

Health, Social Care and Sports Committee's inquiry into suicide prevention.

The Royal College of General Practitioners Wales (RCGPW) welcomes the opportunity to respond to the Health, Social Care and Sports Committee's inquiry into suicide prevention.

RCGPW is grateful for contributions to this response to Dr Nigel Mathers, Dr Clare Gerada, Dr Steve Mowle, Dr David Paynton and Dr Liz England who have previously responded on behalf of RCGP to an enquiry to the Westminster Select Committee enquiry into the same subject last year as well as to local members from Wales.

The RCGPW is part of the RCGP, which is the largest membership organisation in the United Kingdom solely for GPs and GPs in training. Founded in 1952, it has over 50,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with expertise in patient-centred generalist clinical care.

Our response focuses on the role of general practice in preventing suicide. Although self harm may be related to suicide as described in Talk to Me 2 some of those presenting with self harm have a different disease protectory. This needs to be taken seriously and those who self harm should always be assessed for suicide risk.

Summary

1. Talk to Me and Talk to Me 2 were published to link with the Mental Health Plan and help the strategy for preventing suicide in Wales preventing suicide. There is clearly a role for general practice and GPs to play in reducing suicide. However, there are many issues which mean that general practice is currently constrained in its ability to prevent suicide. We are aware that the implementation of the strategies set out in Talk to Me 2 are patchy particularly the improvements in school counselling services. Some counselling services to universities and higher education services have been reduced. We are not aware of improvements in occupational health services in relation to mental health and wellbeing. In some areas it was reported to us, where there have been several suicides within a school, counselling services may be stretched and young people and children traumatised by multiple bereavement issues needing additional skills that may not be easy to access.
2. There are many challenges which mean it is difficult to ensure that all patients at risk of suicide are identified and that all risks are acted upon, such as a lack of opportunities for assessment, the interface between primary and secondary care, and the current crisis in general practice. Universal screening for suicide risk is not practicable, though there are some factors which could provide the basis for increased opportunistic assessment, such as the presence of long term physical health conditions or drug and alcohol misuse.

3. Even when a patient has been assessed as being at high risk of suicide, there are many barriers to referral which mean that GPs are often left unable to act when they assess a patient as being at high risk, most often a lack of capacity within secondary care services. The interface between primary care and secondary care often prevents GPs from referring suicidal patients to treatment and must be improved, for example by mandating secondary care services to respond to the referring GP within a certain time frame, especially in urgent cases. The location of mental health services within clusters or general practice would also allow more suicidal patients to be seen by a specialist.
4. There is a role for increased training for GPs and all health professionals to improve suicide risk assessment and treatment. However, this must be manageable and provide multiple options for health professionals. Funding should be provided to extend training for GPs to four years to allow trainees more exposure to patients who are at risk of self-harm, suicide, or who have mental health problems.
5. Ultimately, GPs will be limited in their ability to prevent suicide as long as the service continues to be under-resourced and under-staffed.
6. There is potentially scope for adopting a zero-suicide strategy which has been shown to be effective in preventing suicide, and is explored later in this submission.

Suicide risk assessment in primary care

7. There is some evidence to suggest that many individuals who commit suicide consult with their GP close to the time of their death. The 2014 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness states that 45% of people who commit suicide consult with their GP in the preceding monthⁱ. This has led to concerns about low levels of risk assessment.
8. However, a Nuffield Trust study, also in 2014, found that two-thirds of patients see their GP at least once during the last three months of lifeⁱⁱ. This suggests that it is not only people who commit suicide who are likely to consult their GP close to the end of their life, but that it is in fact all people who are likely to do so. It is therefore difficult to conclude that the correlation between prevalence of GP consultations in the month prior to death for people who commit suicide is due to poor risk assessment of suicide in general practice.
9. The National Confidential Inquiry also found that 37% of people who died by suicide had not seen their GP in the previous year. Among the 37% who had not seen their GP, suicide risk was increased by 67%ⁱⁱⁱ. Therefore, even if suicide risk assessment in general practice were significantly improved, a significant

proportion of those who commit suicide would still not be helped due their non-attendance at their GP.

