國內常用自殺方式與工具之防治策略

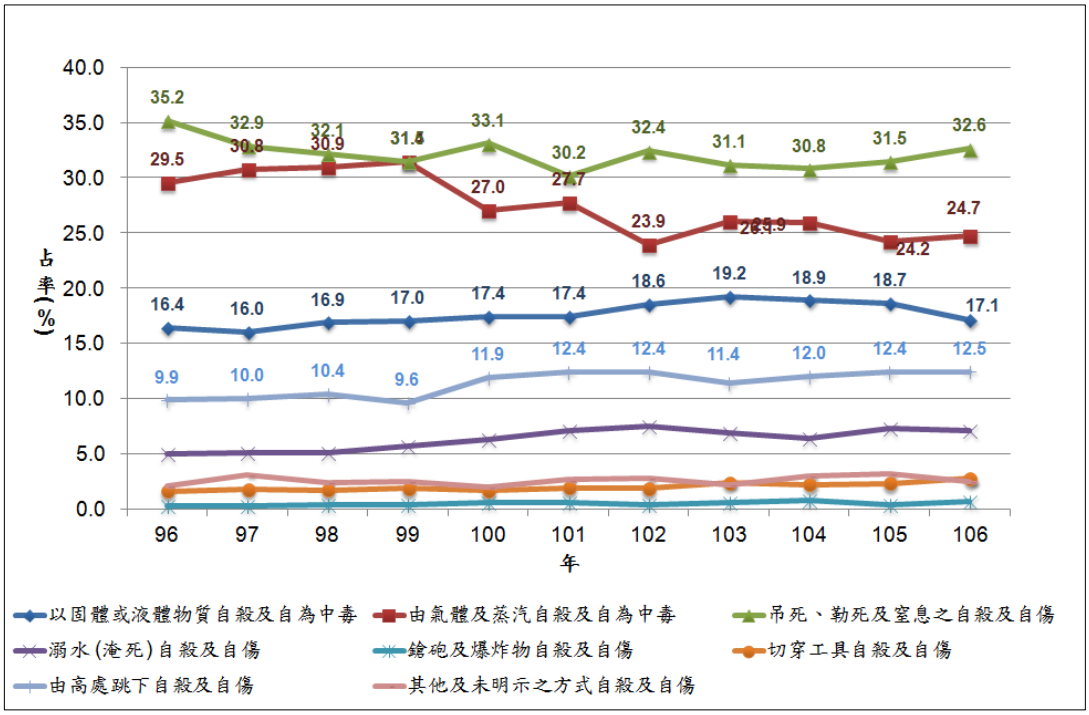
(108 年 3 月 29 日上網公告)

本文係依衛生福利部委託辦理 108 年度「全國自殺防治中心計畫」企劃書第四項第五點「更新並條列歷年收集之國外資訊及作法，針對國內常用自殺方式或工具提出具體可推動之防治策略，供本部、各縣市衛生局及關訪員參考運用，並刊登於中心網頁。」之項目撰寫。

