EDITORIAL

"Suicide: prevention is the only way"

Shyamanta Das
Assistant Professor of Psychiatry
at Fakhruddin Ali Ahmed Medical College Hospital, Barpeta

The theme of the 21st Annual Conference of Indian Psychiatric Society, Assam State Branch held on 10th and 11th September, 2011 at Lokopriya Gopinath Bordoloi Regional Institute of Mental Health, Tezpur was "Suicide: prevention is the only way."

Suicide prevention has been incorporated within the World Health Organization Health for All strategy[1] and has received substantial support from the United Nations.[2] Furthermore, in recent years several countries have developed national suicide prevention programmes.[3] Increased suicide rates in young people have probably acted as a stimulus behind this trend.[3] However, suicide rates in most countries remain higher in older populations and prevention programmes must include this increasingly larger sector of society.[3]

When considering prevention strategies, it is important to be aware of and sensitive towards issues relating to culture and ethnicity.[3] For example, while suicide rates are generally relatively low in young females in the United Kingdom, this is not the case in young Asian females of the Hindu faith, in which rates appear to be relatively high and greater than those of their male peers.[4] The issues surrounding such deaths are often related to cultural clashes regarding values and expectations between young Asian females and their parents.[3]

Broadly there are two approaches to suicide prevention.[5,6] As described by Rose[7] in the context of prevention of health problems in general, one can distinguish between population approaches, which aim to decrease risk in the population as a whole, and high-risk group strategies, in which specific groups that are at increased risk are targeted.

Also the common adage that if people are intent on committing suicide they will find a means is not necessarily correct,[3] When one method of suicide is no longer available people do not automatically turn to another, or if they do it may be to one that is less likely to cause death.[3]

Given the very strong link between suicide and depression, and the risk of death from overdose of some of the older antidepressants, there has been much debate about whether more extensive use of newer, less toxic antidepressants would prevent suicides.[3] This is not a simple question, as some patients respond better to the older tricyclic antidepressants.[3] Another consideration concerns the cost of the newer antidepressants compared with the older varieties.[3] Also it is very important to remember that most people who are taking antidepressants do not kill themselves with their antidepressants but use other methods.[3] This and the probable selective prescribing of SSRIs to people judged to be at risk may account for the finding that suicide rates were higher in patients taking fluoxetine, than patients taking other and in some cases more toxic antidepressants.[8] Nevertheless, common sense dictates that patients known to be at risk, and especially those with a history of suicidal behaviour, should be prescribed the less toxic preparations.[3]

If environmental changes are made such that a popular suicide site becomes safer, this does not mean that people at risk automatically move to using another site.[3] Clinicians involved in the development of suicide prevention strategies should look very carefully for local patterns which might provide clues about potentially effective measures for reducing access to methods.[3] Specific strategies may be required depending on local patterns.[3] For example, the high rates of suicide in rural areas of developing countries due to self-poisoning with pesticides might be reversed with safe-storage programmes.[3]

Psychiatrists involved in designing suicide prevention strategies might ensure that there are effective local educational programmes for clinicians in primary care and other settings regarding detection and treatment of people with mental disorders.[3] The largest impact of media influence is on young people, although there is also influence on older people.[9] In each country, consideration should be paid to the development of consensus statements

about media policies in relation to reporting and portrayal of suicide,[10] which could be produced by joint working parties including representatives of the press, clinical and voluntary agencies, and experts in the field of suicidal behaviour.[3]

In view of the strong link between suicide and mental illness, effective treatment of psychiatric disorders must be a central theme in suicide prevention.[3] However, detection of people with disorders will depend on the awareness that they and those around them have regarding the signs and symptoms of disorder, and their willingness to seek appropriate help.[11] These important stages on receiving effective help will depend on the general public's attitudes towards mental illness and knowledge of its nature and the feasibility of treatment.[3]

Volunteer-run telephone helplines and similar services may benefit greatly from the support and advice of local clinicians, who should regard them as a potentially valuable element in a local suicide prevention strategy.[3] The association between suicidal behaviour and unemployment and poverty suggests that in order for suicide rates to change markedly these important socio-economic factors must be modified.[3] The main role of psychiatrists may be in highlighting these factors.[3] The considerable evidence that changes in the economic environment can exert a powerful influence on suicide rates indicates that governments with serious intentions to reduce suicide rates should address these issues.[6]

