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Interacting with patients at risk of self-harm or suicide - A qualitative study of community pharmacists and pharmacy staff

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ABSTRACT

Background: Suicide and self-harm are significant public health concerns. Community pharmacies are accessible and frequented regularly by the public, making them well positioned to identify and intervene with those at risk. The aims of this research project are to evaluate pharmacy staff experiences of dealing with people at risk of suicide/self-harm, and explore how best to support staff during these interactions.

Methods: Semi-structured online and telephone interviews were conducted with a sample of community pharmacists and community pharmacy staff (CPS) in the south west of Ireland. Interviews were audio recorded and transcribed verbatim. The Braun and Clarke approach to inductive thematic analysis was used to analyse the data.

Results: Thirteen semi-structured qualitative interviews were conducted in November–December 2021. Most participants had encountered a person at risk of suicide/self-harm in their practice, however participants described a lack of training and guidelines around how to navigate these scenarios. Three major themes emerged: *(i) Interacting with patients at risk of suicide/self-harm- facilitators and barriers; (ii) Referrals and signposting; (iii) Addressing uncertainty*. Positive relationships between the person and pharmacy staff facilitated interactions, while privacy, time constraints and uncertainty among staff were seen as barriers. Participants felt it was necessary to refer at-risk people to other supports, and made suggestions for increasing staff confidence through the implementation of support tools within the pharmacy setting.

Conclusions: This study highlights that at present, community pharmacy staff feel uncertain regarding how to handle interactions with people at risk of suicide/self-harm, due to lack of training and supports. Future research should focus on building upon existing resources and obtaining specialist and stakeholder input to produce the most effective support tool(s), tailored to the pharmacy setting.

1. Introduction

Suicide is one of the leading causes of death worldwide; according to the World Health Organisation approximately 700,000 people die by suicide every year, the equivalent of one in one hundred deaths in 2019.[1] Previous self-harm is a significant risk factor for subsequent suicide; 1 in 25 people who present to hospital following an act of deliberate self-harm will die by suicide within five years.[2] In 2018, there were 12,465 presentations to hospital for self-harm in Ireland alone.[3] Due to the prevalence of suicide/self-harm in the population, it is critical that healthcare professionals (HCP) are educated on how to identify and engage with these suicidal/self-harm patients.

Community pharmacy is one of the most accessible of all healthcare settings, with 73% of the Irish population living <2 km from a pharmacy, and the average adult frequenting a pharmacy 41 times per annum.[4] The community pharmacist is trusted and held in high regard, with 94% of individuals reporting that they trust the advice of their pharmacist, and 70% reporting that they are more likely to visit their pharmacy than attend the General Practitioner (GP) in the case of minor ailments,[4] health conditions that can be managed with minimal or readily accessible treatment, or self-care advice. This puts community pharmacy staff in a unique position to identify those at risk of suicide/self-harm, and initiate early intervention.

Despite their accessibility and trusted position in society, pharmacists and pharmacy staff lack knowledge and confidence in relation to dealing with people at risk of suicide or self-harm, with staff feeling ill-prepared and ill-equipped to fully engage in this role.[5,6] In an Irish context, a national survey of pharmacists and Community Pharmacy Staff (CPS) demonstrated the high frequency with which people at risk of suicide presented, the lack of knowledge and training in this area, and the desire for further education and support. A total of 88.5% (n = 194) of survey respondents reported no previous suicide prevention training[7] despite the Health Service Executive (HSE) in Ireland including in its suicide prevention strategy, *Connecting*

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for Life the goal of "Supporting communities to prevent and respond to suicidal behaviour," and offering a suite of relevant training resources. Furthermore, the data collected from this national survey were mainly quantitative in nature, with one free-text response option provided. A more in-depth qualitative exploration of pharmacist and CPS experiences, perspectives and opinions would provide greater insights.

In addition to formal education, Standard Operating Procedures (SOPs) and guidance documents are regularly implemented to support pharmacy staff through common clinical scenarios which they may encounter at work.[8] Such documents are designed to clarify care pathways, address uncertainty, and increase confidence among staff. A support tool specific to suicide prevention in a community pharmacy setting may be a resource of value in this instance also.

