SUMMER INTERNSHIP

AT

IIHMR, DELHI (APRIL1 TO MAY 31, 2020)

A REPORT

BY

DR. SRISHTI SINGH

Post-graduate Diploma in Hospital And Health Management

2019-2021

Acknowledgement

I would like to express my special thanks of gratitude to my mentor Dr. Manish Priyadarshi as well as my teachers including Mrs. Divya Aggarwal who gave me the golden opportunity to do this wonderful project which also helped in doing a lot of Research and I came to know about so many things.

I am thankful to them.

Secondly I would also like to thank my parents and friends who helped me a lot in finishing this project in this limited time.

I am making this project not only for marks but to also increase my knowledge.

THANKS TO ALL WHO HELPED ME

(Completion of Summer Internship from respective organization)

DECLARATION

I SRISHTI SINGH, hereby declare that this Internship Assignments entitled

a. ……. b……c……..d……is the outcome of my own study undertaken under the guidance

of Prof/ DR. Manish Priyadarshi, IIHMR-New Delhi. It has not previously formed the basis for the award of

any degree, diploma, or certificate of this Institute or of any other institute or university. I have duly

acknowledged all the sources used by me in the preparation of this field internship report.

Date:

Sign:

Postgraduate Diploma in Hospital and Health Management

International Institute of Health Management Research

New Delhi

CERTIFICATE OF COMPLETION

The certificate is awarded to

Name _____ (PG/ _____[Enrollment Number]))

In recognition of having successfully completed her/ his Internship in the department of

Title _____and has successfully completed her/his Project on _____ [Title of the Project]

Date_____

Organisation _____

She/ He has found to be a committed, sincere and diligent student who has a strong zeal for

learning.

We wish him/her all the best for future endeavors

Dean- Academics Student Affairs Mentor Name & Signature

FEEDBACK FORM

Name of the Student:

Summer Internship Institution:

Area of Summer Internship:

Attendance:

Objectives met:

Deliverables:

Strengths:

Suggestions for Improvement:

Signature of the Officer-in-Charge (Internship)

Index

Task 1: NHM UTTAR PRADESH

Task 2: Rashtriya Kishor Swasthya Karyakram

Task 3: To assess the mental health awareness among youth of India.

- Abstract
- Review of literature

Task 4: report

- Introduction
- Rationale
- Research question
- Methodology
- Objectives
- Review of literature
- Findings
- Discussion

References

Acronyms

- NHM: National Health Mission
- Approx.: approximately
- IMR: Infant Mortality Rates
- ASHA: Accredited Social Health Activist
- RKSK: Rashtriya Kishor Swasthya Karyakram
- MMR: Maternal Mortality Rate
- TFR: Total Fertility Rate
- CHC: Community Health Centre
- PHC: Primary Health Care
- MO: Medical Officer
- ANM: Auxillary Nurse And Midwife
- NRHM: National Rural Health Mission

TASK 1

About National Health Mission (NHM)

The National Health Mission (NHM) was designed with the aim of providing accessible, affordable, effective and reliable healthcare facilities in the rural and urban areas of the country, especially to the poor and vulnerable sections of the population.

In the State of Uttar Pradesh, National Health Mission has made special efforts for reaching out to the community at grassroots level. NHM focuses on affordable, accessible, accountable, effective and quality services to the masses specially to the vulnerable groups of the community.

GOALS

The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

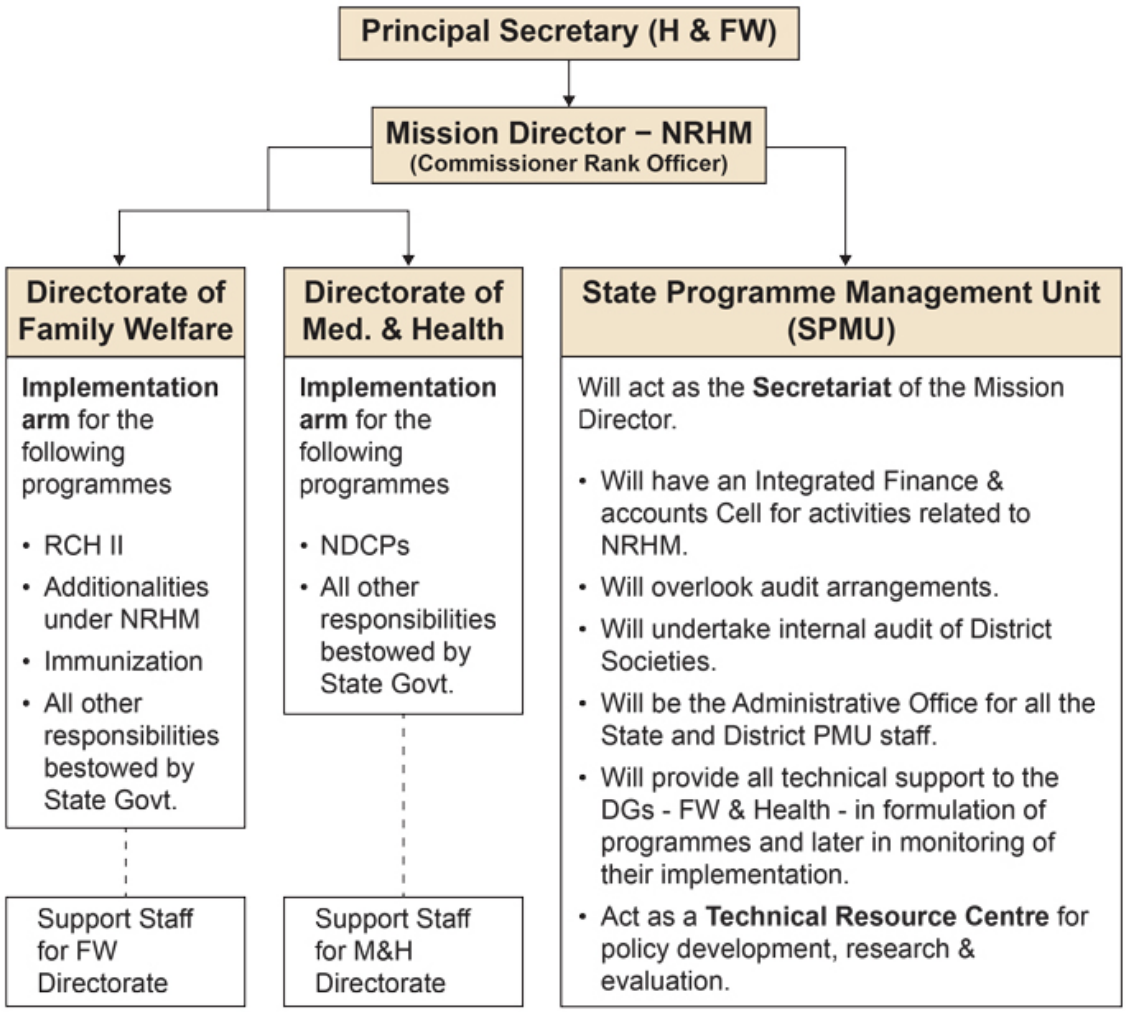
- To prevent and control of communicable and non-communicable diseases
- To upgrade AYUSH (Aurvedic Yoga Unani Siddh and Homopath) for promotion of healthy lifestyle.
- To reduce Maternal Mortality Rate (MMR) to 258/ lac live births
- To reduce Infant Mortality Rate (IMR) to 36/1000 births
- To reduce Total Fertility Rate (TFR) to 2.8
- Malaria mortality reduction rate by 60%
- Under National Blindness Control Programme (NBCP), objective is to reduce the prevalence rate from 1% to 0.5 by year 2012.
- Safe drinking water and sanitation facilities to greater than 60% of villages.