Prevention of suicide in patients with psychiatric disorders must be a major element in any suicide prevention strategy.[12] Risk is often greatest during the early stages of a disorder.[11] The risk factors in schizophrenia indicate that risk tends to be highest between episodes of acute illness when patients may have insight and feel hopeless about their circumstances and prospects.[3] Risk is related more to affective symptoms than core features of the disorders.[13] The use of the newer atypical antipsychotics may also be beneficial.[14] The particularly high risk in the weeks following a break-up of a relationship for patients with severe alcohol abuse[15] again points to the need for continuity of support in the community.[3]

There is good evidence that well-trained, non-medical psychiatric staff can effectively carry out assessments and arrange aftercare.[3] Models for ideal services exist, such as those published by the National Institute for Clinical Excellence[16] in the United Kingdom. Certain occupational groups are known to be at relatively high risk of suicide.[3] It is interesting to note that all these groups have relatively easy access to dangerous methods for suicide.[3] There are relatively high suicide rates in prisoners,[17] especially young males on remand.[3] Clinicians involved in local suicide prevention programmes should include prisons in their considerations.[3]

References

1. World Health Organization. (1994). Ninth general programme of work covering the period 1996-2000. World Health Organization, Geneva.

2. United Nations. (1996). Prevention of suicide: guidelines for the formulation and implementation of national strategies. Department for Policy Coordination and Sustainable Development, New York.

3. Hawton, K. and Taylor, T. (2009). Treatment of suicide attempters and prevention of suicide and attempted suicide. In New oxford textbook of psychiatry (eds. MG Gelder, NC Andreasen, JJ Lopez-Ibor Jr, JR Geddes), pp. 969-78. Oxford University Press, Oxford.

4. Soni Raleigh, V. and Balarajan, R. (1992). Suicide and self-burning among Indians and West Indians in England and Wales. The British Journal of Psychiatry, 161, 365-8.

5. Hawton, K. (2005). Prevention and treatment of suicidal behaviour: from science to practice. Oxford University Press, Oxford.

6. Lewis, G., Hawton, K., and Jones, P. (1995). Strategies for preventing suicide. The British Journal of Psychiatry, 171, 351-4.

7. Rose, G. (1992). The strategy of preventive medicine. Oxford University Press, Oxford.

8. Jick, S.S., Dean, A.D., and Jick, H. (1995). Antidepressants and suicide. British Medical Journal, 310, 215-8.

9. Hawton, K. and Williams, K. (2005). Media influences on suicidal behaviour: evidence and prevention. In Prevention and treatment of suicidal behaviour: from science to practice (ed. K. Hawton), pp. 293-306. Oxford University Press, Oxford.

10. Pirkis, J., Blood, R.W., Beautrais, A., et al. (2006). Media guidelines on the reporting of suicide. Crisis, 27, 82-7.

11. Jamison, K.R. and Hawton, K. (2005). The burden of suicide and clinical suggestions for prevention. In Prevention and treatment of suicidal behaviour: from science to practice (ed. K. Hawton), pp. 183-96. Oxford University Press, Oxford.

12. University of Manchester. (2006). Avoidable deaths. Five year report of the National Confidential Inquiry into suicide and homicide by people with mental illness. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, Manchester.

13. Hawton, K., Sutton, L., Haw, C., et al. (2005). Schizophrenia and suicide: a systematic review of risk factors. The British Journal of Psychiatry, 187, 9-20.

14. Meltzer, H.Y., Alphs, L., Green, A.I., et al. (2003). Clozapine treatment for suicidality in schizophrenia. Archives of General Psychiatry, 60, 82-91.

15. Murphy, G.E., Armstrong, J.W. Jr, Hermele, S.L., et al. (1979). Suicide and alcoholism: interpersonal loss confirmed as a predictor. Archives of General Psychiatry, 36, 65-9.

16. National Institute for Clinical Excellence. (2004). Clinical guideline 16. Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. National Institute for Clinical Excellence, London.

17. Fazel, S., Benning, R., and Danesh, J. (2005). Suicides in male prisoners in England and Wales, 1978-2003. Lancet, 366, 1301-2.