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Original Research Article

A Study to Assess the Suicide Risk of Patients Admitted in t Psychiatric Ward with a View to Develop a Guideline for Staff Nurses on the Nursing Care of Patients with Suicide Risk, in a Tertiary Hospital, Kochi

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ABSTRACT

Background: Everyone in the mental health system may be at one time or the other, at risk for self harm and suicide. This study was done to assess the suicidal risk of patients who are admitted in psychiatric ward of a tertiary care hospital at Kochi, Kerala and to develop a guidelines for suicidal prevention for staff nurses.

Materials and Methods: The research design adopted for this study was non-experimental descriptive design. The sample for the present study consisted of 30 patients who are admitted in psychiatry ward of Amrita Institute of Medical Science, Kochi. The sampling technique used is convenience sampling. The researchers developed a suicide risk assessment scale. The validity and reliability of the tool was tested. The method used in this study was interview with structured questionnaire.

Result: Results shown that 100% did not have suicidal plan as such, but 13.3% of them had death wishes. Majority of the subjects i.e. 96.6% had symptoms such as guilt, hopelessness, helplessness, shame, impaired problem solving. In 69% of the subjects there were more than 4 symptoms, 90% of the subjects had significant life events such as financial loss, loss of loved one, love failure, failure in examination, majority of them i.e. 74.1% had at least 2 events. History of suicide attempt is seen only in 6.7% of the subjects, 93.3% of them didn't have any such attempts. Moreover 16.7% of them have family history of suicide and 83.3% of them didn't have any significant history. There was a significant association between suicidal risk and educational level.

Conclusion: Many patients had expressed the depressive symptoms and also it has been observed that there was a significant association between suicidal risk and educational level. A guideline for suicidal prevention has been distributed to all staff nurses working in the psychiatric ward after getting validated from experts.

Key words: Suicidal risk, Staff nurses guidelines, psychiatric patients, nursing care of suicidal risk.

INTRODUCTION

Suicide *(sui-self; cide-murder or deliberate self harm)*can be defined as the intentional taking of one's own life in a culturaly non-endorsed manner.[1] Suicide is highly stigmatized in contemporary society, even more so than mental illness. The fear of being stigmatized prevents individuals with strong suicidal thoughts from seeking treatment.[2]

A Psychiatric Mental Health nurse will inevitably care for persons who try to harm themselves or express feelings such as 'I wish I were dead' or 'there is nothing worth living for'. The act of self harm is behaviour-an expression of an internal feeling state. Being suicidal is not a disease-it is not a disorder. Although we are compelled to try to prevent people from killing themselves we will not always

succeed. Everyone in the mental health system may be at one time or the other, at risk for self harm and suicide.

It is the responsibility of the nurse to be alert to the possibility of this behaviour, to have the knowledge to assess for suicide and to have the basic skills needed to support and care for the suicidal patient.[3] The world health report 2001, estimates that every year I million people worldwide commit suicide (100,000 per year in India out of 1 million in the world every year), while 10 to 20 million people attempt suicide[4].

Suicide is among the top 10 causes of death in India and most other countries. The official suicide rate in India in 2008 was 10.8 per 100,000 population per year (9.7 in 1995, 6.3 in 1980). In 2000, the rate in men was 12.2 per 100000 and in women 9.1 per 100000 with an overall male to female ratio of 64:36 in 2008(NCRB)[4].

According to the National Crime Records Bureau (NCRB), there were 125,017 suicides in India in 2008 which is an increase of 1.95 over the previous year. In 2003, there were about 300 suicides per day or 1 suicide every 5 minutes. The comparable period prevalence rate for suicide throughout world ranges from 5 per 100,000 population per year to 30 per 100,000 population per year[4].

Horowitz et.al noted the increased number of adolescence seeking emergency treatment with mental health problems particularly self destructive behaviour and described the expanded responsibilities of the emergency department staff related to triaging mental health issues. Screening in the emergency department has also been identified as an important intervention in suicide prevention[5].

MATERIALS AND METHODS

The basic approach used in the present study is quantitative approach. The research design adopted for this study was non-experimental descriptive design. The setting of the study was confined to the psychiatry ward of Amrita Institute of Medical Science, Kochi. The sample for the present study consisted of 30 patients who are admitted in psychiatry ward of Amrita Institute of Medical Science, Kochi. The sampling technique used is convenience sampling. In order to assess the suicide risk of patients admitted in psychiatry ward, the researchers developed a suicide risk assessment scale. The instruments are devices utilized to collect data. The method used in this study was interview with structured questionnaire. A suicide risk assessment scale was developed by the investigators. The instrument has two Section I and Section II. Section I consisting of 8 questions to categorise demographic characteristics and 5 questions to assess the clinical variables.

Statistical Analysis

The suicidal risk was assessed using percentage analysis, and the association between demographic variables and the risk was assessed using Chi-square test

RESULT

Section A-Demographic variables and clinical characteristics of the subjects

Table 1: Frequency and percentage distribution of subjects based on clinical variables n=30.

