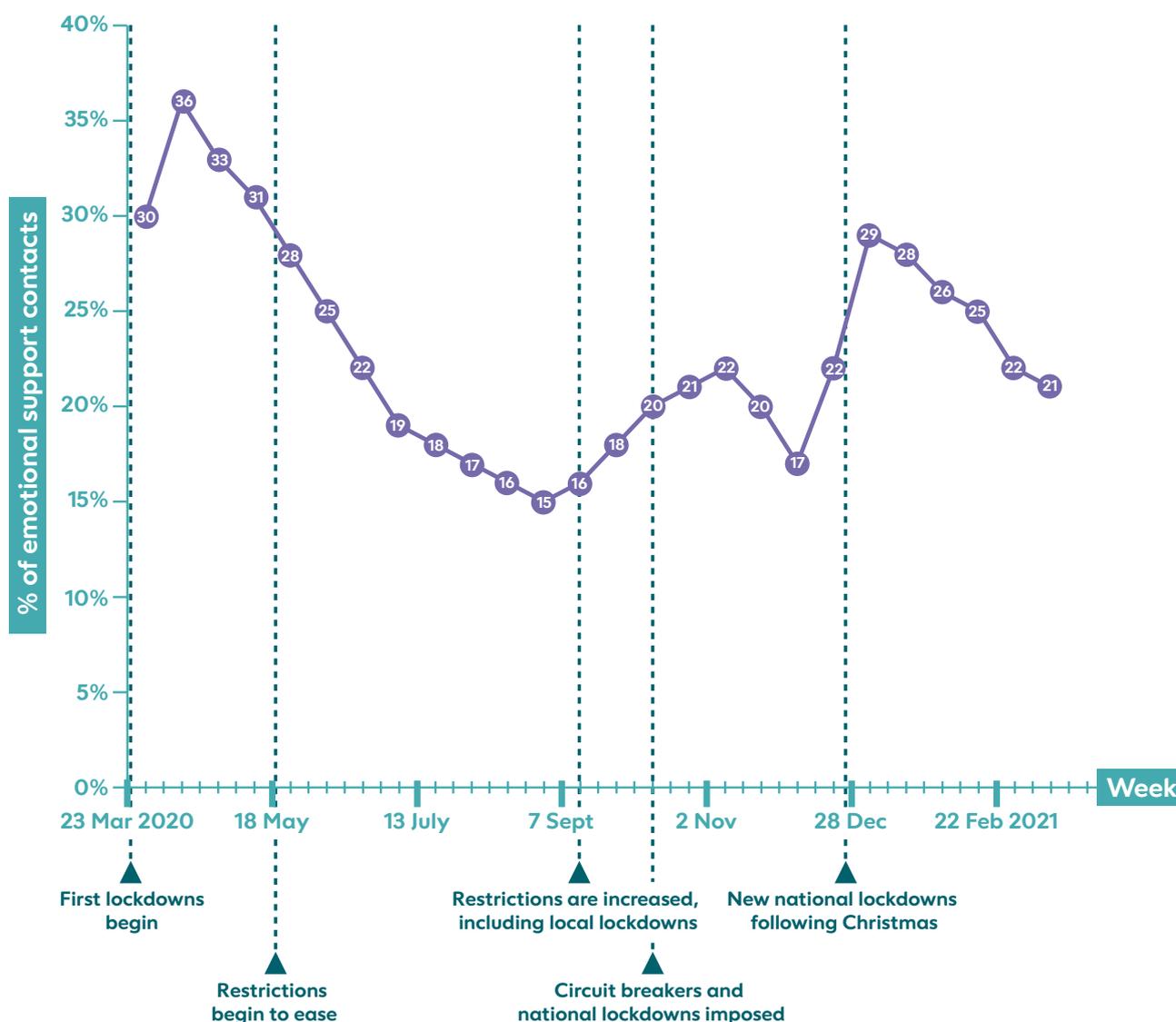
The direct impact of coronavirus on use of Samaritans services

In the year since restrictions began, we provided emotional support 2.3 million times by phone and email. Coronavirus was raised as a specific concern in more than half a million emotional support contacts – 22 per cent of the total number. However, our volunteers suggest it has affected all callers in some way.

Concerns about coronavirus peaked early in the first lockdown in April 2020, when this was a

concern in over a third of all emotional support contacts. Since then, the pattern has generally mirrored UK lockdowns, with concerns about coronavirus being more common in times of tighter restrictions. Concerns about coronavirus decreased over the summer months, before rising gradually through autumn and winter (see figure 1). During the January 2021 national lockdowns, discussion of coronavirus rose to its highest frequency (29 per cent) since mid-May 2020.

Figure 1: percentage of emotional support contacts where coronavirus was a specific concern in the UK and ROI during the year since restrictions began



5. How has coronavirus affected our callers' lives?



We've also seen a change in the way people use our services during this time - in the year since social distancing restrictions began, we answered over half a million emails, a 23 per cent increase compared to the previous year. Volunteers told us that some people prefer typing over talking and have found it difficult to talk on the phone in private.

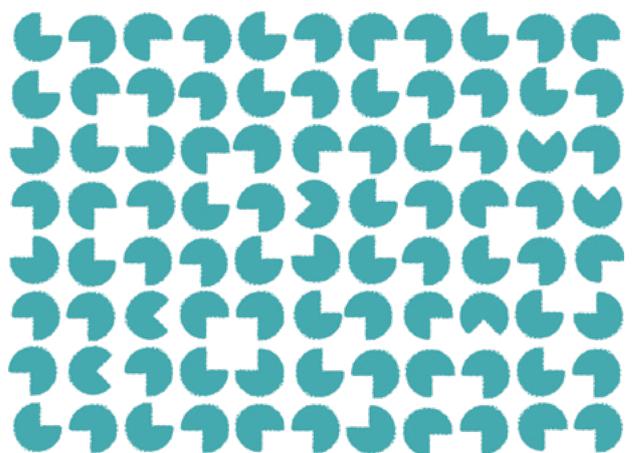
We also received 12 per cent more calls at night (2am - 6am) compared to the previous year. Coronavirus was more likely to be a specific concern in phone calls than emails (26% vs 15%) and calls with coronavirus as a specific concern were 40 per cent longer - an average of 24 minutes, compared to 17 minutes in other emotional support calls (median averages). Calls occurring at twilight or night (10pm-6am) were also slightly more likely to be related to coronavirus than calls in the daytime (27% vs 25%).

Analysis of the Samaritans helpline in the Republic of Ireland found that calls were longer in the four weeks following the first lockdown compared to just before the lockdown or the same time the previous year¹⁷. This change was greatest in the early hours of the morning (1am - 6am), with significantly more calls lasting 30 minutes or longer. The study suggested that service users relied on Samaritans services more during the first lockdown, and that this may have been the result of increased isolation, worsening mental health, and reduced access to other forms of support. Preliminary findings from analysis of the UK helpline for the same time period indicates that there was not an increase in call duration among UK callers^a.

Analysis of the University of Glasgow's *Mental Health and Wellbeing Study* (MHWS) found that help-seeking was higher during the first 8 months of the pandemic, compared to the 6 months before the pandemic began, especially due to online help-seeking. Help-seeking from social media or online increased from 3 per cent during the 6 months before the pandemic to 40 per cent in the first 8 months of the pandemic.

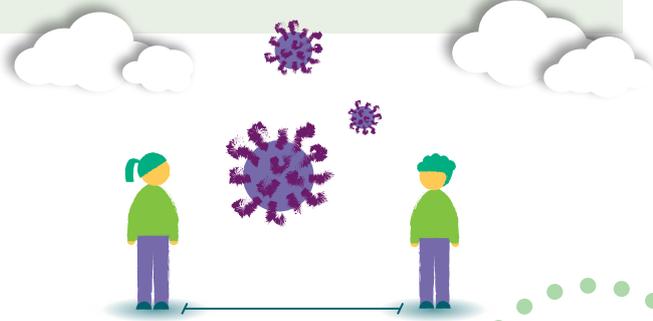
The frequency that suicidal thoughts or behaviours were expressed does not appear to have changed as a result of the pandemic. Suicidal thoughts or behaviours were discussed in a quarter of emotional support contacts, which was the same as in previous years, and this remained stable throughout the year since restrictions began.

a. This research is ongoing and carried out in partnership with Ulster University



5. How has coronavirus affected our callers' lives?

As well as generally changing the way in which people contacted Samaritans, the nature of the conversations we had with callers about coronavirus during the year changed and often mirrored the external events of lockdowns and the public narrative about coronavirus.



First national lockdowns (March – May 2020)

In March and April, many contacts from people concerned about catching coronavirus or infecting members of their family.

As lockdown progresses, concerns about catching the virus decrease, but concerns about the knock-on effects of lockdown continue to increase.

Key concerns include feelings of isolation, worries about job and income loss, lack of access to support services especially among people with pre-existing mental health problems, and family rifts being caused by disagreements on lockdown rules.



Summer and fewer restrictions (June – July 2020)

Number of contacts about coronavirus stabilises, and concerns about the financial, social, mental health-related and familial impacts of lockdown remain strong themes.

These concerns are often accompanied by a sense of confusion about the changing guidance, as restrictions ease.



