

REPORT

SAMARITANS

Centre for
Mental Health



Strengthening the frontline

Investing in primary care for effective suicide prevention

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Executive summary

Suicide is a major public health problem. Around 6,000 people die by suicide every year in the UK, with someone taking their own life every 90 minutes (ONS, 2018; Samaritans, 2018). These deaths are devastating and shatter lives.

Suicide prevention is often only seen as an issue for mental health services, yet around two-thirds of people who take their own lives aren't in contact with mental health services in the year before they die (NCISH, 2018a). Many, however, visit their GP in the months before their death. Primary care therefore has a crucial role to play in identifying people who could be at risk of suicide and ensuring they receive appropriate treatment and care.

This report looks at the changes that are urgently needed to strengthen suicide prevention in primary care. Centre for Mental Health worked with Samaritans to carry out this research. We conducted a review of the literature; we put out a 'call for evidence', asking experts in this area to submit information about best practice; we surveyed people who had personal experience of seeking help in primary care for suicidal feelings; and we interviewed GPs from across England.

Our research found five areas in need of improvement:

1. **Education and training:** there is consensus that education is crucial to suicide prevention and that more needs to be done to enable GPs to access effective, ongoing training.
2. **Primary care practice and staffing:** people told us that the therapeutic relationship between patient and GP needs to be a

priority. However, many aspects of primary care, such as short appointment times and staff who are already working at full capacity, are not compatible with this.

3. **Emotional support for GPs:** many GPs are not getting the support they need with their own emotional wellbeing, particularly following the death of a patient by suicide.
4. **Effective care pathways for people who are feeling suicidal:** there is little evidence of effective pathways between primary care and both clinical and social support.
5. **Ease of making referrals and accessing further support:** many GPs face considerable challenges referring patients on to further support. These include high thresholds for eligibility, variation in availability of services and lack of access to expert advice.

Recommendations

To address these issues, government should:

1. Roll out evidence-based suicide prevention training for existing GPs on an ongoing and easy-to-access basis, and ensure that it is sufficiently covered in the curriculum for new GPs.
2. Expand training for GPs so all trainees are given adequate exposure to patients who are at risk of self-harm and/or suicide, and are provided with the skills to recognise, treat and manage depression.
3. Invest in emotional support services to ensure that all GPs have the support they need with their own wellbeing.

4. Develop and evaluate care pathways for people with suicidal feelings and people at risk of suicide, as part of the implementation of the NHS Long-Term Plan and the national suicide prevention strategy.
5. Direct social prescribing towards local areas with the highest rates of suicide as a priority, to improve access to social and community support for people experiencing suicidal thoughts and/or at risk of suicide.
6. Ensure safer prescribing for people at risk of suicide, in order to improve and strengthen risk assessment by prescribers and to reduce access to potentially harmful medication.

Local policymakers, including Integrated Care Systems, should:

7. Establish liaison arrangements with mental health professionals to offer guidance and support when GPs need specialist input for working with suicidal patients.
8. Ensure primary care representatives and social prescribing link workers are represented in multi-agency suicide prevention groups and consult widely with these groups when determining priority interventions.

And GP practices should:

9. Support continuity of care, monitoring and follow-up of people identified as being at risk of suicide by, for example, offering appointments with the same GP, establishing practice-wide policies on suicide prevention and actively seeking contact with at-risk patients who disengage.

Introduction

Despite a welcome reduction in the number of people who have died by suicide in recent years, there is still a long way to go. Latest figures show that 5,821 people across the UK took their own lives in 2017 (ONS, 2018). Suicide is complex and there is rarely one reason behind it. Mental illness, particularly depression, is an underlying factor in most suicides (Rihmer, 2011). Additionally, many societal, economic, individual and environmental factors interact to increase a person's risk, and in some cases shock life events and changes in circumstances can play a significant role (O'Connor & Kirtley, 2018).

Proactive community-based interventions supported by responsive primary care services are crucial in addition to effective mental health services. They are particularly important given that less than a third of people who died by suicide in England between 2006 and 2016 were in contact with mental health services in the year before their death (NCISH, 2018a). In contrast, many people who take their own life are in contact with their GP in the months before they die, with estimates ranging from 32-66% in the month leading up to their death and 75% in the six months before (Pearson *et al.*, 2009; Saini, 2015; Leavey *et al.*, 2017). While it is not known why people had GP appointments during this period, contact with primary care could be an opportunity both to recognise distress and to build a strong therapeutic relationship that may enable a person to ask for help, either at that time or at another point in the future.

Over the last decade good progress has been made by policymakers to reduce suicide:

- In 2012, the UK government published its national suicide prevention strategy, which set out groups at higher risk and priority areas for action;
- A national target has been set to reduce suicide by 10% by 2020/21;

- New National Institute for Health and Care Excellence (NICE) guidelines on how to prevent suicides in community and custodial settings have been published;
- Nearly every local area in England now has a multi-agency suicide prevention plan in place;
- A cross-government work plan has been published;
- And, as we move towards Integrated Care Systems, all local health systems are expected to develop cross-organisational five-year plans to be implemented from August 2019 on how they will deliver the ambitions within the Long-Term Plan, which include a continued focus on multi-agency work to prevent and reduce suicide (Department of Health, 2012; NHS England, 2018; NICE, 2018; NHS, 2019).

However, there is still often a disproportionate focus on reducing risk for those in contact with secondary services. While it is clearly important to ensure lives are saved amongst this group, many people who are at risk of suicide do not access these specialist services and are often not reached by formal interventions (NHS Digital, 2016). This problem is compounded by a lack of access to, and availability of, wider community services, social support and public health services.

