

SUICIDE PREVENTION



INFORMATION FOR FAMILY PHYSICIANS



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Bangalore - 560 029,
India

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FOREWORD

Mankind marches ahead in its quest for growth and development : the changing social, economic and health pattern of societies is a living testimony to this growth and development. Suicide, an index of disturbed society is one of the leading causes of morbidity, mortality, socioeconomic losses and diminished quality of life. There have been some efforts by Indian researchers to understand this problem in its various dimensions and much more needs to be done.

It is shocking to note that nearly 1,10,000 persons completed suicides in India and Bangalore city alone has been recording more than 1500 suicides every year. Nearly 10-20 times this number have attempted and lakhs of people would have passed through suicidal thoughts. This complex problem is often an interplay of various health, social, economic and cultural factors, specially in a country like India experiencing poverty, illiteracy and ignorance.

Undoubtedly, suicide prevention is everyone's business in every society. Only an integrated, coordinated, intersectoral approach in a scientific manner is likely to yield results. The departments of Epidemiology and psychiatry undertook population based and hospital based research in this area, resulting in a greater body of knowledge for prevention programmes. Following research, Gururaj and Mohan Isaac initiated a series of capacity building workshops for doctors and hospital administrators, NGOs in health care, educational institutions, police and legal officers, child and women development organizations and media professionals. The perspectives, impressions and recommendations of these workshops are being brought out as "Information" handbooks for these professionals. These books should guide our Policymakers and professionals in developing national suicide prevention policy on a scientific approach with the involvement of everyone working in this area. I strongly urge the Indian society to consider suicide prevention as a major agenda of the present decade to save our precious human resources.

❖ **D. Nagaraja**
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PREFACE

Suicides are now recognized as a public health and social problem in every country, including India. Suicides have been on the increase in every part of India, in both urban and rural areas. As per National Crime Records Bureau reports, the city of Bangalore has been recording highest number of suicides for several years. Wide variations have been noticed in suicide problem and pattern in several parts of the country. The complex and cumulative interaction of social, health, cultural, economic and environmental factors are known to result in suicides. As majority of suicides happen in the young and productive segments of society, it is a phenomenal loss to developing societies.

Even though the problem is on the increase, a scientific understanding of the problem has not been attempted in a major way. National Institute of Mental Health and Neuro Sciences recognized the problem during 1995 and initiated a major study in the city of Bangalore. A large scale and indepth population based study was undertaken to unfurl the epidemiological dimensions of suicides. Two reports entitled “Epidemiological of Suicides in Bangalore” and “Suicides ...beyond numbers” are available to readers, providing scientific details. Simultaneously, the Ministry of Health and World Health Organization, South-East Asia Regional Office facilitated the study on “Risk factors for completed and attempted suicides” in Bangalore. This work has been completed and results are available to researchers, policy makers and public health administrators.

Dissemination of research results, capacity building process and development of intervention programmes are urgently required for prevention of suicides. As causes of suicides are several, interventions must be intersectoral. Prevention programmes require the participation of professionals from health, education, social welfare, commerce, industries, excise, media and others to initiate programmes. However, it was felt that there is need for awareness programmes, sensitization of issues, consensus building and identifying key components for prevention within each sector.

With this in view, NIMHANS initiated and completed a series of workshops for doctors and health administrators, family physicians, NGOs in mental and general health, heads of educational institutions, police and legal professionals, child and women development organizations and media personnel. In each of the workshops,

researchers and other prominent people shared their opinions while participants deliberated and identified key areas of activity. The issues, discussions, recommendations and activity components have been summarized in these 7 reports as “information documents”; viz ‘Information for Health Professionals’, ‘Information for Non-Governmental Organizations’, ‘Information for Educational Institutions’, ‘Information for Family Physicians’, ‘Information for Police Personnel’, ‘Information for Woman and Child Development Organizations’, and ‘Information for Media Professionals’. Each document has been organised into 3 parts. First section provides an overview of suicides in Bangalore focusing on the problems, causes, impact, neglect of suicides, role of intersectoral approach and capacity building measures. Section 2 delves in detail on various issues discussed during the workshop and remedial measures for action. Details of the workshop and participants are provided in Section 3. To maintain uniformity, section 1 is common in all reports and the remaining 2 sections are unique for each of the workshops.

Undoubtedly, these information documents are not a prescription but a proposition. It shows the possibility of wide variety of interventions to be considered - prioritized - implemented within and across different sectors. The suggested mechanisms are aimed at reducing suicides in general, while focussing on the problem in different societal groups. It is our hope that 5 P’s - Politicians, Policy makers, Professionals, Public and Press of society recognize the problem and initiate activities.

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We wish to acknowledge the invaluable contribution of many organizations and individuals participating in the process of suicide prevention in Bangalore. We are thankful to Dr. D. Nagaraja, Director and Vice-Chancellor and Dr. M. Gourie Devi, Former Director of NIMHANS for all encouragement, help and all co-operation towards the study and series of workshops held at NIMHANS during 2002-03. Our sincere gratitude to Karnataka State Council for Science and Technology for providing financial support to complete Phase I studies (1998-2000). Our deep sense of gratitude to the Ministry of Health- Government of India and World Health Organization - South East Asia Regional Office, for providing financial support to complete the II Phase of project on Case Control studies and Capacity Building workshops during 2001-2003. Our sincere appreciation to all the keynote speakers and resource persons for bringing their views and perspectives in these workshops. With specific reference to this workshop, we are thankful to Dr. Srinath Herur and Dr. B.C. Rao, (members of the Indian Association of General Practitioners). Our profound thanks to all the participants for deliberating intensely on many issues of Suicide Prevention.

We gratefully acknowledge the inputs and contributions of Dr. Ranjani Ramanujam, Senior Research Officer, under the project 'Identification of risk factors and capacity building measures for prevention of suicides'. Her valuable inputs in preparation for the workshops, handling correspondence, summarizing the proceedings and development of the manuscript is sincerely acknowledged.

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1. INTRODUCTION

Health is a fundamental human right and a world wide social goal. An understanding of health and disease along with delivery of affordable quality health care is the basis of all health care. Health has evolved over the centuries as a concept from an individual concern to a world wide social goal and encompasses the whole quality of life. Health involves individuals, state and international responsibility and its promotion is a major social investment. The purpose of health services is to improve health status of the population and is essential for social and economic development. Health services must be designed to meet the health needs of the community through the use of available knowledge and resources.

The health sector has been striving to improve health of people and to usher in a better quality of life among individuals. Historically, societies have strived to achieve better health status through a number of medical advancements along with improvements in education, income levels, better access to quality health care and improving quality of services. However, a large number of people in the country are still far placed in receiving even the minimum services. Nevertheless, over a period of time gross mortality and morbidity have changed resulting in a decline of death rates. Significantly, the burden of disease has been changing and now mankind is facing a combination of communicable, non communicable diseases and injuries.

The word “Suicide” first used by Sir Thomas Brown in 1642 in his “Religio medici” has evoked a variety of reactions in public minds. These reactions vary from anger, distress, ridicule, anxiety, tension, fear, sadness and stigma. Suicide, as such means, “an intentional determination to end one’s life, an unexpected way of death, where the willingness to die originates within the person and there is the presence of known or unknown causes to end one’s life”. Suicide whether completed, attempted or considered, is also a state where available options and future possibilities are never considered before the act. Throughout history, the word ‘Suicide’ has had different meanings to different people. Various meanings attributed to the term include “The murder of oneself”, “nothing less than a (sort of) exit”, “an end to psychic conflicts”, “a conscious act of self-inflicted cessation”; “an act of despair of which the result is not known, occurring after a battle between

an unconscious death wish and a desire to live better”, “to love and be loved”, “to live or not to live” and others. The term ‘Parasuicide is referred to non-fatal acts in which an individual deliberately causes self-injury. In whatever way the word is defined and understood, undeniably it is an act of self-destruction and a major loss to the society.

There is considerable debate all over the world as to why people commit suicide, since self-destruction of human beings has always been a matter of curiosity. Since suicide is an act of killing oneself performed by the person with his/ her full knowledge, and knowing fully well the results of the final outcome, it is always considered something very close to the person committing the act. The various causes for a suicide are by and large many and complex, ranging from social, economic, health, cultural, political, religious and other areas of an individual’s life. Recent research indicates that suicides are multifactorial in nature, cumulative due to number of causes which are progressive and operate over a period of time. A small percentage of impulsive suicides have been extremely difficult to understand. Since causes are multifactorial, several options are also considered in prevention of suicides.

