

St. Paul's Hospital Millennium Medical College

Ethiopian Field Epidemiology and Laboratory Training program



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St. Paul's Hospital Millennium Medical College

**PREVALENCE And ASSOCIATED FACTORS OF SUICIDAL IDEATION
And ATTEMPTS AMONG MENTALLY ILL PATIENTS AT ST. PAUL'S
HOSPITAL MILLENNIUM MEDICAL COLLEGE, IN ADDIS ABEBA,
ETHIOPIA**

BY; Awal Dawud

**A THESIS SUBMITTED TO THE DEPARTEMENT OF PUBLIC HEALTH
St. PAUL'S HOSPITAL MILLENNIUM MEDICAL COLLEGE IN PARTIAL
FULFILMENT FOR MASTER DEGREE OF PUBLIC HEALTH IN FIELD
EPIDEMIOLOGY**

ADDIS ABABA, Ethiopia

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Saint Paul's Hospital Millennium Medical College

Department of Public Health

**Ethiopian Field Epidemiology and Laboratory Training
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Acronyms

CI	Confidence Interval
CIDI	Composite International Diagnostic Interview
DSM-5	Diagnostic and statistical manual of mental disorders, fifth edition
LMIC	Low and Middle Income Countries
MDD	Major Depression Disorder
OR	Odd Ratio
SMD	Severe Mental Diseases
SPHMMC	St. Paul Hospital Millennium Medical College
SPSS	Statistical Package for the Social Sciences
WHO	World Health Organization
WMH	World Mental Health

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Abstract

Background: There is a big difference between thinking about suicide and acting it out. Some persons may have ideas of suicide, but they will never act on. Some plan for days, weeks, or even years before acting, whereas others take their lives seemingly on impulse without advance planning. Every year, more than 800,000 people die due to suicide (one person every 40 s) ranking as the second leading cause of death next to traffic accidents among 15–29 years of age. The most common method to attempt suicide in children and adolescents is the use of hanging, poisoning, slashing, and shooting. The objective of this study was to assess the prevalence and associated factors of suicidal ideation and attempts among mentally ill patients at outpatient department of St. Paul's Hospital Millennium Medical College, in Addis Ababa, Ethiopia.

Method: Institutional based cross-sectional study design was employed and conducted from December/2019 to January/2020. Data was collected using consecutive sampling technique until the required sample size was achieved the total sample size of 385. It also collected by psychiatry nurse. To collect the data we use Suicidal Behavior Questionnaire Revised (SBQ-R) with modification, Oslo scale and self prepared questionnaire were interviewer administered. Pretest was made on 5% of sample size at St. Peter Hospital and identified problems were amended accordingly. The data collectors were supervised daily and filled questionnaire was checked daily. Variables having P-value of less than 0.05 was used to determine significance. The collected data were coded and entered in the computer using Epi info version 7.2.1.0 software, exported to and analyzed using SPSS version 23 for cleaning and analysis.

Result: A total of 385 patients were participated in the study. Of these 216 (56%) were males. Their age ranges from 18 to 85 years old. The prevalence of suicide ideation was 255 (66.2%). The finding from multivariable logistic regression analysis showed that felt hopeless had 2.79 times more likely risk for suicide ideation and attempts than those not felt hopeless. Which is [AOR=2.79, 95% CI (1.11, 6.98)]. Similarly risk factors like family history of mental illness [AOR= 1.94, 95% CI (1.12, 3.36)], family history of suicide [AOR= 2.44, 95% CI (1.17, 5.08)], stopping of medication [AOR= 2.56, 95% CI (1.00, 6.53)] and primary and secondary education of participants [AOR =5.86, 95% CI (1.30, 26.41) and AOR=3.61, 95% CI (1.01, 12.88)] respectively had appositve association with suicidal ideation and attempts.

Conclusion and Recommendation: As the findings of this study showed the prevalence of suicidal ideation and attempt were found to be significant among patients with mental illnesses. Additionally, this public health important problem is found to be more common among male

patients than females. Being hopeless, family history of mental illness, family history of suicide, stopping medications and education level of study participants were found to be factors associated with suicidal ideation and attempts among patients with mentally illness. Thus, early detection of likely causes of suicidal attempts and ideation as well as subsequent timely interventions such as health education and social supports can play paramount roles for preventing suicide among patients with mental illness.

Keywords: Suicidal ideation, Suicidal attempts, Risk factors

1. Introduction

1.1 Background

Diagnostic and statistical manual of mental disorders, fifth edition (DSM-5) defines suicidal ideation as thoughts about self-harm with deliberate consideration or planning of possible techniques of causing one's own death, while suicide is the act of intentionally causing one's own death and suicide attempt is an attempt to end one's own life, which may lead to one's death [1]. There is a big difference between thinking about suicide and acting it out. Some persons may have ideas of suicide, but they will never act on. Some plan for days, weeks, or even years before acting, whereas others take their lives seemingly on impulse without advance planning [2].

The analyses of the prevalence and correlates of suicidal ideation yielded comparisons and contrasts among the five sub-Saharan countries namely Botswana, Kenya, Tanzania, Uganda and Zambia among boys and girls. There are many possible factors related to the culture and lifestyle which could account for these variations, one of which could be greater exposure to certain risk factors because of the adverse sub-Saharan Africa issues and challenges [3]. In addition to the above China and India accounted for approximately 50 percent of all suicides [4]. Also self-harm was one of the top 10 causes of years of life lost in many countries and regions, including Australia, China, Europe, India, and Japan.

Risk situations and events that may trigger suicide attempts or suicide are: situations that may be experienced as injurious (without necessarily being so when evaluated objectively): vulnerable children and adolescents may perceive even trivial occurrences as deeply injurious and react with anxiety and disordered behavior, while suicidal young people perceive such situations as threats directed against their self-image and suffer from a sense of wounded personal dignity; family disturbances; separation from friends, girl-/boyfriends, classmates, etc.; death of a loved one or other significant person; termination of a love relationship; interpersonal conflicts or losses; legal or disciplinary problems; peer-group pressure or self-destructive peer acceptance; bullying and victimization; disappointment with school results and failure in studies; high demands at school during examination periods; unemployment and poor finances; unwanted pregnancy, abortion; infection with HIV or other sexually transmitted diseases [5].

Studies shows that factors found to be associated with suicide ideation among young people in Africa were female gender [6, 7], loneliness [8], sadness [9, 10], and anxiety [11]. For example,

Alcohol use has been found to be associated with suicidal ideation in Zambia [10] and substance use with ideation in Tanzania, Seychelles [9], and Benin [6]. In addition to this Social, psychological, cultural and many other factors can interact to increase the risk of suicidal behavior, but the stigma attached to suicide means that many people who are in need of help feel unable to seek it. Other risk factors for suicide include previous suicide attempts, mental health problems, harmful use of alcohol, drug use, job or financial loss, relationship breakdown, trauma or abuse, violence, conflict or disaster, and chronic pain or illness [12]. Furthermore several environmental, psychosocial and behavioral factors have been found to be associated with suicidal ideation, suicidal attempts and suicide in studies conducted in various countries. Physical, sexual and emotional abuses have been associated with adolescent suicidal ideation and attempts [13]. It is noted that suicidal behaviors often coexist with other health risk behaviors like aggressive behavior, smoking, and experience of sexual intercourse [9, 13] are associated with suicidal behaviors in adolescents. Studies in other countries also revealed that parental support, family factors as well as psychological factors also influence suicidal behavior [9].

The method of the suicide attempt influences the morbidity and completion rates, independent of the severity of the intent to die at the time of the suicidal behavior. The most common method to attempt suicide in children and adolescents is the use of hanging, poisoning, slashing, and shooting. [2, 14] Moreover, information on suicide behavior, including ideation, attempts and completed suicides in Africa is lacking. Although not all suicidal ideation materialize in to suicide attempts or suicide, it is the first step on the path to suicide [10]. In different country the method for suicide and prevalence of suicide were different for example the second and third leading methods of suicide in the United States are suffocation (eg, hanging, about 25 % of suicides) and poisoning (e.g. drug overdose; about 15 %) [4].

Suicide ideation and attempted were related to many severe mental health problems like anxiety, schizophrenia, bipolar, mood-disorder, depression and other. Studies shows that for example anxiety was present in 51.4% of individuals who reported suicide ideation in Benin [6], Evidences indicated that persons with bipolar disorder are 30 times more likely to make a suicide attempt during their lifetime compared to those with no psychiatric disorder [15]. Close to one-third of persons with bipolar disorder attempt suicide [16]. Researchers estimate that in the general population 29% of bipolar patients made at least one suicide attempt during their lives. Studies done in Jimma university shows that 119 (44.1%) of schizophrenic participants and 128 (47.1%) of bipolar participants have suicidal ideation and, 56 (20.58%) of schizophrenic participants and 58 (21.32%) of bipolar participants have suicidal attempt [17].

Suicide is a serious, preventable public health problem that results in social, emotional, and economic consequences in families, friends, and colleagues [18]. Because suicide remains a sensitive issue, it is very likely that it is under-reported due to stigma, criminalization and weak surveillance systems. It demands our attention and action even though its prevention and control are difficult [19].