Effective suicide prevention within primary care is critical to deliver on these national policy objectives and to reach at-risk groups, particularly those who might not openly ask for help or support. While the importance of primary care in suicide prevention is reinforced across government policy documents, in practice much more still needs to be done to strengthen primary care and help save lives. To this end, in this report we look at the evidence for best practice in identifying and supporting people who are at risk of suicide, before proceeding to discuss what needs to happen to embed this practice in primary care.

Methodology

This report focuses specifically on the role primary care can play in preventing suicide in individuals who are experiencing suicidal thoughts or who are at a high risk of suicide. While the work of primary care encompasses many areas and many professionals, we have focused predominantly on the role played by GPs.

The research that forms the basis of this report was carried out between June 2018 and January 2019. The report brings together findings from multiple sources:

- A review of the academic and professional literature.
- Responses to an online survey on suicide prevention in primary care from individuals who had visited their GPs when they were experiencing suicidal thoughts and feelings. The survey was circulated on social media by Samaritans and Centre for Mental Health. It was completed by 38 people (82% female).
- ‘Call for evidence’ responses from 16 organisations and individuals involved in the field of suicide prevention. Submissions included training programmes, safety planning and risk assessment tools, and follow-up interventions. The call for evidence was issued through Centre for Mental Health’s and Samaritans’ networks and social media channels.
- Semi-structured interviews with nine experts in suicide prevention and/or primary care: five GPs (including clinical commissioners) with a special interest in mental health, two academics, one campaigner and one director of public health.

What do we know about best practice in suicide prevention?

This section of the report will summarise what is known about best practice in primary care. Where possible, it will identify what has been shown to work specifically for people who are feeling suicidal and those who are at risk of suicide. It will also highlight areas where knowledge is insufficient to determine best practice.

Identifying people who are at risk of suicide

Overview

- There are a number of evidence-based characteristics or risk factors commonly associated with people who die by suicide.
- An understanding of these factors and the complex ways they interact is an essential starting point for identifying people who may be at risk of suicide in primary care.
- To identify people who are at risk of suicide, this understanding must be combined with information about the feelings of the individual patient – information which often depends on the patient putting their feelings into words.
- Crucial to facilitating this communication are the mental-health-friendliness of the practice as a whole and the skills of the GP in forming a relationship with their patient.
- Once a patient has communicated that they are feeling suicidal, standardised instruments are of limited value for determining treatment; instead the focus should be on identifying the person's individual support needs and exploring how these could be addressed.

Evidence-based risk factors

Suicide is complex and there is rarely one reason behind it. However, there are several characteristics or risk factors commonly associated with people who die by suicide. The evidence supporting these characteristics is well established and widely recognised. At-risk groups include:

- Men (men are three times more likely to die by suicide than women);
- People in the age group 40-44 years;
- People in the care of the mental health services;
- People with a history of self-harm;
- People in contact with the criminal justice system;
- People who have been bereaved or affected by suicide;
- People living in areas of higher socioeconomic deprivation;
- People who are unemployed;
- People working in the least skilled occupations (e.g. construction workers);
- People with a low level of educational attainment;
- People who do not own their home (Samaritans, 2017; DHSC, 2019b).

A study by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness looked specifically at primary care patients who died by suicide. It identified the following markers of risk:

- Frequent attendance, increasing attendance or non-attendance;
- Multiple psychotropic drugs, and specific drug combinations such as benzodiazepines with antidepressants;
- Mental health diagnosis, especially depression (NCISH, 2013).

Of these, depression has been shown to be a particularly important target for intervention.

A large-scale systematic review of suicide prevention strategies noted that “a key prevention strategy is improved screening of depressed patients by primary care physicians and better treatment of major depression” (Mann *et al.* 2005, p. 2065). This has been recognised in the cross-government suicide prevention strategy and workplan which recommend improvements in the identification, treatment and management of depression in primary care (Department of Health, 2012 & 2014a; DHSC, 2019b).

In addition, Public Health England has developed a Suicide Prevention Profile tool (PHE, n.d.). The tool collates and presents national and regional data on suicide, covering information such as associated prevalence, risk factors and service contact. It can be used by primary care to understand trends in suicide rates specific to their local area. Awareness of these markers of risk – national, regional and those that are shown by primary care patients – is an essential starting point for suicide prevention.

Clinical and communication skills

In order to increase the success of identifying people who are at risk of suicide, information about at-risk groups must be combined with information about the individual patient. Therefore, it is essential that (1) the patient is able to communicate their feelings and (2) the GP is able to recognise and facilitate this communication.

The groundwork for the success of this encounter may be laid before a patient feels suicidal. Every interaction a patient has with the practice or with their GP has the potential to affect how ready and able they will be to talk about their mental health in an appointment. If, ultimately, they don't feel able to do this – and evidence indicates that a majority of patients who die by suicide do not – then primary care's best opportunity to identify the risk and to intervene will have been missed (Pearson *et al.*, 2009). Hence, creating a mental health-friendly primary care practice and building strong relationships with patients are vital preliminary steps towards suicide prevention.

Ideally, from the perspective of suicide prevention, this relationship will be with one

GP who sees the patient for as many of their appointments as possible. This is because, if a GP knows the patient and has a sense of what is normal for them, they will be in a better position to notice if something is wrong; they will not be entirely dependent on the patient volunteering the information. However, in many cases, often owing to practical challenges in the workforce, such as limited appointment times and workload pressures, the GP will not know the patient well, if at all.

