Kemenkes
RS Marzoeki Mahdi

# CHILD AND ADOLESCENT SUICIDE SCREENING AND PREVENTION GUIDELINE

National Center for Mental Health - Marzoeki Mahdi Hospital

Ministry of Health of the Republic of Indonesia

Guideline prepared & recommended by the National Centre For Mental Health, Indonesia, WPA Task Force for the Advancement of Child & Adolescent Mental Health Services in Low-Middle Countries (2020-2023), Asian Federation of Psychiatric Associations ( AFPA) and The SAARC Psychiatric Federation (SPF)

BEST PRACTICE GUIDELINE

# THE SCREENING AND PREVENTION OF SUICIDE AMONG CHILDREN AND ADOLESCENTS

For the National Center for Mental Health - Marzoeki Mahdi Hospital and affiliate Hospitals, Indonesia

September 2024

Kemenkes
RS Marzoeki Mahdi

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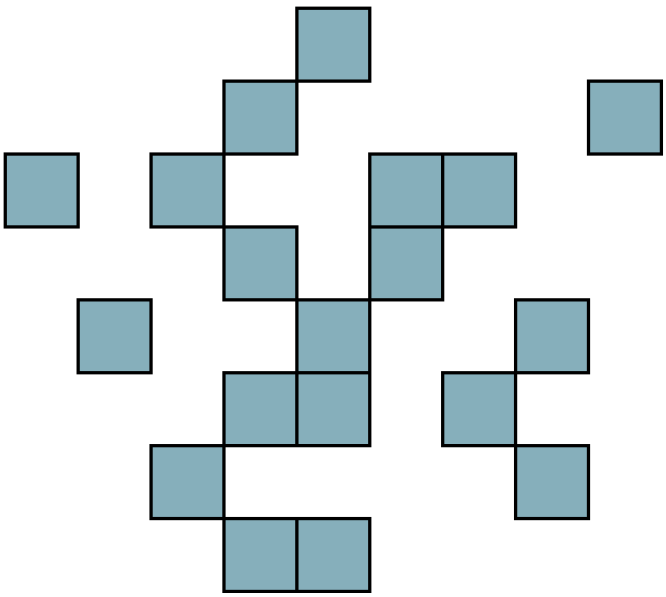

**MINISTER OF HEALTH**
**REPUBLIC OF INDONESIA**

## FOREWORDS

Dear Esteemed Colleagues,

I am honored to present to you the Child and Adolescent Suicide Prevention Guideline, a significant milestone in our commitment to safeguarding the mental health and well-being of our youth. This guideline is made by collaboration between PKJN RS Marzoeki Mahdi, The World Psychiatric Association (WPA), Asia Federation of Psychiatric Associations (AFPA), and SAARC Psychiatric Federation (SPF). This comprehensive document reflects our collective efforts to address a pressing concern that affects families and communities across Indonesia.

Suicide among children and adolescents is a deeply concerning issue that demands our utmost attention. It is not merely a statistical figure but a tragic loss of potential and future. We believe that prevention begins with knowledge, awareness, and timely intervention.

This guideline is more than just a compilation of strategies; it is a testament to our dedication to fostering a supportive environment where young minds can thrive. It provides a framework for educators, healthcare professionals, caregivers, and policymakers alike to recognize warning signs, offer effective support, and promote resilience among our youth.

I extend my heartfelt gratitude to all those who contributed their expertise and dedication to the development of this guideline. Your tireless efforts are invaluable in our mission to protect our most vulnerable populations.

Let us continue to work together, across sectors and disciplines, to implement these guidelines effectively. Together, we can make a difference and ensure that every child and adolescent in Indonesia receives the support they need to navigate life's challenges with hope and resilience.

Yours sincerely,

**BUDI G. SADIKIN**
Minister of Health of the Republic of Indonesia

H.R. Rasuna Said Street Block X5, Kav. 4-9 Jakarta 12950 Phone/Fax (+6221) 5201591

# GUIDELINE STEERING COMMITTEE

Chair, Guideline Steering Committee
Dr. dr. Nova Riyanti Yusuf, SpKJ
President Director, National Center for Mental Health, Indonesia

Co-Chair
Dr. Ahsan Nazeer
Associate Professor, Clinical Psychiatry, Weill Cornell Medicine, NY, USA

Dr. Afzal Javed
Immediate Past President of the World Psychiatric Association

Dr. Prasad Rao G
President-Asian Federation of Psychiatric Association (AFPA)

Dr. Gautam Saha
Immediate Past President of the SAARC Psychiatric Federation (SPF)

# GUIDELINE DEVELOPMENT WORKING GROUP

dr. Rahmi Handayani, Sp.KJ, MARS-Medical and Nursing Director
dr. Ayie Sri Kartika
Ns. Bustomi S.Kep, M.K.M
Ns. Nano Supriatna, S.Kep., M.K.M
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dr. Ira Savitri Tanjung, Sp.KJ (K) A
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Ns. Yuli Handayani, S.Kep
Ns. Yuyun Yusnipah, S.Kep
Rianto, S.I.Kom
Ahmad Nurul Islam, A.Md
Nadya Oktaviana, S.I.Kom

**Acknowledgment/Disclaimer**

This guideline is not intended to replace the health professional's judgment in screening and managing a suicidal youth. It is a statement of best practice based on the most recent available evidence (at the time of publication ). This guide and associated video is for education and training purposes only and can not be used for commercial purposes.

