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Psychiatry Research 294 (2020) 113501

Contents lists available at ScienceDirect

Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

Review article

"Guarding the Gatekeepers": Suicides among Mental Health Professionals and Scope of Prevention, A Review

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ARTICLE INFO

Keywords:
Suicide
suicidality
mental health professional
psychiatrists
stigma
prevention

ABSTRACT

Suicide is a social evil that is considered to be a global epidemic. Mental healthcare professionals (MHP) (psychiatrists, clinical psychologists, psychiatric social work, etc.) are often involved as 'gatekeepers' in the management of suicidality and suicide prevention. Even though the risk of suicide in medical profession has received attention in research, there has been scarcity of literature related to the same in MHPs. They are not immune to the perils of psychological distress and its cascading consequences including suicide, contrary to the popular societal myths. The intrinsic and extrinsic pressures of the profession, persistent discourse in managing the psychological distress of others, professional burnout, self-stigma, societal apathy and easy access to psychotropics are certain factors making the MHPs more vulnerable. This disengagement and stress can contribute to depression, anxiety and complex trauma in the MHPs. The situation is furthermore compounded in developing countries with resource constraints, low MHP: patient ratio and inflexibility of work schedules. This makes tailored interventions, peer counselling, periodic mental health screenings and administrative understanding and accountability necessary at all levels. Keeping this in background, the review glances at the risk factors of suicide related to MHPs, highlights the problem statement and discusses the possible interventions.

1. Introduction: The Problem Statement

The new Indian Mental Health Care Act (MHCA) of 2017 (Vadlamani and Gowda, 2019) has decriminalized suicide but the ripples of a suicidal death or attempt continue to disrupt the life of the individual in particular and a mental health professional (MHP) at large. The recent suspected suicide of a celebrity (Sushant Singh Rajput) ("Sushant Singh Rajput dies by suicide at 34 in Mumbai," 2020) and of three medical professionals at one of the premier institutes of India, (All India Institute of Medical Sciences, New Delhi) including one MHP in a span of two months ("Another AIIMS doctor commits suicide — third in the past month | Cities News,The Indian Express," n.d.), may have more in common than meets the eye at first glance. Both come from a background of adequate awareness, accessibility, affordability and acceptability with demanding and constantly scrutinized professions that may conjure a toxic amalgam of self-harm that remains bereft of an antidote (Ventriglio et al., 2020). This underground pandemic of MHP's suicide is an interplay of the epidemiological triad of host vulnerabilities and environmental stressors catalysed by the agent of maladaptive coping. The old saying, *"Physician, heal thyself."* may find an equally redundant corollary in *"Psychiatrist, mind thy psyche."* which may provide poetic injustice to the profession and the mental well-being of the MHPs (Rosen, 1973). The suicide rate among the medical fraternity is said to be between 5-7 times the general population with psychiatrists on the unfavourable end of the spectrum across specialities (Dutheil et al., 2019a). The higher prevalence of depression, anxiety, substance use and self-medication in doctors including MHPs further fractures the mental health system and thus, necessitates a special discussion about their suicidal risk and prevention (Bhugra et al., 2019). Keeping this in the background, this review highlights the vulnerabilities of MHPs for suicide and possible preventive strategies.

2. Suicide in medical professionals: Factors and risks involved

It is a known fact, that under years of pressure a piece of coal transforms into a sparkling diamond. However, as the stress-performance curve's bell shape tells us that undue stress negatively impacts performance which manifests exponentially in high precision and demanding profession such that of medical personnel. The ubiquitous need for perfection impales the scope of mistake and this adrenergic overdrive may just be one of the etiological factors predisposing an individual to mental illnesses. As has been noted, the rates of depression and anxiety in doctors are not only higher than the general population but also more than other professionals (Gerada, 2018).

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https://doi.org/10.1016/j.psychres.2020.113501
Received 16 September 2020; Accepted 3 October 2020
Available online 08 October 2020
0165-1781/

Even though their resilience maybe reinforced by the financial security, social status and gratification, both immediate and delayed, a medical professional is, at the end of the day, not immune to medical ailments which include mental health issues. Intrinsic vulnerabilities which may from a distant perspective appear helpful as a professional can invariably turn counterproductive. The nurture-nature debate holds its ground in the conceptualization of Knudson's two-hit hypothesis in the current context (Knudson and Jr., 1971). The first hit in terms of genetic predisposition, adverse childhood experiences and experiences of loss are similar to anyone else (Gerada, 2018). The second hit is made more liable due to the nurturing of nature of an individual with traits like perfectionism, obsessiveness, driven, competitive, individualistic, ambitious and elements of martyrdom which are a Pandora's box, that when contained and regulated do no harm unless stress unveils a plethora of problems (Ventriglio et al., 2020).

