Suicide and its Prevention: Brief Review

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ABSTRACT

Suicide is known to humanity since the birth of mankind and it is understood as a process, which starts much before the act and passes through various stages of suicidal thought-ideas-behaviours-attempts-completed act, drawing the subject from stage of helplessness to hopelessness, and eventual despair. In India, suicide is an unrecognized, hidden and a silent epidemic. In this brief review we will review the epidemiology of suicide mainly in the Indian context, important risk factors, management of suicidal subjects and prevention of suicide.

Key words *: Suicide, risk factors, prevention, management*

SUICIDE: *Past and present*

Suicide has been known to humanity since the birth of mankind. However, it has become a matter of increasing concern only recently, because of its increasing incidence among the youth, men and women in every part of the world. Further, it is only in the recent decades that a scientific understanding of the issue has begun.

Suicide has been in existence for centuries in India. Descriptions of suicidal behaviour can be found in the ancient texts of Ramayana and Mahabharata. In the more modern ages the concept of sati, self- immolation at specific times (for example the incidents of such behaviour following the report of the Mandal Commission), cases of 'fast unto death' practiced by *satyagrahis*, are all classical examples of the various forms of suicide. In this selective review we will discuss the epidemiology, important risk factors, management of suicidal subjects and prevention of suicide.

DEFINITION: *Intentional self-murder*

The concept of suicide is derived from Latin, *sui* (oneself) and *cide* (killing). Simply speaking suicide is intentional self-murder.

According to the noted French sociologist Emile Durkheim "*Suicide is any death that is the direct or indirect result of a positive or negative act accomplished by the victim himself/herself which, he/she knows or believes will produce this result*"[1].

Important facts derived from the definition are **suicide must be death**, non-fatal suicide attempts, self-destructive thoughts or gestures, partial suicides and so on, strictly speaking are not suicide.

Suicide must be self-inflicted i.e. the agent must not be another person, atrophy or disease of the human body or an external, impersonal agent encountered capriciously.

Risk-taking that leads to death is suicide, if the indirect casual sequence can be specified and was intentional.

Not doing something to prevent death (as well as positive action to cause death) can be suicidal, for example not taking life saving drugs.

Suicide is intentional death, death must be certain or thought to be certain as an outcome of the act.

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Table-1
The 10 Commonalities of suicide

1. The common purpose of suicide is to seek a solution
2. The common goal of suicide is cessation of consciousness
3. The common stimulus in suicide is intolerable psychological pain
4. The common stressor in suicide is frustrated psychological needs
5. The common emotion in suicide is helplessness-hopelessness
6. The common internal attitude in suicide is ambivalence
7. The common cognitive state in suicide is constriction
8. The common action in suicide is agression
9. The common interpersonal act in suicide is communication of intent
10. The common consistency in suicide is with lifelong coping patterns

Although each suicide is an idiosyncratic event common characteristics of the phenomenon can often be delineated (see Table-1).

SUICIDE AS A PROCESS: *The highway to suicide*

It is to be remembered that suicide is a process, which starts much before the act and passes through various stages of suicidal thought-ideas-behaviours-attempts-completed act, drawing the subject from stage of helplessness to hopelessness, and eventual despair. The above described terms/stages are included under the generic term 'suicidal behaviour", which is seen on a continuum or as a **"highway leading to suicide"**. The highway begins with the first suicidal thought, the first threat or attempt, and ends in suicide. As in the case of any trip destined for a certain end point, one can always change one's mind, take a different road to another destination, or turn around and come back.

EPIDEMIOLOGY: *The size of the problem*

The importance of suicide from the public health point of view is persistently unrecognized even though it counts as one of the leading causes of mortality. The decision to label a death as suicide can often be a legal one, which can lead to an underestimation of the size of the problem. Studies have shown that official figures may represent only about half to two-thirds of the actual number of all suicides.

