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Suicide

A 50-year-old man attends your surgery feeling low in mood. He has recently lost his job and his wife has left him. During the consultation, he mentions that life is not worth living any more. He is making poor eye contact and appears very depressed. How should you approach this consultation?

Managing a suicidal patient can be a major challenge in primary care. Many clinicians report finding it difficult to effectively assess risk in patients who express suicidal thoughts, including finding it difficult to identify who is 'really' suicidal, and lacking confidence in how to manage patients at risk of suicide. Nevertheless, suicide prevention remains of paramount importance in order to help save lives.

The death or risk of death of a patient by suicide can severely affect health professionals and may trigger many strong feelings including failure, guilt

and fear. Caring for patients who repeatedly self-harm can also evoke powerful emotions including anger, fear or a desire to save them. Self-care for health professionals is therefore an important aspect of managing suicide in patients.

Health professionals can also be at risk of suicide. Links for sources of support are given at the end of this article and in the article *Support for health professionals*.

This article was reviewed in July 2026.

1. Key statistics for suicide

Suicide remains a relatively rare event, with an age-standardised rate of 11 deaths/100 000 people in the UK. Rates declined steadily from the 1980s, but have risen slightly in recent years, up from 9.6/100 000 in 2017. Around three-quarters of cases are in men, and men aged 45–64y have the highest risk, with 22.4 deaths/100 000 in 2023 ([Office for National Statistics, 2023](#)).

Suicidal thoughts are a lot more common than suicide attempts. Between 3.5% and 5% of people reported suicidal thoughts in the past year, but only 0.5–0.7% of individuals made an attempt to end their life ([BMJ 2017;356:j1128](#)).

It is also important to consider the impact of suicide on those who are left behind. Each suicide can affect up to 50 people, leaving bereaved relatives with an increased risk of suicide themselves, as well as physical and mental illness ([BJGP 2016;66:e737](#)).

2. Suicide in children and young people

A report by the Royal College of Paediatrics and Child Health ([RCPCH, 2020, State of Child Health](#)) highlights that, in children and young people:

- Suicide is one of the leading causes of death for young people aged 10–19y.
- In England, a quarter of young people aged 11–16y and nearly half of those aged 17–19y with a mental health disorder reported that they have self-harmed or attempted suicide at some point in their lives.
- In those aged 15–24y in the UK, male suicides are three times more common than female suicides.
- Risk factors are summarised in the box below.

Factors increasing the risk of suicide among young people

- Current mental illness and distress.
- History of self-harm.
- Use of alcohol or drugs.
- Parental separation, death or mental illness.
- History of abuse.
- Chronic physical health conditions.
- Difficulties in family relationships.
- Family history of suicide.
- Stress at home, work, or in place of education.
- Identifying as LGBTQ+.

([BMJ 2024;386:e073515](#))

3. Understanding suicide

Suicide is a behaviour, not a diagnosis. It is complex and multifactorial, and can be impulsive or premeditated. While families are often desperate to know why it has happened, it is not always possible to be certain of the reasons behind someone dying by suicide. Only around a quarter will leave a suicide note, and this may not include clear reasons for their death. Even the individual themselves may not fully understand their own motivations for a suicide attempt, or their mental state may change very rapidly ([BJPsych Bulletin 2023;48:1](#)).

Useful terminology includes:

- **‘Died by suicide’:** always use this term rather than saying ‘committed suicide’.
- **Suicidal ideation:** thoughts, feelings, ruminations or preoccupations with death and suicide, which exist on a spectrum of severity ([BMJ 2026;393:e086834](#)):
 - Passive suicidal ideation: thoughts of being better off dead, e.g. “I wish I wasn’t here” or “I wish I could go to sleep and never wake up”.
 - Active suicidal ideation: thoughts of ending one’s own life, but without plans or intent to act on the thoughts.
 - Suicide with low intent: has developed a suicide plan, but with little or no intention of acting on it (see below).
 - Suicide planning with high intent: has developed a suicide plan and intends to act on it.
- **Suicidal intent:** the wish to die and expectation of death by suicide.

