Suicide Prevention strategy framework for Madhya Pradesh

Prepared by Centre for Social Sector Development

Atal Bihari Institute of Good Governance and Policy Analysis
An Autonomous Institute under the Govt. of Madhya Pradesh)
Sushasan Bhavan, Bhadbhada Square, Bhopal
Project team

Special Guidance

1. Shri Padamvir Singh, Director General
2. Shri Akhilesh Argal, Director
3. Shri. Mangesh Tyagi, Principal Advisor, Centre for Governance

Guidance

Shri Madan Mohan Upadhyay, Principal Advisor, Centre for Social Sector Development

Project co-ordinator

Mangala Gowri M S, Deputy Advisor, Centre for Social Sector Development

Support Staff

1. Aishwarya Chandrashekhar (Data Analyst)
2. Enshaw Raza (Data Entry Operator)
Title

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Atal Bihari Vajpayee Institute of Good Governance and Policy Analysis (AIGGPA) undertakes research on various schemes, problems and policy issues and works in collaboration with concerned Departments to provide strategic inputs and suggestions. The core staff of the institute co-ordinates and executes the research programmes. The institute conducts extensive brain storming sessions and workshops with subject matter experts in order to validate the findings.

**A retrospective study on suicides in Bhopal and suicide prevention mechanisms in Madhya Pradesh** was taken up by the institute as Bhopal witnessed a steady growth in the number of suicides in the past few years. The Crime Investigation Department and mental health experts in the state have been a part of the study. The outcome of the study is a strategy framework to reduce the number of suicides in Madhya Pradesh. We hope that the report turns out to be a milestone in bringing out a comprehensive suicide prevention programme for Madhya Pradesh.

Date: 10-01-2017

(Padamvir Singh)

Director General

Atal Bihari Vajpayee Institute

of Good Governance and Policy Analysis

Bhopal
Executive Summary

Centre for Social Sector development in Atal Bihari Vajpayee Institute of Good Governance and Policy Analysis had taken up a retrospective study of suicides in Bhopal in order to develop a suicide prevention framework for the state. The study was done on secondary data.

The report is classified into three parts. Part A deals with the study of suicides in Bhopal in the stipulated time frame to understand the major trends. Due to the urban nature of the sample involved, it might not qualify as a representative sample for the predominantly rural population of Madhya Pradesh. Nevertheless care has been taken to broaden the scope without causing major losses in the fidelity of the data received. It also documents the suicide prevention mechanisms available in Madhya Pradesh at present. The present status of mental health infrastructure in the state has been captured in this regard. The analysis of the secondary data brought out certain trends.

The major trends that emerged during analysis was that 20-30 age group is the most vulnerable category and males are more prone to suicides than females. The trend was the same in the whole of MP as well. The youth, that is 10-40 age group comprise around 60% of the total suicide cases. Hanging is the most preferred option for committing suicides in Bhopal. In Madhya Pradesh, consumption of chemicals is the topmost method for suicide. Private job holders, housewives, labourers and students form the high risk category. Quantification of causes showed that family problems, mental problems, diseases and financial problems were the major causes for suicides. Student suicide also emerged as a matter of concern. The main reason for student suicide seemed to be academic stress.

Part B deals with comparative study of suicide prevention strategies from across the world to understand best practices. The strategies of Australia, Scotland, England and USA were looked into for inputs. Suitable practices have been incorporated in our suicide prevention framework.

Part C is the strategy framework proposed by the research team which was validated in a workshop of relevant stakeholders. A workshop to develop a suicide prevention strategy for the state was conducted on December 2, 2016 in which various stakeholders participated and the possible strategy options were discussed at length.
Over 800,000 people commit suicide every year all over the world and many more attempt suicide.\(^1\) Worldwide, suicide is one of the three leading causes of death among those in the most economically productive age group (15-44 years) and the second leading cause of death in the 15-19 years age group (Patton et al., 2009). The statistics from National Crime Records Bureau puts the figure for India to be around one lakh persons per year. But far more people are affected by the incidence of suicides. Research is crucial in this field, as an evidence based framework is the way to move forward to develop a comprehensive suicide prevention strategy for the state. With this end in view, the Centre for Social Sector Development, AIGGPA took up a retrospective study on suicides in the state capital Bhopal to identify the vulnerable groups and associated risk factors. Based on the evidence received and on comparative study of suicide prevention strategies in other countries, a brainstorming session was conducted in the form of a workshop with stakeholders from various walks of life. The strategy framework was prepared accordingly. Due to the predominantly urban nature of the population of Bhopal, the findings may have an urban tilt. But there weren't much variations in the findings of Bhopal in comparison to Madhya Pradesh. Nevertheless the rural nature of the state has been kept in mind while preparing the strategy framework.

As per the National Crime Record Bureau (NCRB), the number of suicides in the country during the decade (2004–2014) has recorded an increase of 15.8% (1,31,666 in 2014 from 1,13,697 in 2004). The rate of suicides is showing a mixed trend during the decade.

\(^1\) As per WHO report [http://www.who.int/mental_health/suicide-prevention/en/]
As per the report of NCRB for the year 2014, the highest incidents of 16,307 suicides were reported in Maharashtra followed by 16,122 suicides in Tamil Nadu and 14,310 suicides in West Bengal accounting for 12.4%, 12.2% and 10.9% respectively of total suicides in the country. Karnataka (10,945 suicides) and Telangana (9,623 suicides) accounted for 8.3% and 7.3% respectively of the total suicides reported in the country. These 5 States together accounted for 51.1% of the total suicides reported in India. The remaining 48.9% suicides were reported in the remaining 24 States and 7 UTs. Madhya Pradesh reported 9039 suicides which accounts for 6.9% of the total number of suicides in India.

In the same year, Madhya Pradesh saw a suicide rate of 11.9 compared to the national rate of 10.6. Puducherry reported the highest rate of suicide (40.4) followed by Sikkim (38.4), A & N Islands (28.9), Telangana (26.5), Kerala (23.9) and Tamil Nadu (23.4). The 2014 report places Madhya Pradesh in the 17th position in the matter of rate of suicides and has placed the state in the alert category as its rate exceeds the national average.

Coming to the distribution of incidences of suicides in the major cities, There were 19,120 suicides in India's largest 53 cities (for the year 2012). Chennai reported the highest total number of suicides at 2,183, followed by Bengaluru (1,989), Delhi (1,397) and Mumbai (1,296). Jabalpur (Madhya Pradesh) followed by Kollam (Kerala) reported the highest rate of suicides 45.1 and 40.5 per 100,000 people respectively, about 4 times higher than national average rate. But there has always been wide variation in suicide rates, year to year, among Indian cities. The particular study has taken data of suicides in Bhopal for the past three years and analyzed it with a view to compare the findings with the whole of Madhya Pradesh.

**Rationale of the study**

The low and middle income countries bear the larger part of the global suicide burden. And mostly these countries are not equipped enough to prevent suicides. Unable to keep pace with the rising demand for mental health care, they are especially hindered by inadequate infrastructure and scarce economic and human resources. (Vijayakumar
2005). Though there have been several studies on suicides regarding causes, risk factors and even on the issue of farmer suicides, a systematic and comprehensive study capturing the data on ground and linking it with the existing policy framework is yet to be done. Incidence of suicides is on the rise in Bhopal as well as the whole of Madhya Pradesh. The Accidental Deaths and Suicides in India report for 2014 released by the National Crime Records Bureau shows that Bhopal recorded $56.6^2$ suicides per 1 lakh population which is probably the highest in the country. The increasing incidences of suicide in Bhopal call for a study into the causes of suicide and also a comprehensive suicide prevention strategy by the government.