The rating scales (ASQ and C-SSRS) recommended in this guideline were developed by Dr. Lisa Horowitz at the National Institute of Mental Health (USA) and Dr. Kelly Posner at Columbia University (USA), respectively. C-SSRS (https://cssrs.columbia.edu/) and ASQ (https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials) are available in the public domain and can be downloaded from the above URLs. The flow diagrams (decision trees) for ASQ and C-SSRS are modified from the National Institute of Mental Health, USA (URLs provided at the bottom of the diagrams).

The Early Detection of Risk Factors of Suicidal Ideation is a rating scale developed by Dr. Nova Riyanti Yusuf (Indonesia). It is currently not available in the public domain.

# EXECUTIVE SUMMARY

Indonesia is a country in Southeast Asia and is comprised of 17,508 islands. About 270 million people live on these islands. Indonesia has a Mental Health Act and Universal Health Insurance that was ratified at the beginning of the last decade. Like other Low and Middle-Income Countries (LMICs), mental health services in Indonesia are strained by limited finances, a limited trained workforce, a lack of awareness, and a significant stigma that prevents parents from seeking mental health services for their children and adolescents.

Despite there being no systematic epidemiological surveys, from the perspectives of clinical practitioners, the prevalence of child and adolescent mental health disorders appears to be in the range of global prevalence. Some surveys, including the Indonesia Basic Health Survey, have reported an increase in mental health disorders during the last few years. Depression is one such disorder that has resulted in higher utilization of healthcare resources among late adolescents and young adults.  A meta-analysis from Indonesia has linked depression with high secondary school dropouts, a sense of loneliness, and poor socioeconomic status. Depression also is one of the key risk factors for suicide.

Because of different challenges, including poor reimbursements from the insurance (if suicidal ideations are listed in the diagnosis), there is no valid data available on suicide and self-harm cases at Marzoeki Mahdi Hospital. The data from the WHO and Sample Registration System (SRS) shows a mortality rate of 1.7-3.4 per 100,000 people. However we know that, globelly, suicide is the second leading cause of death among late adolescent teens and young adults. The utilization of a validated instrument for screening children and adolescents in both behavioral and non-behavioral settings has been suggested by The Joint Commission.

Feeling lonely and rejected by peers are unique risk factors for attempted and completed suicide in Indonesia.

# 01-DEFINITIONS

According to a recent survey, suicidal ideations have risen from 13.8% in 2017 to 60% in 2023 among university students in Indonesia.

**Suicide:** Self-inflicted death with evidence (either explicit or implicit) that the person intended to die (1).

**Suicide attempt:** Self-injurious behavior with a nonfatal outcome accompanied by evidence (either explicit or implicit) that the person intended to die (1).

**Suicidal ideation:** Thoughts of serving as the agent of one's death. Suicidal ideation may vary in seriousness depending on the specificity of suicide plans and the degree of suicidal intent (1). Making preparations of when and how to execute the suicide, as well as considering how one's death may affect others, constitute part of suicidal ideas.

**Suicidal intent:** Hope and belief that an act of self-harm will result in death.

**Suicide threat:** Suicide threats are statements made to others that imply an intention to take one's own life and can be accompanied by steps to carry out a suicide plan.

**Lethality of suicidal behavior:** Person's understanding of the likelihood that an attempt will lead to death.

# 02-FACTORS ASSOCIATED WITH AN INCREASED RISK OF SUICIDE

| Psychiatric Diagnosis | Physical Illness | Psychological Features |
|---|---|---|
| Major depressive disorder<br>Bipolar disorder<br>Psychotic disorders<br>Alcohol use disorder<br>Other substance use disorders | Diseases of the nervous system<br>Multiple sclerosis<br>Huntington's disease<br>Brain and spinal cord injury<br>Seizure disorders<br>Malignant neoplasms<br>Chronic hemodialysis-treated renal failure<br>Systemic lupus erythematosus<br>Pain syndromes<br>Functional impairment | Hopelessness<br>Severe anxiety/panic attacks<br>Shame, guilt or perception of humiliation<br>Psychological overwhelm<br>Poor self-esteem<br>Family conflicts<br>Domestic violence<br>Recent loss of a loved one or a stressful life changing event |

| Behavioral Features | Childhood Traumas | Demographic and Psychosocial |
|---|---|---|
| Impulsiveness<br>Aggression<br>Agitation<br>Suicidal ideations/intents or plans<br>Suicide attempts (including aborted or interrupted)<br>Lethality of suicidal plans or attempts<br>Access to lethal means for suicide<br>Substance abuse | Sexual abuse<br>Physical abuse<br>**Genetic and familial effects**<br>Family history of suicide in first-degree relatives<br>Family history of mental illness,<br>Family history of substance use disorders | Male Gender<br>Adolescent and young adult<br>Identity Issues<br>Bullying<br>Family conflicts<br>Academic pressures |

# 03.1-RISK SCREENING

Suicide screening is a *methodological approach* that involves the utilization of a standardized instrument (rating scale) to identify youth who may be susceptible to taking their own lives.

