Chapter 8

Suicide Prevention
Identification, Intervention and Mitigation of Risk

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Suicide and self-harm cause significant emotional distress, morbidity and mortality. Primary care and general practitioners (GPs) are at the front line of suicide prevention. Most risk-assessment tools rely on demographic and mental illness risk factors reflecting a whole population across its lifetime. These do not accurately predict suicide in an individual at a particular moment, failing both clinicians and patients. Even risk factors associated with the highest odds ratios and significant statistical associations in studies may be limiting. Also, absent risk factors does not mean absent risk.

Self-harm, suicidal behaviour and suicidal thoughts may be precursors to suicide and patients experiencing these require a compassionate response. However, stigma and reluctance to disclose coupled with the fear of GPs in being responsible in 'managing' risk are barriers. Suicide mitigation focuses on identifying patients' individualized risk factors, needs and strengths, instilling hope and empowering them to seek and accept support. The belief that suicide is inevitable is outdated and not backed up by evidence. Some clinicians may see suicide prevention as outside their remit, but suicide can be prevented until the final moment. The key is compassion, safeguarding, safety planning, hope and mitigating risk factors while addressing mental illness and life crises. This chapter provides an overview of current research evidence offering practical strategies for everyday busy clinical practice enabling every encounter to be an opportunity to reduce distress and potentially save lives.

Suicidal Thoughts and Suicidal Acts

In the United Kingdom in 2014 (the latest date for which data are available), more than 6,100 people died by suicide, of whom three-quarters were men. This total is more than three times higher than the number of deaths due to road traffic accidents. Suicide is the biggest killer of men under 50 in the United Kingdom, accounting for one in four deaths in men under the age of 35. Non-fatal self-harm (with or without suicidal intent) is one of the most common reasons for presentation to emergency departments and for acute hospital admission. Hawton *et al.* (2007) estimate that there are more than 200,000 hospital attendances following self-harm in England every year. The suicide rate in men in 2014 was 16.8 per 100,000, and the suicide rate among women has also increased to 5.2 per 100,000, to the highest in a decade (Scowcroft 2016). The United Kingdom has one of the highest rates of self-harm in Europe at 400 patients per 100,000 of the population (Horrocks & House, 2002; Royal College of Psychiatrists, 2010).

Most acts of self-harm do not result in presentation for medical attention, so self-harm is largely a hidden community problem with real-term figures an unknown (Cole-King *et al.*, 2011). Although the function of self-harm is generally not to end one's life, there is a link

between self-harm and suicide and both are viewed as sitting on a continuum of suicidal behaviour. It is estimated that 6.4 per cent of the UK general population have engaged in self-harm; however, the rate rises to 25.7 per cent in women aged 16–24 (McManus *et al.*, 2016). Suicidal thoughts are common when one is facing problems, feeling distress or experiencing a life crisis. Estimates suggest that the lifetime prevalence of suicidal ideation is around 9 per cent; however, only 2.7 per cent go on to attempt suicide (Nock *et al.*, 2008). We think that the prevalence is much greater but that stigma stops people disclosing. In a 2009 study 12 per cent of patients attending a cardiology clinic expressed suicidal ideation (Shemesh *et al.*, 2009). These patients were immediately assessed by mental health professionals, and suicide risk and four patients to required inpatient treatment.

In the United Kingdom more than 90 per cent of people who die by suicide have seen their GP in the past year (National Confidential Inquiry, 2014). Chronic medical illness is a risk factor for completed suicides and GPs are ideally placed to assess their patients' mood when reviewing them for a physical condition. GPs treat the overwhelming majority (about > 95 per cent) of patients with mental health problems. GPs also see patients who attend with physical health problems or life events, so provide the potential to also intervene with these patients.

As noted before, simple compassionate questions can uncover undisclosed suffering and identify suicidality. The current Quality and Outcome Framework (QOF) as a whole is a reminder to ask about suicidal thoughts, especially the screening for depression in chronic illness, and, used judiciously, can act as an 'early warning system' or at least put it on the clinical agenda (Quality and Outcomes Framework Guidance for GMS Contract, 2011/2012).

Suicidal thoughts usually start when the person feels overwhelmed by problems or situations. A person does not necessarily want their life to end; they just want to escape from intolerable distress and see suicide as the only option. A number of psychological processes may make a person more prone to self-harm and suicide. Losses and abandonment in relationships are common precipitants in both self-harm and suicide. Additionally, defeat, humiliation and entrapment, when the person sees no positive future and way out of their current situation, are also strong predictors of suicidal behaviour (O'Connor, 2016).

The majority of people who die by suicide also have a mental disorder although the presence of suicidal thoughts is not always a feature of mental illness. These can occur in anyone whether they have a mental illness or not, and develop in response to emotional distress or despair. While the risk of suicide and self-harm among people with depression is higher than in the general population, the majority of people with depression do not take their lives. It is estimated that under 5 per cent of people who receive hospital treatment for an affective disorder die by suicide and most with depression will not experience suicidal thoughts (Bostwick & Pankratz, 2000; Randall *et al.*, 2014).

Mental illness is more strongly associated with suicidal ideation than with suicide attempts (Nock *et al.*, 2009). The research indicates that psychiatric risk factors are very poor predictors of suicidal behaviour (Bolton *et al.*, 2015). The majority of people in the United Kingdom with a mental disorder other than a psychosis get no treatment (see Chapter 25), therefore primary care has a key role in earlier detection and treatment of mental disorder to improve outcomes.

See Figure 8.1 for a diagrammatic representation of the factors which contribute to the development of suicidal thoughts, plans and action. A range of background factors can lead the person to a state of unbearable pain. It is this that leads to suicidal thoughts and

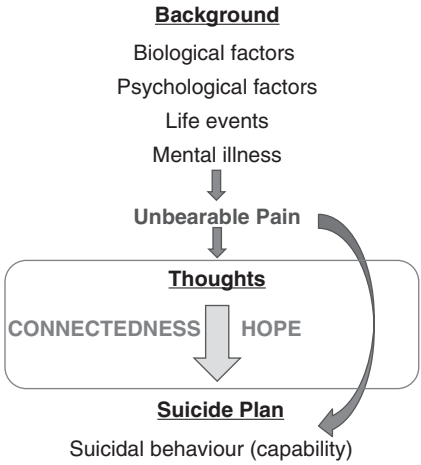

Figure 8.1 Theories of suicide

behaviours. Importantly, suicidal behaviour can occur in the absence of a suicide plan. However, hope for the future and feelings of connectedness can reduce the likelihood of suicidal thoughts or suicidal behaviour for those in unbearable pain.

