Malaysian

Guideline On Suicide Prevention and Management

MALAYSIA GUIDELINE ON SUICIDE PREVENTION AND MANAGEMENT

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Contents

1. INTRODUCTION

A mandate was given by the World Health Organization under the auspices of Disease Control Division, Ministry of Health Malaysia to form a national core team to develop guidelines, training manuals and protocols to address mental health and psychosocial issues in suicide prevention and disaster situations. A sub-committee was subsequently formed to focus on suicide management.

This generic guideline for suicide prevention and management can be used by all relevant agencies, government premises (healthcare facilities, prisons, schools and other institutions) as well as at public places and in the community at large.

The editorial board used two approaches; brainstorming on the current gaps in prevention and management of suicide in the country, and also using an existing "Guideline on Suicide Risk Management in Hospital Selayang", a hospital-based document developed by the Suicide Risk Management Committee, Department of Psychiatry & Mental Health, Hospital Selayang as a basis of framework and discussion. A preliminary literature review was also done to gather more information on best practices elsewhere.

In terms of burden of "disease", the national annual incidence rate of suicide in the country was published in 2009, is 1.18 per 100,000 (National Suicide Registry Malaysia). The National Health Morbidity Study 2011 reported that 1.7% of respondents had suicidal ideations; 0.9% had plans and 0.5% had suicide attempts. However to date, there is no nationwide data on attempted suicide. Nevertheless, even though there is only one suicidal death, it is a reflection of failure of mental health safety-net of the family, community and also the service providers.

The implementation of this guideline calls for innovative, new models of community mental health tapping on the strength of all relevant agencies. Some of these new ideas include Community Mental Health Centres, also known as Mentari which are walk-in centers with doctors and counselors for all mental health issues. Engagement with consumer groups (suicide survivors), friends and family of the victims, NGO like Befrienders, Malaysian Mental Health Association; and Talian Nur under the Ministry of Women, Family and Community Development, needs to be initiated.

Since this is the first draft, the authors would like to evaluate the document for its completeness, the breadth of scope coverage), practicality of processes recommended and its user-friendliness, process indicators such as number of trainings conducted, number of staff trained and level of competency and finally the impact of the guideline on suicide awareness and management flow of work and a decrease in repeat attempters. This will be done one year from its launch and the writing committee welcomes feedbacks from all quarters.

2. OBJECTIVES

2.1 To promote a collaborative approach in the prevention of suicide for frontliners

a - There need to be a committee at the national and local level comprising of people from different background to provide a momentum for implementation of suicide prevention activities.

b - Term of reference of the response team committee may include:

i. Assisting the organization in the implementation of suicide prevention programs
ii. Customize strategies and processes to suit the needs of the respective agencies
iii. To monitor the incidence of suicide in their locality or agency
iv. Have regular meetings to discuss the progress of the above activities

2.2 To increase suicide awareness

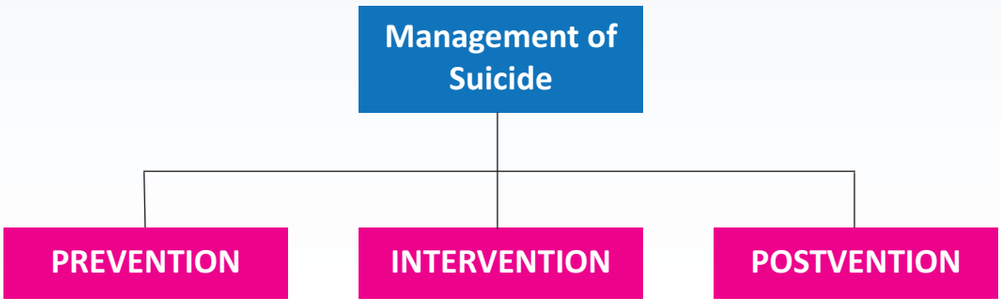
This can be done using various mediums i.e. campaigns, leaflets, short videos etc.

2.3 To introduce the use Suicide First Aid

2.4. To provide a guide for management, training, monitoring and research in suicide.

3. MANAGEMENT GUIDELINE

Management is divided into three levels, as shown below:



3.1 PREVENTION

(Intro paragraph) – front-liners need to be alert about recent behavior changes.