Worldwide

Among countries reporting suicide, the highest rates are found in Eastern Europe and the lowest are found mostly in Latin America, in Muslim countries and in a few of the Asian countries. There is little information on suicide from African countries. Rates tend to increase with age, but there has been a recent alarming worldwide increase in suicidal behaviour amongst young people aged 15 to 29 years. Suicide is a leading cause of death for young adults. It is among the top three causes of death in the population aged 15-34 years. Taken as an average of 53 countries for which complete data is available, the age-standardized rates for suicide are 15.1 per 100000 (lakh) people. The rates for males was 24, and for females 6.8 per lakh of people. The rate of suicide is almost universally higher among men compared to women by an aggregate ratio of 3.5 to 1, with only exception of rural China. On the other hand, in most places more women than men attempt suicide[2].

India

As in many other countries, suicide in India is an unrecognized, hidden and a silent epidemic. The only source of information for suicide rates in India is the National Crime Records Bureau. According to the Bureau, in 1968 there were 40 thousand suicides, which increased to 110 thousand in the year 1999, an increase of 175 %, which is indeed staggering. The national suicide incidence rate for India was 11.2/lakh/year, in 1999, which then reduced slightly to 10.8 /lakh/year in 2000. According to 1999 figures the states of Kerala (8.9%), Karnataka (10.5 %), Maharastra (13.0 %) and West Bengal (13.6 %) contributed for nearly 50 % of total suicides, while the highly populated states of Uttar Pradesh and Bihar contributed for only 4.5 % and 1.75% respectively. Kerala recorded the highest suicide ratio when compared to population. However, this significant difference between different states could be due to reporting practices rather than true differences. Male to female suicide ratio was 59: 41, with young adults (15-29 years) and middle-aged people (30-44 years) being the two age groups with the highest contribution to the overall suicide rate at 37 % and 34 % respectively. The incidence of suicide decreased with increase in education. Highest rates were found in married and self-employed individuals. Among the major causes for suicide at the national level, the five major contributors were illness (20 %), family problems (20.6 %), disappointment in love (3.4 %), poverty (2.6 %) and failure in examinations (2.1 %). The common methods employed in suicide completers were poisoning (37 %), hanging (25 %), self-inflicted burns (11.1 %) and drowning (9 %)[3].

However in 2000, highest suicide rate was reported from Maharastra (12.9 %) followed by West Bengal (12.8 %), Karnataka (11.4 %), Tamil Nadu (10.1 %) and Madhya Pradesh (10.0%). Further, the states which reported significant rise in suicides in 2000 over 1999 were Nagaland (rise in 113.3 %), Mizoram (82.1%), D & N Haveli (68.7%), Arunachal Pradesh (54 %) and Jammu & Kashmir (43.9%). On the contrary Bihar reported a significant decline in suicide rate of 72.4 % in the year 2000 compared to 1999[4].

In a recent study from Vellore the highest suicide rate in the world has been reported among young women in South India. The research is of major importance, according to the World Health Organization, as it brings to light Asia's suicide problem. The average suicide rate for young women aged 15 to 19 years living around Vellore in Tamil Nadu was 148 per lakh. This compares to global suicide rate stands at 14.5 deaths per lakh. Hanging was the most common method used, followed by poisoning using insecticide[5].

RISK FACTORS: *The multiple origins of suicide*

Suicide is now understood as a multidimensional disorder, which results from a complex interaction of several risk factors such as psychiatric illnesses, chronic physical illnesses, familial factors, psychological characteristics, stressful life events and sociodemographic factors and so on, as shown in table-2.

Table-2

Factors predisposing to suicide

- Psychiatric illnesses
- Social factors
- Chronic physical illnesses
- Familial/genetic factors
- Biological mechanisms
- Psychological characteristics
- Past attempts
- Stressful life events

Psychiatric illnesses

Studies from both developing and developed countries reveal an overall prevalence of mental

disorders of 80-100% in cases of completed suicide[6]. About three-fourths of all suicide victims suffer from one of the two psychiatric disorders – depression or alcoholism.

