Suicide is a leading cause of death internationally, and self-harm significantly increases the risk of suicide (Hawton et al., 2015; World Health Organization, 2014). To tackle this global health crisis a multisystem, inter-faceted, joined up approach across health and social care, education, judicial, financial, and voluntary sectors is needed. Within this, the health setting of primary care holds unlocked potential for suicide prevention (Michail et al., 2020). In this editorial, we outline the importance of focusing on primary care for suicide prevention and introduce a new special interest group for the International Association for Suicide Prevention.

What is primary and community health care?

The World Health Organization defines primary health care as a whole of society approach to health and well-being centred on the preferences and needs of individuals, families, and communities, which focuses on the interrelated aspects of physical, mental, and social health and wellbeing (World Health Organization & United Nations Children's Fund (UNICEF), 2018). This approach needs to encompass the continuum of health care; from health promotion and prevention; to treatment and rehabilitation, within people's daily environments (World Health Organization & United Nations Children's Fund (UNICEF), 2018).

Primary care services often provide a first point of contact in a health system and generally include the services of general practice, community pharmacy, dental and optometry teams, although this may differ across lower and middle income countries (LMICs) (Charles, 2019). Community health services strive to support people of any age and often with complex multiple problems in their homes and communities. They closely complement primary care services and cover a diverse range of activities that can be both difficult to define and can vary across regions and countries (Charles, 2019). In the National Health Service (NHS), United Kingdom (UK), examples of community health services include community occupational therapy and physiotherapy, health visiting and sexual health services, nursing homes, school nursing, voluntary sector and caring services, (Charles, 2019).

Why primary care for suicide prevention?

High quality evidence has identified increasing rates of self-harm in young and older people being recorded in general practice electronic patient health records (Marchant et al., 2019; Morgan et al., 2018; Morgan et al., 2017). This indicates an increased workload for primary care teams in relation to self-harm but highlights the opportunity for early identification and intervention. Carr et al (2016) found that only a small number of patients recorded in primary care to have harmed themselves were referred for specialist support, thus identifying the need to develop support and interventions within primary care.

A recent systematic review found that general practitioners (GPs) and family medicine physicians have an important role in self-harm management and encompasses: frontline assessment and treatment, ongoing management in primary care, and referring to specialist care (Mughal et al., 2020). Patients have stated that screening for suicidal thoughts should occur in primary care and GPs feel similarly about patients who are depressed (Bajaj et al., 2008).

The Programme for Improving Mental Health Care (PRIME) consortium found that across Ethiopia, Uganda, South Africa, India, and Nepal 10% of people presenting to primary care facilities reported suicidal thoughts in the past year (Jordans et al., 2018). The PRIME consortium also found that having a mental health problem, being female, and younger in age, were all features associated with suicidal behaviour (Jordans et al., 2018). These findings from LMICs stress the importance of engaging in suicide prevention in primary care and the need for specific strategies to reduce suicide in these settings. This also represents an opportunity for tailored screening to help primary care professionals identify suicidal thoughts, intent and possible future risk of suicide early, to enable intervention.

A qualitative study of primary health care professionals in Nicaragua found that primary health care staff wanted to improve their ability to identify and treat young people with suicidal behaviour and saw primary care as an important setting to do this in, however within the constraints of limited time and resources (Obando Medina et al., 2014).

A recent study found that 85% of people who died by suicide in Wales were in recent contact with general practice; and that patients most often consulted for mental health concerns (John et al., 2020). An English report found that risk of suicide increased with more GP consultations especially in the three months before suicide (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), 2014). This highlights the importance of making each healthcare contact count in primary care and aiming for enhanced mental health care of all patients (John et al., 2020; Pearson et al., 2009).

Community pharmacy staff recognise they are an underused yet key component of a system response to suicide prevention (Gorton et al., 2021; Gorton et al., 2019). The value of this has been recognised in England through the incentivisation of community pharmacy staff to complete suicide prevention training before February 2021 (Pharmaceutical Services Negotiating Committee, No date): we are not aware of similar schemes in other countries. However, since 2018, all pharmacists registered in Washington state in the USA have been mandated by law to undertake suicide prevention training (Graves et al., 2018).

In the recent NHS Long Term Plan (National Health Service, 2019), there is a commitment to the development of integrated and enhanced primary care and community mental health services in the UK. As primary and community health services develop and evolve over time, it is paramount that both healthcare settings in countries become more connected: this will provide a strong foundation for the assessment and management of people with self-harm and suicidal behaviours internationally (Michail et al., 2020; Senarathna et al., 2008).

