The role of social prescribing in increasing resilience of individuals with suicide risk factors: A brief intervention for suicide prevention

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ABSTRACT. This paper presents a model for how social prescribing can be utilised as a brief intervention to increase the resilience of individuals with risk factors for suicide. As a leading cause of avoidable death, there is a strong public health motivation to reduce the rate of suicides, and there has been a call for research on mechanisms that increase the exposure of individuals and communities to multiple protective factors against suicide risk (McClean *et al* 2008). To our knowledge, this paper is the first examination of the specific role which social prescribing can play in suicide prevention.

We review case studies and service data from the MyScript (Developing Health & Independence) social prescribing service in Bath and North East Somerset to illustrate positive outcomes in working with individuals with risk factors for suicidal behaviour. At an individual level, several aspects of social prescribing are identified which support suicide prevention, namely: gatekeeping and early intervention, compassionate engagement, a person-centred approach, and integration of clinical and non-clinical sources of support. These influences combine to build resilience through improvements to social connectedness, hopefulness, reasons for living and problem-solving ability. We adopt improvement in subjective wellbeing as a measure of increased resilience.

The open referral criteria for MyScript allow it to function flexibly as either an "upstream" wellbeing model or as a targeted intervention for vulnerable populations. Although the majority of MyScript beneficiaries are low-risk for intentional harm to self, over thirty percent (31.7%) of MyScript beneficiaries in 2017/2018 were identified as being at elevated (either high- or medium-) risk of harm to self over the course of service. In brief interventions of three or four sessions, social prescribers support individuals to access a range of community resources which aid their wellbeing. In 2017/2018, over three-quarters (76.2%) of MyScript beneficiaries who were at elevated risk for harm to self were connected with community resources in the category of "enjoying and achieving", over two-thirds (68.2%) accessed resources to support their self-management, over half (55.5%) were linked up with resources to support their economic wellbeing, and over a quarter (28.6%) of elevated-risk beneficiaries accessed resources to support their physical health.

Social prescribing offers important contributions to identified areas for action in the national suicide prevention strategy, including reducing the risk of suicide in key high-risk groups and tailoring approaches to improve mental health in specific groups (Department of Health 2012, Public Health England 2016, NICE 2018). The role of social prescribers to dynamically integrate multiple forms of support is highly compatible with the "whole system approach" advocated by the national suicide prevention strategy (Public Health England 2016). Social prescribers are central to maximizing access to resources at a local level – satisfying in a novel way the central tenet of the national suicide prevention framework which emphasizes the importance of 'joining up' local services and support (Department of Health 2012). Due to these significant contributions, this paper recommends that suicide prevention be considered a core aspect of holistic social prescribing services. This has implications for service delivery, including integration with primary care and interfaces with crisis services and local strategic multi-agency suicide prevention planning.

1. Introduction

This paper examines the scope of social prescribing to increase the resilience of individuals with risk factors for suicide, including those who express suicidal feelings. As a service, social prescribing is dedicated to enabling individuals to better cope with life stressors – whether social, physical, financial or otherwise – by developing personalised solutions that make the most of available resources. As 'link workers', social prescribers capitalise on two distinct sets of resources to improve wellbeing: those internal to the beneficiary (e.g. problem solving or coping strategies), and those external to the beneficiary (e.g. community services or groups). This dual perspective allows social prescribers a privileged position for supporting beneficiaries' resilience to risk factors for suicide. Recent discussion of suicide mitigation has challenged the common perception that specialist psychiatric knowledge and training are required to help an individual cope with suicidal thoughts (e.g. Cole-King 2010) and has highlighted the potential for relatively minor interpersonal interventions to prevent suicides (Fleischmann *et al* 2008), particularly when interventions combine to produce a synergistic effect (van der Feltz-Cornelis *et al* 2011). At the beneficiary-facing level, social prescribers have the time and opportunity to discuss issues impacting on quality of life, and can use beneficiary insights to help identify needs and a framework for possible solutions. Facing outwardly to community assets, social prescribers then have the capacity to maximize a beneficiary's access to appropriate services and support – contributing to a 'joining up' of local resources which has been recommended as best practice for effectiveness of suicide prevention (see van der Feltz-Cornelis *et al* 2011, Department of Health 2012, Public Health England 2016). This paper presents a model for how social prescribing can be utilised as a brief and potentially life-saving intervention.

Conversations about quality of life are routine in social prescribing sessions, and present an ideal time and place for early intervention for those at risk of suicidal behaviour. It is not uncommon for individuals to voice within a social prescribing assessment the sense that life is not worth living (see Kimberlee 2013). Indeed, suicidal thoughts are prevalent in the general population: across the lifetime and within the UK population at large, a fifth of adults (20.6%) report that they had thought of taking their own life at some point (McManus *et al* 2016). Within a given year (2014), 5.4% of 16 to 74 year olds report they had experienced suicidal thoughts (McManus *et al* 2016). The feelings of a suicidal person can usually be described as "a triad of helplessness, hopelessness and despair" (WHO 2000: 12). Disclosure of suicidal thoughts will depend on what an individual chooses to reveal, but a compassionate and empathetic approach has been indicated to increase disclosure (Larson and Yao 2005; Cole-King, Green *et al* 2013), making those professionals who work closely with distressed individuals key "gatekeepers" (van der Feltz-Cornelis *et al* 2011) for recognising those individuals who are approaching personal crisis.

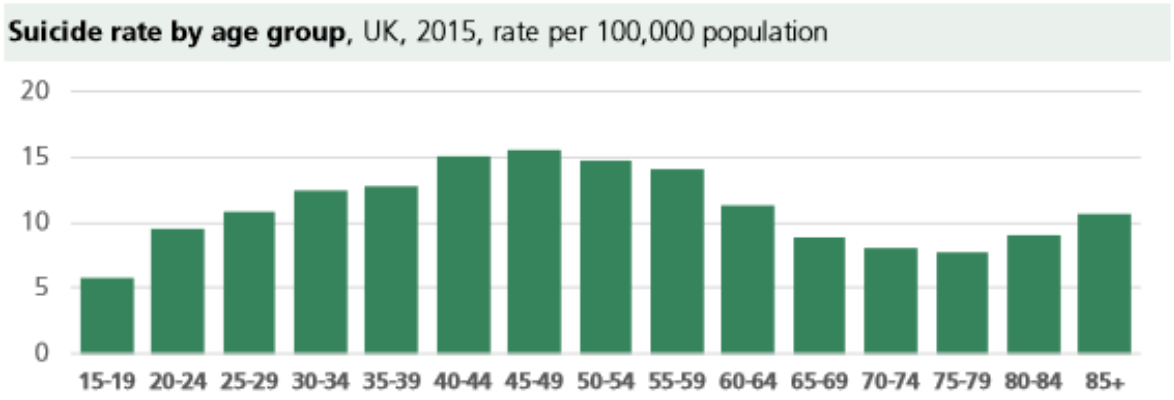
Suicidal ideation is not straightforwardly linked to suicidal intent. Suicidal thoughts encompass a broad continuum from fleeting thoughts of self-harm to a definite plan to die, and the transition from ideation to behaviour is highly complex and poorly understood (Casey *et al* 2008). A cross-national study (Nock *et al* 2008: 99) indicates that among those individuals with suicidal thoughts, there is only a 33.6% probability of individuals ever making a suicide plan, and a 29.0% probability of individuals ever making a suicide attempt. On the flip side, Nock *et al* (2008: 99) estimate that there is a 15.6% probability that those individuals *without* a suicide plan will make an attempt. Many suicides happen impulsively and there is a

[1] ACKNOWLEDGMENTS. Many thanks to my MyScript colleagues Rachel Dawson, Diane Girling and Veronica Kuperman for helpful discussion and encouragement. Thank you to Paul Scott at B&NES Public Health for sharing ideas and particularly for support with relevant national guidance and local data. Any mistakes are my own.

host of social, psychological, cultural and other factors which interact to lead a person to suicidal behaviour (WHO 2014). Given the uncertain transition of suicidal behaviour, and known challenges in identifying those most in danger of taking their own life (see e.g. Cole-King, Green *et al* 2013), there is particular need for early intervention approaches with a wide application across the population which seek to improve resilience to risk factors (see Section 4.2).

In comparison to the prevalence of suicidal thoughts, there is a relatively low incidence of completed suicide. In the UK in 2015, suicide occurred at a rate of 10.9 in 100,000 (Office for National Statistics 2017). Rates of completed suicide are highest for those aged 40-59, as indicated in Figure 1 below.

Figure 1. *Suicide rates in the UK by age group (2015)*



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Approximately twenty times this number attempt suicide (WHO 2014, Casey *et al* 2008), with elderly people known to engage in suicidal behaviour with greater intent and greater lethality than younger age groups (Cattell 2000). Due to the complexity of the transition from suicidal thoughts to attempt, there are acknowledged difficulties in designing, implementing and evaluating suicide prevention strategies (Windfuhr 2009). However, as a leading cause of avoidable death, there is a strong public health motivation to reduce the rate of suicides, and there has been a call for research on mechanisms that increase the exposure of individuals and communities to multiple protective factors against suicide risk (McClean *et al* 2008). To our knowledge, this paper is the first examination of the specific role which social prescribing can play in delivering multifaceted, personalised protections against suicide risk.

The aim of this paper is threefold:

- Identify the *aims* of national suicide prevention strategy which social prescribing complements.
- Identify the *means* though which social prescribing supports suicide prevention at an individual level: namely, through gatekeeping and early intervention, compassionate engagement, a person-centred approach, and integration of clinical and non-clinical sources of support.
- Present case studies of *experience* of social prescribing in increasing resilience of individuals with risk factors for suicide.

Social prescribing is in its nascency as an independent field (see Polley *et al* 2017), though it has its roots in the non-medical guidance which GPs have long offered their patients within primary care. This paper is intended to add to awareness of the delivery and benefits of this growing service, inform best practice, and indicate areas for further research. Given the statistical rarity and complex transitions of suicidal

behaviour, and the present small scale of social prescribing practice, this pilot study cannot directly consider evidence for a reduction in rate of suicide – instead, we adopt improvement in subjective wellbeing as a measure of increased resilience.

In what follows, we examine the potential for social prescribing to improve resilience of adults vulnerable to suicide risk, by increasing their exposure to protective factors. The organisation of the paper is as follows. We begin in Section 2 with an overview of major risk factors for suicide, and then introduce in Section 3 the work social prescribing does with vulnerable populations. In Section 4, we hone in on the aspects of social prescribing which support suicide prevention at an individual-level. In particular, social prescribing will be presented as a flexible and person-centred early intervention which makes the most of community assets: it offers compassionate engagement to boost social connectedness, hopefulness, reasons for living and problem-solving skills. This is evidenced in Section 5 with case studies from the MyScript (Developing Health & Independence) social prescribing service in Bath and North East Somerset which illustrate positive outcomes in working with individuals with risk factors for suicidal behaviour, including those suffering from depression, social isolation, past suicide attempts and/or recent bereavement from suicide. We conclude in Section 6 with implications for service delivery.