It is estimated that the lifetime risk of suicide in people with mood disorders (chiefly depression) is 6-15%; depression is thus the diagnosis most commonly associated with suicide. Most depressives commit suicide early in the course of their illness, more males than females; and the chance of a depressed person killing himself/herself is increased by being single, separated, divorced, or recently bereaved. Suicide among depressed patients is more likely at the onset or end of a depressive episode. The risk of suicide is also high during recovery from the symptoms and immediately after discharge from a hospital.

Alcoholism carries a 7-15% lifetime risk of suicide. Alcoholic suicide victims are usually middle-aged unmarried males who are friendless and socially isolated, and have been drinking heavily. Alcoholism, depression and antisocial personality disorder together carry a formidable risk of suicide.

Several other psychiatric disorders such as schizophrenia, personality disorders, and drug dependence also have high rates of suicide[7].

Social factors

Durkheim was the first to point out that the social and cultural contexts influence the risk of suicide. Since then it has been conclusively demonstrated that the phenomenon of suicide has strong ecological associations. In some situations psychosocial factors add on to clinical conditions, in others they may predominate. Certain social factors that have consistently identified are:

Sex: In the majority of countries more males than females, commit suicide; the male/female ratio varies from country to country[8]. China is the only country in which female suicides outnumber male suicides in rural areas and are approximately equal to male suicides in urban areas[9].

Age: The elderly (above 65 years) and the younger (15-30 years) age groups are at increased risk of suicide[8]. The rise in overall suicide rates in many Western countries is to a large extent due to an increase in suicide in younger age groups. Even countries with a stable or decreasing overall rate have often still witnessed increased rates in the young. The international spread of this phenomenon suggests that it might be partly related to social changes, changing attitudes to suicide, and easier access to means of committing suicide[2]. The suicide rate by age for India also reveals that the suicide rates peak for both men and women between the age 18 and 29 [10]. Table-3 depicts some of the important correlates of suicide in young adults.

Table - 3

Correlates of suicide in the young

- Disturbed family background
- Psychiatric disorder
- Physical illness
- Past attempts
- Precipitating life events
- Role models (imitation suicides)

Marital status: Divorced, widowed and single people are at increased risk of suicide[11,12]. Marriage appears to be protective for males in terms of suicide risk but not significantly so for females. Marital separation and living alone increase the risk of suicide[13].

Occupation: Certain occupational groups such as dentists, farmers and medical practitioners have a higher risk of suicide[14-16]. There is no obvious explanation for this finding, though access to lethal means; work pressure, social isolation and financial difficulties might be the reasons[17].

Unemployment: There are fairly strong associations between unemployment rates and suicide rates, but the nature of these associations is complex. The effects of unemployment are probably mediated by factors such as poverty, social deprivation, domestic difficulties and hopelessness. The recent spate of suicides among farmers in Maharastra, Punjab and Andhra Pradesh highlights this link further. On the other hand, people with mental disorders are more likely to be unemployed than people in good mental health. At any rate, due consideration should be given to the difference in the significance of recent loss of employment and long-term unemployment: greater risk is associated with the former[17].

Rural/urban residence: In some countries suicides are more frequent in urban areas, whereas in others they occur more frequently in rural areas[17].

Migration: Migration - with its attendant problems of poverty, poor housing, lack of social support and unmet expectations - increases the risk of suicide[17].

Others: Certain social factors, such as the ready availability of the means of committing suicide and stressful life events play a significant role in increasing the risk of suicide[17].

Chronic physical illnesses

Suicide risk is increased in chronic physical illness. In addition, there is generally an increased rate of psychiatric disorder, especially depression, in people with physical illness. Chronicity, disability and negative prognosis are correlated with suicide. The physical illnesses commonly associated with high suicide rates are cancers, epilepsy, multiple sclerosis, head injury, Huntington's disease, dementia etc[8].