- **Suicide planning and preparation:** specific ideas or plans for an impending suicide attempt. This could include the method, plans to access the method, a time or setting for the event, writing a suicide note, preparing a will and giving away personal belongings or property. In general, suicide plans that are premeditated, unlikely to be discovered and involve the choice of a highly lethal method usually indicate a plan with a greater or more imminent suicide risk. Rehearsing aspects of a suicide attempt should be taken extremely seriously.
- **Suicide attempt:** any purposeful action that is associated with an implicit or explicit intent to die, regardless of the objective lethality of the method.
- **Self-harm:** intentional physical harm by self-injury or self-poisoning, regardless of motivation. Avoid using the term 'deliberate self-harm' as this implies that the individual may be to blame for the act rather than struggling to cope with overwhelming emotion.

The nature of suicidal ideation and level of intent can fluctuate over time, not always progressing in a linear way. For example, someone may move rapidly from passive suicidal thoughts to planning with high intent. Suicidal ideation may also be acute (with episodes that resolve within seconds or hours) or chronic and persistent (with fluctuations in severity over months to years) ([BMJ 2026;393:e086834](#)).

What is important to remember is that suicide is not inevitable; with the right support, people can find their way through a suicidal crisis and recover. Much of this support will be provided within primary care, alongside the involvement of specialist mental health services.

4. Suicide and primary care attendance

The majority of people who die by suicide have consulted their GP in the preceding year, and 47% have attended primary care in the previous month ([BJGP 2016;66:e737](#)). A case-control study looking at patterns of primary care consultations in the five years before suicide found that rates of consulting among patients who died by suicide tended to rise continuously, especially in the last 3 months. The suicide risk was 6x higher in those who consulted more than once a month in the final year compared with those who consulted once a year, regardless of sociodemographic characteristics or the presence (or absence) of known psychiatric illnesses. Reasons for consulting were not necessarily related to mental health difficulties, and included medication review, depression, pain and sleep disturbance ([BJGP 2024;74:e426](#)).

Escalating or high frequency of consultations for any reason (>1 per month) should be a trigger to consider mental health difficulties and carry out a suicide risk assessment.

5. Risk factors for suicide

It is useful for clinicians to have a broad understanding of risk factors associated with a higher risk of suicide. Remember that some of these factors are fixed, but others may be modifiable or may change with circumstances.

Suicidal ideation is a key risk factor for suicidal behaviour, and precedes all suicidal behaviour and deaths by suicide. However, many people with suicidal thoughts will not make a suicide attempt. In England, around a quarter of adults (25.4%) report having had thoughts of taking their own life at some point in their life, compared with 7.8% who report having made a suicide attempt ([NHS England, 2025](#)). The interval between suicidal thoughts and behaviour can vary widely, ranging from minutes to years.

More than half of people with suicidal thoughts (54.1%) may not disclose them to others ([BMJ 2026;393:e086834](#)).

Other factors associated with an increased risk of suicide ([Evidence-Based Mental Health 2022;25:148](#)) include:

- A history of self-harm or suicide attempts.
- Mental health problems, including depression, schizophrenia, bipolar disorder, substance misuse and personality disorder.
- Family history of mental health problems or suicide.
- Recent adverse life events, particularly relationship breakdown or conflict, legal problems and family conflict.
- Socioeconomic status, particularly social isolation or unemployment.

Neurodivergence and suicide risk

Neurodivergence is associated with an increased risk of suicide. There are more suicide attempts and death by suicide among autistic people compared with the general population, with the highest risk in autistic females and in autistic people without co-occurring intellectual disability ([Molecular Autism 2023, 14:12](#)). A systematic review also found an association between ADHD and suicide in all age groups. The risk seems to be partly mediated by the presence of comorbid conditions such as depression, substance misuse and conduct disorder ([World J Psychiatry 2017;7:44](#)). The risk of suicide has also been found to be higher in the period immediately before starting drug treatment for ADHD; the risk remains elevated immediately after the start of treatment and returns to baseline levels during continued treatment, suggesting that effective treatment may reduce the suicide risk ([JAMA Psychiatry 2017;74:1048](#)).

Protective factors

We can also consider 'protective factors' which may reduce the suicide risk,

although the evidence base is relatively weak and the importance of different factors varies greatly between individuals. These include ([BMJ 2017;356:j1128](#)):

- A strong religious faith.
- Family support to find alternative solutions to problems.
- Having children at home.
- A sense of responsibility for others.
- Problem-solving skills.

