Health Foundation Nepal

Feasibility of Mental Health Crisis Helpline Services for the Prevention of Suicide in Nepal

Research Report

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- Study team

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Abbreviations and acronyms

DoHS	Department of Health Services
CSI	Client Satisfaction Interview
EDCD	Epidemiology And Disease Control Division
GBV	Gender Based Violence
GHSQ	General Help-Seeking Questionnaire
GoN	Government of Nepal
HFA	Health Facility Assessment
HFN	Health Foundation Nepal
KII	Key Informant Interviews
KIs	Key Informants
KAP	Knowledge, Attitude And Practices
LMICs	Low And Middle-Income Countries
LMIC	Low Middle Income Countries
MIS	Management Information System
MHPSPC	Mental Health Promotion And Suicide Prevention Centre
MoHP	Ministry Of Health And Population
NWC	National Women Commission
NHRC	Nepal Health Research Council
NCD	Non Communicable Disease
NGO	Non-Government Organization
PAHS	Patan Academy of Health Sciences
SD	Standard Deviation
SPSS	Statistical Package for Social Scientists
SWOT	Strength Weakness Opportunity Threat
TPO-Nepal	Trans Psychology Organization Nepal
TUTH	Tribhuvan University Teaching Hospital
WHO	World Health Organization

Executive Summary

Health Foundation Nepal (HFN) is working to improve the mental health and nutritional status of vulnerable and poor women in Nepal through mental health screening and counselling services. Suicide is a major public health concern globally and locally. According to the WHO, nearly 7000 people die by suicide annually in Nepal, which is 24.90 suicides per 1,00,000 people. Crisis helplines typically provide services to persons at risk of suicide or thinking about suicide. Although evidence for their efficacy is scare, helplines enjoy a justified reputation for their unique ability to (a) offer service at times when other services are unavailable; (b) offer confidentiality and anonymity to clients; (c) provide information about other treatment resources; and (d) provide a safe, nonjudgmental environment enabling clients to articulate complex feelings. This study aims to analyze availability, effectiveness and feasibility of Mental Health Crisis Helpline Services in Kathmandu Valley by exploring the service status; knowledge, attitude and practices; and satisfaction outcome of crisis helpline services clients.

This is a descriptive cross sectional study following both qualitative and quantitative approach. The study population included clients of age above 18 years receiving health services from Tribhuvan University Teaching Hospital (TUTH) and Patan Academy of Health Sciences (PAHS) and mental health service providers of TUTH, PAHS, TPO-Nepal, Mental Health Promotion and Suicide Prevention Centre and Chhahari Nepal for Mental Health.

A total of 204 clients with mean age of 30 years participated in the mental health utilization survey. The awareness on the helplines among the clients was 13.7% whereas utilization was quite low (2%). The total 10 clients who used helpline service from TUTH were interviewed for client satisfaction interview. Majority of the clients (N=8) were satisfied and feel benefitted with the services they received. A total of 15 participants from different organizations working on mental health were enrolled for Key Informant Interview. The major challenges for helpline service accessibility were: minimal budget, or government investment for mental health, lack of trained service provider, lack of time for proper counselling through phone to those who cannot come to health facility, busy networks due to limited number of call lines, lack of feedback of provided services and follow up for motivation in providing services. Merely absent recording and reporting system of mental health services is the other major challenge. Likewise, the challenges in demand side or clients' side were: lack of awareness on mental health and available services for mental health problems, literacy and funding. Most of the people were unaware about the helpline services, social stigma, cost inaccessibility, higher expectation of counselling through phone, reluctance to visit health facility and urban centered helplines. Street clients with even no access to phone are the most vulnerable among them.

The culture of getting help through helpline is in emerging phase in Nepal. Across all types of informants, a significant gap exists in the level of knowledge and utilization concerning helpline services. Public Health awareness campaigns about helpline services together with availability of funding could address this situation. We recommend that the focus on continuous quality improvement be not limited to helplines. Recording calls is a good way for call centers to continuously assess the quality of the services that a helpline is providing. The call responders should have training in effective communication strategies that draw from evidence-based methods, like motivational interviewing. These approaches could pave the way for help-seeking and increased receptivity to referrals.

INTRODUCTION

1.1. Background

Suicide is a global phenomenon. Globally around 800,000 people die by suicide every year and; nearly one third of all suicides occur among young people (WHO, 2018). Suicide attempts are up to 30 times more common compared to suicides; over 16,000,000 people worldwide attempt suicide every year out of which in every 40 seconds, someone in the world dies by suicide (WHO, 2018). Though, suicide occurs at all stages of the lifespan it is the second leading cause of death among 15–29 years old and the second leading cause of death for females aged 15–19 years (WHO, 2018). These data correspond to an overall global age-standardized suicide rate of 10.5 per 100,000 population in 2016, 13.7 and 7.5 per 100, 000 for males and females respectively (WHO, 2018). It is anticipated that, by 2020, 1.5 million people will die each year by suicide, and between 15 and 30 million will make a suicide attempt (Bertolote, Fleischmann, 2015).

The South-East Asia Region of the World Health Organization (WHO) accounted for 39% of total global suicides (Hossain, 2017). Suicide rates in this region vary enormously from 0.43/100,000 to 31.0/100,000 (including both national and sub-population rates) (Hossain, 2017). With an average of 25.2, this is more than twofold with estimated mean suicide rate of 11 for the world (Hossain, 2017), and about 50% higher than a new estimate of 17 for the Southeast Asia region (Hossain, 2017). Nepal does not go far from this burden and among women of reproductive age specifically. Overall 6840 people die by suicide annually, which is 24.90 suicides per 1,00,000 people (Cousins, 2016). Nepal lacks a systematic data collection and there is not yet any prevalence study on suicide in Nepal (Pradhan, Poudel, Thomas and Barnett, 2011), however, WHO claimed that Nepal has second highest suicide per capita in South Asia (WHO, 2018).

In a recent study done among 1440 respondents age 10 or older in the Ilam district by Karki et al (2017), 4.5% of respondents were found suicidal ideators. The prevalence of suicidal ideation was 14.1% among those with a family history of suicide. Likewise, suicidal ideation prevalence was 22.3% among those with severe depression. Suicidal plan was found prevalent among suicidal ideators with severe depression (43.8%). About 8% of suicidal ideators were found with severe depression had attempted suicide in the same study.

Suicide is often referred to as a major public health concern in theory, but in practice it is classified as a mental health issue for intervention and prevention policy development. The risk factors for suicidal ideation are family disputes, academic failure, financial hardship, alcohol use, physical illness, mental illness, and family history of suicide, anger issues, and low coping skills (Karki et al, 2017). Suicide was reported to

have psychological effects on families and friends in the study. Women from reproductive age were found severely affected, with 16 per cent of the total death toll (leading cause of death), due to various socio-cultural and economic factors (Simkhada et al, 2015). Suicide is heavily associated with mental illness among people with suicidal thoughts and attempts ranges from approximately 50% in community samples up to 90% in clinical samples (Nock et al, 2009). The presence of a mental illness is an identified risk factor for future suicidal ideation and attempts (Mortensen et al, 2000) and the risk of suicide increases by multiple times in the presence of co-morbidity of mental illness.

Currently four out of five people with severe mental illness in Low and Middle Income Countries (LMIC) receive no effective treatment. Though the treatment gap for mental illness is significant all over the world, around 76% and 85% of people with severe mental illness in low and middle-income countries receive no treatment for their mental illness (Rathod et al, 2017). The large burden of mental illness in low and middle-income countries (LMICs) has revealed a great need for identifying, testing, and scaling successful mental healthcare interventions (Acharya et al, 2017).

1.2. Help-seeking behavior during mental illness

People's need for regular contact and caring is ideally met by other people around them, such as parent, siblings, friends, teachers and colleagues. However, some people, because of geographical or other types of isolation such as chronic physical or mental illness, may neither have opportunities for interaction nor receive the caring connections or feelings of belonging that they need to maintain a desire to live. Delivery of mental health services to clients has been impacted by the introduction of technology. Across the world, the telephone has been a medium of providing counselling for many years; with services being provided by mental health professionals or by trained volunteers. Telephones often engage with persons who are not otherwise receiving help for their suicidal thoughts.

Changes in technology have resulted in changes in the ways in which mental health services are being provided to clients. While the telephone was the first means of providing telemental health, the internet has given rise to a multitude of new ways of providing and accessing support through computer mediated communication, through email, chat rooms, and other such methods (Fukkink and Hermanns, 2009). Telemental health can be provided by a range of service providers such as counsellors, psychiatrists, social workers, nurses, primary health providers and others.

Generally, the prevalence of professional help seeking behavior for mental illness is ranging from 35% to 50% in developed countries (Magaard et al, 2017 and Alonso et al., 2018) and from 10% to 15% in developing countries (Haile et al, 2017, Keynejad et al., 2018, Roberts et al., 2018, Evans-Lacko et al., 2018). Help seeking behavior is influenced by fear of stigma and embarrassment, lack of time, comorbid substance

use, demographic and geographical variation (Evans-Lacko et al., 2018), co-morbid chronic illness (Roberts et al., 2018), psychosocial factors (Kohrt et al., 2018 and Magaard et al, 2017), perceived cause, accessibility, and effectiveness of the treatment (Teferra and Shibre, 2012). Models of help-seeking regard as an internal, sequential process within the individual, moving through recognition, expression, identification of sources of help, and subsequent willingness to disclose, may not reflect reality (Rickwood et al., 2005).

1.3. Emergence of helpline services as help-seeking behavior

In the middle of the twentieth century, the telephone services began to provide mental health services by The Samaritans in the United Kingdom (Kreitman, 1976). The Samaritans helpline and other similar nature helplines have opened in countries all over the world since then. These helplines are focused on providing emotional support for those in needs and more specifically to help deal with crisis situations such as suicide. Crisis helplines have the potential to serve vulnerable individuals in crisis. Helplines enjoy a justified reputation for their unique ability to (a) offer service at times when other services are unavailable (Stein & Lambert, 1984); (b) offer confidentiality and anonymity to clients (McCord & Packwood, 1973); (c) provide information about other treatment resources; and (d) provide a safe, nonjudgmental environment enabling clients to articulate complex feelings. Helplines offer the added benefit of allowing callers to freely initiate and terminate contact (Slem & Cotler, 1973). In recent years, there has been a rapid expansion of services using new technologies (Mishara & Kerkhof, 2013), mostly using Internet chat services and text messaging interactions from mobile telephones.

Helpline service utilization surveys indicate that despite high awareness of hotlines and high satisfaction ratings among those who do contact hotlines, adolescents' access hotlines infrequently (King, 1977) and less than they access other help sources (Offer et al 1991). In a sample of 3,000 Alabama college students, King (1977) identified 66 (2.2%) who had called a limited-hour telephone counseling center. Over two-thirds of all callers rated the hotline as somewhat effective to extremely effective. In a Midwest sample of 497 adolescents, Offer and colleagues (1991) assessed the help-seeking tendencies of disturbed adolescents. Thirty-seven percent of disturbed adolescents were aware of hotline services and 1.8% had called a crisis hotline in the past year, significantly fewer than had contacted guidance counselors, clergy members, or mental health professionals.

