Towards A Suicide Free Society

Identify Suicide Prevention
As Public Health Policy*

Ajai R. Singh
Shakuntala A. Singh

ABSTRACT

Suicide is amongst the top ten causes of death for all age groups in most countries of the world. It is the second most important cause of death in the younger age group (15-19 yrs.), second only to vehicular accidents. Attempted suicides are ten times the successful suicide figures, and 1-2% attempted suicides become successful suicides every year. Male sex, widowhood, single or divorced marital status, addiction to alcohol or drugs, concomitant chronic physical or mental illness, past suicidal attempt, adverse life events, staying in lodging homes or staying alone, or in areas with a changing population, all these conditions predispose people to suicides. The key factor probably is social isolation. An important WHO Study established that out of a total of 6003 suicides, 98% had a psychiatric disorder. Hence mental health professionals have an important role to play in the prevention and management of suicide. Moreover, social disintegration also increases suicides, as was witnessed in the Baltic States following collapse of the Soviet Union. Hence, reducing social isolation, preventing social disintegration and treating mental disorders is the three pronged attack that must be the crux of any public health programme to reduce/prevent suicide. This requires an integrated effort on the part of mental health professionals (including crisis intervention and medication/psychotherapy), governmental measures to tackle poverty and unemployment, and social attempts to reorient value systems and prevent sudden disintegration of norms and mores. Suicide prevention and control is thus a movement which involves the state, professionals, NGOs, volunteers and an enlightened public.

Further, the Global Burden of Diseases Study has projected a rise of more than 50% in mental disorders by the year 2020 (from 9.7% in 1990 to 15% in 2020). And one third of this rise will be due to Major Depression. One of the prominent causes of preventable mortality is suicidal attempts made by patients of Major Depression. Therefore facilities to tackle this condition need to be set up globally on a war footing by governments, NGOs and health care delivery systems, if morbidity and mortality of the world population has to be seriously controlled. The need, first of all, is to identify suicide prevention as public health policy, just as we think in terms of Malaria or Polio eradication, or have achieved smallpox eradication.

Key Terms: Suicide Prevention, Social Isolation, Social Disintegration, Depression, DALY (Disability Adjusted Life Years), Global Burden of Diseases, Psychiatric treatment in suicide

* First Published as Mens Sana Monographs I: 2, July-August 2003.
Introduction

A student kills himself to escape the ignominy of exam failure. A woman burns herself to escape daily harassment by in-laws over inadequate dowry. A finance dealer ends his life to fend off the horde of creditors. The scion of an industrial empire kills himself after an uneasy marital relationship. The scion of another empire shoots himself after killing family members in an inebriated state. A stockbroker ends life after suffering huge losses in a stock market crash. Three sisters hang themselves from the ceiling fan as they see no end to their poverty and misery. A mother jumps to death with her kids for a similar reason. Lovers fling themselves from ‘suicide points’ all the world over. Buddhist monks immolate themselves over Vietnam. Roop Kunwar commits Sati at Deorala. A sadhu immolates himself over a Ram Temple at Ayodhya. Fans immolate themselves over the death of a politician cum matinee idol, and even over the arrest of another such. A terminally ill patient ends his (and other’s) misery by taking an overdose. Another requests for, and secretly gets, euthanasia performed to end his saga of endless pain and suffering. A Film Director falls from the terrace under suspicious circumstances and we accept it as an end because he was suffering from Chronic Depression. Somehow, the diagnosis helps us place the event in perspective and accept it as justified, even if undesirable. It does not shock us, or benumb us, as much as the others.

Are these just gory newspaper headlines we avidly read but quickly gloss over? Macabre details to acknowledge, but knowingly accept as inevitable facts of life? It does not involve us, so we do experience a twinge of compassion, a brief wringing of the heart, and pass on. Are we to feel guilty? That hardly helps, unless it is a propeller to action. Is our bored insulation justified? That is so only if denial is the sole mechanism we utilize, and ostrich the only animal we admire.

We know that suicide has existed since time immemorial, but we also know that the modern attempts at suicide prevention have not. Number of people feel secure that suicide does not affect them, they are not suicide...
prone. Their family members are reasonably secure, confident types, not the ones to succumb to suicidal thoughts and impulses. The fact, however, is that everyone in his life time has contemplated suicide sometime or the other, and almost everyone knows of someone or the other whose life has been prematurely terminated in this manner. And even if we know people do commit suicide there is something tangible and definite we can do to save a life. So to think of moving towards a suicide free society may not be that farfetched an idea.