前言

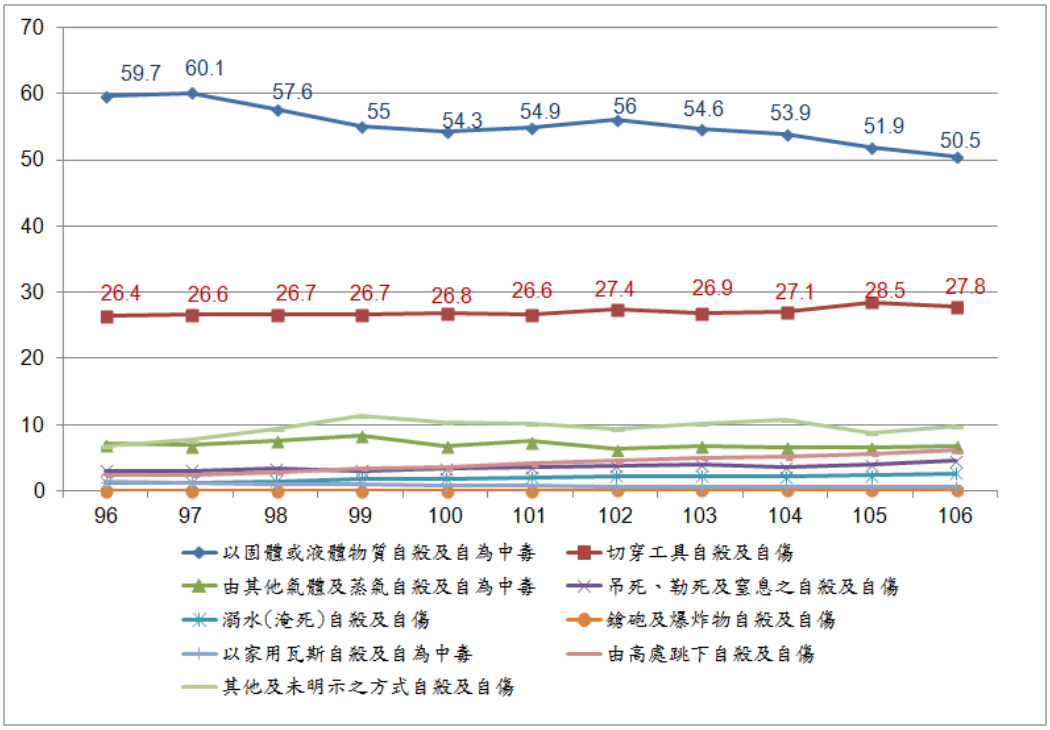
我國對自殺高風險個案採取之自殺防治策略，分別為全面性(universal)、選擇性(selective)與指標性(indicated)三面向。全面性策略重點在促進全體民眾心理健康，同時施以自殺相關資訊之監測；選擇性策略聚焦在高風險族群，強化其心理健康篩選及風險辨識；指標性策略則是關注高自殺風險個人，提供自殺企圖者即時的關懷與介入服務。其中，系統性的推動自殺防治工作使全面性自殺防治策略被認為有效降低自殺死亡發生，因此，本文將針對自殺防治全面性策略，回顧過去一年之相關實證研究，就國內常用自殺方式與工具提出具體之防治策略。

分析近十年自殺身亡使用方法與工具之占率(請見下圖一)，以「吊死、勒死及窒息自殺及自傷」約占三成(30.2%～35.2%)，106 年最新數據為 32.6%，為所有自殺死亡中比例最高之方法，近年有微幅上升趨勢；其次為「由氣體及蒸汽自殺及自為中毒」，民國 96 年至 99 年一度超過三成(30.8%～31.4%)，而後逐漸下降，最新106年數據為24.7%;再來是「以固體或液體物質自殺及自為中毒」，從 96 年起在二成左右徘徊，106 年最新數據為 17.1%，有些為下降趨勢；而同樣為逐漸上升的「由高處跳下自殺及自傷」，從 96 年未滿 10%至今已有 12.5%，為第四常見自殺方法；排名第五的「溺水(淹死)自殺及自傷」雖未滿 10%但依然逐年些微上升至 7.1%亦不容小覷。



圖一、民國 96 年到 106 年自殺方法死亡占率折線圖

在自殺通報使用方法與工具方面(請見下圖二)，依比例排序則以「以固體或液體物質自殺及自為中毒」超過半數比例為最多(51.9%～60.1%)；「切穿工具自殺及自傷」近三成(26.4%～28.5%)；而低於 10%的項目為「由其他氣體及蒸氣自殺及自為中毒」、「由高處跳下自殺及自傷」、「吊死、勒死及窒息之自殺及自傷」與「溺水(淹死)自殺及自傷」等。



圖二、民國 96 年到 106 年各自殺方法通報占率折線圖

綜合比較上述自殺身亡與通報之使用方法比例，以下將針對「吊死、勒死及窒息自殺及自傷」、「由氣體及蒸汽自殺及自為中毒」、「以固體或液體物質自殺及自為中毒」、「由高處跳下自殺及自傷」與「溺水(淹死)自殺及自傷」等五種高危險性自殺方法之防治策略提出討論。本文依據全國自殺防治中心 13 年來的工作成效與近年國外最新文獻回顧，在聚集專家召開諮詢會議後，歸納出自殺方法的防治策略，將實務與研究整合成得以提供政策擬訂與專業人員工作之建議方針。

