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SUICIDE MANAGEMENT AND PREVENTION: SUGGESTED PROTOCOL

by
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AN ABSTRACT OF THE PROJECT OF

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Suicide is a tragic and devastating event that continues to be among top twenty leading cause of death among nations of different age groups. Psychiatry illness contributes to 90% of suicide cases, it is estimated that around one million people die each year from suicide. These figures exclude rates of suicide attempts, which is believed to be twenty times higher if not more.

Despite Lebanese Ministry of Public Health recognition of the high prevalence of mental disorders, which is believed to be equivalent to rates in Western Countries, our government until this day lacks a structured policy and plan for mental health awareness and prevention, and still lacks a structured system for collecting and recording data on suicide rates.

The project will provide an overview on suicide epidemiology, factors associated with suicide, guidelines national guidelines for suicide prevention, and a suggested protocol based on evidence-based recommendations for suicide management and prevention to be adapted by the psychiatry department at the American University of Beirut Medical Center.

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CHAPTER I
INTRODUCTION

Suicide is serious health problem, which continues to be third leading causes of death among individuals aged 15-44 years (WHO, 2012). Suicide has an enormous psychological and social impact on the family and the community (U.S. Department of Health and Human Services, 2012). Psychiatric disorder is considered a major risk factor that contributes to 90% of suicide cases (Nock & Hwang et al., 2010). Clinicians effort towards understanding suicide and its prevention started in 1950's in the United State (U.S.), several efforts expanded later, as a result, the first National Strategy for Suicide Prevention was released in 2001 (U.S. Department of Health and Human Services, 2012).

Despite the lack of mental health policies in the general health delivery system and the lack of epidemiological statistics on suicide rates in Lebanon (WHO, 2011), the prevalence of mental disorders is estimated to be as high as in Western countries (WHO, 2010). The aim of this project is to develop a protocol for suicide management and prevention, based on the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action (U.S. Department of Health and Human Services, 2012), and tailored to the needs of high risk individuals presenting to American University of Beirut Medical Center (AUBMC) through Emergency Department (ED), and psychiatry inpatient and outpatient clinics.

A. Background

Suicide became of social interest during 1600's, as it was reflected in art, theatre and academia. Philosophical debate on suicide returned in 1608 after John

Donne the English poet defended suicide in his writings. Later, a new approach of human society was developed early 19th century. In 1897, Emile Durkheim had his first publication on social analysis, which was one of the reasons that suicide is less stigmatized now a day. He argued that suicide is not just an individual choice, and that external stressors from society contribute to this act. The second major influence for suicide to be destigmatized was through the development of psychology; Sigmund Freud addressed suicide in terms of one's inner mental and emotional state and suggested that a mental disorder is a medical condition. The conception that psychological distress could be triggered by biological, psychosocial and environmental factors helped many countries change their civil and criminal laws on suicide, and that suicide is not a crime (Jacob Crouch Foundation, 2011).

Efforts of clinicians on understanding suicide and its prevention started in 1950's in the United State (U.S.). The first Suicide Prevention Center opened in Los Angeles, California in 1958. Effort expanded later in 1966, as a result, the Center for Studies of Suicide Prevention was established at the National Institute of Mental Health (NIMH) of the National Institute of Health (NIH), and consequently, several national nonprofit organizations were established and were devoted to work on suicide prevention. In 1970, NIMH organized a task force team to discuss the status of suicide prevention. Later in 1983, the Center of Disease Prevention (CDC) established a Violence Prevention Unit alarmed public on the drastic increase rates of suicide among youth. In 1996, survivors of suicide and politics in U.S. participated in launching a campaign to encourage creation and implementation of national strategies on suicide that was based on the United Nations guidelines. These efforts resulted in recognizing suicide as a public problem in the U.S., and promoted a modern suicide prevention movement. The first National Strategy for Suicide Prevention was released

in 2001, this strategy included recommendations for a public health approach to prevent suicide, which was based on awareness, interventions, and methodologies. In the years that followed, several efforts and activities facilitated the advancement of suicide prevention. (U.S. Department of Health and Human Services, 2012)

According to the WHO, approximately one million people died from suicide, which represent one death every 40 second. It estimated that by year 2020 the rates from suicide will increase to one death every 20 seconds (WHO, 2012). Until this day, suicide in many countries is under-reported because of the stigma, religious concerns and social attitudes; and statically not accurate because of death cases hidden under other causes of death like single car accidents, unobserved drowning or undetermined death (Karam & Hajjar et al., 2007; U.S. Department of Health and Human Services, 2012; Goldney, 2013). The median suicide rate for the countries of the Eastern Mediterranean Region is 4.90 per 100 000 people, compared with 6.55 for all countries of the world. On average, 86% of these people are in low/middle-income countries (WHO, 2012).

Suicide rates remains to be the highest in Eastern European countries, specifically in Lithuania and the Russian Federation (WHO, 2012). In the U.S, in 2010, suicide accounted for 38,364 deaths, a rate of 12.4 per 100,00 (Centers for Disease Control and Prevention, 2010), while in Canada and United Kingdom (U.K.), death of suicide accounted for 3,890 for year 2009 and 6,045 for year 2011, this is equivalent to 11.5 and 11.8 per 100,000 people (Office of National Statistics, 2011; Government of Canada, 2012). Furthermore, in the U.S., suicide is the third leading cause of death among ages 10-24, second leading cause of death among ages 25-34, and fourth leading cause of death among ages 35-54 (Centers for Disease Control and Prevention, 2010), whereas in Canada; it is the ninth leading cause of death among all

age groups, with highest rates among ages 40-59 (45%) and 15-39 (35%) (Government of Canada, 2012), whereas in the U.K, the highest rates of suicide reported was among ages 30-59 (Office of National Statistics, 2011). In regards to the methods used in suicide, drug poising remains to be the most common method used among females, however in males; firearms are the most commonly method in U.S, and hanging (including strangulation and suffocation) the most commonly method in Canada and U.K. (Office of National Statistics, 2011; Centers for Disease Control and Prevention, 2010; Government of Canada, 2012).

Death from suicide is only part of the problem; for every person who dies by suicide, thirty other people tend to survive their suicidal attempt, and every suicide is at many times preceded by several suicide attempts (U.S. Department of Health and Human Services, 2012). The burden of suicidal behaviors is hefty, as it affects suicide survivors along with their families and friends with unbearable emotional distress and pain, not to mention the financial burden allied by the medical costs and loss of productivity. There is no doubt that suicide is a major preventable public health problem; however suicide is a multi-determined phenomenon which occurs in light of interactive complex which includes biological, social, psychological and environmental risk and protective factors (U.S. Department of Health and Human Services, 2012; WHO, 2012). Understanding the interactive relationship between risk and protective factors, and how these interactions can be modified, is the first step towards prevention, not to mention the combined effort that is needed from the government, health care institutes, communities organizations, families and individuals to decrease suicide and suicide attempts rates (U.S. Department of Health and Human Services, 2012).

B. Significance

The incidence of suicide is on the rise, specifically in low-income and middle-income countries where they bear the largest part of the global suicide burden, whereby the WHO postulates that by year 2020 two percent of global burden will be attributed to suicide. This debilitating postulation obligated the WHO to identify suicide as a priority condition in the Mental Health Gap Action Program for 2008. According to the WHO report, there is an urgent compelling need for governments to develop conceptualized comprehensive national prevention strategies, this demands a multi-sectorial approach, including but not limited to; the Ministry of health, Education and Social Welfare, public health sectors, mental health services, politicians, suicide survivors and their families, and non-profit organizations and media (WHO, 2012). It is proposed that suicide prevention strategies establish effective mechanisms to monitor and gather data on suicide and suicide attempts, increase awareness on suicide prevention and reduce stigma associated with suicide behaviors, identify risks and protective factors associated with suicide behaviors, optimize psychological support for individuals who attempted suicide and for families of individuals who committed suicide through community network and crises centers, restrict access to the means of suicide behaviors (firearms, pesticides…) and use of alcohol, increase public and media awareness of the magnitude of the problem and the availability of effective prevention strategies, and improve health systems responses to suicide behaviors (WHO, 2012 & 2013).

Suicide in developing countries, including the Lebanon, has received little attention in research over the past years despite its importance and severity. Till this day suicide and suicide attempts are prohibited by religion and considered a sin that brings shame and dishonor to the victims and their families. It is believed that due to

religious and social taboo, most suicide and suicidal attempts incidents are covered up and underreported (Lester, 2006; Karam & Hajjar et al., 2007), its believed that in some countries 20 to 100 percent of suicide cases are underreported (Bertolote & Fleischmann, 2002). These factors attributed in the nonexistence and scarcity of epidemiological prevalence statistics of suicidal behaviors in developing countries (Karam & Hajjar et al., 2007; Mahfoud & Afifi et al., 2011).

In Lebanon, psychiatric disorders are estimated to contribute to 14.5 % of the global burden of disease, however only five percent of mental health expenditures are covered by the government (WHO, 2011). According to the WHO report, mental health legislation was initiated and was last revised in 1983, not to mention the absence of Mental Health Department within the Ministry of Public Health (MoPH), death of mental health policy and inadequacy of a structured system to collect and record mental health data, including suicide rates, within the government setting (WHO, 2011). Since 1975, the WHO has been recommending the integration of mental health services into primary care settings, yet recommendations continue to be proposed. It is estimated that only one percent of primary and secondary schools have either part-time or full time mental health professionals, and 1 to 20 percent of schools implement school-based activities to promote mental health and prevent mental disorders (WHO, 2010). Similarly, majority of primary health care doctors and nurses (WHO, 2010) and less than 20% of police officers, judges and lawyers (WHO, 2010), have not received official training or educational activities on mental health over the past few years. To add to the scarcity, emergency/disaster preparedness plan for mental health, and forensic facilities and units still does not exist (WHO, 2010).

Over the past few years, significant numbers of patients were admitted to the ED and the psychiatry inpatient unit, at AUBMC, because of suicidal thoughts and

attempts, not to mention number of patients lost due to suicide post discharge. Following the mission and vision of AUBMC, which is dedicated to improve health through delivering an outstanding patient-centered care, and providing high quality and safety services to meet needs of community in Lebanon and region (AUBMC, 2014) and in response to the WHO global targets by 2020: 80% of countries will have at least two functioning national, multi-sectorial promotion and prevention programs in mental health, which estimates a drop in the rates of suicide in countries will be reduced by 10% (WHO, 2013). This project aims at preparing a protocol for comprehensive suicide assessment, developing appropriate treatment plan, guidelines for discharge plan and follow-up care by mental health providers working at AUBMC, for people at risk of suicide presenting to the Emergency Department (ED), the psychiatry outpatient clinics, and admitted to the psychiatry inpatient unit. The protocol will shed light on latest evidence-based clinical practices that are recommended by national suicide strategies that have been evaluated for their effectiveness in reducing suicide rates.

CHAPTER II
LITERATURE REVIEW

There is no doubt that suicide is a major, preventable public health problem that affects people of all ages; nevertheless it is a very complex behavior that presents in different forms and levels of severity. Suicide behavior may range from self-inflicted injury, suicidal ideations, suicide plans, suicide attempts, to complete suicide. The holistic view of suicide behavior delineates that no single path leads to suicide. (U.S. Department of Health and Human Services, 2012) Comparatively, throughout life, a merger and synergy of chronic and acute risk factors that tend to increase the likelihood of suicide behaviors among these individuals (U.S. Department of Health and Human Services, 2012; Centers for Disease Control and Prevention, 2012).

Based on the World Health Ranking statistic for 2011, suicide rates in Lebanon are estimated to be 3.3% (World Health Rankings, 2011), nevertheless, countries with low suicide rates are often suspected for labeling suicide cases as natural, accidental or undetermined deaths (Lester, 2006). In Lebanon, only 5% of health research publications are on mental health issues (WHO, 2010), as a result, there is scarcity of epidemiological statistics to weigh risk factors. Suicide prevention attempts to reduce and modify risk factors that are believed to increase risks of suicidal behaviors, and boost factors that promote resilience and help strengthen, support, and protect individuals from suicide (U.S. Department of Health and Human Services, 2012; Centers for Disease Control and Prevention, 2013).