In these circumstances, much depends on the patient putting their feelings into words. But when it comes to a subject such as suicide that is plagued by stigma and myths, this is not necessarily a straightforward thing for the patient to do. Responses to the survey included the following comments: “[suicide] is a scary thing to talk about” and “it's a difficult subject to broach”. The fears of respondents included being judged, not having their feelings taken seriously and losing control of the situation because they had crossed “the risk assessment red lines”. As a result, patients may imply that they are feeling suicidal without saying it directly, or book an appointment for a physical health problem to “test the waters”, only talking about their feelings at the last minute, if at all (Michel *et al.*, 1997; Robinson & Roter, 1999). Therefore, GPs need the skills and time both to recognise the behavioural and verbal cues provided by the patient, and to help the patient feel safe enough to talk openly and honestly about their feelings.

Standardised tools, such as the Patient Health Questionnaire (PHQ-9) and the SAD PERSONS Scale, may play a role in facilitating this conversation. However, as NCISH has noted,

Clinicians tell us that tools, if they are used, should be simple, accessible, and considered part of a wider assessment process. Treatment decisions should not be determined by a score. Risk tools and scales have a positive predictive value of less than 5%, meaning they are wrong 95% of the time, and miss suicide deaths in the large ‘low risk’ group. [...] Risk is often individual, suggesting the management of risk should be personal and individualised.

NCISH, 2018b, p. 13

Similarly, NICE (2011) recommends:

- That risk assessment tools and scales are not used to predict future suicide;
- They should not be used to determine who is offered treatment and who is discharged;
- Instead, a psychosocial assessment should be carried out.

Once a patient has indicated that they are feeling suicidal, the emphasis should not be on trying to quantify and categorise their risk in a standardised format; instead, a more clinically useful approach is to assume the risk is serious and to move on to thinking about how best to support the patient as an individual (Hawgood & De Leo, 2016; Cole-King & Platt, 2017).

Supporting patients who are at risk of suicide

Overview

- The value of relationships in suicide prevention should not be underestimated.
- A positive therapeutic relationship is not only the context in which suicide prevention takes place but also a protective factor in its own right.
- Everyday aspects of good clinical care, such as listening to patients and treating their feelings with compassion and respect, are disproportionately important for patients who are feeling suicidal.
- Continuity of care, including offering appointments with the same GP and actively following up with the patient, are also crucial.
- Relationships beyond primary care, such as family and community, are a resource that can be drawn on to support patients at risk of suicide.
- In addition, there are several structured interventions that can be carried out within primary care to keep the patient safe while they wait for further support.

- These include psychosocial assessment, safer prescribing, and monitoring and follow up.
- For some patients, these measures may be sufficient; but others will require further support beyond primary care.
- Currently, such support is not widely available and little research has been done into what it should look like if it were to exist.

Relationships

“There can hardly be any doubt that a trusting and consistent relationship with a health professional is of eminent importance.”

Michel (2000, p. 668) on suicide prevention in primary care

This report has already touched on the centrality of the doctor-patient relationship in identifying risk of suicide and, in online survey responses, the therapeutic relationship came up repeatedly as the most positive aspect of the participants’ experiences in primary care. They reported that nothing was more important to mitigating their suicidal feelings than being listened to and being believed. Participants repeatedly emphasised that their GPs “actually listened” and “took [their] feelings seriously”. They also mentioned other aspects of the therapeutic relationship that had made a difference to them, including the quality of the GP’s presence (“supportive”, “understanding”, “thoughtful”, “caring”, “empathetic” and “kind”), being treated as partners in decisions, and being given longer appointments, last minute appointments or end-of-day appointments – further proof, they felt, that their GPs actually cared.

The premium these individuals placed on what many GPs would regard as simply good clinical practice is understandable when seen in the light of their feelings and expectations. Participants described how, when they were suicidal, they believed they were “unworthy of help” and that people would be better off without them. They also described past

experiences of having their feelings brushed aside. One woman wrote about how a previous doctor had told her “just not to think those negative thoughts”. Set against this backdrop, seemingly everyday aspects of the GP’s care, such as listening to and treating patients with respect and compassion, can be remarkably powerful – so powerful that they are therapeutic in their own right.

These findings are in line with other research. Guidelines for supporting individuals at risk of suicide emphasise the importance of developing trusting working relationships from the outset, treating the person with respect and listening to them (Michail & Mughal, 2018; NCCMH, 2018a). Research suggests the power of the therapeutic relationship to mitigate suicidal distress comes from its potential to foster feelings of hopefulness, connectedness and being cared for (Collins & Cutcliffe, 2003; Cooper *et al.*, 2011).

Continuity of care is another protective aspect of the therapeutic relationship. Suicidal patients often experience a sense of inertia or ambivalence about seeking help; if they lose touch with services, they may find it especially difficult to reconnect, and this can be part of a general drift towards isolation, hopelessness and suicide. Transitions between services are recognised to be particularly vulnerable times for patients (Bickley *et al.*, 2013; NCISH, 2013 & 2017; NCCMH, 2018a). This is true, albeit to a lesser extent, of gaps between appointments. Continuity of care – which includes seeing the same GP, booking follow-up appointments, and actively seeking contact with the patient if they cancel or do not attend appointments – can help the patient to feel that they are being held by an ongoing therapeutic relationship.