Should we join the crusade towards a suicide free society? Maybe. But any standpoint is worth consideration only after we review the facts of the case.

Here, then, are some of the facts.

**The Magnitude Of The Problem**

More than 4,00,000 people commit suicide all around the world every year. It is amongst the top ten causes of death for all ages in most countries of the world. In some, it is amongst the top three causes of death in the younger age group (15-34 years). Moreover, it is the second most important cause of death in the age-group 15-19 yrs., second only to vehicular accidents. Which just goes to show how young and prospectively brilliant lives are sniffed out in this tragically premature manner.

If this were not enough, we must note that suicide is under reported by 20-100%. If we take the 1994 figure reported above as the base, this figure in 2000 was projected as 5,00,000 plus. Even if we take 60% under-reporting (average of 20-100%), we are talking of around 8,00,000 lives all around the globe getting exterminated in this manner every year. And the figure is rising. If this does not qualify for it to be called a public health issue, what does?

Moreover, this is the figure of successful suicides. Attempted suicides are around ten times the figure i.e. 8,00,000 people attempt suicide, out of which 8,00,000 succeed in ending their lives. Attempted suicides involve a great effort on the part of medical and paramedical professionals and health care delivery systems, the immediate caregivers, the NGOs, and society at large to manage this colossal burden of morbidity and mortality. Moreover, research studies have found that 1-2% attempted suicides become successful suicides every year. This means 10-20% attempted suicides will end their lives in a decade.
Therefore, prevention and treatment of both potential and attempted suicides and identifying the population at risk has to become a major public health priority area.

A number of risk factors of suicide have indeed been identified. Factors that predispose to successful suicide are male sex (males outnumber females 2.5:1; while in attempted suicides, females outnumber males 10:1); widowed, single or divorced marital status; addiction to alcohol or drugs; concomitant chronic physical or mental illness; people staying in lodging homes or living alone and in areas with a changing population. The key factor probably is social isolation, for the widowed and single consistently have higher suicide rates than the married, and widows with children have lower rates than those without. Such at risk population, in other words, is in greater need of psychosocial measures involving crisis intervention and rehabilitation.

Consider the Indian scenario, which is equally pertinent to us, probably moreso. As elsewhere, suicide is amongst the top ten causes of death here, and amongst the top three between the ages 16-35 years. While in 1984 around 50,000 people committed suicide (50,571, i.e. 6.8 per lakh), in 1994 this figure rose to 90,000 (89,195 i.e. 9.9 per lakh). At present we have nearly a lakh Indians dying of suicide every year, which is 20% of the world suicide population: another dubious distinction for this country, beside the population explosion. And suicide attempters are ten times the suicide completers. This means around ten lakh Indians attempt suicide every year, out of which one lakh succeed*. What an ironic success rate indeed! In other words, 2740 people attempt suicide and 275 Indians kill themselves every day by suicide. Even the greatest supporter of eugenics or population control would not even remotely recommend such a method.

We just discussed that suicide is under-reported. There are various reasons for this, common amongst these being the competence in medicine and law of those who issue Death Certificates, the mechanism used for collecting vital statistics, and the social and cultural attitudes of the community. For, we must know that, unlike most other causes, suicide stigmatizes the survivors as well.

*And if we consider even 60% under-reporting, the figure is 16 lakh attempters and 1.6 lakh suicidal deaths (eds.).
W.H.O. Study

Before we decide what public health measures need to be adopted, we must also know what are the findings of relatively recent researchers. In an important W.H.O. Study, Bertolate (1993) established a clear-cut connection between suicide and mental disorders. He found that out of a total of 6003 suicides, 98% (5866) had a psychiatric disorder. While affective disorder (i.e. Depression and Mania) was found in 24%, 22% showed Neurotic and Personality Disorders, 16% had substance abuse (alcohol and/or drugs), 10% had schizophrenia and 21% had other mental disorders. Only in 2% cases no psychiatric diagnosis could be made.