A. Risk and Protective Factors

Suicide behaviors are often related to chronic and acute risk factors. Chronic risk factors include predisposing and potentially modify risk factors: mental disorders

and physical illnesses. While perpetuating non-modifiable risk factors, include: socio-demographics, history of suicide attempt and self-inflected behaviors, history of trauma, and family history. Acute risk factors: recent life stressors, active suicidal ideations, recent discharge from psychiatric hospital and acute psychological symptoms (American Association of Suicidology, n.d.)

1. *Predisposing and Potentially Modifiable Chronic Risk Factors*

a. Mental Disorders

Numerous studies has confirmed the association between mental disorders and suicide behaviors, it is estimated that 90% of people who die from suicide have diagnosable mental disorder (Bertolote & Fleischmann et al., 2002; Nock & Hwang et al., 2010), which includes; mood disorders, anxiety disorders, personality disorders, psychotic disorders and substance use disorders.

Mood disorders, specifically major depressive disorder and bipolar disorder, are most common psychiatric disorders associated with highest risk for suicide and it's believed to be the most life threatening psychiatric illness (U.S. Department of Health and Human Services, 2012). Individuals with bipolar disorders and major depressive disorders are 20 times at higher risk to attempt suicide (Kutcher & Chehil, 2012), in addition, 15 to 19 percent of individual with bipolar disorder tend to die of suicide, specifically during psychotic manic episode (Nock & Kessler, 2006) or severe depressive episodes (U.S. Department of Health and Human Services, 2012).

Alcohol and substance abuse is the second leading cause of death due to suicide after mood disorders (U.S. Department of Health and Human Services, 2012), it is estimated that individuals with alcohol abuse and dependency are 4.6 to 4.8 times at higher risk to attempt suicide attempt (Nock & Hwang et al. 2010; Bolton &

Robinson, 2010) and 4.2 increased risk for individuals with substance abuse and dependency (Nock & Hwang et al. 2010). Comorbidity of substance use disorder with other mental disorders is common, including mood disorders, posttraumatic disorders, anxiety disorders and personality disorders. Not to mention individuals treated for alcohol and substance abuse are ten folds at risk to die from suicide. (U.S. Department of Health and Human Services, 2012)

Anxiety disorder has been also been associated with suicide ideation and attempts (U.S. Department of Health and Human Services, 2012), with increased risk individuals with posttraumatic stress disorders (Bernal & Haro et al., 2007; Bolton & Robinson, 2010; Nock & Hwang et al., 2010), generalized anxiety disorders (Bernal & Haro et al., 2007; Nock & Hwang et al., 2010), panic disorder and social phobia (Nock & Hwang et al., 2010). Anxiety disorders frequently occur with other psychiatric disorders including mood disorders, personality disorders and substance use disorders, which in return increase likelihood of suicide attempts (U.S. Department of Health and Human Services, 2012).

Studies indicated that personality disorders (Nock & Borges et al., 2008), specifically borderline personality disorder (BPD), is associated with three folds increase for suicidal attempts (Bolton & Robinson, 2010) and estimated that 3 to 10 % of individuals with BPD die of suicide (U.S. Department of Health and Human Services, 2012). Individuals with BPD tend to frequently engage in self-inflected injury and impulsive aggressive acts, and have recurrent suicidal attempts, however, death of suicide usually occurs later in course of illness and after long course of unsuccessful treatment (U.S. Department of Health and Human Services, 2012).

Schizophrenia was also found to be associated with suicide (Bertolote & Fleischmann, 2002; Nock & Borges et al., 2008), studies revealed that up to 5% of

patients diagnosed with schizophrenia will die from suicide, with highest percentage early stage of diagnosis (3 to 5 years of onset), risk of suicide tend to elevate when patient is in active psychotic phase and presenting with depressive symptoms, of high socioeconomic status, higher level of education (U.S. Department of Health and Human Services, 2012).

b. Physical illnesses

Individuals with serious chronic physical illness; such as cancer, *Human Immunodeficiency Virus* (HIV) infection and Acquired Immunodeficiency Syndrome (AIDS), neurological disease and other chronic diseases, are associated with an increased risk for suicidal behaviors (U.S. Department of Health and Human Services, 2012; WHO, 2002). Cancer is considered the most common medical illness associated with suicide, precisely within first five years of disease diagnosis, this can be elucidated by treatment side effects, and manifestation of mental disorders, like depression and anxiety (U.S. Department of Health and Human Services, 2012). With respect to *individuals with* HIV infection and AIDS, studies revealed an increased risk for suicide behaviors, with lifetime prevalence ranging from 22 to 50 percent for suicide attempts among individuals with HIV, risk heightens among young individuals, at early stage of diagnosis and in presence of psychiatric illness (U.S. Department of Health and Human Services, 2012; WHO, 2002).

Neurological disorders; like Huntington disease, Parkinson's disease, multiple sclerosis and, epilepsy, spinal cord injuries (SCI) and traumatic brain injuries (TBI), were also found to be associated with increase risk of suicide behaviors. Studies revealed that major depressive disorder is thought to be a consequence of Huntington and Parkinson's disease. Among individuals with Huntington disease lifetime prevalence of suicide attempts vary from 4.8 to 17.7 percent, conversely in

Parkinson's disease suicidal ideations were found to be more prominent. Turning to individuals with multiple sclerosis, studies showed that 37 to 54 percent of these individuals suffer from depression, along with other mental illness; hence there is an increased risk for suicide (U.S. Department of Health and Human Services, 2012). Suicide rates among individuals with epilepsy rang from 0 to 25 percent. This is thought to be associated with impulsivity, aggression, and chronic disabilities generated from the disease (WHO, 2011; U.S. Department of Health and Human Services, 2012). SCI and TBI increase risk for depression and suicide, moreover, individuals with moderate TBI are three to four at higher risk to die of suicide (U.S. Department of Health and Human Services, 2012). Other medical conditions such as migraine, chronic renal disease, cardiovascular and gastrointestinal disorders, and liver disease are implicated in suicide behaviors.

2. *Perpetuating Chronic Non-modifiable Risk Factors*

a. Socio-demographic

Emerging evidence suggests that perpetuating factors such as socio-demographics factors are associated with the increase risk of suicide behaviors. In general, Males are three to four times at higher risk than females to die by suicide (Office of National Statistics, 2011; Centers for Disease Control and Prevention-2012; Government of Canada, 2012). When it comes to engaging in suicide behaviors, men are at higher risk to engage in suicide behaviors; including suicide attempts and plans, with intent to die (Nock & Kessler, 2006), whereas women are at higher risk to engage suicidal behaviors; including suicide attempts, self-inflected injuries, suicidal ideations (Nock & Borges et al., 2008; Bernal & Haro et al., 2007) and suicidal plans (Borges & Nock et al., 2010), with intent to call for help. Moreover, studies revealed that lesbian

and bisexual females are two to three times at higher risk to attempt suicide than heterosexual females; likewise gay and bisexual males are four times at higher risk to attempt suicide than heterosexual males (U.S. Department of Health and Human Services, 2012).

Young individuals between age 15 and 35 years old (Nock & Borges et al., 2008; Bernal & Haro et al., 2007), and older adults above age 60 years old (Simon & Hales, 2012; U.S. Department of Health and Human Services, 2012; Ballon & Waller-Vintar, 2010) are more prone to engage in suicidal behaviors.

Being unemployed, having lower educational attainment, being unmarried or previously married, either due to separation, divorce or death of spouse (Bolton & Robinson, 2010; Bernal & Haro et al., 2007; Borges & Nock et al., 2010; Nock & Borges et al., 2008; Nock & Kessler, 2006) were all found to be associated with increase risk for suicide behaviors.

b. History of Suicide Attempt and Self-Inflicted Injury

Previous suicide attempt is believed to be a predictive risk factor for death by suicide. In many cultures suicide is treated with silence, prejudice and misunderstanding, this in return leaves suicide survivors struggle with reintegration into their community. Suicide survivors struggle with shame, guilt, fear from rejection, self-doubt and social isolation, which might lead to reattempting suicide and increase risk of death by suicide (U.S. Department of Health and Human Services, 2012).

Self-inflected injuries; including cutting, burning and hitting, can lead to serious injuries that in many situations need medical interventions, not to mention the permanent scarring left behind and risk for accidental death as a consequence of such behavior. It is believed that suicide thoughts and suicide attempts tend to increase with time among individuals with self-inflected behaviors regardless of the intent behind

their behavior (U.S. Department of Health and Human Services, 2012). Regardless of intent behind self-inflicted behaviors, research implies that there is increased risk for self-inflected behavior recurrences, in addition to the increased risk of dying by suicide within 10 years (U.S. Department of Health and Human Services, 2012) specially if intensive treatment not available, however most of these individuals are not taken seriously specially when presenting to ED (Skeem & Silver et al., 2006).

c. History of Trauma and Abuse

The presence of trauma and abuse in ones life is believed to intensify risk of suicide behavior particularly when it interacts with psychological, biological, medical and socio-demographic factors (Nock & Borges et al., 2008). Studies revealed strong correlation between adverse events in juvenile's life and likelihood of negative outcome throughout maturity, including suicide behaviors (U.S. Department of Health and Human Services, 2012). History of family abuse (U.S. Department of Health and Human Services, 2012) and child neglect/maltreatment (Nock & Borges et al., 2008), including emotional, sexual and physical abuse, incline risk for suicide plans and attempts (Borges & Nock et al. 2010; U.S. Department of Health and Human Services, 2012). With multiple rapes and molestation, risk for suicide tends to further increase (Borges & Nock et al. 2010).

d. Family History

Family history of suicide was found to be associated with increased increase risk for suicide (U.S. Department of Health and Human Services, 2012), moreover, individuals exposed to suicide and suicide attempts among family members has also been found to increase suicide risk in those individuals (De Leo & Heller, 2008). Studies have also found that suicide risk increase in presence of violence and

substance abuse in the family, high level of conflicts, presence of legal/disciplinary problems and poor family support (Borges & Nock et al. 2010; U.S. Department of Health and Human Services, 2012).

3. *Acute Risk Factors*

a. Recently Discharged from Psychiatric Hospitalization

Based on research, suicide attempts for psychiatric patients peaks within first week of admission (inpatient setting), and immediately after discharge; mainly first week and up to one month (Simon & Hales, 2012), whereby national surveys conducted in the U.K. showed that 40 % to 47% of death from suicide occurred within the first month after discharge, with highest peak within first week. Risk factors for suicide was unplanned discharge, lack of continuity of care, admitted for suicidal attempt, self-harm and suicidal ideations prior to admission, and unemployment (Links & Nisenbaum et al., 2012; Meehan and Kapur et al., 2006, Bickley and Hunt et al., 2013). In regards to suicide rates during hospitalization, 31% of patients died in the inpatient ward, most frequent method used was hanging, and most incidents took place in bathrooms and single patients' room. Staff members believed that most cases could have prevented with close observation, increased staff members, and proper staff training (Meehan and Kapur et al., 2006). Moreover, among adolescent who were admitted to psychiatry inpatient for suicidal ideation, 13.9% attempted suicide within 3 months and 25% within 18 months post discharge (Prinstein & Nock et al., 2008).