In a sample of 519 adolescents of 9th through 12th grade mandatory health courses, Gould et al (2006) assessed the attitudes toward the use of telephone crisis services (hotlines) in six high schools in New York State. Few adolescents (2.1%) used hotlines and negative attitudes were stronger toward hotlines than they were toward other formal sources of help. In a study on association between help-seeking behavior and nearly lethal suicide attempts overall, friends/family were consulted most frequently (48%) than a health professional (Barnes, Ikeda, and Kresnow, 2001).

In another study, few adolescents (2.1%) were found having ever used hotlines and that negative attitudes among adolescents were stronger toward hotlines than they were toward other sources of help (Gould et al., 2006). In most cases it is difficult to measure the effectiveness of crisis lines in preventing suicide because of the anonymous nature of interactions with callers and the relatively short and generally single-service sessions without follow-up or continuity. However, some research provides encouraging results. A major study of the outcomes achieved for telephone callers to a crisis line in the USA found that intent to die was reduced by the end of the call (Gould et al., 2007). Likewise, a separate study conducted in Sweden found telephone interventions to have an effect on patients who at their suicide attempt had other treatment than psychiatric and in those with no treatment (Cedereke, Monti and Öjehagen, 2002). Another study in Australia that examined telephone callers to a youth crisis line also found measurable reductions in suicidal ideation during the call (King et al., 2003). Participants who received the intervention as mobile phone-based psychotherapy were found to achieve significant improvements in reducing suicidal ideation and depression than those receiving usual care (Marasinghe, Edirippulige, Kavanagh, Smith and Jiffry, 2012). A recent study in California, USA evaluated services, structure, and organization and the potential challenges among suicide prevention hotlines in California (Ramchand, Jaycox, and Ebener, 2017). The study identified three primary challenges that suicide prevention hotlines currently face or could face in the future: (a) variability in the quality of the services they provide, (b) shifting telecommunication trends (c) and financial sustainability.

1.4. Helpline services operating in Nepal

Research from countries such as Australia, USA, the United Kingdom and Sweden indicates the efficacy of mental health services provided over the telephone. In Nepal as well, helplines have been set up to extend scarce mental resources to a wider population, and to cover a wider area. Helpline services in Nepal provide a range of services; from counseling, psychosocial support, advice and referral. Some helplines are government run while others are run by voluntary organizations, e.g. Child helpline of CWIN-Nepal which was the first toll-free helpline for children in need of care and protection, bringing together various voluntary organizations and community organizations. They respond to calls from children to ensure that cases are reported immediately to the police so that they can start investigations promptly. It helps vulnerable children and has been receiving more calls from victims every year with total 12,693 in 2016 and 21,610 in 2017. More children have started calling hotline 1098 for help, which means awareness has increased of hotline ("More children calling hotline 1098 for help", 2018).

Other government-run helplines include 1145 for violence against women by the National Women Commission (NWC). NWC helpline launched *Khabar Garaun* 1145 in December 2017. The reporting of

GBV cases has been increasing since its establishment, and survivors have started coming forward as the helpline received 37,249 calls from November, 2017 to June, 2018 ("Addressing gender-based violence in Nepal", 2019).

In response to the growing burden of suicide, under the initiation of TUTH, 24-hour hotline service was started in 2015 for psychosocial support and suicide prevention. The hotline service started as pilot phase which is running as a part of integrated service being provided by TUTH. Anyone facing suicidal ideation, or even witnesses such suicidal thought; they can call the mobile number to receive help for psycho-social support. On-duty resident doctors have this number and it's an extra duty to them. Later PAHS also started providing the helpline services besides TUTH. Apart from the government-run helplines, there are helplines run by voluntary organizations, such as TPO-Nepal and MHPSPC.

1.5. Rational/justification of study

This study aimed to identify the feasibility of mental health crisis helpline services for the prevention of suicide in Nepal. Suicide prevention strategy is important because it indicates a government's clear commitment to prioritizing and tackling suicide, while providing leadership and guidance on the key evidence-based suicide prevention interventions (WHO, 2014). The suicide prevention is also an integral component of the WHO *Mental Health Action Plan 2013–2020*, with the target of 20% increase in service coverage for severe mental illness and a 10% reduction of the suicide rate in member countries by 2020 (Saxena, Funk, & Chisholm, 2013).

However, there have been no nationwide studies assessing the need for crisis helplines or the capacity to meet the needs of people and more research is needed to identify need for and access to helplines and the capacity to meet the demand for these services. With the rapid growth of tele mental health in developing countries, there is clearly an urgent need for solid evidence of its impact to justify and guide the investment of resources in such systems. Despite major increases in feasibility study in recent years, most large tele mental health implementations have little or no feasibility data. To date, most studies have been small; focused on process indicators rather than patient outcomes or on the attitudes of users and patients; and performed mostly by academic groups. An increased focus on including feasibility as part of tele mental health implementations is necessary and should be adopted by organizations implementing or funding such systems. One method is for large funders to include resources for feasibility or make them a requirement for implementation. It is also necessary to translate the evidence into policy and program of government. This research could be instrumental in exploring the existing suicide prevention programs including suicide helpline services in Kathmandu valley and at the same time recommending the government or service provider to introduce or amend the strategies and services so as to facilitate the quality of service optimally.

The results of this study are of special interest because of government's concern towards provision of e-health services countrywide. Thus evidence from the study on the benefits and limitations of helpline services should be of direct relevance to other districts in Nepal and indeed other LMICs with similar profiles of mental health problems. Studies like this are needed to continue to understand awareness of and barriers to using services offered by helplines.

In summary, the study could be beneficial to:

Policy makers: This study might provide guidance to policymakers in formulating new policy towards suicide prevention such as establishing helpline in public health facilities or giving focused attention to suicide prevention rather than lumping under the umbrella of mental health.

Existing Body of Knowledge: This study would add valuable information to the existing body of knowledge regarding understanding of the current and future mental health programs in Nepal.

Mental health programs: Results of this study would help understand existing services and their challenges. The insights obtained from survey might be helpful in tailoring the suicide prevention program as per client need.

Clients: This can help the system so that people with suicidal ideation can get better service and support in the future.

Mental health professionals: The mental health professionals can learn from the outcome of the study.

1.6. Objectives

This study seeks to assess, identify and explore the scenarios from client side as well as service providers of existing helpline services guided by the following objectives:

General Objectives:

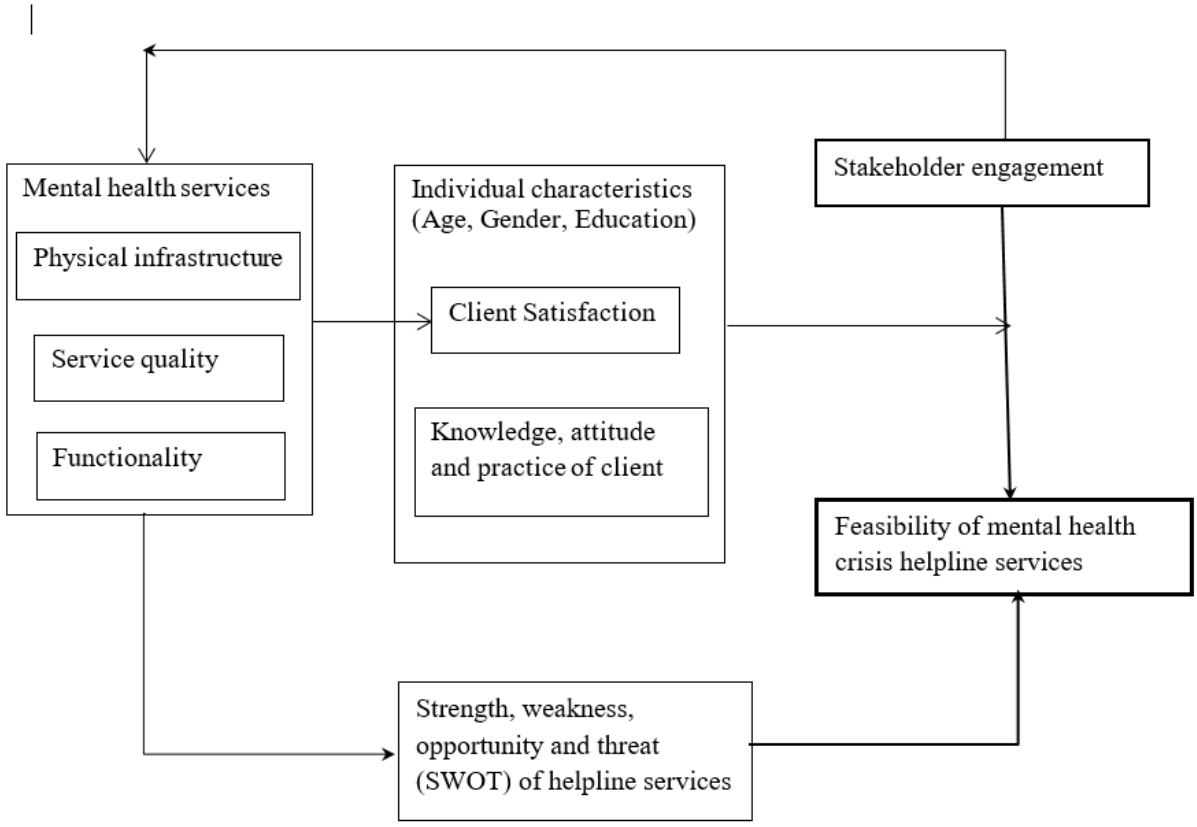
To analyze availability, effectiveness and feasibility of Mental Health Crisis Helpline Services in Kathmandu Valley.

Specific Objectives:

1. To assess knowledge, attitude and practices of people on availability of mental health services by socio-demographic characteristics
2. To assess the level of client satisfaction and overall quality of helpline services in selected pilot health facilities
3. To explore the current practices, strengths, weakness, opportunity and challenges of the existing crisis helpline services
4. To identify the physical, quality and functionality of the existing crisis helpline services in Kathmandu valley

1.7. Conceptual Framework

Figure 1 *Conceptual Framework*



1.8. Study Variables

Dependent variables

i. Client satisfaction

ii. Mental health services

1. Physical infrastructure
2. Service quality
3. Functionality
4. The strength, weakness, opportunity and challenge of the existing mental health services

Independent variables

1. Socio-demographic variables of clients (age, gender, education, family type, marital status etc.)
2. Knowledge, attitude and practices (KAP) of the clients on mental health and mental health crisis helpline services.

1.9. Operational Definition

Crisis Helpline services

A crisis helpline service is a teleservice which offers emotional support to person(s) in distress in its minimalistic form. It may help the individual. Crisis lines are often referred to as helplines, telephone counseling services, hotlines, distress lines and telephone emergency services.

People with Mental Illness

Mental illness, also called mental health disorders, refers to a wide range of mental health conditions, disorders that affect your mood, thinking and behavior. Examples of mental illness include depression, anxiety disorders, schizophrenia, eating disorders and addictive behaviors.

Psychiatrist

A psychiatrist is a medical doctor (M.D. or D.O.) who specializes in mental health, including substance use disorders.

Psychologist

Psychologist assess diagnose and treat individuals suffering from psychological distress and mental illness. They also perform psychotherapy and develop treatment plans

Suicidal Behavior

Suicidal behavior is any action that could cause a person to die, such as taking a drug overdose or crashing a car on purpose or hanging with rope or falling from building.

