# *"Analysis of Suicide cases in Indian Air Force: Causes and Corrective Measures"*

**A Dissertation Submitted to the Panjab University, Chandigarh for the Award of Master of Philosophy in Social Sciences, in Partial Fulfilment of the Requirement for the Advance Professional Programme in Public Administration (APPPA)**


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**UNDER THE GUIDANCE OF**

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# CERTIFICATE

It is hereby declared that this submission is my original piece of work and to best of my knowledge and belief, it contains no material previously published or written by any other person. I am aware of the University's norms and regulations regarding the plagiarism including the disciplinary action that it may invite. Any use of the works by any another author, in any form, is adequately acknowledged at their point of use or in the Bibliography.

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I have the pleasure to certify that **Air Commodore NK Singh** has pursued his research work and prepared the present dissertation titled **'Analysis of Suicide cases in Indian Air Force: Causes and Corrective Measures'** under my guidance and supervision. The same is result of research done by him and to best of my knowledge; no part of the same has been part of any monograph, dissertation or book earlier. This is being submitted to the Panjab University, Chandigarh, for the purpose of Master of Philosophy in Social Sciences in partial fulfillment of the requirement for the Advanced Professional Programme in Public Administration (APPPA) of Indian Institute of Public Administration (IIPA), New Delhi.

I recommend that the dissertation of **Air Commodore NK Singh** is worthy of consideration for the award of M. Phil degree of the Panjab University, Chandigarh.

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# EXECUTIVE SUMMARY

The word "suicide" was derived from the Latin phrases sui (meaning "of oneself") and caedes (murder). As per National Institute of Health (GoI), India has the highest suicide mortality rate of any country in the world. Recent years have seen an average of approximately one hundred Indian military personnel taking their own lives each year. Even the loss of just one trained soldier during times of peace because of this act is tragic, not just for the organisation in which he or she served and their family but also for society and the nation as a whole.

In India, a social and public health response to suicide is critical, and it should be supplemented with a mental health approach. In India, mental illness is a risk factor for suicide; however, there are additional risk factors. These are usually associated with societal systems and unique pressures. Suicide is avoidable, and a social and public health approach aimed at modifying attitudes regarding suicide through educational initiatives and legislative levers is a critical step in such a strategy as decriminalising suicide.

The primary objective of this study is to conduct research into incidents of suicide in the Indian Air Force and to understand the factors that contribute to an attempt to review the existing suicide prevention measures (SPM) implemented in the IAF and their impact. The purpose of this study is to offer a few corrective measures that are both implementable and actionable to reduce suicide.

In Armed forces the nature of job and charted of duty of each individual is very clearly defined. The specifics of each individual's job description and duty responsibilities are laid out in great detail in the armed forces. But due to the increased introduction of weapon platforms and equipment without an increase in manpower,

the concept of "one man for one job" has been reinterpreted to mean "one man for almost one and a half jobs." Despite the fact that the vast majority of personnel are capable of successfully operating in such conditions and are battle-ready or battle-hardened, a few have shown some signs of weakness, while the fact remains that no military organisation can afford to suffer the loss of even one trained soldier as a result of this act.

Moreover, it is a common saying in the military that "a true soldier is not measured by fearlessness; a true soldier is measured by their willingness to face their fears." Depression and other mental health issues that can lead to suicidal ideation are double killers. There have been many different actions taken by the IAF as suicide prevention measures. Losing a trained air warrior who is made battle ready through very systematic training, conditions, and environment, because of this extreme step is sad not only for the organisation in which he or she served and his or her family, but also for society and the nation as a whole.

What has aspired or forced me to do study on the subject was my tenure as Command Personnel Staff Officer (CPSO) at one of the Commands of Indian Air Force. There was always a big question: are we doing enough? Are measures adopted not giving sufficient impact which was desired? Through this study, an attempt has been made to find limitations and lacunas in the existing suicide prevention measures and suggest more feasible suicide prevention guidelines and measures with the same intended outcome of curbing suicide. Even if the life of one Air Warrior is saved by the measures recommended, the study would succeed in achieving its objective.

As part of the literature review, various theories were studied. Some of the important theories are discussed in this paper, which gives the perspectives of various thinkers.

Also the of suicide cases and ratio of the country is compared with that of Defence services and CAPFs. The existing suicide prevention measures for these services are also reviewed.

The objectives of the study were to review the existing suicide prevention measures (SPM) available in the IAF and to provide policy recommendations and actionable suggestions for corrective measures to decrease the rate of suicide in the IAF. After carrying out the literature review and setting the objective of the study, various reasons and factors leading to suicide are discussed in the paper, as follows:

- Financial burden
- Domestic problem
- Health/incurable illness/impotency
- Psychiatric problem
- Love affairs or illicit affairs

The research paper circumscribes the primary data available with NCRB and BPRD for analysis, along with the replies of Raksha Mantri and Raksha Rajya Mantri on number and suicide prevention strategies in Parliament,were taken for analysis. Suggestions to reduce the trend are given in recommendations as organisational action, administrative measures, and best practises to be adopted or initiated. A dedicated hotline staffed by on-duty medical assistants, on-duty police officers, or on-duty officers has been suggested. Involving and counselling individuals left behind following a suicide is also recommended. The paper also provides a check list for supervisors dealing with high-risk personnel. Few new counseling proformas have been made and given in study for pre and post leave counseling, Reporting on duty /posting, Six monthly counseling and counseling of personnel who underwent stress

post Court of Inquiry (CoI) or departmental actions. An important aspect of strengthening the buddy system and keeping track of financial burden has been stressed in this study.

As part of the study, five case studies have been given without disclosing the details of the individuals or locations. The lessons learned have been incorporated into recommendations. This study is done more on the emotional thoughts of saving the air warriors, with aim that even if one life is saved due to suggestion and recommendations given in this paper, the objective will be achieved.

# CHAPTER 1

## INTRODUCTION

असूर्या नाम ते लोका अन्धेन तमसावृताः
ताꣳस्ते प्रेत्याभिगच्छन्ति ये के चात्महनो जनः

**“One who takes one's own life goes towards asuras and pretas and he heads towards a loka of total darkness.”**

**Isha Vasya Upanishad**

### 1.1 Background

It has been said that suicide "is possibly prevented if it is thoroughly understood," and both of these statements are true: suicide is a global occurrence and a serious public health concern. In young adults all throughout the world, suicide ranks as the third largest cause of death overall. The word "suicide" first appeared in the English language in the seventeenth century. It was derived from the Latin phrases sui (meaning "of oneself") and caedes (murder) India has the highest suicide mortality rate of any country in the South East Asia area, with 16.3 deaths by suicide occurring for every one million people in the country. This compares to a regional average of 13.2 and a global average of 10.6. In India, the vast majority of those who take their own lives are under the age of thirty, accounting for 37.8 percent of all suicides. The fact that 71% of people who commit suicide in India are under the age of 44 places an enormous burden on society on multiple fronts, including the social, the emotional, and the economic fronts. This age range comprises the majority of the Indian Armed Forces and Central Armed Police Force personnel who are considered to be in a state of readiness for active duty in battle. Recent years have seen an average of approximately one hundred Indian military personnel taking their own lives each year.

The results of the calculation speak for themselves. Even the loss of just one trained soldier during times of peace because of this act is tragic not just for the organisation in which he or she served and their family, but also for society as a whole and the nation as a whole.

In this day and age, suicide has emerged as one of the most pressing societal issues, touching the lives of each and every one of us in some way or another. In our modern society, this is a common occurrence and a regular topic of discussion in the media. In India, a social and public health response to suicide is critical, and it should be supplemented with a mental health approach. In India, like in Western nations, mental illness is a risk factor for suicide. However, there are extra risk factors in India. These are usually associated with societal systems and unique pressures. Suicide is avoidable, and a social and public health approach offers a framework in an integrated system of interventions at numerous levels within society, including the person, the family, the community, and the health care system. Modifying attitudes regarding suicide through educational initiatives and legislative levers is a critical step in such a strategy (e.g. decriminalising suicide).

The primary objective is to conduct research into incidents of suicide in the Indian Air Force. Hope is a strong word that motivates millions of people across the globe and is spoken in a wide variety of languages. People have been pulled from hopeless circumstances and into better lives because of the power of hope, and it is hope that has kept humanity alive long enough for them to grow in better lives. Hope lessens our sense of powerlessness, boosts our happiness, brings down our stress levels, and overall improves the quality of our lives. Hope, or hopefulness, can increase a person's ability to cope with adversity and their quality of life. On the other hand,

hopelessness, also known as deprivation or a lack of hope is related with depression and anxiety, all of which have a detrimental impact on quality of life. A person who does not have any hope for the future is likely to acquire a pessimistic outlook not only on his own life but also on everything else in his immediate environment. He may get the impression that the people and things in his immediate surroundings had grown hostile against him. The issue, which was somewhat unimportant when he still had hope, has now ballooned into a major source of stress that he is unable to manage.

The purpose of this study is to understand the many factors that contribute to suicide in the Indian Air Forces by performing a content analysis of previously published literature and identifying gaps in the suicide prevention measures (SPM) that have been taken by the services. The purpose of this study is to offer a few corrective measures that are both implementable and actionable to the Indian Air Force (IAF), in the hopes that doing so will foster an atmosphere of support and trust among the troops.

### 1.2 Statement of Problem

In Armed forces the nature of Job and charted of duty of each individual is very clearly defined. The specifics of each individual's job description and duty responsibilities are laid out in great detail in the armed forces. The total number of available positions has been frozen, and the armed forces are being modernised and equipped with a new generation of weapons and other associated equipment. As a result, the expectations placed on personnel and the amount of work they must complete have increased. This problem has multiplied out of all proportion as a result of the fact that more weapons and equipment have been acquired without corresponding increases in manpower. As a consequence of this, the concept of "one

man for one job" has been reinterpreted to mean "one man for almost one and a half jobs." Evidently, as a result of this, the workload as well as the indirect stress on the personnel has increased. Each individual is equipped to perform at their highest level and produce the best results possible despite the extremely hazardous, demanding, and stressful conditions that they face throughout the selection process as well as the training curriculum. It is the ultimate goal of every Academy and Training Institution for each individual warrior to develop themselves mentally and physically to the point where they are ready for battle. Despite the fact that the vast majority of personnel are capable of successfully operating in such conditions and are battle ready or battle hardened, a few had shown some signs of weakness. Even if the reasons and circumstances that led an individual to engage in the behaviour of inflicting self-harm are unique to that person, the fact remains that no military organisation can afford to suffer the loss of even one trained soldier as a result of this act.

An important question that needs answer is, "What was or were the reasons for taking this extreme step?" Fear is something that every soldier experiences, regardless of whether they serve in the regular military, the paramilitary forces, or the Central Armed Police Forces. But what determines whether or not you are a true soldier is whether or not you are willing to face them. Those people who never have the guts to confront their phobias are the ones that we need to locate so that we can assist them in overcoming their anxiety. It is not a matter of having fears; rather, it is a matter of facing them. It is a common saying in the military that "a true soldier is not measured by fearlessness; a true soldier is measured by their willingness to face their fears." This is an accurate assessment of what it means to be a true soldier. A soldier who faces his or her fears head on has earned the right to wear that title. It takes a lot more than just being brave, in good health, and fitness if you want to make it as a good

combat soldier in the military. The "qualities" that are most highly valued are those that pertain to a person's mental capabilities. This is the issue that we are going to have to deal with: a knowledgeable person has made a mistake. What exactly are the conditions or factors that he felt did not work for him and why does he feel this way? Why has a young man who was once so vibrant and full of life and joined the military with so much optimism become such a feeble and hopeless individual that he chose to take his own life? Is it possible that the circumstances of his service have left him hopeless? If it wasn't due to the conditions of the service, then what are these other factors? Can something be done to identify these factors or causes at an early stage and put some preventative or corrective measures into place so that a valuable life is not lost?

### 1.3 Rationale of the Study

Depression and other mental health issues that can lead to suicidal ideation are a double killer. They do not kill the victim until after they have eliminated all hope for the victim. In some circumstances, it might appear as though there is no chance of a positive outcome. Horrific things take place in people's lives, both in the external world and in their own minds. It is of the utmost importance to gain an understanding of the factors that have contributed to the current hopelessness. Why does a soldier who lives in a community that is willing to even die for their common cause, i.e. the dignity and respect of the nation, feel so alone that he does not find his team mates or comrades suitable to share his agony and personal problems? This begs the question: what could possibly be more important than the dignity and respect of the nation? Investigating the reasons and factors that are attributed to a lack of hope could be helpful in isolating the primary driver of the recent uptick in the number of suicides committed by IAF personnel. The trend needs to quicken its pace, and every effort

should be made to bring an end to it. There have been many different actions taken by the IAF, all of which have resulted in something, but not to the level of satisfaction that was desired. The question of what else can be done is one that senior commanders always have on their minds. Losing a trained air warrior who is made battle ready through very systematic training, conditions, and environment because of this extreme step is sad not only for the organisation in which he or she served and his or her family, but also for society and the nation as a whole. What has aspired or forced me to do study on the subject was my tenure as Command Personnel Staff Officer (CPSO) at one of the Commands of Indian Air Force. While as CPSO I was responsible to ensure that all the policies issued by Air Hq on prevention of Suicide are understood and implemented in various units of my Area of Responsibility. A feedback mechanism to look into effectiveness of implemented policies also existed. But since all the causalities were reported to me initially, I was always concerned that are we doing enough? Are measures adopted not giving sufficient impact which was desired? Through this study an attempt has been made to find out limitations and lacunas in the existing Suicide Prevention Measures and suggests for more feasible suicide preventive guidelines/ measures for curbing suicide. Even if life of one Air Warrior is saved by the measures recommended, the study would succeed in achieving its objective.

# CHAPTER 2

# LITERATURE REVIEW

## 2.1 Defining Suicide

Suicide and attempted suicide are major public health challenges. Suicide is a major public health issue in India. An estimated 230,314 suicides occurred in India in 2016, accounting for 37% and 25% of global female and male suicides, respectively. An issue of concern for public health all across the world is suicide. The World Health Organisation (WHO) has estimated that approximately one million people commit suicide every year. This represents one death every forty seconds, almost 3000 deaths every day, and one suicide attempt every 3 seconds. Every year, suicide claims the lives of up to 800 000 people around the world. The majority of suicides (85%) in the world occur in low and middle-income countries. In many countries, suicide is one of the top three causes of death among adolescents and young adults between the age of 15 and 24 years, and one of the top ten causes of death overall.