Finally, it is important to note that, although this section has focused on therapeutic relationships, it is well established that positive relationships and social connectedness in general are associated with a lower risk of suicide (Scottish Government Social Research, 2008). For patients with little social support or community involvement, this suggests that social prescribing could play an important role in suicide prevention (Iliffe & Manthorpe, 2005). It also adds strength to calls for greater

involvement of the patient’s family, carers and significant others in suicide prevention (Department of Health, 2014b & 2017; NCCMH, 2018a).

Structured clinical interventions

A structured intervention is a pre-established course of action to support patients who have been identified as at risk of suicide. For patients at imminent risk of suicide, the standard course of action is referral to a crisis service. For patients with a diagnosable mental health condition, diagnosis (if not previously made), medication and referral to talking therapies are widely recognised interventions. For others, there are several interim clinical interventions, such as psychosocial assessment, safer prescribing, monitoring and follow-up, that can be carried out in primary care. These provide a supportive structure that can help to keep the patient safe while they wait for further help.

Psychosocial assessment

- A psychosocial assessment, unlike a risk assessment, is collaborative, patient-centred and needs-based (Hawgood & De Leo, 2016).
- It identifies a patient’s risks and resources with a view to deciding practical next steps towards keeping the patient safe.
- NICE (2011) recommends a psychosocial assessment for people who have self-harmed.
- Furthermore, self-harm research indicates that such an assessment can be a protective intervention in its own right (Bergen *et al.*, 2010).
- Evidence suggests its benefits derive from (1) identifying steps towards further support and (2) the patient-centred nature of the interaction (Hunter *et al.*, 2013). To spell out the implications of this, if further support is not forthcoming or if the assessment is conducted as a ‘tick box’ exercise, its value is likely to be diminished.
- Psychosocial assessments are believed to have similar value for suicide prevention (Department of Health, 2014a; NCCMH, 2018a).

Safer prescribing

- A large-scale systematic review of suicide prevention strategies concluded that “[there] is now strong evidence that restricting access to lethal means is associated with a decrease in suicide and that substitution to other methods appears to be limited” (Zalsman *et al.*, 2016).
- NICE (2019) has recently published advice on optimising medicines and reducing access to medicine, as part of its guidance on suicide prevention. This advice includes:
 - Restricting availability of medicines for purchase, prescription and in the home;
 - Reducing stockpiling;
 - Carrying out medication reviews.

Monitoring and follow up

- Research has shown that suicidal patients are particularly vulnerable when they lose contact with services or when they are transitioning between services (Bickley *et al.*, 2013; NCISH, 2013 & 2017; NCCMH, 2018a).
- These events can add to already unbearable feelings of loneliness, hopelessness and uncertainty, potentially tipping suicidal feelings into actions.
- Therefore, it is crucial that primary care has procedures in place to actively maintain contact with suicidal patients and to monitor developments in their care.
- It is also critical that primary care practices are actively engaged and represented in their local suicide prevention partnership.

For some people, these interventions alone will be sufficient support. Their suicidal feelings may ebb naturally over time, or the circumstances that gave rise to them may improve. In these cases, a period of watchful waiting with reduced access to lethal means may be enough. For other people, more is needed; these interventions can help to keep them safe while they wait for further support but, ultimately, this additional support must be forthcoming.

Promising work is being done to establish links between primary care and other services. For example, Liverpool Clinical Commissioning Group runs Advice on Prescription, a social prescribing scheme enabling direct referrals from GPs to Citizens Advice services to help tackle socio-economic causes of suicidal feelings, such as financial hardship and housing difficulties (NSPA, 2017). However, such schemes are currently predominantly small-scale, not widely available and in need of evaluation.

Our research indicates that the more typical situation is one of a ‘postcode lottery’ in which GPs are heavily reliant on local third sector provision to fill the gaps in services. And, where appropriate community-based interventions aren’t available, GPs themselves often end up providing the additional care by, for example, offering more frequent appointments (Saini *et al.*, 2010). An all too common situation for these patients was summed up by one of the respondents to the online survey: “The further support didn’t happen.” Therefore, the development and evaluation of care pathways between primary care and other services needs to be made a high priority.

Recommendations

Government should:

1. Develop and evaluate care pathways for people with suicidal feelings or for people at risk of suicide, as part of the implementation of the NHS Long-Term Plan and the national suicide prevention strategy.
2. Ensure safer prescribing for people at risk of suicide, in order to improve and strengthen risk assessment by prescribers and to reduce access to potentially harmful medication.

And GP practices should:

3. Support continuity of care, monitoring and follow-up of people identified as being at risk of suicide by, for example, offering appointments with the same GP, establishing practice-wide policies on suicide prevention and actively seeking contact with at-risk patients who disengage.

What needs to happen for this to become part of primary care?

This section considers the challenges and complexities involved in making best practice a reality. It will also draw on research, where it exists, to indicate how these challenges might be overcome.

Embedding knowledge of best practice in primary care

Overview

- Training for GPs is imperative to improving suicide prevention in primary care.
- Our research indicates that two areas of training are likely to have the greatest value:
 - First, suicide awareness that tackles myths and stigma.
 - Second, skills training that affirms the value of everyday clinical and communication skills to suicide prevention, such as listening and responding with respect and compassion, and that provides guidance on how to safely explore suicidal feelings within a ten-minute appointment.
- Other aspects of best practice in suicide prevention should be embedded in policies and procedures. These include:
 - Automated systems for flagging risk factors;
 - Identification, treatment and management of depression;
 - Additional measures for higher risk populations;
 - Safety planning;
 - Safer prescribing;
 - Continuity of care, follow up and follow through;
 - Learning from serious incidents.

