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Opinion
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Interventions for Suicide Prevention: The Need of the Hour

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Opinion

Suicide is a phenomenon common to a multitude of processes and conditions. It is a major mental health concern across the globe. As per WHO, around 800000 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 very obviously a health problem which needs to be addressed. When these patients come in contact with emergency services, more often than not, the medical issues at hand are addressed but the mental health needs not met with. The patients may be apprehensive about seeking medical attention in the first place. The perception among this population is that they may be treated differently than other patients and are considered a burden on an already overworked staff in the hospital and not as someone having "real" problems [1].

Owing to less than optimal understanding of the nuances of treating a case like this among the accident and emergency department (A&E) staff, often, these patients may not be referred to psychiatry at all during their treatment in the emergency room. Since each attempt increases the risk of another attempt [2,3], it is crucial to offer these patients mental health services and engage them in treatment right from the A&E itself. The first contact with mental health workers in this process should be suitably private area in the A&E department. Even brief interventions at this point could decrease future self harm [2]. A retrospective chart review in our urban tertiary care unit showed that over a span of three years, over four hundred cases of self harm and suicide were treated in the A&E. However, none of these cases were referred to a psychiatrist at the entry to and only six of these cases saw a psychiatrist just before discharge from A&E. It was only the patients who were admitted for a longer duration of care that were subsequently referred to psychiatry. A large proportion of these patients do not come back to us for a follow up. The reasons for not seeking psychiatric help could be due to attached stigma, fear of legal issues and lack of availability of focussed services.

The visits to emergency rooms provide us an opportunity to engage them in treatment as a large number of these patients do not seek care on their own, otherwise as has been noted time and again. There is also a need for focussed services for patients with self harm. Dedicated help lines and clinics with holistic service are required for this patient population. Most of the patients come in contact with health care services only during a crisis. These patients require not just pharmacotherapy but considerable psychosocial inputs as well. 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 [2,4,5].

Another important measure discussed in this regard is the "gatekeeper training". This refers to training individuals in the community who are in contact with a large number of members of the community on a regular basis [6]. These individuals can be trained to identify people at risk within the community, a large proportion of whom would; as discussed before; not seek assistance on their own. There is an urgent need for early intervention for patients with suicidal behaviour and assertive regular follow ups as self harm is more often than not a recurring phenomenon. Focussed multidisciplinary services for risk assessment and management of self harm can make a lot of difference.

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