THE TASK FORCE ON
MENTAL HEALTH
FOR CHILDREN AND YOUTH

# WORKSHOP MANUAL ON DEPRESSION AND SUICIDE

## Designed for General Pediatricians

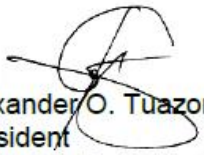
## FOREWORD

We welcome the fruition of months of dedicated work by the PPS-PSCAP Task Force on Mental Health for Children and Youth. The Task Force was created with the singular desire to address Mental Health Issues afflicting our Filipino youth, particularly Depression and Suicide whose incidences have notably risen in recent years. Composed of leading practitioners and officers of the Philippine Society for Child and Adolescent Psychiatry (PSCAP) and the Philippine Pediatric Society, represented by its officers and those of the Philippine Society of Adolescent Medicine Specialists (PSAMS) and the Philippine Society for Developmental and Behavioral Pediatrics (PSDBP), the Task Force set themselves the goal of equipping General Pediatricians with the needed knowledge and skills in helping to address Suicide. This learning module is a vital component of this campaign, together with the partnership between the Child Psychiatrist and the Pediatrician.

Pediatricians, as child advocates, endeavor to promote the health of children based on the fundamental concept of comprehensive and integrated care, a holistic approach to child health and development. Thus we address not only the patient but also his external environment, his family, community and physical surroundings. But there is an internal environment that demands the same holistic approach - that of the balance of mind, body and spirit. The ancient Greek ideal of the perfect man is applicable as much to an adult as to a child in his various stages of development, to a cultural and philosophical approach to living as to health management. As pediatric practitioners, we have largely immersed ourselves with physical and cognitive milestones. Now we have to deal with imbalance caused by an affliction of or manifestation by the spirit: depression, aloofness, dark thoughts. This immense complexity of interactions is most acutely seen in the child and the young with a mental health condition.

This module is an initial humble step in empowering the Pediatrician to effectively manage Suicide. In the same way that Pediatricians strive to employ holistic health management, its execution and success are dependent on a multifaceted team approach: a partnership between the pediatrician, patient, family and all those who figure significantly in the child's life.

I would like to congratulate and thank the members of the Task Force who have offered their time and expertise: Drs. Cornelio Banaag, Rosa Maria Hipolito Nancho, Francis Xavier Daniel Dimalanta, Vanessa Kathleen Cainghug, Ma. Rochelle Buenavista-Pacifico, Nerissa Dando, Jacqueline Navarro, Ma. Zairah Jane Castelo and Kenneth Ross Javate. I would also like to thank UMED for its valuable assistance in the production of the module, in particular Dr. Edilberto Garcia Jr., Dr. Loreta Dayco and Ms. Julie Anne Tuazon.



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**OBJECTIVES**

General Objectives:

To enhance and strengthen the capacity of primary care physicians and pediatricians in the early management of depression and suicide among children

Specific Objectives:

1. To describe the epidemiology, risk and protective factors of depression and suicide among children and adolescents.
2. To develop skills in recognizing early signs and symptoms (red flags) of suicide and depression among children and adolescents.
3. To understand comorbid conditions that, if undetected and untreated, may lead to suicidal behaviour.
4. To demonstrate initial psychosocial and/or pharmacologic intervention and management of children with depression and suicide.
5. To provide ways and means to coordinate referral system for patients requiring further mental health evaluation and management.
6. To recommend strategies to prevent depression and suicide among children and adolescents.

## I. INTRODUCTION

The World Health Organization has sounded alarm at the rising rates of suicide. There is a growing number of people resorting to taking their lives among the young, therefore stressing the need for suicide to be considered a public health issue rather than a mere event to be treated as a police case. Worldwide, suicide is said to be the second leading cause of death among adolescents.[1] For the past two to three decades, there has been a noticeable surge in attempted and completed suicides all over the world. It is estimated that about one million people worldwide commit suicide. Many countries in Asia show varying rates of suicide. The People's Republic of China is estimated to account for about 25% of the total suicide deaths globally. In the Philippines, however, there are only about 5 deaths due to suicide per 100,000 as reported in 2010 by the WHO Western Pacific Region data.[2]

Suicide is rare before puberty but suicide rates have been reported to increase dramatically during early adolescence and young adulthood. Suicide risk changes at each developmental stage, coinciding with the increase in incidence of mood disorders. An earlier report on the Health of Adolescents in the Philippines published by the World Health organization Western Pacific Region, depression, anxiety, and mood disorders were common among students surveyed.[3] Forty two percent had felt sad or hopeless over the past two weeks in the past year and 17.1% had seriously contemplated committing suicide and 16.7% had planned how they will commit suicide. By 2011, the subsequent Global School Health Survey, showed that 20.1% of students surveyed had seriously considered suicide in the past 12 months and 13.8% had actually attempted suicide one or more times.[4] Redaniel reported a rise in suicide rates for both males and females with the highest rates in the ages 15 -24 years of age.[5] Non-suicidal behavior among our teens and youth is also quite concerning. Studies report that about 10% of youth resort to self-mutilation (cutting, burning or hitting oneself, scratching oneself to the point of bleeding and interfering with healing). This behavior can become chronic and lead also to actual suicidal behavior.[6]

Screening for suicide is an important first step in the prevention of suicide. The importance of screening children and adolescents for possible suicide has led to the development of several screening tools both for depression and suicide. Screening for both conditions are now recommended by the United States Preventive Services Task Force (2009) for all adolescents 12 -18 years old.[7] According to the USPSTF, there is moderate benefit for screening for Major Depressive Disorders in those aged 12 and up. However, there is insufficient evidence for screening MDD in ages 11 years and below. USPSTF also mentioned that there was insufficient evidence as to the harm of screening for depression in adolescents. Some screening tools have been used in the primary care setting. Once screening is done, it is important to ensure that there are resources available for accurate diagnosis, effective treatment, and appropriate follow-up. Likewise, the American Academy of Pediatrics' Bright Futures recommends annual screening of children and adolescents for emotional and behavioral problems.

Not to be overlooked is the importance of screening for depression in children and adolescents. Clinicians and other health providers should be able to evaluate depression as well as screen those who present with emotional health concerns. Screening for depression may be able to prevent its progression into deeper mental health problems and possibly suicide.

The recommendation of the American Academy of Child and Adolescent Psychiatry states that evaluation for depression should also include screening for harm to self and to others.[8] It is believed that since suicidal behavior results from a continuum of thoughts of death and intent to die and a clear plan to die, it is important to screen for suicide. There are various types of suicidal behavior, from actual self-harm to non-suicidal self-injurious harm that carries clear motivation to relieve anger, sadness, and loneliness rather than end life. Going beyond screening it is also important to be able to provide some counseling and implementing some management and safety plans. All these need to be considered.

Pediatricians and primary care physicians are considered the gateway in the assessment and treatment of mental health concerns in patients. Primary care physicians are the first contact of patients who come for mental health concerns. Many adolescents seek consult with a physician in the emergency room and outpatient department. A certain amount of awareness and preparedness for detecting the subtle signs of

anxiety, depression, and mood disorders may be relevant in these settings where adolescents may come to reach out for help.

The Philippine Pediatric Society, Inc. (PPS) has taken cognizance of the need to take care of the mental health of our children and adolescents. Recognizing that not all pediatricians are at ease with handling mental health issues, the PPS has asked the assistance of The Philippine Society of Child and Adolescent Psychiatry (PSCAP) to come up with this training module. It is hoped that with this training manual, pediatricians and primary care physicians will be more comfortable in confronting the issues of depression and suicide. This module will start with recognizing the importance of resilience in every child. It will also tackle suicide, its epidemiology, risk and protective factors, and different forms of suicide. It will introduce various suicide screening forms that have been found to be practical for use in various clinical settings. Getting used to these forms will be helpful in clinical practice. Beyond the screening, however, is being able to trigger the referral system to assist the patient and the family in dealing with the issues of depression and/or suicide.

Majority of patients with emotional and behavioral problems will access mental healthcare services through their primary care physicians. Pediatrician need to acknowledge that mental health is as important as physical health, and should be part of the developmental surveillance for children's wellbeing. Pediatricians have the unique opportunity to observe children as they grow and develop. The pediatricians may observe, for example, early signs of Attention Deficit Hyperactivity Disorder (ADHD) in a young child and can initiate appropriate management before comorbidities occur. In the same manner, the pediatrician may observe behavior suggestive of depression in a school age child or a teenager requiring interventions before the young person becomes suicidal. Pediatricians are also more likely to know the child's family history of depression, anxiety, suicide, alcoholism and substance use. The pediatrician should, therefore, be proactive in recognizing similar problems in the young patients.

We hope that this module will increase the confidence of every pediatrician to recognize mental health problems in their patients and screen every patient encountered for depression and suicide.

## II. OVERVIEW OF SUICIDE IN CHILDREN AND ADOLESCENTS

### A. Epidemiology

Suicide is a global health concern. In fact, according to the World Health Organization approximately over 804,000 people die of suicide every year and is the second leading cause of death among the 15-29 age group worldwide.[1]

Among the youth, in western countries such as in the United States, suicide was found to be the third leading cause of death among young people. In fact, in the year 2006, data showed that suicide rate among youth aged 10-19 years in the U.S. was 4.6 per 100,000 persons. Research also shows that rates of suicide increases with age and those higher rates of completed suicide were found in boys while higher rates of suicidal ideations and attempt were seen in girls. In terms of methods, firearms were found to be the leading cause of suicide method followed by hanging and self-poisoning. Comorbidity of psychiatric disorders such as mood, anxiety, and substance use disorders were found to be present in up to 80-90% of adolescent suicide victims. Further evaluation showed that 60 percent of adolescents who committed suicide were clinically depressed at the time of the suicide.[2]

In Asia, although frequently underreported due to socioeconomic, cultural and religious factors,60 percent of the world's suicide are found in the continent with the highest suicide rate found in South East Asian Countries.[3] In the Philippines, suicide is also found to be underreported due to stigma or misclassification as injury or accidents, yet trend seem to be increasing. In a study by Redaniel et al. an increase in the incidence of suicide in males from 0.23 to 3.59 per 100,000 and 0.12 to 1.09 per 100,000 among females were found between 1984 and 2005. Male rates were found to be consistently higher than female rates. Similarly, the highest suicide rate was found in the younger population of 15- 29 age group among females. In the same study, common used methods were found to be hanging, shooting and organophosphate ingestion with family and relationship problems found to be common stressors.[4] Among the youth, research on epidemiology of suicide rates in the Philippines is limited. In a 2011 Global Based Health Survey conducted by World Health Organization on 5,290 students in the Philippines, 16.3 percent among students aged 13-15 years old were found to have seriously considered attempting suicide in the past 12 months while 12.9 percent attempted suicide one or more times during the past 12 months.[5] In another survey in 2013, conducted on Filipino youth of 15 - 24 years of age, youth with suicidal ideation were found to be about 8.7 percent while those who attempted suicide were found to be 3 percent with majority of the suicide attempters found to be females and residing in the NCR region.[6]

### B. Definition of Terms

Suicide according to the American Psychiatric Association is a self-inflicted death with evidence of intent to die. Suicidal behavior can occur in different presentations. It is necessary to differentiate the types of behavior as part of suicide risk assessment. This protocol makes use of terms based on those described in the Columbia Suicide Severity Rating scale.

The Columbia Suicide Severity Rating Scale differentiates the different domains of suicidal ideation and suicidal behavior. Constructs such as severity of ideation, intensity of ideation, behavioral sub scale and the lethality sub scale are used. **Suicidal ideation** therefore is rated on a 5 point ordinal scale and includes wishes to be dead, non-specific active suicidal thoughts, suicidal thoughts with methods, suicidal intent and suicidal intent with plan. The intensity of the ideation is also measured by frequency, duration, controllability, deterrents and reason for ideation. **Suicidal behavior** on the other hand, includes not just actual attempts of suicide but also interrupted attempts, aborted attempts and preparatory activity to suicide. It is important to further qualify lethality of actual attempts on an ordinal scale.[6]

**Non suicidal self-injury** is an emerging concern among the youth. It is necessary in suicide risk assessment to define and differentiate non suicidal self-injury from suicide or suicidal attempt. An important feature of non-suicidal self-injury is that one repeatedly inflicts shallow injury to the surface of one's body often made by knife, razor or any sharp object. This self-injury may involve a series of superficial cuts usually on the frontal areas of the thighs and dorsal side of the forearm. It can be

differentiated from suicidal intent as the purpose of non-suicidal self-injury is to reduce negative emotions or a form of self-punishment rather than death. Often, an individual would feel an immediate relief during the process. The proposed criteria for non-suicidal self-injury on DSM 5 are as follows:[7]

- In the last year, individual has 5 or more days, engaged in self-intentional self-inflicted damage to the surface of his body of a sort likely to induce bleeding, bruising or pain with the expectation that it will lead only to minor or moderate physical harm.
- The individual engages in the self-injurious behavior with one or more of the following expectations :
    - to obtain relief from a negative feeling or cognitive state
    - to resolve an interpersonal difficulty
    - to induce positive feeling
- The intentional self-injury is associated with at least one of the following:
    - interpersonal difficulties or negative feelings or thoughts occurring immediately prior to the self-injurious act
    - period of preoccupation with the intended behavior that is difficult to control prior to engaging in the act
    - thinking about the self-injury that occurs frequently even when it is not acted upon.
- The behavior is not socially sanctioned and is not restricted to picking a scab or nail biting
- It causes clinical significant distress or interference in functioning
- It does not occur exclusively during psychotic episodes, delirium, substance intoxication or substance withdrawal

**C. Myths About Suicide**

Despite increasing rates of suicide and growing media attention towards the subject, myths about suicide have continually hindered proper assessment and intervention. One of the common misconceptions about suicide is that suicide happens suddenly without warning. This is not often the case, as most suicides are preceded by warning signs. It is therefore important to be knowledgeable about these warning signs and risk factors in assessing the suicidal risk of a person. Another myth is that someone suicidal is determined to die. Contrary to this belief, suicidal people are often ambivalent about dying. Timing of intervention is therefore imperative as it prevents the completion of suicidal act. Another common misconception is that talking about suicide is discouraged as it can be misinterpreted as encouragement. This is an important myth to debunk as suicidal people often have trouble in talking openly about suicidal thoughts for fear of judgment therefore, talking about suicide can allow an individual to discuss feelings and provide option to rethink about suicide. Another myth is that only people with mental disorders are suicidal. Although mental disorder is a risk factor for suicide, not all people with mental disorders are found to be suicidal. Lastly, it is often believed that if someone is suicidal then the person will remain suicidal. It is important to note that suicidal thoughts are not permanent, and with the proper assessment and intervention, suicide is preventable.[7]

## III. COMORBID PSYCHIATRIC ILLNESSES

Suicide is really a sensitive topic to discuss. Most people want to avoid it but when it happens to family or a relative, the easiest way to cope with it is to think that it will go away tomorrow. But it usually does not. In most cases, suicide is a result or consequence of another problem which was unresolved, and the victim's train of thought is that the only solution to the pressing problem is killing himself. These problems or disorders which have a high suicide risk are what we call 'Co Morbid Disorders'. It is a common notion that suicide results from a depression. However, various other mood and psychiatric problems also have a high risk for suicide. This can be:

1. Mood Disorders (Depression and Bipolar Disorder)
2. Anxiety Disorders
3. Disruptive disorders in children like Oppositional Defiant Disorder, Conduct Disorder and the new diagnosis in DSM 5, Disruptive Mood Dysregulation Disorder.
4. ADHD
5. Post Traumatic Stress Disorder and Adjustment Disorder
6. Psychotic Disorders like Schizophrenia
7. Alcohol and Substance abuse
8. Personality Disorders

### Mood Disorders

Mood disorders are the usual culprits in the etiology of suicide. The DSM 5 Criteria for Major Depressive Disorder is 5 or more of the following, and must have been present for at least two weeks. In addition, irritable mood can substitute for depressed mood in children.