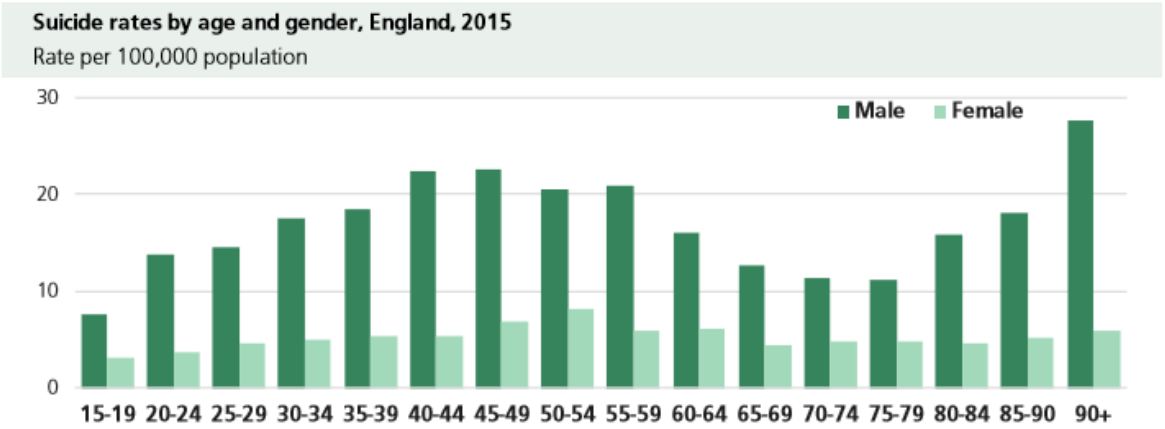
2. Suicide impacts and risks

Suicides are preventable. The majority of suicidal individuals are ambivalent about wanting to end their life, in a "see-saw battle between the wish to live and the wish to die" (WHO 2000: 12). A range of public health initiatives seek to tip the balance back to safety and lower the incidence of suicide (e.g. WHO 2010, 2014; Department of Health 2012; Public Health England 2016). In the UK, suicide rates have fallen by 26% since 1981, although the rate among men has fallen at a slower rate than that among women (Office for National Statistics 2016). The World Health Organisation notes that heightened suicide risk in an individual is often short-term and situation-specific. It is a myth that once someone is suicidal they will always be suicidal, and many individuals who previously struggled with suicidal thoughts do go on to live long lives (WHO 2014: 47).

The costs to society of attempted or completed suicide are immense. It is estimated that on average, a single suicide intimately affects at least six other people (WHO 2000: 5). If a suicide occurs in a school or workplace it has an impact on hundreds of people (WHO 2000: 5). In addition to the immeasurable distress to a suicidal individual and to others involved, there are tangible costs (e.g. lost earnings over a lifetime, emergency services response) which bring the estimated expense of a completed suicide for those of working age in England to over £1.6million (McDaid *et al* 2011). Suicide attempts also entail an economic and social burden (WHO 2014: 25).

A range of statistics points to the impact which suicide has within the population. Suicide is the leading cause of death in the UK among men aged 20-49 (Office for National Statistics 2016). Suicide is also now the leading cause of death directly related to pregnancy in the year after mothers give birth (House of Commons Health Committee 2017). Among women in the UK aged 20-34, suicide is the most common cause of death – although men of the same age group have a suicide rate four times higher (Office for National Statistics 2016). There is known to be a significant gender gap in suicide, linked to such factors as differences in help-seeking behaviour and lethality of method of suicide (Schrijvers *et al* 2012, WHO 2014). Suicide rates tallied by age and gender are indicated in Figure 2, which shows significantly higher rates of completed suicide by men across the lifespan.

Figure 2. *Gender differences in suicide rates in England across the lifespan (2015)*



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Despite greater numbers of men taking their own life, women are known to have higher rates of suicidal ideation and (non-fatal) suicide attempts – an effect which is known as the "gender paradox of suicidal behaviour" (see Canetto and Sokinofsky 1998, Schrijvers *et al* 2012). This gender balance is reflected in a 2014 self-reporting survey (McManus *et al* 2016) which showed that while overall one person in fifteen (6.7%) in England had made a suicide attempt in their life, there are greater numbers of women (8%) compared to men (5.4%) who attempt suicide. When both completed and attempted suicides are taken into account, the high rates of suicidal behaviours for each gender motivates the need for prevention strategies reaching both men and women.

2.1 Individual-level risk

As professionals who regularly come into contact with vulnerable individuals, social prescribers have a role as gatekeepers for recognising individuals at risk of suicide (see Section 4.1). This particularly applies for social prescribers working in areas of poverty and deprivation, which are more likely to have higher suicide rates (McClean *et al* 2008, Samaritans 2017). Risks for suicide may be considered at the societal, community or individual level (WHO 2014). Societal level influences include factors such as help-seeking behaviour, while community-level influences include such factors as socio-economic disadvantage, discrimination, and 'copycat' suicides (McClean *et al* 2008, WHO 2014). With respect to community-level influences, Public Health England (2016: 57) have argued that reducing health inequalities and addressing the social determinants of health should be explicitly linked to suicide prevention strategies: however, despite the relevance of social prescribing in this area, this paper will focus discussion on individual-level risk.

For individuals, risk factors for suicide can be grouped into static and dynamic categories (Sinclair and Leach 2017), although there is some overlap. Static risks are those that tend not to vary over time, while those that are dynamic are more amenable to change. Some factors have both static and dynamic aspects. For example, risk related to unemployment is known to be initially high at the point of job loss, but the risk decreases after three months until after about one year, when it then climbs higher again (Cole-King *et al* 2013) – this change gives it a dynamic aspect, although prolonged unemployment could be considered a static risk factor. The sections below give an overview of major static and dynamic risks for suicide for individuals.

2.2 Static risk factors

The following static factors are known to elevate an individual's risk for suicidal behaviour (from McClean *et al* 2008; Department of Health 2012; Cole-King, Green *et al* 2013; WHO 2014; Sinclair and Leach 2017):

- gender: men are three times more likely than women to die of suicide, though women are more likely than men to attempt suicide
- previous suicide attempt (the single most important risk factor for suicide in the general population worldwide)
- mental health disorders, such as mood disorders, personality disorders and schizophrenia
- history of self-harm
- history of child abuse
- family or community history of suicide
- chronic illness, including epilepsy
- LGBT+ and other minority identity
- specific occupational groups, such as doctors (particularly female), nurses, veterinary workers, farmers and agricultural workers
- personality traits including extroversion, impulsivity and anger

2.3 Dynamic risk factors

Suicidal thoughts, though not *predictably* linked to suicidal behaviours (Casey *et al* 2008, Nock *et al* 2008), are a major risk factor. In their cross-national study, Nock *et al* (2008) estimate that 29% of people with suicidal thoughts went on to make a suicide attempt, usually within one year of onset of thoughts. Given the difficulty in predicting suicide, Cole-King, Green *et al* (2013: 276) advise that it is prudent for practitioners to take disclosure of all suicidal thoughts seriously. Suicidal thoughts are associated with great distress for the people who experience them, and identifying individuals with suicidal thoughts is a vital opportunity to help those who are at increased risk of taking their own life (McManus *et al* 2016: 2).

In addition to suicidal thoughts, dynamic factors which significantly contribute to risk of suicide include (from McClean *et al* 2008; Department of Health 2012; Cole-King, Green *et al* 2013; WHO 2014; Sinclair and Leach 2017):

- hopelessness
- psychological stress
- social isolation
- unemployment
- unmanageable debt
- alcohol and substance misuse
- bereavement
- family breakdown
- psychiatric discharge
- any stage of the criminal justice process

The following section describes the combined impact of multiple risks.

2.4 Interactions of risk

A comprehensive review of risk and protective factors commissioned by the Scottish government (McClean *et al* 2008) emphasizes the multifaceted nature of suicide risk. For example, the high rates of suicide in older men (see Figure 2) may reflect the combined impact of depression, social isolation, bereavement, and physical illness (Department of Health 2012: 13). For many people, it is the combination of risk factors which drives suicidal tendencies, rather than one single factor (Department of Health 2012: 9).

Depression is frequently cited as one of the most important risk factors for suicide (e.g. Department of Health 2012). Depression has a high prevalence in the general population, with one in six adults in England affected by depression or related conditions at any one time (Department of Health 2012: 27). The impact of depressive symptoms goes significantly beyond low mood: in typical depressive episodes, the individual usually also has a loss of interest, enjoyment and energy – together with common symptoms such as sleep disturbances, anxiety and reported pain in different parts of the body (WHO 2000: 6). These symptoms exacerbate psychological stress and can have a knock-on effect in other areas such as social withdrawal. Amongst those suffering from depression, suicide risk is highest at the early stages of the illness, in early relapse, or early recovery – with suicide risk decreasing with increasing duration of the illness (WHO 2002: 8). In high income countries, having a mood disorder such as depression is the strongest risk factor for acting on suicidal thoughts, particularly if this is accompanied by substance misuse or stressful life events (Nock *et al* 2008).

In addition to depression, there is evidenced need to expand the notion of suicide risk to include a wide range of mental disorders, as described in McClean *et al* (2008: 29):

> *"Across all age groups, genders and in a wide range of geographical locations, several diagnoses of mental illness have been established as risk factors for completed suicide, including: affective disorders (including depression, bipolar disorder etc), schizophrenia, personality disorders and childhood disorders. A history of psychiatric treatment in general is also a risk factor. In schizophrenia and borderline personality disorder suicide risk appears to be elevated around the time of first diagnosis. However, there is also evidence (for bipolar disorder and schizophrenia) that, while these diagnoses carry elevated risk, this is further exacerbated by other risk factors, such as a history of suicide attempts, other psychiatric diagnoses, drug or alcohol misuse, anxiety, recent bereavement, severity of symptoms and hopelessness."*

This description highlights the multifaceted nature of risk, the impact of mental health conditions, as well as the elevated risk associated with the onset of a mental health disorder. For those who are hospitalised for their mental health condition, there are high rates of suicide in the three months following discharge, particularly for first admission to hospital (NCISH 2014, Crawford 2004).

There is a complex interplay between contributing risk factors for suicide. For example, loneliness – a common feature of social isolation – is correlated with mental health problems including depression and anxiety, as well as both suicidal ideation and attempt (Mann *et al* 2017). Stressful life events – including job loss and relationship problems – contribute risk and may act as a trigger factor for suicidal behaviour. Bereavement is a particularly high risk for elderly men, with the first year of widowhood an especially vulnerable period (Cattell 2000). Family and friends bereaved by suicide are often vulnerable and are more likely to take their own lives than the general population (Department of Health 2012; WHO 2014).

When risk factors combine with hopelessness, Cole-King, Green *et al* (2013: 279) point to several 'red flag' warning signs which indicate an individual is at very high risk of suicide: these may include a sense of

entrapment, a sense of being a burden on others, or a sense of having nothing to live for. If an individual's perception of the future is persistently negative and hopeless, this is of particular concern if the individual is only able to see one to two hours into the future.

In the following section, we introduce the role which social prescribing plays in working with individuals with risk factors for suicide.

3. Social prescribing as a wellbeing service

The Royal College of GPs has recently called for every GP practice to have a dedicated social prescriber embedded within it (RCGP 2018). Social prescribing has been highlighted as a means of integrating primary care with wider health and care systems, as well as offering improvements towards the social and economic determinants of health (NHS England 2016, Polley *et al* 2017). With their specialist knowledge of local services, social prescribers are an effective means of connecting individuals to community assets. Moreover, as will be described in Section 4, social prescribers have within their professional toolkit several skills which have been independently identified as beneficial in engaging with individuals at risk of suicide – including compassionate engagement, a holistic and person-centred approach and strategies for kindling hopefulness and problem-solving.

A social prescriber characteristically works one-to-one with individuals to motivate them to make changes in areas of their life which would be of benefit to them. The social prescriber acts as a 'link worker' to support an individual to access groups or services of their choice in the community. Approaches vary, but a holistic model of social prescribing builds broadly on an individual's needs and interests to support wellbeing: beneficiaries have conversations in which they learn about possibilities to support their social, emotional or practical needs, and then 'co-produce' their own personalised solutions using whatever resources are locally available (Kimberlee 2013, Polley *et al* 2017). This intervention offers a beneficiary hope that their circumstances can change, and presents a pathway and motivation for moving forward. This empowering and person-centred approach has been described as "an opportunity to implement a sustained structural change to how a person moves between professional sectors and into their community" (Polley *et al* 2017: 11). The dual perspective of social prescribers – oriented to individual needs and to community assets – facilitates an optimal matchmaking process: this encourages a multi-agency network of support which is highly personalised and responsive to an individual's requirements and interests.