After induction into the profession, the biosphere is comprised of personal, structural and endemic factors (Ventriglio et al., 2020). Personal factors entail pre-existing psychiatric illnesses, the disparity between demand and capacity with inadequate support that may predispose an individual to trauma, stress and eventual decompensation (Gerada, 2018). The perceived lack of control may steer one into a psychological Bermuda's triangle of guilt, low self -esteem and sense of failure. The structural factors or the milieu in which medical professionals are supposed to function is a dynamic one. The constant flux of managerial issues and extensive documentation further increases the woes arising from the disparity between demand and supply resulting in hurried patient consultations. There is a dearth of space and time for unwinding and reinvigorating oneself resulting in exhaustion and burnout.

The paradox of maintaining professional boundaries at the same time being an empathetic professional, especially at the time of loss, grief and bereavement are crucial endemic factors that repeatedly challenge the psychological homeostasis of an individual (Murphy et al., 2019). A systematic review and meta-analysis conducted by Dutheil et al. (2019) included 61 studies related to suicides, suicidal ideations and suicidal attempts among medical-related professionals. The overall standardised mortality rate (SMR) was reported to be 1.44 with the U.S. physicians being at a higher risk than rest of the world. This can also be due to the fact that suicides, especially in physicians, is grossly under-reported from the developing countries and thus limited in existing literature (Bhugra et al., 2019). Suicidal ideation was strongly linked to attempts and help seeking prior to the act. The relative risk of suicide in females was noted to be higher than their male counterparts across age groups. The hypothesis being that females juggle multiple responsibilities of their household and workplace especially in conventional societies. Also, interestingly the risk of suicide shows attenuation as one graduate to senior posts leaving the junior trainees the most vulnerable (Dutheil et al., 2019). The academic pressure, balancing work and life may be overwhelming for freshly recruited, many are able to adapt and adjust but some may be unable to cope. Certain specialities like anaesthesiologist, psychiatrist, general physician and general surgeon (Ventriglio et al., 2020) have been observed to be at a higher risk due to easier access to lethal drugs, long working hours, lack of autonomy and/or dealing with stressful traumatic experiences (client suicide, intra-operative death, etc.).

"*Don't do unto others what you don't want others to do unto you.*" – Confucius

Medical professionals refrain from discussing their mental health. Even though a recent online survey shows 80% respondents were reporting burnout, with the majority having a diagnosable psychiatric illness cross-sectionally or in the past 1 year, mainly depressive disorder and substance use disorder; around 20% were against seeking any sort of assistance or help (Bhugra et al., 2019). The major barriers in help-seeking arise from the stigma against mental illness, " The Scarlett Letter" (Hawthorne, n.d.) of being infidel towards one's profession on account of a "minor mood disturbance" is deeply ingrained in ignorance and lack of awareness thereof. The perception of mental illnesses being a sign of weakness in character and somehow avoidable limits help-seeking (Mortali and Moutier, 2018). Self-stigmatization only increases the perceived stigma and results in the internalization of negative views of others by self. In addition to this, the absence of a formal streamlined redressal channel the issues of confidentiality and disclosure become important as much of a doctor's practice maybe based on his reputation and fortitude (Ventriglio et al., 2020). The gruelling scrutiny by regulatory bodies and judgments regarding the doctor's capacity to practice in the presence of mental illness only dissipates the desire to discuss the same. This may lead to the "second victim" syndrome arising from blame and consequent isolation may inflict emotional trauma and disruption of the circadian rhythm (Ventriglio et al., 2020).

"*Tell me, do you bleed?*" – Batman vs Superman, 2016.

