

Suicide prevention: what can primary care do to make a difference?

“The most critical elements in helping those with suicidal ideation are achieving some engagement with the suicidal person and providing hope that their life can improve. Sometimes, that relies on you carrying the hope for them, until things change enough for them to share it.” — PROFESSOR PETE ELLIS

In late August, 2017 the Chief Coroner released a sombre statistic – 606 people in New Zealand died by suicide in the past 12 months; an increase for the third consecutive year and almost double the road toll.¹ Age-standardised rates by ethnicity reveal that Māori die by suicide at approximately twice the rate of non-Māori.² Young people are also over-represented in suicide statistics. New Zealand has the highest rate of youth suicide among 41 developed nations, with latest statistics showing that 15.6 adolescents per 100,000 aged 15 to 18 years died by suicide in New Zealand in 2012/13, compared to 3.0 in the United Kingdom, 6.8 in Australia and 7.6 in the United States.³

Clearly we have a problem. There has been much effort from individuals and organisations around New Zealand in

suicide prevention, but we are yet to find the right formula for reversing this phenomenon. The reasons for suicide are multifactorial, as are the reasons why it is so challenging to address this on a population level. What we can do, however, is to focus on an intervention, one person at a time.

We asked several experts around New Zealand for their guidance on managing interactions with patients in primary care who are experiencing suicidal thoughts or behaviour. This is not intended to be a comprehensive guide, but it is the start of a conversation about suicide that we encourage all health professionals to consider. As individuals, we cannot stop 606 deaths per year, but if each of us intervene in a meaningful way with just one person, that is what can make a difference.

1. Provisional suicide statistics 2016/17. Office of the Chief Coroner of New Zealand. Available from: <http://coronialservices.justice.govt.nz/assets/Documents/Publications/suicide-statistics-media-release-20170828.pdf>
2. Statistics New Zealand. NZ social indicators: Suicide. Figure 3. Available from: www.stats.govt.nz/browse_for_stats/snapshots-of-nz/nz-social-indicators/Home/Health/suicide.aspx N.B. latest suicide statistics are from 2013.
3. Innocenti Report Card 14. United Nations Children's Fund (UNICEF), 2017. Available from: www.unicef-irc.org/publications/pdf/RC14_eng.pdf N.B. latest worldwide suicide statistics are from 2012/13.

Raising the issue

Only a portion of the total number of people who die by suicide are seen in general practice, therefore it is crucial that any opportunity for intervention is acted on. If in the course of a consultation a patient expresses verbally or non-verbally that their mood is low, they should be assessed for suicide risk. This can be done in a formal manner, but it is often best approached as a conversation, using clinical judgement as to how far the questions go. There is no one right way to ask about suicide, and the only wrong way is not to ask at all. The manner and tone of asking is more important than the words used. Be empathic, sensitive and non-judgemental, in a way that invites the patient to share the depth of their concern and despair. Be direct and specific in your questions, leaving no ambiguity about what you are asking. For example:

“How bad has it got?”

“Has it ever been so bad that you have thought about harming yourself in any way?”

“Have you thought about ending your life?”

Questions about the patient’s lifestyle, home, relationships, family/whānau, culture, religion/spirituality, education, employment, activities and friends adds important context to understanding their mental wellbeing and distress. Consider other vulnerability factors in their history, such as previous suicidal behaviour or knowing someone who has attempted suicide, mental illness, long-term illness, adverse child experiences, abuse, alcohol or drug misuse.

Assessment tools

“Suicide risk assessment has poor predictive accuracy. The better aim is to manage risk, not arrive at a position of certainty about it”.

— PROFESSOR SUNNY COLLINGS

Stopping a conversation to administer a formal assessment is likely to be disruptive, but it may be useful to become familiar with such tools to ensure that pertinent information is incorporated into the clinical interview. For example, the SAD PERSONS acronym highlights risk factors for suicide and self-harm (see below); although bearing in mind that most people with these characteristics will not die by suicide and cumulative risk is more important than individual risk factors. The Beck Hopelessness Scale⁴ is a validated tool for assessing severity of risk and is recommended in some guidelines. The HEADS assessment tool (see footnote for web link) is a framework for a semi-structured interview for assessing the health and wellbeing of adolescents, including questions about depression and suicide.⁵

