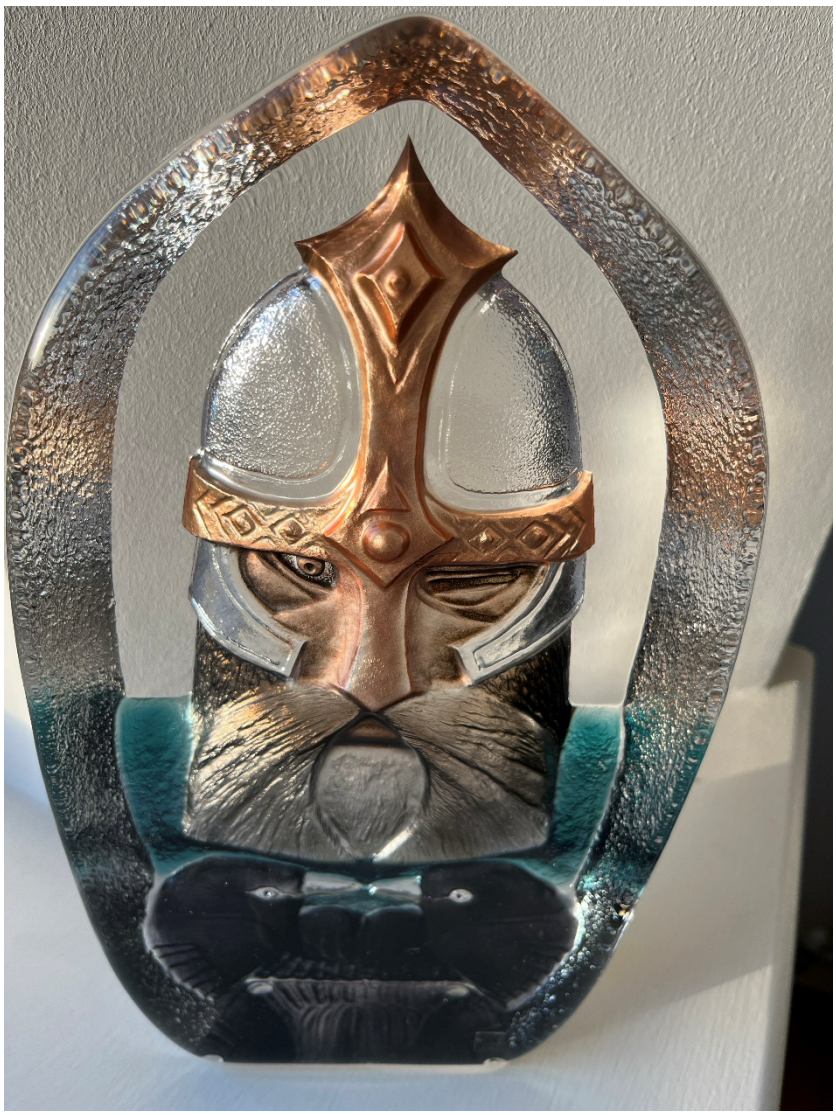
“A Light in the Darkness”

A Report into Suicide Prevention in Sweden



Odin **by Mats Jonasson. Photographed and owned by Chris Hanvey.**

Dr Chris Hanvey.
The Churchill Fellowship 2025.

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Acknowledgements

If it takes a village to raise a child, I suspect it takes a lot of generous people, unselfishly giving their time, to put together a Churchill Fellowship. I am most grateful for the support, enthusiasm and practical help they were all prepared to give in order to make my visit to Sweden possible. Gratitude is due to:

The Churchill Fellowship for their generous grant and willingness to accommodate my unexpected illness. And for the encouragement and support they unfailingly offered.

Adele Owen QPM. Greater Manchester Suicide Prevention and Bereavement Support Programme Manager and a Churchill Fellow.

Professor Keith Hawton. CBE Emeritus Director, Centre for Suicide Research, Oxford University.

Asa Eriksson. Public Health Nurse.

Professor Gergo Hadlaczky. Associate Professor of Psychology at the Karolinska Institute, Head of the National Center for Suicide Research and Prevention (NASP) Stockholm Health Care Service.

Rickard Bracken. General Secretary, MIND, Sweden.

Lisa Wendby. Senior Manager, MIND, Sweden

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Miriam Jacobson. Psychologist, Deputy Manager, Hjalplinjen.

Professor Margda Waern, Sahlgrenska Suicide Group, Department of Psychiatry and Neurochemistry, The University of Gothenburg.

Members of the research team of the Sahlgrenska Suicide Group.

Willliam Jack. For your generous personal insights.

Rosie Hanvey, amanuensis, wise guide and unfailing support.

Chris Miller, friend, Samaritan and invaluable critical reader.

Natasha Hanvey-Davey

Personal profile.
My professional background is in psychology and social care and my last post before retirement was as Chief Executive of the Royal College of Paediatrics and Child Health. I was awarded a Churchill Fellowship in 2023 but due to illness was not able to take it up until May/June 2025. I am grateful for the flexibility and forbearance of the Churchill Fellowship. I became interested in the prevention of suicide as a Samaritan; firstly in Nottingham and later Devon and continue to be involved in a charity that through its 23,000 volunteers daily and nightly demonstrates the best of the UK's voluntary sector.

Executive Summary. The challenge of suicide prevention is of international concern. Sweden is a significant case study in that it experienced relatively high levels of suicide in the 1970's and set about developing a range of initiatives to improve suicide prevention and lower the number of deaths. Most recently it has launched a ten-year strategy aimed at both improving mental health and diminishing deaths by suicide.

Through meetings with civil servants, university departments, state and not -for -profit organisations – encompassing policy, research and practice- I was keen to understand Sweden's strategy and its likely effectiveness.

A mixed pattern of state and non-profit organisations revealed the need to tackle suicide holistically through state and voluntary organisations. This was underpinned by a strong research base, embracing AI and new technologies for better services, plus a range of helplines for diverse aspects of suicide prevention. Psychology and social work professionals play a crucial role in managing the significant increases in mental health referrals.

From this flows recommendations both to Samaritans in the UK, as they currently undertake a major review of their work and purpose in 2025(1), and also for those in government and other stakeholders responsible for suicide prevention strategies.

1. Introduction Why Sweden?

Suicide is a global challenge. With approximately 720,000 recorded deaths a year (likely to be a significant underestimate), coupled with the explosion in mental health referrals, many countries face a perfect storm. Sweden emerges as an example of a European country that has made a significant commitment to suicide reduction from the high levels of suicide in the 1970's.