Worldwide, suicide rates have increased by 60% over the last half century. There are no boundaries when it comes to suicide; it affects people in every corner of the world. A suicide attempt is a key risk factor for subsequent suicide. Families, friends, classmates, co-workers, and communities are frequently abandoned in the aftermath of a suicide or attempt to take one's own life, which might leave them grieving or without support. Those who are in need are discouraged from requesting assistance due to stigma and silence. The bulk of suicides, or 79%, take place in low- and middle-income countries, where resources for diagnosis and management are frequently lacking. This is despite the fact that suicide continuing to be the second

highest cause of death among those aged 15–29. These troubling facts shed light on a tragedy that has been going on for some time and can no longer be ignored.

Tripathi "et al.",(2022) have presented evidence-based strategies to tackle suicide, using interviews, case studies, and conversations that lay readers can make sense of, while proposing an outline of steps that policy makers, journalists and key stakeholder groups can collaborate on to provide better solutions and save precious lives in India.

Murali (2021) described the time after she lost her husband In April 2017, Dr T.R. Murali to suicide. In the wake of that devastation, her life changed forever. As she struggled to find her feet and begin to live again, the author discovered that survivors of suicide loss are unheard and unseen, their needs and concerns not recognised. She writes of the angst of the survivor, and of the overwhelming feelings of confusion, anger, shame, loneliness and guilt that survivors of suicide loss face.

Bhakto (2021) described that as many as 819 personnel of the Army, Navy and IAF have died by suicide in the last five years, apart from cases of "fratricide", which once again underlines the need for better suicide prevention and stress management policies in the over 14-lakh strong armed forces.

Vadlamani and Mahesh (2019) explained increasing prevalence of suicides in recent years. The number of persons who attempt to die by suicide is 25 times that of the number of those who die by suicide every year. Indian Government passed the Mental Healthcare Act (MHCA), 2017 in the middle of 2018. Section 115 of the act decriminalized the attempt to die by suicide, thereby reducing further stress on the

victim. This has legal implications along with cost implications for the government is explained in the article.

David Bren (2021) describes suicide is a complex public health problem of global importance. Suicidal behaviour differs between sexes, age groups, geographic regions, and socio-political settings, and variably associates with different risk factors, suggesting aetiological heterogeneity. Although there is no effective algorithm to predict suicide in clinical practice, improved recognition and understanding of clinical, psychological, sociological, and biological factors might help the detection of high-risk individuals and assist in treatment selection.

Somasundaram et al. (1989) revealed the occurrence of suicidal conduct in the classic Tamil work "Purananuru," written during the "Sangham" era. The article describes Perun Koppendu's self-immolation after the death of her husband, a Cheran king's fast-to-death in retaliation to guards' insults, and the suicides of notable monarchs and poets as a result of mourning. This article specifically mentions Tamil literary masterpieces to highlight the impact of religion and other cultural ideas on how people view suicide and how it is portrayed in popular culture.

**2.2 Theories on Suicide**

To undertake through Literature Review, various theories were studied. Some of the important theories are discussed here. Main theories affecting the actual environment are discussed in detail. The major theories of what causes suicide are derived from the following perspectives:-

**2.2.1 Biological Theories** – Suicide results because of the malfunctioning of the human body attributed to genetics, temperament, substance intoxication, and neurochemical imbalances.

Biological Theorists Holmes and Rahe (1967) proposed that suicide results from chemical dysregulation in the brain combined with stress and predisposing negative life situations.

(a) Suicidal behavior is derived from a malfunction in the human body, or dysregulation of "happy" chemicals in the brain

(b) This dysregulation - combined with a trigger, substance intoxication, or psychiatric episode - creates stress.

(c) Diathesis - a culmination of predisposing factors like family dysfunction, psychiatric problems, hopelessness, and loneliness – create the vulnerability for suicide

**2.2.2 Psychodynamic Theories** – Inner conflict and unconscious drives create thoughts and emotions. Thoughts and emotions precipitate behaviors whose intensity are stimulated by environmental stimuli. Psychodynamic Theorists David Malan states that suicide results from accumulated trauma. Though it sounds extremely simplistic, most psychologists, to certain degree, concur with this theory. Krauss posits that an unachieved goal or dysfunctional relationship, representing an unattainable object, is killed when the person dies by suicide. Edwin Schneidman asserts that suicide, or death of the personality, is the only solution for the ambivalence towards life and death created by hopelessness and helplessness.

**2.2.3 Sociological Theories** – A systems' perspective on how social relationships, socioeconomic conditions, and disparities within society impact suicidal behavior.

Sociological Theorists

Emile Durkheim Theory (1897) proposed that four societal failures are causes for suicide:

(a) Egoistic-Not enough integration due to a looser social network or belief system.

(b) Anomic-Not enough regulation because of rapid change and poor adaptability.

(c) Altruistic-Too much integration when a person sacrifices their life for society's benefit.

(d) Fatalistic-Too much regulation and control by society.

**2.2.4 Thomas Masaryk Theory**

Masaryk's thesis(1881) that irreligiosity is the main predisposing cause of suicide is predicated on the assumption that religious belief is a powerful means of coping with those vicissitudes and adversities of life which throw men into despair. He said:-

(a) Religion is considered to be the main basis of morality in society

(b) Irreligiousity deregulates the social organism

(c) Increased social disorganization increases despair and unhappiness

**Cognitive Behavioral Theories** – The way people acquire and interpret information impacts their choices and behaviors; especially if the perception is hopelessness and helplessness.

Aaron Beck explains Cognitive-Behavioral Theory with following functions:-

(a) Psychiatric disturbance / psychological pain

(b) Hopelessness is pervasive regarding self, the future, and the world in general.

(c) Dysfunctional automatic thoughts skew perceptions of self, future, and the world

(d) Schema develop. Common "themes" are estrangement and unbearability.

(e) Suicidal ideation

**2.2.5 Interpersonal Theory** –The most current suicide theory which integrates psychodynamic and cognitive behavioral theories into one cohesive theory. Erik Erikson (1959) defines the Interpersonal Theory as **the desire for death may be transformed into actual suicidal behavior when the individual's personality is dominated by the dystonic features of the ego**, which emerged earlier during the unfavorable psychosocial development. Erik Erikson contributes that overwhelming feelings of guilt exceeds the ability to cope, resulting in suicide.

**2.2.6 Benjamin Wolman** theorized that "anti-culture" creates a climate for suicidal thoughts because of:

(a) The estrangement inherent in our way of life;

(b) The decline of family ties;

(c) The depersonalization in human relations;

(d) The loss of the individual in a mass society.

Italian statisticians also gave some theories sought to explain suicide. Ferri and Morselli believed that the constant psychological antecedent of suicide is a state of extreme excitation, where in fact it is frequently preceded by depression.

Interpersonal Theorists Dr. Joiner Theory (2005) while explaining the interpersonal-psychological theory of suicidal behavior proposes that an individual will not die by suicide unless s/he has both the desire to die by suicide as well as the ability to do so. He further defined that:-

(a) Thwarted belongingness is a profound sense of loneliness, alienation, and isolation

(b) Perceived burdensomeness is a belief that one is a liability, expendable, or that their presence creates a hardship for family members / loved ones.

(c) Acquired capacity for suicide is a sense of fearlessness about physical pain and dying.

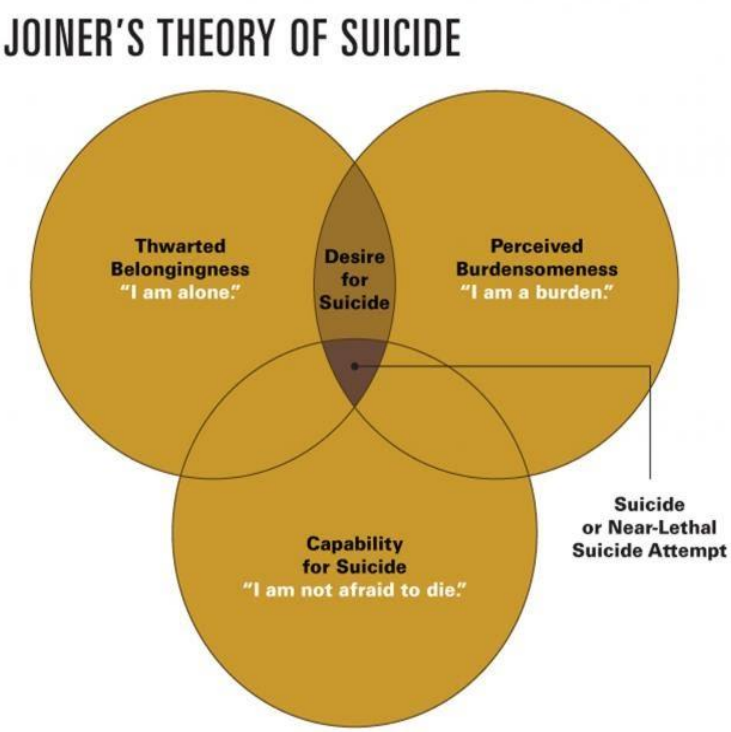



**Figure 1. Illustration of Joiner's Theory of Suicide**

**2.2.7 David Klonksy and Alexis May's Three Step Theory (3ST) of Suicide :** There has been considerable uptake of the Three-Step Theory (3ST) of suicide since its publication in 2015. The 3ST is a concise, evidence-based, and actionable theory that explains suicide in terms of four factors: pain, hopelessness, connection, and capability for suicide.

Step 1. Development of Suicidal Desire

Step 2. When Does Suicidal Desire Become Strong?

Step 3. Progression from Suicidal Thoughts to Actions

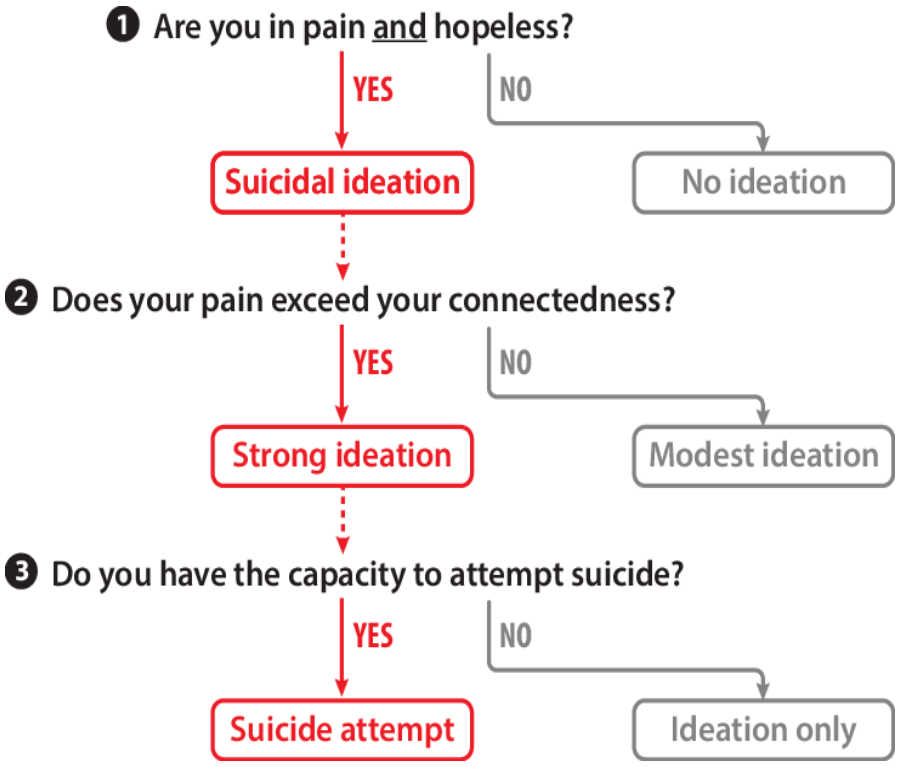



**Figure 2. Illustration of Three Step Theory**

## 2.3 Suicide in India

It has been described by Radhakrishnan and Andrade (2012) that suicide rate in India is 10.3. In the last three decades, the suicide rate has increased by 43% but the male female ratio has been stable at 1.4 : 1. Majority (71%) of suicide in India are by persons below the age of 44 years which imposes a huge social, emotional and economic burden. Poisoning, hanging and self-immolation (particularly women) were the methods to commit suicide. Physical and mental illness, disturbed interpersonal relationships and economic difficulties were the major reasons for suicide. The vulnerable population was found to be women, students, farmers etc. A social and public health response in addition to a mental health response is crucial to prevent suicidal behaviour in India.It is absolutely necessary to develop national policies for suicide prevention in order to move suicide prevention further up on the political agenda. It is vital to have both a national strategy and an action plan linked with it in order to go forward with the implementation of suicide prevention. Without these, efforts are likely to wane, and prevention of suicide will continue to get insufficient attention. It is of the utmost importance that governments take the initiative in developing comprehensive multi-sectoral programmes for the purpose of preventing suicide among the general public as well as vulnerable individuals in particular.

Nandi et al.(1978-79) looked at suicide rates in Bengal for a hundred years, from 1872 to 1972, using public data. They found that the number of suicides went from 2.36 per 100,000 people in 1872 to 15.96 per 100,000 people in 1972, which is a big jump. The study also found that most suicides were done by men, with those between the ages of 18 and 30 being the most likely to do so. The most common way they did this was by poisoning themselves.

In his study of suicide rates in a rural area of northern Karnataka, Hedge(1980) found that 9.3 out of every 100,000 people died by suicide. The study also found that most of the people were men (67%). The study also showed that suicide rates in rural areas were the same as in cities.

Shukla "et al.",(1990) study's on suicides in Jhansi city found that more women (34/100,000) killed themselves than men (24/100,000). Several other differences between men and women were also found. Women were much younger (24.6 years) than men (28.9 years), and self-immolation was the most common way women killed themselves, while being run over by a train was the most common way men killed themselves. The most common causes were said to be fights in the home and mental illness. The study found that there were 29 cases for every 100,000 people.

Banarjee "et al."(1990), who looked at how vulnerable Indian women are, agreed with these results. They found that 43 out of every 100,000 people in Bengal died by suicide and that more women (79.3%) than men died by suicide. 75% of the victims were under 25 years old, and the most common reason for suicide for women was a fight with their husband. For men, the most common reason was a fight with their parents. Most people who killed themselves did so by eating insecticide

In his hospital-based study on suicide attempts, Venkoba Rao (1974) found that most of the people who tried to kill themselves were men. He also found that people between the ages of 15 and 25 were most likely to try to kill themselves. A big risk factor was found to be a lack of social cohesion. Twenty percent of the people who tried suicide also had a family history of mental illness or suicide attempts. It wasn't thought that how or when (day or night) someone tried to kill themselves would change their mind.

