

## Suicide mitigation in Primary care:

**Suicide is not the inevitable outcome of suicidal thoughts. Suicidal thoughts occur in response to emotional and physical pain. Most people just want to feel better, rather than end their life.**

### Why is this important for GPs?

About 5,000 people die every year in the UK by suicide. This is twice as many people as die in road traffic accidents. Only 25% of people who die by suicide are known to specialist mental health services although a high percentage will have had contact with primary care around the time of their death.<sup>i</sup>

**Of the 1,722 10-19 year olds who died by suicide only 14% were known to specialist services.**<sup>ii</sup>

### Suicide mitigation:

Starts from the assumption that suicidal thoughts need to be taken seriously and met with empathy and understanding on every occasion. Many suicidal individuals are ambivalent about living or dying. Increasing hopefulness, resilience and reasons for living have been shown to reduce suicide risk.

**GPs can collaborate with their mental health colleagues to develop their skills in this area.** Best practice should involve both advisory and partnership arrangements, particularly given the new commissioning processes.

### How to ask about suicidal thoughts:

Research shows that suicide risk is often not documented in routine assessments, including in cases of people who died by suicide. The first stage of mitigating suicide

risk is compassion. This is the bedrock of an assessment, without which the clinician is unlikely to elicit a truthful account of suicidality as some patients may be initially reluctant to share such thoughts. When presented with a patient with depression or emotional distress, clinicians should routinely ask about suicidal thoughts and acts of self-harm.<sup>iv</sup>

The establishment of a therapeutic alliance and trusting relationship between professional and patient is essential if the latter is to disclose suicidal thoughts and permit the clinician to make a sound psychosocial assessment, it can also be a protective factor against suicide.

- Patients respond better in response to a non-judgemental, empathic and confident approach;
- Be aware of body language (both GP and patient);
- Start with open questions, followed by closed specific questions about suicide intent.)

### Assessment of suicidal thoughts

(Based on the CK Continuum & CK Classification)<sup>v</sup>

Suicide intent lies on a continuum from fairly common vague, passive suicidal thoughts to rarer high suicide intent/high lethality suicidal acts.

All aspects of suicidal thoughts need to be identified:

- Perception of the future as persistently negative and hopeless;
- Nature of the suicidal thoughts ie frequency, intensity, persistence etc;
- Degree of suicide intent: planning and preparation for suicide attempt; Putting affairs in order
- Ability to resist acting *on* their thoughts of suicide or self harm.

### Importance of a plan: WHO World Mental Health Survey Initiative<sup>vi</sup>

(n=84,850) 29% people with suicidal thoughts went on to make a suicide attempt, usually within a year of onset of the thoughts.

- 56% probability of a suicide attempt if also had a suicide plan
- 15.4% probability of a suicide attempt if they did not have a suicide plan.

### Risk factors:

The prediction of suicide is fraught with difficulty and the level of accuracy is likely to be very low. Under these circumstances it is prudent to take all suicidal thoughts with complete seriousness

Assessment of suicide risk requires a biopsychosocial assessment of the patient including details of their suicidal thoughts, intent, plans, personal, demographic factors and a comprehensive mental state examination.

The clinician should be familiar with established risk factors and risk groups (see

below) for suicide at a population level, but should not rely wholly on this knowledge when assessing risk in specific individuals. Thus, a person may be at high risk of suicide even in the absence of membership of a high risk group.

Conversely, not all members of high risk groups are equally at risk of suicide. Moreover, suicidal thoughts (and risk) can vary across a relatively short time period. The assessment of suicide risk by the clinician needs to be individually focused and carried out on a regular basis.

### High risk groups

- Presence or history of psychiatric illness
- Previous self harm/suicide attempts
- Recent discharge from psychiatric hospital
- Alcohol/drug misuse.

The strongest risk factor for acting on suicidal thoughts in high income countries is a mood disorder, particularly if accompanied by substance abuse and/or stressful life events.

### Warning signs

'Red flag warning signs' may be indicative of an impending suicidal act in patients who may be at risk of suicide. In the absence of conventional population-level risk factors they may be incorrectly identified as 'low risk'.

Impulsivity alone is unlikely to predict suicide, but may increase the likelihood of a completed suicide in a

patient experiencing suicidal thoughts. Please see risk factor table for a summary of all the evidenced-based risk factors for suicide.