The process of suicide screening can be conducted either independently as a part of the universal screening, or can be a part of the broader behavioral health assessments in the specialized centers.

A *universal* screening program is implemented for all individuals within a group, irrespective of their perceived risk level relative to the general population. For instance, a comprehensive screening initiative may encompass individuals living in provinces of Bali, Riau Islands, Special Region of Yogyakarta, Central Java, and Central Kalimantan, which has the highest suicide rates in Indonesia.

*Selective* programs are employed to evaluate individuals who belong to a certain group that has a higher likelihood of suicide. For example, a school district may implement a selective screening program that specifically focuses on the Balinese students, who as an ethnic group exhibit a much higher suicide rate compared to other counterparts.

In Yogyakarta, Indonesia, some people believe that *Pulung Gantung* (blue-red light that flash through the sky) is a divine signal  for suicide by hanging (2).

# 03.2-RISK ASSESSMENT

The term "suicide assessment" often refers to a thorough evaluation conducted by a mental health professional to:

- Validate the presence of a suspected suicide risk.
- Assess the immediate threat to the individual.
- And determine an appropriate treatment plan.

While assessments may encompass structured questionnaires, they can also include more informal conversations with the patient and their parents/guardians to get a deeper understanding of the patient's cognitive processes, actions and the protective factors such as immediate family support.

1. Risk assessment should be performed in the context of a clinical assessment that is:
    - Person and family-centered
    - Recovery orientated
    - Trauma-informed
    - Culturally competent
2. Risk assessment involves the use of structured clinical judgment informed by careful consideration of the following:
    - Risk factors
    - Social isolation
    - History of traumatic life events/abuse
    - Previous suicide attempts
    - Peers and school-related stressors.
    - Warning signs
        - Making threats to end one's life
        - Access to means
        - Evidence that one has a suicide plan
        - Writing or talking about a potential self-harming behavior
        - Hopelessness and lack of purpose in life
        - Intense mood lability and dysphoria
        - An intent to seek revenge from loved ones
        - Withdrawing from the family
        - Substance use
    - Protective factors
    - Patient's mental status at the time of presentation

3. If significant risks are identified, a care plan should be formulated with the patient (and family/support person as appropriate). The safety care plan may include the following:

- Identification of specific triggers that may compromise safety.
- Formulating strategies that enhance the patient's capacity to keep him/herself safe.
- Specific actions to be taken by the family or loved ones during a crisis.
- Identify how the patient and their family will monitor the safety.
- Document the risk assessment and safety care plan and share it with the patient and family/support person.

4. Patients are to be assessed for risk to themselves and others at critical points including:

- Initial assessment/evaluation.
- At change or transfer of care.
- If there is a significant change in the patient's mental state.
- On discharge or move to less supportive circumstances.

5. While the goal is to work together to keep the patient safe, there will be situations where the patient's mental status and insight are such that they cannot assess the consequences of their actions. In these circumstances, a clinician should follow the mental health law to consider involuntary commitment.

- In complex situations where there is felt to be a high risk of harm and resources are not available to keep the person under supervision, the clinician must consult with the line manager, social work department, legal department, and the hospital's ethics department, and document these consultations.

# 04-TRIAGE IN THE EMERGENCY DEPARTMENT

| Recommended Triage Code | Description | Treatment Acuity | Management |
|---|---|---|---|
| 1 | Active suicidal ideations | Immediate | Supervision<br>• 1:1 observation with the nurse and keeping the patient at arm's length.<br>• 1:1 observation will continue until the clinician's assessment indicates that risk is reduced. In that case, 1:1 will be discontinued, and 15-minute checks will be initiated.<br><br>Actions<br>• Inform the emergency room physician<br>• Keep the room free of any unsafe objects (sharp objects, ligature points)<br>• Perform body check<br>• In food tray, use plastic/wood non-sharp utensils<br>• Ask about thoughts of harming others<br>• Alert the psychiatry on-call physician |

Modified from The Assessment and Management of People at Risk of Suicide: For Emergency Departments and Mental Health Services Acute Assessment Settings-Ministry of Health-New Zealand Guidelines Group (NZGG). http://www.health.govt.nz/publication/assessment-and-management-people-risk-suicide.