Tiered systems and rising rates (August – October 2020)

Number of contacts about coronavirus rises steadily, though lower than in April. Most discussions remain focused on the financial, social, mental health-related and familial impacts of the ongoing restrictions.

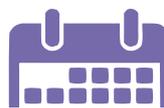
Uncertainty and hopelessness about the future – due to increasing restrictions and rising infection rates – becomes a strong theme.



National lockdowns reimposed (November – December 2020)

Number of contacts about coronavirus remains higher than in summer. Concern about catching the virus or infecting loved ones re-emerges as a significant theme, alongside ongoing worries about the financial, social and mental health impacts of restrictions.

Uncertainty and hopelessness about the future persist among many callers, and, as the national lockdown is imposed, this is commonly reported alongside feeling less able to cope.



Further lockdowns and vaccination programme (January – March 2021)

Excitement and concerns about easing restrictions becomes a more common theme. A key concern is that restrictions will be lifted too quickly, people will behave irresponsibly, or the emergence of variants of coronavirus will lead to a further lockdown.

The vaccine programme is generally viewed positively and there is hope that it will prevent further lockdowns, with only a small minority questioning it.

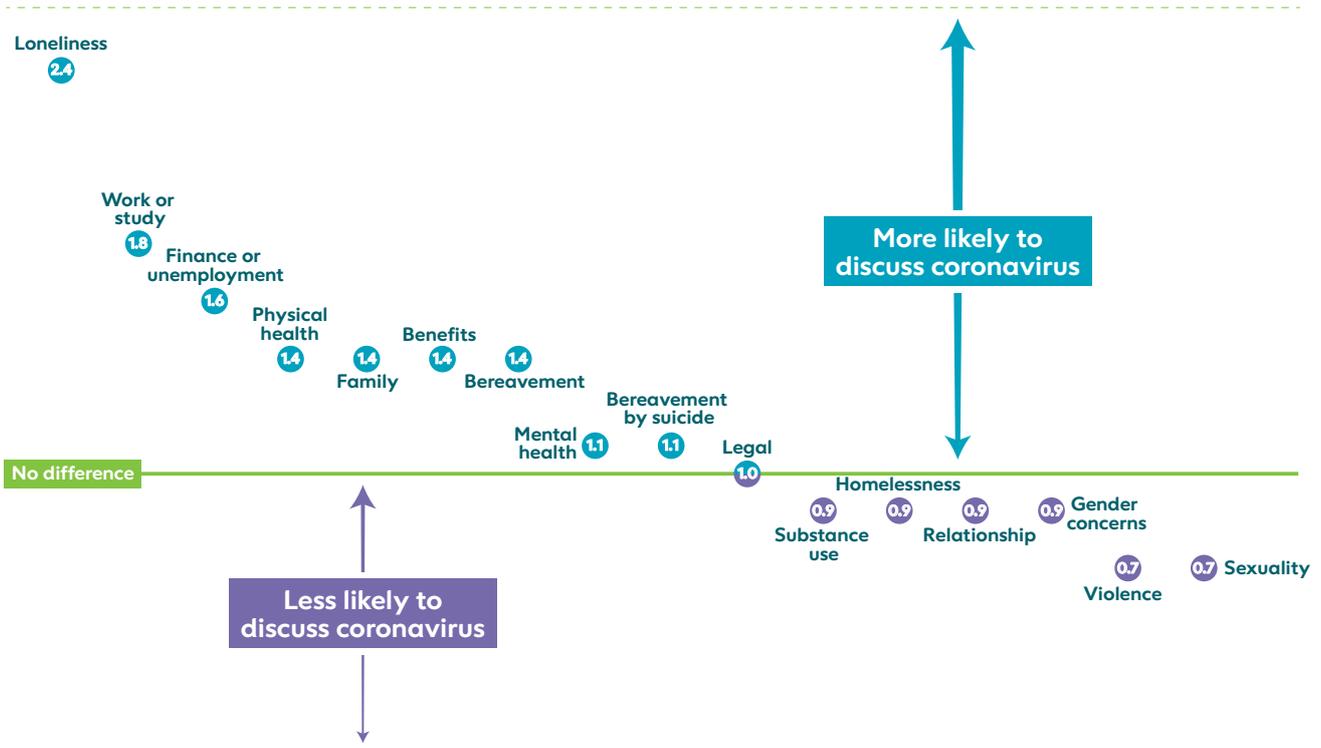
5. How has coronavirus affected our callers' lives?



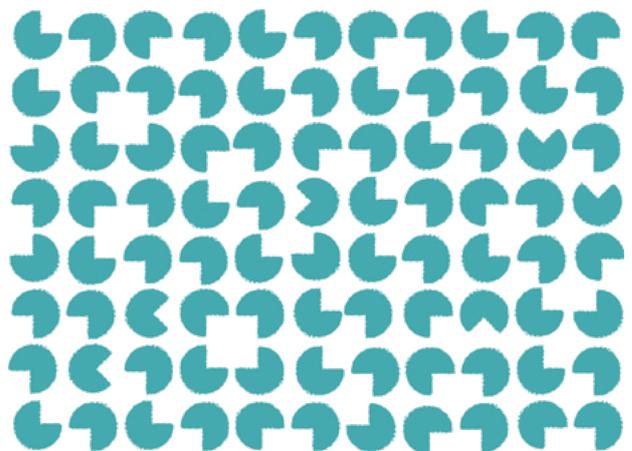
The most common concerns raised in calls were similar, whether coronavirus was raised as a specific concern or not. However, as shown in Figure 2, there was some variation. Calls where loneliness and isolation were a concern were the most likely to involve concerns about coronavirus. Calls related to family, finance

and unemployment, work or study, benefits, bereavement, and physical illness were also strongly associated with having concerns about coronavirus. By contrast, calls where violence and abuse or sexuality were a concern were the least likely to involve concerns about coronavirus.

Figure 2: Likelihood (adjusted odds ratio) of a call being related to coronavirus, by other caller concerns



The following sections explore some of these concerns and how they have changed over the year since restrictions began.



5. How has coronavirus affected our callers' lives?

Mental health

Mental ill-health was the most common concern in contacts to Samaritans during the year since restrictions began, raised in almost half (47%) of emotional support contacts (over 1 million contacts), which a slight increase compared to the previous year (45%).

Discussion of mental health fluctuated over the course of the year. It was a concern in a higher proportion of contacts than the previous year from March to November 2020, with the gap closing from November 2020 to March 2021, when it came up in a similar proportion of contacts.



First national lockdowns (March – May 2020)

A growing number of contacts about lockdown exacerbating pre-existing mental health conditions (eg, depression, OCD, anxiety) and lack of access to mental health support caused by lockdown.



Summer and fewer restrictions (June – July 2020)

Concerns about pre-existing mental health conditions and lack of access to mental health support persist as a key concern and are raised with an increasing sense of distress, hopelessness and entrapment.

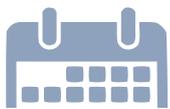
Reports of mental health support being inadequate are also common.



Tiered systems and rising rates (August – October 2020)

A sense of hopelessness, distress and entrapment about access to mental health services and worsening mental health continues, and is more frequent than in previous months.

Worries about being able to cope with ongoing restrictions, while having to adapt to new types of online support and navigating overwhelmed mental health services, become major themes.



National lockdowns reimposed (November – December 2020)

Concerns about access and adapting to online support remain common.

The impact of the restrictions on callers with pre-existing mental health conditions continues to be raised, but volunteers also increasingly speak to people who've experienced mental health problems for the first time during the pandemic.

These concerns continue to cause distress and a sense of hopelessness with many increasingly relying on family or friends for support.



Further lockdowns and vaccination programme (January – March 2021)

The lack of access to mental health support continues to be a major concern, as callers worry about the future. Callers feel they have nowhere to turn and many feel neglected and abandoned.

Throughout the third national lockdown, the lack of face-to-face support, as well as community support and activities, has led to callers to feeling isolated. This is further contributing to worsening mental health, a concern which has persisted throughout the year.

5. How has coronavirus affected our callers' lives?

Loneliness

Loneliness and isolation were a concern in 29% of emotional support contacts during the 12 months since restrictions began. This was a total of over 680,000 contacts and a 9% increase compared to the previous year.

Phone calls about *loneliness and isolation* were also the strongest predictor of having concerns about coronavirus. Calls concerning loneliness or isolation were 2.4 times more likely to involve specific concerns about coronavirus, compared to calls where *loneliness and isolation* were not raised even after adjusting for other factors.



First national lockdowns (March – May 2020)

More calls about loneliness raised, especially among those who were already isolated before lockdown or living alone.

More calls where people 'just want to chat', having been deprived of usual human contact, or who have been separated from their families due to the restrictions.



Summer and fewer restrictions (June – July 2020)

Feelings of intense loneliness linked to experiencing months of social distancing restrictions start to emerge.

People previously isolated or living alone remain most affected. Samaritans' helpline continues to be used as a source of meaningful human connection.

Concerns about isolation and loneliness as a result of not being able to see family/friends remain a theme for some callers.



Tiered systems and rising rates (August – October 2020)

Frequency of calls about loneliness/isolation stabilises.

The cumulative effects of living through months of social distancing restrictions becomes a more frequent concern.

Concerns about loneliness and isolation being exacerbated by the new, tightening restrictions are also discussed by some callers.