1.2 Statement of the problem

The burden of suicide constitutes a serious public health issue worldwide that needs mental health professionals increase their awareness towards suicide warning signs. Suicide warning signs are associated with acute factors that inform clinicians about observable signs, expressed emotions, and important for saving lives by early detection and intervention for those at risk [20]. Every year, more than 800,000 people die due to suicide (one person every 40 s) ranking as the second leading cause of death next to traffic accidents among 15–29 years of age. Among nearly 250 causes of death, suicide was the 14th leading cause of global mortality [13]. And it is also predicted that, by 2020, the rate of death due to suicide will be increased to one every 20 seconds [21]. In many countries it ranks first or second as a cause of death among both boys and girls in this age group [5]. Fifty percent of all violent deaths in men and 71% of women were accounted for suicides globally.

Suicide continues to be a serious problem in high-income countries. And also, 79% of all suicides occur in low- and middle-income countries which bear the larger part of the global suicide burden [22]. Although in high-income countries three times as many men die by suicide as women, the male to female ratio for suicide is more even in low- and middle-income countries, at 1.6 men to each woman. Suicide rates for both men and women are lowest in persons under 15 years of age and highest in persons aged 70 years or older in almost all regions of the world. In some regions, suicide rates increase steadily with age, while in others there is a peak in suicide rates in young people. In low- and middle-income countries, young adults and elderly women have much higher suicide rates than their counterparts in high-income countries, while middle-aged men in high-income countries have much higher suicide rates than those in low- and middle-income countries [12].

Internationally, suicide rates range from highs of more than 25 per 100,000 persons in Scandinavia, Switzerland, Germany, Austria, the eastern European countries, and Japan, to fewer than 10 per 100,000 in Spain, Italy, Ireland, Egypt, and the Netherlands [23]. The rates of suicide among adolescents and young adults have increased considerably over the last decades

[24]. In addition to this in sub-Saharan Africa, death from suicide is estimated to be 34, 000 per year [25]. The prevalence of suicide ideation was estimated to be 7% in Tanzania [9], 6.2% in Seychelles [11], 31.3% in Zambia [12], 23.3% in Benin [6], and 21.6% in Uganda. This even occurs despite the fact that some mental health problems may arise from infectious diseases[26]. But in Ethiopia there were no adequate research on the magnitude or burden of suicidal ideation and attempts of all mental illness and also there were localized research was done and in addition there were no enough known research done on prevalence of the case at a national level of Ethiopia. This research contributes for those who will study further nationally on suicide ideation and attempts.

1.3 significance of the Study

Evidences have shown that people with severe mental disorders (SMD) are at higher risk of suicide. However, in low- and middle-income countries (LMIC), including Ethiopia there is limited research concerning suicide attempts and suicide ideations in people with severe mental disorders (SMDs) [27]. Most of the researches done were specific to one disease or factor but this study aims which psychiatry problem/mental health problem more likely disclose or affected by suicidal ideation and attempts and to give emphasis/attention for those highly risky patients. And there are many risk factors that increase the risk of suicide. This study will used to work on those factors and stakeholders can use this study for action plan of intervention. There were no adequate research done in Ethiopia on all mental health illness that increases to suicide ideation and attempts. So this study hoped to fill the gap of those neglected severe mental problems and to give attention. The objective of this study was to assess suicide ideation and suicide attempts in people with all mental illness (like depression, anxiety, schizophrenia, bipolar, mania and others) that diagnosed during data collection. Therefore, this study used to assess the prevalence and associated factors of suicidal ideation and attempt among mentally ill patients at psychiatry department in St. Paul's Hospital Millennium Medical College.

2. Literature Review

A cross-sectional survey was conducted in Peru with a sample of 916 secondary school adolescents in 2014 about factors Associated with Suicidal Ideation and Suicide Attempt. From the study a large number of factors; demographic, socio-environmental, psychological and behavioral factors are significantly associated with increased risk of suicidal ideation and suicide attempts. In this study, the prevalence of suicidal ideation and suicide attempt was 26.3% and 17.5%, respectively, which is relatively high when considering similar studies in various parts of the world. And to be a female and unhappy with their lives were associated suicidal ideation and attempts [27].

Across-sectional school-based study of 1067 students was done on prevalence and associated Factors of suicidal behavior among secondary School Students at Kut City/Iraq in 2007. From the study participants the prevalence of suicidal behavior among secondary school was 8.3%. And had association of suicidal behavior with the explanatory study variables like who felt loneliness, sadness, hopeless, sleep and appetite disturbance were more likely involved in suicidal behavior. And also shows that students who were subjection to corporal punishment and have poor grade level were more likely involved in suicidal behavior[28].

A cross sectional study done in Iran on suicidal ideation, plans, and attempts with 421 samples of Iranian Students: prevalence and some new risk and protective factors. From the total sample 80% of them were answered the question regarding the main suicide methods of suicidal ideation they thought of. Of these students, 17 (23.9%) thought of overdosing on medicines, 4 (5.6%) thought of eating poison, 6 (8.5%) thought of hanging, 6 (8.5%) thought of throwing oneself from a height, 4 (5.6%) thought of cutting their wrists, 3 (4.2%) thought of self- burning, 2 (2.8%) thought of stabbing oneself, 1 (1.4%) thought of using guns, and 1 (1.4%) thought of eating chalk. And students who reported suicide attempt in their lives, about 90% (30 subjects) answered the question regarding the main suicide method they actually used. Of these, 11 (33.3%) used overdosing on medicines, 5 (15.2%) used eating poison, 8 (24.2%) used hanging, 2 (6.1%) cut their wrists, 2 (6.1%) used stabbing, 1 (3%) used self- burning, and 1 (3%) used eating chalk [29].

A research done in Italy on Prevalence of suicide ideation, plans, and attempts and related risk factors in Italy which is cross sectional study: Results from the European Study on the Epidemiology of Mental Disorders-World Mental Health study. From the study the Presence of a mental disorder was significantly associated with risk factors like substance use disorders (OR, 6.7-59.8), followed by mood disorders (OR, 8.4-17.4) and anxiety disorders (OR, 4.9-9.9) [30].

A cross sectional study was done on prevalence and correlates of suicidal behaviors (ideation, plan and attempt) among adolescents in senior high schools Ghana. The prevalence of suicidal behaviors was 18.2%, 22.5% and 22.2% for suicidal ideation, suicidal plan and suicidal attempt respectively. A total of 317 (16.0%) of the participants reported feeling of anxiety during the past 12 months and 367 (18.4%) reported feelings of loneliness within the same time frame. About 43.8%, 37.5% and 28.2% of the participants reported to have been bullied, physically attacked and involved in a physical fight on once or more occasions respectively [31].

A study done in Nepal on factors associated with suicidal ideation and suicidal attempts among adolescent students: Findings from Global School-based Students Health Survey. It is across sectional study design. From study participants 4.36% had anxiety and 6.27% had felt lonely. Slightly 40.09% had experienced physical attack and 39.15% had been involved in physical fighting. Similarly, 6.17% had been using tobacco products and 8.58% had already initiated drug use. Around 13.59% had considered suicide while 10.33% had attempted suicide. Around 23.72% of study participants were of age 16 years or older [32].

A research done in South Africa on Suicidal ideation and attempt among South African medical students from the University of Pretoria (UP), the University of Cape Town (UCT) and the University of the Free State (UFS) were invited to participate in an anonymous and voluntary questionnaire. Across sectional study and a total of 874 medical students completed the survey. Most were in their 2nd and 3rd years and <25 years of age; 63% were female and 58% were in a current relationship. From them 11.9% of all students had a previous diagnosis of depression and 4.7% of another psychiatric diagnosis. Mood-enhancing medication had been used by 15.8%. A total of 37.5% of students answered that their 'Life is not worth living' and 32.3% reported suicidal ideation. The overall prevalence of suicidal attempt among medical students at the three universities was 6.2%. There were no significant differences between universities [33].

Another institutional based cross -sectional study was conducted on Prevalence of suicidal ideation and allied factors among patients with depressive disorder visiting psychiatry outpatient unit of Dessie referral hospital, South Wollo, Ethiopia. A systemic random sampling technique was used to get 423 patients from April to May 2015. Based on the study two hundred six (50.2%) of participants diagnosed as having depressive disorder for less than 1year. Regarding frequency of episode, 170 (41.2%) of study participants had experienced symptoms of depression within one week period and 219 (53.4%) every one week to one month period. One hundred ninety three (47.1%) reported that they had family history of

depressive disorder. And among those who have used these psychoactive substances majority, 157(83.1%) use khat. One hundred seventy two (42.0%) had current use of these substances [34].

A study done on behaviors among People with Mental Illness at Jimma University Teaching Hospital Psychiatry Clinic, South West Ethiopia and it is facility based cross-sectional study design with consecutive sampling technique was employed from October 26, 2014 to November 24, 2014. From the study the prevalence of suicidal ideation in the past one year was 115 (29.9%). Out of those 63 (54.8%) had once and 34 (29.6%) had twice suicidal ideation at two different point in time. And 109 (28.3%) patients had threat of suicide attempt or they told to other people as they were going to commit suicide. out of those 87 (79.8%) once and 22 (20.2%) more than once told to others. And Among 62 suicide attempters 47 (75.8%) were attempted at home. The most frequent means/methods used for suicide attempt were hanging in 28 (45.2%) followed by poison 11 (17.2%) and drug/medication overdose 10 (16.1%) [17].

