The Knowledge Regarding Identification and Prevention of Suicide Among Care Giver of Mentally Ill Patient in Selected Health Care Institutes In Pune City

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Abstract

Many of mentally ill patients are committing suicide due to various factors. The health care professional is mainly focusing on preventing the suicidal incidence among mentally ill patients. Caregiver of mentally ill patients have an important role in preventing suicidal incidence. The adequate knowledge of care giver on perceiving warning sign of the suicide and knowledge of care giver regarding prevention of suicide prevent the incidence of suicide in mentally ill patients. The present study aims to assess the knowledge of care givers regarding identification and prevention of suicide in mentally ill patient and find the association between the knowledge and the demographics variables of the care givers. Material and method: A descriptive study was conducted, using 20items structured questionnaire. 200 care giver was chosen for the study through non-probability purposive sampling techniques. Result: the obtained result data revealed that, maximum participants were male 64%, majority 44.5% belonged to the 46-55 year of age group, regarding duration of care maximum 37.5% participants were <5 years, maximum 55% participants were belonged to the hindu religion and maximum 58% participants were from rural areas and 76.5% participants were not previous information regarding suicide identification and prevention and maximum 46.5% participant's family income was 30001 to 60000. Finding related to knowledge score of care giver regarding identification of suicide 47.5% of care giver had average knowledge, 40% care giver had poor knowledge and 12% care giver had good knowledge and finding related to knowledge score of care giver regarding prevention of suicide was 52% participants were average knowledge, 5.5% participants had good knowledge and 42.5% participants had poor knowledge. Conclusion: from the above finding, the researcher concluded that there is a great need of improve the knowledge level of care giver because average knowledge is not good knowledge. The researcher also recommends for care giver to attend the workshop, community health programme related to suicide identification and prevention to enhance the knowledge regarding suicide identification and prevention.

Keyword: *knowledge, suicide identification and prevention, caregiver's*

INTRODUCTION

Suicide is an act of taking once own life voluntarily. The word suicide is derived from two Latin words Sui meaning self and cedere meaning to kill oneself. Hence suicide is an act of willfully ending one's own life. Suicide is a type of deliberate self-harm and is defined as a human act of self-intentioned and self – inflected cessation (death). Most often it ends with a fatal outcome.[1]

Suicide is the third leading cause of death among young worldwide. Suicide is the final outcome of complex interactions of biological, genetic, psychological, sociological and environmental factors. It is an increasingly important public health issue: from 1990 to 2010 the number of global suicides increased by 32%. It is particularly important among young adults 15 to 49 years of age among whom it accounts for 4.8% of all female deaths and 5.7% of all male deaths.[2]

Many of mentally ill patients are committing suicide due to various factors. The health care professionals are mainly focusing on preventing the suicidal incidence among mentally ill patients. Caregivers of mentally ill patients have an important role in preventing suicidal incidence. The adequate knowledge of caregivers on perceiving the warning signs of suicide can prevent the incidence of suicide in mentally ill patients.

Suicidal attempt is considered to be one of the common emergencies. Usual onset more than 70 years and 15 to 30 years old and death 1.5% mostly suicide do by hanging, fire, pesticide poising. Schizophrenia, bipolar disorder, depression, personality disorder and substances abuse including alcohol and benzodiazepine are the most risk of factor of suicide. There has been an increase in the rates of suicide in India over the years, although trends of both increases and decline in suicide rates have been present. Distinct from global demographic risk factors, In India, marital status is not necessarily protective and the female: male ratio in the rate of suicide is higher. The motives and modes of suicide are also distinct from western countries. Preventive strategies implemented at a community level and identifying vulnerable individuals maybe more effective than global strategies.[3] Suicide ranks among the most tragic events in human life, causing a great deal of serious psychological distress among the relatives of the victims at the family level as well as great economic problems for the whole society in a statistical sense.

OBJECTIVES

The objective of the study are:

1. To assess the knowledge about identification of suicide among caregivers of mentally ill patients.
2. To assess the knowledge about prevention of suicide among caregivers of mentally ill patient.
3. To find out the association between finding and demographic variables.