National lockdowns reimposed (November – December 2020)

Some callers find the new national lockdown is exacerbating their loneliness, with social plans being disrupted at short notice.

An increasing number of callers discuss how protracted isolation has left them feeling less able to cope as the pandemic goes on.



Further lockdowns and vaccination programme (January – March 2021)

Almost a full year of social distancing has taken its toll on some callers. Callers note that the winter lockdown feels lonelier and more isolating than previous ones.

Some callers, however, express hope and optimism about their isolation and loneliness being alleviated due to vaccine rollout and the promise of restrictions being lifted.

5. How has coronavirus affected our callers' lives?



Family

Family concerns were raised in a third of all emotional support contacts during the 12 months since restrictions began. This was a total of over 760,000 contacts, a similar number to the previous year.

Phone calls concerning *family* were 40% more likely to involve specific concerns about coronavirus, compared to calls where *family* was not raised even after adjusting for other factors.



First national lockdowns (March – May 2020)

A growing number of contacts about passing the virus to loved ones, alongside concerns about the health of vulnerable family members (especially the elderly) and being separated from family through lockdown.

We also see a growing number of concerns about family rifts and disagreements, which cause increasing distress as lockdown continues.



Summer and fewer restrictions (June – July 2020)

Worries about being separated from loved ones continue to be reported by some callers.

Concerns about family rifts and disagreements resulting from living and working in close quarters over a long time continue as a major theme and are discussed with a growing sense of distress.



Tiered systems and rising rates (August – October 2020)

Anxiety over the impact of future and tightening restrictions on family contact also begin to feature among some callers.

Concerns about being separated from loved ones and disagreements resulting from living and working in close quarters continue.



National lockdowns reimposed (November – December 2020)

Concerns about being separated from family are reported with increasing distress, especially in the run up to Christmas.

Concerns about loved ones catching the virus or passing the virus to family re-emerge, especially among callers who work in care or as frontline healthcare staff.

Family tensions resulting from living and working in close quarters remain a significant theme.



Further lockdowns and vaccination programme (January – March 2021)

Callers continue to discuss the impact of close living arrangements with increased tensions, particularly between parents and children. Callers also remain concerned about the prospects of family members catching coronavirus, particularly among healthcare workers.

On the other hand, those who have been separated from families are positive and excited about the promise of restrictions easing and are looking forward to spending time with their families, seeing friends and rekindling relationships with people they have lost contact with during the pandemic.

5. How has coronavirus affected our callers' lives?

Finances and work

Work and study were raised in 10% of all emotional support contacts during the 12 months since restrictions began. This was a total of over 220,000 contacts, a reduction compared to the previous year. However, phone calls concerning *work and study* were 80% more likely to involve specific concerns about coronavirus, compared to calls where *work and study* was not raised even after adjusting for other factors.

Finances and unemployment were raised in 6% of all emotional support contacts during the 12 months since restrictions began. This was a total of over 140,000 contacts, a reduction compared to the previous year. However, phone calls concerning *finance and unemployment* were 60% more likely to involve specific concerns about coronavirus, compared to calls where *finances and unemployment* were not raised even after adjusting for other factors.

The above indicates that, while the overall number seeking emotional support for concerns about finances and work has not increased, those who do seek support are commonly experiencing concerns specifically linked to the pandemic.



National lockdowns reimposed (November – December 2020)

The impacts of recession become more common, with job and income loss becoming a more significant theme among callers.

As national lockdown is imposed, for some callers these concerns intensify and are discussed with more distress. As in previous months, these concerns are exacerbated by uncertainty about financial support from the government.



First national lockdowns (March – May 2020)

A growing number of contacts where anxiety about job loss or being furloughed are raised.

Concerns about being able to access food, money and benefits are also discussed frequently.

Worries about not being able to support family, and potential homelessness raised by people who already lost their job/income become a common theme as lockdown continues.



Summer and fewer restrictions (June – July 2020)

Calls about potential and actual job loss, reduced incomes or being furloughed remain frequent, and are causing similar levels of distress as during early months of restrictions.

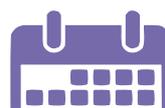
Concerns continue to be focused on the knock-on effects of job and income losses, including being able to support family and potential homelessness.



Tiered systems and rising rates (August – October 2020)

As well as anxiety about jobs and income, the early impacts of the recession also come up, with some callers daunted by having to find a job or support a family in a more competitive market.

Uncertainty about whether the financial support from the government will continue is also discussed by some callers.



Further lockdowns and vaccination programme (January – March 2021)

Contacts about finance and job loss remain frequent, with callers either having lost their jobs or expressing anxiety that they may do so in the future. Callers are also worried about finding a job in the current climate, and fear government financial support coming to an end.



6. Which groups are we particularly concerned about?

Suicide is affected by social and economic inequality, with factors such as financial situation, family life and social connections all affecting a person’s risk of dying by suicide. While coronavirus has changed everyone’s lives, evidence suggests the pandemic may impact some groups’ suicide risk more than others. For instance, the pandemic has meant an increase in unemployment and loneliness¹⁸, and these things may be more acutely experienced by groups such as middle-aged men and young people¹⁹. This section explores five key groups that this research identified, whose suicide risk may be exacerbated as a result of the pandemic.

People with pre-existing mental health conditions

Introduction

It is estimated that there are around 7.5 million people in England with common mental health conditions such as depression, obsessive-compulsive disorder, and anxiety²⁰. People diagnosed with these conditions are eight times more likely to take their own life than the general population²¹.

While many people who experienced a dip in their wellbeing in the early months of lockdown returned to normal wellbeing fairly quickly, research suggests that people with pre-existing mental health problems were more likely to face deteriorating or consistently poor mental health during the pandemic²². One study from November 2020 in Scotland found that over half of people with existing mental health problems felt their mental health had worsened recently, compared with the start of the pandemic²³.

What do we know from contacts to Samaritans?

Over the year since restrictions began, there were over one million contacts to Samaritans from people concerned about their mental health. Mental health was the most common concern among contacts since the pandemic began, raised in 47 per cent of contacts, a slight increase on the previous year.

In our volunteers’ conversations with callers, three key themes were raised: access to mental health support and services, quality of mental health support and loss of community support.

Access to mental health support and services

Even before the pandemic, mental health services were struggling to cope with demand²⁴. For people who needed support, coronavirus meant reduced access to already-strained mental health services. One report found that almost half of people with mental health problems in Scotland felt they did not get care or treatment because of the pandemic²⁵. Services have seen patients arriving at crisis point, with more severe needs, as well as a higher proportion of first-time patients, and practitioners have also raised concerns about increased demand²⁶.



Over one million contacts to Samaritans from people concerned about their mental health.

6. Which groups are we particularly concerned about?



According to our volunteers, many callers to our helpline expressed worries about reduced access to mental health support throughout the year, even during the easing of restrictions in the summer across the UK and Republic of Ireland. Callers spoke to volunteers about a range of barriers to accessing support, including mental health and crisis teams being unavailable, appointments being cancelled, long waits for treatment and difficulties getting referrals through GPs. For those with pre-existing mental health conditions, the pandemic led to reduced access to the mental health support and services they had previously used.

Quality of mental health support

Health and social care organisations have worked hard to maintain support services during the pandemic, but some of our callers said that the mental health support available to them was inadequate. In the early months of the first lockdown our callers started to report that the mental health support they received was patchy and unreliable. In the months that followed, we heard that the lack of face-to-face support in particular was a concern among callers, with online support confusing and much less effective for some.

The uncertainty around if and when care will resume to 'normal' and feelings of abandonment were major concerns among people trying to access support for their mental health²⁷. Since early in the pandemic, callers spoke to our volunteers about feeling neglected by mental health services, and as time progressed this increasingly generated feelings of frustration and hopelessness.

“Quite a few callers have found it difficult to talk to their GP or mental health worker or feel that they are not being listened to, they feel that their concerns are just dismissed. They feel like they don't matter and are being forgotten or neglected”

– Samaritans volunteer

Loss of community support

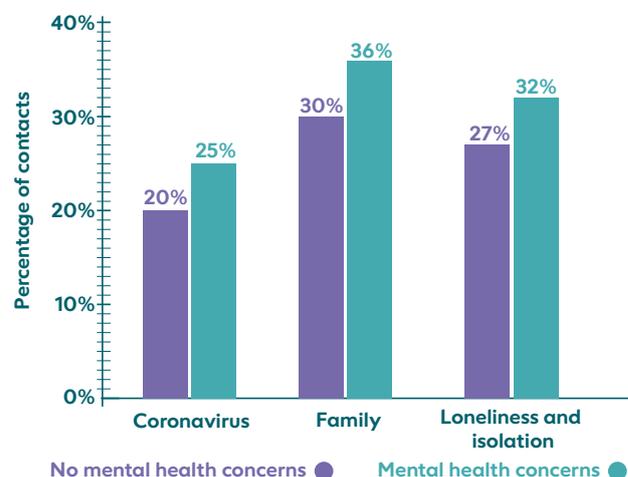
Volunteers reported that limited access to networks of community support, such as meeting with friends, going out for coffee or for walks, was a prominent theme for people with pre-existing mental health conditions throughout the year. In many cases, this was directly linked to coronavirus, with callers feeling torn about doing activities that might reduce their feelings of isolation, but might increase their chance of catching coronavirus.