Another institutional based cross -sectional study done conducted on prevalence and associate factors of suicidal ideation and attempt among people with schizophrenia at Amanuel mental specialized hospital Addis Ababa, Ethiopia. From study participants males 246(60.0%) were the highest one, with a mean age of 33.8 years ($33.8 + 10.753$ SD). Most of the respondents were single 258(62.9%) and unemployed 223 (54.4%). Two hundred sixty nine (65.9%) of the study participants were living with their family and 69 (16.8%) were living with spouse. From the study Participants 91 (22.2%) of them had planned to commit suicide and most of the participant 59(74.7%) attempt once in their life time experience [35].

3. Objective

3.1 General Objective

To assess the prevalence and associated factors of suicidal ideation and attempts among patients with mental illness at St. Paul's Hospital Millennium Medical College in- Addis Ababa, Ethiopia

3.2 Specific Objectives

- ✚ To assess the prevalence of suicidal ideation and attempts among patients with mental illness at St Paul's Hospital Millennium Medical College
- ✚ To determine the associated factors for suicidal ideation and attempts among psychiatry patients attending at SPHMMC.

4. Method

4.1 Study Area

St. Paul's Hospital Millennium Medical College was established at the center of the country, Addis Ababa, through a decree of the Council of Ministers in 2010, although the medical school was opened in 2007. And the hospital was established in 1968 by the late Emperor Haile Selassie. It is governed by a board under the Federal Ministry of Health. The college has more than 2800 clinical, academic, administrative and supporting staffs. St. Paul's hospital in addition to all medical services it also provide medical specialty services to patients who are referred from all over the country, teaching medicine and nursing students and doing basic and applied researches. And the inpatient capacity is more than 700 beds. The SPHMMC has many specialist programs and has many departments including Psychiatry department. The psychiatry department started around before 40 years i.e. in 1975 Ethiopian calendar and had 12 psychiatry specialists, 4 psychiatry nurses, 3 clinical nurses, 2 clinical psychologist and 2 masters in psychiatry. The service given in the department include all services given in OPD are given in it. But they only have an admission of substance abuse recuperation. The college establish public health department and teaches MPH in a weekend program and also start FETP program before 10 years.

4.2 Study design and period

Institutional based cross-sectional study design was employed and the study was conducted from December/2019 to January/2020.

4.3 Population

Source population: All new and old cases of mental illnesses that were attending at SPHMMC were considered as a source population.

Study Population: All patients with mental illness attending outpatient department of SPHMMC during the study period were considered as a study population.

4.4 Inclusion and Exclusion Criteria

4.4.1 Inclusion criteria

All adult aged 18 years and above diagnosed as a case of mental illnesses and had been attending the out-patient department of SPHMMC study period.

4.4.2 Exclusion Criteria

Patients who were severely ill and those having cognitive, communicating, those having dementia and hearing problems not included. And also those psychiatry patients who were not volunteer to participate in the study not included.

4.5 Study variables

Dependent variables

- ✚ Suicidal ideation and attempts

Independent variables

Socio-demographic; age, sex, occupation, education, social support, marital status, religion, ethnicity, socio-economy

Clinical Risk factors; diagnosis, duration of illness, stoping of medication, substance use, severity of illness, disability, family history of suicide, comorbidity of chronic disease

Social support of the patient

External (environmental) risk factors; Lone less, Hopeless, IDP, Academic failure, Death in family, Family conflict, Interpersonal conflict, financial loose

Suicidal methodes ; hanging, poisonong/drug over dose, electricity, self cutting, jumping from high buildings or lands and other

4.6 Operational Definitions

- **Suicidal ideation and attempts;** is defined as the respondent responds that he/she ever thought about or attempts him/herself.
- **Comorbid chronic physical/medical;** these patients come to psychiatry OPD that have chronic disease like TB, HIV, CA, DM and others.
- **Social Support; according to Oslo Social Support Scale (OSSS)** a score ranging from 3 to 8 is considered as poor social support, a score ranging from 9 to 11 is moderate social support and a score ranging from 12 to 14 is strong social support [36].
- **Diagnosis;** these are psychiatry cases/illness that was known during history taking of the patient.
- **Low income :** those who are their monthly income less than 1000 Et.Birr [37].

4.7 Sample size determination

The sample size was determined using single population proportion formula as follows.

$$n = \frac{(Z_{\alpha/2})^2 P(1-P)}{d^2}$$

Where P = the prevalence 64.8% (0.648) from Mekonen D. study [38], d= Absolute precision or tolerable margin of error (d) =5%=0.05. $Z_{\alpha/2}$ = Z value at ($\alpha = 0.05$) = 1.96 corresponding to 95% confidence level. After adjusting for 10% contingency for non-response rate, a total of 385 study populations were involved in the study.

4.8 Sampling technique and procedures:

All patients coming to SPHMMC psychiatry OPD during data collection period were included in the study by using consecutive sampling technique until the required sample size was achieved. Both new and follow up patients were included in the study.

4.9 Data collection procedures and instruments

Data was collected using interviewer administered structured questionnaire. The questionnaire includes questions related to patients socio-demographic characteristics and related factors, patient clinical characteristics, social support of the patient, environmental risk factors and the methods used for suicidal attempts, and items related to patients' suicide behavior i.e. ideation and attempt.

Patients were diagnosed by psychiatrists, psychiatry residents and senior or expert mental health professionals. Therefore, diagnosis and some clinical factors were reviewed from the patient's chart.

Items to assess suicide ideation and attempt were used adapted from Suicidal Behavior Questionnaire Revised (SBQ-R) [39] with modification. The items included in the questionnaire were; item 1 taps in to life time suicidal ideation and attempt, item 2 assesses the frequency of suicidal ideation over the past twelve months and item 3 taps into the threat of suicide behavior. Level of social support among patients with mental illness was assessed using the 3 item Oslo Social Support Scale (OSSS) and the scores range from 3-14 [40].

4.10 Data Processing and Analysis

Data were checked for completeness and consistency. Then they were coded and entered in the computer using Epi info version 7.2.1.0 software, exported to and analyzed using SPSS version 23 for cleaning and analysis. The patients' socio-demographic and clinical characteristics were analyzed using descriptive statistics i.e. frequencies and percentages were calculated for the

categorical variables. A binary and multivariable logistic regression analysis were used to measure the association between the dependent variable and independent variables using an OR and 95% CI. Variables having a p -value<0.2 in bivariate analysis were fitted to multivariable logistic regression. Those variables having P-value of less than 0.05 was used to determine significance. The strength of the association was presented by odds ratio at 95% confidence interval. Finally, the results of the study were summarized by using tables, graphs and narrative description.

4.11 Data quality Assurance

The English version questionnaire was translated to local language (Amharic) and back translated to English by independent person to check for consistency and understandability of the tool. Translation of questionnaire was done by the involvement of language experts. The data was collected by psychiatry nurses and supervised by expert mental health professionals. Training was given for data collectors and supervisors. The data collectors were 10 nurses and 2 supervisors. Pre-test was conducted on 5% of the study sample size at St. Peter Specialized Hospital among patients with mental illness before the main study was conducted to identify impending problems on data collection instruments and to check consistency of the questionnaires, and the performance of the data collectors. Identified problems were amended accordingly. Besides to these, the data collectors were supervised daily and the filled questionnaires were check daily by the supervisors and principal investigator.

4.12 Ethical considerations

Ethical approval and clearance for this study was obtained from IRB (the Institutional Research Board of St. Paul's Hospital Millennium Medical College). At all levels, concerned officials were communicated and permissions to conduct data collection were obtained. All the necessary explanation about the purpose of the study and its procedures were explained with the assurance of confidentiality. Written and verbal consent from the study participants were also secured.

4.13 Dissemination of results

The result of this study would be presented to SPHMMC departement of public health. Furthermore, the result will be disseminated to the hospital, federal ministry of health and other stakeholders both Non-governmental and Governmental organizations. In addition, efforts will be made to present the findings on different workshops and the manuscript of the research will be published in reputable national and international Scientific Journals with peer review.

5. Results

5.1 Socio-demographic Characteristics of the study participants

A total of 385 patients were enrolled to the study with the response rate of 100%. Of the total patients 216 (56%) were males. Their age ranges from 18 to 85 years. Of the total 197 (51%) were single, 166 (43%) were Orthodox Christian religion followers, 232 (48.9%) were illiterates, 140 (36.4%) of their education were from grade 9th to 12th and 77 (18.4%) were private/NGO employers as described in Table1.

Table 1; Socio-demographic characteristics of study participant patients with Mental Illness where attending the psychiatric department of SPHMMC, in Addis Ababa.