Sometimes the answer to the seemingly insinuating rhetoric maybe an affirming yes lest the doctor proves his immortality and freedom from suffering. The final phenotype of psychological suffering may lie on a spectrum of varying severity. Ranging from few symptoms to diagnosable psychiatric illnesses and suicide, at the opposite end. If distraught the doctor may do a "disappearing act" wherein he may take French leave and not answer calls, be late to work, when present may tardy or take frequent leaves on account of "physical" sickness. A picture of depersonalization and "presenteeism" wherein physical presence may be devoid of mental alertness is also observed. A more active manifestation may be "Clinical rage" with rage, low threshold for frustration and distress tolerance (Ventriglio et al., 2020).

With increasing rates of burnout, disengagement and exhaustion in physicians, the incidence of depression, anxiety, post-traumatic stress disorder (PTSD) are on the rise. A recent survey showed suicide was the second most common cause of death in residents training over 14 years (Yaghmour et al., 2017). In an Australian survey, approximately a quarter of doctors reported having had thoughts of suicide before the past 12 months (24.8%), and 10.4% reported having had thoughts of suicide in the previous 12 months. An important predictor of suicidality is suicidal ideations (Shanafelt et al., 2009). In 2008, a survey done in surgeons showed levels of suicidal thoughts were between 1.5 and 3.0 times more common among surgeons than the general population (Shanafelt et al., 2009). Importantly, only 26.0% of the surgeons with suicidal thoughts had sought help, whereas 60.1% were reluctant to seek help because of concern that it could affect their medical license. Thus, not only is there a need to discuss about suicide in medical professionals but also paramedical staff (like nurses, etc.) which may facilitate a systemic change in our approach and treatment of this vulnerable population as it suffers in silence (Davidson et al., 2020).

3. Suicidal risk in Mental Health Professionals (MHPs)

Mental health professionals include psychiatrists, psychiatric nurses, clinical psychologists and psychiatric social workers. To the surprise of a few, practicing in mental health does not provide passive immunity to mental afflictions. The most common methods of suicide have been noted to be self-poisoning and hanging which is alarming due to easy access to regulated and lethal drugs (Ventriglio et al., 2020).

The longitudinal observation of important checkpoints may provide a holistic perspective.

As has been mentioned before, psychiatry is one of the branches which has persistently shown higher rates of suicide compared to other specialities. What factors result in this notorious distinction?

- The intriguing question is if working in mental health predisposes an individual to risk-factors for suicide or does mental health-related professions attract more psychologically 'vulnerable' physicians?
- There is no definite answer to this question. However, one of the propositions might be that some physicians who choose the realm of mental health might do so due to their own unconscious conflicts

which may need resolution if albeit capriciously (Rosen, 1973; Gerada, 2018). This of course is a not a generic statement but just might be one of the possibilities.