Nevertheless, it's also important to remember that people are more than simply risk factors – they are a whole person with a personal story, needs, strengths, vulnerabilities and assets. Taking a whole-person approach is likely to be far more satisfying as a clinician, and may even help reduce the risk of suicide as you build a relationship and rapport through the assessment.

6. Suicide and self-harm in survivors of critical illness

A study suggests that survivors of critical illness have increased risk of suicide and self-harm, especially those with a prior history of mental health problems and/or those who received invasive life support for their illness. This suggests that, in primary care, we may need to be vigilant in those who have survived critical illness. In addition to reviewing their physical wellbeing, we should also remember to review their mental wellbeing and consider suicide risk assessment where appropriate ([BMJ 2021;373:n973](#)).

7. Why is risk assessment so hard?

The prediction of suicide is fraught with difficulty and provides a major challenge. Suicide and self-harm are complex, and are rarely due to a single cause. There may be no prior warning, and the person may hide their intent to die from those around them ([BJPsych Bulletin 2023;48:1](#)).

The emerging consensus from meta-analyses is that 'suicide risk assessment' has a very low level of accuracy:

- Many of the people who die by suicide are assessed as 'low risk' on risk assessment, even if this assessment occurs shortly before the person's death.
- Suicidal thoughts are important, but not all individuals who express these thoughts will go on to act on them and as many as 60% of people who die by suicide do not express suicidal thoughts when asked by a GP or psychiatrist ([BJPsych Open 2019;5:e18](#)).
- Many of the people assessed as high risk do not die by suicide during that episode of care (possibly, but not exclusively, because of the care put in place around them).
- No single feature or group of risk factors in the suicidal risk assessment has a particularly good predictive value for identifying those most likely to die by suicide.

8. Primary care risk assessment of patients with suicidal thoughts

Despite the difficulties in 'risk assessment', it remains essential to carry

out a comprehensive evaluation of patients presenting with suicidal thoughts and to document this in the medical record. This should include details of any suicidal thoughts, intent, plans, personal and demographic risk factors, and a mental state examination. Useful information may also be gained from third parties such as family, friends and colleagues.

Who should complete a suicide risk assessment? The first part of a suicide risk assessment should be carried out by the clinician who first has contact with the patient, and this could be any member of the primary care or community team. It involves having an open discussion about the nature of any suicidal thoughts, which will enable you to spot people at higher risk of suicide, allowing you to escalate your concerns if appropriate.

Remember, talking about suicide doesn't make it more likely. This is true for both adults and young people. In fact, having a supportive conversation with an empathic health professional may reduce the risk of suicide. If suicide is an 'acting out' of emotional distress, then to find ways to put the feelings into words and express emotional pain in the context of a supportive and compassionate relationship with a health professional may reduce the risk of a suicidal action ([BJPsych Bulletin 2023;48:1](#)).

Suicide risk assessment – what to ask

Don't make assumptions about suicidal intent on the basis of a previous pattern of self-harm or a previous suicide attempt. Carry out a thorough risk assessment and explore any suicidal thoughts, plans and intent during the current presentation (NICE 2022, NG225).

Try to assess where the patient is on the continuum, which may range between:

Vague, fleeting thoughts of escape  *High intent, high lethality, advanced plans*

When asking about suicidal thoughts, it is important to use direct questions that do not leave room for misunderstandings, but also to introduce questions gently and incrementally (perhaps mention that these are common questions asked to all) to help the person feel comfortable to reply openly and honestly (BMJ 2017;356:j1128, BMJ 2024;386:e073515):

- How are you feeling? How is your mood?
- Are you feeling hopeless or that life is not worth living?
- Have you thought about how you might end your life or made any plans to do so? What sort of thoughts have you had?
 - How often do you have these thoughts? Are they getting more frequent?
 - How intense or powerful are they? Do you feel able to resist acting on them?
 - Have you made any plans to act on these thoughts?
- Have you ever tried to harm yourself in any way?
- Do you have access to any methods for ending your life?
- Have you done anything to prepare for ending your life such as writing a will?
- What stops you from ending your life? Does anything make life worth living or make you feel more hopeful?
- Is there any available support (family, friends, carers)?

