

# Access to health care prior to suicide: findings from a psychological autopsy study

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## SUMMARY

*Previous research has suggested that progress towards suicide reduction targets may be achieved by improving the ability of general practitioners to recognise and treat mental illness. Using data from a study of suicide completers who were not in contact with specialist mental health services, we found that the rate of detection and treatment of mental health problems in primary care was high. The major barrier to receipt of care for mental health problems prior to suicide was non-consultation. The study also shows that detection and management in primary care does not necessarily result in prevention of suicide. Implications for public education, access to primary care services and the potential for suicide prevention are considered.*

**Keywords:** healthcare access; primary care; psychiatry; suicide

## Introduction

MENTAL illness is known to be strongly associated with suicide.<sup>1</sup> However, three-quarters of those who commit suicide in the United Kingdom are not receiving specialist mental health care at the time of death.<sup>2</sup> There are four possible explanations for this: (a) they were not mentally ill, (b) they were mentally ill but did not consult, (c) they were mentally ill and consulted their general practitioner (GP), but psychiatric symptoms were not detected or treated, and (d) they were mentally ill, consulted their GP and were diagnosed and managed in primary care without referral to psychiatric services. Little is known about suicide completers who are not in contact with mental health services. In the present study, we investigated 100 such cases and interpreted the findings in terms of Goldberg and Huxley's model of filters on the pathway to care.<sup>3</sup>

## Method

The data presented here were gathered as part of a case-controlled study using the well-established psychological autopsy method.<sup>4</sup> The research team were notified of all suicides and open verdicts recorded by coroners in the county of Devon, England (with a population of approximately 1 000 000) between 1995 and 1998. Open verdicts were assessed and included only where there was a clear likelihood of suicide. Cases were eligible for inclusion if aged 18 years or over, resident in Devon and not in contact with mental health services at the time of death. Data were collected by means of semi-structured interviews with one or more relatives or close friends of the deceased. GP records were also examined to corroborate details of healthcare contacts and treatment. The interview schedule included detailed questions about mental state in the month prior to death, based on ICD-10 criteria. Diagnoses of mental illness in the final month were made on the basis of both interview data and information contained in the GP notes. A detailed account of the study methods is given elsewhere.<sup>2</sup>

## Results

A total of 474 suicides and open verdicts were recorded during 1995–1998, of which 77% were not in contact with mental health services. After excluding those in contact with services ( $n = 110$ ), open verdicts considered unlikely suicides ( $n = 26$ ), those aged less than 18 years ( $n = 8$ ) and not resident within the county ( $n = 35$ ), there were 295 eligible cases. Working consecutively through these, researchers contacted the next-of-kin requesting an interview. The recruitment target of 100 cases was reached

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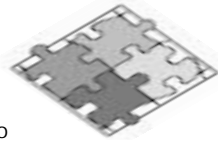
**HOW THIS FITS IN**

*What do we know?*

Previous research has suggested that improving general practitioners' ability to detect and treat mental illness would make a major contribution towards the prevention of suicide.

*What does this paper add?*

Our results suggest that general practitioners are doing very well at detecting and treating mental illness in those who present to them prior to suicide. Non-consultation is the major obstacle on the pathway to care. Moreover, detection and treatment in primary care does not guarantee suicide prevention.



after 183 families had been contacted, giving a positive response rate of 55%. A response rate of 50–60% is usual for psychological autopsy studies.<sup>4</sup>

Of the 100 cases, 67 were male and 33 female. Age ranged from 18–87 years; 30% were under 35 years, and 26% were aged 65 years and over. The sample was representative of the eligible population in respect of age, ethnicity and verdict.<sup>2</sup> Women were slightly over-represented and, as in all psychological autopsy studies, the need to locate a reliable informant created an unavoidable bias towards those with more stable social circumstances.<sup>4</sup>

In nearly a third of cases (32%) we found insufficient evidence to establish a diagnosis of mental illness in the month prior to death (Figure 1). One individual from this group was found to have been receiving long-term psychopharmacological treatment without a definitive diagnosis. Of the 68 whom we judged to have been suffering from mental illness, 30 (44%) had not consulted their GP in the month leading up to suicide. Ten of these were being treated for a previously diagnosed mental health problem, but had not made contact with their GP in their final month. Of the 38 who were ill and consulted, all except nine were diagnosed and treated. Of the total sample, 40 were being treated for mental health problems by their GP.

In terms of Goldberg and Huxley's filters on the pathway to care,<sup>3</sup> 44% failed to pass through the first filter (decision to consult), while only 24% were stopped at the second (recognition by GP).

Table 1 shows the distribution of diagnoses and summarises the characteristics of consulters and those who were diagnosed and treated. In line with the literature,<sup>5</sup> women were more likely than men to receive a diagnosis of mental illness (odds ratio = 4.42; 95% confidence interval = 1.82 to 10.72).

