Suicide Prevention: GPs professional views & practice experience

Findings of a Survey

Monitoring & evaluating the implementation of CfL

December 2017

Background: Connecting for Life (C*f*L), Ireland's national, coordinated, multifaceted strategy to reduce deaths by suicide and self-harm, recognises the important context that primary care plays in suicide prevention. Within this context, the General Practitioner (GP) plays a vital role.

In May 2017, the Monitoring & Evaluation Team & Clinical Advisor in the National Office for Suicide Prevention (NOSP) designed a survey, which in conjunction with Irish College for General Practitioners (ICGP), was circulated to all members and associates of the ICGP. The findings from the survey are being used by the NOSP Clinical Advisor to identify needs and inform service planners to shape how services might be better designed and delivered for and to, primary care practitioners to support their work with suicidal and self-harming persons.

This paper summarises the findings from a survey of General Practitioners exploring a number of areas in relation to their experiences with patient suicide

Key points:

- General Practitioners (GPs) have an important role to play in suicide prevention. The majority of individuals are in contact with their GP prior to suicide, particularly those with a mental illness. Thus, GPs are well placed to intervene.
- 469 GPs across all nine 9 HSE Community Health Organisations (CHOs) in Ireland completed the survey.
- The vast majority of GP respondents (77%) reported having experienced a patient suicide; most of whom reported that the patient suicide(s) had an adverse effect on them (68%). It must be noted that a limitation of the study is the possible over-representation of GPs who had experienced the suicide of a patient; they may have different views and experience than their counterparts.
- The majority of GP respondents had not undertaken any previous suicide prevention training (81%); those who had undertaken such training showed more positive attitudes towards suicide prevention, more confidence in dealing with patient needs and in identifying appropriate service for onward referral in comparison to those with no experience of prior training.
- Although the majority of GP respondents (59%) reported adequate preparedness for assessing a suicidal person(s), only a small proportion had actually received training on formalised assessment of suicide risk. Moreover, two-thirds of GP respondents (64%) reported that they did not have adequate preparation for their role in the use of a safety plan.
- The GP survey respondents reported limited access to specialist support services. For example, only a minority of GPs responded that there were additional services at their practice to deal with suicidal persons (15%). Moreover, only one-third of GP respondents (33%) reported that their practice had a personal liaison with psychiatric services.
- The top rated gaps in services for suicidal persons as identified included 'Accessing urgent statutory mental health services, including child and adolescent services', and 'Accessing crisis counselling/support services'.

Background

Connecting for Life (C*f*L), Ireland's National Strategy to Reduce Suicide 2015-2020, sets out a vision of an Ireland where fewer lives are lost through suicide, and where communities and individuals are empowered to improve their mental health and wellbeing. The strategy recognises that suicide is a major health problem that requires the attention of a broad range of professionals across multiple sectors.

The role of primary care in preventing suicide is generally recognised, as GPs are often the first health professional contact for individuals who are experiencing distress or suicidal thoughts. Research shows high levels of attendance in primary care in the period prior to completed suicide. A review of studies estimated that 45% of those who died by suicide saw their GP in the month before their death; only 20% saw a mental health professional[1]. Another review of the published studies indicated that between 16% and 25% of patients who died by suicide visited their GP in the week prior to death[2]. This does not mean that the GP patients who died by suicide communicated their intent to do so during their last appointment with their GP. On the contrary, there is evidence to suggest that while suicidal ideation is present in a significant proportion of depressed primary care consultations, it is rarely discussed[3].

Additionally, the fact that many mental illnesses are predominantly managed in primary care in Ireland[4] and the high prevalence of mental illness in individuals who die by suicide[5] highlights the importance of the role of GPs in recognising and providing the necessary treatment to individuals who may be at risk of suicide .

There is evidence to suggest that initiatives within primary care can contribute to suicide prevention. For example, primary care screening may be able to identify adults at increased risk of suicide: subsequent psychological therapies targeting suicide prevention could be effective treatment in adults[3]. In addition, there is some evidence to support education and training of suicide prevention in primary care. For example research indicates two of the most widely used suicide prevention training packages STORM (Skills Training on Risk Management) and ASIST (Applied Suicide Intervention Skills Training) can lead to significant improvements in participants' attitudes and confidence[6]. However, the effectiveness of GP training-specifically in reducing suicide rates has been equivocal. There is some evidence that combining educational programmes with better access to depression treatment has a greater impact on reducing suicide mortality compared with use of educational programmes alone[7].

