Suicide and attempted suicide is an important health issue and the number of people who die of suicide exceeds that of conflicts. Kashmir has been suffering from a low intensity war since last 20 years in which thousands have been killed or injured. There has been a phenomenal increase in cases of psychological disorders along with suicide and suicide attempts. Suicide in a conflict zone is viewed with indifference due to focus on the physical part of trauma. Difficulties faced by the suicidal patient and his attendants are seldom highlighted. 1408 patients who reported to emergency room for suicide attempt from 2000 to 2008 were taken for the study. All the patients underwent the hospital protocol for poisoning management. Patients were subjected to detailed psychiatric evaluation and questions were specifically asked about the difficulties encountered during management. Most of the cases were females with 92.11% belonging to the Muslim religion. 76.20% cases were from a rural background. 32.5% had been referred because of the lack of specific antidotes. Forty-three percent required arrangement of transportation by their own family members. Fifty-seven percent had been stopped for security checks along the way. Seventy-three percent felt that the attitude of the staff hostile. Twenty-three percent of patients had to share a bed. Almost all patients were questioned by security agencies within the hospital. More than 68% patient reported hostility amongst their neighbors. Suicidal poisoning is a significant health problem in Kashmir and management of these cases is fraught with difficulties across the spectrum of health care. Educating the doctors at primary care about first aid, improvement in community services followed by long term resolution of the conflict would go some way in alleviating the difficulties faced by a suicidal patient and his family in a conflict zone.
the most commonly used i.e. 62.59%, Rodenticides 21.36%. Drugs like benzodiazepines, antidepressants in 12.23% & others in 3.82%. The psychiatric morbidity of the patients has been shown in Table 2. Of the 1408 cases almost all reported that the poison they had used was easily available to them and no special effort had been made at the procurement. Sixty-three percent of those who had taken benzodiazepines, antidepressants reported that they themselves or a family member was taking these drugs due to symptoms brought on directly by turmoil related factors. At the primary care level, 32.5% had been referred because of the lack of specific antidotes. This was particularly seen in cases who had taken benzodiazepines, antidepressants, and rodenticides. Sixty-five percent patients were referred to our hospital after receiving initial medical care at the primary health center, sub district hospital or the district hospital. Out of this group 43% required arrangement of transportation by ambulance. Sixty-five percent patients were referred to our hospital after receiving initial medical care at the primary health center, sub district hospital or the district hospital. Out of this group 43% required arrangement of transportation by ambulance.

### Table 1. Socio demographic profile of patients.

| Gender          | Number | %       |
|-----------------|--------|---------|
| Males           | 525    | 37.28   |
| Females         | 883    | 62.71   |
| Age             |        |         |
| <15             | 184    | 13.06   |
| 16-30           | 851    | 60.44   |
| 31-45           | 267    | 18.96   |
| >45             | 106    | 7.52    |
| Marital status  |        |         |
| Married         | 342    | 24.28   |
| Unmarried       | 989    | 70.24   |
| Divorced        | 52     | 3.69    |
| Separated       | 25     | 1.77    |
| Domicile        |        |         |
| Rural           | 836    | 59.37   |
| Urban           | 267    | 19.03   |
| Semi urban      | 305    | 21.66   |
| Economic class  |        |         |
| Upper           | 239    | 16.97   |
| Middle          | 901    | 63.39   |
| Lower           | 268    | 19.03   |
| Family status   |        |         |
| Joint           | 536    | 38.06   |
| Nuclear         | 645    | 45.80   |
| Extended        | 227    | 16.12   |
| Education       |        |         |
| Illiterate      | 127    | 9.01    |
| Primary level   | 164    | 11.64   |
| Undergraduate   | 759    | 53.90   |
| Graduate        | 328    | 23.29   |
| Postgraduate    | 30     | 2.13    |
| Occupation      |        |         |
| Student         | 760    | 53.97   |
| Home makers     | 464    | 32.95   |
| Self employed   | 121    | 8.59    |
| Government employed | 63 | 4.47 |