Suicidal thoughts or suicidal ideation

Suicidal thoughts or suicidal ideation means thinking about or planning suicide. Thoughts can range from a detailed plan to a fleeting consideration. It does not include the final act of suicide.

Suicide prevention

Suicide prevention is a collection of efforts to reduce the risk of suicide.

Suicide counselors

Suicide counselors help people considering taking their own lives find reasons to live. They identify at-risk individuals, determine how much of a danger they pose to themselves, and work with suicidal clients in counseling in helpline service.

METHODOLOGY

2.1. Study Design

This study was organization-based, cross-sectional anddescriptive. . The study included both quantitative and qualitative methods. It has been suggested that mixed methods using qualitative and quantitative measures are important to understand the suicide studies (Kral et al., 2012), hence it incorporated both qualitative and quantitative methods. It was conducted at the TU teaching hospital, Patan Academy of health sciences, Mental Health Promotion and Suicide Prevention Centre, TPO-Nepal and Chhahari Nepal. Most of the selected organizations have been providing crisis helpline services for suicide prevention. They have also been conducting suicide prevention activities in the country. They offer support, crisis counseling, local referrals, and the ability to dispatch crisis response to callers.

Table 1 *Overview of study objectives, study population, respective tools and study sites*

Study Objective	**Study population**	**Study design**	**Data collection method**	**Study Site**
To assess knowledge, attitude and practices of people on availability of mental health services by socio-demographic characteristics	general hospital clients	Quantitative methods	Survey	Hospitals (TUTH & PAHS) patients
To assess the level of client satisfaction and overall quality of helpline services in selected health facilities	Helpline Service Clients	Both Quantitative & Qualitative methods	Client Satisfaction Interview	TUTH
To explore the current practices, strengths, weakness, opportunity and challenges of the existing crisis helpline services	Program Managers, Mental Health Professionals	Qualitative methods	Key Informant Interview Guidelines	TUTH, PAHS, TPO – Nepal, MHPSPC, Chhahari Nepal
To identify the physical, quality and functionality of the existing crisis helpline services in Kathmandu valley	Managers and service Providers from selected facilities providing mental health services	Both Quantitative & Qualitative methods	HF Assessment	TUTH, TPO – Nepal,

2.2. Study Population

The study population were general hospital clients visiting Tribhuvan University Teaching Hospital (TUTH) and Patan Academy of Health Sciences (PAHS); clients of mental health services visiting TUTH and program personnel from TUTH, PAHS, TPO-Nepal, MHPSPC and Chhahari Nepal who have been involved in the mental health program in Nepal. The respondents were of age more than 18 years

2.3. Sample Size

There was a mixed sample size depending on settings. About 204 clients visiting hospitals were selected. Ten clients were recruited for the client satisfaction interview. Health Facility Assessment of four helplines was carried out. Fifteen Program managers and mental health professionals were selected for KIIs.

Sample Size Calculation

A sample size of 203 respondents was calculated using the formula developed by Krejcie & Morgan (1970) for determining sample size for a given population [when the population is known].

Data collection ended when 204 respondents were interviewed for mental health service utilization. Formula used for total sample size estimation is given below:

$s = \chi^2 NP (1-P) \div d^2 (N-1) + \chi^2 P(1-P)$

where,

s= required sample size

$\chi^2 = 2.706$ (the table value of chi-square for 1 degree of freedom at the 90% confidence level)

N= the population size = 28,721,971 (https://www.worldometers.info/world-population/nepal-population/)

P= the population proportion = 0.25

d= the degree of accuracy expressed as a proportion= 0.05 (Significance level= 5%)

2.4. Sampling technique

The sampling employed mixture of random sampling and purposive sampling techniques. The survey was obtained through random sampling while client satisfaction interview, KII and HF assessment made use of purposive sampling.

2.5. Criteria for sample selection

The general hospital clients meeting the inclusion criteria and who were willing to participate in the research were included for survey whereas helpline service clients were selected for Client Satisfaction

Interview. The KII were conducted with the program managers and HF assessment includes the helpline service providers operating in Kathmandu valley.

2.6. Data collection techniques/ instruments

This study took the following approaches to assess the feasibility of mental health crisis helpline services for the prevention of suicide in Nepal:

- Survey
- Client Satisfaction Interview
- HF assessment
- Key Informant Interviews

Survey

Demographic and mental health survey was done with general population through face to face interview using semi-structured questionnaire. The demographic questionnaire seeks to elicit information with regard to age, gender, racial/ethnic background, marital status, geographic mobility, and marital status and education. Respondents were asked specifically about: (1) knowledge and awareness and utilization of helplines; (2) practice access to and preferences for type of crisis service medium (e.g., phone, online chat, text message, and social networking sites); and (3) attitudes about help-seeking through crisis helplines. The items are a mix of forced choice, Likert scale, rank order, and open-ended. The General Help-Seeking Questionnaire (GHSQ) was modified to meet the need of this study.

Client Satisfaction Interview

To understand the satisfaction of the clients, the mental health service clients were interviewed. The cases at TUTH were purposefully selected to include the clients who have already used the mental health service. The cases shed light on the satisfaction level and effectiveness of the existing helpline services. Several items were added from the Client Satisfaction Questionnaire (Attkisson CC; Larsen D), and questions assessing reasons for seeking help were adapted from the demographic variables (age, sex, ethnicity).

HF Assessment

HF assessment was done in TUTH and TPO-Nepal using standard checklist to identify the overall status of mental health services including suicide prevention programs. The inventory questionnaire includes questions in WHO's SARA tool for the *health facility* services availability and readiness *assessment.* The HF Assessment utilized SARA tools with some contextual modifications to meet the needs of health programs. The core questionnaire reflects generally accepted standards for health care services.

Key Informant Interviews (KIIs)

A total of 15 key informants working in Nepal with appropriate expertise in a range of fields including mental health, suicide prevention and mental health including policy makers, program managers, psychiatrists, psychologists, Non-Government Organization (NGO) workers, GoN agencies and mental health activists were interviewed. These include Psychiatrists working in government, non-government and teaching hospitals, inside the Kathmandu valley.

The KII utilizes the interview tools developed by Karki et a (2017) with contextual modifications and development to meet the needs of mental health programs. Interviews were conducted by the study team, using a pre-designed guideline, and all the interviews were tape recorded and key points recorded by a note-taker accompanying the interviewer. The interviews were first transcribed into Nepali and then into English. Various themes were developed linked to the research objectives and a thematic analysis was carried out. Numerous quotes from the KIIs were included throughout the research. It is important to remember that the KII quotes included in this report would represent the views of the respondents, and not the authors, and what they reveal may not necessarily be accurate. Names of respondents were not included to protect their identity.

2.7. Validity and reliability of tools

The tools that were informed by current literature were created in consultation with experts from EDCD and HFN. The standard tools were modified to meet the need of this study. The survey was pre-tested in similar settings in Kathmandu. The study site wasn't included in the study sample. Based on the pre-test findings, necessary changes were made to the questionnaire.

2.8. Data Collection

Field enumerators were provided with one-day training by the experts from HFN. Training covered protocol, sampling design, sampling procedure, recruitment process, consent taking procedures and interview skills. Besides, study objectives and the purpose of the study were explained along with the ethical consideration, role, and responsibilities of the team members.

This study used survey questionnaire for quantitative study and interview checklist among people with mental illness. Moreover, this study used KII among program managers of study sites using interview guidelines. HFA was conducted at selected HFs using semi-structured questionnaires.

All the data collection tools were developed in Nepali language. Interviews were conducted in local language. Arrangement for stationery and logistic was done before the field work. Interviews were conducted in a private place preferably in a private room or other safe place agreed to by the study

participants. No names were mentioned in the tools and notes.

2.9. Data quality assurance

The following measures were adopted to ensure data quality:

Before data collection and during training:

- Survey Commcare app's validation rules were checked by entering test values. The field enumerators were familiarized with data entry screens, vocabularies and choice options to minimize erroneous data entry.
- The field enumerators' understanding of the study objectives and questionnaire was tested and correct interpretations were reinforced.
- Field enumerators practiced implementing the questionnaire and consent form through mock test until they were clear on the tools and use of the mobile app.
- Field manual, study protocols and guidelines were developed and provided to the field researchers and field supervisors for standardized interpretation of research method and tools.

During data collection and data entry into mobile phones:

- Ensure field manual, study protocol and guidelines were followed.
- Consistency of participant's response was verified. Responses against previous answers were confirmed where appropriate and inadmissible responses were detected.
- Field enumerators were regularly monitored using a monitoring checklist.
- Data were synchronized to cloud based server daily after review by researchers.
- Data collection was monitored in real time by accessing data from servers and carrying out standard quality check protocols.

After data collection:

- Quality check mechanisms such as range checks, logical checks and skip instructions were developed which helped to detect errors during data cleaning.
- After completion of data collection, the responses were verified by organizing a debriefing meeting with experts and field enumerators.
- The datasets were stored in password protected computers with backup.

2.10. Data management and analysis

After the field work, the completed questionnaires were brought to the HFN's office. The completed

questionnaires were re-checked by the study team to ensure that the questionnaires are properly filled. The datasets were downloaded from Survey Commcare servers and imported into SPSS version 21 for analysis.

For quantitative data, descriptive analysis was conducted and any outliers or inconsistencies were checked against original data. Descriptive statistics were carried out. SPSS was used for statistical analysis. The results were disaggregated by socio-demographic variables. Number and percentages were calculated for binary, categorical or ordinal variables. Questions that used Likert scale were recoded according to its original scale. Mean (SD) of Likert scale responses were calculated. Necessary findings were presented on the relevant tables.

For qualitative data, interviews, KIIs and HFAs were transcribed word for word in local language. The researchers then translated the Nepali transcriptions into English within after 1-2 days of interview. Each transcript covered a note describing the setting and the issues identified in the interview or discussion as well as thoughts about the session. The transcribed data/notes were translated into English onto electronic files. Cross-checking of transcribed and translated notes with the recordings was conducted. KIIs and interviews were transcribed to: (1) become familiar with each individual situation; (2) identify text that may be unclear due to differences in the cultural context; (3) point out areas in which interviewing and transcription techniques could be improved; and (4) identify recurrent themes.

To ensure confidentiality, each respondent was provided a participant number in the interview sheets which was used only during the analysis. These numbers were not linked with any other information about the participants. Data coding and data entry were done by the trained research organization staff. A thematic analysis approach was applied for qualitative analysis which is the most commonly used method in health research. Hence, each transcript was read carefully and frequently in thematic approach. Researchers look for particular patterns, themes, concerns or responses which are posed repeatedly by the participants. Deductive codes were developed prior to the study, based on the study themes, and inductive codes were added during data analysis. Quotes illustrating the findings were identified and presented in the study report.

2.11. Ethical Considerations

- The study was conducted in compliance with all human rights and ethical standards. Permission to assess respondents was sought from the authorities of participating organizations. All the required approvals and authorizations were gained before data collection began.