Method

In conjunction with the Irish College for General Practitioners (ICGP), a survey was circulated to approximately 2,917 members and associates of the ICGP in the Republic of Ireland in May 2017. The survey, informed by a review of the literature, was designed by the Monitoring and Evaluation (M&E) team in the NOSP in conjunction with the Clinical Advisor at the NOSP, and pilot tested by the M&E team at NOSP and the Research Unit at the ICGP.

The survey aimed to explore a number of areas in relation to GPs' experiences with patient(s) suicide, and included the following:

- GPs' experience of patient(s) suicide and the effect that this had on them
- GPs' identified gaps in services for suicidal persons
- GPs' preparedness to assess suicidal persons
- The supports, and policies and procedures in place in GP practices to deal with suicidal persons
- GPs' attitudes towards suicide prevention

The survey was distributed by the ICGP to its members via SurveyMonkey®, an online survey

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[1] Luoma J, Martin C, Pearson J.(2002). Contact with mental health and primary care providers before suicide: a review of the evidence. American Journal of Psychiatry 159 (6): 909-16.

[2] Saini, P. (2015). Suicide Prevention in mental health patients: the role of primary care. A thesis submitted to the University of Manchester for the Degree of Philosophy in the Faculty of Medical and Human Sciences

[3] Vannoy SD, Robins LS. (2011). Suicide-related discussions with depressed primary care patients in the USA: gender and quality gaps. A mixed methods analysis. British Medical Journal open, 1 (2).

[4] McDaid, S (2013). Mental Health in Primary Care in Ireland: A Briefing Paper: Mental Health Reform: Dublin Ireland

[5] Arensman, E. *et al* (2013). The Second Report of the Suicide Support and Information System: The National Suicide Research Foundation, Cork.

[6] See for example: Morriss R, Gask L, Webb R, *et al.* (2005) The effects on suicide rates of educational intervention for front-line health professionals with suicidal patients (the STORM Project). Psychological Medicine, 35, 957-960. Dolev R, Russell P, Griesbach D, Lardner C. (2008) The Use and Impact of Applied Suicide Intervention Skills Training (ASIST) in Scotland: An Evaluation: Annex - A Review of the International Literature. The Scottish Government.

[7] Szanto K, Kalmar S, Hendin H, Rihmer Z, Mann J. (2007) A suicide prevention program in a region with a very high suicide rate. Archives of General Psychiatry, 64 (8), 914-920.

package. A reminder email to complete the survey was sent to members of the ICGP approximately one week after the initial email was circulated. As a result, 469 GPs completed the survey (resulting in a response rate of 16%).

Although this study has a comparatively large sample, the findings must be interpreted within the context of a number of limitations; most notably the over-representation of GPs who had experienced the suicide of a patient. Such GPs may have different views and experiences than their colleagues who have not experienced a patient suicide.

DEMOGRAPHICS: The majority of GP respondents were female (60%), 40% were male. Approximately one-third of respondents (34%) were in GP practice for less than 10 years, a similar proportion (36%) was in practice between 11 and 25 years, and the remaining 30% were in practice for more than 25 years. The majority of GP respondents were in a group practice (79%); 21% were in a single practice. Similar proportions of GP respondents served urban (41%) and mixed populations (42%). Only 17% of GP respondents served rural populations. GPs' representation across the 9 HSE CHOs was achieved (SEE TABLE 1).

Table 1: Survey Respondents by CHO area

CHO1: Donegal, Sligo/Leitrim/West Cavan and Cavan/Monaghan	**7%**	**(33)**
CHO2: Galway, Roscommon and Mayo	12%	(53)
CHO3: Clare, Limerick, and North Tipperary/East Limerick	9%	(39)
CHO4: Kerry, North Cork, North Lee, South Lee, and West Cork	16%	(71)
CHO5: South Tipperary, Carlow, Kilkenny, Waterford, and Wexford	10%	(47)
CHO6: Wicklow, Dun Laoghaire and Dublin South East	12%	(55)
CHO7: Kildare/West Wicklow, Dublin West, Dublin South City and Dublin South West	10%	(44)
CHO8: Laois/Offaly, Longford/Westmeath, Louth and Meath	6%	(27)
CHO9: Dublin North, Dublin North Central and Dublin North West	18%	(82)

Key Findings:

Research suggests that **patient suicide in general practice occurs more frequently than a practitioner might expect** with GP's encountering, on average, one every three years[8]. Survey respondents were asked about their experience of patient suicide;

- More than three-in-four GP respondents experienced a patient(s) suicide (77%). In the majority of instances (66%) the GP reported that the patient was also under the care of specialist (e.g. mental health) service at the time.

