RCGP SCOTLAND

RCGP Scotland consultation response

A Suicide Prevention Strategy for Scotland

August 2022

1.1 Do you agree with the proposed vision, described below, for the new Suicide Prevention Strategy:

"Our ambition is a Scotland where everyone works together to prevent suicide.

To achieve this we will work with communities to become safe, resilient and inclusive - where people who have thoughts of taking their own lives, or people affected by suicide, are offered effective, compassionate and timely support, and a sense of hope."

YES

1.2 - Why?

RCGP Scotland welcomes the opportunity to contribute to a new Suicide Prevention Strategy and Action Plan by Scottish Government and COSLA. We are the membership body for general practitioners in Scotland and exist to promote and maintain the highest standards of patient care.

Suicide is always a tragic loss of life. Such a devastating and traumatic event often has repercussions on future generations too, in terms of their emotional wellbeing. The College recognises the prime importance of societal and public health factors in preventing suicide and support efforts to address those.

RCGP agrees that suicide prevention requires broad action from many areas of society and we support this vision. However, there would be some utility in providing further detail which the statement currently lacks.

This very overarching vision that might benefit from some more clarity, for example, to support initiatives that improve societal understanding of mental health and suicide, to set out the political and economic approaches, to enable professionals to work together to prevent suicide.

1.3. To what extent do you agree with the following guiding principle:

Suicide prevention is everyone's business. We will provide opportunities for people across different sectors at local and national levels to come together to connect and play their part in preventing suicide. **Agree**

1.4. To what extent do you agree with the following guiding principle:

We will take action which addresses the suicide prevention needs of the whole population and where there are known risk factors such as poverty, marginalised and minority groups - **Strongly agree**

1.5. To what extent do you agree with the following guiding principle:

All developments and decisions will be informed by lived experience. We will also ensure safeguarding measures are in place across our work. **Agree**

1.6 To what extent do you agree with the following guiding principle:

*Effective, timely and compassionate support will be available and accessible to everyone who needs it including people at risk of suicide, their families/carers and the wider community -**Agree***

1.7. To what extent do you agree with the following guiding principle:

We will ensure the needs of children and young people are addressed and their voices will be central to any decisions or developments aimed at them - **Agree**

1.8. To what extent do you agree with the following guiding principle:

To build the evidence base, quality improvement methodology and testing of new, creative and innovative practice will be embedded in our approach. ***Strongly agree***

1.9. Please use the box below to share any other comments you have in relation to the principles described above.

Much of the work round mental health, self-harm and suicide is done in general practice and this would require Protected Learning Time (PLT) in practices with adequate resource and cover if GPs and their teams are going to be able to engage in this in a meaningful way. Adequately funded and resourced PLT would allow general practice teams to come together to learn and embed new guidance.

Tackling known risk factors such as those in poverty, marginalised or in minority groups will require the work of decades of political and economic change. Currently with the cost of living crisis and societal marginalisation of the poor and of others, these are currently worsening. Some of this will relate to UK policies, but there is much to be done and we welcome the emphasis on marginalised groups and ethnic minorities.

We agree that policies should be informed by lived experience. However, with a very significant workforce deficit, we increasingly need to be aware of unrealistic expectations of a system in great difficulty, and the experiences of those delivering care too.

GPs must, of course, always provide care when someone is having thoughts of suicide. However, we suggest that there is insufficient emphasis in the strategy on their work as important providers, and other mental health services: it is increasingly difficult for GPs and others to deliver the care they would want and people need. The majority of mental health care in the community is delivered by GPs – and the general practice workload and workforce crisis means that there is increasing pressure in the system. To promise that care will always be available and accessible there needs also to be discussion on how that will be achieved and maintained – for instance, we need to see the guarantees of expansion of GP resource for this principle to have meaning. Some GPs are reporting having to increasingly support those with moderate to severe mental illness because of the psychiatry (and community psychiatric nurse) shortages too. Often patients who miss an outpatient appointment are immediately discharged from care, meaning that the GP has to then take that on: non-engagement with services is associated with suicide risk, and there is little consideration of this in the strategy.

We support the principle of aiming to address the needs of children and young people, but the Audit Scotland report on CAMHS[i] is clear that we are falling far, far short, and the evidence is of yet further rises in workloads. Much of this section needs to be reframed in terms of principle rather than desired outcome, the latter not achievable for a long time (if ever).