(<http://rcgp-innovait.oxfordjournals.org/content/early/2011/03/30/innovait.inr018.abstract>)

**The following are 'red flag' signs and indicate when a patient requires urgent specialist advice/input:**

**Well formed suicidal plans and preparations/recent worsening with distress.**

**Hopelessness:** especially if only able to see a brief future, 'nothing to live for', guilt, 'I'm a burden'.

**Distressing psychotic phenomena,** persecutory & nihilistic delusions; command hallucinations perceived as omnipotent.

**Sense of 'entrapment'**

**Pain/chronic medical illness**

**Perception of lack of social support:** no confidants; Major relationship instability; Recently bereaved.

### Should I refer to mental health services?

If you uncover suicidal thoughts triage to assess if your patient has a serious mental illness (requiring review by specialist) and/or is safe to review in 1 or 2 days, a heightened form of

'watchful waiting'. May require a mental health referral if they have a mental illness.

A trusted GP is often best placed to offer support and may use phrases such as "I want to support you and you need you to know that we are here for you until you feel better. Can I see you tomorrow/in the next couple of days/next week and see how you are getting on?"

**If 'red flag' warning signs/immediate risk of suicidal behaviour (and especially if a patient is unknown to the GP) the patient will require:**

- **Immediate discussion with/referral to mental health services**
- **A robust safety plan**
- **Adequate support**
- **Removal of access to means if possible.**

The time frame will depend on the clinical situation. The next stage in mitigating suicide risk is the co-creation of a 'safety plan'. The patient-professional relationship can also be a powerful protective factor against suicide.

### What is a safety plan?

GPs collaborate with patients to explore reasons for living, develop strategies to help stay safe, and establish a network of support (carers can assist if appropriate).

An immediate safety plan will depend on the severity of the suicidal thoughts; the more severe the thoughts, the more the clinician will need to

direct care and support to keep the patient safe.

Interventions should be identified by the patient. However, in circumstances where the patient is unable to articulate their wishes or when the risk is high, it may be necessary for the clinician to take a more directive role.

### How to co-create a safety plan:

The key is to enable the patient to generate their own reasons for living. A safety plan will usually include:

- Actions or strategies to help resist suicidal thoughts;
- Names of supportive family and friends
- Professional support
- Voluntary support organisations, see later;
- Agreed actions to take when suicidal thoughts become stronger and/or more persistent;
- Access to out of hours support (when people may be at their most vulnerable and 'the system' is not obvious to distressed patients or their carers)
- Use the 'Feeling on the Edge' resource

<http://www.rcpsych.ac.uk/mentalhealthinfo/problems/feelingontheedge.aspx>

**We strongly advise all GPs to undertake suicide awareness and skills training.**

Many patients have suicidal thoughts in the absence of

any mental illness in which case the GP may be the only professional involved.

Training can both refresh assessment skills and teach the 'language' of an effective referral that requires a response from services and help develop new pragmatic ways to mitigate suicide risk if secondary care not involved.

### Key learning

- **Do not be scared to ask whether your patient has suicidal thoughts – this is the first step in reducing their risk of completing a suicide.**
- A therapeutic relationship enables disclosure of suicidal thoughts.
- All suicidal thoughts, however 'minor' require a response that needs to be compassionate, proportionate and timely.

### Extremely important:

Not all parts of an individual's presentation are of equal weight when assessing risk. Clinical Factors, Mental State Examination are most important when assessing and responding to suicide risk.

Suicidal thoughts/plans, loss of hope and emotional pain/distress need compassion, diligent identification and a robust safety plan

**Document the date, time and important factors in the history and examination. 'If you did not document it then you did not ask it**

### Strategies from the 'C-K Bank of Hope' <sup>vii</sup>

Intense suicidal feelings are often short lived (acknowledge that individuals may have long lasting suicidal thoughts which can still be very distressing);

**Maximise your patient's ability not to act on their suicidal thoughts by reducing the power of these thoughts.**

- Share examples of others who made serious and potentially lethal suicide attempts but changed their mind half way through and realised that they did not want to actually die: **Their real wish was to feel better, not to actually end their life.**

### Support organisations

**Samaritans**(24 /7)

Tel: 08457 909 090

W: [www.samaritans.org](http://www.samaritans.org)

**PAPYRUS HOPELineUK**

Tel: 0800 068 41 41,

W: [www.papyrus-uk.org](http://www.papyrus-uk.org)

**The National Self-Harm**

**Network W:** [www.nshn.co.uk](http://www.nshn.co.uk)

**Get Connected:** Help for under

25s who self-harm, (1-11pm)

Tel: 080 8808 4994

[www.getconnected.org.uk/home](http://www.getconnected.org.uk/home)

**Selfharm.co.uk** for young people W: [www.selfharm.co.uk](http://www.selfharm.co.uk)

**CALL Helpline** (Wales):

24/7, support and information.