Communication skills for patients with suicidal thoughts

Communicating about suicide is complex. However, it is important to develop effective ways to elicit and respond to suicidal thoughts. Here are some key communication skills:

- Building rapport can improve the clinical assessment and offer comfort and support to the patient.
- Always respond to suicidal thoughts with compassion and empathy, which may make it easier for the patient to disclose distressing thoughts and feelings.
- Take time to listen, ask open questions and explore the person's perspective without judgment. Be aware of your body language and your tone of voice.
- Avoid using negative questions that may bias the person's response ("No thoughts of harming yourself?").
- Be mindful of a mismatch between what people say and your clinical instinct – some patients will deny suicidal thoughts in their final consultation.
- Notice your own emotions – highly depressed people may evoke feelings of boredom or make you feel the patient is undeserving, or you may find that a consultation with a suicidal patient triggers distressing emotions and you are in need of active self-care, such as connecting with a colleague or taking a short break.

9. Management in primary care

The next step is to use the information you have gathered to make a judgement about the risk of harm to the individual. This should take into account ([BMJ 2017;356:j1128](#), [NICE 2022, NG225](#)):

- Your assessment of the level of risk, taking into account the full clinical picture and any relevant risk and protective factors.
- Whether you consider the person is safe to go home or needs urgent

referral to a crisis team or hospital admission.

- In discussion with mental health services, whether a Mental Health Act assessment is appropriate.

If you are concerned that there is an immediate risk to the person's safety, refer urgently to specialist mental health services or the crisis team, involving family or carers when appropriate ([NHS England, 2025](#)).

If the patient does not need admission:

- **Look for treatable problems** (mental illness, alcohol use, drug use). Active treatment of underlying depression may be essential for effective management of a suicidal patient.
- **Take steps to improve safety and reduce the risk of self-harm**, e.g. disposing of stockpiled medication or asking a relative to look after tablets.
- **Proactively review the patient:** after an episode of self-harm that has not required hospital assessment, NICE ([2022, NG225](#)) recommends review within 48h as the risk of repeat self-harm is highest. For suicidal thoughts without self-harm, there is no specified period for review; it will depend on your level of concern and other factors such as how much support they have at home.
- **Carry out a medication review.** Be cautious about prescribing medications that are highly lethal in overdose such as tricyclic antidepressants or opiates. Also think about the quantity of medication being prescribed – consider collaboratively planning strategies such as weekly scripts to reduce the risk.
- **Look for ways to strengthen protective factors**, e.g. can social support for the patient be improved?
- **Give information about support services**, e.g. [Samaritans](#), [CALM](#) (see below), or practical help such as for housing or financial issues.

10. Microskills: managing patients with suicidal thoughts

These skills are useful where you decide an urgent referral is not required:

- Encourage an internal locus of control and a sense of self-efficacy: “I do not have to be a passive victim of suicidal thoughts.” “I can have the thoughts and still choose not to act on them.”
- Help the individual to view their suicidal thoughts as a symptom of their distress rather than some powerful impulse that they cannot resist. Their real wish may be to feel better, not to die.
- Empathise with the person’s distress and remind them that suicidal thoughts and feelings may be intense and distressing, but they come and go and do not last forever.
- Use distraction: encourage the individual to engage in alternative behaviours such as social interaction and physical activity to manage negative thoughts and low mood.
- Identify simple problem-solving techniques to help the individual cope with triggers for suicidal thoughts or adverse life events. Problem-solving skills are often significantly impaired in people at times of crisis.
- Collaborate to develop a safety plan which includes tangible reminders of the patient’s reasons for living, such as names and photos of loved ones and pets.

11. Suicide prevention

There is evidence that some strategies are effective for suicide prevention. These include offering effective treatment for depression, restricting access to lethal means, and school-based awareness programmes ([Lancet Psychiatry, 2016; 3:646](#)).

Can we prevent suicide in people at higher risk?

