Why people who attempt suicide need more than meds

September 18 2017, by Jason Bantjes

Credit: Unsplash/CC0 Public Domain

Meet Jane. She's 22 years-old. She has a quirky smile and an unconventional sense of humour. She's finished high school and has a young baby. She has been unemployed for a long time.

When her mother died, she was devastated. Her only support structure was gone. And the responsibilities of being an unemployed single mother became too much. She felt alone and unsupported. She felt that she would never escape the unemployment trap. She saw no alternatives.

So she tried to take her own life. She ended up in an intensive care unit and needed to be in hospital for more than a month, having multiple surgeries and medical interventions for her self-inflicted injuries.

Jane is not alone. In South Africa it's estimated that about one completed suicide takes place every hour. This is on a par with developed countries like the US and UK. The statistics also show that people who attempt suicide are at high risk of repeating the action. They are also 20 to 30 times more likely than the general population to die by suicide.

If Jane had better access in her community to integrated psychological, social and psychiatric interventions she would possibly not have endangered her life and landed in hospital. A growing body of research shows that integrating these three services are best practice for reducing suicide risk.

But this isn't the case in South Africa. People are able to access medical care at their clinics – which is the first point of care for most – but psychologists, psychiatrists and social workers are not always part of the primary health care setting.

In addition to the integrated services, mental health care providers also need to understand what people who attempt suicide need to prevent future episodes. Globally this has hardly been done.

Our study set out to get an insider perspective from people who had made medically serious suicide attempts. Our aim was to identify ways in which future suicide risk could be reduced by learning from the

patients.

Our findings confirm that a integrated approach to suicide prevention is needed in South Africa. But it also highlights the need for person-centred, psycho-social support and psychiatric services at clinics in communities.

And in addition to building patient's resilience, the solutions need to address social and economic issues, such as poverty, inequality, and interpersonal violence.

Consulting the real experts

As part of our study we interviewed patients admitted to an urban hospital after a medically serious suicide attempt. The patients we saw ranged from 18 to 67 years old.

In the stories they told we recognised many well known risk factors for suicide: lack of relationships, social isolation, loneliness, interpersonal conflict, substance use, severe depression, poor problem-solving skills, feelings of hopelessness and being trapped, as well as disempowered.

Patients from low-resource communities also had additional problems. Firstly they could not access psycho-social services at a primary health care level or get on-going psychiatric help.

Many described how they struggled to access mental health care at a community level. They often had to wait for a long time before they could see a mental health professional. And when they finally got a turn, they felt rushed by the psychiatric service providers. Their community clinics and day-hospitals often did not have counselling services – there were only nursing sisters they could see once a month, if they were lucky.

Some patients also struggled to get the medication they needed. Reasons included having to taked time off work every month to go to the clinic and often having to wait in long queues. As a result, they would often go home empty handed.

In addition to these challenges, they live in communities with oppressive social and economic conditions. Endemic violence, structural poverty, enduring inequality and continuous trauma all contributed to making life unbearable.

Our findings draw attention to the health care context in which suicide attempts happen in South Africa. There are a number of problems with the structure and delivery of health care that impede mental health promotion at a comunity-based primary health care level.

The significant mental health treatment gap is one problem. There is a shortage of public mental health resources, and a lack of access to effective and affordable mental health care.

The other challenge is the fact that primary health care in the country is still predominantly biomedically orientated, in other words there's still a focus on dispensing medicine rather than providing more counsellors and integrating social services into clinics.

A new approach

It's difficult to prevent suicides, partly because so many different factors contribute to the problem. But the situation is not hopeless. There are effective interventions for suicide prevention and help is available.

Our study provides important insights into the type of support patients say they need. These requests are not unreasonable or unimaginable: appropriate, affordable, accessible, ongoing psych-social and psychiatric

care.

These are recommended in international suicide prevention guidelines and best practice standards for delivering mental health care.

South Africa has the policies and legislation in place to support such an approach. For example, plans have been made to create posts for registered counsellors in the health care system and counsellors have been trained to fill these posts.

But there have been delays in implementing these policies into all primary health care settings. Resources are scarce but there are also issues around allocating and managing resources.

It's equally important to recognise the socio-economic and contextual problems people face in low and middle income countries. These need to be addressed at a political and economic level to reduce suicidal behaviour. This requires different government departments and community organisations to work together to address problems such as violence, substance use, poverty and inequality.

This article was originally published on The Conversation. Read the original article.

Provided by The Conversation