“A very regular occurrence is callers becoming depressed due to not seeing people and not leaving the house much, or anxiety over contracting the virus and meeting others after restrictions are lifted, or pre-existing diagnoses being worsened for these reasons”

– Samaritans volunteer

This was a common cause of anxiety for all groups, but appears to have had a greater impact on people with pre-existing mental health conditions, who may be more reliant on community support to maintain wellbeing. As seen in figure 3, some concerns more commonly overlap with mental health concerns:

Figure 3: the frequency that various caller concerns were raised in contacts where mental health was a specific concern, vs where it was not*



*Only concerns with the most significant increases are reported.

6. Which groups are we particularly concerned about?



Volunteers found that lack of community and social support was causing particular hardship during the second wave of restrictions in October 2020. This suggests that the return of restrictions may have been more challenging than the initial lockdown, which is supported by evidence of a 'pulling together' effect in the early lockdown, that may not have carried through to later restrictions.

“Lack of contact with others, lack of routines to give life some framework, lack of contact with community support and mental health workers, all exacerbated mental and emotional conditions enormously.”

– Samaritans volunteer

The combination of lost routine, a lack of access to community-based coping mechanisms and reduced mental health support meant many with mental health conditions found it harder to cope throughout the pandemic.

Young people and self-harm

Introduction

Self-harm is more common among under 25s and has been rising in recent years across the UK²⁸, particularly among young women⁴¹. While most people who self-harm will not go on to take their own life, it is a strong risk factor for suicide²⁹. Across the UK, suicide rates among young people have also risen in recent years, with rates among young people in Scotland reaching its highest level since 2002, and rates for young women in England and Wales reaching the highest rate on record for this group¹. The reasons for suicide are complex, but some of the more common factors among young people are academic pressures and bullying, workplace, housing and financial problems³⁰.

Young people have been hugely affected by the restrictions resulting from the pandemic³¹. Social lives were curtailed at an important life stage, and work and education opportunities were put on hold for many. We also know that young people, especially young women, experienced the most significant deterioration in mental health in the first month of restrictions³² and other studies suggest this continued later into 2020³³.

What do we know from contacts to Samaritans?

The specific ages of Samaritans callers are not recorded^b, however surveys of volunteers found that many had heard from a growing number of young people over the year since restrictions began. Samaritans has seen a 2 per cent increase in the number of contacts about self-harm compared to the 12 months before the pandemic, totalling 184,157 over the year since restrictions began.

In our volunteers' conversations with young people there were four key themes: access to mental health and self-harm support, family tensions, lack of peer contact and negativity about the future.

Access to mental health and self-harm support

Volunteers told us that access to mental health support was the most common concern among young people and the majority of volunteers regularly spoke to young people about this. Similarly, young people's reduced access to community support services or networks, such as support provided in schools, social activities, or physical activity groups, was a common cause of distress. Our volunteers suggested that young people saw the loss of these support structures or coping mechanisms as a key driver for the decline in their mental health.

b. Since data is only collected to indicate whether the caller was over or under 18, where known

6. Which groups are we particularly concerned about?



“ [Callers] recognising the positivity they got from peer activities and the knowledge that a health professional was no longer there for them. ”

– Samaritans volunteer

Our volunteers reported that, as the restrictions tightened into the winter, they were hearing from more young adults with worries relating to managing or resisting self-harm. Samaritans volunteers suggested there had been an increase in contacts with young people about using self-harm as a coping mechanism. Volunteers also spoke of a rise in callers who had returned to self-harm as a way of trying to cope, or who were struggling to resist self-harm in the absence of other support. During the past year, in 22 per cent of contacts where self-harm was discussed, the caller was resisting self-harm.

This was higher when coronavirus was a specific concern:



As our service data doesn't capture specific ages, we cannot track how this has changed over time. However, we do know that discussion of self-harm was much higher among under 18s. In the past year, a third (35%) of callers aged under 18 discussed self-harm compared to 7 per cent of adults.

A study of patients who presented in hospital with self-harm during the first lockdown also suggests that coronavirus-related factors such as loneliness or a reduction in support services were linked to the self-harm in nearly half (46%) of cases³⁴.

c. Pre-Covid social media ($\chi^2=200.37$ (2), $p<0.001$); pre-Covid friends and family ($\chi^2=170.23$ (2), $p<0.001$)
d. $\chi^2=27.49$ (2), $p<0.001$
e. Pre-Covid: ($\chi^2=50.16$ (2), $p<0.001$); post-Covid ($\chi^2=100.92$ (2), $p<0.001$)
f. Pre-Covid - Male ($\chi^2=32.90$ (2), $p<0.001$); Female ($\chi^2=19.36$ (2), $p<0.001$). Post-Covid - Male ($\chi^2=52.83$ (2), $p<0.001$); Female ($\chi^2=25.23$ (2), $p<0.001$)
g. Pre-Covid - Female ($\chi^2=104.14$ (2), $p<0.001$); Male ($\chi^2=50.65$ (2), $p<0.001$). Post-Covid - Female ($\chi^2=81.68$ (2), $p<0.001$); Male ($\chi^2=51.31$ (2), $p<0.001$)

Analysis of the University of Glasgow's MHWS data on help-seeking:

We found that young people (18-29 year-olds) were more likely to seek emotional support than older age groups across all support types, both before and during the pandemic.

➤ For both men and women, young people were more likely to seek emotional support than older age groups

➤ Before the pandemic, seeking help from family and friends was most common across all age groups, but highest among young people. Nine in ten young people had sought emotional support from friends or family during the 8 months since restrictions began, compared to six in ten over 60s.

➤ Before the pandemic, the largest difference in help-seeking for different age groups was seeking help on social media^c. Differences were smallest, but significant, for community groups or clubs^d.

➤ Help-seeking from Samaritans' helpline was more common among young people than older age groups, and the difference increased during the pandemic^e. The effect of age on likelihood to seek help from Samaritans was stronger among men than women^f.

➤ Among men, during the pandemic, the strongest associations with age were for contacting Samaritans, other helplines or voluntary services, and seeking help online. Younger men were much more likely to seek support from these than older age groups.

➤ During the pandemic, young women were more likely to seek emotional support than women aged 30+, especially from social media and online. The effect of age on likelihood to seek help from social media or online was stronger among women than men^g.

6. Which groups are we particularly concerned about?



Family tensions

Social distancing restrictions led to many students and young adults returning to their family home, for example due to universities closing. Volunteers told us that family tensions were a concern for many younger callers, who frequently spoke about this as exacerbating their mental health problems. Feelings of lost freedom and of being trapped or isolated were common.

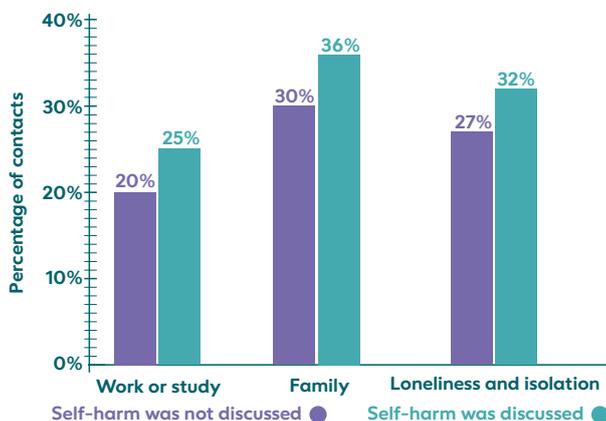
In addition, some younger callers talked about not wanting to share details about their mental health struggles with their parents. For example, volunteers told us that some younger callers felt increased anxiety about hiding evidence of their self-harm from family members. Some felt their family members did not understand their mental health needs, while others did not want to 'burden' their parents who might be experiencing their own stresses relating to the pandemic.

“ There is often a reluctance to confide in parents regarding how bad they feel because parents are already stressed due to the effects of coronavirus restrictions. ”

– Samaritans volunteer

Over the year since restrictions began, callers of all ages were more likely to mention self-harm alongside concerns about loneliness or isolation, and family than other callers.

Figure 4: the frequency that various caller concerns were raised in contacts where self-harm was discussed, vs where it was not*



*Only concerns with the most significant increases are reported.

Lack of peer contact

Before the pandemic, research found that young people feel lonely more often than older age groups³⁵. This appears to have worsened during the pandemic - one study found that almost half of young people reported feeling lonely as a result of the pandemic after nearly a year of restrictions, compared to a third at the beginning of the first lockdown³⁶. Evidence in Scotland also shows that loneliness during the pandemic was most common among young people and became decreasingly common among older age groups³⁷.

Our volunteers noted that a lack of peer contact or loneliness were common concerns from young callers, and that coronavirus restrictions have exacerbated this. Volunteers also told us that young people expressed concerns that they were losing contact with friends due to the coronavirus restrictions. As friendships tailed off during the lockdowns, young callers expressed anxiety about returning to schools and not having a place in their usual social groups or circles. For those attending university, students discussed concerns about not meeting peers on their courses or making friends, with high levels of loneliness and isolation a common thread among contacts from undergraduates.

Our previous research also found an association between loneliness and self-harm - people who had self-harmed in the past year were 10 times more likely to report feeling very lonely and isolated (31% vs 2.4%)³⁸.