SAD PERSONS acronym: risk factors for self-harm and suicide

- S:** Sex – male
- A:** Age – <19 or >45 years
- D:** Depression
- P:** Previous attempt
- E:** Excess alcohol or substance use
- R:** Rational thinking loss
- S:** Social supports lacking
- O:** Organised plan
- N:** No spouse
- S:** Sickness

Taking immediate action

If a patient reveals suicidal thoughts, firstly, make it clear that you would like to help. The next questions should be directed to ascertain their level of:⁶

- **Desire** – psychological pain, hopelessness, feeling trapped, feeling alone, feeling like a burden
- **Capability** – previous attempts, availability of means, acute symptoms of mental illness (see below), impulsivity
- **Intent** – preparatory behaviours (e.g. writing a note, making a will), specific plan and expressed intent to die
- **Buffers/connectedness** – family/whānau and social supports, planning for the future, engagement with people (including considering what affect their proposed actions would have on others), ambivalence about suicide (they have not made up their mind yet), sense of purpose

The following points may also be useful:

- Ask the same question in various ways to ensure you elicit a complete response; sometimes a patient may only reveal the thoughts that they regard as relatively acceptable, but they have other thoughts that are more difficult to share
- Explore the reasons the patient feels that these thoughts have occurred now; if the reasons are unclear, consider the possibility of a psychosis and delusions/hallucinations. Also consider this if the patient’s mood is not congruent with their suicidal ideation, or if they

4. Tool must be purchased, available from: www.pearsonclinical.com.au/products/view/42

5. For further information, see: Addressing mental health and wellbeing in young people, available from www.bpac.org.nz/BPJ/2015/October/wellbeing.aspx

6. Joiner TE. Why people die by suicide. Cambridge, MA: Harvard University Press, 2005. Also see, www.apa.org/science/about/psa/2009/06/sci-brief.aspx

Effective engagement with young people

While there are many commonalities in what causes people to experience suicidal thoughts, certain contributing factors may be more likely in young people, such as social isolation/alienation, violence (physical, sexual, emotional), risk-taking behaviour (especially associated with alcohol and drugs), sexual identity and breakdown of romantic relationships. Socioeconomic deprivation increases risk, but an advantaged background should not be seen as excluding any of these contributing factors, and it may be accompanied by added risks such as high expectations from family.

Assessment and management of suicidal thoughts in a young person is undertaken in much the same way as for any other patient. However, certain aspects are of greater importance, such as ensuring that they are surrounded by people who can provide support, and engaging with these people to obtain a fuller picture of the patient's wellbeing and social challenges. As appropriate, and with consent, this may include family, teachers, school counsellors and other people who have been involved in the young person's care.

Key points for effective communication with young people include:

- Consider their stage of cognitive development when formulating questions and interpreting responses; e.g. can they think abstractly (think about thinking) or think in the future? A non-committal answer may simply reflect their level of complexity of thought rather than indicating a low mood.
- Consider the technique of communicating with a young person using emotions rather than a logical argument
- Build trust before asking questions which require more private/personal answers
- Explain that the information they discuss is confidential, unless you think their safety is at risk, but you will involve them in any decisions about this
- Acknowledge their individual identity from their parent/caregiver; if appropriate, ask the parent to leave the consultation so the young person can speak in private
- Listen without judgement and avoid being perceived as "telling-off" or lecturing
- Be aware that young people may be more impulsive and have a more romanticised view of death than older people.

✔ Ideally a young person who is experiencing suicidal thoughts should be referred for an evaluation by a clinician who is skilled in interviewing and working with children and adolescents.

* For further information, see: "Addressing mental health and wellbeing in young people", www.bpac.org.nz/BPJ/2015/October/wellbeing.aspx

are severely depressed with elements of psychosis (which may be accompanied by marked psychomotor retardation or agitation).

- If the suicidal thoughts are not current, discuss what has changed since they had these thoughts and whether this change in circumstances is likely to last.

✔ If the patient's degree of suicidal ideation and plans is marked, a more detailed mental health assessment is indicated, followed by referral to secondary care mental health services.

"De-escalating suicide risk can be done by simply asking what is happening for the [patient] that got them to this point and listening non-judgementally. During the course of the conversation there is almost always reference made to things in the [patient's] story that connects them to life. This could be valued relationships, being needed (even by pets), future plans, etc...This can be an opportunity to highlight strengths and help them to realise that while it is very painful to have these feelings, they do pass."

