EVALUATION OF SADBHAVNA TREATMENT PROTOCOL IN SEONDARY PREVENTION OF SUICIDE (SELF-HARM)

ATTEMPTS AMONG HEROIN ABUSERS IN A REHAB CENTRE SET-UP

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INTRODUCTION

Suicide (Self-Harm) is legally defined as “An act of deliberate intentional self-killing.” It generally originated from an “Aggression towards self following the internalization of frustration or disappointment related to a loved one.” Psychologically Freund defined it as “A murderous attack on an internalized object which has become a source of ambivalence.”

Attempts of Suicide (Self-Harm) is not uncommon among drug-abusers. Apart from direct intervention by Pharmacotherapy for de-addiction treatment, customized Non-Pharmacological Psychotherapy must be imparted for conflict-resolution in such vases for long-term cost-effective prevention in domicile environment.

Secondary suicide prevention is particularly important but not always given the attention that it deserves, in part because research into secondary prevention is only just starting to be applied to clinical practice.

At Sadbhavna Ceenter of Addiction Science & Mental Health Research, we have developed a treatment protocol which is a unique blend of modern western addiction medicine with ancient Indian wisdom. This amalgamation makes our treatment protocol perfectly acceptable to Indian youngster drug (esp. heroin) abusers; as is evident in 4 case reports enclosed. All these patients are free of addiction and self-harm ideation on follow-up till date.

PATIENT 1

Bioprofile : PatientMr. Manjot Singh (name changed), Aged 35 yrs / Male, Sikh, Mechanical Engineer, Married, Unemployed was admitted on 08.01.2016 and relieved on 10.03.2016 after he received treatment satisfactorily.

History of Addiction

A 33-years old male with history of Substance Abuse for 11 yrs with Alcohol, Heroin Opium, Smack & Tobacco addiction

1. At the age of 22 years, he started to take alcohol with his friends at parties.

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2. At the age of 24 years, he started taking Heroin by smoking & after one year, he started taking it by I/V. Initial dose was 500 mg/day. The end dose 1 gm/day.
3. At the age of 31 years, he has started consuming Opium. He was abused it for 2 months after that he quit it.
4. At the age of 32 years, he started consuming tobacco. He tried only 4-5 times, after that he left it totally.

History of De-addiction Treatment & Relapse

1. He was admitted in rehab centre Baba Sohan Singh foundation, Jalandhar in 2014 where he received for 6 months. He stayed sober for 2 months after treatment. After that he again got relapsed with Heroin.
2. He has taken treatment from Sadbhavna centre of addiction science & mental health research, Raikot. He was admitted in rehab on 27.08.2015 & taken treatment for 4 months (21.12.2015). He stayed sober only 9 days, after that he got relapsed with Alcohol on New Year.
3. He was again admitted in Sadbhavna centre of addiction science & mental health research, Raikot on 08.01.2016 & taken treatment for 2 months.

History of Self-Harm (3 Episodes)

Manjot Singh had inter-personal conflict with his mother.

1. At the age of 33 years in Oct. 2014, he had an episode of anger with his mother due to interference in his tasks. So, he attempted suicide by cutting his blood vessels. Medical intervention was provided by his relatives (aunt) by taking him to Hospital.
2. He again had severe conflict with his mother & he attempted suicide hanging a rope to ceiling fan in May 2015. Luckily, the fan's ceiling broken down & nothing happened to him.
3. Then, 3-4 months later in August 2015, he again tried to attempt suicide by poisoning method (consumed Phenyl tablets 4-5 in quantities). No internal reaction occurs of taken Phenyl tablets. So his life is saved.

Analysis of History of Self-Harm

A. Predisposing Factors

No.	ISSUE	BRIEF DETAILS	YES	UNSURE	NO
1	Positive Family History				No
2	Early Parental Loss				No
3	Rejection by Family	Perceived Rejection by Family & Loneliness			Yes
4	Rejection by Girlfriend				No
5	Physical illness				No
6	Impotence				No
7	Psychiatric illness				No

8	Physical Abuse				No
9	Sexual Abuse				No
10	Emotional Abuse				No
11	Inter-Personal Conflicts	With Mother over Drug Abuse			Yes
12	Bullying by Peers				No
13	Study: Poor Performance				No
14	Substance abuse	Multiple Substance Abuse Since last 11 yrs			Yes
15	Unemployment	Though Engineer by Qualification			Yes
16	Poverty				No
17	Feeling of Hopelessness	Due to Unemployment			Yes
18	Intra-Personal Conflicts				No
19	Low Self Esteem	Due to Unemployment			Yes
20	Poor Life Skills : Poor Problem Solving Poor Coping				Yes