In another hospital-based study, Lal and Sethi(1975) found that most women who tried to kill themselves were under 30 years old, housewives or domestic help, married, and made less than or equal to Rs. 200 per month. More women with lower levels of education and from joint families tried to kill themselves, while more men with higher levels of education and from unitary families tried to kill themselves.

Badrinarayana (1975) showed that people between the ages of 10 and 30 were more likely to try to kill themselves. Mental illness and messed-up relationships between people were named as the main causes. Venkoba Rao found that having an extramarital affair was also a risk factor for a spouse to try to kill themselves. Nandi et al. looked into the link between the availability of insecticides that kill and the number of suicides. The study's conclusion was that the high number of suicides had nothing to do with how easy it was to get a poisonous insecticide. Instead, the number of suicides depends on why people do it.

Bagadia et al.(1979) tried to look into the link between unemployment and suicide. They came to the conclusion that unemployment may be a big factor in suicide, but it doesn't seem to be the main cause. The study suggested that both being unemployed and wanting to kill yourself could be caused by some of the same psychopathological factors. But Srivatsava et al. (2004) found that being unemployed, having a stressful life event in the last six months, having a physical disorder, or having idiopathic pain are all sure signs that someone will try to kill themselves.

Several studies have focused on high-risk and vulnerable groups, such as students, the elderly, women, people in the military, farmers, migrants, and people with long-term physical and mental illnesses. Venkoba Rao (1976) in his article about students, who tried to kill themselves, said that over a 10-month period, 35 students

tried to kill themselves, and seven of them were successful. The most common way was to eat insecticide. There were more men at the school than women . Most of the students were between the ages of 16 and 30, and most of them were studying Arts and Sciences. Eight of them had tried to kill themselves before. In the sample, there was no sign of below-average intelligence.

In a different study on the social and medical factors that are linked to teen suicide attempts, Kumar,et al.(2000) compared the possible risk factors of teen and adult suicide attempters and found that the teens had much higher levels of depression, hopelessness, lethality of event, and stressful life events. In their study of high school students, Sharma et al.discovered (2008) that there was a lot of suicide risk behaviour. Almost 16% of the students had thought about suicide, and 5% had tried to kill themselves. Females were seen as being more vulnerable. People who did risky things more often were thought to have role models who drank and smoked.

Rao Venkoba (1989) looked at depression and suicidal behaviour in older people. He found that the risk of a suicide attempt being successful is twice as high for older people as for younger people. He also found that older people get depressed because they don't have enough social connections, not because they are alone. In a study of 100 female burn patients at the Madurai Medical College, Venkoba Rao, et al.(1983) found that 70% were attempts at suicide, 25% were accidents, 3% were murders, and 2% couldn't be put into any other category. Marriage and relationship problems were the most common reasons people tried to kill themselves, followed by mental and physical illnesses.

Jacob, et al.(2002) compared people with seizure disorder and bronchial asthma. They found that 34% of the epilepsy group and 13.3% of the asthma group had been diagnosed with major depressive disorder. Sixteen percent of the group with

epilepsy had tried to kill themselves at least once in the past year, and twenty percent of the group said they were thinking about killing themselves right now.

Latha and Bhat (2005) looked at how often people with terminal cancer had suicidal thoughts and found that only 9.2% had very strong suicidal thoughts. 3.8% of the people who had suicidal thoughts had a history of major depression in the past. The depressive states were caused by things like pain, knowing what was wrong, and understanding the illness. The study's conclusion was that suicidal thoughts and the desire to die seemed to be caused only by having a mental disorder.

In a two-year follow-up study of people with schizophrenia and depression who had tried to kill themselves, Gupta et al.(1992) found that 51.8% of the people who tried to kill themselves had a personality disorder, 42% had neurotic symptoms as children, and 23.5% had a history of drug dependence. During the follow-up period, 17.1% of the people with schizophrenia tried to kill themselves again, and one succeeded. This was compared to 19% of the people with depression.

In their study of people with major depressive disorder, Srivastava and Kumar(2005) found that 17% of those who had suicidal thoughts had tried to kill themselves. Risk factors included being younger than 30 years old, having a higher level of education, being a single man or woman, being married, or being a student. People who tried to kill themselves also had more suicidal thoughts, anger, and paranoid symptoms.

In a study about the military, Goel (1975) said that suicide attempts are not a big health problem in the army and that being in the army doesn't make a person more likely to commit suicide than the rest of the population. In his study, Chakraborthy (2002)said that people who tried to kill themselves in the Indian Army were older than

those in the West. People who tried to kill themselves said that being alone and not being able to make friends were big reasons why.

Chavan, et al.(2008) used psychological autopsies to find that almost 58% of the victims were migrants from other parts of India. Most of them were young men. This shows that migrants are a particularly vulnerable group (age 20 to 28 years). Most people who killed themselves did so by hanging themselves. In 61% of the cases, psychosocial stressors and psychiatric illness were found. Only 16% had tried to get help before their attempt.

Behere and Behere (2008) on a study about farmer suicides in the Vidarbha region, used the psychological autopsy method to figure out what was going on. They found the five reasons for farmer suicides. These are (1) chronic debt and the inability to pay off debts that have built up over time; (2) economic decline, which can cause problems like family fights, depression, alcoholism, etc. (3) The money the family gets after a suicide helps pay off debts. (4) The loss of grain, and (5) The rising costs of farming supplies and the falling prices of farm goods.

**2.4 Suicide in Army and Navy**

The Economics Time (2022) reported that over 800 armed forces personnel have committed suicide in the last year, with maximum suicides reported from Indian Army, the government informed Rajya Sabha today. "819 armed forces personnel committed suicide in the last 5 years , with the Army reporting a maximum of 642 such cases, Indian Navy had 29 cases . Because of the shockingly high number of active-duty service members who kill themselves while on the job, there is an immediate and pressing need to make structural reforms in the armed forces and to

place a higher emphasis on finding solutions for those who are serving in danger zones.

**2.5 Suicide in IAF** As per the information received from IAF as outcome of various Courts of Inquiries, total of 150 cases have been reported in last five years. Main causes of suicides in IAF are given as:-

i Marital Domestic and Personal reasons (MDP) counts for about 40 suicides

ii Medical reasons accounts for 16 suicides.

iii Financial Issues are reason behind 17 suicides cases.

iv Stress and Mental Health led to around 28 cases.

v Mixed reasons or reasons not established are about 49.

**2.6 Suicide Prevention Strategies**

There haven't been many papers that focus solely on suicide prevention methods or a methodical, scientific review of a method. Singh(1972) analysed community activities, psychiatric and medical activities, suicide prevention centres, psychiatric emergency services, crisis intervention centres, the role of general practitioners, research, and the media in his study. He also looked at research and the media. He emphasised the importance of the psychiatrist in addressing this issue in his final remarks.

In his study, Venkoba Rao (1999) outlined the risk factors for suicide attempts, their links to mental diseases, and the biological proof of suicidal conduct. According to the article's mentioned research, general practitioners should get education, and the availability of antidepressants, paracetamol, and pesticides should be restricted in order to reduce the risk of suicide.

Jena and Siddharta (2004) evaluated literature from both India and outside for papers on non-fatal teen suicide attempts. They claimed that in order to lower the rates, non-fatal suicidal behaviour among teenagers needed to be assessed and successfully addressed. They came to the conclusion that there is a huge demand for study in this area because there are so few Indian studies in this field. In order to promote referral and efficient care, the paper also emphasises how crucial it is for professionals including general practitioners, teachers, paediatricians, and school counsellors to receive training on how to recognise non-fatal suicide behaviours in teenagers.

In an editorial, Vijayakumar (2007) acknowledges the urgent need for suicide prevention in India and emphasises the necessity for diverse suicide prevention initiatives because suicide is a complicated problem. To create and carry out a national plan that is affordable, suitable, and pertinent to community needs, collaboration, coordination, and dedication are required. In India, preventing suicide is more of a social and public health goal than a conventional mental health practise. She says in her conclusion that now is the ideal moment for mental health experts to take proactive, leadership roles in preventing suicide and save thousands of young Indians.

# CHAPTER 3

# RESEARCH METHODOLOGY

## 3.1 Objectives

Mental health promotion and suicide prevention are important initiatives of Indian Air Force (IAF) for its personnel. The alarmingly high number of serving soldiers committing suicide while on duty calls for an urgent need for structural changes in the armed forces and a greater focus on remedies for those in IAF. To bridge the policy gap for suicide existing in the IAF, there is a need to understand phenomena better and take further steps based on available knowledge in terms of future research, interventions and policy level changes.

Considering the same, the objectives of study are:-

i To study the rate of suicide among the personnel of Indian Air Force in last five years.

ii To study the reasons and patterns of suicide among the personnel of Indian Air Force in last five years.

iii To review the existing Suicide Prevention Measures (SPM) available in IAF.

iv To assess the impact of Suicide Prevention Measures on personnel of IAF.

v To provide policy recommendations and actionable suggestions for corrective measures to decrease the rate of suicide in IAF.

## 3.2 Research Strategy and Design

Qualitative research strategy is planned to be employed for the study. Since the research is not based on theories, there are no hypotheses and the study would be

based on critical research design. The study would employ content analysis, review and elucidation of available data and case study.

### 3.3 Research Methods to be Applied and Data Source

The data collection and analysis was undertaken in the following manner:-

i Primary data of published government reports, Seminar reports conducted by institutes like National Crime Records Bureau, Bureof Police Research and Development etc was taken and analysed. Secondary data was collected from open source material and analysed.

ii Regular interaction with Air HQ, Command HQs of IAF and other institutes conducting studies on the subject was another vital source of building up towards the research.

iii Data, comments and analysis on various issues available on the internet was made use of to answer primary questions building up to the research objectives.

iv Content and trend analysis was undertaken as part of the research to analyze data collected and arrive at logical inferences.

v Focus Group Discussion with officers dealing with making and implementation of policies and discipline was conducted.

### 3.4 Research Questions

After carrying out the literature review and setting the objective of the study, following main question needs to be answered:-

RQ 1. What is trend and pattern of Air Warriors who committed Suicide?

RQ 2. What are various factors forcing personnel to take extreme step of self-harm?

RQ 3. What are the various Suicide Prevention Measures implemented by the IAF?

RQ 4. What is the impact of Suicide Prevention Measures available and implemented on personnel of IAF?

RQ 5. What innovative policies and other measures can be introduced in IAF to curb the suicide?

### 3.5 Limitations and Scope

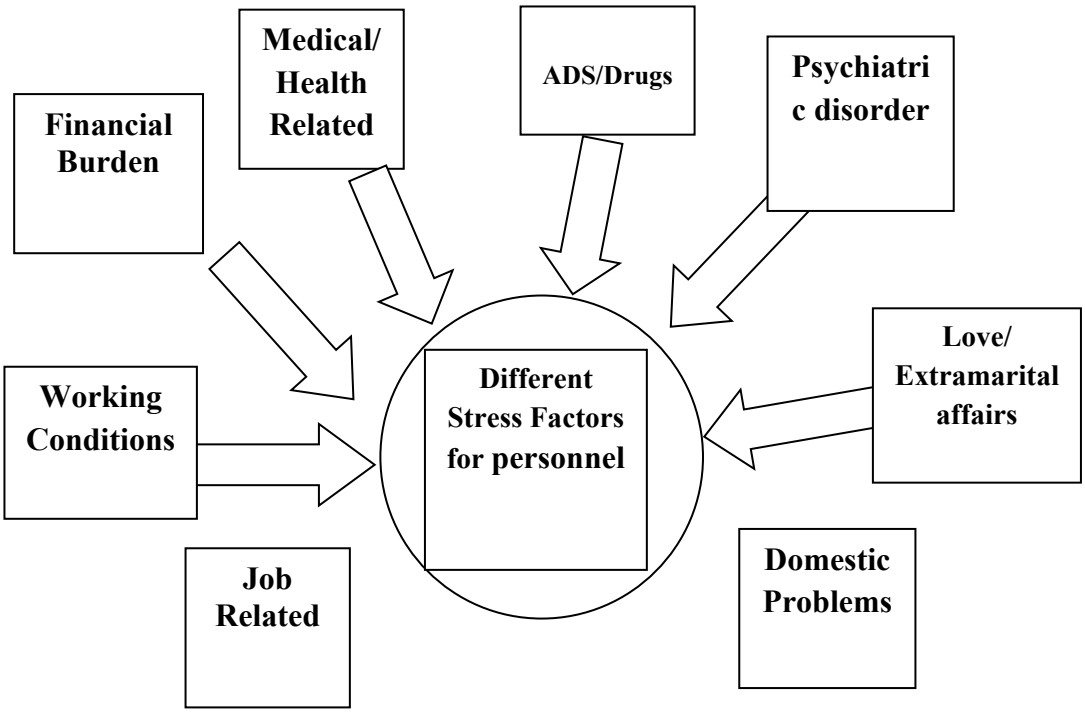
Suicide is a global phenomenon and a major public health concern and 'it is possibly preventable if it is well understood'. This study is an attempt to understand various factors leading to 'suicide in IAF with the existing literature and the lacuna in the Anti-suicidal measures adopted by the service. Information available on the subject is mainly through departmental Court of Inquiry (CoI) reports and discussion with very few families of victims. Due to the sensitive nature of the subject and non sharing of the confidential information by the other services the study is limited to the available information on IAF only. Better analysis of appropriate official documentation and more quantitative and qualitative studies would help in understanding the phenomena

better. Innovative research designs are needed to address this knowledge gap as it will facilitate optimal allocation of resources for suicide prevention. This gap needs to be filled in future by a comprehensive study by the joint services organization like IDS or under the umbrella of CDS by providing official data of respective services. The scope of this study is limited to the IAF for ongoing trend, existing suicide prevention techniques and implemented policies and required changes in polices which are the need of the hour to save the organization from the dangerous trend of suicide.

### 3.6 Case Studies and Focus Group Discussion

Certain case studies were taken to understand the various problems and stress areas. Specific cases are covered in this paper in data analysis chapter. Due to sensitive and confidential nature of the problem name are being kept anonymous. As details of departmental inquires are confidential in nature, therefore reasons available on open sources and in public domain are made part of this study. Certain Stress factors identified for analysis and Focus Group Discussion are as given in following figure.