3.1.1 Creating Awareness

Our committee strongly supports ongoing mental health campaigns e.g. coping styles, anti-bully. Promoting a healthy work culture and safe environment.

3.1.2 Providing A Save Environmnet

A safe physical environment should be ensured at all times as to reduce accesses to any methods of self-injury. In custodial care, minimise hanging points such as shower heads, light fixtures, curtain rods and door knobs. To reduce access to jumping as a method of suicide, building specifications especially for schools, should be taken into consideration. Here, it is recommended that the walls of the building should be at suitable height. Windows have to be reinforced. Provision of close circuit camera around premise especially at 'blind-spots' would also be helpful.

3.1.3 Screening

Screening for risk factors will include identification of specific factors and features that may increase or decrease the risk for suicide. Risk factors are divided into low, medium and high risk. Screening of 'at-risk' individuals are done using the following format (refer appendix 1):

- Development of Suicide Profiles
- Profiling of inmates in custodial care can help identify high-risk individuals and situations

3.1.4 Early Detection

Expression of suicidal thoughts or intentions by anyone needs to be addressed seriously and considered as a warning sign for a future attempt. To minimize the risk of a suicide, risk factors have to be identified in order to determine the level of suicidal risk. Several warning signs (RED FLAG STATEMENTS) that someone is planning or thinking of suicide are:-

- Expressing comments such as “I just can’t take it anymore”, “I wish I were dead”, “There is no way out”or “All my problems will end soon”.
- Always thinking of dying
- Having symptoms of major depressive disorder
- Having “death wishes”
- Settling personal affairs, tying up loose ends or saying ‘good-bye’ to family or friends; or asking for forgiveness

3.1.5 Risk Assessment for Suicide

This helps to determine level of risk for suicide and decide on plan of management. Specific risk factors are identified to gauge the level of suicidal risk.

3.1.6 Psychological First Aid

Psychological First Aid is a helpful tool for immediate response when an individual with suicidal risk has been identified. This includes ensuring a safe environment for the person or if the suicidal intent has been expressed via phone, ensure that there is someone who can be with the person until help arrives. Remain calm, listen and define the problem. Convey support and be non-judgmental and neutral always.

Building rapport with the individual is crucial and can be done with the following questions:-

1) How do you feel at the moment?
2) What is your mood like?
3) Do you feel that no one cares for you?

ASSESSMENT SUICIDE INTENT

1) I appreciate how difficult this problem must be for you at this time. Some of my patients with similar problems/ symptoms have told me that they have thought about ending their life. I wonder if you have had similar thoughts?
2) When did you have these thoughts?
3) How often do you have these thoughts?
4) Do you think that your situation is hopeless?
5) Do you have a plan to take your life?
6) Have you had similar thoughts before?
7) Have you ever attempted to harm yourself before?

ASSESSMENT FOR SUICIDE PLAN

1) Have you thought of harming yourself?
2) What have you thought of doing?
3) Have you come close to acting on this?
4) Have you made any plan to carry this out?
5) What has stopped you up until now?

ASSESMENT OF PROTECTIVE FACTORS

Person's support system (family, friends) has to be identified and mobilised to reduce the risk.

3.1.7 Triaging For Patients With Suicide Risk

Individuals identified to have low risk for suicide can be referred to a trained counselor. Those with moderate and high risk for suicide , should be referred to Psychiatric services available at nearest health clinics or hospital emergency department.