LEADERSHIP

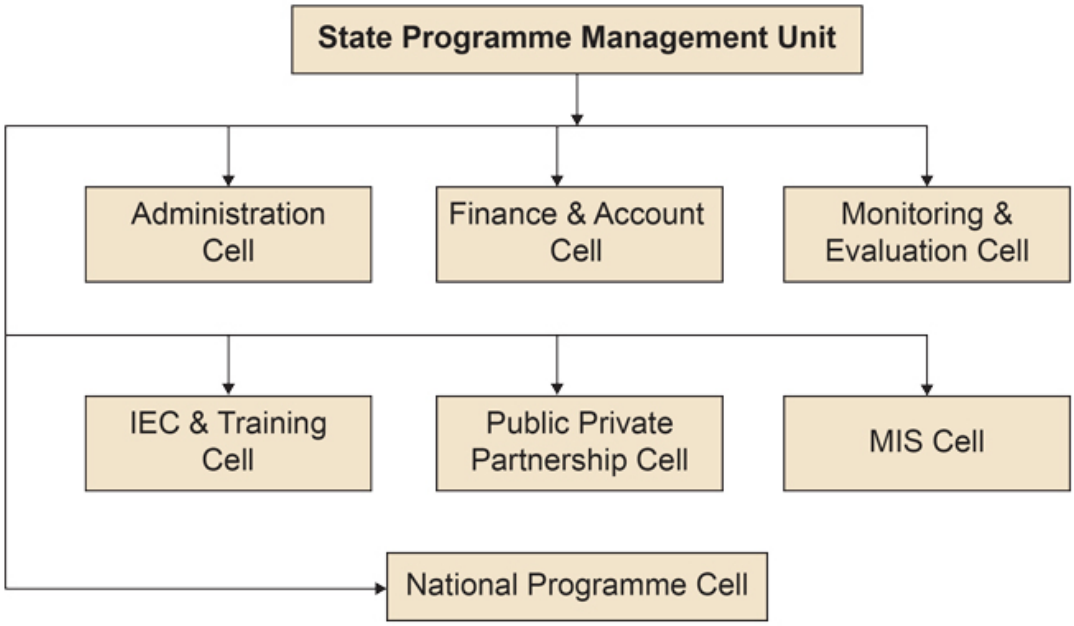
NAME OF OFFICER	DESIGNATION
Shri Vijay Vishwas Pant, IAS	Mission Director(NHM)

ORGANOGRAM

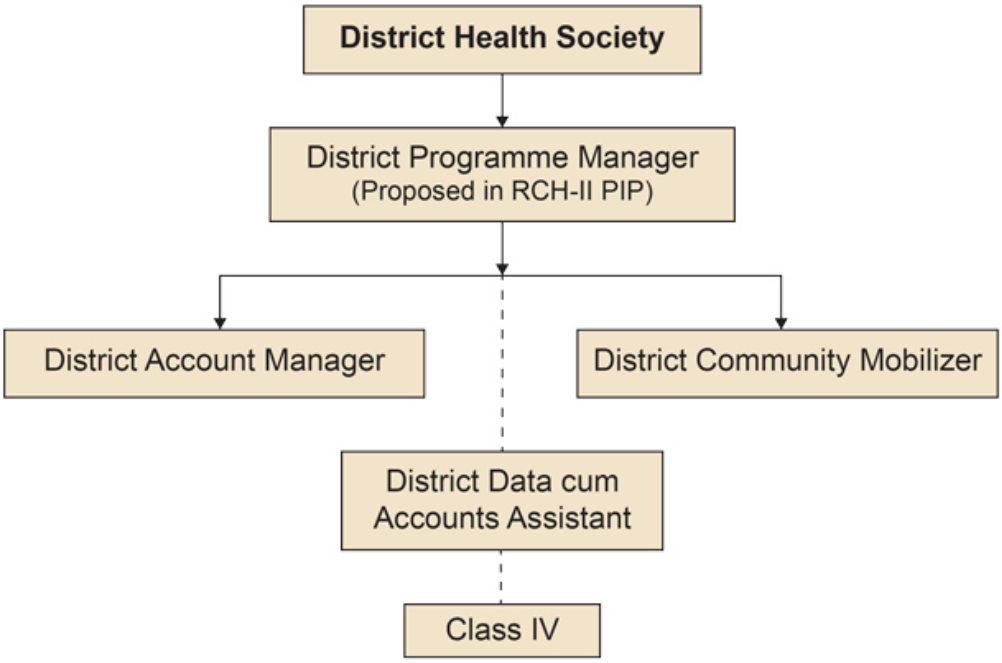
1) Organogram for Nrhm Implementation at State LeveL



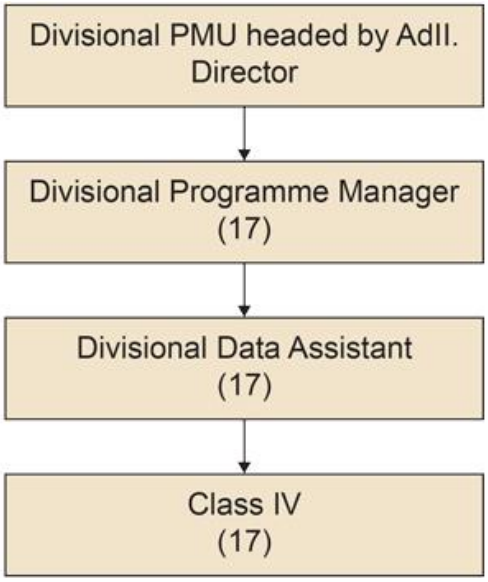
2) Structure of State Programme Management Unit (SPMU)