1. Depressed mood
2. Markedly diminished interest or pleasure in daily activities
3. Significant weight change
4. Insomnia or hypersomnia
5. Psychomotor agitation or retardation
6. Fatigue or low energy level
7. Feelings of worthlessness
8. Decreased concentration
9. Recurrent thoughts of death.

Other mood disorders in children which merit our attention are early onset Bipolar Disorder and Disruptive Mood Dysregulation Disorder. In adults, to be diagnosed with Bipolar I Disorder, one must have an episode of Mania which is a distinct period of an abnormally and persistently elevated, expansive or irritable mood lasting for at least 1 week, with at least 3 of the following symptoms:

1. Inflated self-esteem or grandiosity
2. Decreased need for sleep
3. More talkative than usual
4. Flight of ideas
5. Distractibility
6. Increase in goal-directed activities
7. Excessive involvement in activities that have a high potential for painful consequences

The Bipolar symptoms in prepubertal children may include extreme mood dysregulation, severe temper tantrums, intermittent aggressive or explosive behavior and high levels of distractibility and inattention. Bipolar Disorder in this population can be difficult to differentiate from ADHD because the symptoms can be similar. It is important to remember that symptoms of Bipolar Disorder are intermittent while in ADHD, they are continuous. Children who have Bipolar Disorder also suffer from long periods of depression which can be very difficult to treat. It is during these periods of depression that suicide attempts are high.

In the DSM 5, a new disorder has already been included, that is the Disruptive Mood Dysregulation Disorder. It is characterized by developmentally inappropriate and recurrent temper outbursts at least three times per week, along with persistently irritable or angry mood between temper outbursts. For this disorder, the symptoms must have been present for at least a year and onset of symptoms must be present by age 10 years old.

Different anxiety disorders may also put a child at risk for suicide like Separation Anxiety Disorder, Generalized Anxiety Disorder, Social Anxiety, Panic Disorder and selective Mutism. Anxiety Disorders are characterized by recurrent emotional and physiological arousal in response to excessive perceptions of perceived threat or danger. Most children with high levels of anxiety are also achievers in school. Any slight perception that they may have been unable to achieve their goals will be interpreted as a failure and put them at risk for suicide. In children with Social Anxiety, any perceived rejection from others will cause depression and subsequently suicide.

What we have to bear in mind with mood disorders especially Depression is that the emotion that the patient is feeling is persistent and not good such that they feel that killing themselves is the only escape.

**Disruptive Disorders**

The 2 most common disruptive disorders in children are Oppositional Defiant Disorder and Conduct Disorder. In the DSM 5, Oppositional Defiant Disorder is divided into 3 types: Angry/irritable mood; argumentative/defiant behavior and vindictiveness. The disorder is diagnosed if a child has at least 4 symptoms from the 3 groups within a 6-month period. Children with ODD often lose their tempers, are easily annoyed and feel irritable most of the time. They also display a pattern of arguing with authority figures, refuse to comply with requests, deliberately break rules and purposely annoy others. They do not take responsibility for their actions. They blame others for their misbehavior and are spiteful.

Conduct Disorder on the other hand, is characterized by aggression and violation of the rights of others. The behaviors of children with this problem can be grouped into 4 categories: physical aggression or threats of harm to people (or animals), destruction of property, theft or acts of deceit, frequent violation of age-appropriate rules.

Remember that these behavior patterns are enduring and cause difficulties in school and academics as well as relationships with peers and family.

**Attention Deficit Hyperactivity Disorders (ADHD)**

ADHD is a very popular problem especially among preschoolers and school age children. Basically, ADHD symptoms constitute: several inattentive or hyperactive-impulsive symptoms which must be present by age 12 years. Children with this problem often have significant impairment in academic functioning as well as social and interpersonal situations. Although suicide is not part of the symptoms of ADHD, it is worth noting that more than 50% of children with ADHD will develop co-morbid disorders such as learning disorders, anxiety and mood disorders and disruptive disorders. When they grow into adolescence, substance abuse is another big risk for them. And all of these co morbid disorders will put the child at risk for suicide.

**Trauma, Stressor-Related Disorders and Adjustment Disorder**

Children who are victims of or are exposed to traumatic events are at high risk for developing Post Traumatic Stress Disorder. And this in turn increases their risk for suicide. Adjustment Disorder on the other hand is an emotional response to a stressful event. The emotional response is usually a depression or anxiety, which again, puts the child at risk for suicide.

In children less than 6 years old Post Traumatic Stress Disorder (PTSD) happens when the child is exposed to actual or threatened death, serious injury, or sexual violence in one or more of the following ways (DSM 5):

1. Directly experiencing the traumatic event/s.
2. Witnessing, in person, the traumatic event/s as it occurred to others especially primary caregivers.
3. Learning that the traumatic event/s occurred to a parent or primary caregiver.

The diagnosis of PTSD needs one or more of the following symptoms associated with the traumatic event:

1. Recurrent, involuntary and intrusive distressing memories of the traumatic event.
2. Recurrent distressing dreams in which the content of the dream is related to the traumatic event.
3. Dissociative reactions
4. Intense or prolonged psychological distress at exposure to internal or external cues of the traumatic event.
5. Marked physiological reactions to reminders of the traumatic event.

In addition, the patient has to have persistent avoidance of stimuli associated with the traumatic event/s or negative alterations in cognitions and mood associated with the traumatic events, beginning after the event or worsening after it.

As can be gleaned from the symptoms of PTSD and trauma, the mood of the child is again affected negatively. This in turn contributes to a persistent experience of stress and bad emotions which can put the child at risk for suicide.

**Psychotic Disorders**

Psychotic Disorders are usually misunderstood by most people. There are several types of psychotic disorders but only Childhood Onset Schizophrenia will be discussed. The DSM 5 diagnosis of schizophrenia includes at least one of the following: delusions, hallucinations, or disorganized speech and at least one of them present most of the time for a month and cause impairment in social, academic or occupational functions. Additional symptoms may be disorganized or catatonic behavior, or negative symptoms (e.g. anhedonia). The disturbance must persist for at least 6 months to be diagnosed as Schizophrenia. When the onset of Schizophrenia is in childhood, it is usually more chronic, with more severe social and cognitive consequences compared to the adult-onset. Again, suicide is not part of the criteria for Schizophrenia, but children with psychotic disorders are at higher risk for suicide compared to the norm. Usually, suicide happens due to the hallucinations (e.g. voices telling the child to kill himself) or thought insertions of suicide.

**Adolescent Substance Abuse**

Substance use and abuse start during the teenage years, and this is the stage wherein children start experimenting with cigarettes, marijuana and alcohol. Although not all children will develop and addiction, those who have co morbid psychiatric disorders, genetics, dysfunctional families, parental and peer substance use, early onset of cigarette smoking will increase the risk of developing substance addiction. Substances of abuse contribute largely to completed suicides and suicide attempts as they will alter the child's mood and lower his impulse control.

**Personality Disorders**

Although a personality disorder cannot be diagnosed until a child is 18 years old, its development starts as young as adolescence. Cluster B personalities like Narcissistic, Histrionic, Borderline and Antisocial are at risk for suicide. Children with Obsessive Compulsive personality characteristics have high anxiety levels and any perceived failure might trigger depression and suicide.

These different co-morbid disorders tell us that suicide does not happen by itself. Something is not well with the child who commits suicide, emotionally and psychologically. But if these co-morbid disorders are addressed early enough, suicide can be prevented.

## IV. SUICIDE RISK ASSESSMENT

### A. Warning Signs

Warning signs for suicide are the earliest identifiable signals that a child or adolescent may imminently harm himself or herself. They are likened to "red-flag" signs that can be seen in or expressed by the child or adolescent, sharing some features of an actual suicidal event. By being imminent, implies that the act may possibly occur within minutes, hours, days or months of the observed behavior. Moreover, warning signs tend to be less well-defined, episodic, variable in nature and not ordinarily observed in the individual or in the general population, causing it to be overlooked or ignored. They may overlap with risk factors, as previously considered, but the most distinguishing feature differentiating warning signs from risk factors is its relation to current functioning, making it a proximal (near-term risk) rather than distal (long-term risk) association to a suicidal event.[1] Risk factors refer more to long-term probabilities for suicide to occur after months or years and speak more of objective situations or circumstances that a child or adolescent may find themselves in (e.g. psychopathology, abuse, conduct disorder) rather than the very subjective and palpable nature that warning signs present (e.g. talking about suicide or death often, withdrawal, insomnia). Another differentiating point is that risk factors can stand alone in determining the likelihood for suicidal tendencies while warning signs are only relevant when they present collectively. Finally, risk factors are geared towards use of experts and authorities in predicting threat for suicide whereas warning signs serves the primary purpose of saving lives through improved recognition of those at risk and facilitating the much needed referral for professional care.[2]

In 2008, the American Academy of Child and Adolescent Psychiatry[3] updated the list of symptoms and warning signs specifically for adolescents who may try to kill themselves. Other similar agencies like the Suicide Prevention Resource Center (SPRC) have also compiled a list of youth-specific suicide warning signs which may be referred to for recognizing those at imminent threat of suicidal behavior.[4] Below is a compiled list of warning signs.

**Suicide Warning Signs**

- Actually talking about suicide or plans for this
- Seeking out ways to harm or kill oneself
- Expressing statements like: "I'm going to kill myself", " I wish I were dead" or " I shouldn't have been born"
- Being preoccupied with death in conversations, writings or drawings
- Giving verbal hints with statements such as: "I won't be a problem for you much longer," "Nothing matters," "It's no use," and "I won't see you again"
- Making statements about hopelessness, helplessness, worthlessness, or being "beyond help"
- Marked personality change and serious mood changes, anxiety, agitation, grief or shame
- Not tolerating praise or rewards
- Exhibiting impulsivity such as violent behaviors (rage/anger), rebellious behavior, or running away
- Engaging in reckless, risk taking behaviors (alcohol/drugs)
- Loss of interest in things one cares about or activities previously enjoyed
- Giving away favorite possessions
- Withdrawal from friends and family, avoiding social gatherings
- Lack of apathy or care about once appearance or dressing
- Change in eating habits, loss or gain in weight
- Change is sleeping patterns
- Often complaining about physical symptoms, often related to emotions such as stomach ache, headache, fatigue, etc.
- Complaining of being bad or feeling rotten inside
- Becoming suddenly cheerful after a period of depression-this may mean that the student has already made the decision to escape all problems by ending his/her life
- Difficulty concentrating, thinking clearly and a decline in quality schoolwork or grades

Identifying suicide warning signs may be the most important piece of information applicable in clinical practice in order to assess, manage, and respond to and save children and adolescents in the brink of suicide. Often associated to suicidal thoughts and behaviors is alterations in mental status, specifically depression which usually precedes the warning signs, thereby increasing patients risk level. Also consistent is increasing hopelessness and intent to end one's life.[2] There are several ways of eliciting suicidal warning signs. It may be done through indirect observation, reports from close contacts like parents, siblings, teachers, close friends and classmates, direct interview or through internet sites that provide this kind of service through questionnaires and more efficiently through formal screening. If the patient is a minor, parental consent for an interview is necessary and it is advisable to interview both parties separately as most children and adolescents would usually withhold information in the presence of their parents. Confidentiality should be observed but it should be explained to the child or adolescent that some information may need to be disclosed to parents especially if the patient's life may be in imminent danger. Safety should always take precedence over confidentiality. A suggested approach to confidential inquiry into suicidal thoughts or concerns is to initially ask a general question such as "Have you ever thought of killing yourself or wished you were dead?" This should be asked towards the end of an interview and regardless of answer should be followed by, "Have you ever done anything on purpose to hurt or kill yourself?" More details should be obtained for an affirmative answer to either question such as past and present thoughts and behaviors, time frames, expositions, suicide plans and accessibility to potentially lethal devices. It is very important to reconcile discrepancies between what a patient says and what he does[2] by asking him or her to explain further. Avoid abrupt and intrusive question as these can reduce rapport and compromise disclosure by the child or adolescent.[5] The more suicide warning signs elicited, the greater the risk of suicide in the child or adolescent thereby indicating the need for immediate professional attention.

**B. Identifying Risk and Protective Factors**

There are no specific tests capable of identifying a suicidal person but specific risk factors exist.[1] Risk factors are characteristics that make it more likely for an individual to consider, attempt or die by suicide.[2,3] They are considered as indicators for a child's or adolescent's potential for self-harm. It is important to note that the lack of most risk factors does not make an individual safe from suicide.[1]

Protective factors on the other hand are those that make it less likely for an individual to consider, attempt or die by suicide.[2,3] Protective factors are also known as resilience factors and are helpful in preventing suicide and reducing the factors that increase risk for suicide.[2] Protective factors protect and nurture adolescents in high risk situations and they promote well-being.[4]

Knowledge of risk and protective factors may help prevent suicide. The importance of risk and protective factors may vary by age, gender and ethnicity.[2]

**The following are risk factors[1,2] for youth suicide**:

- Previous suicide attempt
- Physical abuse
- Sexual abuse
- Feelings of hopelessness or isolation
- Personal mental health problems:
    - Sleep disturbances
    - Depression
    - Bipolar disorder
    - Substance intoxication and substance use disorders
    - Psychosis
    - Posttraumatic stress disorder
    - Panic attacks
    - Conduct disorder or disruptive behaviors
    - History of aggression, impulsivity, severe anger

  - Pathologic internet use

- Parental psychopathology
- Juvenile delinquency
- School problems
- Exposure to suicidal behavior of friends or acquaintances, or in the media
- Chronic physical illness
- Bullying
- Impaired parent-child relationship
- Being homeless/or having run away from home
- Life stressors such as interpersonal losses (relationship, social, work) and legal or disciplinary problems
- Access to firearms or other means

**Demographic Risk Factors[1,2]**

- Being male (for death by suicide)
- Being female (for suicide attempt)
- Homosexual or bisexual orientation, or trans-gender identity
- Family history of suicidal behavior
- History of adoption

**The following are protective factors[2] for youth suicide:**

- Family cohesion (family with mutual involvement, shared interests, and emotional support)
- Good coping skills
- Support from teachers and other relevant adults
- Perceived connectedness to the school
- Positive relationships with other school youth
- Reduced access to means for suicidal behavior
- Help-seeking behavior/advice seeking
- Impulse control
- Problem solving/conflict resolution abilities
- Social integration/opportunities to participate
- Sense of worth/confidence
- Stable living environment
- Access to and delivery of effective care for mental/physical/ substance disorders
- Responsibilities for others/pets
- Religious or cultural beliefs that discourage self-harm
- Sports team participation

**C. Screening Tools for Depression and Suicide**

Suicide in all its forms, carry significant morbidity and mortality. Research and clinical experience show that it can be effectively managed and prevented, especially if detected early. Suicide screening is therefore highly critical and should be within the competence of pediatricians who traditionally are the gatekeepers of young people's health. In 2016, the American Academy of Pediatrics released a clinical report on suicidality in adolescents, stating that primary care pediatricians should be comfortable screening patients for suicide. Likewise, screening for depression is critical, considering how up to four-fifths of suicide attempts are inextricably linked to clinical depression. (Horowitz, et al., 2009) The Bright Futures Guidelines for Health Supervision published by the American Academy of Pediatrics likewise recommends depression screening for all adolescents between the ages of 11 and 21 years of age. (Hagan, et al., 2016) As such, the Children and Youth Mental Health Working Group recommends that all adolescents be initially screened for depression using the self-report version of the Patient Health

Questionnaire (PHQ-9) and those who screen positive for depression and/or suicidality, be further assessed using the clinician-administered screener version of the Columbia Suicide Severity Rating Scale (C-SSRS). The level of risk in the C-SSRS will determine the recommended clinical action. The process of screening is summarized in the figure below. In all cases, the primary care physician should provide initial psychosocial measures and appropriate recommendations to ensure the safety of the patient and family.

