Greater Manchester
Urgent Primary Care Alliance

Suicide and Suicide Prevention

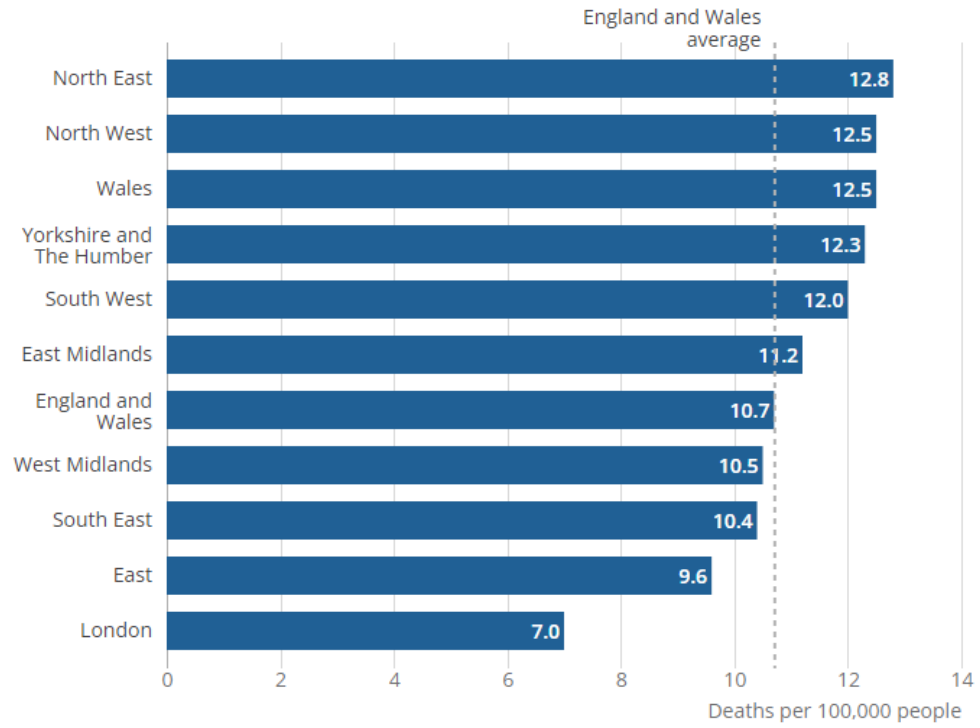
GMUPCA has experienced an increase in Mental health calls over the past year. A proportion of these calls involve patients experiencing suicidal ideation and low mood. Effective clinical triage ensures patients receive the right care at the right time, either though the Greater Manchester Mental Health team or signposting to the registered GP without an ambulance.

However, GMUPCA has received inappropriate 'actively' suicidal patients with a visual fatal plan and the means to carry out this plan. These cases can and should be passed back to NWAS with an upgrade (+/- GMP) if the patient/public is believed to be in imminent danger. The importance of these lifesaving conversations cannot be underestimated. Although, suicide is an uncommon outcome, it is important to be mindful of local themes, NICE guidance and national strategies that underpin our approach to patients during these calls. The suicide of a patient can have a devastating effect on the patient's family, and psychological impact on professionals involved in their care.

Suicide Statistics

In the UK there are over 5000 deaths per year from suicide. [1] 75 % of these occur in men. The Northwest had the second highest suicide rate in the UK in 2022.[1]

Age-standardised suicide rates for English regions and Wales, deaths registered in 2022