2. Aim

The aim of this study was two-fold: (i) to qualitatively evaluate pharmacy staff's past experiences of interacting with people at risk of suicide/self-harm during their time working in community pharmacy, and (ii) to explore how best to future support suicide prevention efforts in the community pharmacy setting with regard to education and other tangible support tools.

3. Methods

3.1. Ethical considerations

Ethical approval was granted for this study from the Social Research Ethics Committee (SREC) at University College Cork, reference number 2021–011. Participant identifiers were protected via anonymization of transcripts and demographics forms. Should any participants become triggered by the interview process due to the sensitive nature of the research topic, additional professional support was available.

3.2. Participants

Community pharmacists and staff currently working in the community pharmacy setting were invited to participate in semi-structured interviews. All demographic locations within Ireland, participants over 18 years of age, all roles within the community pharmacy setting, and all duration of community pharmacy experience were eligible to take part. Those not currently employed in the community pharmacy setting, and those under the age of 18 were excluded, while only those who volunteered to take part were invited to complete the interview process. To ensure adequate representation from all subgroups, a sampling matrix was devised, to include role, age, gender, location, and experience (Table 1).

3.3. Study recruitment

Purposive and snowball sampling methods were used to recruit participants. Community pharmacy staff known to the study authors were invited to take part in the study. Interviewees then informed their own networks, to extend the scope of recruitment. The final sample size was determined using the Francis et al. method.[9] Ten interviews were initially conducted, followed by a subsequent three interviews to confirm that no new themes had emerged.

Table 1
Participant sampling matrix.

Pharmacist	Pharmacy technician/OTC* staff
Male	Female
<40 yrs	>40 yrs
Independently owned pharmacy	Chain pharmacy
Rurally based	Urban based
<10 years' experience	>10 years' experience

Key: OTC: Over The Counter.

3.4. Interview procedure

Those approached who were interested in the study were sent a Participant Information Leaflet (Appendix A) and Consent Form (Appendix B) to be completed prior to commencement of the interview. Participants were told about the purpose of the study, and reminded that they could withdraw their consent at any time during the interview, or in the two weeks that followed.

Interviews were conducted either online or via telephone, at a time that was convenient to the participant by NO'R and EK, under the supervision of CO'M, a pharmacist and pharmacy lecturer with a PhD in clinical qualitative research. A series of demographic questions (Appendix C) were followed by a conversation which was informed by an interview topic guide (Appendix D). This was developed based upon a review of previously published literature, findings from a national survey of this cohort,[7] and discussion among the authors. The topic guide was assessed for face and content validity and reliability by conducting a pilot interview between the PhD expert and the primary researchers. Any additional areas of interest which arose during subsequent interviews were included by iterative adjustment of the topic guide informed by field notes. As these adjustments were minor, no interviews were excluded as a result. Participants were informed that they could request copies of their transcripts to check for accuracy if desired, but no participants availed of this.

3.5. Data analysis

Interviews were audio recorded, transcribed, and redacted by the authors to allow for immersion in the data and familiarization with the transcripts. Analysis was guided by Braun and Clarke's Thematic Analysis.[10] Whilst the use of a coding framework was considered, an inductive approach to analysis was deemed most appropriate, to allow the data to drive the results. It was decided to allow the findings to emerge without restriction, rather than pre-empting them, or attempting to fit them into predetermined categories. This ensured that no unexpected findings were missed.

Analysis involved several initial readings of the transcripts, which were then coded independently by two researchers using NVivo Version 12® (QSR International Corp.).[11] Codes were grouped into initial themes, which were verified by reading the corresponding excerpts and the entire data set again, before naming and defining them. Agreement was reached at each stage via group discussion.

3.6. Guidelines

The study is reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (Appendix E).

4. Results

A total of thirteen interviews (pharmacists n-10; pharmacy technicians $n = 3$) were conducted between November 8th 2021 and December 8th 2021. Full socio-demographic information is presented in Table 2. Nobody withdrew their contributions to the study.