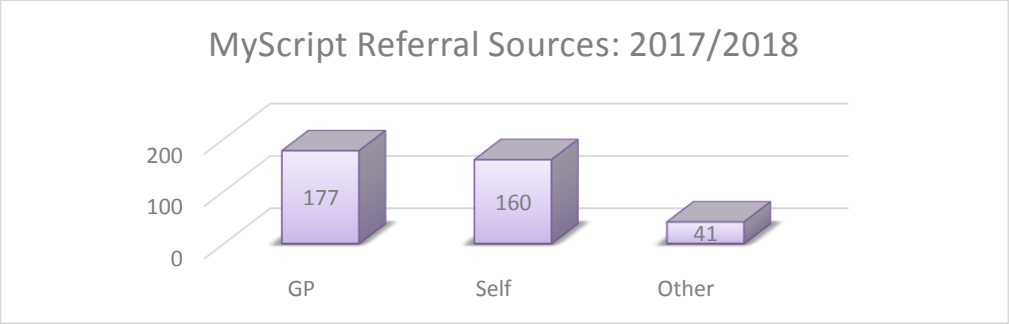
In what follows, we turn to a description of the holistic MyScript social prescribing service at Developing Health & Independence which is embedded in each GP surgery across Bath and North East Somerset.[2] The primary care setting of this service has high relevance to suicide prevention: it is known that the majority of people who die by suicide are in contact with their GP in the year before their death, with 45% of people who die by suicide having seen their GP in the month before their death (Public Health England 2016: 19), with suicide risk rising with increasing number of GP consultations (NCISH 2014).

[2] Local analysis of deaths reviewed by the Avon Coroner in 2016 indicate that some of the highest risk groups in this locality are similar to those known nationally, including: young and middle aged men (from 30-59 years old), people with a history of self-harm, offenders, and people in contact with mental health services (Paul Scott, B&NES Public Health Suicide Prevention Lead, personal communication 04/10/18).

3.1 A GP surgery-embedded service

The MyScript service in Bath and North East Somerset has been operating since 2015 through Developing Health & Independence and offers open referral criteria, to any adult who wishes to improve their wellbeing who is registered at any of the 27 GP surgeries within the county. Individuals can be referred to the service by their GP or other professionals, or they can self-refer. Of the 378 individuals referred to MyScript over 2017/2018, 47% of referrals came from GPs, 42% were self-referrals, and 11% came from other professional sources including the community mental health services. These referral sources are illustrated in Figure 3.

Figure 3. *Referral sources for the MyScript service in Bath and North East Somerset (2017/2018)*



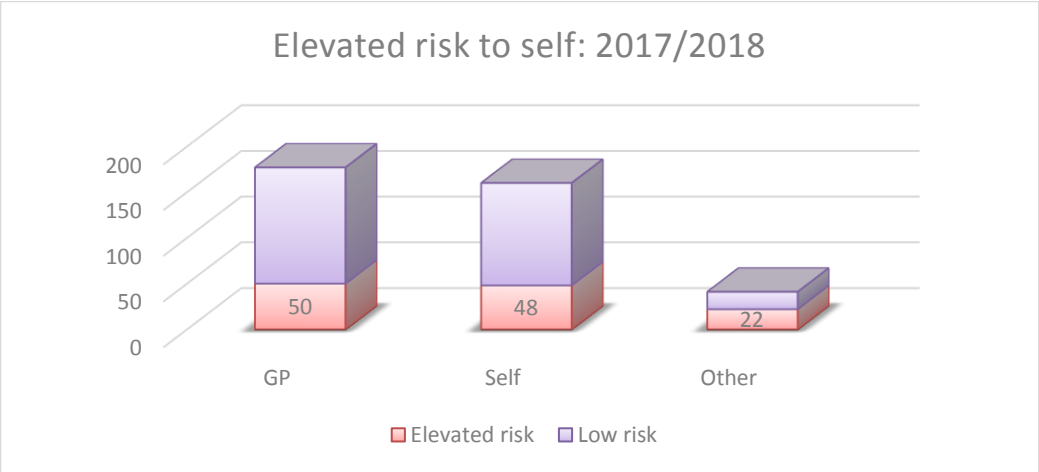
After the referral, individuals are typically offered three 50-minute social prescribing appointments. The majority of beneficiaries are seen at their GP surgery but this is flexibly adapted to individual needs, so that some will receive telephone support, home visits, or meetings in a community setting. The intervention is short-term (with appointments over the course of two or three months) but allowing the opportunity for individuals to self-refer back into the service in future if additional needs are encountered.

An initial assessment appointment gauges any areas of concern to the beneficiary, and identifies goals which the individual would like to meet with the support of the MyScript service. Following the assessment, the social prescriber gathers information on available resources which may be of interest to the beneficiary, and presents these findings in a second appointment. The social prescriber and beneficiary collaborate to determine which of the resources would best suit the beneficiary, and chart a path for the beneficiary to engage with these selected resources. The third session consolidates change: the beneficiary feeds back on their experience and the social prescriber supports with any troubleshooting required. In Section 3.4, we return to how this standard three-session delivery can be adapted to four sessions to suit the needs of beneficiaries at elevated-risk of harm to self. In Section 5.4, we give an example of how volunteers at MyScript can give beneficiaries extra support in overcoming social anxiety to access community activities, by accompanying them as they try group activities and help them get settled in.

3.2 Work with populations with a range of risk profiles

The open referral criteria for MyScript allow it to function flexibly as both an “upstream” wellbeing model (see Section 4.2) or as a targeted intervention for vulnerable populations. Although the majority of MyScript beneficiaries are low-risk for intentional harm to self, over thirty percent (31.7%) of MyScript beneficiaries in 2017/2018 were identified as being at elevated (either high- or medium-) risk of harm to self over the course of service. This is indicated in Figure 4, which shows the range of risk profiles across GP-referrals, self-referrals or other referral sources. Factors to signal elevated risk of harm to self are reported suicidal thoughts, self-harm, and recent or historical suicide attempts.

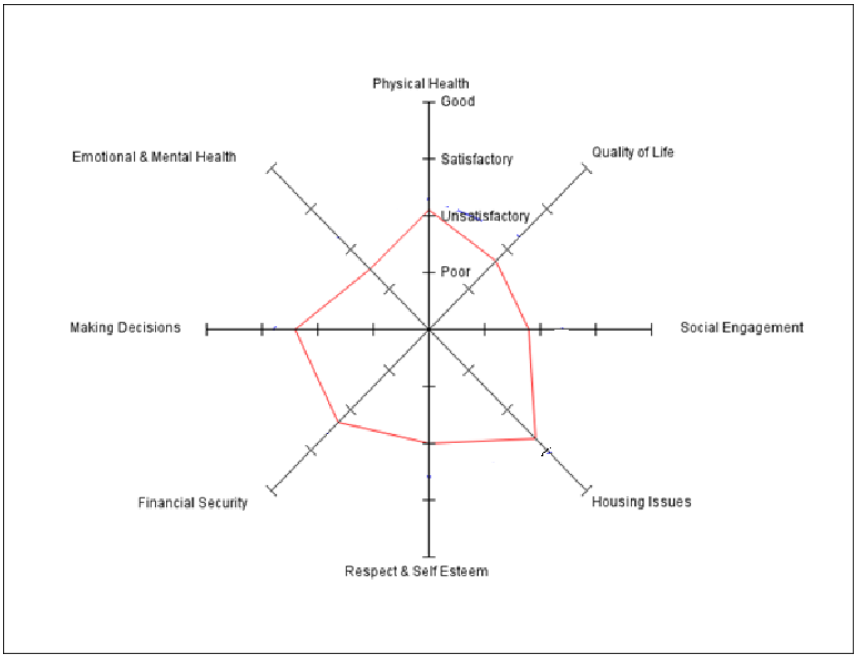
Figure 4. *Proportion of MyScript beneficiaries identified as elevated risk to self (shown by referral source)*



Of the 120 individuals identified in 2017/2018 as elevated risk, 67 (56%) were women and 53 (44%) were men.

Potential risks to self may be flagged by professional referrers, but are probed for all individuals during a comprehensive assessment which spans topics of (1) social engagement, (2) housing issues, (3) respect & self-esteem, (4) financial security, (5) making decisions, (6) emotional & mental health, (7) physical health, and (8) overall quality of life. Individuals reflect on each of these eight areas, and express their satisfaction or wish for change, which is recorded using a 4-point scale (0=poor, 1=unsatisfactory, 2=satisfactory, 3=good). These Inventory for Brokerage Service Outcomes (IBSO) scores constitute a subjective measure of wellbeing and are taken during the initial assessment and at completion of service to allow for tracking of any changes. Figure 5 illustrates the aggregate subjective wellbeing scores for assessments (initial appointments) for MyScript in 2017/2018.

Figure 5. *Aggregate subjective wellbeing for initial appointments for MyScript 2017/2018*



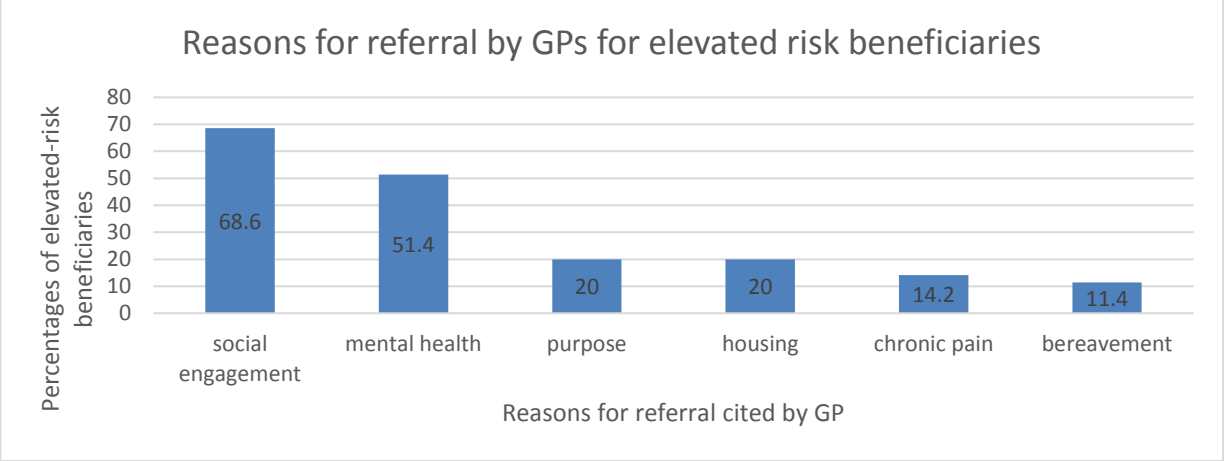
As shown in Figure 5, the aggregate well-being scores for MyScript beneficiaries are at less-than-satisfactory levels for all the domains assessed at the initial appointment, reflecting the broad needs of service beneficiaries.

3.3 Integrated working

Social prescribing has been highlighted as a means of integrating primary care services with non-clinical services including those within the local community and third sector. With nearly half of all referrals coming from GPs, MyScript has close links with primary care – and complements the existing position of GPs as one of the first points of contact for people who are experiencing distress or suicidal thoughts (Department of Health 2012: 51).