B. Precipitating Event

No.	ISSUE	BRIEF DETAILS	YES	UNSURE	NO
1	Death of Loved One				No
2	Sudden Rejection	By Mother			Yes
3	Physical Illness				No
4	Acute Psychiatric Illness				No
5	Loss of Job	For Drug Abuse at Work			Yes
6	Debt / Loss of Money	For Drug Abuse			Yes
7	Abuse Physical / Sexual				No
8	Sudden Emotional Stress				No
9	Sudden revelation of Illicit Relation of Spouse				No
10	Impotence	For Drug Abuse			Yes

C. Contemplation (Methods Options Planned)		**Why not adopted**
1	Drowning	Water-body Not Available
2	Cutting Blood Vessels	**1st Attempt**
3	Jumping from height	Fear of Height
4	Hanging	**2nd Attempt**
5	Gunshot	Not Available
6	Sharp Penetrating Objects	Idea did not come in mind
7	Overdose	Did never get enough substance
8	Poisoning	**3rd Attempt**
9	Electrocution	Fear of Pain
10	Railway / Bus / Vehicles	Idea did not come in mind
11	Any Other (Specify)	Nil

D. Action (Actual Method Used)

1. **Attempt 1** Action : Cut Radial Artery (Left) Date : Oct. 2014
2. **Attempt 2** Action : Hanging from Ceiling Fan Date : May 2015
3. **Attempt 3** Action : Poisoning by Rodent Killer Date : Aug. 2015

E. Post-Action (What Happened After Action / Medical Intervention)

Emergency Medical Assistance given & life saved

F. Current status

PhysicalNormal Physical Ability but with Substance Abuse Disorder

Psychological

▪ Continued desire to die	No
▪ Current Contemplation	No
▪ Current Action ideated	Nil
▪ Access to means of suicide	Nil
▪ Coping Mechanism & Strength	Developing

Presently, he realized his mistakes and he is working on his coping skills & doing activities for the maintenance of recovery like Prayer, counseling, sharing & JFT etc.

Mental Status Examination

Evaluation Criteria

1. Denial	2. Resentment	3. Self-Pity
4. Un-manageability	5. Willingness for Treatment	6. God

Final Opinion Assessment of Suicidal Risk with Heroin & Tobacco Addiction

Cognitive Functions FOLSTEIN MINI MENTAL STATUS EXAMINATION

Score **31**

Opinion **Normal Cognitive Function**

PATIENT 2

Bioprofile : Patient Joginder Singh (name changed), 28 yrs, Male, was admitted on 28.02.2016 and discharged on 03.04.2016 in satisfactory condition.

Admission Procedure & Consent

Patient Joginder Singh was admitted to Sadbhavna Center of Addiction science & Mental Health Research, Raikot on 28.02.2016 by his father Gurmail Singh under the consent that his son is a drug-addict and is a liar and his behavior and attitude are not good. He submitted that Joginder Singh cannot and should not be trusted under any condition.

Chief Complaints

1. Pain in whole body x 2 days
2. Restlessness x 1 week
3. Anxiety x 2 months

H/O Substance Abuse

Patient had a history of consuming

1. Chewing Tobacco (Hathi Gola) for last 6 yrs
2. Cigarette Smoking (Red & White) for 3 yrs
3. Opium for 3 yrs
4. Heroin (Mostly Smoke but IV administration from last 7 days) for 1 yr
5. Tab. Tramadol for 3 months
6. Ganja (Smoke) for 20 days
7. Inj. Fortwin (IM) took at the time of tournament
8. Alcohol took occasionally
9. Morphine Injection tried once

In last 30 days, before admission he has consumed

1. Heroin – 3.5 gm
2. Chewing Tobacco – 30 Packets
3. Cigarette Smoking – 20 cigarettes

Analysis of History of Self-Harm

A. Predisposing Factors

No.	ISSUE	BRIEF DETAILS	YES	UNSURE	NO
1	Positive Family History				No
2	Early Parental Loss				No
3	Rejection by Family				No
4	Rejection by Girlfriend	Both Families are not willing for marriage			Yes
5	Physical illness				No