The creation and destruction of mankind has been a matter of intense intrigue for many years. In recent years, the emerging self-directed violence or suicides and destruction by others or homicides for a wide variety of reasons has been a matter of debate across the world. Voices are emerging from every corner of the globe to understand and prevent or reduce the same in every country. What drives a person to the ultimate state of self-destruction or deliberate self-harm has baffled scientists, researchers, priests, philosophers, lawyers, doctors, social workers and others for decades. Suicide as an entity has cut across countries, societies and communities within geographical locations. No barriers of age, sex, class, religion exist in suicides. Suicide or deliberate self-harm, an event considered as more of a cultural or social phenomenon is recently recognized as a public health problem in every country. The phenomenon of suicides in the recent years has become so common that no single day passes without reading, hearing or watching an act or attempt in the media. Some recent headlines from the leading newspapers of Bangalore city indicate that it is a day-to-day event.

- July 31st, 2001: Deccan Herald: **Suicide:** Dejected over his wife and children walking out of his house, a 45-year-old man committed suicide by hanging at his residence in _____ police station limits on Sunday night.
- July 31st, 2001: Deccan Herald: **Suicide:** A 30 - year old woman committed suicide by setting herself ablaze in _____ police station limits. Poverty is said to have provoked her to take the extreme step, police suspect.
- August 3rd, 2001: Indian Express: **2 more farmers commit suicide:** Two farmers in Karnataka, unable to repay their debts, allegedly committed suicide in separate incidents. _____ of _____ village in _____ district consumed pesticide at their fields on Wednesday. He was upset over not being able to repay his loans. Another peasant, _____, 48, of _____ village in _____ district also committed suicide by hanging himself on Tuesday from the roof of his pump house. He was not able to clear his loans amounting to Rs. 2 lakh, which he had incurred for drilling his bore wells.
- August 4th, 2001: Deccan Herald: **Dowry Death:** Unable to bear the alleged harassment for dowry by her in-laws, a newly married girl committed suicide by hanging in _____ police station limits on Wednesday night.
- August 7th, 2001: Deccan Herald: **College student commits suicide:** A II PUC student from _____ College committed suicide by hanging herself from a ceiling fan in hostel in _____ police station limits. Police suspect dejection in love to have provoked her to take the extreme step.
- August 8th, 2001: Deccan Herald: **Cop commits suicide over wife's chit business:** Affronted by his wife's refusal to close down her chit fund business, a police constable committed suicide by hanging at his residence in _____ police station limits in the wee hours of today. The deceased has been identified as _____, aged 40 years, a constable attached to the crime wing of the _____ police station in the city. On returning home last midnight, _____ got into a verbal argument with his wife while having dinner. Following this, _____ walked into one of the rooms, bolted the door from inside and hanged himself to the ceiling with two lungis.
- August 8th, 2001: Deccan Herald: **Suicide:** Following an argument with her mother-in-

law, a 28-year old woman committed suicide by setting herself ablaze in _____ police station limits last night.

- August 9th, 2001: Deccan Herald: **Man commits suicide over 'harassment' at office:**

Unable to bear the harassment from his company's management, a 28-year-old man, executive of a multi-national company dealing in electronic gadgets committed suicide by consuming poison at his residence in _____ police station limits.

- August 10th, 2001: Deccan Herald: **Newly-wed couple ends life in City hotel:**

A newly-married couple from _____ committed suicide by consuming a huge dose of sleeping pills in a hotel room at _____ in the city. The deceased have been identified as _____ (23), a MBBS graduate and _____ (19), a final year student of computer application course from _____.

The couple were married two months ago. Police said the couple ended their lives after consuming around 150 Gardenal tablets which is a sleep inducing medicine. However, the exact motive for the extreme step is yet to be ascertained.

- August 11th, 2001: Times of India: **The grass was not greener on the other side for her:** A case of dowry harassment has been registered against _____, a _____ settled in _____, for ill-treating his Indian wife that ultimately led her to take her own life in the city on July 29th.

- August 12th, 2001: Times of India: **Councilor commits suicide:** _____, the newly elected councilor from _____ CMC in _____ police station limits committed suicide by hanging herself from a ceiling fan at her mother's house in _____ on Saturday afternoon.

Myth: *A person attempting or completing suicide says "My time is over, God is calling me"*

Fact: *This is because of some personal beliefs. It might be the person's feeling that he or she has reached the end of life and nothing more can be done. Some people may be hearing voices or seeing images due to specific mental problems. Such responses by people should be taken seriously by people around him/her.*

2. THE PROBLEM

In India, suicides are more of a medicolegal problem than a health or societal problem. Hence, information on suicides is collected and compiled by police departments. The health surveillance systems are still not established in the country. As health care institutions do not report on attempted suicides and presence of suicidal behaviours among care seekers, data on this is not available. Even the few studies in this area from health researchers and social scientists rely upon police sources. Given the complexities of reporting- investigation - analysis - utilization of information for inputs in policies and programmes and skills and competence of investigating authorities, the available information has major limitations. In view of the medicolegal dimensions of suicides, it is understood that majority of the acts would get registered with police. However, all completed and attempted suicides are not registered with police due to fear, stigma and legal compliments. Nevertheless, with the absence of information on this problem from health sector, this will be the only available data till alternative and reliable systems come into effect.

Myth: *Only others commit suicide. It will not happen to me.*

Fact: *Majority of the people have a fleeting thought of ending his/ her life in a crisis situation, but not everyone pursues the thought. When such thoughts repeat continuously, increases in frequency and severity and, begin to affect day-to-day activities, suicides are likely to occur.*

Globally, it was estimated that nearly one million people died from suicide during the year 2000. In simple terms, this means one death every 40 seconds. In India, it is reported that nearly 1,10,587 people completed suicides during 1999 with a male to female ratio of 1.2:1, respectively. From nearly 68,744 suicides in 1989, the numbers increased to 1,10,587 by 1999 (Figure 1). During this year, 65,488 men and 45,099 women ended their lives in a tragic way. One suicide is reported every 5 minutes in the country. Nearly 70% of suicides occur in the age groups of 15-39 years (Figure 2). One in every three suicide victims was a youth

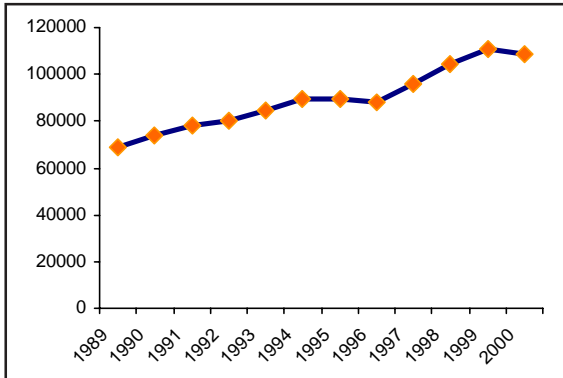


Figure 1: Incidence of Suicides in India from 1989-2000

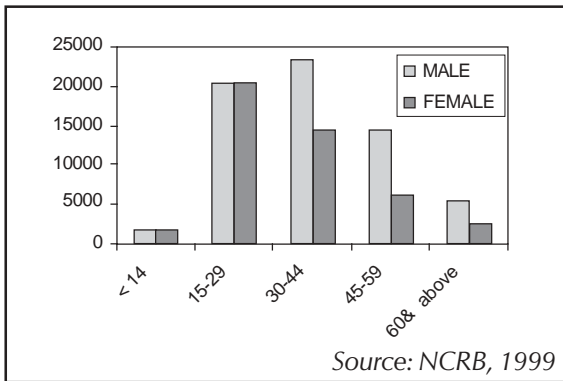


Figure 2: Age-Sex Distribution of Completed Suicides

Myth: *If a person has attempted suicide once, he will not repeat the same.*

Fact: *This is not true, It is known that attempters are likely to repeat/ complete the act in the first one or two years after the event. These persons need constant observation, an empathetic understanding and appropriate care. After a brief period of recovery, if the person goes back to contemplating death, he/she needs to be supported, observed and cared for.*

(15-29 years). More women committed suicides in their young ages compared with men. 61 housewives (as against 57 in 1997) on an average committed suicide in a day in the country. Significant regional variations are noticed with the states of Kerala, Karnataka, Maharashtra and West Bengal, accounting for nearly 50% of total suicides. The cities of Bangalore, Mumbai, Chennai and Delhi reported nearly 1,900, 1,400, 1,100 and 800 suicides, respectively, during 1999. Every day 3-4 suicides are reported from these cities. The common means adopted for suicides were hanging (25%), poisoning (37%), self immolation (11%) and drowning (9%). A number of factors in social, economic, cultural and health areas have been implicated in causation of suicides.

Karnataka is one among the top 5 states with highest suicide rates in India. During 1996 and 1997, 8,800 and 10,225 persons completed suicides, an increase of nearly 40%. During the year 2000, nearly 12,375 individuals completed suicides in the state (Figure 3). The male to female distribution was 60% and 40%, respectively. Persons in the age group of 15-29 years and 30-44 years contributed for 30% and 35%, respectively. The common methods of suicide were poisoning by organophosphorus compounds (42%), hanging (25%), drowning (15%) and self-immolation (10%). Various social, cultural, health related and economic problems have been identified as contributing factors for suicides.