In 2017/2018, for GPs who cited reasons for their MyScript referral for elevated-risk beneficiaries, the main identified needs are social engagement (68.6%), mental health needs (51.4%), sense of purpose (20%), housing needs (20%), chronic pain (14.2%), and bereavement (11.4%). This is shown in Figure 6. Note that total percentages exceed one hundred percent due to referrals having multiple reasons cited.

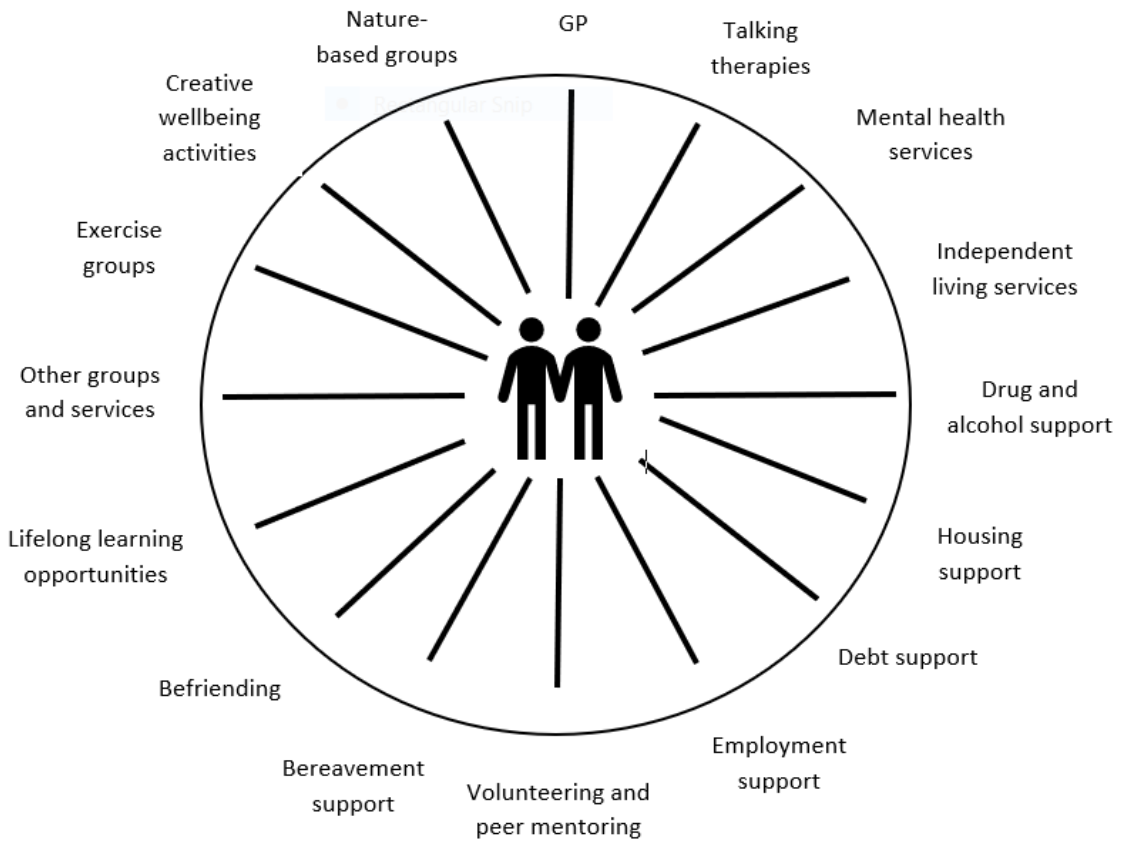
Figure 6. *Cited reasons for referral by GP for elevated risk beneficiaries of MyScript, 2017/2018* (N=35)



These referral reasons relate to several of the risk factors for suicide identified in Section 2, including social isolation, mental health disorders, chronic illness and bereavement.

Following on from the referral, social prescribers work to link individuals up to a range of groups, activities and services according to their needs. Social prescribers are central to maximizing access to community assets and can therefore be considered linchpins for delivery of multi-agency interventions (see also Section 4.4). This is illustrated in Figure 7, which indicates the range of resources which a holistic social prescribing service such as MyScript connects a beneficiary to. The social prescriber and beneficiary are represented in a non-hierarchical pairing at the centre, reflecting the 'co-production' of the choice of resources.

Figure 7. *Social prescribers as linchpins for integrated working*



3.4 A brief intervention model

As a wellbeing service flexible to the needs of its beneficiaries, the session provision for MyScript can be adapted to accommodate the needs of low-risk or elevated-risk individuals. While low-risk beneficiaries are typically offered three sessions (as described in Section 3.1), elevated risk beneficiaries may benefit from an additional session to allow time to collaboratively draft a safety plan, using self-help material as a template (see Section 4.4.3) to record which activities are helpful as coping strategies for suicidal thoughts.

Whether offered across three sessions or four, the focus of this brief intervention is on nurturing the beneficiaries' interests and encouraging their efforts to make positive change. The typical delivery of this strengths-based approach is shown in Figure 8, outlining the content across the three or four appointments. Note that if the social prescriber feels the beneficiary is at imminent risk of harm to self, a referral back to the GP (Polley *et al* 2017: 42) or crisis services for additional support is appropriate.

Figure 8. *Typical session provision for engaging with low-risk or elevated-risk MyScript beneficiaries*

Low-risk individual
Appt #1: assessment of needs
Appt #2: community resources
Appt #3: consolidating change

Elevated-risk individual
Appt #1: assessment of needs & safety plan (emergency contacts)
Appt #2: Safety plan & route to change
Appt #3: community resources
Appt #4: consolidating change

Before turning to examples in practice of brief interventions with elevated-risk individuals in Section 5, we first consider in Section 4 those aspects of social prescribing which support its effectiveness in suicide prevention.

4. The role of social prescribing in suicide prevention for at-risk beneficiaries

At global, national and local levels, suicide prevention strategies are a major public health aim (e.g. WHO 2014, Department of Health 2012, B&NES Public Health 2018). The 26% fall in suicide rates in the UK since 1981 (Office for National Statistics 2016) reflects the impact of a wide range of public health initiatives. These interventions may be classed as *universal*, *selective*, or *indicated* prevention approaches (see WHO 2014). *Universal* prevention measures, which are designed to reach an entire population, include reducing availability of lethal methods, guidance on sensitive media reporting on suicide, and efforts to destigmatize help-seeking behaviours. Prevention strategies may also *selectively* target vulnerable groups, and can include workforce development training (e.g. Applied Suicide Intervention Skills Training) for staff that work with high risk populations. *Indicated* interventions apply to those high-risk individuals who have previously attempted suicide and may include a range of behavioural therapies as well as non-specialist approaches. Social prescribing can be applied as a selective or indicated intervention, and can also contribute to aspects of universal interventions such as destigmatizing help-seeking behaviour.

There is a growing body of evidence that relatively minor interpersonal interventions can prevent suicides, even for high-risk individuals (see Cole-King, Parker *et al* 2013 for discussion). For example, in a large multi-country study of low-cost indicated interventions, Fleischmann *et al* (2008) describe how an exchange of short letters expressing concern for a person's wellbeing led to a reduction in suicide rate for people who had previously attempted suicide. There is significant scope for non-specialist interventions for suicide prevention. A WHO report (2000: 13) offering guidance to GPs stresses that beyond treatment of any underlying illnesses, few suicidal people require support for longer than two or three months and "the focus of support should be providing hope, encouraging independence, and helping the patient to learn different ways of coping with life stressors."

Effective suicide prevention strategies are those which build resilience at the individual– or system–level. As McClean *et al* (2008: 15-16) describe, "the study of resilience, that is the capability of individuals and systems (families, groups, and communities) to cope successfully in the face of significant adversity or suicide risk, is a useful way of identifying protective factors. The capability for resilience develops and changes over time, is enhanced by protective factors within the individual system and the environment, and contributes to the maintenance or enhancement of health."

Public Health England (2016: 9) advises that "a whole system approach is required" for suicide prevention. The national strategy for England is set out in *Preventing Suicide in England: a cross-government outcomes strategy to save lives* (Department of Health 2012) and is supported for delivery at local levels by *Local suicide prevention planning: A practice resource* (Public Health England 2016). A guiding principle of the national strategy is the multi-agency work which coordinates the "whole system" approach at local levels through strategic suicide prevention partnerships (see Public Health England 2016, NICE 2018). Two principle objectives are outlined: to reduce the suicide rate in the general population and provide better support for those bereaved or affected by suicide (Department of Health 2012). There are six areas for action in the national strategy (Department of Health 2012), as represented in the left-hand column in Figure 9. Social prescribing programmes complement several of these aims, as proposed in the right-hand column in Figure 9.

Figure 9. *National areas for action in suicide prevention and potential contributions of Social Prescribing*

	NATIONAL AREAS FOR ACTION	POTENTIAL CONTRIBUTIONS OF SOCIAL PRESCRIBING
1	reduce the risk of suicide in key high-risk groups where the suicide rate is high and there is a known statistically significant increased risk of death by suicide, such as: men, people who self-harm, people who misuse alcohol and drugs, people in the care of mental health services (Department of Health 2012)	• improve mental health and quality of life[†] • reduce isolation, for example through community based engagement[†] • facilitate access to tailored programmes, groups or services for people with particular needs[†] • link between health and non-health services[†] • support multi-agency interventions[†] • offer improvements towards the social and economic determinants of health[†] • motivate behaviour change[‡] • facilitate recovery and growth • reduce barriers to treatment of depression[†] • enhance social infrastructure[‡]
2	tailor approaches to improve mental health in specific groups such as: survivors of abuse or violence, people living with long-term physical health conditions, people with untreated depression, people who are especially vulnerable due to social and economic circumstances, people who misuse drugs and alcohol (Department of Health 2012)	• improve mental health and quality of life[†] • reduce isolation, for example through community based engagement[†] • facilitate access to tailored programmes, groups or services for people with particular needs[†] • link between health and non-health services[†] • support multi-agency interventions[†] • offer improvements towards the social and economic determinants of health[†] • motivate behaviour change[‡] • facilitate recovery and growth • reduce barriers to treatment of depression[†] • enhance social infrastructure[‡]
3	reduce access to the means of suicide (Department of Health 2012)	• occasional safeguarding interventions (in the event of disclosure of intended means)
4	provide better information and support to those bereaved or affected by suicide (Department of Health 2012)	• facilitate access to bereavement support for people bereaved or affected by suicide[§] • enhance social infrastructure[‡]
5	support the media in delivering sensitive approaches to suicide and suicidal behaviour (Department of Health 2012)	
6	support research, data collection and monitoring (Department of Health 2012)	• contribute intelligence on local trends and gaps in support[§]

[†] See Polley *et al* (2017).

[‡] From the key outcomes described by programme stakeholders in the Social Prescribing Conference Report (2016), as cited by Polley *et al* (2017: 12).

[§] Paul Scott, B&NES Public Health Suicide Prevention Lead (RJ personal communication 04/10/18).

Social prescribing offers significant, overlapping contributions in supporting those in high-risk groups (area for action 1) and in facilitating improvement of mental health (area for action 2), with additional potential contributions including supporting those members of the community who have been affected by suicide (area for action 4). A comprehensive review of each of these potential contributions of social prescribing is beyond the aims of this paper. Instead, we limit discussion to the impact which social prescribing has at an individual level. Specifically, we examine the key *means* by which social prescribing can contribute to suicide prevention through the use of brief interventions. Five aspects of social prescribing are considered: a gatekeeping role (Section 4.1), early intervention (Section 4.2), compassionate engagement (Section 4.3), a person-centred approach (Section 4.4), and integration of clinical and non-clinical sources of support (Section 4.5).