6	Impotence				No
7	Psychiatric illness				No
8	Physical Abuse				No
9	Sexual Abuse				No
10	Emotional Abuse				No
11	Inter-Personal Conflicts				No
12	Bullying by Peers				No
13	Study: Poor Performance				No
14	Substance abuse	Multiple Substance Abuse Since last 6 yrs			Yes
15	Unemployment	Due to addiction			Yes
16	Poverty	Due to Unemployment			Yes
17	Feeling of Hopelessness				No
18	Intra-Personal Conflicts				No
19	Low Self Esteem	Due to Unemployment & Poverty			Yes
20	Poor Life Skills : Poor Problem Solving Poor Coping				Yes

B. Precipitating Event

No.	ISSUE	BRIEF DETAILS	YES	UNSURE	NO
1	Death of Loved One				No
2	Sudden Rejection	By Girlfriend			Yes
3	Physical Illness				No
4	Acute Psychiatric Illness				No
5	Loss of Job				No
6	Debt / Loss of Money				No
7	Abuse Physical / Sexual				No
8	Sudden Emotional Stress				No
9	Sudden revelation of Illicit Relation of Spouse				No
10	Impotence				No

C. Contemplation (Methods Options Planned) Why not adopted

Method	Why not adopted
1 Drowning	Not Available
2 Cutting Blood Vessels	Done
3 Jumping from height	Fear of Height
4 Hanging	Fear
5 Gunshot	Not Available
6 Sharp Penetrating Objects	Idea did not come in mind
7 Overdose	Did never get enough substance
8 Poisoning	Present but not done
9 Electrocution	Fear of Pain
10 Railway / Bus / Vehicles	Idea did not come in mind
11 Any Other (Specify)	Nil

D. Action (Actual Method Used)

Cut blood vessels (In 2014)

E. Post-Action (What Happened After Action / Medical Intervention)

Saved by getting pressure bandage at home

F. Current status

Physical **Fit & Healthy but with Substance Abuse Disorder**

Psychological

- Continued desire to die (Sometimes) — Present
- Current Contemplation — Nil
- Current Action ideated — Nil
- Access to means of suicide — Nil
- Coping Mechanism & Strength — Doing Physical exercise & Prayer

Present Status

The patient shoed keen interest in Physical Exercise & working out in Body-Building gymnasium for long time. In rehab, he spent spare time in physical workouts (free-hand & also in gym).

The patient underwent regular non-pharmacological treatment from 08.03.2016 in the form of JFT (Just For Today), Group Therapy, Individual Counseling, Introspection sessions etc. up to 02.04.2016. During this time, he wrote daily Reflections which showed his admission of past mistakes and willingness to undergo treatment.

Mental Status Examination

Final Opinion Assessment of Suicidal Risk Addiction with Multiple Substance Abuse

Cognitive Functions <u>FOLSTEIN MINI MENTAL STATUS EXAMINATION</u>

Score **26**

Opinion **Normal Cognitive Function**

PATIENT 3

Bioprofile: Patient Manjit Singh(name changed) , 24 years / Male, D.Pharmacy, Unmarried presented on 17.05.2015 & relieved on 21.11.2015.

History of addiction

A 24-years old male with history of Heroin addiction for 1-yr & 8-months with alcohol, opium, charas, benzodiazepine.

At age of 18-years, he started to take alcohol with his friends at marriage parties (Beer). The dose was 60 to 90 ml. He started taking beer for enjoyment. Gradually he started taking alcohol occasionally with friends. At same age, he started smoking cigarettes with his friends. However he did not like the odor of alcohol. He found an alternative in cough syrup. He used to take 2 bottles of cough syrup (200 ml) per day. At age of 20 years, he started charas with his friends and suffered from seizures. The patient took treatment for seizures. Ar age 23-years, he started taking Heroin by Intravenous route. Initial dose was 500 mg per day. The end-dose was 1 gm / day.

Twice he has taken OPD rehab treatment for addiction – first from Astha Neuro-Psychiatric Hospital, Jagraon in 2011-12 and second from Rajendra Hospital, Patiala in 2013.

Again he was admitted in Rehab. Center, Barnala in 2013 where he received treatment for 6 months& stayed as volunteer for 1 month 7 followed up for 2 months. Then he had conflicts with his father who used to interfere in his job. Then he went to his addict friends & again started taking Intravenous Heroin (0.5 gm/day).