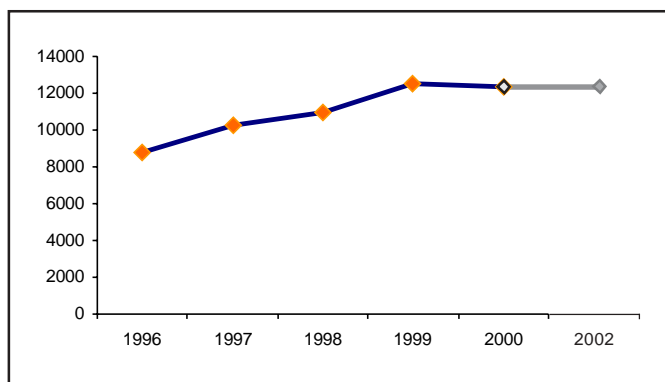


Figure 3: Incidence of Suicides in Karnataka from 1996-2002

The city of Bangalore has been growing at a phenomenal rate during the last decade. The city has been acclaimed to be a fast developing technological hub in South East Asian region and is one of the top cities in the world. The city with a population of nearly 6 million is also a place for witnessing changes in all spheres of life. The current suicide rate in Bangalore is around 34/1,00,000 population. The city has witnessed increasing suicides from nearly 500 in 1990 to about 1500 in 2002, an increase by 3 times (Figure 4). Highest number of suicides in the city occur in the age group of 15-29 years, with slightly higher rates among men compared with women. Among the common methods of suicides are hanging, poisoning and self-inflicted burns. A recent study undertaken by NIMHANS along with the City Police Department and 12 major hospitals has unraveled several dimensions of suicides in Bangalore (1, 2)

1. Gururaj G. & Isaac M.K., Epidemiology of Suicides in Bangalore, NIMHANS, Bangalore. Publication No. 43, 2001
2. Gururaj G. & Isaac M.K., Suicides Beyond Numbers, NIMHANS, Bangalore. Publication No. 44, 2001

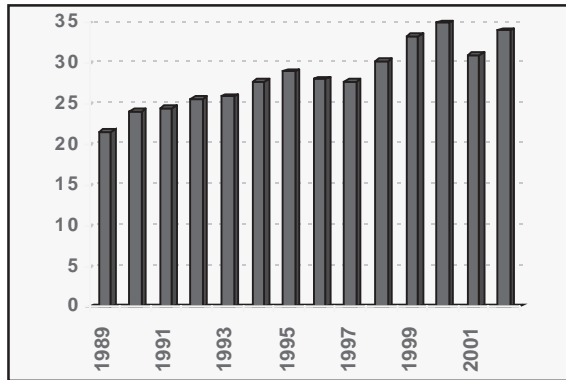


Figure 4: Suicides In Bangalore 1989-2000

Myth: *A person who talks about suicide does not commit it, but only threatens in order to draw attention.*

Fact: *While some people use minor degrees of self-harm to draw attention of people around them, most people give clues at some point by talking about the same. Such clues should be taken seriously.*

While completed suicides are generally reported to police due to medico legal requirements, attempted suicides are not reported to any agency, even though care is provided by all health care agencies. The number of people attempting suicides in Bangalore is not known since all attempted suicides are not reported to any agency. However, the ratio of completed to attempted varies from 10-20. It is estimated that nearly 19-20,000 persons attempt suicide in the city of Bangalore. The precise number of people with a suicidal thought is usually not known from general population. It is estimated that suicidal behaviours are more by 50-100 times, compared with completed suicides.

3. WHY DO PEOPLE COMMIT SUICIDE

Myth: *It is not possible to identify a person likely to commit suicide. Nobody can suspect his/her intention.*

Fact: *This is not always true. Majority of people give a clue or warning sign or commit an act, which should be taken seriously (talking about death wishes, donating their belongings, writing sad stories, poems etc.).*

This question has been baffling the minds of everyone connected with management and prevention of suicides. Suicides occur due to a number of social, economic, cultural, religious, health related and other factors. A recent large scale analysis of completed and attempted suicides in Bangalore has identified many factors. An ongoing case control study in Bangalore is expected to throw more light on causative mechanisms. In developing countries like India a number of factors related to culture, family life, education, growing aspirations and inability to tolerate negative

feelings contribute in a big way for suicides. As per the words of RFW Dieksten (1989), "Suicide is a parasuicidal phenomenon. On the one hand it appears to be the most personal action an individual can take. On the other hand, it is ubiquitous, has occurred throughout human history in all corners of the world and often under circumstances that show such a striking similarity that one has but to conclude that social factors play an important, if not decisive role in it's causation".

In India and its cities, research has not progressed to understand the aetiology of suicides. Much of the research is based on analysis of police records, which has severe limitations from an analytical perspective. Preliminary analysis of police and hospital records from Bangalore indicate that suicides are associated with age, sex, education, occupation, marital status, living environment of the person, health status and many other factors. Further, specific - precipitating and triggering factors vary from person to person depending on the situation - mode - context and nature of the issue. Research over the last two decades has identified number of causes. Some prominent reasons found to have an association with suicides are events in one's interpersonal life, negative life events, certain illnesses like depression - alcohol abuse - personality and behavioural problems, presence of physical,

emotional and sexual violence, previous history and family history of suicides, long-standing use of alcohol and drugs, unresolving problems in education - occupation and marital life, chronic, debilitating and terminal illnesses and others. In addition, absence or lack of protective factors in an individual like support system, crisis help, coping abilities, decision making skills, communication, resource availability, religious practices, positive outlook and life satisfaction also contribute for the occurrence of suicides.

A passing suicidal thought happens to most of the individuals in a crisis situation. However, not every one passing through this phase would think, attempt or complete the act. Some individuals due to their inability to cope with the stress and also due to lack of adequate support mechanisms, finally find suicide as an option. However, the word option by definition indicates that there are choices. If one considers suicide as a choice, it takes away the options and life even before a solution can be found and put into practice before death. However, many times the causes are multifactoral, repetitive, progressive and time bound. The causes are also specifically interrelated to one another and become cumulative over a period of time.

4. THE IMPACT OF SUICIDES

For every human being committing suicide, the impact experienced by numerous family members, friends and acquaintances are varied and significant. The sudden, unexpected death of a close person often shocks his family, friends and other known people. Such an act will affect a child's healthy growth, marriage, employment and family-social interactions. The stigma associated with suicides is also large that many families change their residence, job, school and other activities. While the real impact is yet to be ascertained, it is estimated that nearly 2-3% of total economic burden is due to suicides. Although the act is over for the person who dies, survivors are often left with many questions. With suicide, the problem, pain, suffering and trauma is merely transferred to those who survive and is experienced by everyone in the society.

5. LEGAL STATUS OF SUICIDES

According to Indian Penal Code Sec 309, attempt at suicide is a punishable offence. However, on 27th April, 1994, the Supreme Court Judgement delivered by two-judge constitution bench headed by Justice B.L. Hansaria declared that the provisions for punishment under section 309 of the Indian Penal Code were unconstitutional. However, two years later on 21st March, 1996 the Supreme Court Judgement delivered by five-judge constitution bench headed by Justice J.S. Verma declared that Attempt to Commit Suicide or its abetment is a penal offence, thus, reversing the earlier judgement. In view of this judgment, suicides in India are considered an offence and draw legal impunity.

6. NEGLECT OF SUICIDES

Even though many lives are lost, many people are hospitalized and the impact is significant, suicides have been one of the most neglected areas. There is little understanding and awareness about the need for preventing suicides. Some of the reasons for this situation are:

- ❖ People consider suicide as acts due to “karma, aapatthu, sins of past life, bad time or bad luck”. Many families believe that it is beyond their reach to save the life of a person.
- ❖ To listen, read or see an act of suicide has become such a day to day event, leading to a sense of apathy. Even though tense and anxious moments are experienced by people, mechanisms on how to prevent such acts are considered only when such an act affects a person known intimately to us. People become serious and inquisitive and attribute suicides to ‘individual failures’, without realizing that complex etiological factors are actually responsible for the act.
- ❖ In many societies, suicides carry large amount of stigma. Hence, it is natural to hide these acts and not to extend it beyond the person or his family. While this is a debatable issue from moral and ethical angles, public and scientific debate on recognizing the problem, identifying solutions and implementing strategies has not occurred.