SI. No.	Clinical Variables	Frequency	Percentage.
1.	**Duration of illness**		
	<6 months	3	10
	6-12 months	3	10
	1-5 years	10	33.3
	5-10 years	4	13.4
	>10 years	10	33.3
2.	**Duration of treatment**		
	<6 months	15	50
	6-12 months	5	16.6
	1-5 years	6	20
	5-10 years	2	6.7
	>10 years	2	6.7
3.	**Compliance to treatment**		
	Good	26	86.6
	Moderate	2	6.7
	Poor	2	6.7
4.	**Physical illness**		
	Yes	9	30
	No	21	70
5.	**Associated co- morbid illness**		
	Diabetes	2	6.7
	Hypertension	3	10
	Hepatitis	4	13.3
	Nil	21	70

About 26.7% patients fall in the age group between 25-35 and another 26.7% in the 35-45 years. Majority of the samples 53.33% of subjects are males and 46.67% of them are females. Most of the subjects are married i.e. 60%) of them, whereas 33.4% of them are unmarried. 43.3% subjects have monthly income in the range of 5000-10,000. Most of them are educated up to degree level i.e.43.3%, rest of them are educated at least up to tenth standard 43.3%. Most of them are employed privately i.e. 40%. About 83.3% of the subjects are Hindus and Christians constituted 13.4%. Majority of the sample i.e. 50% are diagnosed with BPAD, schizophrenia 10%, alcohol dependent syndrome about 36.7% and only 3.3% of them has conversion disorder. The duration of illness was more than 10 years in about 33.3%, and in 13.4% of subjects it is 5-10 years. Compliance to treatment is good in about 86.6% of the subjects and is comparatively poor in 6.7% of the subjects. There is no co morbid illness in about 70% of the subjects, 13.3% of the subjects have Hepatitis, 10% have hypertension and 6.7% of them have diabetes

Section B-Risk of suicide among patients admitted in Psychiatry Ward.

Table 2: Risk of suicide among patients admitted in Psychiatry Ward.

Suicide risk	Frequency	Percentage (%)
Mild	21	70
Moderate.	9	30
Severe.	0	0

Table 3: Frequency and distribution of items based on the scores

S.I No	Item		Frequency	Percentage (%)
1.	Suicide plan.	Yes No	0 30	0 100
2.	Death wishes	Yes No	4 26	13.3 86.7
3.	Symptoms. a. 2-3 symptoms. b. Upto 4 symptoms. c. More than 4.	Yes No	29 1 5 4 20	96.6 3.4 17.2 13.8 69
4.	Significant life events. a. 2 events. b. 3-4 events. c. More than 4 events.	Yes. No.	27 3 20 5 2	s90 10 74.1 18.5 7.4
5.	History of suicidal attempt.	Yes. No.	2 28	6.7 93.3
6.	Family history.	Yes. No.	5 25	16.7 83.3

The above table shows that all the subjects i.e. 100% did not have suicidal plan as such, but 13.3% of them has death wishes. Majority of the subjects i.e. 96.6% have symptoms such as guilt, hopelessness, helplessness, shame, impaired problem solving. In 69%of the subjects there is more than 4 symptoms. 90% of the subjects have significant life events such as financial loss, loss of loved one, love failure, failure in examination, majority of them i.e. 74.1% have at least 2 events. History of suicide attempt is seen only in 6.7% of the subjects, 93.3% of them didn't have any such attempts. Moreover 16.7% of them have family history of suicide and 83.3% of them didn't have any significant history.

Section C-Association of selected variable demographic variables with suicidal risk.

The analysis was done using SPSS software and the computed values are as follows.

Table 4: Depicting the association between demographic data and suicidal ris n=30

Demographic data	Suicidal risk		Chi - square	df	p Value
	Mild	Moderate			
Gender					
Male	13	3	2.066	1	0.151.
Female	8	6			
Education					
Upto 10th	11	2	6.557	2	0.038*
Degree	6	7			
PG	4	0			
Religion					
Hindu.	17	8	0.524	2	0.77
Christian.	3	1			
Muslim.	1	0			
Compliance To Treatment.					
Good	19	7	1.245	2	0.536
Poor	3	1			

*Significant.

The above tables depicts that the calculated chi square value is less than 0.05 for the educational level, therefore there is a significant association between suicidal risk and educational level.

DISCUSSION

This study was designed with the following objectives,

1. To assess the suicide risk of mentally ill patients using risk assessment scale.
2. To develop a guideline for staff nurses in managing patients with suicide risk .
3. To find association between the suicide risk and selected demographic variables.

The data was collected using a structured questionnaire which was developed by the investigators. The technique followed was structured interview technique. The findings of the study are discussed under the following headings.

Sample characteristic

Thirty patients admitted in the psychiatric ward were selected for the study by using total enumeration sampling.