- The intrinsic nature of the psychiatric illness may deprive professionals of immediate gratification. The chronic nature of many illnesses may not have a favourable prognosis and a sense of incapacity and helplessness may loom over the treating MHP. Unlike a benign neoplasm or refractory error which may be remedied by quick interventions with immediate results.
- The subjective nature of interpretation of symptoms may lead to varied explanations for the same in the absence of concrete objective assessment which may give a sense of ineptitude and lack of clinical acumen thereof, especially in young trainees. Assessment of 'self-perceived' distress, anxiety and stress are often assessed by MHPs based on the yardstick of 'diagnostic categorization' which delays help-seeking. Impaired mental wellbeing and quality of life are mistakenly equated with 'psychiatric disorders' and the perceived distress is intellectualized rather than a healthy assumption of the 'sick role' that can promote access to care and peer support (Murphy et al., 2019).
- The steep learning curve which includes honing not just knowledge but fostering good communication skills, empathy, discretion and maintains boundaries maybe a tedious and convoluted path.
- The self-medication hypothesis holds its ground firmly in the case of MHPs. In a survey of psychiatrists (Balon, 2007) it was found that around 43% responders would consider self-medication if depressed. This is an outcome of a constellation of factors –
  a The symptoms of psychiatric illness (depression, etc.) like shame, guilt, negative perceptions about self, etc. may result in fatigue – physical and cognitive and limit the ability to ask for help ("Depressed Psychiatrists and Self-Prescribing | Psychiatry & Behavioral Health Learning Network," n.d.).
  b The simplification of symptoms and use of medical jargon may lead to self-diagnosis which hinders one to seek further help ("Depressed Psychiatrists and Self-Prescribing | Psychiatry & Behavioral Health Learning Network," n.d.).
  c The easy accessibility to psychotropics, including psychoactive substances by means of a medical representative or self-prescription is another slippery slope.
  d Substances of abuse like alcohol, etc. as a quick remedy to one's distress is common nevertheless act as gateways to further recalcitrant deterioration.
- The profile of patients and their illnesses predisposes MHPs to highly litigious vulnerability thus requiring extensive documentation and medico-legal issues (Murphy et al., 2019).
- **Stigma** exists at three levels – self, societal and professional level. An MHP may be subjected to stigma based on the branch of specialization due to prevailing misconceptions and lack of communal awareness, which may be perpetuated by internalization of these negative stereotypes. The lack of knowledge may lead to discrimination by a fellow medical professional and lack of societal reinforcements which can lead to the development of shame, guilt and self-doubt (Dutheil et al., 2019). Social attribution theories and cognitive psychology explain how 'internalizing social stereotypes' can inherently affect the beliefs, self-perceptions, self-esteem and practice in any profession that eventually reflect on the self-care and help seeking (Corrigan, 2000). The same can be applied to MHPs as well considering the widely prevalent 'stereotypes' about mental health and mental healthcare providers. 'The Health Stigma Discrimination (HSD) model' by Stangl et al. (2019) posits that internalized stigma might lead to 'self-othering' and social segregation which further perpetuates discrimination among those affected. Such self-stigma can affect MHPs especially when they witness the widely prevalent myths and misconceptions about mental health, thus 'mirroring' the social stigma in the process. Lack of self-awareness, fear of social reactions and prejudice can act as 'drivers' whereas occupational inequality, increased workload and social apathy can act as 'facilitators' for "stigma marking" (Stangl et al., 2019). This can enable a wide range of discriminatory behaviours, which worsens social relationships, creates social exclusion and reduces social acceptance (Parker and Aggleton, 2003). Like any other vulnerable group, MHP may also suffer from perceived stigma, associated stigma and internalized stigma, which may be connected with the general 'othering' associated with 'mental health' and 'psychiatric practice' in many nations. Such traditional stigma even though dealt with by the MHPs in their daily practice, can also victimize them quite often (Murphy et al., 2019; Stangl et al., 2019)
- The arduous process of therapeutic interventions including long term therapy especially with clients of personality disorders, substance use or chronic relapsing severe mental illness may be a stressor. This can result in burnout, exhaustion and lack of time to relax. This can trigger personal conflicts in the therapist's life, especially problems with attachment, behavioural control and self-concept.
- Complex trauma may be an important and recurrent component in lives of many MHPs. It arises from chronic stress and repeated exposure to patient's trauma which can be self-reflected in interpersonal context. Briere and Scott (2015) has defined 'traumatic event' as an event that arouses a person's past stressors causing impaired coping and resilience. Sartor (2016) mentioned the concept of **'vicarious trauma'** that can occur with continued work and efforts with traumatized clients. Such trauma was shown to reduce self-efficacy and social connectedness. Vicarious trauma has been a well-researched concept in the field of mental health especially among combat veteran therapists, military psychology and child psychologists (Jordan et al., 2010). Peer supervision, mental health consultations, social support, self-care and leisure are proposed to act as resilience factors and stress buffers to mitigate this personal and professional trauma. Working in certain sensitive areas like gender-based violence and childhood sexual abuse can trigger self-traumatization, similar experiences of the past and childhood attachment patterns, which can further lead to maladaptive coping, stress, sleep disturbances and depression: all of which can be the risk factors for suicides (Coleman et al., 2018).

Vicarious trauma is an important risk factor for MHPs, that can drive and facilitate chronic stress leading to impaired psychological wellbeing and quality of life, which along with self-stigma and reduced help-seeking can possibly increase the risk of suicides (Figure 1).

- Clinical psychologists are especially vulnerable as they engage in emotionally draining and often distressing prolonged psychotherapy sessions (Dialectical Behavioural Therapy, etc.). The laying down of one's emotional guard for better acceptance and acknowledgment of the clients distress makes them at risk of being adversely affected by such content. The transient failure of the therapeutic intervention may devoid the therapist of the larger picture on the road to client recovery and a novice therapist may integrate this momentary mistake into an adverse cognitive schema about self which may snowball into larger negative perceptions. In the lack of proper training, lack of expert supervision and paucity of peer group support clinical psychologists are left in the dark. The legal implications, as history provides an insight (Tarasoff I and Tarasoff II), can be extremely daunting and tricky adding on to the woes of the therapist.
- The psychiatric social workers often do the most tedious tasks in the absence of immediate gratification and reinforcement. The community work may expose them to many perils of being mentally ill and bring them in contact with authorities that may be distant and aloof.
- The important interjection of suicide in clients and the consequent effect on mental health professionals needs detailed discussion.