A Lancet review highlighted that ([Lancet 2022;399:1903](#)):

- Cognitive behavioural therapy (CBT) has the strongest evidence for reducing suicidal ideation and repeat self-harm compared with treatment as usual.
- Dialectical behavioural therapy (DBT) is an intensive group psychological intervention which incorporates principles of CBT, mindfulness, acceptance and emotional regulation skills, and may reduce self-harm and crisis service use. DBT may be particularly helpful for individuals with long-standing emotional and interpersonal difficulties, and who may be considered as having a personality disorder.
- Brief interventions such as brief contact, care coordination, safety planning or other short-term therapies have been associated with a reduction in suicidal behaviour in some studies; however, the evidence base is small.
- A small study suggests that using distraction and distress-tolerance skills may be helpful in reducing suicidal ideation in people with comorbid mood disorders and borderline personality disorder in the short term ([J Psychiatr Res. 2021;133:32](#)).
- However, another RCT looking at low-intensity interventions in adults with frequent suicidal ideation found that care management did not significantly reduce risk of self-harm, and brief dialectical behaviour therapy skills training actually increased risk of self-harm compared with usual care ([JAMA, 2022;327:630](#)).

- Digital treatments for suicide and self-harm have shown promise, but some mobile phone apps are not evidence-based and may even contain harmful content.

Drug therapy for suicide prevention

Effective treatment of underlying mental health conditions with medication may reduce suicidal behaviour ([Am J Psychiatry 2021;178:611](#)):

- Antidepressants, particularly SSRIs, can reduce the risk of suicide in people with depression and anxiety. The effect is likely to arise from effective treatment of depressive symptoms. Careful monitoring is essential when initiating treatment in young people because increased suicide thoughts may arise in the early stages.
- Lithium has been also associated with reduced suicide rates in people with bipolar disorder and depression, with suicide risk up to five times lower in patients receiving treatment.
- Ketamine may be of benefit in the acute management of a suicidal crisis ([BMJ 2022;376:e067194](#)). A study of 156 people admitted with severe suicidal ideas found that a ketamine infusion was safe and effective, leading to a rapid reduction in depressive symptoms and suicidal thoughts which persisted for 6 weeks in two-thirds of participants. The strongest benefit was seen in people with bipolar disorder who have a high suicidal risk with limited options for treatment of depression – as antidepressants may risk triggering episodes of mania. Benefits were less clear in those with major depression or other disorders. The mechanism is incompletely understood but may relate to its analgesic effect. However, this will only ever be appropriate for use in acute settings in secondary care and is highly unlikely to be initiated in primary care.

Suicide prevention in schools

A multicentre randomised controlled trial found that a pupil-based awareness programme which involved 2h of lectures, 3h of roleplay plus a workbook delivered over 4w led to a 50% reduction in suicide attempts and severe suicide ideation after 12 months ([Lancet 2015;385:1536](#)). *This a relatively simple intervention that has shown a significant lasting benefit. Another thing for schools to cram into the curriculum?*

12. Suicide prevention guidance

NHS England has published guidance to support the national suicide prevention strategy, emphasising that relational, dynamic and compassionate care should be at the centre of suicide prevention ([NHS England, 2025, BMJ 2025;389:r1140](#)). Key features of the guidance include recommendations to:

- Avoid using suicide risk tools or stratification into low, medium or high-risk categories because current evidence does not show that they reliably predict suicide.
- Instead, carry out risk assessments using a biopsychosocial framework that explores context and protective and precipitating factors, alongside the patient's own account of safety. Use a dynamic approach that adapts to changing needs and circumstances.
- Focus on trust, collaboration and continuity in patient care; building a safe and supportive therapeutic relationship is strongly associated with improved outcomes in suicide prevention.
- Create personalised written safety plans in partnership with patients, agreeing immediate and longer-term actions, and offering regular review and follow-up.
- Communicate clearly and compassionately, avoiding jargon and stigmatising language, and encouraging openness.

- Involve trusted others, such as family, carers or friends, where appropriate (particularly for children and young people), while balancing the need for confidentiality and safeguarding.
- Promote inclusivity by ensuring care is responsive to the needs of marginalised or higher-risk groups.
- Support practitioner wellbeing by providing appropriate supervision, training and organisational support.

This guidance formalises what many primary care clinicians already practise: emphasising a whole-person approach, and the value of trust and continuity of care. It clarifies best practice and helps move us away from risk tools that lack evidence and can detract from building strong relationships with vulnerable patients. The greatest challenge is likely to be how to sustain this approach within pressured services, where time and support are limited.