RCGP strongly supports the principle of involving children and young people in decisions – there is evidence that alienation and isolation is a factor in suicides in this age group[ii]. We also note that suicides are rising in those under 20, though remain low overall, but the UK data indicates that self-harm in that age group – an adverse prognostic factor for future suicide - is rising rapidly. Although the strategy refers to working across the life stages, it perhaps needs greater emphasis on young people, because the causes and responses needed do differ.

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) states that factors relating to suicide, and the means of preventing them, are multiple and also differ according to different societies and settings. It is important that Scotland builds her own evidence base. Lacking in the strategy is much mention of suicide relating to alcohol and drugs – where Scottish prevalence is high.

It is notable in the NCISH report that Scotland had a higher number of mental health outpatient DNAs (Do Not Attends), where care usually reverts to the GP, as well as fewer interventions by crisis services. The strategy repeatedly refers to suicide prevention strategies, and alongside that, there needs to be a parallel reference to mental health and mental health services. Health inequalities and suicide are associated – especially in poor middle-aged men – and often linked to drug and alcohol use as well as poverty and isolation. That is also insufficiently emphasised in the paper.

Throughout we need to recognise that services are severely limited just now – and when there is financial resource to support there is often not the workforce. That applies across the board, but GPs and their teams are under severe pressure and undertake more mental health consultations than any other profession. 90% of people with mental health problems are cared for entirely within primary care, which includes people with serious and enduring mental illness (SMI) and around 30% of people who see their GP have a mental health component to their illness (pre-pandemic)[iii] . However, the consultations relating to mental health are anecdotally higher since people have faced the pressures of the pandemic and other factors. The indications are that GPs probably consult with over 10% of their practice population every week so this represents an extremely high workload. GPs also see patients who are distressed and have suicidal ideation and have to manage those often with little support.

RCGP Scotland does recognise that mental health is a key part of the work of the general practitioner: the focus of the GP is long-term relational care, understanding the wider background of people's lives, working with families (where the mental ill health or suicide of a family member can have devastating effects which also need the GP to intervene and support), understanding the local mental health supportive landscape (which is helped by new multi-disciplinary team (MDT) members including link workers) and co-ordinating care. There is also a key role for providing medical care for those with multi-morbidity, both mental and physical, so often a factor in those in middle and older age groups committing suicide. We remain very committed to this work, but are increasingly concerned by the workforce shortages and particularly retention, the rising workload and that some GPs are now finding it increasingly difficult to provide the time, space and regular review so needed by this group of patients. This mirrors other workforce shortages and we note there is insufficient emphasis on workforce shortages and pressures in the draft strategy. RCGP Scotland has called for at least one mental health clinician in every practice, and we are nowhere near achieving that despite GMS contract aspirations.

1.10. To what extent do you agree with the following outcome:

Outcome 1: The environment we live in promotes the conditions which protect against suicide risk – this includes our psychological, social, cultural, economic and physical environment.

Strongly agree

1.11. To what extent do you agree with the following outcome:

Outcome 2: Everyone has a clear understanding of suicide, its prevention, and associated risk and protective factors. Everyone is able to respond confidently and appropriately when they, or others, need support. - ***Agree***

1.12. To what extent do you agree with the following outcome:

Outcome 3: Everyone affected by suicide is able to access appropriate, high quality, compassionate, and timely support - that promotes recovery. This includes people of all ages who experience suicidal thoughts and behaviour, anyone who cares for them, and anyone affected by suicide in other ways. - ***Strongly agree***

1.13. To what extent do you agree with the following outcome:

Outcome 4: All suicide prevention activity is designed with lived experience insight. Action will be informed by up-to-date practice, research, intelligence, and improved by regular monitoring, evaluation and review. - ***Strongly agree***

1.14. Please use the box below to share any other comments you have in relation to the outcomes described.

We would very much like to see these outcomes be achieved.

However, we are forced to question their feasibility. With outcome 2, many in society will not be interested in suicide prevention: might it be an objective better targeted for all those working in education, health and social care, for instance? We wonder if the population would be more likely to engage with more specific messaging, which feels more immediate to their everyday lives - around the associated risk and protective factors. Examples, all pertinent to suicide prevention include using social media safely, social isolation and community cohesion, a society with values where people can feel hopeful, engaged, and able to better understand and develop relationships.