### Discussion

Kashmir has been suffering from a low intensity conflict for the last 20 years. The fatalities, injuries and disabilities suffered during attacks and fighting are obvious examples of the impact of conflict. However, there are also health consequences from the breakdown of services. These indirect consequences may remain for many years even after a conflict ends. With the decline of the economy, constant fear and uncertainty the stress levels in the valley have become considerably higher. Due to the tenuous nature of our medical resources sometimes trivial injuries cause death due to the delay in intervention adding to an already stressful environment. No study about the problems facing suicidal poisoning cases and their attendants vis a vis management problems has been conducted in an conflict zone. There has been approx. 60% increase in suicide rate world over the last several years, a recent study in Kashmir has found that the number of suicidal attempts has increased more than 250% over the last 18 years compared with the pre turmoil period. This increase can be seen as a result of overwhelming of the coping strategies due to excessive external stresses. Vicious circle of violence along with insecurity and loss of job opportunity has provided a very fertile ground for attempting suicide. Insurgency situations like ours have a few peculiar problems which may or may not be seen not seen in normal type of settings. From the initial availability of poisonous substances to the problems in the hospital these seriously undermine the health care and subsequent management. More than 95% patients in our study were referred directly or indirectly to a tertiary care center. A health care system is one of the earliest casualties of the social and economic disruption in conflict. This thing is reflected in the absence of medicines, staff and infrastructural facilities including ill equipped primary and secondary health centers. These difficulties are compounded at the primary centers by non availability of ambulance services due to lack of petrol, absence of driver or use of the vehicle for purposes other than it is supposed to be used for. All the above factors lead to high percentage of patients being referred along with the delay in referrals which was more than one hour in 11% of our patients.

The hallmark of a conflict zone is establishment of check points at frequent places leading to delay in reaching hospitals. Patients from far flung and border areas particularly have to face lot of inconvenience and greater number of

### Table 2. Psychiatric Morbidity in suicidal attempters.

| S.No. | Diagnosis                          | N   | %    |
|-------|------------------------------------|-----|------|
| 1.    | Adjustment disorder with or without depressive features | 510 | 36.22|
| 2.    | Depressive disorder                | 375 | 26.63|
| 3.    | Post traumatic stress disorder     | 129 | 9.16 |
| 4.    | Panic disorder                     | 42  | 2.98 |
| 5.    | Personality disorders              | 101 | 7.17 |
| 6.    | Substance abuse                    | 51  | 3.62 |
| 7.    | Bereavement/grief reaction         | 64  | 4.54 |
| 8.    | Schizophrenia & other psychotic disorders | 71 | 5.04 |
| 9.    | No identifiable cause              | 46  | 3.26 |
| 10.   | Others                             | 19  | 1.34 |
check points to reach the hospital leading to delay and subsequent increase in morbidity and mortality. In our study more than 57% of the patients and their attendants had to face this problem.

Twenty-three percent of our patient population could not get a bed in the emergency or had to share one with another patient. This non-availability of emergency beds is due to over burdening of hospital resources by continuous fighting. In addition to the routine emergency patients both medical and surgical, a constant flow of blast or bullet injury victims puts tremendous strain on the hospital resources. Whereas some of these patients can be easily managed at the primary care they are invariably referred either due to collapse of these institutions or the doctors there want to play safe. This is in addition to the patient preference for the tertiary care at place like ours, where they feel that a better care is available. These all lead to very high bed occupancy rates particularly of the emergency beds. About 73% of our study group felt the attitude of staff hostile towards them. In sensitivity and desensitization of the staff towards sufferings of suicidal patients may be due to repeated traumatic killings. This can be also due to either exhaustion due to long working hours or presence of non trained staff at a place where a technical person could have handled better. Absence or paucity of the equipment adds to the problem. Many times deliberate self harm is taken as an attention seeking behavior by the staff thus leading to thinking that these patients are just a wastage of time. This is a very important factor in successful outcome for a suicidal patient. These problems are often due to a lack of clarity among the staff in their work with suicidal patients and a positive impact is noted of training in suicidology and supervision on job clarity. These problems were more in nurses and assistant nurses than among the psychiatrists. The tendency of those immediately concerned with the patient to deny the occurrence of suicidal events contributes to the difficulty of helping suicidal patients. This occurs not only in the patients caregivers but also with the professional staff involved. Interference into hospital affairs from various quarters related directly or indirectly to the conflict leads to indiscipline. This interference might come from government quarters in the form of arrests, detention and transfer of staff without taking into consideration the effect on the functioning of the hospitals. The pressure from the ultras manifested as weakness in applying strong administrative policies due to a threat perceived by the administra tors. This indifference percolates to the staff, patients or their attendants thus leading to difficulties in implementing rules and regulations. Many of the people shun their duties and even prefer staying at home without any genuine reason. Non availability and absence of staff leads to stop gap arrangements which in turn affect the quality of work. This indiscipline leads to destruction of the work culture which reflects in the patient care.

