Editorials

Suicide prevention and COVID-19:

the role of primary care during the pandemic and beyond

The COVID-19 pandemic has brought with it multiple threats to mental wellbeing — the possibility or reality of serious physical illness; complex COVID-related bereavement; lockdowns that cause isolation and inhibit social contact, or that can increase exposure to abuse in the family; caring for children unable to go to school; and precarious employment and redundancy, failing businesses, and financial insecurity. The pandemic has exacerbated the longstanding pressure on resources and underinvestment in both statutory mental health and wider community services. Against this background we outline the current evidence for impact of COVID-19 on self-harm and suicide rates, and we consider how primary care can contribute to suicide prevention during COVID-19 and after the acute crisis has passed.

IMPACT OF COVID-19 ON MENTAL HEALTH

There is international evidence of raised prevalence of anxiety disorder, post-traumatic stress disorder, and depression symptoms, especially during lockdowns implemented to contain COVID-19, and particularly in young people and those living with children.[1,2] Those with pre-existing mental and chronic illness may be at higher risk.[3] These increases in prevalence of symptoms of mental illness are important in their own right, and may also increase suicide risk.

SELF-HARM, SUICIDE, AND COVID-19

Self-harm is the strongest risk factor for suicide. Although thoughts of self-harm and suicide are common accompaniments of adversity and poor mental health, evidence to date has not indicated increased rates of self-harm during the UK's COVID-19 epoch.[4] Data from electronic health records in UK general practice identified substantial reductions in recorded incident diagnoses of anxiety disorders, depression, and self-harm episodes during April 2020 compared to previous years.[5] Although these rates had returned to expected levels in England by mid-September 2020, we do not yet know the impact of the subsequent stringent regional restrictions and two successive national lockdowns. Marked reductions in help seeking are potentially worrying and warrant close observation. These records-based investigations, however, cannot reveal whether self-harm incidence has fallen commensurately in the community, since the COVID-19 pandemic began.

Suicide is complex and rarely due to a single cause. Evidence about the impact of COVID-19 on suicide rates is emerging. There was a reported rise in thoughts about suicide among young people in the UK during early phases of the pandemic, but such thoughts are common in distress and do not necessarily predict subsequent suicide.[6] During the spring and summer months of 2020, suicide rates in the UK and other western countries were found not to have increased;[7] however, increased suicide rates were reported in females and young people from July to October 2020 in Japan, and, in the State of Maryland, US, case counts rose among Black residents while falling among White residents from March to May 2020.[8,9]

For self-harm and suicide, it is possible that the incidence may have risen during the challenging 2020–21 winter months, and risk could rise further in the aftermath of COVID-19, especially as the economic impact of the crisis takes full effect. Thus, ongoing monitoring of these patterns is crucial.

Box 1. Concerning clinical features in primary care

- Sex: suicide is 3 times commoner in males, especially in middle age (45–49 years)
- History of mental illness, especially with recent inpatient care
- Chronic physical illness and disability
- Social adversity: poor social support; social isolation/unconnectedness; loneliness; recent bereavement; or unemployment
- Perceived burdensomeness
- Low self-worth
- Hopelessness
- History of, or current, self-harm and/or alcohol/substance misuse
- Active plans for suicide and access to means

THE ROLE OF PRIMARY CARE

Suicide prevention is considered a multisector public health responsibility, and within this, primary care is a setting where most people (up to 85%) who die by suicide have been seen in general practice the year before, and where high-risk groups such as middle-aged males aged 45–49 years can be identified.[10,11] Although suicide is a major public health and primary care challenge, it can be uncommon for some individual practice teams. GPs do, however, consult with many patients who are distressed, who have harmed themselves, and who express suicidal thoughts and intent. Evidence is currently lacking, but it is possible that levels of distress, anxiety, thoughts about suicide, and self-harm in the community will increase through the later stages of the COVID-19 pandemic and its aftermath, and some GPs have already noticed increases in these presentations.