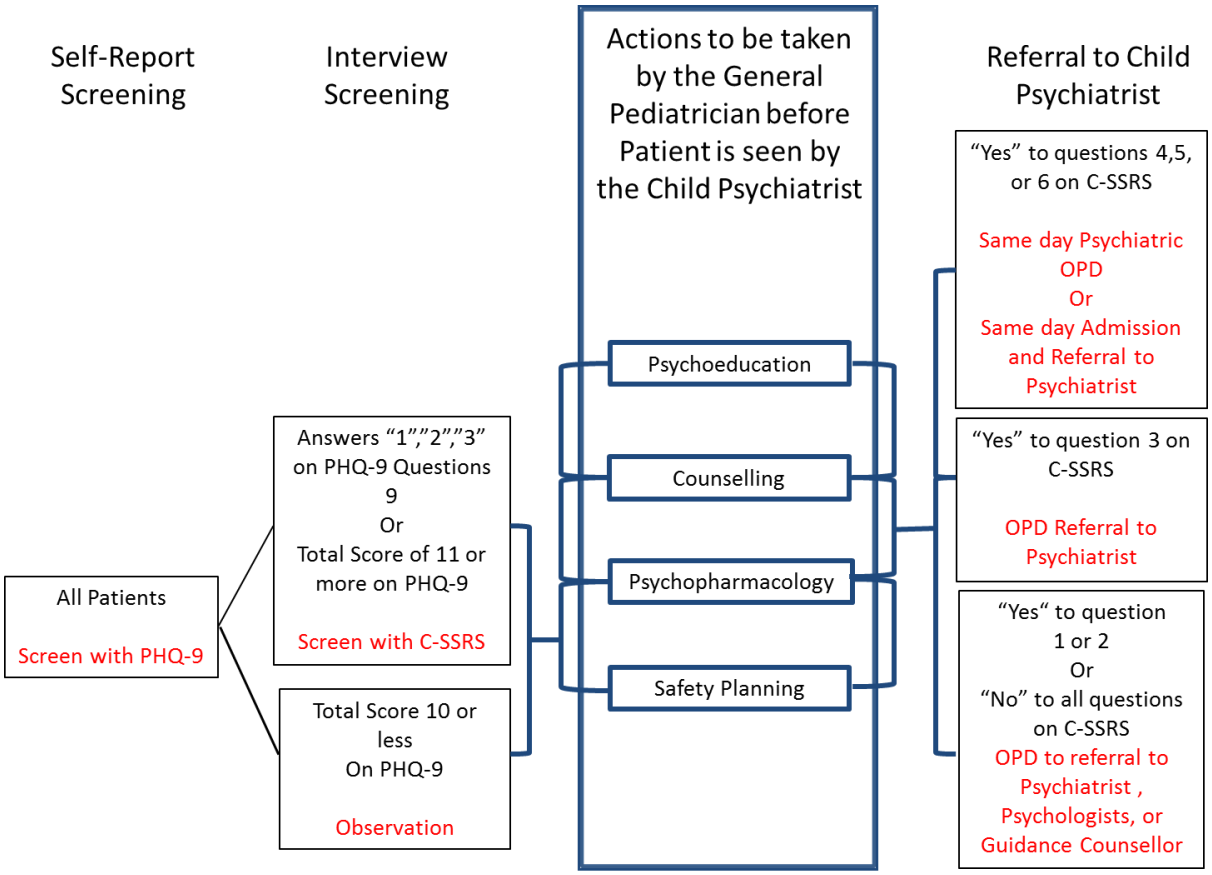


Figure 1. Recommended Actions of General Pediatricians based on the Columbia Suicide Severity Rating Scale

***General Approach to Screening for Suicide***

Pediatricians should be comfortable screening for mental health issues, including suicide, mood disorders, as well as substance abuse, through the use of self-administered scales and clinical interviewing. It has been established that suicide screening, or asking about suicide symptoms does not cause or increase suicidal thoughts nor trigger other psychiatric symptoms in young persons. (Gould et al., 2005)

Young persons should be interviewed separately from their parents as they are more likely to withhold important information in their presence. Parents can be informed that the clinician will first speak with the patient and afterwards with them in order to elicit their concerns, as well as obtain more information. Once alone with the patient, the pediatrician should assure the patient that confidentiality should be respected to the degree possible, with the caveat that for patients at risk of harming themselves or others, safety takes precedence over confidentiality. For instance, one can say: "I want to assure you that as much as possible, what we will talk about will remain between us. However, if I have reason to believe that you are

at risk for harming yourself or others, your safety is much more important so I will have to discuss this with your family."

From the perspective of medical ethics, in the case of a serious threat to the integrity of one's life and well-being posed by suicide, the value of beneficence outweighs that of the patient's autonomy. Therefore, a physician in fact has a duty to ensure that the patient is safe by informing those who would be able to ensure this, such as parents or guardians, even if it would go against the expressly stated wishes of the patient. The same principle applies in recommending hospital admission in the case of a clear and demonstrated danger for suicide, whether the family chooses to follow this advice or not.

In the case of suicidal ideation or behavior, it is most important to obtain information on the following: the sequence of events that preceded the threat, current problems and conflicts, and the degree of suicidal intent. Relevant risk factors should be identified. Pediatricians should also assess the individual's coping mechanisms and the degree of support available from the family and other resources, including attitudes toward mental health intervention and follow-up.

The interview should be conducted with care and sensitivity. An abrupt and intrusive style of questioning can result in a failure to establish rapport and thus, a lower likelihood of the patient sharing mental health concerns. One can begin with open-ended and relatively non-threatening question such as: “Aside from [non–mental health concern], how have you been doing?” “I know that a lot of people your age have a lot going on. What kinds of things have been on your mind or stressing you lately?” “How have things been going with [school, friends, parents, sports]?” This can be followed by more detailed questions.

***Screening for Depression***

The Patient Health Questionnaire (PHQ-9) is recommended by the American Academy of Pediatrics as a valid screening tool for depression in young persons. (Shain, 2016) The PHQ-9 was derived from the depression subscale of a broader screening tool developed in the 1990's namely the Patient Health Questionnaire (PHQ), which includes depressive, anxiety, somatoform, alcohol, and eating disorders among its domains. Over time, the PHQ-9 has grown in popularity as a stand-alone screener for depression and has been validated by various large-scale research studies in young persons. A validated Filipino translation of the instrument is available for use and is included in the appendix of this manual.

The PHQ-9 is self-administered instrument consisting of nine questions that assess the severity of symptoms reflecting the criteria for a major depressive episode as listed in the latest edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-5). Scoring is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all", "several days", "more than half the days", and "nearly every day", respectively. PHQ-9 total score for the nine items ranges from 0 to 27. The PHQ-9 has been validated as a screening tool for depression among adolescents aged 13-17 years. In a sample of 442 youth, a PHQ-9 score of 11 or more had a sensitivity of 89.5% and a specificity of 77.5% for major depression. Higher PHQ-9 scores were significantly correlated with increasing levels of depression and potential self-harm. (Richardson, et al., 2010)

Although the tool is self-administered, the Working Group recommends administering the screening tool to the adolescent while physically separate from parents and/or guardians. This is to avoid any hesitation that can arise from being in the presence of adults and therefore may aid in more honest disclosure.

***Screening for Suicidality***

The AAP report further recommends that adolescents who endorse suicidality on a scale such as the PHQ-9 should be assessed clinically. As such, the Working Group recommends that any patient who either answers "1", "2" or "3" to the ninth question of the PHQ-9 (thoughts on suicide or hurting self) or a total score of at least "11" (representing moderate severity of depression symptoms) be screened for suicidality using the screen version of the Columbia Suicide Severity Rating Scale (C-SSRS).

The C-SSRS was developed by a team of investigators from Columbia University, the University of Pennsylvania and the University of Pittsburgh. Its use is advantageous for two reasons. First, it is clinician administered and rated, thereby allowing for clinical assessment, although questions have already been phrased for use in an interview format. Training for the use of the scale in healthcare settings can be easily done requiring no more than twenty minutes to an hour. Moreover, the C-SSRS has been designed for use by health care professionals, including pediatricians and primary care providers without specialized mental health training (website). Second, it makes a distinction between suicidal ideation and behavior, as well as detailed investigations of each, allowing for a more nuanced stratification of risk and therefore treatment planning. (Posner, et al., 2011)

The C-SSRS is supported by an overwhelming number of research studies documenting its reliability and validity as a suicide screening tool for adolescents. As such, it is considered the gold standard in suicide assessment, having been endorsed by institutions such as the World Health Organization and the US Centers for Disease Control and Prevention. It has also been declared by the US Food and Drug Administration as the standard for measuring suicidality in clinical trials. The makers of the instrument have made its use free in community and healthcare settings. Moreover, it has been translated and linguistically validated in over a hundred languages, including Filipino, Cebuano, and Hiligaynon.

To use the screener version of the C-SSRS (See Appendix B), the clinician asks a series of two to six questions, marked by "yes" or "no" answers. Questions have been formulated to use plain and direct language, which is most effective in obtaining honest and clear responses. The clinician should always ask questions 1 and 2. If there is a "yes" response to 2, then all the remaining questions should be asked. If there is a "no" response to 2, then the clinician may go directly to question 6.

The task force recommends using the answers given by the patient as a guide for risk stratification and treatment planning as follows:

Table 1. Answers to C-SSRS

| Answers to C-SSRS | Risk Assessment | Recommended Course of Action |
|---|---|---|
| "YES" to Questions 4, 5 or 6 | High Risk | Counseling / Psychoeducation and Inpatient Safety Planning with Pediatrician<br><br>Admission to Hospital<br>with referral to a Psychiatrist<br><br>OR<br><br>Same day outpatient consult with a Child and Adolescent Psychiatrist (facilitated by the Pediatrician) |
| "YES" to Question 3 | Medium Risk | Counseling / Psychoeducation and Outpatient Safety Planning with Pediatrician<br><br>with<br><br>Outpatient referral to a Psychiatrist |
| "YES" OR “No” to Questions 1 or 2<br><br>AND<br><br>"NO" to Question 6 | Low Risk | Counseling/Psychoeducation and Outpatient Safety Planning with Pediatrician<br><br>with possible<br><br>Referral to a Psychologist, School Counselor, or a Psychiatrist |
| "NO" to Questions 1 and 2<br><br>AND<br><br>"YES" to Question 6 | *Possible Non-Suicidal Self-Injurious Behavior<br><br>Medium or High Risk (depending on clinical judgment) | Depending on clinical judgment, follow recommendations for high risk or medium risk |

It must be emphasized that the above recommendations do not replace the importance of clinical judgment and decision making, taking into account individual considerations. Further details regarding the management of a suicidal patient is discussed in the next chapter.

## V. SUICIDE INTERVENTION

### A. General Approach to a Suicidal Patient

The adolescent should be interviewed separately from the parent as they are more likely to withhold important information in the parent's presence. Confidentiality should be assured as much as possible, but they should be informed that if they pose a risk to themselves or others, safety takes precedence and there may be a need to break confidentiality. The pediatrician should inform parents and guardians when they believe that the patient is at risk, even against the express wishes of the patient.

Care needs to be taken in interviewing to increase report and the likelihood of the patient sharing sensitive mental health concerns. Initial questions should be open-ended and relatively non-threatening. More detailed questions using the format of the C-SSSR can follow once the adolescent is at ease. Suicidal thoughts should never be dismissed as unimportant, and the clinician should take care to communicate sympathy and understanding.

- Assuring confidentiality
    - “I want to assure you that as much as possible, what we will talk about will remain between us. However if I believe that you are at risk for harming yourself or others, then your safety takes precedence so I will have to break confidentiality."
- Ways to start a conversation:
    - “I’ve been feeling concerned about you lately”
    - “When did you begin feeling like this?”
- What you can say that helps?
    - “You’re not alone in this. I’m here for you.”
    - “I may not understand exactly how you feel, but I care about you and I want to help.”

### B. Psychoeducation and Counselling of Suicidal Patients and their Families

Once elicited, suicidal thoughts or pronouncements should never be dismissed or deemed unimportant. Acknowledging the seriousness of the pronouncement effectively communicates the understanding of how seriousness of the patient's suffering to the point that ending one's life is considered an alternative. ("You must really be suffering deeply for you to be thinking of hurting yourself.") Moreover, one should reassure that the patient's cry for help has been heard and that assistance is on the way. (Effective means of communicating concern and reassurance include: “You’re not alone in this. I’m here for you.” “I may not understand exactly how you feel, but I care about you and I want to help.”) One should then inform the patient about the need to inform the family about the suicidal ideation in order to facilitate a plan for treatment. ("As I said a while ago, I'm going to have to inform your family about these suicidal thoughts so we can enlist them in a plan that can keep you safe and address the suffering. Rest assured I will only communicate what is necessary and keep the other information between us.)

Psychoeducation should then be initiated with the patient and family regarding the risk of suicide in the patient, the recommended plan of action, as well as the appropriate safety plan, as discussed in the subsequent sections. When appropriate, as in cases wherein families are skeptical as a result of a lack of understanding of mental health issues, psychoeducation should also emphasize the understanding of suicide as a medical emergency and depression as a medical illness as defined in the International Classification of Diseases of the World Health Organization. This can provide an opening to explain the

biochemical basis of depression and suicide as a brain illness. One can explain that emotions and cognitions are served by the brain, which functions as a result of a delicate balance of chemicals called neurotransmitters, which research has proven to be imbalanced in clinical depression. As such, part of the treatment may be to provide medications that will restore this balance. Equally important is an explanation of suicide and depression from a psychosocial perspective, for example, that it is the result of severe and persistent cognitive distortions in the patient's views of self, others, and the future, which result in the observed changes in the patient's thinking and behavior. As such, counseling and psychotherapy by a trained professional may also be part of the treatment.

Informing parents about the possibility of suicide and depression in their child can be a daunting task. While some parents will be open to the possibility and eager to carry out the physician's recommendations, other parents may be in denial or hostile to the findings, particularly those coming from backgrounds where mental health concerns are largely stigmatized. There are also those who will react with excess anxiety and emotionality, which can in turn, further burden the depressed and suicidal adolescent. The clinician should therefore be mindful to balance between the dual and sometimes competing tasks of effectively communicating the gravity of the situation and reassuring that treatments for suicide and depression are available and effective. This can only be done if the clinician remains calm and composed in the face of varying reactions from families and steadfast in what he or she believes will be the best course of action to ensure the patient's safety and well-being. It would help to be aware of one's personal reactions to prevent interference in assessment and treatment and avoid either overreacting or underreacting to the demands of the situation. Taking all these into consideration will allow the clinician to communicate effectively with the family.