— RENEE MATHEWS

Formulating a safety and management plan

After managing any immediate crisis, the next step is to work with the patient on creating a safety plan. The plan should include professional and social supports that are available at all times if the suicidal thoughts are current, or daily if the thoughts were in the recent past. Include phone numbers for seeking help after hours (e.g. local acute mental health services, help lines such as Lifeline), and identify family or friends that they can rely on (see below).

The plan should also include internal coping strategies that provide a distraction and potential for a sense of pleasure or mastery, e.g. going for a walk, listening to music, playing with a pet. Identify any distressing triggers that can be avoided. Discuss things that the patient could look forward to, e.g. a particular celebration or holiday. Recovery involves building strength and resilience so include aspects in the plan that develop these attributes, e.g. joining a group, reconnecting with a cultural or spiritual background, learning a new skill.

“Most people who are suicidal have a degree of ambivalence. Talking it through can help people identify and strengthen the reasons to keep living. Sometimes these conversations may need to be daily.”— PROFESSOR SUNNY COLLINGS

Involving partners and family/whānau

The patient should be encouraged to confide in their partner, family/whānau or other support person about their suicidal ideation. Young patients require an adult to support them, not just a friend. N.B. in some cases informing a family member will not be appropriate if they are contributing to the suicide risk, e.g. an abusive relationship.

It can sometimes be difficult to facilitate this discussion with a patient as they may be ashamed or embarrassed about revealing their suicidal thoughts. Ask the patient what they think the risks are of them (or you) disclosing their situation to their family. Ask them what they think the benefits would be, and then help them to weigh up the decision. Offer to role play the conversation to make the patient more comfortable with what they, or you, will say.

“I need to tell someone else in your support circle as I can’t help you so well without their support. I can tell them on the phone whilst you are listening in if you like and we can work out what it is you would like me to say. I really need to tell them as I am very concerned about your safety.”

— DR SUE BAGSHAW; Example of a conversation with an adolescent

In the interests of long-term relationships (both the patient’s relationship with you and with their family), it is far better to negotiate consent. However, if a patient who is acutely suicidal declines the involvement of others, a clinician may over-ride this in the interests of keeping the patient safe. Note that this authority extends only to the information necessary to keep that person safe.

A statement such as the following can be discussed with patients regarding confidentiality:⁷

“What you say is confidential, unless I believe that you are at serious risk of harm to yourself, or others. In such a case I will take necessary steps to protect your safety, although wherever possible I will discuss these steps with you before I take them.”

Supporting the supporters

Many people feel daunted by the thought of supporting a person who is suicidal – what do they say? What if they say the wrong thing? Are they to blame if something goes wrong? These support people require advice and support themselves. The following points may be useful for support people:

- Make a plan with the patient as to what assistance they would like
- Agree on who else can be contacted if things get more difficult or you find yourself unable to cope with the situation or just need a break, e.g. another support person or the mental health crisis team
- Acknowledge the suicidal person’s distress, and give them an opportunity to talk about this, the reasons for it and possible solutions, e.g. if there are particular triggers involved
- Be non-judgemental and understanding; realise that the person is experiencing pain just as they would from any severe physical pain, e.g. a broken leg
- Constant enquiry is unlikely to be helpful; provide a listening ear, rather than unsolicited advice
- Encourage joint participation in activities, e.g. playing sports, seeing a movie or concert, socialising with positive people
- Be aware of high risk periods and provide extra support during this time, e.g. meetings with certain people, court appearances
- Stay with them through bad periods, so they know they do not have to cope alone, but make sure you are replaced by someone else at times so you can keep up your strength to keep supporting

7. NZGG and MOH. Assessment and Management of People at Risk of Suicide. 2003. Available from: http://www.health.govt.nz/system/files/documents/publications/suicide_guideline.pdf

“Basically just listen without judgement and communicate that you are there for them and that they are valued and cared for. A major contributor to suicidal thoughts is feeling alone and a burden to others.” — RENEE MATHEWS

Understanding the warning signs

There are no reliable methods for detecting when a patient is at imminent risk of suicide. However, there are particular behavioural characteristics that can be warning signs, such as if the patient no longer talks about the future, they have made

peace with family and friends, they have given away their possessions or they convey a sense of positivity or happiness as they have made the decision to end their pain. Drug or alcohol intoxication and psychosis (e.g. due to mental illness) increases risk, as does knowing someone who has died by suicide.