Suicidal thoughts occur in response to emotional and physical pain, particularly when accompanied by hopelessness for the future and a sense of entrapment. The vast majority of suicidal people are highly ambivalent about living and dying; however, the degree of their emotional pain sometimes prevents them from recognizing and exploring alternative options to suicide. It is not that they necessarily wish to end their life: they are just unable to see any other way to deal with the situation.

Self-Harm and Suicidal Behaviour

New evidence suggests that there is more of an overlap between suicide and self-harm than previously thought, so self-harm should be taken seriously (Klonsky & Alexis, 2013). Self-harm behaviour mediates the release of centrally produced endorphins, which may be one of the mechanisms whereby temporary relief from distress occurs. However, it can quickly become addictive or less 'effective' so that the nature or intensity of the self-harm increases and the repeated use of pain as a means of managing stress increases the risk of fatal suicidal behaviour (Nock & Prinstein, 2004). Cutting is the most common form of self-harm; however, there is evidence of risky self-asphyxiation behaviour which may also be viewed as a form of self-harm; accidental death is a risk (Busse *et al.*, 2015). Self-harm appears to be particularly associated with difficulties in problem solving and coping, especially when linked to relationships (Townsend *et al.*, 2001).

Self-harm and suicide attempts are very strongly associated with death by suicide. Almost half of the general population and just more than half of young people who end their life by suicide have previously harmed themselves (Appleby *et al.*, 1999). However, the majority of people who self-harm or attempt suicide do not die by suicide despite the increased risk. Self-harm behaviour, when previously used as a method of managing pain, can, in the context of unbearable distress, escalate and result in death. Early identification

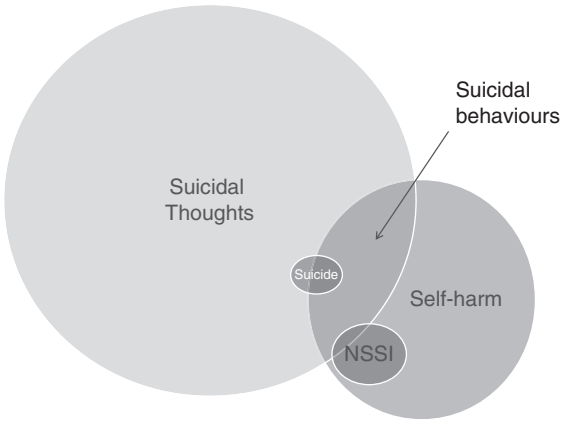

Figure 8.2 Relationship of self-harm to suicide*

and intervention can minimize distress and reduce the likelihood of such a coping mechanism becoming established and entrenched. Two UK studies show that having a psychosocial assessment reduces repetition of self-harm (Kapur *et al.*, 2002) and a Cochrane review of self-harm interventions by Hawton states that interventions can reduce the frequency of repetition of self-harm (Hawton *et al.*, 2016).

Figure 8.2 represents the relationship between self-harm and suicide, demonstrating that only a small proportion of those engaging in non-suicidal self-injury (NSSI) have suicidal thoughts and that many of those with suicidal thoughts who die by suicide do not self-harm.

Challenges and Opportunities When Assessing Patients in Primary Care

Tension exists in general practice between the 'gold standard' of exploring every suicidal thought or action and the reality of a 10-minute consultation. However, GPs are at the front line of suicide prevention and have the opportunity for early identification, assessment and prompt intervention of patients with suicidal thoughts. GPs with heightened awareness and willingness to ask questions around self-harm or suicide in the context of a compassionate consultation can uncover patients at risk of suicide even if that is not their presenting complaint. Only 25 per cent of those who die by suicide are known to specialist mental health services; the majority of the remaining 75 per cent have contact with front-line services, including primary care, a significant proportion in the weeks before their death. Women and older patients are more likely to have sought care in the month before suicide than men and younger patients (Luoma *et al.*, 2002). GPs are also in the unique position of having follow-up opportunities to enable repeated assessments to build a clearer picture with opportunities to source further information from families, friends, carers and other people, including professionals. This conundrum in general practice of how to rapidly triage can be assisted by use of the SAFETool (see Chapter 25), which enables busy GPs to access tailored triage questions, keeping this within the context of the consultation.

Importance of Assessment Following Self-Harm or a Suicide Attempt

Although most people who self-harm do not intend to end their life, self-harm increases the likelihood of future suicide (see Box 8.1), such that every episode of self-harm needs to be taken seriously. National Institute for Health and Care Excellence (NICE) guidelines recommend that all patients receive a psychosocial assessment following self-harm (NICE, 2004, 2011); this intervention in itself can reduce repetition of the behaviour. In the general hospital, staff can minimize the chance of early self-discharge through compassionate engagement with patients who attend following self-harm. An assessment of suicidality is often not documented in routine clinical assessments. Though this may be inappropriate in a few consultations, it could result in inadequate assessment of suicidality (Malone *et al.*, 1995). Also, the way clinicians assess risk is likely to be influenced by their knowledge and attitude towards the subjects of suicide and self-harm, particularly the belief that risk must be eliminated or that blame will be attributed (Cole-King & Lepping, 2010).

