

Suicide prevention in young people:

optimising primary care

INTRODUCTION

Youth suicide is a global public health concern. Despite significant differences in suicide rates depending on age, sex, and country, young people remain a key target for prevention and intervention with late adolescence (15–19 years) identified as a time of heightened risk and increased clinical focus worldwide.¹ Among the many stressors that increase vulnerability to suicide in young people, social risk factors including poverty, bullying, academic pressures, and social isolation play key roles.²

Suicide prevention may be considered an issue for specialist mental health services. However, given that many of the determinants of suicide lie at the heart of social adversity, there is a strong need for the shared role and responsibility between health, social care, education, the justice system, and the voluntary sector. Within a multifaceted public health approach to suicide prevention, we highlight the vital role of primary care.

GPs are often the first and the last healthcare contact for those who die by suicide³ and a trusted source for help-seeking for mental illness in young people.⁴ While the general practice consultation holds exceptional potential to support young people at risk of suicide,⁵ there are unique challenges that often prevent GPs from providing optimal care to this cohort.⁶ These include time constraints, heavy workload, and a lack of integration with specialist mental health services, which means that most of the time GPs have to manage complex cases in relative isolation.⁶ An identified lack of specialist education has also left many GPs feeling ill equipped to meet the multiple, diverse, and complex needs of young people at risk of suicide.⁶ Therefore, while GPs have an important role to play in youth suicide prevention, the complexities of primary care settings are not always acknowledged.⁶

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MOVING FORWARD

Primary care is the bedrock of any health system. As such, it needs to be at the forefront of effectively identifying and supporting young people at risk of suicide. In the present article, we identify key principles that could help improve youth suicide prevention in primary care. We highlight international examples where these principles have been adopted, demonstrating how service innovation in primary care needs to align with changing needs and demands in relation to youth suicide prevention. The examples identified are supported by wider policy context and grounded in general practice realities.

Enhanced and integrated primary and community mental health services

Mental health services for young people need to be fully integrated in primary health care and have a strong community focus. The NHS Long Term Plan⁷ outlines expanded community multidisciplinary teams including GPs, pharmacists, allied health professionals, and social care staff, aligned with new primary care networks working together to provide integrated, coordinated, inclusive, and personalised care for at risk young people.

This means that GPs will now be supported by a wider team of health professionals to collaboratively manage complex cases. For this initiative to be successful, we need to evaluate service models and build and expand a diverse workforce focusing on mental health in education, communities, and primary care. Provision of specialist education on youth development, and

specifically on enhancing competencies and capabilities in conducting psychosocial assessments with young people, should be part of the RCGP core curriculum for GP trainees.

The Well Centre in the UK is a prime example of a community focused multidisciplinary youth health centre where young people can discuss their health concerns with a youth worker, counsellor, or doctor in a safe and confidential space. The Well Centre (in Streatham, south London), is run by a GP practice in collaboration with a local youth-work charity, and therefore has a strong community focus. This means that the Centre is accessible and acceptable to those young people who might not otherwise visit their GP or seek help from mainstream services.

In Australia, the headspace model, developed in 2006 to address the increasing gaps in the delivery of youth mental health services, is unique in that it provides multidisciplinary frontline care to young people aged 12–25 years.⁸ The headspace model centres around integrated, highly accessible, and youth-friendly service hubs that deliver primary care, mental health, substance misuse, and vocational services from one location. It provides a seamless pathway of care across the adolescent and young adult age range, bridging the gaps between child, adolescent, and adult services. There are now over 100 headspace centres across Australia plus an online service, which provides evidence-based treatment delivered by trained mental health clinicians. The headspace model is now being rolled out in Ireland, Denmark, Israel, Iceland, and the US.⁹

Digital innovations

Technology has a potential to improve healthcare provision. Yet, the unique potential of technological developments in suicide prevention has not been fully realised in primary care. Given that young people are digital natives, evidence-based technological

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innovations could be implemented in primary care to facilitate engagement, assessment, and management.

One such innovation is Check Up GP;¹⁰ an online health and lifestyle screening tool designed to be used by young people in GP waiting areas in Australia to screen for a range of health, psychological, social, and emotional questions (including suicidal behaviours) prior to their appointment. A summary report is automatically sent to their GP prior to the consultation. The tool facilitates engagement and rapport, particularly when it comes to discussing sensitive issues with GPs; reduces unmet needs; and promotes person-centred care.

Another example refers to clinical decision support systems (CDSS) and plans set out in The NHS Long Term Plan⁷ to use such tools to enhance healthcare professionals' ability to deliver personalised care specifically in those at risk of self-harm or suicide. An electronic CDSS to support GPs in the assessment and management of suicide risk is currently being piloted in the UK.¹¹ Such a tool could provide a standardised method for recording data on suicide risk, assessing ongoing social circumstances or risk factors, identifying needs, and facilitating appropriate management options.

Promoting shared decision-making

Young people should be at the forefront of decisions made about their care. Shared decision-making (SDM) refers to a structured process, which requires the full participation of both clinician(s) and patient(s) working in close alliance to form decisions about all aspects of care.¹² The evidence-base for SDM in mental health is small but rapidly increasing.^{12,13} Some of its benefits include improved satisfaction with treatment and increased compliance;¹³ reduction in symptom severity;¹⁴ and improved understanding of, and attitudes towards, recovery.¹⁴

In the field of youth suicide prevention, the efficacy and implementation of SDM is unexplored. The RCGP, in the educational resource *Suicide in children and young people: Tips for GPs*,¹⁵ support the co-production of an agreed upon safety plan between young people and their GP as part of an ongoing assessment of risk and needs in primary care. Working with young people (and wherever appropriate, their families) to help them identify what could keep them safe and agree on follow-up plans is a core element of SDM. In Australia, Orygen has produced a clinical practice document¹⁶ about the use, principles, and implementation of SDM in the context of youth mental health as a way

of improving young people's experience of service provision.

CONCLUSION

Suicide prevention requires a multiagency public health approach with a strong focus on early intervention and prevention. GPs are situated at the heart of communities and are therefore attuned to the physical, mental health, and psychosocial care needs of young people. Effective, enhanced, and integrated models of primary and community mental health services that involve evidence-based digital options, promote SDM, and, are socially, culturally, and developmentally acceptable to young people are key principles for optimising primary care for improved suicide prevention in the 21st century.

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Competing interests

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