壹、吊死、勒死及窒息自殺及自傷

此自殺方法的致命性高達七成，欲藉由管制危險物品取得的方法來防治上吊是非常困難的一項任務(僅約 10%發生於監獄、醫院或矯治機構) (Gunnell et al., 2005; Yau & Paschall, 2018)，由於大部分的案例發生於家中，其上吊或窒息物品(如電源線、皮帶、繩索、塑膠袋等)或環境難以防範。因此，一般防治策略重點強調早期發現高風險個案，並進行環境控制、上吊企圖者(near-hanging)的緊急處置、以及全面性防治策略三者(吳佳儀、李明濱，2017)。此外，文獻中多提及醫院病人與監獄受刑人的上吊防治策略，乃以環境控制與管理人員培訓兩向度為重點方向，以下條列其要點：

一、環境控制

(一) 監獄內改裝

1. 改變獄窗設計，去除欄杆，或是用壓克力包覆。
2. 使用嵌入式燈具或受力就會掉落的燈具。
3. 移除掛勾並使用非欄杆式的床。
4. 使用嵌入式與牆壁平行的櫥子。
5. 水龍頭與馬桶供水開關改為按鈕式，移除洗手槽固定塞子。

(二) 醫院內改裝(Gunnell et al.,2005)

1. 檢視院內可能發生上吊的環境，並更改硬體設施以維護病患安全，像是避免使用固定式支架的床、蓮蓬頭以及窗簾軌道。
2. 評估住院病患自殺風險，高風險病患宜去除皮帶、腰帶、毛巾、床單、鞋帶等可能會被使用作為自殺的工具。
3. 注意大多數的上吊事件並非完全懸空式的自殺行為(即懸吊高度低於身高)。

(三) 管理人員培訓

1. 監獄或者護理人員隨身攜帶可切斷的刀做緊急反應(Gunnell et al.,2005)。
2. 訓練醫院急診人員針對上吊企圖個案進行緊急救治(Gunnell et al.,2005)。
3. 培訓管理人員早期高危個案辨識與自殺風險篩檢分級能力，了解其自殺危險/保護因子以利醫療轉介，並明確界定監獄和社區衛生保健服務之間個別化的持續健康照護路徑（Borschmann et al., 2018）。
4. 針對潛在高風險者與上吊存活者的緊急處置與後續關懷，致力於增加對自殺預防程序的順從性以及發展良好治療性的溝通(Tanimoyo et al., 2018)，同時加強其問題解決技巧與衝動控制(Kõlves et al., 2018)

貳、由氣體及蒸汽自殺及自為中毒

此自殺方式包含汽車廢氣、燒炭、氦氣與其他氣體及蒸氣。臺灣近年致力於木炭販賣管理，請店員特別關心只買炭但沒買肉、烤肉醬等相關用品的民眾，觀察其是否面露憂鬱神色,適時提供求助資訊,有若干民眾也因此被挽回寶貴性命。美國與英國研究也發現,汽車加裝觸媒轉化器(catalytic converters)減少一氧化碳的排放可降低使用汽車廢氣自殺之死亡率，因此分別於 1975 年、1993 年頒布相關法令強制執行(Brock, 2003; Mott, 2002; John et al., 2018)。此外，以下提供其他幾項具體防治策略供參考：

一、連鎖量販店及便利商店收銀機可在客人購買木炭時顯示提醒關懷訊息，跳出「適時關懷，珍惜生命」字樣，提醒店員特別關心該位民眾。

二、於木炭外包裝印製或張貼警語、求助資訊，並隨機抽驗通路商販賣之木炭商品是否印製警語與衛生福利部自殺防治安心專線 0800-788-995 免付費電話。

三、由於木炭包裝屬「商品標示法」規範，建議請經濟部修正條例，未來將木炭外包裝印製警語列為強制性執行。

四、與販售之通路商合作，於賣場木炭販賣架上或其週邊牆面，張貼自殺防治相關宣導海報，或於櫃台等明顯處張貼宣導海報、放置關懷吊牌、摺頁或小卡等宣導資訊，尤其在烤肉熱季前夕(如中秋節)擴大燒炭自殺防治之宣導。