Based on Gunnell et al. finding, 11.7% of total admissions to psychiatric admission were related to self-inflected behaviors and 38% were readmitted within 12-month period (Gunnell and Hawton et al., 2008). In a prospective follow-up study done in Canada on patient admitted because of suicidal ideations, self-inflected

behavior or suicidal attempt, authors found that 39.4% of cases had recurrent self-inflected behavior and attempts within 6 month after discharge (Links & Nisenbaum et al., 2012).

b. Psychological and Psychosocial Risk Factors

Psychological factors include recent suicide attempt, active suicide ideations or suicide plan; rapid mood swings; feeling of purposelessness, hopelessness, burdensome, shame or guilt; active psychotic symptoms like command hallucination and paranoid delusion; and presence of aggression, impulsivity and severe insomnia Other psychosocial risk factors include severe recent stressful events such as interpersonal loss or conflicts, unemployment, financial problems, and legal issues. All these factors are believed all to increase risk of suicide in the near future. (American Association of Suicidology, n.d.; Ballon & Waller-Vintar, 2011)

4. Protective Factors

Although much recent research into suicidal behaviors has focused on exploring risk factors, however there has been relatively little research directly focusing on protective factors from suicide. It has been speculated that protective factors act to mitigate risk factors associated with suicide, thus reducing its likelihood. Protective factors are skills, strengths, or resources that help individuals deal more effectively with stressful life event through enhancing resilience and helping counterbalance risk factors (Ballon & Waller-Vintar, 2010; U.S. Department of Health and Human Services, 2012). One of the most important protective factors is enhancing individual attributes like cognitive abilities, self-perception of competence, temperament and personality, self-regulation skills and positive outlook of life, in addition having strong family and social support, and having strong religious and

spiritual values, are also believed to counteract suicide. Further having community resources and services like easy access to mental healthcare facilities, support groups for suicide survivals and their families, and crises intervention hotline tend to reduce suicide risk (Simon & Hales, 2012, Ballon & Waller-Vintar, 2010; Nock & Borges et al., 2008).

C. Religion and Suicide

Suicide in no longer a criminal offense in many countries, however the religious and social factors are believed to be the main contributing factors behind underreporting and registration of suicide behaviors. Due to fear of social stigma and religious beliefs, many families do not disclose the true nature of death by suicide (Khan, 2005).

Despite technology and science remarkable advancement, it is estimated that 90% of world's population is involved in some religious and spiritual rituals (Koening, 2009). Religion is the beliefs, practices, and rituals related to the sacred; it guide individuals within a social group on life after death and rules about conduct. Spirituality however is the rules, regulations, and responsibilities of an individual that are associated with a certain religion (Koening, 2012).

Historically suicidal behavior has been considered a gravely wrong moral action; the stances of different religions about suicide are approximate. According to Jewish law suicide is considered a sin and a very serious offense; life is a divine gift and killing self it is considered total defiance of God's will for the individual to live the life span allotted (Jacobs, n.d.). Similarly Christianity considers suicide a grave and sometime a mortal sin, in addition, one's life –body and soul- is property of God that is sacred and should be preserved, destroying wrongly asserts dominion over what is God's (Saunder, 2003). Also in Islam, Muslims know that "God is He who gives life

and it is only He who can take life", hence suicide is viewed as worst of all sins that is prohibited and unpardonable to ones spiritual journey, leading to hell (Abdul-Khaaliq, 2010). Recent studies propose that religion can prevent from suicide primarily through religious doctrines that prohibit such act, and through religious support that will help individuals with psychological pain to cope better, and gain hope and meaning for life. In contrast, religious involvement is thought to exacerbate religious conflicts, guilt, fear, and isolation among individuals with psychotic disorders, anxiety disorders, and history of suicide attempts (Koening, 2009 & 2012).

D. Studies in Lebanon

Lebanon has been subjected to several wars and local conflicts over past few decades; these distressing situations exposed citizens to experience and witness several traumatic events. The impact of war on people, particularly children, is believed to affect their cognitive, emotional and social development; this in return puts them at a higher risk to develop psychiatric disorders (Farhood, 2013). Other studies also found positive association between war-related traumatic events and psychiatric disorders. In South Lebanon for example, prevalence of Posttraumatic Stress Disorder (PTSD) was found to be 24.1%, depression 16% with co-morbidity of 59.6% (Farhood & Dimassi, 2012), these findings were similar to a previous study done earlier in same region, where prevalence of PTSD was found to be 29.3% (Farhood & Dimassi et al., 2006). Additionally, Karam et al. found that 68.6% of selected sample were exposed to at least one wars event, and 25.8% met at least one of the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV) criteria; with highest prevalence for anxiety (16.7%), mood disorders (12.6%) (Karam & Mneimneh et al., 2009). Furthermore, a national epidemiological survey done by the WHO, results from Lebanon found that the prevalence of psychiatric disorders based on DSM-IV criteria

was 17%, the most prominent disorders was anxiety (11.2%), and major depression (4.9%). Additionally, strong correlation was found between war- related traumatic events and psychiatric disorders onset (Karam & Mneimneh et al., 2006).

Few studies have investigated prevalence of suicidal behaviors among Lebanese individuals. A Global Health Survey done among adolescent between 11 and 16 years, the authors found that prevalence of suicide ideation was 16%, hopeless was 38%, and 12 to 14 % felt lonely or worried over past 12 months, in addition 33.8 % and 17.3 % of adolescent reported history of bullying and sexual harassment (Mahfoud & Afifi et al., 2011). A previous study done among students at American University of Beirut found that prevalence of suicide ideation and suicide attempt to be 13.9 and 6.3 percent (Karam & Hajjar et al., 2007), in both studies prevalence of suicide ideations was higher among females. Surprisingly prevalence of suicide ideations was similar to other countries of the Eastern Mediterranean Region (13-17)% (Mahfoud & Afifi et al., 2011). Likewise, in a cross-national study across 17 countries including Lebanon, found main risk factors for suicidal behavior was being female, young (18-34 years), less educated, unmarried and having mental disorders. Analysis also revealed strong correlation between mood disorders and suicidal ideation, plan, and attempt in high-income countries, while in low-income countries; association was highest with impulse-control disorders. Whereas for prevalence of suicide behaviors, suicidal ideations was 9.2%, suicide plan 3.1%, and suicidal attempt 2.7%, an intriguing finding in the same study suggested that 60% of those with suicidal ideations have developed suicidal plan or suicidal attempt within the same year (Nock & Borges et al., 2008).

In a prospective study done by Sinno et al. on patterns of self-poising among children and adolescent admitted to ED at AUBMC and Makassed General Hospital,

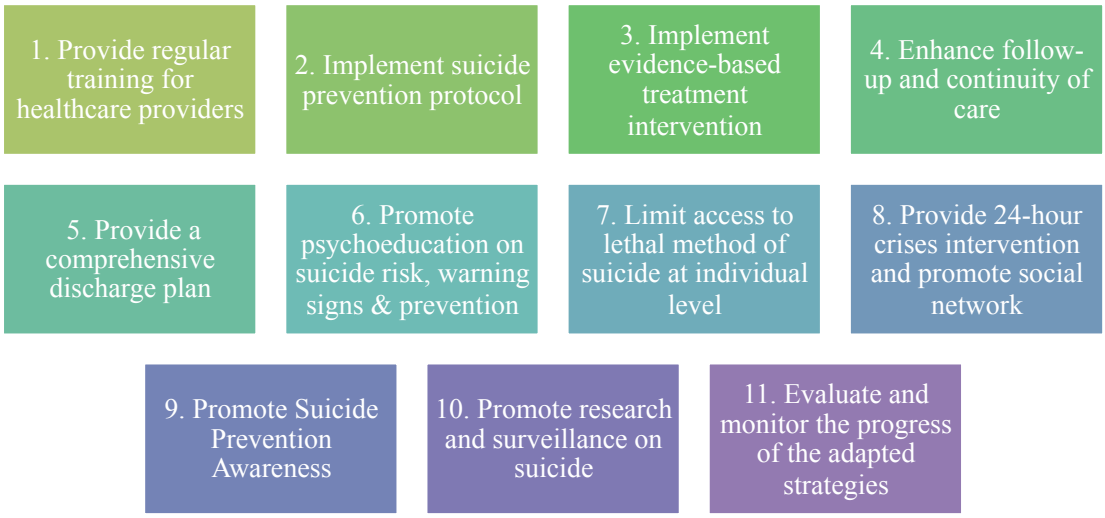
authors found that among adolescent, incident of intentional self poisoning are five folds higher among females, noting that the pharmaceutical poising was most prominent irrespective of gender (Sinno & Majdalani et al., 2009). Bruffaerts et al. conduct a national survey, across 21 countries including Lebanon, to study association of child adversity and lifetime suicide behavior, results revealed that lifetime prevalence of suicide ideations, suicidal plans and suicide attempt were 9.4, 3.1 and 2.7 percent, interestingly there was strong association between suicide behavior and history of sexual and physical abuse (Bruffaerts & Demyttenaere et al., 2010). Another recent national survey, across 21 countries including Lebanon, found that only 39% of individuals who engaged in suicide behavior in past year received treatment, of which 23% visited a mental healthcare. Surprisingly barriers for not seeking treatment were; 58% perceived low need for treatment, 26.7% thought they can handle the problem alone, 11.5% thought they will get better, 11.7 % had financial barrier, and 10.9% had resources barrier. Intriguing finding was for stigma, where only 6.7% thought that is was a barrier for them to seek treatment (Bruffaerts & Demyttenaere et al., 2011).

E. Theoretical Framework

Suicide is a public health problem, hence, a multisectoral collective effort-government, healthcare industries, communities, academics, and organizations-is needed to reduce incidence of suicide (WHO, 2013; U.S. Department of Health and Human Services, 2012). Over past few decades, the WHO along with other countries, including U.S. and U.K., have developed several national strategies for suicide prevention. Although national suicide prevention strategies differ in their model and structure nevertheless they share the same main core elements. These core elements that are directed towards: creating a supportive environment that promotes mental health and reduce risks for suicide behaviors; promoting wellbeing through providing

supportive systems, services and resources; encourage the implementation and integration of evidence-based treatment interventions; increase surveillance and promote research (U.S. Department of Health and Human Services, 2012; Department of Health, 2012; WHO, 2013). For the purpose of this project, interventions from the "2012 National Strategy for Suicide Prevention: Goals and Objectives for Action" goals will be adopted and tailored to be culturally sensitive to the Lebanese population. This National Strategy for Suicide Prevention is the result of a joint effort by the Office of the U.S. Surgeon General and the National Action Alliance for Suicide Prevention (Action Alliance), which was first introduced in 2001 and reviewed recently. The proposed goals bring together resources in organized efforts and provides action plans that can be implemented in diverse sectors in the community, from healthcare systems and policy-makers to media and public, to prevent suicide. National Strategy for Suicide Prevention perceive healthcare providers as key gatekeepers for suicide prevention; hence certain interventions need to be integrated when developing a suicide prevention action plan at a healthcare facility (U.S. Department of Health and Human Services, 2012). Since the interventions of the project reflect the interventions of the national strategy it is worth listing goals related to the project (figure 1).

Figure 1: Suicide Prevention Interventions,



Adopted from "2012 National Strategy for Suicide Prevention: Goals and Objectives for Action"

Suicide is the result of the complex interplay risk and protective factors that occurs in the context of the individual's relationships, community, larger society, and culture. Understanding how these factors are interrelated is the first step towards building a public health approach for suicide prevention. The Social Ecological model (SEM) provides a framework for understanding how individuals and their social environments mutually affect each other across the lifespan (Dahlberg & Krug, 2002). The model was adapted and used for public health and health promotion and was used to provide an ecological perspective on health psychology and public health with a particular focus on several problem areas, including adolescent pregnancy, dietary change, and mental health like child abuse and violence (Dahlberg & Krug, 2002; McLeroy, et al. 1988). More recently, the National Alliance on Mental Health- New Hampshire (NAMI-NH) adapted this model in the Connect program. The Connect program provides training on suicide prevention, intervention and postvention for professionals, including mental health and substance abuse providers (Connect, 2014).

The Social Ecological Model will provide a useful framework for viewing suicide prevention intervention for suicide and suicidal behavior along the four levels of influences: individual, relationship, community, and society at large. The framework of the suggested protocol will be planned to implement evidence-based interventions that can reduce risk factors and increase protective factors at each level in this adapted model (Figure 2).