This study effectively proved what psychiatrists all around the globe who handled suicidal patients knew all along. That there was a strong case for a connection between psychiatric disorders and suicide. And the centuries of theological and moral debate over whether a person had the right to end his life or not, or whether it was a sin or not, was not really based on an awareness of the ground realities, for it applied to a few isolated cases. The legal position of considering suicide as a crime against the State had also missed the mark. They were all well intentioned but poorly informed attempts at suicide prevention. This W.H.O. study, and earlier and subsequent ones, prove that mental health professionals have an important role to play in the prevention and management of suicide. The very fact a diagnosis can be made implies some methods of treatment, prevention and rehabilitation can be applied.*

But we must not forget that if mental health workers have an significant role to play, so have a number of others. Society itself has the notorious ability to generate and perpetuate various expressions of deviance and social disintegration. A recent example of social disintegration and its role in suicide increase has been witnessed in the Baltic States, especially Lithuania, following the collapse of the former

*See also page 34-38 for discussion on a counter-view point about how much psychiatric diagnosis and treatment has helped in suicide prevention.-eds.
Soviet Union. It reported the world’s highest suicide rate i.e. 50 per lakh population, according to a relatively recent research report (Haghighat, 1997).

We also know that suicides are more common in the urban slums, lodging homes and in people staying alone where social isolation is prominent. Moreover, measures to tackle poverty and unemployment are dependent on governmental initiative. Reducing social isolation, preventing social disintegration and treating mental disorders is the three pronged attack that must be the crux of any public health programme to reduce suicide, of course with suitable governmental effort mentioned earlier. Thus, Befriending programmes for the socially isolated, change that does not lead to fragmentation of the social psyche and ethos for the society at large, and efficient and affordable mental health care for the psychiatric patient, is the need of the hour. All these must synergize for any public health programme planned to combat suicide.

**What Can You Do?**

Can you reduce social isolation, prevent social disintegration, and help treat mental illness? Yes, you undoubtedly can. If you can identify those who suffer from social isolation, the people at risk we talked of earlier, you can do something about it, or put them on to someone who can. If you see disintegration, of values and norms in the social network around you, because of whatever reasons, and in whatever guise, you should stand up and protest against it, and help those who are its victims. You should resist attempts of instant messiahs in a hurry to do good, you should seek such social change that does not disrupt. When you know that suicide is preventable and psychiatric treatment can get a person rid of his suicidal thoughts, you must motivate a colleague, a relative or a friend, to seek professional help and savor the immense mental satisfaction of a life saved. That is what you can do.

This calls for an integrated outlook wherein the approach of saving life after a suicidal attempt must combine with psychiatric treatment, including crisis intervention and drug treatment, counselling and sociotherapy. This is at the individual level. But it must be combined with
Just as we think in terms of Malaria or Polio eradication, or have achieved small pox eradication, the effort has to be put in to bring about suicide eradication. On a similar war-footing, with a similar concerted total effort.

measures to tackle poverty, unemployment and attempt to change value systems at the social level. We realize, therefore, that suicide prevention and control is a movement. It involves the State, professionals, lay volunteers and the public (Venkoba Rao, 1999). But the great need is to first of all identify it as a public health issue (Sartorius, 1996). Just as we think in terms of Malaria or Polio eradication, or have achieved small pox eradication, the effort has to be put in to bring about suicide eradication. On a similar war-footing, with a similar concerted total effort.

Permit us to present some more statistics, which further establish the connection between psychiatric illness and suicide.

Why must you know all these morbid statistics about the association between psychiatric illness and suicide? Because psychiatric illnesses are treatable. Because a patient of Major Depression or Schizophrenia, or other psychiatric disorders, can be helped to get rid of his suicidal thoughts and impulses by taking treatment. Moreover, suicide risk is lifelong for patients with mental disorders (Baxter and Appleby, 1999). 15% of mood disorder patients subsequently commit suicide and 45-70% of suicides have mood disorder. 19-24% of suicides have made a prior suicide attempt and 10% of suicide attempters subsequently commit suicide in 10 years (Roy, 2001). Helping such people out of their problems is what mental health professionals all the world over are doing day in and day out. This is where you can help if you come to know of someone with suicidal ideas. You can help him by convincing him, or his family members, to seek suitable psychiatric help. A past suicidal attempt is perhaps the best indicator that a patient is at increased risk of suicide. Epidemiological studies show that persons who commit suicide may be poorly integrated into society. Social isolation increases suicidal tendencies among depressed patients (Sadock and Sadock, 2003).