Mean interview length was 20 min and ranged from 11 to 30 min. The key themes and subthemes that emerged are summarized in Fig. 1 and described in more detail below.

4.1. Theme 1: Facilitators and Barriers

Eleven of the thirteen study participants reported having engaged with a person at risk of suicide/self-harm in the community pharmacy. A positive interpersonal relationship was seen as a facilitator to these interactions. Time constraints, lack of privacy, and feelings of unpreparedness among staff were identified as key barriers.

Table 2
Participant socio-demographics.

Demographic	N (%)
Gender	
Female	9 (69)
Male	4 (31)
Age (years)	
18–24	1 (8)
25–30	3 (23)
31–40	4 (31)
41–50	2 (15)
>50	3 (23)
Education	
Masters	7 (54)
Bachelors	2 (15)
PhD	2 (15)
Diploma	1 (8)
Certificate	1 (8)
Role in pharmacy	
Pharmacist	10 (77)
Pharmacy Technician	3 (23)
Years of experience	
0–3	1 (8)
4–10	6 (47)
11–20	2 (15)
21–30	2 (15)
>30	2 (15)
Geographical location	
Urban	10 (77)
Rural	3 (23)
Pharmacy type	
Chain	7 (54)
Independent	6 (46)

4.1.1. Interpersonal relationship

Participants agreed that a positive relationship between the person and staff was a major facilitator to interactions with those at risk of suicide/self-harm in the community pharmacy setting. To establish and nurture this relationship, participants felt that familiarity and trust between staff and customers were essential.

> *"I suppose one thing that might encourage someone is, if they have a good relationship with the staff, or the pharmacists in there. That they knew, they were someone they could trust and speak to." Technician 1 (T1)*

> *"I suppose this patient was collecting items regularly in the pharmacy, so she was in maybe five out of the seven days of the week…You would have a different relationship with patients who are going to be in so often" Pharmacist 6 (P6)*

One pharmacist spoke about the importance of communication, listening, and empathy in eliciting the best outcome from such interactions.

> *'We didn't know what maybe other implements she might have had with her. So, we needed to keep a close eye on her, to talk to her, to calm her down. Just to be supportive, to be a listener, to be empathetic.'* P8

This sentiment was echoed by Pharmacist 9, who spoke about being "friendly and open… respecting [patients'] boundaries then as well." P9

However, participants emphasised the importance of keeping patient-staff relationships professional, and not getting too personally involved in the patient's situation. In some cases, staff found it hard to define boundaries, and recognize the extent to which they should be involved in the scenario.

> "And if they did want to speak to you, then again well and good. But I suppose you'd have to keep your distance to a certain extent; you know not to get too personally involved." T3

> "I found [the encounter with a person at risk of suicide] hard that night, [knowing] where you draw the line. So, you can safely say I've done as much as I can. I can't go any further than this because it would be inappropriate" P4

4.1.2. Privacy and time constraints

Participants agreed that a positive and long-standing relationship with staff would encourage those at risk of suicide/self-harm to seek help in the community pharmacy. However, they felt that people may be discouraged from seeking support due to a perceived lack of privacy in the pharmacy. Pharmacy staff felt that a fear of being overheard would be a major deterrent for people.

> *"If they knew a lot of the front of shop staff, they might feel uncomfortable, that maybe they might feel like things won't be confidential or that someone might overhear them." P10*

Yet, many participants believed this privacy issue may be overcome by promotion and utilisation of the consultation room.

> *"From the community pharmacy point of view, I think one of the biggest obstacles would be the openness… which can be overcome with the use of the consultation room or, you know, having conversations in a little bit more private, quieter space" P6*

Participants were also aware of time constraints in the pharmacy and noted that lengthy interactions with patients may not always be feasible. This was seen as a further barrier to engagement with those at risk of suicide/self-harm in the community pharmacy. Staff acknowledged the busy nature of the pharmacy and noted how interactions with at-risk patients would be more difficult if there was only a single pharmacist on duty.