4.1 Gatekeeping

Most people who take their own lives have not been in touch with mental health services (Department of Health 2012: 9). Indeed, a self-reporting survey in England found that of those who have experienced a non-fatal suicide attempt, only half of people (50.1%) sought any help at all after their most recent suicide attempt (McManus *et al* 2016). Of those who did seek help, McManus *et al* (2016) report that about a quarter went to a GP, a quarter went to a hospital or specialist medical or psychiatric service, and a fifth tried to get help from family or friends.[3] There is an evident gap in support for suicidal individuals, as well as a need to prevent escalation of individuals' sense of crisis in the first place.

To help fill the gap in support, NICE guidelines (2018) advocate the role of community "gatekeepers" in early detection of suicidal risk within different target populations (see also van der Feltz-Cornelis *et al* (2011) and WHO (2014)). A "gatekeeper" is any non-specialist who is in a position to identify whether an individual may be contemplating suicide (WHO 2014: 38). These potential catalysts for support include teachers, pharmacists, police and youth workers, among others. Van der Feltz-Cornelis *et al* (2011: 326) identify as best practice the need for training for these non-specialist members of the community in the following areas of suicide prevention:

- detection of depression and suicide risks.
- theoretical aspects of depression and suicide (e.g., symptoms, treatment)
- practical elements (e.g., how to talk about suicidality, detect suicidality, handle an acute suicidal crisis)
- what to do if treatment needs are encountered
- populations vulnerable to suicide
- presentation and distribution of information materials for various vulnerable populations

By embedding suicide prevention within the community, this broadens the access points for reaching at-risk individuals. This is particularly important given that with widespread stigma or taboo around suicide, many people contemplating suicide do not know who to speak to (WHO 2014: 65).

As wellbeing practitioners who regularly work with populations with risk factors for suicide, social prescribers have an emerging role as professionals who frequently come into contact with people who are contemplating suicide: gatekeeping is one way in which social prescribers can support suicide prevention, despite a lack of specialist mental health training. Social prescribers' gatekeeping work can help break

[3] Men and women were found to be equally likely to seek help after a suicide attempt, and using GPs as a source of support following a suicide attempt was equally common across age-groups (McManus *et al* 2016).

down barriers around discussing suicide, and link up support in coping with suicidal thoughts. Conversations about one's quality of life and mental health are a central component of social prescribing sessions, and techniques from Applied Suicide Intervention Skills Training (ASIST) allow MyScript workers to probe cues for elevated risk such as low mood or hopelessness, and work to keep someone "safe for now". One member of the MyScript team describes how she uses her ASIST training to intentionally "normalise" discussion of suicidal thoughts, and gives individuals a chance to open up about their feelings to someone who is not afraid to listen. Individuals who disclose suicidal thoughts in MyScript sessions often remark that they have limited opportunity to otherwise discuss these thoughts to those around them – citing diverse reasons including the stigma of poor mental health, the wish to avoid burdening those in their life, the absence of anyone in their life to open up to, and fear of the consequences such as a worry about being sectioned under the Mental Health Act.

As will be described further in Section 4.3, disclosure of suicidal thoughts can itself be considered a protective factor. Upon disclosure of suicidal thoughts, MyScript workers have the opportunity to discuss a safety plan, and can source additional help for an individual as appropriate – complementing support available from the GP and community mental health services, by offering specialised self-help materials (e.g. Rethink Mental Illness' *Coping with Suicidal Thoughts*) and building resilience through protective factors (see Section 4.4). If the social prescriber feels the beneficiary is at imminent risk, an immediate referral back to the GP (Polley *et al* 2017: 42) or crisis services is appropriate. In instances in which a beneficiary discloses means of planned method of suicide, the social prescriber's role may include safeguarding actions to reduce access to means of suicide (e.g. actions to limit stockpiling of medications).

4.2 Early intervention

While there is an acknowledged need for better detection of individuals who are approaching personal crisis, there is also a strong argument for improved means of preventing escalation in the first place. McClean *et al* (2008: 10) advise that one of the central aims of suicide prevention should be "to enhance individual and psychosocial protective factors in the general population (and those who are more vulnerable) that prevent them from becoming future members of suicide risk groups where possible e.g. mentally ill, prisoners, unemployed, in poverty." This implies an early intervention approach with a wide application across the population.

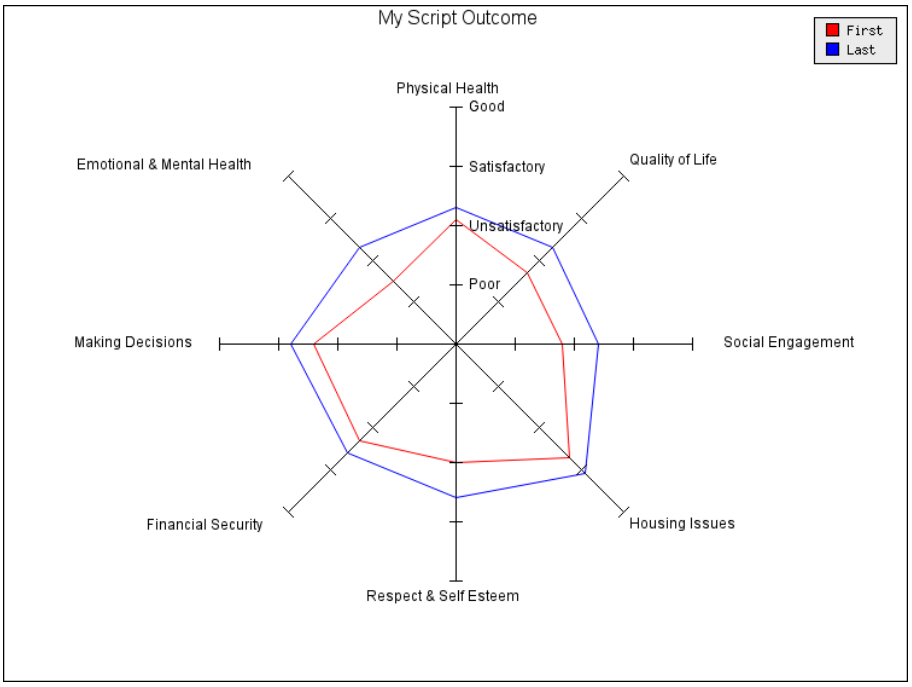
The World Health Organisation discusses "upstream" wellbeing approaches as potential protective measures against suicide for the general population (WHO 2014: 44). These interventions – which promote healthy lifestyle practices of positive coping strategies and well-being – can include measures to promote regular exercise and sport, adequate sleep and diet, consideration of the impact on health of alcohol and drugs, healthy relationships and social contact, and effective management of stress.

This early intervention approach is echoed in the *Preventing Suicide in England* strategy (Department of Health 2012: 11), which outlines a public health strategy using general and targeted measures to improve mental health and wellbeing, intended to reduce suicides across the whole population. The strategy prioritises the need to prevent problems from getting worse and avoiding the need for more expensive interventions later on. In particular, the national strategy cites the need for better recognition and treatment of mental health disorders, especially depression. It is known that early treatment of depression allows faster recovery (Department of Health 2012: 28), and that untreated depression heightens suicide risk (Department of Health 2012: 27). Barriers to recognition and appropriate treatment of depression include pressures in primary care, mental health "illiteracy" in individuals with depression, reluctance of individuals to seek help (in part due to fear of stigmatization), as well as poor treatment compliance (van

der Feltz-Cornelis *et al* 2011: 320). Social prescribing has a potential role in lessening the burden of depression in the population, particularly given that the strong link between depression and loneliness (Masi *et al* 2010, Mann *et al* 2017) provides fertile ground for social prescribing initiatives which work to reduce loneliness and social isolation.

Social prescribing offers a novel opportunity for early interventions which benefit wellbeing (see Polley *et al* 2017: 12). In the MyScript social prescribing service, the assessment appointment gauges any areas of concern to an individual, and is followed up by work which can prevent problems from getting worse. Recall from Section 3.2 that subjective wellbeing is tracked in MyScript via a 4-point scale measuring eight domains. As illustrated in Figure 10, aggregate outcomes for 2017/2018 show an improvement across all eight wellbeing domains, from the first appointment to the last.

Figure 10. *Aggregate outcomes for MyScript in 2017/2018 tracked across eight domains*



This broad improvement indicates the wide-ranging impact which social prescribing has as an intervention. The success of MyScript as an "upstream" intervention is also reflected in the 91% of individuals who report an improvement in one or more domain in 2017/2018 (Developing Health & Independence 2018). (In Section 4.4 we explore further the multicomponent aspect of social prescribing interventions.)

4.3 Compassionate engagement

In working with an individual at risk of suicide, Cole-King, Green *et al* (2013: 276) note that "a compassionate approach is by far the most useful interaction for positive engagement". Cole-King, Parker *et al* (2013: 285) describe compassion as "commonly defined as a sensitivity to distress (in oneself or others) that is accompanied by a commitment to try to do something about it." They point to research (Gilbert and Irons 2005, as cited by Cole-King Parker *et al* 2013) which indicates that compassion is in fact a complex combination of attributes and qualities, which boils down to six essential traits: sensitivity, distress tolerance, empathy, non-judgement, sympathy and motivation.

A range of benefits has been cited for compassionate engagement with a suicidal individual. In advice for GPs, WHO (2000: 11) note that "listening with empathy is in itself a major step in reducing the level of

suicidal despair". The guidance advises that after rapport has been established, it is an ideal time to enquire about suicidal feelings for anyone exhibiting distress, to check whether the person is having suicidal thoughts. They note that it is a myth that enquiring about suicidal intent increases the likelihood of suicidal acts, and in fact, by showing a willingness to understand, one will "often reduce the anxiety surrounding the feeling; the patient may feel relieved and better understood" (WHO 2000: 11).

Cole-King, Green *et al* (2013: 276) argue that compassionate engagement is important to eliciting disclosure of suicidal thoughts – a vital first step to accessing support which they highlight "must not be underestimated", and which can itself be considered a protective factor against suicide. When an individual discloses their suicidal thoughts to a professional, they are trusting the professional with what may be painful and difficult information to relay; compassionate engagement facilitates this sense of trust. This type of positive engagement is valuable in overcoming the stigma or taboo in discussing suicidal ideation, and can reinforce useful help-seeking behaviour.

Compassionate engagement has also been highlighted as the foundation of the collaborative creation of a safety plan. Cole-King, Green et al (2013: 279) describe that practitioners need "to invest time in listening to, and engaging with, the patient, exploring reasons for living, developing strategies to help keep them safe and establishing a network of support. The safety plan is patient-centred and personalised." The work of social prescribers to enhance protective factors (see Section 4.4) can complement a safety plan.

For social prescribers, compassionate engagement is a core skill set. Polley *et al* (2017: 38) describe the ability to engage with people as one of the essential qualities of a social prescriber: "link workers need to be able to engage, empathise, listen, empower and motivate individuals". Social prescribers must have the ability to build rapport and must also have high levels of distress tolerance which allow them "the ability to manage people with acute anxiety and crisis" (Polley *et al* 2017: 38).

Compassionate engagement is facilitated by the sense of trust which can build up over the generous time allotted to social prescribing sessions. Standard MyScript appointments are 50 minutes each. Adequate time in sessions is a factor in eliciting disclosure of suicidal thoughts, since it allows one to lead into the topic gradually after rapport has been established (see WHO 2000).