13. Suicide: impact on families

In the aftermath of suicide, it is common for bereaved family members to experience a range of emotions, including depression, anxiety, guilt, extreme sadness, numbness and nightmares. There may be feelings of anger, both towards the deceased as well as healthcare professionals who cared for them. Physical reactions are common, including nausea, vomiting, loss of appetite, breathlessness, numbness, physical pain, lack of energy and feeling weak. There may be nightmares, memory loss and intrusive images of the deceased. Negative health behaviours such as excessive alcohol and over-eating may be used as a coping mechanism ([BMJ Open 2018;8:e019472](#)).

Being bereaved by suicide is associated with many adverse physical and mental health outcomes in the short and long term ([BMJ](#)

[Open 2018;8:e019472](#)). These include an increased risk of:

- Suicide.
- Depression.
- Other mental health conditions.
- Psychiatric admission.
- Physical health problems, including poorer general health, increased pain and greater reporting of physical disorders such as cardiovascular disease, COPD, hypertension and diabetes.
- Suicide-bereaved family members also typically attend GPs more often and have higher rates of outpatient physician visits for physical illnesses.

These effects can be long-lasting. The first week is described as the worst stage after a death for about one-quarter of suicide-bereaved individuals, but many family members struggle with the loss for at least the first year. In one-fifth of cases, these feelings can persist for 3 years or even longer ([BMJ Open 2017;7:e014487](#)).

Both formal professional support and informal support from friends, families and others are important during this time. However, those bereaved by suicide may be less likely to receive informal support following the death than those bereaved by other causes ([BMJ Open 2017;7:e014487](#)).

Supporting bereaved families in primary care

A qualitative study in the BJGP explored the experiences of parents bereaved by suicide and how we can offer effective support in primary care ([BJGP 2020;70:e102](#)). This found that:

- Feelings of shame and stigma can make it difficult for families bereaved

by suicide to seek help or support. There may be a fear of other people's reactions to the death, or concerns about upsetting others when talking about it. This fear extends to health professionals, and parents expressed a sense of relief for not being judged when accessing support.

- Primary care often plays a central role in the provision of care and support. Most parents of children who had died by suicide found their GP approachable and were able to highlight positive examples of practice and support. However, others emphasised the desperation and helplessness they felt when their GP was unsure how to respond to them. Some may disengage from services if they perceive that health professionals have responded unhelpfully or inappropriately.
- There is wide variability among GP services in terms of the protocols and support structures that are in place to support this vulnerable group of patients. Most families expressed a wish to be proactively contacted by their general practice following the loss. This may be as simple as acknowledging the death, letting families know that support is available and signposting to local and national resources.
- The importance of not feeling alone and being able to normalise experiences of grief was highlighted, which can provide hope for getting through a hugely difficult experience. It can be very helpful to share experiences by talking to others who have experienced suicide bereavement. This may be accessed via suicide bereavement support group meetings, either in person or online.

14. Self-care for health professionals

Both the death/risk of death of a patient by suicide, and caring for people who self-harm, can have a major effect on health professionals ([RCPsych CR234 2022](#), [University of Oxford, 2023](#)).

Each clinician will respond to a patient's death differently, but it is often highly distressing and may be one of the most difficult experiences encountered in our professional lives. It can trigger many strong emotions within clinicians, including feelings of sadness, failure, guilt, fear, shame and self-doubt. The effect on health professionals is variable, and individual vulnerability may be influenced by many factors, including our personal characteristics, our relationship with the patient, clinical involvement and support received after the event.

No one is to blame for a death by suicide

Following the death by suicide of a patient, colleague or even a family member, health professionals may feel that they are to blame for the death. It is common to ruminate over any contact and treatment provided, questioning whether something was missed or more could have been done. We may fear that we have made a mistake which contributed to the death, or that we may be blamed by others. These feelings may pass within a few weeks, but their impact may continue for a long time and be very intense or overwhelming.

It's important to recognise that no one is to blame for a death by suicide.

All health professionals have a responsibility to support patients and offer the highest standards of care, but this should be separated from a sense of criticism and self-blame for a distressing and often traumatic event.