With a population of 10.5 million (April 2025) and a land mass 1.85 times larger than the UK, Sweden presents as a young country by European standards, having experienced significant levels of immigration, with the biggest population being 30–40-year-olds (20.4% of the population). Of the total average number of 1,200 suicides a year in Sweden, elderly men over 85, have the highest proportion, relative to the size of their group, although the largest number of lives lost lies in the 45-64 age group (300 a year).

Today, in Sweden, two thirds of suicides are men. As a result of high suicide rates in the 1970's, (between 1971 and 1975 the rate was about 20 per 100,000 of the population), Sweden launched a number of initiatives. These ranged from a "Zero Suicide" manifesto, which was part of a 2008 public health bill, to the characterization of suicide as a "psychological mistake"- a slogan now discarded and regarded with embarrassment in some circles.

For example, Professor Gergo Hadlaczky at the Karolinska Institute- Stockholm's foremost research unit for suicide prevention -also asserts that, like the NHS's recently published report *Staying Safe from Suicide,*2025(2), Sweden is moving away from the risk prediction of suicide, with its ineffective and largely outdated tick-box approach to risk assessment to a more holistic approach. Suicide rates in Sweden have now come down to about 12.3 per 100,000 population, according to a World Population Review (WPR) 2025, which places Sweden as 57th in the international table of suicides (deaths per 100,000). According to the WPR Sweden previously had a high suicide rate, with the most suicides in the developed world during the 1960's.

Sweden's politics have evolved since the 1930's, impacting social welfare and health policies like suicide prevention. The Social Democrats, in power from 1932-1976, established high taxes, extensive public services and generous welfare. Their progressive 1956 Socialhjalpslagen Social Aid Law made Sweden one of Europe's most socially advanced nations. But the past, in Sweden, is a foreign country, they do things differently now. Today, a minority government, reliant on anti-immigration support, still maintains high taxes but addresses health and social issues differently, influencing how suicide prevention and mental health are tackled.

2. Sweden's Strategy for suicide prevention.

In 2025 Sweden launched the "*National Strategy for Mental Health and Suicide Prevention, 2025-2034"* (3) promising the vision of "*a society that promotes good and equal mental health for the entire population, where no one should find themselves in a situation where the only perceived way out is suicide".* Of the two arms of central government policy- The Public Health Agency and the National Board of Health and Welfare, it is the latter that has the lion's share of implementing the strategy.

Charlotte Lindholm, from the National Board feels that one of the strengths of a ten-year strategy, which has been signed off by all parties, is that it will outlast changes in government administrations. Ambitiously, the strategy embraces twenty-seven separate agencies. As well as working at national, regional and municipal level, through health and social welfare, it includes business life, civil society, the research community and decision makers.

Agencies involved include bodies as diverse as insurance, transport, housing and the police. Ms Lindholm defined the overall purpose of the strategy as being threefold. 1. A whole of society approach, achieved by strengthening national coordination. 2 A focus on promotion and prevention, through joint work on mental health and suicide prevention and 3 To improve services for people living with mental illness and/or mental disorders.

It combines mental health and wellbeing and it is essential to understand the centrality of this holistic approach to suicide prevention in Sweden, whether this is cut horizontally across organisations or vertically amongst the various parts of central and local government. We will later see small examples of the way seemingly unconnected bodies have come together to tackle suicide prevention. During my visit, the National Board of Health and Welfare was in the process of arranging a series of days when a wide range of statutory and not-for- profit organisations would be brought together to discuss how they could contribute to the implementation of the strategy in its totality.

Learning

- Sweden's experience would suggest that to be effective a comprehensive suicide prevention strategy needs to consider including health, social welfare, not-for-profit organisations, business and commerce, public services and research, at a national, regional and local level

3. Aims and objectives

I was only interested in embarking upon a project funded by the Fellowship that would make practical proposals for improving suicide prevention in the UK. Through the experience of three sets of players: policy makers/government officials; researchers; and service providers- (both state and not for profit organisations) the aim was to explore what works or doesn't work in Sweden, what was transferrable and what might be learnt. Limited contact was made with the essential voice of service users, but unfortunately the scope and timing of the Fellowship did not permit a detailed examination of this. Where possible descriptions were drawn out of services to understand in more detail what an initiative might mean for service users.

An adjunct to the Fellowship was an opportunity to visit Umea, in the north of Sweden, to understand a little of the life of the indigenous Sami people. Through some prior research, it was evident that their traditional lives and culture had been severely encroached upon by 21st century existence. Significantly, amongst young male Sami reindeer hunters, suicide rates were supposedly high. The Fellowship provided an opportunity both to see how Sweden had responded to this group and what lessons might be learnt for other marginalised communities.

4. Approaches

During the course of a month a range of organisations made themselves generously available, often through the hospitable Swedish tradition of Fika, involving coffee and waist expanding cakes. Both my wife, Rosie, and I individually took notes during the meetings and where PowerPoint presentations were made or references to publications cited, these were all pursued subsequently. The month provided ample evidence of the reality that people take pride in what they do and are eager to demonstrate to others how they strive to make a difference in their daily work. There is a very real privilege in being the recipients of this energy, enthusiasm and knowledge.

What follows are my findings based on the conversations and material provided by the various organisations we visited. It will quickly become evident that themes recur with the familiarity of a well-known tune. The need for an holistic approach to strategic planning has already been noted. Added to this are the requirement for multi-disciplinary teams, the importance Sweden places on public health education, the development of AI and digital tools to assist in service provision, the role of professionals in screening help-line services, the necessity for a strong research arm and the intriguing balance between volunteers and professional staff. At all times it was important to keep in mind that what works in Sweden might not be transferrable to the UK or vice versa.

What this report is not is a comparison between suicide prevention strategies in Sweden and the UK: that was never part of the brief. It was an attempt to understand what has happened in Sweden to reduce the number of suicides and to try to make sense of how this had occurred. To some extent it ignores the thinking, strategies and practice that exist for suicide prevention services in the UK. However, occasionally, when I have knowledge of some

developments or policies in the UK that bear obvious comparison, then reference to these is made.

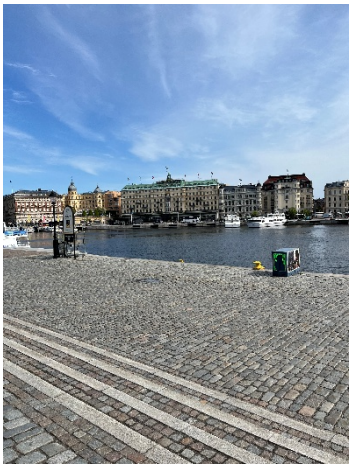
A good example of this is the experience of the PAM Enheten ambulance service which partly sprang from a determination that it should not be the police that makes admissions to mental hospitals. I refer to the Metropolitan Police's document *Right Care, Right Person* (4) which proposed a comparable policy. Similarly, a great deal is made in the report of Sweden's preventive suicide services' use of AI. This is not to deny that work is going on within statutory and voluntary services in the UK to develop similar schemes.