Negativity and concern about the future

People aged 16-24 have experienced the biggest drop in employment compared to other age groups due to higher numbers working in hospitality and retail¹⁸. The increase in unemployment is concerning as there is a significantly higher rate of suicide among unemployed, compared to employed people³⁹. Financial concerns, such as problem debt, are also associated with increased suicide risk⁴⁰.

6. Which groups are we particularly concerned about?



Volunteers told us that uncertainty and negativity about the future, relating to economic factors, were key themes in contacts from young people. For younger callers who were just starting out in work, volunteers described concerns from callers about whether they would keep their job. Among those seeking employment, concerns centred on whether they would find a new role in a very competitive job market. Volunteers reported that these concerns extended to those still in education, either school or university. For these callers, looking ahead brought uncertainty both about whether their qualifications would be affected by their reduced time in school, and how they would fare when they did enter the job market.

Beyond employment, some callers discussed concerns that they would not achieve the appropriate qualifications, which would then impact their future career choices or employment prospects. Volunteers noted that a few young callers expressed “fear of being a lost generation” and concerns about the impact on their futures.

“Several were students who literally felt they could die in their rooms and no-one would know for days.”

– Samaritans volunteer

“The younger people I have spoken to... don't want to be tagged as 'the covid generation' as they see this will impact their ability to get a job. Some have said they don't feel they will get the results they expected prior to covid, and now feel like they will miss out on so much in the future.”

– Samaritans volunteer

Middle-aged men

Introduction

Middle-aged men in the UK and Republic of Ireland have the highest suicide rates of any age or gender group, a fact that has persisted for decades⁴¹. Key risk factors for this group, such as unemployment, relationship breakdown and unmanageable debt, have been exacerbated by the pandemic⁴². We know regional income inequality affects this group too, with data from England showing that men living in the most deprived areas are up to three times more likely to die by suicide than men from the most affluent areas⁴³.

The pandemic has led to unprecedented economic uncertainty, job losses and recession⁴⁴. We know that past recessions have increased suicide rates, particularly among middle-aged men, and that during the 2008–2010 recession, there were an estimated 1,000 excess suicides in England - 846 more men and 155 women than expected⁴⁵. During this period of unprecedented economic upheaval, it is vital that we take into account economic factors and their impact on suicide risk among this high-risk group.

What do we know from contacts to Samaritans?

We provided support over 946,000 times to men in the year since restrictions began, a slight reduction on the previous year, but we do not collect data on whether they were in midlife.

In our volunteers' conversations with men there were three key themes: worries about financial and economic future, coping alone, and strain on relationships.

6. Which groups are we particularly concerned about?



Worries about financial and economic future

Over the past year, male callers were slightly more likely than female callers to raise concerns about finances or unemployment (7.4% vs 6.4%), though it is clearly a factor affecting people of all ages and genders during the pandemic.

Volunteers told us financial concerns were frequently described in the context of male callers' fears and uncertainty about the future – losing their standard of living, job loss and redundancy, or losing their business if they were self-employed.

For men in midlife, volunteers reported that feelings of shame at no longer being employed were often linked to guilt at not being able to support their family. Feeling a lack of control and powerlessness was especially common, with many male callers feeling a need to be the breadwinner and provide for their family, but unable to do this in the unstable external environment.

“ [Many] seem to take the loss of a job very hard and feel that they are letting their partners and children down by not being able to be the breadwinner in the family. ”

– Samaritans volunteer

Another common feature of these contacts is feelings of failure and low self-worth. This is particularly common where male callers had lost their job or felt a job loss was imminent, and was reported more frequently by volunteers in the summer and autumn of 2020, when the furlough scheme was expected to be wound down.

Analysis of the University of Glasgow's MHWS data on help-seeking:

Research shows less well-off, middle-aged men face the highest suicide risk, but that deprivation increases suicide risk for men and women across working ages.

Analysis of the MHWS found that there was a drop in help-seeking among people on low incomes from voluntary services and from friends or family.

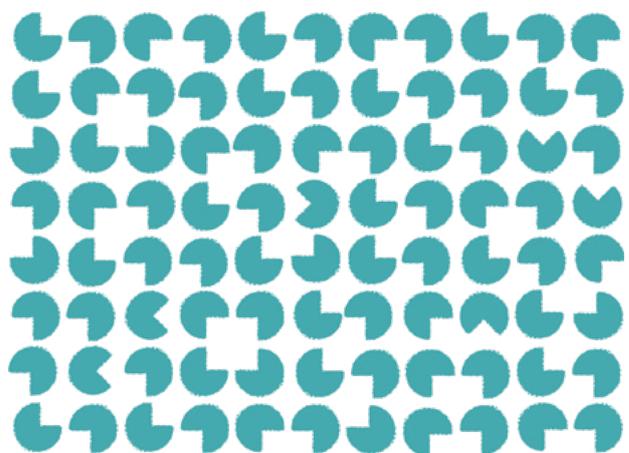
➤ Before the pandemic, people on low incomes were 12 per cent more likely to report seeking help from friends or family and 29 per cent more likely to seek help from voluntary support services or helplines^h. During the pandemic this changed, with people on low incomes becoming equally likely to seek help from these sources.

➤ Across nearly all support types, the likelihood of people on low incomes seeking help reduced during the first 8 months of the pandemic compared to those on higher incomes.

➤ An exception was community groups or clubs. Before the pandemic, people on low incomes were less likely to seek help from these community sources than people on higher incomes, and this remained unchanged during the pandemicⁱ.

h. Family and friends - OR: 1.12, 95% CI: 1.01, 1.24). Helplines or voluntary services - OR: 1.29, 95% CI: 1.02, 1.63.

i. Pre-Covid - OR: 0.73, 95% CI: 0.58, 0.91. Post-Covid - OR: 0.74, 95% CI: 0.58, 0.93





6. Which groups are we particularly concerned about?

Coping alone

Research from before the pandemic shows that men can be less likely to open up when feeling low, particularly men in midlife⁴⁶. Through the year, volunteers have consistently told us that the most common theme among male callers was related to coping alone – and men not wanting to burden others with their problems. Many male callers have felt that they have to ‘put on a brave face’ rather than openly sharing their concerns and feelings with loved ones, because they fear being a burden to those close to them.

Volunteers felt that, for many male callers, a perception that ‘others are worse off’ inhibits their help-seeking and can lead to feelings of failure when they don’t feel able to cope alone.

“Some men are suffering but don’t want to worry their family/friends as they may be going through their own problems, which may put pressure on the relationship.”

– Samaritans volunteer

The restrictions over the past year appear to have further limited opportunities for some men to open up. For instance, the closure of facilities such as gyms, pubs, sporting venues and cafes has heightened feelings of loneliness and isolation among male callers, which has become a more common concern during the past year:

Heightened feelings of loneliness and isolation among male callers:



j. OR: 0.31, 95% CI: 0.24, 0.38

k. Counselling or therapy - pre-Covid OR: 0.63, 95% CI: 0.52, 0.77; post-Covid OR: 0.71, 95% CI: 0.57, 0.89. Community group - pre-Covid OR: 0.70, 95% CI: 0.56, 0.87; post-Covid OR: 0.69, 95% CI: 0.55, 0.87. Social media or online - pre-Covid OR: 0.43, 95% CI: 0.37, 0.51; post-Covid OR: 0.49, 95% CI: 0.41, 0.59.

These spaces can facilitate open conversations and appear to be a way of coping with or exploring difficult feelings. This echoes findings from previous Samaritans research, *Out of sight, out of mind*, which found that these spaces can enable human connection and provide an alternative to traditional support⁴⁷.

Some callers reported to volunteers that their social circle had become smaller as a result of the closures and were worried these relationships might not return. Others have spoken of using drugs and alcohol to cope with loneliness.

Concerns about drugs and alcohol were almost twice as common among male callers than female:



Analysis of the University of Glasgow’s MHWS data on help-seeking:

We found that men were less likely to seek help than women from most sources of support and this dynamic has not altered as a result of lockdown.

➤ During the first 8 months of lockdown, men were 69 per cent less likely to seek help from friends or family than women, which is similar to before the pandemicⁱ.

➤ Men were also less likely than women to seek help from professional therapy, community groups or online, both before and during the pandemic^k.

➤ Younger men were more likely to seek emotional support than those aged 30–59 or 60+ across most support types, both before and during the pandemic. Those in the oldest age group were least likely to seek support across most support types.

6. Which groups are we particularly concerned about?



Strain on relationships

Research shows that relationship breakdown can affect men in midlife more than women⁴⁸. This is for a range of reasons, including some men not having the same type of social network as many women, which can mean a relationship breakdown is felt more intensely. In addition, men are often more likely to relocate following a relationship breakdown, and this often means living away from children.

Over the year since restrictions began, relationship problems were a concern in one in five emotional support contacts from men (21%), similar to previous years. Our volunteers told us that the concerns raised appear to be worsened by coronavirus, for instance because of impact of working in close quarters with family members, pressures of home-schooling and increased family tensions. One concern that has particularly affected some men, mostly in midlife, was loss of contact with children for separated fathers. Volunteers describe fathers who were unable to see their children for long periods due to the lockdown, shielding or a perception of having restricted access to the children.

“Men who have children but who are separated from the other parent are distressed about not having seen their children for many months. They feel their children are being ‘kept’ from them under the cover of ‘lockdown conditions’, with no one to appeal to.”