If there is suicidal plans or attempts - need to assess risk

- Current plan
- Previous behavior
- Resources

		REPORTED	OBSERVED	RECOMMENDED INTERVENTIONS
BLUE	**Low Risk Patients**	• Some mild or passive suicide ideation, with no intent or plan • No history of suicide attempt • Available social support	• Cooperative; communicative; complaint with instructions • No agitation/ restlessness • Irritable without aggression • Gives coherent history	• Suicide caution • Allow accompanying family/friend to monitor while waiting • Refer to psychiatry from ED or as in -patient referral if in ward. • Reassessment of suicidal behaviour as required.
YELLOW	**Moderate Risk Patients**	• Suicide ideation with some level of suicide intent, but who have taken no action on the plan • No other acute risk factors • History of psychiatric illness & receiving treatment	• Agitated/restless • Intrusive behaviour; bizarre/ disordered behaviour • Confused; withdrawn/ uncommunicative • Ambivalence about treatment	• Body & belonging search to remove items that could be used for self harm. • Suicide & if indicated absconding precaution. • Refer to psychiatry from ED or as in -patient referral if in ward. • If in medical/surgical ward, encourage family to accompany. • Reassessment of suicidal behaviour as required.
RED	**High Risk Patients**	• Made a serious or nearly lethal suicide attempt • Persistent suicide ideation or intermittent ideation with intent and/or planning • Psychosis, including command hallucinations • Other signs of acute risk • Recent onset of major psychiatric syndromes, especially depression • Been recently discharged from a psychiatric inpatient unit • History of acts/threats of aggression or impulsivity	• Extreme agitation/ restlessness • Physically/ verbally aggressive • Confused/ unable to cooperate • Requires restraint • Violent behaviour • Possession of a weapon • Self-destruction in department	• Body & belonging search to remove items that could be used for self harm • Urgent referral to & rapid evaluation by psychiatry. • Constant staff observation and/or security in ED and in the wards. • Inpatient admission • Administer psychotropic medications and/or apply physical restraints as clinically indicated

3.2 INTERVENTION LEVEL

In a suicide crisis, the local level response team must respond fast and buy time while waiting for the formal rescue team to arrive. Main rescue team would be the Fire and Rescue Dept. The local response team needs to designate specific tasks and a dedicated communication line whenever staff in that organization becomes aware of a suicide attempt occurring in their premises.

3.2.1 Suicide Acute Response Team (SART)

Objective:

- To organize a team approach in the immediate acute management of incident of suicide attempt in government institutions, eg. Schools, Universities, Hospital, Prisons, Government Institutions.

Activation of SART:

- When an incident of attempted suicide occurs in an institution and is detected by any staff of that institution, the staff shall notify the designated SART Leader immediately.

Role of SART members:

1. Team Commander:
   - Most senior & experienced on site officer.
   - Initial on sites & leadership of SART.
   - Liaison & coordination with relevant emergency response agencies.
   - Immediate mobilization of on site team members.

2. Logistics Officer:
   - Prepare resources for managing incident.

3. Communication Officer:
   - Obtain details of suicide attempter: Name, history & profile of suicide attempter.
   - Notification of Head of Organization/ Department Chiefs.
   - Authorized communication with relevant emergency response agencies: Police, Fire & Rescue, Civil Defence & Hospital Emergency Medical Response Team.
   - Notification of next of kin.
   - Authorized communication with mass media.

4. Security Officer:
   - Security & cordoning of incident site.
   - Provide site evidence management.

5. Emergency Negotiator/ Counsellor:
   - Provide initial emergency psychological First Aid.
   - Implement initial de-escalation management of incident.
   - Provide interim intervention before definitive specialized management.

6. Emergency First Responders:
   - Provide initial emergency medical first aid, Basic Life Support& CPR cardiopulmonary resuscitation. if needed before arrival of specialized medical care.

3.2.2 Immediate Actions

Scope: within 24 hours of the event

Aim:

a) Provide resuscitation if patient is still alive, and ensure patient's dignity if he/ she had died
b) Notify the relevant officers as soon as posible so that a response committee can be formed immediately
c) Efficient scene management and transfer of body to the mortuary

3.2.3 Implementation Care Plan

No.	Action	Responsibility
6.1.1	Upon witnessing any suicide event, staff shall remain calm: Information to be relayed: i. Location of where the patient is found ii. Identity of patient (if wrist tag still intact) iii. Contact numbers of his/ her next-of-kin	Staff whom first arrived at scene
	Suicide first aid All staff need to be trained in basic skills Once the Acute Response team is activated, they will take over the negotiation processs Pass over to the Fire and Rescue team when they arrive	
6.1.2	If person persisted still carrying out attempt: Immediate medical management i. If patient still alive, to provide cardiopulmonary resuscitation and initiate appropriate clinical management. ii. If patient has died, to cover patien's body with a large plastic sheet to prevent it from being viewed by inappropriate people	**IMPORTANT:** Need guidance regarding how to cover pt's body while waiting for police to arrive. This is due to the advent of social media – the longer the body is left at site, the more photos will appear on twitter etc. In hospital:"scoop & run"