五、輔導大賣場或商店(連鎖量販店、便利商店)成為自殺防治示範商店，如將木炭放置明顯處、設立木炭儲放櫃加強管制或上鎖，由店員協助方可取得等，限制其易取得性。

六、透過新聞媒體及記者會宣導燒炭自殺或一氧化碳中毒之後遺症等。

參、以固體或液體物質自殺及自為中毒

此自殺方式包含安眠藥鎮定劑、服用或施打毒品過量、除安眠藥鎮定劑外藥物、一般農藥、一般病媒殺蟲劑、巴拉刈農藥與化學物品。以農藥自殺之防治若從政策面著手則能顯現成效，孟加拉自 2000 年起禁用高危險性農藥後，因農藥自殺身亡人數顯著下降，且並未造成農業就業或稻米產量之負面影響(Chowdhury et al., 2018)。以斯里蘭卡在 2008 年起施行劇毒農藥禁令的經驗(Knipe et al., 2017b)顯示，施行三項劇毒農藥(Paraquat 巴拉刈、Dimethoate 大滅松及 Fenthion 芬殺松)的輸入及使用禁令之後，使用農藥自殺死亡的案例大幅減少了 50%，約旦、薩爾摩也證實禁用劇毒農藥與自殺死亡率下降有關聯性(Ajadcic-Gross et al., 2008; John et al., 2018)。南韓在 2012 年 10 月後，禁止 paraquat 巴拉刈在國內販售，亦減少了 37%的使用農藥之自殺死亡率(Cha et al., 2016)。而臺灣經過近幾年的研究與推廣，即將在 2020 年禁用劇毒農藥巴拉刈，想必能大幅降低使用該方式自殺之比例。以下將分別針對使用農藥與一般藥物採取自殺之防治策略進行闡述：

一、農藥

(一) 推動「落實」販賣業者販售劇毒性農藥管理之登記。依據農藥管理法規定，販賣劇毒性成品農藥，應遵守下列事項：

1. 備置簿冊，登記購買者姓名、住址、年齡、聯絡方式及購買數量，並保存三年。
2. 不得販賣予未滿十八歲之兒童及少年等。
3. 詢問購買者之用途，非為核准登記之使用方法或範圍者，不得販賣。

(二) 安全存放宣導：於民眾購買劇毒性農藥時，詢問其用途並提醒民眾剩餘農藥應妥善保存，勿放在隨意取得之處，以避免誤食等；並透過農會系統共同宣導在家中儲存時應妥善保管(例如上鎖等)，或設立社區集中農藥儲存機構，由機構指定人員來管理農藥的儲存發放(Reifels et al., 2018)。

(三) 農藥購買建議採用以舊罐換新農藥的方式來管制。

(四) 導入非農藥為基礎的農業害蟲管理方式：農作物多樣化、瞭解昆蟲生活史用自然物質驅蟲、夏天深耕法、光陷阱、營火、黏蟲板、費洛蒙陷阱等(Reifels et al., 2018)

(五) 宣導資訊

1. 於農會及農藥販售等據點，張貼或放置自殺防治相關宣導資料。
2. 於農藥商品外包裝，加印關懷警語、求助資訊，或貼上相關資訊貼紙等
3. 透過媒體宣導安全存放農藥(如巴拉刈)及誤食之中毒症狀和後遺症等。
4. 透過農會、農改場及農藥販售通路，向農民宣導壓力管理及珍愛生命守門人之概念，呼籲人人互相關懷，並推廣簡式健康量表(心情溫度計)，促進農民進行自我心理健康管理(Joob & Wiwanitkit, 2018)。
5. 強化緊急醫療救護，加強急診對於常見農藥中毒之處理及急救。
6. 透過農會、四健會系統，關懷探視區內孤獨老農民。

二、一般藥物

(一) 針對藥物管理研擬服藥、領用藥物、非處方藥物包裝與藥物最大劑型條例，避免讓患者有過度儲藥的機會(Jin et al.,2016; Joob & Wiwanitkit, 2018; Kang, 2018; Kõlves et al., 2018; Maduemem, Adedokun & Umana, 2019)。