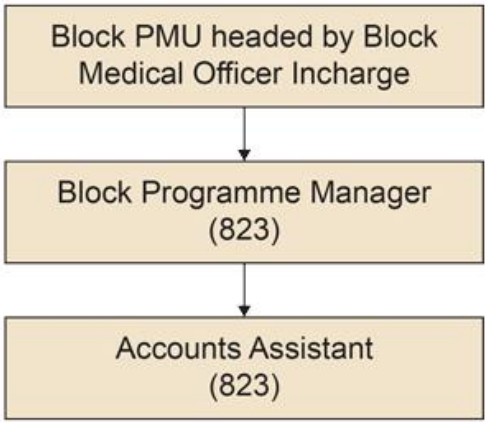
3) District PMU



4) Divisional PMU



5) Block Level Units



PROGRAMMES

1) Rashtriya Bal Swasthya Karyakram (RBSK)

- Rashtriya Bal Swasthya Karyakram (RBSK) aims at early identification and early intervention for children from birth to 18 years to cover 4 Ds viz. Defects at birth, Deficiencies, Diseases, Development delays including disability.
- There is a provision in the programme that children of 0-6 years age group will be specifically managed at District Early Intervention Centre (DEIC) level while for 6-18 years age group, management of conditions will be done through existing public health facilities.
- First level of screening is being done at all delivery points through existing Medical Officers, Staff Nurses and ANMs. After 48 hours till 6 weeks of age the screening of newborns is being done by ASHA at home as a part of HBNC package.
- Outreach screening is being done by dedicated mobile health teams of children of 6 weeks to 6 years at Anganwadi Centres and 6-18 years children at School.

TARGET AGE GROUP

Aim to cover children of 0-6 years of age in rural areas in addition to children enrolled in classes Ito XII in Government and Government aided Schools.

2) Rashtriya Kishor Swasthya Karyakram (RKSK)

The Ministry of Health and Family Welfare has launched a new adolescent health programme- Rashtriya Kishor Swasthya Karyakram. The programme envisages strengthening of the health system for effective communication, capacity building and monitoring and evaluation.

TARGET AGE GROUP

The new adolescent health (AH) strategy focuses on age groups 10-14 years and 15-19 years with universal coverage i.e. males and females; urban and rural; in school and out of school; married and unmarried and vulnerable and under-served.

OBJECTIVES

Improve nutrition, Enable sexual and reproductive health, Enhance mental health, Prevent injuries and violence, Prevent substance misuse, Address conditions for NCDs.

3) REPRODUCTIVE AND CHILD HEALTH

The second phase of RCH program i.e. RCH - II has been commenced from 1st April 2005 the five year file 2010. The main objective of the program is to bring about a change in mainly three critical health indicators i.e. reducing total fertility rate, infant mortality rate and maternal mortality rate with a view to realizing the outcomes envisioned in the Millennium Development Goals, the National Population Policy 2000, and the Tenth Plan Document, the National Health Policy 2002 and Vision 2020 India.

4) INTEGRATED DISEASE SURVEILLANCE PROJECT

Integrated Disease Surveillance Project funded by the World Bank is being implemented since November 2004 with the objective of strengthening surveillance system with various Communicable Diseases and Risk Factor of Non-Communicable Diseases. One of the important components of the Project is to use Information Technology and Communication Technology in data management, analysis and rapid response in case of impending outbreaks. To strengthen transmission of data, the Ministry of Health & FW and Indian Space Research organization (ISRO) have agreed to cooperate in providing satellite linkage for various activities under World Bank funded Integrated Disease Surveillance Project. ISRO would provide adequate bandwidth on one of its satellite, EDUSAT for this Project. This satellite has 5 regional beams and one national beam covering the entire country.

5) ROUTINE IMMUNIZATION PROGRAMME

State Level Task Force for Strengthening RI –

- The State has an established Task Force under the chairmanship of Principal Secretary, Medical, Health & Family Welfare, Govt. UP.
- This task force meets once every quarter to review the RI program.
- Besides different wing representatives of Health & Family Welfare Dept., the members include Secretaries of other Departments, such as, ICDS, Panchayati Raj, Education, Urban development authorities, representatives of NPSP(WHO),

UNICEF, CARE, Rotary, SIFPSA, IMA, IAP others.

Core Group

- Core group at State level under the chairmanship of Director General (National Program, Monitoring & Evaluation) provides technical support as well as monitors the progress made on a regular basis.
- The members of the Core group include Director (FW), AD UIP, AD MCH, AD IEC, AD RCH, CCO, Partner agencies - UNICEF and NPSP (WHO)
- The core group meets every month to discuss and review the strategies.

RI Monitoring

- Monitoring of RI sessions is taking place for the last 3 years by Govt, UNICEF and NPSP
- This is further being strengthened through intensive efforts by Government and partner agencies
- At present the State is monitoring RI sessions on a standardized RI monitoring format, which is in the process of revision & developed by the State with assistance from UNICEF & NPSP.
- The compilation of data for each district is being done by NPSP district SMO units and being forwarded to the NPSP state RI cell for analysis and corrective actions.

6) REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME

- Tuberculosis (TB) is an infectious disease caused by a Bacterium, Mycobacterium tuberculosis. It is spread through the air by a person suffering from TB. A single patient can infect 10 or more people in a year.
- Modern anti-TB treatment can cure virtually all patients. It is, however, very important that treatment be taken for the prescribed duration, which in every case is a minimum of 6 months. Because treatment is of such a long duration and patients feel better after just 1-2 months, and because many TB patients face other problems such as poverty and unemployment, treatment is often interrupted.

- Therefore, just providing anti-TB medication is not sufficient to ensure that patients are cured. The DOTS strategy ensures that infectious TB patients are diagnosed and treated effectively till cure, by ensuring availability of the full course of drugs and a system for monitoring patient compliance to the treatment.
- The DOTS strategy along with the other components of the Stop TB strategy, implemented under the Revised National Tuberculosis Control Programme (RNTCP) in India, is a comprehensive package for TB control.
- The DOTS strategy is cost-effective and is today the international standard for TB control programs. To date, more than 180 countries are implementing the DOTS strategy. India has adapted and tested the DOTS strategy in various parts of the country since 1993, with excellent results, and by March 2006 nationwide DOTS coverage has been achieved.

7) NATIONAL IODINE DEFICIENCY DISORDER CONTROL PROGRAMME

- Iodine Deficiency is a worldwide major public health problem. About 1.5 billion people at risk of Iodine Deficiency Disorders (IDD) and more than 70 million are having Goitre and other IDD problem. Government of India (GOI) launched a 100% centrally assisted National Goitre Control Programme (NGCP) in 1962. Aimed at production and supply of iodized salt to known endemic areas and survey of areas where Goitre was reported.
- The Survey conducted showed that no point of the country is free from IDD, including plain and coastal regions. The Central Goitre Control Review Committee 1983 recommended universal iodization of edible salt for human consumption in the country and notification was issued under Prevention of Food Adulteration (PFA) Act, 1954.
- A new evidence that come to light that Iodine is the most common cause of preventable mental retardation among children has led to an international focus on elimination of IDD. Thus, the NGCP was renamed as National Iodine Deficiency Disorder Control Programme (NIDDCP) in 1992.

8) NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

Directorate of National Vector Borne Disease Control Programme (NVBDCP) is the central nodal agency for the prevention and control of vector borne diseases in India. It is one of the Technical Departments of Directorate General of Health Services, Government of India.

NVBDCP deals with following diseases: -

1. Malaria
2. Dengue
3. Filaria
4. Japanese Encephalitis
5. Kala-azar

ANNUAL REPORT

- The mission is conceived as an umbrella programme subsuming the existing programmes of health and family welfare, including the RCH-II, National disease control programmes for malaria, TB, kala azar, filarial, blindness and iodine deficiency and integrated disease surveillance programme.
- The budget head for NRHM shall be created in B.E. 2006-07 at national and state levels. Initially the vertical health and family welfare programmes shall retain their sub-budget head under the NRHM.
- The Outlay of the NRHM for 2005-06 is in the range of Rs.6700 crores.
- The Mission envisages an additionality of 30% over existing Annual Budgetary Outlays, every year, to fulfill the mandate of the National Common Minimum Programme to raise the Outlays for Public Health from 0.9% of GDP to 2-3% of GDP.
- The Outlay for NRHM shall accordingly be determined in the Annual Budgetary exercise.
- The States are expected to raise their contributions to Public Health Budget by minimum 10% p.a. to support the Mission activities.
- Funds shall be released to States through SCOVA, largely in the form of Financial Envelopes, with weightage to 18 high focus States.

TASK

2

Rashtriya Kishor Swasthya Karyakram

It was launched by Ministry of Family Health And Welfare on january7'2014 by targeting the adolescents, male and females of aged group 10-19years of age to enhance nutritional status, reproductive health and substance abuse, among other issues.

Since 23% of the entire population of Rajasthan is of adolescents, therefore focuses to provide universal coverage, despite of gender, geographical area, educational background, marital status, vulnerable or under-served. As the adolescent group of population will serve and form the constructive force of social and economic transformation.

Leadership

Dr Nidhi Purohit, consultant RKSK, 9982333434

Key Principle

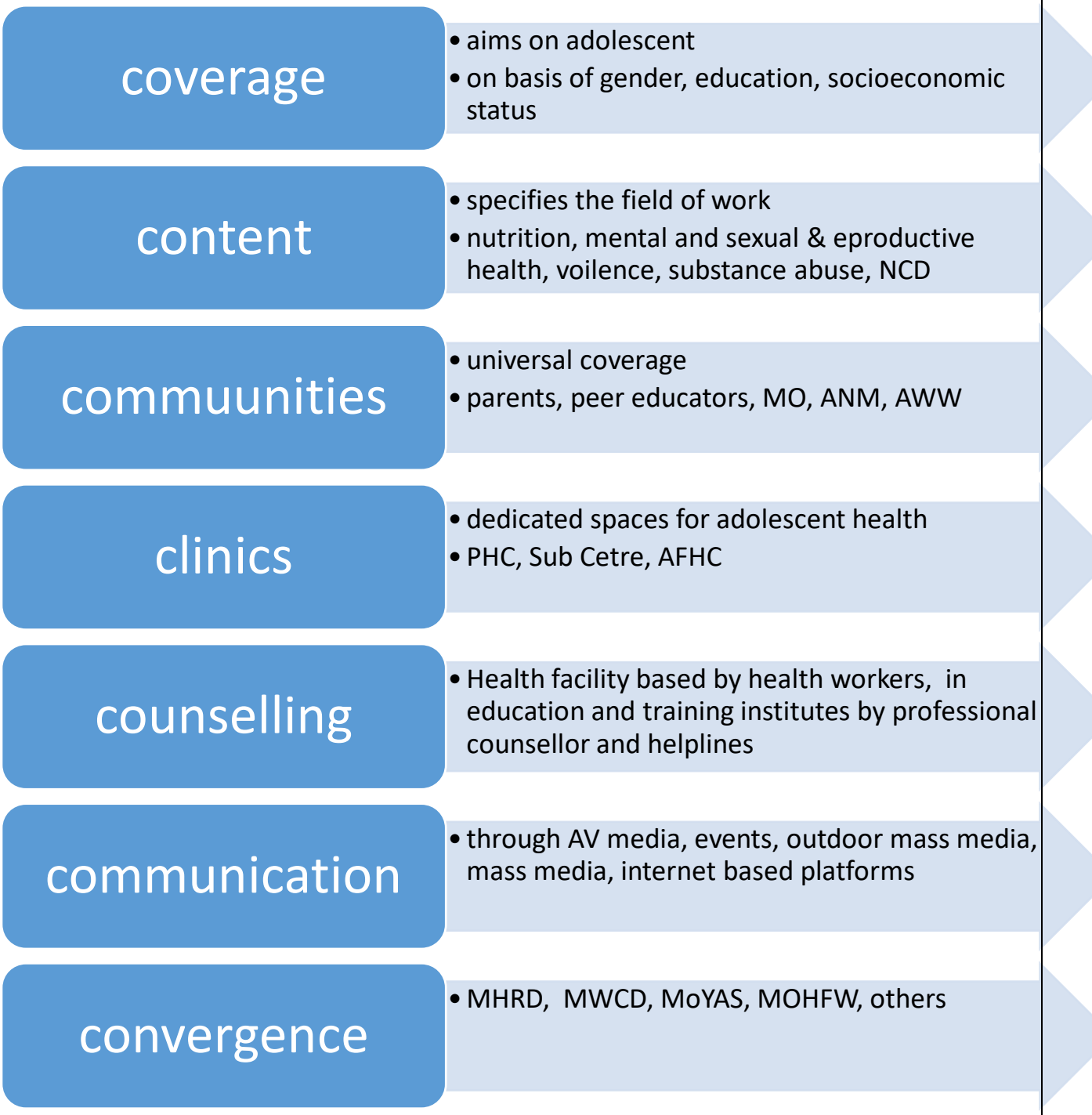
- Adolescent participation and leadership
- Equity and inclusion
- Gender equity
- Intersectoral strategic planning

Vision

Enabling all adolescents in India to realize their full potential by making informed and responsible decisions related to their health and wellbeing and by accessing the services and support they need to do so.