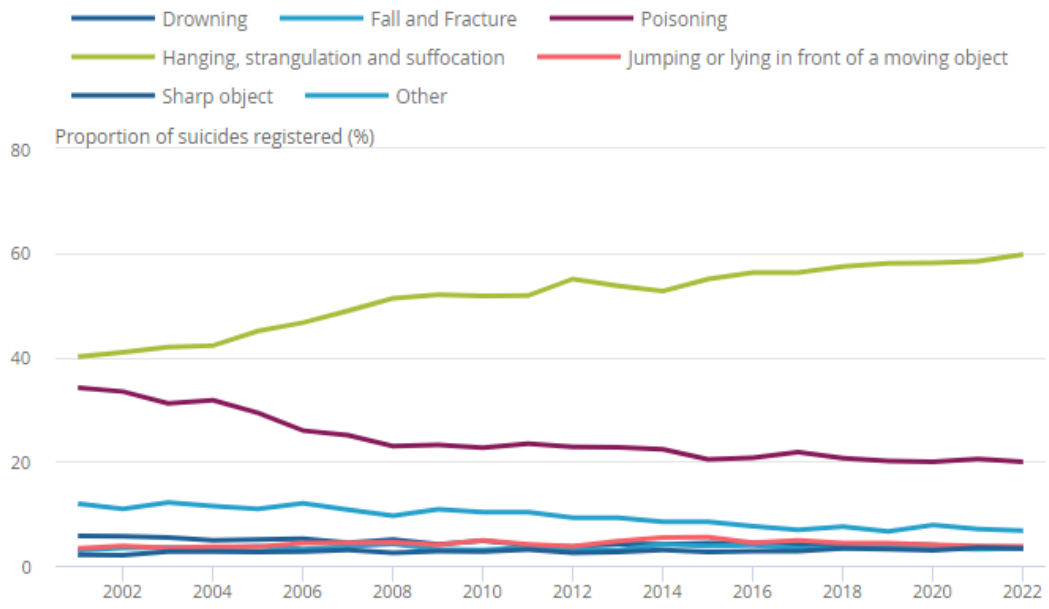


Source: Suicides in England and Wales from the Office for National Statistics

Method

The most common method of suicide in England and Wales was hanging, strangulation and suffocation, which accounted for 59.7% of all suicides in 2022. Please see the table below for the proportion of suicides caused by hanging. The second most common method was poisoning (19.9%).

Proportion of suicides by method, England and Wales, registered between 2001 and 2022



Source: Suicides in England and Wales from the Office for National

Psychiatric Co-morbidity

Approximately 90% of people who die by suicide have an underlying psychiatric disorder.[2] Depression is the most common factor found in approximately 60% of cases. This may be complicated by other mental health issues compounded by alcohol/drug misuse, and personality disorder. Approximately half of those who take their own life will have had contact with a health care professional in the three months before death.

Suicide Myths

Can rating scales be used to quantify risk?

NICE (2022) guidance[3] on self-harm does not recommend the use of risk assessment scales to predict future suicide or repetition of self-harm. Risk assessments should be used with caution and include conversations about hopelessness and suicidality. Some patients with few risk factors can exhibit verbal or non-verbal cues that provoke a feeling of unease, responding to your clinical intuition will guide clinical judgement.

Does enquiry about suicidal thoughts increase a patient's risk?

There is no evidence to suggest that patient's risk is increased after a conversation about suicide. There is evidence that a visual image can influence behaviour. (If you think about suicide, do you have a picture of what this might involve?).

The patient is alone and doesn't want me to inform family or friends.

During GMUPCA consultations it is essential to ask about the patient's current location. If patients are in imminent danger, this information can be lifesaving. In addition to NWAS, the police may need to be informed (Section 136 Mental Health Act). If the patient can engage, it is helpful to explore why the patient doesn't want family or friends involved. They can play an important role in supporting depressed and suicidal patients and help to keep them safe. If the patient gives consent, try to get contact details of family or friends, and offer to contact them with the patient's permission.

The patient has previously expressed suicidal thoughts, when should I worry?

It is important to identify factors which may destabilise the patient including alcohol/drug misuse, relationship breakdown, homelessness, hopelessness, and active plans. These patients have an increased risk of suicide.

Do suicidal patients have capacity?

Capacity is decision specific and will fluctuate with time, especially in patients experiencing mental health crisis. The Mental Capacity Act does not currently provide an appropriate framework for determining whether a suicidal patient has the capacity to take their own life. Please consider the European Convention on Human Rights (Article 2): clinicians have an obligation to take 'operational steps to secure life'.[4] The Kerrie Woolterton case has been controversial and highlights the interface between capacity, ethics, law, and patient autonomy.

Should I communicate my concern to patients?

An empathetic and collaborative approach is encouraged in patients who have acute mental health concerns. Discussing a safety plan and highlighting resources available is recommended. If patients have psychosis or cannot engage in a consultation, please refer the patients back to NWAS if you consider they are in imminent danger.

Suicide is inevitable.

Suicide is not inevitable. The NHS England Suicide Prevention Strategy aims to reduce the suicide rate over the next five years.