– Samaritans volunteer

¹ Either via the dedicated NHS line or contacts to the general helpline which were known to be from healthcare workers

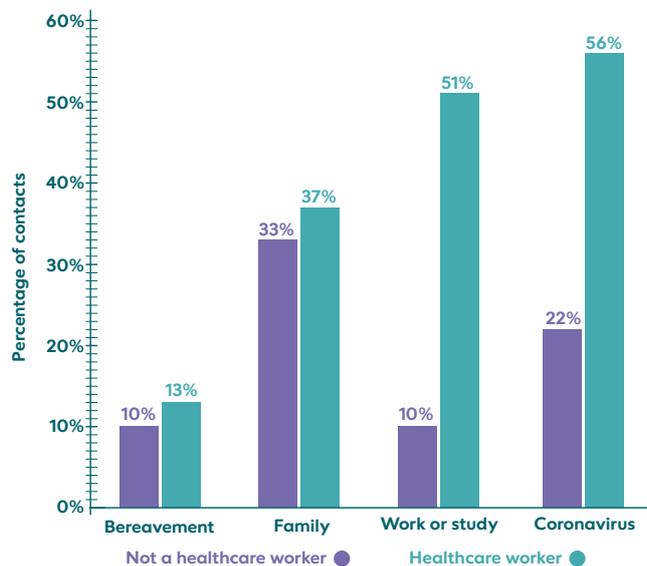
*Only concerns with the most significant increases are reported.

Healthcare workers

Coronavirus has had a significant and direct impact on the life and work of healthcare workers. In a recent report published by Mind, two-thirds (69%) of emergency responders felt their mental health has deteriorated as a result of the pandemic⁴⁹. In April 2020, Samaritans launched a specific [wellbeing support line for health and social care workers in England and Wales](#), funded by the NHS, the Department of Health and Social Care and the Welsh Government. This recognised the significant mental and emotional pressures they faced during the pandemic. We also supported healthcare workers from across the UK and Republic of Ireland through our main helpline during this time.

Across the two helplines, in the year since restrictions began, we provided emotional support 17,254 times to healthcare workers¹. In more than half of these contacts (56%), coronavirus was raised as a specific concern; meaning healthcare workers were more than twice as likely to specifically mention coronavirus as a concern than other callers (22%).

Figure 5: the frequency that various caller concerns were raised in contacts with healthcare workers, vs contacts with other callers*





6. Which groups are we particularly concerned about?

In our volunteers' conversations with healthcare workers there were six key themes; stress, exhaustion and burnout, the changing nature of distress, anxiety about going to work, lack of resources and support, guilt and the impact of the pandemic on their relationships with others.

Stress, exhaustion and burnout

Healthcare workers were much more likely to raise concerns about work compared to other people contacting Samaritans. Concerns about work or study were raised in half of healthcare worker contacts (51%) compared to 10 per cent of other contacts to Samaritans.

The data we collected in both November 2020 and March 2021 relating to our conversations with healthcare workers identified stress, exhaustion and burnout as a common theme. Volunteers generally cited three main causes: working long shifts, the nature of the work, and the length of the ongoing pandemic.

Volunteers told us that callers often discussed working extremely long shifts which could be physically and mentally demanding. As a result, many volunteers had received contacts from healthcare workers at the end of a shift, who wanted to 'offload' or 'vent'.

As well as the time spent working, the nature of the work was contributing to stress, exhaustion and burnout. Volunteers noted that callers were under extreme pressures at work and were struggling to deal with such high volumes of death and critical care. In addition, volunteers spoke about callers who had been re-deployed as experiencing additional pressures, for instance working in jobs they did not feel adequately trained for, worrying about doing a bad job, and being forced into excessive responsibility in a short amount of time.

“Undoubtedly the death rate caused the most anguish, and the inability to give the standard of care they felt they should. Also, people working in areas where they had little experience.”

– Samaritans volunteer

In relation to the length of the pandemic, callers were concerned about the future and the possibility of another wave of coronavirus, which would extend the stressful working conditions they had already endured for so long.

Changing nature of distress

As with many callers, many healthcare callers felt the pandemic had taken its toll on their mental health and were often concerned about the long-term impacts to their mental health. On calls to the dedicated NHS and social care workers' helpline in England and Wales, volunteers noted that healthcare workers' distress levels had remained similar over the course of the pandemic, although the nature of distress had changed. For instance, volunteers reported a sense of callers "running on adrenaline" during the early pandemic peaks and therefore contacts were primarily focused on what was going on in the here and now. Volunteers described a "covid comedown" later on, where the long-term impacts of the pandemic built up, resulting in exhaustion and strong emotions due to callers having more time and space to reflect on both the past and the future.

Anxiety about going to work

Volunteers reported that healthcare workers were often anxious about going to work. In many cases they feared what they would see that day, often as a result of distress about the number of deaths and amount of severe illness they had witnessed. Some callers showed signs of trauma from the current situation or previous traumas being triggered. Volunteers also noted that callers



6. Which groups are we particularly concerned about?

were fearful of contracting coronavirus, and in particular, were worried about passing the virus onto friends or family members, especially older or vulnerable people. Many volunteers had heard from callers who were considering leaving their job, as they did not enjoy their job anymore.

Lack of resources and support

A large number of volunteers, on both helplines, had spoken to healthcare workers who felt a lack of resources and support in the workplace. Concerns included not having access to practical resources such as Personal Protective Equipment, mostly in the early days of lockdown, or being under-staffed due to staff sickness, placing additional pressure on them. Callers were also concerned about not receiving adequate emotional support, alongside a sense of being underappreciated by their employer. Volunteers in the focus groups recalled callers discussing a crisis in management and feeling misunderstood, isolated and disempowered at work. In addition to not knowing where to seek emotional support at work, volunteers stated that callers were often very reluctant to seek help due to a fear of losing their job or being viewed as inadequate.

Guilt

Despite feeling stressed, exhausted and burnt out, volunteers described guilt being common among frontline healthcare callers. This included guilt about the burden on their colleagues if they were not able to work due to shielding or healthcare issues, including time off for mental health problems.

Among those who were able to work, volunteers described callers' strong sense of guilt at not being able to do more to help patients. Particularly, volunteers cited callers feeling guilty about families and loved ones being unable to visit those who were dying, at not being able to prevent more deaths and at not being able to show compassionate responses to patients and families such as hugging, due to social distancing

restrictions. Volunteers also heard from callers who said their exhaustion and burnout meant they were unable to give their best support to patients.

Relationships with others

As with contacts that weren't from healthcare workers, family concerns and concerns about loneliness and isolation were common. However, healthcare workers' relationships with others have been affected in unique ways. Across both helplines, this included callers who had moved away from their families to reduce their exposure to the virus, or due to being relocated to a different workplace. Because of this, many healthcare workers were feeling isolated and lonely.

“ Frontline workers living away from home [are] frightened of infecting the family, I've had quite a few doctors/ nurses in this situation... Several were living at the hospital because of vulnerable family members. ”

– Samaritans volunteer

Where callers were still living with their families, volunteers noted that this, too, placed additional strains both on the frontline healthcare worker and their family. Volunteers regularly heard from callers who were concerned about long working hours, meaning they had little time to spend with their family. Other healthcare workers reported feeling unsupported by their family, for instance pressure from family members who did not want them to work in such dangerous conditions. In addition, many callers felt unable to share their emotional stresses with families, as they didn't want to burden them.

“ 12 hours a day in COVID ward then a relationship or family to look after and protect, and a lack of equipment PPE brings its toll. Who do you turn to when death surrounds you? ”

– Samaritans volunteer

6. Which groups are we particularly concerned about?

People in prison

People in prison are significantly more likely to die by suicide than people in the general population⁵⁰. This group has also been particularly affected by the pandemic, experiencing changes to regimes and increased isolation. Movement in prison has been severely restricted with some people having to spend up to 23 hours a day⁵¹ in their cells, while other are confined to landing or wing 'bubbles'. This has affected people's opportunities to exercise, take part in meaningful activity or socialise with other residents. On top of that, many have worried about their loved ones outside, with bans on family and social visits for much of the year. Some have had to cope with grieving on their own after the death of family members.

Support to people in prison by our helpline in England and Wales increased in the year since restrictions began, but there was a drop in support through the Listener Scheme (our peer support programme in prisons across the UK and Republic of Ireland). This likely reflects the impact of social distancing restrictions on people in prison, limiting their opportunities to leave their cell to speak to a Listener, as well as data not being logged because external Samaritans volunteers have had reduced access to prisons due to the restrictions. In Scotland, the Listener scheme was suspended between March and August 2020. We answered almost 125,000 emotional support contacts via our helpline in England and Wales from people in prison, an increase of a third compared to the previous year. The Listener Scheme supported people 27,000 times, a 47 per cent drop in logged contacts in the year since restrictions began, compared to the previous year.

In our volunteers' conversations with people in prison there were two key themes: isolation from increased cell time, and uncertainty about future visits and release dates.