> *"The pharmacy is so busy, you're trying to get all the prescriptions out, you don't have an hour to spend with a patient." P1*

> *"In some pharmacy situations you might be kind of on your own. If you start having a big discussion with someone for half an hour, well there'd be a build-up of tasks and things to be done." P5*

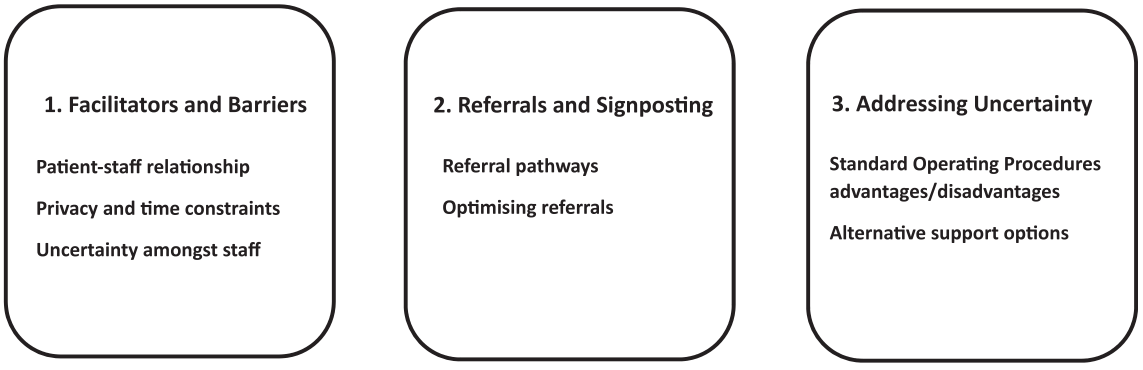

Fig. 1. Major themes/subthemes.

Another pharmacy technician emphasised the importance of time when encouraging patients to speak up without rushing or pressurising them.

"Just let them take their own time, not to put any pressure. And definitely not to look at your watch. That is the one thing that people are inclined to do I suppose, because today is a rushed world." T2

4.1.3. Uncertainty among staff

One of the most frequently reported barriers to effective interactions with at-risk patients was uncertainty among staff regarding how to deal with this cohort. This uncertainty was attributed to a lack of training and an absence of clear guidelines on how to handle such scenarios. Uncertainty ultimately led to a lack of confidence. None of the participants reported having undergone training in suicide prevention. Thus, many staff learned through experience, and relied upon previous encounters during interactions with at-risk patients. Some participants believed that newly qualified pharmacists who lack this experience may struggle during these interactions.

"I haven't done any specific courses [on suicide prevention]. So, I suppose from kind of, I suppose, the experience I've had over the years. I felt quite comfortable talking to her [the patient] from talking to people, you know who might suffer from chronic depression." P6

"I don't know if I would have been able to deal with that [interacting with an at-risk patient] as a newly graduated pharmacist." P1

None of the participants reported having clear guidelines in their pharmacy regarding how to deal with people at risk of suicide/self-harm.

Q: Can I ask do you have anything in your pharmacy at the minute, to do with self-harm or suicide? Do you have any sort of guidance tool or an SOP or anything like that at the minute?

P: No, no. P10

This lack of training/guidelines created an atmosphere of uncertainty and unpreparedness among staff. Participants reported a subsequent lack of confidence during interactions with those at risk. In some cases, staff lacked the confidence to directly ask the person if they were considering suicide.

"I guess I didn't feel particularly prepared, I didn't really know what to do" P1.

"Q: Did you ever you know, address [whether they were considering suicide] with them?

A: No" P5

In the absence of training/guidelines, many participants reported feelings of fear, worry and anxiety following interactions with people at risk of suicide/self-harm. Staff were often left feeling unsure as to whether they had handled the scenario correctly. In some instances, staff worried it would be their fault if harm was to come to the person.