The first objective was to assess *the suicide risk of mentally ill patients using risk assessment scale.*

Among the 30 subjects 70% has mild suicide risk and 30% has moderate suicide risk. No patients were having severe risk of suicide (Table 4). These data reveals that majority of mentally ill patients who admitted in psychiatric ward have at least mild suicidal risk.

Bisconer, Sarah W, Gross, Douglas M assessed the suicide risk of mentally ill inpatients in a psychiatric hospital. The sample was adults receiving acute psychiatric treatment in a public hospital. The study consisted of 2 groups: 25 patients admitted for suicidal behavior and 42 patients admitted for other reasons. Analyses were conducted to discriminate between the 2 groups on study instruments. Six instruments were used to assess suicide behavior and symptoms of anxiety and depression. No single instrument predicted suicide risk without significant error. Best practice instructs the use of a standardized instrument and clinical interview to evaluate suicide risk. Standardized assessments must be used as part of a structured clinical interview.

As presented in the 19th congress of European Psychiatric Association, EPA2011 Mental health professionals often classify patients' suicidal risk inaccurately. The study was conducted by Dr. Kate Manley and Dr. Julian Beezhold to examine the suicide risk for various clinical scenarios with a particular focus on ambiguous cases. A total of 720 MHPs from a broad range of disciplines were asked to assess suicide risk for 10 clinical scenarios developed to provide a mixture of high-, medium-, and low-risk cases. About 20% of MHPs suggested that they didn't know how to classify a patient. About 40% of MHPs were more cautious and opted for a high-risk classification. The remaining 40% were less cautious and assumed that the patient was at

low risk for suicide. The study also identified the need for better risk assessment training, for MHPs

This study which we conducted using a small sized sample did not seem to classify the patients accurately into appropriate category of suicide risk. Moreover the researchers had not used any standardized suicide risk assessment tool in this study

The second objective was to *develop a guideline for staff nurses in managing patients with suicide risk.*

As per the analysis result there are patients with suicidal risk among those admitted in the psychiatric ward. We prepared a nursing guideline for the staff nurses, giving them directions in caring these patients.

The third objective was to *find association between the suicide risk and selected demographic variables*

The data shows that about 27% of the patients fall in the age group between 25-35 and another 27% in the 35-45 years. 6.6% of them are above 65years of age. Fifty three percentages of subjects i.e. 16 of them are males and 46.67% i.e. 14 of them are females. Most of the subjects are married i.e. 18 (60%) of them, whereas 33% of them are unmarried. Majority of them are educated up to degree level i.e. 43%, rest of them are educated at least up to tenth standard (43%). The subjects have monthly income in the range of 5000-10,000 (43%). Most of them are employed privately i.e. 12 (40%). About 83% of the subjects are Hindus compared to Christians who only consist of 13%. The diagnosis for admission consists of mostly psychoses i.e. about 60% of them whereas the rest consist of substance abuse about 11 (36%) of them. Mostly the duration of illness is chronic in about 66% of the subjects; also there is good compliance to treatment constituting about 87% of the population. There is also co morbid illness in about 30% of the subjects, which predominately consist of Hepatitis and about 44% of them affected with it.

Table 4 depicts that variables like gender, marital status, religion, diagnosis, compliance to treatment and co morbid illness are not related to the suicidal risk.

These findings reminded us of the study conducted by SrivastavaMK[10] to analyse the risk factors associated with attempted suicide like variables related to socio demographic characteristics, family background, recent stressful life events, physical and psychiatric morbidity. Significant association was not revealed in respect to marital status, type of family, early parental losses, family history of suicide and presence of psychiatric morbidity.

According to Betty Neuman's concept, in this study the lack of social support and coping can induce suicidal ideations among people. We measured the risk for suicide in mentally ill patients by assessing their psychological and socio cultural dimension in the LOR. Their previous attempts, lethality and, intentionality were measured. Assessment of the suicide risk provided data emphasizing the need of the preventive measures to be adopted in the clinical settings by the nurses while caring the mentally ill patient

CONCLUSION

The study on the assessment of suicide risk among patients admitted in psychiatry ward yielded only results of patients having moderate and mild suicide risk. The researchers has been able to fill the lacunae that existed in identifying and detecting the risk factors involved in patients, that may precipitate suicide. Moreover the research provided an option to develop a tool that further enhanced the knowledge of the researchers in developing appropriate items in assessing the construct of suicide. Further based on the understanding of the researchers a guideline was prepared detailing what are the steps to be taken in the assessment of suicide risk of patients when they are admitted to the ward irrespective of their diagnosis.

The study maybe summarised to have the following limitations:-

1. The sample size taken was considerably less (n=30) which could have resulted in limiting the generalizability of the study.
2. The sample was heterogenous in nature in terms of diagnosis, which further restrict any plausible explanation for the association of suicide risk with the variables.
3. A standardized tool would or may have yielded better understanding of the phenomena of interest.
4. A standardized scoring may have helped to categorise patients better into mild, moderate and severe risk.

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