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Suicide prevention and 'The Health of the Nation'

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In setting out a health strategy for England the White Paper, *The Health of the Nation* includes mental illness as one of its five key areas for action. Within mental health three targets are set out.

Targets

> to improve significantly the health and social functioning of mentally ill people
> to reduce the overall suicide rate by at least 15% by the year 2000 (from 11.1 per 100,000 population in 1990 to no more than 9.4)
> to reduce the suicide rate of severely mentally ill people by at least 33% by the year 2000 (from the estimate of 15% in 1990 to no more than 10%).
>
> *The Health of The Nation (1992)*

It is important to realise that the suicide rates quoted in these targets include undetermined injury (open verdicts) and they refer specifically to England. How feasible is this challenge? How realistic are these targets to be achieved by the year 2000? Responses have been mixed. Enthusiasts have already leapt into action, welcoming the prospect of a renewed national interest in suicide prevention. Others have expressed caution, even disbelief at the very idea of tackling suicide prevention in this way. The present paper attempts to answer reservations which have been expressed in recent months, and goes on to suggest important elements in any strategy which sets out to achieve some degree of suicide prevention.

How feasible is suicide prevention? – Some questions and answers

Question: Not all suicides can be prevented: by focusing down on them will we not merely accentuate the guilt feelings of healthcare professionals who did their best under difficult circumstances?

Answer: The targets merely enjoin us to attempt the prevention of a minority of suicides, namely those which might be preventable. It is fully accepted that some will still occur despite excellent clinical care, and others will not even make contact with services.

Question: Unless adverse political and social factors are dealt with, and these are not within the power of healthcare professions to influence, what hope is there of reducing suicide rates?

Answer: While adverse conditions and events are undoubtedly important, nevertheless individual factors such as personal vulnerability and mental illness also play a significant part in the suicide. In attempting to achieve a modest reduction in suicide rates, it seems sensible to look at ways of improving the mental health care of individuals at risk.

Question: Is it feasible to aim at suicide rates when suicide is such a rare event?

Answer: The incidence of suicide is very similar to that of 'common' organic diseases such as ulcerative colitis, Crohn's disease and multiple sclerosis. Strangely enough we do not encounter reservations with regards to early detection and prevention of these conditions. So why the defeatist attitude about the task of suicide prevention? Suicide risk often extends over a long period of time before suicide finally occurs and can be encountered throughout the whole spectrum of clinical psychiatry. The low base rate of suicide does mean that a GP with a practice size of 2000 might encounter suicide itself only once in four years: a health centre which serves a greater population would meet proportionately more. Each GP probably encounters each year ten patients who exhibit some form of non-fatal deliberate self harm: among these some will present significant suicide risk. These numbers are small, and represent only a very small proportion of all consultations. Nevertheless, the principles of care inherent in suicide prevention relate to the whole spectrum of clinical psychiatric practice from assessment and management of the depressed to those who are personality disordered and exhibit challenging and aggressive impulsive behaviour. If we improve these many facets of clinical care the suicide rates will probably themselves become reduced. To see the rates as an end in themselves is misjudged.

Questions: Surely persons who commit suicide do not seek help before the event; so what part can doctors be expected to play in preventing such deaths?

Answer: On the contrary, significant number of suicides do seek medical help before they kill themselves. Thus a recent study of unexpected deaths in Avon classified as suicide on clinical grounds, has shown that 55% had seen their GP in the last three

months of their lives and 26% had been in contact with psychiatric services (Vassilas & Morgan, in preparation). It was also demonstrated that young men who kill themselves, when compared with older suicides, are far less likely to seek such help either from medical or psychiatric services. It has to be conceded that this is a particularly worrying finding with regard to suicide prevention because it is in young men, and in no other group, that significant and progressive increases in suicide rates have been demonstrated throughout England in recent years.

How should we proceed

The establishment of good clinical practice (Morgan & Owen 1990)

Instead of merely following hunches regarding causes of suicide, the first step should be to ensure that each clinical service observes sound principles in assessing individuals who might be at risk of suicide. This means thorough systematic clinical evaluation and the acquisition of relevant clinical skills, which include all of those relevant to depression (Paykel & Priest, 1992), interviewing suicidal individuals, and being aware of the several hazards that may cloud clinical assessment and judgement. Suicide risk is not confined to the severely depressed: it may be accompanied by challenging even aggressive behaviour, denial of risk, or gross fluctuation in the degree of distress, and severe alienation from others, all of which may mislead the unwary. Decisions whether or not to admit to hospital are going to be difficult in years to come as community care assumes predominance over the traditional in-patient facility. What should be the rules for managing suicide risk in the community? How often will suicidal patients who warrant intensive in-patient care be denied it because of lack of its availability? How often is this happening now and at what price? Within hospital units, how often are there well established codes of practice concerning levels of supportive observation which depend upon the degree of suicide risk? Are patients able to stay long enough to ensure that significant problems in their lives are addressed adequately or are they discharged possibly prematurely merely on the basis of symptomatic (misleading) improvements? (Morgan & Priest, 1991).

Multidisciplinary audit

As a basis for the way forward, *The Health of the Nation* recommends that each service should set up a procedure for multidisciplinary audit of unexpected deaths. The ground rules for this are currently being set out, but certain principles can be underlined. It is necessary to match mortality data with registers of contact at all points in a clinical service, including not only psychiatric in-patient units but also mental health centres, out-patients, day hospitals, and general practitioners. Audit itself should involve systematic enquiry based on an agreed questionnaire. Otherwise it merely becomes a process of reassurance which is at risk of ignoring the more difficult and painful issues. Whatever is set up needs to be feasible and not excessively demanding: for example it would be very useful if the questionnaire to be used as part of the Royal College Confidential Enquiry into suicides could be utilised as the basis of multidisciplinary audit as required by *The Health of the Nation* strategy, the one initiative thereby facilitating the other; otherwise repetition will be tiresome and even unacceptable to some. It should also be remembered that audit of this kind needs to be conducted sensitively, without engendering feelings of unfair and unnecessary criticism and recrimination. Increasingly in the future there will be fears of litigation and so the method of documentation will need scrupulous attention. Our current hospital base meetings, at which it has proved very difficult to ensure full attendance, are followed by a newsletter for clinical staff which identifies any important themes which might have ensued from the audit discussion. No patient's name is mentioned. Presumably audit based on hospital ward teams or multidisciplinary teams in the community would enjoy a better attendance but again it is important not to be overambitious: audit discussions which occur as an extension perhaps of routine intake conferences are more likely to succeed than those which demand a more extensive and separate time commitment.

To set out a plan to reduce suicide rates at the present time of severe economic recession and worsening social distress might make even the most rabid enthusiast pale a little: the risk is that overwhelming adverse social factors might cancel out gains which are earned through improving standards of clinical care. What is certain however is that nothing will happen for the better if we do not try.

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