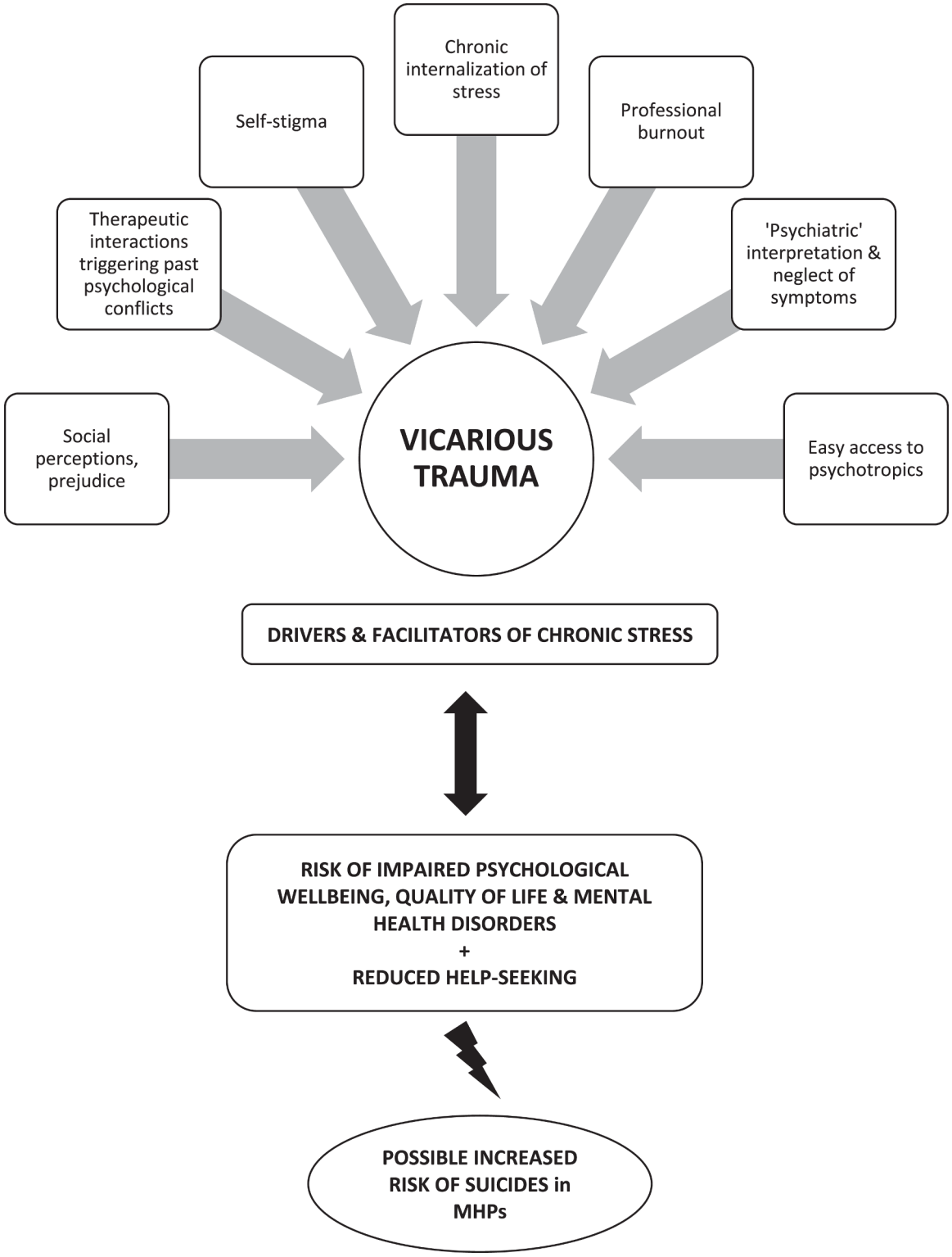

Fig. 1. Specific risks in the mental healthcare professionals (MHP) that lead to vicarious trauma and facilitate chronic stress, eventually increasing the likelihood of psychosocial dysfunction and impaired quality of life, thereby enhancing the possible risk of suicides.
Genetic vulnerabilities are common risk factors for any individual and hence not included in the figure.
MHP: Mental Healthcare Professional.

