

Suicide prevention targeting middle-aged males: the role of primary care

SUICIDE PREVENTION IN PRIMARY CARE

Primary care has a significant role to play in suicide prevention. Evidence across a range of studies suggests that, on average, 80% of people who die by suicide have been in contact with primary care in the year before dying by suicide, and 44% in the preceding month.¹ Although this represents a significant opportunity for preventative measures, the challenges of identifying who is at risk and how to optimally intervene remain stark.

Of all suicide deaths registered in 2021 in England and Wales, three-quarters were by males.² Moreover, middle-aged males are the highest risk group, as from 2010 onwards, the suicide rates for males aged 45–64 years are higher than every other age-specific group (20.1 deaths per 100 000 in 2021). Therefore, this group represents an important target for suicide prevention efforts, although age and gender alone are insufficient for suicide risk detection purposes.

To address this challenge we need to better characterise risk in this group. To this end, Mughal and colleagues³ conducted

a national case series study to establish antecedents to suicide in middle-aged males who had consulted a GP before dying by suicide. Drawing from a range of data sources, including the coroner, police, criminal justice, and NHS reports, they found that two-fifths (43%) had consulted a GP in the previous 3 months, with more than half reporting a mental health problem. Further, males who had recently consulted their GP were more likely to report a physical illness, recent history of self-harm, a mental health problem, and have experience of a work-related problem compared to those who had no recent GP contact. The authors suggest that GPs should be vigilant to the potential for suicide risk when these factors present themselves in middle-aged male patients.³

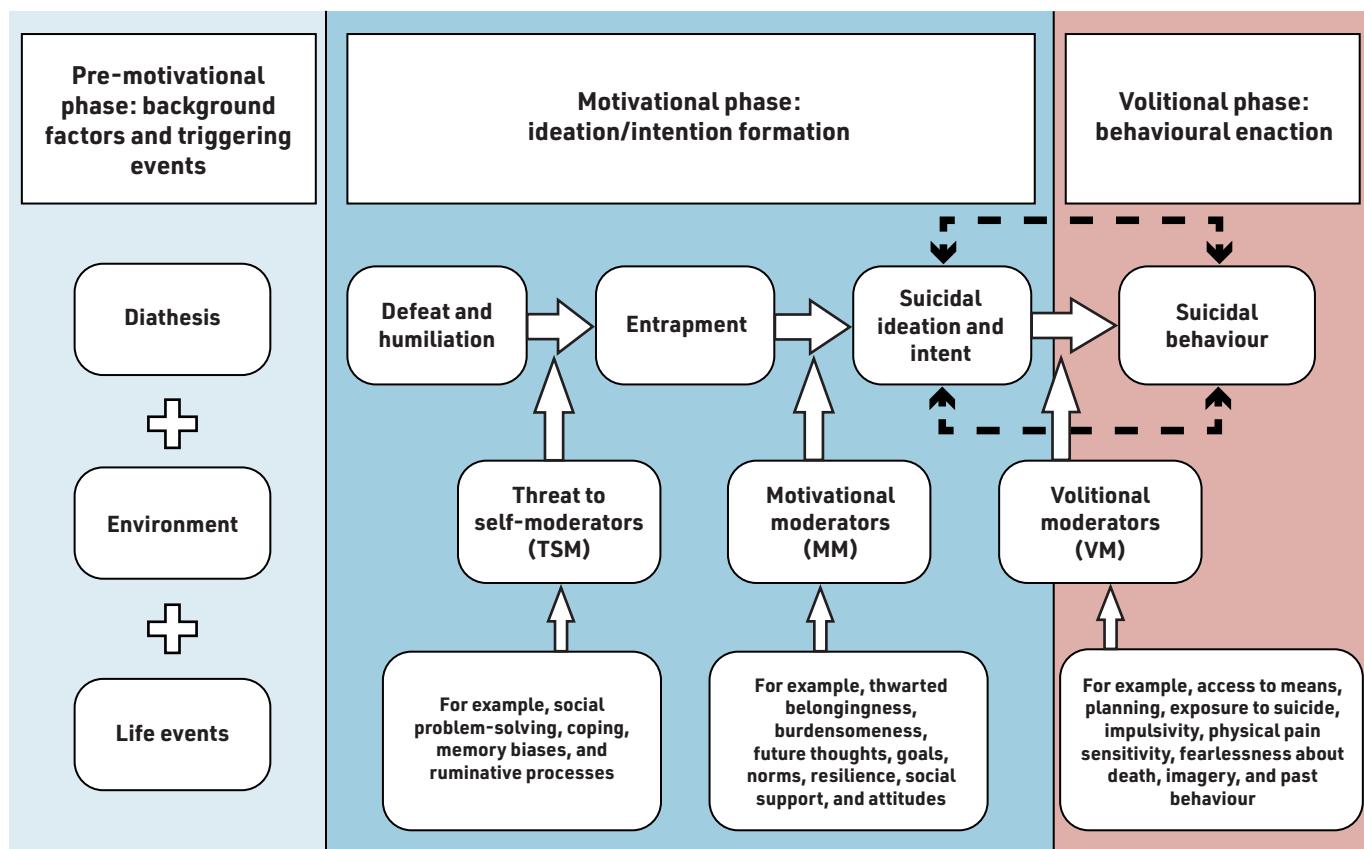
SUICIDE RISK FACTORS FOR MALES

The Mughal *et al* findings are consistent with a recent systematic review of suicide risk factors for males⁴ that identified the leading risk factors for suicide: including physical