Maximising the effectiveness of suicide risk assessment in primary care

10. There is certainly a role for general practice and wider primary care to play in identifying and reacting to suicide risk, and there are some factors which can be used to more reliably identify a need for suicide risk assessment.
11. As well as finding that GP non-attendance increased suicide risk, the National Confidential Inquiry also found that risk of suicide increased as the number of GP consultations with the patient grew, with a 12-fold increase in suicide risk in patients that attended their GP more than 24 times in the final year of their life^{iv}. This correlation between very high rates of GP attendance and suicide risk tallies with known risk factors for suicide, for example long-term physical health problems, drug and alcohol misuse, a diagnosis of a personality disorder, and current and past mental health problems. Each of these risk factors for suicide may also cause a patient to attend their GP more often.
12. There is insufficient evidence to recommend general screening for suicide prevention in primary care, but factors such as those listed above can be used to form the basis of a more targeted assessment approach. Risk markers and areas of concern such as those mentioned above could be flagged in patient records, or an electronic alert could be added to highlight patients, for example, with increasingly frequent attendance or patients prescribed more than one psychotropic drug, or specific combinations such as benzodiazepines with antidepressants.
13. The RCGP Perinatal Mental Health toolkit has a section on managing suicide risk for those at risk with perinatal mental health issues but also those at risk of domestic violence: <http://www.rcgp.org.uk/clinical-and-research/toolkits/perinatal-mental-health-toolkit.aspx>
14. Doctors are a high-risk group and there needs to be an emphasis on ensuring that all doctors particularly GPs are registered with a GP and that they have access to good occupation health services with counselling and wellbeing support. For those patients who are not attending general practice, opportunistic screening could be trialled, for example during new patient health checks when they register with a GP. This would help to establish a patient's suicide risk when they register with their GP so that the GP could proactively reach out to high risk patients even if they are not attending general practice regularly.

Difficulty referring patients

15. Even when suicide risk is accurately identified, many GPs report problems referring patients to specialist services. For example, one study found that in two cases out of 27 where GPs made referrals, these referrals were not acted upon by the service as a matter of urgency and the two patients in question died within two weeks of their final GP consultation^y. Though these are not large numbers they are not insignificant, and they certainly corroborate anecdotal evidence the College has received in answering this inquiry, namely that GPs are consistently having difficulty having their referrals accepted when referring patients to specialist mental health services. This has been reported in Wales from individual GPs during the preparation of this report. Teenagers can compound problems as referral to CMHS is restricted especially in some parts of Wales.
16. In some areas GPs reported that referral in hours for assessment by Mental Health worked well for patients presenting to general practice services. Patients who presented outside of the 9am-5pm hours Monday to Friday and often earlier on a Friday found the services less good. This was compounded if there were additional transportation issues causing undue additional distress for patients. There were particular problems reported by a GP from Blaenau Gwent area. Sometimes arranging referral takes up a considerable amount of GP time. The GP may need to track down and speak to different mental health care professionals.
17. In one case, a College member reported being unable to get a patient accepted into secondary mental health services due to a divergent assessment of risk. This meant that the GP was left with no other option but to advise the patient to attend A&E if suffering from a crisis. This is clearly unacceptable and speaks to the relative unavailability of specialist mental health services as well as the problem of the primary/secondary care interface in suicide risk assessment. There are also problems when patients have mental health as well as substance or alcohol abuse issues. There can also be problems if patients are older and do not fit the criteria for the Primary Care Mental Health Team or the Crisis unit.
18. The suicide prevention requires communication between secondary and primary care as being vital to ensuring high levels of care for patients who are identified as being at risk of suicide. We have not found evidence to suggest that communication has improved since the implementation of Talk to me or Talk to me 2.
19. At the least, progress must be made on simplifying the interface between primary and secondary care. GPs will always be limited in their ability to prevent suicide

- when secondary mental health services disagree with the GP's assessment of risk or simply do not have the capacity to accept referrals from GP services.
20. In Wales Community Mental Health has been moved essentially out of secondary care but it is not part of primary care and not linked to general practice. It has meant that services are closely zoned into localities, and patients who move find that they often must wait re-referral and it has separated it further from secondary and tertiary care mental health. The increased location of mental health services in primary care should also be considered. 90% of all initial patient contact occurs within general practice, including for mental ill health. To render more efficient, the process by which patients receive treatment for mental ill health, the movement of mental health services closer to the community should be supported. Funding and staff resources for this should be relocated from other parts of mental health.
 21. Most Gps have access to counsellors in their own practices as well as to assessments by the primary care mental health support services (PCMHSS). The waiting time for therapy via these services may be long i.e. 3-6 months. These healthcare workers should be trained in assessment of suicide risk and be able to refer patients onward for management in mental health. Currently counsellors are unable to see children and young people under 18 years and there are limited services via PCMHSS for this group.
 22. For those in education or work there is a great importance in being able to get contact health support and counselling including occupation health and wellbeing services. We are concerned that although Talk to Me 2 advocated these being increased, cut backs relating to austerity have occurred.