Assessing a patient who may be at risk of suicide in primary care or following self-harm or a suicide attempt requires a biopsychosocial assessment, including: details of their suicidal thoughts, intent and plans; personal and demographic information; and a mental state examination. Although up to 90 per cent of suicide deaths are likely to have occurred in conjunction with a mental illness (Cavanagh *et al.*, 2003), less than a third of people who die by suicide in the United Kingdom have had contact with specialist mental health services in the 12 months before their death (National Confidential Inquiry, 2010). A large proportion of those who have not had such contact will have been seen in primary care or at the general hospital and many will have been known to have mental health problems (O'Neill *et al.*, 2014). However, only 25 per cent of people saw their GP after their last suicide attempt (McManus *et al.*, 2016). The pervasive expectation that risk must be controlled, and preferably eliminated, might paradoxically increase the likelihood of patients taking their own lives, than reduce it, as it can drive risk 'underground' and cause people to be reluctant to identify patients at risk of suicide for fear that they are unable to 'manage suicide risk'. 'Suicide mitigation' is a more helpful approach than 'suicide risk management' (Cole-King & Lepping, 2010a). As long as suicide is seen as the preserve of specialist mental health

BOX 8.1 Important Facts about Self-Harm

- Self-harm lies on a continuum of suicidal behaviour, and increases the person's capability for further suicidal behaviours. Once a person has self-harmed, the likelihood that he or she will die by suicide increases 50 to 100 times, compared to someone who has never self-harmed.
- Twenty per cent of people who attend hospital after self-harm repeat within a year (many return to the same hospital).
- One in 50 who attend hospital after self-harm will die by suicide within one year and 1 in 15 within nine years.
- More than 50 per cent of people who die by suicide have self-harmed (15 per cent within the previous year).
- People who self-harm also have a higher mortality from all causes (not just suicide).

(Chan *et al.*, 2016)

services, opportunities for intervention will be missed and, critically, every actual contact, wherever it occurs, must be an opportunity to intervene and prevent suicide.

Assessing a Patient for Suicidal Thoughts, Plans and Behaviour in Primary Care

Given the recognized flaws in the reliance on risk-assessment tools, it is no longer considered appropriate to use terms such as 'low risk' or 'high risk' in relation to suicide, nor is it appropriate to only respond to those who meet certain risk criteria. We therefore propose that suicide should be discussed with all patients who report mental health symptoms, life crises and difficulties coping with stress. The clinician should nonetheless be familiar with established risk factors and risk groups for suicide at a population level. It is important that clinicians do not rely wholly on this when assessing individuals. A person may be at high risk of suicide even though not a member of a high-risk group and, conversely, not all members of high-risk groups are at equal risk of suicide. The strongest risk factors for acting on suicidal thoughts in high-income countries are previous suicidal behaviour and a mood disorder, particularly if accompanied by substance abuse and/or stressful life events. The presence of 'red flag' warning signs suggests that that someone may be particularly at risk of suicide. However, risk factors and red flag warning signs should not be used to predict or rule out an individual suicide (or attempt).

The NICE guidelines state that everyone should receive a psychosocial assessment following self-harm (NICE, 2004, 2011). The importance of a thorough assessment is also supported by findings from the National Confidential Inquiry (2014) which highlight the need for assessment and management of patients at risk of suicide. The assessment must involve a thorough examination of individuals. This should include their risks, needs and protective factors and their interpersonal and social circumstances. The assessment of a patient at risk of suicide by general practitioners may need to be carried out on a regular basis, and it may be useful to gain a second opinion from a colleague if appropriate. As an example, impulsivity alone is unlikely to predict suicide. However, it may increase the likelihood of suicide if a person has few protective factors in place such as self-identified reasons for living, social and emotional support or access to professional emergency contacts.

It can be difficult to address the topic of suicide with patients as many clinicians are concerned that discussing suicide will lead to their patients seeing this as an option, or that it will encourage suicidal behaviour. Clinicians themselves may simply be uncomfortable about discussing this sensitive topic. There is now a wealth of evidence showing that asking about suicide does not promote new suicidal thoughts and is, in fact, associated with disclosure and progression towards recovery (Dazzi *et al.*, 2014). People who feel suicidal can often experience additional feelings of guilt or embarrassment about their thoughts, which can further contribute to a spiral of shame and suicidal behaviour. By asking about suicide, and responding in a calm, non-judgemental manner, the clinician normalizes and destigmatizes these thoughts. This serves as a validation of patients' experience and is often an enormous relief for them. A variety of approaches may be used to ask about suicide, and examples are provided in Box 8.2. While a variety of terms are available to describe suicide, it is important to use clear, direct language that the person is capable of understanding. Vague terms, or pejorative terms (e.g. 'doing something stupid') are to be avoided.

BOX 8.2 Assessment of a Patient with Suicidal Thoughts and Feelings (based on the CK Continuum & CK Classification, Cole-King, 2010*)

Assessment of Suicidal Thoughts

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:
Nature of the suicidal thoughts, frequency, intensity, persistence, intended outcome
Perception of the future as persistently negative and hopeless, hope, alternatives
Degree of planning, Internet research, learning about method, looking for place and time
Degree of preparation, putting affairs in order, stockpiling tablets, masking discovery
Ability to resist acting on their thoughts of suicide or self-harm.

Examples of Clear Language When Asking about Suicide

Is life worth living?
Have you wanted to harm yourself?
Have you had thoughts of suicide?
Have you ever thought about taking your own life?
Have you ever wished your life would end?
Have you ever thought about ending your life?
What has stopped you acting on those thoughts so far?

Suicide mitigation starts with the assumption that the expression of suicidal thoughts, however that is presented, always needs to be taken seriously and met with empathy and understanding. It is in this context that the clinician needs to probe further regarding the nature of the thoughts, their perception of the future, preparation, planning and an ability to resist. This informs the likelihood of the person acting on those thoughts or urges. Once a person has disclosed feelings of hopelessness for the future, thoughts of self-harm or thoughts of suicide, detailed questions about the nature of the thoughts and their frequency and duration are vital. It is important to discuss the likelihood of them acting on the thoughts, the strength of the urge towards self-harm or suicide and whether the person has a suicide plan and access to a method.

Undertaking a discussion about suicide is potentially life-saving, but the clinical encounter is heavily dependent on what the patient chooses to reveal or keep hidden. In the assessment process we rely on our patient to trust us with the often painful and difficult disclosure of their suicidal thoughts. The establishment of a therapeutic alliance and trusting relationship is essential for disclosure and permits the clinician to make a sound psychosocial assessment. The therapeutic relationship itself can also be a protective factor against suicide (Cole-King, 2010b, 2011). Though verbal content is important, people's non-verbal behaviours and the way they communicate distress are critical.