A recent survey (Murch et al 2018) of fifteen MyScript beneficiaries over a seven-week period in 2018 lends weight to the role of compassionate engagement in social prescribing: the survey results indicated that MyScript beneficiaries found their social prescribers highly effective in engaging with and motivating them. Four questions measured beneficiaries' experience of the social prescriber's motivation and engagement: '*My MyScript contact "…was highly motivated to encourage me", "…considered ALL the challenges I raised", "…involved me in ideas and decision-making", "…was proactive in encouraging my efforts".*' Using a 7-point scale (where 1= strongly disagree and 7= strongly agree) there was a mean score of 6.63 across these four questions (Murch et al 2018: 26). As this study did not address the beneficiaries' risk levels, further research is required in to the role of compassionate engagement in social prescribing specifically examining the relationship with beneficiaries who are at elevated risk of harm to self.

4.4 Protective factors specific to the individual

People living with suicidal thoughts are a heterogenous group, with diverse stressors, and the protective factors against suicide are likewise specific to the individual's circumstances and experiences. McClean *et al* (2008: 15-16) define protective factors as "societal or psychosocial conditions or individual behaviours that lessen the likelihood that an individual will engage in suicidal behaviour." Cole-King, Parker *et al* (2013: 287) point to evidence for the value of a person-centred approach in crafting holistic support for a suicidal

individual – this treats the individual as a whole person, rather than reducing them to a narrow clinical need such as their physical health.

It is striking that resilience factors are in fact better predictors of suicidal behaviour than the amount of exposure to stressful life events (McClean *et al* 2008: 8). In the sections below, we consider major categories of protective factors for individuals, which include social connectedness (Section 4.4.1), hopefulness and reasons for living (Section 4.4.2) and problem-solving skills (Section 4.4.3).

4.4.1 Social connectedness

Social support and connectedness has been found to be protective against suicide among a range of population groups, particularly in social settings in which individuals felt a sense of belonging (McClean *et al* 2008).

WHO (2014: 44) describe how strong personal relationships increase an individual's resilience and act as a protective factor against the risk of suicide. An individual`s closest social circle – partners, family members, peers, friends and significant others – are noted to have the most influence. This social support acts as a significant "buffer" to external stressors which could otherwise compromise social, emotional and financial wellbeing.

When an individual is socially isolated, there is an identified role in boosting community connectedness via support of third sector organisations (Cole-King, Parker *et al* 2013: 288). Social prescribing is a strong mechanism for increasing social connectedness, performing a 'matchmaking' between beneficiary interests and community groups. In MyScript, social engagement of beneficiaries is increased through matchmaking with a diverse range of social activities, such as befriending, creative arts groups, coffee mornings, lifelong learning associations and exercise groups (see Section 4.4).

4.4.2 Hopefulness and reasons for living

For any type of suicidal ideation – whether thoughts are passive and fleeting, or active and persistent – Cole-King, Green *et al* (2013: 278) emphasize the value of instilling hope and uncovering reasons for living. McClean *et al* (2008: 8) describe that "high levels of reasons for living, future orientation and optimism protect against suicide attempt among those with depression." Positive reasons for living can be linked to an individual's social connectedness – such as their personal relationships or children (McClean *et al* 2008: 58). However, a range of alternative sources of positivity have been identified as protective, including self-empowerment, spirituality, a sense of personal or professional success, a sense of having a full and active life, or having confidence in medical treatment (McClean *et al* 2008: 58).

The comprehensive 50-minute assessment for MyScript is the starting point of social prescribing sessions which aim to nurture a beneficiary's interests and personal aims. This person-centred approach builds on an individual's strengths, and connects the beneficiary to community resources that can help sustain these interests. For example, in Section 5.1, we consider an example of how engagement with creative arts through social prescribing supports quality of life and sense of purpose.

In the following section, we turn to how social prescribing implements highly-personalised coping strategies for life stressors, using techniques of solution-focused interviewing.

4.4.3 Problem-solving skills

Solution-focused interviewing is one means by which social prescribers can encourage beneficiaries to take positive control of their situation. Cole-King, Green *et al* (2013: 281) identify the role of solution-focused interviewing in helping empower suicidal individuals to construct realistic and workable solutions to their problems. In solution-focused interviewing, the use of open questions with positive presuppositions plants a seed of hopefulness and encourages future-oriented thinking. Cole-King, Green *et al* (2013: 281) give several examples of solution-focused questions which can be used as part of discussion to collaboratively build a safety plan. They include the following questions (Cole-King, Green *et al* 2013: 281):

> *"How have you coped with this situation up to now?"*
>
> *"When you look back on this testing period in your life, what do you think the main thing that got you through it will have been?"*

These open questions encourage an individual to develop their own solutions to problems, and can promote a sense of efficacy. This chimes with McClean *et al* (2008: 64), who describe that "much of the evidence on protective factors is about the individual having or gaining […] an element of control over the kind of coping skills they employ, the way in which they react to adverse life situations positively, the reasons they identify for living [and] optimism for the future."

An important aspect of problem-solving is knowing how to respond in a crisis, and having the ability to seek help when this is needed. Van der Feltz-Cornelis *et al* (2011: 326) identify as one of their six key elements of best practice in suicide prevention the importance of individuals having familiarity with services and self-help activities which facilitate access to professional help. This can include: targeted information materials (e.g., leaflets for people in bereavement or survivors of suicide) providing concrete advice and help; or a medical emergency card for high-risk individuals, showing a contact telephone number and recommending steps to take in an acute crisis, including telephone numbers of important local services. These practical aids provide scripted help for times when an individual needs a prompt for their 'safety plan' to kick in. One example of self-help guidance for the UK is the *Suicidal thoughts: How to cope* factsheet made publicly available by Rethink Mental Illness (2016): this includes practical guidance on creating a personalised safety plan, together with helpful contact numbers and tips on dealing with crisis. In Section 5, we give examples of how such self-help materials may be used in social prescribing.

Evidence from Murch et al (2018) supports the positive role of social prescribing in encouraging beneficiaries to take control of their situation and develop knowledge and skills. Murch et al's (2018) survey included two sets of questions which assessed MyScript beneficiaries' experience in each of these areas. Three questions measured beneficiaries' sense of control: '*My MyScript contact "…made me feel I was directing my life", "…made me feel confident to do things by myself" and "…helped me set clear goals*".' Four questions gauged effectiveness of social prescribers in working with beneficiaries on knowledge and skills: '*My MyScript contact "…helped me identify solutions", "…helped me identify NEW solutions", "…respected my contributions", and "… provided me with helpful information"*.' This survey, completed by fifteen MyScript beneficiaries over a seven-week period in 2018, used a 7-point scale (where 1= strongly disagree and 7= strongly agree). For the three questions measuring beneficiaries' experience of being encouraged to take control of their situation, the mean response was 5.84 (Murch et al 2018: 26), reflecting a positive sense of self-efficacy. For the four questions gauging beneficiaries' experience of how social prescribers worked with them to gain knowledge or skills, the mean score was 6.47 (Murch et al 2018: 26), supporting a highly positive contribution of social prescribing to problem-solving. Although this

study did not consider suicide risk of the beneficiaries, it is consistent with a general assessment of social prescribing as encouraging of beneficiaries' sense of control and problem-solving. Further research is required to specifically assess social prescribing interventions for beneficiaries with elevated-risk profiles.

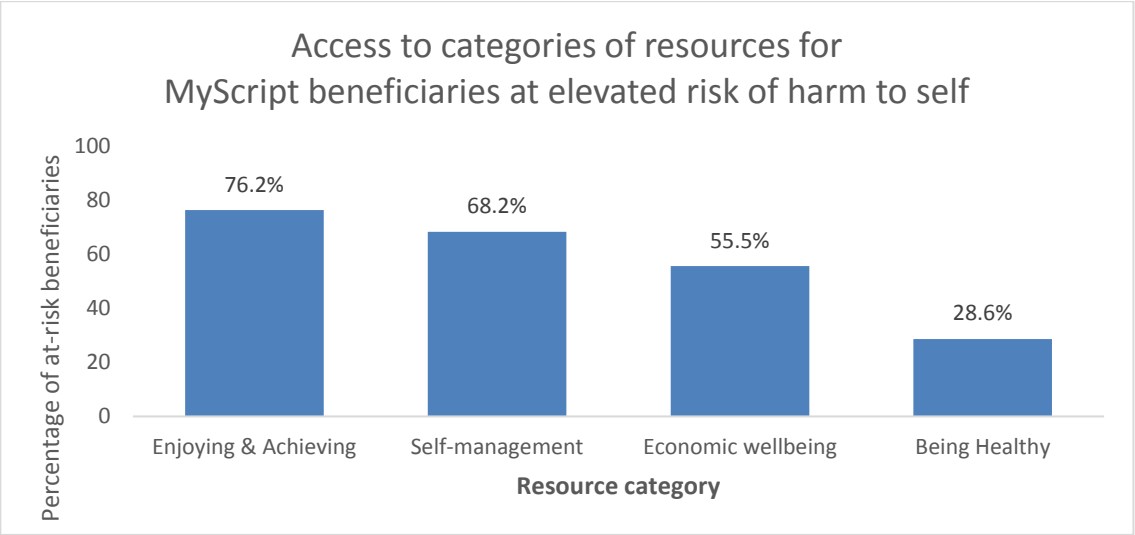
4.4 Multicomponent interventions

A range of guidance points to the value of collaborative interventions in suicide prevention. As described in Section 2.4, suicide risk is multifaceted and there is a complex interplay between contributing factors. Effective suicide prevention approaches are consequently likewise multifaceted. The *Preventing Suicide in England* strategy (Department of Health 2012: 11) states that "suicide prevention is most effective when it is combined as part of wider work addressing the social and other determinants of poor health, wellbeing or illness". This national strategy emphasizes the importance of integrated working using local resources, stressing that services can achieve more by working together than they can in isolation. This accords with McManus *et al* (2016) who urge that "synergistic combinations ought to be part of recommended best practices" in suicide prevention.

In achieving multicomponent interventions, communities are known to play a critical role in suicide prevention (WHO 2014). Given that resilience factors are better predictors of suicidal behaviour than the amount of exposure to stressful life events (McClean *et al* 2008: 8), there is a justifiable need to identify mechanisms that increase the exposure of individuals and communities to multiple protective factors (McClean et al 2008: 11). A central claim of this paper is that social prescribing is a powerful vehicle for integrating services within the community, to increase individuals' exposure to multiple protective factors (Section 3.3). The work of social prescribers to link up beneficiaries with multiple sources of support acts as a 'bottom-up' approach to multi-agency interventions: this person-centred work starts with the needs of the individual and moves on to facilitate matchmaking with suitable agencies. This work complements the 'top-down' multi-agency suicide prevention approaches which are coordinated at local levels through strategic suicide prevention partnerships (see Public Health England 2016, NICE 2018).

In advice for clinicians, Cole-King, Green *et al* (2013: 278) describe the broad approach required as a best practice in response to patients disclosing suicidal thoughts. This comprehensive response includes providing signposting resources, instilling hope and uncovering reasons for living, performing social support mapping, and creating a safety plan including third sector support to increase resilience. The work of social prescribers is complementary to these aims. As shown in Figure 11, social prescribing supports individuals to access a range of community resources which aid their wellbeing. In 2017/2018, over three-quarters (76.2%) of MyScript beneficiaries who were at elevated risk for harm to self were connected with community resources in the category of "enjoying and achieving" – this includes lifelong learning opportunities, befriending, creative wellbeing activities, nature-based activities and community groups such as choirs. Over two-thirds (68.2%) of elevated-risk MyScript beneficiaries accessed resources to support their self-management, such as mindfulness, talking therapies or psycho-educational courses. Over half (55.5%) of elevated-risk beneficiaries were linked up with resources to support their economic wellbeing, such as employment preparedness programmes or signposting for debt or benefits advice. Finally, over a quarter (28.6%) of elevated-risk beneficiaries accessed resources to support their physical health, such as exercise, healthy eating or drug and alcohol support.