Primary care interventions

There have been a number of studies that have evaluated primary care delivered interventions for suicide prevention (Milner et al., 2017). Almeida et al (2012) conducted a cluster randomised controlled trial (RCT) of a GP targeted educational

intervention (personalised feedback and educational material) for older adults in Australia and found that the intervention led to a significant reduction in self-harm behaviour during follow-up. A four-level intervention programme aimed to improve outcomes for depressed patients in Nuremberg, Germany, included the training of primary care physicians across 12 sessions, provision of educational videos, and the availability of a specialist hotline for individual patient advice, and resulted in a significant reduction in suicide attempts compared to the control region (Hegerl et al., 2006).

A collaborative care intervention of trained care managers supporting primary care physicians in the management of older adults with depression resulted in good adherence to depression medication and reduced suicidal ideation over two years (Alexopoulos et al., 2009). In addition, a training programme across Germany, Hungary, Ireland, and Portugal found that training community facilitators such as social workers, nurses, and teachers can improve facilitator knowledge and confidence on suicidal behaviours, thus encouraging early detection and intervention (Coppens et al., 2014).

In Iran, an integrated tiered suicide prevention programme into primary health care resulted in higher detection of depressive disorders and lower numbers of suicides (Malakouti et al., 2015). However, well conducted RCTs such as Grimholt et al (2015): structured continued GP follow-up for adults who self-poisoned; and Bennewith et al (2002): an invitation for a GP consultation and clinical guidelines for the GP after hospital presenting self-harm, resulted in no significant reductions in self-harm at follow-up.

The studies that offer promising findings need adaption and replication across countries; and the development and testing of new complex and system level interventions are important in understanding how primary care can effectively intervene. These must be undertaken with parallel process evaluation to gain insights into what components work for who, and why, and also in understanding what patients and clinicians find acceptable.

The development and testing of new interventions such as the Community Outpatient Psychotherapy Engagement Service for Self-harm (COPESS), and an electronic clinical decision support tool for the management of suicidality in primary care may soon yield positive results (Horrocks et al., 2018; Saini et al., 2021).

Coronavirus implications

The coronavirus disease (COVID-19) pandemic is refocusing attentions to the importance of mental health on individuals, communities, and nations, and the risk of suicide that COVID-19 brings (Gunnell et al., 2020). Recent evidence identified that suicidal thoughts especially in young adults and those from socially disadvantaged backgrounds are rising in COVID-19 (O'Connor et al., 2020); and older adults with multimorbidity in Hong Kong reported significantly higher levels of isolation and anxiety early in the COVID-19 outbreak (Wong et al., 2020).

At present, the impact of COVID-19 on rates of suicide internationally is largely unchanged, and statistical evidence found a reduction in suicide rates early in the

pandemic compared to pre-pandemic expected levels across 12 countries or areas (Pirkis et al., 2021). There however is the need for continual monitoring of rates and to remain vigilant moving forward into the pandemic.

There is a need to monitor the pandemic and post-pandemic periods within and across countries where economic and social hardships may persist in the pandemic recovery period, while vaccination programmes are established. The formation of the international research collaboration for suicide prevention in COVID-19 is welcome (Niederkrotenthaler et al., 2020), but it is crucial that both primary care and community settings are focuses of new and ongoing COVID-19 related research (Mughal et al., 2021).

Special interest group

A new international collaborative: the *Suicide Prevention in Primary Care Special Interest Group (SIG)* of the International Association of Suicide Prevention has been established. This international collaborative network will bring together clinicians, researchers, policymakers, commissioners and people with lived experience. It will identify future research priorities and build the evidence base in both developing and developed countries. The new knowledge generated will be used to harness the potential of, and identify, opportunities to optimise primary care and community settings in a system-wide approach to suicide prevention across the globe.

Future needs

There have been recent strides in building the evidence base of suicide prevention in primary care (Almeida et al., 2012; Bellairs-Walsh et al., 2020; Bennewith et al., 2002; Beškovnik et al., 2011; Farr et al., 2021; Hegerl et al., 2006; Milner et al., 2017; Morgan et al., 2017; Rihmer et al., 2012; Saini et al., 2021; Saini et al., 2010), however the field remains under-developed and under-researched.

With primary care settings often being the first point of contact in most countries, it is imperative that new ways of identifying and intervening for people at risk of suicide are found, grounded in high-quality research, and informed by patient and public involvement. The new suicide prevention in primary care SIG will support this.

Future research needs to focus not only on interventions at the population level, but also on interventions at an individual level, that are inclusive and personalised, with an understanding of what works for who, why, and when. There are opportunities to improve clinical and community practice, informed by education and training, but this has to be evidence-informed and continually evaluated to ensure resources are best utilised.

Primary and community health care settings have been somewhat neglected over the years in preference of specialist mental health settings in suicide prevention; but they offer an important opportunity for early identification, intervention, and ongoing support for people who experience suicidal behaviour. Primary and community care has important potential that needs further exploration through robust research that considers implementation and sustainability early on, and that harnesses the expertise

of patients and the public. This will culminate in whole person care for patients, families, and societies, in the global challenge and ambition of preventing suicide around the world.

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