No.	Action	Responsibility
6.1.3	**Immediate Safety Management** i. Security person need deploy officers to secure the scene ii. Seal/ cordon the area where suicide act took place	(despite our best efforts, reporters/ public tend to find good angles to get photos
6.1.4	**Immediate Communications & Administrative management** i. Family ii. ? Who else	Sister-on-call
6.1.5	**Management of dead body** i. Provide cooperation for police to conduct investigations ii. Transfer of patient from scene to the mortuary	All the above officers
6.1.6	**Other actions at local area** i. Confirmation of the deceased's identity; obtain contacts for patient's next-of-kin and compile patient's clinical notes and investigations ii. Identify other vulnerable patients & secure the area patient exited. iii. Breaking of bad news to the deceased's next-of-kin to be carried out by doctor in-charge; and to escort them to the forensic department iv. Assess staff, patients, and witnesses at risk for trauma reaction and decide on possible debriefing of staff	
6.1.7	**Management at Forensic Department** i. Ensure availability of a bereavement room where next-of-kin can be placed while waiting for the release of the deceased's remains ii. Consider involving psychiatric services iii. Consider on policy for facilitate the release process	
6.1.7	**Universal precaution must be observed at all times**	
6.1.9	Management of Incident site (post - removal of body) Handling/ collection of remains/ body parts to refer protocol for management of pts with HIV - use PPE	Appendix on Universal Precaution

3.3 POSTVENTION

The ultimate death of a person is a tragedy and likely to have profound effect to the people around the victim. Hence it is important to take steps to limit the impact and prevent further cases including copycat suicides (appendix 2). Care must be taken when breaking bad news (appendix 3). This includes:

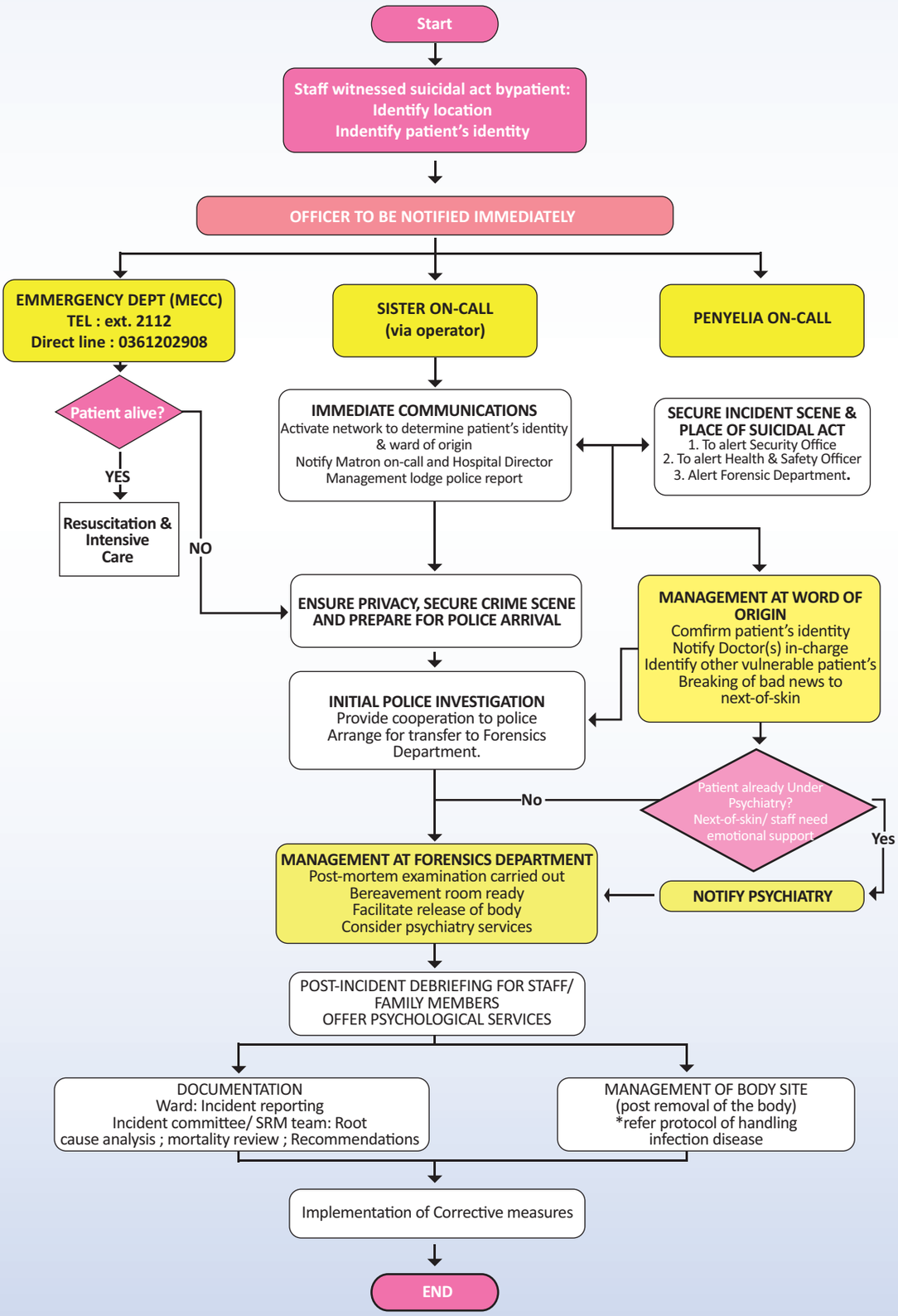
1. Support of grieving individuals including next of kin, spouse & health care workers.