Prevention strategies should include a continuum of activities that address four levels of the model. These activities should be developmentally appropriate and conducted across the lifespan.

Individual: The first level identifies biological and personal history factors that increase risk for suicide. Among these factors are history of mental disorders and substance/alcohol abuse; previous suicide attempts, history of abuse, poor coping and problem-solving skills; hopelessness, impulsive and/or aggressive tendencies, job or financial loss (Dahlberg & Krug, 2002). Prevention approaches include emotional, social and behavioral skills training, psychotherapy, and psychoeducation to ensure treatment compliance (U.S. Department of Health and Human Services, 2012).

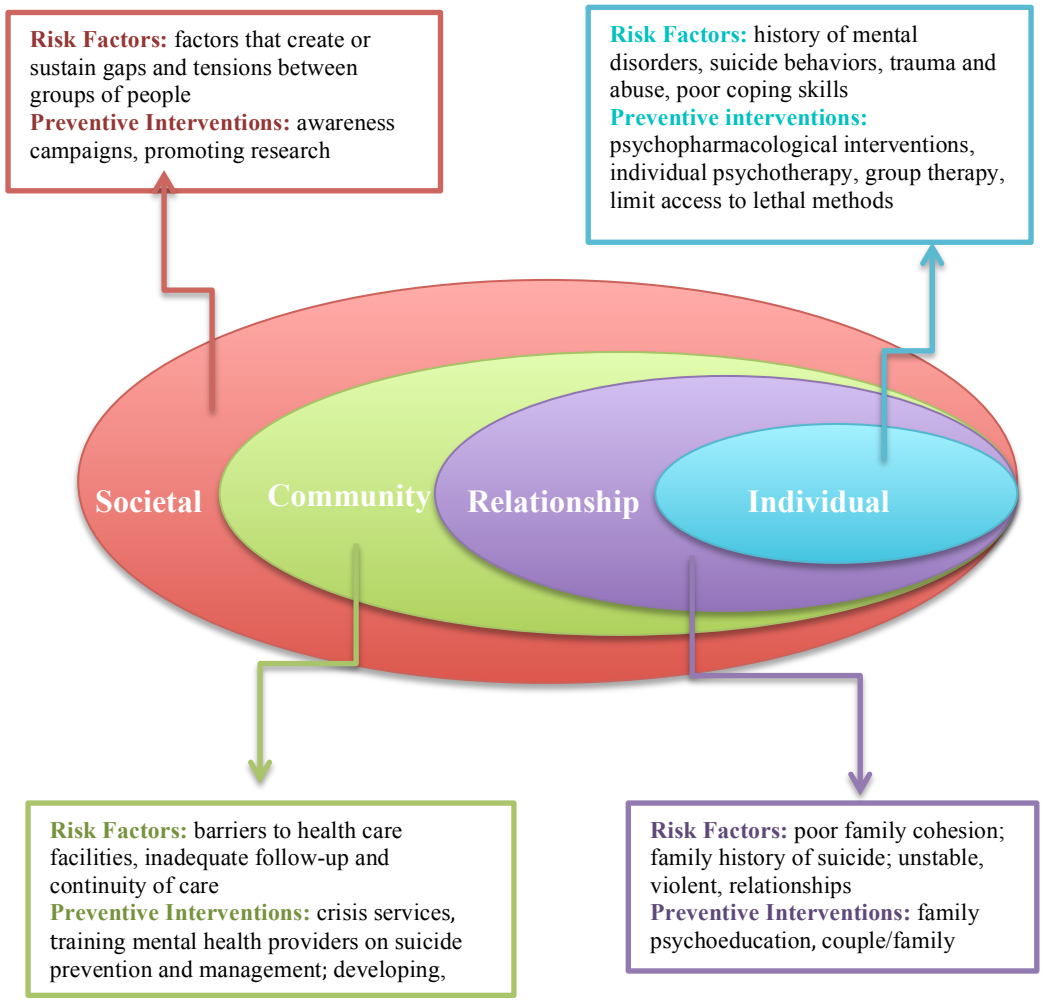
Relationships: The second level examines a person's closet social circle influences that contribute to suicide risk. For example having poor family cohesion; family history of suicide; and an unstable, violent, relationships (Dahlberg & Krug, 2002). Preventive interventions may include family psychoeducation, support groups, family or couple therapy (U.S. Department of Health and Human Services, 2012).

Community: The third level explores community and social environments that influence risk for suicide. This includes barriers to health care facilities, inadequate follow-up and continuity of care, and lack of social support services (Dahlberg & Krug, 2002). Preventive approaches include hospital policies for suicide prevention,

training health care providers on suicide assessment and management, crisis services and social support services at community level (U.S. Department of Health and Human Services, 2012).

Societal: the fourth level looks at the board societal factors such as religious or cultural belief systems, societal norms, and economic or social policies that create or sustain gaps and tensions between groups of people (Dahlberg & Krug, 2002). Preventive activities can include social media and awareness campaigns (U.S. Department of Health and Human Services, 2012).

Figure 2. Suicide Risk/Prevention Interventions in a Social Ecological Model



Adapted from: The Social Ecological Model (Dahlberg & Krug, 2002) and the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action (U.S. Department of Health and Human Services, 2012).

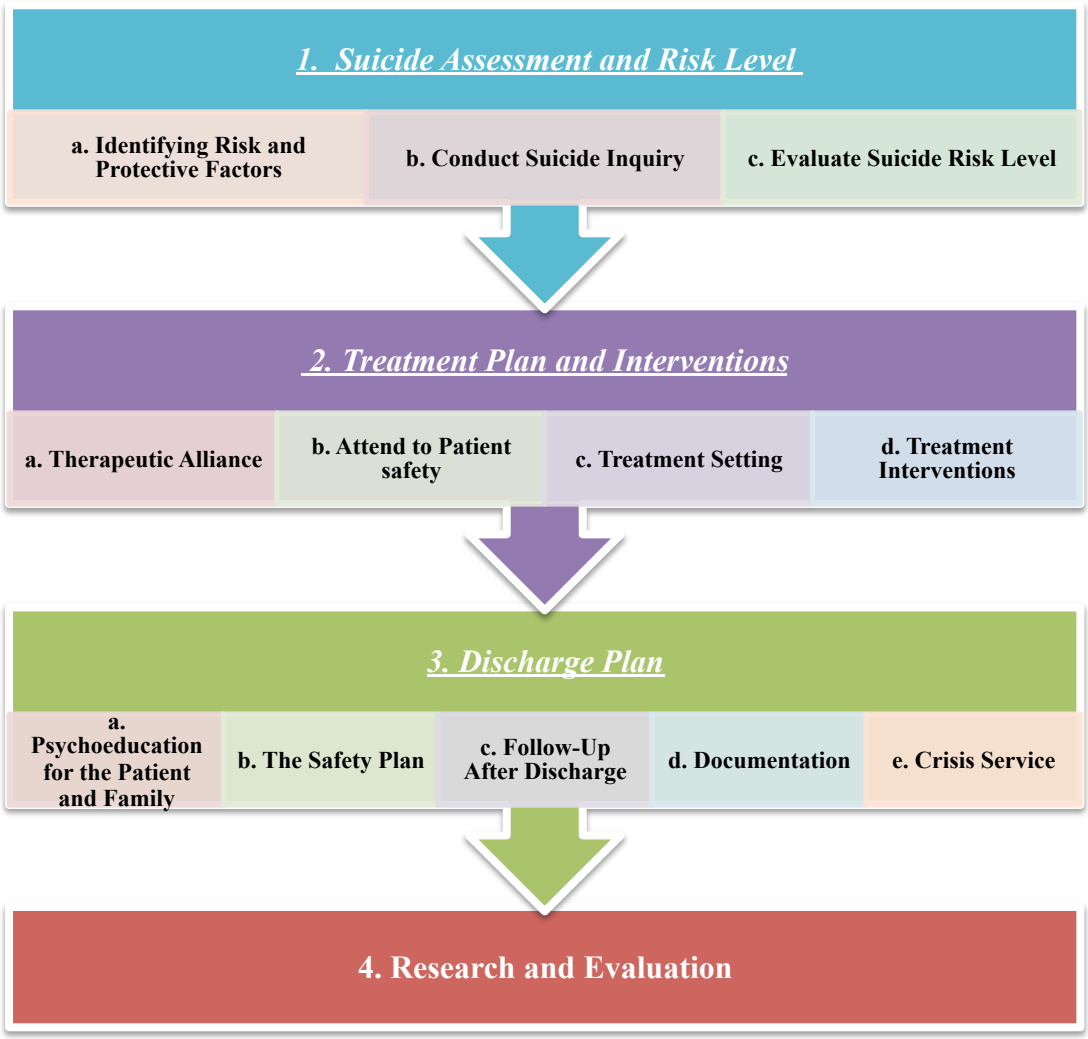
CHAPTER III
SUICIDE MANAGEMENT AND PREVENTION

Mental health providers-psychiatrist, psychotherapist, psychiatry residents, psychotherapist interns, psychiatric registered nurses, psychiatric social workers-are considered main key gatekeepers in suicide prevention. They are the ones who come in most frequent contact with individuals at risk for suicide in ED, outpatient clinics, and psychiatric inpatient unit. Not to mention that individuals at high risk for suicide are most commonly seen in the ED, however many go unrecognized, and almost half of individuals who get recognized fail to follow-up because appointments are weeks away from initial ED visit. One of the reasons for this gap is lack of mental healthcare providers, including registered nurses and residents, training on suicide assessment that takes into account understanding risk factors associated with suicide, and ability to detect early or acute warning signs and symptoms. (Knesper, 2010; U.S. Department of Health and Human Services, 2012)

The suggested protocol will cover core component interventions that are directed towards suicide prevention and management, it will be based on the "Social Ecological Model" (Dahlberg & Krug, 2002) and will adduce interventions adopted from the "2012 National Strategy for Suicide Prevention: Goals and Objectives for Action" (U.S. Department of Health and Human Services, 2012) tailored to meet the needs of the Lebanese population.

Suicide prevention and management (Figure 3) provides brief description of the evidence-based interventions to be adopted in the psychiatry department at AUBMC starting with comprehensive assessment and suggested treatment plan and interventions, followed by recommendations for a comprehensive discharge plan, and ending with evaluation for the protocol and research.

- **Figure 3: Suicide Management And Prevention Protocol**



A. Suicide Assessment and Risk Level

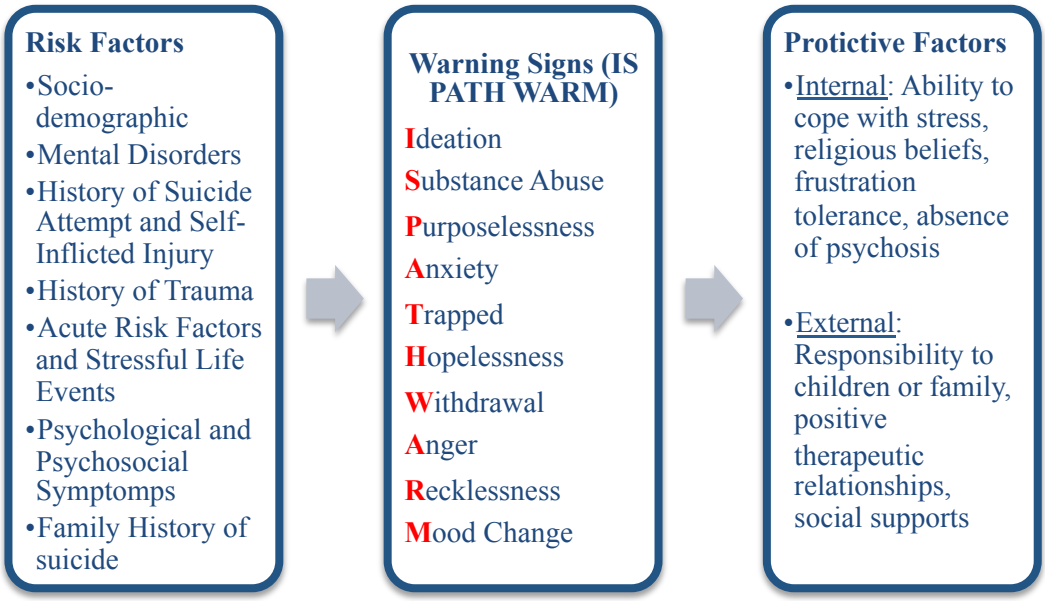
Mental health providers carry responsibility for assessing, developing appropriate treatment interventions, and managing individuals at risk for suicide. Suicide assessment should be considered at all points of entry into the health care facility, with occurrence of any suicidal behaviors, and whenever a significant clinical change is noted. Additional consideration for psychiatric inpatient unit, suicide assessment should be conduct before increasing privileges, before giving pass, and before discharge. In outpatient clinics, mental health providers should conduct suicide assessment upon first visit, follow-up appointment after being recently discharged

from inpatient unit or ED, when significant clinical changes are noted, and at various points throughout treatment (Ballon & Waller-Vintar, 2010).