NEED OF THE STUDY

About 800,000 people die by suicide worldwide every year, of these 135,000 (17%) are residents of India, a nation with 17.5% of world population. Between 1987 and 2007, the suicide rate increased from 7.9 to 10.3 per 100,000, with higher suicide rates in southern and eastern states of India. In 2012, Tamil Nadu (12.5% of all suicides), Maharashtra (11.9%) and West Bengal (11.0%) had the highest proportion of suicides. Among large population states, Tamil Nadu and Kerala had the highest suicide rates per 100,000 people in 2012. The male to female suicide ratio has been about 2:1.There is a wide variation in the suicide rates within the country. The southern states of Kerala, Karnataka, Andhra Pradesh and Tamil Nadu have a suicide rate of > 15 while in the Northern States of Punjab, Uttar Pradesh, Bihar and Jammu and Kashmir, the suicide rate is < 3.The number of published reports specifically studying the psychiatric diagnoses of people who die by suicide has been relatively small (n = 15629). The majority (82.2%) of such reports come from Europe and North America with a mere 1.3% from developing countries. Two case control studies using psychological autopsy technique have been conducted in Chennai and Bangalore in India. Among those who died by suicide, 88% in Chennai and 43% in Bangalore had a diagnosable mental disorder. However, diagnostic evaluations were not done in the Bangalore study.[4]

Countless experts have found that affective disorders are the most important diagnosis related to suicide. In Chennai, 25% of completed suicides were found to be due to mood disorders. However, the suicide rate increased to 35% when suicide cases with adjustment disorder with depressed mood were also counted. The crucial and causal role of depression in suicide has limited validity in India. Even those who were depressed, were depressed for a short duration and had only mild to moderate symptomatology. The majority of cases committed suicide during their very first episode of depression and more than 60% of the depressive suicides had only mild to moderate depression. According to a government report, only 4.74% of suicides in the country are due to mental disorders. Personality disorder was found in 20% of completed suicide. Cluster B personality disorder was found in 12% of suicides. Suicide is major public health concern. Suicide is complicate and tragic but it is often preventable. Knowledge about the suicide identification and prevention is help to save the life of client. [5]

Providing education to aware the care giver of mentally ill patient about early sing and prevention of suicide.

MATERIAL AND METHOD

A descriptivedesign was used for the research study. After reviewing the previous researches and facts related to knowledge regarding identification and prevention of suicide the data collection tool was developed based on the objectives of the study. The tool consisted of three sections, first section deals with demographic data like age, gender, education and monthly family income etc. whereas second section is Structured knowledge questionnaire on identification of suicide and last third section is questionnaire to knowledge regarding prevention of suicide. Tool was validated from 23 subject experts. After validation, the reliability of tool was also calculated by Karl-Pearson Correlation Coefficient" and it was found reliable.

Non probability purposive sampling technique was used to collect the data. The data collection tool was shared to potential participants. The data collection from 200 Care giver who provide care to mentally ill patients was completed from 19th July 2019 to 19th August 2019 in Mental Health Institutes of Pune city.

Statistical Analysis

Statistical analysis was executed on Microsoft Excel-2016. In descriptive statistics frequency, percentage, mean and standard deviation was calculated. Chi-square non parametric test was used to find out the association of demographic variables with their knowledge.

ANALYSIS OF DATA

Aftercollecting the data the information were organized and presented under the following sections:

SECTION-I: Analysis related to the demographic variables of the care giver in frequency and percentage.

SECTION-II: Analysis related to knowledge regarding identification of suicide among the care giver.

SECTION-III: Item wise analysis of knowledge of care giver regarding identification of suicide.

SECTION-IV: Analysis related to knowledge regarding prevention of suicide among the caregiver.

SECTION-V: Item wise analysis of knowledge of care giver regarding prevention of suicide.

SECTION-VI: Analysis related to association of demographic variables with knowledge regarding identification of suicide among care giver.

SECTION-VII: Analysis related to association of demographic variables with knowledge regarding prevention of suicide among the care giver.

SECTION I

Analysis related to the demographic variables of the nurses in frequency and percentage distribution.

Table: 1 frequency distribution of participants as per demographic variables.

n = 200

Demographic Data				
Sr.No.	**Parameters**		**Frequency**	**Percentage(n=200)**
1.	Gender	Male	128	64%
		Female	72	36%
2.	Age (years)	25-35	20	10%
		36-45	50	25%
		46-55	89	44.5%
		56-60	41	20.5%
3.	Education	Secondary	56	28%
		Higher Secondary	67	33.5%
		Under Graduation	60	30%
		Post-Graduation	17	8.5%
4.	Duration of care (year)	<1	72	36%
		<5	75	37.5%
		5-10	25	14..0%
		>10	28	12.5%
5.	Religion	Hindu	110	55%
		Muslim	59	29.5%
		Christion	25	12.5%
		Sikh	6	3%
6.	Residence	Urban	84	42%
		Rural	116	58%
7.	Previous information	Yes	47	23.5%
		No	153	76.5%
8.	Family income	<10000	22	11%
		10001-30000	61	30.5%
		30001-60000	93	46.5%
		>60001	24	12%