2. Providing psychological first aid to high risk survivors.

3. Appropriate memorial activities eg. Religious memorial services, Islamic “tahlil”,

4. Reinforcement of prevention strategies.

4. FLOW CHART FOR MANAGEMENT OF INPATIENT SUICIDES



5. MONITORING AND RESEARCH GUIDELINE

Monitoring and research program planning and assessment of intervention strategies. This Includes:

1) Epidemiological studies
   Identify high-risk groups & changes in suicidal behaviour over time,
   Provide baseline data for testing the outcomes associated with specific intervention and prevention programs;

2) Studies assessing interaction between biological, psychological and social factors & its contribution to suicide;

3) Studies assessing the most effective approaches to the treatment of suicide attempters and for dealing with the aftermath of suicide;

4) Evaluation studies examining the impact of the full range of suicide prevention activities

GLOSSARY

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

Aborted Suicide Attempt:
Potentially self-injurious behavior with evidence (either explicit or implicit) that the person intended to die but stopped the attempt before physical damage occurred.

Suicidal Ideation:
Thoughts or serving as the agent of one's own death. It may vary in seriousness depending on the specificity of suicide plans and the degree of suicidal intent.

Suicidal Intent:
Subjective expectation and desire for a self-destructive act to end in death.

Lethality of suicidal behavior:
Objective danger to life associated with a suicide method or action. Note that lethality is distinct from and may not always coincide with an individual's expectation of what is medically dangerous.

Non-suicidal self-injury:
Direct, deliberate destruction of one's own body tissue without any intent to die, such as cutting or burning one's own skin.

Intentional self-harm or poisoning:
This is the term used to describe suicidal behaviour in the ICD-10. The various categories are listed in Chapter XX i.e. External Causes of Mortality and Morbidity (codes X 60-X 84) {World Health Organization, 2007 #5}. The diagnosis will be based on a post-mortem examination of the dead body and other supporting evidence that shows a preponderance of evidence indicating the intention to die.

Inpatient suicide:
Suicide committed by a medically ill patient who is hospitalized in Hospital Selayang; within the hospital premises.

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APPENDIX

APPENDIX 1: SCREENING

1. Identify risk factors		
	Source of information	Patient, medical records, previous, treatment providers, family, friends, school, employers.
2. Individual Risk Factors		
I.	Male	
II.	Age 15-35	
III.	Age over 65	
IV.	Previous history of attempts or self-harm	
V.	Family History of suicide	
VI.	Chronic Physical or disability	- Malignancy - HIV / AIDS - Peptic Ulcer disease - Kidney failure - Pain/ chronic pain - Functional impairment/ disability - Disease of nervous system, esp. MS and TLE
VII.	Psychiatric issues/ illness	- Depression - Schizophrenia - Other psychotic illness - Personality traits/ disorder - Alcohol/ substance use disorder
VIII.	History of sexual or physical abuse or neglect	
IX.	People in prison or police custody	
X.	People with sexual identify conflicts	
XI.	Homelessness	
XII.	Poor social supports/ social isolation	
XIII.	Environmental	- Access to lethal means of suicide, eg height, firearms
3. Symptom Risk Factors		
I.	Depressive Symptoms	
II.	Psychotic symptoms	- Command hallucination
III.	Hopelessness	
IV.	Worthlessness	
V.	Anhedonia	
VI.	Anxiety/ agitation	
VII.	Panic Attacks	
VIII.	Anger	
IX.	Impulsivity	
X.	Chronic Insomnia	