Health care professionals who are empathetic and compassionate encourage increased disclosure by patients about their concerns, symptoms and behaviour, and are ultimately more effective at delivering care (Larson & Yao, 2005). Negative attitudes and 'malignant alienation' (including therapeutic nihilism of professionals towards challenging patients) may intrude on the therapeutic relationship and actually contribute to a suicide (Watts & Morgan, 1994). Conversely, a more positive and understanding approach helps build a therapeutic alliance between suicidal patients and their therapists that can be a protective factor against suicide (Collins & Cutcliff, 2003).

For a variety of reasons (e.g. stigma, shame, fear or embarrassment), people may conceal or minimize their suicidal thoughts. People who are suicidal often report feeling ashamed, being reluctant to report this as a result of the stigma surrounding mental illness. The research on stigma and mental illness suggests that suicidal people may feel that others will judge them negatively. Some may also internalize the negative stereotypes that others hold about mental illness and this can lead to feelings of low self-worth. It is therefore important that, in discussions about suicide, clinicians adopt a non-judgemental stance. They should reassure patients that having suicidal thoughts or mental illness symptoms does not reflect badly on them as an individual.

How to ask about the nature of suicidal thoughts:

- Encourage patient engagement through the application of a non-judgemental, empathic and confident approach.
- Be aware of body language (both yours and the patient's).
- Start with open questions, followed by closed, specific questions about suicide intent and access to methods.
- Follow up with questions about barriers to action and reasons for living.

Box 8.2 provides guidance on asking about suicidal thoughts and feelings. It is important to maintain an open non-judgemental approach to the whole discussion, asking generally about feelings of hopelessness about the future, thoughts of self-harm, plans, behaviour and suicide attempts. It is important to note that suicidal behaviour may occur among those with no suicide plan or intent to die. The factors associated with impulsive suicidal behaviour (substance use, exposure to suicide and self-harm) should also be discussed. When a person reveals that they have experienced thoughts of suicide, it is important to ask about the frequency of the thoughts and when they occur, and whether the person has a plan for suicide.

The World Health Organization's World Mental Health Surveys (N = 84,850) found that 29 per cent of people with suicidal thoughts went on to make a suicide attempt, usually within a year. The probability increased to 56 per cent if there was a plan, and was 15.4 per cent if there was no plan (Nock *et al.*, 2008). Information about any suicide plan should be elicited and the clinician should establish whether the person has taken steps towards acting on the plan, for example, by putting their affairs in order. Increasing hopefulness, resilience and reasons for living have been shown to reduce the risk of suicidal behaviour. It is therefore important that, throughout the encounter, the clinician emphasizes the fact that treatment and recovery are possible.

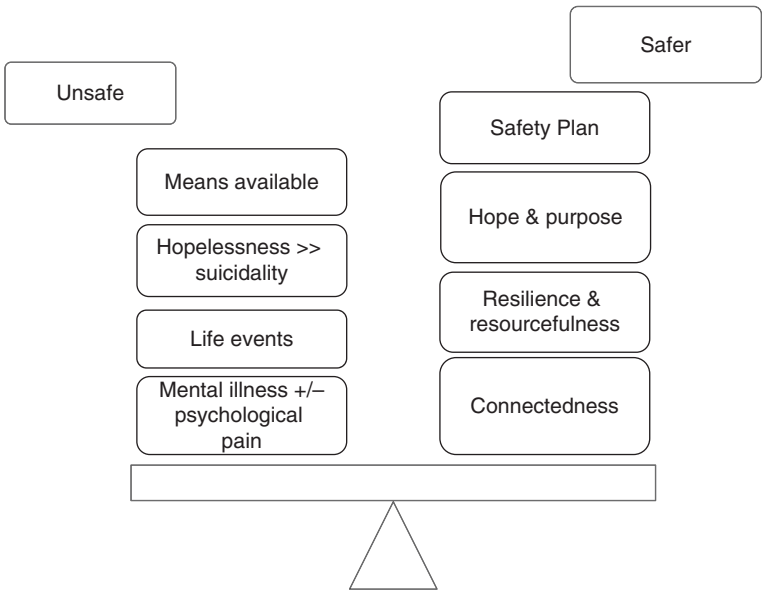

Figure 8.3 Tipping the balance towards safety*

Clinicians can gain useful and important information from third parties, such as family, friends or first responders, in addition to any objective evidence, particularly if someone has self-harmed or attempted suicide. The Triangle of Care document highlights the importance of collaborating with carers and the potential benefits to patients (Worthington, *et al,* 2013). Examples of objective evidence include: making plans or preparations for suicide, choice of method (if there has been a suicide attempt or self-harm), attempts to avoid discovery and a written note or will. Where there is concern about a person's risk of suicide, family members may serve as vital informants, with information that the patient themselves may not wish to disclose.

One of the challenges is maintaining patient confidentiality, while at the same time ensuring that key information about ideation, previous attempts and circumstances is disclosed and discussed. In 2014 a consensus statement on information sharing and suicide prevention was prepared by the Department of Health and signed by nine organizations, including the Royal College of General Practitioners and the Royal College of Psychiatrists. This clearly states that duty of confidentiality is no justification for not listening to the views of family members, friends or contacts. Their perspective may offer unique insights regarding the individual's situation or state of mind (Department of Health, 2014). This enhances the assessment, the care and the GP's response. It is also best practice to ensure families know how to access services in a crisis, all available self-help and online and helpline support as well as support services for carers.