([BJPsych Bull 2024;49:1](#))

Strategies for clinician self-care

Self-care and organisational support for health professionals following the suicide of a patient are both important, including providing access to practical support or counselling if needed. Some important strategies include:

Connect with others	Withdrawing from others, at work or at home, can lead to an increased sense of isolation, and creates more time to ruminate in an unhelpful way about the loss. After a traumatic or distressing event, we will recover more effectively if we lean in and connect with our social support systems. Remember, you are not alone in coping with this experience. It can help to talk to trusted members of your family, friends, colleagues or a mentor who can offer emotional support and encouragement. Many clinicians also find it helpful to talk confidentially to a colleague who has been through something similar, or other clinicians involved in caring for the patient who has died.
Find ways to self-soothe	Treat yourself like a good friend, colleague or even one of your own patients. Be kind to yourself and choose activities that will help you relax and wind down. You might find it helpful to practise relaxation or mindfulness, or engage with gentle exercise, as healthy coping strategies. Going for a walk with a friend, or a similar activity, might be an invaluable distraction if you are feeling preoccupied and unable to stop thinking about the death.
Express your emotions	It is important to find ways to express and process your distressing emotions. You may feel more tearful, easily upset, irritable or impatient than usual. Be patient and give yourself time and space to recover.
Care for your physical wellbeing	It can help to have some structure in your day such as planning activity and rest times. Be realistic and don't push yourself too hard or overwork, which can lead to exhaustion or burnout. Aim for regular sleep patterns, eat regular, healthy meals and stay physically active. Avoid turning to alcohol or other drugs to 'self-medicate' or as a coping strategy for emotional distress.

Adjust your working patterns	Consider whether you would benefit from making temporary adjustments to your working patterns. It may be helpful to stick to your regular routine, but, if you are feeling highly distressed or overwhelmed, you may need some time away from work, or a reduction in your hours, to help you recover.
Seek help and support	Support is available and can help you get through the toughest times. You may have access to formal or informal debriefing following a patient's death. You can seek support from your GP or an organisation such as NHS Practitioner Health . You may also benefit from talking to a counsellor or therapist.

When to seek further help or support following the death of a patient by suicide

- You have frequent intrusive thoughts or images of the events around the suicide.
- You have nightmares or disturbed sleep.
- You have become more irritable, tearful or anxious than previously.
- You are avoiding people or situations that remind you of the suicide.
- You find yourself avoiding situations where you may need to make difficult clinical decisions.
- You are starting to take longer than usual over work tasks, doubting your judgement or having difficulty concentrating.
- You have persistent low mood or poor motivation.
- You are avoiding social contact.
- You have begun to think about leaving your role/working in the health services altogether.

15. Suicide in clinicians

Suicide rates for physicians have decreased over time, and the suicide rate for male doctors is currently no higher than the general population. However, for female doctors, rates of suicide remain higher than the general population, with a risk ratio of 1.76 (CI 1.4–2.21). A high level of heterogeneity exists across studies, suggesting that the risk may vary among different physician populations. Further research is needed to identify specialities or groups at higher risk of suicide ([BMJ 2024;386:e078964](#)).

Risk factors for suicidality in clinicians include family history of suicide, past experiences of trauma or abuse, isolation, mental illness and drug misuse ([BMJ 2024;386:q1758](#)). Personality traits such as perfectionism, obsessiveness and competitiveness, when combined with highly-stressful work environments, can lead to guilt, low self-esteem and a persistent sense of failure. Clinicians may also have greater access to potentially-dangerous drugs, including opiates and anaesthetic agents.

Being the subject of a complaint or regulatory process can also be a major contributing factor. Distress and suicidal ideation increased with the severity of the complaint, and levels were highest after a referral to the regulator. The protracted nature of regulatory processes may also play a role.

If you are going through a complaint, seek support (even if you don't yet feel you need it); if a colleague is going through a complaint, proactively offer support.

What can we do to prevent the most tragic outcome for doctors with mental health problems?

A BMJ editorial ([BMJ 2024;386:q1758](#)) highlighted some ways that we can act to reduce mental distress and suicide risk. While this paper focused on doctors, these recommendations apply to other groups of clinicians:

- Paying attention to the basic emotional and psychological needs of staff, including working patterns that allow a sensible work–life balance.
- Addressing issues in the workplace that are conducive to poor mental health, including lack of teamwork, bullying, a culture of naming and shaming, and lack of support when things go wrong.
- Having access to early intervention and confidential mental health treatment services and psychological support, particularly during periods of high stress such as the investigation of complaints or serious incidents.
- For female clinicians, who remain at a higher risk of suicide than the general population, it is also important to understand more about likely contributing factors such as discrimination and sexual harassment, and to develop gender-specific interventions to protect female clinicians' mental health.