Assessing risk of suicide by stratifying people into risk categories or assigning risk scores is not a useful way to determine what action to take in primary care because of poor positive predictive values (ranging from 1.3% to 16.7%).[12] Particular challenges may arise because of overshadowing with physical symptoms (including 'long COVID') and because it is difficult to predict when distress will ameliorate naturally as situations improve, or when difficulties will persist. Nonetheless certain features, alone or in combination, should raise concern for heightened suicide risk and these are highlighted in Box 1. These should aid decision-making and can be readily elicited in a primary care consultation.

COVID-19 has rapidly changed the primary care context, such as the implementation of remote consultations to reduce COVID-19 contagion, but principles of good care remain. Therefore, an important element of suicide prevention in primary care should be to improve mental health care for all patients. The response to identified heightened suicide risk in primary care should include the following components:[13]

- supported self-management, including a discussion about staying safe during difficult times and signposting to self-care resources (for example, online and third-sector support);
- follow-up with active surveillance for deterioration; and

- referral to specialist mental health services.

Members of the primary care team other than GPs, including practice nurses, clinical pharmacists, physiotherapists, dentists, and physician associates, have an important part to play in identifying and intervening for patients with suicidal thoughts and self-harm, which may facilitate early help seeking during the COVID-19 crisis.

For primary care to become an effective part of the multi-agency approach to suicide prevention during the pandemic and beyond, there has to be effective collaborative working with other sectors such as the education and social care systems, and uniformity in approaches. Facilitators and future priorities to enable primary care to lead the way in suicide prevention during COVID-19 are identified below.

FACILITATORS

Improved communication between mental health services, including liaison psychiatric and community services, and primary care teams can facilitate enhanced management for people who have harmed themselves.[13] Tailored services for primary care teams to signpost patients who have suicidal thoughts or have harmed themselves are needed to facilitate effective care for people in distress.[13]

Third-sector organisations can play a supporting role in providing psychological therapy for patients who have harmed themselves or expressed suicidal thoughts, especially given the lack of bespoke provision of care for these patients through the Improving Access to Psychological Therapies programme.[14]

FUTURE DIRECTIONS

The planned integrated community and primary care mental health services for self-harm, as outlined in the NHS Long Term Plan (www.longtermplan.nhs.uk), may help to facilitate rapid intervention and treatment, although continued financial investment is needed to sustain such services. It is crucial that these services communicate effectively with primary care teams, are available for GPs to refer to, and include young people.

During 2021, primary care networks have the potential to invest in mental health professionals working in general practice. This may improve care and therapeutic relationships for patients at heightened suicide risk. Remote consultations provide a challenge for clinicians as rapport may be detrimentally affected; an evidence base for best practice in remote mental health and self-harm assessments has not yet been established. There is a pressing need for research to develop and test primary care delivered interventions to reduce self-harm and suicide risk in all patients, in partnership with patients and the public, to mitigate suicide risk during the COVID-19 pandemic and beyond.

Faraz Mughal,
GP and National Institute for Health Research (NIHR) Doctoral Fellow, School of Medicine, Keele University, Keele.

Allan House,
Emeritus Professor of Liaison Psychiatry, Division of Psychological and Social Medicine, Leeds Institute of Health Sciences, School of Medicine, University of Leeds, Leeds.

Nav Kapur,
Professor of Psychiatry and Population Health, NIHR Greater Manchester Patient Safety Translational Research Centre and Centre for Mental Health and Safety, University of Manchester; Manchester Academic Health Science Centre; Greater Manchester Mental Health NHS Foundation Trust, Manchester.

Roger T Webb,
Professor in Mental Health Epidemiology, NIHR Greater Manchester Patient Safety Translational Research Centre and Centre for Mental Health and Safety, University of Manchester; Manchester Academic Health Science Centre, Manchester.

Carolyn A Chew-Graham,
GP Partner and Professor of General Practice Research, School of Medicine, Keele University, Keele.

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ADDRESS FOR CORRESPONDENCE

Faraz Mughal
School of Medicine, Keele University, Keele ST5 5BG, UK.

Email: f.mughal@keele.ac.uk

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