The suicide assessment should generally not be seen as a separate process from the clinical assessment and the ongoing identification of the patient's needs, problems and strengths. The more clinicians understand about the nature of suicidal thoughts, the more they will be able to empower patients not to act on them. Some individuals have recurrent,

BOX 8.3 Risk Factors and Red Flag Warning Signs as Part of Triage Assessment.*

Demographic and Social

Perception of lack of social support, living alone, no confidants

Males (may not disclose extent of distress or suicidal thoughts)

Stressful life event (e.g. recently bereaved, debt/financial worries, loss of attachment/major relationship instability, job loss, moving house, engagement with criminal justice system)

Personal Background

Substance misuse alcohol/drugs

Feels close to someone who died by suicide (family or non-kin) or exposure to suicidal behaviour of key others (family, peers, favourite celebrity)

Use of suicide-promoting websites or social media

Access to lethal means

Clinical Factors in History

Previous self-harm or suicide attempt (regardless of intent, including superficial cutting)

Mental illness, especially recent relapse or discharge from inpatient mental health care

Impulsivity or diagnosis of personality disorder

Long-term medical condition: recent discharge from general hospital, especially pain

Mental State Examination and Suicidal Thoughts

High degree of emotional pain and negative thoughts (hopelessness, helplessness, guilt, 'I'm a burden')

Sense of entrapment or strong sense of shame

Suicidal ideas becoming worse

Suicidal ideas with a well-formed plan and/or preparation

Psychotic phenomena, especially if distressing: persecutory or nihilistic delusions; command hallucinations perceived as omnipotent

If red flag warning signs/immediate risk of suicidal behaviour, the patient will require:

- Immediate discussion with/referral to mental health services
- A robust safety plan (see later in this chapter)
- Adequate emotional and social support
- Removal of access to means

chronic or intractable suicidal thoughts. Others experience a unique pattern of thoughts and impulses as they progress towards a suicide attempt – their 'crisis signature'. Patients can be helped to monitor these thoughts, to recognize their 'triggering events' and to engage in self-management strategies and seek support before they engage in self-harm or attempt suicide. Box 8.3 provides details of the risk factors and red flag warning signs that should be discussed in the suicide assessment.

Case Vignette*

Dave Smith, a 54-Year-Old Married Caretaker

Dave works at a local care home and attended his GP surgery as an emergency with his wife. He has no past psychiatric history but has type 2 diabetes managed with diet and medication and an old back injury for which he takes painkillers. He has been irritable for a couple of months. He is managing at work, though anxious, and getting behind with household chores such as the family finances, leading to unopened letters and bills. Dave's uncle ended his life by suicide a number of years ago and Dave was very deeply affected at the time. Dave has two grown-up children and five primary-school-age grandchildren. One daughter lives locally and the other four hours away. Dave has a couple of close friends but has said he is too busy to see them and has recently given up his hobbies. His wife says he has been drinking more than usual, although he has recently stopped going to the pub where he used to go every Friday night.

His GP uncovers a debt problem and Dave reports feeling hopeless and guilty about this, even to the point of wondering if life was worth living at the start of that week. Today, when confronted by his wife regarding all their unpaid bills, he broke down, admitting that he was struggling. The GP establishes that Dave has suicidal thoughts and has started ruminating about the suicide of his uncle. Dave had not yet started to make any plans or preparations for suicide and manages to banish such thoughts as he doesn't want to die and leave his beloved family. Careful questioning suggests that there is no depressive illness. The GP assessed Dave as not requiring immediate referral to mental health services, but due to his negative and suicidal thoughts, they co-produced a safety plan (see later in this chapter) and arranged a review for later that week. They also co-produced a well-being plan: regular contact with grandchildren, physical activity, eating a healthy diet, reducing alcohol, picking up old hobbies and re-establishing contact with friends.

Dave's Safety Plan

Element of Safety Plan	Actions and Information
Reasons for living	Photos of wife, daughters, grandchildren. Think of friends and wider family, holidays, TV, sport. Remind myself I'm a good husband, father, granddad, friend
Safe environment	Keep medication in a locked cabinet until situation improves
Identify distress triggers	Debts: make a budget, call the bank & National Debt Line 0808 808 4000 www.nationaldebtline.org/ Worrying about work – speak to line manager
Calming/distracting activities	Go for a walk, watch home movies of grandchildren or favourite TV, listen to music, read newspaper, puzzles
General support	Speak to wife and daughters (include their names and all contact numbers) Samaritans: freephone 116 123, CALM freephone 0800 58 58 58 or www.thecalmzone.net
Professional support	See GP, out of hours if needed
Emergency contacts	Samaritans freephone 116 123 www.connectingwithpeople.org/StayingSafe Attend emergency department (previously called A&E)

Suicide and Young People

People usually take their own lives because the distress of living becomes too great, or illness or other personal circumstances seem intolerable. Young people in particular can have difficulty coping with stressful life events and remaining hopeful about the future when faced with failure or loss. This can lead to suicidal thoughts. Statistics published by the National Confidential Inquiry (2016) demonstrate that a high proportion of the young people who died by suicide had experienced life events such as bereavement, family ill health, bullying, neglect or abuse. For some people an apparently 'routine' event such as exam pressure or common conditions such as asthma or acne served as the 'final straw' and precipitated suicidal behaviour.

It is important that GPs listen to young people and realize that for some a seemingly 'minor' issue could lead to suicidal thoughts. Also risk factors and red flags may not be present. Only one in five young people aged between 16 and 24 with suicidal thoughts would seek help from a GP, so it is vital to take them seriously when presenting. Young men are particularly unlikely to seek help unless severely distressed (Gulliver, Griffiths & Christensen, 2010). Young people's perceived stigma and embarrassment, problems recognizing symptoms (poor mental health literacy) and a preference for self-reliance are the most important barriers to seeking help. However, there is evidence that young people perceive positive past experiences, and social support and encouragement from others, as aids to the help-seeking process.

It is therefore important that information about a young person's suicidal thoughts are shared with their family and support network. Strategies for improving help-seeking by adolescents and young adults should focus on improving mental health literacy, reducing stigma and taking into account the desire of young people for self-reliance. Poor or limited problem-solving skills are considered relevant. The risk may also increase when young people identify with people who have taken their own life, such as a high-profile celebrity or another young person. It is not usually the nature of the issue or life crisis itself that elevates the risk of suicide, it is the person's perceptions of how it will impact their future. It is therefore important to ask about whether the person can see a solution or a way of overcoming the difficulties that they are presented with.

A recent paper identifies some of the challenges faced by some GPs when treating young people who self-harm, including their perceived difficulties in communicating with the young people who they felt were at risk of suicide (Michail, Tait & Churchill, 2017). Sadly, half of all young people who have died by suicide had a history of self-harm; therefore, self-harm should be viewed as an opportunity for suicide prevention and mitigation. Most young people who self-harm are able to develop alternative ways of coping and replace the act of self-harm with less harmful coping strategies.