Approximately 40% of individuals who die by suicide have had some previous contact with mental health services with 70% of these individuals having contact with mental health services in the 12 months before their death (Kielty et al., 2015; Sherba et al., 2019). The suicide of a client can lead to personal and professional distress, resulting in changes in professional practice (Murphy et al., 2019).

- Personal distress – Feelings of guilt, sadness, shock, anger and irritability are not uncommon especially if the client is young or mother of young children. Greater levels of distress are felt if a close

relationship is established and the MHP has been involved in the therapy process for long.

- Professional distress – Sometimes client suicide may be unexpected and may come as a shock leading to adverse professional sequelae like reduced self-confidence, self-doubt and reluctance to work with clients expressing suicidal ideations subsequently.
- Changes in professional practice – Positive changes in practicing include heightened alertness with more frequent formal and informal risk assessments with greater supporting skills. Better documentation in view of "blame culture' and "fear of litigation" may promulgate vicarious resilience.

MHPs may thus, along with family members and loved ones be "suicide survivors" and must cope with grief and disbelief that can predilect to mental illnesses.

4. Developing countries: an Indian perspective

The fabric of India is embellished with religion, culture and its socio-ethnic diversity. These result in manifestations of psychological distress in varied ways and often as proxy measures to seek help for mental health issues. The collectivistic society and lack of a psychological model of illness predispose individuals, including mental health professionals, to adapt more physical models of illnesses. "Culture idioms of distress" are a common entity used as a substitute for psychological stress by masquerading it as physical symptoms like abdominal discomfort, multiple bodily pain symptoms which are vague and non-specific, etc. Thus, somatoform symptoms are oft-seen under various other specialities before being shunted to psychiatric assistance. The larger societal acceptance and acknowledgment of physical symptoms, lack of linguistic competency and stigma may defer required treatment and divert from the actual cause of distress, predisposing to adverse outcomes like suicide.

In the dearth of literature on suicide in mental health professionals the recent NMHS survey provides important insights (Murthy, 2017). With an estimated prevalence of any mental morbidity of 13.7% and current mental morbidity of 10.6% (Gautham et al., 2020) approximately 130 million people require mental health services. At-risk MHPs, form the neglected fraction of dual service providers and consumers or 'prosumers'. The treatment gap as reported by the National Mental Health Survey (NMHS) 2015-16 is around 70-92% for various mental illnesses. According to the mhGAP, WHO the treatment gap for mental disorders is estimated to be more than 75% ("WHO | WHO Mental Health Gap Action Programme (mhGAP)," 2020). This highlights the absolute and alarming need for MHPs to take care of mental health needs. However, the abysmal manpower of the median number of psychiatrists in India of 0.2 per 100,000, psychiatric social workers in India of 0.03 per 100,000, clinical psychologists in India of 0.03 per 100,000 and nurses in mental health in India of 0.05 per 100,000 is far below the global median ("WHO |Mental Health Atlas 2005," 2014) . This not only is an indicator of a lack of MHPs but an indirect indicator of the work burden and need to work overtime to take care of the mentally ailing due to acute staff shortage. MHPs end up working more than their capacity resulting in exhaustion, burnout and neglect of self-care predisposing to mental illnesses and suicide invariably.

Especially in India, 'psychiatry' or any other related mental health profession has been traditionally stigmatized. Referred to as *"paagolon ka doctor"* in Hindi (doctor of the lunatics), visiting or even personally connecting with a psychiatrist is not considered in 'good light'. Widespread misinformation, biased portrayal by the popular media and rumour-mongering further worsen the 'images' of MHP in the community (Kishore et al., 2011). Added to the fact, psychiatry has traditionally wrestled to prove its 'biological' foothold in the scientific community, which has been misinterpreted by many as a 'pseudoscience'. This often leads to 'ambiguous' position of MHPs in the medical fraternity. Studies from India has shown that people prefer to visit a general physician, faith healer or someone close to them, rather than visiting a MHP when they feel sad or anxious (Kishore et al., 2011). Venkatesh et al. (2015) reported high perceived stigma in Southern India both towards people with mental illness as well as MHPs. All these factors can impair work satisfaction, social inclusion and resilience in the MHP community, adding to the pre-existing vulnerabilities of some. The lack of proper review boards, grievance and redressal committees and fear of loss of professional opportunities further worsen the shadow pandemic of the acute and chronic mental health gap. This elucidates the dire need for more studies and policy-level changes for vouchsafing the interests of the MHPs in India.