No.	Variables	Category	Frequency	Percent
1	Age	28-37 Years	133	34%
		18-27 Years	95	25%
		38-47 Years	79	21%
		>= 48 Years	78	20%
2	Sex	Male	216	56%
		Female	169	44%
3	Marital Status	Single	197	51%
		Married	126	33%
		Divorced	39	10%
		Widowed	23	6%
4	Religion	Orthodox	166	43%
		Protestant	111	29%
		Muslim	96	25%
		Other	12	3%
5	Ethnicity	Amhara	126	33%
		Oromo	123	32%
		Gurage	55	14%
		Tigre	28	7.5%
		Silte	27	7%
		Other	26	6.5%
6	Education	Illiterate	31	8%
		1-8 Grade	109	28%
		9-12 Grade	140	37%
		College and Above	105	27%
7	Occupation	Private/NGO Employee	71	18%
		No Job	60	16%

		Gov't Employee	59	15%
		House Wife	52	14%
		Merchant	42	11%
		Student	42	11%
		Daily Labourer	31	8%
		Farmer	8	2%
		Other	20	5%
8	Income	<1000 Birr	195	51%
		1000-2000 Birr	56	14%
		2000-4000 Birr	61	16%
		>= 5000 Birr	73	19%
9	Residence	Rural	23	6%
		Urban	362	94%
10	Social support	Poor	168	44%
		Moderate	136	35%
		Strong	81	21%

5.2 Clinical Characteristics of Participants

Off the total 297 (77%) of participants were diagnosed as mental illness cases before coming SPHMMC. As to the duration for being psychiatric patients among the study participants, 195 (51%) reported that they suffered from the mental illnesses for more than five years before coming to SPHMMC. Regarding the frequency of mental illness recurrences 108 (28%) of study participants were experienced single relapse during their illness period. And 183 (48%) of the participated had family history of mental illness. But most of the participants had no history of previous mental illness. And 156(41%) of the psychiatry patients had stop their prescribed medication (Table 2).

Table 2; Clinical characteristics of participants visiting psychiatric OPD of SPHMMC, Addis Ababa, 2020

No.	Variables	Category	Frequency	Percent
1	Having mental illness before coming here?	Yes	297	77%
		No	88	23%
		>60 Months	195	51%
		13-60 Months	82	21%
		<= 12 Months	20	5%
3	Having Chronic Diseases	Yes	51	13%
		No	334	87%

4	Family Hx of Mental Illness	Yes	183	48%
		No	202	52%
5	Family Hx of Suicide	Yes	79	21%
		No	306	79%
6	Stopping Of Medication	Yes	156	41%
		No	229	59%
7	Recurrence/relapse of the illness	No relapse	151	39%
		Single	108	28%
		2-4	92	24%
		5 and above	19	5%
		Continues	15	4%
8	Substance Use	Yes	89	23%
		No	296	77%
9	Substance	Khat	72	19%
		Alcohol	70	18%
		Cigarette	70	18%
		Hashish	9	2%
		Cocaine	2	1%
10	Other Substance	Ganja	8	2%
		Canabis	1	0.50%

From all respondents of psychiatry patients, 106(28%) of them had major depression disorder and the lowest percentage of the case were those patients or participants that had other mental illness were 17(3%). Other mental illness include dysthymia, insomnia, epilepsy, social phobia, post prenatal psychosis, post traumatic disorder, dementia and hypersomnia. (See figure 1.)

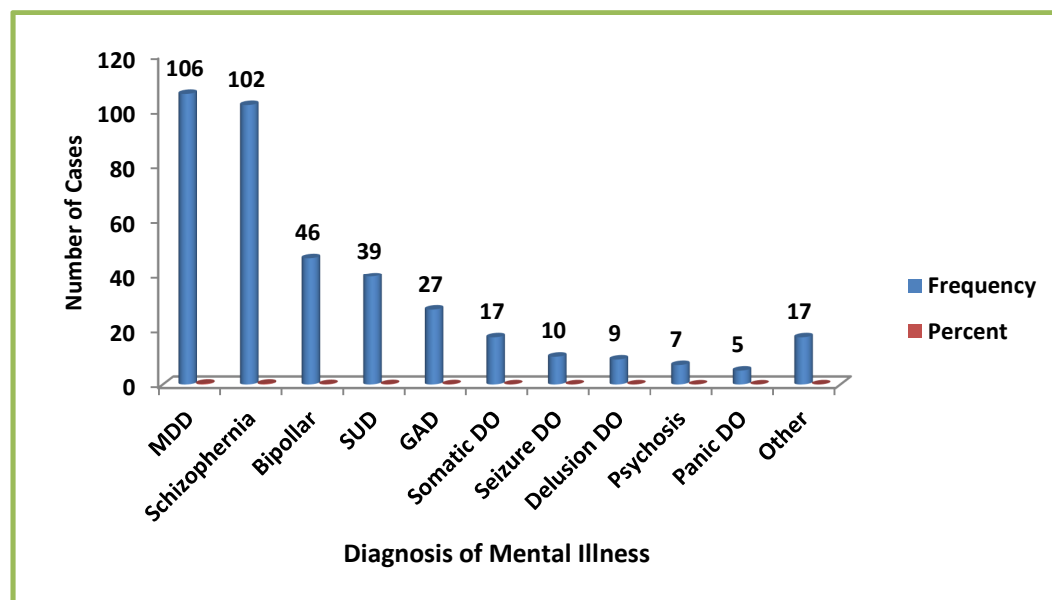


Figure 1; Types of Metal illnesses diagnosed among study participant patients in SPHMMC, Addis Ababa, Ethiopia, 2020 (n=385)

From all respondents that were both suicidal ideation and attempts which diagnosed MDD were 71 (34.4%) and the lowest percentage both suicide ideation and attempts which diagnosed like social phobia and others had 1(0.5%). (See table 3)

Table 3; Mental Illnesses diagnosed among the study participants and those who reported in both in Suicidal Ideation and Attempts during study period, SPHMMC; 2020

Sno.	Variable (Diagnosis)	Suicidal Ideation and Attempts	
		Frequency	Percentage
01	MDD	71	34.4%
02	Schizophrenia	53	25.6%
03	Bipolar	28	13.5%
04	SUD	21	10%
05	GAD	14	7%
06	Seizure DO	7	3.4%
07	Somatic DO	4	2%
08	Other Mental illness*	9	4%

* other illness include Epilepsy 3, Panic DO 2, Hypersomnia 1, social phobia, 1, post prenatal psychosis 1 and post traumatic 1

5.3 Prevalence of Suicide Ideation and Attempt

The prevalence of suicide ideation among 385 respondents was 255 (66.2%) [Males =143 (37%), females=112 (29%)] and the magnitude of suicide attempt was 210 (55%) [Males =115 (30%), females=95 (25%)]. And from the study participants 207(54%) of them had thought of suicide and attempt. And 19 (5%) of them were told to someone that were going to commit suicide or that might to do it in their life time experience. (Table 4)

Table 4; Frequency distribution of suicide ideation and attempt among Mental Ill Patients in SPHMMC, Addis Ababa, Ethiopia, 2020 (n=385)

Variable	Category	Frequency	Percent	Male	Percent	Female	Percent
Have you ever thought about killing yourself?	Yes	255	66%	143	37%	112	29%
	No	130	34%	73	19%	57	15%

Have you ever attempted to kill your self	Yes	210	55%	115	30%	95	25%
	No	175	45%	101	26%	74	19%
Suicidal Ideation and attempts?	Yes	207	54%	113	29%	94	25%
	No	178	46%	103	27%	75	19%
Have you ever told someone commit suicide	Yes	19	5%	12	3%	7	2%
	No	239	62%	133	35%	106	28%
Suicidal Ideation or attempts?	Yes	258	67%	145	38%	113	29%
	No	127	33%	71	18%	56	15%

Among all mental patients of the participants the age of 28-37 years of suicidal ideation, suicidal attempts, suicidal ideation and attempts and suicidal ideation or attempts were the most affected age group. (See the following figure)

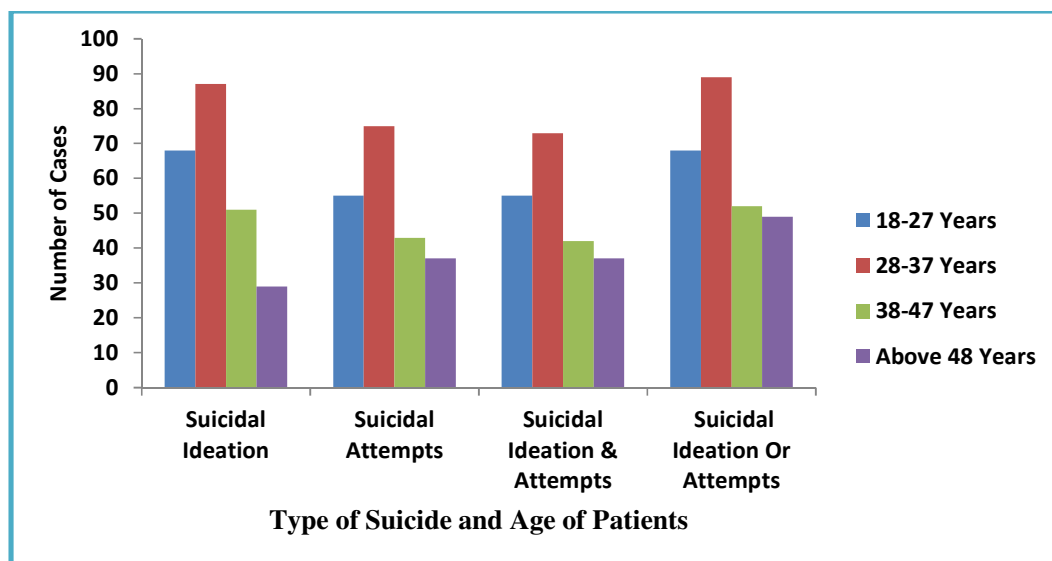


Figure 2; Distribution of suicide Ideation and attempt by age among Mental Ill Patients of Psychiatry OPD of SPHMMC, Addis Ababa, Ethiopia, 2020 (N=385)