If someone has made a past suicidal attempt and survived, note that he is at increased risk. See that he doesn't suffer from social isolation, he gets integrated into the social mainstream and takes treatment, if necessary, for any psychiatric disorder so as to remain psychologically fit and/or not get a relapse.
Hence what you can do this: if someone has made a past suicidal attempt and survived, note that he is at increased risk. See that he does not suffer from social isolation, he gets integrated into the social mainstream and takes treatment, if necessary, for any psychiatric disorder so as to remain psychologically fit and/or not get a relapse. Moreover, suicide has been linked with being chronically ill. For example, one out of every six long-term dialysis patient over the age of 60 stops treatment, resulting in death (Neu and Kjellstrand, 1986). Suicide rate among cancer patients is one and half times greater than that among non-ill adults (Marshall et al, 1983), and suicide among men with AIDS is estimated at more than 36 times the national rate for their age group (Mazurk et al, 1988).

What do you do here? All patients with chronic sickness need to be protected from social isolation. See that they are not left out, uncared for, neglected. It is tiring and taxing to care for them all right. But they have a right to live on with dignity as long as they can, and your effort in that direction can never go a waste.

**DALY And Burden Of Disease**

But let us get on with the other recent findings on suicide.

Over the last ten years, W.H.O., with the World Bank and Harvard Medical School, has developed DALY (Disability Adjusted Life Years), which is a measure of the burden that a disease entails (Murray and Lopez, 1996). This was a multicentric study involving both developed and developing countries. Its findings in 1990 and projection for 2020 are real eye-openers. While in 1990 malaria and T.B. were prominent, mental illness ranked very high. Unipolar Major Depression (3.7%) ranked fourth after Lower Respiratory Tract Infection (8.2%), Diarrhoeal

In the global burden of diseases, Depression (3.7%) was rated above Ischaemic Heart Disease (3.4%), and Mental Disorders (9.7%) ranked just below Cardiovascular Disorders (10.5%) in the total burden. In 2020, the global burden of Unipolar Major Depression (5.7%) will be a close second to Ischaemic Heart Disease (5.9%). Compared to the Heart institutes, what should then be the increase in the number of centres to treat Depression?
Towards A Suicide Free Society: Identify Suicide Prevention As Public Health Policy

disease (7.2%) and Prenatal conditions (6.7%). It must be noted that two of the above conditions are infectious diseases and one involves childbirth, all of which are recognized major physiopathological stressors. None of these are the so-called ‘Life-Style’ diseases. Amongst those, Depression (3.7%) was rated above Ischemic Heart Disease (3.4%) in the global burden. This effectively dispelled the common man’s notion that Depression is a major problem only in the developed world. Moreover, as of now, Mental disorders (9.7%) rank just below Cardiovascular Disorders (10.5%) in the total burden.

The projections for 2020 are equally revealing. Depressive disorders are expected to be the second highest cause of disease burden worldwide (Brown, 2001). The global burden of Unipolar Major Depression (5.7%) will be a close second to Ischemic Heart Disease (5.9%), followed by Traffic Accidents (5.1%), Cerebrovascular Accidents (4.4%) and Chronic Obstructive Pulmonary Disease (4.2%). Malaria, T.B. and Prenatal conditions would become less important. Compared to the sophisticated Heart Institutes and other places to treat Ischemic Heart disease of which every city boasts, what should be the increase in the member of sophisticated Centers to treat Depression, where public awareness and governmental thrust is abysmally small? How much greater is the need for public and private funding, the general awareness, the will and programmes to combat it?

“Unfortunately, only about one third of individuals with depression are in treatment, not only because of underrecognition by health care providers but also because individuals often conceive of their depression as a type of moral deficiency, which is shameful and should be hidden. Individual often feel as if they could get better if they just ‘pulled themselves up by the bootstraps’ and tried harder. The reality is that depression is an illness, not a choice, and is just as socially debilitating as coronary artery disease and more debilitating than diabetes mellitus or arthritis. Furthermore, upto 15% of severely depressed patients will ultimately commit suicide. Suicide attempts are upto ten per hundred subjects depressed for a year, with one successful suicide per hundred subjects depressed a year. In the United States for example, there are approximately 300,000 suicide attempts and 30,000 suicides per year, most, but not all, associated with depression... mood disorders are common, debilitating, life-threatening illnesses, which can be successfully treated but commonly are not treated. Public education efforts are ongoing to identify cases and provide effective treatment” (Stahl, 2003).

A useful rule of thumb given by the same author is the rule of sevens, with regard to the connection between suicide and major depression:

i) One out of seven with recurrent depressive illness commits suicide.
ii) 70% of suicides have depressive illness.
iii) 70% of suicides see their primary care physician within six weeks of their suicide.*
iv) Suicide is the seventh leading cause of death in the United States.