Suicide: Risk[5]

The table below from the Devon Partnership Trust highlights key topics and open questions to consider during a consultation with someone who has depression and may be at risk of suicide.

All patients with depression should be assessed for possible risk of self-harm or suicide.

Risk factors for suicide identified through research studies are:

Risk factors specific to depression	Other risk factors for consideration	Possible protective factors	In assessing patients' current suicide potential, the following questions can be explored:
– Family history of mental disorder. – History of previous suicide attempts (this includes self-harm). – Severe depression. – Anxiety. – Feelings of hopelessness. – Personality disorder. – Alcohol abuse and/or drug abuse. – Male gender.	– Family history of suicide or self-harm. – Physical illness (especially when this is recently diagnosed, chronic and/or painful). – Exposure to suicidal behaviour of others, either directly or via the media. – Recent discharge from psychiatric inpatient care. – Access to potentially lethal means of self-harm/suicide.	– Social support. – Religious belief. – Being responsible for children (especially young children).	– Are they feeling hopeless, or that life is not worth living? – Have they made plans to end their life? – Have they told anyone about it? – Have they carried out any acts in anticipation of death (e.g. putting their affairs in order)? – Do they have the means for a suicidal act (do they have access to pills, insecticide, firearms…)? – Is there any available support (family, friends, carers…)? – Where practical, and with consent, it is generally a good idea to inform and involve family members and close friends or carers. This is particularly important where risk is thought to be high. – When a patient is at risk of suicide this information should be recorded in the patient's notes. Where the clinician is working as part of a team it is important to share awareness of risk with other team members. – Regular and pro-active follow-up is highly recommended.

The National Confidential Inquiry into Suicide and Safety in Mental health (annual report 2024) has highlighted seven 'Clinical Messages' to consider when looking after patients with acute mental health concerns.

Please see the Clinical Messages below. There is recognition of specific groups at risk of suicide including university students, and autistic people. The Zero Suicide Alliance[6] has produced free online training to help understand the challenges autistic people face and how these can contribute to suicidal thoughts. The training lasts for an hour and concentrates on four bespoke scenarios. GMUPCA recommends this training for all clinicians.

CLINICAL MESSAGES

1. Clinical care

Our reports have indicated how important it is to suicide prevention to address factors such as socioeconomic adversity, alcohol and drugs, physical health, clinical risk assessment, and suicide risk in children and young people, and in autistic people. The new national suicide prevention strategy for England and equivalent policies in other UK countries have highlighted these issues as priorities for safer care.

2. Acute mental health care settings

There is concern currently about safety in mental health in-patient services. To address this, services need to focus on: creating a therapeutic ward environment; the physical safety of the in-patient unit itself; safe transition from ward to community, pre- and post-discharge; early follow-up after in-patient discharge; and prompt access to crisis services.

3. Suicide by autistic people and those with ADHD

Diagnoses of autism spectrum disorder and ADHD are becoming a larger part of suicide prevention in mental health services, especially among young people. Clinicians may require specific training to recognise and support these patients. Awareness is needed of the high rates of suicide-related internet use prior to suicide among autistic people and drug misuse among patients with ADHD. Responding to self-harm and childhood trauma is crucial to both diagnostic groups.

4. Suicide by in-patients aged under 25

There has been recent concern over in-patient safety for young people. Services need to be aware that in-patients in this age group who die by suicide may have different clinical characteristics to adult in-patients, with proportionately more deaths on the ward and Mental Health Act detention, and with enhanced nursing observations being more frequent. Attention is needed to potential ligatures and ligature points used on the ward for this group, and to the importance of admission to local units where possible.

5. Suicide by young students

Promotion of a "whole university" approach to mental health is important to prevention, especially as high risk in students may be difficult to identify by conventional risk factors. Support should be enhanced at key times of risk, such as the start of the academic year and in the lead up to exams. There needs to be a clear pathway to NHS mental health services.

6. Suicide by patients with a one-off assessment

Care is needed when discharge is considered following a single assessment. In considering follow-up plans, clinicians should be aware of the potentially serious impact of recent adverse events such as financial difficulties and relationship break up. Alcohol and drug misuse add to risk and indicate a greater need for follow-up.