When we saw the frequency of the suicide ideation and attempt that tried to kill them the rarely or one time frequency is the highest one. See the following pie chart. (Figure 3)

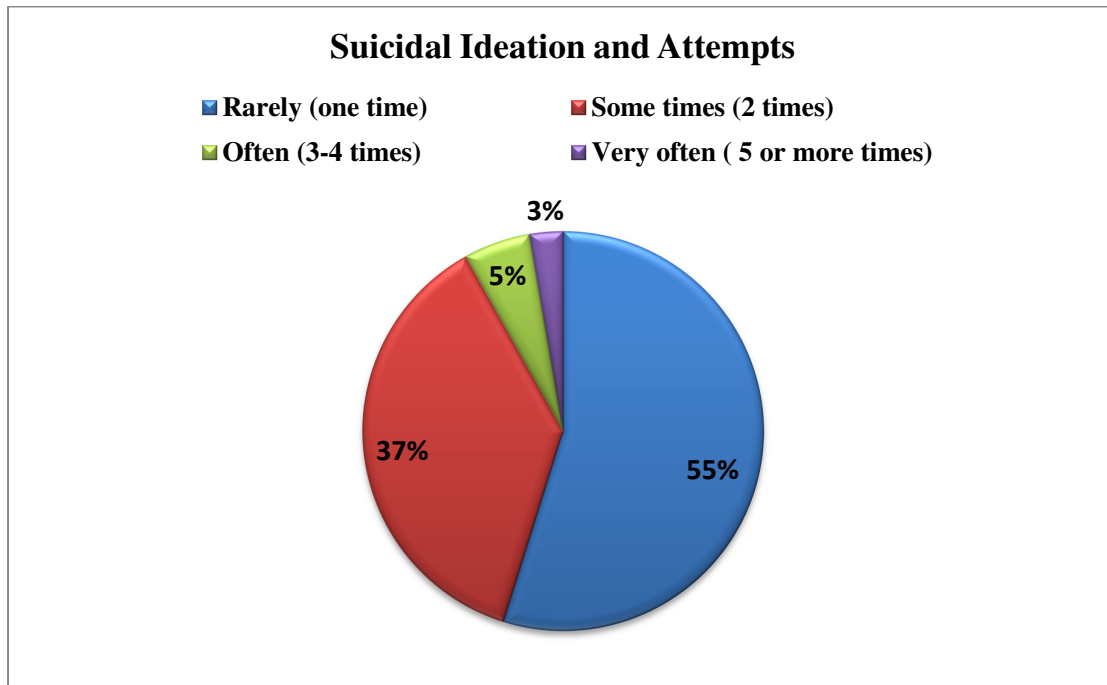


Figure 3; Percentage distribution of frequency of suicide Ideation and attempt among Mental Ill Patients in SPHMMC, Addis Ababa, Ethiopia, 2020 (n= 385)

5.4 Methods of Suicidal Ideation and Attempts

From all methods listed in the questionnaire and the participants apply on them and think to kill themselves based on sex were drug over dose/poisoning were the highest one Female (51) and male (47). See the following figure 4.

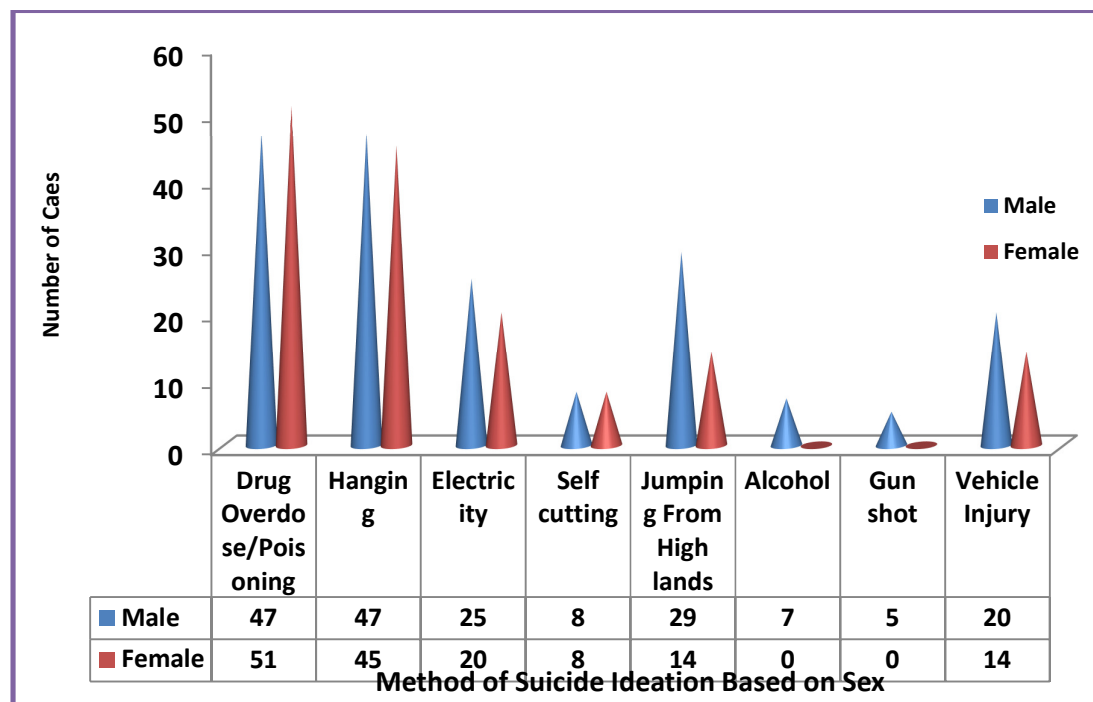


Figure 4; Frequency Distribution of Methods of Suicidal Ideation and Attempts by sex among Mentally Ill Patients in SPHMMC, Addis Ababa, Ethiopia, 2020

5.5 Factors associated with suicidal ideation and attempt

5.5.1 Bivariate Analysis

From the bivariate analysis of suicide ideation and attempts in relation to each descriptor variables age, marital status, occupation, education, religion, monthly income, residence of the participant, duration of the mental illness, family history of the mental illness, family history of suicide, stopped medication of mental illness, social support of Oslo scale, recurrence/relapse of the mental illness, current psychiatric diagnosis, felt hope less, having mental health and death in family were variables that fulfilled the minimum requirement (0.2 level of significance in this study) for further assessment and entered in to multivariate logistic regression. Variables like sex, ethnicity, place of residence, chronic diseases, in general substance in use (khat, cigarette, alcohol, hashish, cocaine and other), disability, lone less, insight, family conflict, economic burden, academic failure, interpersonal conflict and to be IDP were not significant at 0.2 level of significance and were excluded from further analysis. (See table 4)

Table 5; Bivariate Logistic Regression Results of suicide ideation and attempt among Mental Ill Patients in SPHMMC, Addis Ababa, Ethiopia, 2020 (n=385)

Variables	Category	Suicide ideation and attempt		COR (95% CI)	P-Value
		Yes	No		
Age	18-27 years	55	40	1.348(0.770, 2.361)	0.296
	28-37 years	73	60	1.524(0.834, 2.784)	0.171
	38-47 years	42	37	1.258(0.672, 2.352)	0.473
	≥ 48 years	37	41	1	
Marital status	Single	111	86	0.830(0.343, 2.007)	0.679
	Divorced	14	25	0.360(0.124, 1.042)	0.060
	Married	68	58	0.754(0.304, 1.868)	0.541
	Widowed	14	9	1	
Educational status	Illiterate	12	19	0.669(0.295, 1.515)	0.335
	1-8 th grade	60	49	1.297(0.757, 2.219)	0.344
	9-12 th grade	84	56	1.588(0.953, 2.267)	0.076
	≥ College	51	54	1	
Occupation	Farmer	5	4	1.500(0.288, 7.807)	0.630
	Housewife	32	21	2.400(0.836, 6.891)	0.104
	Merchant	22	21	1.650(0.560, 4.860)	0.364
	Gov't employee	31	28	1.661(0.593, 4.653)	0.335
	Private/NGO employee	37	38	1.378(0.503, 3.779)	0.533
	Student	25	16	2.437(0.820, 7.250)	0.109
	Daily labor	22	20	1.821(0.582, 5.698)	0.303
	Jobless	33	29	1.833(0.655, 5.131)	0.248
	Others	5	5	1	
Income	<1000	113	82	1	
	10001-2000	28	28	0.726(0.400, 1.317)	0.292
	2001-4000	29	32	0.658(0.369, 1.171)	0.155
	>4000	37	36	0.746(0.435, 1.280)	0.287
Residence	Rural	11	12	1	
	Urban	196	166	1.28(0.55, 2.99)	0.557
Family history of mental illness	Yes	119	64	2.40(1.59, 3.63)	0.000
	No	88	114	1	
Family history of suicide	Yes	59	20	3.14(1.80, 5.48)	0.000
	No	148	158	1	
On medication for mental illness	Yes	183	147	1	
	No	24	31	0.62(0.35, 1.11)	0.106
Stop medication	Yes	108	48	2.95(1.924, 4.537)	0.000
	No	99	130	1	
Current psychiatric diagnosis	Schizophrenia	52	50	1	
	MDD	97	40	1.61(0.93, 2.76)	0.090
	Bipolar D/os	28	18	1.49(0.73, 3.03)	0.265
	Other Psychotic D/os	3	14	0.20(0.05, 0.76)	0.018
	Anxiety disorders	18	17	1.02(0.47, 2.19)	0.963
	SUD	21	18	1.12(0.53, 2.35)	0.761
	Somatic D/os	4	13	0.29(0.09, 0.96)	0.044