Finally, I attempt to summarise the learning from each visit and to turn these into recommendations at the end of the report. These are simply listed at this stage. My hope is that they will be separated out, some to go to the UK Samaritans, who, fortuitously, are undertaking a major review of their work, and some to those departments of the UK government that have a responsibility for suicide prevention. Again, where similar developments are taking place in the UK, the recommendations might seem unnecessary, but where Sweden is developing new ideas and practises, the hope is that lessons might be examined in the UK.

The privilege of the Fellowship was the opportunity to talk to so many enthusiastic experts, eager to improve suicide prevention services. The responsibility that goes with this privilege is to use this learning to point to possible improvements here in the UK. In keeping with all recipients of Churchill Fellowships, my firm aim is to make proposals that will have a lasting impact and work, in this case, towards a reduction in the number of people who take their own lives.

5. The Research Base

Sweden's 10-year suicide strategy emphasises the importance of underpinning practice with sound research; a belief that is shared in the UK and realised through, for example, such units as Professor Keith Hawton's Centre for Suicide Research at Oxford University and bodies like the National Suicide Prevention Alliance. During the course of the Fellowship I visited the staff at three universities: in Stockholm, Umea and Gothenburg, each of which concentrated on very different aspects of suicide prevention.



5a. The Karolinska Institute

An old joke has a psychologist interviewing a robber and asking him why he robs banks- "because that's where the money is" comes the logical and not surprising reply. Similarly, Professor Gergo Hadlaczki's (Associate Professor at the National Centre for Suicide Research and Prevention at the Karolinska Institute Stockholm) assertion that we still don't understand why people consider suicide, might, superficially attract the same scepticism in the face of the obvious- "because they no longer wish to live".

But the Karolinska Institute, while demonstrating what has been learnt about suicide, also shows what more understanding is needed. The National Centre for Suicide Research and Prevention (NASP) was established as part of the Karolinska Institute in 1993 and sees itself as an evidence-based knowledge foundation engaged in research, strategic public health work, education and information dissemination around suicide. It is, like Gothenburg, (later visited), interdisciplinary with specialists in public health, psychology, psychiatry, molecular biology and anthropology, and has a staff of approximately twenty-five whole time equivalents.

Dr Hadlaczki, who jointly heads the unit, strongly supports the NHS' *Staying Safe from Suicide (*ibid) with its move away from risk prediction in suicide to a more holistic approach, and has devoted some of his work at NASP to wholescale suicide prevention amongst young people, mainly through the YAM and SUPREME research projects.

The Youth Aware of Mental Health (YAM) initiative is a school-based programme for young people, aged 13-17 in which they learn about and explore the topic of mental health. It is an evidence-based programme designed to take place in classrooms around the world. Students actively engage with the topic of mental health through role play and pupil led discussions. YAM has engaged with more than 170,000 teenagers in 17 countries with more than 1,600 people having been trained as YAM instructors. Supported by the Karolinska Institute, YAM is robust in making some links between the programme and a reduction in the number of new cases of suicide. This engagement with young people as a preventive strategy appears throughout Sweden's public health, like a name running through a stick of rock and is also reflected in another major NASP initiative, the SUPREME project, outlined below.

Suicide Prevention By Internet and Media Based Mental Health (SUPREME) is again aimed at adolescents. It is a multi-language, culturally adapted, highly interactive website accessible to the general public. The aim is to improve the mental health and well-being of European adolescents. Started in 2010 at the Karolinska Institute it has partners in seven countries: Italy, England, Sweden, Spain, Lithuania, Estonia and Hungary. Unlike YAM, which operates through schools, it is internet based, offering mental health promotion to reach the most vulnerable adolescents in need. It targets young people between the ages of 14 and 24, based on the belief that mental health problems such as depression, anxiety and conduct disorders, that persist without treatment and may lead to suicide, establish a foundation through adolescent patterns of behaviour and life choices. Dr Hadlaczki is passionate about the engagement of young people in suicide prevention, whether this is through internet or school routes and is equally committed to what he describes as "scalable interventions".

In this context, links between the Karolinska Institute and the rail network are, as we shall later see, also reflected in the work of another organisation MIND. The scheme is similar to the *Small Talk Saves Lives* (5) *campaign*, delivered by the Samaritans in 2017 in partnership with Network Rail, the British Transport Police and the wider rail industry. It aimed to

encourage and empower railway staff and members of the public to have conversations with those on a railway platform appearing distressed.

But work in Sweden goes further. Dr Hadlaczki quoted experimental work in Japan where they use blue lighting in the subway system to provide a calming influence on passengers. One practical result of this has been a specific research project at the Karolinska Institute exploring the psychological, emotional and behavioural effects of artificial lighting. It aims to examine how lighting affects different psychological states, emotions and behaviour more generally.

Dr Hadlaczki also quotes the work of David Gunnell (6) who looked at incidents of suicide on the Ellington Bridge in Washington. Putting barriers up to make suicide more difficult resulted in fewer suicides, but, strangely, the nearby Taft Bridge did not experience a corresponding increase in death by suicide.

A tentative conclusion from this was that suicide can sometimes be a fairly spontaneous action and can be deflected. This holistic approach to suicide prevention, linked to what Dr Hadlacki describes as scalable interventions, bears comparison with attempts to design out crime by building estates that maximised natural surveillance or controlled access and created a sense of ownership. It reflects Sweden's holistic approach to suicide prevention and mirrors the widespread engagement of a wide range of agencies in the ten-year strategy.

Learning

- The need to ensure that a workable suicide strategy is underpinned by a strong research arm to investigate and evaluate practice
- A strong focus on young people and mental health education helps to underpin the suicide prevention agenda
- Scalable interventions, like adapting the environment, can help suicide prevention

5b. Umea

Suicide research at Umea University has assumed a very different focus. Umea is located in the mid-northern part of Sweden and the university includes the Vardduo Centre for Sami Research which is engaged in coordinating and initiating new Sami and indigenous research and offering courses for those wishing to learn about Sami culture and language.