**C. Process of Referral**

All admissions of suicidality must be taken seriously and clinicians will not do wrong to err on the side of safety. The physician should explain the plan to both the patient and the parents in a calm and reassuring manner, albeit in a way that conveys the gravity of the situation.

Patients assessed as high-risk need to be assessed by a psychiatrist within the day. If possible, same-day outpatient referral should be facilitated with a child and adolescent psychiatrist for immediate assessment and treatment planning. This can be done with the pediatrician contacting the psychiatrist and securing an appointment for the patient, as research shows that as much as sixty percent of patients screened positive for mental health concerns do not end up receiving the necessary care. In the Philippines where consult with a psychiatrist is generally stigmatizing and difficult, the risk of such a referral is even greater.

If a same-day outpatient consult cannot be secured for the patient, the safest course of action is immediate hospitalization under the service of the pediatrician, with referral to a psychiatrist. This allows for the adolescent to be placed in a safe and protected environment and allows for a complete and timely evaluation. This can also set the stage for initiation of therapy in a controlled setting, and arrangement of appropriate mental health follow up care.

If a patient is assessed as medium risk, a referral for outpatient consult with a child and adolescent psychiatrist can be done. Again, the pediatrician is advised to facilitate the process of arranging the referral to ensure that the recommendation is followed.

Low risk patients can meanwhile be referred to a psychologist or guidance counselor. Considering again however the high rates of at-risk patients falling through the cracks and not receiving treatment, it is recommended that the pediatrician make efforts to facilitate the referral beyond giving contact information. One possible method is to instruct one's secretary to call for the appointment with the mental health provider on behalf of the family during the consultation.

As much as possible, all interventions should be noted in the patient's record for legal purposes.

**D. Safety Planning**

The specific means of management will depend on the level of risk. In all cases, safety planning should be initiated, depending on whether one intends to treat in the inpatient or outpatient setting.

***Safety Planning at the Outpatient Clinic***

Safety planning intervention is a systematic approach to maintaining safety of a suicidal patient. It is developed by Stanley and Brown for use in emergency departments, trauma centers, crisis hotlines, as well as ongoing outpatient treatment of suicidal patients. This intervention takes 20-45 minutes and is administered in a collaborative manner with the patient. Its goal is to provide patients with specific coping strategies and support sources once suicidal thoughts arises hence decreasing risk for suicidal behavior. The basic components of the safety plan consist of six steps.

Table 2. Safety Plan Template

| |
|---|
| 1. Recognise warning signs ( " what are thoughts, mood, behaviour or situations that you associate with suicide?" )<br>a. _____<br>b._____ |
| 2. Identify Internal Coping strategies ( What can i do on my own to cope with suicidal thoughts? "<br>a._____<br>b._____ |
| 3. Identify social contacts and settings as a means of distraction ( Who can i call or where can i go to distract me from suicidal thoughts?")<br>a. _____<br>b._____ |
| 4. Enumerate people that will help resolve suicidal crisis. ( Who can help me when i am suicidal?" )<br>a. _____<br>b._____ |
| 5. Identify Mental health professionals and agencies with their corresponding contact numbers ( " Who are the professionals i can contact during a suicidal crisis?"<br>a. _____<br>b._____ |
| 6. Reducing potential lethal means ( How can i make my environment safer? "<br>a. _____<br>b._____ |

The first step in safety planning intervention is to recognize warning signs such as situations, thoughts, moods or behavior that happens before a suicidal act. It is encourage for warning signs to be more specific as it will be an effective cue for the patient. Examples of warning signs would include feeling depressed or hopelessness.

The second step is employing internal coping strategies wherein the patient is asked to identify strategies that they can use on their own once suicidal thoughts emerge. By identifying and employing these internal strategies, patient's self-efficacy will be enhanced as well as help create a sense of mastery from suicidal urges. Such strategies would include going for a walk, listening to music as well as going online.

The third step is utilizing social contacts and settings as means of distraction from suicidal thoughts. The patient is asked to identify individuals such as family members, friends or groups as well as social settings which may help distract themselves from suicidal thoughts. This step will enable the patient to be more connected with people and give a sense of belongingness.

The fourth step in safety planning intervention is contacting family members or friends who may help resolve the crisis. Contrary to the third step, the patient explicitly reveals to the selected family members or friends when they are in crisis and would need support and assistance. It is important that contacts close to the patient are identified and should be knowledgeable of the safety plan.

The fifth step is contacting mental health professionals or agencies. A list of names of clinicians and agencies as well as corresponding telephone numbers should be listed down. Patients are then instructed to contact professionals or agencies if previous steps in the safety plan are not effective in resolving the crisis. Possible concerns and problems that may hinder the patient from seeking professional help should be addressed. Whenever possible the clinician should initiate a referral to the appropriate mental health professionals.

The last step in safety planning intervention is reducing potential use of lethal means. This step would include safely storing and dispensing medication and restricting access to knives, guns or other lethal means. Questions about access to lethal means should be routinely asked in assessment. The specific action needed to make the environment safer as well as the length of time restriction of access should be noted in the safety plan (Stanley et al, 2012).

***Safety Planning for Hospital Admissions***

A child who was found to be high risk of committing suicide should be hospitalized. Ensuring the safety of the patient includes: 1) Patient is admitted at a hospital room where patient would not have access to potential sources of harm 2) Once admitted, patient must be placed on a suicide precaution. 3) A 24 hour watcher should be ordered to ensure the patient's safety at all times. 4) Proper documentation of assessment of suicide risk and intervention done during the treatment. 5) Medication such as antihistamines (e.g. Diphenhydramine 25-50 mg/cap 1 cap as needed) or benzodiazepines at the lowest possible dose (e.g. Clonazepam 2mg/tab, 0.25 -2 mg as needed ) may be used to calm or sedate the patient if deemed necessary.

***Discharge Instructions and Safety Planning at Home***

An evaluation of the suicidal risk of the patient should be done to determine if the patient is ready for discharge. Prior to discharge, an assessment of the availability of the family members at home should be conducted. The amount of support should be discussed with parents as well as the need to have a supportive person at home at all times. Once patient is evaluated to be safe to go home, psychoeducation of the parents regarding the child's condition as well as specific issues or situations that may cause further suicidal behavior should be done. Safety plans once at home such as limiting access to firearms, lethal medications and alcohol or disinhibiting substances as well as the need for a supportive person to be with the patient at all times, must be discussed with parents or caregiver and properly documented. Lastly, a follow up appointment should already be scheduled before discharge to improve treatment compliance. (Shaffer et al, 2001). An example of discharge instructions that can be given to the family is found below.

Table 3. Sample Discharge Instructions

1) Ensure that a supportive person is with the patient at all times
2) Remove access to firearms, lethal medications or any potential sources of self harm
3) Avoid alcohol or drugs that can have disinhibiting effects
4) Be compliant to prescribed medication/s. Take home medications include the ff:
   A. _____
   B. _____
5) Do not miss appointments. The next follow up appointment is scheduled on : _____

**E. Psychopharmacology**

Psychopharmacological interventions can be used in children and adolescents presenting with suicidal behaviour if necessary. The level of risk as well as other symptoms such as anxiety and depression should be taken into consideration before using pharmacologic agents. For low risk patients, although medication is not generally necessary, anti-anxiety medication such as benzodiazepines (e.g. clonazepam and alprazolam) or antihistamines (e.g. hydroxyzine and diphenhydramine) may be given to calm the patient if deemed necessary. For medium risk patients on the other hand, anti-depressants (e.g. fluoxetine, sertraline and escitalopram) may be started on patients with depressive symptoms while waiting to be seen by a psychiatrist. In addition, benzodiazepine and anti-histamines may be given as needed to calm and sedate the patient if necessary. For high risk patient, anti-depressants and anti-anxiety medications may likewise be started to address both depressive and anxiety symptoms while the patient is admitted at the hospital and is waiting to be seen by a child and adolescent psychiatrist. Common psychotropics medications that can be prescribed including their dosages, indications and side effects are found on Table 4 and Table 5.

Table 4. Medications for Anxiety and Sedation

| Drug | Dosage Forms | Dosage Range | What to watch out for |
|---|---|---|---|
| Antihistamine<br>Diphenhydramine | 25 mg tab, 50 mg tab, 12.5 mg/5 ml | 5 mg/kg per day in divided doses<br>OR:<br>Adult and children> 12 yr: 12.5-25 mg qid<br>Children 6 yr-<12 yr 12.5 mg qid | Sedation and anticholinergic symptoms (dry mouth, constipation) |
| Hydroxyzine | 10 mg tab, 25 mg tab, 2 mg/ml | 1-2 mg/kg/day in divided doses (6 and older: 50-100mg/day in divided doses; less than 6 years old: 50 mg/day in divided doses) | |
| Benzodiazepine<br>Clonazepam | 2 mg tab | 0.25 mg – 2 mg/day | Sedation, drowsiness, decreased alertness, disinhibition |
| Alprazolam | 250 mcg tab, 500 mcg tab | 0.25 – 4 mg/day | |

Table 5. Anti-depressants

| Given to patients diagnosed with Major Depressive Disorder or with Anxiety disorders | | | | |
|---|---|---|---|---|
| **Drug** | **Dosage Forms** | **Dosage Range** | **Starting Dose** | **What to watch out for** |
| Fluoxetine | 20 mg capsule | 20-80 mg/day | 10 mg/day | Gastrointestinal (decreased appetite, nausea, diarrhea, dry mouth), headache, fatigue, insomnia/hypersomnia. In case of Bipolar Disorder patients, patients may present with manic symptoms |
| Sertraline | 50 mg tab | 50-300 mg/day | 25 mg/day | |
| Escitalopram | 10 mg tab, 20 mg tab | 10-40 mg/day | 5-10 mg/day | |
| | | | | |

In starting psychotropics in children and adolescents, it is important to start low and go slow. Psychoeducation of the parents regarding possible side effects should be done before starting the medication. It is also necessary to advise the parents to keep medications at a safe place and to be the one to dispense the medication as it may be used by the patient as a means of suicide. Close follow up is necessary once patient is started with medication.

**F. Psychosocial Support**

The psychosocial support that can help the suicidal adolescent will come from the people around him or from the people he interacts with. Since the adolescent's interests will now involve his community more than his core family, the different sectors of his community have important contributions in providing much needed psychosocial support to the suicidal adolescent. Possible sources of psychosocial support are the following.

1. **Family** - The family is still the suicidal adolescent's source of primary support. Good family relationships and stability contribute a lot to helping the patient recover from depression and suicide. According to the study of S. Daniel & D. Goldston, (Feb. 2010), family support and involvement is vital

to the success of treatment with suicidal youth. The parents after all are responsible for helping the patient get appropriate mental health care and maintaining treatment. They will be crucial in carrying out the safety plan and monitoring of the patient. It is also vital to educate the whole family about suicidal behavior and psychiatric disorders as well as process family conflicts. In cases when the patient has very poor family support, admission to a psychiatric facility may at times be the only option

2. **Community** - In the community, a popular means to help patients who are suicidal are what we call suicide hotlines where an adolescent who has intense suicidal thoughts and feels alone and isolated can call and talk to. In the Philippines a popular suicide hotline is called "Hopeline" which was established by the Department of Health, together with the World Health Organization, and Natasha Goulbourn Foundation. Hopeline is a 24/7 suicide prevention hotline, in observance of the National Suicide Prevention Awareness Day. Hopeline may be reached at (02) 804-4637; 0917-5584673; and 2919 for Globe and TM subscribers.

   Other resources in the community which can help suicidal patients are the media, which is a very powerful tool to educate the public. The church and religious organizations are also doing a lot to help suicidal patients. A study by Greening & Stoppelbein in December 2002 evaluated psychosocial buffers for their relative contribution to adolescents' perceived risk for suicide. The study showed that Orthodoxy - commitment to core beliefs - emerged as the single correlate after controlling for the effects of other buffers.

3. **Peers** - Adolescence is a time in a person's life wherein he will learn to negotiate conflicts with peers with less involvement for his parents. Teens are also now relying more on friends rather than parents (S. Daniel & D. Goldston, Feb 2010). Thus the importance of support from peers cannot be overemphasized. Peers can give good or bad influences on the adolescent who is now curious about exploring his world. Oftentimes, when the family is unable to give vital support, a troubled teen recourse is to turn to his peers.

4. **School** - A very important psychosocial institution which can potentially help the suicidal adolescent is the school because this is where he or she spends around 8 hours every weekday. Schools are where the adolescent's symptoms of a mood or mental illness are first observed next to the home. Thus teachers, guidance counselors and the school administration should be alert to observed problem behaviors in their students and refer them to appropriate mental health professionals as need be.

   A study by Kostenuik & Ratnapalan, August 2010, said that the most important protective factors for suicide are: social support, a sense of family cohesion, school connectedness, sports involvement and academic achievement all of which can reduce a teen's risk. Emotional and psychological support from friends and family also appears to safeguard against suicide. A WHO Fact Sheet also said that building life skills in children and adolescent, and providing them with psychosocial support in schools and other community settings can help promote good mental health. Programs to help strengthen ties between teenagers and their families are also important protective factors against suicide.

The specific programs for the different sources of psychosocial support will be elaborated in the next section (VI. Suicide Prevention and Postvention)

## VI. SUICIDE PREVENTION AND POSTVENTION

Beyond the screening and detection of suicide in an adolescent lies also the importance of doing some suicide intervention and prevention. We now recognize the importance of identification and treatment of psychiatric disorders if we are to prevent suicide in our youth. It seems likely that **earlier identification and earlier symptomatic relief** are important components of the prevention and treatment of youth suicidal behavior. We have to recognize that the majority of suicide completers and attempters never come to the attention of specialty mental health care. In a study by Brent et al.[1] and Shaffer et al.[2] they noted that only 7–20% of adolescent suicide completers had been seen for mental health treatment in the previous 1 to 3 months prior to the suicide. Better linkages to mental health and on-site delivery of services may serve to bring help to these young people.

The Guidelines for Adolescent Preventive Services (GAPS), first released in 1997 by the American Medical Association, recommends that all adolescents should be asked annually about behaviors or emotions that indicate recurrent or severe depression or risk of suicide.[3]

Attempts to reduce attempted and completed suicide rates can be divided into three levels. The first level or Primary prevention level aims to reduce suicidal ideations, attempts or assist completed suicide through the development of school policies, training of professionals to detect early warning signs and risk factors, incorporating suicide prevention curriculum in schools, and helping adolescents discuss their feelings and thoughts. The second level aims to deal with the adolescent who has threatened or actually attempted suicide. Here, activities include ensuring the safety of the adolescent and referring the adolescent to mental health services. At the tertiary level, postvention programs are attempts to mitigate the impact of an actual episode of a threatened, attempted, or actual completed suicide. Programs here aim to assist survivors and also aim to prevent the glorification of a suicidal act.

A sytematic review of various prevention strategies done by Mann et al. showed that education of physicians and removing access to lethal means proved to be effective among suicide-prevention strategies.[4] The creation of preventive services, crisis counseling and crisis hotlines as a response to the problem of suicide still need further research according to an evidence-based report done in Australia.[5]

Restricting access to methods used in suicide by educating parents about keeping guns or cabinets in locked cabinets may be an effective preventive strategy. The rationale here is that adolescents may not really intend to die but because of access to these means, may attempt to commit suicide. Studies on means restriction have been mixed with some giving positive effects, but others showing no significant results.