Familial/genetic factors

Several studies show that suicide tends to run in families. In some situations the family member who committed suicide may serve as a role model. However, most of the evidence indicates that genetic factors are involved in suicide. Genes involved in transmission of psychiatric disorders such as depression, alcoholism or schizophrenia could be responsible. There might also be a genetic factor for suicide independent of these disorders[18,19].

Biological mechanisms

A disturbance of brain serotonin is the commonest biological abnormality in suicide. People with low levels of cerebrospinal serotonin metabolites commit suicide more impulsively and die by violent means more often[20].

Past attempts

A past suicide attempt is perhaps the best indicator that a person is at increased risk of committing suicide. Studies show that up to half of the victims have made a previous attempt[8].

Psychological characteristics

Psychological characteristic commonly associated with suicide include unbearable psychological pain. (a deep anguish, in which the person feels especially hopeless and helpless), narrow or rigid thinking (individual sees suicide as the one and only solution for their current difficulties), ambivalence, sense of vulnerability (lacks of personal strength), loneliness and feelings of rejection [8].

Stressful life events

Recent life stressors associated with increased risk of suicide include marital separation, bereavement, family disturbances, change in occupational or financial status, rejection by a significant person, failure in examination, failed love affairs, shame and threat of being found guilty and so on[8].

ASSESSMENT OF SUICIDAL SUBJECTS/ SUICIDAL ATTEMPT

Empathy, sensitivity, awareness

The first and most immediate step is to allocate adequate time to the patient, even though many others may be waiting outside the room. By showing a willingness to understand, the physician starts to establish a positive rapport with the patient. Closed-ended and direct questions at the beginning of the interview are not very helpful. Remarks like "You look very upset; tell me more about it" are useful. Listening with empathy is in itself a major step in reducing the level of suicidal despair. It is important to remember that various myths are attached with suicide and deal with them (see Table-4).

Table-4

Common myths about suicide[21]

- It is not possible to prevent a person from committing suicide (The great majority of suicides are preventable)
- People who commit suicide do not tell anyone about their intentions (Majority of the suicide victims communicate their intentions)
- Talking about suicide may actually provoke such acts (Talking may reduce the anxiety and diminish chances of an attempt)
- People who attempt suicide, are definitely going to complete it sometime (Not everyone who attempts suicide once is going to repeat it)

Assessment and treatment of suicidal subjects involves translation of knowledge about the risk factors for suicide into a coherent plan for careful evaluation and clinical management of suicidal patients. Assessment *involves* ***identification of factors associated with the suicidal attempt, to determine motivation for the act, to determine intent of the act, to determine lethality of the act, to assess continuing risk of suicidal behaviour etc.*** There are certain general principles of assessment for suicide attempts, and when assessment is done properly it can be itself be therapeutic as most of the time it provides the first opportunity for the patient to discuss their difficulties with a clinician. The general principles include: [1] whenever possible the subject's account should be supplemented by information from others such as a spouses, relatives and friends, colleagues or family physicians; [2] although the suicide attempt may seem non-serious, the person must be taken seriously; [3] assessment is an ongoing process and person should be reassessed continually; [4] a guesswork approach should not be used while working with suicidal persons.

MANAGEMENT OF A SUICIDAL PATIENT:

Comprehensive and multi-modal

Because of the need to respond to a suicidal crisis, treatment should be provided with a "wrap around" service delivery system that included resources for emergency intervention, inpatient, short-term and long-term outpatient intervention. Management of suicide attempts or suicidal threats involves emergency or crisis service intervention, inpatient care, outpatient care, specific psychotherapies, psychopharmacological intervention and prevention of future attempts. Proper management requires certain general principles as given in table-5.