'Talking not Harming' is an important transition in the road to recovery. Treating self-harm behaviour involves gradually replacing coping through self-harm with less harmful strategies. This work should be undertaken in collaboration with clinicians with specialist training in self-harm. Paradoxically, it can be counterproductive to simply forbid the person to engage in self-harm, or remove their access to methods of self-harm. In addition, it is well established that under-treated depression in children and young people is associated with a higher risk of suicide. The possible risks of harm from antidepressants or psychological therapy must always be balanced against the benefits of treatment and the elevated risk of suicide in untreated depression.

Referring to Mental Health Services

The best outcomes for patients with mental illnesses are achieved with collaboration between secondary and primary care (Gilbody *et al*., 2006). If you uncover suicidal thoughts, and the presence of any of the red flag warning signs, it is important to assess whether your patient has a mental illness, requiring urgent mental health specialist contact and/or if it is safe to review in one or two days; this is a heightened form of 'watchful waiting' and the time frame will depend on the clinical situation. If a person is suicidal and has a plan that will be enacted in the near future, psychiatric inpatient care may be necessary. In the case of a patient with an identifiable mental illness, but who is less acutely suicidal, it is appropriate to discuss a treatment plan for the mental illness. In these cases it is important to find ways of instilling hope that the treatment will be effective, and to gain the patient's cooperation in adhering to the treatment strategy, whether it be medication, talking therapies or a combination of approaches.

The interaction often involves a process of negotiation with the patient, with the goal of getting the patient to put their plan for suicide on hold and keep themselves safe until the treatment starts to work. It is important to note that the severity of mental illness is frequently unrelated to the risk of suicide, and that people can enact suicide plans when they are appearing to show signs of recovery.

For individuals where there is a situational crisis or life events it may be necessary to link with other support agencies and offer a psychological therapy. Collaborative and narrative approaches to the suicidal patient offer promise in helping patients at risk of suicide to stay safe (Michel *et al*., 2002). The next stage in mitigating suicide risk is the co-production of a 'safety plan'. Safety planning has been recommended as an adjunct to treatment (Stanley *et al*., 2008; Stanley & Brown, 2012; Jobes, 2016). This is where the patient, usually in cooperation with a doctor, makes a plan to keep themselves safe while undergoing treatment for the underlying mental illness or situational crises. Social relationships and connectedness is protective among those with suicidal thoughts (Joiner, 2005). The patient–professional relationship can also be a powerful protective factor against suicide. A trusted GP is often best placed to offer support and may use phrases such as 'I want to support you and you need 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 hear how you are getting on?'

The 'Bank of Hope'

In addition to identifying risk factors and red flag warning signs, clinicians should focus on promoting protective factors, such as reasons for living, hopefulness, personal resilience and resourcefulness. Meaning and purpose in life is individualistic and possible for all humans (Jobes *et al*., 2011), Even a brief psychological intervention with contact may be effective in reducing subsequent suicide mortality (Fleischmann *et al*., 2008). The 'Bank of Hope' is a set of simple coping strategies designed to promote resilience and to decrease the impact of distress felt by individuals in emotional and physical pain (Cole-King *et al*., 2009, 2011). The strategies are designed to instil hope, to enhance the self-efficacy and internal locus of control of a suicidal person and to reduce the potency of suicidal thoughts and thus the likelihood of acting on these thoughts. Please see Box 8.4 for an overview of these.

The Bank of Hope strategies have been developed as an adjunct to treatment as usual. A tailored history, mental state assessment, treatment and safety plan are still required in addition to sharing these strategies with patients. The key is facilitating patients to think

BOX 8.4 Therapeutic Strategies from the Bank of Hope (Cole-King, 2009)*

Maximise the power of the individual not to act on their suicidal thoughts:

- Increase well-being and resilience – enhance protective factors.
- Increase emotional resourcefulness and share simple problem-solving techniques to better equip them to deal with their triggers for suicidal thoughts or adverse life events should they occur/continue.
- Increase internal locus of control – 'do not be a *passive victim* of suicidal thoughts'.
- Increase self-efficacy – uncover or learn the skills and techniques not to act on suicidal thoughts.

Reduce the power of suicidal thoughts:

- Help patients see that suicidal thoughts don't last forever.
- Intense suicidal feelings are often short-lived (although acknowledge that individuals may have long-lasting suicidal thoughts which can still be very distressing).
- Share examples of others who made serious and potentially lethal suicide attempts but who changed their mind immediately before or halfway through and realized that they did not want to actually die, it was just that they felt so desperate and hopeless that they did not know what else to do to make those feelings go away. **Their real wish was to feel better, not to actually die.**
- Reduce the 'power' of their suicidal thoughts, while acknowledging and validating the distress they can cause to the individual experiencing them.
- Help the individual experiencing suicidal thoughts to view those thoughts as nothing more than 'a symptom of distress' (like having a temperature due to a viral illness), rather than some powerful magical impulse that they cannot resist.

about their reasons for living and to find cognitive and/or physical cues to promote hopefulness. GPs should never presume that they know what these cues are or judge the importance of these cues to the individual patient. There is no hierarchy of reasons to stay alive. The co-produced safety plan uses tangible reminders and cues, patients' own reasons for living and strategies they have rehearsed to deal with their distress.

For some patients in extreme distress or thinking of carrying out a plan for suicide imminently the Bank of Hope strategies may be limited in empowering them not to act on their suicidal thoughts. If this approach appears not to be working for the patient, they may be at an even greater risk. In this situation, the Bank of Hope strategies can be used as a 'diagnostic aid' to discriminate between degrees of distress and the immediacy of suicide. This detail will form part of an effective emergency referral to mental health services. These can be further enhanced by the use of some simple solution-focused techniques.

Social prescribing is one way of connecting patients to other forms of community support and beneficial interventions (Faulkner, 2004). It is a particularly powerful way of addressing mental health problems and self-harm in primary care while maintaining people outside of hospital and specialist care. It is a non-medical referral option that can operate alongside existing treatments to improve health and well-being. Another important initiative is the use of care navigators placed in GP surgeries to help patients deal with issues such as debt and housing, thus reducing the demand for antidepressants and secondary care referrals (Grayer, 2008).