There are several youth suicide prevention programs ranging from general education about suicide to crisis center hotlines. The different prevention strategies are designed to prevent suicide in various ways. For example, gatekeeper training and screening programs are designed to identify people at risk of suicide and refer them to mental health services. Conversely, hotlines are intended to help people who are experiencing a crisis

Gatekeeper training programs aim to train adults to detect students or adolescents who have certain risk factors or warning signs about suicide and to give appropriate responses when detected. Studies on gatekeeper training have been encouraging because it can help increase awareness and instill favorable attitudes among teachers and adults to detect and assist students who need help.

The following are descriptions of different prevention strategies:

a. **School Gatekeeper Training**. This type of program is directed at school staff (teachers, counselors, coaches, etc.) to help them identify students at risk of suicide and refer such students as appropriate. These programs also teach staff how to respond in cases of a tragic death or other crisis in the school.

b. **Community Gatekeeper Training**. This type of gatekeeper program provides training to community members, such as clergy, police, merchants, and recreation staff, as well as physicians, nurses, and other clinicians who see youthful patients. This training is designed to help these people identify youth at risk of suicide and refer them as appropriate.

c. **General Suicide Education**. These programs provide students with facts about suicide, alert them to suicide warning signs, and provide information about how to seek help for themselves or for others. These programs often incorporate a variety of self-esteem or social competency development activities.

d. **Screening Programs**. Screening involves the administration of an instrument to identify high-risk youth in order to provide more targeted assessment and treatment. Repeated administration of the screening instrument can also be used to measure changes in attitudes or behaviors over time, to test the effectiveness of an employed prevention strategy, and to obtain early warning signs of potential suicidal behavior.

e. **Peer Support Programs.** These programs, which can be conducted in either school or non-school settings, are designed to foster peer relationships, competency development, and social skills among youth at high risk of suicide or suicidal behavior.

f. **Crisis Centers and Hotlines.** Among other services, these programs primarily provide telephone counseling for suicidal people. Hotlines are usually staffed by trained volunteers. Such programs may also offer a "drop-in" crisis center and referral to mental health services.

g. **Means Restriction.** This prevention strategy consists of activities designed to restrict access to handguns, drugs, and other common means of suicide.

A systematic review done by Isaac et al in 2009 and published in the Canadian Journal of Psychiatry showed that “a multifaceted approach to suicide prevention is required and suicide awareness training in military personnel and family doctors significantly decreases the suicide rate.[6] However, this study did not include children and adolescents among the subjects. Nevertheless, the study showed that gatekeeper training may be an effective component of a broad suicide prevention strategy.

School-based prevention program that taught problem-solving skills and enhanced school–child connections found that overall, there were improvements in suicide risk factors, but no difference between the experimental program and a brief suicide screening followed by case management. Some school-based programs that focused on suicide awareness did not show much success since most students with suicidal intention became more distressed and failed to present themselves for care. Guo in 2003 stated that there was “uncertainty and insufficient evidence that school-based preventive strategies” work for adolescents.[7]

School-based suicide awareness curriculums have been found to increase knowledge and awareness about suicide among students. Its advantage is that it can reach a wider population and provide peer group support. Furthermore, it might be able to detect students who are in different phases of the spectrum of suicide – from ideators to attempters, to students who engage in non-suicidal self-harm behavior, to completers.

Currently, there is lack of evidence to support a universal suicide school-based curriculum. However, mental health strategies to promote self-esteem were found to have some impact on the young people’s mental well-being.[8]

Parenting training interventions to reduce parent and family risk factors in suicide have shown some promise in terms of reduction in conflict with the adolescent and satisfaction and confidence as parents.

Media portrayals of suicides have been shown to be a risk factor for future suicide. There are two interventions affecting social media worth looking into, and these are: developing guidelines on the

reporting of suicide and provision of mental health education. The guidelines were designed to report as few details of the suicide as possible, remove the romantic portrayal, not using the word 'suicide' as a headline, not including the picture of the victim, and description of alternative solutions. Suicide rates were shown to be reduced by 20% over a four-year period. Internet usage and other media means have not been fully evaluated for its potential benefits or harm in youth suicide prevention.

According to the Center for Diseases in Children (CDC),[9] most suicide prevention strategies can be incorporated into two conceptual strategies:

1. Increase the recognition of suicidal youth and their referral to existing mental health resources

2. Directly address identified risk factors

One promising approach to suicide prevention using the health care system is the training of primary care physicians to recognize, treat and, if necessary, refer patients with mental illness, especially depression. [10] Assessment of suicide risk of the individual is best undertaken by direct questioning of the young person. Therefore there may be an important role to be played by primary care practitioners in the identification, management and treatment of psychiatric illness.[11]

Promising approaches with youths that focus on developing their problem-solving skills and increasing their general coping skills may gather further evidence in their support. Interventions designed to support families and promote cohesion between parents and children have shown promise and have some evidence to back it up.[11]

Promising interventions should be pursued and should not be implemented without rigorous evaluation. Unfortunately, majority of systematic review studies on the effective means of reducing suicide in adolescents seem to point to the idea that a combination of preventive strategies are better than just a single approach**.** [7]

***Postvention***

Suicide can affect a person in various types of relationships with the deceased: either as a family member or distant relative, as a neighbour, as a classmate or as a friend, an employee-employer relationship. There is a distinction between "suicide survivorship" and "exposure to suicide". The former applies to the bereaved who had a personal and close relationship with the deceased (e.g., a friend or a family member), the latter reflects a situation of a person who did not know the deceased personally but who knows about the death through reports of others or media reports (e.g., suicide of a celebrity) or who has personally witnessed the death of a stranger (e.g., train drivers or police). Intervention After a Suicide. Strategies have been developed to cope with the crisis sometimes caused by one or more youth suicides in a community. They are designed in part to help prevent or contain suicide clusters and to help youth effectively cope with feelings of loss that come with the sudden death or suicide of a peer. Preventing further suicides is but one of several goals of interventions made with friends and relatives of a suicide victim -- so-called "postvention" efforts.

Postvention is defined by K. Andriessen and K. Krysinska as "activities developed by, with or for suicide survivors, in order to facilitate recovery after suicide and to prevent adverse outcomes including suicidal behaviour".[12] It refers to interventions and programs for survivors following a death by suicide. Following a suicide, the whole community should work together. Every survivor can receive and should receive support. Efforts at postvention aim to reach suicide survivors who are exposed directly or indirectly to the victim and to ensure that they receive help and support. This timely provision of services provides good understanding of the process of bereavement and acknowledges everyone's individual differences in the experience. Bereavement after suicide focuses on grief, shame, guilt, social stigma and isolation, and a search for the meaning of the death.

There are 4 main footholds in a postvention program. They are: Support, learn, counsel, educate.

A whole-community approach in postvention strategies[13] is important and there are important steps to remember:

1. verify the death and the cause – families may want to keep the cause private; there are pros and cons to sharing;

2. coordinate resources – a crisis response team should be quickly organized, composed of resource persons and people close to or familiar to the person who committed suicide – policies/ guidelines should be in place;

3. disseminate information – provide a written statement expressing condolences to the family and providing factual information about the suicide, the plan for support, and changes in schedule at work or school;

4. support those most impacted by the death – although family and friends may be most affected, close associates, school mates, school staff, romantic partner, team partners may be likewise affected. Being able to reach out to the most affected, being able to mourn the loss, and providing support to the most vulnerable during important sensitive milestones in the life of the person may be important;

5. identify those people at most risk – these are: those who suffer from depression, those who have had a previous suicide themselves, those who have a loss in the family, those who identify with the deceased, and those who felt responsible for the death or feel they could have prevented the death;

6. commemorate the event – facilitate a "healthy grieving process" by remembering the deceased in activities like fund-raising, exhibits, celebration of life events, etc.

7. provide psychoeducation on grieving, depression post-traumatic stress disorder, and suicide – use evidence-based curriculum in discussing depression, suicide, PTSD, and knowing when grieving is a normal reaction;

8. provide services as needed within the community – preferrably organized before suicides occur, protocols on how to respond to subsequent suicides should be in place;

9. link to resources – make sure you are aware of available resources within your area; create a directory;

10. evaluate and review – all postvention efforts should be reviewed, get feedback after each activity.

Jordan and McIntosh have proposed a framework encompassing various levels of grief reactions.[14] According to this framework, in suicide bereavement one can recognize reactions present in bereavement after all types of death, such as sorrow and yearning to be reunited with the deceased, reactions characteristic for bereavement after unexpected deaths, e.g., shock and sense of unreality about the death, and elements of bereavement after violent deaths, e.g., trauma of finding a mutilated body and shattered illusion of personal invulnerability. In addition to these shared reactions, suicide survivors experience features which seem unique to suicide bereavement, such as anger at the deceased for "choosing" death over life and the feeling of abandonment.

Jordan and McIntosh suggest that the first step in postvention is to listen to the survivors and explore their needs and experiences.[14] Of course, one **ultimate goal of postvention is to prevent suicidality in the survivors**. A study showed that the incidence of depression in children whose parents had died of suicide was longer than if the parents had a sudden natural death. Siblings of suicide victims suffered more depression, anxiety, post-traumatic and grief reactions. Other reactions were related to the

disruption of family relations and routines, functional impairments in daily activities, difficulties with social and familial relationships, spiritual struggles as well as financial and juridical problems.

Mechanism for increased risk of suicidal ideation and behaviour and at-risk behaviours observed among some of the survivors were:

1. identification with the deceased
2. social modelling
3. punishment for perceived self-blame
4. genetic factors

According to the World Health Organization, the coming together of those bereaved by suicide can provide the opportunity to be with other people who can really understand, because they have been through the same experience; to gain strength and understanding from the individuals within the group, but also to provide the same to others.

There is a paucity of research studies to determine the efficacy of interventions (primarily on family and group interventions), although most studies have found some small positive effects on the interventions studied. Research on postvention strategies are limited. There is some evidence that some school-based programs may be more harmful. They are usually designed to prevent a series of suicides (cluster suicides) or contagion suicides when they identify themselves with the individual or with the cause, or see a reward in the act.

***Family Interventions***

Suicide impacts the family in several ways. For one thing, the suicide may be a consequence of some family dysfunction that has resulted in family disorganization and distress. Some studies have shown that families with suicide have shown more abuse, substance abuse, dysfunction, and psychiatric disorder than families without suicide. Hence, issues of blame and guilt may arise after a suicide. It is wrong however to conclude that suicide is a proof that a family is dysfunctional. Family interventions following suicide have been studied but the interventions to itigate the negative effects for families bereaved by suicide have not been extensively studied.[14]

Family interventions include:

1. creation of a psychologically safe setting where family members can share their grief and get support from others;
2. getting help to secure self from the social stigma imposed by others;
3. assessment of psychiatric morbidity among other family members.

***Individual Grief Therapy***

Individual grief therapy has not been studied specifically in the context of suicide. However, Jordan enumerates some “tasks of healing” that may be relevant for suicide survivors, and these are:

1. **Containment of the truma**. PTSD-type of responses have been recorded and these include: physiological arousal, flashbacks, disruption of biorhythms, irritability, emotional numbing.

2. **Learning skills for dosing grief, finding sanctuary, and developing psychic analgesia**. The purpose of this is to be able to control the pain by reducing it to manageable levels. Self-soothing activities include: massage and meditation. Distraction and avoidance skills include: recognizing and avoiding triggers associated with the suicide, and cultivating positive affective experiences. These stated techniques are combined with exposure skills like: visiting the grave, looking at photographs and videos, etc.

3. **Creating a psychological autopsy through a personal narrative of the suicide experience.** This method can help the survivor answer some of the "whys" in the complex nature of why the suicide occurred, what role people played, and to be able to forgive oneself for some actions that might have been taken differently.

4. **Learning skills to manage changed social connections**. A suicide may disrupt the social bonds among people. Survivors may encounter blame, anger, outright alienation from people around them. Jordan describes an "avoidance behavior" observed among those surrounding the survivor. He calls it a "social ambiguity", which emanates not from an outright condemnation of the suicide but an awkwardness on how to deal with the survivor.

5. R**epair and transformation of the bond with the deceased.** This is a psychological healing between the mourner and their loved one after the suicide. It involves the rupturing of the relationship with the deceased.

6. **Memorialization of the deceased.** This may be more difficult if the deceased committed suicide. It entails remembering the whole life of the deceased while putting suicide in the context of life. It refers to the act of putting value into a deceased person's life rather than in the manner that one died.

7. **Restoration of function and reinvestment in LIFE.** The therapist helps the bereaved one derive pleasure, meaning, and purpose in life without the deceased.

Mental health professionals can help survivors in their own healing process. There may be different ways in which grief among survivors are handled, based on the social attitudes, culture, ethnicity, and practices of people. Hence, postvention strategies have to be **culturally sensitive**.

From the public health perspective, several efforts have been made to support postvention strategies such as: development of public polices and programs, creating a suicide awareness day, exhibits, dissemination of brochures and books on death and suicide, public walks and art exhibits. There are few studies as yet that determine the effectiveness of postvention strategies in the public health perspective. It is important to weigh what is the level of suicide in a society and the society's attitudes towards suicide survivors.

Lately, there has been a call for the implementation and creation of policies for postvention strategies as well as more research studies on how these postvention strategies can lead to suicide prevention . These include:

1. standardization of definitions for " suicide survivor" and "postvention" and identify the number of people affected by suicide (Operational and consensus);

2. methodologically sound studies to identify subgroups of survivors by age, gender, types and closeness to the deceased;

3. conduct effectiveness studies of postvention strategies.

Suicide is a devastating episode in the life of a person, family, and community. The goal of suicide prevention according to the Center for Diseases in Children is to reduce factors that increase risk and to increase factors to promote resilience.[17]

It is with this in mind that the community – physicians, families, individuals - need to increase awareness and be able to make a positive change for everyone.

## VII. CLINICAL CASES

### Small Group Discussion Flow

Three cases will be discussed. For Case 1, the first half will be initially discussed after the lecture on suicide risk assessment. The second half will be discussed after the lecture on suicide management.

Case 2 and if time permits, case 3 will be discussed in small groups of 6-7, to be facilitated by a psychiatrist or pediatrician from the team. The facilitator guides the group in answering the questions based on the case.

The participants may refer to the manual to give their answers. Answers should highlight the points presented during the lectures.

After the group discussion, a representative from the group will be given 5 minutes to summarize the experiences of the group, including areas of difficulty and questions that may have arisen from the participants.

**Clinical Case 1 (Paracetamol Overdose and Love Affair)**

S.D. is a 16 year old, female, who was brought in at the ER by her parents due to overdose of paracetamol after break-up with her boyfriend.

History started 5 hours prior to consult, when the patient was overheard by the mother to have a heated argument over the phone with her boyfriend who was later found out to have broken up with her. SD then went to her room and locked herself up until 3 hours prior to consult, her friend texted her mother that SD ingested 10 tablets of Paracetamol 500 mg inside her room and not feeling well. SD was seen vomiting and weak-looking when her mother entered her room and admitted to taking 10 tablets of Paracetamol thus was brought immediately to the ER.

HOME:

SD is the youngest of 2 siblings, her older brother is already 22 years old. Her parents are OFW from Saudi Arabia for 10 years who just went home last year after her grandmother died. SD and her brother were taken care of by their grandparents when their parents worked abroad. SD is most especially closer to her grandmother so she was deeply affected when she died. SD admitted feeling awkward towards her parents until now. Her parents are running a small sari-sari store business in their home at the moment but plan to go back abroad when everything is settled.