**Objectives of the study**

1. To understand the demographic trends of suicides in Bhopal for the past three years
2. To quantify major causes of the suicides in Bhopal for the selected time frame
3. To identify the policies and interventions of state government for suicide prevention
4. To review suicide prevention policies at national and international levels and suggest state specific strategies for interventions.

**Methodology**

The study has been primarily designed as a retrospective research based on secondary data. The data for the proposed timeframe (March 2013- October 2016) was collected from the CrimeInvestigation Department and medical colleges/government hospitals and analyzed on the basis of set parameters. Inputs was taken in the form of semi-structured interviews from psychologists and other mental health professionals. A comparative study of the policy interventions on suicides in a few other countries was captured so that the report helps to bring out a comprehensive policy framework on suicides for state government. A tentative strategy framework was prepared based on the above and a workshop was organized which was attended by mental health experts and stakeholders from various departments. An appropriate framework for the state was discussed at

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length and modifications made on the strategy framework. The strategy framework given in part C of the report has been prepared after rounds of brainstorming.

Scope of the study

The study looked into all the reported cases of suicides for the years 2013, 2014, 2015 and till October 2016 in Bhopal district. Analysis was conducted with the help of secondary data provided by the CrimeInvestigation Department. Unstructured interviews were held with mental health professionals and other stakeholders working in the same area. A workshop comprising of mental health professionals and other field experts were conducted to discuss a framework appropriate for Madhya Pradesh. Suicide prevention strategies of UK, USA, Scotland and Australia were looked into to identify those elements which will be useful while devising a strategy for the state.

Limitations of study

The study is primarily secondary data based. The data obtained from the Police Department were succinct and to the point. In a topic where there is tremendous scope for subjectivity, we have not gone into the immediate triggers. No primary study was conducted to verify causes or economic status. The study was limited to Bhopal district only and hence the sample was predominantly urban in nature. It cannot be termed as a representative sample for the whole of the state. The data on the number and details of suicides available with the State Crime Record Bureau is restricted to three years which severely limits the chronological scope of the study.
Findings and analysis based on retrospective study of suicides in Bhopal

Part A
Background

A retrospective study based on secondary data on suicides was conducted in Bhopal district of Madhya Pradesh to understand the trends, risk factors, vulnerable groups and major causes. The data for the same was provided by the Crime Investigation Department, Bhopal. Though our objective was to take up the data of the past five years, the present study includes the police station wise data for the years 2013, 2014, 2015 and 2016 (up to 30th October.) All reported cases of suicides in the above mentioned time span has been included in the study.

An overview of the situation in Madhya Pradesh

As per the report on suicides by National Crime Records Bureau for the year 2014, Madhya Pradesh accounts for 6.9% of the total number of suicides in the country. Rate of suicides i.e. the number of suicides per one lakh population, has been widely accepted as a standard yardstick for comparison. While the all India rate for 2014 was 10.6, Madhya Pradesh reported a suicide rate of 11.9 for the same time period. MP holds the 17th position in this regard. Puducherry has the highest rate of suicides among Union territories and Telengana has the highest rate of suicides among the states.

The population of Madhya Pradesh was 72 million as per 2011 census. It is the fifth largest state of India by population. According to recent estimates, the population of Madhya Pradesh in 2015 was 78,492,606. Every year, the state adds around 1.4 million people to its ever growing population. More than 75% of state population reside in villages whose main occupation is agriculture.

The suicide scenario in Madhya Pradesh for the past decade has been depicted below. The graph shows an increase of 19.4 % in 2009 which has remained relatively stable except for a leap of around 7% till 2013. But the year 2015 showed another leap of 20% causing an upward swing in the graph.

The rate of suicides as per the year's population for the past few years is given in Figure 2. The rate has been calculated on the population of that particular year and what we see is a general decline in the rate of suicides till 2014 and a sudden shoot up in 2015. In terms of the number of suicides, we see an increase of 13.9% in the year 2015 when compared to 2014 where as the increase in the rate of suicides can be put approximately at 1.4%.

That being the general scenario of Madhya Pradesh, one need to examine the situation in the major cities of the state to understand the prevalence of suicides amongst them. Indore, Bhopal, Jabalpur and Gwalior are the major cities in the state and Figure 3 gives an overview of the suicide status of the cities vis a vis Madhya Pradesh. Suicides in Bhopal account for 2.3%, 3.5% and 4.6% of the total number of suicides in Madhya Pradesh for the years 2012, 2013 and 2014 respectively. Percentage share of suicides from Bhopal is steadily on the rise as per the data. The tables of certain graphs are given in the annexure. The numbering of the table and the graph have been done alike so that Table 1 in the annexure relates to Figure 1 in the report, Table 2 in the annexure relates to Figure 2 and so on.
A retrospective study of suicides in Bhopal and suicide prevention mechanisms in MP

Figure 2: Rate of suicides in MP over the years

![Rate of suicides in MP over the years](image)

Figure 3: Suicides in Madhya Pradesh and suicide incidences in major cities of MP

![No of suicides in MP](image)

The percentage share of suicides from these cities are 15.23%, 16.73% and 18.50% for the years 2012, 2013 and 2014 respectively. The population of these districts (as per 2011 census) is given below to understand their share in the total population of Madhya Pradesh.

<table>
<thead>
<tr>
<th>No</th>
<th>Name of the district</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Indore</td>
<td>3,276,697</td>
</tr>
<tr>
<td>2</td>
<td>Bhopal</td>
<td>2,371,061</td>
</tr>
<tr>
<td>3</td>
<td>Jabalpur</td>
<td>2,460,714</td>
</tr>
<tr>
<td>4</td>
<td>Gwalior</td>
<td>2,030,543</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>1,013,9015</td>
</tr>
</tbody>
</table>
They account for roughly 14% of the total population of the state. The data above does not point out to urban preponderance of suicides and hence we need to assume that the distribution of the incidences of suicides is spread throughout the state. So a strategy to prevent suicides must factor in this aspect also.

Profile of Bhopal District

According to the 2011 census, Bhopal District has a population of 2,371,061, of which males and females were 1,236,130 and 1,134,931 respectively. The district has a population density of 855 inhabitants per square kilometre (2,210/sq mi). Its population growth rate over the decade 2001-2011 was 28.46%. Bhopal has a sex ratio of 918 females for every 1000 males, and a literacy rate of 80.37%. It constitutes 3.05 % of the total population of MP. Out of the total Bhopal population for 2011 census, 80.85 percent live in urban regions of district. In total 1,917,051 people live in urban areas. 19.15 % population of Bhopal district live in rural areas of villages. The total population of Bhopal district living in rural areas is 454,0104.

Analysis and Interpretation

The study covered suicide cases from 34 police stations in Bhopal. The data obtained spanned over a period of three years and cases of all age groups were looked into.

The data has been categorized into the respective years of their occurrence. As mentioned above, the data for 2013, 2014, 2015 and the first ten months of 2016 was used for analysis. The year wise break up as well as the consolidated analyses and interpretations are given in the sections below.

Trends that emerged during analysis of suicides in Bhopal

Demographic trends

The data shows a steady increase in the number of suicides in Bhopal in the past four years. Though suicides in general are on a rise, there is drop in the percentage of rise.

2014 witnessed a major leap of 23% in suicides whereas the increase in 2015 is 12%. Figures for the first ten months of 2016 shows an average of 41 deaths/ month.

There is a consistent increase in the number of suicides among men and any strategy of suicide prevention should consider this aspect of the data. Suicides amongst women are showing a declining trend on the other hand. As other external variables are not accounted for, no conclusions can be drawn regarding the reason behind the trends.