- Most of the GPs reported that the patient suicide had an adverse effect on them (68%), and led them to experience feelings of guilt, sadness, upset, failure, reduced confidence, but also to practice more awareness/vigilance when dealing with patients.

- **TABLE 2** presents a thematic analysis of the data obtained for an open-ended survey question in which GPs were asked to explain how the patient suicide(s) made them feel. A common theme identified was feeling a sense of failure and/or feeling a sense of responsibility. In addition respondents commented on the impact of a patient suicide on their future practice.

Although Connecting for Life (C*f*L) and other national strategies highlight the importance of primary care in suicide prevention, the complexity of **recognition and management of suicide risk by GPs**, is rarely acknowledged[9].

- The majority of GP respondents' (59%) reported adequate preparedness for assessing a suicidal person(s). By contrast, only a small proportion of respondents reported actually receiving training on formalised assessment of suicide risk[10]; for example, only 3% of GP respondents reported having undertaken specific skills training on risk management (i.e. STORM training).

- Almost two-thirds (64%) of GPs reported that they did not have adequate preparation for their role in the use of a safety plan.

- Moreover, less than half of GPs surveyed said that they had adequate preparation to ensure that their clinical practice was judged adequate (42%).

[8] Halligan P & Corcoran P. (2001). The impact of patient suicide on rural general practitioners. British Journal of General Practice, 51, 295–296.

[9] Leavey *et al* (2017). The failure of suicide prevention in Primary Care family and GP perspectives - a qualitative study. BMC Psychiatry, 17(1), [369].

[10] There are various scales to assess suicide risk that cover mental health state, symptoms and intent. In the UK it is recommended that GPs use the patient health questionnaire (PHQ-9) for assessing and monitoring depression (NICE CG23, 2004) and 'biopsychosocial assessments' to assess patients' risk (NICE CG90, 2009).

Table 2. Themes, sub-themes, and indicative quotes about the effects of a patient suicide(s) on GPs.

Theme	Sub-theme	Example of Indicative Quotes
Failure	Letting down	'Feeling of failure, of letting them down'
	Lack of awareness	'Felt a failure for not being more aware of patients thoughts and feelings'
	Questioning	'Sense of failure, questioning what else could have been done'
	Doubt	'Instilled doubt in one's management, knock-on effect on other patients and wider community'
	Inadequacy	'Feelings of inadequacy'
	Incompetence	'Feel incompetent'
Responsibility	Guilt	'You always wonder could you have done more. You feel guilt, guilt, guilt'
	Remorse	'Remorse for not referring'
	Regret	'Regret'
	Missed signed	'I felt bereft, as if I should have done more, and worried that I missed some sign'
Distress	Upset	'Found it upsetting. Staff v upset'
	Sad	'I felt sad that I could not help my patients stay alive and make meaning to their life'
	Grieving	'Whole practice grieves as we feel such sympathy for the family'
	Lasting a long time	'Poor sleep even 9 months later find sometimes difficult to talk about'
Future practice	More aware	'I am now much more vigilant for that 'setting affairs in order' behaviour'
	Reduced confidence	'Not confident in dealing with depressed young males'
	Nervous	'Nervous other family members may be at risk as they also suffer depression'
	Review of own practice	'Make you look at your own practice and the services as a whole'
	Note taking	'Patient professionally has led me to ask and document any questions about suicide'
Other	Shock	'Shocked, flashbacks of image of body'
	Disappointment	'Surprise and disappointment'
	Disillusionment	'Very disillusioned – GP is not properly resourced to deal with psychiatric illness'
	Helplessness	'Felt helpless'
	Problems sleeping	'Disrupted sleep'
	Anger at patient	'A traumatic, shocking experience. Anger at the person in question for doing it'
	Criticism from family	'Criticism from some members of patients family'
	Lack of support	'Why is this the first time I have been asked? We are treated terribly. All that stress. There's no genuine support for GPs'

It is important to have appropriate services in place to effectively assess and manage patients with suicidal behaviour and to ensure **access to specialist mental health services** when required. In this regard, GPs are important gatekeepers between patients and mental health services.