The Sami are an indigenous group who live in the northern parts of Sweden, Norway, Finland and Russia's Kola Peninsula. In Sweden they are now recognised as one of the country's

official national minorities and have a distinct culture, language and traditions that are protected by Swedish law. Reindeer herding is a significant part of Sami culture, although they have learnt to supplement income through tourism, fishing, crafts and other trades. Sami roots go back between 3,00 and 10,000 years and they now face challenges like land rights disputes, the impact of climate change on reindeer herding and the need to preserve their culture in the face of modern life. Reports have recorded many years in which the Sami population have been discriminated against, with their traditions eroded. This has resulted in a loss of identity, segregated education, forcible removal from their traditional homelands and a long struggle to protect grazing lands from industrialization.

Although there is no census, the Sami population in Sweden is calculated to be between 20,000-40,000 people. There is now a Sami parliament, consisting of thirty-one members, elected for a four-year term. In 2000 Sweden recognised Sami as an official minority language and, as an example of how they are gradually being acknowledged, the Swedish suicide prevention strategy has noted the separate contribution of the Sami people in its implementation.

This attempt to understand a little of Sami life, in relation to suicide and as part of my Fellowship, was partly because I had read that the Sami experience relatively high suicide rates. Secondly given the multi-racial context within which suicide prevention services now operate in the UK, I was keen to explore whether there were any lessons that might be transferable. A BMC Public Health paper, first published in 2021 "*Mapping suicide prevention initiatives targeting indigenous Sami in Nordic countries",* (7) wrote of suicide being a major public health issue among indigenous Sami in Nordic countries. Two leading researchers, Dr Petter Stoor and Professor Ellinor Salander Renberg have devoted several years looking at mental health and suicide and its prevention amongst the Sami in Norway and Sweden.

The starting point for this research was an approach by a nurse, working with and related by marriage to Sami people in what she perceived to be an increase in suicide amongst male reindeer herders. In discussion with me, Professor Renberg described the slow, sensitive and patient process necessary to establish trust amongst the Sami communities. A history characterised by abuse, violations and racism had inevitably led to a mistrust of establishment Swedish institutions and an understandable questioning of to what purpose any research would be put. Would the research result in practical action and, importantly, a reduction in suicide rates? The Sami were familiar with hit- and -run research which led to few practical benefits. A wry observation was made that in any Sami gathering you would inevitably find all the family or friends and, sitting in the corner, an anthropologist.

Professor Renberg spoke of the slow and patient process necessary to demonstrate the genuineness of the research and the determination to turn findings into action. The research, and that pursued in the BMC article, focused on male Sami reindeer herders who felt they had lost their identity and were disconnected from their traditional Sami world. They were losing a cultural identity, were subject to ethnic discrimination and denied culturally adapted mental health services. Not only was there a challenge to help them with suicide prevention but to strengthen some of the cross-border cooperation, given the wide area in which they lived and travelled.

As a result, seventeen initiatives targeting Sami were developed between 2005 and 2019, inspired by the question "How is the problem represented?" (6) Responses to how to prevent

suicide among Sami were broken down into (1) “shortcomings on individuals (2) relational (3) community/cultural (4) societal (5) and health systems.(8) All initiatives were adapted to the Sami context, varying from tailor-made culture specific approaches, to targeting Sami with universal approaches. (One practical off-shoot of this has been the establishment of a specific Sami helpline, Girku SOS, working closely with the Church of Norway and offering both a telephone and text-based service).

The research findings argued that the dominant rationales for suicide prevention were addressing shortcoming on individual and relational levels and raising awareness in the general public. But not far behind was the need to broaden perspectives in prevention, planning, improving health systems for Sami and promoting cultural empowerment among the Sami themselves.

From Umea I took two valuable lessons for suicide prevention services. The first is the point made forcibly by Professor Renberg, that it takes infinite patience and time to establish the sort of trusting relationships which make any kind of meaningful research or action possible. When mistrust is the basis of former relationships this is additionally important. The second is an awareness that suicide services have a strong cultural dimension and the traditional model of “one- size -fits -all” may no longer be appropriate particularly for a country like the UK, where Asian, Black, mixed or multiple ethnic groups, for example, are increasingly requiring support alongside the white population.

As we shall see later, MIND a not-for-profit organisation in Sweden, is able to offer translation support for its services in seven languages to overcome language barriers. We have a considerable distance to travel before we too are gearing suicide prevention services to culturally specific considerations.

Learning

- Building culturally sensitive suicide prevention services in order to meet need requires patience, trust and a considerable time scale. It is not a quick fix
- Services and bodies offering suicide prevention need increasingly to be sensitive to the languages and culture in which the services are being offered

5c. Gothenburg

The highest rate of suicide in Sweden is observed in men more than 85 years old (54.2 per 100,000 inhabitants). To address this, Professor Margda Waern, a psychiatrist at Sahlgrenska University Hospital, part of the University of Gothenburg (GU), has built a multi-disciplinary team of bright researchers, including biological medical, psychological somatic and pharmacological specialists who bring a range of perspectives into suicide and depression amongst elderly people. This multi-disciplinary approach allows exploration of how different factors in people’s lives interact to develop suicidal behaviour, depression and other mental disorders. Professor Waern is also keen to counteract what she describes as the “cliché” that suicide among older adults is somehow an expression of “normal” ageing.

The research group works closely with the Department of Psychology and is part of AgeCap, GU’s Center for Ageing and Health. Collaboration extends to research groups in Stockholm, Lund, Orebro and Umea in Sweden and international links with other countries. The research has assumed four major approaches. The first of these is large scale population-based studies: for example, the “Prospective Population Study of Women in Gothenburg” and a separate

study into Women and Alcohol in Gothenburg. The second group are what are described as "Clinical Cohort studies" beginning with medical records and conducting a nationwide retrospective review of medical records of people who died by suicide in Sweden. One of these studies follows the subsequent careers of 804 individuals, who received care after suicide attempts or non-suicidal self-harm (9). A third group of studies – "intervention research"- involved a psychological treatment study for suicidal behaviour amongst elderly patients. These intervention studies looked at a specific training intervention for inpatient staff caring for elderly people with psychosis. The group at Gothenburg have developed innovative thinking about the lack of psychological support that is offered to elderly people.

Aged people, the researchers forcibly argued, generally, don't get access to the same psychological interventions that young people receive and usually don't have recourse to the same sophisticated language and mental health "speak" that has almost become the lingua franca of more recent generations. As a result, one of the team has been offering "existential psychology" to a group of older adults (70+) with suicidal behaviour. Rather than talk about ADHD, "triggering events" or "autistic traits", for example, the language used reflects terms and ideas that sit more comfortably with elderly people- a language of freedom, hopelessness, anger, grief, death or isolation, for example. As part of this work family members are also invited to participate in a portion of the intervention.