<table>
<thead>
<tr>
<th>No</th>
<th>Year</th>
<th>No of suicides</th>
<th>Total</th>
<th>Ratio(F:M)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>2012</td>
<td>207</td>
<td>130</td>
<td>337</td>
</tr>
<tr>
<td>2.</td>
<td>2013</td>
<td>264</td>
<td>152</td>
<td>416</td>
</tr>
<tr>
<td>3.</td>
<td>2014</td>
<td>343</td>
<td>124</td>
<td>467</td>
</tr>
<tr>
<td>4.</td>
<td>2015</td>
<td>257</td>
<td>157</td>
<td>414</td>
</tr>
</tbody>
</table>

Figure 4: No: of suicides in Bhopal gender wise

As per the data, men are more prone to suicides than women and there is a dip in the number of women who commit suicide in 2015. As we do not have more data on this, it will be difficult to predict if this is just an aberration or if it is a trend to watch for. A
longitudinal study in this regard will clarify things in a better way. The male female comparison for the said years are illustrated below.

**Figure 5: Male Female Comparison of those who committed suicide**

Higher number of suicides by men is a global phenomenon and the state as well as Bhopal too show the same trend.

The demographic profile of the victims indicate a strong tendency among youths to commit suicide. In 2013, the most vulnerable age group to commit suicide were between 20 to 30 years which comprised of 59.85% males and 40.14% females. 20-30 age group comprised 43% of total fatalities of the year. (Ages of 4 victims were not known.) 10-20 age group formed 25% of the total number of reported deaths. The trend continued in 2014 also with 20-30 age group comprising 40% of total number of suicide incidences closely followed by 10-20 and 30-40 age group. 2015 also maintained the trend, thus pitting the youth as the most vulnerable section. Annual gender wise breakup of the demographic profile is given in the following table. If we add up the 10-20 group age group along with it, the incidence of suicides among youth is alarming. The 10-30 age group constitute 68% of the total number of suicide cases in 2013, 62% in 2014 and 57% in 2015. In 2013, amongst the women who committed suicide 44% belonged to 20-30 age group whereas, 42% percentage of men who committed suicide were in the 20-30 bracket.
A retrospective study of suicides in Bhopal and suicide prevention mechanisms in MP

Figure 6: Age wise classification of suicide cases for 2013

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 10</td>
<td>2%</td>
</tr>
<tr>
<td>10 to 20</td>
<td>4%</td>
</tr>
<tr>
<td>20 to 30</td>
<td>2%</td>
</tr>
<tr>
<td>30 to 40</td>
<td>9%</td>
</tr>
<tr>
<td>40 to 50</td>
<td>14%</td>
</tr>
<tr>
<td>50 to 60</td>
<td>25%</td>
</tr>
<tr>
<td>60 and above</td>
<td>43%</td>
</tr>
</tbody>
</table>

Figure 7: Age wise classification of suicide cases for 2014

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 10</td>
<td>0%</td>
</tr>
<tr>
<td>10 to 20</td>
<td>0%</td>
</tr>
<tr>
<td>20 to 30</td>
<td>22%</td>
</tr>
<tr>
<td>30 to 40</td>
<td>17%</td>
</tr>
<tr>
<td>40 to 50</td>
<td>0%</td>
</tr>
<tr>
<td>50 to 60</td>
<td>4%</td>
</tr>
<tr>
<td>60 and above</td>
<td>40%</td>
</tr>
</tbody>
</table>

Figure 8: Age wise classification of suicide cases for 2015

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 10</td>
<td>0%</td>
</tr>
<tr>
<td>10 to 20</td>
<td>21%</td>
</tr>
<tr>
<td>20 to 30</td>
<td>23%</td>
</tr>
<tr>
<td>30 to 40</td>
<td>36%</td>
</tr>
<tr>
<td>40 to 50</td>
<td>0%</td>
</tr>
<tr>
<td>50 to 60</td>
<td>21%</td>
</tr>
<tr>
<td>60 and above</td>
<td>4%</td>
</tr>
</tbody>
</table>
Even amongst the youth, males continue to be at high risk and so another study may be conducted to look into the causes behind suicides by males. The percentage of increase in suicides by males in the 20-30 and 30-40 age group is higher compared to the rest. This section is actually youth in their prime and an inquiry into the main causes of suicide by youth in this category need to be done to identify the potential victims. A correlation between the age, gender and causes have been tried to achieve in the next section.
Consolidating the data given above, the study of suicides in Bhopal has given the following trends. In the time frame taken up for study, (2013-2016 till October 30) 1071 men committed suicide. The number of females who took the extreme step is almost the half of the above i.e. 563. Going by their respective population, the percentage of men committing suicide is 0.016% of their total population in Bhopal and that of women is 0.014% of the population of women in Bhopal.

The consolidated data of the above are given in the table below.

### Age wise depiction of suicides

<table>
<thead>
<tr>
<th>Year</th>
<th>0-10</th>
<th>10-20</th>
<th>20-30</th>
<th>30-40</th>
<th>40-50</th>
<th>50-60</th>
<th>60 and above</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>0</td>
<td>84</td>
<td>142</td>
<td>63</td>
<td>30</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>2014</td>
<td>0</td>
<td>91</td>
<td>166</td>
<td>87</td>
<td>38</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td>2015</td>
<td>0</td>
<td>90</td>
<td>149</td>
<td>98</td>
<td>42</td>
<td>23</td>
<td>17</td>
</tr>
</tbody>
</table>

The demographic profile of Madhya Pradesh in suicides also indicate towards the same trend. The data has been obtained from National Crime Records Bureau. Analysis of Madhya Pradesh is given for the year 2014. 14-30 age group comprises 52.1% of the total number of deaths. This is closely followed by 30-45 age group which adds up to 28.4% of the whole. The data implies that any suicide prevention strategy should factor in the age profile of the most vulnerable group.
An attempt to identify the major causes of suicides among the youth was attempted and the following indicators were noticed. Of the youths who came under the bracket of 10-40 years, 868 people committed suicide in the given three years. Substance abuse accounts for 7.71% of the deaths. Women comprise only 0.9% of these. 13.24% of the youths succumbed to some kind of mental problem ranging from anger to depression. And among them 58.26% of them were males and the rest females. 15.55% of the sample population resorted to end their lives due to family problems and here women were ahead of men by a very thin margin of 0.8%. 8.6% of the youth took their lives due to illnesses and domestic violence accounted for 7.4% of the deaths in the given population. Of them 99.6% were females in the said category. Another 7.4% people ended their lives due to financial problems and 4.3% amongst them were in the 20-30 male category. A graphical depiction of the above information is illustrated in Figure 13.

Amongst student suicide, studies related stress seem to be the major reason. In 2013, 42 students committed suicide. 19 cases were related studies related stress. 2014 also witnessed a similar pattern. Of the 49 students who ended their lives in 2014, 17 were clear cut cases of pressure of academics. 31 students committed suicide in 2015. 10 cases were related to problems with studies. So students are also in high risk category and measures need to be taken to create a friendly atmosphere for them in schools as well as their homes.
A retrospective study of suicides in Bhopal and suicide prevention mechanisms in MP

The diagram below shows the respective percentage of causes for the given three years in Bhopal.

**Figure 13: Percentage share of reasons for suicide in Bhopal from 2013-2015**

<table>
<thead>
<tr>
<th>Percentage of causes for suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Problem</td>
</tr>
<tr>
<td>40%</td>
</tr>
</tbody>
</table>

**Causes of Suicide**

23 types of general reasons could be culled out from the police records. Due to the secondary nature of the study, specificities could not be looked into. There is ambiguity on the matter as to whether there were any immediate triggers for suicides in most of the causes. Specific causes are confined to a few cases where the police have explicit records of the causes. The table below gives the details on the prominent reasons for committing suicides.