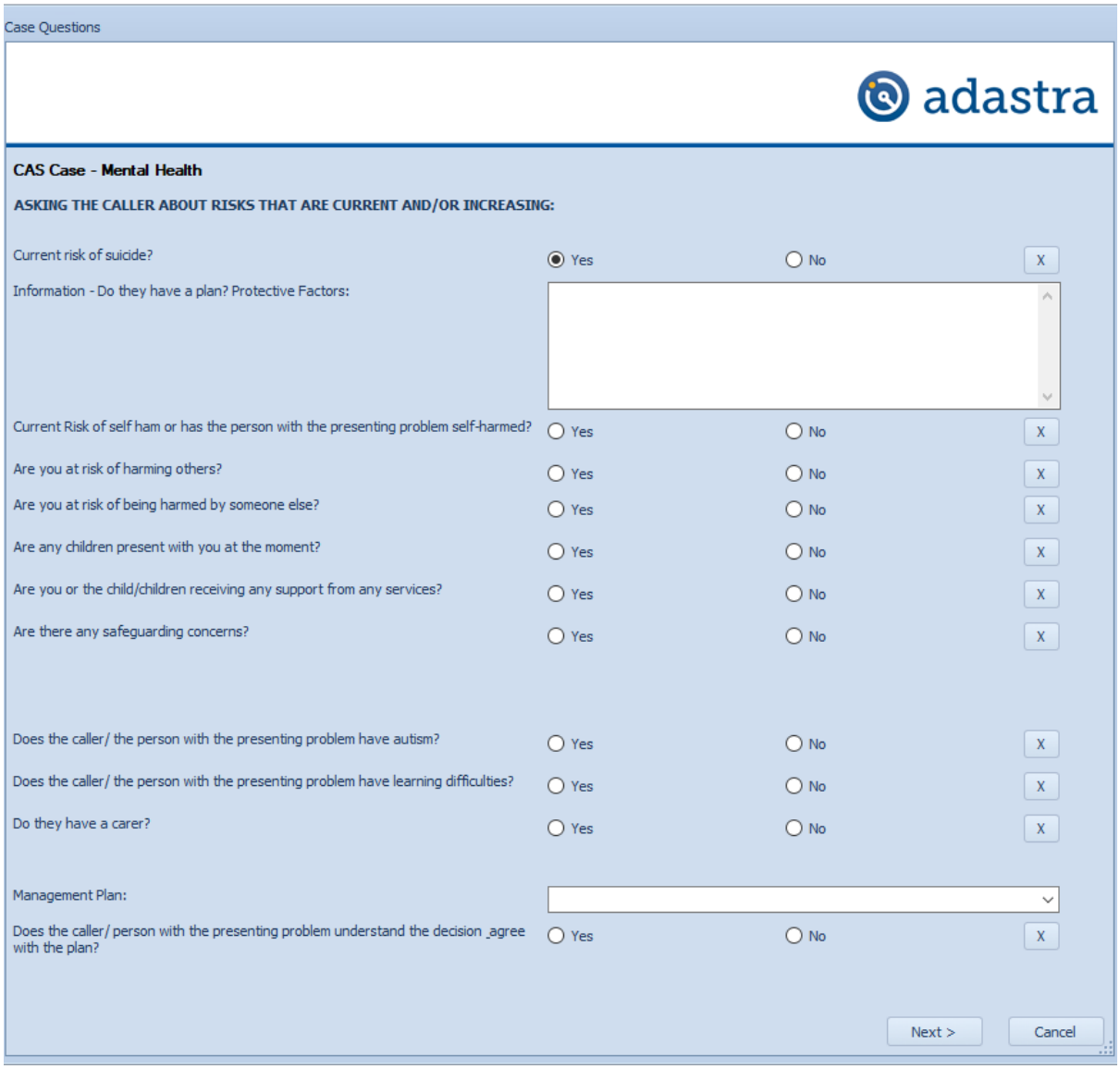
7. Suicide in public locations

The safety of the environment where mental health services are situated needs to be assessed. This should include how easy it is for patients to gain access to high risk locations such as the railway or parks and woodlands. Local suicide prevention plans should address this risk, reflecting joint working between clinical leaders and local authorities. Sensitive discouragement of personal memorials (e.g. floral tributes) and careful media reporting, including via social media, may contribute to prevention.