- Ethical approval was obtained from the Nepal Health Research Council (NHRC) prior to implementation of the study (Ref No: 1367, 16 December 2019).
- This study fully informed participants regarding the aims of the study before the start of the interview process. Participants issued written informed consent. Any identifying information was anonymized in the survey tool as well in the dataset.
- Study procedure was designed to protect participants' privacy, allowing for voluntary participation. During the consent process, it was made clear to participants that they are free to refuse participation and that if they decide not to participate; they may stop at any time and the decision whether to participate will not affect any services they currently receive (in the case of beneficiaries) or their employment. The risk of participating in this study was minimal.
- However, some questions were about suicide and it could make the study participants uncomfortable. They were informed that in such situation they are free not to answer such questions and can leave the interview/discussion at any time they want.
- Similarly, the field enumerators were fully informed about the nature of the study, research objectives and confidentiality of data. Written informed consent was obtained from them for their involvement in the study.
- During the analysis and presentation of the study findings, no names or address of the study participants were mentioned. In some situation, their quotes may be presented in the research report; however, their name or other information which may identify them were not presented or linked.
- Privacy and confidentiality of the study participants were maintained. Analysis was done based on the key variables and no individual cases from any study area were highlighted.

RESULTS

Results: Mental Health Utilization Survey

3.1.1 Demographic Characteristics of Respondents

As shown in Table 2 below, total of 204 interviews were successfully conducted for this mental health utilization survey. Out of 204, 154 respondents were recruited from TUTH and 50 were recruited from PAHS. The respondents were between the age group 18 to 69 with median age of 30. The majority of the respondents (n=128; 60.3%) were below 30 years and rest (n=76; 39.7%) were above 30 years. Likewise, majority of the respondents (n=122; 59.8%) belonged to upper caste groups, (n=42; 20.6%) belonged to disadvantaged *Janajati*, (n=27; 13.2%) belonged to relatively advantaged *Janajati*, (n=10; 4.9%) belonged to disadvantaged non *dalit terai* caste group and only (n=3; 1.5%) belonged to *dalit* group.

Table 2 *Respondents who participated in the Survey*

Characteristics	**Number (N=204)**	**Percent**
Age (Mean ± SD)	30.3 ± 12.2	
Gender		
Male	100	49
Female	104	51
Education		
Illiterate	12	5.9
Below Grade 10	37	18.1
Secondary	119	58.3
Under graduation	26	12.7
Graduation and above	10	4.9
Marital Status		
Unmarried/Single	84	41.2
Married	120	58.8
Family Type		
Nuclear	83	40.7
Joint	105	51.5
Extended	16	7.8
Province		
Province 1	19	9.3
Province 2	8	3.9
Bagmati Province	103	50.5
Gandaki Province	15	7.4
Province 5	20	9.8
Karnali Province	13	6.4
Sudurpaschim Province	26	12.7
Ethnicity		
Dalits	3	1.5

Characteristics	Number (N=204)	Percent
Disadvantaged Janajati	42	20.6
Disadvantaged non Dalit Terai caste group	10	4.9
Relatively advantaged Janajati	27	13.2
Upper caste group	122	59.8

3.1.2 Awareness and utilization of mental health services

Out of the total respondents, only (N=39; 19.1%) were aware about the mental health services available in Nepal. Awareness of available helpline services among the clients surveyed were low, for the TUTH (N=33; 16.2%), the PAHS (N=24; 11.8%), and other mental health services (N=17; 8.3%). Rates of awareness of available helplines among the clients surveyed were quite low 13.7% (N=39). Very few of the clients surveyed had used any helpline, with only 2% utilization of helplines.

Figure 2 *Knowledge of available helpline services*

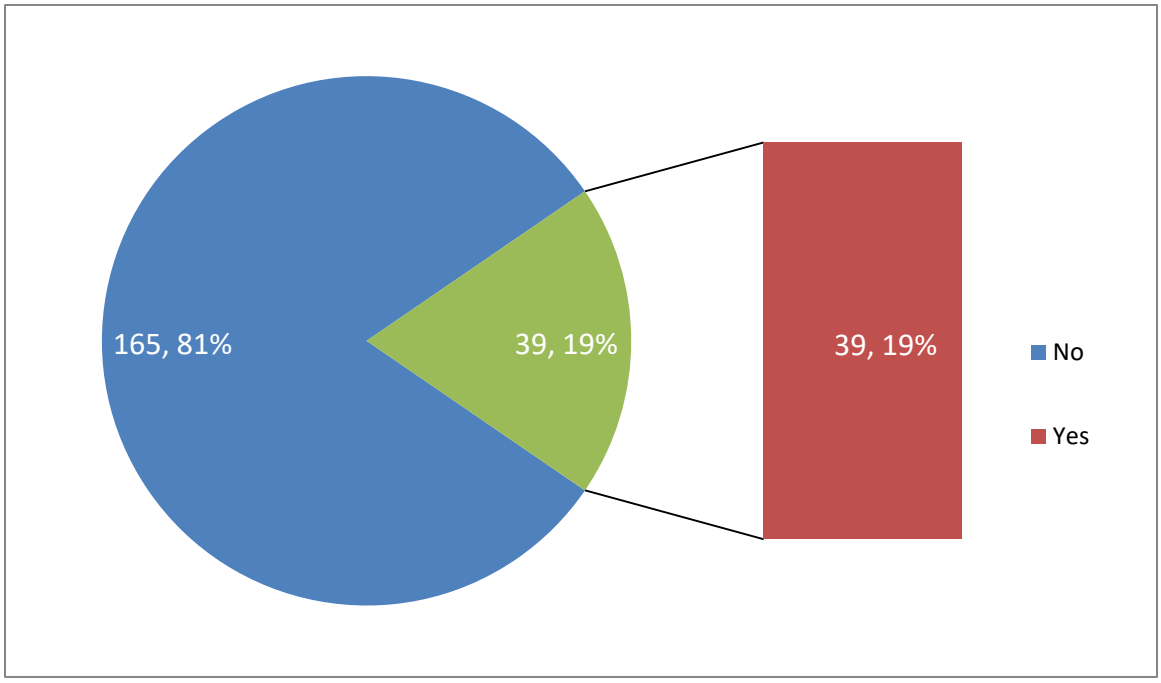
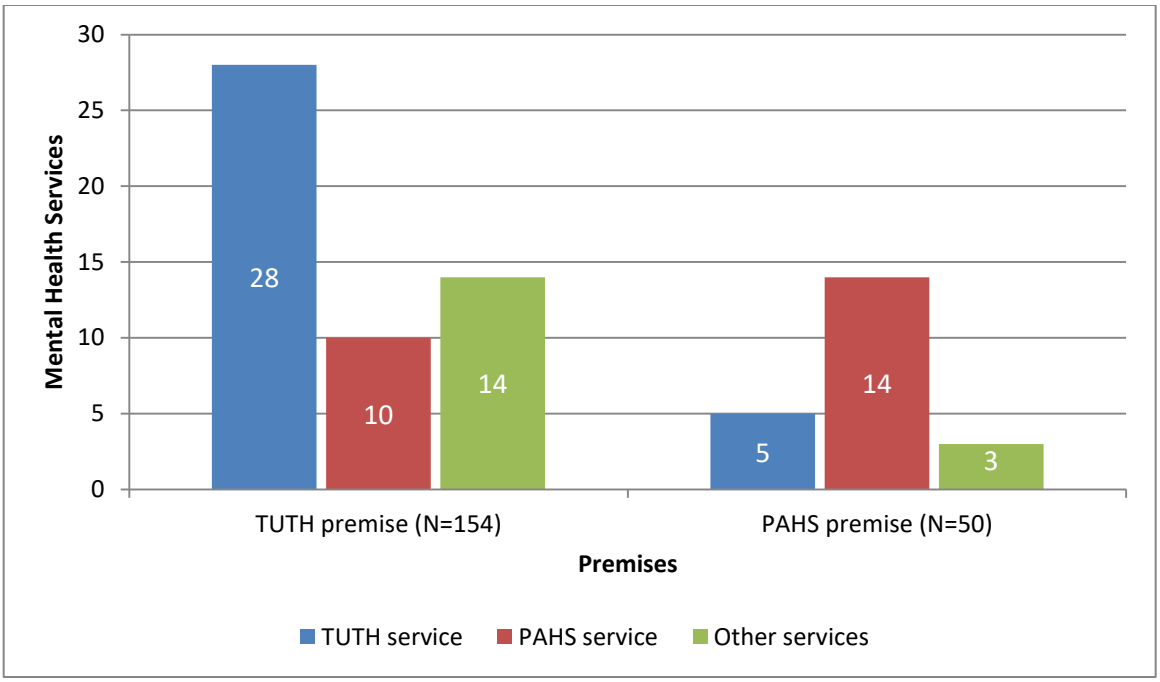


Figure 3 *Level of awareness of available helpline services at various service providers*



Out of the total respondents, 30 or below 30 years' respondents (N=26; 20.3%) were aware about mental health services available in Nepal. Likewise, majority of female (N=20; 19.2%), single (N= 18; 21.4%), literate (N=38; 19.8%), joint family (N=25; 23.8%), Bagmati Province (N=27; 26%), upper caste group (N=25; 20.5%) were aware about mental health services available in Nepal (see Table 3).

Table 3 *Awareness of available mental health services by socio-demographic factors.*

Characteristics	**Number (N=39)**	**Percent**
Age Group		
18- 30 years	26	66.66
Above 30	13	33.33
Gender		
Male	19	19
Female	20	19.2
Education		
Illiterate	1	8.3
Below Grade 10	5	13.5
Secondary	23	19.3
Under graduation	5	19.3
Graduation and above	5	38.5
Marital Status		
Unmarried/Single	18	21.4
Married	21	17.5
Family Type		
Nuclear	11	13.2
Joint	25	23.8
Extended	3	18.8

Characteristics	Number (N=39)	Percent
Province		
Province 1	4	21
Province 2	0	0
Bagmati Province	27	26
Gandaki Province	0	0
Province 5	2	10
Karnali Province	1	8
Sudurpaschim Province	5	19
Ethnicity		
Dalits	0	0
Disadvantaged Janajati	4	9.5
Disadvantaged non Dalit Terai caste group	2	20
Relatively advantaged Janajati	8	30
Upper caste group	25	20.5

3.1.3 Preferences of help seeking for mental health services

Of respondents surveyed, the majority reported having access to a phone (94.6%, n = 193) at home. Partner was ranked as the most preferred way of seeking help in case of mental health problems (mean=4.65). Adults were asked, "*Below is a list of people who you might seek help or advice from if you were seeking help for suicidal thoughts and knew where to find resources to help. Please circle the number that shows how likely is that you are willing to utilize each of these services."* They were presented with eight response options. Preferences, in order of how frequently they are likely and very likely to endorse, besides partner were as follows: seek face-to-face help from parent (mean=4.34), seek face-to-face help from family members and friends (mean=3.56), seek face-to-face help from mental health professionals (mean=2.93).

There were slight differences in preferences between provinces and, among male and female. Females (82%, n = 85) were likely to contact parent more than males (77%, n=100). Very few of the respondents surveyed preferred using helpline (13.3%, n= 4) even among those who had knowledge about helpline.