<table>
<thead>
<tr>
<th>No</th>
<th>Year</th>
<th>Mental Problem</th>
<th>Family Problem</th>
<th>Disease</th>
<th>Financial Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>2013</td>
<td>41</td>
<td>42</td>
<td>24</td>
<td>22</td>
</tr>
<tr>
<td>2.</td>
<td>2014</td>
<td>46</td>
<td>55</td>
<td>43</td>
<td>20</td>
</tr>
<tr>
<td>3.</td>
<td>2015</td>
<td>51</td>
<td>54</td>
<td>43</td>
<td>23</td>
</tr>
</tbody>
</table>
The reasons shown above too indicate towards a strategy that should focus on reducing the stress levels in the community and early identification of potential victims. Family has to play a crucial role and hence sensitizing people in this regard attains tremendous importance. In this context an attempt was made to make a comparison of the situation in Bhopal and Madhya Pradesh.

Comparing the above with the scenario in MP as a whole, the data for the year 2014 has the following findings to offer. Of the reported 9039 cases, the causes of 1326 were not known. Among the reasons known, 1766 people committed suicide due to family problems. 1563 did it due to illness. Another 979 cases ended their lives due to other prolonged illnesses. The graphical depiction of the major causes of suicides in MP is given below.
**Figure 15: Major causes of suicides in MP**

<table>
<thead>
<tr>
<th>Major causes for suicide in MP</th>
<th>Number of suicide cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>family problems</td>
<td>1766</td>
</tr>
<tr>
<td>Illness</td>
<td>1563</td>
</tr>
<tr>
<td>Other prolonged illness</td>
<td>979</td>
</tr>
<tr>
<td>Marriage related issues</td>
<td>962</td>
</tr>
<tr>
<td>Dowry related issues</td>
<td>669</td>
</tr>
<tr>
<td>Mental problems</td>
<td>538</td>
</tr>
</tbody>
</table>

**Modus operandi**

The methods adopted for committing suicide also saw a repetitive trend in all the years with hanging, poison and self immolation as the dominant means used by people. This information may be used while controlling access to chemicals and other substances. Out of 337 cases reported in 2013, 69% hanged themselves whereas 17% consumed poison and 10% opted for self immolation. The same trend continued with minor variations in 2014. 74% of the victims hanged themselves in 2015 and 14% opted for poison. Even among poison, *salphas* seem to be the preferred option. Access to harmful chemicals is probably one area where stringent measures could be adopted.
A retrospective study of suicides in Bhopal and suicide prevention mechanisms in MP

**Figure 15:** Means adopted for committing suicide

Percentage of victims as per the means adopted in 2013

- Hanged: 69%
- Fire: 17%
- Poison: 10%
- Train Accident: 12%
- Drowned: 14%
- Self immolation: 2%
- Shooting: 2%
- Cutting the vein: 1%

**Figure 16:** Means adopted for committing suicide

Percentage of victims as per the means adopted in 2014

- Hanged: 69%
- Fire: 19%
- Poison: 7%
- Train Accident: 17%
- Drowned: 1%
- Self immolation: 2%
- Shooting: 1%
- Jumping from heights: 0%
- Unknown: 1%

**Figure 17:** Means adopted for committing suicide

Percentage of victims as per means adopted in 2015

- Hanged: 74%
- Fire: 14%
- Poison: 6%
- Train Accident: 12%
- Drowned: 2%
- Jumped from the terrace: 1%
- Shooting: 0%
- Cutting the vein: 0%
Comparing the same with the whole of Madhya Pradesh, the trends are similar. Of the 9039 suicide victims in 2014, 1423 opted for death by hanging, 4810 chose poison or other kind of chemicals like sleeping pills or insecticides and 630 immolated themselves. The National Crime records bureau identified 15 means in all Twelve of them are given below as the consumption of sleeping pills, insecticides and other chemicals have been clubbed under one head.

1. By Poison/chemicals
2. By hanging
3. By Fire/Self Immolation
4. By Drowning
5. By Firearms
6. By Self inflicting Injury
7. By Jumping from building
8. Other sites
9. By Jumping off moving trains/vehicles
10. By Coming under running vehicles/trains
11. By touching electric wire
12. By Other means

The graphical depiction of the above data is as under.

**Figure 18: Means adopted for committing suicide in MP**
Socio Economic status/job profiles of the deceased

In order to understand the socio economic status of the victims, their occupations were categorized into possible number of heads. 337 cases were reported in 2013. Of the reported job profiles, the data showed 15 types of job categories which includes housewives as well as students. Those in the unemployed category is not shown in the graph. 20 cases came under the unemployed category. Students formed another large chunk of the victims with their number soaring to 42. Fidelity to the original data has been maintained by maintaining the variety in the job profiles to create a wider canvas.

**Figure 19:** Nature of occupation of the victims for 2013

<table>
<thead>
<tr>
<th>Occupation of victims</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Un-employed</td>
<td>22</td>
</tr>
<tr>
<td>Student</td>
<td>42</td>
</tr>
<tr>
<td>Private Job</td>
<td>66</td>
</tr>
<tr>
<td>Labour</td>
<td>68</td>
</tr>
<tr>
<td>House Wife</td>
<td>2</td>
</tr>
<tr>
<td>Farmer</td>
<td>3</td>
</tr>
<tr>
<td>Driver</td>
<td>4</td>
</tr>
<tr>
<td>Business</td>
<td>1</td>
</tr>
<tr>
<td>Army</td>
<td>1</td>
</tr>
</tbody>
</table>

In a further break up of reasons and jobs in 2013, financial problems and stress accounted for a combined 15.2% in the case of private job holders. Amongst housewives, family disputes, dowry harassment, and problems with spouse constituted 34.32% of the cases. Alcoholism topped the reason for suicides among labourers.

Out of the 419 suicide cases reported in the year 2014, job profiles of 20 cases were not known. The rest of them are shown in the graph above. House Wives were the most vulnerable group in 2014, numbering 101, closely followed by Labourers (85) and Private job holders (72). Family disputes, dowry harassment and problems with spouse turned out to be the major problems for housewives whereas alcoholism and financial problems plagued labourers. Depression, Stress and financial problems seemed to be the main issues of private job holders.
The job profile of 430 cases were known in 2015. This year also saw the repetitive trend of Private job holders (111) being the most vulnerable category followed by labourers (94) and housewives (90).

Amongst the 111 cases of those in Private Jobs, the main reason for suicide was found to be "Family Disputes and Problems" followed by Disease, Financial Problem and Stress.

Of the 94 cases of suicides coming in the Labour category, Alcoholism continued to be the main killer followed by Disease, Family Disputes and Problems and Financial Problems. Amongst the 90 cases of suicide victims who happened to be House Wives, Family Problems and Disputes were the main issues leading to loss of lives.
To identify the suicide prone groups as per their occupation, the demarcation is given in the graph below. Though there were people from other professions also, the trend was tilted largely towards the groups mentioned in graph 20. Only those professions have been depicted in graph 20 whose numbers are atleast above 15. While developing a strategy, these groups need to be taken into account and treated as high risk category.

**Figure 20: Occupational groups that emerged to be in high risk in suicides**
Suicide Prevention Mechanisms in Madhya Pradesh

Situation of mental health care in Madhya Pradesh

The state with a population of over 70 million has just 15 psychiatric doctors in government hospitals, as opposed to 700 as is mandated by the National Mental Health Policy.\(^5\)

As per the findings of various research, 6-7% of the state’s population, or around 4.2 million people, suffer from at least some kind of mental health problem in the state, while another 1-2% or 700,000 to 1.4 million people have serious disorders.