Education and training

“Given the importance of mental health in primary care, every GP should have training in mental health and suicide risk assessment skills.”

Louis Appleby, lead of the National Suicide Prevention Strategy for England (personal communication)


Among the experts interviewed for this report, there was general consensus that GP training is imperative to suicide prevention in primary care. This has been recognised in the Mental Health Core Skills Education and Training Framework, which sets out learning outcomes for health and social care workers in understanding and preventing suicide (Health Education England, Skills for Health & Skills for Care, 2017). The recently published NCCMH self-harm and suicide prevention competence frameworks elaborate on this and set out best practice guidelines for training (NCCMH, 2018b). Two areas of training that our research indicates would have great value are suicide awareness, and clinical and communication skills.


Suicide awareness


Myths and stigma about suicide are prevalent in society. Examples of common myths about suicide are summarised in Box 1. It is difficult for individuals, including GPs, to know whether they hold false beliefs until they have been presented with correct information.


These beliefs have the power to undermine best practice in suicide prevention. For example, if a GP believes that people who talk about suicide are just attention-seeking, they are unlikely to take their feelings seriously. Or, if a GP believes that only people with mental illness are suicidal, they may be blind to suicidal feelings in other patients. Given the barrier myths and stigma can pose to suicide prevention, suicide awareness is too important to be left to chance.

Box 1: Common myths about suicide

Only people who are mentally ill think about suicide 

People who talk about suicide are just looking for attention and shouldn't be taken seriously 

You shouldn't ask about suicide because it might plant an idea 

If someone's feeling suicidal, there's nothing you can do to help 

Adapted from Samaritans (n.d.) and WHO (2014)

Clinical and communication skills

As discussed above, many of the key skills for suicide prevention in primary care, such as listening to patients and taking their feelings seriously, are indistinguishable from good clinical practice. It is important to affirm that these seemingly unremarkable general clinical and communication skills may be as valuable to suicide prevention as more active interventions. In addition to underscoring the importance of general skills, training should provide GPs with specific skills for suicide prevention. The GPs who contributed to this research said they would welcome training on how to safely explore suicidal feelings in a limited amount of time. Specifically, they were keen to learn how best to ask about suicide (see Box 2 overleaf), and how to strike a balance between the openness of interaction needed for a psychosocial assessment and the constraints of a ten-minute appointment. Toolkits have been developed that promote suicide awareness and provide a grounding in many of these skills (see Box 3 overleaf for examples). However, the need remains for formal training opportunities in suicide prevention to be made available and accessible to GPs in a way that is compatible with their busy schedules.

Policies and procedures

This section will consider in more detail how elements of best practice can be embedded in policies and procedures that are compatible with the practical reality of primary care.

Automatic systems for flagging risk

- Systems that flag risk factors on a patient's electronic records are already available.
- They can be programmed to identify certain markers of risk, such as age, gender or changes in the frequency of appointments.
- If the number of markers exceeds a given threshold, the system will alert the GP that there may be a risk of suicide.
- With information about demographic risk embedded in the system, GPs have more freedom to attend to the patient's personal risk factors.

Identification, treatment and management of depression

- A large-scale systematic review of the literature has shown that improving the diagnosis and treatment of depression is an effective intervention in lowering suicide rates (Zalsman *et al.*, 2006).
- Primary care practices should implement the NICE guidelines to improve the identification, treatment and management of depression (Department of Health, 2014a & 2017; DHSC, 2019b).
- NCISH (2013) found a 26% fall in suicide rates in services that implemented NICE guidance.

Additional measures for groups with known risk factors

- The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH, 2018b) has developed a toolkit that includes additional measures for at-risk groups in primary care.

- It recommends that primary care practices put mechanisms in place to ensure further assessment and monitoring of:
 - Patients who present with major physical health issues;
 - Patients with frequent consultations;
 - Patients with multiple psychotropic drugs and specific drug combinations;
 - Patients with other markers of risk.
- It also recommends that services actively seek to engage at-risk groups who may not regularly attend appointments. It suggests one way of doing this would be to include mental health in Health Checks (NCISH, 2013).

Postvention

- Bereavement by suicide is a risk factor for suicide.
- Postvention refers to interventions aimed at supporting people who have been directly affected by a death by suicide (NCCMH, 2018a).
- GPs should receive practical and emotional support and training for working with people who have been bereaved by suicide (Foggin *et al.*, 2016).
- GPs should also receive emotional support themselves when a patient dies by suicide (King *et al.*, 2005; Saini *et al.*, 2010; Saini *et al.*, 2016).

Box 2: Asking about suicidal feelings

There is no evidence that asking about suicidal feelings causes harm. In fact, research indicates that it may help to reduce suicidal ideation (Dazzi *et al.*, 2014; Berman & Silverman, 2017).

Asking a patient about suicidal feelings can:

- Show that you care and are taking their feelings seriously;
- Demonstrate that talking about suicide is not taboo;
- Make it easier for the patient to broach the subject.

There isn't a single right way to ask the question. Its primary function is to start an open and honest conversation, not to gather information (this can always be done later).