- The vast majority of GP respondents (97%) reported that their practice had no written policies/ procedures, regarding mental health. Moreover, less than one-in-five GPs (19%) reported that there were additional services at their practice to deal with mental health issues.

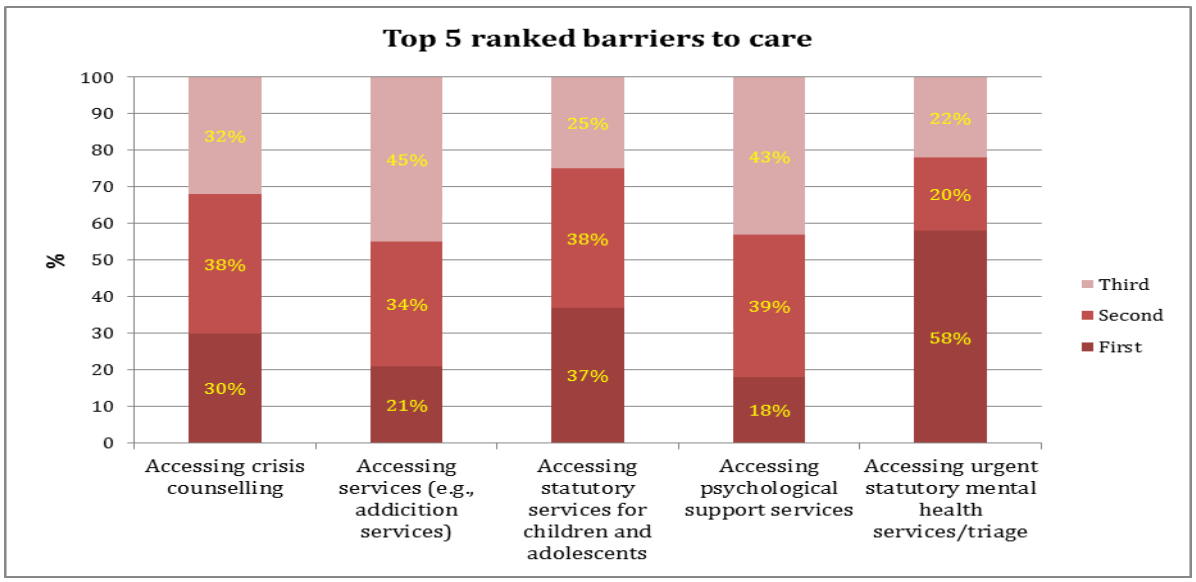
- Even fewer GPs reported that there were additional services at their practice to deal with suicidal persons (15%).Over half of the GPs (56%) reported that there were no
- additional services at their practice, however one-in-two of these GP respondents (n=105) reported that their practice would benefit from them.

- One-third of GP respondents (33%) reported that their practice had a personal liaison with psychiatric services. A similar proportion (35%) reported that their practice did not but would benefit from it

- Respondents were asked their perspective on gaps in service provision for suicidal persons. **Figure 1** shows the top five ranked gaps in services for suicidal patients identified by GPs. Three of these included:

    - Accessing urgent statutory mental health services',
    - 'Accessing statutory services for children and adolescents',
    - 'Accessing crisis counselling/support services'

Figure 1: GP's top five ranked gaps in services for suicidal patients



GPs are likely to **benefit from training/ knowledge in order to identify patients who may be at greater risk of suicide**. They can also then provide the vital link and supportive care for patients until specialist mental health service involvement. Findings from the current survey showed that:

- The majority of GP respondents had not undertaken any previous suicide prevention training (81%).
- But it is worth noting that those who had undertaken such training self-reported more positive attitudes towards suicide prevention[11] , more confidence in dealing with patient needs[12] and in identifying appropriate service for onward referral[13] in comparison to those with no experience of prior training.
- The vast majority of GPs reported also reported that staff at their practice had not received training on suicide awareness (90%) although the benefit of such training was recognised by many (33%).
- In addition, only 2% of GPs reported that there are additional supports at their practice for when a patient dies by suicide. Suicide prevention in primary care is very challenging. GP respondents were also asked to identify one particular **obstacle to the care of suicidal persons** not already covered
- Some of the main obstacles to care of suicidal persons identified by GPs through a thematic analysis of the data obtained from an open-ended question were, the 'time pressures', 'inadequacy of services', and 'lack of support for GPs (SEE TABLE 4).