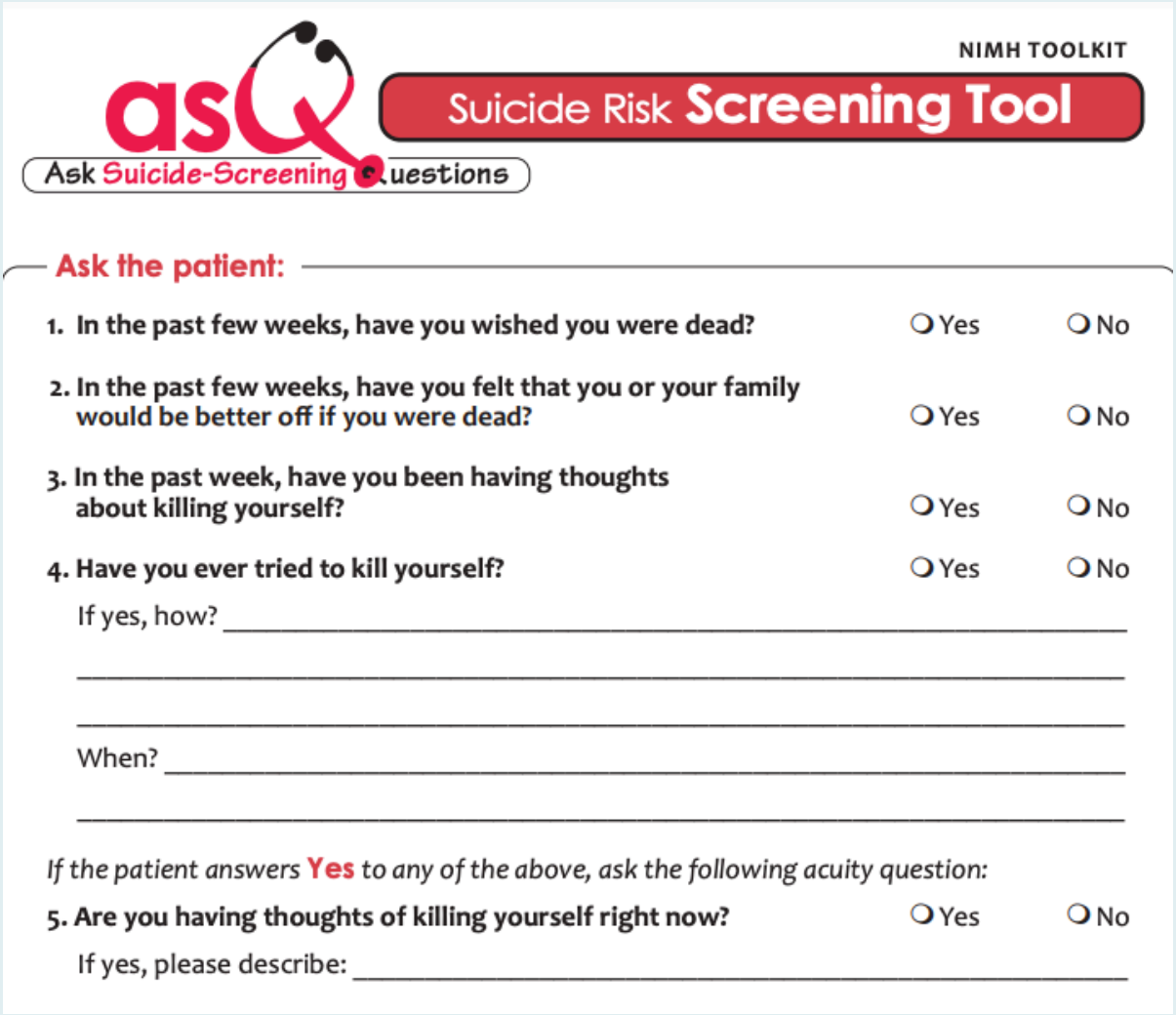
| Recommended Triage Code | Description | Treatment Acuity | Management |
|---|---|---|---|
| 2 | Probable risk of self harm<br><br>Confused/unable to co-operate<br><br>Reported attempt/threat of self-harm | Emergency<br><br>Patient needs to be seen within 10 minutes | Supervision<br>• 1:1 observation with the nurse without keeping the patient at arm's length.<br><br>• 1:1 will continue until the provider's assessment indicates that the constant observation can be discontinued. The provider will then order 15-minute checks.<br><br>Actions<br>• Inform emergency room physician<br><br>• Keep the room free of any unsafe objects (sharp objects, ligature points)<br><br>• Perform body check<br><br>• In food tray, use plastic/wood non-sharp utensils<br><br>• Ask about thoughts of harming others<br><br>• Alert the psychiatry on call physician |

| Recommended Triage Code | Description | Treatment Acuity | Management |
|---|---|---|---|
| 3 | Possible danger to self or others<br><br>Moderate behavioral disturbance<br><br>Passive suicidal ideations<br><br>Ambivalent about treatment | Urgent<br>Within 30 minutes | Supervision<br>• 1:1 observation<br><br>Action<br>• Provide a safe environment for the patient and the staff<br><br>• Alert/consult Child and Adolescent Mental Health Services (CAMHS) |
| 4 | No agitation<br><br>Cooperative<br><br>Gives coherent history<br><br>No active suicidal ideations<br><br>Is actively seeking assistance for their distress | Semi- urgent<br>Within 60 minutes | Supervision<br>• Intermittent observation<br><br>• Consider re-triage if evidence of agitation/aggressiveness<br><br>• Consider 1:1 observation if needed<br><br>Action<br>• Refer to psychiatry outpatient evaluation |

40% of those who commit suicide visit a medical center within one month before killing themselves (4).