Figure 11. *Categories of resources accessed by elevated-risk MyScript beneficiaries, 2017/2018 [N=63]*



In the following section, we illustrate through case studies how integrated working increases exposure to multiple protective factors.

5. Case studies from MyScript: Brief interventions for suicide prevention

We present five case studies which illustrate the effectiveness of social prescribing in building the resilience of MyScript beneficiaries who have risk factors for suicide. These case studies capture the synergistic effect in which multiple factors combine to improve wellbeing for the MyScript beneficiary. In each of these examples, the social prescriber works in tandem with the service beneficiary to identify and realise aims for wellbeing. The social prescriber is integral to drawing in additional sources of support for the beneficiary, and complements the work of outside agencies. The case studies use pseudonyms to anonymise the contributions of the research participants, and identifying details have been altered.

5.1 Social prescribing to increase social connectedness and support adjustment to retirement

Tim, a financially comfortable man in his 60s, was referred to MyScript by his GP for support with his low mood and difficulty adjusting to retirement. At the initial appointment, Tim revealed that he was in fact contemplating suicide – he felt his life was not worth living due to loneliness and lack of purpose. He lived alone and his long days at home on his own were so overwhelming to him that he reported he had been taking reckless risks out of frustration at the emptiness in his life. He felt lost with his depression and had a diminishing sense of hopefulness for his future.

Tim met four times in total with his social prescriber, and the sessions together gave Tim a chance to open up about his loneliness, and unpick his need to find a sense of purpose and belonging. After his needs were assessed, the social prescriber used motivational and solution-focused interviewing to uncover a route to Tim gaining fulfilment in his life, and better structure to his days.

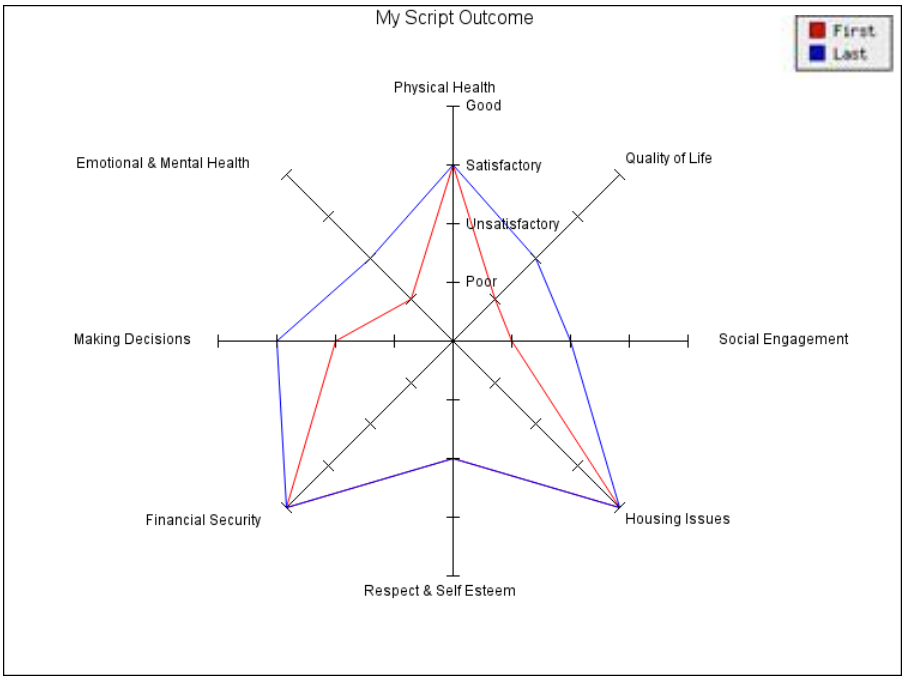
It came up during the second social prescribing session that Tim enjoyed expressing himself through art, and the mention of a local art group piqued his interest. It was an ideal fit for him - by the time of his final social prescribing session, he had attended the art group three times, felt a sense of belonging in the group, and was using his time to create work he was proud of. Tim's mood picked up and he was able to move on to doing other productive things with his time; he opened up to attending further community groups and found he had better motivation for physical activity. Led by his interests, Tim was connected to further

resources in the community, including lifelong learning opportunities, an exercise group and other social outlets. Tim reported feeling buoyed by the options available him.

The sessions were also an opportunity to collaboratively work through Rethink Mental Illness' (2016) self-help template for coping with suicidal thoughts, in order to create a personalised safety plan – this helped increase Tim's awareness of his trigger factors, as well as his coping strategies, and gave him ready access to national helplines which he could contact in case his mood became intolerable in the future. With increased awareness of his need for ongoing emotional support, Tim began seeing a counsellor regularly. The social prescriber ensured that Tim's disclosure of strong suicidal ideation was fed back to Tim's GP, together with the outcome of the social prescribing sessions and an overview of Tim's personalised safety plan. Tim understood that he was welcome to self-refer back into the service should he feel he would benefit from additional social prescribing discussions in future.

At the time of his initial assessment, Tim was experiencing strong suicidal ideation, along with risk factors including social isolation and an increasing sense of hopelessness. As indicated in Figure 12, by the final social prescribing session, Tim reported an increase in social engagement as well as an improvement to his quality of life, emotional & mental health, and confidence in making decisions.

Figure 12: *Wellbeing score: multiple increased areas, including social engagement and quality of life*



5.2 Social prescribing to boost social connectedness and coping strategies for stress

Lydia, a woman in her 50s, self-referred to MyScript and was open with her social prescriber that she had been feeling very suicidal lately. At the time of her assessment, Lydia had been signed off work following a surgical procedure and she was not coping well emotionally with her recovery. Unluckily, her problems had been compounded by the recent theft of her car, which left her feeling that her life had spun out of control. Lydia reported that she was lacking in motivation and she had been having very negative thoughts, with increasing anxiety. Her high stress levels had led her to hide herself away at home.

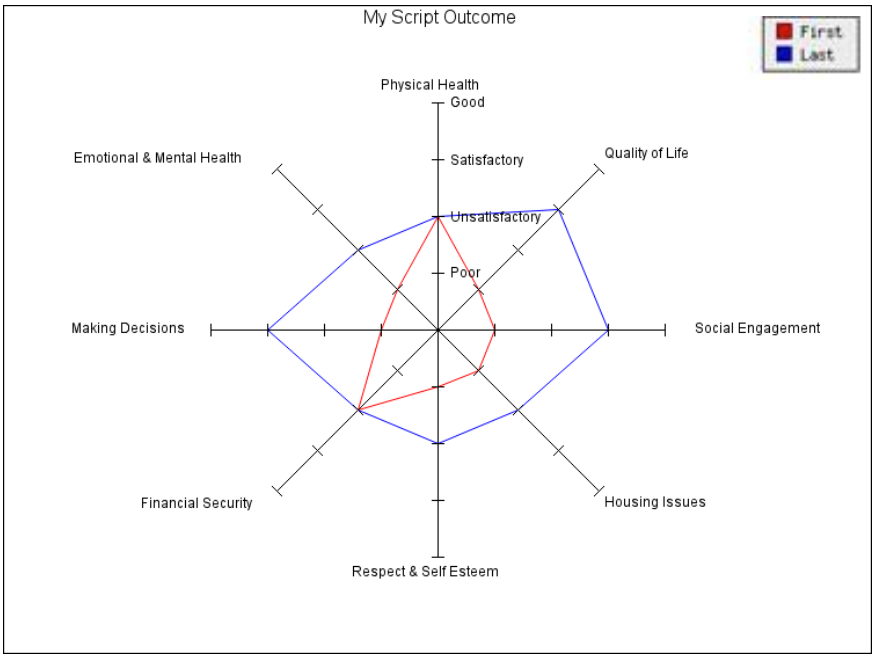
The assessment touched on Lydia's adverse childhood experiences, and her long history of depression. For her depression, Lydia was on medication which had recently been increased by her GP. Over the course

of the two months in which Lydia worked with her social prescriber, she began specialised counselling to help her cope with her adverse childhood experiences. The social prescribing sessions themselves worked on ways to help relieve her stress levels as she undertook this counselling. Starting with her initial session, Lydia and her social prescriber discussed things that make her feel better. Together, they made a plan for how she would go out daily for a short walk and how she would also take up yoga again, on a weekly basis. Lydia responded enthusiastically to this exercise as a manageable 'challenge' she could meet.

This motivational work was very effective in encouraging Lydia to go out – by the second session she was pleased to feed back to her social prescriber how she had managed to go out every day, and had also met her challenge of attending yoga classes weekly. Lydia chose to go to the yoga classes with her daughter, which boosted the positive effects of the outing, since this relationship was a protective factor for Lydia. At her second social prescribing session, Lydia learnt about a local course on mindfulness, which she decided to take part in. Its timing helped support her return to work by reducing her stress levels. By the time of her third social prescribing session, Lydia had enjoyed attending a few of the mindfulness sessions and also had her eye on additional group wellbeing courses for the future.

Lydia's experience of social prescribing boosted her confidence to re-engage with activities outside her home, and supported her with knowledge of how to access positive coping strategies to use in the future. It also motivated Lydia to engage in regular activities with her daughter, strengthening this supportive relationship. This social prescribing intervention complemented the counselling and medication Lydia was receiving. At her initial social prescribing appointment, Lydia was experiencing suicidal ideation, along with risk factors including depression and psychological stress. By her final session, her subjective wellbeing had increased in multiple areas, including social engagement, as shown in Figure 13.

Figure 13. *Wellbeing score: multiple increased areas, including social engagement and making decisions*



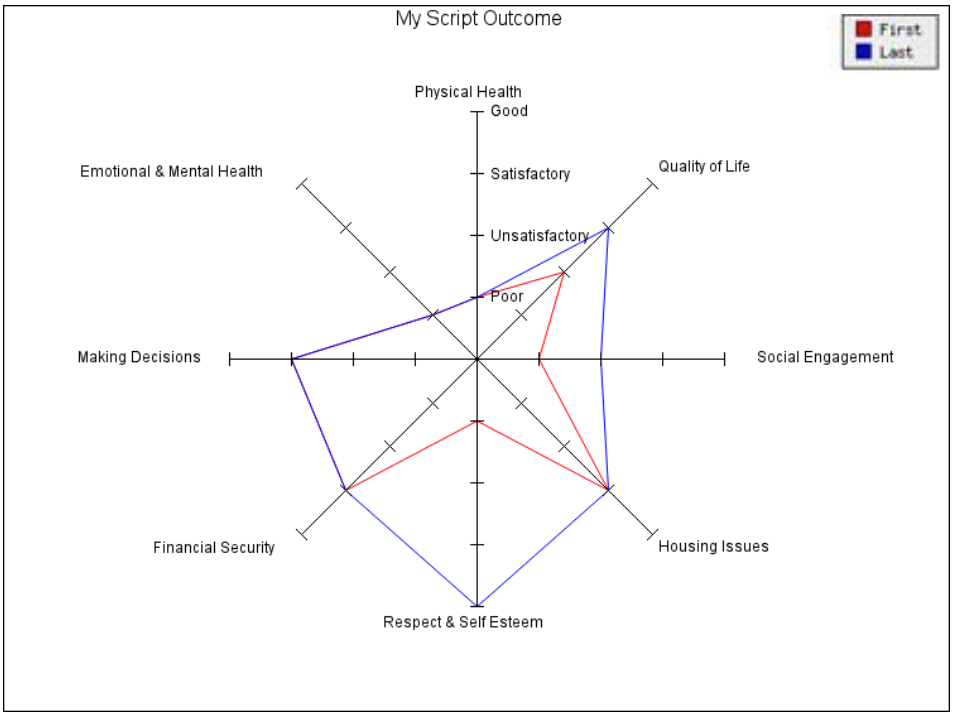
5.3 Social prescribing to boost social connectedness and engagement with personal interests

Sometimes, volunteers at MyScript can help support a service beneficiary to overcome social anxiety in order to access community resources. When Rebecca, a woman in her 70s, was referred to MyScript by

her GP she struggled to leave her house due to anxiety. At her assessment, Renata described how she had been a sociable and outgoing person for much of her life, but recent health problems and worsening depression had led to her feeling cut off from the world. She lived on her own, and reported suicidal thoughts. Her children were a strong protective factor for her, but Renata did voice a growing concern that her problems were becoming a burden on her children. In her assessment, Renata identified as her aim her wish to build up her life, and get back to being able to go out to socialise. Renata was worried about her level of anxiety in trying new things, and responded positively to the prospect of a volunteer from MyScript being able to accompany her to a community group for moral support.