“I worry particularly about those who have lost any hope of things improving in the future, and people who are so strongly self-centred and committed to their suicidal plans that I feel that I have not been able to engage effectively with them in considering alternatives.” — PROFESSOR PETE ELLIS

Providing culturally appropriate care

Culture is an important determinant of mental health. Understanding a patient’s cultural identity may provide insights into causes of suicidal thoughts or how these thoughts are communicated. However, do not assume that because a patient has a particular cultural background that they will assign the same personal meaning to their culture as others, or that their culture has a bearing on their suicidal thoughts. Ask patients about their culture and how this plays a role in their life, do they find strength and resilience from their cultural identity and community or is this a contributing factor to their distress?

For Māori, the presentation, explanation and definition of suicidal thoughts may be different from “western views”, and it is important to recognise and be respectful of this.* If issues related to Māori culture arise in the conversation, it is strongly recommended to seek input from a Māori health provider (e.g. Kaupapa Māori mental health service – ask your local DHB or PHO for contact details) or kaumātua (elder), as guided by the patient and their whānau. This includes issues such as:

- Breaches of cultural protocol, e.g. tapu
- Loss of mana (identity and cultural status) on a personal or collective level
- Experiencing the presence of ancestors

Whānau play an important role in the support and recovery of Māori experiencing suicidal thoughts. Ensure that patients know that whānau (or other support people, e.g. kaumātua) are welcome and encouraged to be present in consultations and be part of developing a treatment plan. Work alongside Māori mental health providers and preferably get to know who you can contact in your area before the need arises.

Each culture is different in their customs, traditions and views of mental health, but the same general principles can be applied: ask about what the patient’s culture or spiritual background means to them and if this is contributing to the way they are presently feeling; be open-minded about explanations for suicidal thoughts and mental health; encourage involvement of family and other important support people (e.g. church leaders); and seek guidance and expertise from cultural health providers for any issues that you are unsure about.

* For further information, see: “Recognising and managing mental health problems in Māori, www.bpac.org.nz/BPJ/2010/June/mentalhealth.aspx

Providing ongoing support

“Preventing suicide takes long-term support and journeying with it is not a short, sharp fix”.

— DR SUE BAGSHAW

A patient who has experienced intense suicidal thoughts requires follow-up until they have regained confidence in themselves, and their safety and any contributing factors to their suicidal ideation have been largely resolved. Suicidal ideation is a symptom, not a disorder in itself, and the follow-up should be focused on identifying and managing underlying mental health and/or social issues. Distinguish grief from depression, and post-traumatic stress disorder from them both. Remember that antidepressant medicines are generally only used to treat depression and accompanying anxiety.

The frequency and nature of follow-up is dependent on individual clinical circumstances, as well as any barriers to seeking treatment, e.g. financial or location. Daily face-to-face consultations or phone calls are appropriate for most patients after they have disclosed suicidal thoughts. This may then be decreased to weekly, then monthly as the patient's symptoms resolve. Knowing that someone will be checking on them can be very comforting to patients who are feeling alone.

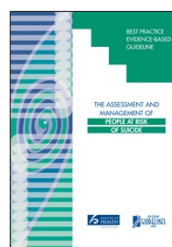
Consider longer term follow-up strategies that may work for your practice population. The “anniversary” of a suicide attempt can be a particularly vulnerable time for some patients, and a phone call or note from the practice at this time may be significant to them.⁸

Final thoughts

Many people experience suicidal ideation at some point in their life, but only a few will seek help. We need to ensure that these people do not go unnoticed; “*leave no one behind*”. Primary care practitioners are skilled in looking for clues in the patient's history that reveal an underlying illness – the same principles apply for detecting unspoken thoughts. Always consider if there is more to the story than the reason the patient has presented, e.g. for tiredness, sore back or headache. Always ask; “*Is there anything more?*”

People who are contemplating suicide think that it is a reasonable option, so our job is to show them that there are other, better, options. Death is final and inevitable, so we must make the most of life.

“Really just showing you care enough to ask about suicide and are not afraid of the answer can make a difference for someone who is thinking about suicide”. — RENEE MATHEWS



Further reading

Assessment and Management of People at Risk of Suicide. New Zealand Guidelines Group and the Ministry of Health, 2003. Available from: www.health.govt.nz/system/files/documents/publications/suicide_guideline.pdf

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8. For further reading, see: Carter G, Clover K, Whyte I, *et al*. Postcards from the Edge project: randomised controlled trial of an intervention using postcards to reduce repetition of hospital treated deliberate self-poisoning. *BMJ* 2005;331(7520):805.



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