History of self-Harm

Manjit Singh had inter-personal comflict with his family members; mostly with father, since childhood. At age of 23 years in March 2014, he had an episode of anger with his father due to the later’s rude behavior & interference in his tasks. At that time, he was free from drugs for 2 days and was having severe bodyache. He attempted suicide by hanging with a rope to ceiling fan. His mother saw him, shouted & saved him. There was no need of any medical intervention.

After this episode, Manjit Singh started living with grandfather in Raikot. In 2015, he again had severe conflict with his father since he refused to give him money. Again in a fit of rage, he attempted suicide by hanging with a rope to ceiling fan. His grandfather saw & saved him.

This incidence created fear among family members. The bondage between him and family members was reduced after this attempt.

Current Status

Currently he realized that the attempts were attacks of temporary insanity. Presently he is working on Anger Management &coping skills. He is gaining strength to cope up with life’s challenges by sharing, praying, behavioral therapy & counseling.

Analysis of History of Self-Harm

A. Predisposing Factors

No.	ISSUE	BRIEF DETAILS	YES	UNSURE	NO
1	Positive Family History				No
2	Early Parental Loss				No
3	Rejection by Family				No
4	Rejection by Girlfriend	At 22 years, when he came back from jail			Yes
5	Physical illness				No
6	Impotence				No
7	Psychiatric illness	Epilepsy since 2011			Yes
8	Physical Abuse				No
9	Sexual Abuse				No
10	Emotional Abuse				No
11	Inter-Personal Conflicts	With father			Yes
12	Bullying by Peers				No
13	Study: Poor Performance				No
14	Substance abuse	Alcohol & Tobacco at 18 yrs Heroin at 23 yrs			Yes
15	Unemployment				No
16	Poverty				No
17	Feeling of Hopelessness	Due to family conflicts			Yes
18	Intra-Personal Conflicts	Related to Study/Job			Yes
19	Low Self Esteem	Not appreciated by family			Yes
20	Poor Life Skills : Poor Problem Solving Poor Coping	Presence of Fear Insecurity Low Self Esteem			Yes

B. Precipitating Event

No.	ISSUE	BRIEF DETAILS	YES	UNSURE	NO
1	Death of Loved One				No
2	Sudden Rejection				No
3	Physical Illness				No
4	Acute Psychiatric Illness	Epilepsy since 2011			Yes
5	Loss of Job				No

6	Debt / Loss of Money				No
7	Abuse Physical / Sexual				No
8	Sudden Emotional Stress	Anger & Resentment			Yes
9	Sudden revelation of Illicit Relation of Spouse				No
10	Impotence				No

C. Contemplation (Methods Options Planned) Why not adopted

	Method	Why not adopted
1	Drowning	Because he knows swimming
2	Cutting Blood Vessels	Thought it was not good idea
3	Jumping from height	Acrophobia
4	Hanging	Done
5	Gunshot	Not Available
6	Penetrating Objects	Unsure about this method
7	Overdose	Nothing significant
8	Poisoning	Do
9	Electrocution	Painful
10	Railway / Bus / Vehicles	Painful
11	Any Other (Specify)	No

D. Action (Actual Method Used)

Hanging from ceiling Fan Year 2013

Hanging from Ceiling Fan Year 2015

E. Post-Action (What Happened After Action / Medical Intervention)

Nothing

F. Current status

Physical Suffers from Epilepsy – currently on medication

Psychological

- Continued desire to die No
- Current Contemplation Nil
- Current Action ideated Nil
- Access to means of suicide Nil
- Coping Mechanism & Strength Prayer & Sharing with fellow inmates

PATIENT 4

Bioprofile: PatientMr. Pritam Singh (name changed), Aged 42 yrs / Male, Sikh, 5th Passed, Widower, Driver was admitted on 18.03.2015 and relieved on 29.12.2015.

Chief Complaints

Patient's family members complained that the patient is

1 A chronic Heavy Alcoholic with continuous craving for it
2 Adjustment Problem at home with
Occasional Violent Behavior,
Family Fights,
Breakage of Utensils,
3 Lies very frequently and shows Untrustworthy behavior

Admission Procedure & Consent

Patient Pritam Singh was admitted to Sadbhavna Center of Addiction science & Mental Health Research, Raikot on 18.March.2015 by his uncle Surjit Singh under the consent that her son is a drug-addict and is a liar and his behavior and attitude are not good. He submitted that Pritam Singh cannot and should not be trusted under any condition.