Do ask about suicide in a way that feels natural to you and that signals you are prepared to hear any answer

Do phrase the questions in a way that allows for a range of answers

Do use direct language such as "suicide", "killing yourself" or "taking your life"

Do treat the question as a way of starting a conversation

Don't phrase the question negatively, e.g. "You're not thinking of killing yourself, are you?"*

Don't phrase the question so that it only recognises the distress of patients who are feeling actively suicidal right now

Don't use indirect or infantilising language, such as "doing something silly"

Don't treat the question as the end of the conversation; suicide is a very difficult thing for many patients to talk about; just because a patient says no, it doesn't mean they aren't feeling suicidal or in a lot of distress

* Research has shown that, when the question is phrased negatively, patients are significantly more likely to deny suicidal feelings (McCabe *et al.*, 2017). It is possible to speculate that patients see it as implying the clinician's preferred answer.

Box 3: Examples of toolkits and guidance*

- Self-harm and suicide prevention competencies frameworks (NCCMH, 2018b)
- Suicide in children and young people: Tips for GPs (Michail & Mughal, 2018)
- Suicide mitigation in primary care (Cole-King *et al.*, 2012)
- Understanding and responding to children and young people at risk of self-harm and suicide: A guide for practitioners in Cambridgeshire (Brown *et al.*, 2014)
(See p. 8 of this guide for a useful section on how to respond to self-harm disclosures, which is equally applicable to suicide disclosures.)
- Suicide prevention: Top ten tips (RCGP, n.d.)

* Although these toolkits are aimed at slightly different populations and/or audiences, much of the information is relevant to suicide prevention for patients in primary care.

Safety planning

- Comprehensive psychosocial assessments of the type carried out in secondary care are not always feasible in a primary care setting.
- GPs emphasised the need for something simple, clinically led, easily accessible and fully integrated into existing IT systems that they can access during appointments.
- Safety plans were felt to be a useful way of identifying individual risk factors and protective factors, in a way that is practical to do in a ten-minute appointment (see Box 4 overleaf for further details).
- GPs who participated in our research also perceived safety plans as valuable for facilitating a more collaborative conversation with a patient.
- Considering reduced, short-term supplies;
- Asking about supplies of over-the-counter opiate-containing medications kept at home or prescribed to someone else in the household;
- Ensuring patients who are newly prescribed antidepressants are aware of the time they take to work.
- These recommendations have been elaborated on in recent NICE (2019) guidelines.

Continuity of care and follow up

- Experts interviewed for this research recommended that, wherever possible, the patient should be offered appointments with their preferred GP.
- While the patient is at risk, a follow up appointment should be booked at the end of each appointment and a mechanism put in place to alert the GP if this is missed or cancelled.
- As far as is reasonably possible, primary care should actively seek contact with the patient if they disengage from care (Michel, 2000, p. 668; NCISH, 2018b).

Safer prescribing

- The prescribed drugs most often taken in fatal overdoses are opiate analgesics and tricyclic antidepressants.
- To reduce patients' access to lethal means, NCISH (2018) recommends that primary care practices have a standard procedure in place for safer prescribing of these drugs, which includes:

- Procedures should be in place to oversee referrals and where referrals fail, again primary care should actively seek contact with the patient.
- NCISH (2013) found a 16-27% fall in suicide rates in services that introduced policies on follow-up of discharged patients and of in-patients who abscond.
- It is also critical for primary care practices to be actively engaged and represented in their local suicide prevention partnership.

Learning from serious incidents

- Procedures should be in place to bolster and share learning from serious incidents, such as when a patient dies by suicide or makes a serious suicide attempt.
- Practices should routinely upload incident reports to the National Reporting and Learning System (NRLS), to help build a more detailed picture of suicide in primary care, which can be used to inform evidence-based interventions.
- To ensure a joined-up approach to suicide prevention, where possible other agencies involved in the patient's care should be included in reviews of serious incidents.

Recommendations

Government should:

1. Roll out evidence-based suicide prevention training for existing GPs on an ongoing and easy-to-access basis and ensure that it is sufficiently covered in the curriculum for new GPs.
2. Expand training for GPs so all trainees are given adequate exposure to patients who are at risk of self-harm and/or suicide, and are provided with the skills to recognise, treat and manage depression.

Box 4: Creating a safety plan

Warning signs and personal triggers

- Are there any specific situations or people that you find stressful or triggering, or that contribute to your suicidal thoughts?
- How will you know when your safety plan should be used?
- What are some of the difficult thoughts, feelings or behaviours that you experience leading up to a crisis?

Creating a safe environment

- What things do you have access to that are likely to be used in a suicide attempt?
- How can we develop a plan to limit your access to these things and to avoid triggering situations?

Identifying reasons to live

- What's the best thing about your life?
- What's the most important thing in your life?
- What things in your future do you look forward to?

Internal coping strategies

- What can you do on your own if you have suicidal thoughts in the future, to avoid acting on those thoughts?
- What can you do to help take your mind off your problems, even for a short amount of time?

Socialisation strategies for distraction and support

- Who helps you to feel good when you socialise with them?
- Where can you go and be around other people in a safe environment?

Trusted contacts for assisting with a crisis

- Among your friends and family, who do you feel you could talk to when you're having suicidal thoughts?
- Who do you feel you could contact to support you during a suicidal crisis?

Professional contacts for assisting with a crisis

- Which services could you turn to for support?
- What health professionals can you involve in your treatment plan?

Adapted from RACGP (n.d.) and Stanley and Brown (2012).