EDUCATION:

SD is a grade 10 student with an average school performance prior to the death of her grandmother but started to have failing grades afterwards. Her teacher noted the change in her behavior after the incident as she became withdrawn and less participation in classroom and school activities in general.

ACTIVITY:

SD used to be very active in extracurricular activities, performing in school programs by dancing and singing but this was stopped after the death of her grandmother. Her friends are also her classmates from school. She has one particular best friend that acts as her confidante.

DRUGS:

SD denies smoking, drinking alcoholic beverage nor using drugs.

SEXUAL ACTIVITY:

SD admitted having sexual intercourse only with her present boyfriend once. She had one other boyfriend 2 years ago. She admitted her arguments with her boyfriend of 1 year became more frequent lately mostly due to jealousy and misunderstanding, thus her boyfriend broke up with her.

SAFETY:

SD denied participating in any dangerous sports or activity. She doesn't know how to drive yet but she always used safety belts when inside the car.

SUICIDE:

SD admitted having suicide thoughts after her grandmother died and had several attempts in cutting herself, as seen by past lacerations in her wrists.

*For Suicide Risk Assessment*

1. What are the warning signs / risk factors in the patient's history that can increase the risk for suicide?
2. What are the protective factors in the patient's history that can mitigate the risk for suicide?
3. What is your approach to interviewing the patient in terms of who should be present? Confidentiality? How to open up about his/her concerns?
4. What screening tool can you administer for depression? *(After letting them answer PHQ9, ask them to turn the page and ask the next question.)* Please score the screening tool as endorsed in the next page. Based on the score, what is the next step?
5. What screening tool can you administer for suicidality? (*Ask them to turn the page and peruse the C-SSRS)*
6. Based on your screening tool result, what is the recommended course of action?

*For Suicide Management*

1. How would you explain to the family the need for this course of action?
2. What are the means by which you can ensure the safety of the patient while awaiting assessment and management by a psychiatrist?
3. What are the instructions you can give to ensure the patient's safety?
4. What are the medications you can give to calm the patient and avoid agitation/excess anxiety?

**Case 1 PHQ-9**

| **Over the last 2 weeks, how often have you been bothered by any of the following problems?** | **Not at all *(Hindi kailanman)*** | **Several days *(Maraming Araw)*** | **More than half the days *(Lagpas sa kalahating bilang ng mga araw)*** | **Nearly every day (*Halos araw-araw*_** |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | ***3*** |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | ***3*** |
| 3. Trouble falling or staying asleep, or sleeping too much. | 0 | 1 | ***2*** | 3 |
| 4. Feeling tired or having little energy | 0 | ***1*** | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | ***2*** | 3 |
| 6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | ***3*** |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | ***3*** |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual– | 0 | 1 | ***2*** | 3 |
| 9. Thoughts that you would be better of dead of or hurting yourself in some way | 0 | 1 | ***2*** | 3 |
| | Score: _____ = Total | | | |

**Case 1 C-SSRS**

| **SUICIDE IDEATION DEFINITIONS AND PROMPTS:** | **Past month** | |
|---|---|---|
| **Ask questions that are in bold and underlined.** | **YES** | **NO** |
| **Ask Questions 1 and 2** | | |
| **1) Wish to be Dead:**<br>Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up?<br>***Have you wished you were dead or wished you could go to sleep and not wake up?*** | **X** | |
| **2) Suicidal Thoughts:**<br>General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan*."<br>***Have you had any actual thoughts of killing yourself?*** | **X** | |
| **If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.** | | |
| **3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act):**<br>Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*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.*"<br>***Have you been thinking about how you might do this?*** | **X** | |
| **4) Suicidal Intent (without Specific Plan):**<br>Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as oppose to "*I have the thoughts but I definitely will not do anything about them*."<br>***Have you had these thoughts and had some intention of acting on them?*** | **X** | |
| **5) Suicide Intent with Specific Plan:**<br>Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.<br>***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** | **X** | |
| **6) Suicide Behavior Question**<br>***Have you ever done anything, started to do anything, or prepared to do anything to end your life?***<br>Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.<br><br>**If YES, ask:** ***Was this within the past 3 months?*** | **Lifetime**<br><br>**Past 3 Months**<br>**X** | |

**Clinical Case 2**

Jenny is a 15 year old, 2nd year HS student in an exclusive girls school. When she was 8 years old, Jenny's parents separated and she was left under the care of her aunt, who was found to be distant and very critical of her. Both her parents are in new relationships and are not in communication with her despite her efforts to contact them. One month ago, her first boyfriend of 6 months cheated and broke up with her. Jean started to be more withdrawn refusing to attend her extracurricular activities in school which she described to be not as fun anymore. Her appetite decreased and she began to lose weight. She feels tired all the time and had difficulty concentrating in school. As a result her grades suffered. Upon interview, Jenny admits to feel depressed and hopeless stating "No one really loves me. At the end everyone leaves". Upon physical examination, there were noted visible superficial cuts on her left distal forearm. When asked about the injury, Jenny verbalized that she had been using a razor to make superficial cuts on her forearm whenever she feels extremely sad about her situation. When asked if she had thoughts about suicide she replies "It's not that I want to kill myself, I really don't have thoughts of committing suicide. I just feel better when I cut. It gives me relief from the pain. I really don't want to die". Jenny denies that she has ever prepared, planned or attempted to commit suicide in the past.

Past Psychiatric History: No previous psychiatric consults

Past Medical History: No known illnesses. No previous hospitalizations

Substance History: Non-smoker, not an alcoholic beverage drinker

Family History: Mother was previously diagnosed with Major depressive disorder after separating from Husband

1. *What are the warning signs / risk factors in the patient's history that can increase the risk for suicide?*
2. *What are the protective factors in the patient's history that can mitigate the risk for suicide?*
3. *What is your approach to interviewing the patient in terms of who should be present? Confidentiality? How to open up about his/her concerns?*
4. *What screening tool can you administer for depression? (After letting them answer PHQ9, ask them to turn the page and ask the next question.) Please score the screening tool as endorsed in the next page. Based on the score, what is the next step?*
5. *What screening tool can you administer for suicidality? (Ask them to turn the page and peruse the C-SSRS)*
6. *Based on your screening tool result, what is the recommended course of action?*
7. *How would you explain to the family the need for this course of action?*
8. *What are the means by which you can ensure the safety of the patient while awaiting assessment and management by a psychiatrist?*
9. *What are the instructions you can give to ensure the patient's safety?*
10. *What are the medications you can give to calm the patient and avoid agitation/excess anxiety?*

**Case 2 PHQ - 9**

| **Over the last 2 weeks, how often have you been bothered by any of the following problems?** | **Not at all** ***(Hindi kailanman)*** | **Several days** ***(Maraming Araw)*** | **More than half the days** ***(Lagpas sa kalahating bilang ng mga araw)*** | **Nearly every day (*Halos araw-araw_*** |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | ***2*** | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | ***3*** |
| 3. Trouble falling or staying asleep, or sleeping too much. | ***0*** | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | ***1*** | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | ***2*** | 3 |
| 6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down | 0 | 1 | ***2*** | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | ***2*** | 3 |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual– | ***0*** | 1 | 2 | 3 |
| 9. Thoughts that you would be better of dead of or hurting yourself in some way | ***0*** | 1 | 2 | 3 |
| | Score: _____ = Total | | | |

**Case 2 C-SSRS**

| **SUICIDE IDEATION DEFINITIONS AND PROMPTS:** | **Past month** | |
|---|---|---|
| **Ask questions that are in bold and underlined.** | **YES** | **NO** |
| **Ask Questions 1 and 2** | | |
| **1) Wish to be Dead:**<br>Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up?<br>***Have you wished you were dead or wished you could go to sleep and not wake up?*** | | **x** |
| **2) Suicidal Thoughts:**<br>General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan*."<br>***Have you had any actual thoughts of killing yourself?*** | | **x** |
| **If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.** | | |
| **3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act):**<br>Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*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.*"<br>***Have you been thinking about how you might do this?*** | | **x** |
| **4) Suicidal Intent (without Specific Plan):**<br>Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as oppose to "*I have the thoughts but I definitely will not do anything about them*."<br>***Have you had these thoughts and had some intention of acting on them?*** | | **x** |
| **5) Suicide Intent with Specific Plan:**<br>Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.<br>***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** | | **x** |
| **6) Suicide Behavior Question**<br>***Have you ever done anything, started to do anything, or prepared to do anything to end your life?***<br>Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.<br><br>**If YES, ask:** ***Was this within the past 3 months?*** | **Lifetime**<br>**x**<br>**Past 3 Months**<br>**x** | |

**Clinical Case 3**

D.M. is an 18 year old, male, college student, who was brought in at the ER by the school due to attempting to jump from a school building. He is a known case of Major Depressive Disorder, diagnosed 1 year prior, with poor compliance with his medications.

1 week prior to admission, the patient was noted to be stressed from school because of the upcoming midterms and some activities in his student organizations. The patient also learned that his grades in accounting are low which made him feel depressed. His appetite slowly decreased and was noted to be spending more time by himself.

1 day prior to admission, the patient posted on Facebook stating that he doesn't feel stable and he is not feeling well. He mentioned his frustrations about how people treat him despite knowing he has depression which makes him want to kill himself. Moreover, his parents mentioned that an anonymous account was used to comment on his post which read "Why not do it? We're tired of your depressive attitude. No one will miss you." He was noted to be more withdrawn since then.

On the morning of admission, the patient was apparently well and in a stable mood. He attended his Accounting class that morning. While in class, he started to feel frustrated because he was having a hard time understanding the subject. Moreover, he was tasked to solve some difficult problems in front of the class and felt being singled out. Afterwards, the patient decided to visit the head of student affairs with his counsellor to vent out his frustrations. He recalled being really emotional inside the room as he was crying and venting out all his frustrations. When his counsellor made a remark that he did not appreciate, he got furious and shouted at him. He ran out of the office immediately after. The staff, worried about DM, called the school guards to watch over him. They followed him discreetly and noticed he started to run towards the ledge of the second floor administrative building. The school guards hurriedly tackled and pulled him back from the ledge as he was about to jump. He was immediately brought to the ER.

HOME:

DM is the eldest of 3 siblings. His father is a lawyer and his mother is a successful businesswoman working in a big company. Both parents work long hours and would usually not be in the house and because of this DM is not close to his parents. His parents are great providers as they would give DM all his needs and wants. His siblings are both male and of age 16 and 14. He is not close to them either as well.

EDUCATION:

DM is a 2nd year college student who initially had good school performance but is slowly declining the past few months. Part of the decline in his school performance was brought about by his difficulty in concentrating in class due to melancholic mood. He had a history of being bullied even since grade school. Now in college, he is still being teased and bullied especially on social media.

ACTIVITY:

DM used to be active in extracurricular activities and is part of the school's rifle team. However, his participation and attendance to their group meetings have slowly dwindled the past few weeks. He teammates are his closest friends and he leans on them for emotional support.

DRUGS:

DM denies smoking, drinking alcoholic beverage nor using drugs.

SEXUAL ACTIVITY:

DM denies having engaged in any sexual activity.

SAFETY:

DM denied participating in any dangerous sports or activities. He doesn't drive and is usually fetched by his family's driver.

SUICIDE:

DM had a previous history of strong suicidal thoughts that lead to his initial consult the year prior. When he started to fail his classes, he started to post morbid statements in his social media pages stating his feelings of hopelessness and low self-esteem.

1. *What are the warning signs / risk factors in the patient's history that can increase the risk for suicide?*
2. *What are the protective factors in the patient's history that can mitigate the risk for suicide?*
3. *What is your approach to interviewing the patient in terms of who should be present? Confidentiality? How to open up about his/her concerns?*
4. *What screening tool can you administer for depression? (After letting them answer PHQ9, ask them to turn the page and ask the next question.) Please score the screening tool as endorsed in the next page. Based on the score, what is the next step?*
5. *What screening tool can you administer for suicidality? (Ask them to turn the page and peruse the C-SSRS)*
6. *Based on your screening tool result, what is the recommended course of action?*
7. *How would you explain to the family the need for this course of action?*
8. *What are the means by which you can ensure the safety of the patient while awaiting assessment and management by a psychiatrist?*
9. *What are the instructions you can give to ensure the patient's safety?*
10. *What are the medications you can give to calm the patient and avoid agitation/excess anxiety?*

**Case 3 PHQ-9**

| **Over the last 2 weeks, how often have you been bothered by any of the following problems?** | **Not at all** ***(Hindi kailanman)*** | **Several days** ***(Maraming Araw)*** | **More than half the days** ***(Lagpas sa kalahating bilang ng mga araw)*** | **Nearly every day (*Halos araw-araw_*** |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | ***3*** |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | ***3*** |
| 3. Trouble falling or staying asleep, or sleeping too much. | 0 | 1 | ***2*** | 3 |
| 4. Feeling tired or having little energy | 0 | ***1*** | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | ***2*** | 3 |
| 6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down | 0 | ***1*** | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | ***3*** |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual– | 0 | 1 | ***2*** | 3 |
| 9. Thoughts that you would be better of dead of or hurting yourself in some way | 0 | 1 | 2 | ***3*** |
| | Score: _____ = Total | | | |

**Case 3 C-SSRS**

| **SUICIDE IDEATION DEFINITIONS AND PROMPTS:** | **Past month** | |
|---|---|---|
| **Ask questions that are in bold and underlined.** | **YES** | **NO** |
| **Ask Questions 1 and 2** | | |
| **1) Wish to be Dead:**<br>Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up?<br>***Have you wished you were dead or wished you could go to sleep and not wake up?*** | **X** | |
| **2) Suicidal Thoughts:**<br>General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan*."<br>***Have you had any actual thoughts of killing yourself?*** | **X** | |
| **If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.** | | |
| **3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act):**<br>Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*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.*"<br>***Have you been thinking about how you might do this?*** | **X** | |
| **4) Suicidal Intent (without Specific Plan):**<br>Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as oppose to "*I have the thoughts but I definitely will not do anything about them*."<br>***Have you had these thoughts and had some intention of acting on them?*** | **X** | |
| **5) Suicide Intent with Specific Plan:**<br>Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.<br>***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** | **X** | |
| **6) Suicide Behavior Question**<br>***Have you ever done anything, started to do anything, or prepared to do anything to end your life?***<br>Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.<br><br>**If YES, ask:** ***Was this within the past 3 months?*** | **Lifetime**<br><br>**Past 3 Months**<br>**X** | |

## VIII. APPENDICES

### Appendix A: Sample Interview in a Pediatrician's Clinic

DOCTOR: Good afternoon, what can I do for you?

PARENT: Her class adviser mentioned that Julie hasn't been doing so well in school- that she doesn't seem to be listening during lessons and has low energy. During breaks, she apparently doesn't go to the cafeteria with her friends, just stays in the classroom by herself to sleep. Maybe she needs vitamins for low blood?

DOCTOR: Ah I see. With your permission, I will speak to Julie alone to do an emotional and behavioral wellness screening. It's a routine screening that we do for all teenagers. Afterwards, I will talk with you to elicit your concerns and discuss my findings. *(Parent leaves)*

DOCTOR: I want to assure you that as much as possible, what we will talk about is confidential and will remain between us. The only exception is that you are at risk for harming yourself or others, your safety is much more important so I will have to discuss this with your family. I know that a lot of people your age have a lot going on. What kinds of things have been on your mind or stressing you lately?"

JULIE: *(Shrugs).* Things have been hard in school.