All these factors are inter related and a multi pronged strategy is needed to deal with these. Education of the public through mass media campaigns about signs and symptoms of suspected poisoning and possible first aid measures. This should also include information about harmful effects of pesticides, safe use, storage and disposal of pesticides along with the use of locked boxes for storage of these chemicals. Previously successful campaigns in mass media have been launched for other programs such as a mother child care programs and polio eradication. The use of prominent religious personalities and sermons at the religious places can also play an important role in educating the public. These people have a high regard in the society and people are expected to listen and obey them. Tighter legislation regarding organ phosphorous might also be enforced to make this compound hard to procure as the mortality encountered in poisoning is almost entirely due to this compound. This along with a strict enforcement of drug dispensing procedures from local chemists can help in the goal of prevention of suicidal deaths and attempts. Education and training of doctors at primary level about initial management of patients of poison, signs and symptoms of various poisons, types of patients to be referred to tertiary care. This approach will lead decrease in mortality and lesser number of referrals to the tertiary care hospital thus indirectly saving meager hospital resources for the more needy patients. Next it is imperative that in all insurgent situations doctors be trained in treating poisoning as the expected rate of such cases is expected to rise in such situations. In an atmosphere of violence it is expected that a whole range of poisons may be encountered and in the emergency casualty departments ready referral manuals should be present to deal with all such eventualities. Suicide precautions must be carefully adhered to by the staff and charts regarding the same may be pasted in the emergency rooms. Supervision and specific training of the staff in suicidology are very important to prevent suicidal behavior in the patients in future. Improvement in community psychiatric services and psychiatric outreach programs which are presently nonexistent in our set up can go a long way in decreasing the stress levels in the community and subsequently the suicidal poisoning cases. Mental health in chronic violence settings should receive full attention through the provision of appropriate community based services that would improve access to care and reduce the burden on the health system. Better organization of the specialized psychiatric services along with coordination with other health care services can lead to improved service delivery for the patients. Sensitization of the medical staff in the hospitals including doctors from other specialties for better management and follow up of suicidal cases is essential for better treatment outcome. In Kashmir programs helping the helpers have been scare even though literature concerning such programs is increasing worldwide. In view of the results of our study the department of psychiatry has been trying its best to educate the hospital staff and the community by outreach programs. However all these approaches can work for short term basis but redressal of the main problem of resolving the conflict can lead to the sustained improvement over long time.

References

1. World Health Organization. Figures and facts about suicide. Geneva, 1999.
2. Roy A. Suicide in Kaplan and Sadock Comprehensive text book of Psychiatry. Philadelphia. Lippincott Williams and Wilkins; 2000 P 2031-35.
3. The Official Site of the Government of Jammu & Kashmir [http://jammukashmir.nic.in]
4. Amnesty International: Impunity for enforced disappearances in Asia Pacific Region must end. Public Statement. Index: ASA 01/007/2007 (Public) News Service No: 167); 2007.
5. de Jong J, Komproe IH, van Ommeren M, et al. Lifetime events and post-traumatic stress disorder in 4 post conflicts settings. JAMA 2001;86:555-62.
6. Margoo AM, Firdosi MM, Banal R, et al. Community Prevalence of Trauma in South Asia – Experience from Kashmir. Jammu Kashmir-Practitioner 2006, 13(Suppl 1).
7. Wani ZA, Dhar SA, Hussain A, Qureshi W. The unreported morbidity of suicidal poisonings during an insurgency: a 16-year Kashmir experience. Tropical doctor 2008;38:170-1.
8. de Jong K, Ford N, van de Kam S, et al. Conflict in the Indian Kashmir Valley I: Exposure to Violence. Confl Health 2008;2:10.
9. Nicholas LM, Golden RN. Managing suicidal patient. Clinical Cornerstone. 2001;3: 47-57.
10. Sederer LI, Summergard PS. Criteria for hospital admission. Hospital and community psychiatry. 1993;44:116-8.
11. Ramberg IL, Wasserman D. The roles of knowledge and supervision in work with suicidal patients. Nor J Psychiatry 2003;57 :365-71.
12. Beisser AT, Blanchette JE. A study of suicides in a mental hospital. Dis Nerv Syst 1961 Jul;22:365-9.