Coping after the suicide of a colleague

The impact of a clinician's suicide on their colleagues can be shocking, distressing and destabilising. It can trigger intense emotional responses, including guilt, anger, sadness and anxiety. This is especially challenging in health settings, where staff work in close-knit teams and face similar organisational pressures as their colleagues.

Leadership plays a crucial role in providing sensitive and structured 'postvention' support to help staff cope and begin healing in the aftermath

of a colleague's suicide ([BMJ 2024;385:g1049](#)). Key actions include:

- **Immediate response** (first day): acknowledge the emotional impact, provide accurate information and support colleagues in managing their distress. Managers should assess staffing needs and encourage affected staff to take time off. It's also essential for managers to receive support, alongside providing it.
- **Short-term support** (first week): provide opportunities for mutual support among colleagues. Offer clear and frequent communication, and address how to inform patients and the public. Memorials or gestures of remembrance, such as condolence books or flowers, can provide comfort.
- **Ongoing support** (first month): monitor staff for signs of ongoing distress such as absenteeism or excessive work hours. Encourage self-care and seek professional help for those struggling to cope. Staff should be encouraged to attend support groups and access professional counselling if needed. As recovery progresses, ongoing support and training in suicide prevention are also essential. This helps staff identify signs of distress, reduces stigma and fosters a culture of mutual support.

The stages of grief are not linear and may be delayed. If, at any stage, you are struggling, it's essential to seek professional help. [NHS Practitioner Health](#) offers free mental health support for health professionals. For more information on support organisations across the UK, including devolved nations, see our article: *Support for health professionals*.

Remember, you are a human being first and a healthcare professional second. It is OK to need rest, time off, counselling or practical support.

	Suicide • Asking about suicide will not make people more likely
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to harm themselves. It enables clinicians to gauge risk and formulate a treatment plan, and is the first step in reducing their risk of suicide.

- Respond to all suicidal thoughts with compassion and empathy, and carry out a risk assessment, even if thoughts are repeated or there have been previous episodes of self-harm.
- Developing a strong therapeutic relationship will help to improve the quality of your risk assessment and may make it possible for the patient to be open about suicidal thoughts and plans.
- Ask clear, direct questions about suicidal thoughts and plans.
- Always document the date, time and important factors in the assessment of a suicidal individual ('If you did not document it then you did not ask it...').
- Take a holistic history that includes a detailed exploration of suicidal thoughts, plans and intent, along with relevant risk and protective factors such as a history of self-harm or comorbid depression.
- CBT has the strongest evidence for reducing suicidal ideation and repeat self-harm.



Useful resources for professionals:

Websites (all resources are hyperlinked for ease of use in Red Whale Knowledge)

- **RCPsych - If a patient dies by suicide: a resource for mental health professionals**

Videos

- **YouTube - Talking to Suicidal People** (video by RCPsych about effective communication with people with suicidal thoughts)
- **YouTube - Suicide and the Risk Elephant** (video by

Useful resources for patients:

Websites

- **Samaritans** (24h confidential helpline. Tel: 116 123. Email: jo@samaritans.org)
- **The Campaign Against Living Miserably (CALM)** (an organisation dedicated to preventing male suicide. Tel: 0800 58 58 58)
- **Staying Safe from suicidal thoughts** (printable electronic safety plan template)
- **distrACT** (information and advice on how to manage difficult feelings, cope with a crisis and find help and support when you need it most)

Apps

- **Stayalive** (suicide prevention app which includes a safety plan)

Leaflets

- **RCPsych: Feeling overwhelmed**
- **RCPsych: Self-harm**
- **Mind: Coping with suicidal feelings**
- **Patient UK: Dealing with suicidal thoughts**
- **Get Self-help: Dealing with suicidal thoughts**

Videos

- **Mind: Talking about suicidal feelings**
- **Headtalks: Surviving suicide** (Josh Quigley talks about his experience of surviving a suicide attempt)

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