Table: 1 presents that among the participant, maximum **44.5%** belonged to 46-55 year of age group, 25% belonged to the age of 36-45 year and 20.5% participants were belonged to the 56-60 and

10% belonged to the 25-35 year of age group. This depicts that most of the participants were from age group 46-55 year. Data also demonstrate that maximum 64% were male and 36% were female. Finding also depicts that majority of participants 33.5% were higher secondary, 30% participants were under graduation, 28% participants were secondary and 8.5% participants were post graduated. Regarding duration of care giver to the patient maximum 37.5% duration of care were <5 years, 36% care giver have duration of care were <1years and 14% of care giver have duration of care were 5-10 years and 12.5% care giver have duration of care were >10years. In religion 55% participants were Hindus, 29.5% were muslim, 12.5% were christian and 3% participants were Sikh. Data also demonstrate that maximum 58% participants were from rural areas and 42% participants were from urban areas.

In further regarding information on suicide identification and prevention maximum 76.5% participants were not having previous information and 23.5% participant's had previous information. Regarding family income maximum 46.5% participants were belonged to 30001 to 60000, 30.5% participant's income were belonged to 10001 to 30000 and 12% participant's family income were belonged to more than 60001 and 11% participant's family income belonged to were less than 10000.

SECTION-II

Analysis related to knowledge regarding identification of suicide among the care giver.

Table: 2 Knowledge score of care giver regarding identification of suicide.

n=200

KNOWLEDGE SCORE				
Parameters	**Poor (1-3)**	**Average** (4-7)	**Good (8-10)**	Total
Frequency	80	95	25	200
Percentage	40%	47.5%	12.5%	100%

Table 2 shows the knowledge score of care giver regarding identification of suicide that majority 95(47.5%) of care givers have average knowledge and 80(40%) care givers have poor knowledge and only 25(12.5%) care givers have good knowledge of suicide identification.

Table:3 Mean knowledge score and standard deviation of care giver regarding identification of suicide.

n=200

KNOWLEDGE MEAN SCORE	STANDARD DEVIATION
4.11	1.84

Table:3 shows that the mean knowledge score of care giver regarding identification of suicide was 4.11 and standard deviation was 1.84.

SECTION-III

Item wise analysis of knowledge of care giver regarding identification of suicide.

Table:4 Maximum correct Reponses of care giver regarding identification of suicide. n=200

ITEM NUMBER	COORECT REPONSE *f*
1	87
2	97
3	**65**
4	67
5	70
6	106
7	80
8	68
9	71
10.	**111**

Table 4 Shows that maximum responses for correct responses is to item 10 and minimum response is to item 3.

SECTION-IV

Analysis related to knowledge regarding prevention of suicide among the caregiver.

Table:5 Knowledge score of care giver regarding prevention of suicide.

n=200

	KNOWLEDGE SCORE			
	Poor(1-3)	**Average(4-7)**	**Good(8-10)**	**Total**
Frequency	85	104	11	200
Percentage	42.5%	52%	5.5%	100%

Table:6 Mean knowledge score and standard deviation of care giver regarding prevention of suicide

n=200

MEAN KNOWLEDGE SCORE	STANDARD DEVIATION
3.72	1.62

Table 6 Shows that the mean knowledge score of care giver of regarding prevention of suicide was **3.72** and standard deviation was **1.62.**

SECTION-V

Item wise analysis of knowledge of care giver regarding prevention of suicide.

Table:7 Maximum correct response regarding prevention of suicide.

n=200

ITEM NUMBER	CORRECT REPONSES *f*
1.	69
2.	84
3.	**58**
4.	**94**
5.	70
6.	71
7.	90
8.	60
9.	67
10.	81

Table 7 Shows that maximumcorrect responses were given to item 4, and minimum correct responses were given to item 3.

SECTION-VI

Analysis related to association of demographic variables with knowledge regarding identification of suicide among care giver.

Table:6 Association of demographic variables with knowledge score of care givers regarding identification of suicide.

n=200

s.n.	Demographic variables		Knowledge score			d.f	p-value	Chi square Calculate value	Chi square Table value	Inference
			Poor	Average	Good					
1.	Gender	Male	49	63	16	2	0.782	0.48	5.99	NA
		Female	31	32	9					
2.	Age	25-35	7	10	3	6	0.8041	3.03	12.59	NA
		36-45	23	22	5					
		46-55	33	42	14					
		56-60	17	21	3					