DOCTOR: I can see you must be having a difficult time. I'm going to ask you to answer a questionnaire that discusses how you've been feeling for the last two weeks. *(Gives the questionnaire)*

JULIE: Okay *(Answers questionnaire)*

**<PHQ-SCORE FLASHES ON SCREEN>**

DOCTOR: That's quite a high score. I also notice that you answered yes to the question on hurting yourself. You must be suffering quite a lot to feel that way.

JULIE: *(Keeps quiet. Looks down at the floor)*

DOCTOR: I'd very much like to help you so I'm going to ask some more questions so I can better do so. Julie, have you wished you were dead or wished you could go to sleep and not wake up?

JULIE: *(Nods)* Sometimes.

DOCTOR: Have you had any actual thoughts of killing yourself?

JULIE: *(Shrugs)*

DOCTOR: I know it's hard to talk about, Julie but I'm concerned about you so I'll assume that's a yes and ask you some more questions. Have you been thinking about how you might do this?

JULIE: *(Nods head)* Yes.

DOCTOR: What are the ways?

JULIE: Well, sometimes I think of jumping off the fourth floor of our classroom building.

DOCTOR: Have you had these thoughts and had some intention of acting on them?

JULIE: *(Looks scared)*

DOCTOR: It's ok to talk about it, Julie, I want to help you. These thoughts of jumping off your building, have you intended to act on them?

JULIE: *(In a quiet voice)* Yeah...

DOCTOR: Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?

JULIE: Well it's my birthday next week and I was thinking of doing then...

DOCTOR: Have you ever done anything, started to do anything, or prepared to do anything to end your life?

JULIE: *(long pause)* Well, I've already started to write my parents a note...

DOCTOR: You must really be suffering deeply for you to be thinking of hurting yourself. “I may not understand exactly how you feel, but I care about you and I want to help. As I said a while ago, I'm going to have to inform your family about these suicidal thoughts so we can enlist them in a plan that can keep you safe and address the suffering. Rest assured I will only communicate what is necessary and keep the other information between us.

## Appendix B. Case Guide Questions

Ice Breaker Questions

- Have you had a case like this?
- How did you handle it?
- What were your difficulties?

Case Related Questions

- What other information do you need from the patient in terms of the history?
- What are the warning signs that this patient may be at risk for suicide?
- What are the risk factors in the patient's history that can increase the risk for suicide?
- What are the risk factors in the patient's history that can mitigate the risk for suicide?
- What is your approach to interviewing the patient in terms of who should be present? confidentiality? How to open up about his/her concerns?
- What screening tool can you administer for depression?
- What screening tool can you administer for suicidality?
- Based on your screening tool result, what is the recommended course of action?
- How would you explain to the family the need for this course of action?
- What are the means by which you can ensure the safety of the patient while awaiting assessment and management by a psychiatrist?
- What are the instructions you can give to ensure the patient's safety once at home?

## **Appendix C.** Patient Health Questionnaire (PHQ-9)

| **Over the last 2 weeks, how often have you been bothered by any of the following problems? (*Nitong nakaraang 14 na araw, gaano ka kadalas binagabag ng alinman sa mga sumusunod na mga problema?)***<br><br>***Use "✓" to indicate your answer (Lagyan ng "✓" ang iyong sagot)*** | **Not at all *(Hindi kailanman)*** | **Several days *(Maraming Araw)*** | **More than half the days *(Lagpas sa kalahati ng bilang ng mga araw)*** | **Nearly every day (*Halos araw-araw_*** |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things *(Di gaanong interesado o nasisiyahan sa paggawa ng mga bagay)* | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless *(Pakiramdam na nalulungkot, nadidipress o nawawalan ng pag-asa)* | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much. *(Hirap na makatulog o manatiling tulog, o labis na pagtulog)* | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy *(Pagkaramdam ng pagod o walang lakas)* | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating *(Kawalan ng ganang kumain o labis na pagkain)* | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down *(Pagkaramdam ng masama tungkol sa iyong sarili – o nabigo ka o nabigo mo ang iyong sarili o ang iyong pamilya)* | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television *(Hirap magtuon ng pansin sa mga bagay, tulad ng pagbabasa ng dyaryo or panonood ng telebisyon)* | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual *(Pagkilos o pagsasalita ng mabagal na maaring napansin ng ibang tao? O ang kabaligtaran – pagiging alumpihit o di mapakali kaya ikot nang ikot nang higit sa karaniwan)* | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better of dead of or hurting yourself in some way *(Nag-iiisip na mas mabuting mamatay ka na lang o saktan mo ang iyong sarili sa ilang paraan)* | 0 | 1 | 2 | 3 |
| FOR OFFICE CODING | _____ + _____ + _____ + _____<br><br>= Total Score: _____ | | | |

**Appendix D.** Columbia-Suicide Severity Rating Scale

| SUICIDE IDEATION DEFINITIONS AND PROMPTS | Past month | |
|---|---|---|
| **Ask questions that are bolded and underlined.** | **YES** | **NO** |
| **Ask Questions 1 and 2** | | |
| **1) Wish to be Dead:**<br>Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.<br>***Have you wished you were dead or wished you could go to sleep and not wake up?*** | | |
| **2) Suicidal Thoughts:**<br>General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself*" without general thoughts of ways to kill oneself/associated methods, intent, or plan.<br>***Have you actually had any thoughts of killing yourself?*** | | |
| **If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.** | | |
| **3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act):**<br>Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*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.*"<br>***Have you been thinking about how you might kill yourself?*** | | |
| **4) Suicidal Intent (without Specific Plan):**<br>Active suicidal thoughts of killing oneself and patient 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.*"<br>***Have you had these thoughts and had some intention of acting on them?*** | | |
| **5) Suicide Intent with Specific Plan:**<br>Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.<br>***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** | | |
| **6) Suicide Behavior Question:**<br>***Have you ever done anything, started to do anything, or prepared to do anything to end your life?***<br>Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.<br>**If YES, ask:** ***How long ago did you do any of these?***<br>· Over a year ago? · Between three months and a year ago? · Within the last three months? | | |

## Appendix E. Natasha Goulbourn Foundation

| Aim to make these individuals feel that someone is ready to listen to them. | |
|---|---|
| Information and Crisis Intervention Center | (02) 804-HOPE (4673)<br>0917-558-HOPE (4673) or (632) 211-4550<br>0917-852-HOPE (4673) or (632) 964-6876<br>0917-842-HOPE (4673) or (632) 964-4084 |
| In Touch Crisis Lines: | 0917-572-HOPE or (632) 211-1305<br>(02) 893-7606 (24/7)<br>(02) 893-7603 (Mon-Fri, 9 am -5 pm)<br>Globe (63917) 800.1123 or (632) 506.7314<br>Sun (63922) 893.8944 or (632) 346.8776 |

**Appendix F. List of Child and Adolescent Psychiatrists in the Philippines (PSCAP)**
**(As of July 2018)**

**FELLOWS:**

| NAME | MAIN CLINIC ADDRESS | CONTACT NUMBERS |
|---|---|---|
| 1. Mary Ann Joy Aguadera, MD, FPPA, FPSCAP | Room 402 Manila Doctors Hospital, 667 UN Avenue, Manila | (02)524-9858/09152016754 |
| 2. Norieta Calma-Balderrama, MD, FPPA, FPSCAP (Founding Fellow) | UERMMMC, Aurora Blvd., Quezon City | 716-1848/ 715-0861 loc 280 |
| 3. Cornelio G. Banaag, Jr., MD, FPPA, FPSCAP (Founding Fellow) | Room 312 MATI, The Medical City, Ortigas Avenue, Pasig City | 634-7714 |
| 4. Jocelyn Nieva Yatco-Bautista, MD, FPPA, FPSCAP (Founding Fellow) | UST Hospital, Room 515 Medical Doctors' Clinics, Clinical Division Building, Espana, Manila | 7313001 local 2497 |
| 5. Vanessa Kathleen B. Cainghug, MD., FPPA, FPSCAP | Room 1227 MAB St Luke's Medical Centre Global City, 32nd St. The Fort Taguig City | 09178309773 |
| 6. Mary Daryl Joyce L. Calleja, MD, DSBPP, FPSCAP | MedMom Institute for Human Development; 2nd Floor, Fun Ranch, Frontera Verde, Ortigas Ave. Pasig City | 09261984103 |
| 7. Lorelei Melanie K. Elma – Chua, MD., FPPA, FPSCAP (Founding Fellow) | Unit 835 Medical Arts Bldg, St. Luke's Medical Center – Global City | 789-7700 loc. 7835 |
| 8. Rhodora Andrea M. Concepcion, MD, FPPA, FPSCAP | Department of Psychiatry CHEERS 7th Floor Phil. Health Center, East Avenue, Quezon City | 925-2401 loc. 3717 |
| 9. Japhet Gensaya-Fernandez De Leon, MD, FPPA (Life), FPSCAP (Founding Fellow) | Room 207 IDH Medical Arts Condominium, West Avenue, Molo, Iloilo | (033) 3377702 loc. 289 |
| 10. Jocelyn Gayares, MD., FPPA, FPSCAP, FPCAM, IFAPA | Room 214 Northpoint Bldg. BS. Aquino Drive. Bacolod City Negros Occ. 6100 | (034) 432-3515/ 0917-300-4487 |
| 11. Anna Josefina Vasquez-Genuino, MD, FPPA (Life), FPSCAP, MPH (Founding Fellow) | Room 313 MAC II, Manila Doctors Hospital, UN Ave. Ermita, Manila; Rm 1003 NTMT Bldg. Manila Doctor's Hospital, Ermita Manila | 525-8970<br>5580888 local 3760 |
| 12. Maria Celina Hizon-Germar, MD, FPPA, FPSCAP | UERMMMCI Hospital, Aurora Blvd., QC | 7161848, 7150861 loc 280; 09391157462 |
| 13. Belle Erika Reyes Nubla-Gestuvo, MD, DSBPP, FPSCAP | Unit 1402 Medical Arts Tower, The Medical City, Ortigas Ave., Pasig City | 988100 local 5175/ 0917-995-1983 |
| 14. Angela Aida W. Halili-Jao, MD, FPPA, FPSCAP (Founding Fellow) | Rm. 508 Richmonde Plaza, Lourdes Drive Cor. San Miguel Ave. Pasig City | (02) 633-3893 |
| 15. Ma. Cynthia Ramos-Leynes, MD, MSc, FPPA, FPSCAP (Founding Fellow) | Room 131 Medical Arts Bldg. Cardinal Santos Medical Center Wilson St., San Juan | 7277664<br>7270001 local 2131 |
| 16. Geraldine Anne Divino-Lobo, MD., FPPA, FPSCAP | Unit 1003 MATI , The Medical City Ortigas Avenue, Pasig City | 6356789 loc. 5119<br>+639176192610 |
| 17. Portia Valles-Luspo, MD, FPPA, FPSCAP (Founding Fellow) | Room 16 Specialty Clinics Philippine Children's Medical Center. Quezon Avenue, QC | 5889900 loc. 305 |

| | | |
|---|---|---|
| 18. Joy P. Malinit, MD, FPPA, FPSCAP | Nurturing Touch Therapeutic Play Clinic, 597 JP Rizal St. Makati City | (02) 5860378/09178288522 |
| 19. Anna Lizza S. Manalac, MD, FPNA, FPPA, FPSCAP | Rm. 208 The Medical City, Clark Mon and Thursday, 3-7pm. | 09258453055 |
| 20. Ruben C. Manapat, MD, FPPA, FPSCAP (Founding Fellow) | Room 510 Medical Arts bldg. FEUNRTF Fairview Quezon City | |
| 21. Aida L. Muncada, MD, FPPA, FPSCAP (Founding Fellow) | Room 424 Medical Arts Bldg. Our Lady of Lourdes Hospital, Sta. Mesa Manila | |
| 22. Georgina Gozo-Oliver, MD., FPPA, FPSCAP (Founding Fellow) | Department of Psychiatry Veterans Memorial Medical Center, North Avenue Diliman, Quezon City | 927-6426 loc 1473/1474/1475 |
| 23. Pureza Trinidad Oñate , MD, FPPA (Life), FPSCAP (Founding Fellow) | Suite 328 Medical Specialty Bldg. Cebu Perpetual Succor Hospital Gorordo Avenue, Cebu City | |
| 24. Myrna N. Quintos, MD, FPPA, FPSCAP (Founding Fellow) | Summit School, 32 J. University Ave., Global City, Taguig | |
| 25. Genuina Ranoy, MD., FPPA, FPSCAP | Rm 615, MAB St. Luke's Medical Center - Global City, BGC, Taguig | 7897700 loc 7615 |
| 26. Sonia Castro-Rodriguez, MD., FPPA (Life), FPSCAP (Founding Fellow) | UERMMMCI Hospital, Aurora Blvd. Quezon City | 716-1848/ 715-0861 loc. 280 |
| 27. Sharon J. Triunfo, MD, FPPA, FPSCAP (Founding Fellow) | National Center for Mental Health 9 de Pebrero St. Mandaluyong City | 531-9001 loc. 449 |

**REGULAR MEMBERS:**

| NAME | ADDRESS | CONTACT NUMBERS |
|---|---|---|
| 1. Marilou Q. Benignos, MD., FPPA | Rm 523 Davao Doctors Medical Tower, Quirino Avenue Davao City | 2212101 loc 6523 09168594675 |
| 2. Elham Mae Z. Bocalbos, MD, DSBPP | UERM Hospital, Aurora Blvd. QC | 09063275910 |
| 3. Agnes Bueno, MD | Room 501 Medical Arts Bldg. St. Lukes Medical Center, QC | 723-8591 |
| 4. Jolly Michelle S. Bustamante, MD | Divine Grace Medical Center, General Trias, Cavite | 09178011555/ 09258208555 |
| 5. Aimee G. Chua, MD | Rm 249 SPICE Bldg. St. Pauls's Hosp, Gen. Luna St., Iloilo City | (033) 3372741 loc 8249 |
| 6. Ma. Zairah Jane Castelo-Corpus, MD, DSBPP | Rm 1701 MATI Clinic, The Medical City, Ortigas Ave., Pasig City | 0908 6915676/ 09453903072 6374178/ 9881000 loc 5231 |
| 7. Evelyn Gapuz, MD, FPPA | Room 1216, Medical Arts Bldg. St. Luke's Medical Center- Global City, Taguig City | 7897700 ext 5216 |
| 6. Josephine I. Gatdula-Edrenal, MD. | Rm 1237 Medical Arts Bldg St Luke's Medical Center- Global 32nd St., The Fort, Taguig City | 09561240062 |

| | | |
|---|---|---|
| 7. Leah Samaniego-Gonzaga, MD., FPPA | • Mary Mediatrix Medical Center<br>• LIpa City, Batangas<br>• Tagaytay Medical Center, Tagaytay City<br>• Immanuel ClinicNasugbu, Batangas | 09172079908/ 09228271204/ 09299206900 |
| 8. Ma. Carmen Lambuson, MD. | Las Pinas City | |
| 9. Elaine Angela O. Leynes, MD | Room 511 MOB 5th Floor Asian Hospital and Medical Center 2205 Civic Drive Muntinlupa City | 771-9294 |
| 10. Grace Macapagal, MD | Room 16 Specialty Clinics Philippine Children's Medical Center, Quezon Avenue, QC | 9246601 loc 305 |
| 11. Minda Luz C. Manas | Healthway Medical, Level 4 Market, Market, BGC, Taguig City | 0917-832-5210 |
| 12. Maria Elena del Mundo Nepomuceno, MD | Rm. 108 Neurosciences Clinic UP-PGH FMAB' Taft Avenue, Manila | |
| 13. Ann Princess Grana- Nespral, MD, DSBPP, FPPA | Room 110 Butuan Doctors Hospital. JC Aquino Avenue, Butuan City, Agusan del Norte | (085) 2250394 09328832043 |
| 14. Spes F. Romero-Reyes, MD, DSBPP | St. Victoria Hospital, 444 J. P. Rizal St, Lamuan, Marikina | 941-4085 loc. 106 942-2022 loc. 106 |
| 15. Eleonor E. Sanchez-Antonio. MD | Rm 705 MOB Civic Place Filinvest Alabang Muntinlupa City | 771-9383 |
| 16. . Luciano Santiago, MD. | Department of Psychiatry, The Medical City, Ortigas Avenue, Pasig City | 631-6961/ 635-6789 |
| 17. Aizah Joyce Lei Tana, MD | Child Neurosciences Center Manila Doctor's Hospital, UN Ave. Ermita, Manila | |
| 17. Cecilia A. Tuazon, MD, FPPA | National Center for Mental Health 9 de Pebrero, Mandaluyong | 5319001 loc. 381 |
| 18. Ruth Villanueva, MD, FPNA, DSBPP | Rm. 17 Doctors Clinic, MCU Hospital, EDSA, Caloocan City | (02) 3672031 |