Figure 4 *Spider chart on contact preferences for mental health services (Gender-wise)*

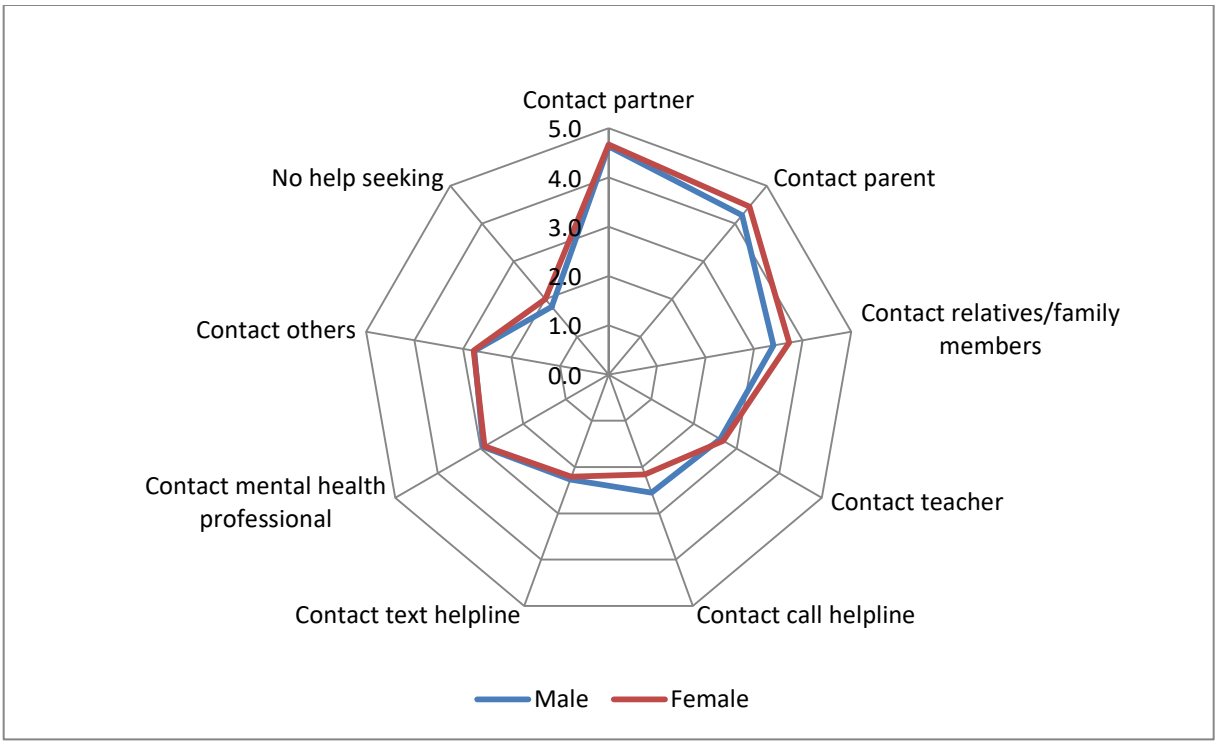
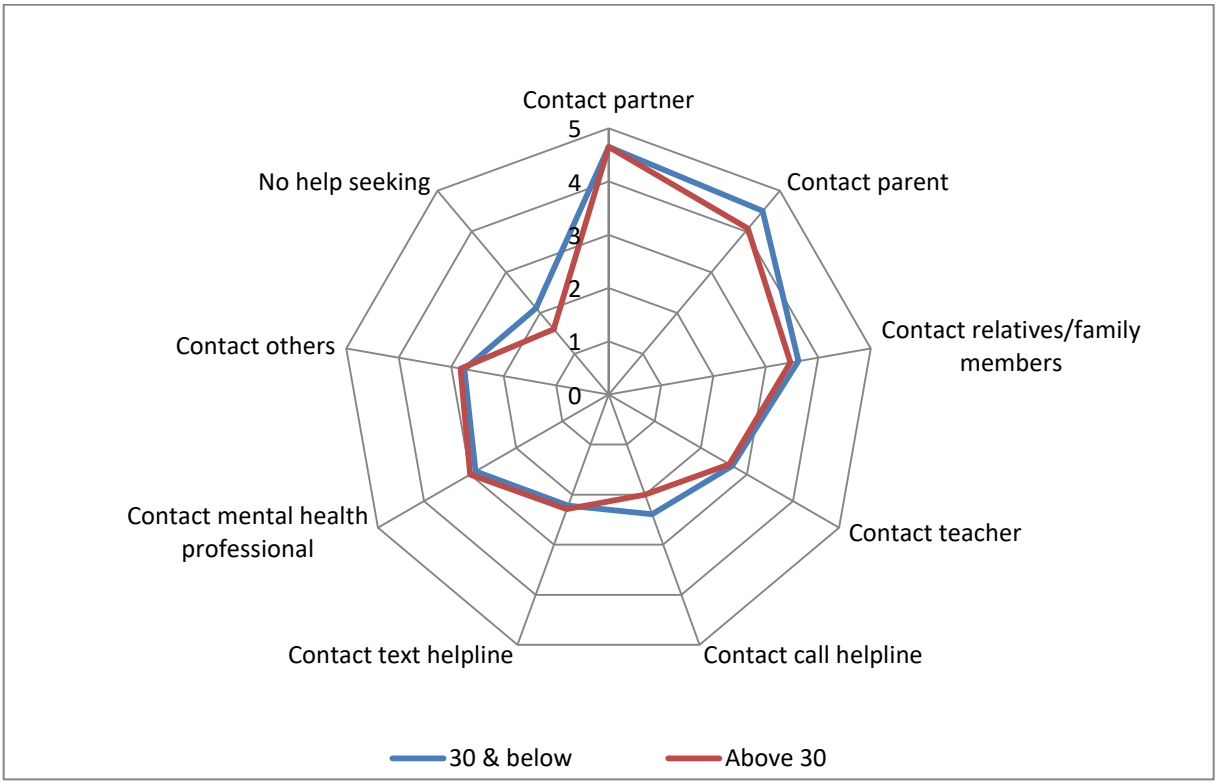


Figure 5 *Spider chart on contact preferences for mental health services (Age-wise)*



3.1.4 Source of information of helpline services

Of respondent surveyed, radio was ranked as the most common means of source of information of helpline services in case of helpline (8.8%, N = 18). Out of 18 respondents, who had mentioned radio as source of information, 12 respondents (66.66%) had educated up to secondary level whereas 14 clients belong to age group of 18-30 years.

By comparison, 6.4% (n = 13), 5.9% (n = 12), and 5.4% (n = 11) mentioned internet & social media, newspaper & pamphlets, TV and relatives as their most often source means, respectively. Very few of the clients surveyed mentioned source of knowledge as mobile phone and text messages (4.9%, n= 10).

Table 4 *Source of information of helpline services among respondents*

Characteristics	Radio	TV	Health Workers	Relatives & Family Members	Newspapers, pumplets etc	Internet, Social Media	Mobile Phone, sms
Age Group							
18-30 years	14	8	10	9	10	11	10
Above 30	4	3	1	1	2	2	0
Gender							
Male	6	3	2	2	3	4	0
Female	12	8	9	8	9	9	10
Education							
Illiterate	0	0	0	0	0	0	0
Below Grade 10	2	0	0	1	0	0	0
Secondary	12	8	9	8	11	13	10
Under graduation	0	0	0	0	0	0	0
Graduation and above	4	3	2	1	1	0	0
Marital Status							
Unmarried/Single	9	5	6	6	6	7	7
Married	9	6	5	4	6	6	3
Province							
Province 1	1	1	2	1	1	1	0
Province 2	0	0	0	0	0	0	0
Bagmati Province	9	7	5	4	5	7	6
Gandaki Province	0	0	0	0	0	0	0
Province 5	2	1	1	2	0	1	0
Karnali Province	1	0	0	0	1	0	0
Sudurpaschim Province	5	2	3	3	5	4	4

Results: Client Satisfaction Interview

Perspectives of Clients

In CSIs, tools were developed to know the client satisfaction level on helpline services. The total 10 clients using helplines were interviewed from TUTH premise. Most of the study participants aged 18-40 years with median age of 25 while 6 out of 10 clients were male.

Mental health services received by clients

Majority (N=7) of the clients interviewed reported to have called the helpline service for non-suicidal counseling. Only 3 of the client had called the helpline for counselling about suicidal thought.

8 clients reported that they were referred in TUTH and not informed about availability of services in other health facilities and 9 of the clients interviewed indicated that they had received all the services they were seeking after referral by the helpline service providers.

Clients calling helpline services on recommendation

The interviewed clients were asked about whether they called helpline services by themselves or on other's recommendations to know their knowledge on availability of needed services. More than half (6 out of 10) of interviewed clients called helpline services by referral of friends and family while 4 clients had called without anyone's recommendations.

Satisfaction of Clients

Majority of the clients (8 out of 10) were satisfied with the services they received from the helpline services at the time of the interview. Most importantly, majority of clients (N=8) reported that they were benefitted fully by service while remaining other expressed that they benefitted partially. The clients were also asked to rate the services in Likert scale they received from the helpline services prior to the visit to referral center. The clients rated counseling, behavior of counsellors and type of information as satisfactory.

However, waiting time was not scored well since only half rated it as satisfactory or highly satisfactory. Of the clients interviewed, 5 of 10 respondents had to wait less than 10 minutes to receive the services. Moreover, two interviewed clients had to wait more than half hour before the call was received by the service provider.

In regards of behavior of counsellors while taking helpline services, 7 out of 10 clients CEIs expressed their satisfaction whereas remaining were dissatisfied. Similarly, majority of the clients interviewed (n=7) were satisfied with the counselling services being provided while remaining expressed their dissatisfaction. And regarding the time given by the counselors, nearly all most all clients (n=8) said that they were satisfied/highly satisfied with the time duration. Likewise, almost all clients were (n=8) expressed their satisfaction towards their talk with the counselor. When clients were asked to make suggestions needed to improve services, they all indicated that there was need for helpline service providers to avail resources such as reducing waiting time and proper follow-up mechanism.

Clients were asked whether their confidentiality and privacy was maintained by service providers to know if service providers are following government protocol to safeguard patient's information. Almost all clients (i.e. 9) said service providers' maintained confidentiality and privacy, however, one client said that confidentiality might not be maintained because the data could be hacked and illegally accessed.

Also, question on information and counseling was asked to understand if clients had really understood what the service providers were counseling them on. Majority of clients i.e. 8 understood information and counseling fully and remaining understood partially. Clients wished counselling to be available in the local language also.

Table 5 *Perceived level of satisfaction of helpline services among respondents*

Items	Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied
Overall satisfaction		2		8	
Privacy during counseling		1		4	5
Counseling	1	2		5	2
Conversation with counselor		2		7	1
Waiting time	2	2	1	2	3
Time given by the counselor		1		4	5
Behavior of counselor	1	1	1	3	4

Results: Health Facility Assessment

KII and Observation

Table 6 *Basic particulars of KIs*

Type of respondents	Number of interviews	Percentage
Psychiatrists	2	33.33
Suicide Helpline Counsellor	4	66.66
Total KII and observation	6	100

Organization or Management

Available Services

According to service providers, helplines are diverse, ranging from stand-alone service providers to programs housed in community mental health centers or mental health service agencies. The service providers mentioned that organizations that operate suicide prevention helplines often engage in activities other than responding to incoming calls.