The volunteer and social prescriber met up jointly with Renata for a second appointment. Renata had mentioned creative writing as a personal interest during the assessment, and so the social prescriber had brought in details of a 'writing for wellbeing' group in the area. Renata was interested to learn about the group, and made plans with the volunteer to meet up so that they could attend her first session together. Renata was confident to arrange her transport plans independently, so she and the volunteer met outside the venue, and Renata benefited from the volunteer's support in getting settled in with the new group. As someone with a love of expressing herself in writing, Renata enjoyed the session to such an extent that she took the initiative to attend similar groups in other areas, arranging her own transport to do so. Renata was pleased with having these sessions as social activities peppered throughout her monthly calendar. Separately, the social prescriber linked Renata up with an independent living service to help with practical support around the house, and give Renata some ongoing support in getting out of the house. By the third social prescribing session, Renata's well-being score (Figure 14) reflected a significant increase in her self-esteem, as she increased her socialising and engaged with her passion for writing.

Figure 14. *Wellbeing score: multiple increased areas, including self-esteem and social engagement*



5.4 Social prescribing to support job preparedness

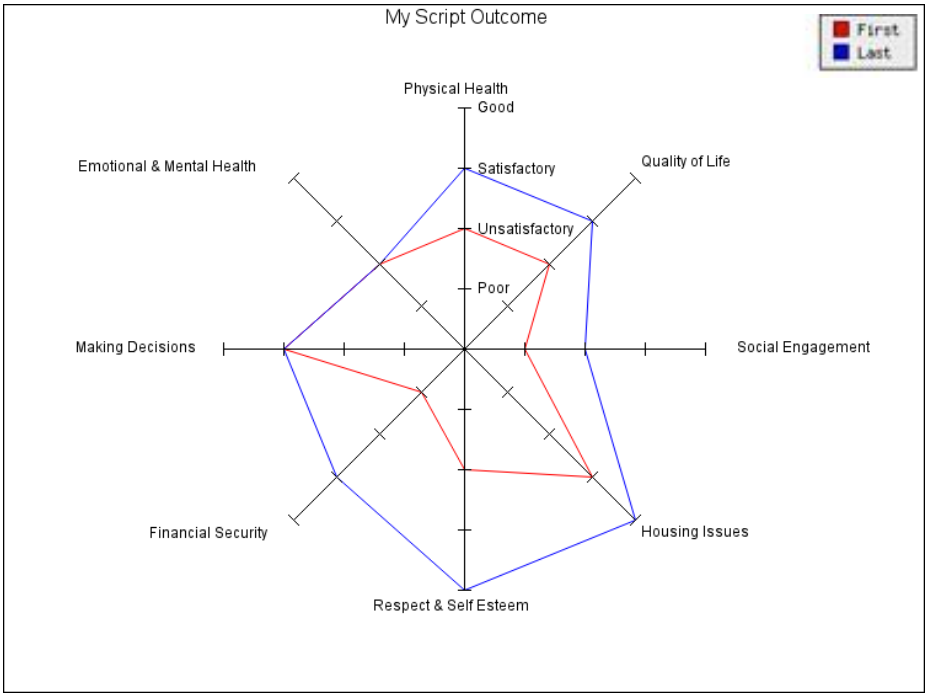
Terry, a man in his 30s, self-referred to MyScript for support in getting his life back on track. He was unemployed and was currently engaged with therapy through the mental health services. He had had two recent bereavements through suicide, and had the insight that the best way for him to cope with these losses was to do things to "sort [his] life out". At the time of his assessment, he aspired to be working but lacked the confidence to start a job search. Terry was also suffering from dental pain so severe that he was not able to eat normally.

Through social prescribing, Terry received motivational support to start his job search, tackle his debts and find a dentist. The social prescriber linked Terry up with an employment preparedness programme tailored to people with multiple barriers to work.

By his final social prescribing session, Terry was enthusiastic about two job offers he had received, and felt confident that he was able to make a positive choice for his future work path. He also felt on top of his dental work and debts. The social prescriber let Terry know about a support group for people bereaved by suicide – although he declined to take part as he felt he had adequate support in place from the mental health services, he was confident he could access such support in future if he felt the need.

At the time of Terry's initial appointment, his vulnerabilities to suicide risk included recent bereavement by suicide, unemployment and poor mental health. Over the course of his social prescribing sessions, the largest increases in subjective wellbeing (Figure 15) were in Terry's financial security and self-esteem.

Figure 15. *Wellbeing score: multiple areas of increase, including financial security and self-esteem*



5.5 Social prescribing to support housing

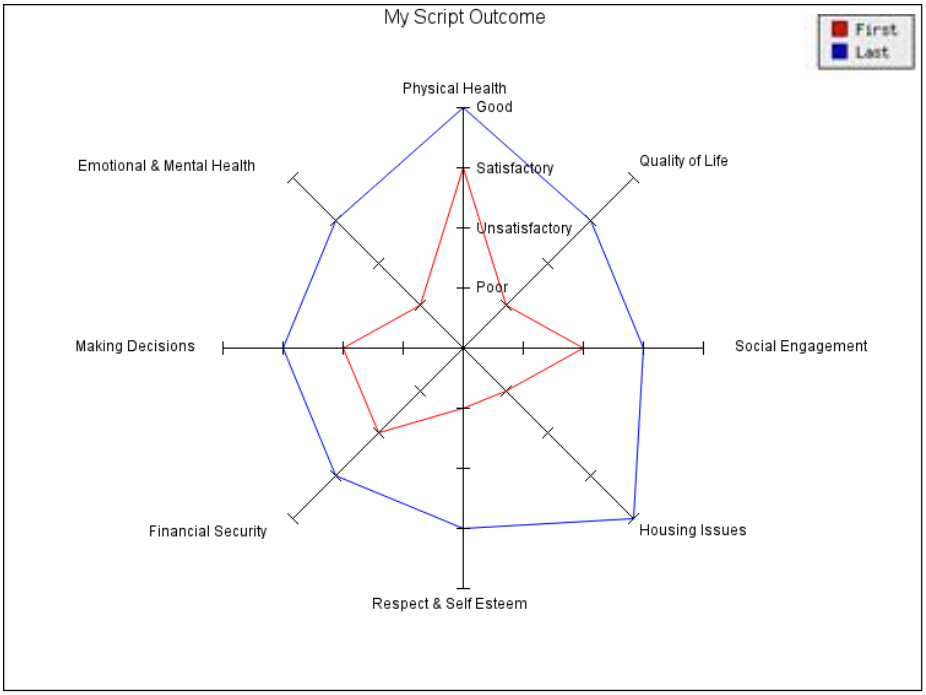
Clive, a man in his 40s, was referred to MyScript by the community mental health team for social and vocational support following a recent suicide attempt. At his assessment, Clive had ongoing heightened

risks for suicide, including suicidal ideation and low mood. He identified that his housing was his biggest source of concern: he had a room in a shared flat, but the noise, mess and conflicts with his flatmates were so stressful to him that he was thinking of leaving the flat to sleep in his car. Clive's social prescriber arranged a referral to a housing agency for support.

By the time of Clive's second appointment, Clive's teenage daughter had made the surprise decision that she wanted to live with her father, and so Clive had moved out of the shared flat and was staying with his daughter, in cramped circumstances with extended family. The housing agency was able to support Clive to make living with his daughter a long-term arrangement. By the time of his third social prescribing session, Clive had successfully moved into a 2-bedroom home with his daughter. Clive reported a positive shift in his mood and self-esteem, which he attributed to his new sense of purpose and focus on his parenting role.

Clive's social prescriber also worked with him to identify activities in his community which would improve his anxiety levels and mood. At the time of his final session, Clive was looking forward to attending a nature-based wellbeing group. As shown in Figure 16, Clive's wellbeing score improved in multiple areas.

Figure 16. *Wellbeing score: multiple areas of increase, including housing issues and self-esteem*



6. Conclusion

In summary, this paper has examined the capacity for social prescribing to support suicide prevention through brief interventions of three or four sessions. We have reviewed case studies from the MyScript social prescribing service in Bath and North East Somerset to illustrate positive outcomes in working with individuals with risk factors for suicidal behaviour, including those suffering from depression, social isolation, past suicide attempts and/or recent bereavement from suicide. At an individual level, several aspects of social prescribing have been identified which support suicide prevention, namely: gatekeeping and early intervention, compassionate engagement, a person-centred approach, and integration of clinical

and non-clinical sources of support. These influences combine to build resilience through improvements to social connectedness, hopefulness, reasons for living and problem-solving ability.

The role of social prescribers to dynamically integrate multiple forms of support is highly compatible with the "whole system approach" advocated by the national suicide prevention strategy (Public Health England 2016). Social prescribers are central to maximizing access to resources at a local level and are thus linchpins to integrated working – satisfying in a novel way the central tenet of the national suicide prevention framework which emphasizes the importance of 'joining up' local services and support (Department of Health 2012). The highly person-centred approach of social prescribing complements the multi-agency suicide prevention partnerships which coordinate actions at a strategic level (see Public Health England 2016, NICE 2018).

The role of social prescribing in suicide prevention raises the following practical implications for service delivery:

- the need for training in suicide awareness and prevention (e.g. Applied Suicide Intervention Skills Training) for all social prescribers.
- the requirement for supportive clinical supervision to help social prescribers manage the additional demands inherent to working with individuals who may be contemplating suicide, both for social prescribers' own wellbeing as well as for safeguarding (see Polley *et al* 2017: 36). For example, peer supervision is one option for supporting reflective practice (Care Quality Commission 2013).
- the consideration of additional time demands to address the needs of elevated-risk beneficiaries, such as delivery of the intervention over four sessions rather than three to accommodate discussion of a safety plan.
- the advantage of participation of social prescribing services in strategic, locally-coordinated multi-agency suicide prevention planning.
- the need for a robust referral pathway to crisis services and/or GPs in case of escalation of needs of the service beneficiary.

Future work is required to explore how increased integration of social prescribing with primary care, coupled with strategic planning to raise awareness of this service, can increase access to this potentially life-saving intervention. It is clear that integration of social prescribing with primary care depends not only on a referral system from GPs, but also necessitates a two-way information exchange to allow social prescribers to feed back to GPs about patients considered to be at risk of suicide.

In conclusion, suicide prevention can be considered a core aspect of a holistic social prescribing service. Social prescribing has a strong role to play in integrating suicide prevention work within a broader framework for promoting mental health and wellbeing, and also supports tailored approaches to improving mental health and reducing risk in high risk groups, in line with key areas for action in the national suicide prevention strategy (Department of Health 2012). As an important component of the local system, social prescribing offers contributions which – combined with other local influences – may reduce the risk at a population level, particularly for higher risk groups. Increased participation in social prescribing programmes will allow future research to measure the impact of this intervention at a population level.

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