# 05-SUICIDE SCREENING PATHWAY

1. Youth suicide is the second leading cause of death for children and adolescents worldwide (4).
2. Children and adolescents presenting to the National Center for Mental Health and its affiliate hospitals who display any of the following criteria will be screened by the nursing staff using the ASQ Suicide Risk Screening Tool (5).
   - Patients identified as having a behavioral health condition; This includes any child ≥ 10 years of age with depressed mood, irritability, anxiety/panic attacks.
   - Any child presenting with suicidal ideation/self-harm behavior.



NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

**Ask the patient:**

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

*If the patient answers* **Yes** *to any of the above, ask the following acuity question:*

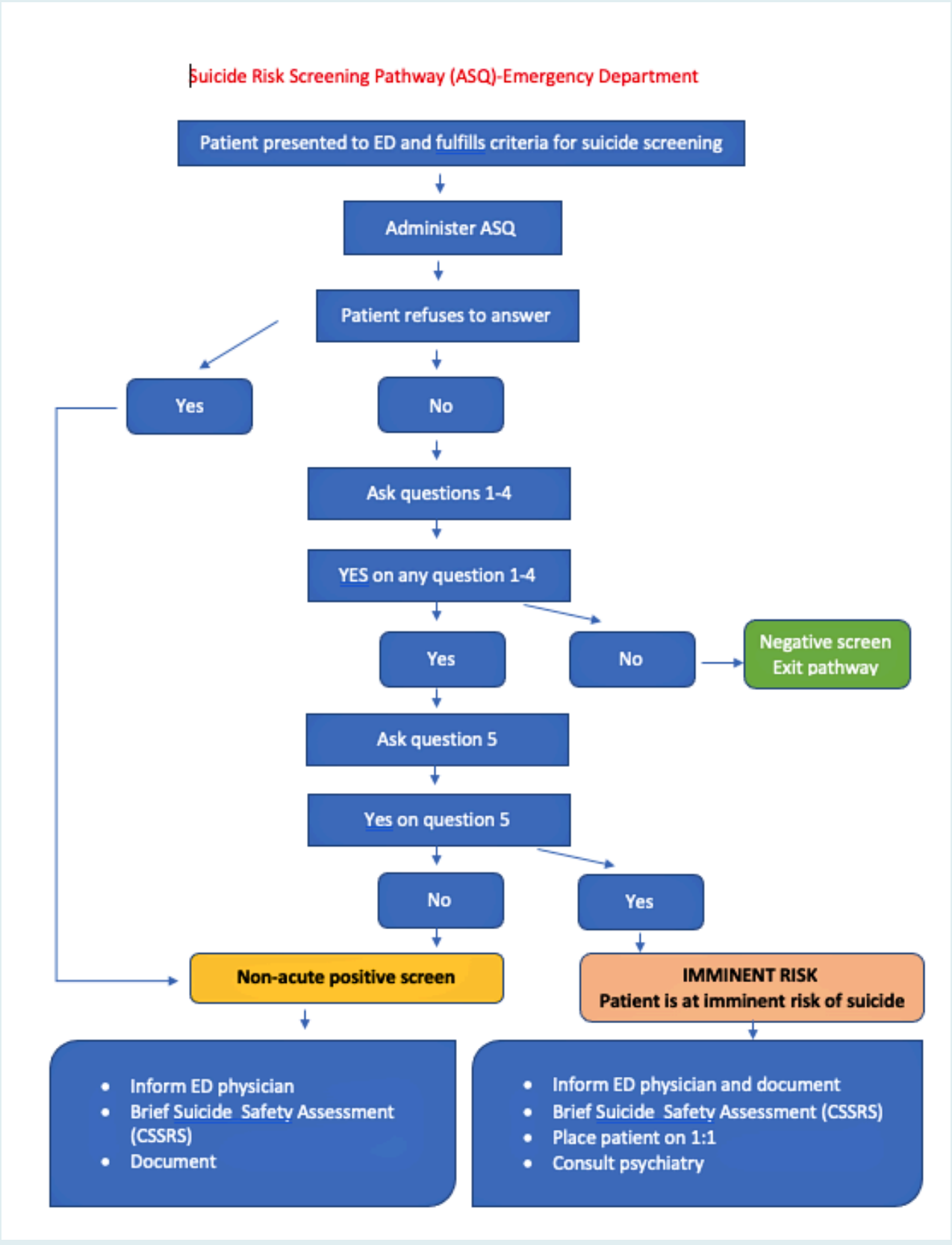
5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

   If yes, please describe: _____

From: https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials

ASQ is a set of 4 questions that takes about 20-30 seconds to administer and has a high sensitivity and negative predictive value. A "yes" response to one or more items can identify 97% of the children and adolescents who are at risk of suicide (5).