H/O Substance Abuse

Patient had a history of consuming

1. Alcohol for last 30 yrs
2. Tobacco Chewing for 30 yrs
3. Opium for 25 yrs
4. Sedatives (Tab. Alprex) for 1.5 yrs

In last 30 days, before admission he has consumed

1. Alcohol – 22500 ml
2. Chewing Tobacco – 30 packets
3. Opium – 240 grams
4. Tab. Alprex – 700 tabs

Analysis of History of Self-Harm

A. Predisposing Factors

No.	ISSUE	BRIEF DETAILS	YES	UNSURE	NO
1	Positive Family History				No
2	Early Parental Loss				No
3	Rejection by Family				No
4	Rejection by Girlfriend	Because girlfriend's family did not accept their relation			Yes
5	Physical illness	HIV			Yes
6	Impotence				No
7	Psychiatric illness				No
8	Physical Abuse				No
9	Sexual Abuse				No
10	Emotional Abuse				No
11	Inter-Personal Conflicts	With brother			Yes
12	Bullying by Peers				No

13	Study: Poor Performance				No
14	Substance abuse	Alcohol & Opium			Yes
15	Unemployment				No
16	Poverty				No
17	Feeling of Hopelessness	Due to his disease condition (HIV)			Yes
18	Intra-Personal Conflicts	Related to his disease condition			Yes
19	Low Self Esteem	Because of HIV, death of his wife			Yes
20	Poor Life Skills : Poor Problem Solving Poor Coping	Presence of Fear Insecurity			Yes

B. Precipitating Event

No.	ISSUE	BRIEF DETAILS	YES	UNSURE	NO
1	Death of Loved One	Wife (In 2014)			Yes
2	Sudden Rejection				No
3	Physical Illness	AIDS			Yes
4	Acute Psychiatric Illness				No
5	Loss of Job				No
6	Debt / Loss of Money				No
7	Abuse Physical / Sexual				No
8	Sudden Emotional Stress	Conflict with uncle & family members			Yes
9	Sudden revelation of Illicit Relation of Spouse				No
10	Impotence				No

C. Contemplation (Methods Options Planned) Why not adopted

	Method	Why not adopted
1	Drowning	In 2014
2	Cutting Blood Vessels	In 2015
3	Jumping from height	Nothing Significant
4	Hanging	Nothing Significant
5	Gunshot	Not Available
6	Sharp Penetrating Objects	Idea did not come in mind
7	Overdose	Nothing Significant

8	Poisoning	2 times (First time in 2007-2008)
9	Electrocution	In 2014
10	Railway / Bus / Vehicles	Idea did not come in mind
11	Any Other (Specify)	Nil

D. Action (Actual Method Used) & Post-Action (What Happened After Action / Medical Intervention)

1. Poisoning in 2007-2008 due to conflict with uncle
   Gastric lavage done in hospital
2. Electrocution in 2014
   No medical intervention
3. Drowning in 2014
   Came out from water
4. Cutting blood vessels in 2015
   4 stitches
5. Poisoning (IV Injection)
   No medical intervention

E. Current status

PhysicalSuffers from AIDS – currently on medication

Psychological

- Continued desire to die No
- Current Contemplation Nil
- Current Action ideated Nil
- Access to means of suicide Nil
- Coping Mechanism & Strength Prayer & Sharing with fellow inmates

CONCLUSION

On analysis of above 4 patients, it is found that in Predisposing Factors of Self-Harm, the similarities present in all cases are

1. Rejection by Girlfriend &/or Family
2. Inter-Personal Conflicts with Family Members
3. Substance Abuse
4. Inemployment & Lack of Life-Goal
5. Feeling of Hopelessness
6. Low Self-esteem due to different reasons
7. Intra-Personal Conflicts
8. Poor Life Skills

Similarities in Precipitating Events in Actual Self-Harm are :

1. Sudden rejection by Family & Girlfriend
2. Sudden Emotional stress

Similarities in contemplations are ;

1. Cutting Blood Vessels
2. Hanging
3. Poisoning

Similarities in actual Action undertaken are :

1. Hanging
2. Cutting Blood Vessels
3. Poisonong

The Coping mechanism imparted in all patients were :

1. Surrender to God
2. Prayer
3. Sharing
4. Physical exercise & other Substitution methods

Except 1 patient where treatment was partial, the psychological status demonstrated absence of suicidal ideation after complete treatment

Sadbhavna De-addiction Treatment Protocol is an Indianized Model of Western Scientific Psychotherapy System. In the above 4 casesm it is proved to be beneficially changing the outlook and mindset of Drug Abuse victims who attempted suicide (Self-Harm)

DISCUSSION

In USA, suicide ranks 8th reason for major cause of death. Women attempt suicide more than men. However, men succeed more in committing the act (70% are males & 30% are females among suicide deaths).