	Other D/os	14	8	1.68(0.65, 4.35)	0.284
Social support	Poor	112	56	2.27(1.60, 4.77)	0.000
	Moderate	61	75	1.12(0.64, 1.96)	0.679
	Strong	34	47	1	
Feeling of hopeless (N=258)	Yes	153	29	2.14(1.13, 4.05)	0.018
	No	54	22	1	
Duration of Illness (N=297)	≤12 months	10	10	0.95(0.37, 2.38)	0.913
	13-60 months	51	31	1.56(0.92, 2.64)	0.097
	≥61 months	100	95	1	
Recurrences/relapse of Mental illness	Continue	11	4	5.39(1.63, 17.77)	0.006
	Single	61	47	2.54(1.53, 4.23)	0.000
	2-4	69	23	5.88(3.29, 10.50)	0.000
	>5	15	4	7.35(2.32, 23.30)	0.001
	No relapse	51	100	1	
Family Death	Yes	48	7	1.89(0.80, 3.04)	0.183
	No	159	44	1	

5.5.2 Multivariable Analysis

The multivariable logistic regression which controls the effect of confounding variables was used by taking all covariates into account simultaneously for suicide Ideation and attempts. Analysis was done after adjusting those variables that fit a p-value of 0.2 in the bivariate analysis and was accepted to export to the multivariate analysis. A p-value of 0.05 was stated to be statistically significant. (See table 6)

In the final model, among the many variables included in the multivariable logistic regression analysis being divorced, felt hopeless, family history of mental illness, primary and secondary education, family history of suicide, stop taking of psychiatric medication, diagnosis of other psychotic disorder and poor social support were the independent predictors of suicidal ideation and attempt among people with mental illness.

Accordingly who have education of primary and secondary have more likely suicide ideation and attempts than those educate college and above. [AOR =5.86, 95% CI (1.30, 26.41) and AOR=3.61, 95% CI (1.01, 12.88)] respectively. And stopped of the requested medication of the mental illness have 2.56 more likely than those not stopped. [AOR=2.56, 95% CI (1.00, 6.53)].

Table 6; Multivariable logistic regression on Prevalence and Associated Factors of Suicidal Ideation and Attempts Among Mentally Ill Patients In Psychiatry OPD at SPHMMC, In Addis Ababa, Ethiopia, 2020 (n=385)

Variables	Category	Suicide ideation and attempt		AOR (95% CI)	P-Value
		Yes	No		
Marital status	Single	111	86	1	
	Divorced	14	25	0.31(0.11, 0.85)	0.022
	Married	68	58	0.90(0.45, 1.81)	0.771
	Widowed	14	9	1.61(0.39, 6.58)	0.506
Educational status	Illiterate	12	19	7.71(0.84, 70.44)	0.070
	1-8 th grade	60	49	5.86(1.30, 26.41)	0.021
	9-12 th grade	84	56	3.61(1.01, 12.88)	0.048
	≥ College	51	54	1	
Social support	Poor	112	56	2.25(1.14, 4.46)	0.020
	Moderate	61	75	0.66(0.33, 1.35)	0.667
	Strong	34	47	1	
Family history of mental illness	Yes	119	64	1.94(1.12, 3.36)	0.017
	No	88	114	1	
Family history of suicide	Yes	59	20	2.44(1.17, 5.08)	0.017
	No	148	158	1	
Stop psychiatric medication	Yes	108	48	2.56(1.00, 6.53)	0.049
	No	99	130	1	
Current psychiatric diagnosis	Schizophrenia	52	50	1	
	MDD	97	40	1.70(0.85, 3.42)	0.135
	Bipolar D/os	28	18	1.49(0.62, 3.60)	0.377
	Other Psychotic D/os	3	14	0.13(0.03, 0.61)	0.010
	Anxiety disorders	18	17	1.68(0.66, 4.28)	0.278
	SUD	21	18	1.39(0.45, 4.34)	0.561
	Somatic D/os	4	13	0.47(0.10, 2.13)	0.325
	Other D/os	14	8	2.29(0.72, 7.28)	0.159
Felt hopeless	Yes	153	29	2.79(1.11, 6.98)	0.028
	No	54	22	1	

6. Discussion

This study was conducted on prevalence and associated factors of suicidal ideation and attempts among mentally ill patients in psychiatry OPD at St. Paul hospital millennium medical college, in Addis Ababa, Ethiopia. Among the participants males have higher magnitude of mentally ill than females. And clinically most of the mentally ill patients were their duration of illness is more than 5 years.

In this study the socio-demographic of the participants sex was differ from other study. In our study Males = (56%) and females= (44%) respectively. This is higher than study done in Dangla in male sex and lower than in female sex (male=48.3% and female = 51.7%) respectively [18]. This is might be high social activity participation or suppress of female than male in that study area. And lowers than that of study done in Gondar Hospital (M=54% and F=46% respectively) [37] and in Istanbul Turkey (Female=30.8% and Male= 69.2%) [40]. But many studies show that males had more suicidal ideation and attempts than females.

On this study the prevalence of Suicidal ideation and attempts was 207 (54%). This finding was higher when compared to a community based studies done in Addis Ababa, which was 2.7% [41]. The reason for the higher magnitude of suicidal ideation and attempts could be due to the difference in study population. And lower compared to the study finding in Gondar which was 64% [38]. And higher than that of study done in Ghana (18.5%) [31] and Palestine (24.6%) respectively [13]. this might be due to differences in the meaning of suicidal thoughts and normative attitudes towards suicide across diverse cultural, religious and economic settings.

This study also found that most adolescents used drug over dose/poisoning as a preferable method to attempt suicide in both sexes but with higher number of preference in female. Which is 48% (M=23% and F= 25%). This study is slightly similar to study done in Fitch 48.9% (M= 23.3% and F= 25.6%) [43]. This might be due to high presence and simple use of drug in both study areas. Our finding was higher than that of study done in Korean (34.9%) [44] and Iranian (33.3%) [29] Respectively. And lower than that of study done in Japan (87.5%) [45]. these differences might be due to cultural difference, availabilities of methods and knowledge of participants.

There are many studies done on educational level of suicidal behavior in the world including our country. In our study primary and secondary education level had likely risk of or positive association of suicidal ideation and attempts. And this study was higher than that of Study done in Amanuel hospital to be primary and secondary education level [AOR= 1.63(0.68, 3.89) and AOR=

2.51(1.11, 5.68) respectively] [35]. This might be due to academic failure or low satisfaction by education in the future of their job.

In addition hopelessness was more likely risk of or positive association with suicidal ideation and attempts which was 2.79 times risk of association. Our study was slightly higher than that of study done in Amanuel hospital [AOR= 2.510 (1.459, 4.320)] [35]. This is might be due to those psychotic patients who won't see futurity and have no any plan to live and were not thinking positively and not eager to use any opportunities which make them in a better position.

Previous studies indicated that marriage could be protective against suicide. Similarly, in our study, we examined that suicide behavior was significantly less common in patients with mental illness who were divorced as compared from those who were single or never married. This study was lower than that of study done in America [AOR=2.1, 95 CI (1.83–2.33)] [46]. Thus, studies further suggested that the highest risk increase is in never married people than separated or divorced [47]. Similarly, being single was associated with increased risk of female suicide in 20–34 year-olds [48]. Furthermore, poor social support was one of the predictors of suicidal behavior in this study. Individuals who had poor social support were 2.25 times more likely to have suicidal ideation and attempt than patients who had strong social support. This was similar to results from recent studies [8, 42, and 49].

In this study patients with family history of mental disorders was significantly increase the rate of suicidal ideation and attempt, which is 1.94 times more likely risk of suicidal ideation and attempts. Which is slightly lower than or comparable to a study done at Jimma university hospital psychiatry out patients; [AOR=2.25(1.11, 4.57)] [17]. In addition, suicide behavior was more likely to happen in patients with family history of suicide behavior when compared with patients without such had not a family history of suicide. Our finding seemed to be similar with studies showing that suicide history in the family increase risk of suicide behavior in patients with mental illness [50, 51]. Fabien T. and his colleagues in their study indicated that a family history of suicide was significantly increasing the risk of history of suicide attempt, higher lethality and frequency of suicide attempt [52].