1. *Identifying Risk And Protective Factors*

Assessment of individuals at risks begins with a comprehensive psychiatric evaluation. Through comprehensive assessment, mental health providers need to identify patient's risk factors and warning signs associated with suicide, and identify patient's protective (Figure 4) (Ballon & Waller-Vintar, 2010).

Figure 4: Identifying Risk And Protective Factors



2. *Conduct Suicide Inquiry*

When suicide ideations are present, mental health provider conduct an open and detailed inquiry about patient's suicidal behavior. Inquire about frequency, intensity, duration of suicidal thoughts, and inquire about extent of suicidal plan and intent (Ballon & Waller-Vintar, 2010). One of the most reliable and useful tools that can add further information for the overall suicide assessment is the Colombia-Suicide Severity Rating Scale (C-SSRS) scale for clinical practice (Appendix I). The C-SSRS

is the only screening tool that assesses the full range of evidence-based ideation and behavior items. Over the past few years, the C-SSRS questionnaires have been used in various settings; primary care settings, healthcare facilities, surveillance, research, and institutional settings, moreover the questionnaires were translated to several languages (Columbia University, n.d.). Posner et al. tested the C-SSRS scale for validity and consistency in three separate studies among adolescents and adults, results on scale showed good convergent and divergent validity, in addition, was proven for high sensitivity and specificity (Posner & Brown et al., 2011).

3. *Evaluate Suicide Risk Level*

The estimation of suicide risk is the quintessential clinical judgment based on discussion and exploration of risk and protective factors and suicidal ideation. The mental health provider determines level of risk (low, medium, high), and develops an appropriate treatment plan based on the risk level (Ballon & Waller-Vintar, 2010).

B. Treatment Plan and Interventions

Treatment plan is a dynamic process that takes into account the capacity of a mental health provider to form therapeutic alliance with patient, and the ability of a mental health provider to address patient's safety, and provide treatment intervention based on patient's needs and suicide risk level (U.S. Department of Health and Human Services, 2012; Knesper, 2010).

1. *Therapeutic alliance*

Therapeutic alliance is a crucial component of the treatment plan; it is usually established with the initial encounter between the mental health provider and the patient. By using empathy and understanding of patient's condition, a mental health provider can build trust, establish mutual respect, and ensure better compliance and

adherence to treatment plan. It is important that the mental health provider discuss patient's current condition, alternative somatic and psychosomatic interventions, goals and expected outcome of treatment plan with the patient and their family (Knesper, 2010; Jacobs et al, 2010).

2. *Attend to patient safety*

Second step in treatment plan is to address the patient's immediate safety, especially if patient is at high risk for suicide. Specific interventions, for patients presenting to ED or admitted to inpatient psychiatric unit, include seclusion, chemical and physical restraint to reduce agitation. Other appropriate interventions include maintaining safe environment through searching and securing patient's belongings, and removing hazardous material from the patient's room. In addition, monitoring patient based on suicide risk, this includes a range of frequency of observations from 1:1 (constant observation), to 15-minute and 30-minute rounds by a health care provider (U.S. Department of Health and Human Services, 2012; Ballon & Waller-Vintar, 2010; Jacobs et al, 2010).

3. *Treatment Settings*

For patients presenting to ED and outpatient psychiatric clinics, choice of appropriate treatment setting generally occurs after comprehensive suicide assessment. When a patient is evaluated to be at high or imminent risk for suicide, inpatient hospitalization should be obligatory and in some cases forced admission should be considered (Ballon & Waller-Vintar, 2010). However, hospitalization for suicidal patients is not considered a treatment, rather, a treatment setting used to facilitate observation, evaluation and treatment process. Important focus should be directed towards patient's social circumstances, risks, and factors that led for admission

(Baguley & Alex et al., 2007). Hence, patient's length of stay at the acute inpatient unit must balance between providing the patient with appropriate care needed in a safe environment, and stabilizing and preparing the patient to be transferred to another treatment facility or to be discharged to live independently in the community (Baguley & Alex et al., 2007).

4. *Treatment Interventions*

Patients with suicidal thoughts, plans and behaviors may benefit best from treatment interventions that integrates somatic and psychosomatic therapies. In general, somatic therapies such as antidepressant, antipsychotics, or mood-stabilizing agents are targeted towards treating the psychiatric disorders. However, supplement somatic treatment like sedative-anxiolytics and low doses of second-generation antipsychotics can be prescribed to target other risk factors associated with suicide such as agitation, anxiety and insomnia (Jacobs et al, 2010). Electroconvulsive therapy (ECT) is another form of somatic therapy that can be used to treat patients with acute suicide behaviors, however evidence suggests efficacy can be attained for only a short period of time (Ballon & Waller-Vintar, 2010; Jacobs et al, 2010).

There is growing evidence on importance of including psychosomatic interventions as a core component of the treatment plan, and to be considered upon admission or soon after being discharge from ED or psychiatric inpatient unit (Knesper, 2010). Clinical trails have found that psychosomatic intervention like cognitive behavior therapy, psychodynamic therapy, and interpersonal psychotherapy to be effective in treating mental disorders like depression and BPD; and demonstrated its efficacy in reducing risk for suicide (Jacobs et al, 2010). However one of the most promising therapies in suicide prevention is dialectic behavioral therapy (DBT). DBT is a theoretically based cognitive behavioral therapy developed initially for individuals

who are suicidal and who engage in self-inflected behavior. Furthermore, results from randomized controlled trails, have showed that DBT was effective in treating individuals with wide range of psychiatric disorders in various treatment settings. DBT approach focus on the psychological aspects of treatment, and devoted to teach individuals skills on emotional regulation, interpersonal effectiveness, mindfulness, and distress tolerance (Knesper, 2010). These skills can be taught through group skills sessions at the psychiatric inpatient unit, ranging from 45 to 75 minute daily sessions to one 90 minute weekly session (Bloom & Woodward et al., 2012). Through coaching and supervision, by trained psychotherapist, registered nurses can perform a more complex role (Baguley & Alex et al., 2007), such as running group skills sessions for patients admitted to the psychiatry inpatient unit at AUBMC. This is believed to add value to patient's treatment plan by helping patient's develop positive life skills and enhancing their resilience

C. Discharge Plan

Process of follow-up, continuity of care, and discharge plan for patients discharged from ED or psychiatric inpatient unit is another crucial component for suicide prevention. Based on research, majority of psychotropic medications need few weeks to reach optimal therapeutic effect, hence with brief psychiatric hospitalization, patients are discharged in a precarious state (Knesper, 2010). Moreover, there is compelling evidence that discontinuities in treatment and fragmentation of care can increase the risk for suicide. In addition, death from suicide is more frequent in the period after discharge from inpatient psychiatric units and ED. Hence, a comprehensive detailed discharge plan that includes patient and family psychoeducation, safety plan, and follow-up recommendations and crises services, is

recommended to be included in the discharge plan (Ballon & Waller-Vintar, 2010; Knesper, 2010; U.S. Department of Health and Human Services, 2012).

1. *Psychoeducation for the Patient and Family*

Patient and family psychoeducation is an important component to be addressed before discharge. All mental health providers are held responsible and are required to perform psychoeducation for the patient and family who present to ED, or are admitted to psychiatric inpatient units (Knesper, 2010). Patient and family can benefit from education given about the patient's symptoms and disorders that being treated for, as well as about the therapeutic approaches employed as part of treatment plan. This will help patient and family make informed decision, anticipate side effects and adhere to treatment (Jacobs et al, 2010).

Understanding that psychiatric disorders are real and that effective treatment are available and necessary may be crucial for the patients who attribute their illness to a moral defect, and for family members who are convinced that nothing wrong with patient. Patient and family should be also educated on how to identify symptoms, such as insomnia, hopelessness anxiety or depression, which may indicate early signs for worsening of patient's condition (Ballon & Waller-Vintar, 2010; Jacobs et al, 2010).

Furthermore, family members should be provided with information about lifetime risk of suicide, difference between suicidal attempt or intent and attention seeking behaviors, and helpful ways to respond positively when patient is in suicide crises. Safety measures regarding possible lethal method, including firearms and access to high doses of medication, for suicide need to be addressed discussed with patient and family. This will also include setting a plan to limit access to these lethal methods. Additional component is discussing the available community-based services

that can facilitate involuntary evaluation, and other mental health care facilities (Ballon & Waller-Vintar, 2010; Jacobs et al, 2010).

Another intervention that could be used to promote psychoeducation for patients and their families presenting to ED or admitted to the psychiatric inpatient unit is providing patient and family with educational brochures that were created for the purpose of the project. The patient brochure aims at guiding the patient on how to take care of themselves after having active suicidal thoughts or attempting suicide. The brochure will provide information to help patient build a support system, learn to live again, get involve in life, and ways to cope with future suicidal thoughts or suicide crisis (Appendix IIa). The second brochure will provide family members with needed information to understand suicide, detect warning signs for suicide, and helpful tips on how they can help someone in suicide crisis (Appendix IIb). Information in both brochures are based on the educational materials available on the American Association of Suicidology website (American Association of Suicidology, n.d.)

The information in the brochure is written at a sixth grade level reading, using simplified words without abbreviations or technical terminologies. Instructions available are accurate and are accepted in clinical practice; moreover they are appropriate to our cultural values and beliefs. Sentences are kept short, with maximum of 10 to 15 words in each sentence. The design is simple, visually appealing and easy to follow. The font size used 12-14 point "Arial" with visible white space on the pages (Aldridge, 2004).

2. *The Safety Plan*

Safety plan is a therapeutic clinical intervention that typically summaries how the patient should respond to their suicidal urges by outlining coping, and problem-solving skills and abilities, and contact numbers that patient can use in case of crisis.

Through collaboration and therapeutic alliance, the mental health providers obtains accurate data of events that emerged before, during, and after the most recent suicide crises-suicide attempt or suicide ideation-and help patient develop a safety plan (Ballon & Waller-Vintar, 2010; Stanley and Brown et al., 2008). The Safety Plan is adopted from the "Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version" and includes six basic steps that patient needs to follow in order (Stanley and Brown et al., 2008).

1) Warning Signs: Mental health provider List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patient's own words (Stanley and Brown et al., 2008).
2) Self-coping strategies: First-level strategies lay out specific things the patient can do to cope with a developing suicide crisis, such as engaging in preferred activities to take his or her mind off of problems (e.g., taking a walk, playing a video game, listening to calming music, meditating, praying). As part of the process of developing this list, the coordinator introduces and teaches brief problem solving and coping skills to the individual (Stanley and Brown et al., 2008).
3) Social distractions: If the initial self-coping strategies do not suffice, the patient is instructed to move to a second-level set of strategies that focus on accessing preferred social contacts who can engage and distract the individual and social settings that serve as distractions, such as going to a local coffee shop or bookstore (Stanley and Brown et al., 2008).
4) Social-support strategies: As third-level strategies, the coordinator and patient develop a list of individuals in the local environment who can provide help in coping with the suicidal crisis, including friends and family members. The plan

lists emergency contact numbers for each person who serves as part of the individual's support network (Stanley and Brown et al., 2008).