There are only around a dozen psychiatrists in the government hospitals and approximately 40 to 50 psychiatrists in the private sector, with most of them based in the urban centres, leaving most of the rural areas without any mental healthcare facilities.

Except for the Indore medical college, post graduate courses haven’t been started in any of other five medical colleges in the state. Even at Indore, two seats were introduced for PG in psychiatry only two years ago. There are no courses even for clinical psychology in any of the medical colleges of the state.\(^6\)

According to proposed norms, there should be one psychiatrist for every 100,000 people, three clinical psychologists for every 200,000 people, two psychiatric social workers for every 100,000 people, and one psychiatric nurse for every 10 psychiatric beds.

MP has just two psychiatric hospitals — Manasik Arogyasala in Gwalior and psychiatric hospital in Indore.

A long term strategy should take into account the dismal picture of mental health infrastructure in the state and efforts should be made to strengthen the same.

MP does not have any comprehensive suicide prevention programme as of now. Sporadic and non-integrated efforts like the Sanjivani programme in Jabalpur do exist. There is no helpline for suicide prevention run by the govt.

However helpline for disabled (1800-233-4397), helpline to complain on violence against women, which is run by the local police (1090), helpline run by ministry of women and child welfare (1091) are the ones that are existent at present.

Certain NGOs like AASRA, MAITREYI, Lifeline Foundation, Sneha, Saath etc are running help lines for suicide prevention.

As the problem of suicides was closely interlinked with mental problems, information was sought from the mental health institutions to understand the level of infrastructure facilities which included personnel and hardware and the table below depicts the scenario.

<table>
<thead>
<tr>
<th>Name of the Hospital</th>
<th>Year</th>
<th>Total no of patients</th>
<th>Total number of mental health cases</th>
<th>% of mental health cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>SS Medical College, Rewa</td>
<td></td>
<td></td>
<td>OPD</td>
<td>IPD</td>
</tr>
<tr>
<td></td>
<td>2013</td>
<td>426947</td>
<td>9570</td>
<td>993</td>
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<tr>
<td></td>
<td>2014</td>
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<td>7964</td>
<td>859</td>
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<td></td>
<td></td>
<td>427844</td>
<td>8716</td>
<td>790</td>
</tr>
<tr>
<td>Gandhi Medical College, Bhopal</td>
<td></td>
<td></td>
<td>OPD</td>
<td>IPD</td>
</tr>
<tr>
<td></td>
<td>2013</td>
<td>397194</td>
<td>9336</td>
<td>289</td>
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<tr>
<td></td>
<td>2014</td>
<td>438822</td>
<td>10672</td>
<td>300</td>
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<tr>
<td></td>
<td>2015</td>
<td>471913</td>
<td>10974</td>
<td>281</td>
</tr>
<tr>
<td>Bundelkhand Medical College, Sagar</td>
<td></td>
<td></td>
<td>OPD</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2013</td>
<td>-</td>
<td>11492</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2014</td>
<td>-</td>
<td>2524</td>
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</tr>
<tr>
<td></td>
<td>2015</td>
<td>-</td>
<td>49</td>
<td></td>
</tr>
<tr>
<td>Medical college, Jabalpur</td>
<td></td>
<td></td>
<td>OPD</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2013</td>
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<td>15025</td>
<td>7.1</td>
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<tr>
<td></td>
<td>2014</td>
<td>233639</td>
<td>16512</td>
<td>7.1</td>
</tr>
<tr>
<td></td>
<td>2015</td>
<td>232989</td>
<td>18136</td>
<td>8.1</td>
</tr>
<tr>
<td>Mental Hospital, Gwalior</td>
<td></td>
<td></td>
<td>OPD</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2013</td>
<td>-</td>
<td>37182</td>
<td></td>
</tr>
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<td>-</td>
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<tr>
<td></td>
<td>2015</td>
<td>-</td>
<td>39437</td>
<td>-</td>
</tr>
<tr>
<td>Mental Hospital Indore</td>
<td></td>
<td></td>
<td>OPD</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2013</td>
<td>-</td>
<td>31132</td>
<td></td>
</tr>
<tr>
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<td>34250</td>
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<tr>
<td></td>
<td>2015</td>
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<td>36529</td>
<td>-</td>
</tr>
</tbody>
</table>
Available HR in hospitals

<table>
<thead>
<tr>
<th>Name of the institution</th>
<th>HR related to psychiatry</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prof</td>
</tr>
<tr>
<td>Gwalior Manasik Arogyalaya</td>
<td>0</td>
</tr>
<tr>
<td>Jabalpur Medical college</td>
<td>0</td>
</tr>
<tr>
<td>Indore Mental hospital</td>
<td>1</td>
</tr>
<tr>
<td>Bundelkhand Medical college</td>
<td>1</td>
</tr>
<tr>
<td>Medical college Rewa</td>
<td>1</td>
</tr>
<tr>
<td>Gandhi medical College</td>
<td>1</td>
</tr>
</tbody>
</table>

PG in nursing in psychiatry is available only in 1 college in MP.

In continuation with our finding that mental problems are one of the major killers in the state, we wanted to know the status of the State Mental Health Plan. The Government of India has launched the National Mental Health Programme (NMHP) in 1982, with the following objectives: 1. To ensure the availability and accessibility of minimum mental healthcare for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of the population; 2. To encourage the application of mental health knowledge in general healthcare and in social development; and 3. To promote community participation in the mental health service development and to stimulate efforts towards self-help in the community.

The District Mental Health Program (DMHP) was launched under NMHP in the year 1996 (in IX Five Year Plan). The DMHP was based on ‘Bellary Model’ with the following components: 1. Early detection & treatment. 2. Training: imparting short term training to general physicians for diagnosis and treatment of common mental illnesses with limited number of drugs under guidance of specialist. The Health workers are being trained in identifying mentally ill persons. 3. IEC: Public awareness generation. 4. Monitoring: the purpose is for simple Record keeping. The study looked into the present status of the state mental health plan which has been given below.
The programme has been rolled out in the above mentioned districts. From Shivpuri in 1997, the programme has rolled out to 20 districts as of now.

The following initiatives have been taken to adhere to the guidelines suggested in the programme. Upgrading district hospitals, setting up counselling centres and reserving dedicated beds to psychiatric patients were part of their efforts to scale up infrastructure.

**Infrastructure**

**A**
- Initiative taken to establish Mental Health Screening & Counseling Room (MannKaksh) in all District Hospitals in OPD wing.

**B**
- 10 Dedicated counseling centers (7 DH & 3 MC) in the year 2016-17.

**C**
- 4 Dedicated bed (2 Male+ 2 Female) for Psychiatric patient in each District Hospital
As far as the HR part is concerned the above requirements have been stipulated. Steps have also been taken to ensure availability of drugs in hospitals. In pursuance of HR upgrading, various levels of trainings were conceptualized whose details have been given below.
Comparative study of suicide prevention strategies of various regions

Part B
In order to develop an appropriate suicide prevention strategy for the state of Madhya Pradesh, proven practices adopted elsewhere could be looked into. With this end in view, suicide prevention strategies of various countries were looked into. Though we would have to formulate a programme keeping in mind the current socio economic scenario of Madhya Pradesh, inputs can be incorporated from best practices followed elsewhere. The highlights of various programmes are given below for comparative analysis.