**Appendix G. List of Adolescent Medicine Specialists in the Philippines (PSAMS)**
**(As of February 2018)**

| Name | Hospital affiliation | Clinic Hours | Contact Number |
|---|---|---|---|
| 1. Nancho, Rosa Maria H. | a. The Medical City – Adolescent Wellness Center<br>b. Manila Doctors' Hospital Rm 704, MAC<br>c. Phil. Children's Medical Center Rm 10 | By appointment<br><br>Mon – Fri except Thurs 10:30-12:30pm by appointment<br>T – Th 4 – 6pm by appointment | (02) 988-7000<br><br>(02) 558-0888 loc 5160<br><br>(02) 588-9900 |
| 2. Tamesis, Alicia B. | a. Fe Del Mundo Medical Center<br>b. St. Luke's Medical Center | Daily except Th & Sat./Sun.<br>Mon & Wed 1- 3 pm<br>Sat 12 – 4pm | (02) 712 -0845<br>(02) 723 - 0101 |
| 3. Llanto, Emma A. | a. Asian Hosp.& Med Center Unit 716, Medical Arts Bldg.<br><br>b. San Juan de Dios Hosp. Unit 26, Harrison Wing, Taft Ave cor. EDSA Ext. | TThS 10:30 -12:30pm<br>Sat. 1:00 – 3:00pm by appointment<br>MWF 3:30 – 5:30pm | (02) 771- 9319<br><br>(02) 831 -9731 |
| 4. Buzon, Rosalia M. | a. Hosp. of Infant Jesus<br><br>B. UST Hospital, Rm. 507 | Mon –Sat 9am -12nn<br>By appointment<br>Except Wed<br>Wednesday by appointment | (02) 731 – 0771<br><br>(02) 986-0155 |
| 5. Cailao, Regina Cruz | a. Phil. Children's Medical Center<br>b. Fe del Mundo Med Ctr | M/Th 9 -11am<br>Sat 8Wed/Sat 10am – 2pmam -10am | 0917-801-3360<br><br>(02) 924 -6601 loc 272 |
| 6. Dando, Nerissa M. | a. The Medical City – Adolescent Wellness Center<br>b. San Juan De Dios Hospital Room 28 Doctor's Clinic | a. Mon 3-6 PM and Sat 9-12 NN By appointment<br>b. Wed and Sat 1-4 PM by appointment | a. (02)988 – 7000 local 6265<br>b. (02) 8319731 local 1237 |
| 7. Olonan, Leoncia N. | Univ. of Sto. Tomas Hospital | By appointment | (02) 986-0155 |
| 8. Valdes, Florianne Feliza | The Medical City Suite 408, Ortigas Ave., Pasig City | By appointment | (02) 638-5945;<br>(02) 988-1000 loc 6232/6444 |
| 9. Quidlat, Ma. Jocelyn N. | Hosp. of Infant Jesus, Sampaloc Mla. Rm 105 - 1556 Laong Laan, | Mon – Sat. Except Wed. 8am – 12nn | (02) 731 – 2771 loc. 105 |
| 10. Cuisia-Cruz, Erlinda S. | a. Philippine Children's Medical Center , Room 5 | a. MWFSat 10-1pm by appointment | (02) 588-9900 local 272<br><br>02 988-7000 loc 6265 |

| | | | |
|---|---|---|---|
| | b. The Medical City - Adolescent Wellness Center | b. TThSat 2-4pm by appointment | |
| 11. De Guzman, Moses C. | Phil. Children's Medical Center<br>Ram. 5 | MWF 4 -6pm | (02) 588 -9900<br>loc 272 |
| 12. Bermejo, Ma. Esel J. | Adventist Medical Center, Bacolod, Taculing, Bacolod City<br>Rm N01 | Daily except Sat<br>10am- 2pm | (034) 433-4831 loc 428 |
| 13. Azan-Red, Deborrah | St. Luke's Medical Center,<br>Quezon City | By appointment | |
| 14. Caparro, Erlyn D. | Mary Johnston Hospital, Rm 140, Tondo, Manila | Mon –Th –Sat<br>11 – 5pm | (02) 245-4021 Local 230 |
| 15. Santos, Karen Grace O. | De la Salle Univ. Med Ctr, Medical Arts Center Rm 521 | MWF 2 – 4pm<br>TThS 10am-12nn | (046) 481 -8000 loc 5521 |
| 16. Iligan, Ester Mont | a. Phil. Children's Medical Center Rm 7<br>b. The Medical City, SM North | Sat 9am – 4pm<br><br>Wed 2 -4 pm<br>Fri 12 -2 pm | (02) 588-9900 |
| 17. Serviento, Pia Parker | Makati Medical Center Rm. L7 1st floor CPM Tower 1 | MWF 10 -3 pm<br>Sat 1 -3 pm | (02) 8888-999 local 2117<br>(0942) 207 0508 |
| 18. Cruz, Liah Ann G. | Metro North Medical Center & Hosp, Rm. 411, Mindanao Ave., QC | T TH S 10:30 pm - 12:30pm | (02) 426-8000 local 411 |
| 19. Torres-Ticzon, Vanessa-Maria F. | a. UP-PGH Faculty Medical Arts Bldg Room 205<br>b. Manila Doctors Hospital | Mon 9-11am, Thu 3-5pm, Fri 10-12nn<br>By appointment<br>Tue 1-3PM<br>Sat 10-12NN | a. (02) 708-0000/ 09430278987<br>b. (02) 558-0888 local 4256/ 09053082554 |
| 20. Sinlao, Lea Riza C. | a. Veterans' Memorial Medical Center Pediatric Conference Room b. Jesus Delgado Mem. Hospital Mezzanine Room 1<br>c. Providence Hosp. Quezon Ave., Room 3 | Mon to Fri 10am-3pm<br><br>Tues 4 -6 pm<br>Sat. 12 – 2pm<br><br>Wed & Fri 4 – 5pm | (02) 927 -6426 loc 1447<br><br>(02) 924 -4051<br>(02) 558-6999 |
| 21. Noblejas-Mangubat, Michelle Anne | Phil. Children's Medical Center Rm 10 | By appointment<br>MWF 4-6 pm | (02) 588 -9900 |

## APPENDIX H. List of Developmental and Behavioral Pediatricians (PSDBP) (As of February 2018)

**METRO MANILA**

| FULL NAME | CLINIC ADDRESS | CONTACT NUMBER |
|---|---|---|
| Victoria Dominique Ang, MD | Cardinal Santos Medical Center | 721-3760 |
| Ma. Theresa Lim, MD | The Medical City | 988-7000 local 5187/ 09178994693 |
| Ermenilda Avendano, MD | Philippine Children's Medical Center | 588-9000 local 320 |
| Maria Michiko Baloca, MD | Medical Plaza Makati | 216-4522 / 09175003368 |
| Maria Paz Irene Bautista, MD | St. Luke's Medical Center-Quezon City | 727-5463 / 723-0101 local 3601 |
| Kathryn Braganza, MD | UST Hospital | 731-0001 local 2656 / 925-2592 |
| Maria Cristina Caguioa, MD | Asian Hospital Medical Center | 771-9000 |
| Christine Leonor Ma. Conducto, MD | Philippine Children's Medical Center | 588-9000 local 320 |
| Marizel Dacumos, MD | St. Luke's Medical Center-Global City | 789-7700 local 7531 |
| Rita Paz Rowena De Guzman, MD | FEU-NRMF Medical Center | 0917-9058858 |
| Francis Xavier Daniel Dimalanta, MD | St. Luke's Medical Center- Quezon City | 723- 0101 local 6208 /726-2578 |
| Joselyn Eusebio, MD | UERMMMC | 715-6844 |
| Agnes Falcotelo, MD | Capitol Medical Center | 400-0886 372-3825 local 3235 |
| Melinda Francisco, MD | M. Francisco Children' Medical Center | 579-1722 |
| Jack Alexander Herrin, MD | Cardinal Santos Medical Center- | 727-0001 local 2171 |
| Joel Lazaro, MD | Asian Hospital Medical Center | 771-9250 |
| Maria Cielo Malijan, MD | Manila Doctor's Hospital | 558-0888 local 138 |
| Stella Manalo, MD | The Medical City | 633-6686 / 09209769306 |
| Anna Lourdes Moral, MD | Philippine General Hospital | 0925-7254312 |
| Jacqueline Navarro, MD | The Medical City | 988-1000 local 5104 / 6362818 |
| Ma. Rochelle Pacifico, MD | Protacio Hospital | 852-2953 / 0917-8066194 |
| Pablito Planta ,Jr., MD | World Citi Medical Center | 438-4772 local 221 / 0919-4763558 |
| Mary Ann Prudencio, MD | Clinica Manila | 0917-9486370 |
| Maria Isabel Quilendrino, MD | Perpetual Succor Hospital and Maternity | 731-1631 / 09328864727 |
| Joan Hazel Ramos, MD | St. Vincent Hospital | 425-4314 / 0917-8857424 |
| Ma. Veronica Reloza, MD | Makati Medical Center | 888-8999 local 2216 / 893-5134 |
| Alexis Socorro Reyes, MD | Philippine Children's Medical Center | 0917-5583238 |
| Marcelino Reysio-Cruz III, MD | Capitol Medical Center | 371-2106 / 0916-6876210 |
| Ma. Noemi Salazar, MD | VRP Medical Center | 532-1471 |
| Jocelyn Sanchez, MD | St. Luke's Medical Center- Global City | 789-7700 local 7931 / 0917-8991237 |
| Jan Harold Sia, MD | Manila Doctor's Hospital | 588-0888 local 5110 / 0917-8056283 |
| Elizabeth Tan, MD | Chinese General Hospital | 711-4141 local 1917 |
| Lourdes Bernadette Tanchanco, MD | MedMom Child Development Clinic | 727-0565 / 0919-3672002 |
| Anna Maria Treichler, Md | Medical Towers Makati | 818-8582 |
| Rita Grace Villadolid, MD | St. Victoria Hospital | 475-1552 local 104 / 0922-8854521 |

**NORTHERN LUZON**

| FULL NAME | CLINIC ADDRESS | CONTACT NUMBER |
|---|---|---|
| Francis Xavier Daniel Dimalanta, MD | A Child's Dream Foundation, Inc. | (074) 446-6121 |
| Millicent Mae De Vera, MD | Notre Dame de Chartres Hospital | (074) 619-8531 to 34 local 216 / 0919-764-4888 |
| Pablito Planta, Jr., MD | Rehabworks Therapy Center | 0922-2684633 / 0917-8093409 |

| | | |
|---|---|---|
| Mary Ann Prudencio, MD | Prudencio Medical Clinic | 0917-9486370 |
| Joan Hazel Ramos, MD | Veteran's Regional Hospital | 0917-8857424 / 0927-7247302 |

**CENTRAL LUZON**

| FULL NAME | CLINIC ADDRESS | CONTACT NUMBER |
|---|---|---|
| Maria Paz Irene Bautista, MD | GESU Child Development Center | 0920-9512831 / 0998-9817348 |
| Kathryn Braganza, MD | Therafun Intervention Center | 0915-2049700 |
| Agnes Falcotelo, MD | Nazarenus Hospital Medical Center | 0933-3817192 |
| Jack Alexander Herrin, MD | 4 Tampo Street Malolos Bulacan | 0928-8651532 |
| Lourdes Bernadette Tanchanco, MD | The Medical City Clark Ambulatory Center | (045) 499-1522 / 0933-8685103 |

**SOUTHERN TAGALOG**

| FULL NAME | CLINIC ADDRESS | CONTACT NUMBER |
|---|---|---|
| Genalyn Aguila,MD | Bacoor Doctor's Medical Center | 0923-8305826 |
| Marizel Dacumos, MD | Helping Hands Pediatric Therapy Center of Batangas | (043) 723-7526 / 0917-5280269 |
| Ma. Theresa De Castro, MD | The Medical City South Luzon | (049) 544-0120 |
| Rita Paz Rowena De Guzman, MD | Southeast Asia Medical Center | (046) 477-0183 |
| Agnes Falcotelo, MD | Mary Mediatrix Medical Center | (043) 773-6800 local 3229 / 0920-267-8832 |
| Melinda Francisco, MD | Thoughts and Works Behavioral Intervention | 0917-5518893 |
| Edna Gonzaga, MD | Metro Lemery Medical Center | 0917-5081870 |
| Joel Lazaro, MD | Calamba Doctors Hospital | (049) 545-0195 local 300 |
| Ma. Rochelle Pacifico, MD | De La Salle University Medical Center | (046) 481-8000 |
| Pablito Planta, Jr., MD | Health Index Multi-Specialty Clinic | (46) 471-0996 / 0933-8524624 / 0942-7455829 |

**VISAYAS**

| FULL NAME | CLINIC ADDRESS | CONTACT NUMBER |
|---|---|---|
| Maria Carolina Alejano, MD | Riverside Medical Center | (034) 433-8943 |
| Myra Altonaga, MD | Cebu Doctor' | 0933-5636631 |
| Jacqueline Espina, MD | Chong Hua Hospital | (032) 254-4293 / 0922-8985173 |
| Celina Gellada, MD | Healthlink (Iloilo), Inc. | (033) 509-0665 / 0920-9504750 |

**MINDANAO**

| FULL NAME | CLINIC ADDRESS | CONTACT NUMBER |
|---|---|---|
| Vida Daria, MD | Ciudad Medical Zamboanga | (062) 992-7330 |
| Annah Rebecca Doroja,MD | Capitol University Medical Center | (0882) 271-2625 local 112/ (0882) 856-4730 local 112 / 0917-9392168 |
| Mervin Edcel Flavier, MD | Davao Doctors Hospital | (082) 222-8000 local 6214 / 0932-5365614 |
| Jeanne Mae Fortuna, MD | Davao Doctors Hospital | (082) 222-8000 local 6421 |
| Ferriza Maria Isaguirre, MD | Brokenshire Memorial Hospital | (082) 305-3171 local 4242 / (082) 221-0808 local 215 / 0932-871-1628 |
| Cindy Llego, MD | Polymedic Medical Plaza | (088) 858-5880 local 2229 / 0932-1882761 |

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