Table-5

General principles of treatment

- Accurate diagnosis and appropriate treatment for associated psychiatric disorder is a major strategy.
- The physician should always inquire about suicidal thoughts and plans as a routine part of every diagnostic evaluation and during every visit. Both positive and negative findings should be documented
- The physician must establish a therapeutic relationship with the patient. The strength of this alliance is an important "life line" for the patient. Some doctors find the use of a "no suicide contract" to be helpful.
- The physician must instruct the family to remove all

potentially lethal objects from the house including gun, knives and medication, insecticides etc. This removal of a method from the immediate access of an impulsive patient also conveys the important message that steps have been taken to help keep the patient alive.

- The physician should always inquire about the patient's compliance with medications and use serum levels when necessary to monitor compliance.
- The physician should always immediately follow-up missed appointments with an acutely suicidal person.

Emergency or Crisis Service Intervention

About three-fourths of people who harm themselves arrive at hospital in the evening. It is recommended that such patients should be admitted overnight, with a view to psychosocial assessment in the daytime. The advantages of this policy are that assessment is likely to be of higher quality and that after-care is easier to arrange during the office hours. In many hospitals, more than half of attendee's are discharged from the emergency department. Patients who leave hospital directly from emergency department and especially those who leave without a psychosocial assessment are less likely to have been offered follow-up. Every patient should have a specialist psychosocial assessment. The purpose of the assessment is to identify factors associated with suicidal attempt, to determine motivation for the act, to identify potentially treatable mental disorders and to assess continuing risk for suicidal behaviour.

Candidates for crisis intervention are those who have clear precipitant, those who have sufficient social support or self-reliance to be able to return for brief therapy, and those who have reasonably good functioning before the precipitating events. In the crisis intervention the patient has a temporary therapeutic relationship with the psychiatrist or other mental health professionals, which terminates on mutual consent. The patient is encouraged to talk about the situation, talk about the upsetting event in detail, and discuss how he/she will cope after the crisis intervention.

If a patient is emotionally disturbed, with vague suicidal thoughts, the opportunity of ventilating thoughts and feelings to a physician who shows concern may be sufficient. Nevertheless, an opportunity for further follow-up should be left open, particularly if the patient has inadequate social support. Whatever the problem, the feelings of the suicidal person are usually a triad of helplessness, hopelessness and despair. The three most common states are:

1. *Ambivalence* The majority of suicidal patients is ambivalent till the very end. There is a seesaw battle between the wish to live and the wish to die. If this ambivalence is instead used by the physician to increase the wish to live, suicide risk may be reduced.
2. *Impulsivity* Suicide is an impulsive phenomenon and the impulse by its very nature is transient. If support is provided at the moment of impulse, the crisis may be defused.
3. *Rigidity* Suicidal people are constricted in their thinking, mood and action and their reasoning is dichotomized in terms of 'either/ or' options. By exploring several possible alternatives to death with the suicidal patient, the physician gently makes the patient realize that there are other options, even if they may not ideal.

Providing support

The focus of the support should be providing hope, encouraging independence, and helping the patient to learn different ways of coping with life stressors. The physician should assess the available support systems, identify a relative, friend, acquaintance or other person who would be supportive to the patient, and solicit that person's help.

In India, with the rising number of suicides, a number of government as well as private and voluntary organisations are offering counselling services to potential victims. **Befrienders India** is one such voluntary association in Delhi. This association offers friendship and concern to those individuals afflicted with loneliness, thereby providing them with an opportunity to share their problems. The association has 10-member centres in Delhi, Chennai, Mumbai, Pondicherry, Secunderabad, Kochi, Ahmedabad, Kolkata, and Thrissur.

A 'no suicide' contract

Entering into a 'no suicide' contract is a useful technique in suicide prevention. A written or verbal contract is commonly negotiated at the start of the treatment in the hope that it will improve treatment compliance and reduces the likelihood of further suicidal behaviour. The usual form of the contract is that patient promises not to engage in suicidal behaviour and should inform parents, therapist or other responsible adults if he/she has thoughts of suicide or develops plans to commit suicide. It is hoped that contract will increase the patient's and family's commitment to treatment, but it should never be a substitute for other types of intervention. The negotiation of the contract can promote discussion of various relevant issues. Contracting is appropriate only when patients have control over their actions.