"When that girl left the shop that time I was like, oh my God. Is she going to say [that she had self-harmed] to her mother? What am I going to do? There was that sense of fear the whole next day" P2

"And then you're thinking, oh, like there's someone's life that's in your hands or whatever, in a way. But at the end of the day, how are you supposed to know what to do with this kind of thing with no training?" T1

4.2. Theme 2: Referrals and Signposting

4.2.1. Referral pathways

In the absence of clear guidelines/training, many participants felt that the main role of the pharmacist was to refer the at-risk person to another individual or organisation.

"I think the pharmacist's role really is directions, trying to direct them to get help. As opposed to solving the problem. We might be influential in maybe someone deciding to go seek help and maybe see the right kind of people" P5

Referral of the patient to their GP was frequently reported by participants. In some cases, participants phoned the patient's GP on their behalf.

"*He [the pharmacist] was saying to her [the patient] you know it would be a good idea to go and speak with your doctor. I think the phone call kind of came to an end, and I think when he [the pharmacist] got off the phone straight away he rang her GP and kind of told him like what the situation was and what the conversation had been."* P10

However, a disconnect between the community pharmacy and the GP following referral was highlighted, and participants described a lack of follow-up from the GP.

"I think they just went to their GP then. But I suppose…you could have a bit of a gap in communication there. Like you wouldn't even know that they actually did go." T1

The Gardaí (Irish Police Service) and mental health services also formed part of the referral pathways as outlined by participants.

"I suppose in a situation where someone, like the situation I was saying where someone rings you from home and you think they're going to do harm. I suppose you'd nearly be ringing the guards (sic) or something in that situation." P10

"There were HSE [Health Service Executive] clinics nearby. And she [the patient] attended counselling from that, in the HSE clinics. So, I encouraged her to go, to go and try get an appointment straightaway" P6

4.2.2. Optimising referrals

However, some pharmacy staff members felt uncertain to whom patients should be referred, and when they should be referred. One pharmacist said they would fear sending the patient to the wrong service.

'I'd be kind of nervous enough about where to like, what kind of services you're supposed to signpost' P7

Many felt it would be beneficial to have a list of local services or a referral contact aid to help them direct the patient to the most appropriate supports.

"I suppose you'd have lists of places to contact. As in pharmacy specific. That evening, I did panic because I was like, I didn't know who to contact. At this hour you don't have a GP." P4

4.3. Theme 3: Addressing uncertainty

In addition to the design of a referral contact aid, participants felt that training or the implementation of a support tool would help to address uncertainty among staff when dealing with people at risk of suicide/self-harm. The desired format of this support tool varied between participants. Some participants favoured hands-on training over a guidance document, while others outlined multiple benefits of the latter.

4.3.1. Checklist/SOP- Advantages and disadvantages

Participants felt that a Standard Operating Procedure (SOP)/checklist would help give them more confidence that they had handled a scenario with a person at risk of suicide/self-harm appropriately. Staff reported frequently utilizing guidance documents currently in place in community pharmacies, such as the emergency hormonal contraception checklist. Staff felt assured they had carried out an effective consultation when checklists such as these were utilized.

"The one for emergency contraception. I literally use that checklist every single time I do it, because at least when you use the checklist, you know, you haven't missed anything really important." P10

Pharmacy staff also felt that having an SOP/checklist in place would help to standardise the care of patients at risk of suicide/self-harm.

"I feel like if there was that SOP in place and it was pharmacy policy…. all patients that might enter being at risk of suicide or self-harm, they're going to get the same care and treatment regardless of what pharmacist is on [duty]" P1

Despite these advantages, some participants felt that a SOP or checklist would be too rigid a format for dealing with people at risk of suicide/self-harm. Some staff felt a SOP/checklist approach would not be applicable to this diverse patient group. Other participants felt that the use of a checklist or SOP in these scenarios would lack authenticity or may seem scripted.

