Letters

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Child neglect

The editorial '*Child neglect: what does it have to do with general practice?*'[1] refers to the RCGP's '*Grasping the nettle*' report 2004[2] that has been formative in developing RCGP guidance. This report mentions the still thorny issue of compulsion in the context of sharing information on a child or family about whom we have concerns, and the unresolved issue of whether we should require all children to have a 'new patient medical'.

It was followed by the '*Keep me safe strategy for child protection*'[3] in 2005 that set out to examine child protection as it relates to general practice, and proposed a unified and consistent approach to safeguarding issues, where neglect often goes with other forms of abuse, and can be recognised by GPs who have known the community and families for years. Neglect goes from generation to generation.

The RCGP was proactive in seeking partnership with the National Society for Prevention of Cruelty to Children (NSPCC) in writing a collection of comprehensive and coherent educational tools that could be disseminated to all GPs for use in practice training and development to help resolve these issues. The Safeguarding Children and Young People Toolkit (2007, updated 2009[4]) was born out of this vision.

The RCGP responded in writing[5] to Lord Laming's report after Baby Peter's death, and has gone on to appoint a Child Health Clinical Champion 2010–2012. Far from neglecting the neglected, the champion has a mandate to form a strategy to prioritise those children most in need and enable GPs to give appropriate support.

Within the RCGP, the Primary Care Child Safeguarding Forum (PCCSF) works to encourage and resource GPs in all aspects of child safeguarding including neglect. We stand with the College's vision.

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DOI: 10.3399/bjgp10X483184

Suicide in later life

The interesting and timely analysis from Pearson and colleagues in the November 2009 issue[1] confirms the richness of the data in the National Confidential Inquiry into homicide and suicide by people with mental illness. The troubling suggestion that people considering suicide may attend their GP for a consultation but still continue to take their own life is not new. This teams' finding that many GPs (following the suicide of a patient) thought that the death had probably been unavoidable is new, and challenges those who think that the recent decline in suicide rates is attributable to greater primary care skills and confidence. It was not surprising to read that risk assessment needs to be refined and that communication between primary and secondary mental health services could be improved.

We suggest that these are not the only tasks. Pearson *et al*'s findings are that 65 of the 247 patients whose cases they reviewed in the northwest of England were aged 57 years and over, that confirms the importance of investigating suicide in later life (60 were aged under 30 years). There remain few studies of suicide prevention for older people, yet they attend primary care more often than other age groups and so offer more opportunities to identify concerns. Most studies of communication between primary care and mental health services relate to services for adults of working age. Current targets in dementia services may further reduce interest in services for older people with depression, a higher risk group for suicide than the general population of older adults.

This is an age group where communication with social care services is important because they are more likely than specialist mental health teams to know the older person well, through their provision of services related to disability or long-term conditions. GPs have much to contribute to social care assessments, support plans, and risk assessments because of their knowledge of individual patients and their risk factors. Care management by social workers or nurse-led case management can benefit from clinical input to interpret any deterioration in mental health and decide on thresholds for action.