**Figure 3. Different Stress Factors for Personnel**



### 3.6.1 Focus Group Discussion (FGD)

Based on the various factors of stress and number of suicide a questionnaire was prepared for focus group discussion. The group consists of Officers dealing with HR and Health issues. These officers are also responsible for implementation of Suicide Prevention Measures.FGD was very informative as people involved in discussion were well informed, dedicated and concerned with the problem. With the adequate seniority and experience they have been working with sincerity and were committed to the organisation. They have been giving feedback to higher ups on Suicide prevention measures and were keen to improve them to reduce or eradicate the problem. Various outcome and factors will be dealt in detail in finding and analysis chapter, however, major reasons and factors attributed to suicide among personnel are as follows:-

(a) Financial burden

(b) Domestic problem

(c) Health/ Incurable illness /Impotency

(d) Psychiatric problem

(e) Love affairs/ illicit Affairs

## 3.7 Research Gap

Innovative research designs are needed to address this knowledge gap which will facilitate optimal allocation of resources for suicide prevention. There is a requirement to develop local and national suicide prevention programs. To make a comprehensive and effective suicide prevention programme at national level, a dedicated research with government support is needed to bridge the existing gap.

# CHAPTER 4

# ANALYSIS AND FINDINGS

## 4.1 Analysis of Causes of Suicides

Academics and non-affiliated media have theorised that the main causes of military troops having suicidal inclinations were inadequate leadership, the unsympathetic attitude of superiors, and the denial of leave over long hauls, even when there was an emergency at the personnel's families. These are some of the possible causes of the issue.

In spite of their reservations, successive administrations have come to acknowledge organisational failures as a significant source of tension. Defense Minister A.K. Antony testified in 2012 that "possible causes for troops committing suicide or fratricide are stress, personal difficulties, financial problems, etc." Planning for counterinsurgency operations takes into account the personnel's physical and emotional health. Antony said that the government has implemented measures to alleviate the crisis, including "counselling, improvement in food and clothes, married accommodation, leave allowances." There is a disturbing trend of 100 military suicides annually. In March of 2020, Defence Minister Shripad Naik reported to the Lok Sabha that 95 members of the Indian Armed Forces had committed suicide in 2019. There were 73 suicides in the armed forces. Increased from 103 in 2017, 2018 had 107 occurrences. The numbers have remained relatively constant over the past decade. This demonstrates how traumatic experiences can be triggered by institutional or working settings. There were 891 suicides among active-duty military personnel between the year 2011 and 2018. This by any means is very high for any nation.

The Defense Ministry compiled data for cases of suicide during the period between January 1, 2014 and March 31, 2017, and came out with the shocking revelation that one person on duty from either the Army, Navy, or Air Force committed suicide every three days. The data for these cases were collected between January 1, 2014 and Marc h 31, 2017. According to the organization's statistics, 348 regulars killed themselves w hile on service. In 2018, Subhash Bhamre, Minister of State for Defence, stated that the Centre focussed on creating better work conditions to address the issue of low morale among soldiers. Bhamre said that the government was also committed to increasing safety precautions for the forces to give them a sense of security. He said, “The broad measures taken include upgradation of security infrastructure and intelligence capabilities, refinement of operational drill and response mechanism, equipping the forces with state-of-art weapons, equipment and surveillance devices, medical support and quick casualties evacuation mechanism.” However, if numbers are anything to go by, the remedies are either not adequate or not implemented well. Over 1,110 soldiers, airmen and sailors took their lives between 2010 and 2019, and that calls for immediate and effective suicide prevention measures rather than blaming marital discords or family disputes for suicides happening while the soldiers are on duty.

Suicidal tendencies amongst security personnel came back to haunt the public conscience after several such cases were reported in quick succession from Kashmir recently, spurring a debate on whether combat operations in a conflict zone, where the locals themselves were more often than not the combatants, could lead to psychological imbalances and needed an institutional and structural response with a focus on counselling, therapeutic remedies or other forms of remedies aimed at strengthening one’s endurance, especially mental endurance.

### 4.2 Incidents of Suicides and Fratricide in CAPFs

A study of BPRD report on suicides and fratricide cases for the last five years was analysed with the propose of comparing with that of IAF. Report has categorically mentioned mode of each & every death with date and its type viz. suicide by hanging, bullet injury, etc. Total cases reported for suicidal and fratricidal deaths are 642 and 45 respectively in last five years. Though the numbers were very high but the factors leading to suicide were common in many cases.The data on the incidents of suicides in CAPFs for last 05 years (2017-2021) has been given in the following tables:

**Suicide Cases**

| YEAR | AR | BSF | CRPF | CISF | ITBP | SSB | TOTAL |
|---|---|---|---|---|---|---|---|
| Year-2017 | 12 | 38 | 39 | 20 | 8 | 7 | **124** |
| Year-2018 | 5 | 32 | 36 | 9 | 6 | 9 | **97** |
| Year-2019 | 12 | 31 | 40 | 17 | 13 | 15 | **128** |
| Year-2020 | 9 | 30 | 54 | 18 | 9 | 18 | **138** |
| Year-2021 | 14 | 44 | 58 | 21 | 10 | 8 | **155** |
| **TOTAL** | **52** | **175** | **227** | **85** | **46** | **57** | **642** |

**Table1. Cause and number of Suicide in CAPFs**

### 4.3 Causes and number of Suicides of Serving Personnel in IAF

Suicide in IAF has been taking life of air warriors. There are cases which are not related directly to the working and service conditions but in many cases the service conditions were also major factor. The data provided by the IAF of suicide cases of last five years is as given below. The analysis of this data indicates that marital discord is the main reason of suicide while it is followed by financial and Depression/ Medical reasons.

**Table 2. Causes and number of Suicides in IAF**

**(Source IAF Data)**

| CAUSES | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 (JUN) | TOTAL |
|---|---|---|---|---|---|---|---|
| **MARITAL** | 01 | 02 | 04 | 04 | 01 | 07 | 19 |
| **MEDICAL** | 00 | 00 | 04 | 06 | 06 | 00 | 16 |
| **FINANCIAL** | 02 | 03 | 03 | 04 | 06 | 03 | 21 |
| **DEPRESSION** | 02 | 00 | 00 | 05 | 07 | 02 | 16 |
| **DOMESTIC** | 04 | 00 | 00 | 00 | 06 | 04 | 14 |
| **STRESS** | 00 | 02 | 00 | 01 | 05 | 00 | 08 |
| **ADS** | 00 | 00 | 00 | 00 | 04 | 00 | 04 |
| **LOVE FAILURE** | 00 | 01 | 01 | 01 | 00 | 00 | 03 |
| **ILLICIT AFFAIRS** | 01 | 01 | 00 | 01 | 00 | 00 | 03 |
| **HOME SICKNESS** | 00 | 00 | 00 | 01 | 00 | 00 | 01 |
| **UNKNOWN** | 11 | 09 | 12 | 10 | 00 | 03 | 45 |
| **TOTAL** | **21** | **18** | **24** | **33** | **35** | **19** | **150** |

The above data is provided by the Directorate of Provost of Air HQ. These reasons were also voiced during focus group discussions. When analysis of the data is done it to find the reasons and age or seniority a high percentage was seen in young air warriors who committed suicide due to various domestic affairs. It has been noticed that among the suicide in IAF, 10% cases are found to be committed by Corporal and below. 75% suicide cases are found to be related to Technical tradesmen. For the purpose of this research, domestic issues are merged with marital discords and home sickness and other property/land related issues, while medical issues covers cases of depression, stress, alcohol dependent syndrome and other psychiatric issues. Similarly, extra marital affairs, and illicit affairs are grouped in Love affair/breakup. The inference of the study indicates three main reasons people committed suicide, these are domestic, Psychiatric and financial. IAF data was also compared with the suicide provided by BPRD of probable reasons of suicide in India. Major reasons identified are as given below.

(a) **Probable Reason (in IAF).**

| | | | |
|---|---|---|---|
| (i) | Domestic issues | - | 33% |
| (ii) | Medical issues | - | 16% |
| (iii) | Financial issues | - | 16% |
| (iv) | Love affair/breakup | - | 11% |
| (v) | Not established | - | 11% |

(b) **Probable reasons to commit suicide in our country is:**

| | | | |
|---|---|---|---|
| (i) | Family problems | - | 32% |
| (ii) | Illness | - | 17% |
| (iii) | Alcohol/durg addiction | - | 6% |
| (iv) | Marriage/Love affairs | - | 10% |
| (v) | Financial reasons | - | 5% |
| (vi) | Unemployment/exam failure/Professional | - | 5% |
| (vii) | Misc reasons | - | 15% |
| (viii) | Not established | - | 10% |

### 4.4 Major Factors Responsible for Suicide

Having studied the various Court of Inquiry reports and Psychological Evaluation and Remedial Actions Committe (PERAC) report of IAF , major factors responsible for suicide cases in IAF may be summarized under three major heads i.e., working conditions, service conditions and personal issues. These can be explained as -

**(a) Working Conditions**

(i) Prolonged separation from family / forced bachelorhood.

(ii) Long shifts / tough duty hours frequently result to fatigue, depression and incurable / permanent problems.

(iii) A sense of imposed limitation

(iv) Poor / inadequate infrastructure at work place.

(v) Not being able to cope with the demanding nature of duty.

**(b) Service Conditions**

(i) Leave related problems.

(ii) Extended Working Hours, even beyond 12 hours in a day.

(iii) Lack of time for rest, recuperation and recreation.

(iv) Lack of job satisfaction / comparison with counterparts & others / promotional avenues.

(v) A feeling of loneliness and a lack of support from friends and family.

(vi) Because coworkers change frequently, unit staff do not feel a strong enough emotional bond to openly discuss personal issues.

(vii) Frequent movements (Permanent/ Temporary)

(viii) Less open transfer policy.

**(c) Personal /Individual Issues**

(i) Stigma of diseases which cannot be told to others.

(ii) Mental / psychiatric disorder.

(iii) Drug / alcohol abuse.

(iv) Extra marital relationship of self or spouse / love failure.

(v) Slow decline of social relations like joint family and other close relations.

(vi) Domestic issues / land related issues at home.

(vii) Financial Loss / debts.

(viii) Poor education of children due to frequent movements and transfers and non-availability of standard schools.

(ix) Easy access to weapons.

(x) Motional / behavioral/ mental/ physical problems.

(xi) Not able to cope up with minor humiliations / derogatory / abusive remarks.

(xii) Victim of groupism / casteism / instigation by others on petty issues.

(xiii) Frequent movements.(Permanent/ Temporarily)

(xiv) Previous suicidal attempts.

(xv) Hopelessness / Depression.

(xvi) Non acceptance of inter caste marriage in the family.

(xvii) Over indulgence on social media leading to aloofness and cut off from peers.

**4.4.1** The three major factors given above can be summarised towards venerable targets which are to be identified and kept under observations are:-

(i) Most personnel committing suicide were introvert in nature and had minimal interaction with colleague.

(ii) Majority of personnel were under financial crisis due to mismanagement of funds.

(iii) Certain cases had revealed that early signs were ignored.

(iv) Excessive drinking was a major contributing factors.

(v) Trained mentors/counselors were rarely utilized by the environment.

(vi) Marital discord, domestic problem or illicit relationship is the major reasons behind suicide in majority of cases.

The above mentioned factors were also compared with the factors responsible in CAPFs identified in BPRD report. Relevant portion of the BPRD report is attached with this study as **Annexure A.**

**4.5 Analysis of Signs indicating high risk of Suicide:** To catch the high risk personnel early, each supervisor must look for early signs in individuals so that corrective measures can be initiated. Some important indicators signs are as follows:-

i. Any one talking about suicide or making statements as “I am going to kill myself” or “I wish I can end my life”.

ii. Talking about means or instruments to access weapons to kill life.

iii. Keeping away from crowd or want to be left alone.

iv. Showing mood swings like depressed one day and high another day.

v. Hopeless talks or showing signs of pains.

vi. Increase use of alcohol or drugs.

vii. Drastic change in normal routine, eating, talking and sleeping patterns.

viii. Taking unnecessary or high risk, dangerous driving or actions.

ix. Throwing or donating costly belongings or indulge in ill-logical actions.

x. Meeting people in a way as it is the last chance, saying such things, bidding goodbye farewells.

xi. Remaining in excited or hipper/ agitated state, which is abnormal.

xii. Withdrawing socially, remain isolated, sleeping less or excessive.

**4.5.1 Actions on observing Signs of High risk**. Such warning signs are not always noticeable, and they may differ from person to person. Some may make their intentions known to all while others can keep such suicidal feelings hidden. The more of these signs are noticed, the greater are chances of such person attempting suicide. While these warning signs are related with suicide, but these may not be the reason that may lead to suicide. Suicidal thinking doesn't get better on its own. It requires urgent and timely intervention of specialist or psychologist to get some help. If

anyone is observed or reported to have shown such or any of these warning signs of suicide, following five steps are to be initiated immediately:-

i. Never leave the person alone.
ii. Ensure no firearms, alcohol, dangerous weapon or sharp instrument is in the custody of the individual or in near vicinity.
iii. Call the National Suicide Prevention Lifeline at iCALL (9152987821) which is an Initiating Concern for All, is a psychosocial helpline, which offers counseling services by telephone, email and chat to individuals in emotional or psychological distress.
iv. Call All India Mental Health Rehabilitation Helpline 'KIRAN' 24×7 Toll-Free (1800-599-0019) for providing psychological support to people.
v. Try to take the person to an emergency room, or seek help from a medical or mental health professional

### 4.6 Analysis of Risk Factors

The early observations of signs given above may be very useful to prevent suicide. However, it is necessary to find out the causes of these suicidal thoughts. These may be result of failure in some difficult situations or not been able to achieve the desired result even after putting extra effort or hard work. Also when one feels that he cannot cope up with tough life situation or with what seems to be a devastating life situation. If you are left with no hope situation for the future, you may erroneously feel that now only solution left is of suicide. One may experience a sort of no alternative solution of the problem, or of a crisis in hand and end of road where he believes that suicide is the only way out. To study the likely risk factors, it is observed that national ratio of attempted suicide is more common for women than men, however, total suicides are

more among men as they use more-lethal methods, such as a firearm etc. The common risk factors are:-

### 4.6.1 Traumatic Stress

Any person, who has had a traumatic experience**,** including childhood sexual abuse, rape, physical abuse, or war trauma, is at a greater risk for suicide, even many years after the trauma. Being diagnosed with post-traumatic stress disorder (PTSD) or multiple incidents of trauma raises the risk even further. This is partly because depression is common after trauma and among those with PTSD, causing feelings of helplessness and hopelessness that can lead to suicide.

### 4.6.2 Impact and Influence of Substance Use

Drugs and alcohol can also influence a person who is feeling suicidal, making them more impulsive and likely to act upon their urges. Substance and alcohol use can contribute to other reasons people commit suicide, such as the loss of jobs and relationships. The cases of substance use and alcohol use disorder are also higher among people with depression and other psychological disorders. If we combined these two, clearly the risks increase.