34%

rise in emotional support through the England & Wales prison helpline



47%

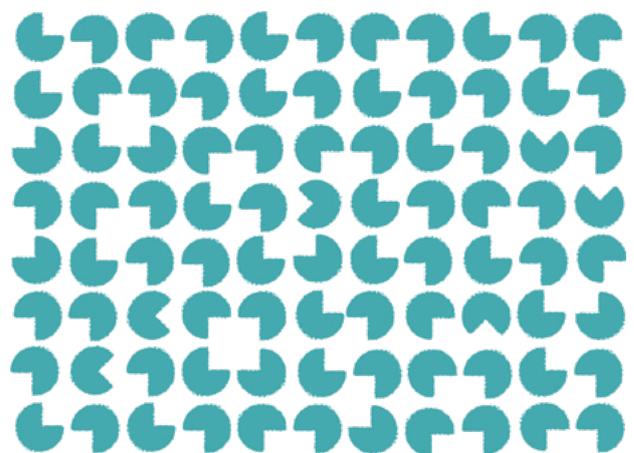
drop in logged contacts through Listeners in prisons

Isolation from increased cell time

Volunteers reported that callers in prison most commonly raised concerns about the changes to their routine, in particular being confined to their cell for 23 hours a day. People in prison had significantly reduced opportunities for meaningful activity such as recreation, workshops and work. In many prisons, visits from family weren't possible and even contact via telephone was limited for many.

Our data from the Listener scheme also highlights an increased percentage of concerns relating to the staff or regime:

17% year before **v** **20%** pandemic year



6. Which groups are we particularly concerned about?



Increased percentage of calls from people in prison to the helpline in England and Wales were about loneliness and isolation:



Volunteers reported that loneliness among people in prison intensified as a result of this lack of meaningful activity or connection. A third of calls to the helpline were about loneliness and isolation, which is an increase compared to the previous year (32% vs 27%), and our Listeners also reported an increase in concerns about this (16% vs 9%).

“ Lots of calls from prisoners about isolation, lack of activities and no visits. This is badly affecting their mental health and wellbeing. ”

– Samaritans volunteer

By contrast, there were fewer contacts than last year from people in prison about bullying, being in prison for the first time or facing problems with other people in prison. This reflects how changes to regime have affected the causes of distress.

Uncertainty about future visits and release dates

Volunteers reported that people in prison have faced increased concerns about the future, with key dates such as visits from family and release from prison being left in limbo. The increased strain on relationships with relatives who they have had little contact with for the last year has affected the wellbeing of people in prison.

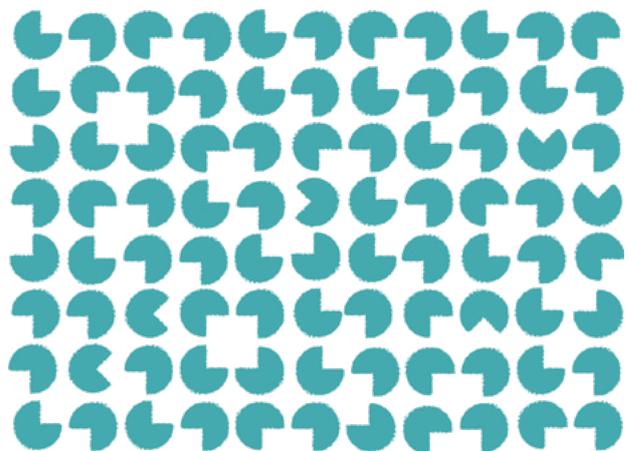
“ Every single call from a prisoner has talked about the impact of being locked up for 23+ hours a day. Many have mentioned the impact of not seeing family. Others have talked about release dates or other important dates being delayed because of lockdown. ”

– Samaritans volunteer

Throughout the pandemic, volunteers told us that callers from prison have also spoken about anxiety and uncertainty about the future relating to legal processes being delayed. This has meant some people’s release dates and home visits were postponed, causing distress. Some people in prison have also worried about access to housing and employment on release, and that access to support services outside of prison may not be available once released into the community.

“ I have spoken to multiple prisoners who cannot be released because they have nowhere to live when they get out as halfway housing has been pared back. ”

– Samaritans volunteer





7. Conclusions

The coronavirus pandemic has had an undeniable impact on people's wellbeing and has exacerbated existing inequalities in suicide risk. As we move to a new phase of the pandemic with the rollout of vaccinations and the easing of social distancing restrictions, governments need to put suicide prevention at the heart of efforts to rebuild.

Our research shows that concerns about loneliness and isolation, finances and work, and family are most strongly associated with distress linked to coronavirus. We identified the ways in which these concerns have changed and manifested over the year since restrictions began. Concerns relating to finances and work have affected both those who have lost their job and those experiencing insecurity about their financial future, with uncertainty about government financial support causing anxiety. Feelings of loneliness and isolation intensified over time for many, as the protracted nature of restrictions had a cumulative effect. People's concerns about family have been diverse, with some being separated from their family for an extended period of time, while others have experienced family tensions caused by being together constantly and sharing a small space.

Our findings also show that, while everyone's lives have been affected by the pandemic, there is reason to be particularly concerned about the impact on some groups' suicide risk.

People with pre-existing mental health conditions have experienced intense and persistent challenges to access the care they need, both from mental health services and community-based support, often grappling with a need for human contact but concerned about catching coronavirus.

Young people have struggled with family tensions, a lack of peer contact and negativity about their future prospects, as the pandemic has affected both their social and economic opportunities, and some people who self-harm have struggled to resist hurting themselves without their usual coping mechanisms.

Middle-aged men have found themselves feeling they need to be strong in the face of immense financial and workplace changes, creating a situation that feels both out of their control and one they must cope with alone.

Healthcare workers have struggled with feelings of anxiety, trauma and mental fatigue from their work during the pandemic, alongside the impact of being surrounded by serious illness and death at unprecedented levels, while often struggling for support and resources.

People in prison have been isolated from family and friends since restrictions began, unable to take part in meaningful activities like work and sport, and have felt the acute effects of extreme isolation from spending 23 hours a day in their cell.

The coronavirus pandemic has brought these sharp inequalities in suicide risk into even greater focus. Action should be taken now to offer support to those most at risk.

Steps taken by governments across the UK and Republic of Ireland to respond to the mental health impact of the pandemic, through mental health recovery plans, strategies, and funding commitments, have been welcome. But there is no room for complacency about suicide rates, which were rising in many areas even before the pandemic. Suicide prevention should be embedded at the outset of governments' approaches to issues including unemployment, debt and loneliness, creating practical means to support vulnerable individuals. Understanding the wide-reaching impact of the pandemic on wellbeing is vital to this, and will continue to be over the coming months and years.



Appendix: further detail on data and methodology

Samaritans service data

As noted in the methodology a dataset of over 4 million anonymous contact records was utilised in this research. This comprised of data collected by Samaritans listening volunteers where:

- emotional support was provided. This excludes contacts where the caller didn't get through to Samaritans, and also excludes answered contacts where emotional support wasn't provided, for example when the caller misused the service.
- contact method was either by telephone or email
- the contact was received between 23rd March 2019 and 22nd March 2021

The variables included in the dataset were:

Broad topics that that raised by the caller as a concern during the contact (e.g. loneliness)

- Benefits/welfare
- Bereavement
- Bereaved by suicide
- coronavirus
- Drug and/or alcohol misuse
- Family
- Finance/unemployment
- Gender
- Homelessness
- Isolation/loneliness
- Legal
- Mental health/illness
- Physical health/illness
- Relationship problems
- Sexuality
- Violence/abuse
- Workplace/study
- Other
- None

Method of contact

- Email
- Telephone

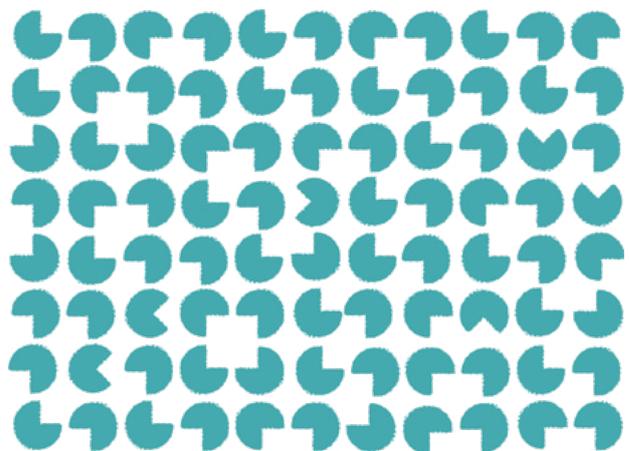
Gender of caller*

- Male
- Female
- Transgender
- Unknown

Age of caller

- Under 18
- Over 18
- Unknown

* Since this data was collected, the categorisation has been updated to include a new gender option for 'Other term used', for callers who are non-binary or use another term to describe their gender. Transgender status is now collected separately to the above gender options.





Whether suicidal feelings or behaviours were expressed during the contact

- Not explored
- Not expressed
- Currently attempting suicide
- Suicidal plan
- Suicidal thoughts

Whether self-harm was discussed during the contact

- No talk of self-harm
- Yes - has never self-harmed
- Yes - self-harmed in past
- Yes - self-harms nowadays

Listeners in prisons collect information on a number of additional concerns:

- Adjudication
- Bullying
- First time in prison
- Immigration issues
- Pre/Post release issues
- Problems with other prisoners
- Problems with staff/regime
- Recall
- Sentencing or sentence progression
- Transfer
- Visits or phone calls

Samaritans volunteer surveys

Seven surveys were conducted with Samaritans Listening volunteers during the year since restrictions began. Each survey collected some comparable data, but questions were dependent on the current external context relating to the pandemic and were adjusted in response to findings from earlier volunteer surveys.