Also, we found out that patients who did not stop their psychiatric medication were 20% less likely to have suicide ideation and attempt. It is fact that patients who are adherent well to their treatment had decreased symptomatology and become functional socially and occupationally. This reduces stigma and increases self-esteem and inspires hope in people with mental illness which indirectly reduces the risk of suicide [53]. Contrary to previous studies [54], this study found out

those patients with other psychotic spectrum disorder such as brief psychotic disorder, schizophreniform disorder, post-partum psychosis etc. have 87% less likely to have suicidal ideation. The possible explanation may be schizophrenia is more severe and chronic than other psychotic disorders. And those other psychotic illnesses were a short term disease or less than six months.

7. Limitation

- ❖ Institutional based studies could not address those patients outside the institution.
- ❖ We assessed the life time prevalence of suicidal ideation and attempt than the point or current prevalence during the stated period of time.
- ❖ This study assessed their status of suicidal ideation and attempt based on their stated response; on this case individuals may not disclose their actual thought or attempt about suicide.
- ❖ The sampling method was non probability of consecutive sampling method up to the sample size was achieved.

8. Conclusion

In our study from socio-demographic of sex males were more affected by suicidal ideation and attempts than female.

The prevalence of suicide ideation and attempt were high showing a significant public health issue among hospital attending and chronic mentally ill patients' that requires a great emphasis.

Most mentally ill patients used poisoning/drug over dose as a preferable method in attempting suicide in both sexes with higher number of preference in female, but hanging was highly preferred by males.

In our study there were risk factors that associated with suicidal ideation and attempts. These risk factors were being primary and secondary grade/school, felt hopeless, stop medication of the mental illness, family history of mental illness, family history of suicide, marital status of divorced, social support of the patient and current psychotic diagnosis of other diagnosis of the illness had positively or more likely risk of association with suicidal ideation and attempts.

9. Recommendation

- ✚ There should be a support for those had psychotic problem by their family, government or NGO's.
- ✚ Parents should be closely attend and took to health facilities for those patients that had short term psychotic problems.
- ✚ And suicide prevention needs to involve different actors and disciplines working on suicide non-governmental and non-profit organizations, universities and civil society at different levels. Because these organization can prevent suicide before creation by supporting them.
- ✚ There should be Political commitment for ensuring that suicide prevention receives the resources and attention that it requires from national, state and local leaders.
- ✚ Early detection and intervention could be most important prevention strategy of suicide in patients with mental illness. Thus, in every health facilities clinicians are strongly recommended in identifying those patients with the high risk factors distinguished above.
- ✚ Prediction of suicide in patients with mental illness is complex and difficult, and efforts at prevention should also focus on optimizing social support and adherence of psychiatric medication for people with mental illness.
- ✚ The SPHMMC should have a different psychiatry treatment centre and rehabilitation centre that separated from other service.
- ✚ EPHI should also conclude mental health under surveillance system.

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11. Annexes

11.1 Consent Form

Introduction

We are interviewing people here in St. Paul hospital millennium medical college in psychiatry OPD for study. The purpose of this study is to identify the prevalence and risk factors associated with suicidal ideation and attempts among mental health patients to help policy makers to plan and take measures regarding health and health related problems.

Confidentiality and consent: “I am going to ask you some very personal questions. Your answers are completely confidential. Your name will not be written on this form, and will never be used in connection with any of the information you tell me. You do not have to answer any question that you do not want to answer, and you may end this interview at any time you want to. However, your honest answers to these questions will help us better understand the prevalence and risk factors associated with suicide. We would greatly appreciate your help in responding to this survey. The survey will take about 15-20 minutes to ask the questions.

Would you be willing to participate?

1. Yes 2. No

If you are willing to participate, please continue to respond to the interview.

Name of data collector_____ signature_____

Thank you very much for your cooperation

11.2 Questionnaire

S. No.	Socio-demographic and clinical characteristics of the patient			
Q.101	Age _____			
Q.102	Sex	1- Male	2- Female	
Q.103	Marital status	1- Single	2- Divorced	3- Married 4- Widowed
Q.104	Religion	1- Muslim	2- Orthodox	3- Protestant 4- Others specify _____
Q.105	Ethnicity	1- Amhara	3- Tigre	2- Oromo 4- Others, specify _____
Q.106	Educational status	1- Illiterate	3- 9-12 th grade	2- 1-8 th grade 4- College and above
Q.107	Occupation	1- Farmer	5- Private/NGO employee	2- Housewife 6- Student
		3- Merchant	7- Unemployed	4- Gov't employee 8- Others, specify _____
Q.108	Average monthly income		_____ ETB	
Q.109	Place of residence	1- Rural	2- Urban	
Q.110	Age at first onset of illness _____			
Q.111	Do you have any physical/medical illness diagnosed by physician like DM, HTN, CA, HIV/AIDS, etc.?		1- Yes 2- No	
Q.112	Do you have any family history of mental illness?		1- Yes 2- No	
Q.113	Family History of suicide		1- Yes 2- No	
Q.114	Have you mental illness/problem before coming here? 1-yes 2-No			
Q.115	If Q.115 Yes Duration of illness		a. <= 12 months b. 13-60 months c. >60 months	
Q.116	Did you on medication of the mental illness?		1-yes 2-No	

Q.117	Did you stop medication that prescribed by physician? 1-Yes 2-No
Q.118	Number of recurrence/relapse 1- Continues 2- Single 3- 2-4 4- 5 and above 5- No relapse
Q.121	Now what is the diagnosis _____
Q.122	Observe the functionality or the disability 1-yes 2- No

PART II; Oslo Social Support Scale to assess social support of the patient

S.No	Item	1	2	3	4	5
Q.123	How many people are so close to you that you can count on them if you have serious problem?	None	One or two	3-5	Above 5	—
Q.124	How much concern do people show in what you are doing?	None	Little	Uncertain	Some	A lot
Q.125	How easy can you get help from neighbors if you should need it?	Very difficult	Difficult	Possible	Easy	Very easy

Q.126	Have you ever thought about or attempted to kill yourself?	1. yes 2. No
Q.127	How often have you thought about killing yourself in the past year?	1) Never 2) Rarely (1 Time) 3) Sometimes (2 Times) 4) Often (3-4 Times) 5) Very Often (5 or more times)
Q.128	Have you ever told someone that you were going to commit suicide, or that you might do it?	1) Yes 2) No

PART III; Factors associated with suicide ideation and attempt

Q.201	Felt hopeless	1- Yes	2- No
Q.202	Feeling lone less	1- Yes	2-No
Q.203	Having insight	1- Yes	2-No
Q.204	Ever substance used?	1-Yes	2- No
Q.205	If Q31 yes what are they?	i. Alcohol ii. Khat iii. Hashish iv. Cocaine v. Cigarette vi. All drug use vii. Other type of drugs	a. yes b. No a. yes b. No a. yes b. No a. yes b. No a. yes b. No
Q.206	Can you tell us the reason for suicide attempt and ideation?	a. Family conflict b. Economic burden/financial loose c. Death in family d. Mental illness/problem e. Academic failure f. Interpersonal conflict g. IDP h. Others	
Q.207	Family history of mental illness	1- Yes	2-No
Q.208	Family history of suicide	1- Yes	2-No
Q.209	Suicide attempts involves which of the following	a. Drug overdose/poisoning b. Hanging c. Electricity d. Self -cutting e. Jumping from high lands or buildings f. Shooting g. Alcohol h. Vehicle injury i. Other	

11.3 Annexes Amharic Translation

የመረጃ እና የፈቃደኝነት መግለጫ ውል ቅጽ

መግቢያ

በቅዱስ ፓውሎስ ሆስፒታል ሜሊኒየም ህክምና ኮሌጅ የስነ አእምሮ ህክምና ክፍል ለጥናት ይረዳን ዘንድ የተያዩ ጥያቄዎችን ሀሙሳን እንጠይቃለን። የጥናቱ ዋና አላማ የአእምሮ ሀሙሳን እራስን የማጥፋት እሳቤ እና እራስን የማትፋት ሙከራ ስረጭት እንደዚሁም ለዚሁ ችግር አባባሽና አጋላጭ ምክኒያቶችን ለማወቅ ይረዳን ዘንድ የሚደረግ ጥናት ነው። በተጨማሪም ይህ ጥናት ለፖሊሲ አውጪዎች ዕቅድ ለማቀድ እና ለችግሩ ዘላቂታዊ መፍትሄ ይረዳ ዘንድ ከፍተኛ አስተዋጽኦ ያደርጋል።

የፈቃደኝነትና ሚስጥራዊነት ስምምነት፤ “የተወሰኑ ግለሰባዊ ጥያቄዎችን አጠይቀዎታለሁ። ስምዎት በዚህ ቅጽ ላይ አይጻፍም፤ ለሚሰጡን ምላሽ እና ሌሎችም ሚስጥራዊነቱ የተጠበቀ ነው። ያልፈለጉትን ጥያቄ ያለመመለስ እና በፈለጉት ሰዓት ጥያቄውን ማቋረጥ ይችላሉ። ነገር ግን የርሶዎ ታማኝ ምላሽ እና ተሳትፎ ለጥናቱ ማለትም እራስን የማጥፋት እና ተያያዥ ችግሮች ስረጭትን ለማወቅ እጅግ ወሳኝ ነው። በቅድሚያም በዚህ ጥናት ላይ ለቃለመጠይቁ ስለተባበሩን እጅግ በጣም አድርገን እናመሰግናለን። ጥያቄውም ከ15-20 ደቂቃ የሚወስድ መሆኑን ልንገልጽለዎት እንወዳለን።

ለቃለ-መጠይቁ ለመሳተፍ ፍቃደኛ ነዎት?