### 4.6.3 Hopelessness

Hopelessness, either in the short-term or as a longer-lasting trait, has been found in many studies to contribute to the decision to commit suicide. The person may be facing a social or physical challenge and may see no way the situation can improve. Research indicates that hope can help us manage stress and anxiety and cope with adversity. It contributes to our well-being and happiness and motivates positive action.

Hopeful people believe they can influence their goals, that their efforts can have a positive impact. Any time degree of hope decreases, the quantum of depression will increase. In other words hope and depression is vice versa. Therefore every effort in organization is towards keeping the hope alive. This is a big task but attainable.

### 4.6.4 Chronic Illness and Pain

If a person has chronic illness or pain with no hope of a cure from suffering, suicide may seem like a way to regain self-respect and control of their life. According to a study in the *American Journal of Preventative Medicine,* the following health conditions were associated with a higher risk of suicide:-

- Asthma
- Back pain
- Brain injury
- Cancer
- Congestive heart failure
- Diabetes
- Epilepsy
- HIV/AIDS
- Heart disease
- High blood pressure
- Migraine
- Parkinson's disease

Chronic pain can also bring in anxiety and depression, which can also increase your risk of suicide. According to research, people with chronic pain are four times more likely to have depression or anxiety than those who are pain-free. A person with

chronic pain or a terminal illness can also feel like a burden to others, as it becomes harder and harder to ask for yet another ride to the doctor's office or more help with household duties or assistance paying for hospital bills. In fact, many people who decide to commit suicide often state that their loved ones or the world, in general, would be better off without them.

### 4.6.5 Social Isolation

A person can become socially isolated for many reasons, including losing friends or a spouse, undergoing a separation or divorce, physical or mental illness, social anxiety, retirement, or due to a move to a new location. Social isolation can also be caused by internal factors such as low self-esteem. This can lead to loneliness and other risk factors of suicide such as depression and alcohol or drug misuse.

### 4.6.6 Use of Antidepressants

Most antidepressants are generally safe, but the Food and Drug Administration requires that all antidepressants carry black box warnings, the strictest warnings for prescriptions. In some cases, children, teenagers and young adults under 25 may have an increase in suicidal thoughts or behavior when taking antidepressants, especially in the first few weeks after starting or when the dose is changed. However, keep in mind that antidepressants are more likely to reduce suicide risk in the long run by improving mood.

### 4.6.7 Other Common Risk Factors

Apart from the risk factors given above, common risk factors increases if he/she :-

i. Has history of attempted suicide earlier.

ii. Feel hopeless, worthless, agitated, socially isolated or lonely.

iii. Experience a stressful life event, such as the loss of a loved one, military service, a breakup, or financial or legal problems.

iv. Has a substance abuse problem like alcohol and drug abuse.

v. Has suicidal thoughts and have access to firearms at workplace or at home.

vi. Has any psychiatrist problem like major depression, post-traumatic stress disorder etc.

vii. Has a family history of mental disorders, violence, including physical or sexual abuse

viii. Has a medical condition that can be linked to depression and suicidal thinking, such as chronic disease, chronic pain or terminal illness

### 4.6.8 Risk factors among Young Air warriors

For the purpose of this study Air warrior below 30 years of age are kept as young Air warriors. Suicide in youngsters can be because of stressful life events. What a young person sees as serious and insurmountable problem, may seem minor to an adult, such as problems at work place or the loss of a friendship etc. In some cases, youngsters may feel suicidal due to certain life circumstances that he or she may not want to talk about, such as:-

i. Having a psychiatric disorder, including depression

ii. Excessive loan, financial burden or debt of self or family.

iii. Pressures of unmarried sisters or brothers.

iv. Fight or quarrel with close friends, relatives or family members.

v. History of physical or sexual abuse in young age or in service.

vi. Problems with alcohol or drugs

vii. Physical or medical issues, for example, becoming pregnant or having a sexually transmitted infection, impotency or any other disease which individual is not ready to share with others even with doctors.

viii. Being the victim of bullying

ix. Being uncertain of sexual orientation or Loss of friends or family acceptance due to revealing sexual orientation

x. Any failure in life including academic or failure in love / one sided love.

xi. End of a close friendship or romantic relationship

xii. Loss of social status

It is very important that young air warriors are made comfortable in various counseling/briefing sessions and encourage discussing such problems. When during mass conferences/ welfare meetings and other common gatherings the aspect of such problems are projected as routine and minor issues will encourage and motivate youngsters not to hide and come out to speak. Anyone having concerns about a friend or family member, asking about suicidal thoughts and intentions is the best way to identify risk and talk. Basic requirement is to increase the faith in the system.

### 4.7 Initiative by Armed Forces Services to improve Mental Health

Minister of State for Defence Ajay Bhatt replied to a question raised by Shri A. A. Rahim MP of CPI(M) in Rajya Sabha on 18th July, 2022 on issue of suicides by servicemen and Ex-Servicemen. Minister provided following information:-

(a) Government doesn't centrally maintain the data on suicides committed by the Ex-Servicemen.

(b) For management of Stress and Suicides in services, the Armed Forces are continuously evolving measures to improve the stress mitigating mechanisms. An elaborate Mental Health programme has been formulated and is in vogue since 2009.

Minister also provided the information to the house that various mechanisms to observe and identify Armed Forces personnel with psychiatry problems including depression and suicidal tendencies are in place. Detailed guidelines for psychiatric examination, diagnosis, treatment and disposal of service personnel and their families suffering from psychiatric disorders have been promulgated by Director General Armed Forces Medical Services (DGAFMS). Personnel at high risk of stress are identified and counseled by unit Commanding Officers, Regimental Medical Officers and Junior Leaders as per laid down procedures. All personnel returning to unit after leave are interviewed, counseled and medically examined by the Regimental Medical Officers. Stress markers/warning signs of stress are looked for and motivational talks rendered to all. Following proactive steps have been taken by Armed Forces Medical Services (AFMS) for providing quality care and support for psychological conditions and disorders in Armed Forces:-

### 4.7.1 Organisational actions

i. Mental health issues including basic counseling skills and combat stress management are a part of military training curriculum for all ranks (officers and other ranks).

ii. Major Armed Forces hospitals have well equipped Psychiatry departments that function as therapeutic, training and teaching centres.

iii. Psychological counselors are trained at earmarked AFMS hospitals and this training helps the medical professionals to identify high risk cases and their further psychological management.

iv. Non-Medical personnel are also trained in basic counseling/mentoring skills. They act as a link between soldiers and well-trained Army Medical Corps (AMC) professional personnel.

v. Studies on causes/issues related to suicide/fratricides are carried out from time to time and suitable educational material is disseminated for education of troops.

### 4.7.2 Administrative actions

i. Addressing grievances through interactions at all levels.

ii. Ensuring Buddy system in units.

iii. Regular and frequent spells of leave is ensured for troops, especially in field areas.

iv. Both Medical and Non-medical personnel are being trained in counseling to offer their services both in peace and in combat zones.

v. Training of doctors and junior leaders to identify and handle high risk individuals.

vi. Providing holistic preventive, promotive, curative and rehabilitative health care.

### 4.7.3 Welfare of troops and families

i. Welfare activities like provision of married accommodation, schooling and recreational facilities are given a thrust.

ii. Armed Forces Wives Welfare Association members (ladies) too are involved in fruitful de-stressing interactions with the wives of soldiers.

### 4.7.4 Yoga and meditation

i. Introduction of Yoga : Yoga as a stress buster has been introduced in the Armed Forces.

ii. Besides these, non-medical counselors like the religious teachers (Pandit/ Granthis/ Maulvis) from each unit are also trained in counselling as the soldiers repose faith in them.

### 4.7.5 Initiative by India Army and Indian Navy to improve Mental Health

(a) **Indian Army**

The issue of stress is being addressed by the Commanders in a comprehensive manner at various levels. Sessions for stress management are organized by Commanders and Psychiatrists at all major stations. Counseling is an intrinsic component of 23 Psychiatric Centres in the Army manned by well trained and qualified Psychiatrists and Psychiatric Nursing Assistants. Specific measures are put in place as part of the multi-pronged strategy to address stress in Army, these include sensitization of Commanders on the subject, addressing grievances through interactions, implementation of 'buddy' system, welfare measures like provision of adequate married accommodation, good schooling, recreation facilities etc.

(b) **Indian Navy**

In order to augment mental Health Care and reduce mental stress among Naval Personnel, the following initiatives been implemented in the Indian Navy:

i. Station Mental Health Centres have been established in Mumbai, Vishakhapatnam, Kochi, Port Blair, Goa and Karwar. Family counselors at Family Welfare centres provide Psychological Counselling.

ii. Psychological Counselling is also provided at full fledged Department of Psychiatry at large Naval stations. Apart from posted psychiatrist, services of clinical psychologists and counselors are hired.

iii. Training of Medical Officer and Paramedical personnel in 'Mental Health First Aid'.

iv. Training of non medical personnel in Mental Health – keep your Buddy safe.

v. Increase in strength of trained Human resources in terms of increased seats for MD (Psychiatry) and starting of new training courses such as M. Phil in Clinical Psychiatry, M. Phil in Psycho Social work and Diploma in Psychiatric Nursing in Department of Psychiatry at INHS Asvini under Scheme B of National Mental Health Programme, Ministry of Health and Family Welfare.

vi. A toll-free Suicide Helpline is available exclusively for Indian Navy personnel at INHS Asvini.

vii. A comprehensive policy to prevent suicide among serving Naval personnel bring out strategy IN-SMART (Indian Navy Strategy for Mental Health Assistance Resilience and Training) was promulgated on 12.04.2022.

### 4.7 Existing Suicide Prevention Measures in IAF

The following suicide prevention measures have been taken by IAF to ensure sound mental health amongst the Air Warriors so as to curb the suicide rate :-

(a) A "Psychological Evaluation and Remedial Actions Committee" (PERAC) under the Chairmanship of Air Officer-in-Charge Administration (AOA) with Air Officer-in-Charge Personnel (AOP) and DGMS(Air) as main members meet twice in a year. The committee has been set up for better understanding of the suicides in the IAF and reviews all measures in IAF for creating a stress free environment and prevention of suicides.

(b) 114 Civilian Psychological Counselors trained in Clinical Psychology and Stress Management has been employed at various stations in IAF for counseling of service personnel and their dependents.

(c) **Service Counselors:** Training of service personnel in psychological counseling and stress management is being conducted at CHAF, Bangalore for a duration of 08 weeks. 149 Air Warriors have been trained till date and are functioning as Service Counselors at various stations in IAF.

(d) **Service Mentors:** A five day Mentor course for training of officers and airmen to facilitate early recognition of psychological symptoms is being conducted at IAM (Institute of Aerospace Medicine). 742 Mentors have been trained till date. These trained Mentors are posted in training establishments and various other stations of IAF for counseling and early recognition of mental illness amongst the trainees, service personnel and their dependents.

(e) All personnel with psychological issues are referred by service mentors and service counselors for further evaluation of SMC (Station Medical Centre) by a trained psychological counselor. If required, they are further referred to a Psychiatrist at the nearest service hospital for follow up.

(f) **Mansik Sahayta Helpline:** All India toll free helpline 1800-110-080 is functional at Air Force Central Medical Establishment, Delhi and caters for any assistance required round the clock.

(g) **Psychological First Aid (PFA)** training has been introduced in all units of IAF with effect from 26 Feb 2020 to recognize early mental health symptoms and provide psychological first aid on the spot. The trained Air Warriors act as first responders and help in developing adaptive coping mechanisms in Air Warriors and families. A total of 4075 Air Warriors have been trained in PFA till date.

(h) **Online Counseling Capsule** for all civilian Psychological Counselors is being conducted by IAM on half yearly basis for their familiarization with IAF working

environment and issues pertaining to the service. Three such courses have been conducted till date last being on 20 Apr 2022.

(i) Educational material in the form of advisory and power point presentations/ movies and suicide prevention have been uploaded on DGMS (Air) website for creating awareness amongst the service personnel and their dependents.

(j) Various workshops and lectures on Mental Health and Stress Management are being conducted quarterly in all IAF stations as part of Mission Zindagi Campaign.

(k) All types of medical treatment including mental health are available to the ECHS beneficiaries through a vast network of Polyclinics, Empanelled Health Care Organisations and Service Hospitals spread across the country.

(l) Adequate funds are always allocated for provision of comprehensive healthcare for armed forces personnel and ex-servicemen which comprises preventive, promotive and curative components. No dedicated fund allocation is made for mental health care, however, the same is ensured within the framework of comprehensive healthcare.

(m) **Programme by Institute of Aerospace Medicine of IAF.** Mental health promotion and suicide prevention are important initiatives of Indian Air Force for its personnel. Institute of Aerospace Medicine (IAM), Bengaluru, has been conducting suicide prevention training programs for the IAF personnel since 1997. More than a 100 programs have been completed. In-time identification of the vulnerable, empowerment of instructors, provision of information about suicide

prevention and improvement of approach toward the *ab initio* who are at risk are the focus of the suicide prevention program (SPP). The efficacy of the mentoring skills imparted during the suicide prevention training in successfully identifying and providing support to the vulnerable *ab initio* cadets in the training establishments of IAF has been reviewed over a period of time. Suicide prevention program being conducted at IAM (IAF) was found to be beneficial to the mentors. It also addressed some of the professional and personal challenges faced by the mentors. Mentors are doing their job but lot more need to be done. Following steps in addition to many others are being taken to minimize / prevent suicides in IAF: -

i. Regular physical activities, Team Games, Yoga, Cultural Program, Celebration of various festivals, etc.

ii. Mentor - mentee system – Section commanders are being trained to be a mentor for their own section.

iii. Strict implementation of Buddy System.

iv. Implementation of effective Grievance Redressal System.

v. Availability of information about service matters, pay, news articles, and important updates of organization activities on Air Force intranet.

vi. Chain of command is being made more responsive, sensitive, effective and responsible.

vii. A culture of no use of slangs, abusive language, etc.

viii. Regular counseling, formal / informal Interview of all Air warriors.

ix. Annual medical checkup and medical support to all personnel. Psychiatrist doctors are available in Military Hospitals 24 hours counseling.

x. A Sadhbhavna Cell in each Station to monitor the progress of overall wellness and resolution of any administrative problem of the personnel.

xi. Five short movies on Suicide Prevention have been uploaded on Air Officer-in-Charge Administration site. These movies are screened regularly during monthly welfare meetings, Flight Safety Conferences, during interval of movies in Air Force cinemas and other quarterly/ monthly meetings with Air warriors. Some reductions in symptoms of Anxiety, Depression, and Posttraumatic Stress have been observed among participants during discussions and feedback after viewing such screenings.