health, lifestyle, and illness (for example, smoking); mental health or psychiatric illness (for example, alcohol dependence and/or diagnosis of depression); experiencing a negative life event or trauma (for example, bereavement); as well as sociodemographic factors (for example, being unmarried and/or having a lower level of education). This review identified a dearth of evidence specifically related to the psychological factors (for example, emotional control and impulsivity) associated with male suicide risk and the impact of past suicidal behaviour on subsequent suicide risk. Similar to Mughal and colleagues, this review highlights the urgent need for a more fine-grained understanding of the complex set of factors that may explain elevated suicide risk among middle-aged males.

It also shines a light on the importance of looking beyond mental ill-health alone as a marker of suicide risk, as the majority of those diagnosed with a mental health condition do not make a suicide attempt or die by suicide.⁵ Therefore, better

Figure 1. The integrated motivational–volitional model of suicidal behaviour (O’Connor and Kirtley, 2018).²¹



identification of factors associated with the development and emergence of suicide risk over and above psychiatric symptoms is of paramount importance.⁶ To this end, a number of models to better conceptualise how these factors operate to increase suicide risk have been developed.

THE INTEGRATED MOTIVATIONAL-VOLITIONAL MODEL OF SUICIDAL BEHAVIOUR

One such model is the integrated motivational-volitional (IMV) model of suicidal behaviour (Figure 1), a tripartite model (pre-motivational, motivational, and volitional phases) outlining the final common pathway to the emergence of suicidal ideation and making a suicide attempt.⁷ The initial pre-motivational phase outlines the biosocial context for suicide risk, proposing that life stressors interact with vulnerabilities to increase risk for suicide, including childhood abuse or trauma,⁸ socioeconomic disadvantage,⁹ or personality factors

such as being high in perfectionism.¹⁰ The motivational phase of the model outlines the pathway to suicidal ideation, specifically that feelings of defeat and entrapment lead to the emergence of suicidal thinking.¹¹ Evidence indicates that internal entrapment (trapped by thoughts and feelings in your head), rather than external entrapment (trapped by external situations) may be especially problematic.¹² Importantly, moderating factors such as positive future thoughts or social support can increase or buffer the risk of entrapment leading to suicidal ideation.^{13,14}