4. Current Personal Risk Factors *The most important risk factors for estimating the current and immediate risk are the personal risk factors (the current mental state) that are impacting on the individual's life at the present time*		
I.	Recent interpersonal crisis	- Especially rejection, humiliation
II.	Recent major loss or trauma or anniversery	
III.	Alcohol intoxication	
IV.	Drug withdrawal state	
V.	Chronic pain or illness	
VI.	Financial difficulties unemployment	
VII.	Impending legal prosecution	
VIII.	Family breakdown, child custody issues	
IX.	Unwillingness to accept help	
X.	Cultural or religious conflicts	
XI.	Difficulty accessing help due to language barriers, lack of information or support, or negative experiences with mental health services prior ro immigration	

APPENDIX 2: CHECKLIST FOR MANAGEMENT OF INPATIENT SUICIDES

	Communication and Administration	Clinical Assessment and Management	Environment of Care	Policy and Procedures
Immediate Actions	• Designate team leader • Create working group to respond to event • Notify family, staff, patients, administrators, legal, and regulatory bodies • Decide on possible media notification	• Identify individuals at risk for suicide. • Assess staff, patients, and witnesses at risk for trauma reaction • Decide on possible debriefing of staff	• Identify changes to the ward (e.g. lock unit, check for windows and cords) • Interact with police and medical examiner (if necessary)	• Create emergency Response checklist with items such as inpatient safety, staff response, communication, and environment • Assess existing policies and procedures for immediate safety • Consider implementing short-term unit restrictions
Short-Term Tasks	• Encourage open communication between patients and staff • Continue conversations with family	• Provide counseling to patients and staff for emotional reactions • Maintain mental health presence on all hospital units • Continue monitoring patients for suicide risk	• Identify and reduce access to lethal means (e.g. temporary netting in atrium, barred windows).	• Conduct Root Cause Analysis and create Action plan • Evaluate patient passes and assessment policies • Decide on policy for travel costs for family members
Long-Term Goals	• Complete changes to policies in Action Plan • Avoid excessive clinical and administrative reactions • Create multidisciplinary team to review adverse events	• Assure adequacy of staff training in depression and suicide • Avoid undue assessment of patients	• Institute environmental modifications as outlined in Action Plan. • Incorporate design modifications and changes for new construction.	• Continue interactions with regulatory agencies. • Identify legal concerns. • Institute Failure Modes and Effects Analysis.

APPENDIX 3 : BREAKING OF BAD NEWS

Vandekieft had adapted the practical and comprehensive model formulated by Rabow and McPhee, that uses the simple mneumonic ABCDE

The ABCDE Mnemonic for Breaking Bad News

Breaking Bad News
Advance preparation Arrange for adequate time, privacy and no interruptions (turn pager off or to silent mode). Review relevant clinical information. Mentally rehearse, identify words or phrases to use and avoid. Prepare yourself emotionally.
Build a therapeutic environment/ relationship Determine what and how much the family wants to know. Have family or support persons present, if available Introduce yourself to everyone. Warn the patient that bad news is coming. Use touch when appropriate. Schedule follow-up appointments.
Communicate well Ask what the family already knows. Be frank but compassionate; avoid euphemisms and medical jargon. Allow for silence and tears; proceed at the family member's pace. Have the family member describe his or her understanding of the news Allow time to answer questions; write things down and provide written information. Conclude the interview with a summary and follow-up plan (e.g. referral to other relevant agencies)
Deal with patient and family reactions Assess and respond to the family's emotional reaction Be empathetic. Do not argue with or criticize colleagues.
Encourage and validate emotions Explore what the news means to the family Offer realistic hope according to the patient's goals. Use interdisciplinary resources. Take care of your own needs; be attuned to the needs of involved house staff and office or hospital personnel.