Phone is the only source of helpline services

Service providers were asked "please provide statistics for all queries and categorize by category of communication (phone, message, chat, email) for each category." Phone was the only source for providing helpline services. The other services like email, message, chat service weren't provided by any helpline services.

Service providers

Helplines are run by a mix of paid and volunteer staffs. Two out of four the service providers mentioned that they had 4-7 staffs working in their helpline service while remaining service providers had residential staffs working periodically on the calls they receive. The service providers also mentioned that they relied on a mix of paid and volunteer staffs. Only one of the service provider said that it had dedicated paid staffs to operate the helpline service. Majority of the service providers (n=5) viewed the staff numbers available in sufficient quantity at helpline services at the time of the interview.

Funding

Helplines are funded by a mix of private and self-funding. The service providers mentioned that three of the 4 helplines depended on self-funding. As such, their funding can come from multiple sources, including private donors to self-funding, and they may not disaggregate the costs associated with running the helpline from their other activities.

Management information system (MIS) of helpline service

All of the service providers mentioned that there is no systematic information system even for suicide case and the only source was police record. The main reason behind this is the lack of funding and logistics in mental health. The service providers also mentioned that they receive daily 1-2 calls on average and they just keep record of total number of calls they receive in a given year.

Training to staffs working in helpline services

Two of the service providers mentioned that they provide orientation to the resident doctors regarding helpline service and provide extra sim and extra duty to the resident doctors.

Suicide risk assessment & referral:

Majority of the service providers stated that they do not particularly mention their service as suicide prevention helpline since there are questions regarding sensitivity. So, they are using the helpline primarily as means of providing the general psychosocial support. However, they do check whether the caller has a suicide plan and imminent danger through determining level of risk. (N=4) KIs also stated that clients were referred to nearby hospital, teaching hospital as well as to the police if required.

Counselling and Client Satisfaction:

According to service providers the callers are generally satisfied with the answers received from the service providers. However, they do not have record keeping of client satisfaction and follow up system till now. It will increase their legal responsibilities. Some of the helpline user faced network problem due to which there is difficulty in assessing the required information.

Supervision and quality assurance of helpline service:

There is no reported system for supervision, quality assurance and documentation however, trainings were conducted on periodic basis. None of the helpline services reported that they routinely supervise their services.

Barriers to effectiveness of helpline service:

All the service providers (n=5) feel clients benefitted by their service and it was helpful for suicide prevention. One of the service provider mentioned that client expect to get every service through phone in free of cost and it is inaccessible to use Ncell mobile user. Whereas busy phone and network problem are the major barriers to the client. The helpline service providers were asked to rate the barriers for effectiveness of the helpline services. The service providers rated capacity of service, availability of staff and funding as main factors affecting the effectiveness of the helpline service.

However, employee capacity building and employee motivation were not seen as barriers for effectiveness of the helpline services.

Table 7 *Perceived level of barriers of items among KIs*

Items	**No obstacle**	**Small obstacle**	**Don't know**	**Enough obstacle**	**Great obstacle**
Capacity of service				1	5
Availability of tools to provide services		4		2	
A place for counseling and other services		4		2	
Availability of staff		1		4	1
Availability of staffs per service		1		5	
Employee status and capacity building		3		3	
Employee motivation		2		3	1
Consistency of service providers				5	1
Other reasons: Funding					6

Results: Key Informant Interview

Table 8 *Basic particulars of Key Informant Interviewees*

Type of respondents	Number of interviews	Percentage
Program Manager	5	33.33
Psychologists	3	20
Psychiatrists	5	33.33
Social Worker	2	13.33
Total KIIs	15	100

Most (33.33%) of the Key Informants were psychiatrists and program managers of the helpline services. Among the KIs, 12 (80%) were involved in providing helpline services and 3 (20%) were providing other services such as consulting and awareness campaign.

Helpline coverage

The KIs said that the helpline services have coverage all over Nepal where phone networks are present but the expansion of service providers were limited to only major city areas.

"We will expand the services but the one who responds the service should also be expanded. If there is no access, then it is not fruitful. So, both of this should be taken simultaneously. Helpline should be expanded because it is phone based and can be handled by centre. But, main development is needed in collaborating access in referral points, access, phone directory page"

(KII, Program Manager)

Helpline service acceptability

The KIs mentioned as helpline is free of cost and they can easily share their feelings, so they have the acceptance. Also people share more comfortable in phone than in person counseling as it doesn't reveal their identity. One of the KIs mentioned due to the stigma associated with the suicide, clients could not talk about suicide at home so they call during cattle rearing time.

"As the helpline is free of cost and they can easily share their feelings so they have the acceptance"

(KII, Psychologist*)*

Helpline service availability

The KIs were asked about the availability of helpline services. Most of the KIs indicated that the helpline was availability to all the people. However, still people were not utilizing it mostly due to lack of awareness about helpline services. One of the KI also mentioned that helpline service providers don't have enough staffing capacity to answer all the calls if people from all over the Nepal start calling them.

"It is available but everyone is not utilizing it because there is no any advertisement of helpline due to no funding. It is available but not accessible by all people".

(KII, Psychiatrist)

Clients utilizing helpline belonged to geographically separated, socially marginalized and communities with financial hardships.

Helpline service accessibility

The KIs mentioned that all the helpline services were not available for 24/7 and to all SIM users. Four of the KIs said that the helpline was accessible to only NTC users for five days in a week and the service was available for only five weeks from 9:30 am to 4:30 pm while it was available for 24 hours to all SIM users in TUTH and PAHS.

"No, it is not accessible to all in our organization because in our helpline, Ncell is not accessible. Only NTC users have access to it. Another there is time limitation as helpline operates from 9:30 am to 4:30 pm"

(KII, Psychologist*)*

Referral system from helpline

All the service providers stated that the people from rural areas had to travel a long distance to visit the mental health service after referred by the helpline counselor as most of them are city centered. Even after the clients visit the mental health services the cost could be a barrier for treatment.

Coordination among organizations working in suicide prevention

According to the KIs every organization should work in holistic approach by strengthening the local organizations. A comprehensive package should be developed to work in a unified approach.

"Suicide is preventable but in low economic country like Nepal it is easy to say but hard to bring in actions. We all have worked individually but if we work in a unified way, divert the funding in one place and work as a full time suicide prevention organization then changes can be brought"

(KII, Program Manager)

Two of the KIs stated that their organization was member of various international organizations. Further, there should be dissemination of their work based on expertise of organization. All of the KIs mentioned that MoHP should take leadership in suicide prevention though coordination with different sectors.

Community attitude towards helpline services:

The culture of getting help through helpline is in emerging phase in Nepal with most of the people having access to mobile phones. The KI's mentioned that centers working for children, women and police provide helpline in Nepal which have helped to increase the community's attitude towards helplines.

"They maintain confidentiality of client where helpline makes easy accessible service for suicide prevention and need of helpline connection with police, doctor, self-help group and everyone should work together for suicide prevention."

(KII, Psychiatrist)

"*Most important is focus on surrounding people for helping hands like listening to your friend word and helping skill (how do you respond)".*

(KII, Psychologist)

Key SWOT Themes

The SWOT analysis resulted in 26 main themes: 7 strengths, 7 weaknesses, 6 opportunities, and 6 threats (Table 9). Strengths and weaknesses were the positive and negative characteristics, respectively, of current crisis helpline services in Kathmandu valley and were primarily identified from the qualitative results based on the HF assessment, CSI and KIIs. The themes weren't straightforward to generate from the results of the analysis. For example, one of the subthemes from the qualitative analysis was the accessibility and availability of services. A closer examination of the raw qualitative data revealed that this result could fall under two SWOT categories: strengths and opportunities. Similar to the results from the KII, social workers felt that there was adequate access to helpline services (SWOT strength), but that there were possibilities for improving this access (SWOT opportunity).

Table 9 *Strengths, Weaknesses, Opportunities, and Threats of Helpline Services*

From the SWOT Analysis Themes

	Strengths		**Weaknesses**
1	People have started to talk about suicide	1	Busy phone network
2	Helpful in immediate suicide prevention	2	Lack of feedback of provided services and follow up for motivation in providing services.

3	Maintains Anonymity and confidentiality	3	Cases neither recorded nor monitored
4	Provides counseling service	4	Inadequate logistics support
5	Clients are more comfortable in sharing their problems	5	Inadequate advertisement of service
6	Cost-effectiveness and 24 hrs. service in some helplines	6	Inaccessible to every mobile users in toll free numbers
7	Referral system about suitable mental health services	7	City centered
	Opportunities		**Threats**
1	Organize more awareness activities such as drama, role play, rally	1	Lack of awareness on mental health and available services for mental health problems
2	Improve accessibility of existing services	2	Higher expectation of counselling through phone
3	Increase use of technology	3	Social stigma
4	Coordination with government	4	Lack of suicide awareness among politicians
5	Apply for grants to fund programs and training	5	Reluctance to visit health facility and urban centered helplines
6	Conduct a community survey to prioritize programs/training people want; to direct funding applications.	6	Minimal budget, or government investment for mental health

DISCUSSION AND RECOMMENDATION

Our study showed that it is effective to run crisis helpline service for the prevention of suicide in Kathmandu valley as majority of clients (eight out of ten) reported that were benefitted fully by service while remaining other expressed that they benefitted partially. This client satisfaction interview was conducted in a setting where the helpline services have been piloted for at least six years. Majority of the clients were satisfied with the services they received from the sites. This is consistent with past report that over two-thirds of all callers rated the helpline as somewhat effective to extremely effective (King, 1977). In a site where basic record keeping was available, more males were found utilizing the helpline services than females. Males were more likely than females to call a helpline which was quite contrasting with the literature on utilization of telephone crisis services (Mishara & Daigle, 2001). According to the service provider, there is widespread difference in gender orientation views and perceptions among Nepalese society with males given priority to seek and utilize health services by the family over females.

The descriptive data from the mental health utilization survey analysis suggest that the majority of our study participants sought help from consultants regarding mental health problems and that

partner; friends and parent were more frequently contacted than all the professional consultants combined. The consultant type contacted least frequently in our study population was the helpline services. While it is positive that most people are willing to talk to someone about their distress, frequently people do not receive the sort of help they need from their informal supports (Offer et al., 1991). These findings raise doubts about the benefit of seeking help from untrained persons (Offer et al., 1991; Rickwood, 1995). In contrast with informal help-seeking, professional help-seeking is widely recognized as providing protection against a variety of mental health risks, including risk factors for suicide (Luoma, Martin and Pearson, 2002). From a suicide prevention perspective, appropriate help-seeking has the potential to protect the individual against the risks associated with the development of suicidal thoughts and behaviours (Kalafat, 1997). Professional psychological help-seeking has also been found to reduce early forms of suicidal risk before the risk develops into active ideation or suicidal behaviour (Kalafat, 1997).

Our finding that family and friends were frequently consulted suggests that they are potentially an important point of intervention and underscores recommendations to expand educational efforts to improve the cognition and response to those at risk beyond professionals (Barnes, Ikeda, and Kresnow, 2001). Also, primary prevention programs aimed at strengthening family and community support networks in general may be a potentially effective strategy in the primary prevention of suicide (Garland & Zigler, 1993).