## 4.8 Review and Analysis of Existing Suicide Prevention Measures in IAF

(a) The meetings of Psychological Evaluation and Remedial Actions Committee (PERAC) should not be of routine nature for completing the formalities of paper action. This committee must review the suicide cases, its reasons and what action needs to be initiated. The review on existing Anti Suicide Measures (ASM) should be done. This should include the effect, impact and lacunas in ASM.

(b) Trained Civilian Psychological Counselors must submit their report monthly with a special mention of any changes required in service conditions or special attention needed for identified high risk individuals.

(c) Section Commanders should necessarily be detailed for undergoing Service Mentors course for having clear ideas of dealing with personnel under the.

(d) Mansik Sahayta Helpline which presently is functioning as All India toll free helpline 1800-110-080 at Air Force Central Medical Establishment, Delhi for providing any assistance required should be replicated at each station for easy accessibility and approach. This should be at places which are manned 24 hours, like Station Medicare Centre, Duty or Orderly Officer or Duty Security Desk. These personnel may not be trained counselor but a written checklist is to be provided to initiate talk with individual who needs assistance .A sample of checklist for to Dos and Don'ts is placed at **Annexure 'D'.**

(e) Though Regular physical activities like PT, games and Yoga are conducted in almost all the Air Force Stations but any individual skipping such events regularly need to be tracked. Also Team Games, community Cultural Program, and Celebration of various festivals etc are to be done as part of organized activities. Timings of PT, games and Yoga activity is to be kept as per weather and temperature conditions so majority of personnel attends it. Games periods in training institution to be increased and made more intresting rather than routine or forced leading to

(f) **Existing Buddy System.** The Buddy system in all the arms of Armed Forces was implemented, however, the effectiveness of this system has not been observed in recent past. The buddy system means each person staying in the billet or barrack has a buddy who stays in close vicinity of the person. Any time buddy feels that his buddy needs special attention/ help him by contacting seniors in the section to initiate the remedial measures. The present buddy is not very effective

as it appears more of paper exercise and effectiveness is left to the individual interest and involvement.

(g) **Mentor - mentee system** is specifically needed for youngsters and new recruit. This not only helps in building the team but also resolve the initial hurdles of settling down, completing administrative formalities and understanding the role and task in the organistion. This help in reducing the stress at workplace and also perform better. This also provides an opportunity to the mentor, who is a senior supervisor to know about his mentee and his official and personal issues.

(h) **Welfare meetings.** These meetings are conducted regularly and a record of such meetings is kept, with minutes of meetings circulated for further necessary actions. It is observed such meetings are clubbed with Aerospace Safety Meetings to avoid calling of large number of personnel again and save time. This at time looses the focus and concentration of people. Also many times welfare meetings becomes MES complaints cell and administration remains busy in giving clarification. Any points which may give clue towards stress of individual persons are either not discussed or loses the focus. It is recommended that a senior person to be detailed to observe any points linked or giving cue for condition or situation leading towards stress or hardship is faced by personnel. Welfare meetings to provide a platform to improve bandings and encourage interaction. It can be clubbed with cohesion day activity and may have more interactive sessions over a cup of Tea so that people are free to share their thoughts and feelings with each other. Senior supervisor to keep an informal track of such talks so that any high risk person can be identified.

(i) Sadhbhavna **Cell.** These cells do exist in majority of Air Force Stations. This cell is responsible for easy moments and centrally receiving the required forms and documents. This cell may also be used to receive any complaint or grievances of personnel. Station Master Warrant Officer to visit this cell more often and co-ordinate/ supervise welfare activities from this cell.

## 4.9 Analysis and Findings of Case Studies

As part of the research total five case studies have been taken without disclosing the details of the individuals or locations. The findings have been analysed to make recommendations to curb such incidents in future. This study is done based on the reports of Court of Inquires and official data shared by the IAF and personal interaction with few left behind. To ensure the confidentiality due to sensitive nature, only that information is revealed here which is available in open domain.

**Case Study I**

**Incident: -** One senior Officer XXX committed suicide by hanging himself with fan a few days back. The news evoked a very strong reaction from veterans and others about the puritanical culture in the armed forces. According to the information available in the public domain, the 43-year-old officer was pushed to the wall. His wife made an application to the authority concerned, alleging an extra-marital affair. She also refuses to give divorce. Officer's version was not taken seriously and lady's complaint was processed. It is learnt that first, he was referred to psychiatric treatment by the Defence authorities and then a Court of Inquiry (CoI) was held in which he was absolved. However, the entire persecution broke him so much that he died by hanging himself.

This officer is learnt to have lived in a room in the Officers' mess, away from his official bungalow. Sad, nobody discovered his aloofness and loneliness. This raises serious questions about the Suicide prevention measures existing and implemented in the organization.

**Impact of Existing Suicide Prevention Measures:-** Counselling of individuals post any departmental inquiry or Disciplinary actions is not in practice in any of the services.

**Findings:-** Post disciplinary inquiry or actions an individual must be counselled by trained and senior person to reduce the stress caused by the final result of the inquiry or even by the process of the inquiry. Instead of pushing back officer into unhappy marriages, the law must facilitate a dignified and speedy exit at the instance of the aggrieved spouse, but the current practice is to persecute the aggrieved more by discouraging, delaying and denying divorce.

**Case Study II**

**Incident:-** One Officer XYZ during a training activity could not perform as per the required expected standard. He was reprimanded by a senior officer in front of all present including juniors. The Officer was performing well till then and was due for promotion shortly. He was always a very hard working and ambitious officer. The officer felt very humiliated and was very depressed as he thought his carrier is over. His family was not staying with him. As he was dejected and depressed, to reduce the stress he went to Bar and had few drinks. He spoke to his wife in the evening and told her to be brave and take care of their kids. As security officer of base he went for security round with service weapon in his official vehicle. Very next early morning he was found dead as he shot himself with the service revolver.

**Impact of Existing Suicide Prevention Measures:-** The incident took place in front of other Station Officers when he was humiliated. Since defence is very close-knit organization, seniors should have spoken to the officer and ccounselled him. His mental condition did not permit him to do duty with weapon.

**Findings:-** Post such incidents, section commander who knows the officers attitude and sensitive nature should have spent some time with the officer. In this case individual should have been counselled by trained and senior person to reduce the stress caused by the incident. In any case, warning signs of depression and stress were not noticed. Knowing the sensitive nature of the officer he should not have been permitted to do duty and should have been kept away from weapons. In fact one of the single officers could have been told to be with the officer that day. Senior officer or senior lady of the Station or should have called the officers wife and checked if they had any conversation that evening. A known of public humiliation of the officer needed some extra efforts to keep an eye on the officer and a case where life could have probably been saved.

**Case Study III**

**Incident:-** One Officer XYZ was detailed for a professional course which is considered as high pressure tough course requiring high professional skills and mental strength. He had applied for withdrawing his name from the course on medical ground. Actually officer was having some medical issues and was out of his primary duties temporarily in recent past. Officer was counseled by his CO to go for the service course as it was a carrier course. Officer's family also accompanied him for the course and were staying in the mess. Officer war reported to have developed some

problem and was not able to cope up with the pressure. Finally he died by hanging himself in officers' mess room when his wife and daughter was away for shopping..

**Impact of Existing Suicide Prevention Measures:-** The known case of medical problem in recent pass should not have been detailed for the high pressure professional course. The senior supervisors should have taken up the case with higher ups for cancellation of the course. Even the Instructors of the course should have noticed the warning signs and taken the corrective actions.

**Findings:-** A lesson learnt for the future for knowing how to handled such cases. A two way counselling could have revealed the mental and physical health of the officer. Very critical, medical officer's recommendations in such cases is to be taken when officer was temporarily down due to some reason. Knowing each other is the best way out to flag the issue to higher authorities in time.

**Case Study IV**

**Incident:-** One Warrant Officer XYZ was posted on deputation to some unit which majorly civilian organization. He was staying in the IAF mess but most of other personnel staying that mess were from different units so not much social interactions was there with other persons staying in the same mess. His family was staying away and he was in his early fifties. He became emotionally attached to one lady co-worker at his place of work. After staying about three years together, he came to know that she is retiring and leaving to stay with her family in other city. He came under depression and started to live aloof and sad. Finally he could not live with the thought of losing her he committed suicide by hanging himself and left a note behind giving details of his action.

**Impact of Existing Suicide Prevention Measures:-** The Warrant Officer was on deputation outside IAF. Due to this reason his routine counselling was not taking place. As of now there is no provision of asking feedback of counselling from other organization where any person gas gone on deputation. The in-charge of the mess has not taken interest of knowing the well being of the individual as he was from different unit. The Area Warden has not kept this aspect in his mind and any warning signs have gone unnoticed.

**Findings:-** Apart from asking a yearly feedback to parent organisation form the office where individual is on deputation, the in-charge of the mess and area warden of that unit may be made responsible for keeping a check on the personnel staying in their mess and area of responsibilities.

**Case Study V**

**Incident:** A young unmarried air warrior posted to a big Station was staying in living-ins billet (Barrack). He has taken loan from two three banks and private people to construct house for his parents in the native village and also to repay the debt of his father. He developed friendship with a lady who was elder to him. After some time he started staying in a rented house in a small town close to his Station. This lady also started fetching money from him. The air warrior came under financial burden and stated staying quite and depressed. No one in his section, Unit or Billet knew that he is not staying in campus. He took leave to visit his parents and after staying few days with the lady went to his village. On the day his leave was getting his body was found on railway track close to the city Railway station where his Unit was located. Later during inquiry it was established that he could not cope up with financial burden and

committed suicide to repay the loan through his insurance money. He kept the secret of his girlfriend from his parents and friends.

**Impact of Existing Suicide Prevention Measures-** The existing suicide prevention measures failed to identify the mood swings, depression and any other warning signs. Area warden, section commander, Billet in-charge and friends failed in their duty to track that he is not staying inside billets and used to be away to stay with the lady. No information of his financial burden was available with the Unit.

**Findings:-** All the recommendations made in the study like awareness, identifying warning signs, strengthening buddy system, area warden's responsibilities and serious counselling before and after leave may have alert the system, and probably this was a case where a life could have been saved.

# CHAPTER 5

## CONCLUSION & RECOMMENDATIONS

***'Take any suicidal talk or behavior seriously. It's not just a warning sign that the person is thinking about suicide—it's a cry for help.'***

### 5.1 Conclusion

Sometimes people attempt suicide not so much because they really want to die, but because they simply don't know how to get help. Suicide attempts are not a cry for attention but a cry for help. It becomes a way to demonstrate to the world just how much they are hurt. Unfortunately, these cries for help may sometimes prove to be fatal if the person misjudges the lethality of their chosen method. People who make a failed attempt are also at a much higher risk of trying again, and their second attempts are much more likely to be lethal. Suicide, taking own life, is a tragic reaction to stressful life situations and all the more tragic because suicide can be prevented. It may seem like to a high risk person that there's no way to solve problems and that suicide is the only way to end the pain. But one can take steps to stay safe and start enjoying life again. For this first step is to identify the signs which a person who is high on risk to commit or try suicide is likely to show. These may be early indicators which if notices on time and action initiated may save one life. We have analysed various indicators and high risk factors in previous chapter. Suicide is preventable if warning signs are identified in time and suitable measures initiated to reduce and remove these factors. Like the Flight safety and Security it is every one responsibility. All efforts to be made to ensure each air-warrior remains fighting fit to serve the Nation.

## 5.2 Recommendations

Suicide is a serious public health issue that can have lasting consequences for individuals, families, and communities. The positive side of this aspect is that it is possible to prevent suicide. Suicide prevention requires strategies at every level of society. This includes individual, family, friends and community strategies for prevention and protection. By learning the warning signs, promoting prevention and resilience, and committing to social change, everyone can help prevent suicide. Suicide is a complex human behaviour influenced by multiple interdependent factors. To combat the rapidly growing and multifaceted problem of suicide, no single strategy is likely to be the most effective. Instead, it is preferable to take an organised, multifaceted, mutual prevention approach that addresses both mass level and individual level factors, and to workout best practise from each approach in order to create policies, SOPs, and action plans. An effort is made to examine the best practises and determine what works best. ***To touch the Sky with Glory and follow the mission statement of IAF i.e., People First-Mission Always***, following 12 pronged suicide prevention strategies may be recommended to curb the suicide in IAF.

(i) Education / Awareness Programmes

(ii) From Mental Illness to mental –wellness

(iii) Area Warden / Gatekeeper Training

(iv) Restriction of access to means

(v) Improving and Strengthening the Buddy System

(vi) Opening a dedicated Toll Free 24-hour hotline (**Aaiye- Bataiy)**

(vii) Left Behind teaching

(viii) Coach or Mentorship Scheme

(ix) E-learning Forums: ‘Hum Saksham’

(x) Check on Financial Burden

(xi) Series of Spiritual talks and Meditation sessions: ‘Samarpan’

(xii) Records and Documentation of Counselling

### 5.2.1 Education / Awareness programmes

**(i)** Community-based strategies, a unified approach, and the identification of at-risk populations constitute the ideal conditions for an effective awareness programme. Focused suicide awareness programmes, such as screening of small clips/ documentaries in regimental theaters or movie halls during breaks, coverage of brief talks during various briefings / conferences, informal group discussions, and Nuker-Nattaks /dramas, pop up messages on computers on intranet etc; have shown to improve the recognition of suicide warning signs. Distribution of educational materials in conjunction with media outreach and training of identified personnel appears to be more effective than distribution of educational materials alone. Sharing the experiences of victims and survivors of suicide is beneficial for increasing awareness. Not only the experience of a suicide survivor, but also the experience of the family members of a person who committed suicide, the types of stigma they faced, shame, fear, isolation, and rejection by society, family, and friends, will open the eyes of individuals at risk. Awareness programmes for air warriors specially senior supervisors should include risk factor education, information on suicide support initiatives, and stigma-reduction initiatives.

**(ii)** All the personnel need to be apprised during welfare meeting, Aerospace safety meetings, on cohesion day and monthly DSC darbars about social advancements in modern times. Everyone needs to be aware of how quickly society is changing and how it affects people's lives and relationships,

leading to significant changes in emotional relationships and values. Mobile Phone Close supervision and surveillance is to be kept on the behavior of personnel who are making large number of mobile calls during off duty hours. He may be in stress and steps should be taken to find out the reasons for his stress and steps should be taken to ameliorate this stress.

### 5.2.2 From Mental Illness to mental –wellness

Institutionally we should stop using word mental -illness and must migrate to wellness. Efforts should be made to reduce the stigma attached with mental health and encourage personnel to come out from this stigma or self-limiting belief in order to avail the medical facilities provided by the force administration or services provided by mental health professionals. Provision for regular family counseling should also be there at different locations. There is a urgent need to change the name of proforma from Form -10 to some other name like Mental Wellness or some thing else. Education of primary health care physicians by a trained and experienced counsellor in recognising and responding to emotional and mental agony and suicidal feelings is required to assess depression recognition and management.