The samples are not mutually exclusive. Therefore, any volunteer may have responded to multiple surveys throughout the year.

Survey	Sample size	Data collected on
April 2020	1,932	<ul style="list-style-type: none"> • Caller distress, anxiety and suicidality • Changes in the nature of caller concerns • Most common concerns for callers specifically discussing Covid-19 • Changes in discussion suicidality or self-harm • Changes in the way Samaritans services are used
May 2020	1,341	<ul style="list-style-type: none"> • Caller distress, anxiety and suicidality • Most common concerns • Change in frequency and/or distress caused by most common concerns, compared to previous survey • Changes in the nature of caller concerns for callers specifically discussing Covid-19



Survey	Sample size	Data collected on
June 2020	1,394	<ul style="list-style-type: none"> • Caller distress, anxiety and suicidality • Most common concerns • Change in frequency and/or distress caused by most common concerns, compared to previous survey • Change in frequency of calls and most common concerns among young people and people in prison • Changes in the way Samaritans services are used • Changes in the nature of caller concerns for callers specifically discussing Covid-19
July 2020	956	<ul style="list-style-type: none"> • Caller distress, anxiety and suicidality • Most common concerns • Change in frequency and/or distress caused by most common concerns, compared to previous survey • Change in frequency of calls and most common concerns among young people and men • Changes in the way Samaritans services are used • Changes in the nature of caller concerns for callers specifically discussing Covid-19
October 2020	1,439	<ul style="list-style-type: none"> • Most common concerns, including for particular groups: men, young people, people with mental health conditions • Concerns relating to Christmas and winter • Changes in the nature of caller concerns for callers specifically discussing Covid-19
January 2021	2,089	<ul style="list-style-type: none"> • Most common concerns, including for particular groups: men, young people, people with mental health conditions • Frequency of discussion of psychological risk factors for suicide
March 2021	1,615	<ul style="list-style-type: none"> • Most common concerns, including for particular groups: men, young people, people with mental health conditions, frontline healthcare workers, people in prison, military veterans • Common discussions about the latest national lockdown, vaccination programme and easing restrictions



Data from the UK COVID-19 Mental Health & Wellbeing Study

As noted in the methodology section, variables relating to sources of helpseeking behaviour included Friends or family, Samaritans via telephone, Other helplines or voluntary support services, Professional counselling or therapy, Community groups/clubs, and Social media/online. Further detail on the measures of this within each wave are provided in the table below.

	Data collection period	Sample size	Measure of help-seeking (All responses on a three-point Likert scale of never/once/more than once)
Wave 1	31 March to 9 April 2020	3,077	Baseline (pre-COVID) helpseeking behaviour was asked with ' <i>In the six months before the COVID-19 pandemic, how often did you seek emotional support from [helpseeking behaviour source]'</i> Subsequent help-seeking behaviour was assessed with: ' <i>Since the start of the COVID-19 pandemic how often have you sought emotional support from [helpseeking behaviour source]'</i>
Wave 2	10 April to 27 April 2020	2,742	Within waves 2-6 helpseeking behaviour was assessed with ' <i>in the last two weeks how often have you sought emotional support from [helpseeking behaviour source]'</i> .
Wave 3	28 April to 11 May 2020	2,604	
Wave 4	27th May to 15th June 2020	2,384	
Wave 5	17th July to 7th August 2020	2,144	
Wave 6	1st October – 4th November 2020	2,283	



Sociodemographic data was captured through the following questions:

Gender

Gender was collected through the following question:

Which gender identity do you most identify with?

- Female
- Male
- Transgender Female
- Transgender Male
- Gender Variant/ Non-Conforming
- Other
- Prefer not to answer

This was recoded as 'Male' and 'Female'. There was not enough data to robustly report on gender variant/non-conforming respondents.

Age

Age was collected through the following question:

Which of these age ranges do you fall into?

- Under 18
- 25-29
- 30-34
- 35-39
- 40-44
- 45-49
- 50-50
- 55-59
- 60-65
- 65-59
- 70-74
- 75-79
- 80-84
- 85+

Socio-economic group

Income was collected collected upon recruitment to the research panel, which preceded participation to the *UK Covid-19 Mental Health and Wellbeing study* so as to obtain a stratified nationally representative sample. The National Readership Survey social grade was used as an indicator of socioeconomic group (SEG; see below for groups).

- A – Higher managerial, administrative and professional
- B – Intermediate managerial, administrative and professional
- C1 – Supervisory, clerical and junior managerial, administrative and professional
- C2 – Skilled manual workers
- D – Semi-skilled and unskilled manual workers
- E – State pensioners, casual and lowest grade workers, unemployed with state benefits only

This was recoded as 'high' (i.e., A + B + C1) and 'low' (i.e., C2 + D + E) income.



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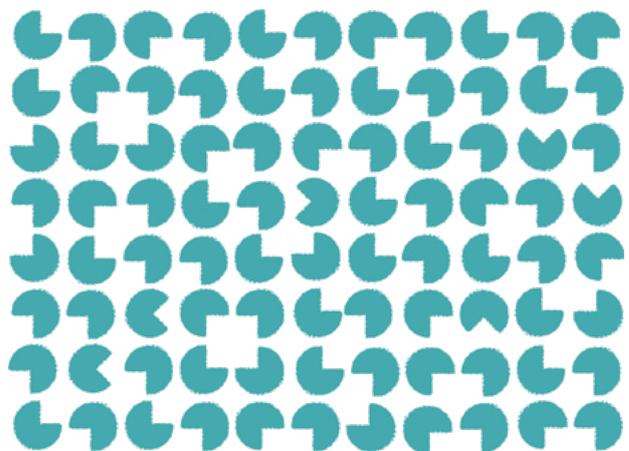
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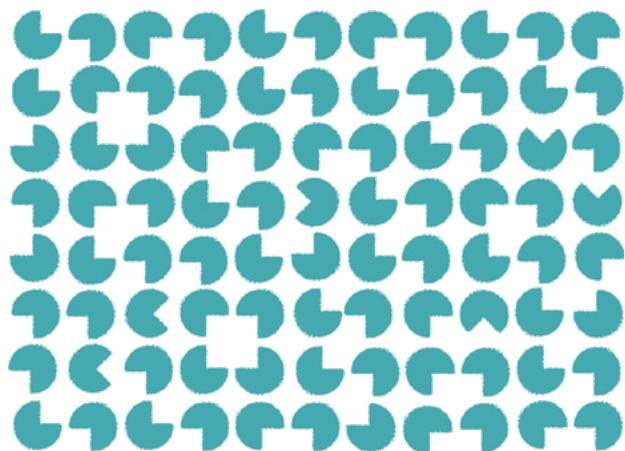
This research was undertaken in line with Samaritans Research Ethics Policy.





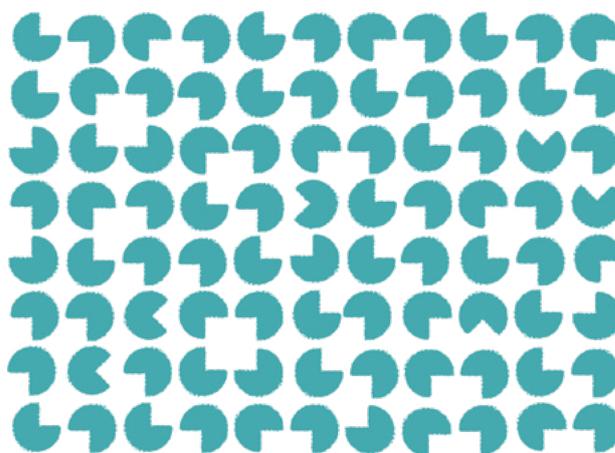
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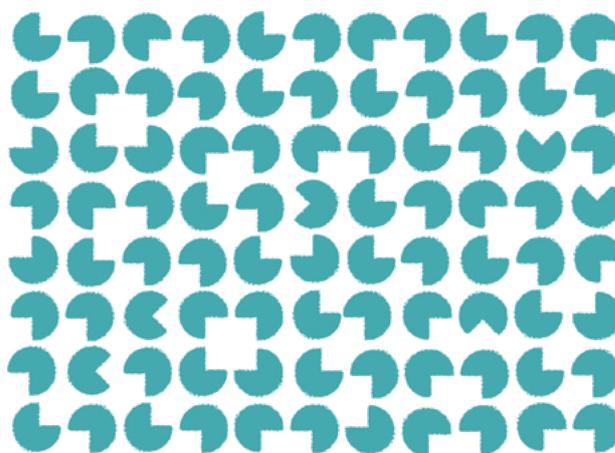
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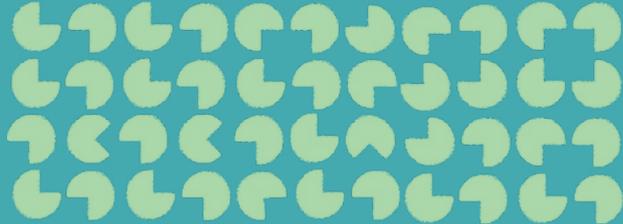




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