Empowering GPs to make use of best practice

Overview

- Suicide prevention is not the responsibility of a single service; it is inherently systemic with feedback between all levels (see Figure 1).
- Consequently, the support available to patients beyond primary care has an impact on suicide prevention within primary care.
- This impact is direct: poor communication between levels of care leads to gaps in services that vulnerable patients may fall through.
- It is also indirect: GPs need to feel confident that, if they ask about suicide, they will have the resources to safely respond.
- These resources include a range of trusted and appropriate options for referral (i.e. the support available to the patient beyond primary care), and the professional and emotional support available to GPs themselves.
- Training and skills are not sufficient for suicide prevention in primary care; even GPs with considerable expertise in suicide prevention may be reluctant to ask a patient about suicidal feelings if these additional levels of support are not in place.

Support for patients beyond primary care

Suicide prevention is not the responsibility of any single service. As Leavey *et al.* (2017) write, “[it] often depends on a delicate collaboration between multiple agents and agencies in which availability and timing, knowledge and communication, relationships and trust, all contribute.” The danger for research that

focuses on particular areas of care is that what happens (or fails to happen) at the interface between services is overlooked. This liminal space is as much the responsibility of primary care as it is of any other service and thus it falls within the remit of this report.

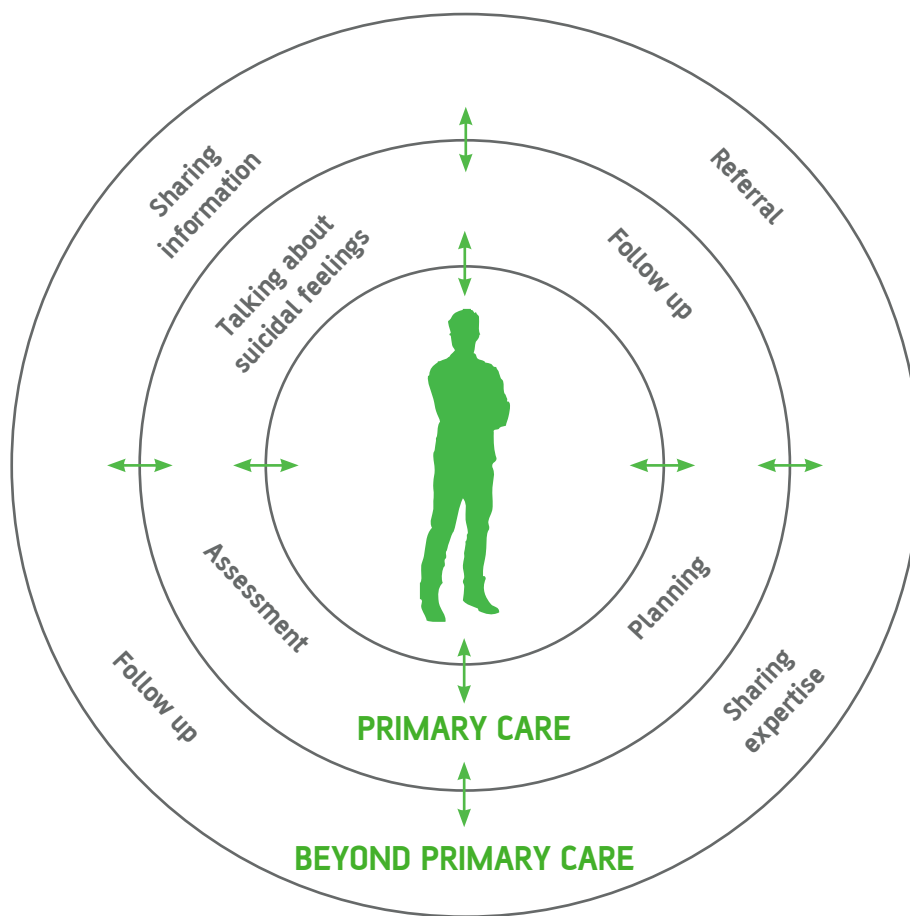
The importance of a collaborative approach to suicide prevention is widely recognised:

- Research into best practice in suicide prevention has recommended more collaboration between different levels of care (Pearson *et al.*, 2009; Leavey *et al.*, 2017; NCISH, 2018b).
- Partnership-working forms part of the cross-government suicide prevention strategy (Department of Health, 2012).
- It is the cornerstone of the National Suicide Prevention Alliance’s strategic framework (NSPA, 2016).
- One of the key learning outcomes of the Mental Health Core Skills Education and Training Framework is the ability to “demonstrate a coordinated and systems wide approach to suicide prevention, sharing knowledge and learning from others” (Health Education England, 2017, p. 32).

Research indicates that support for patients beyond primary care affects suicide prevention within primary care through two pathways: one direct, the other indirect. The direct pathway is the well established fact that suicidal people are particularly vulnerable when they are transitioning between services (Bickley *et al.*, 2013; NCISH, 2013 & 2017; NCCMH, 2018a). This report has already considered what can be done within primary care to stop people from falling through the gaps between services. However, a systemic approach could prevent the gaps from occurring in the first place. This is a question of good communication between services and better understanding of one another’s cultures and working practices.

The less direct pathway through which support for patients beyond primary care affects suicide prevention is through GPs’ confidence. The

Figure 1: Suicide prevention at the interfaces



GPs interviewed for this research felt that their ability to work effectively with suicidal people was a function not only of their skills and training, but also of their belief that they would be able to offer the person appropriate further support. More than one GP spoke about feeling reluctant to ask about suicidal feelings, not because of lack of knowledge, but because they feared it would be worse for the patient and for themselves if they “opened a can of worms” with no guarantee that they would be able to safely manage the consequences. By contrast, when GPs had access to a range of trusted referral options within their community, they felt empowered to explore the patient’s feelings, confident that they would have something to offer.