Implementation plan

In association with UNFPA, National Adolescent Health Strategy was developed which realigns the prevailing clinic-based curative approach for a comprehensive model emphasizing continuum of care of adolescents health and developmental needs. It introduces community-based interventions through peer educators and is underpinned by collaborations with other ministries and state governments.



Components

- Weekly Iron & Folic Acid Supplementation Programme
- Menstrual Hygiene Scheme
- Adolescent Friendly Health Clinic
- Peer Educator

- Quarterly Adolescent Health Day

Objective

- Improve nutrition
  Reducing the prevalence of malnutrition
  Reducing the prevalence of nutritional anemia
- Enable sexual and reproductive health
  Reducing teenage pregnancies
  Providing knowledge, attitudes and behavior
- Improving mental health
- Prevention of injuries and violence
- Prevent substance abuse
- Control NCDs

Communication

- Base line assessment regarding the awareness, behavioral practice and predisposing factors and media group in the targeted population and service provider of the district should be known to carry out the plan.
- Key behaviors should be identified which needs to be changed
- Setting goals for enhancement of awareness and behavioral changes to be achieved in that district
- Developing plan in respect to media to reach out the target population and healthcare providers
- Budgetary and necessary approvals should be obtained

Progress

- Telephone helpline for the adolescent available 24*7
- 274 MO and 350 ANM trained
- 1853 Adolescent Health Day organized

Financial Guidelines

For district with 2 million population per annum

s.no	Budget head	Budget in lacs
1	Facility based services	6.0
2	School based services	70.0
3	Community based services	217.2
4	Miscellaneous	375.7
	Total	620.9

Weekly Iron & Folic Acid Supplementation Programme

Aims to scale back nutritional anemia by administration of IFA substitutes free of cost in adolescents both girls and boys going to school from class 6^{th} to 12^{th} and girls who don't go to school on weekly basis.

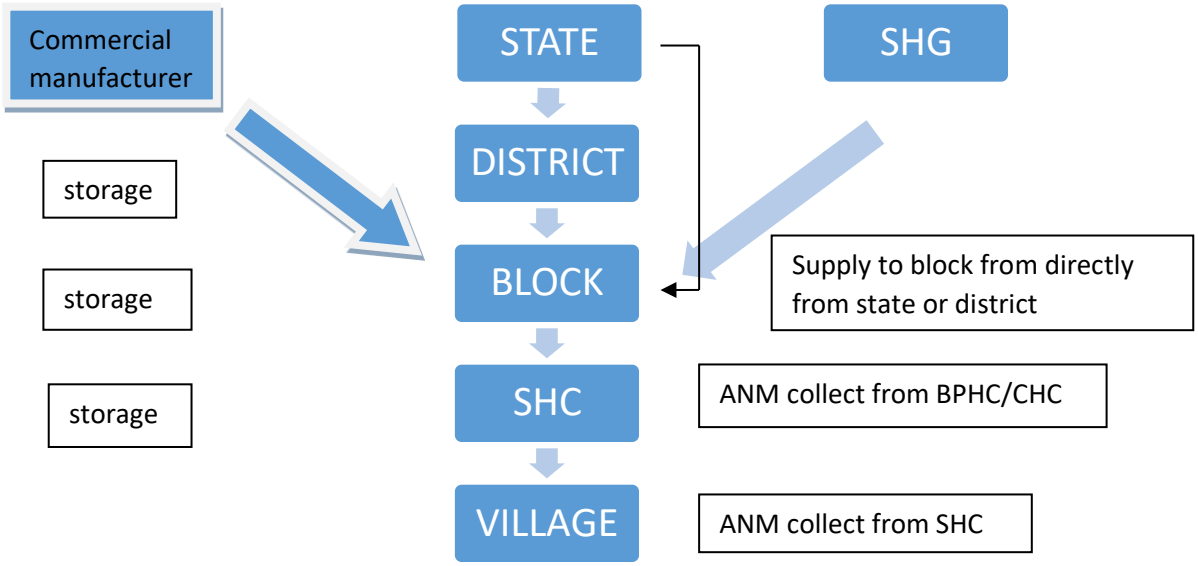
And also Albendazole is provided every half yearly for deworming.

Counseling pertaining to improve dietary habits are also provided in order to reduce deworming.

Menstrual Hygiene Scheme

Aims to adequate knowledge and information about sanitary napkins and its usage and disposal to adolescent girls of rural areas done at various level by ASHA, ANM, MO, CMHO.

SUPPLY AND STORAGE CHAIN



Adolescent Friendly Health Clinic

It is resource center for the healthcare providers where counselors plays crucial role by informing, educating and counseling the clients about the health issue and also refer them to the health facilities.

Besides within the clinic, counselor visits school, community, youth clubs, colleges twice a week addressing and sensitizing adolescents, caregivers about health care

Manpower

DH	CHC	PHC	OUTREACH
2 dedicated counselors/ICTC counselor	2 dedicated counsellors	2 MO	Counselors ANM
2 MO- 1 male and 1 female Specialist - 1(gynecologist, pediatrician. Surgeon, dermatologist,	2 MO – 1 male and 1 female	1 ANM/LHV	