The suicidal impulse is stronger between 14 ro 18 years as they find it difficult in adjusting to new status & new social expectations. If he adjusts reasonably, the rate of suicide decreases. Common Risk Factors are 1. Absence of Parents 2.Unemployment of parents 3.Family History of Self-Harm 4.Parents with Psychiatric Illness. In mid-age women, the critical period is between 45 to 54 years. Common reasons are 1. Difficulty in adjustment, 2.High Role expectations 3.Low Role performance, 4.Feeling of uselessness, and 5.Poor health. Middle-aged men may also face problems after retirement due to poor health, maladjustment, non-fulfillment of financial responsibilities etc. All these people perceive that self-killing is the only available & permanent solution for their misery. Unmarried, widow, divorced, separated, isolated, lonely living are at greatest risk. Suicidal rate are observed more in high & low Socio-Economic classes than in Middle-Class. Lawyer, Police Officials, Insurance Agents, Dentists, and Medical Professionals are higher risk. It is higher among urban than among rural population.

Causes

A. Psychological Causes

Perception of

1. Isolation
2. Hopelessness
3. Helplessness
4. Grief

5. Reaction to stress
6. Severe Frustration
7. Intolerable Psychological Pain
8. Unfulfilled needs & desires
9. Escapism
10. Guilt, Shame, Fear of humiliation

B. Social causes

1. Physical Abuse
2. Schloastic Difficulties
3. Social isolation
4. Lack of Social Support
5. Economic Failure

C. Family causes

1. Disturbed Inter-Personal Relationship
2. Family Discard
3. Lack of Parental & Familial Care
4. Parental separation
5. Family Conflict
6. Death of Loved ones

Classification

In 1951, Emil. Durkheim classified Social Categories of Suicide

1. Egoistic Suicide : One who has lost social integration with their social support group. It is a response of the person who feels separated and apart from social mainstream, e.g. divorce
2. Altruistic : It results from a response to a cultural expectation, e.g. sati.
3. Anomic Suicide : It occurs in response to the change that occur in an individual life, e.g. loss of job, recurrent failures.
4. Revengeful Suicide ; It occurs to spite others or experiencing as being unfriendly, e.g. wife committing suicide to take revenge on unfaithful husband.

Assessment

A]. Recognition / Suspicion of Suicidal Ideation

1. Behavioral Clues : Ingestion of small amount of some potential lethal drugs
2. Writing Suicidal Notes
3. Sudden Change of Moods

B]. Verbal Clues

Passing Negative Statements, e.g
I'm useless,
Everything is going wrong,
No need for me to live,

This is the last time you'll see me

C]. Situational Clues

There are inherent in life-experiences associated with stress, e.g. diagnosis of fatal illness

D]. Non-Verbal Clues

1. Sleeping too much or too little
2. Lack of interest in social activities
3. Poor performance
4. Substance Abuse

E]. Emotional Clues

1. Hopelessness
2. Helplessness
3. Powerlessness
4. Neglect of personal Welfare
5. Sudden Intense Interest in Personal Insurance
6. Change in appetite / weight / behavior / activity level
7. Low Energy Level

Methods of Committing Suicide

A]. Slow Lethal Methods : These allow time for rescue because of slowness of their physiological action

1. Self-Poisoning by Pill ingestion
2. Inhaling Domestic Gas
3. Wrist Cutting

B]. High Lethal Methods

1. Gun-Shot
2. Hanging
3. Drowning
4. Car-Crash
5. Falling in front of a Moving Vehicle or Railways
6. Self-Immolation
7. Jumping from high altitude
8. Piercing of Vital Organs (Harakiri)
9. Carbon Monoxide poisoning

Management of Suicide Attempts

A]. **Assessmen**t : it the most critical step to ensure safety of patient.