5. The Possible Strategies

To prevent a completed suicide may be like finding a needle in a haystack, if not impossible extremely difficult. As per a recent study, the majority of patients who may be deemed to be at high risk of suicide may not attempt it, while half of all suicides occur in people seemed to be at low risk (Large et al., 2017). The generalizing of MHPs being at a higher risk of suicide based on preliminary data may be a reductionist approach. As statistically, we know correlation does not amount to causation. To get a better understanding instead of extrapolating data, one needs to back trace the commonalities amongst the MHPs who attempt or complete suicide (Rosen, 1973). The fact that suicide estimates are grossly under-reported, with many suicides being masqueraded as accidental deaths. The undoing of the same would be to perform a psychological autopsy on suspected suicide cases of MHPs to elucidate the predisposing and precipitating factors resulting in the unfortunate outcome (Rosen, 1973).

***"Depression: Let's Talk"*, WHO**

The above statement holds the beacon of change at the gates of the gatekeepers. Primordial and primary prevention is better than cure. This includes changes at the systemic level which facilitate early detection and interventions. A conducive work environment that nurtures learning as well as self-reflection, personal growth, self-care and autonomy opens vistas to positive mental health (Ventriglio et al., 2020). Assisting junior doctors to manage workload demands and patient contact will have beneficial effects on their work enthusiasm and mental health. The establishment of a redressal committee or a grievance/welfare committee that is approachable and functional may act as a buffer to emotional turmoil (Mortali and Moutier, 2018). Talking to colleagues and superiors allows ventilation and introspection, the therapeutic effect of knowing people understand and validate your emotions is the premise on which many therapy schools are based on. Health Education England in a recent report (2019) suggested a number of measures which include the appointment of wellbeing guardians in each hospital, better occupational health access with a focus on the spiritual and psychological wellbeing of medical staff (*NHS Staff and Learners' Mental Wellbeing Commission*, 2019). This can be reinforced by individual counselling and wellness workshops which create awareness at the same time ease the trepidations in communication on such volatile topics. Earlier recognition can be ingrained in MHPs by making it an integral part of their training and education, to be kind to your own and recognize early signs of distress in an MHPs which may have an altered manifestation due to their profession. Peer support may bolster individual psychological resilience which manifests as multistage enhanced functioning – clinical, educational and managerial.

Gatekeeper training is already a popular model in suicide prevention. The term "gatekeeper" refers to "individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine." They can be trained to "identify persons at risk of suicide and refer them to treatment or supporting services as appropriate" (U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012). It has been consistently stressed in the

literature that any individual irrespective of the socio-economic class, background or professional expertise can act as a "gatekeeper" against suicide if he/she is able to identify the 'warning signs'. This approach has been evidence-based in schools, medical settings, primary care, emergency staff and communities (Wyman et al., 2008). Details of the 'gatekeeper model' for suicide prevention is covered by Burnette et al. (2015), and is beyond the scope of this review. MHPs being well-versed in this 'train the trainers' approach can also act as "gatekeepers" for their peers within the communities with appropriate awareness and empathy.

The fear of disclosure resulting in the withdrawal of license and professional loss is not unfounded. The authorities need to be sensitive to this information, avoid naming, blaming and shaming whilst providing a safe space to discuss and guide.