Treating the underlying disorder

Patients should be evaluated for the underlying psychiatric disorders like depression, schizophrenia, anxiety disorders, alcohol dependence etc and should be treated appropriately, preferably by a psychiatrist.

PREVENTION: *Primary, secondary and tertiary*

Suicide prevention is considered as the ultimate objective of the art and science of suicidology[10]. Suicide prevention can be done at various levels and accordingly the interventions can be divided into primary (at the level of society), secondary (early diagnosis and treatment) and tertiary prevention.

Primary Prevention

Primary intervention involves changes at the level of society to modify the risks associated with suicide

Economic deprivation: Suicides are closely linked to poverty and economic deprivation. Hence, poverty alleviation programmes should be strengthened. This needs identification of economically marginalized communities and specific at risk families along with identifying pathways of growth.

Education: Skills for children and families to handle educational backwardness, examination failures, limiting parental aspirations and making the education environment safer, child-friendly and less burdensome are some measures that should be promoted.

Unemployment: Major reforms are required to ensure job security, to provide avenues for employment, to ensure security for less privileged sections and women, to eliminate child labour, to guarantee economic security for farmers/ agricultural families with limited resources and for people working in unorganized sector.

Migration: Suicides are common in slums and among low-income communities spreading in the suburbs of the cities. These are also environments characterized by a high degree of social disintegration and a relative lack of supportive mechanisms. These areas are also characterised by higher rates of family and marital disharmony, crime and violence against women, alcohol abuse, child labour, lower education, school dropouts and social disharmony. There cannot be a single answer to tackle this problem. As slum proliferation is linked to economic survival and migration, answers have to come from many

corners aimed at improving socio-economic status and at improving quality of life by providing better education, employment opportunities, promoting women's self-help groups etc.

Marriage and family: Family conflicts, disruption of family life and strained relations between different family members are the focal point of concern in suicides. Family support and counselling services should be expanded in a big way to all areas. Counselling services for high-risk families should be strengthened in a big way through local area volunteers at community levels. This essentially means identifying "problematic families" with conflicts, disruptions, and disorganized mechanisms and with strained relations. Such families should be targeted for intervention programmes in urban and rural areas.

Alcohol: Alcohol usage has been associated in its relation to causation of suicides, both directly and indirectly. Alcohol is linked from social, economic, developmental and health dimensions to suicide. However, the liquor industry is also a major source of revenue in all societies. 'Economy v/s Safety' has been an important issue with the former occupying a preferred place in Indian Society. A number of interventions in the area of alcohol prevention and control are required. Restrictive and responsible alcohol usage should be promoted and 'at risk individuals and families' should be given extra attention. Some of the major strategies likely to yield results in this direction are (i) identification and rehabilitation of individuals with alcohol problems, (ii) support system for families with an alcoholic individual towards management and counselling services, (iii) limiting the availability of alcohol in the community, and (iv) increasing awareness among society about dangerous effects of alcohol.

Stigma reduction programmes: There is a great need to promote mental health awareness across all sections of society to allow better detection and timely treatment of mental disorders which are the major causes of suicide. Stigma reduction programmes, better skills for identification and management of potential suicidal persons by primary care and family physicians, expanding coverage of mental health services and better accessibility to mental health care should be promoted. Suicide prevention must form an integral part of family-oriented mental health care activities.