- ❖ Legal complications and police investigation are a component of the stigmatizing process. To avoid these situations, false information and declarations are given for official purposes, thus, burying the real issues.
- ❖ Underreporting and misclassification being common in the area of suicides, the real problem is not analyzed in different situations due to lack of scientific information at different levels. Hence, the real burden and causes of the problem are not known clearly.
- ❖ The real lack of professional participation in prevention and policy-making issues has been one of the major obstacles to bring suicides out of shadows. Apart from provision and improvement of emergency and hospital care services, the other vital elements have not been addressed by health professionals.
- ❖ With very few people having access to proper general and mental health services across the length and breadth of the country, suicide prevention has not developed on an intersectoral approach. Hence, instances in district and taluk levels and even in cities, just receive a cursory look at the events.
- ❖ Since problem, pattern and causes of suicides are different in Indian cities and towns, a fundamental requirement is the availability of research information on various issues related to suicide. It is known that as long as the suicide phenomenon is not analyzed in different analytical dimensions, efforts towards prevention will be scant and limited.
- ❖ “Victim blaming” is a common factor, without understanding that a number of social, environmental, biological, occupational and family related factors play a cumulative

Myth: *If once the thought of suicide comes seriously in an individual, he/she will definitely complete it at some time.*

Fact: *Not everyone who thinks of suicide is likely to repeat the same. However, it has been shown by scientific research that persons with history of attempted suicide are at a greater risk of completing the act over the next few months or in the following year or two. Timely help and support can help the person to get over the death wish for the rest of his/her life.*

Myth: Asking about suicidal thoughts to some persons may precipitate the act.

Fact: This is not true. In fact, not asking about suicide may prevent identification of a person at high risk of suicide at an early stage.

and an interactive role in the occurrence of suicides.

7. APPROACHES TO PREVENTION

Since causes of suicides are multifactorial extending to all spheres of life, the answers to prevention must also be multisectoral. From a public health point of view, the major steps towards prevention are identifying the problems in its various dimensions, understanding risk factors, developing interventions focused on risk factors and, identifying what works in individual societies. Implementing these solutions on an integrated, and coordinated platform often helps in reducing the problem, thus improving health of societies. One of the approaches likely to provide long-term solutions is the intersectoral approach (Figure 5). In this approach, the problem is identified in its various facets and inputs are provided by all concerned sectors. With coordinated joint action plans, efforts should be made from all concerned agencies to implement these plans as suicide prevention is everyone’s responsibility.

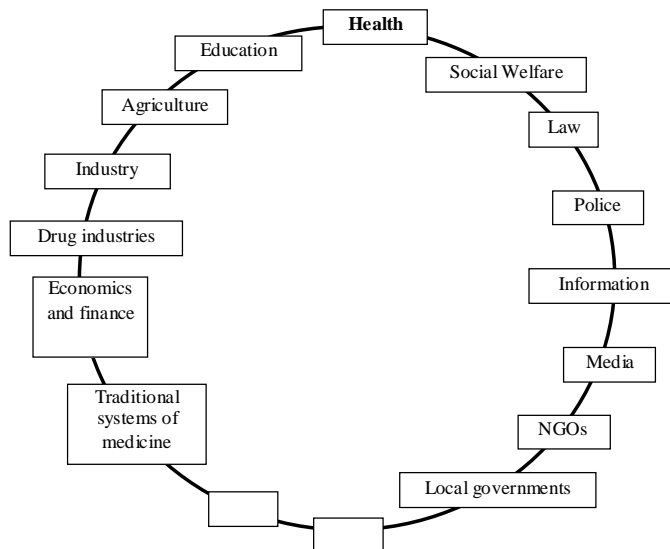


Figure 5: An intersectoral approach to Suicide Prevention

In this approach, health sector has to take a lead role in developing - implementing - evaluating suicide prevention programme as it is a matter of life and death and hence, a health problem. Health Ministries and professionals have to take major responsibilities in guiding and leading other sectors and professionals towards a framework of action for suicide prevention.

As depicted in the figure, suicide prevention strategies have to be developed in all sectors and it is important to identify specific inputs from each of the sectors. Further, intervention changes with the problem on hand (Eg. suicides among children, adults, women).

Myth: *Only poor people who cannot afford basic requirements of life commit suicide.*

Fact: *Suicide is not a problem related to class, age or gender. Depending on the social, environmental, economic or mental health status, anybody can commit suicide. It is seen that suicides among poor people is reported in press more frequently.*

8. TOWARDS CAPACITY BUILDING ACTIVITIES

Investments in diagnosis and management through technological and medical inputs has dominated the health sector for several decades. This is true not only in Bangalore but in every part of the globe. Massive inputs into more doctors, drugs, equipments and related infrastructure has occupied central place in health care delivery system. This has resulted in very little inputs for prevention - policies and research (socio-epidemiological nature), thus resulting in conspicuous absence of culturally relevant - cost-effective - sustainable preventive programmes.

Research during the last two decades all over the world has amply demonstrated that suicides are predictable and preventable. Some of the countries have translated this into action by investing in programmes, relevant manpower and supportive networks. In India and its various corners, interested professionals and those working in suicide prevention are only few. This situation is compounded further as it is not

Myth: *Suicide runs in families. So, nothing can be done.*

Fact: *As per research findings, there is some association for hereditary basis of suicide. There is a possibility that some mental illnesses which cause suicidal tendencies, occur in families. This general observation is not true for all suicides.*

clear as to what are the programmes likely to result in suicide reduction. The reasons for this are absence of descriptive and analytical information on suicide and lack of manpower to implement and evaluate programmes. In this scenario, strengthening human and institutional capabilities is a key step in the process of capacity building. Capacity building within health promotion is defined as “the development of sustainable skills, structures, resources and commitment to health improvement in health and other sectors to prolong and multiply health gains many times over”. Capacity building refers to a set of activities related to creation, expansion or upgradation of a set of desired

qualities and resources called capabilities that can be drawn for desired outputs continuously over a period of time. This process refers to equipping professionals from health and related sectors with adequate knowledge - skills - resources - options and useful choices to develop activities on an individual - institutional and a societal basis. Professionals and people need to work together to achieve common goals.

With the problem being enormous and impact being significant, coordinated and concerted actions in the country and in Bangalore city are few and negligible. There is need for bringing people and professionals from different sectors together on a common platform. Sensitization and awareness based on problem definition - identification and roles and responsibilities needs to be carried out across the length and breadth of country and in every city. In order to evolve suitable strategies for- prevention, early diagnosis and management, expansion of after care services and to develop policy responses, NIMHANS, Bangalore, undertook the project “Capacity Building Strategies for Suicide Prevention” with support from World Health Organization and Ministry of Health, Government of India, during the year 2002-03. Under the project, series of workshops were conducted to i) increase awareness among professionals from different sectors, ii) identify what actions can

be developed at different levels to evolve suicide prevention programmes in a collaborative manner with inputs from all sectors and to identify existing barriers to be overcome for suicide prevention programmes. The workshops were conducted for health professionals, non-governmental organizations, educational institutions, police officers, legal agencies, media personnel and other agencies.

In this connection, a workshop for Family Physicians was held in Bangalore at NIMHANS on April 21, 2002. Forty Family Physicians attended the workshop to discuss various issues of suicide prevention and to identify their role in this process. (Refer to Annexure I for details of the Workshop). The recommendations and areas requiring action are presented in the following sections. During the course of workshop, several of the issues presented by speakers were discussed in depth by the participants. While significant advances have been made in acute management of suicide survivors, efforts are lacking for prevention programmes. It was felt unanimously that the city of Bangalore needs to address the growing problem of suicides through an intersectoral approach with the participation of a number of agencies. The following recommendations are placed herewith to be included in future programmes.

Myth: *Suicidal persons are always mentally ill.*

Fact: *This is not entirely true. However, a large number of people attempting suicide are depressed, unhappy, sad or violent before the act. Further, mentally ill persons carry higher risk of suicides. But, many physically and mentally healthy people also commit suicide. The inherent desire to live and a battle between "to live" or "not to live", makes these people unhappy before the act.*

FACTS ON COMPLETED SUICIDES IN BANGALORE

- As per national figures, highest number of suicides has been reported from the city of Bangalore.
- Suicides are on the increase in the city of Bangalore currently. During the year 2000, nearly 1,730 persons completed suicides and it is estimated that nearly 15,000 people attempted suicides.
- Maximum number of suicides occurred between 15-29 years (42%) and 30-44 years (31%).
- Suicides are slightly more among men compared with women (M: F::58%:42%).
- Suicides are more frequently registered among lower and middle-income group (80%).
- Nuclear families (94%) had more number of suicides in comparison with joint families.
- Skilled and unskilled workers (24% and 19%) were more, compared to professional and semiprofessional groups.
- Highest number of suicides occurred between 12 noon to 6 pm (34%).
- Alcohol consumption was a major risk factor in 15% of suicides. Among them, 56% were under the influence of alcohol at the time of the act.
- Home and its surroundings were the most common place of occurrence (82%), especially among women (92%).

Contd.....

- Maximum number of suicides occurred when the person was alone at home (56%).
- Nearly 10% had made a previous suicidal attempt in the past.
- An obvious (recorded) mental disorder was present in 9% of suicides.
- Causes of suicide were multifactorial in nature. As per the study, the five major causes among men as per police records were chronic physical illness (32%), family problems (10%), alcohol related problems (14%), financial problems (8%) and unemployment (4%). Among women, major causes were illness (42%), family problems (18%), marital disharmony (5%), frustration in life (4%) and school related problems (3%). The identification of these causes is based on what the family members have reported and real causes could be different.
- The commonly employed methods were hanging (47%), poisoning (31%), self-inflicted burns (18%) and drowning (3%).
- Only 14% of men and 18% of women received first aid (of some type) prior to death.