The last group of studies are aimed at home care/special housing. Research has looked at attitudes to suicidal behaviour and mental illness among care staff and supervisors in home care/long term care facilities in the Vastra Gotaland region of Sweden. The unit have provided focus groups on suicide prevention work with staff in home care/long term care facilities and have extended this to include interviews with relatives of care recipients in home care settings.

The benefits of this multi-disciplinary approach are easily evident. The team quote an elderly suicidal woman whom, it transpired, had been waiting for a pain reducing operation for a condition she had endured for three years. The combination of delay for the operation, continual pain and an inability to convey to medical staff her frustration had led to despair. The team were able to obtain a date for the operation and the result was an immediate improvement in her mental health. Providing support in a multi-disciplinary context, allowed medical help to be obtained which assisted with other elements of her care.

For the first time, too, since my arrival in Sweden, there was reference to the use of social prescribing. I had imagined, given the progressiveness of so much of Sweden's health and social care, that there would be a considerable investment in the use of social prescribing, across health and social care. But prior contact with the UK National Academy for Social Prescribing revealed that this did not seem to be the case. Where there was evidence it was in the area of loneliness, seen as a public health challenge in Sweden. The Gothenburg researchers, however, were able to quote a study which revealed a home care assistant who was permitted by the social care agency to use her allocation of time to drive an elderly person to a day centre to reduce her social isolation. In another example a carer took an elderly man to a relative's grave, which he had requested, rather than doing the usual domestic tasks for him.

This brief analysis hardly does justice to the work of researchers in Gothenburg or, indeed Umea and Stockholm. It is snapshot of what is a broad attempt to address suicide prevention from a range of differing research perspectives. It tries to answer, from a research

perspective, Dr Hadlaczky's statement that we still do not understand what leads people to commit suicide. It makes the point that behind the need for an holistic operational strategy is the equal need for sound research which will underpin and evaluate health and social care services.

Learning

- The benefit of adopting a multidisciplinary approach to suicide prevention research
- Attention needs to focus on elderly people who don't have access to the language or practice of some psychological interventions and may be ignored by services

Having begun the Fellowship by learning about Sweden's ten-year suicide prevention strategy and the work of three research departments, it is now appropriate to turn to the services themselves.

6. Hjalplinjen

While the 10-year Swedish suicide strategy does not make specific reference to many existing or planned services, it does single out the establishment of a new helpline, Hjalplinjen. Sweden already had in existence two state funded and national helplines- one for drug and the other alcohol abuse which had been running for between five and 10 years. In Summer 2024 the decision was taken to set up a third to assist suicide prevention. It was to operate 24/7 and be part of Public Health Stockholm. But while part of the public health care system, the callers were to be anonymous.

The dedicated use of professional staff to a service that would be a national helpline created a hugely different model from, say, Samaritans, with its 23,000 volunteers. Miriam Jacobson a psychologist and deputy manager of Hjalplinjen emphasises that, at the beginning of contact, it is made clear that the call will last approximately 30 minutes- 10 minutes for the "history taking", 10 for exploration and 10 for solutions. Mindful of the explosion of mental health referrals, the staff are able to separate out the less urgent calls without being "kidnapped", as Miriam expressed it, by calls which are more an expression of the human condition. Hjalplinjen sees itself as a dedicated mental health service, not responding to the increasing problems of loneliness or autism, for example, but much more specifically focused.

But the system has further directed intervention. Being a helpline which covers the whole of Sweden there are sometimes delays in answering calls. While waiting, callers are provided with signposts to other forms of support, websites or organisations. Callers are also invited to hold on until the call is answered or to be phoned back and there is a text-based service, like the Samaritans Online Chat, with a slower reply time, for those who prefer this. Two more differences distinguish the Swedish helpline. Miriam is keen to emphasise that the professional staff "own" the talking, may make demands on the callers and, while remaining non-judgemental, can advise with actions that callers might follow. The service is also planning to offer some callers a course of the widely used Cognitive Behaviour Therapy, where this is felt to be appropriate. The helpline is also able to refer on to psychiatric services when this is deemed appropriate.

Staff employed by Hjalplinjen work long shifts under what is considerable pressure. During the course of a shift they will move from taking telephone calls to online chats, simply to vary pace and pressure. But, according to Miriam, there appears to be little difficulty attracting staff who welcome the fact that there is, unlike other aspects of the health care systems, little administration and about 97% of their time is spent in direct contact with callers. Staff felt liberated from other statutory agencies, where they felt compelled to spend higher levels of time in administration, record keeping etc.

Two striking issues arise from the Hjalplinjen model. The first is the wholesale embracing of AI, particularly to signpost callers to other services or suggest websites or organisations that might offer assistance. This also has the advantage of providing some kind of contact while callers are waiting to speak to one of the Hjalplinjen staff but also can serve to divert some callers to other solutions. As we shall see from MIND, another service that has embraced AI, the potential of this technology is undoubtedly still in the initial stages of development.

The second issue links together the use of volunteers and the large rise in mental health referrals. In the UK alone which, in some instances mirrors Sweden, membership of the British Association for Counselling and Psychotherapy has almost doubled since 2010 from 33,000 to 60,000 and a YouGov survey from 2021 showed 85 per cent of us agreed that "it is a good idea to seek counselling or psychotherapy for a problem before it gets out of hand" (Sunday Times January 16, 2022 (9)). Furthermore, a Guardian Opinion piece of the same year calculated 1.6 million people are on waiting lists for mental health services, while another 8 million need help but cannot even get on these lists. As the Guardian article dramatically asserts, "even children are showing up at A&E in despair, wanting to die". (Guardian, 6 September 2022 (9)).

The response of Hjalplinjen to this mental health epidemic is the use of professional staff; they can triage callers, provide skilled support and where appropriate refer on to other psychiatric services. The discipline of making it clear from the outset that calls will last 30 minutes represents an approach which is probably only possible with professional staff, who have the confidence and experience to direct the way calls progress. But it is very different from the tradition of Samaritan calls, dealt with by the army of 23,000 volunteers who receive training but would not claim to be professional mental health specialists. The statistic that mental health/illness calls are the top category of Samaritan referrals, followed by family and then isolation/loneliness provides further evidence of how real this mental health epidemic is becoming.