Summary

An empathetic approach to patients with acute mental health issues is highly recommended. Try and use open questions and consider the patient's perspective. 'You'll never really understand a person until you consider things from his point of view' [8]

If you think that a patient is in imminent danger, please upgrade to an NWAS Category 2 response and consider if the police may be required should there be a risk to both the patient and others. Please use the mental health question set (below) in Adastra as an aide memoire to help signpost to the appropriate mental health services to ensure that patients receive the right care at the right time.



Please feedback cases (qands.mastercall@nhs.net) that should not have been allocated to CAS, including patients that are actively suicidal and/or not at a home address.

Discuss and document if family or friends are present. If the patient consents to contact with loved ones, their support is invaluable.

Safety netting: Staying Safe website, provides vital 'Safety Plan' guidance with online templates. Signpost to local and national resources. Be specific. Involve the community mental health team if appropriate. Please see the table below with a list of resources. [5]

Resources

Sources of help for patients, family, friends and carers

General

Samaritans Tel: 08457 90 90 90
http://www.samaritans.org

NHS 111 Tel: 111
http://www.nhs.uk/111

NHS Choices: depression
http://www.nhs.uk/conditions/depression

NHS Choices: suicide
http://www.nhs.uk/conditions/suicide

Royal College of Psychiatrists: Depression
http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/depression.aspx

Therapeutic

Mind: how to cope with suicidal feelings
http://www.mind.org.uk/help/diagnoses_and_conditions/suicidal_feelings

Beyond Blue: depression
http://www.beyondblue.org.au/index.aspx?link_id=89

Healthtalkonline: depression
A website which explored themes around depression, with illustrative interviews
http://www.healthtalkonline.org/mental_health/Depression

CALM (Campaign Against Living Miserably)
A website which offers support for distressed people, especially young men
http://www.thecalmzone.net/what-is-calm/

Papyrus
Support for young people with suicidal thoughts
http://www.papyrus-uk.org/support/for-you

For relatives, friends and carers

Mind: how to support someone who is suicidal
http://www.mind.org.uk/help/medical_and_alternative_care/how_to_help_someone_who_is_suicidal

Papyrus
Support for parents
http://www.papyrus-uk.org/support/for-parents

Bereavement by suicide

Help is at hand
A resource for people bereaved by suicide and other sudden, traumatic death. Can be downloaded from:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_116064.pdf

Healthtalkonline: bereavement due to suicide
A website which explores themes around bereavement, with illustrative interviews with bereaved people
http://www.healthtalkonline.org/Dying_and_bereavement/Bereavement_due_to_suicide

Self-help books

Gilbert, P. (2009). Overcoming depression: A guide to recovery with a complete self-help programme. London: Robinson.

Veale, D., & Willson, R. (2007). Manage your mood: How to use behavioural activation techniques to overcome depression. London: Robinson.

Westbrook, D. (2005). Managing depression. Oxford: OCTC Warneford Hospital.

Williams, J. M. G. (2007). The mindful way through depression: Freeing yourself from chronic unhappiness. New York: Guilford Press.

Butler, G., & Hope, R. A. (1995). Managing your mind: The mental fitness guide. Oxford: Oxford University Press.

Suicide has a devastating impact on families. It can also have a profound impact on clinicians., If you feel that you have been affected by a case or a patient that has committed suicide, please contact your line manager or Medical Director who will listen and support with empathy, understanding and kindness.

Training for CAS Clinicians

1. Suicide Awareness for professionals: this popular online course is free to anyone working or volunteering in Stockport.

The next sessions are scheduled for:

Thursday 18th April 9.30am to midday

Thursday 16th May 9.30am to midday

Wednesday 22nd May 9.30am to midday

For more information, please email: info.wellbeing@stockport.gov.uk

2. Samaritans online advice

3. Zero Suicide Alliance: short online training units on suicide awareness

4. MIndEd Hub free online training

5. Living life to the full website offers online courses and resources.

References

1. Suicides in England and Wales - Office for National Statistics (ons.gov.uk)
2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1489848/
3. https://www.nice.org.uk/guidance/ng225/chapter/Recommendations#risk-assessment-tools-and-scales
4. Mental capacity in practice part 2: capacity and the suicidal patient | BJPsych Advances | Cambridge Core
5. (dpt.nhs.uk)
6. https://www.zerosuicidealliance.com/autism-suicide-training
7. Lee, H. (1960) To Kill a Mockingbird. Philadelphia. J.B. Lippincott & Co.