psychiatrist, mental health)			
2 staff nurses	2 staff nurses	1 health assistant	

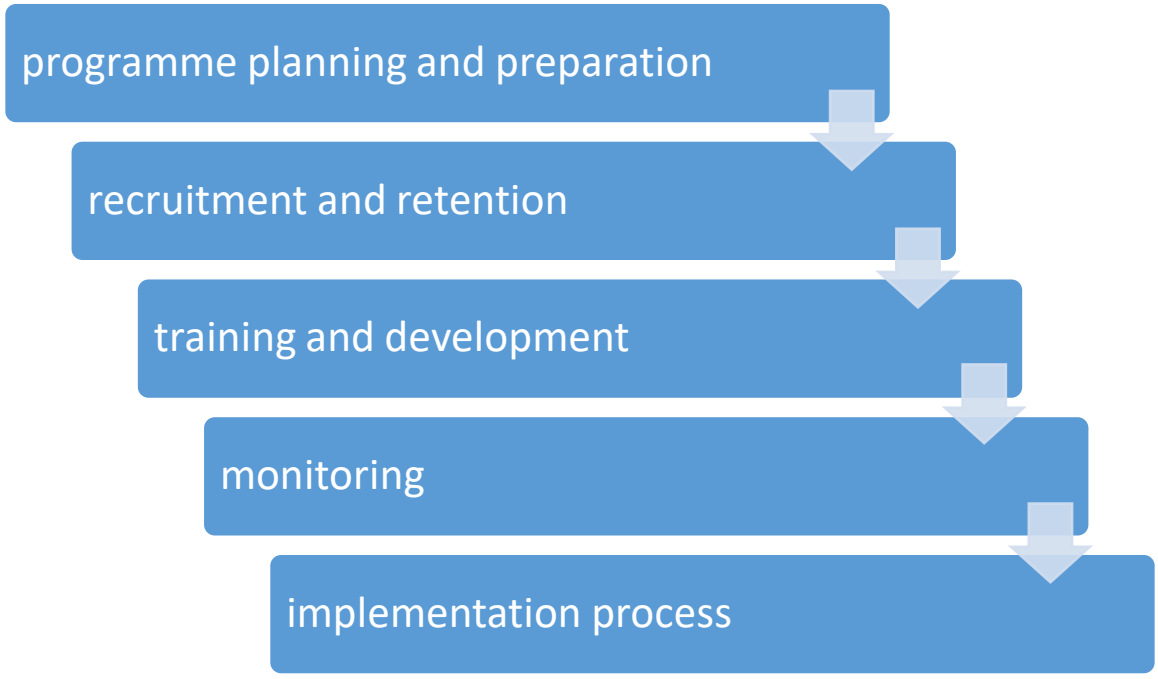
Peer Educator

Under this programme, 4 peer educators are selected every village 2 boys and 2 girls called SAATHIYA who facilitated by ASHA workers for consultation in Village Health Sanitation and Nutrition Committee.

Saathiya along with other adolescent from community conduct sessions with PE kits hebdomadally for an hour or two. They also maintain records about each session and number of participants addressed where they sensitize the participants about health and various facilities, they can avail in AFHC.

ASHA act as coordinator of saathiya to ensure the smooth working and activities at the village level.

Operating guidelines structure



Indicators

Strategies	Indicators
Peer educator programme	% of peer educator enrolled against planned % of peer educator trained out of enrolled % of session held by educator against planned
Weekly iron folic supplementation	% of monthly coverage in and out of school % of beneficiaries from albandazole in six months % of IFA stock out from school
Menstrual hygiene scheme	Total number of girls covered % of girls provided with sanitary packs
Adolescent friendly health clinic	% AFHC operationalized against planned % of counselors available at AFHC % of adolescent counseled against total client registered.

Challenges

- Lack of participation of the society
- Availability of resource

TASK 3

Introduction

Despite of various programmes and efforts made to improve mental health, but still it has been a cause of concern around the globe. Number of factors has been attributed for it including lack of services, lack of awareness, myths, misconceptions and stigma and low priority to mental health, out of which lack of awareness can be seen one of the major sources of the problem.

Aim: To assess the mental health awareness among youth of India.

Methodology

The study reviewed various literature based on internet search using various databases like Goggle Scholar, PubMed. The article using specific keywords were searched and five articles were considered based on their relatively published ten year.

Results: Based on the various literatures available, it can be concluded that there is a lack of awareness among youth of India only a few considered mental health professionals as possible sources of help. Majority of youth felt friends and parents were source of help. Lack of sources, myths, misconceptions can also be witnessed as affecting mental health among youth.

Keywords: mental health literacy, mental illness, adolescents, help seeking.

Articles reviewed

1. Attitudes, Belief, and Perception Toward Mental Illness Among Indian Youth

It is the descriptive study conducted at Amity University Rajasthan with a sample of 150 college undergraduate and postgraduate students I n the age group of 18 to 27 years to assess belief, attitudes and perception about causes and treatment of mental illness with respect to depression and schizophrenia.

The study conducted observed that depression had easily recognized them schizophrenia among participants. Stressful factors have been endorsed as the most important cause for depression and schizophrenia.

2.What adolescent girls know about mental health: Findings from a mental health literacy from urban slums setting in India

The study conducted to explore the mental health literacy and help seeking patterns in a group of 337 young women between 16 and 19 years from urban slums. Two vignettes on depression and self-harm were used to assess recognition of the disorder, help seeking and knowledge of treatments available. Majority of women said friends and parents were source of help and there is due to lack of awareness and stigma for not considering any professional help.

3.Mental health literacy among university students from University of Delhi

The study was to assess the mental health literacy among the student of Delhi University. Study was done using a description exploratory, cross sectional survey design on 100 (50 males and 50 female) postgraduate students. In the finding, it showed most of the students had well awareness about the identification with mental disorders like depression and psychosis. Most of the students rated psychiatrist and immediate community members as the most reliable help. The study indicates overall mental health literacy among the students in Delhi was found adequate, but not satisfactory in the area of risk factors.

4.Mental health literacy among late adolescents in South India: what they know and what attitudes drive them

A cross- sectional study was conducted to assess the mental health literacy, help seeking behavior and beliefs, attitudes towards mental illness among randomly selected pre university college students in Udipi Taluk of Southern India. Where 916 participants were taken among which 54.15% were males and 45.85% were females where only 29.04% and 1.31% identified depression and schizophrenia simultaneously. In findings it can be seen that adolescents preferred reaching out to informal sources including family members rather than professional help. There is an urgent need for improvement in the awareness of mental health among adolescents.

5.Youth and mental health: challenges ahead

The article discusses about the mental and substance use disorders (MSUDs) where about 20-25% of the young people suffer worldwide. National mental health survey of India estimated current prevalence of mental disorder in the age group of 18-29 years is 7.39% excluding the tobacco disorder. There is a huge treatment gap ranging 73.5% for severe mental disorder and 85% for common mental disorder and to 91.1% for substance disorder. There are number of barriers for youth to take care of their mental health like lack of services, lack of awareness, myths, misconception, stigma and low priority to mental health. Early identification and intervention, raising community awareness regrading MSUDs are the need of the hour. Schools, colleges should aim and strategized different program to maintain mental health.

References

---

1) http://www.mamcjms.in/article.asp?issn=2394-7438;year=2019;volume=5;issue=2;spage=83;epage=88;aulast=Chowdhury

2) https://doi.org/10.4103/ijpsym.ijpsym_108_18

3) http://www.ijpn.in/article.asp?issn=2231-1505;year=2017;volume=13;issue=1;spage=1;epage=7;aulast=Arundev

4) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4904760/

5) http://www.ijmr.org.in/article.asp?issn=0971-5916;year=2018;volume=148;issue=4;spage=359;epage=361;aulast=Chadda

TASK 4

Introduction

Suicide is the act of intentionally causing one's own death. Every year close to 800 000 people take their own life and there are many more people who attempt suicide. In Western countries, the suicide rate is high in the 15–24 age group and highest in the elderly. The male female ratio is greater at 3 or >3: 1 and the divorced, widowed and separated have a higher risk of suicide. In Asia, the highest rates are often found in the young (below 30 years), the male female ratio is smaller at 2: 1 (India 1.4 : 1, China 1 : 1.3) and married women are at a higher risk. Various risk factors are attributed categorized into physical, mental and social domain. Mental health plays major role wherein depression is the most common. Depression is classified as a mood disorder. It may be described as feelings of sadness, loss, or anger that interfere with a person's everyday activities. Depression may occur as a result of family history, early childhood trauma, drug or substance abuse, medical condition or chronic illness.