### 5.2.3 Area Warden / Gatekeeper Training

Designated Area Wardens or Gatekeepers must frequently visit and interact with all personnel in their Area of Responsibility. During their interaction and visits they must put extra attention to specially identify/recognise high risk individuals who have suicidal thoughts or are at high risk for suicide. Potential gatekeepers include area wardens, senior supervisors, colleagues, coworkers, religious teachers, peers,

family friends, training staff, and counsellors who have been specifically appointed. All of them share the benefit of significant face-to-face contact with a large number of trusted community members. All of the aforementioned individuals must receive training on suicidal behaviour, risk factors, warning signs, available support system, signs of depression, communication, and counselling skills to address the at-risk population.

In order to assess the effectiveness of gatekeeper training, it is necessary to establish the level of organisational support required and determine acquired learning. Additionally, questions remain regarding the long-term durability of skills acquired through refresher programmes. For a better desired result, gatekeeper programmes must include a wide range of individuals, including senior supervisors, religious teachers, Air Focre civilians, legal experts, medical attendant, women officers and Air Force police personnel. Awareness programmes for area wardens (also known as gatekeepers) should include Warning sign identification, risk factor education, enhancing communication skill for 24 x 7 help hotlines, information on suicide support initiatives, community welfare officers charter and stigma-reduction rules and initiatives.

### 5.2.4 Reducing / restricting access to resources

As it targets the entire population, including those whose suicidal risk remains undetected, ensuring the restriction/curtailment of means used for suicide attempts is an effective strategy for the prevention of suicides. There are various ways to restrict access to means of suicide, including elimination of potentially lethal means, put impediments or difficulty to access and buddy mode duties where odd hours/ night guard duties are conducted at isolated places. It has been determined that restricting

access to dangerous pesticides, substituting lethal pesticides with less lethal compounds, double-lock boxes, and the non-pesticide cleaning materials are effective at preventing easy access to dangerous materials. Keeping Phenyl, cleaning materials, disinfectants, and Acids in secure, locked containers will reduce access to these harmful materials.

Identifying high-risk individuals through a variety of techniques and methods, and imposing restrictions on duties involving firearms or in the vicinity of areas where access to firearms is feasible. In addition, such individuals should not be assigned to off-hours or remote locations with firearm responsibilities. Evidence suggests that strict implementation of no individuals permitted to keep firearms at home, avoiding giving them to high-risk individuals, and depositing personal weapons with Station Armory gun to be more effective than implementing punitive laws and stringent actions in reducing the risk of suicide. Other methods include withdrawing analgesics from unlocked emergency rooms, restricting sales of barbiturates and caffeine tablets to reduce overdose suicide attempts, restricting measures on hanging by replacing common fan rods with anti-suicide fan rods, erecting barriers at hotspots for jumping, and limiting access to charcoal. Few failed suicide attempts have demonstrated that anti-suicide rods of ceiling fans have saved lives as it spring actions opens beyond the weight of 25 kg.

### 5.2.5 Improving and Strengthening the Buddy System

The effectiveness of current buddy system needs to be revisited and revised keeping in view the increase in cases of suicides and attrition in the IAF. A strong buddy system needs to be put in place where buddy not only alert the system in case of any abnormal behaviour but also should be so friendly with his buddy that he is aware of his most of the personal and professional problems. As far as possible buddy should

stay in same room/ barrack. Buddy to develop a relationship of trust and mutual acceptance. Buddy is to be aware of all personal issues and problem and one should have trust to tell his personal even secret details to his buddy. It may take time, during which buddies play, eat, walk and even go out to market etc together. As far as possible people working in same section, same shift give single accommodation in same barrack. It means that of trust has to be built between them. For that proper briefing should be carried out of all the identified and designated buddies. The experience and observation made as per appointment held by self that at many places, it has become dysfunctional or more of paper exercise. It can be reintroduced with some new name such as '**Mere Sathi or Apna Dost etc.** These exchanges between the buddies would address air warrior's psycho-social needs by providing an effective peer support. Individuals would feel that someone is caring for them and therefore, would open up for sharing their concerns with their assigned buddies. Trust and belongingness may finally result in sharing of vital feelings and opening up may reduce half of the trauma and depression. Timely information to higher authorities may safe a precious life.

### 5.2.6 Toll-free 24x7 Helpline: 'Aaiye- Bataiye'

A helpline titled like '**Aaiye- Bataiye'** needs to be set up to provide tele-counselling to the personnel. It is a well-known fact that speaking about a problem reduces stress levels significantly. This will provide the personnel an outlet and anonymity to express their problems and voice their grievances freely. Research indicates that many a times suicide happens in a fit of anger. This very moment which transpired in the life of the person can be deferred if he gets a confidante to talk to. Therefore, this situation can be handled adequately. A dedicated hotline staffed by on-

duty medical assistants, on-duty police officers, or on-duty officers will be established. These on-duty personnel should have a check-list of DOs and DONTs to follow while speaking with a person from a high risk group. While a basic suicide prevention checklist is attached as Annexure B to this paper, comprehensive check list of dos and don't while conversing with a vulnerable person is prepared and given below:-

**Suggested "Dos and Don'ts"** for **24 x 7 Helpline/ Hotline**.

**Dos:**

(i) Be authentic. Let the individual know that they are not alone and that you care. Finding the appropriate words is not nearly as important as demonstrating your care.

(ii) Listen. Allow your friend or loved one to release their emotions. Even if the conversation seems negative, the fact that it is occurring is a positive sign.

(iii) Be compassionate and nonjudgmental. The suicidal individual is doing the right thing by discussing their emotions, regardless of how difficult it may be to hear.

(iv) Provide hope. Assure your loved one that assistance is available and the suicidal feelings are temporary. Let the individual know that you value their life.

(v) Take the individual seriously. If a suicidal person says, "I'm so depressed, I can't go on," inquire if they are having suicidal thoughts. You are allowing them to share their suffering with you; you are not imposing your ideas on them.

**Don't:**

(i) Debate with the suicidal individual. Avoid phrases such as "You have so much to live for," "Your suicide will harm your family," and "Just pull yourself together."

(ii) Pretend to be shocked, deliver a lecture on the value of life, or argue that suicide is unacceptable.

(iii) Guarantee confidentiality or be sworn to confidentiality. You may need to speak with a mental health professional in order to keep the suicidal individual safe. If you pledge to keep your conversations confidential, you may be required to break your word.

(iv) Offer solutions to your loved one's problems, give them advice, or make them feel as though they must justify their suicidal thoughts. It does not matter how severe the problem is, but rather how severely it is affecting your friend or loved one.

(v) Accuse yourself. You can't "fix" someone else's depression. The happiness or unhappiness of your friend or loved one is not your responsibility.

(vi) Respond in hurry during a crisis. Be Calm and think before action. Refer checklist.

(vii) If a friend or family member tells you they are contemplating death or suicide, it is important to assess the person's immediate danger. Those at the greatest risk of committing suicide in the near future have a specific

suicide PLAN, the MEANS to carry out the plan, a SET DATE for carrying out the plan, and the INTENT to carry out the plan.

(viii) Do not, under any circumstances, leave a suicidal person alone.

### 5.2.7 Left Behind teaching to Preventing suicide

Any person suffers emotionally after having suicidal ideas or trying to commit suicide. For instance, someone may have so many suicidal thoughts that they are unable to go about their regular lives. And while many suicide attempts are spontaneous acts committed in the heat of the moment, they can result in severe or life-altering injuries including organ failure or brain injury. Grief, rage, despair, and guilt are frequent emotions for individuals left behind following a suicide, sometimes referred to as suicide survivors. Two crucial measures must start in order to prevent suicidal thoughts: -

(a**) Begin the necessary therapy**. Suicidal thoughts are likely to reoccur if the underlying reason is not addressed. A person can be ashamed to ask for help for mental health issues, but receiving the appropriate care for depression, drug abuse, or another underlying issue will improve his outlook on life and help keep him safe.

(b) **Resurrect and build the network of support.** A person may find it difficult to discuss suicidal thoughts, and his or her friends and family may not completely get the experience. In any case, he must establish contact and ensure that those who matter are aware of what is happening and available to help. Another option

is to seek assistance from a place of worship, a support network, or other local services. The risk of suicide can be decreased by feeling connected and supported.

(c) **Suffering of Left Behind Family Members**. It is essential to spread the word in the environment that to ensure the well being of your family, you are required to be there. Short movies, talks and clips can be shown during welfare meetings and during interval of movies in Regimental Theaters depicting hardship, stigma and shame a family faces post suicide of the individuals. Various problems do including that of financial burden does not get resolve for left behind survivals. There are few cases where due to technical reasons, family did not received normal financial help or aid as death was due to suicide, or received very late as inquiry took very long time. On the other hand positive aspect of dealing the problems by sharing with seniors and friends should be highlighted.

### 5.2.8 Coach or Mentorship Scheme

This was started by the organisation but was not sustained or followed up in letter and spirit. It is recommended to restart mentorship scheme in the forces wherein a Mentor i.e., Senior Warrant Officer/ Officer may be assigned to a junior employee i.e., Mentee. Mentor acts as a critical friend, counsellor, career advisor and coach to the mentee. Various benefits of mentoring for personnel are given below:-

(a) Increased self-confidence and self-awareness.

(b) Development of strong communication skills.

(c) Growing a personal network within the forces.

(d) Someone to give guidance and help in reducing stress.

(e) Supporting mental health problems.

(f) Lowering anxiety.

(g) Feel of a support system.

### 5.2.9 E-learning Forums: 'Hum Saksham'

A webpage should be created on the website of each Command of IAF as well as Air Officer-in Charge Administration (AOA) Site. Though quite a few audio-visual material were developed and hosted on AOA site in the form of small clips to give the intended message or to drive home the point of being positive even in the darkest/ hardest of times. More clips and audio-visual songs/ poems may be developed highlighting glimpses of divyangjan who are managing well in the most difficult situations and may encourage people to lead life with conviction. Moreover, a mobile app needs to be developed which can make personnel aware about mental health issues and provide them various tips on managing self. This app would prove to be of immense help for those personnel who are undergoing physical and mental stresses due to various reasons such as family / domestic problems, financial instability, operational difficulties, sleep disorder, anger, drug / alcohol abuse and post-traumatic stress disorder (PTSD). This app can also be made available to the family members of the IAF personnel through Air Force Family Welfare Association (AFFWA).

**5.2.10 Check on Financial Burden.** As of now IAF is keeping a track on the take home salary component of the pay to ensure at least minimum sufficient amount is available for routine family expenses. However, when individual takes loan from outside banks than repaying capacity is known to the organization. Financial hardship is one of the major reasons of suicide cases in IAF. Therefore a strong case needs to be taken up with Finance Ministry through MoD, to direct all the Banks to take

recommendations of the organization on Loan Forms. This will enable the IAF to know and control, how much money is available with the individual for monthly requirement. A proper briefing andn counseling can be planned for such air warriors for financial awareness programs and financial literacy to avoid heavy loan / debts.

### 5.2.11 Series of Spiritual talks and Meditation sessions: 'Samarpan'

A series of Spiritual talks and Meditation sessions can be organised wherein renowned spiritual guru of any faith such as B. K. Shivani or SatguruJaggi Vasudev or any other enlightened person who do not campaign their organization can be called once a month to touch the chord of spirituality. Spirituality is the key to bring personnel out of their depression and frustration. Yoga and Meditation classes can help in stress management in a big way.

**5.2.12 Records and Documentation of Counselling.** Counseling is **part** of the service procedures. Every officer and Airmen is counseled in his service carrier on different ocessions and seniority. The present format of counselling provides a very good mechanism of improving the professional side of air warrior. However, knowing and keeping record of his mental health, personal problem, stress level and support needed during rough phases of life needs special attention. Various reports, incidents and inquiry revealed that most of the suicides were attempted by the personnel after coming back from leave, a new person in the unit when others are not aware of him and his problems and post undergoing any inquiry or investigation. After discussing with many senior officers and with personal experience of dealing such cases as part of HR team of IAF, this study has developed three formats of counselling proformas. These are to be filled post leave, on arrival of posting and post inquiry or disciplinary action.

**(a) Post Leave Counselling Format.** Immediately after reporting back from leave format given below is to be filled by the individual. It should be the responsibility of the section commander to go through all the points and before interviewing the air warrior on his reporting. This can help knowing about some stress and problem individual for further actions. A suggested format is given below:-

**Post leave Questionnaire**

i. How was your leave?

ii. Where and with who did you spent your leave period?

iii. Was it a planned / routine leave or there was some specific requirement?

iv. Did you face any problem in getting leave? Was it approved in time?

v. Did your requirement was fulfilled? Could you complete the task?

vi. Do you have any problems? (if so)

vii. Answer following question if you answer to question 6 is yes.

(a) When did the problem begin?

(b) Are any of your friends / relatives aware of your problem?

(c) Have you discussed your problem with anyone? If yes with whom?

(d) Is your problem resolved or still continuing?

(e) Is the problem is of domestic nature, health, property issue or financial matter?

(f) Are you able to manage your problem or it is causing you stress, anxiety or depression?

(g) Would you like to discuss this problem with any of your senior or colleague? If yes with whom?

viii. Have you suffered from any trauma or abuse (Physical / emotional / sexual)? If yes would you like to share with someone? If yes with who?

ix. Is there any requirement to go on leave again? If yes why, when and for how many days.

x. Anything else you would like to inform?