Given the almost overwhelming pressure from mental health referrals, the question has to be raised as to how long the Samaritans' position remains sustainable. Firstly, because they cannot offer skilled mental health advice despite the wish of callers and secondly, because the service may reach a stage where it simply cannot cope with the sheer volume of callers. A recurrent theme during my Fellowship in Sweden was the dilemma of voluntary versus paid services.

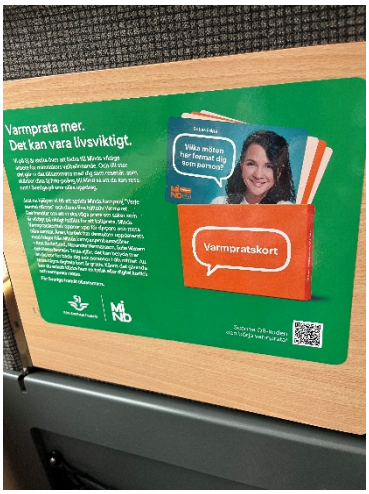
In 1970 Richard Titmuss wrote The Gift Relationship (11), which is ostensibly an account of the blood donor service in the UK but, is cleverly about altruism more widely. Titmuss argues that the blood donor service in the UK is more successful and healthier (in terms of blood contamination) than, say, the USA. Because it is free; people feel they are paying something back into the NHS and it feeds into a climate of altruism that is more than happy to offer something for nothing.

It is the same spirit that led to the establishment of Samaritans; building telephone help and support into first a national and later international network of call lines. From its origins in 1953 Samaritans can evidence receiving a total of 134 million calls and continues to provide a 24/7 service 52 weeks a year. During the last 72 years it is little more than a cliché to say that society has been transformed. As well as the explosion in mental health, previously referred to, mobile phones and social media have come to dominate life and social, economic and political pressures have increased enormously. Samaritans are inevitably constrained by the income they can raise, a predominantly older group of volunteers and systems that may not be as appropriate for the 21st century as they were for the20th . And at the heart of this is the use of volunteers, as opposed to some paid staff.

The following inconvenient truths will need addressing:
*Is it sustainable to provide the present service solely with volunteers?
* How does an organisation like Samaritans respond to the huge growth in mental health admissions?
* How can Samaritans harness AI and new technology to strengthen its services and what would this look like?
* Is it possible (and this also falls into the consideration of MIND outlined below) for one helpline to fulfil the increasingly complex range of calls currently embraced by Samaritans?

Learning

- To explore with Samaritans the findings from Sweden and the questions listed above which they raise



7. MIND

In many ways my contact with MIND continued the dialogue and questions which Hjalplinjen prompted. MIND is a nonprofit organisation, first established in Sweden in 1931 and now employing 45 staff and approximately 750 volunteers. Much of this growth has come during the last ten years. The vision embraces the concept of “compassionate support” and its CEO Rickard Bracken asserts that the overriding aim is to achieve a society that promotes mental wellbeing, in which people receive the support they need, abnegating the feeling that they have to take their life. The organisation’s 2025-28 strategy encompasses a

threefold aim of support, political influence and the creation of a sustainable organisation. As well as the services they run, they also see themselves very much involved in political influence and advocacy for better services.

The foundation of MIND's services is that they don't offer one but several helplines tailored to different needs:
Crisis and mental health support
* The first of these is the MIND Sjalvmordslinje (suicide line) "for those suffering from mental illness and have thoughts of taking your own life". It is an anonymous service.
* Secondly, MIND Livslinje (Lifeline) a chat service for young people aged 16-25, to discuss "what feels difficult in life".
Support by life stage or role
* MIND Aldrenlinje (Age Line) which provides a service for elderly people who are feeling unwell mentally or just longing for someone to talk to. As the literature asserts " a supportive conversation with someone who listens can be both nice and relaxing".
* MIND Foraldralinje (Parent Line) is aimed at those who are parents or close relative, both of small and large children and who have concerns about parenting or questions relating to child development.
Peer to peer and community support.
* MIND Forum "which is a moderated online support forum, where you can talk with others who are logged into the forum network. Here you can talk anonymously about life, give and receive support"

There are here some important questions about the decision to split the helplines for what are, in some cases, different age groups. In the UK, the two main helpline services are Childline, for children and young people under the age of 19 and Samaritans, mainly for adults although Samaritans do also receive a sizeable number of calls from children and young people. Essentially it means that Samaritan volunteers could, in the one shift, be alternating between a highly fraught suicide call to a lonely elderly person, prisoner or man or woman devastated by the breakup of a relationship. For MIND not only does the separate chat lines make it easier to focus on the call, but, like Hjalplinjen it means that focused supporting material can be provided while callers are waiting. The Parent line is a good example of this, where callers are directed to support material for parents and those caring for children.

MIND also offers follow-up support to the suicide helpline, providing BCI or Brief Contact Intervention. Callers are offered up to seven follow up calls within a 12-month period as a way of containing the issues and diverting callers away from statutory services. Callers can also be offered repeated text messages, postcards and letters, helping to provide a temporarily constituted social support network around people who otherwise lack it. It will come as little surprise to learn that MIND also use paid, professional staff, particularly for the night times, when demand can be high and volunteers are reluctant to become involved.

MIND's strategy extends to support for young people, hoping to equip them for life by promoting good mental health, as very much part of Sweden's public health agenda. This is done by promotional material for schools and moderated chat-lines, supported with expert council, reference groups and young referees. The production of leadership training material and prompt sheets that can be used for study material are very much focused on increasing knowledge amongst young people about mental illness in order to strengthen their skills to help both themselves and others.

MIND has also been very active in work on preventing suicide on the transport system, through a 2024 rail project. Calculating that there were approximately 135 suicides on the transport system annually, MIND put up posters in all of the 100 stations on the Stockholm metro and 53 stations used by commuter trains. Extra posters were provided for ticket halls and barrier lines and although MIND are cautious not to overclaim for the results of this initiative, they remain "cautiously optimistic" that, at the initial stages of evaluation, it had a positive effect on the numbers of those taking their lives on the railways.

Like Hjalplinjen, MIND have enthusiastically embraced AI. Again, this involves providing on-line signposting to websites, while callers wait for the phone to be answered and includes a range of written information which can be accessed via the organisation's website. From a very superficial understanding of Swedish life, it does feel as if there is a greater willingness than in the UK to embrace and access information on-line and it could be that it helps prevent the need for some callers to have recourse to a direct phone call.