1. አዎ

2. አይ

ለቃለ-መጠይቁ ፈቃደኛ ከሆኑ የሚከተሉትን ጥያቄዎች ይመልሱ

የጠያቂው ስም----- ፊርማ-----

ስለትብብረዎ በጣም አድርገን እናመሰግናለን።

የመጠይቅ ቁጥር _____

የጤና ድርጅቱ ስም _____

የመረጃ ሰብሳቢው ስም _____ ፊርማ _____ ቀን _____

የተቆጣጣሪው ስም _____ ፊርማ _____ ቀን _____

ተ.ቁ	ጥያቄ	መልስ
ክፍል አንድ፤ አጠቃላይ መረጃ እና ጤና ነክ መረጃ		
101	ዕድሜ	-----ዓመት
102	ጾታ	1. ወንድ 2. ሴት
103	የጋብቻ ሁኔታ	1. ያላገባ(ች) 2. ያገባ(ች) 3. አግብታ(ቶ) የፈታ(ች) 4. የሞተባት (የሞተበት) 5. ሌላ ካለ ይግለጹ
104	ሃይማኖት	1. ሙስሊም 2. ኦረቶዶክስ ክረስቲያን 3. ፕሮቴስታንት 4. ሌላ (ይግለጹ)
105	ብሄር	1. አማራ 2. ኦሮሞ 3. ትግሬ 4. ሌላ(ይግለጹ)
106	የትምህርት ሁኔታ	ሀ. ያልተማረ ለ. 1-8ኛ መ. 9-12ኛ ሠ. ኮሌጅ እና ከዚያ በላይ
107	የስራ ሁኔታ	1. ግብርና 2. የቤት እመቤት 3. ነጋዴ 4. የመንግስት ተቀጣሪ 5. NGO/የግል ድርጅት ተቀጣሪ 6. ተማሪ 7. የቀን ሠራተኛ 8. ሌላ(ይግለጹ)
108	የቤት የወር ገቢዎ በገንዘብ ቢተመን ምን ያህል ይሆናል ?	-----የኢትዮጵያ ብር
109	የመኖሪያ ቦታ	1. ገጠር 2. ከተማ
110	እዚህ ሆስፒታል ከመምጣትዎ በፊት የአዕምሮ በሽታ ነበረበዎት ?	1. አዎ 2. አይ
111	ጥ. 110 መልሱዎ አዎ ከሆነ በሽታዉ ሲጀምረዎት ዕድሜዎት ስንት ነበር ?	-----ዓመት
112	ጥያቄ 110 መልሱዎ አዎ ከሆነ ምን ያክል ጊዜ ሆነዎ ?	1. አንድ ዓመትና ከዛ በታች 2. ከ 1-5 ዓመት 3. ከ 5 ዓመት በላይ
113	በሀኪም የተነገረዎት እንደ ስኩዋር፣ ካንሰር፣ ደም ግፊት፣ ቲቢ፣ HIV እና ሌሎች በሽታዎች አለበዎ ?	1. አዎ 2. አይ

114	በቤተሰቦች የአእምሮ በሽታ ታሪክ/ህመም አለ?	1. አዎ 2. አይ
115	እራስን የማጥፋት ታሪክ በቤተሰብ አለ?	1. አዎ 2. አይ
116	ለአዕምሮ ህመሙ መድሃኒት እየወሰዱ ነው?	1. አዎ 2. አይ
117	የታዘዘለዎትን መድሃኒት አቁዋርጠዋል?	1. አዎ 2. አይ
118	የአዕምሮ ህመሙ ስንት ጊዜ ተነሳበዎት ወይም አገረሽበዎት?	1. ሁሌም 2. አንድ ጊዜ 3. 2-4 ጊዜ 4. 5 እና ከዚያ በላይ 5. ምንም
119	በላፈው 1 ዓመት ማንኛውንም አደንዛዥ እጽ ይጠቀሙ ነበር?	1. አዎ 2. አይ
120	ጥ. 119 መልሰዎ አዎ ከሆነ ምን አይነት እጾችን ይጠቀማሉ?	-----
121	አሁን የበሽታዎ ዓይነት ?	-----
122	የአካል ጉዳተኝነት ሁኔታ (መመልከት)	1. አለ 2. የለም

ክፍል ሁለት፣ የአስሉ ማህበራዊ ድጋፍን ስኬልን የተመለከተ መረጃ

ተ.ቁ	ተራ ቁጥር	1	2	3	4	5
201	ምን ያህል የቅርብ ሰው አለዎት አስቸጋሪ ነገር ቢገጥምህ ሃሳብዎን የሚያካፍሉት ?	ምንም	1 - 2	3-5	ከ5 በላይ	-
202	የርሶዎ የቅርብ ሰው የሚሉት እርሶዎ በሚሰሩት ስራ ምን ያክል ግድ ይላቸዋል /ያሳስባቸዋል ?	ምንም	ጥቂት	እርግጠኛ ያልሆነ	የተወሰነ ብዙ	
203	የጎረቤቶቻችሁ/ሽ እርዳታ ቢያስፈልግህ/ሽ በቀላሉ እንዴት ታገኛቸዋለህ/ሽ ?	በጣም አስቸጋሪ	አስቸጋሪ	ይቻላል	በቀላሉ	በጣም በቀላሉ

204	እራስዎን ለማጥፋት አስበዉ ያዉቃሉ ?	1. አዎ 2. አይ
205	እራስዎን ለማጥፋት ሙከራ አድርገዉ ነበር?	1. አዎ 2. አይ
	ጥ. 26/27 መልሰዎ አዎ ከሆነ ምን ያክል ጊዜ ሞክረዋል ወይም አስበዋል ?	ሀ. ምንም ለ. አንድ ጊዜ ሙ. ሁለት ጊዜ ሰ. 3-4 ጊዜ ፈ. በጣም ብዙ ጊዜ (5 ና ከዛ በላይ)
206	እራስዎን ለማጥፋት ሲያስቡ ወይም ሲሞክሩ ለሰዉ ይነግሩ ነበር ?	1. አዎ 2. አይ

ክፍል ሦስት፤ እራስን የማጥፋት ሃሳብ እና ሙከራ አባባሽ ችግሮች መረጃ (ጥ. 204 እና 205 መልሰዎ አዎ ከሆነ)

301	ተስፋ መቁረጥ ይሰማዎታል ?	1. አዎ 2. አይ
302	ብቸኝነት ይሰማዎታል ?	1. አዎ 2. አይ
303	የአእምሮ ህመም/ችግር እንዳለባቸዉ ያምናሉ ?	1. አዎ 2. አይ
304	አደንዛዥ ዕጽ ይጠቀማሉ ?	1. አዎ 2. አይ
305	ጥ.304 መልሰዎ አዎ ከሆነ ከሚከተሉት የትኞቹ ናቸዉ ? (ከአንድ በላይ መምረጥ ይቻላል)	1. አልኮል 2. ጫት 3. ሃሺሽ 4. ኮኬይን 5. ሲጋራ 6. ሁሉንም እጠቀማለሁ 7. ሌላ ካለ ግለጹ
306	ምክኒያቶዎት ምን ነበር እራስዎን ለማጥፋት ያሰቡበት እና የሞከሩበት ችግር ? (ከአንድ በላይ መምረጥ ይቻላል)	1. በቤተሰብ ጠብ 2. በገንዘብ ማጣት ወይም ክስረት 3. በቤተሰብ ሞት ምክኒያት 4. በአዕምሮ ህመም ምክኒያት 5. በትምህርት ከክላስ ስለወደቁ 6. የርስ በርስ ግጭት ወይም ጥል 7. ከሚኖሩበት ቦታ ስለተፈናቀሉ /ሰለተሰደዱ 8. ሌላ ካለ ይግለጹ
309	ከሚከተሉት በየትኛዉ ዘዴ እራስዎን ለማጥፋት ሙከራ አድርገዋል ? (ከአንድ በላይ መምረጥ ይቻላል)	1. በመርዝ/መድሃኒትን ከመጠን በላይ በመዉሰድ 2. እራስን በማነቅ 3. ኤሌክትሪሲቲ በመጠቀም 4. እራስን በማድማት/ለማረድ በመሞከር 5. እራስን ከከፍታ ቦታ በመወርወር 6. በመሳሪያ /ሽጉጥ በመጠቀም 7. አልኮል በመጠጣት 8. በመኪና አደጋ እራስን በማጋለጥ 9. ሌላ ካለ ይግለጹ