"I don't think an SOP can deal with these types of situations because you really cannot predict what way they are going to creep out. It could be the methadone guy, it could be some person coming into the pharmacy with cuts, presenting them at the counter….. So, I don't know if that [an SOP] would be the way to go" P2

"I think unless you've had a bit of experience of using those checklist-type forms, they can be very formulaic and unnatural. And it takes a little bit of time to get used to how you're going to adapt it to a more natural style of questioning." P3

4.3.2. Alternative formats

Some participants expressed a desire for hands-on training as a means of addressing uncertainty when dealing with people at risk of suicide/self-harm.

"I don't know would a much better idea be for pharmacists to kind of attend a compulsory seminar or if there was a direct thing as part of your CPD [Continuing Professional Development] that each year a pharmacist would have to engage, like attend a course" P2

Others believed that a combination of guidance documents and training would be the best way to educate pharmacy staff on how to manage these scenarios appropriately.

"*So I think, maybe training people will, you know, help the pharmacist who.. some are a bit rigid and they kind of follow the checklist too much… But, any further training will help the pharmacist go, okay, this point really doesn't, you know.. it doesn't suit this scenario. And actually, the two of them [checklist and training] together would probably work well." P4*

5. Discussion

Most participants interviewed in this study reported having engaged with a person at risk of suicide/self-harm in the workplace. Facilitation of these interactions occurred through strong patient-staff relationships, and barriers included time and privacy constraints, as well as lack of certainty regarding the best course of action in such situations. Participants called for specific, pharmacy targeted education in suicide prevention, and presented the potential for structured guidance in the form of checklists or SOPs to inform interactions.

It is clear from the findings of this study that interactions between pharmacists and CPS and those at risk of suicide or self-harm are common, which correlates with the existing literature on the subject. Murphy et al.[12] reported that 85% of pharmacists surveyed had interacted with a patient at risk of suicide at least once. Cates et al. similarly reported frequent interactions, with one-third of study participants having known a patient who had attempted suicide or had suffered from suicidal thoughts.[13] Due to this frequency of interaction, pharmacy staff have ample opportunity to identify and intervene with those at risk of suicide/self-harm.

Participants in this study noted that a positive therapeutic relationship between community pharmacy staff and the patient facilitated such interventions. Staff felt that solid, long-standing relationships encouraged those at risk of suicide/self-harm to seek support in the community pharmacy, thus improving outcomes. Positive clinician-patient relationships and familiarity with the patient have proven beneficial in improving patient outcomes in other settings.[14–16] However, pharmacy staff stressed the importance of keeping these relationships professional. In some cases, participants felt it was difficult to find the balance between emotional involvement and professionalism. This is a common struggle reported by healthcare professionals when dealing with patients at risk of suicide/self-harm.

Many study participants have encountered a suicidal patient in practice, yet none had received training or education on suicide prevention. Existing studies examining interactions between community pharmacy staff and suicidal patients also reported low levels of suicide prevention training among staff. For example, Gorton et al. reported that none of their study participants had received suicide prevention education or training.[17] However, this trend is not exclusive to pharmacists, as in a recent survey of Irish GPs, 81% had not completed previous suicide prevention training either.[18]

In addition to a lack of training, participants in this study reported an absence of support documents and guidelines for handling interactions with patients at risk of suicide/self-harm. None of the staff interviewed reported having an SOP available on how to handle these scenarios, and without official guidelines, participants reported relying on past experiences to guide their interactions with at-risk patients. Similarly, pharmacists working in the United Kingdom also reported depending on prior life experience during interactions with patients at risk of suicide/self-harm.[17] Depending solely on personal experience in the absence of formal education meant that participants in this study were often unaware of how to communicate effectively with a patient at risk of suicide. When dealing with those at risk, experts have highlighted the importance of directly asking if the patient is considering suicide.[19] However, some participants were not aware of this, and believed it was better not to broach the subject with their patients fearing this may exacerbate the situation.