But MIND's use of AI goes further than this. While aware of the ethical issues, MIND are aiming to transform recorded calls into transcriptions- with all personal and confidential information redacted. The aim is to look at the nature of the interaction between caller and volunteer. It can then be used for training purposes and provide valuable information about the nature of suicide calls and what might work when dealing with challenging interactions. Clearly there are complicated issues connected with confidentiality and the collection of data, which need to be very carefully unravelled. But it does feed into Dr Hadlaczki's earlier quoted statement that we still don't know much about why people commit suicide.

Reference has been made to MIND's use of moderated chat lines. The not-for-profit organisation would argue that it provides a particularly useful tool for young people and the hope is that it will, again, alleviate the need for more serious intervention. MIND have produced some useful material, indicating that adults don't always have a very accurate recollection of what it is to be a young person with all the challenges they face. They would doubtless add, from the way that the service is set up, that there is something very powerful about sharing experiences with other young people, if only to understand that problems can be shared.

Two notable aspects of MIND's work are its multilingual services and commitment to advocacy. MIND offers interpretation in seven languages, reflecting Sweden's diverse society. Additionally, MIND takes an active role in raising awareness about suicide and mental health, influencing social awareness about suicide and mental health. It also seeks to shape social policy through the use of ambassadors who promote improved services, fundraising, plus mental health education.

Learning

- Consideration needs to be given as to how digital advice services could be made more widely available, to support the work of the help lines
- An examination of whether the differing requirements of various groups now mean that they will need their own specialist helplines
- Further discussion is needed as to whether the staffing of helplines at peak and unsocial hours will ultimately lead to a salaried/professional service here in the UK
- Much more research is needed into the further potential of AI as a training tool for volunteers

8. PAM-Enheten

Pam-Enheten, the most widely reported suicide prevention service in Sweden, was originally developed in Stockholm and now operates also in Gothenburg and Malmo. Rebecca Almeran, a specialist nurse in psychiatric care, who is a key member of the Stockholm services, explained that the psychiatric services in Stockholm were determined that, following suicide attempts, they did not want admissions to psychiatric hospitals to be made by the police. (A move which reflects the Metropolitan Police's *Right Care, Right Person* initiative (ibid)). Before the service was set up there were about 15 police transports to the psychiatric emergency department every day.

Pam-Enheten aims to reduce suicide attempts and visits to psychiatric emergency departments by providing mobile care to the population. The service features specialised ambulances staffed by paramedics, psychiatric nurses and essential medical resources. Rebecca describes it as mobile care, administering to Stockholm's 2.44 million population and working to reduce the 1,500 suicide attempts in the region every year, the 350 suicides and the 20,000 visits a year to the psychiatric emergency departments.

Calls to PAM-Enheten are triaged and responded to under emergency protocols. The service's primary focus is on acute mental illness; cases involving suicidal threats and is entirely state funded. The majority of callers are between the ages of 25 and 64 with an equal distribution between men and women. In terms of calls, the majority are in the 25-44 age group (41%) with those between 45 and 64 providing a quarter of callers. Calls are equally distributed between men and women.

Rebecca is careful to emphasise that this is an acute service, responding to conditions that can lead to injury to the patient or others, significant deteriorations in their medical condition or severe damage to property. Responding to questions about the huge upsurge in mental health referrals, Rebecca was quick to assert that this is not a service for those with less serious mental health conditions. "Life", as Rebecca wryly asserted, "is not a psychiatric condition", and the ambulance is only used for serious crises, often when a compulsory hospital admission is necessary, when there is a risk of/ or ongoing suicide attempts or an acute psychiatric condition .The reality is that the hours during which the service operates are being extended and the government are prepared to put more money into the scheme, and it

testifies to a service that has huge political support, as well as attracting international attention.

While gaining interest and in some cases emulation from a number of other countries, it is only operating in three of Sweden's major cities and could prove problematic in rural areas, where distances between populations could be greater and responding in a reasonable time scale more difficult. Given the repeated argument that significant amounts of police time are inappropriately devoted to mental health crises, PAM -Enheten guarantees that it is a dedicated psychiatric service where police engagement is usually only used for the protection of the psychiatric staff. As the UK responds to the epidemic in mental health referrals, the PAM-Enheten model deserves further consideration.

Learning

- Sweden's PAM-Enheten service to be considered alongside other models for the management of acute mental health illness/suicide community services

9 Conclusions and summary

In this final part of the report, I hope to extract overarching themes, which emerged from the study of Sweden's suicide prevention services. Inevitably they interlink, occasionally contradict and never cease to demonstrate the complexity of health and social care policy. In the film *The Paleface,* the cowardly Bob Hope finds himself in a gun fight with the town's notorious gunslinger. As he walks down the main street, in preparation for his high noon shoot-out, Bob Hope is offered whispered advice behind locked doors as to how he can win. "The wind's in the east, so shoot to the west". "He shoots from the right, so lean to the left" being rough accounts of the advice proffered which, not surprisingly, succeeds in muddling the pusillanimous Bob Hope. Suicide prevention can seem a little like this- the more you experience and the more advice you get, the more complex it becomes!

Indisputably, the overarching issue, from which others spring, is the rise in mental health referrals which both Sweden and the UK are sharing. In the UK this is usually attributed to the "trauma" of the pandemic coupled with the cost-of-living crisis, causing hardships for thousands of families. Dr Sarah Hughes, the Chief Executive of MIND UK was quoted as saying "The nation's mental health is deteriorating and our system is overwhelmed, underfunded and unequal to the scale of the challenge" (Mind Press Release, 3 July, 2025 (12)) Under the NHS ten-year plan (13), the government has announced improvements to existing mental health systems and, of note, an intention to harness technology to assist in the provision of 24 hour care. But an open mind is needed as to how far this epidemic is fuelled by a society that has taken on the language of mental health and assumes, in the adapted words of Rebecca Almeran from PAM-Enheten that life is indeed a psychiatric condition. From time-to-time arguments about "grit", mental toughness or the perseverance needed to achieve positive mental health surface, and earlier in 2025 both the Ministers of State for Health and Education, put their heads above the parapet, arguing for children to be taught resilience in their responses to what life sometimes throws at them.

The rise in mental health referrals poses two critical questions: the role of paid vs volunteer staff and the need for specialized care. While the UK provides various mental health services, Samaritans, the primary suicide support provider is entirely volunteer based. This aligns with Richard Titmuss' The Gift Relationship which examines altruistic attitudes made with no explicit or implicit right or wish for a return gift or reward. The point was made that this is as much at the core of Samaritan's work, as it is in the UK's blood transfusion services. However, with immense societal changes since 1953, it is crucial to assess if Samaritans' model can handle the complexities of modern mental health challenges effectively.