Rationale

The detailed and extensive research had been carried out to learn about the relation between depression and suicide. This is an attempt to understand the degree of correlation between the two entities and bring the attention of the concerned authorities so that help can be provided to people suffering from depression to prevent the loss of life.

Research Question:

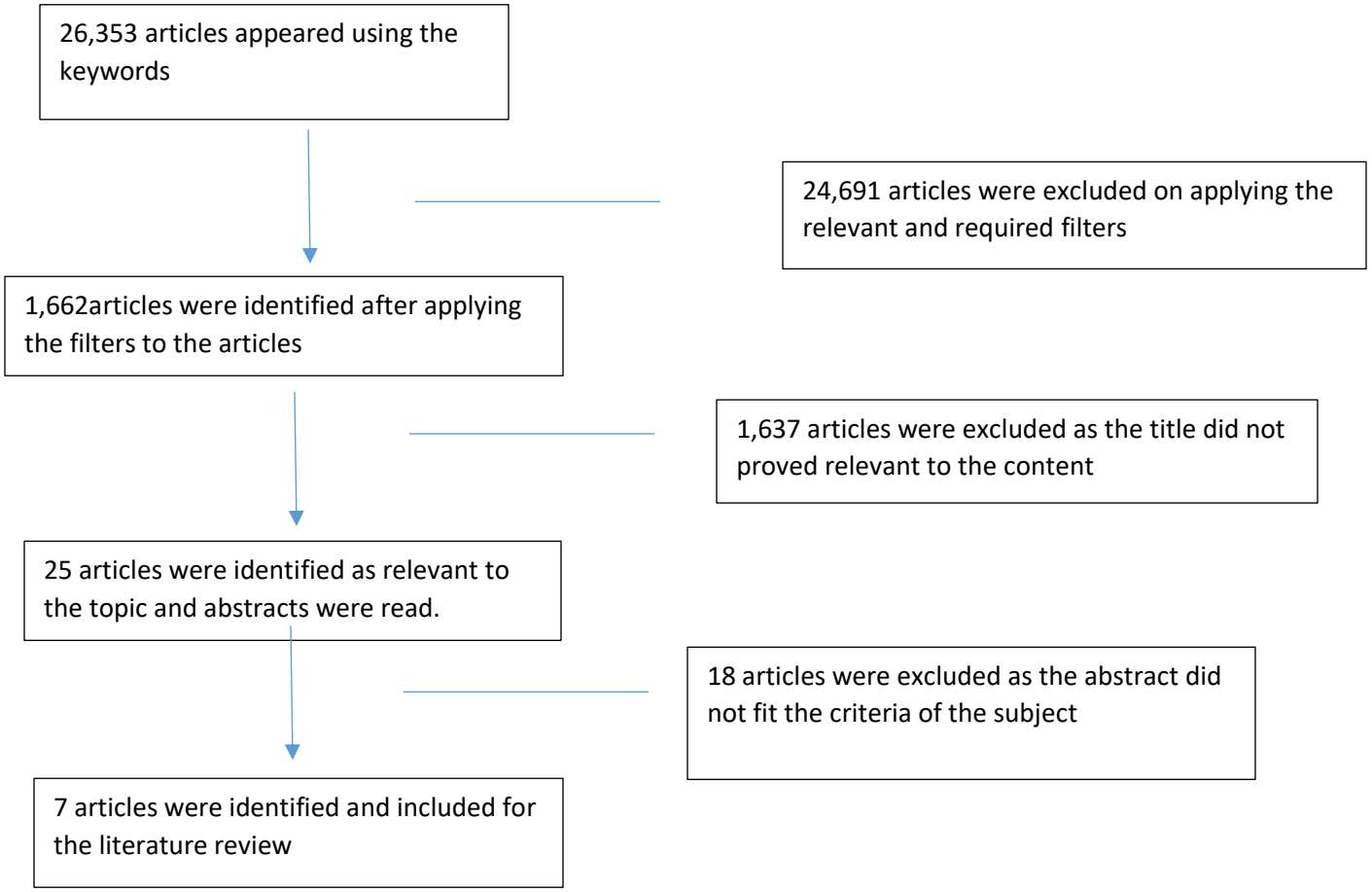
To find the relation between suicide ideation and depression

Methodology:

The study reviewed various literatures based on internet search using various databases like

- Google Scholar
- PubMed
- Medline
- Scihub
- Research net

The articles using specific keywords were searched and



Objectives:

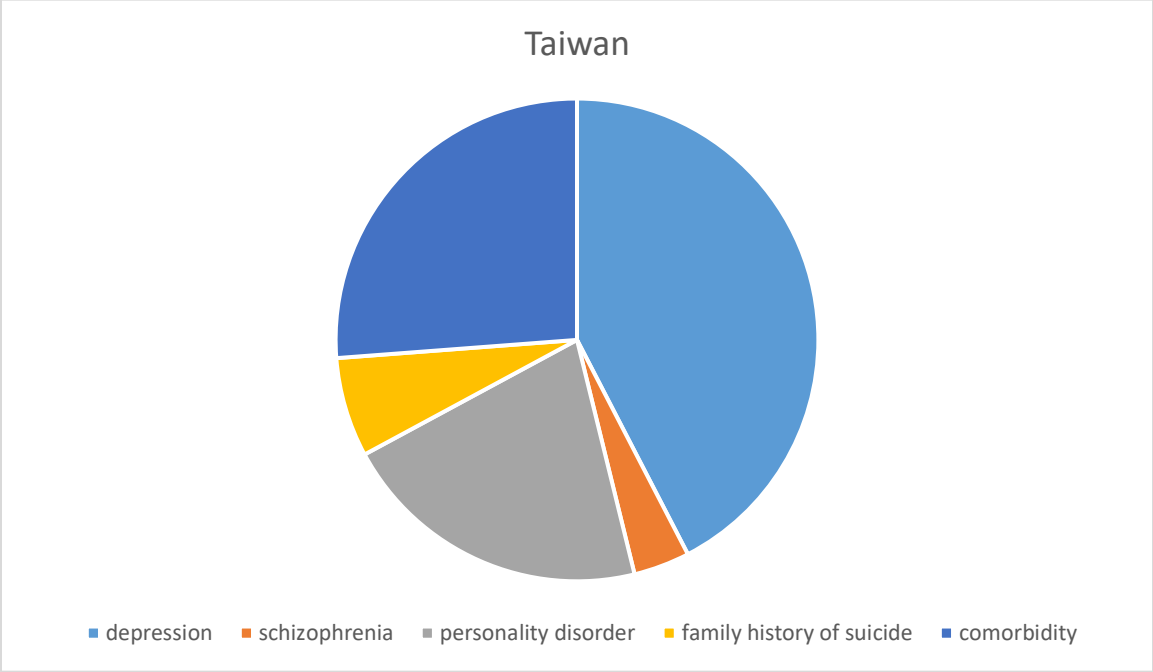
- To know the relation between the depression and suicide ideation.
- To learn the importance of mental health.
- To identify most common situation or condition under which people commits or attempts suicide