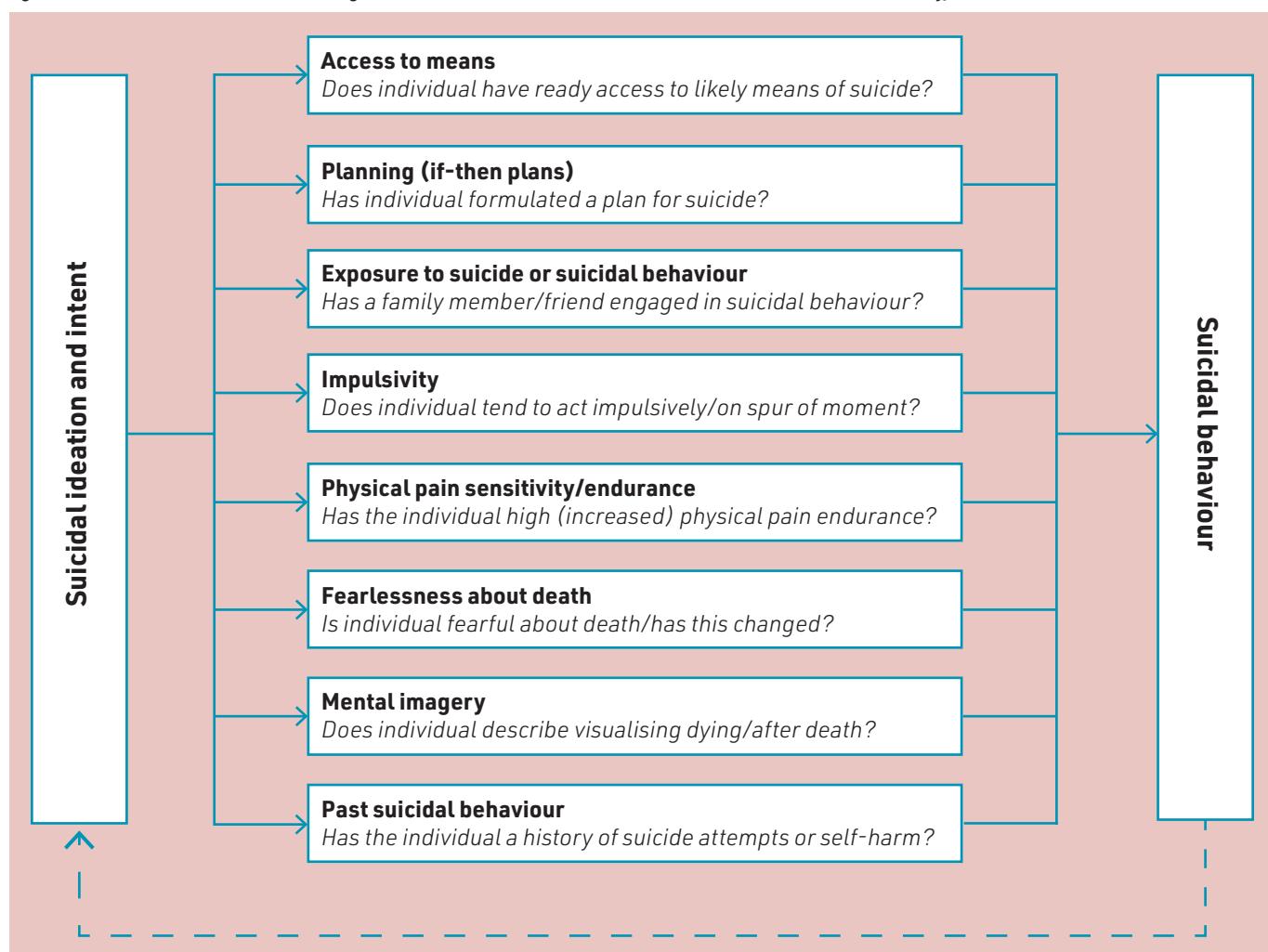
Finally, the IMV model outlines a group of factors called volitional moderators (Figure 2) that are thought to increase the likelihood that someone will act on their thoughts of suicide.¹⁵ Importantly, these factors assist in identifying who may make a suicide attempt, and as they are potentially modifiable they represent potential targets for clinical intervention. Collectively, these volitional moderators may make suicide as an option more accessible, for example, evidence suggests that making

a single past suicide attempt is associated with an increased risk of repetition,¹⁶ and exposure to the suicide of a close friend or family member can increase risk of self-harm five-fold.¹⁷ Further, having access to the means for suicide increases risk for a suicide attempt,¹⁸ with those in certain occupations, such as veterinarians and doctors, having increased suicide risk due their access to means.¹⁹ Being impulsive can also increase risk, as impulsive people may have had more painful experiences, increasing an individual's capability for suicide.²⁰

KEEPING AT-RISK PATIENTS SAFE

Although recognising the factors that may be associated with an increased risk for suicide is important, knowing how to intervene and keep someone at risk safe is critical. This is particularly pertinent for those in primary care settings, where contact time is limited. Asking a patient about suicide can be a necessary but challenging task, and it should be emphasised that there is

Figure 2. The volitional moderators (factors) that govern the transition from suicidal ideation to suicidal behaviour (O'Connor and Kirtley, 2018).²¹



“... patients who received safety planning and telephone support reported 45% fewer suicidal behaviours than those who had not over a period of 6 months.”

no evidence that asking about suicide will increase an individual's risk for suicide.²² An added challenge is the emerging body of evidence that common risk assessment tools are no better than chance at identifying who will go on to make a suicide attempt,²³ and such literature suggests a comprehensive psychosocial assessment is required; which may be difficult with GP time constraints.

Promisingly, there is growing evidence that brief contact (single person encounter) suicide prevention interventions appear to be effective at reducing subsequent suicidal behaviour and increasing engagement in follow-up mental health care.²⁴ Of particular note is safety planning: a person-centred, tailored, six-step crisis plan that identifies the warning signs of a suicidal crisis and provides clear actions for how to respond to keep the

individual safe. A landmark study has found that patients who received safety planning and telephone support reported 45% fewer suicidal behaviours than those who had not over a period of 6 months.²⁵ Therefore, incorporating the co-creation of safety planning into a brief appointment with at-risk patients including males may be a potentially life-saving opportunity.²⁶

CONCLUSION

It is clear that further research, such as that by Mughal and colleagues, is required to achieve a richer picture of the complex interplay of risk and protective factors that increase suicide risk, particularly for middle-aged males who make up a devastatingly high proportion of those who die by suicide. There are some encouraging findings that

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brief compassionate interventions can be effective, and this is something that should be further explored in this at-risk age group.

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