# 05.1- ASQ DECISION PATHWAY




Modified from: https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials

# 05.2- COLUMBIA-SUICIDE SEVERITY RATING SCALE

1. If the ASQ screening is positive, the Columbia-Suicide Severity Rating Scale (C-SSRS) (6) will be used to assess the child/adolescent's suicidal ideation, behavior, and suicide risk.
    - While ASQ can be administered by any non-clinical person, only a physician or a mental health professional can administers C-SSRS.

**SAFE-T Protocol with C-SSRS (Columbia Risk and Protective Factors)**

| **Step 1: Identify Risk Factors** | |
|---|---|
| **C-SSRS Suicidal Ideation Severity** | |
| **1) Wish to be dead**<br>*Have you wished you were dead or wished you could go to sleep and not wake up?* | □Y □N |
| **2) Current suicidal thoughts**<br>*Have you actually had any thoughts of killing yourself?* | □Y □N |
| **3) Suicidal thoughts w/ Method** (w/no specific Plan or Intent or act)<br>*Have you been thinking about how you might do this?* | □Y □N |
| **4) Suicidal Intent without Specific Plan**<br>*Have you had these thoughts and had some intention of acting on them?* | □Y □N |
| **5) Intent with Plan**<br>*Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?* | □Y □N |
| **6) C-SSRS Suicidal Behavior** | **Lifetime** |
| **6a)** *"Have you ever done anything, started to do anything, or prepared to do anything to end your life?"*<br>Examples: Collected pills, took out pills but didn't swallow any, went to the roof but didn't jump; or actually took pills, cut yourself, tried to hang yourself, etc. | □Y □N |
| | **Past 3 Months** |
| **6b)** If "YES" Was it within the past 3 months? | □Y □N |

| | |
|---|---|
| **Activating Events:**<br>□ Recent losses or other significant negative event(s)<br><br>**Treatment History:**<br>□ Previous psychiatric diagnosis<br>□ Dissatisfied with treatment<br>□ Non-compliant with treatment<br>□ Not receiving treatment | **Clinical Status:**<br>□ Depression (sad mood, hopelessness, crying, changes in sleep or appetite, fatigue, difficulty concentrating, sleep problems)<br>□ Command Hallucinations to hurt self<br>□ Severe anxiety<br>□ Homicidal Ideation<br>□ Abuse (Physical, emotional, sexual)<br>□ Family history of suicide |
| □ **Access to lethal methods:** Ask specifically about presence or absence of a firearm in the home or ease of accessing | |

| **Step 2: Identify Protective Factors** | |
|---|---|
| **Internal:**<br>□ Fear of death due to pain and suffering<br>□ Identifies reasons for living<br>□ _____<br>□ _____ | **External:**<br>□ Belief that suicide is immoral/Haram<br>□ Responsibility to family or others<br>□ Supportive social network of family or friends<br>□ Engaged in work or school |

| **Step 3: Specific questioning about Thoughts, Plans, and Suicidal Intent** | |
|---|---|
| **C-SSRS Suicidal Ideation Intensity (with respect to the most severe ideation 1-5 identified above)** | **Month** |
| **Frequency**<br>***How many times have you had these thoughts?***<br>(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 | |

Modified from: https://cssrs.columbia.edu/wp-content/uploads/C-SSRS_Pediatric-SLC_11.14.16.pdf