5) Professional-support strategies: As a fourth level of support, the plan lists relevant contact information for mental health professionals and agencies available to help the individual. The plan also reminds the individual to immediately call AUBMC crisis hotline or come to the ED if the situation becomes urgent (Stanley and Brown et al., 2008).
6) Means restriction: As a final step, the plan identifies ways to restrict access to the means by which a patient might carry out suicide, such as through use of drugs or a weapon (Stanley and Brown et al., 2008).

During this process, the mental health providers can follow a series of brief intervention instructions to help patient fill the Safety Plan template (Appendix III), using the patient's on words.

3. Follow-Up After Discharge

Based on recent evidence-based recommendation, follow-up post discharge from ED inpatient unit need to be immediate. A successful strategy that has been proven for its effectiveness is scheduling first appointment between 24 to 72 hours, or at most within one week after discharge depending on suicide risk level. Among other recommendations is to take the appointment before discharge for patients at ED. Another evidence-base practices that is recommended, is following-up with patients who miss their appointment and contacting patient first day after discharge (U.S. Department of Health and Human Services, 2012; Knesper, 2010).

4. *Documentation*

Documentation of suicide risk assessment is the responsibility of all mental health providers as it ensures proper communication between mental health providers, ensures ongoing assessment, and evaluates treatment progress and outcome. Clear and complete documentations is necessary for suicide risk assessment as it helps to ensure proper communication among mental health providers, keep track on the ongoing assessment and evaluation of patient progress, provides rational for treatment interventions and plan, and serves as a quality indicator (Ballon & Waller-Vintar, 2010). A clear and complete documentation should be written with every risk assessment done and should include suicide risk level, basis of these risks, treatment plan process and interventions done to reduce risk level (Ballon & Waller-Vintar, 2010).

For the purpose of the project, a "Clinical Pocket Guide for Suicide Assessment and Management" was created (Appendix VI).

5. *Crisis Service*

Providing crisis service is critically important to individuals in crisis, they have been proven to be effective and were associated with the greatest reduction in suicide rates. Crisis services, 24-hour hotline, provide 24 hours a day, 7 days a week services by skilled, trained counselors These services are devoted to provide emotional support, crisis counseling, suicide prevention, and referrals for individuals who are in suicidal crisis or emotional distress (U.S. Department of Health and Human Services, 2012). In 2008, the National Suicide Prevention Lifeline developed policy guidelines for crisis call center to assist callers at imminent risk for suicide (National Suicide Prevention Lifeline, 2008). Figure 5 provides the unified parameter for developing a suicide crisis service policy based on the National Suicide Prevention Lifeline (2008).

Figure 5. Policy for Helping Callers at Imminent Risk for Suicide

Adopted from the National Suicide Prevention Lifeline Policy (National Suicide Prevention Lifeline, 2008)

Activating a crisis service at AUBMC will offer unique opportunity to help and influence, certain people's lives, by providing primary support mesh, readily available to the nation.

D. Research and Evaluation

First step towards research and evaluation is promoting surveillance, which refers to the ongoing, systematic collection, analysis, interpretation, and timely use of data for health services actions towards reducing suicide and suicide attempt rates (U.S. Department of Health and Human Services, 2012), which is a lacking area in the Lebanese system. Once applied surveillance data will serve a base for research and evaluation on suicide prevention interventions over time, and will contribute to a more effective and efficient deliver of health care to patients with high risk for suicide (U.S. Department of Health and Human Services, 2012).

Research is a critical ingredient to promote mental health and prevent suicide (U.S. Department of Health and Human Services, 2012), with the gaps; much more research is needed, in different cultural contexts, on prevalence of mental disorders and suicide behaviors, efficacy of somatic and psychosomatic treatments, and risk and protective factors associated with suicide among Lebanese population

The primary range of interventions enlisted in this chapter are clinical guidelines for suicide management and prevention, it describes in details the process to interventions to be adopted from time patient present to AUBMC till being discharged; psychotherapeutic approach in the psychiatric inpatient; and crisis services. Knowing that these interventions are adopted from the "2012 National Strategy for Suicide Prevention: Goals and Objectives for Action" (U.S. Department of Health and Human Services, 2012), and tailored accordingly to the Lebanese population, however, testing there cultural sensitivity is a must. Hence, evaluation of these interventions should incorporate suicide related outcomes measure as a way of assessing the potential effects of such intervention on preventing suicide behavior.

CHAPTER IV
CONCLUSION AND RECOMMENDATIONS

Adopting this protocol not only guarantees the delivery of exclusive service to troubled individuals presenting to the AUBMC everyday, it also emphasizes the mission and vision of AUBMC in providing excellence of care and optimal benefits to the region. It is a structured protocol tailored from the "2012 National Strategy for Suicide Prevention: Goals and Objectives for Action" (U.S. Department of Health and Human Services, 2012), this protocol ensures a complete assessment, proper treatment plan and comprehensive discharge plan; it is highly specific and directed towards prevention of suicide behaviors.

Training should also be a primary goal in suicide prevention, through providing clear-cut training, mental health providers will be competent to assess patients at risk for suicide, develop a comprehensive treatment plan to reduce risk of future relapses and suicide attempt, and provide a structured and comprehensive discharge plan (Baguley & Alex et al., 2007; Knesper, 2010). Individuals who are hospitalized will benefit from skill group training that is based on DBT core concepts and upon discharge form ED or psychiatric inpatient unit, a safety plan, educational brochures for patients and family on suicide prevention and an extended follow-up care will be provided to the patients. In addition, the crisis service is one of a kind in the region aimed at providing a fall back net for individuals in suicide crisis.

For better coordination and communication, it is recommended to have an Advanced Practice Psychiatric Nurse (APN). The APN can focus on "care coordination, financial management, and resource utilization to yield cost-effective outcomes that-are patient-centric, safe, and provided in the least restrictive setting" (Leonard, Miller and Llewellyn, 2012). Role and function include, but not limited to,

assessing health and psychological needs of patient and family, coordinate with other health care providers to develop a case management plan; identify and provide education based on patient and family needs; and facilitate communication and coordination among mental health providers, involving the patient in decision-making process in order to minimize service fragmentation (Leonard, Miller and Llewellyn, 2012). Other responsibilities can include, contact and follow-up with patient at risk for suicide after discharge, and manage patient in crises through counseling.

Some of the recommendations to be considers is utilizing a computerized resources system in the hospital, to facilitate use of follow-up services and keep track of patient's medical records. For example, names of patients at risk for suicide will be "flagged"; consequently psychiatrist and psychotherapist will be continuously updated on patient's condition and suicide level. It can also be used as a reminder for patients at risk and in need for immediate appointment or for automated appointment for patient's presenting to ED (Knesper, 2010).

Other recommendations to be considered in the near future are devising an awareness campaign aimed at increasing community knowledge and understanding about suicide and suicide preventive measures, in addition to reducing stigma and discrimination. Moreover, the promotion of crisis services in the community through media guarantees outreach to the population.

CHAPTER V
APPENDIX

A. Appendix I: Colombia-Suicide Severity Rating Scale

1. Adult Risk Assessment

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann

RISK ASSESSMENT - ADULT

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.

Past 3 Months	Suicidal and Self-Injurious Behavior	Lifetime	Clinical Status (Recent)
☐	Actual suicide attempt	☐	☐ Hopelessness
☐	Interrupted attempt	☐	☐ Major depressive episode
☐	Aborted or Self-Interrupted attempt	☐	☐ Mixed affective episode (e.g. Bipolar)
☐	Other preparatory acts to kill self	☐	☐ Command hallucinations to hurt self
☐	Self-injurious behavior ***without*** suicidal intent	☐	☐ Highly impulsive behavior
Suicidal Ideation Check Most Severe in Past Month			☐ Substance abuse or dependence
☐	Wish to be dead		☐ Agitation or severe anxiety
☐	Suicidal thoughts		☐ Perceived burden on family or others
☐	Suicidal thoughts with method (but without specific plan or intent to act)		☐ Chronic physical pain or other acute medical problem (HIV/AIDS, COPD, cancer, etc.)
☐	Suicidal intent (without specific plan)		☐ Homicidal ideation
☐	Suicidal intent with specific plan		☐ Aggressive behavior towards others
Activating Events (Recent)			☐ Method for suicide available (gun, pills, etc.)
☐	Recent loss(es) or other significant negative event(s) (legal, financial, relationship, etc.)		☐ Refuses or feels unable to agree to safety plan
Describe:			☐ Sexual abuse (lifetime)
			☐ Family history of suicide (lifetime)
☐	Pending incarceration or homelessness		**Protective Factors (Recent)**
☐	Current or pending isolation or feeling alone		☐ Identifies reasons for living
Treatment History			☐ Responsibility to family or others; living with family
☐	Previous psychiatric diagnoses and treatments		☐ Supportive social network or family
☐	Hopeless or dissatisfied with treatment		☐ Fear of death or dying due to pain and suffering
☐	Non-compliant with treatment		☐ Belief that suicide is immoral; high spirituality
☐	Not receiving treatment		☐ Engaged in work or school
Other Risk Factors			**Other Protective Factors**
☐			☐
☐			☐
☐			☐
Describe any suicidal, self-injurious or aggressive behavior (include dates)			

2. *Adult Lifetime Recent – Clinical*

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Lifetime**	**Past 3 months**
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Have you made a suicide attempt?*** ***Have you done anything to harm yourself?*** ***Have you done anything dangerous where you could have died?*** ***What did you do?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to end your life when you _____?*** ***Or Did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?*** *(*Self-Injurious Behavior without suicidal intent) If yes, describe:	**Yes No** ☐ ☐ Total # of Attempts _____	**Yes No** ☐ ☐ Total # of Attempts _____
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	**Yes No** ☐ ☐	**Yes No** ☐ ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred)*. Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?*** If yes, describe:	**Yes No** ☐ ☐ Total # of interrupted _____	**Yes No** ☐ ☐ Total # of interrupted _____
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?*** If yes, describe:	**Yes No** ☐ ☐ Total # of aborted or self-interrupted _____	**Yes No** ☐ ☐ Total # of aborted or self-interrupted _____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?*** If yes, describe:	**Yes No** ☐ ☐ Total # of preparatory acts _____	**Yes No** ☐ ☐ Total # of preparatory acts _____

	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over).	*Enter Code*	*Enter Code*	*Enter Code*

SUICIDAL IDEATION		
Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.	**Lifetime: Time He/She Felt Most Suicidal**	**Past 1 month**
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe:	**Yes No** ☐ ☐	**Yes No** ☐ ☐
2. Non-Specific Active Suicidal Thoughts General non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	**Yes No** ☐ ☐	**Yes No** ☐ ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it…and I would never go through with it."* ***Have you been thinking about how you might do this?*** If yes, describe:	**Yes No** ☐ ☐	**Yes No** ☐ ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe:	**Yes No** ☐ ☐	**Yes No** ☐ ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** If yes, describe:	**Yes No** ☐ ☐	**Yes No** ☐ ☐
INTENSITY OF IDEATION		
The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal. Lifetime - ***Most Severe Ideation:*** _____ (***Type # (1-5)***) _____ (***Description of Ideation***) Recent - ***Most Severe Ideation:*** _____ (***Type # (1-5)***) _____ (***Description of Ideation***)	Most Severe	Most Severe
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	____	____
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	____	____
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	____	____
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	____	____
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on	____	____

3. *Adult Since Last Visit – Clinical*

SUICIDAL IDEATION	
Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.	Since Last Visit
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe:	**Yes** ☐ **No** ☐
2. Non-Specific Active Suicidal Thoughts General, non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	**Yes** ☐ **No** ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it…and I would never go through with it."* ***Have you been thinking about how you might do this?*** If yes, describe:	**Yes** ☐ **No** ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe:	**Yes** ☐ **No** ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** If yes, describe:	**Yes** ☐ **No** ☐
INTENSITY OF IDEATION	
The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). ***Most Severe Ideation:*** ____ _____ ***Type # (1-5)*** ***Description of Ideation***	Most Severe
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	____
Duration ***When you have the thoughts, how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	____
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	____
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	____
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling)	