Though the helpline is slowly getting acceptable in Nepali society, clients are still stigmatized as they reported that they would feel embarrassed to talk about mental health problems with a service provider if their friends and families know they had utilized the service. The stigma was clearly captured from rates of awareness of available helplines among the clients surveyed, which was quite low 13.7% (N=39) and from the key informant interview where service provider mention clients to call helpline when they were outside the home. In fact, very few of the clients surveyed had used any helpline, with only 2% (N=4) had utilized helplines. This information is consistent with past studies of having awareness of available services but low usage (Gould et al. 2006). However, all the mental health helpline services were found quite under-utilized compared to other helplines available in Nepal such as GBV and child helpline services due operational challenges of service providers for running the helpline services besides lack of awareness and social stigma among clients. Perhaps increasing awareness of these services, which are anonymous, easily accessible, and likely to appeal to clients, may provide some benefit in preventing suicide in society. In order to increase awareness and give advertisement, radio was found the most active medium among participants.

Although clients were concerned with stigma, the service providers felt that awareness would

decrease stigmatization towards helpline services. This finding calls for the need to address issues of stigma in the community. Most of the organizations that operate suicide prevention helplines received no direct funding which makes them difficult to run sufficient awareness campaign and increase staff capacity. In addition, organizations that operate helplines often engage in activities other than responding to incoming calls. As such, their funding can come from multiple sources, including private donors and self-paid, and they may not disaggregate the costs associated with running the helpline from their other activities.

One of the most important findings of the study is that both service providers and clients appear to welcome the advantages and convenience of helpline service. However, there is need to address issues pertaining to shortages of staff, training, monitoring and stigma in the community through funding and awareness campaign. If these challenges are addressed, issues of workload, underutilization of helpline services and waiting time will be resolved.

In providing helpline services, efforts should be put in place to ensure that waiting time is not unnecessarily increased. The increase of staffs at helpline service provider would reduce the waiting time by increasing staff. It should also be noted that both clients and service providers identified shortage of staff as the major barrier to effective service. Although service providers indicated that training of and staff capacity was constraint, all the service providers were oriented on running service smoothly.

The high rates of mental health problems reported by previous studies raised an important issue for researchers and mental health professionals to consider as they provide suicide prevention programs. Since due to lack of proper MIS we were not able to identify or track all the clients' personal data, who reported problems. None of the suicide prevention helplines track and report data on call volume, or how many calls are answered in a given time frame. However, there is variability across service providers with respect to call volume. However, call volume does not equate to the number of unique individuals in distress, seeking a referral, or in crisis who call helplines. Helplines receive prank calls and calls in which the caller immediately hangs up or just talk for time pass. Finally, not all callers to helplines are at need of psychosocial support or at immediate risk of suicide. Likewise, the privacy issue is particularly important when delivering messages that might be disturbing to some of the participants. Thus, it is important to assess the safety and acceptability of the message when designing helpline services and future suicide awareness programs. The issues related to maintaining anonymity in suicide awareness and prevention studies deserve further investigation.

Although respondents reported preferring to reach out to a helpline over emails or text messaging if they felt suicidal, general communication patterns suggest a shift toward a preference for chat and text over traditional phone-based communication. However, as mentioned earlier, no organizations currently offer these options, likely because the costs of providing chat and text services are significant (Grant,

2015). Our study also revealed uncertainty about whether helplines are meeting the needs of at-risk populations in Kathmandu valley. The findings from our study provide support for the relevance of the helpline services for prevention of suicide in Nepal. The findings indicate that a helpline service would be an acceptable and effective strategy for promoting early detection of suicidal behaviour and promoting help seeking behaviour among Nepalese community.

Conclusion

The culture of getting help through helpline is in emerging phase in Nepal. Our study revealed the major challenges for accessibility on the demand side or clients' sides were: were lack of awareness on mental health and available services for mental health problems literacy, social stigma, cost inaccessibility, higher expectation of counselling through phone, reluctance to visit health facility and urban centered helplines. Street clients with even no access to phone are the most vulnerable among them. The low utilization of helplines and the stigma toward them among clients is particularly distressing in light of evidence of the short-term efficacy of helplines that use this resource. This potential source of help appears to be inadequately tapped by client.

Likewise, the challenges on the supply side (service provider side) were: minimal budget, or government investment for mental health, lack of trained service provider, lack of time for proper counselling through phone to those who cannot come to health facility, busy networks due to limited number of call lines, lack of feedback of provided services and follow up for motivation in providing the services. Merely absent recording and reporting system of mental health services is the other major challenge.

Finally, public health awareness campaigns about helpline services together with availability of funding could address this situation. The efforts of mental health organizations and hospitals to collaborate with one-another to expand the available quality services is commendable and praiseworthy. Establishing nationwide partnerships and suicide prevention center could target and develop strategies to mitigate some of these limitations at the local level. The results of the study are of special interest because Nepal placed importance on studies regarding mental health and suicide as a suicide prevention strategy and suicide prevention has been one of the key components of the WHO *Mental Health Action Plan 2013–2020*, with the target of reducing the rate of suicide in Member States by 10% by 2020. Thus evidence from the

study sites on the practical effectiveness (and challenges) of helpline services should be of direct relevance to other mental health organization with similar profiles who wants to run helpline services.

Recommendations

In light of the results we found, we offer the following recommendations:

Service Provider

- We recommend that the focus on continuous quality improvement be not limited to helplines. Recording calls is a good way for call centers to continuously assess the quality of the services that a helpline is providing.
- The call responders should have training in effective communication strategies that draw from evidence-based methods, like motivational interviewing. These approaches could pave the way for help-seeking and increased receptivity to referrals.
- The service provider should have 24 hours' helpline service with night staff and toll free number accessible to every network user to talk freely about their problems any time.
- Educating the public to recognize signs of suicide risk and encouraging those at risk to seek help, should be promoted.
- Some client requires expertise from other fields. The call responders' team should include personnel from multiple disciplinary fields such as psychiatrist, psychologist, social worker, counsellor etc. so that they are able to address the clients facing different mental health issues.
- The service providers may partner with local mental health service providers to follow up with high-risk patients after a mental health–related hospital discharge; these practices have been found to delay or prevent reattempts.
- To accommodate clients' preferences, chat- and text-based crisis support services need to be strategically established. However, chat and text should not necessarily be stand-alone services.
- A centralized, online directory like yellow page could ensure that call responders can provide callers with up-to-date information on available and appropriate services and resources.

General Public

- It is important for callers to understand that the service providers can't provide all the services they want during the single call.
- Come out of suicidal myths and stigma and reach the helpline services. The families and

communities should provide social support to the individuals.

- Self-help group of suicide ideation and survivors would be beneficial for overcoming the stigma of suicide. Self-help group of family that has been affected by loss of family member can also be formed in order to support themselves and others.

Government

- Suicide prevention strategy is important because it indicates a government's clear commitment to prioritizing and tackling suicide, while providing leadership and guidance on the key evidence-based suicide prevention interventions. Government of Nepal should tailor the suicide prevention programs on the need basis as a suicide prevention strategy.
- Government should support to conduct awareness programs in the schools, colleges and communities by providing fund to the mental health organizations to remove the suicidal myths and promote the utilization of helplines.
- The government should take initiative for establishment of suicide prevention center that can provide regular and integrated services related to suicide prevention such as training, monitoring of helplines to studies and awareness, prevention, promotion and intervention programs.
- There was mixed availability of paid psychiatrist, psychologist, psychiatric social workers, and counsellor at the service sites. The government should support the organizations providing mental health services for full time availability of human resources and to fulfil the post.
- There was no monitoring and supervision of the crisis helpline services from the government. Monitoring body of helpline counselor is needed. There should be regular monitoring and supervision by government.
- The government should ensure that helpline services are accessible to all types of clients and make availability of treatment centre nationwide not merely based on city centre.

Mental health Agencies

- The mental health agencies should engage in running suicide prevention awareness programs in schools and colleges.
- Build helping skills of the people around in awareness program on how to respond and support if somebody around them talks about suicide.
- Provide advertisement on suicide prevention programs and give ways to minimize the means of suicide.
- Be involve to increase reporting of suicide, also awareness needs to be increase among public that suicide in not illegal.

Limitations of the study

- This study was conducted in selected HFs only and findings of these HFs will not represent other HFs of the country.
- The data do not allow us to examine the nature of the respondent-consultant interaction and whether these interactions are successful in preventing suicide or harmful in nature, thus these help-seeking behaviors cannot be interpreted as being risk factors or protective factors for a nearly lethal suicide attempt based on the associations described in this study.
- This study was conducted using a hospital-based sample and cannot be generalized to those people who haven't visited hospital. There is a distinct possibility that people outside of a hospital system have less access to mental health, and therefore the knowledge and utilization rates reported in the present study may not apply to other populations of Nepal.
- The hospitals were all of urban areas so the results cannot be generalized to rural or more ethnically diverse settings.
- This study has adopted descriptive cross-sectional study, which means it gives a snap shot scenario of the study population. Thus, the findings cannot show a cause-effect relationship.
- There may be a possibility of response bias. Study participants are expected to provide honest responses to the study questions asked; however, in some circumstances this assumption may be breached due to factors such as, social desirability or recall bias.
- Some questions are based on sensitive topics of suicide, so there may be risk of refusal from the client.

More research is needed to estimate the return on investment of adopting new strategies to improve health care services. This can be done by evaluating new services when they are incorporated into existing practices or by modeling the potential effects before adopting new services. More analytic studies regarding help-seeking would significantly contribute to our understanding of the role of help seeking in suicide prevention. Our findings suggest that efforts to better understand the role of help-seeking in suicide prevention, including help sought from family and friends, deserves further attention.

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Annexes

Annex 1- Informed Consent

Informed Consent

Namaste,

My Name is _____. I am working for Health Foundation Nepal, Sanepa Lalitpur. We are conducting a formative research on feasibility of Mental Health Crisis Helpline Services for the Prevention of Suicide in Nepal. This interview will take about 15-20 minutes.

I assure you that the information, your views will be confidentially treated and will not be used in other purpose beyond this study.

Do you agree to participate in this study?

Yes…….

No…….

If you agree to participate in the study, please sign below:

Signature of Respondent: _____

Date: _____

Annex 2- Mental Health Survey Questionnaire

1. Mental Health Survey Questionnaire

SECTION A: BASIC DATA

1	Age (In completed years)	_____		
2	Gender	Male	1	
		Female	2	
		Others _____	3	
3	Place of residence	_____		
4	How long have you and your family been living at this residence?	_____		
5	Marital status (circle one answer)	Single/ never married	1	
		Married	2	
		Separated/ Widowed	3	
6	Religion (Circle one answer).	Hindu	1	
		Buddhist	2	
		Islam	3	
		Christianity	4	
		Other _____	5	
7	What is the highest educational level completed?	_____		
8	What is your current family type?	Nuclear	1	
		Joint	2	
		Others	3	

Section B: Awareness and Utilization of helplines

9	Do you know about the Helpline services available in Nepal?	Yes	1	
		No	2	
10	If yes, please mention the program operating in Nepal?	_____		
11	Have you ever heard or learnt of Suicide Prevention Program before (prior to this interview)?	Yes	1	
		No	2	
		Others _____	3	
12	How did you hear or learn about helpline services?	Radio	1	
		Television	2	

	(Please select all mentioned/that apply)	Health workers	3	
		Relatives / Community members	4	
		Newspaper/ Posters/Other print materials	5	
		Internet / Blog / Website / Social Media /Facebook	^	
		Mobile phone / text messages	&	
		Others _____	*	
13	Have you ever made use of the suicide helpline services?	Yes	1	
		No	2	
		Others _____	3	

Section C: Access to and preferences for type of crisis service medium

14 Below is a list of people who you might seek help or advice from if you were seeking help for suicidal thoughts and knew where to find resources to help. Please circle the number that shows how likely is that you are willing to utilize each of these services.