Legal Enforcement: Legal enforcement must be strengthened towards banning over the counter sale of drugs. Especially, the sale of drugs like antiepileptics, sedatives, hypnotics, tranquillizers, anxiolytics and antipsychotics, antidiabetics, antihypertensives should be controlled. Banning easy availability of organophosphorus compounds should be undertaken seriously. Some of the measures likely to yield results are (i) wider publicity and awareness among public about dangers associated with organophosphorus compounds, (ii) bolder, visible and prominent labels on these products, (iii) educating families not to keep these compounds at home and keeping them away from 'at risk' individuals, and (iv) strict dispensing of large quantities only for responsible individuals.

Training: Health professionals in all settings must exercise great caution in identifying 'suicide prone' and 'high-risk' individuals at early stages. The necessary training in this direction should be incorporated at all levels of education, ongoing mental health training programmes and in national health programmes.

Media: Media (print and visual) can play a major role in suicide prevention. Increasing public awareness about the problem, disseminating information about sources of help are some of the more appropriate ways the media can help to prevent the problem. Far too often there is a tendency of the media to sensationalize such acts or glorify such individuals. Since this often

contributes to further 'copycat' suicides the public will be better served by the media presenting actual facts and reliable information about the problem in its various dimensions.

Legal issues: At present attempted suicide is a legally punishable offence in India, but unfortunately this does not serve as a deterrent for suicide. On the contrary, it prevents people from seeking treatment as this would lead to medico-legal entanglements. Therefore, the law needs rethinking and appropriate revision [10].

Secondary Prevention

Secondary Prevention involves identifying the subjects at high risk of suicide and treating them as soon as possible

Identify and treat mental Illnesses: Identifying, treating and managing those with a mental illness are very important interventions. Individuals and families need to be educated about the symptoms of mental illness, especially depressive disorders, chronic alcoholism and adjustment disorders. Since persons with mental disorders are at an elevated risk for suicide, their families need to be aware of symptoms and signs of mental illness along with timely intervention. Proper medication, counselling services, family support and readjustment to life situations are essential in these situations. Individuals diagnosed with a mental health problems hospitalized and discharged to their homes are also at greater risk as they shift from supervised institutional structures to families. Family members should be educated to provide special care for such individuals.

Identifying high-risk groups: Many high-risk groups have been identified such as the socio-economically deprived groups, adolescents in 15-24 yrs of age, recently married women, those suffering from chronic disorders, alcoholics and their families, distressed and disturbed families, those with previous history of attempted suicides and specially, individuals and families with a mental illness[8]. Identifying these groups, identifying specific problems within these individuals and families, providing intervention through pharmacological and non-pharmacological methods in the form of promoting coping skills in these groups, providing long-term social support are all important intervention strategies that need to be implemented.

Help lines: Establishment of emergency help lines and counselling services will be a major step to provide care for those with suicidal attempt, ideas and behaviors, for families with a completed suicide.

Tertiary Prevention

Tertiary prevention involves avoiding suicide in survivors of suicide attempts and family members of suicide completers or suicide attempters

Suicide (completed/attempted/ threatened) carries considerable stigma in all section across the Indian society. Suicide survivors and families face considerable guilt and shame, and experience long-term problems ranging from legal difficulties to changes of residence/jobs/school. Such individuals and families thus require supportive pharmacological and non-pharmacological interventions on a long-term basis. Equipping them with coping skills for future living is a fundamental requirement. A strong, supportive and understanding family and peer groups forms the backbone for rehabilitation of such subjects, it should be strengthened effectively. In defined geographical areas, suicide survivors should be encouraged to form "self help supportive groups" by professionals.

Role of Nongovernmental Organization (NGOs) in suicide Prevention

NGOs can play a very important role in suicide prevention activities at various levels. They can provide services like: round the clock telephonic

crisis intervention for relationship problems, academic stress, financial burden etc, training the volunteers for counselling people, providing sensitization programs for high risk individuals, organizing stigma reduction programmes etc. In India, many NGOs like Sneha (Chennai), MPA (Bangalore), Saarthak (Delhi) and Prerna (Mumbai) have been providing suicide prevention activities in various parts of the country.

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