3.	Education	Secondary	28	20	8	6	0.0013	21.79	12.59	A
		Higher secondary	31	30	6					
		UG	15	40	5					
		PG	6	5	6					
4.	Duration of care (year)	<1	34	32	6	6	0.3457	6.73	12.5916	NA
		<5	31	33	11					
		5-10	9	14	5					
		>10 year	6	16	3					
5.	Religion	Hindu	46	52	12	6	0.1	10.28	12.59	NA
		Muslim	25	28	5					
		Christion	5	14	6					
		Sikh	3	1	2					
6.	Residence	Urban	40	58	18	2	0.10	4.47	5.99	NA
		Rural	40	37	7					
7.	Previous information	Yes	7	28	12	2	0.0005	19.9	5.99	A
		No	73	67	13					
8.	Family income	<10000	11	10	1	6	0.0004	24.41	12.59	A
		10001-30000	35	21	5					
		30001-60000	27	55	11					
		>60001	7	9	8					

*, association at **0.05** level of significance

Note: If chi-square table value is greater than chi-square calculated value then there is no association. Only three demographics variables education, previous information and family income were calculated more than chi square table value so these three demographic variables were associated with knowledge score of suicide identification.

SECTION-VII

Analysis related to association of demographic variables with knowledge regarding prevention of suicide among the care giver.

Table:7 Association of demographic variables with knowledge score of care givers regarding prevention of suicide.

n=200

S.n	Demographic variables		Knowledge score			d.f	p-value	Chi square calculated value	Chi square table value	Inference
			Poor	Average	Good					
1.	Gender	Male	57	64	7	2	0.73	0.61	5.99	NA
		Female	28	40	4					
2.	Age(years)	25-35	9	9	2	6	0.47	5.54	12.59	NA
		36-45	20	27	3					
		46-55	33	51	5					
		56-60	23	17	1					
3.	Education	Secondary	37	18	1	6	0.00057	23.80	12.59	A
		Higher secondary	25	39	3					
		UG	17	39	4					
		PG	6	8	3					
4.	Religion	Hindu	49	45	7	6	0.21	8.35	12.59	NA
		Muslim	29	28	2					
		Christian	6	18	1					
		Sikh	1	4	1					
5.	Duration of care(year)	<1	38	31	3	6	0.07	11.50	12.59	NA
		<5	33	39	3					
		5-10	5	20	3					
		>10	9	14	2					
6.	Residence	Urban	47	31	6	2	0.0013	13.22	5.99	A
		Rural	38	73	5					
7.	Previous information	Yes	8	34	5	2	0.0002	17.22	5.9	A
		No	77	70	6					
8	Family income	<10000	14	5	3	6	0.0029	19.89	12.59	A
		10001-30000	32	27	2					
		30001-60000	34	56	3					
		>60001	5	16	3					

*, association at **0.05** level of significance

NOTE: If chi-square table value is greater than chi square calculated value then there is no association. All chi-square table values were less than chi-square calculated values except gender, age, religion and duration of care. so there all other demographic variables were associated with knowledge score regarding suicide prevention four demographics variables education, residence, previous information and family income were calculated more than chi square table value so these five demographic variables associated with knowledge score of suicide prevention. All the p-values were less than 0.05 except gender, age and religion so there were all other demographic variables were associated with knowledge score regarding suicide prevention. Only three demographic variables were not associated with knowledge score of suicide prevention.

DISCUSSION

Present study supported by a study conducted by Ms. Soji S Sazi et.al on "care givers knowledge on early warning sign of suicide in mentally ill patient". Finding shows that 64.1%were male care givers in duration of care given to the patient finding shows that 42.2% care giver had less than 1 year of experience. In religion 60.9% were belong to Hindu religion. In residence finding show that 64.1% care givers live in rural area.[7]

Present study support by a study conducted by Mr. Raghu D.M. on "to assess the impact on STP on knowledge of suicide prevention among parents of adolescent's". The finding shows that 63.33% were male, in religion category 58.33% were Hindu. After STP 63.33% having adequate knowledge.[5]

This study also supports by a study conducted by KalpanaRegmi et.al on, "To assess the knowledge of parents regarding suicidal behavior among adolescent's." the finding shows that majority of 54% were males, 27% were Muslims. In income finding suggests that 24% of them had 10001 to 15000 rs. Findings regarding the knowledge score of the suicidal behavior was found 92% were moderately adequate. Findings also suggest that mean score 51.50% having knowledge on warning sign of suicidal behavior, mean score 49.93% having knowledge on prevention and management of suicidal behavior, mean score 50.13% having knowledge on risk factors of suicidal behavior. The overall knowledge mean score was 52.44%.[6]

CONCLUSION

It is important that care giver is responsible for the patient care and safety. Suicide identification and suicide prevention are important for the care giver. If care giver has good knowledge regarding suicide identification and prevention, then they can prevent the patient. The result show the average knowledge and average knowledge is not good knowledge so care giver knowledge increase by workshop, community health education programme regarding suicide identification and prevention.

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