(二) 與藥局合作，於店內如立牌、海報、單張、結帳櫃檯電視廣告、店內廣播等通路，宣導自殺防治概念；並於店內週邊牆面，張貼自殺防治相關宣導海報，或於櫃台等明顯處張貼宣導海報、放置關懷吊牌、摺頁或小卡等宣導資訊。

(三) 與藥師公會及社區藥局合作，加強縣市內社區藥局及藥師之「珍愛生命守門人」繼續教育訓練，提高藥事人員對藥物購買者自殺徵兆敏感度，強化藥事人員對於自殺高危險群處遇態度與轉介行為。

(四) 加強非精神科開立安眠藥鎮定劑之教續宣導，包含處方合理性、自殺警訊辨識與處置(Reisch, Pfeifer & Kupferschmidt, 2018)。

(五) 特殊病人用藥注意事項：

1. 慢性疼痛病人：該症狀病人有很高的比例合併憂鬱症及自殺意念，臨床醫師若開立鴉片類止痛藥，務必開立較短期的處方，且最好由家人保管，同時加強家屬對自殺警訊的敏感度(Namkee et al., 2018)。
2. 憂鬱症病人：其在急性期時將合併高比例的自殺意念，醫師開立用藥時，宜優先考慮過量時較不易造成生命危險的用藥，如抗鬱劑的使用，「選擇性血清素回收抑制劑(SSRI)」、「選擇性正腎上腺素/血清素回收抑制劑(SNRI)」，就比傳統的三環抗鬱劑安全。

肆、由高處跳下自殺及自傷

預防高處跳下的自殺事件皆以設施的安全性強化為主，許多研究發現增設柵欄與安全網有助自殺率下降(John et al., 2018)，像是橋柵欄高度在 2.3 公尺以上，以及架設低於行人路面 4 公尺深的安全網，或限制至少在 15 公尺以上的高度禁止跳躍而加設護欄及安全網等(Hemmer et al., 2017)。以下將列舉其他幾項具體策略提供參考：

一、硬體安全裝置及監測有利於防治自殺(Barber et al.,2014)：

(一) 頂樓標示：於高樓頂樓以張貼海報或噴漆方式，標示關懷警語、求助資訊等。

(二) 安全裝置：加裝頂樓監視器、頂樓安全門裝置警報系統、安全網設置等。

(三) 巡守防治：由住宅大廈保全人員或社區巡守隊，加強頂樓監視器監測及巡視。

(四) 對自殺熱點(常發生自殺行為)建築物，建議管委會加強監視系統管理，及盡量避免無關人員出入頂樓安全門。

(五) 建築管理處於建築物之停車場設置三樓以上(含三樓)及建築物之頂樓為商業用途者，未來使用執照核發時，副知衛生局相關負責單位，以提供相關宣導訊息。

二、高樓的安全設計、醫院與精神醫療機構樓梯和屋頂入口管制，甚至設置緊急諮詢用電話，都可能有預防自殺的效果。

伍、溺水(淹死)自殺及自傷

年老多病者是浴缸溺死的高危險群，特別是久病年邁且具有精神疾病病史和自殺史之女性，故預防方式仍應著重在分析發生事前的原因和線索並加強年長久病者的社會支持網絡等(Nowers, 1999)。因此，勿使年長多病體衰者有機會進入浴缸，並額外加強社會支持網絡等(Nowers, 1999)成為最根本的防治策略。另外，針對戶外水域自殺事件的防範，有以下兩點建議：

一、將自殺熱點區域納入規畫設置巡邏區(Cox et al., 2013)。

二、在自殺熱點或水邊設立警告標示以及電話，限制進入深水區域。

三、於自殺熱點、水邊或橋上加裝護欄(John et al., 2018)

最後，期盼上述條列之全面性自殺防治策略得以連結社區、商家、醫療與照護機構到各地方衛生局處，甚至是大眾媒體管道，推廣各社群之自殺防治知能，促成網網相連的安全防護系統，落實「人人都是自殺防治守門人」之終極目標。

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