### Highlights of Australian Suicide Prevention Programme

As part of its response to the National Mental Health Commission Review of mental health programs, the Australian Government announced a renewed approach to suicide prevention in November 2015, through the establishment of a new National Suicide Prevention Strategy. The new Strategy involves:

1. A systems-based regional approach to suicide prevention led by Primary Health Networks (PHNs) in partnership with Local Hospital Networks, states and territories, and other local organisations with funding available through a flexible funding pool;

2. National leadership and support activity, including whole of population activity and crisis support services;

3. Refocused efforts to prevent suicide in Aboriginal and Torres Strait Islander communities, taking into account the recommendations of the Aboriginal and Torres Strait Islander Suicide Prevention Strategy; and

4. Joint commitment by the Australian Government and states and territories, including in the context of the Fifth National Mental Health Plan, to prevent suicide and ensure that people who have self-harmed or attempted suicide are given effective follow-up support.

PHNs have been tasked with commissioning regionally appropriate suicide prevention activities and service. PHNs will also work with Local Hospital Networks and other local organisations to support better targeting of people who fall in the risk of suicide. It is expected that PHNs will support the implementation of culturally appropriate activity, guided by the goals and actions identified within the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*. 
The Scottish Government’s strategy to reduce suicide focuses on 5 key themes of work in communities and in services with 11 commitments to continue the downward trend in suicides and contribute to the delivery of the National Outcome to enable people to live longer, healthier lives.

The key themes are:

A) Responding to people in distress
B) Talking about suicide
C) Improving the NHS response to suicide
D) Developing the evidence base
E) Supporting change and improvement

England probably has one of the most clearly spelt out suicide prevention strategy with goals and actions taken to achieve the goals. The strategy seeks to be comprehensive, evidence-based, specific and subject to evaluation, and will be delivered as one of the core programmes of the National Institute for Mental Health in England (NIMHE). The goals of the Programme have been listed as below.

Goal 1: To reduce risk in key high risk groups
Goal 2: To promote mental well-being in the wider population
Goal 4: To improve the reporting of suicidal behaviour in the media
Goal 5: To promote research on suicide and suicide prevention
Goal 6: To improve monitoring of progress towards the Saving Lives: Our Healthier Nation target for reducing suicide
Lynchpins of US Suicide Prevention strategy

The revised strategy of 2012 emphasizes the role every American can play in protecting their friends, family members, and colleagues from suicide. It also provides guidance for schools, businesses, health systems, clinicians and many other sectors that takes into account nearly a decade of research and other advancements in the field since the last strategy was published.

The NSSP features 13 goals and 60 objectives with the themes that suicide prevention should:

- Foster positive public dialogue; counter shame, prejudice, and silence; and build public support for suicide prevention;
- Address the needs of vulnerable groups, be tailored to the cultural and situational contexts in which they are offered, and seek to eliminate disparities;
- Be coordinated and integrated with existing efforts addressing health and behavioral health and ensure continuity of care;
- Promote changes in systems, policies, and environments that will support and facilitate the prevention of suicide and related problems;
- Bring together public health and behavioral health;
- Promote efforts to reduce access to lethal means among individuals with identified suicide risks;
- Apply the most up-to-date knowledge base for suicide prevention.

Suitable measures from the above were taken while developing the strategy.

Workshop on suicide prevention

A workshop to develop a strategy framework to prevent suicides in Madhya Pradesh was conducted in AIGGPA on December 2nd, 2016. It was headed by Dr. R N Sahu, Head of the Department, Gandhi Medical College. Mental health professionals from other parts of the state as well as private institutions attended the workshop. Stakeholders from Women and Child Welfare Department, Nagar Palika, School Education Department, Police and
media participated in the workshop. Inputs taken from them were collated and added to the tentative strategy framework prepared by the core team of AIGGPA. Topics of discussion ranged from identification of potential victims, upgrading health and mental health infrastructure, challenges in setting up help lines to crisis management and treatment. Our framework was shared with the experts for validation.
Suicide Prevention Strategy for Madhya Pradesh- Framework Document

Part C
A retrospective study of suicides in Bhopal and suicide prevention mechanisms in MP

Document Name: Strategy for Prevention of Suicides in Madhya Pradesh

Document Purpose: Guidance

Date of Publication:

Target Audience: Medical functionaries, Public Health Staff, Local Bodies, Women and Child Welfare department, private Healthcare Professionals, GPs, JPs, District collectors, Communications Leads, Emergency Care Leads, ICDS, Youth forums, Police, Educational Institutions, Transport bodies, Voluntary Organisations

Description: The document provides a framework to devise a suitable suicide prevention strategy for the state of Madhya Pradesh.

Based on the data obtained from the CrimeInvestigation Department and the study of various suicide prevention strategies undertaken by various countries, a strategy framework has been developed to reduce suicides in Madhya Pradesh.

Assumptions

1. An individual normally commits suicide when he/she is not able to cope with a particularly stressful situation or combination of situations both external and internal. There may at least be some cases where early detection and timely intervention would help the person.

2. There are pre-disposing medical conditions in certain persons that make them more vulnerable to suicides. Such persons can get relief, if they are timely identified and provided the necessary clinical support/counselling.

3. The current facilities and support mechanism to persons in distress is inadequate in the government and the private sector.

4. Suicide prevention mechanisms will not prove counter-productive.
**Objectives**

- To reduce the number of suicides in the state
- To provide assistance to persons who are in a state of mental distress.

**Approach**

Suicide prevention is multi-dimensional and therefore a multi-pronged approach of suicide prevention needs to be adopted. The strategy should include separate but integrated components for specified targets. Due to the complexity of the problem, a decentralized mechanism needs to be developed which should focus on access to relief.

According to the WHO document Public Health Action for prevention of suicide, a strategy should include the following aspects:

- A national strategy not only outlines the scope and magnitude of the problem, but more crucially, recognizes that suicidal behaviors are a major public health problem
- A strategy signals the commitment of a government to tackling the issue
- A cohesive strategy recommends a structural framework, incorporating various aspects of suicide prevention
- A strategy provides authoritative guidance on key evidence-based suicide prevention activities i.e. identifies what works and what does not work
- A strategy identifies key stakeholders and allocates specific responsibilities among them. Moreover, it outlines the necessary coordination among these various groups
- A strategy identifies crucial gaps in existing legislation, service provision and data collection
- A strategy indicates the human and financial resources required for interventions
- A strategy shapes advocacy, awareness raising, and media communications
- A strategy proposes a robust monitoring and evaluation framework, thereby instilling a sense of accountability among those in charge of interventions
• A strategy provides a context for a research agenda on suicidal behaviours

Before finalizing the approach and the framework, the stakeholders need to be identified who will have a role in the prevention framework. The state should go for an all inclusive approach while identifying the stakeholders. A tentative list of possible stakeholders is given below.

Ministry of Health, Education and Social Welfare; public health managers, physicians, nurses, emergency care staff, pediatricians, bereavement specialists, administrators, statisticians, coroners and medico-legal staff etc (from public health sector); psychiatrists, clinical psychologists, mental health nurses, social workers (from mental health sector); parliamentarians, policy makers, politicians; teachers, counselors, administrators, student leaders (from education sector), police, fire services, ambulance services, prison and criminal services, courts, defence forces; survivors and families etc. can be involved. Apart from the above, relevant stakeholders from agriculture sector, NGOs, media and researchers can also be included to make the process more consultative.

The approach adopted will follow the three phases of identification, intervention and mainstreaming. They should in turn be categorized as short term and long term, wherein time frame can be set and actionable items can be monitored.
Identification

It will be difficult to predict suicides. But research across the world suggests the existence the certain risk factors or pre-dispositions which might precipitate into a crisis. Our study on suicides in Bhopal brought out some of the risk factors which can be broadly termed as causative factors. The risk factors may or may not result in certain symptoms listed below (taken from secondary sources of literature). These act as indicators of an inherent problem in the individual.

