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Editorial

Suicide Prevention: Current Status

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I N T R O D U C T I O N

According to the WHO, around 8 lakhs people die of suicide every year and up to 25 times as many make a suicide attempt. Attempted suicide is self-injury with the desire to end one's life that does not culminate in death. According to the Section 309 of Indian Penal Code (IPC), suicide attempt was considered as an offence. It might have been implemented to act as a deterrent to prevent suicidal attempts. However, suicide attempts occur in the background of severe mental stress. According to a previous study, 93% of suicide attempters were found to be mentally unwell at the time of commission of suicide attempt. Therefore, it is necessary to decriminalize suicide. Universal attempt to decriminalize suicide has been made. In India, Sec 309 IPC has remained untouched and not amended for the past 155 years, thus warranting a relook and repeal. The Delhi High Court first condemned Sec 309 IPC as "anachronism unworthy of society" (1985). Supreme Court in 1994 called it "irrational and cruel and hence void" which was then overruled by a panel of judges.

According to the Section 115 of Mental Healthcare Act (MHCA) 2017, suicide attempters are presumed to have severe stress, not to be punished and the government should have duty to provide care, treatment, and rehabilitation to reduce the risk of recurrence. Decriminalization might lead to openly seeking help, improvement in epidemiological data, better planning, and resource allocation.[1]

Studies reveal that 16% of the people who attempt suicide will do so again within the subsequent year. Mental disorders are associated with high risk of life-time suicidal behaviour; 4.3% men and 2.1% women were found to later die by suicide.[2] Suicidal behaviour in high risk populations can be prevented. Pharmacological treatment has shown positive results in randomised studies. Some studies of psycho-social intervention have shown promising results mainly for select patient populations. The main obstacle is the low base rate of suicide, which ultimately is the clinical outcome of interest in clinical trials. It means trials should either have unrealistic large sample sizes or extensive follow-up periods in order to secure sufficient data material.[3]

The task of suicide prevention is challenging because of lack of evidence regarding the efficacy of individual approaches of intervention. Suicide is linked with multiple factors acting throughout the life course to alter brain function, causing behavioural cognitive and emotional changes that increase risk for suicidal behaviour, particularly in the

context of psychopathology. To prevent suicide attempt in at risk persons, wide range of biological behavioural and clinical factors are targeted. In a South-Korean study, suicide-attempters benefitted from a phone-base national aftercare programme in terms of reduced risk of suicide.[4] In another study allow risk of suicide was reported in those who received psycho-social therapy after self-harm.[5]

To prevent suicide certain social factors, need to be taken into consideration such as regulating the availability of suicide means, to improving access and organization of health and support services.

There is a strong association between psychiatric illnesses and suicidal behaviour. Psychotherapeutic and pharmacotherapeutic interventions in suicidal patients with psychiatric illness is of great help. There is reasonable evidence for the use of cognitive behaviour therapy in decreasing suicidal behaviour both in adults and adolescents.

Though anti-depressants decrease the suicidal risk in depressed patients, some studies suggest that antidepressants could lead to treatment-emergent suicidal ideation. There are certain drugs which are helpful in preventing suicide risk in certain clinical conditions such as lithium decreases suicide risk in mood disorders and clozapine in psychosis. Ketamine can be used in emergency situations to rapidly and effectively treat acute suicidal condition.[6]

Other than restricting access to lethal means, pharmacological and psychological means, there are certain programs which are effective in suicide prevention such as school-based awareness program.

The Mental Healthcare Act 2017 recognises suicide attempt as the outcome of disturbed psyche requiring intervention. The Act puts responsibility on the government to prevent recurrence of suicide attempts.

Conflict of Interest: None

References

1. Sneha V, Shivappa M, Rudra Prashanth N et al. Decriminalization of suicide as per Section 115 of Mental Health Care Act 2017. *Indian Journal of Psychiatry* 2018: 60: 147-148.
2. Nordentoft M, Mortensen PB, Pedersen CB. Absolute risk of suicide after first hospital contact in mental disorder. *Arch Gen Psychiatry* 2011; 68: 1058-1064.
3. Bolton J, Gunell DJ, Turek G. Suicide risk assessment and intervention in people with mental illness. *British J Psychiatry* 2015; 351: h4978.
4. Pan YJ, Chang WH, Lee MB et al. Effectiveness if nationwide aftercare program for suicide attempters. *Psychological Medicine* 2013; 43: 1447-1454.
5. Erlangsen A, Lind B, Stuart EA et al. Short- and long-term effects of psychosocial therapy provided to persons after suicide attempt: a register based, nationwide multicentre study using propensity score matching. *Lancet Psychiatry* 2014; 2: 47-58.
6. Zalsman G, Hawton K, Wasserman D et al. Suicide prevention strategies revisited 10-years systematic review. *Lancet Psychiatry* 2016; 3(7): 646-659.

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