Training

23. Many GPs have reported that they have not received formal training in preventing self-harm and suicidal ideation – clearly it is important to ensure that this is addressed. Current suicide prevention training models have been successful, for example the STORM programme which improved skills and was well-received by GPs and staff.
24. There is also evidence to suggest that final consultations with patients who commit suicide have been liable to be of limited utility in terms of suicide prevention. In one study, interviews with 159 GPs whose patients committed suicide found that in only 15% of cases did the patient express suicidal thoughts or intentions during their final consultation, only 26% of GPs reported being concerned for their patient's safety during the final consultation, and only 16% felt that the suicide could have been prevented^{vi}. The risk that regular attenders at GPs surgeries are not regularly reassessed for suicidal risk remains a possibility

and enhanced education for GPs focussing on targeted risk assessment would help to improve this.

25. However, training programmes must be flexible in order that all GPs and primary care staff are able to benefit. Current models may present a barrier to engagement as they can be quite intensive, lengthy, and inflexible: given the current unsustainable workload of GPs and their staff, due to persistent underinvestment and a chronic shortage of GPs, these training models may be inappropriate for many GPs and their staff. Future training programmes should focus on developing a broader package of training to deliver benefit for those who are unable to attend courses, for example by making greater use of online resources. There is also a need for better monitoring of outcomes from educational approaches to measure their impact on suicide prevention in primary care.
26. The College has collaborated with the Royal College of Psychiatrists to produce many resources on approaches to suicide prevention. The RCGP has developed a mental health toolkit with a specific suicide and crisis care section, a suicide assessment toolkit, and information sharing guidance:
<http://www.rcgp.org.uk/clinical-and-research/toolkits/mental-health-toolkit.aspx>
Healthcare professionals are also able to access an RCGP eLearning module on suicide prevention free of charge. The College continues to work in this area and is a signatory to the Crisis Care Concordat.
27. The RCGP has had its case for four-year GP training accepted in principle. However, this has not been delivered and the funding has not been made available. Four-year GP training, with an extension of the minimum time spent in general practice placements to 24 months, and an increase in the proportion of trainees undertaking psychiatry placements, will better prepare new GPs with the skills to be able to provide high quality care for people at risk of self-harm and suicide, along with numerous other complex and multiple health problems. The Government must now act to deliver four-year GP training.

Zero suicide strategy

28. There is evidence that a zero-suicide approach could be successful in reducing suicide. In Detroit, Michigan, a programme was launched by Henry Ford Health System whereby zero suicides was adopted as a target and actions were taken such as the establishment of a protocol to assign patients into one of three levels of risk for suicide, each requiring a specific intervention; the provision of training for all psychotherapists to develop competency in Cognitive Behavioural Therapy; and the establishment of three means of access for patients – drop-in group medication appointments, same-day access to care or support, and email updates. This led to a reduction in the suicide rate in Henry Ford Health System's

patient population by 75% from 89 suicides per 100,000 patients to 22 per 100,000 from 2001 to 2005. By 2008, the group had achieved a zero-suicide rate^{vii}.

29. Research should be conducted to explore how such a strategy could be adopted in the UK to deliver a whole system approach to suicide reduction.

Resourcing

30. Ultimately, while there are many means by which the ability of GPs to improve suicide reduction could potentially be improved – such as improved training, an improved interface between primary and secondary care, and the increased location of mental health services within general practice or clusters – the ability of GPs to prevent suicide will be necessarily constrained by the conditions in which GPs are working and the sustainability of general practice.
31. Since 2005 the level of investment in general practice has significantly declined as a proportion of the NHS budget, and the number of GPs has failed to keep pace with rising demand, with the number and complexity of consultations increasing due to an ageing and growing population. This has left general practice overburdened, with GPs themselves facing unsustainable workloads. In this context, the ability of GPs to make any meaningful contribution to suicide prevention is reduced.
32. Therefore, as well as the actions above, we request that the Welsh Government ensure that funding is transferred into general practice and the issues addressed in the RCGP Transform Document are implemented to improve access for patients, and give GPs the time they need to make the fullest possible impact on suicide reduction. <http://www.rcgp.org.uk/news/2016/october/rcgp-wales-calls-for-297m-extra-investment-by-2021-to-save-general-practice.aspx>

i

Suicide in primary care in England: 2002-2011. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester, 2014. p.3

ii

Exploring the cost of care at the end of life. Nuffield Trust, 2014. p.2

iii

NCISH, p.3

iv

NCISH, p.3

v

Pearson, 2009.

vi

Primary care contact prior to suicide in individuals with mental illness. Pearson, Anna, et. al.
British Journal of General Practice, November 2009, 59 (568). pp. 825-832

vii

Depression Care Program Eliminates Suicide. Detroit, Michigan: Henry Ford Health System,
2010. Available at: <http://www.henryford.com/body.cfm?id=46335&action=detail&ref=1104>