Identification of risk factors is crucial in any suicide prevention strategy. This needs to be done at the level of the high risk groups as well as the entire population. The causative factors are categorized into three heads- individual, socio cultural and situational. They are given below.

❖ Individual

- Predisposition
- Mental disorder
- Substance abuse
- Anger
- Depression
- Disease
- Dissatisfaction with work/life
- Gambling
- Loneliness

❖ Socio cultural

- Stigma associated with revealing problems
- Barriers in accessing health care especially mental health and substance abuse treatment
- Exposure to suicidal behaviour

❖ Situational

- Bereavement
- Dowry harassment
- Failure in Exam
- Family Problems
- Financial Problems
- Harassment at work/surroundings
- Litigations
- Failure in love life

For any kind of intervention, the target group needs to be identified. The data on Bhopal clearly highlighted the high risk groups. Their profile is listed below in the decreasing order of their frequency.

**Gender**
1. Males
2. Females

**Age group**
1. 20-30
2. 10-20
3. 30-40

**Occupational details**
1. Private job holders
2. Housewives
3. Labourers

The data for the years included in the study shows that males are consistently more at risk than females.

- The most vulnerable age group is the 20-30 years group closely followed by the 10-20 years group, which points to a strategy that should focus primarily on youth and their problems.
- When shifting from a general approach to a tailored strategy, the target groups' profession also matters and here the dominant trends are tilted towards private job holders, housewives and labourers.
- The major risk factors that emerged out of the data analysis are broadly family related problems, and mental issues ranging from anger to depression.
- In an attempt to map the existing infrastructure to assess the access to mental health care or help lines available in the state, what emerged was a dismal picture and hence any long term programme should also consider this facet of the
problem. An extremely skewed patient doctor ratio of 70000000:15\(^7\) (in Govt. Sector) makes the identification of mental problems difficult.

**Intervention**

Due to the complex nature of the problem involved, interventions have to be on multiple areas, overlapping each other for an integrated solution. The proposed interventions can be broken down into various segments depending upon the target audience.

**Universal Intervention**

**Target Group**: All

**Platform**: Based mainly on citizen engagement

Aiming for a period of next ten years, which should include immediate interventions and long term measures, the following action plan, may be adopted.

**Immediate Interventions**

- **Assessing resources and requirement**: For any intervention to be fruitful, availability of resources is necessary. This includes as evaluation of financial, infrastructural and human resources needed for a comprehensive strategy. It may include the following.
  - Primary care and mental health professionals
  - Other facility and community-based health workers
  - Personnel in charge of developing and implementing policies on mental health and to reduce the harmful use of alcohol
  - Counselors at school, workplaces, prisons and jails
  - First line responders including emergency, police and fire services
  - Native healers and practitioners of alternative medicine, where relevant
  - Allocation in annual budgets by federal or central governments for suicide prevention
  - Allocation by central, state or local governments

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- Private funding from philanthropists or foundations
- Support from NGOs
- Support from international agencies
- Public-private partnerships (PPPs)

❖ **Create awareness**: The first step towards reducing the number of suicides is to create awareness regarding the problem in the form of a campaign for better health including mental health. Awareness needs to be raised along with advocacy and proper communication to influence policy makers and public opinion. This is essential in mobilizing political commitment and resources to drive the process forward. The campaign should take up the concept of value of life. This campaign will have two aspects. 1. It will involve mass publicity taking support from various stakeholders like NGOs, media etc. The IEC directorate may spear head the initiative in the lines of programmes like AIDS campaign, Malaria eradication etc. Funds for the same could be provided by Department of Public Health and Family Welfare (Actionable item by Department of Mental Health and Directorate of IEC). **Need to talk it out**: Another campaign needs to be organized to address social stigma associated with talking out problems. Mental health issues and other personal traumas need to be desensitized. The campaign should be highlighting the need to talk it out without fearing the element of societal stigma.

❖ **Use of social media**: As the data shows the victims of suicide are predominantly the youth, social media could be used to the advantage of such campaign. The media can play a vital role in the strategy development process keeping stakeholders informed, generating wider understanding of the issue which results in creating a broad sense of ownership and increasing participation. The public requires an understanding of the issue and this is what the intervention should be aiming at. Videos explaining the symptoms to be watched out for, and interactive portals that address the doubts of the targeted section can be thought of. The only limitation with this intervention is that they may remain confined to the erudite section of the population. (Actionable item by Department of Public Relations)

❖ **Identification of vulnerable persons**: The primary environment where the potential victim operates needs to be targeted so as to identify symptoms at the earliest, which in turn would lead to identification of the patients who have some
issues of mental health. Accepting suicide as a health hazard would also go a long way in removing stigma associated with it. Certain section of the vulnerable population may be identified through health camps.

- **Media sensitization**: This can be done through workshops and other focus group discussions. Guidelines need to be issued to the media to portray traumatic issues in a sensitive manner so that potential victims do not get disturbed by the same.

  (Actionable item by Department of Public Relations)

**Long term measures**

- **Trained personnel**: We need to create a network of trained paramedics at the community level. They could be volunteers who have some understanding on community health matters.

- **Making mental health infrastructure accessible**: The mental health infrastructure scenario in Madhya Pradesh is far from being encouraging. Access to timely care is important while talking of creating a mental health net in the state. Access points can be at multiple levels.
  - Primary level-at the level of the community
  - Secondary level-The local health care hospital in government/private sector.
  - Tertiary level-Specialist facility that includes IPD apart from designated psychiatrists.

- With this end in view, first points of contact outside family need to be created in the lines of ASHA *karyakarta* at all localized points who would advise the family/ victim on further course of action. Mental hygiene practices can be included in the training of health workers.

- The local points will be native volunteers who should be trained in basic counselling techniques. He / She should be in the know of professionals of the next wrung to whom the victim may be directed in case of need.

- The concept of a local mental health counsellor could be taken up on a pilot basis in high incidence areas before a full roll out in the state.

- On a long term basis, more professionals need to be trained in the area of counselling and psychiatry. A post graduate degree in psychiatric social work can be run in more colleges so that more professionals are available at the grassroots level.
Increase the number of seats: There is an acute shortage of doctors and paramedics who are specialists in psychiatry. There are around only half a dozen seats in government colleges for PG is psychiatry All Medical colleges in the state need to take it on priority, by enhancing seats in PG courses for Doctors and paramedics. Nursing (psychiatry) courses should also be increased. As on date, only one private college provides a course in MSc. Nursing psychiatry.

Psychiatry wing in all district Hospitals: At present, the availability of psychiatrists at district hospitals is almost nil. Those suffering from prolonged as well as terminal illnesses also need counselling services from time to time. A psychiatry wing with some reserved beds needs to be earmarked in private hospitals too. (Actionable item by Department of Health and Family Welfare.)

Use of personnel from AYUSH: The Department of AYUSH has a large staff consisting of medicos and paramedics. They can also be given training in identification of psychiatric problems.

Short term training courses for Doctors: The state mental health plan already has incorporated this actionable item and they are conducting one month training courses to doctors. This should be scaled up as the doctors have direct interface with people. It will be helpful for them while interacting with patients with tendency of mental problems. They may also be able to identify early symptoms of distress.

- Ambulance services for emergency care: Ambulance services could be increased by clubbing it with other programmes of the same kind.