As we saw in both MIND and Hjalplinjen, these services are unapologetic about the use of professional (and paid) staff both to triage calls, refer on when appropriate and, in an increasing number of cases, provide time limited behavioural treatment. It would represent a huge sea change for Samaritans to take on either paid staff, who would occupy those tricky to fill overnight and unsocial hours shifts or professionally trained experienced staff (who may or may not be paid) to deal with the mental health referrals.

This discussion is inextricably linked to the issue of specialist help lines. MIND provided ample evidence of Sweden's experience of requiring separate helplines for differing groups. Again this is very different from the Samaritan model where, during a three-hour shift, a volunteer might, for example, take a call from a lonely widow needing company, a prisoner on a noisy wing worried by bullying or a young person who wishes to report being abused by

an adult. Today, according to Samaritans, 1 in 5 calls is about suicide, begging the question as to whether the role has become too dissipated and needs the more specialist, dedicated helplines that Sweden offers, particularly since only about two thirds of calls to Samaritans get through.

Two solutions are possible, both requiring a significant change for the Samaritans. The one would involve the organisation becoming more focused on suicide, with some other option(s) for the range of other callers that they receive. This could result in the kind of specialist helplines that exist in Sweden and run by MIND. An alternative is a dedicated suicide line, run by therapists and more closely plugged into existing psychiatric services. This would leave Samaritans free to concentrate on the four out of five calls from those with serious needs but not imminently contemplating suicide. These are far from simple choices, but as the volume of calls grows, the ability of organisations like Samaritans to cope appropriately with the sheer volume of calls will diminish.

Inextricably bound up in this is the medium to long term ability of Samaritans to survive solely with volunteers. It is much less of an issue in Sweden where there is not the very strong voluntary sector history and tradition of sustained volunteering and so the decision to involve paid staff to run suicide lines was perhaps more easily taken. For Samaritans - where the volunteers tend to be in the older age groups -it is also increasingly more difficult to fill shifts in the middle of the night where the need can be greatest. Working people may find it difficult to do a night shift and then appear for work the next day. The inclusion of paid staff for night sessions, while considerably increasing costs and potentially having a demotivating impact on volunteers, would provide another possible solution to the volunteer versus specialist dilemma.

More learning can be taken from Sweden from both the role of public education and that of peer support. Public education falls very much under the remit of Sweden's ten-year suicide prevention strategy and, in parenthesis, links in with earlier advocacy of a wide range of agencies to embrace a comprehensive suicide strategy. Dr Hadlaczki at the Karolinska Institute was keen to discuss projects to promote positive mental health in schools, involving discussion in class, role play and other interactive means of engaging children and young people. The emphasis is firmly about ways of achieving positive mental health, rather than the medicalisation of what are often the everyday stresses and strains of being human.

Similarly, as we saw from MIND helplines, the inclusion of moderated groups, peer to peer support and advice through other websites provide ways into debates about mental health that may be more in keeping with other areas of young people's lives and the way they communicate. Significantly, the on-line chat service, launched by Samaritans in 2020 to accompany the telephone service, tends to attract younger people for whom texting is a preferred and more natural method of communication. It may also point to another view that with an increasingly complex society we need different strategies for different age groups. So, in an ideal world, for example, a chat line for elderly people, like the MIND model, might sit alongside online chats or web-based services for other groups.

In parenthesis, before visiting Sweden I had expected to find the same engagement with social prescribing as is increasingly being seen in the UK. Contact with the College of Social Prescribing suggested that it was not as widely embraced as a preventive strategy as is happening in some parts of the UK. A Swedish community nurse gave examples of specific projects aimed at alleviating loneliness, as possibly the green shoots of a social prescribing

agenda. Reference was also earlier made to Dr Waern's unit in Gothenburg where a home care service offered social prescribing, rather than the usual domestic services, but on questioning other services during my Sweden visit, social prescribing was not part of their everyday preventive armoury.

Lastly, in terms of overarching themes, the need for a strategy that takes in health, education, social care, the voluntary sector, business, government at both a local and national level, planning, law and all the other aspect of our complex society is overwhelming. Suicide prevention needs to be tackled in a holistic way, if we are truly serious about reducing the numbers of those who annually take their lives.

We have progressed a considerable distance from the days when those who killed themselves were buried in unmarked graves. But 720,000 deaths from suicide every year are witness to the fact that there is still much to do. What emerged from my Churchill Fellowship was the determination and inspiration to build services that did everything to save lives. A determination in Samuel Beckett's words to "Ever tried. Ever failed. No matter. Try again. Fail again. Fail better."

The challenge of suicide prevention statistics is that you will never know for sure how many lives have been saved and by which initiatives. What is not in doubt is the absolute determination by thousands of professionals and volunteers to offer those feeling "hope-less" and in despair a little light in the darkness.

Learning.

- The challenge of volunteer versus paid and/or professional staff needs to be grasped.
- Further research is needed on the advantages of specialist help lines for different age groups
- The relationship between the mental health epidemic and suicide prevention requires further research
- The need for an overarching strategy, involving a wide range of agencies is overwhelming

10. Next Steps

I hope to move forward in two ways:

1. Specific recommendations to Samaritans UK. This is timely, as, in 2025, the organisation is in the process of planning a new strategy which will guide the next few years of its development.

2. Separate recommendations to the UK government, through the Parliamentary Under Secretary of State for Mental Health.

11. Recommendations

1. That a UK suicide prevention strategy needs to include health, social welfare, not- for-profit organisations, business and commerce, public services and research at a national, regional and local level.
2. That a workable suicide strategy needs to be underpinned by a robust research arm.
3. Focus on young people and mental health prevention will help to stimulate the suicide prevention agenda.
4. Small scalable interventions, like adapting the railway system, can help suicide prevention.
5. Suicide prevention strategies need to be culturally sensitive and patiently built over time.
6. Suicide prevention services need to be delivered to communities in appropriate languages.
7. Suicide prevention research needs to be undertaken by multi-disciplinary teams.
8. Services should ensure that the needs of elderly people are not ignored but integral to any suicide strategy.
9. Future strategy needs to investigate whether it is sustainable to provide a purely volunteer led national helpline and whether professional/paid staff are now required.
10. To explore how suicide prevention services respond to the large growth in mental health referrals.
11. To grasp the potential that AI and new technology offers to suicide prevention services and as a training tool for volunteers.
12. To consider a range of specialist helplines, in order to accommodate the increasingly diverse range of callers.
13. Experimentation to see how digital advice services could assist the task of helplines.
14. To investigate whether mobile suicide units have a place in the armoury of suicide prevention strategies.

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September 2025