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Need for Suicide Prevention Clinic in Tertiary General Hospital Settings

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Suicide is occasionally considered as a common final pathway for an individual facing diverse adverse circumstances. Suicide is a major concern across the globe. As per WHO(2013), around 8, 00 000 people die due to suicide every year and an even larger number attempt self- harm. Suicide is one of the leading causes of death among adolescents and young adults globally. It is a health problem which needs to be addressed.

Among developing nations, India witnesses significant number of suicide. As per National Crime and Records Bureau (NCBR, 2015) in India nearly 1,33,623 deaths occur due to suicide [1]. The major risk factor for suicide is mostly an untreated and frequently undiagnosed mental disorder [2].

Although suicide is one of the major causes for mortality among psychiatric patients, in the Indian context research efforts in this area have been sparse. It is found that role of biological factors also equally important in determining the biological vulnerability for suicide attempt in psychiatric ill patients. Preventive measures have to be taken at all the levels from primary to tertiary. At the primary level,efforts have to be made to decrease the modifiable risk factors such as more restrictive and effective alcohol/ drug policy/legal policy like banning over-the-counter sale of drugs and decreasing the availability of lethal methods. At the secondary level there is need for early identification and effective management of psychiatric disorders. Finally at the tertiary level intervention are required for the suicide survivors. History of past suicide attempt being an important predictor of future attempts, it is important to have trained mental health professionals for risk assessment for suicidal behaviour at various health services.There is dearth of published data on number of structured suicide prevention clinics or services in India. Despite increasing awareness and decriminalization of suicide attempt under the Mental Health Act 2017, help-seeking by suicide survivors is uncommon. It may be due to fear of stigma or lack of suicide prevention clinics by trained mental health professionalswho are trained to handle such issues sensitively, resulting them to be guarded about further risk assessment later. Psychiatry services are available at the Tertiary care health centres are often underutilized. Owing to less than optimal understanding of the nuances of treating a case like this among the accident and emergency department (A & E) staff, these patients may not be referred to Psychiatry at all during their treatment in the emergency room. It is necessary to have a trained mental health professional to assess them during entry level at the accident and Emergency (A&E) Department to ease there [3].

Assessment at an A&E department is a key opportunity to engage with a young person who self-harms. A retrospective chart review of suicide attempters brought to the A&E Department of the Teaching Hospital, M S Ramaiah Medical College from January 2014-July 2017 showed none of the 397 attempters referred for evaluation by a psychiatrist at the entry to A&E department and only 6 of them being referred later before discharge. The reason for not accessing mental health services could be also denial from patients and their caregiver probably due

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to stigma or various other legal and social issues. Hence there is an utmost need for setting up a Suicide Prevention Clinic comprising a trained psychiatrist to be attached to A & E Services for better risk assessment and prevention of future suicides. Dedicated helplines and clinics with holistic services are required for this patient population. Most of the patients come in contact with health care services only during a crisis. Suicide risk assessment being a dynamic process, these patients require not just pharmacotherapy but intensive and specific psychosocial inputs as well in the form of serial suicide risk formulation. There is also a need to ensure follow ups and involve families in treatment where feasible and necessary. Issuing of wallet cards with warning signs, apps dedicated to safety planning, use of emails and web services like podcasts for awareness and ensuring follow ups are some of the measures that have been looked at [4,5].

An ideal intervention should include 3 sessions to be given to both the survivor and the family members regarding identification of flag signs andpsycho education for nature of problem and need for assertive follow ups at suicide prevention clinic. These steps are likely to ensure better reach out to suicide survivors and break the chain of attempts and re-attempts.

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