**Discussion**

It is often suggested, despite some contrary evidence,<sup>6</sup> that progress towards suicide reduction targets could be achieved by improving the ability of GPs to recognise and treat mental illness.<sup>7</sup> Our findings show, however, that failure by GPs to detect and treat mental illness occurred in very few cases (9%). The rate of detection and treatment was high: of those who were mentally ill and consulted, 76% (29

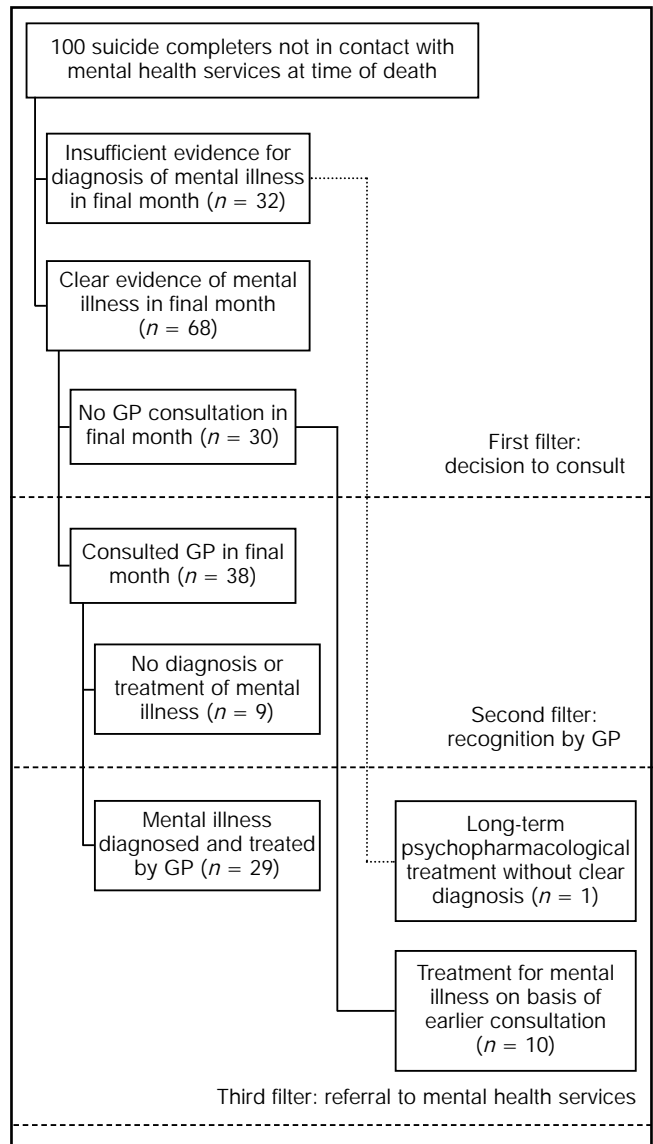


Figure 1. Filters on the pathway to care prior to suicide.

out of 38 patients) were recognised as having a mental health problem and were offered treatment in primary care. This figure is far higher than the usually quoted 50%, but accords with recognition rates found in longitudinal studies.<sup>8</sup> This means that, for individuals who were mentally ill, the second filter (recognition by GP) was the easiest to pass through. The first filter (decision to consult) was considerably more difficult to pass. In other words, non-consultation, particularly in the final month, appears to have been a greater barrier to receipt of care than non-detection.

Goldberg and Huxley identify the third filter (referral from primary to secondary care) as the least permeable.<sup>3</sup> It is not possible in the present study to comment on referral rates from primary to secondary care. Nor is there any way of knowing whether being seen by a specialist would have altered the outcome in these cases. However, it would appear that, where individuals presented, the presentation

Table 1. Distribution of consultation and treatment by age, sex and diagnostic category.

	Total diagnoses from all sources	Consulted in month prior to suicide	Detected and treated by GP <sup>a</sup>
Men (n = 67)	43 (64%)	27 (40%)	19 (28%)
Age (years)			
18-34	13	7	5
35-64	20	12	10
65+	10	8	4
Women (n = 33)	25 (76%)	17 (51%)	21 (64%)
Age (years)			
18-34	7	6	7
35-64	11	7	8
≥65	7	4	6
Diagnostic category			
Affective disorders	51	32	33
Neurotic disorders	9	5	6
Schizophrenia	1	0	1
Alcohol/substance abuse only	6	1	0
Other	1	0	0
Total mental illness	68	38	40

<sup>a</sup>Not all consulted in final month: includes all who passed through second filter and were receiving treatment for a mental health problem (n = 40).

was such that the GP believed the condition could be managed in primary care. In other words, mental disorder did not appear so severe, nor the degree of risk so high, as to indicate immediate referral to specialist services. This raises questions about risk assessment. Concerns have been expressed about low rates of assessment for suicide risk,<sup>9</sup> and our study reinforces these: recording of risk assessment was evident in only 15% of cases.

Despite the very high rate of detection and treatment of mental health problems in primary care, these 100 suicides were not prevented. The extent to which such deaths are preventable has been extensively debated and will remain elusive, since there is no measure of how many lives are saved by clinical intervention.

Further work is needed to explore the factors influencing the decision to consult. Our findings suggest that, henceforth, the focus should be on the search for ways in which vulnerable individuals can be encouraged to access health care at times of crisis.

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