*Such a simple measure as a sensitized primary care physician, or general practitioner, who looks out for depressive symptoms and suicidal thoughts in his patients, can effectively curb a large number of these 70% suicides.-eds.
The hidden cost of depression as a considerable burden on society and the individual, especially in terms of incapacity to work, has been noted in the UK (Thomas and Morris, 2003). The hidden cost of not treating depression is 30,000 to 35,000 suicides per year in the United States alone (Stahl, 2003). The figures are equally applicable to the other countries, including India. The role of care-providers, governmental bodies and enlightened citizens is clearly cutout and needs to be focussed in the direction of suicide prevention. What more need be said?

The projection in 2020 for all mental disorders is 15% i.e. from 9.7% in 1990, the global burden of mental disorders will rise to 15%, a rise of more than 50%, of which one third will be due to Unipolar Major Depression.

Why are we looking at these statistics here? Because the major cause of premature mortality in Unipolar Major Depression is suicide. In fact the major cause of premature mortality in psychiatric conditions taken as a whole is also suicide. Thus, study of the various dimensions of suicide is so very important. And treatment of mental disorders can be one sure way of reducing the rising suicide rates the world over.

The Global Burden of Disease Study has been an eye-opener for public health programmes.

**Suicide Prevention : How?**

There are at least three important thrust areas in suicide prevention that will help implement the plan to reduce social isolation, prevent social disintegration and treat mental disorders:

(i) Sensitize family physicians to early signs of Major Depression and other psychiatric disorders with serious suicidal risk;

(ii) Carefully assess the claims of Samaritans, Befriending programmes, Help-lines etc. in reducing suicide-rates and encourage their efforts if so found; and

(iii) Effective treatment in psychiatric hospitals/clinics and efficient care following discharge by mental health professionals using well proven methods.

**Paradigm Shift**

The outlook towards suicide has undergone a distinct paradigm shift. First was the *theological approach*, which considered suicide to be a sin. Then came the *moral approach* of philosophers, which debated whether suicide was rational or irrational. (The debate still continues of course.) This was followed by the *legal*
The paradigm shift in tackling suicide can be summarised in a few words: treating has replaced preaching.

clinical diagnosis, treatment and prevention have become prominent. The paradigm shift involved can be summarized in a few words: treating has replaced preaching (Heyd and Bloch, 1984). The suicidal subject is regarded as a victim of external forces, or as a patient; he is thus absolved from any moral responsibility for the act. It is easy for society to label suicide as moral cowardice, virtuous heroism, mortal sin, or even demoniac intervention (Heyd and Bloch, 1984). What is probably more important is to face it as a social and psychological problem whose cause is still not fully clear, but within the scope of health care delivery systems to manage, of course in liaison with other care givers.

Concluding Remarks

India has come a long way but still has far to go. Compared to a handful of psychiatrists at the time of independence, we have more than 3000 psychiatrists in the country (1 per 3.33 lakh: the ideal should be at least ten times more). Include other mental health workers and the number is 10,000 plus (i.e. 1 per 1 Lakh: not that bad, the ideal number should be 1:25,000 or less, which means the work force must increase by at least four times). Moreover, the major benefit of most psychiatric services are not within the reach of the majority of our population especially those living in villages, small towns or the big city slums (Wig, 2001). We know, therefore, what is the manpower needed to tackle the unfinished agenda of mental health in general and suicide prevention and management in particular.

Suicide is ubiquitous, under-reported and probably also under-researched. Study of its various dimensions-preventive, therapeutic, rehabilitative, social, ethical etc. needs to be furthered amongst medical professionals, social thinkers, legislative bodies, NGOs, care givers and survivors. Only then the pious and well-intentioned religious commandments of yore, and bioethical discussions of philosophers today, will become synergistic with psychosocial intervention and rehabilitative programmes.

It will also be one significant manner to further an earlier W.H.O. slogan (for the year 2001-2002): ‘Mental Health: Stop exclusion, dare to care’, in an effort at more humane patient care, a less psychopathological environment and, hopefully, a more egalitarian society.
So, that is the picture. It has stirred you to think. It has stirred you to act. Look out for the suicide prone individuals. Get acquainted with NGOs like Befrienders International or the Samaritans. Ask if Suicide Help-lines need your assistance. Help a suicide prone individual seek professional care. Contribute your mite to the movement to make society suicide-free.

It is not just a dream. It is a goal we must all work together for.

Shall we, then, walk the talk?