**(b) Questionnaire Reporting on Posting.** To know about a person when he reports on posting either from training institute or from other unit, a standard format is suggested so that new supervisors and seniors at workplace are familiar with his basic nature and problems. This form is in addition to all other arrival formalities forms which are in existing practice. The format is given below:-

i. How was your previous tenure/ training period?
ii. Do you have any problems? How have you been recently?
iii. Have you ever had problems with your mental health in the past?
iv. Has anyone in the family suffered from any kind of mental health problems?
v. Please specify, if there is anything about your personal or social life, including housing, work and finances etc, which you find distressing?
vi. Have you suffered from any trauma or abuse (Physical / emotional / sexual)?
vii. What about money or family problems, your own health or someone else's health?
viii. Can you concentrate on talking to someone, or listening to Radio, or watching TV or reading news-papers or books?
ix. Have you cried at all or felt like crying?
x. Do you get depression / mood swing any time? Is it there most of the time or just a few hours at a time?
xi. What have you enjoyed doing recently?
xii. Do you get agitated at times? What is your reaction that time?

xiii. Do you feel hopeless? Have you felt that life wasn't worth living?

xiv. Have you thought of ending it all?

xv. Did you actually do anything to harm yourself?

xvi. Have you had trouble sleeping recently? (If yes :-) Do you have difficulties in falling asleep?

xvii. Do you enjoy your food? Have you been eating more or less than usual?

xviii. Loss of appetite Increase in appetite Rate appetite loss/increase Weight Loss/Gain Have you lost (or gained) weight in the past three months?

xix. Phobias – specific phobia or being in a small room, or being frightened by some kinds of animals, heights, dark places, washing hand many times etc(specific phobia).

xx. Phobias – social phobia or being the focus of attention, e.g. eating out, public speaking etc.

xxi. Do you have any other unusual (strange) ideas or beliefs (e.g. people are going to harm you)

xxii. Disorientation - time Some people when they are unwell or upset lost track of time What is the date today?

xxiii. Can you specify what day of the week is it? What month? What year?

xxiv. What is the name of this place? Where is it located?

xxv. Have you tended to forget things recently? (What kind of things?) (Names of your family or close friends?) (Where you have put things?)

xxvi. Alcohol misuse, specify about your drinking habits (alcohol)? How much do you drink? Do you have strong desire to drink alcohol every day?

xxvii. Can you usually stop drinking after one or two drinks? Has the amount you drink increased over a period of time?

xxviii. Have you had psychological/emotional difficulties for a long time? Is it since teenage years?

xxix. Have Personality problems caused problems in relationships or at work? (Are you a quick-tempered person?)

xxx. Anything you would like to mention/express.

**(c) Post CoI or Disciplinary Action Counselling -** Counselling of individuals post any departmental inquiry or Disciplinary actions is not in practice in any of the services. It is recommended that Post disciplinary inquiry or actions, each individual must be counselled by trained and senior person to reduce the stress caused by the final result of the inquiry or even by the process of the inquiry. A suggested post disciplinary action counselling proforma is as given below:-.

**Post Court of Inquiry or Disciplinary Action Counseling**

i. Were you aware of reasons the CoI was initiated ?
ii. Were you given sufficient notice and time to prepare for explanations?
iii. Are you satisfied with outcome of Inquiry? If not why.
iv. Do you feel any stress post inquiry?
v. Are you feeling any tiredness or fatigue after Inquiry is over?
vi. Are you able to sleep properly? If not how much is sleep disturbance?
vii. Do you feel any change in eating habits? If yes what?
viii. Any change in social activities post Inquiry?

ix. Are you discussing your problem with any of your family member or friends? If yes with whom, and what is their response?

x. Is there any big change in your behavior pattern?

xi. How are you feeling now days?

xii. Do you need to express yourself and talk to anyone on this?

xiii. Are you depressed or find everything is OK?

xiv. Do you think your Organisation is neutral and supportive?

xv. Do you find any change in behavior of your colleagues?

xvi. Are you comfortable in working in same office post this incident?

xvii. Do you have any time suicidal behavior?

xviii. Specify the occasions and reasons?

### 5.3 Way Forward

While implementing the recommendation of this research is desirable some existing Suicide Prevention Measures, which are in practice needs to be strengthened and implemented in letter and spirit. Keeping all the points discussed and studies in this research, it is suggested that as part of Each Life Matters campaign for IAF, all the air warriors are to be taught four major protective factors to prevent suicide. These are:

(a) Effective mental health care

(b) A sense of affiliation with other people, families, communities, and organisations.

(c) Life abilities (including problem-solving skills and coping skills, ability to adapt to change)

(d) Self-esteem and a sense of meaning or purpose in life.

Finally it can be concluded that suicide is notoriously difficult to detect, predict, and prevent due to a multitude of factors and despite the significant progress made in

recent years towards understanding the risk factors for suicidal behaviour, and conceptualizing how they may work together to produce these outcomes. Suicide is final manifestation of problems faced by an individual, which are considered as unbearable, unmanageable and unending by him. It's significant to remember that suicide can be avoided and that there are numerous resources available to assist individuals who are in need. Even while it might have seemed as though someone had everything they could ever want, they most likely didn't feel that way. There is no one-size-fits-all approach to the complicated and diverse problem of suicide prevention. One has to be alert, vigil, sympathetic, and ready to go extra mile to ensure each life is important. ***'Each Life Matters- Happy Landings'***

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**Annexure-A**

## CAUSES OF ATTRITION AND SUICIDE (BPR&D Report)

Major factors responsible for attrition and suicide cases as identified by BPR&D report may be summarized under following heads: -

**WORKING CONDITIONS**

**High level of stress of personnel** –

(a) Job and Service conditions related Issues.

(b) Family and social aspects related Issues.

(c) Leadership related Issues.

(d) Welfare related Issues.

(e) General Issues.

(f) Poor Infrastructure and Lack of Basic amenities.

**SERVICE CONDITIONS**

**(a) Issue of slow Promotion and frequent Posting**

**(b) Leave related Issues**

**(i)** Delay in the process of getting leave leading to uncertainty.

**(ii)** Arbitrary exercise of in deciding leave matters.

**(iii)** Lack of transparency or partiality a d discretion in granting leave.

**(c) Overburden of work resulting in less rest and sleep deprivation**

**(d) Welfare related Issues**

**(i)** Lack of proper organisational and institutionalised methods of stress management.

**(ii)** Counseling mostly only on paper.

**(iii)** Insufficient means for recreation.

**(e) Not getting help from Civil Authorities and lack of legal support**

(i) Most of the personnel feel that the civil authorities are not helpful.

(ii) When these personnel deployed in tough areas, away from home, face any legal or land related problem then it becomes a source of stress for them. They feel cheated and betrayed as they are protecting the country but nobody bothers for protection of their families.

**(f) Less operational strength**

Due to increasing workload due to new inductions and shortage of manpower, overburden long working hours leads to sleeplessness and anxiety among personnel.

**(g) Leadership related Issues**

(i) Poor communication and Inapproachability of seniors i.e., Personnel feel that they cannot approach their seniors as and when required.

(ii) Pressure to Perform **-Zero Error Syndrome.**

(iii) Lack of Empowerment and not being heard by the Seniors i.e. Personnel are of the opinion that they are not consulted even in matters affecting them. Moreover, their opinion is also not taken into account and therefore, they feel disempowered. It is one of the major stressors for the personnel.

**PERSONAL ISSUES**

**(i)** Separation from family leading to marital discord.

**(ii)** Nuclear family.

**(iii)** Land Property related legal Issues:-

**Other Issues Related To Family and Social Aspects**

80% suicides happen when personnel come back to work after availing leaves. Majority of suicide cases take place between seven to fifteen days after returning from home (after availing leaves) and re-joining the duty. However, it reflects that even after the leave was over, the responsibilities or issues at home front were not over and the individual who committed suicide was physically present at duty and mentally at home. **The issues on after leave resulting in stress and depression are-**

(i) Death of spouse or a family member.

(ii) Marital discord or Divorce.

(iii) Financial crunch /loss.

(iv) Family welfare.

(v) Education of Children.

(vi) Illness or disability of a family member.

(vii) Physical injury or chronic pain of a person.

(viii) Excessive alcohol use or drug abuse.

**(a) Gap between Expectation and Reality**

(i) The trigger for suicide may be either family related or duty related. It means that if at least one front between professional and personal life is easy and smooth, it remains easier to manage stress level.

(ii) The cases of suicide by female personnel are very few and suicides are attempted and committed majorly by male personnel. Male personnel hesitate in sharing their problems because of fear of being mocked by other personnel or hurting ‘male ego’ in sharing their problem with others.

(iii) Adverse situations in the personal life of a person with weak mental strength might lead a person to commit suicide.

(iv) People with economic compulsions may end up taking their lives for easing up the pressure.

(v) Mental health, till now is considered as a serious taboo not only in the Forces but in the society as well. In Forces, it also comes with the apprehension of being mocked and taunted as weak, worthless, and even result into loss of service. This is the reason that those people who face some mental health issue never share it with their seniors or colleagues. They even try to hide it. By the time, strangeness in behaviour, surfaces, it gets too late.

From the aforementioned points, it can be concluded that suicide is notoriously difficult to detect, predict, and prevent due to a multitude of factors and despite the significant progress made in recent years towards understanding the risk factors for suicidal behaviour, and conceptualizing how they may work together to produce these outcomes. Suicide is final manifestation of problems faced by an individual, which are considered as unbearable, unmanageable and unending by him.

**Conclusion and Recommendation for attrition and suicide (BPR&D report)**

In different forces, so far the efforts for Stress Management have often been ad hoc, random and generally unsystematic. These recommendations can largely be classified into four categories:

(i) Initiatives for ensuring mental well-being.

(ii) Improving Service conditions and Welfare related Initiatives.

(iii) Communication, Advocacy and Outreach related Initiatives.

(iv) Providing and improving Interaction among various cadres.

**Annexure-B**

# Basic suicide prevention Checklist

If a friend or family member tells you they are contemplating death or suicide, it is important to assess the person's immediate danger. Those at the greatest risk of committing suicide in the near future have a specific suicide PLAN, the MEANS to carry out the plan, a SET DATE for carrying out the plan, and the INTENT to carry out the plan. The likely plan needs to be assessed and information to be shared with correct people to defuse the crisis. To ensure correct flow of sequential events in response to any likely or potential suicide case by observing the warning signs or even reported as alert, a brief but unambiguous check list is required to be followed by an average person. This needs to be in simple steps to be taken on this information. A simple check list that can be followed is:-

## (a) Communicate your concerns: How to start communicating

You might wonder whether it is wise to interfere if you notice the suicide warning signs in a person you care about. What if you're wrong? What if the person becomes upset? It is common to feel anxious or terrified in such situations. But the sooner help is given to anyone who displays suicide thoughts or shows other warning signals, the better. Anyone might find it quite challenging to talk about suicidal thoughts and feelings with a friend or family member. However, the simplest option to find out whether someone is suicidal if you are unsure is to ask. Compassion cannot drive someone to commit suicide. In reality, allowing a suicidal person to communicate their feelings can offer solace from loneliness and

repressed bad feelings and may even stop a suicide attempt. Best way to start communication or initiate discussion is as follows:-

(i) I've been feeling worried about you recently.

(ii) I've noticed some changes in you recently and was wondering how you're doing.

(iii) I wanted to check on you because you haven't been acting like yourself recently.

(iv) When did you first experience these emotions?

(v) Did something occur that caused you to feel this way?

(vi) How can I best assist you at this time?

(vii) Have you considered seeking assistance?

(viii) Are you comfortable talking to me?

(ix) Do you trust me, or shall I call any of your friends?

(x) You are very important person for me and this organization.

(b) **What you can say that will be helpful**:-

(i) You are not alone. I'm here to help.

(ii) You may not believe it at the moment, but your feelings will change.

(iii) I may not fully comprehend how you feel, but I care about you and want to assist you.

(iv) When you are tempted to give up, tell yourself that you will persevere for just one more day, hour, or minute—whatever you can handle.

(v) Your ideas are always taken seriously. Tell me what do you think in present situation.

(c) **Suggested "dos and don'ts"** while conversing are as given:-

**Dos:**

(i) Listen instead of being in hurry to tick and complete your checklist.

(ii) Be patient and in observing mode.

(iii) Be genuine. Let the person know that he/she is not alone and that you care. Finding the proper words is not nearly as important as demonstrating your care.

(iv) Allow the person to release his/ her emotions. Even if the conversation seems negative, the fact that it is occurring is a positive sign.

(v) Be compassionate and nonjudgmental. The suicidal individual is doing the right thing by discussing emotions, regardless of how difficult it may be to hear.

(vi) Offer hope. Assure your friend that assistance is available and the suicidal feelings are temporary. Let the individual know that you value his/her life.

(vii) Take the individual seriously. If a suicidal person says, "I'm so depressed, I can't go on," inquire if they are having suicidal thoughts. Allow them to share their suffering with you; you are not imposing your ideas on them.

(viii) When taking give undivided attention so as to display full faith and concern.

**Don't:**

(i) Debate with the suicidal individual.

(ii) Avoid phrases such as "You have so much to live for," and "Your suicide will harm your family," etc.

(iii) Pretend to be surprised, deliver a lecture on the value of life, or disagree that suicide is undesirable.

(iv) Guarantee confidentiality. You may need to speak with a mental health professional in order to keep the suicidal individual safe. If you pledge to keep your conversations confidential, you may be required to break your word.

(v) Offer solutions to your loved one's problems, give them advice, or make them feel as though they must justify their suicidal thoughts. It does not matter how severe the problem is, but rather how severely it is affecting your friend or loved one.

(vi) Blame yourself. You can't "fix" someone else's depression. The happiness or unhappiness of your friend is not your responsibility.

(vii) Respond promptly during a crisis.

(viii) Do not, under any circumstances, leave a suicidal person alone.

**(d) Provide assistance and support**

Once you have identified a likely high risk person, have communicated to him as per check list given above, thereafter the best way to assist is by listening with empathy. Communicate that they are not alone and that you care. However, do not assume responsibility for healing. You can offer support, but you cannot heal a suicidal individual. They must make a commitment to their own recovery. It takes a great deal of courage to assist a person who is suicidal. Witnessing a struggling person with suicidal thoughts can evoke a variety of complicated emotions. While assisting a suicidal person, always

remember to take care of yourself. Find a trusted friend, family member or counsellor with whom you can discuss and receive support. Following support can be provided:-

(i) Get expert assistance. Contact a crisis hotline for required information and recommendations. Motivate the individual to see a mental health professional, assist them in locating a treatment centre, or accompany them to a doctor's appointment.

(ii) Ensure that your friend takes the prescribed medicines as per advice of Doctor. Inform the doctor if any side effects are observed or the conditions deteriorate.

(iii) Those suicidal tenancies generally do not believe that they can be helped; therefore, you may need to be more proactive in offering assistance. Take initiative visit, call, and invite the individual to talk.

(iv) Encourage positive lifestyle changes, such as a healthy diet, adequate rest, and daily exposure to at least 30 minutes of sunlight or nature. Light exercises and walking will help in improving the mood swings.

(v) Encourage the individual in making a list of potential triggers for a suicidal crisis, such as the birthday / anniversary of loved one who has been lost, alcohol, or relationship stress. This information should be available with supervisors and contact information for the individual's doctor, and friends who can be called during any emergency.

(vi) Remove and restrict the assess to potential suicide means, such as pills, knives, razors, and firearms. If the individual is likely to take overdose, keep such medicines under lock and key or in required small quantities as per necessity.

(vii) Continue your assistance and maintain contact with the individual by call or visits on irregular intervals. Such support is crucial to ensuring that person on risk stays on the path to recovery.