Developing a Safety Plan

A safety plan is an agreed set of activities, strategies, people and organizations to contact for support if someone is concerned about engaging in self-harm or becoming suicidal, or if their suicidal thoughts get worse. A safety plan should be co-produced by the patient, who will identify most of the elements; if the patient is unable to articulate their wishes or when the risk is high, however, the clinician may have to take a more directive role. A safety plan can be developed over more than one session and may need to be revised regularly, depending on individual need. A safety plan can be paper based or recorded electronically.

A safety plan is different from a 'no suicide contract', for which there is no empirical evidence base and is not recommended (Rudd *et al.,* 2006; McMyler & Pryjmachuk, 2008). The biggest difference is that the development of a safety plan is led by the person in distress. It is a co-produced set of strategies that the person at risk finds helpful and it includes people they nominate and trust to contact for support and a discussion of how they can make their lives safer by removing or mitigating access to means. If none of that works, they have a 'ready-made' plan of a pathway they can use to access specialist suicide prevention or National Health Service (NHS) support, when they need it at a time that they need it.

Many people find it difficult to disclose thoughts of suicide due to stigma, fear or embarrassment. Even if a patient does not disclose or has not yet developed suicidal thoughts, their practitioner may consider co-producing an 'ultra brief' safety plan to better equip their patient should they ever become suicidal in the future. Making such a safety plan will build a patient's own resilience and resourcefulness to confront any potential future suicidal thoughts due to new triggers and life events or recurrences of distress or a worsening of a mental illness.

A safety plan should include:

- Reasons for living and reasons not to harm themselves.
- A plan to create a safe environment. How can they remove or secure things they could use to harm themselves? Can they identify and avoid things that they know make them feel worse? These are called distress triggers.
- Activities to lift mood, calm or distract.
- People to talk to if distressed. Include contacts for general support (not necessarily confiding their suicidal thoughts) and specific suicide prevention support.
- Professional support such as 24-hour crisis telephone lines.
- Emergency NHS contact details.
- Personal agreement that the safety plan was co-produced and a commitment to follow when required.

Include names and all phone numbers for people to contact.

Specific Ways that GPs Can Contribute to Suicide and Self-Harm Prevention

The newly published House of Commons Health Committee 'Suicide prevention: interim report' HC300 highlights the vital role of GPs and that they need more training. 'To help people who are in contact with primary care services, GPs need better training in suicide risk' (House of Commons Health Committee, 2016). NICE guidelines should be promoted and implemented across primary care. In addition to assessing and providing targeted interventions to reduce the likelihood of suicide, as noted earlier, GPs have a specific role in

managing and treating any underlying illness, including a mental disorder, as this also has an impact on reducing future suicide. A recent paper by Knapp, McDaid and Parsonage (2011) demonstrated the potential cost-effectiveness of this approach. This describes a model of early recognition, intervention (including increased access to psychological therapy) and pharmacological therapy as having an effect on reducing suicide. This describes a multi-intervention approach that may be cost-effective within the first year. It is therefore possible that by raising awareness and improving suicide risk-assessment skills, some suicides could be prevented. More robust training could reduce morbidity and mortality (Sudak *et al.*, 2007).

A key element of suicide intervention is reducing or removing access to lethal means. One consideration is for GPs to prescribe all medication in small amounts. This can be aided by weekly scripts or asking the pharmacist to dispense on a weekly basis. There may also be the option to involve carers (or others) who could look after and 'monitor' medication use. It might identify someone stockpiling. This would be part of creating a safe environment in a safety plan. It is known that some antidepressants are more toxic in overdose than others and it would be prudent to consider less toxic medication where people may be at risk of suicide.

Primary care teams are at the frontline of suicide prevention, yet most NHS professionals currently experience little or no appropriate and relevant training in assessing and responding to patients at risk of suicide and self-harm. Educating primary care clinicians can help protect against suicide in their patients by improving the recognition and treatment of depression. 'Physician education' is one of only a few measures to significantly reduce suicide rates. Training of health professionals has also been shown to reduce the stigma surrounding self-harm and to improve the care of patients following self-harm. More robust training could reduce morbidity and mortality (Mann *et al.*, 2005).

The Impact of Suicide

The House of Commons Health Select Committee report (HSC 2017) recommended that 'high-quality support for all those bereaved by suicide' should be included in all local suicide prevention plans. Those bereaved by a suicide are at increased risk of mental health and emotional problems and are at higher risk of suicide themselves (Pitman *et al.*, 2016). It is vital that their GP feels confident to talk to them about suicide and to know where they can access the right support, which is essential.

Previous research suggested that about six people are significantly adversely affected by each death of someone by suicide. New research by Cerel and colleagues (2014) suggests that the figure is considerably higher, with more than 130 people being adversely affected.

Dealing with the suicide of a patient is extremely distressing. In a recent study GPs talked of their duty to care for their bereaved patients who had lost their adult children to suicide. The GPs talked of difficulties in knowing what to do, and in particular their perceived absence of other suicide bereavement support services. GPs reflected on the impact of the suicide on themselves and described a lack of support or supervision (Foggin *et al.*, 2016).

The excellent resource 'Help Is at Hand: A Resource for People Bereaved by Suicide and Traumatic Deaths' offers practical support and guidance for those bereaved by suicide (see Resources List). Support after Suicide is a partnership of organizations that provide bereavement support in the United Kingdom, and GPs are encouraged to visit their website to familiarize themselves with all the available support (http://supportaftersuicide.org.uk/).

Addendum: A Solution-Focused Therapy Approach

Solution-focused brief therapy (SFBT) was developed in the 1980s by Steve de Shazer and Insoo Kim Berg of the Brief Family Centre in Milwaukee in the United States. Solution-focused interviewing can help people construct realistic and workable solutions to their problem situations. The approach is based on solution-building rather than problem-solving (Iveson, 2002). The most empirical support was found for the strength-oriented techniques in comparison to the other techniques and for the co-construction of meaning (Franklin, 2017).