FACTS ON ATTEMPTED SUICIDES IN BANGALORE

From an analysis of 1260 attempted suicide from 12 hospitals in Bangalore city during 1999, it was estimated that nearly 19,000 persons attempted suicides in the city of Bangalore (Ratio of completed to attempted – 1:10). Further,

- Attempted suicides were most common in the age group of 20-24 years (26%).
- The attempted suicides among men were higher than in women (M:F::53%:47%).
- Maximum number of attempted suicide cases belonged to nuclear families (95%).
- Nearly 98% of attempted suicides occurred in lower and middle socioeconomic groups.
- Attempted suicides occurred mostly among skilled workers (21%) and semiprofessionals (18%).
- Suicides were attempted mostly during evening and night times (45%). Most suicide attempts occurred at home and its vicinity (96%). Suicides at home were higher among women (88%) compared with men (59%).
- Regular consumption of alcohol was documented among 27% of Males and 1.5% of Females. Within this group, 84% of males and all females were under the influence of alcohol at the time of the act.
- Previous History of attempted suicides was higher among men (20%) than in women (14%).

Contd.....

- The commonest mode of attempting suicide was by poisoning (65.5%). The commonly used substances were Metacid (18.7%), Rat poison (18%), Baygon spray (17.1%) and also various neuro-psychiatric drugs (18.6%).
- Among men, the 5 major causes of suicides were: family conflicts (34%), illness (15%), financial problems (14%), alcohol related problems (10%) and job /career accompanied problems (6%). Among women the 5 major causes were: Family conflicts (46.3%), illness (18.8%), marital disharmony (9%), financial difficulties (6%) and love disappointments (4%).

Among attempted suicides, only 58% cases received some type of first aid care prior to reaching the study hospitals. 53.7% of males and 48.8% of females attempting suicides received first aid services. In cases of suicide attempts by burns, 43% of victims did not receive any first aid due to the family's lack of knowledge. 14% of men & 19% of women died within the hospital at various points of time and among burns, 82% of these deaths were due to increased severity.

9. ISSUES AND ACTIONS

- ◆ About a decade back, infectious and inflammatory diseases, mostly communicable diseases were the major problems for medical professionals. But currently, the focus has diverted to epidemics of non-communicable diseases like diabetes, hypertension and mental illnesses resulting due to the modernization and liberalization process. Suicides are a major public health problem in today's society. Family physicians need to prepare themselves to face this changing scenario for provision of care in the community.

The participants of the workshop felt that Continuous Medical Education programs should be held for family physicians to keep their knowledge updated, so that they are capable of handling cases of emotional and mental disorders including suicides.

- ◆ Family physicians are generally the first to be approached in case of a health problem by the people. In such situations, they frequently come in close contact with persons facing mental trauma/distress and even those who are contemplating suicide. However, it is well-recognized that some cases of mental illness go undetected and timely help may not be available. Family physicians need to recognize the importance of this problem and provide timely medical care and referral services to people.

The workshop participants recommended periodical training programs in various aspects of suicide prevention and aftercare services. Recognizing warning signs of suicide - early identification of mental health problems such as depression, alcohol dependence, schizophrenia and bipolar disorders - first level management of these disorders and - establishing referral networks were identified as priority areas of training. NIMHANS and other NGOs could undertake lead role in organizing these training programs towards suicide prevention.

Individuals at high risk

Since suicide is a widespread non-random phenomenon in every society, it is important to develop measures for early identification. While no general symptoms and signs as applicable to other health problems are found, research till date indicates that it is possible to identify people at high risk of suicides. Since these people are all around us, special efforts should be made to identify them and provide timely help. These individuals are those experiencing the following thoughts and ideas.

Thinking and feeling

- ◆ *repeating that “destiny is calling them”, “hearing words from God”, or “joining a known person in heaven”, “I cannot go on”, “I am planning to die”, “enough of this life”, etc.*
- ◆ *feelings of extreme self-hatred, feeling guilty, worthless or ashamed.*
- ◆ *feeling of loneliness, helplessness, hopelessness and worthlessness.*

Behaviours

- ◆ *complaining of “persistent boredom”, inertia, lethargy and “don’t know what to do” with decreasing interest in hobbies, sex, and other activities which they enjoyed earlier.*
- ◆ *participating in excessive religious activities, significantly more than previously observed or not participating in religious activities in which they were participating earlier.*
- ◆ *expressing loss of confidence, self-esteem and faith, loneliness, anxiety, etc.*
- ◆ *having withdrawn behavior and inability to relate to family and friends.*

Changes perceived by self or observed by others

- ◆ *having conflicts within themselves or with other members of the family on a continual basis, of a non-resolving nature.*
- ◆ *with a history of previous suicidal attempt(s).*

- ◆ *with a change in personality - showing irritability, pessimism, depression, apathy, anger or violence along with a change in their eating or sleeping habits; crying spells, sudden desire to tidy up personal affairs, writing a will etc.; writing suicide notes, songs and stories.*
- ◆ *repeated mention of death or suicide on a regular basis.*

Situations

- ◆ *too much pressurized by family for economic and other gains (such as dowry, or high achievement in academics).*
- ◆ *experiencing recent loss of a person due to death, violence, separation or a broken relationship.*
- ◆ *losing their status, jobs and income - suddenly.*
- ◆ *recently discharged from hospitals (and those staying at home), with mental disorders or other terminal illnesses (such as cancer, HIV/AIDS, tuberculosis and congenital health problems, etc.,) or those currently suffering from any psychiatric illness - specially depression and alcohol abuse.*
- ◆ *facing sudden economic loss due to migration, crop failure, economic upheaval, loss of day-to-day livelihood, natural disasters and others.*
- ◆ *Experiencing excessive/intolerable physical abuse/sexual abuse/emotional abuse.*
- ◆ *Having sudden failures in life, examinations, severe property losses, etc.*
- ◆ *with a recent family history of suicide.*

- ◆ Family physicians can play a vital role in extending psychosocial support to high-risk individuals in suicide prevention.

It is well-known that family physicians are extremely busy in practice and time would be a major constraint. However, if the family physicians listen to the distressed person empathetically - with openness and concern even for a short while, they would be able to identify symptoms of emotional or psychological problems and suicidal ideations and tendencies. They should assure the person of total confidentiality and rapport should be established, so that the person is able to express him/herself. If the person talks about death, then it should be taken seriously. The family and friends of the person should be taken into confidence and the problem must be discussed with them, as these are the people who are with the patient all the time. Sometimes, it is good for family physicians to enquire openly about suicidal thoughts and feelings among their patients. Due to stigma and fear, some patients may not openly talk about these issues. Enquiring will help in early recognition of the problem to offer remedial measures. Considering the importance of the problem, family physicians should be equipped with counseling skills, which could be offered to individuals and family members. It is essential to recognize that these skills will play a major role in the management of other non-communicable diseases as well, including mental health problems. Short-term (one or two days) workshops could be organized by NIMHANS and other agencies to bridge this vacuum.

In 1983-1984, the Swedish Committee for the Prevention and Treatment of Depression offered an educational program on diagnosis and treatment of depressive disorders to all general practitioners on the island of Gotland. The program has been carefully evaluated; 1982 was used as the baseline and the main evaluation was carried out in 1985. After the educational programs, the frequency of sick leave for depressive disorders decreased, the frequency of inpatient care for depressive disorders decreased to 30% of that at the baseline;

the prescription of antidepressants increased, but prescription of major tranquilizers, sedatives and hypnotics decreased. The frequency of suicide on the island decreased significantly. This study describes the long-term effects. In 1988, 3 years after the project ended, the inpatient care for depressive disorders increased, the suicidal rate returned almost to baseline values and the prescription of antidepressants stabilized. Thus, the effects were strictly related in time to the educational programs, indicating that the effects were real and not only a coincidence with local trends on Gotland. Furthermore, the results indicate that educational programs that can have pronounced effects on the health care system have to be repeated approximately every 2 years if long-term effects are to be expected.

Source: Rutz W, von Knorring L, Walinder J: Longterm effects of an educational program for general practitioners given by the Swedish Committee for the prevention and treatment of depression: acta Psychiatrica Scandinavica, 85, 83-88.

- ❖ Due to the large number of ongoing training workshops for doctors, it would be difficult for another training program on suicide prevention.

Since there is no separate national program on suicide prevention, training programmes for doctors should be incorporated into the existing national mental health programme. This would ensure that resources are used economically. This calls for a coordinated effort among various professionals in the field of mental health and other areas.
- ❖ Doctors (in both government and private sectors) hesitate to treat cases of attempted suicide due to the impending medico-legal consequences. This delay in treatment might even cost the patient's life.