Some participants cited the implementation of an SOP or checklist as a possible means of addressing uncertainty and increasing confidence among staff. The design and utilisation of SOPs have been shown to increase confidence levels among other healthcare professionals. In a study by Lucas et al., emergency department staff working in hospitals lacking specific SOPs expressed lower levels of confidence regarding patient treatment, and a lack of SOPs was also linked to a delay in the treatment of patients.[20] Conversely, the documentation of treatment was improved with the use of SOPs in preclinical emergency medicine.[21] Checklists are already used to support pharmacists during other consultations, such as Guidance for Pharmacists on the Safe Supply of Non-Prescription Ulipristal Acetate 30 mg (ellaOne) for Emergency Hormonal Contraception.[22] Checklists are also employed in other areas of healthcare[23] leading to decreases in death rates and improved patient outcomes.[24] The SAVES acronym may be a useful approach to guide these sensitive conversations: Signs (of suicide risk); Ask (about suicide); Validate (feelings); Expedite (referral); Set (a reminder to follow-up). Designed by Carpenter et al., this guide for gatekeeper behaviours could be used on its own or incorporated into a more structured guidance document, to provide reassurance post-conversation that the appropriate actions had indeed been taken.[25]

In contrast, some staff interviewed in this study felt that a checklist or SOP format would not be suitable for guiding interactions with patients at risk of suicide/self-harm. These participants felt that hands-on training courses would be more beneficial in practice. Indeed, suicide prevention training courses have been shown to increase healthcare professionals' confidence and knowledge in this area.[26] The HSE have developed a number of online and face-to-face suicide prevention training programmes such as SafeTalk and ASIST (Applied Suicide Intervention Skills Training),[27] however none of these specifically target the community pharmacy setting. The need for direct training in suicide prevention is beginning to be addressed at an undergraduate level. Connecting for Life, Ireland's National

Strategy to Reduce Suicide,[28] intends to roll out standardised training in suicide prevention for all third level healthcare courses. However, qualified pharmacists currently working in the community, pharmacy technicians and other pharmacy staff must also be educated. It is therefore imperative that standardised training courses and guidance be provided to these staff to address uncertainty and increase confidence. It may be that a combination of training and guidance documents are the answer. Further research is required to pilot such interventions.

This study is not without its limitations. All participants volunteered to complete an interview on their experiences with patients at risk of suicide/self-harm, leading to possible selection bias. It is possible that pharmacy staff who had never encountered an at-risk patient in practice were deterred from partaking in the study, which may have skewed the results. Conversely, those with a special interest in suicide prevention may have been more eager to participate, and their views may not be representative of the population. There also exists the risk of interviewer and response biases. Reflexivity of the researchers may have influenced their contributions. In addition, most of the participants interviewed were pharmacists, thus limited insight was gained into the opinions of other CPs.

Impact and translation of findings for practice.

This study has supported what is already known about the accessibility of community pharmacy to those most mentally vulnerable, and provides first-hand accounts of pharmacy staff being the initial point of contact for patients. Future initiatives need to utilize the frequency and quality of patient interactions in a community pharmacy setting to both identify and intervene with those at risk of suicide/self-harm.

The findings presented highlight the lack of knowledge and confidence that pharmacists and pharmacy technicians currently experience in relation to interactions with patients who may be at risk of suicide or self-harm. This supports the need for education tailored to the pharmacy setting, which is both relevant and accessible, integrated into the undergraduate programme, but also available and promoted at a community level to all pharmacy staff.

Participants in this study voiced contrasting views in relation to the use of SOPs alone. Future initiatives would be best focused on compiling a comprehensive toolkit of resources to include SOPs, education and resource lists, with evaluation of such interventions at a national level.

6. Conclusions

Suicide and self-harm are pressing public health issues. Interactions between pharmacy staff and those at risk of suicide/self-harm are common, likely due to the accessibility of community pharmacy, and the strength of the therapeutic relationship. However, this study highlights that at present, pharmacists and CPS feel under prepared to handle such interactions appropriately. This may be overcome through a multi-faceted approach, to include the development of a checklist/SOP style guidance document, a referral contact aid and/or tailored training. Future research should focus on obtaining specialist and stakeholder input to produce and pilot the most effective support tool(s), which will serve to increase staff confidence during interactions with people at risk of suicide/self-harm, and ultimately improve outcomes.

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Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary data

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