- Community participation: Solutions need to begin at the family level first and hence the risk factors and associated symptoms need to be popularized, creating a public discourse on the same. Family and community should work hand in hand in this regard. The gatekeepers need to be sensitized in this regard and the gatekeepers may undertake the onus of educating the family. Gatekeepers are those who come in frequent contact with the members of the community. Their role has been mentioned in detail in the section on tailored intervention.

- A 24 Hour Helpline: All days talk line needs to be instituted to handle calls of those in distress. This is not only essential to prevent suicides but also to reduce the levels of stress experienced by high risk groups. Help lines can develop safety parameters according to the needs of specific cases. Apart from counselling in
distress, the helpline can branch out to spread awareness and provide guidance. The government needs to establish clear working protocols of the helpline with police, legal aid agencies, shelter homes etc. As a long term measure, systems need to be developed to maintain records and conduct surveillance of identified victims.

- Help lines of 1090 and 1098 dealing with violence against women (which are already in existence) need to be popularized using ICT to encourage more callers to avail the services. As per the scenario in MP, dowry related suicides is a major area of concern. These help lines need to be popularized on a large scale so that more people are able to access them in need.

- **Continued research**: Continued research needs to be carried out to elicit further evidence. Information from voluntary sectors need to be collated to get the changing picture of suicide incidences. The current mechanism of incident reporting needs to be looked into and modified to improve data collection and to set research agenda. A recording system can be established to record suicide incidences and attempts which will help in quantifying the problem.

- **Setting up crisis management centres**: Crisis management centres need to be set up to rescue people. The crisis management centre may be linked to the help lines to track the identified victims for better effectiveness. The crisis management team needs to be well trained in rescue operations and also linkages need to be established with ambulance services, hospitals and the police department. They need to be well equipped in infrastructure with regular maintenance.

- **To build up resilience**: Training programmes can be conducted at various levels to build up resilience in the community and to encourage leadership traits among the youth.

- **To promote programmes of social well being**: Social welfare programmes need to be promoted as suicides are closely related to social well being. Community leadership programmes of Jan Abhiyaan, Women and Child Welfare Dept. and Tribal Dept. may be oriented towards suicide prevention.

- **Establish linkages between NGOs and Government**: Only a multi agency framework will be able to cater to the vast population in the state. Hence linkages with organizations of similar mandate will strengthen the reach of the government.
- **Partnership with Happiness Department**: The state of Madhya Pradesh has taken the lead to set up a separate agency for happiness. This agency should take upon itself the onus of looking into suicides and designing suitable programmes and implementing them through related Govt. Departments and NGOs.

- **Plan for underprivileged/backward areas of the state**: The social milieu adds on to the mental state of a person. Financial problems and societal pressures and harassment have been major reasons for people ending their lives. Any strategy to reduce mental distress and suicides should focus on: 1. Tribal blocks/districts, 2. Economically backward blocks/districts. Pro-active engagement of citizens in developmental activities is essential.

- **De-addiction Activities**: De-addiction cannot be a one-time programme. It has to be run on a continuous basis. Community initiatives can also be taken up to reduce substance abuse. Jawaharlal Nehru Hospital for cancer runs de-addiction programmes on a regular basis. More programmes to this effect can be designed and rolled out in the entire state. (Actionable items by Department of Social Justice and Department of Health and Family Welfare.)

### Tailored intervention

**Target**: Identified high risk groups

**Platform**: Through specific programmes designed to that effect

This is intended for those groups who come in the high risk category. They may be listed as per our findings.

- Students
- Housewives
- Survivors of abuse or violence, including sexual abuse
- People living with long-term physical health conditions
- People with untreated depression;
- Victims of substance abuse
- People who have suffered sudden/major financial losses

- **Counselling in educational institutions**: Students and other youngsters pursuing studies along with jobs are of high priority. The environment needs to be so created that the pressure of academics is diffused. Vocational training needs to be incorporated as a part of the curriculum so that students find other avenues of job once out of the education system. **Counselling** to the students as well as the
parents should be adopted on a regular basis. The creative instincts of the students should be tapped and channelized in the right direction.

- **Helping women in distress**: Dowry related deaths are a cause of major concern in MP. Timely identification of the problems and intervention are essential in this regard. Help lines working for helping women subject to violence need to be popularized and women complainants need to be treated with sensitivity in police stations and other forums.

- **Strengthening palliative care and financial support**: Palliative care system needs to be made stronger for those suffering from terminal illnesses. Prolonged illnesses may prove to be financially draining for the victims. Support in this regard may prevent them from ending their lives.

- **Sensitizing staffs**: Mental health needs to be given primary importance in the system. As mentioned earlier, primary points of contact need to be established who can identify the symptoms of depression and stress early and prompt them to treatment. Staff of hospitals also need to be sensitized towards the issue of mental health of people visiting hospitals.

- **Support to bereaved families**: The bereaved families should be given effective and timely support to get over the trauma. The family members themselves become potential victims and hence they need to be watched over by the local points for subtle changes in behaviour.

- **Gatekeeper training**: Gatekeepers are those who come in frequent contact with the members of the community. As they interact with the community members in natural and often non-medical environment, they can be trained to recognize risk factors.

**Key gate keepers**:

- Primary health care providers
- Mental health care providers
- Emergency health care provider
- Teachers and other school staff
- Community leaders
- Police officers and other first responders
- Military officers
- Social Welfare Workers
• Spiritual and religious leaders
• Traditional healers
• Media Professionals

**Follow up**

Proper follow up mechanisms need to be put in place to ensure that the victim/ family is able to lead a normal life thereafter.

Even if access to tertiary care is not readily available, the victim should be in the watch of the primary sector/ local points.

**Mainstreaming:**

- Treatment for mental health should not be looked down upon. It has to be highlighted as a necessity so that more and more people seek help.
- Awareness programmes need to be created to this effect so that victims who choose to seek help are able to go back to the mainstream without difficulty.

The intervention framework can be summarized as follows.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Target group</th>
<th>Actionable items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal</td>
<td>All</td>
<td>• Create awareness&lt;br&gt;• Encourage community participation&lt;br&gt;• Train personnel&lt;br&gt;• Identify victims&lt;br&gt;• Create multi level access points&lt;br&gt;• Start and popularize help lines&lt;br&gt;• Sensitize media&lt;br&gt;• Upgrade mental health infrastructure&lt;br&gt;• Build up resilience of community&lt;br&gt;• Promote programmes of social well being&lt;br&gt;• Establish linkages with like- minded organizations&lt;br&gt;• Set up Crisis Management Centres</td>
</tr>
</tbody>
</table>
### Tailored
Identified high risk groups
- Create counselling services in educational institutions
- Help women in distress
- Strengthen palliative care
- Provide financial support to the terminally ill
- Sensitize health care staff
- Decrease substance abuse
- Support bereaved families

### Mainstreaming
Those who attempted suicide
- Mental health treatment be projected as necessary
- De-stigmatize the incident.
Annexure of Tables

Table 2
Rate of suicides in Madhya Pradesh

<table>
<thead>
<tr>
<th>Year</th>
<th>Population</th>
<th>No of suicides</th>
<th>Rate of suicides</th>
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Table 3 No of suicides in the major cities of MP

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<th>Year</th>
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<th>Jabalpur</th>
<th>Gwalior</th>
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<td>2013</td>
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<td>2014</td>
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Table 6 No of suicide cases age wise in 2013 in Bhopal

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<th>Age Groups</th>
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<td>20 to 30</td>
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<td>30 to 40</td>
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<td>60 and above</td>
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Table 7 No: of suicide cases age wise in 2014 in Bhopal

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<th>Number of Suicide Cases</th>
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Table 8: No of suicide cases age-wise in 2015 in Bhopal

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Table 13: Table of suicides in Bhopal showing causes age wise

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