The doctors have to be sensitised about the medico-legal issues associated with suicides. Further, police should also give importance for treatment and care of person rather than investigation. This should be carried out in close coordination with the health, judiciary and police department. Regular

workshops have to be conducted in order to face the problem areas as encountered by the doctors to remove legal hurdles in patient care. This would give them a better insight into the problem and thus enable them to provide immediate treatment to persons who have attempted suicide.

- ◆ Poisoning by freely available ‘Over the counter drugs’ are one of the common methods of committing suicide. This calls for concerted efforts by the doctors to end this menace.

The doctor community must work along with the department of Drug Control with the objective of bringing out stringent laws in order to curb ‘Over the counter drugs’ problem. The staff of the department of Drug Control and the Retail Druggists must be sensitised about the implications of providing drugs without proper prescriptions. Strict legal measures must be undertaken towards retailers who provide drugs without a prescription. Doctors need to inform family members to keep a close watch on ‘high-risk suicide group’ and keep any drugs away from the reach of people (especially children). Doctors also need to educate family members to purchase only required amount of drugs and only for a short period of time.

- ◆ Misuse of prescriptions by people is one of the major reasons for ‘Over the counter drugs’ problem.

The doctors must take meticulous care while writing a prescription for the patients. Prescriptions for drugs, which are considered to be hazardous to one’s health in large quantities, must always be accompanied by specific dates and dosages. More over, while prescribing for epileptic and other mentally ill patients, doctors must restrain from giving medications for a long period. Instead, they should encourage regular follow-ups.

- ◆ Terminally ill patients suffering from cancer, HIV/AIDS, cardiac problems and others are a potentially high-risk group for suicides.

There is a constant need to reassure and encourage chronic patients and their family members in a positive way to handle health problems. Several pharmacological and non-pharmacological methods need to be combined for reducing pain and suffering. Family physicians can play a vital role in this process as they have a close rapport with patients and their family members.

- ◆ Self and accidental poisoning by organophosphorus compounds (OPCs) is a common method of attempting suicides, since these are freely available all over the place, efforts are required to reduce accessibility to the same.

Family physicians need to educate family members on hazardous role of OPCs at homes. Families should be informed not to stock any of these commonly available items like metacid, TIQ20, Baygon spray etc. at homes. If required to be used, they should be brought-used - and discarded. This should be specially followed at home, whenever there are suicide prone individuals. Further, the association of family physicians must take up this issue with Ministry of Agriculture and Fertilizers to ban easy availability of such products in all shops.

List of Bangalore Helplines

Vanitha Sahaya Vani	1091
Elders Helpline	1090
Makkala Sahayavani	1098
HIV/AIDS Helpline	1097
SAHAI - Suicide Prevention Helpline	5497777
Women's Police Cell	2290028
Women's Voice	2214478
Vimochana	5496934

**Know more about organizations offering supportive services
in Suicide Prevention in India.
(All the agencies offer services through telephone,
face to face counselling and through postal correspondence)**

The Samaritans - Sahara

'Sevaniketan', Sir J.J. Road, Byculla Bridge

MUMBAI 400 008

Tel: +91-22-307 3451

Lifeline Foundation

2/8 A, Sarat Bose Road

KOLKATA 700 020

Tel: +91-33-474 5255 or 474 5886

Website: <http://education.vsnl.com/n4h/>

Sumaitri

NDMC Complex 1st floor

48 Babar Road, Nr. Bengali Market

NEW DELHI 110 001

Tel: +91-11-371 0763

Website: <http://www.sumaitri.org>

Maithri

Vimalalayam Building, Ashir Bhavan Road

Kaceripadi, **KOCHI** 682 018

Tel: +91-484-396 272 or 396 273

Sneha

7, Avvai Shanmugam Lane, (Lloyds Lane), Royapettah

CHENNAI 600 014

Tel: +91-44-811 5050

Website: <http://www.webindia.com/np/india/sneha.html>

Saath

B12 Nilamber Complex, H.L. Commerce College Road

Navrangpura, **AHMEDABAD** 380 009

Tel: +91-79-630 5544

Aasra

A-4, Tanwar View, CHS,

Plot NO - 43, Sector 7, Koparkhairane

NAVI MUMBAI 400 709

Tel: +91-22-754 6669

Maitreyi

255 Thyagumudali Street

PONDICHERRY 605001

Tel: +91-413-339 999

Roshni

70, Paigah Colony, Behind Anand Cinema,

S.P. Road,

SECUNDERABAD 500003

Tel: +91 40 790 4646

Prerana

For Suicide Prevention & Crisis Intervention

Om Prakash Villa, Off Devi Dayal Road, Mulund (W),

MUMBAI 400 080.

Tel. : 590 5959

Some organizations working in Bangalore to help individuals with suicidal thoughts and behaviours are:

Medico Pastoral Association
47, Pottery Road, Frazer Town
Bangalore
Tel: +91 80 5497777

Janodaya
3, 9th Cross, 5th Main,
Jayamahal Extn, Bangalore 46
Tel: 3332564

Police Counseling Cell
Vanitha Sahaya Vani,
Police Commissioner's Office,
Infantry Road, Bangalore 01
Tel: 1091, 2942865

APSA
Namma Mane, # 34,
Annasandra Palya, Vimanapura Post
Bangalore 17
Tel: 5231719, 5232749

Parivarthan
3310, 8th Cross, 13th Main,
HAL II Stage,
Bangalore 08
Tel: 5298686

Vathsalaya Charitable Trust
246, 8th E Main, HRBR Layout,
Banaswadi,
Bangalore 43
Tel: 5457360, 5452749

CREST
Kasturinagar, 3rd D Cross,
Bangalore 16
Tel: 5453076

Karuna Mother Theresa Home
2, 2nd Cross, Silver Jubilee Park Road,
Bangalore 02
Tel: 2217463

Mahila Dakshata Samithi
66/A, Sanjaynagar Main Road,
Bangalore 94
Tel: 3410042

Sumangali Seva Ashram
Cholanayakanahalli,
RT Nagar Post,
Bangalore 32
Tel: 3439190

St. Michael's Convent
80 ft Road,
Indiranagar,
Bangalore 38
Tel: 5282811, 5252406

Banjara Group- Banjara Academy
Helping Hand
418, 1st Main 1st Block, R.T Nagar,
Bangalore 32
Tel: 3535787, 3535766

Vishwas
17th Main, HAL 2nd Stage
Indiranagar
Bangalore
Tel: 5272705

Richmond Fellowship Society of India
Asha, 501, 47th Cross, 9th Main
V Block, Jayanagar, Bangalore 41
Tel: 6645583, 6346734

Psychiatry Departments of Major Hospitals and Contact Persons

St. Martha's Hospital

Nrupathunga Road

Bangalore-5600 01

Ph.2275081

(Contact person: Dr. Ajit Bhide)

Dr. B.R. Ambedkar Medical

College and Hospital

Kadurgondanahalli

Bangalore-560045.

(Contact person: Dr. Hiremath)

**Kempegowda Institute
of Medical Sciences**

K.R. Road, V.V. Puram

Bangalore-560004

(Contact person: Dr.Ashalatha)

Bangalore Baptist Hospital

Bellary Road, Hebbal

Bangalore-560024

Ph: 3330321

(Contact person: Dr. Meera Balraj)

Victoria Hospital

Bangalore Medical College

Fort, Near Market

Bangalore-560 002

(Contact persons: Dr. Chandrashekar,
Dr. Prashanth)

St. John's Medical

College and Hospital

Sarjapur Road

Bangalore-560034

(Contact persons: Dr. Prakash Appaiah,
Dr. Sheila Daniel and Dr. Manohari)

**M.S. Ramaiah Medical
College and Hospital**

New BEL Road

Bangalore-560054

(Contact person: Dr. Ghorpade)

**National Institute of Mental Health
and Neuro Sciences**

Hosur Road, Bangalore 560 029

Ph: 6995000

(Contact person: Dr. C.R. Chandrashekar)

Know more about research - prevention - policy issues from:

National Crime Record Bureau

Ministry of Home Affairs
Government of India
East Block - 7, RK Puram
New Delhi 110 066
Tel: 6172324, 6177427
Email: ncrb@nda.vsnl.net.in
Website: www.ncrbindia.org

National Institute of Mental Health And Neuro Sciences

Hosur Road
PO Box No. 2290, Bangalore 560 029
Karnataka
Website: www.nimhans.kar.nic.in

Institute of Human Behaviour and Allied Sciences

GT Road, Dilshad Garden,
PO Box 9520,
New Delhi 110 095
Website: <http://delhigovt.nic.in/dept/health/healfr.htm?ihbas.htm>

Indian Council of Medical Research

V. Ramalingaswami Bhawan,
Ansari Nagar,
New Delhi - 110 029, India
Website: icmrhqds@sansad.nic.in
Tel: 6963980, 6962794, 6962895, 6560707, 6560234
Fax: 6868662, 6856713