Thus, changes need to occur at an -

- **Individual level** – recognition of exhaustion, burnout and stress in self and others, reducing in the self-stigma of suffering from a mental illness, communicating suicidal wishes with someone and acknowledging the severity of such fleeting thoughts, taking time for self-rejuvenation, not equating academic proficiency to happiness and respecting one's limitations.
- **Organizational level** – Public policy reforms, with the regulation of working hours, adequate redressal committees, fostering a caring and empathetic work environment, recognizing the science behind suicide.
- **Societal level** – Improvement in knowledge, attitude and practice with regards to the work of MHPs which might help in social inclusion and reduction of stigma. Media has a significant role to play usual. The portrayal of MHPs, understanding of their work, reporting mental health issues and suicides, as well as sharing their lived experiences will encourage societal support, empathy and collectivism. Media reporting of suicide can have significant impact on public reaction and attitudes, and MHPs cannot be considered immune to the same (Cheng et al., 2007). WHO has laid down clear guidelines for media reporting of suicides that can be adhered to for sensitive depiction of events, reduce stigma and negativism, as well as foster awareness related to mental health (World Health Organization, 2017). In most cases however, there is failure to comply with these guidelines in terms of failure to mention the supporting sources, excessive detailing of the 'act' rather than the background and prevention and unnecessary speculation related to the trigger (Utterson et al., 2017). The relationship between media sources and MHPs can get strained over discussion related to 'high profile' suicides and repeated such discourses and interviews will affect their mental wellbeing. Healthy and collaborative discussions with media over suicides improves information-education-communication (IEC) gap and reduces stress on MHPs.
- Administrative level: Facilitating research into the suicide risk of MHPs, legislations and relevant policy-making; encouraging help-seeking and reduction of medico-legal complications in case of a suicidal attempt.

Considering the ongoing Coronavirus disease 2019 (COVID-19) pandemic, it will be unfair not to mention the increased psychological burden on the healthcare workers, which include the MHPs (Spoorthy et al., 2020). Further, considering the psychosocial toll of the outbreak, the workload and burnout in MHPs may also increase. Though, reports of increased suicide in the general population have been reported recently, systematic research especially in suicidal risk of healthcare professionals is lacking (Gunnell et al., 2020). Rapid dissemination of data and adequate surveillance of national mortality, surveys and scientific literature will help researchers and policy makers estimate the impact of the pandemic on the mental health professionals. The International COVID-19 Suicide Prevention Research Collaboration (ICSPRC) is working with the International Association for Suicide Prevention (IASP) and WHO to formulate a strategic and evidence-based protocol for suicide prevention during the COVID-19 pandemic (Niederkrotenthaler et al., 2020). It is imperative that the "voices" of MHPs are also included in the decisions and strategy making processes.

6. Conclusion

Prevention of suicide and management of suicidality are common attributes for mental health professionals. Like any other profession, mental healthcare workers too are not immune to the mental distress themselves. This review highlights the risk factors for MHPs related to suicide and proposes certain strategies to mitigate them. While many of these might be similar to the existing suicide-prevention methods, certain areas like societal and self-stigma, improving self-awareness among MHPs, peer support, healthy involvement with media and finally 'vicarious trauma' are tailored towards the need of those who work in the field of mental healthcare. This includes both medical and non-medical professionals. The authors would like to stress on the fact that though many of these measures are propositions that are not yet evidence-based, they are grounded in clinical experience and can potentially serve as framework for further empirical research. Work-related factors, distress modelling, burnout and occupational frustration, as well as therapeutic nihilism with regard to chronic psychiatric disorders, are the most-studied factors increasing the suicide risk of MHPs (Sherba et al., 2019). Though the risk of suicides in medical professionals is well researched in literature, MHPs occupy a very limited part in this discourse. This applies more to the low and middle-income countries, where infrastructural deficits, resource limitations and administrative fallacies further compound the picture. The persistent involvement and dealings with the 'psychological problems of others' can lead to chronic stress and complex trauma that reflect on self-identity, self-esteem and occupational performance. Regular peer debriefing and mental health screenings have been proposed for physicians serving at high-risk situations (Ventriglio et al., 2020). The same model needs to be applied for MHPs with identification of the vulnerable groups, especially at the student-level. Like any form of suicide prevention, this too is a collective responsibility which needs systematic research into the suicidal risk and prevalence among MHPs, regular data audit in case of physician suicides, both of which can shape policy and legislation. Lived experiences of those MHPs who have faced suicidal ideations or have undergone significant stress might help understand the psychological crisis and resilience factors. MHPs are often involved in community awareness programs and gatekeeper training, however, personal implementation of 'learnt strategies' often stays as a challenge. Understanding of this risk at all hierarchical levels, targeted mental-health interventions for those at-risk, encouraging peer discussion and psychotherapeutic help among MHPs and decreasing self-stigma related to mental health are the ways forward for gating the lives of the 'gatekeepers'.

Declaration of Competing Interest

None

Funding

None to disclose

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