

Correspondence

Managing suicide risk in primary care

05 June 2021

We read with interest Professor Morgan's special article on predicting short-term suicide risk.¹ We are grateful for the mention of the extensive body of evidence suggesting the futility of suicide risk assessments and alleged risk factors including suicidal thoughts and behaviours in predicting suicide risk. We appreciate the statements 'To base assessment of ongoing risk on the individual's mental state during a single interview is clearly likely to be highly unreliable' and 'An important trigger for relapse is stress, particularly stress that has previously been present and has not been resolved'. It is important that the above facts are conveyed to the patient's general practitioner (GP) via the suggested correspondence. However, we wonder about the purpose of the proposed 123-word paragraph ending with the sentence 'Overall, however, the predicted level of suicide risk must still be regarded as significant, requiring vigilance until I next see him/her'. What action is required of the GP when they receive similar letters about almost every patient seen by the mental health services? If the patient requires vigilance for their mental health, would this not best be provided by secondary care mental health services with their array of highly specialist teams and army of experts? What aspects of suicide prevention are the GPs better equipped for than the secondary care mental health services? It is important to acknowledge that it is not possible to reliably predict suicide risk from single consultations. However, it appears the suggested correspondence is unrealistically asking an already overstretched primary care service to pick up responsibility in a specialist area. Furthermore, we would be grateful for any guidance on how to better assess and manage suicide risk during a 10 min GP consultation than during the 30-60 min assessment by specialists.

Ann Maria Albert, GPST3, Oxford GPVTS, UK. Email: Annmaria.albert1@nhs.net;
Hannah Gallen, GPST1, Reading GPVTS, UK; **Misha Gaur**, GPST3, Reading GPVTS, UK

Reference

- 1 Morgan G. Predicting short-term suicide risk: allowing for ongoing variation in severity of intent. *BJPsych Bull* 2021; **45**, 105-8.

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Author's reply:

17 June

I am grateful to Drs Albert, Gallen and Gaur for their interest in my paper. Unfortunately they appear to have misunderstood some major points which I make. I certainly do not suggest that the assessment of suicidal thoughts is futile in short-term prediction of suicide. I argue exactly the opposite,

presenting evidence that provided this is carried out correctly and appropriately, it should have significant predictive value.

What is more, I do not in any way suggest that ongoing care of suicidal patients should be handed back to the general practitioner (GP), certainly not before their problems have been resolved. My suggested letters are meant as clinical summaries which should be sent routinely to GPs by any psychiatric team as part of good ongoing clinical care. They do not mean, in any way, that the secondary service thereby should relinquish ongoing clinical care of their patients before treatment is complete.

How to maintain good ongoing supportive care of patients who have experienced a suicidal crisis is an important clinical challenge. My paper considers how the psychiatrist might attempt to achieve this, by emphasising concern to provide the form of help which would be most acceptable to the patient, and to which he/she would readily turn should the crisis recur.

Gethin Morgan, Emeritus Professor of Mental Health, University of Bristol, Bristol, UK. Email: hilary.howard@blueyonder.co.uk

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Fluctuation of suicide intent and other matters in psychosocial assessment post self-harm

Professor Morgan's article rightly focuses on the fluctuations in suicidal intent among mentally ill people undergoing the various crises and vicissitudes of life. He emphasises the importance of repeated assessments, rather than relying on the initial one, to accommodate these fluctuations in intent.

He appears to have given up on prospects of predicting longer-term suicide risk but has not commented on the emerging body of evidence suggesting the effectiveness of combining an app-based questionnaire with inflammatory biomarkers such as interleukin subtypes, SAT1 and Toll-like receptor subtypes.¹ These biomarkers probably reflect the degree of underlying stress which Professor Morgan describes, with some quantitative features provided in addition. These types of hybrid assessments should cover both the short- and longer-term risks but will not predict when (or under what circumstances) the lethal behaviour could take place.

Consequently, mitigation needs simple strategies such as Dr Cole-King's suicide safety plan, a brief document co-produced with the patient, held by the patient and carer, describing what to do and who to contact if suicidal intent reaches a climax.²

Brief hybrid assessments might also be less intrusive and distressing to patients compared with the standard 'psychosocial assessment' carried out in emergency room settings, typically by junior psychiatric liaison staff and often under time pressure (including the 4 h wait and expectations of prompt bed clearance and discharge as the person is deemed 'medically fit'). Often