Thrani Center for Crisis Control

Thiruvananthapuram, **Kerala**, India - 695 037
Cell: ++91-98461-35003 Tel: ++91-471-300333 / 300334
Email: thrani@yahoo.com
Website: <http://www.geocities.com/thrani/article.htm>

International Organizations working in the area of Suicide Prevention

American Foundation for Suicide Prevention

120 Wall Street, 22nd Floor
New York, New York 10005

United States of America

TOLL-FREE: 888-333-AFSP

Tel: (212) 363-3500

Email: inquiry@afsp.org

Website: www.afsp.org

American Association of Suicidology

4201 Connecticut Ave., NW
Suite 408, Washington, DC 20008

United States of America

Tel: (202) 237-2280

Website: www.suicidology.org

Befrienders International

26/27 Market Place
Kingston upon Thames
Surrey KT1 1JH

United Kingdom

Tel: +44(0) 20 8541 4949

Website: www.befrienders.org

International Association for Suicide Prevention

I.A.S.P. Central Administrative Office
Le Barade, F-32330 Gondrin

France

Tel: +33 562 29 11 42

Email: iasp@aol.com

Website: www.iasp1960.org

Samaritans

The Upper Mill, Kingston Road
Ewel, Surrey
KT17 2AF

United Kingdom

Tel: 020 8394 8300

Email: admin@samaritans.org

Website: www.samaritans.org

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Australian Institute for Suicide Research and Prevention

Griffith University - Mt Gravatt Campus
Brisbane - Queensland 4111

Australia

Website: <http://www.gu.edu.au/school/psy/aisrap/>

Universitäts Nervenlinik, University of Wuerzburg

Füchsleinstr.15, 97080 Würzburg

Germany

Tel: +49-(0)931-203-248

Email: clips-psychiatry@mail.uni-wuerzburg.de

Website: <http://www.uni-wuerzburg.de/IASR/>

World Health Organization

Avenue Appia 20, 1211 Geneva 27

Switzerland

Tel: (+ 41 22) 791 21 11

Website: www.who.int

World Health Organization: South East Asia Regional Office

Nirman Bhawan, Room 534, 'A' Wing

Maulana Azad Road

New Delhi 110011

Tel: +91 (11) 23370804/ 23370809

Website: www.whosea.org

Canadian Association for Suicide Prevention

c/o The Support Network

#301, 11456 Jasper Avenue

Edmonton, Alberta T5K 0M1

Canada

Tel: (780) 482-0198

Email: casp@suicideprevention.ca

Centre for Suicide Research

Department of Psychiatry

University of Oxford, Warneford Hospital,

Oxford OX3 7JX

United Kingdom

Tel: 44 (0) 1865 226258

Email: csr@psych.ox.ac.uk

Website: www.psychiatry.ox.ac.uk/csr

**Proceedings of the Workshop on
“Suicide Prevention - Capacity Building Strategies”
For General Practitioners in Bangalore**

Held on April 21st, 2002

At National Institute of Mental Health and Neuro Sciences, Bangalore - 29

Family physicians are often a key component of society and family health in the Indian situation. In order to equip them with necessary skills, to exchange views and to develop common strategies in suicide prevention, a workshop on “Suicide Prevention: Capacity Building Strategies” for the General Practitioners of Bangalore city was held at NIMHANS, Bangalore, on April 21st, 2002. We acknowledge the support of Ministry of Health, Government of India, and World Health Organisation, New Delhi. With the emergence of suicides as a public health and developmental problem, 50 family physicians and resource persons interacted in the workshop to develop programs aimed at family level towards prevention of suicides.

The participants included family physicians from different areas of Bangalore city. Being busy professionals, the participants and resource persons had an area of interest in suicide prevention since it is the family physician who is in close contact with the family and plays varied roles like that of a friend, physician and counsellor.

The resource team included faculty of NIMHANS (Dr. Gururaj G. and Dr. Mohan K. Isaac) along with the members of Indian Association of General Practitioners (Dr. Srinath Herur and Dr. B.C. Rao). Participants contributed equally for the deliberations of the programme.

The workshop consisted of lectures on the various facets of suicide with communicative interaction between the resource persons and the participants. In her inaugural address, Prof. M. Gourie Devi, Director and Vice-Chancellor, NIMHANS, Bangalore, felt the need to reduce suicides as these had surfaced as a major health hazard, especially over the last decade, affecting people from

different social, economic, cultural, religious and racial backgrounds. She also expressed deep concern about the alarming rise in number of suicides among educated people (like professionals in various disciplines). She stressed on how various factors like socio-economic conditions, living status, debt issues, family conflicts and others drive individuals to suicide. She opined that increasing literacy and socio-economic development has led to an increase in the rate of suicides: for e.g., among cities, Bangalore which is considered the IT capital of India and among states, Kerala which has the highest literacy rate in the country had the dubious reputation of having the highest number of suicides. While in states like Bihar, where the standard of living is very poor, suicide rates are very low. She also spoke about how the phenomenon of suicides existed among other forms of life, like a particular species of birds, which would go and hit themselves against a huge wall in groups and die. She emphasized that this workshop should focus on saving lives and how each individual and organization should participate in this process. Dr. Gourie Devi emphasized that suicide prevention programs of a focused, targeted nature should be developed in every part of India.

An overview of suicides in the city of Bangalore was presented by Dr. G. Gururaj, Professor of Epidemiology, NIMHANS, based on the recent epidemiological study undertaken by NIMHANS in collaboration with Bangalore City Police and 12 major hospitals and media with financial support from Karnataka State Council for Science and Technology, Bangalore. It was emphasized that nearly 1,800 - 2000 people completed suicides in Bangalore alone, every year making the city have the highest suicide rate in the country. Suicides among young people (15-39 years) constituted nearly 60% of total suicides with an almost equal distribution among men and women (59% and 41%). The mode of suicides were mainly hanging and poisoning with a preponderance of self-immolation among young women. Suicides were also found to be significantly higher in the lower socio-economic strata of society and also among those with lower levels of education and less skilled employment categories. In that way, this was observed to be a major problem directly linked to several socio-economic issues like poverty, unemployment, illiteracy and many other factors. The fact that easy availability of organophosphorus compounds and drugs was one of the principle factors

responsible for high occurrence of suicides was highlighted. Suicide, thus, is a complex phenomenon with cumulative factors which are repetitive and progressive in nature and linked to life events. Alcohol consumption, both directly and indirectly contributed for 15% of completed suicides, 25% of attempted suicides and 40% of those suicides with an in-depth analysis. A past history of mental illness and previous suicidal attempts were responsible risk factors for 10% of suicides (based on police records), each, respectively. An intersectoral integrated approach was necessary in order to develop preventive strategies for the city of Bangalore. It is well-known that in case of any health problem, we tend to approach our family physician first. Hence, it is the family physician who would have developed a personal rapport with his patients, which makes him/her more capable to identify a patient who has suicidal ideation and thus prevent such an act. The various ways and means by which family physicians could participate in preventing suicides were also presented.

Dr. B.C. Rao, member of the Indian Association of General Practitioners spoke about how both the internal as well as external environment drives a person to commit suicide. He said that mental trauma is common in both extremes of age as they find it difficult to cope with intractable situations and are very vulnerable. The environment in which we live is fundamentally wrong where there is no proper support structure for persons in distress. He stressed that it is better to presume a person to be prone for suicide than ignore him/her as a neurotic. He then spoke about suicide bombers and others who commit suicide as a form of protest. He raised a question if all this was really worth it. He emphasized on the role of a doctor in an assisted suicide or helping a terminally ill patient to end his life and thus his suffering by either withdrawing life support systems or by actively assisting the person to die. He said it was a debatable issue if the doctor should or should not participate in euthanasia. He then spoke about the preventive aspect of suicides. According to him, prevention is possible but not always. The family physician has a very important role in recognizing the early symptoms of emotional trauma and suicidal tendencies. He also stressed on the importance of proactive counselling as a major mode of preventing suicides.

Dr. Srinath Herur, President of the Indian Association of General Practitioners, spoke about the role of family physicians in suicide prevention. He said that there were suicidal gestures which were warning signals to the people around. He said that plans and actions of some may appear unlikely to succeed, while others indulge in self-destruction. These acts are all different ways of communicating to others about their suicidal intent. According to him, the method of suicide depends on cultural factors and access to various methods and it reflects the seriousness of intent for eg.,

Jumping	-	Survival rare
Consumption of drugs/poisoning	-	Rescue possible
Bizarre methods	-	Psychosis
Firearm injuries, Hanging	-	Violent methods

He emphasized on the fact that suicides were on the rise especially among professionals. He then spoke about the family physician's role in suicide prevention. When a case of attempted suicide is brought to the family physician, the various steps of management are providing immediate resuscitative care, doing a psychological assessment and giving aftercare. Most important is to have a sympathetic, committed, concerned and understanding attitude not only with the patient but also with his/her family and friends. He then presented two case studies:

Case 1:

A 50 year old lady was approached by her son for money. When she refused, it ensued in an argument and the son left the house in a huff. She immediately consumed Baygon spray. She was discovered 3 hours later and taken to the hospital but unfortunately died on the next day. While she was in the hospital, the son called the doctor and asked him to take proper care of his mother. He then took his car to a lonely place and consumed Tic20. He died 4 days later in the hospital.