Review of literature

Different articles give different theories regarding the suicide ideation amongst people, although mood disorder including depression has always given weightage while accounting for the risk factors. An article by Annette L. Beautrais enumerated large number of risk factors contributing to suicidal ideation and suicides amongst the young adults. He assessed the mood disorders estimated the odds ratio ranging from 11.0 to 27.0 which was maximum than any other risk factor. In a study by Yeates Connwell et al, he assessed the suicidal ideation and risk factors in older age group which concluded depression is one major cause with odds ratio of 12.5 along with various other reasons including physical and social

factors. In another article by Marta Miret et al. reports that depression and bipolar depression constitutes highest risk of suicide based on report by WHO 2001. The depression constitutes for 28% of attributable risk for suicide which could be reduced by preventing depression and early treatments. They also state that suicide bears both social and economic cost. An article by Barbara Weber states that 17-23% of college students experience depression. The strongest correlation between depression and suicide ideation to be 0.62 followed by hopelessness and loneliness. In article by Lakshmi Vjayakumar, the study was done to assess the risk factor of suicide in Asia. Depression was the most common cause of suicide with 89% in Taiwan, 35% in India and 40% in China. Therefore, it can be said that depression is the most common cause of suicide ideation.

Findings



The above chart enumerates the percentage attributed to various risk factors for suicide in Taiwan. The study done amongst college students to find the correlation between risk factor and suicide ideation where in 0.62 was the value attributed to depression, 0.52 and 0.20 value to loneliness and stress. Risk factors for suicide in older adults in mental health, physical health, and social domains that are derived from statistical testing of multivariate models in methodologically sound, controlled studies. Different domains include social and economic disadvantage, childhood and family diversity, individual vulnerabilities, mental disorders and exposure to stressors with maximum weightage to depression.

Discussion

The suicidal crisis is also often anticipated or accompanied by three symptoms: anxiety (inner turmoil), agitation and irritability, key features also found patients with depressive symptoms. Often suicides occur in mild-to-moderate depression. . The diagnosis of a mental disorder is not a enough explanation for suicide. Though diagnosable mental disorders were found in 60–90% of the persons who died by suicide 75–93% of them never received any treatment. Mental disorders occupy a premiere position in the matrix of causation. Suicide is a multidimensional problem and hence multilevel interventions with a multidisciplinary team are necessary for effective prevention of suicidal behaviors. The research implies that reduction in the prevalence of mood disorders amongst people should be a prime target of the concerned authorities.

References

Wagner, Barry M. “Family Risk Factors for Child and Adolescent Suicidal Behavior.” Psychological Bulletin, vol. 121, no. 2, Mar. 1997, pp. 246–98. DOI.org (Crossref), doi:10.1037/0033-2909.121.2.246

“Suicide Attempts in Children and Adolescents.” American Journal of Psychiatry, vol. 139, no. 10, Oct. 1982, pp. 1257–61. DOI.org (Crossref), doi:10.1176/ajp.139.10.1257.

(“Australian Library and Information Association, Reference and Information Service Section, Conference and Exhibition, 6-8 September 1999, Sydney, Australia”)

Ahearn, Eileen P., et al. “MRI Correlates of Suicide Attempt History in Unipolar Depression.” Biological Psychiatry, vol. 50, no. 4, Aug. 2001, pp. 266–70. DOI.org (Crossref), doi:10.1016/S0006-3223(01)01098-8.

Langley, G. E., and N. N. Bayatti. “Suicides in Exe Vale Hospital, 1972–1981.” British Journal of Psychiatry, vol. 145, no. 5, Nov. 1984, pp. 463–67. DOI.org (Crossref), doi:10.1192/bjp.145.5.463.

Haas, Ann Pollinger, and Herbert Hendin. “Suicide Among Older People: Projections for the Future.” Suicide and Life-Threatening Behavior, vol. 13, no. 3, Sept. 1983, pp. 147–54. DOI.org (Crossref), doi:10.1111/j.1943-278X.1983.tb00012. x.

Steinmetz, K. “Rovinsky’s and Guttmacher’s Medical, Surgical and Gynecologic Complications of Pregnancy 3rd Edition. Edited by Sheldon H. Cherry, MD, and Richard L. Berkowitz, MD. Baltimore: Williams & Wilkins, 1985. 676 Pages. $98.00, Hardcover.” Journal of Nurse-Midwifery, vol. 31, no. 2, Mar. 1986, p. 114. DOI.org (Crossref), doi:10.1016/0091-2182(86)90112-6.

Weltgesundheitsorganisation, editor. Mental Health: New Understanding, New Hope. Repr, World Health Organization, 2002.

The Lancet Neurology. “Celebrities Needed to Promote Brain Research in Europe?” The Lancet Neurology, vol. 2, no. 11, Nov. 2003, p. 647. DOI.org (Crossref), doi:10.1016/S1474-4422(03)00564-7

Edwards, Alexis C., and Kenneth S. Kendler. “Depression: Causes and Treatment, Second Edition. By A. Beck and B. A. Alford. (Pp. 456; $27.50; ISBN-13: 9780812219647.) University of

Pennsylvania Press: Philadelphia, PA. 2009.” Psychological Medicine, vol. 40, no. 5, May 2010, pp. 872–73. DOI.org (Crossref), doi:10.1017/S0033291709991668.

Carpenter, William T., et al. “Deficit Psychopathology and a Paradigm Shift in Schizophrenia Research.” Biological Psychiatry, vol. 46, no. 3, Aug. 1999, pp. 352–60. DOI.org (Crossref), doi:10.1016/S0006-3223(99)00088-8.

Lester, David. “Suicidal Behavior in Bipolar and Unipolar Affective Disorders: A Meta-Analysis.” Journal of Affective Disorders, vol. 27, no. 2, Feb. 1993, pp. 117–21. DOI.org (Crossref), doi:10.1016/0165-0327(93)90084-W.

Carpenter, William T., et al. “Deficit Psychopathology and a Paradigm Shift in Schizophrenia Research.” Biological Psychiatry, vol. 46, no. 3, Aug. 1999, pp. 352–60. DOI.org (Crossref), doi:10.1016/S0006-3223(99)00088-8.