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	Since Last Visit
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Have you made a suicide attempt?*** ***Have you done anything to harm yourself?*** ***Have you done anything dangerous where you could have died?*** ***What did you do?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to end your life when you _____?*** ***Or did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?*** *(*Self-Injurious Behavior without suicidal intent) If yes, describe: **Has subject engaged in Non-Suicidal Self-Injurious Behavior?**	**Yes No** ☐ ☐ Total # of Attempts _____ **Yes No** ☐ ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred)*. Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?*** If yes, describe:	**Yes No** ☐ ☐ Total # of interrupted _____
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?*** If yes, describe:	**Yes No** ☐ ☐ Total # of aborted or self-interrupted _____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?*** If yes, describe:	**Yes No** ☐ ☐ Total # of preparatory acts _____
Suicide: Death by suicide occurred since last assessment.	**Yes No** ☐ ☐
	Most Lethal Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code* _____
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury	*Enter Code* _____

4. *Pediatric/Cognitively Impaired-Lifetime Recent Clinical*

SUICIDAL IDEATION		
Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.	**Lifetime: Time He/She Felt Most Suicidal**	**Past 1 month**
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you thought about being dead or what it would be like to be dead?*** ***Have you wished you were dead or wished you could go to sleep and never wake up?*** ***Do you ever wish you weren't alive anymore?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
2. Non-Specific Active Suicidal Thoughts General, non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you thought about doing something to make yourself not alive anymore?*** ***Have you had any thoughts about killing yourself?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it…and I would never go through with it."* ***Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)? What did you think about?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having <u>some intent to act on such thoughts</u>, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do?*** ***This is different from (as opposed to) having the thoughts but knowing you wouldn't do anything about it.*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you ever decided how or when you would make yourself not alive anymore/kill yourself? Have you ever planned out (worked out the details of) how you would do it?*** ***What was your plan?*** ***When you made this plan (or worked out these details), was any part of you thinking about actually doing it?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
INTENSITY OF IDEATION		
The following feature should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). ***Lifetime - Most Severe Ideation:*** _____ _____ ***Type # (1-5)*** ***Description of Ideation*** ***Recent - Most Severe Ideation:*** _____ _____ ***Type # (1-5)*** ***Description of Ideation***	Most Severe	Most Severe
Frequency ***How many times have you had these thoughts?*** ***Write response***_____ (1) Only one time (2) A few times (3) A lot (4) All the time (0) Don't know/Not applicable	____	____

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Lifetime**	**Past 3 Months**
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Did you ever do anything to try to kill yourself or make yourself not alive anymore? What did you do?*** ***Did you ever hurt yourself on purpose? Why did you do that?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to make yourself not alive anymore when you _____?*** ***Or did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons, not at all to end your life or kill yourself (like to make yourself feel better, or get something else to happen)?*** *(*Self-Injurious Behavior without suicidal intent) If yes, describe:	**Yes No** ☐ ☐ Total # of Attempts _____	**Yes No** ☐ ☐ Total # of Attempts _____
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	**Yes No** ☐ ☐	**Yes No** ☐ ☐
Has subject engaged in Self-Injurious Behavior, intent unknown?	**Yes No** ☐ ☐	**Yes No** ☐ ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but someone or something stopped you before you actually did anything? What did you do?*** If yes, describe:	**Yes No** ☐ ☐ Total # of interrupted _____	**Yes No** ☐ ☐ Total # of interrupted _____
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but you changed your mind (stopped yourself) before you actually did anything? What did you do?*** If yes, describe:	**Yes No** ☐ ☐ Total # of aborted or self-interrupted _____	**Yes No** ☐ ☐ Total # of aborted or self-interrupted _____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you done anything to get ready to make yourself not alive anymore (to end your life or kill yourself)- like giving things away, writing a goodbye note, getting things you need to kill yourself?*** If yes, describe:	**Yes No** ☐ ☐ Total # of preparatory acts _____	**Yes No** ☐ ☐ Total # of preparatory acts _____

	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____

5. *Pediatric/Cognitively Impaired-Since Last Visit Clinical*

SUICIDAL IDEATION	
Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.	**Since Last Visit**
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you thought about being dead or what it would be like to be dead?*** ***Have you wished you were dead or wished you could go to sleep and never wake up?*** ***Do you wish you weren't alive anymore?*** If yes, describe:	**Yes** ☐ **No** ☐
2. Non-Specific Active Suicidal Thoughts General, non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you thought about doing something to make yourself not alive anymore?*** ***Have you had any thoughts about killing yourself?*** If yes, describe:	**Yes** ☐ **No** ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it…and I would never go through with it."* ***Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)? What did you think about?*** If yes, describe:	**Yes** ☐ **No** ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do?*** ***This is different from (as opposed to) having the thoughts but knowing you wouldn't do anything about it.*** If yes, describe:	**Yes** ☐ **No** ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you decided how or when you would make yourself not alive anymore/kill yourself? Have you planned out (worked out the details of) how you would do it?*** ***What was your plan?*** ***When you made this plan (or worked out these details), was any part of you thinking about actually doing it?*** If yes, describe:	**Yes** ☐ **No** ☐
INTENSITY OF IDEATION	
The following feature should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). ***Most Severe Ideation:*** _____ _____ ***Type # (1-5)*** ***Description of Ideation***	Most Severe
Frequency ***How many times have you had these thoughts?*** ***Write response***_____ (1) Only one time (2) A few times (3) A lot (4) All the time (0) Don't know/Not applicable	____

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Since Last Visit**
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Did you <u>do anything</u> to try to kill yourself or make yourself not alive anymore? What did you do?*** ***Did you hurt yourself on purpose? Why did you do that?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to make yourself not alive anymore when you _____?*** ***Or did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons, <u>not at all</u> to end your life or kill yourself (like to make yourself feel better, or get something else to happen)?*** (Self-Injurious Behavior without suicidal intent) If yes, describe:	**Yes** **No** ☐ ☐ Total # of Attempts _____
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	**Yes** **No** ☐ ☐
Has subject engaged in Self-Injurious Behavior, intent unknown?	**Yes** **No** ☐ ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but someone or something stopped you before you actually did anything? What did you do?*** If yes, describe:	**Yes** **No** ☐ ☐ Total # of interrupted _____
Aborted Attempt or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but you changed your mind (stopped yourself) before you actually did anything? What did you do?*** If yes, describe:	**Yes** **No** ☐ ☐ Total # of aborted or self-interrupted _____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you done anything to get ready to make yourself not alive anymore (to end your life or kill yourself)- like giving things away, writing a goodbye note, getting things you need to kill yourself?*** If yes, describe:	**Yes** **No** ☐ ☐ Total # of preparatory acts _____
Suicide: Death by suicide occurred since last assessment.	**Yes** **No** ☐ ☐
	Most Lethal Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code* _____
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury	*Enter Code*

B. Appendix IIa: patient Brochure

What Should I Do To Survive My Emotional Pain

Learn How To Help Yourself

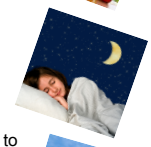
- This brochure was created to help you move forward after you have seriously thought of ending your life, or attempted to end your life.
- Feeling suicidal does not mean that you are weak or crazy. It only means that you have pain more than you can cope with right now.
- Today you may feel exhausted, hopeless, or even angry. You may also feel embarrassed or even ashamed.
- All these feeling can be overwhelming, and may seem permanent at the moment.
- But with time and support, you can recover, and all the symptoms you are going through now can get better
- Everyone's recovery is different. Some people have persistent thoughts of suicide. For others, such thoughts may accompany certain moods or circumstances.
- Following these simple steps can help you feel better and prevent negative and destructive thoughts in the future.

Step 1: Learn to Live Again

- Whenever you are recovering, the world can look dark and unwelcoming. It will take sometime before you can start to feel comfortable again
- **Follow healthy ways to keep your stress level controlled**

1. Exercise regularly
2. Eat right and do not skip meals
3. Get out in the sun or into nature for at least 30 minutes a day.
4. Get enough sleep
5. Plan ahead to remain calm and learn to recognize and release tension in your body.
6. Practice yoga, meditation and breathing techniques to calm your body and mind.

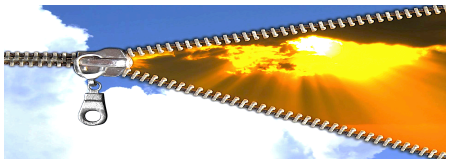




Step 2: Build a Support System

Surround yourself with positive influences and people who make you feel good about yourself.

- It is important that you have at least one person in your life that you can trust and be honest with.
- This person can be a friend, family member, colleague, or mentor
- In case you started to have thoughts of ending your life, this person can help you from harming yourself and help you through recovery
- When your feeling alone, remember that there are people in your life who care about you and are willing to help.



Step 3: Get Involved in Life

- **Accept the moment as it is:** focus on the moment and what is happening now instead of what you would like to see happen or what you are worried could happen
- **Let go of the idea of a perfect life**: Not everything is going to work out perfectly, no matter how hard you want it to or how hard you try
- **Expect change:** When you accept that change is possible, it helps you be more flexible and less stressed.
- **Write your thoughts and feelings** in a daily journal
- **Make a written schedule** for yourself everyday and stick to it, no matter what
- **Take a mini-break:** Close your eyes and take three deep breaths while imagining yourself in a peaceful place; in a garden, on a beach, or any place you find relaxing
- **Use humor:** Lighten up a stressful situation. Watch a funny movie, read a funny book, or laugh with your friends.
- **Take up a hobby:** Gardening, stamp-collecting, reading, cooking, or any physical activity. Hobbies add value to your life and take you away from stresses.
- **Get in touch with your creative side:** Try painting, drawing, or taking photos. The important thing is to externalize thoughts and feelings that are causing you stress.
- **Organize time** to spend with friends and allow time to make new ones.
- **Make time** for things that bring you joy and comfort, like listening to praying, music, movie
- **Smile:** Try it right now and notice any change in how you look and might feel

Step 4: Cope with Suicidal Thoughts

- Remember to identify triggers or situations that lead to the feelings of hopelessness and suicidal thoughts
- Plan to minimize the effect of these triggers in your life.
- Sometimes when you are under pressure and having suicidal thoughts, it will be hard to make decisions.
- Ask for help from some you trust who can help you work through your feelings and thoughts
- Promise yourself not to do anything right now
- Avoid staying alone
- Do not keep these suicidal feelings to yourself
- Make your home safe by removing things you could use to hurt yourself
- Take hope, there is a very good chance that you are going to live through these feelings

- Remember to keep your safety plan somewhere near you so you can refer to it as needed.
- If you felt that you are not able to control your suicidal thought and you cannot keep yourself safe, reach out for help immediately.
- You can go to the closet **Emergency Department** in your area or **Call AUBMC Hotline.**

SUICIDE
HOTLINE
01-355555

For more information visit our website:
www.suicidepreventionguide.org

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Social worker		01-350000 ext. 7629
Clinical Assistance (Adult)	Private Clinic and OPD	01-350000 ext. 5650/1
Regiestered Nurse (Adult)	Outpatient	01350000 ext. 5653
Clinical Assistance (Child and Adolescent)	Private Clinic and OPD	01-759622 ext. 7888
Registered Nurse (Child and Adolescent)	Outpatient	01-759622 ext. 7888

C. Appendix IIb: Family Brochure

How to Help Someone who is Suicidal

- This brochure was created to help you support someone who feels suicidal, giving practical suggestions for what you can do and where you can go for support.
- Suicidal feelings can be frightening and painful for the person who is experiencing them, as well as for their partner, family and friends.
- Suicide is a desperate attempt of a person to stop the unbearable pain and suffering.
- As much as they have the desire to die, deep inside they wish there was an alternative to committing suicide, but they just can't see one.