It may help to look at suicide across the different age ranges. Children and young people have been mentioned, but the highest risk, by far, are those in middle age (especially men) and there is another higher risk group in the 80+ age cohort, associated with ill health, isolation and bereavement, and where different approaches will be needed.

Outcome 3 is laudable too but will require large and significant changes in the available workforce over a sustained number of years. GPs aim always to give timely, compassionate, high-quality support, but this is likely to be eroded as we go forward, particularly as we lose doctors with many years of continuity of care of their patients. Figures from RCGP tracking survey, in field 3 March - 18 April 2022, found that a third of Scottish GP respondents indicated that they will retire in the next 5 years. There is a significant shortage of psychiatrists, some GPs no longer having access to a local one. We note in the NCISH report that the majority of those committing suicide had severe mental illness (bipolar or schizophrenia) and this needs to be specifically considered too.

For outcome 3, we recommend noting that in a system restricted in terms of workforce and facing a rising workload we need to optimise care within a stressed system, the long-term aim being offering everyone the care they deserve. There is evidence of unmet need especially in highly deprived populations[iv].

1.15. Do you agree that the Suicide Prevention Strategy and action plan should have this as a priority area:

Build a whole of Government and whole society approach to address the social determinants which have the greatest link to suicide risk. ***Strongly agree***

1.16. Do you agree that the Suicide Prevention Strategy and action plan should have this as a priority area:

Strengthen Scotland's awareness and responsiveness to suicide and suicidal behaviour. - ***Strongly Agree***

1.17. Do you agree that the Suicide Prevention Strategy and action plan should have this as a priority area:

Promote & provide effective, timely, compassionate support - that promotes recovery. - ***Strongly agree***

1.18. Do you agree that the Suicide Prevention Strategy and action plan should have this as a priority area:

Promote a coordinated, collaborative and integrated approach. - ***Strongly Agree***

1.19. Please use the box below to share any other comments you have in relation to the priority areas described.

Currently, services feel very fragmented with pressures in both mental health and GP services meaning that the scope for communication and interface working is now limited. There is sometimes conflict between services – GPs feel that they are sometimes carrying heavy high risk mental health workloads, patients previously managed by community mental health teams, having to manage ill patients that have been discharged when still unwell, poor access to emergency psychiatric services, and so on.

In some areas GPs are having to detain suicidal patients when that would be more appropriately done by specialist services, and we need an urgent review of why that happens as it compromises the patient's care under mental health legislation. The Scottish Government National Workforce Strategy for Health and Social Care outlined that at the end of 2020, there was a shortfall of 53 full time equivalent Mental Health Officers[vvi]. They have a crucial role in detaining those who have suicidal intent and refuse admission, and again this shortfall sometimes leaves GPs unsupported in the face of additional difficult emergency work.

1.20. Do you agree with the proposed approach to delivery and the new Scottish Delivery Collaborative.

To help us deliver the strategy and achieve the actions in our Action Plan we are proposing a new Scottish Delivery Collaborative. A description of this collaborative can be found below:

Scottish Delivery Collaborative: a Scotland wide delivery team on suicide prevention. It will bring together local practitioners with the national implementation team and harness insights from the Academic Advisory Group (AAG), Lived Experience Panel (LEP) and Youth Advisory Group (YAG).

The collaborative will use an agile planning approach and constantly develop and evaluate effective strategies to improve our reach and support for people who are at risk of suicide, including using technology. Public Health Scotland will play a key role in supporting the Collaborative to put knowledge into action and building an active learning approach. ***YES***

1.21 If you answered no, what would you change about the proposed delivery approach and why? You may also want to provide suggestions for an alternative approach.

RCGP Scotland calls for GP and primary care input into this Collaborative. It is often GPs that manage patients with mental health care outwith hospitals, including many patients who are self-harming or have suicidal ideation, and this workload is often under documented.

1.25. Is there anything else you want to tell us about the proposed strategy document?

We would recommend more mention in the Strategy about the roles of the GP, the third sector, alcohol and drugs, Health and Social Care Partnerships, and the new National Care Service.

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[i] Blog: Child and Adolescent Mental Health Services | Audit Scotland (audit-scotland.gov.uk)
[ii] NCISH-2022-report-bookmarked-FINAL.pdf (nspa.org.uk)
[iii] RCGP position statement on mental health in primary care - September 2017
[iv] Health Inequalities in Scotland (gla.ac.uk)

[vi] National Workforce Strategy for Health and Social Care in Scotland