

Suicide Prevention: Beyond Mental Disorder

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ABSTRACT

Suicide is a conscious act of the will with personal and societal ramifications. Its conscious and volitional nature deepens its tragic impact. India has high suicide rates compared to the other countries and also has intriguing distinctiveness due to the reports of higher rates from areas with better health indices and gender opportunities. In this article, I present a broader paradigm, in contrast to the usual 'mental disorder paradigm', which puts forward practical points for a multi-level engagement of healthcare service, community and policy makers.

Key words: *Deliberate self-harm, India, prevention, suicide*

Suicide is the tragic and untimely loss of human life all the more devastating and perplexing because it is a conscious volitional act. Suicides have occurred since the beginning of recorded history. Legal and religious prescriptions against suicide began to decline in the late 17th century. In place of "possession by spirit," "Unreasoning Passion" began to be associated with suicide. Bertolote *et al.*^[1] have quoted Bourdin as stating that "Suicide is always a disease and always an act of insanity" and gradually suicide came to be considered as a mental health issue.

India has the dubious distinction of accounting for the highest number of suicides (245,075) in the world in 2012 (WHO 2014). Why has the suicide rate of India increased from 6.8 in 1984 to 10.5 in 2014 in spite of becoming an economic power? Why are suicides in Southern states higher than the Northern states in spite of having better health indices?^[2] Why are the suicide rates highest in young women between

15 and 24 years in spite of increasing education of women?^[3,4] The answers to these questions are probably beyond the mental disorder paradigm of suicide.

However, the most important question is that in spite of the magnitude of the problem, why there so little effort to prevent suicide?

A study based on the Global Burden of Diseases 2010 stated that the relative risk of suicide in an individual with major depressive disorder was 19.9 (odds ratio [OR] = 9.5–41.7), with schizophrenia was 12.6 (OR = 11.0–14.5), and with alcohol dependence was 9.8 (OR = 9.0–10.7).^[5] However, in low- and middle-income countries, the role of mental disorders is accorded less importance. Equal importance is given to sociocultural and environmental factors. Life

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events, stressors, and depression are not necessarily mutually exclusive although they may be located at different points along suicidal pathway.

How can psychiatrists and other mental health professionals help prevent and reduce suicides?

POLICY

- a. Attempted suicide continues to be a criminal offense according to IPC 309 of India. Although the government has stated that it will repeal the archaic law, it has not become a reality. Renewed commitment by the mental health professionals is needed to repeal this law which is an impediment to suicide prevention efforts
- b. Alcohol has been involved in at least one-third of all suicides in India (Gururaj *et al.* 2004).^[6,7] Reducing alcohol availability and consumption has been recommended by the WHO as an important strategy in reducing suicide. Prohibition was a significant issue in the recent elections. Hence, the time is ripe for psychiatrists to become involved in framing and implementing alcohol policies
- c. The influence of media is ever expanding. Suicide is often portrayed sensationally, and guidelines on the reporting of suicide formed by the WHO and CDC are often flouted. The mental health professionals are often approached by the media for their views, and they should be trained to use this opportunity to inform the media about appropriate reporting of suicidal behavior.

HEALTH SECTOR

- a. Psychiatrists should be actively involved in training the general practitioners (GPs) in diagnosing and treating depression. Research has shown that majority of suicidal persons had visited their physician in the previous 3 months and also that educating the GPs reduces suicide.^[8]
- b. They should train the emergency room doctors on sensitive handling of persons who have attempted suicide and provide a clear referral pathway to mental health services
- c. They should also train nurses, community health workers, ASHA's, and other health workers on identifying suicidal behavior and in provision of immediate support to the suicidal person
- d. Following a suicide attempt, 18 months is the high-risk period for a repeat attempt and suicide. Hence, those who have attempted suicide should be followed up on a regular basis and continuity of care has to be ensured to prevent repetition.

COMMUNITY

- a. Mental health professional should be involved in training other gatekeepers such as police, teachers, and religious leaders in the identification and support of individuals at high risk of suicidal behavior
- b. They should be involved in the school health system and women's group in mental health promotional program and to enhance resilience and problem-solving skills which reduce suicidal behavior
- c. Mental health professionals should actively collaborate with local nongovernment organizations and crisis lines involved in suicide prevention
- d. During times of disaster, mental health professionals should be at the forefront of the community to provide psychological support and reduce suicidal behavior.

Following two initiatives by SNEHA highlight the importance of working closely with the community to reduce suicide:

We investigated the usefulness of trained volunteer delivered mental health support for the bereaved persons following the 2004 Asian tsunami. Nonrandomized control design involving all adults aged 18 years or above who lost at least one close family member during tsunami from two geographically different coastal areas in Chennai, India was recruited for the intervention and control sites, 45 and 57, respectively.

A trained lay volunteer visited the bereaved family once a month for a period of 1 year and offered empathetic listening. After 1 year of this intervention, the participants were interviewed again.

Participants receiving interventions on a consistent basis from trained volunteers were less likely to report depressive symptoms and general psychological distress compared with participants who did not receive the above intervention. Regression analysis for predicting the effect of intervention on the difference between the baseline and follow-up in Beck Depression Inventory (BDI) as well as General Health Questionnaire (GHQ) scores, found a significant association between intervention and the improvement in BDI (adjusted β [standard error (SE)]: -0.53 [2.44]; $P = 0.000$) and GHQ (adjusted β [SE]: -0.52 [1.81]; $P = 0.001$) scores. Suicidal attempts were also significantly less in the intervention group. This shows that lay volunteers can be trained to offer emotional support and that it reduces suicidal behavior among the bereaved.^[9]

Pesticide suicides are considered the single most important means of suicide worldwide. We undertook this study to examine the feasibility and acceptability of a centralized pesticide storage facility as a preventive intervention strategy in reducing pesticide suicides. A community randomized controlled feasibility study using a mixed methods approach involving a household survey; focus group discussions (FGDs) and surveillance were undertaken. The study was carried out in Kattumannarkoil in Tamil Nadu. Two centralized storage facilities were constructed with local involvement and lockable storage boxes were constructed. Each family in the village had its own locker at a centrally located place to store their pesticides. These boxes, two feet by two feet in size, made of wood, were fixed to the wall and could not be removed from the facility. At baseline, 4446 individuals (1097 households) in the intervention and 3307 individuals (782 households) in the control sites were recruited, whereas at follow-up, there were 4308 individuals (1063 households) in the intervention and 2673 individuals (632 households) in the control sites. The results from the FGDs revealed that most participants found the storage facility to be both useful and acceptable. In addition to protecting against wastage, they felt that it had also helped prevent pesticide suicides as the pesticides stored here were not as easily and readily accessible. The primary analyses were done on an intention to treat basis. Following the intervention, the differences between sites in changes in combined, completed, and attempted suicide rates per 100,000 person-years were 295 (95% confidence interval [CI]: 154.7, 434.8; $P < 0.001$) for pesticide suicide and 339 (95% CI: 165.3, 513.2, $P < 0.001$) for suicide of all methods. This simple and cost-effective community intervention has the potential to reduce pesticide suicides.^[10]

Mental health professionals should emerge from the comfortable confines of clinic/hospital and collaborate with a variety of stakeholders and develop locally relevant and culturally appropriate interventions to reduce suicides in their respective communities.

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Conflicts of interest

There are no conflicts of interest.

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