# 05.2- C-SSRS

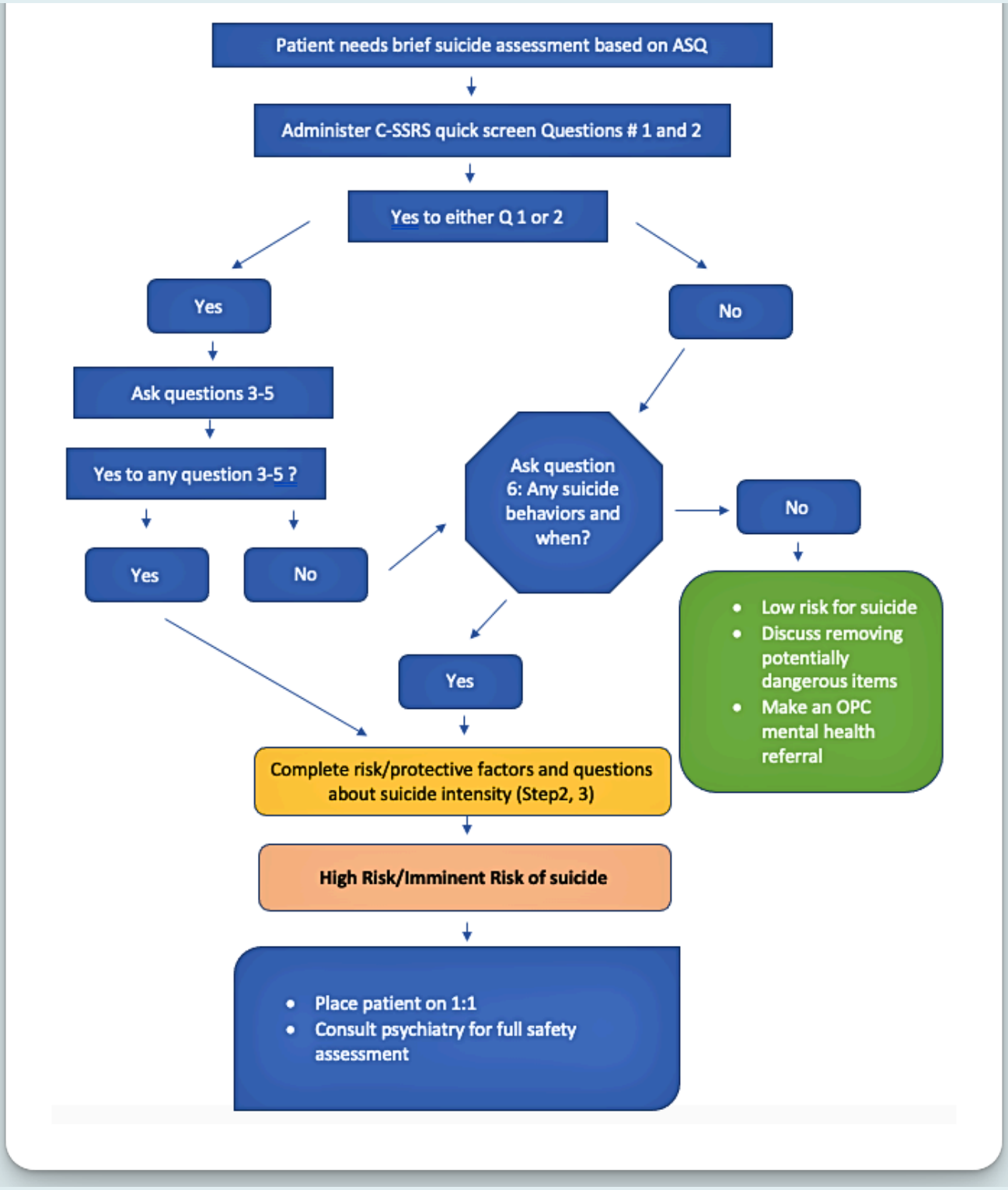
| C-SSRS Suicidal Ideation Intensity (with respect to the most severe ideation 1-5 identified above) | Month |
|---|---|
| **Frequency**<br>***How many times have you had these thoughts?***<br>(1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day | |
| **Duration**<br>***When you have the thoughts how long do they last?***<br>(1) Fleeting - few seconds or minutes<br>(2) Less than 1 hour/some of the time<br>(3) 1-4 hours/a lot of time<br>(4) 4-8 hours/most of day<br>(5) More than 8 hours/persistent or continuous | |
| **Controllability**<br>***Could/can you stop thinking about killing yourself or wanting to die if you want to?***<br>(1) Easily able to control thoughts<br>(2) Can control thoughts with little difficulty<br>(3) Can control thoughts with some difficulty<br>(4) Can control thoughts with a lot of difficulty<br>(5) Unable to control thoughts<br>(0) Does not attempt to control thoughts | |
| **Deterrents**<br>***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 suicide?***<br>(1) Deterrents definitely stopped you from attempting suicide<br>(2) Deterrents probably stopped you<br>(3) Uncertain that deterrents stopped you<br>(4) Deterrents most likely did not stop you<br>(5) Deterrents definitely did not stop you<br>(0) Does not apply | |
| **Reasons for Ideation**<br>***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?***<br>(1) Completely to get attention, revenge or a reaction from others<br>(2) Mostly to get attention, revenge or a reaction from others<br>(3) Equally to get attention, revenge or a reaction from others and to end/stop the pain<br>(4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling)<br>(5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling)<br>(0) Does not apply | |
| **Total Score** | |

**Step 4: Determine Level of Risk and Develop Interventions to LOWER Risk Level**

| RISK STRATIFICATION | TRIAGE |
|---|---|
| **High Suicide Risk**<br>☐ Yes to items #4 or #5)<br>Or<br>☐ Yes to item # 6a | ☐ Initiate psychiatry consult<br>☐ Place patient on 1:1 |
| **Moderate Suicide Risk**<br>☐ Yes to item #3<br>Or<br>☐ Yes to item # 6a | ☐ ED physician will contact Psychiatry on-call to discuss<br>☐ Place patient in a room with parent.<br>☐ 15 mins checks |
| **Low Suicide Risk**<br>☐ Yes to item #1 or #2 | ☐ Consider outpatient referral to psychiatry |

Modified from: https://cssrs.columbia.edu/wp-content/uploads/C-SSRS_Pediatric-SLC_11.14.16.pdf