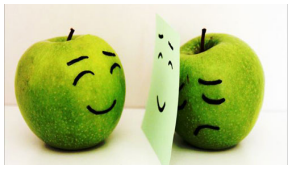
What causes suicidal feelings?

- There are different reasons why someone might experience suicidal feelings.
- Suicidal feelings may appear suddenly or develop gradually over time.

Some common risk factors that may contribute to someone feeling suicidal include:

1. Major psychiatric illness (depression, bipolar disorder, schizophrenia)
2. Substance abuse and alcohol abuse
3. Long term difficulties with relationships, friends and family
4. Losing sense of purpose
5. Significant losses in a person's life
6. Previous suicide attempts
7. History of trauma or abuse

Recognizing Suicide Warning Sign



1) Signs that requires contact with a professional

- Inability to sleep or sleeping all the time
- Withdrawing from friends, family and/or society
- Increasing alcohol or drug use
- Acting recklessly or engaging in risky activities
- Rage, anger, seeking revenge
- Avoiding things or reliving past experiences
- Anxiety, agitation
- Dramatic changes in mood
- No reason for living - no sense of purpose in life
- Feeling trapped -like there is no way out
- Hopelessness

2) Signs that require immediate attention:

- Thinking about hurting or killing self
- Looking for ways to kill self
- Seeking access to pills, weapons or other means
- Talking or writing about death, dying or suicide
- Sudden improvement in mood after being down or withdrawn
- Giving away favorite possessions

Common Misconceptions about Suicide

- People who talk about suicide won't really do it.
- Anyone who tries to kill him/herself must be crazy.
- If a person is determined to kill him/herself, nothing is going to stop them.
- People who commit suicide are people who were unwilling to seek help.
- Talking about suicide may give someone the idea.

Suicide prevention tip #1: Speak up if you're worried

- Talking to a family member about their suicidal thoughts and feelings can be extremely difficult for anyone.
- But if you're unsure whether someone is suicidal, the best way to find out is to ask.
- Giving a suicidal person the opportunity to express feelings can provide relief from loneliness and negative feelings, and may prevent a suicide attempt.
  1. Let the person know you care, and that they are not alone.
  2. Let the suicidal person express his feelings and thoughts. No matter how negative the conversation seems, the fact that it exists is a positive sign.
  3. Be sympathetic, non-judgmental, patient, calm, and accepting.
  4. Reassure the person that help is available and that the suicidal feelings are temporary.
  5. Let the person know that their life is important to you.

Suicide prevention tip #2: Respond quickly in a crisis

- If a family member tells you that they are thinking about death or suicide, it's important to evaluate the immediate danger the person is in.
- The following questions can help you assess the immediate risk for suicide:
  - Do you have a suicide plan?
  - Do you have what you need to carry out your plan (pills, gun, etc.)?
  - Do you know when you would do it?
  - Do you intend to commit suicide?
- **Level of Suicide Risk**
  - Low — Some suicidal thoughts. No suicide plan. Says he or she won't commit suicide
  - Moderate — Suicidal thoughts. Vague plan that isn't very lethal. Says he or she won't commit suicide.
  - High — Suicidal thoughts. Specific plan that is highly lethal. Says he or she won't commit suicide.
  - Severe — Suicidal thoughts. Specific plan that is highly lethal. Says he or she will commit suicide.

Suicide prevention tip #3: Offer help and support

- If a friend or family member is suicidal, the best way to help is by offering an empathetic, listening ear. Let your loved one knows that they are not alone and that you care.

1. Get professional help.
2. Follow-up on treatment.
3. Those contemplating suicide often don't believe they can be helped, so you may have to be more active at offering assistance.
4. Encourage positive lifestyle changes
5. Remove potential means of suicide, such as pills, knives, razors, or firearms. Keep them locked in a safe place.
6. Continue your support: Your support is vital to ensure your loved one remains on the recovery track.

HOPE

If a suicide attempt seems imminent

- Don't leave them alone
- Remove any lethal means
- Don't try to handle the situation without help
- Get help from a trained professional as quickly as possible
- Take person to the closet **Emergency Department** in your area or **Call AUBMC Hotline.**

SUICIDE
HOTLINE
01-355555

For more information visit our website:
www.suicidepreventionguide.org

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Social worker		01-350000 ext. 7629
Clinical Assistance (Adult)	Private Clinic and OPD	01-350000 ext. 5650/1
Regiestered Nurse (Adult)	Outpatient	01350000 ext. 5653
Clinical Assistance (Child and Adolescent)	Private Clinic and OPD	01-759622 ext. 7888
Registered Nurse (Child and Adolescent)	Outpatient	01-759622 ext. 7888

D. Appendix IIIa: Safety Plan

Safety Plan

Step 1: Warning signs:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:

1. _____
2. _____
3. _____

The one thing that is most important to me and worth living for is:

_____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place 4. Place _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5:Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services _____
   Urgent Care Services Address_____
   Urgent Care Services Phone _____
4. Suicide Prevention Hotline Phone: _____

Step 6: Making the environment safe:

1. _____
2. _____

Safety Plan is adapted from Treatment Manual to Reduce Suicide Risk: Veteran Version (Stanley & Brown, 2008)

E. Appendix IIIb: Safety Plan Instructions

Safety Plan: Brief Instructions

Step 1: Recognizing Warning Signs.
First step in developing a safety plan involves helping patient recognize signs and symptoms that precede prior a recent suicide crisis. These include personal situations, certain behaviors, mood, thoughts, thinking process, and images

1. Ask, "*How will you know when the safety plan should be used?"*
2. Ask, "*What do you experience when you start to think about suicide or feel extremely distressed?*"

Step 2: Using Internal Coping Strategies and Identify a Reason to Live.
Patient in this step is asked to list some internal coping strategies, in an order of priority, to help him take his mind off the problem and cope even if it is just for a brief period. It is important to get feedback about likelihood of using such strategies. In case a barrier was identified, the mental health provider uses problem-solving approach to identify other alternative coping strategies. Patient will be also asked to identify at least one reason worth living for.

1. Ask, *"What can you do, on your own, if you become suicidal again, to help, to yourself not to act on your suicidal urges?"*
2. Ask *"How likely do you think you would be able to do this step during a time of crises?"*

Step 3: Utilizing Social Contacts that Can Serve as a Distraction from Suicidal Thoughts and Who May Offer Support.
Patient is asked to identify social settings and people in his social environment who will be able to distract him from his problems and suicidal thoughts and urges. It is important to advised patient to exclude environments that include alcohol or substance use. Patient is educated that this step focuses on socializing rather than reaching out for help

1. Ask "Who or what social settings help you take your mind off your problems at least for a little while?"
2. Ask "Who helps you feel better when you socialize with them?"

Step 4: Contacting Family Members or Friends Who May Offer Help to Resolve a Crisis.
Patient asked to list people who can be of support when he is in crisis. It is important to discuss with patient if he is able to disclose his suicidal thought with these people and about the possibility to engage them in his safety plan.

1. Ask "Among your family or friends, who do you think you could contact for help during a crisis?" or "Who is supportive of you and who do you feel that you can talk with when you're under stress?"
2. Ask "How likely would you be willing to contact these individuals?"

Step 5: Contacting Professionals and Agencies.
In this step the patient list his mental health clinician-including psychiatrist and psychotherapist, emergency department, 24-hour local urgent care services, and suicide prevention hotline with their contact numbers. It is important to discuss with patient about his expectations, and possible obstacles that might prevent from calling a professional or agency for help.

1. Ask, "Who are the mental health professionals that we should identify to be on your safety plan?"
2. Ask, "Are there other health care providers?"

Step 6: Reducing the Potential for Use of Lethal Means.
Patient is asked about possible lethal means that he might be using including firearms, sharp instrument, medications, or drug. Later after, a plan is set to restrict access to these methods by having them safely stored by a designated, responsible person before they are in crises.

Safety Plan is adapted from Treatment Manual to Reduce Suicide Risk: Veteran Version (Stanley & Brown, 2008)

F. Appendix VI: Clinical Pocket Guide for Suicide Assessment and Management

CLINICAL POCKET GUIDE FOR SUICIDE ASSESSMENT AND MANAGEMENT

Remember: suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges, before giving pass and before discharge.

1. Identify Risk and Protective Factors

Risk factors
Psychiatric Disorders: mood disorders (major depressive disorder and bipolar disorder), alcohol and substance dependency, anxiety disorders, personality disorders (borderline personality disorders), schizophrenia. **Suicide Behaviors:** history of suicide attempts, aborted suicide attempts and self-inflected injuries **History of Trauma:** history of physical or sexual abuse, neglect, loss/separation **Psychological symptoms**: recent suicide attempt, suicide ideation/plan, purposelessness, impulsivity, aggression, hopelessness, severe anxiety/panic, alcohol intoxication, severe insomnia, active psychotic symptoms (command hallucinations), chronic pain. **Psychosocial risks:** recent stressful life events such as interpersonal loss or conflict, job loss, financial difficulties, legal problems **Acute risks:** recently discharged from hospital, current suicide attempt **Family history:** suicide, alcohol/substance abuse, violence **Access to firearms or large doses of medications**
Protective Factors
Internal: coping skills, personality traits, past response to stress, capacity for reality testing, ability to tolerate psychological pain and satisfy psychological needs. **External:** responsibility to others, positive therapeutic relationships, social supports

2. Conduct Suicide Inquiry

SUICIDE INQUIRY	Warning Signs
Ideation: thoughts about dying by suicide-frequency, intensity, duration **Plan**: timing, availability of method, setting, and actions made in furtherance of the plan, suicide note. **Lethality:** lethal vs. nonlethal. Access and availability of suicide method (firearm, high doses of medication), rehearsals(loading gun, tying rope) **Intent**: The degree to which a person intends to carry out the plan and take their own life. **Degree of Ambivalence:** reasons to live vs. reasons to die ***For Youths:** ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors, or disposition	I Ideation S Substance Abuse P Purposelessness A Anxiety T Trapped H Hopelessness W Withdrawal A Anger R Recklessness M Mood Change

Remember: manage and treat every patient making a suicide attempt and/or having suicidal ideation as if a next suicide attempt will result in death.

3. Evaluate Risk Level/Intervention

Risk Level	Risk/Protective Factors	Suicidality	Recommended Intervention
High	• Recent onset of major psychiatric disorder • protective factors not relevant • Psychosis (command hallucinations) • Recently discharged from psychiatric inpatient unit • history of acts/threats of aggression or impulsivity	• Made a serious or nearly lethal suicide attempt • Persistent suicide ideations or intermittent ideations with intent and/or plan	• Admission generally indicated • Constant observation needed • Appointment within 24 hours if discharged
Moderate	• No acute risk factors • Few protective factors • Active therapeutic alliance with mental health professionals	• Thought of death, with no intent or plan	• Admission may be necessary
Low	• Strong protective factors • Active therapeutic alliance with mental health professionals	• Suicidal thoughts with no intent or plan • No history of suicidal attempt	

4. Management and Discharge

Treatment Plan and Intervention	Documentation	Discharge plan

• Establish and Maintain a Therapeutic Alliance
• Attend to the Patient's Safety
• Determine a Treatment Setting
• Develop a Plan of Treatment (psychopharmacological and psychotherapy)
• Promote Adherence to the Treatment Plan
	• Suicide risk level
	• Basis of the risk, including:
	  • risk factors
	  • protective factors
	• Treatment planning process
	• Plan for reducing the risk level
		• Prescription for medications secured
		• Education to the Patient and Family Provided
		• Safety plan developed
		• A follow-up appointment have been recommended and if possible scheduled 48-72hrs after discharge

Clinical Pocket Guide for Suicide Assessment and Management developed from the content of "The American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors" and "2012 National Strategy for Suicide Prevention"

CHAPTER VI
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