Tel: 0800 132 737

Text 'help' to 81066

[www.callhelpline.org.uk](http://www.callhelpline.org.uk)

**SANEline:** Information and emotional support if affected by mental illness [Tel: 0845 767 0800](tel:08457670800) (6pm -11pm),

E: [info@sane.org.uk](mailto:info@sane.org.uk)

W: [www.sane.org.uk](http://www.sane.org.uk)

E: [info@mind.org.uk](mailto:info@mind.org.uk)

**The Big White Wall:** Support for over 16's. Monitored 24/7 by Wall Guides

W: [www.bigwhitewall.com](http://www.bigwhitewall.com)

**CALM:** help targeted at men, 15-35 if depressed or down.

Tel: 0800 585858,

W: [www.thecalmzone.net](http://www.thecalmzone.net)

**ChildLine.** Tel: 0800 111

**Parentline Plus.**

Tel: 0808 800 2222

**Drinkline Helpline.**

Tel: 0800 9178 282

**National Drugs Helpline.**

Tel: 0800 77 660

**CRUSE** (Bereavement)

[www.crusebereavementcare.org.uk](http://www.crusebereavementcare.org.uk) Tel: 0870 167 1677

**RELATE:** [www.relate.org.uk](http://www.relate.org.uk)

**Survivors of Bereavement**

**by Suicide (SOBS)** Tel: 9am to 9pm daily - 0844 561 6855, e: [sobs.support@hotmail.com](mailto:sobs.support@hotmail.com)

**Depression Alliance.**

Tel: 0845 123 2320 W:

[www.depressionalliance.org.uk](http://www.depressionalliance.org.uk)

**NHS Direct.** Tel: 0845 46 47

**Mind infoline:** Tel: 0300 123 3393 (Mon-Fri 9am -6pm)

**Winston's wish** (Bereavement support for children/families)

Tel: (Mon to Fri 9am- 5pm)

08452 03 04 05:

W: [winstonswish.org.uk/](http://winstonswish.org.uk/)

**National Debtline**

Tel: 0808 808 4000

**Consumer Counselling**

**Credit Services** (anonymous advice in 10 min).

W: [www.cccs.co.uk/](http://www.cccs.co.uk/)

**Further training:  
Primhe Mental health in  
primary Care diploma**

[www.primhe.org.uk](http://www.primhe.org.uk)

**Connecting with People  
Suicide Awareness**

**Training.** 2 hour modules enhance participants' ability to safely and compassionately, triage and respond to a patient with suicidal thoughts.

[info@openminds.org.uk](mailto:info@openminds.org.uk)

**STORM Training:**

Academically evaluated suicide skills-based training for health professionals.

[www.stormskillstraining.co.uk](http://www.stormskillstraining.co.uk)

**ASIST Training:** 2 day suicide skills intervention training (Prior medical training is not required).

[www.livingworks.net](http://www.livingworks.net)

---

<sup>vi</sup>Nock, M, Borges, G, Bromet, EJ et al. Cross-national prevalence and risk factors for suicidal ideation, plans and attempts.

<sup>vii</sup>Cole-King, A; Green, G; Peake-Jones, G Gask, L. OpCit

**Authors:**

Dr Alys Cole-King, Dr Ian Walton, Prof Linda Gask, Prof Carolyn Chew-Graham, Prof Stephen Platt

**On behalf of the  
RCGP/RCPsych Primary  
care Mental Health Forum**

---

<sup>i</sup> Luoma, JB, Martin CE et al. Contact with Mental Health and Primary Care Providers Before Suicide: A Review of the Evidence. *American Journal of Psychiatry* 2002;159:909-916.

<sup>ii</sup> National Confidential Inquiry into suicide and Homicide by people with mental illness [www.manchester.ac.uk](http://www.manchester.ac.uk)

<sup>iii</sup> Cole-King A, Lepping P. Suicide mitigation: Time for a more realistic approach. *BJGP* (2010a) 60: 3-4.

<sup>iv</sup> Cole-King, A; Green, G; Peake-Jones, G Gask, L. InnovAiT 2011; doi:

10.1093/innovait/inr018

<sup>v</sup> Cole-King, A; Green, G; Peake-Jones, G Gask, L Ibid