It will take time for these care pathways to be developed. One source of help that is immediately available for many patients beyond primary care, however, is social support. A consensus statement issued by the RCGP among others provides strong support for sharing information with the family and friends of people at risk of suicide (Department of Health, 2014b). There is evidence that working more closely with patients’ families and friends could improve suicide prevention by bolstering the supportive framework beyond health services (NCCMH, 2018a; NCISH, 2018b). Many local areas are also commissioning wider social and community suicide prevention interventions, such as Men’s Sheds, to target at-risk groups. However, care pathways need to be urgently established to join up all these sources of support and ensure a smooth transition.

Support for GPs

Professional support

Among GPs, the professional support for which there is the greatest appetite is psychiatric consultancy provided by a named and trusted specialist. Simply knowing that there is a reliable and knowledgeable point of contact can give GPs confidence in working with suicidal patients. The value of having mental health staff, such as nurses and therapists, working in primary care and/or holding regular mental health clinics has also been emphasised (Leavey *et al.*, 2017). Other forms of professional support that have the potential to strengthen suicide prevention in primary care are physician associates and ‘navigators’ who compile a list of resources and services within the community for social prescribing.

Emotional support

Most GPs are likely to lose a patient across their careers to suicide. GPs can be deeply affected by such a death, yet there are few formal support systems available to them and they receive little supervision (Davidsen,

2011; Foggin *et al.*, 2016; Saini *et al.*, 2016). To ensure GPs have the opportunity to reflect on what has happened and process their feelings, research recommends Critical Incident Reviews combined with meaningful peer support and the option of more formal emotional support (King *et al.*, 2005; Saini *et al.*, 2010; Saini *et al.*, 2016). NHS Workforce Wellbeing Guardians, as recommended by the NHS Staff and Learners’ Mental Wellbeing Commission, could play a valuable role in enforcing this (Health Education England, 2019).

Even without the tragedy of a bereavement, GPs face the day-to-day stress of long hours and heavy caseloads. There is a high incidence of burnout among GPs (Matthews-King, 2015). Burnout can lead to a lower tolerance for emotionally demanding interactions, potentially compromising a GP’s ability to respond compassionately to a patient who presents with suicidal feelings. Even more concerning is that it may lead GPs themselves to feel suicidal (being a doctor is a risk factor for suicide) (Department of Health, 2012). The emotional wellbeing of GPs, then, is crucial to suicide prevention, both as an end in itself, and as a means to an end of supporting suicidal patients.

Recommendations

Government should:

1. Invest in emotional support services, to ensure that all GPs have the support they need with their own wellbeing.
2. Direct social prescribing towards local areas with the highest rates of suicide as a priority, to improve access to social and community support for people experiencing suicidal thoughts and people at risk of suicide.

Local policymakers, including Integrated Care Systems, should:

3. Establish liaison arrangements with mental health professionals to offer guidance and support when GPs need specialist input for working with suicidal patients.
4. Ensure primary care representatives and social prescribing link workers are represented in multi-agency suicide prevention groups and consult widely with these groups when determining priority interventions.

Conclusion

Urgent changes are needed to strengthen suicide prevention in primary care. The picture that emerged from our research is one that gives reasons for hope, while also demonstrating that much work remains to be done to ensure all at-risk groups and people experiencing suicidal feelings receive the support they so crucially need, when they need it.

There is a growing evidence base around suicide and what works to prevent it which provides a strong starting point for suicide prevention strategies. However, much more needs to be done to ensure this knowledge is having an impact on the day-to-day working of primary care, enabling GPs to more effectively support patients at risk of suicide.

To ensure best practice is embedded in primary care, evidence-based interventions, such as safety planning and safer prescribing, must be reflected in the policies and procedures of general practice; and GP education and training is essential. However, policies and training will not be enough on their own. They must be accompanied by systemic changes to primary care, such as evidence-based referral options, access to social prescribing, and professional support for GPs. For many people, primary care will only be one link in the chain of support that ensures they get the help they need. Urgent action is therefore required to develop and evaluate care pathways that bridge the gap between primary care and further support.

In addition, throughout this research many people who have experienced suicidal feelings emphasised the importance of the therapeutic relationship within primary care. It is essential that everything possible is done to enable GPs

to prioritise this relationship, particularly if they identify someone who may need more help. This requires not only that GPs have the skills for providing person-centred and tailored support, communication and guidance, but also that they have the necessary practical and emotional resources. This will require changes to health care frameworks, such as increased appointment times and investment in the primary care workforce.

This report's findings should inform the implementation of the NHS ten-year plan for primary care. In particular, with the roll out of 'digital first' primary care and online appointments, the value of face-to-face communication for people who feel suicidal must be taken into account. While these innovations are welcome and will help improve access, they must be introduced in a way that is aligned with suicide prevention. Likewise, the ambition to create primary care networks across local areas could be a valuable resource for increased collaboration across agencies and with local suicide prevention partnerships, if they are implemented in an integrated way.

Investment in these areas could reap rewards across suicide prevention. However, while there is increasing recognition of the key role primary care plays in suicide prevention, more needs to be done to ensure this recognition is translated into meaningful changes that have an impact on GPs and general practice as a whole. Our research has identified significant steps that can be taken to drive forward change. While the gains from any one of these steps taken alone are likely to be small, combined and adopted in a strategic way across government policy and primary care, they will help save lives.

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