1. Observable Behavior Traits

   Anxiety

   Insomnia

   Expressed extreme shame on a Real or Unreal Incidence

Restlessness

Real or Imaginary serious illness

Auditory or Visual Hallucination

2. History of Client : Carefully taken history will reveal the predisposing factors & precipitating events which contribute to the current crisis of extreme self-destructive thoughts. it the patient has considered suicide in past, explore the following :

   Frequency and extent of Suicidal Ideation

   Contemplated Means

   Feelings associated with Suicide

   Ability to imagine how loved one would be affected by suicide

3. Information from Friends & Family

   Collect Past history, esp. previous attempts & psychiatric illness

   Physical Examination

   Psychological Evaluation

   Low Self Esteem

   Low communication Level

   Ineffective coping skills

B. Intervention :

1. Make Treatment Plan
2. Try to motivate the patient to accept it
3. Decide whether the client should be admitted to hospital or treated on OPD basis.
4. It it is an OPD case, ask for address & telephone number and tell the patient that he can call in case of any need anytime.
5. If case is significant, IPD care is required

These depend upon following

1. Intensity of Suicidal Ideation
2. Severity of Any associated Psychiatric Illness
3. Social support system

C. Prevention

1. Primary Prevention

   Education and Improve the skills of Community Team Members to assess High-Risk Patients

   Early recognition of Psychiatric Illness

   Identifying Stressors

   Assist the family and patient to modify the stressful situations

2. Secondary Prevention

   Establishment of Crisis Prevention & Counseling Center

   Provide treatment for Actual Suicide Crisis in clinics, telephone hotlines in hospitals

Guidance & Counseling services for suicidal attemptors

3. Tertiary Prevention

   Intervention with family & friends of a person who has committed suicide

   Follow-Up & Continuity of Care

   Establishment of Strong Support system

LEARNING POINTS

Suicide (Self-Harm) makes 1.5% of the global burden of disease. Suicide should and can be prevented. 83% of persons who committed suicide have had contact with a primary care physician within a year of their death and up to 66% of have had such contact within a month of their death. However, the suicidal ideation was missed by the physicians.

Suicidal behavior has been conceptualized as a continuum of thoughts and behaviors ranging from suicidal ideation to completed suicide. Recent retrospective research delineates seven distinct categories of “suicidality”: (1) completed suicide, (2) suicide attempt, (3) preparatory acts toward imminent suicidal behavior, (4) suicidal ideation, (5) self-injurious behavior without intent to die, (6) non-deliberate self-harm, and (7) self-harm behavior with unknown suicidal intent.

Mann et al. found that five methods are effective in secondary suicide prevention: pharmacological interventions, psychological interventions, follow-up care, reduced access to lethal means, and responsible media reporting of suicide.

Among psychological interventions, suicidal patients often benefit from therapies that address the repetition of suicidal thoughts and behaviors, treatment adherence, and other factors commonly associated with suicidality. Motivational Psychotherapy decreases both suicidal ideation and the re-attempt rate. Interpersonal 1 to 1 & JFT psychotherapy decreases suicidal ideation. Problem-solving therapy through individual counseling works to improve the mediating factors of suicidality; such as hopelessness and depression. Better psychological treatment of Substance Abuse Disorder and alcoholism, even in the absence of overt suicidal thoughts or behaviors, also appears to decrease suicide rates.

1. **No single treatment is appropriate for everyone**.

Treatment varies depending on the type of drug and the characteristics of the patients. Matching treatment settings, interventions, and services to an individual’s particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

2. **Treatment needs to be readily available.**

Because drug-addicted individuals may be uncertain about entering treatment, taking advantage of available services the moment people are ready for treatment is critical. Potential patients can be lost if treatment is not immediately available or readily accessible. As with other chronic diseases, the earlier treatment is offered in the disease process, the greater the likelihood of positive outcomes.

3. **Effective treatment attends to multiple needs of the individual, not just his or her drug abuse.**

To be effective, treatment must address the individual’s drug abuse and any associated medical, psychological, social, vocational, and legal problems. It is also

important that treatment be appropriate to the individual's age, gender, ethnicity, and culture.

4. **Behavioral therapies—including individual, family, or group counseling—are the most useful form of drug abuse treatment.**

Behavioral therapies vary in their focus and may involve addressing a patient's motivation to change, providing incentives for abstinence, building skills to resist drug use, replacing drug-using activities with constructive and rewarding activities, improving problem-solving skills, and facilitating better interpersonal relationships. Also, participation in group therapy and other peer support programs during and following treatment can help maintain abstinence.

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