References
1. Baxter D. and Appleby L. (1999), Case Register Study of Suicide Risk in Mental Disorders, Br. Jr. Psy., 175, p322-26.
2. Bertolote J.N.(ed)(1993), Guidelines for the Primary Prevention of Mental, Neurological and Psychosomatic Disorders, IV, Suicide, Geneva, WHO.
3. Brown, P.(2001), Effective treatments for mental illness are not being used, WHO says, BMJ, 323, p769.
4. Haghighat Rahman, (1997), Psychiatry in Lithuania: the highest rate of suicide in the world, Psychiatric Bulletin, 21, p 716-19.
5. Heyd D. and Bloch S. (1984). The ethics of suicide. In Sidney Bloch and Paul Chodoff’s (eds) Psychiatric Ethics, Ox. Uni. Press N.Y., p 193-94.
6. Marshall J., Burnett W., and Brasure J. (1983), On Precipitating factors: Cancer as a cause of suicide, Suicide and Life Threatening Beh., 13, p 15-27.
7. Mazurk P. M., Tierney H., Tarfidd K., Gross E. M., Morgan E. B., Hsu M.A., and Mann J. G. (1988), Increased Risk of Suicide in persons with AIDS, JAMA, 259, p 1332-33.
8. Murray C.J.L. and Lopez A.D. (ed), (1996), The global burden of disease: a comprehensive assessment of mortality and disability from disease, injury and risk factors in 1990 and projected to 2020, Cambridge Mass., Harvard Uni Press.
9. Neu S. and Kjellstrand C. M. (1986), Stopping long term dialysis: An empirical study of withdrawal of life-supporting treatment, New Eng. Jr. of Med., 314, p 14-19.
10. Roy A. (2001), Suicide. In B. J. Sadock and V. A. Sadock (ed.) Kaplan and Sadock’s Comprehensive Textbook of Psychiatry, 7th Ed., Vol-2, : Lippincott Williams and Wilkins, Baltimore p2031.
11. Sadock B. J. and Sadock V. A. (2003), Suicide. In Kaplan and Sadocks Synopsis of Psychiatry Behavioral Sciences/ Clinical Psychiatry, 9th Ed., : Lippincott Williams and Wilkins Phil., p916.
12. Sartorius N. (1996), Suicide as a public health problem: an International perspective, Arch Ind. Psychiatry, 3.
13. Stahl, S.M. (2003), Depression and Bipolar Disorders. In Essential Psychopharmacology: Neuroscientific Basis and Practical Applications, Second Edn, Cam. Uni. Press 2000, First South Asian Ed. 2003, Foundation Books, New Delhi. p 139-41.
14. Thomas, C. M. and Morris, S. (2003) Cost of depression among adults in England in 2000, Br. Jr. Psy. 183, p 514-519.
15. Venkoba Rao A., (1999), Towards Suicide Prevention, Ind. Jr. of Psychiatry, 41, 4, p 280-88.
16. Wig N.N., (2001), World Health Day 2001, Editorial, Ind. Jr. of Psychiatry 43, 1, p-4
Questions that the Second Monograph raises

1. What concrete steps could be taken to reduce social isolation, prevent social disintegration and treat mental disorders?
2. Is setting up Centres to treat Depression a workable proposition? Are there specialized Centres like this working anywhere and what has been the experience like?
3. What are the important Indian studies in the field of suicide treatment and prevention?
4. Are there biological markers of suicide?
5. How much does disintegration of social institutions like the family contribute to suicide increase?
6. What is the evidence to support the work of Befrienders International, Samaritans, Suicide help-lines etc. in the field of suicide prevention?
7. What could other NGOs do in the area of suicide prevention?
8. What could the enlightened citizen do to save a person from suicide?
9. What are the distress signals that should arouse the suspicion that a suicidal attempt is likely?
10. Is suicide prevention as public health policy a viable community health programme initiative?
11. Does the moral philosopher’s arguments about rational or irrational suicide hold any ground?
12. How do we account for deaths like Jnaneshwar’s, or Rama’s?
13. Do other animals commit suicide, or is it a phenomenon peculiar only to humans?
14. Has psychiatric treatment really helped reduce suicide rates, or has it remained constant inspite of their best efforts?
15. It is desirable that some individuals, who have no escape route whatsoever, be allowed to end their lives?
16. Is there a case for Physician-assisted suicide, or euthanasia?
17. How can the mass media do responsible suicide reporting?
18. Is there any other way of looking at this problem? One which presents a diametrically opposite position or a refreshingly different perspective to this whole issue?