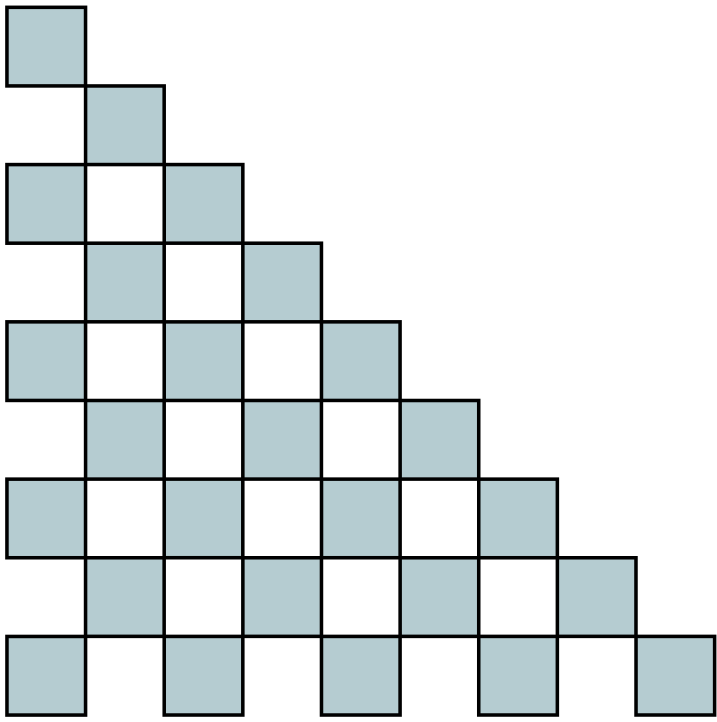
# 05.3- C-SSRS DECISION PATHWAY




Modified from: https://cssrs.columbia.edu/wp-content/uploads/C-SSRS_Pediatric-SLC_11.14.16.pdf

# 05.4- EARLY DETECTION ON RISK FACTORS OF SUICIDAL IDEATION-DR. NOVA RIYANTI YUSUF

1. The CSSRS is to be re-administered during any treatment course when there is a change in the patient's condition, which would indicate an increased risk for suicide (e.g., mental status, re-exacerbated symptoms, change in psychosocial stressors).
2. Based on C-SSRS scores, the patient will be categorized as low, moderate, or high-risk.
3. The risk category will determine whether a comprehensive risk assessment by a member of the Mental Health Care Team is necessary.
4. Members of the mental health team will have the following options to choose from:
    - Conduct a thorough psychiatric evaluation.
    - Use the rating scale "Early Detection on Risk Factors of Suicidal Ideation" developed by Dr. Nova Riyanti Yusuf (*next page*).
    - Admit the youth in the child and adolescent mental health unit, if needed, and then complete the "Early Detection on Risk Factors of Suicidal Ideation" and start the treatment.



| No. | Items | Strongly Disagree | Disagree | Agree | Strongly Agree |
|---|---|---|---|---|---|
| 1. | I feel like the people in my life would be happier without me. | 1* | 2 | 3 | 4 |
| 2. | I feel I am a burden to my friends, family, and society. | 1 | 2 | 3 | 4 |
| 3. | I think my death will bring relief to the people in my life. | 1 | 2 | 3 | 4 |
| 4. | I feel like people around me want to get rid of me. | 1 | 2 | 3 | 4 |
| 5. | I think everything I do is always considered to worsen the existing situation of the condition. | 1 | 2 | 3 | 4 |
| 6. | I feel other people care about me. | 4 | 3 | 2 | 1 |
| 7. | I feel I am part of something useful. | 4 | 3 | 2 | 1 |
| 8. | I am lucky to have many friends who care and support me. | 4 | 3 | 2 | 1 |
| 9. | I feel abandoned. | 1 | 2 | 3 | 4 |
| 10. | I feel not understood by the people around me. | 1 | 2 | 3 | 4 |
| 11. | I feel isolated. | 1 | 2 | 3 | 4 |
| 12. | I feel lonely even though there are many people around me. | 1 | 2 | 3 | 4 |
| 13. | I feel bad things will happen to me. | 1 | 2 | 3 | 4 |
| 14. | I feel it's useless trying because I won't succeed. | 1 | 2 | 3 | 4 |
| 15. | I feel it's better if I give up because I can't make my condition better. | 1 | 2 | 3 | 4 |
| 16. | I feel like my life continues to be unlucky. | 1 | 2 | 3 | 4 |

1. Add the scores for each item.
2. If the total score is 34 or more, it can be stated that the respondent is at risk for suicidal ideation.

# SAFETY PLANNING BEFORE DISCHARGE

1. Do the Stanley-Brown Safety Planning intervention (copyrighted and available at https://suicidesafetyplan.com/forms/)
2. Check with the family that lethal means, medication, and other dangerous items can be effectively secured or removed.
3. Check that there is a supportive person in the home who can monitor the patient.
4. Check that a follow-up appointment has been scheduled, ideally within 72 hours.
5. Ensure adolescent has no current suicidal intentions or plans.
6. Check that the family and the youth is agreeing to return to the mental health service if their suicidal intent returns.

## STAFF TRAINING

1. Staff at the National Center for Mental Health and its affiliate hospitals will be trained in the following manner:
    - Audio-visual on-demand training of ASQ and C-SSRS.
    - Live lectures on suicide prevention and management in youth.

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