Case 2:

A 15 year old boy came to the doctor and asked him about Gardenal and its effects. The perplexed doctor wondered why this young boy wanted to know about Gardenal. When probed, the boy, who was the younger of 2 brothers came out with the truth that he had not done well in his SSLC exams and he was always compared by his parents to his elder brother who was better in studies. The parents were then called and counselled and the boy's life was saved.

Dr. Herur then spoke about the various ways by which Family Physicians can play an active role in preventing suicides:

1. Proactively ask about feelings in depressive patients.
2. Give them separate time, when they can be spoken to without being in a hurry.
3. Listen with openness and concern.
4. If the person speaks of death, then take it seriously.
5. Enlist family and friends as their support is very important to help the patient cope with the situation.
6. Provide appropriate medical care to the person.

Dr. Herur concluded by saying that in the current scenario, peer and social pressures, financial problems, chronic illnesses, marital discord, mental illness and alcohol abuse were the major causes for suicide and these areas have to be combated.

Dr. Mohan K. Isaac, Professor, Department of Psychiatry, NIMHANS, spoke about the management of persons who have attempted suicide. He said that the first step was to assess the suicidal act, the individual and the significant others like close relatives and friends. An attempted suicide, many a time, is impulsive, done in order to get relief from terrible state of mind and is a cry for help; may be

manipulative, may be to show hostility towards someone or something, due to acute/chronic problems, emotional disorders or personality traits like being immature, egocentric, dependent and anxious.

He then spoke about the various factors for assessing persons who have attempted suicide. These are stressful life events and coping strategies adopted, defence mechanisms in case of conflicts, availability of social support, living situation, risk factors for suicide, availability and lethality of suicidal methods. Stressful life events are events in one's life which are stressful and cause mental disequilibrium. They may occur in any of the areas like personal and interpersonal, family and social, education, work, financial, marital and sexual, health, bereavement, reparation/divorce or even change of residence. Coping strategies are conscious, mental or behavioural strategies that are adopted by people to tackle stressors or to mitigate the effects of stressors. Some of the healthy coping strategies are problem solving, discussing with family/friends, seeking support from others, professional consultation, physical/mental activity, opting for a change in environment, acceptance of the problem and following religion or having faith in god. Some of the unhealthy coping strategies are avoidance of stressors, excessive

The Helping Process

- ◆ Communication
(Verbal and Non-verbal) (Desirable/Undesirable responses)
- ◆ Confidentiality
- ◆ Rapport building
- ◆ Ask 'open ended' questions
- ◆ Specific exploration of conflicts / stress factors
- ◆ Interviewing the significant others
- ◆ Commonly applied techniques:
 - * Ventilation, Abreaction
 - * Reassurance
 - * Suggestion, Persuasion, Explanation
 - * Reinforcement

dependence on others and substance abuse (alcohol, tobacco, drugs). He then spoke about the various steps of problem solving which are: identifying the problem, generating alternatives and then evaluating them, selecting and implementing the best solution.

According to Dr. Isaac, conflicts are internal pressures or mental struggles which arise when there are hindrances to the fulfilment of needs/desires or when one is faced with 2 opposing needs and one has to be chosen. The defence mechanisms of a person serve to reduce the tension produced by conflicts. These mechanisms are mental processes of which we are generally unconscious. Examples of defence mechanisms are denial projection, rationalization, displacement, humour, sublimation and somatization.

To conclude, he spoke about how a family physician can help a person in distress and prevent a suicide.

During the course of workshop, several of the issues presented by speakers were discussed in-depth by the participants. It was felt unanimously that the city of Bangalore needs to address the growing problem of suicides through an intersectoral approach with the participation of a number of agencies. The following recommendations are placed herewith to be included in future programs:

1. About a decade back, the main focus of family physicians was on diseases like fever, infections and inflammations of various organs but now his/her role has changed as non-communicable diseases and diseases due to modernization and liberalization, like diabetes, hypertension and mental illnesses. So, there should be CMEs held for the family physicians to keep their knowledge updated, so that they are capable of treating these patients.
2. The participants of the workshop felt that it was important to train family physicians for counselling techniques, early identification and aftercare services to reduce suicidal behaviours among every citizen since family physicians have a greater interaction with family members, their increasing role in crisis management was identified.

3. The family physicians should be able listen to the distressed person empathetically, with openness and concern. They should assure the person of confidentiality and rapport should be strengthened so that the person is able to express him/herself. If the person talks about death, then it should be taken seriously. The family and friends of the person should be taken into confidence and the problem must be discussed with them as these are the people who are going to be with the patient all the time.
4. In the current scenario, suicides are very high among youngsters, especially students and those on the threshold of their careers due to excessive peer and parental pressure and a very high degree of competition. Family physicians must be trained to identify such cases and give them adequate care and support so that they do not take the extreme step of suicide and also to counsel their family and friends as these are the people who are with them all the time.
5. As suicides are very common among the youth, school and college teachers should be trained on adolescent mental health problems and how to help them cope with it.
6. Alcoholism is known for its widespread ill-effects, affecting the physical, psychological and social health of the individual and the family. It is known to not only cause various physical illnesses, but also leads to problems like suicide, road traffic accidents, domestic violence, absenteeism to school among children of alcoholics and also, is a leading cause for poverty due to economic debts and loans. As general practitioners come in contact with people belonging to various groups of the society, it would be possible for them to identify the problem of alcoholism in the early stages itself, hence enabling them to treat the person or make the appropriate referrals and provide longterm aftercare services.
7. In the present-day society, depression is widely prevalent, but largely unnoticed and untreated, leading to an increase in the number of suicides. As general practitioners are usually the first to be approached for any kind of medical help by the people, it would be easier for them to identify cases of

depression. This would enable them to make an early diagnosis and treatment, thus preventing suicides.

8. Though general practitioners deal with large numbers of people and a wide range of problems, there is no proper networking or reporting system to analyse the nature and extent of problems handled by them. Hence, there is a need, atleast among specific family physicians to develop some simple techniques of registries and records information. This would reveal the type of problems handled, remedial measures offered and extent of follow-up and recovery among their care receivers.
9. Chronic and terminally ill patients/children and young adolescents are known to be at greater risk of suicides. They require emotional and psychological support apart from medical help (in required situations). A combined holistic approach should be practiced by family physicians.
10. Professional bodies like Indian Medical Association and regional/city branches should seriously examine the growing problem of suicides and develop periodical training programs on skills of handling their problems.

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Know more about suicide research and prevention initiatives in Bangalore

- ♣ Gururaj G & Issac MK, Epidemiology of Suicides in Bangalore, NIMHANS, Bangalore. Publication No. 43, 2001
- ♣ Gururaj G & Isaac MK, Suicides beyond numbers, NIMHANS, Bangalore Publication No. 44, 2001
- ♣ Gururaj G, Ahsan MN, Isaac MK, et al., Celebrate life: Suicide Prevention- Emerging from darkness. World Health Organization: Regional Office for South East Asia, New Delhi, 2001
- ♣ Report of the project: "Identification of risk factors and capacity building measures for prevention of suicides" funded by World Health Organization, Regional Office for South East Asia, New Delhi
- ♣ Reports of the workshops on "Suicide Prevention- capacity building strategies" - 7 information book series:
 - Information for Health Professionals
 - Information for Non-Governmental Organizations
 - Information for Educational Institutions
 - Information for Family Physicians
 - Information for Police Personnel
 - Information for Woman and Child Development Organizations
 - Information for Media Professionals

SAHAI - Suicide Prevention Helpline



LIFE. YOU'RE WORTH IT

5497777



If you are a family physician, you could

- ◆ Identify individuals with suicidal thoughts and offer timely help.
- ◆ Provide treatment to those with depression, alcohol dependence and other mental illnesses.
- ◆ Enquire about suicidal thoughts openly with patients and their families.
- ◆ Keep a close watch on individuals & families with suicidal ideas you encounter in your practice.
- ◆ Provide psychosocial supportive care to individuals suffering from terminal illness like cancer, HIV/AIDS, accidents, disabilities etc.
- ◆ Establish referral system in your work with nearby mental health professionals.
- ◆ Incorporate counselling services into your day-to-day practice.
- ◆ Educate family members to remove all dangerous products (e.g., drugs, organophosphorus compounds, sharp objects) from easy reach of the suicidal individuals at home.
- ◆ Disseminate right type of information to local media personnel.
- ◆ Equip yourself with adequate knowledge and skills for suicide prevention.
- ◆ Influence local policy makers, politicians and police to undertake right type of activities at the right time for prevention of suicides (e.g., legal reforms on suicides, limiting easy availability of organophosphorus compounds and drugs, stigma reduction and increasing care for suicidal persons).