Finally, under Connecting for Life, 17 multi-agency area-level suicide prevention action plans have been developed and are aligned with the national strategy. The planning process for these action plans focused on bringing together a wide range of stakeholders to achieve the buy-in and support necessary to lay the foundations for effective implementation of the national strategy at an area-level. The survey found that;

- The vast majority of GPs were not yet familiar with their local area-level C*f*L action plan (82%), although in several instances these plans were still in development.
- Moreover, the majority of GPs did not know about their local Resource Officer for Suicide Prevention (ROSP), just over one-fifth said they knew about their local ROSP, but have had no contact with them in the past (21%).

Suicide prevention in primary care is important but very challenging for GPs. The evidence points towards the benefits to GPs from training on the recognition and management of suicide risk. However, in order to facilitate GPs to manage patients with suicidal behaviour improved connections with and access to mental health services is essential.

[11] Prior training: Mean rating = 18.9; No training: Mean rating = 20.8; a lower score indicates more positive attitudes to suicide prevention (ATSP Scale).
[12] Prior training: Mean rating = 7.2; No training: Mean rating = 6.3; a higher score indicates greater confidence.
[13] Prior training: Mean rating = 7.0; No training: Mean rating = 6.0; a higher score indicates greater confidence.

Table 4. Themes, sub-themes and indicative quotes about the obstacles to GPs care of suicidal persons.

Theme	Sub-theme	Example of Indicative Quotes
Resources	Time	'Acknowledgement of how time consuming it is to provide good mental health support in general practice. There is no remuneration of any form for such extended consultations'
	FEMPI cuts	'Time and fempi cuts, we've had to reduce our appointment time from 15 to 10 minutes to survive'
	Takes time to deal with patients in distress	'Lack of time in busy GP services to devote sufficient time to patients in distress'
	Funding	'Funding to employ enough GPs to allow me to spend enough time with patients to assess them properly'
Inadequacy of services	Waiting time too long	'There is a huge difficulty in having suicidal patients being seen by a psychiatrist quickly and adequate follow up with the same psychiatrist'
	Lack of urgency	'Lack of urgency of acute services'
	Services overwhelmed	'Psych service acute and non-acute overwhelmed'
	Poor access	'Poor access to psychological services'
	Limited	'Access to social worker reviewer at weekends and after 5pm'
	Lack of training	'Lack of training/confidence in how to manage a person who self-harms/PD'
	Negative opinion of CAMHS	'Significant problems with teenagers/young people due to CAMHS staffing fiasco'
	Referral to A & E not appropriate	'Non compassionate response in A & E'
	Cost of mental health services	'Accessing psychology for people who cannot afford to pay is a major obstacle'
	Counselling	'Lack of counselling'
	Psychiatric services	'No psychiatric services of any stature'
	Dual diagnosis	'Disjointed services, particularly for younger patients with dual diagnoses'
Spontaneous suicides	Spontaneous	'Spontaneous suicides in young people who have apparently been perfectly normal and have never spoken or behaved in a manner that suggested that they were at risk'
	Out of the blue	'I have had a few out of the blue cases, those seeing nobody for any issues'
Lack of support for GPs	Debriefing	'We need debriefing and support. There is none other than colleagues post suicide counselling/debriefing with other professionals to look at what could have been done better. We are all ploughing our own furrows'
Other	Risk assessment tool	'Formal and feasible risk assessment tool within the practice to use to have documentation of same. Urgent access to counselling and addiction services'
	Various agencies are confusing	'The various agencies are confusing –if there was a website like Pathways to Dementia it would be great'
	Societal issues	'Societal issues beyond my control'
	Problems	'I have had suicides in people with mental health problems, addiction alcohol'
	Obstacles	'A number of obstacles'
	Lack of openness	'Patients lack of openness to allow discussion with relatives etc.'

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