Words with a positive connotation (i.e. 'good', 'success' and 'solution') can be more helpful in building a sense of hopefulness and/or self-efficacy compared to those with negative connotations (i.e. 'bad', 'failure' and 'problem') (Henden, 2017). However, it is important to acknowledge the individual's current level of suffering, and not minimize this, in order to avoid being interpreted as patronizing. It is distressing to a patient if they feel that they are being invalidated, and so compassion and sensitivity are required, and questions such as the 'Miracle Question' will need sensitive handling if someone is in despair. Presuppositions, which may be defined as 'implicit, unconscious suggestions', seem very rarely to be resisted by patients and impact at a deeper level, often promoting a sense of self-efficacy. This assists future-orientated thinking. Presuppositional open questions which are affirming and empowering can assist a health care professional support a patient to stop the progression of their suicidal thinking and planning, such as:

'How did you cope with previous difficult/distressing situations?'

'How have you coped with this situation up to now?'

'When you are feeling just a little more optimistic, what thoughts about the future might you be having?'

'When you look back on this testing period in your life, what do you think the main thing will have been that got you through it?'

The (adapted) Miracle Question can serve as a useful question to ask a suicidal person at first interview:

'Just suppose when you go home tonight . . . you go to bed . . . go to sleep . . . a miracle happens . . . and all these strong suicidal feelings and ideas are gone. Only you won't know this miracle has happened, as you are asleep at the time.

When you wake up in the morning . . . what will let you know that the miracle has happened? What will be the first thing you will notice?'

Key Points

- Suicidal people don't necessarily want to die. They are in unbearable psychological pain; they don't want the life they are living, and see no prospect of it getting any better.
- Mental illness, addictive substances, information about treatments and also erroneous fears about inevitability of suicide, etc. can alter how we see the future.
- Addressing any underling health needs (mental or physical), psychological or social factors can mitigate risk of suicide.
- Behaviour is best described as a cry of pain (*not* a cry for help).
- Hope for the future can prevent action in response to suicidal thoughts.

- Connectedness with others can prevent action.
- Do not be scared to ask about self-harm or suicidal thoughts – this is the first step in reducing the risk of completing suicide.
- If suicidal thoughts or plans, or self-harm, are disclosed, it is important to ask about intent to die, imminent plans and access to methods. Removing access to lethal means saves lives.
- All patients who self-harm or experience suicidal thoughts, however 'minor', require a co-produced safety plan and triage mental health assessment.
- All GPs and primary care practitioners should undertake suicide awareness and intervention training.
- Document the date, time and important factors in the history and examination. 'If you did not document it, then you did not ask it.'
- Make sure you have a contact number, preferably a mobile, so that you can contact your patient if they do not turn up at the follow-up session.
- Use a meaningful and collaborative framework that supports this documentation.

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Related E-learning and Podcasts

The Lancet Psychiatry and the Mental Elf. 'Preventable harm' based? Podcast of debate hosted at University College London, 22 July 2016. www.thelancet.com/lanpsy/audio (accessed 15 Nov 2016)

BMJ Talk Medicine. Revisiting the bridge. Podcast. https://soundcloud.com/bmjpodcasts/revisiting-the-bridge

RCGP suicide prevention e-learning www.rcgp.org.uk/learning/online-learning/ole/suicide-prevention.as

Online webinar in youth suicide prevention www.nationalelfservice.net/campfire/suicide-prevention-in-young-people/

Recommended Reading

NICE has developed two sets of clinical practice guidelines on self-harm for the NHS in England, Wales and Northern Ireland:

- Short-term management and secondary prevention of self-harm in primary and secondary care http://publications.nice.org.uk/self-harmcg16
- Longer-term management of self-harm. It includes recommendations for the appropriate treatment for any underlying problems (including diagnosed mental health problems). It also covers the longer-term management of self-harm in a range of settings http://publications.nice.org.uk/selfharm-longer-term-management-cg133

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Resources for People at Risk of Suicide

GPs are encouraged to review the following resources and share them with patients wherever the opportunity arises. They are an ideal source of support and patients can be included in their safety plans; a bookmark on their smartphone or tablet, for reference and later reading, can be very powerful.

Staying safe if you're not sure life's worth living has practical, compassionate advice and links for people in distress www.connectingwithpeople.org/StayingSafe.

The ***U Can Cope*** film has inspirational stories from three people for whom life had become unbearable but who found a way through with support www.connectingwithpeople.org/ucancope.

The following Royal College of Psychiatrists leaflets include practical, compassionate advice and links to numerous UK crisis support organizations, including Samaritans who offer a free call helpline available round the clock on 116123.

- ***Feeling on the edge helping you get through it*** – for people in distress attending the emergency department following self-harm or with suicidal thoughts www.rcpsych.ac.uk/healthadvice/problemsdisorders/feelingontheedge.aspx.
- ***Feeling overwhelmed and staying safe*** – for anybody struggling to cope when bad things happen in their life and includes advice on how to make a safety plan www.rcpsych.ac.uk/healthadvice/problemsdisorders/feelingoverwhelmed.aspx.
- ***U Can Cope*** – designed to help young people develop resilience and cope with any current/future difficulties in their life; helpful for adults too www.rcpsych.ac.uk/healthadvice/parentsandyouthinfo/youngpeople/ucancope.aspx.

  All three leaflets are available at www.connectingwithpeople.org/ucancope.

For People Bereaved by Suicide

Help Is at Hand booklet

www.nhs.uk/Livewell/Suicide/Documents/Help is at Hand.pdf

DearDistressed Project

#DearDistressed invited bloggers with lived experience to write and publish a letter to themselves that would have helped them in their darkest moments. Sharing the personal experience of recovery is an incredibly personal and powerful way to reach and help others who are struggling with some much-needed hope http://connectingwithpeople.org/wspd16.

The project has two main objectives:

- To send a clear message to anyone emotionally struggling that 'suicidal thoughts are a sign to change something in your life, not to end your life, and that it IS possible to recover, with the right support'.
- To send a clear message to everyone that 'anyone can find themselves thinking that life isn't worth living and it's essential to seek support'.

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