	Extremely Likely 	Likely 	Neutral 	Unlikely 	Extremely Unlikely 
Partner					
Parent					
Other relative / family member					
Teacher					
Call phone help line					
Text phone help line					
Mental health professional					
Others_____					
I would not seek help from anyone					

Thank you for your cooperation and prompt response.

Annex 3- Client Satisfaction Interview

2. Interview questionnaire with clients

1. Date and duration of interview:

- Date of interview / day / month/ year : _____
- Duration: _____ Starting Time: _____

  Ending Time: _____

2. Name of participant: _____
3. Age of participant: _____
4. Gender of participant: Male / Female/ Others
5. Interview location: _____
6. Name of the service provider organization :_____

Place _____Ward _____

VDC/Municipality _____ District _____

7. Where is your birth place? (District) _____

8. Can you read and write?

a. Yes b. No

9. What is your highest education?

a. Primary level b. Secondary c. Higher secondary

d. Graduate level e. Postgraduate level f. Other

10. Marital status

a. Unmarried b. Married

c. Divorce d. Separated

11. What kind of mental health care have you received?

a. Helpline Services

b. Other Services _____

12. Have you taken mental health care yourself or by someone else's recommendation?

a. Self

b. By the recommendation of someone else

13. If you were taken by someone else's recommendation, who recommended you?

a. Health workers

b. Women's Health Volunteer Service

c. Dhaami/Jhakri

d. Family members

e. Friends

f. Others _____

14. Do you often use this service for mental health?

a. Yes

b. No Go to question No. 16

15. If yes, what is the reason behind using this service?

_____

Go to question No. 18

16. If no, what is the reason behind not using this service?

17. If you do not use mental health services, which service do you use?

18. How long have you waited to receive the mental health service? _____

19. After using mental health services, did you get the information you need?	Yes	1	
	No	2	
	Don't know/ Don't remember	3	
20. Do you feel that you have any benefit after using this service?	Yes	1	
	No	2	
	Don't know/ Don't remember	3	

21. Did you get the service you want from the mental health worker?

a. Yes

b. No

22. Why did you use mental health services? Please briefly describe your experience of mental health services.

23. What do you like about mental healthcare services?

24. Did you know anything about mental health services you didn't know before?

25. How satisfied are you with the mental health services you receive? Ask about each topic.

	Very dissatisfied	dissatisfied	neutral	Satisfied	very satisfied
Overall satisfaction					
The privacy during consultation					
Counseling					
Conversation with psychologist					
Waiting time					
Time given by the psychologist					
Behavior of psychologist					

Explain if any topics were given a dissatisfied or very dissatisfied position.

26. What do you think should be done to make you more satisfied with the mental health care services you receive?

Thanks for your help and feedback.

Annex 4- Mental Health Facility Assessment

3. Mental Health Facility Assessment

Name of Interviewer_____ District _____

Name and position of interviewee _____ Location_____

Interview start time_____ Interview end time: _____

Date 2076/ /

Section: A General Information

1. Name of Service Provider _____

   Place_____Ward_____VDC/Municipality_____

   _____

   District _____

2. How many years have you worked in this organization? _____
3. How do you work at this organization?

   a. Volunteer b. Job

   c. Owner d. Other_____

4. How is resource management done for this organization?

   a. From donors within the country b. from foreign donors

   c. Government subsidy d. from the fees charged to the institution

   e. Other _____

Q.	Questions and Filters	Responses

Section B: Available Services

5. What services are provided by this facility?

a._____

b._____

c. _____

d._____

6.

What is the client's convenience and environment at this organization?	Excellent	Good	satisfactory	Not satisfactory	Bad	Not Available
	1	2	3	4	5	6
Cleanliness						
Drinking water						
Electricity						
Living arrangements						
Counseling and Treatment Room						
Internet						
Phone						
Other _____						

Section C: Helpline Services Operational Questions

7. Does the public know about the helpline number? Yes (1) No (2)

8. When did the government recognize your helpline?

9. Should your helpline service be renewed? If so, when?

10. When the helpline is contacted and responds to this helpline, please explain the process.

11. When the helpline is contacted at this helpline and you do not respond, please explain the process.

12. Do you have email, message, chat service to provide helpline service? If so, how do you use each of these services?

13. Please provide statistics for all queries and categorize by category of communication (phone, message, chat, email) for each category.

How many customers were there during the

Phone	Message	Chat	Email	Other
1	2	3	4	5

last month for helpline services?

14. How many clients were referred? Where?

15. How many of the clients in the contact line did not provide helpline service? Why?

16. How many client issues does your staff usually address per day?

17. Please tell us when you can use this helpline service.

Time in the week	Time
_____ day	Whole day
	Partial day
	Other (Specify) _____

18. Which category of people most commonly use helpline service? What services are available to help them through the helpline?

19. Does service providers systematically evaluate suicidal thinking? What types of medical legal guidance services are used?

20. What kind of relationship is maintained between the helpline service provider and the client? How is privacy maintained when providing and monitoring services?

21. Is there any monitoring arrangement for the service provider? What kind of offline services are provided after the helpline service?

22. Who provides helpline services? What kind of training have they received?

23. Was the helpline service helpful to people in crisis? How was the effectiveness of the service monitored and evaluated?

24. How relevant is the helpline service in the context of widespread Internet use today? Has the use of the helpline service changed after the widespread availability of Internet services?

25. Please evaluate the factors affecting the effectiveness of the helpline service in this organization.

Items	No obstacle	Small obstacle	Don't know	Enough obstacle	Great obstacle
	1	2	3	4	5
Capacity of service					
Availability of tools to provide services					
A place for counseling and other services					
Availability of staff					
Availability of staffs per service					
Employee status and capacity building					
Employee motivation					
Consistency of mental health care providers					
Other reasons :_____ _____					

Section D: Staffing

26. How many employees are there in this organization?

27. Does this organization also have volunteer staff?

28. How many employees are required for this organization?

29. What do you think is the number of counselors available at the helpline service? (Check one box.)	More	1
	Sufficient	2
	Insufficient	3
	Less	4
	I don't know	5

Thank for your help and feedback.

Annex 5- Key Informant Interview

4.Key informant's questionnaire

4.1 Program Manager (Mental Health Services Officer, Head of Mental Health Organization)

Name of Interviewer_____ District _____

Name and position of interviewee _____ Location_____

Interview start time_____ Interview end time: _____

Date 2076/ /

Section: A General Information

1. Name of Service Provider _____

   Place_____Ward_____VDC/Municipality_____

   _____

   District _____

2. How many years have you worked in this organization? _____
3. How do you work at this organization?

   a. Volunteer b. Job

   c. Owner d. Other_____

4. How is resource management done for this organization?

   a. From donors within the country b. from foreign donors

   c. Government subsidy d. from the fees charged to the institution

   e. Other _____

Section: B Mental healthcare program

5. Can you share a bit about your experience with the mental health care program?
6. What are the main barriers to access for mental health services? Geographical conditions, service provider capacity, traffic, etc.
7. Are there any laws or regulations hindering Nepal's mental health care program? If so, what are they?

9. Does this organization make the following efforts to advocate for legalizing mental health reform?			

	Yes	No	
Review of the Status of Laws on Mental Health and Mental Health	1	2	
Reinforcement of mental health and mental health laws	1	2	
Advocacy for the Law of Strengthening Mental Health for the Public Good	1	2	

Section : C Suicide prevention program

10. Can you tell us about Suicide Prevention Program runing in Nepal?
    (Providing psychotherapy, counseling centers, rehabilitation centers, psychosocial support, other mental health programs, etc.)
    Who is making the services available?
    What are the strong aspects of these programs? What about weak points?
11. Which Suicide Prevention Programs Are Effective? And why?
12. What are the main causes of suicide? How do you think we can reduce the number of suicides?
13. What are the main challenges facing the entire field of suicide prevention programs? What makes you look at the challenges?
14. What are the potential challenges to improving suicide prevention programs?
15. What opportunities or concerns will be enforced in the Suicide Prevention and Suicide Prevention Program in the country?
16. Is your organization involved in any public awareness campaign on suicide prevention issues? Public awareness campaigns, access to specific classes and areas, etc.
17. If so, can you describe some achievements? What are the program's priorities?
18. What kind of activities are you conducting through your organization in collaboration with other organizations - suicide and suicide prevention programs from the Ministry of Health?
19. Are there opportunities to improve that collaboration? Is there a process to collaborate with your organization? Which organizations are participating? Who should be in the debate but not?
20. Does your program and organization have some resources (physical, humanitarian, financial) that are not currently available, further strengthening the potential for suicide prevention programs?

Section D: Helpline service

21. What do you think about helpline services? Who started it? Why was it needed? Are there enough infrastructure to operate the helpline?
22. Is helpline services accessible to all people? What steps have been taken to improve access and use of the helpline service?
23. What are the most common complaints about helpline services?
24. How do you get the community's perception of the community towards the helpline?
25. How much do all people know about the helpline service available?
26. How do you get public awareness about helpline services?
27. How effective is a helpline service for suicide prevention?
28. What are your suggestions to make this service even better?
29. What are the most important obstacles and challenges facing people using helpline services?
30. How do you think these barriers can be overcome, and what role can the government play in assisting?
31. Do you have any other recommendations for expanding suicide ÷ suicide prevention programs that are not currently in use?

Thanks for your help and feedback.

4.2 Service Provider Organization (Mental Health Services Program Manager)

Name of Interviewer_____ District _____

Name and position of interviewee _____ Location_____

Interview start time_____ Interview end time: _____

Date 2076/ /

Section: A General Information

1. Name of Service Provider _____

Place_____Ward_____VDC/Municipality_____

_____

District _____

2. How many years have you worked in this organization? _____
3. How do you work at this organization?

a. Volunteer b. Job

c. Owner d. Other_____

4. How is resource management done for this organization?

a. From donors within the country b. from foreign donors

c. Government subsidy d. from the fees charged to the institution

e. Other _____

5. Please describe the services provided by this organization to help people with mental health problems? (Geographic area, target group, services)

6. What resources are currently available to your organization and which resources are not available but are needed for Suicide Prevention Program?

7. How can your organization contribute differently than the Suicide Prevention Program?

8. How do mental health clients get here (eg family, relatives, police, social workers)?

a. _____

b. _____

c. _____

d. _____

9. What do you think causes mental problems?

(Such as religion, family conflict, unequal relationships, drug use, alcohol consumption, unemployment)

a. _____

b. _____

c. _____

10. How do you currently report Suicide Prevention? What websites, what sources magazines, internet contacts, etc.

11. In the future, how would you like to submit Suicide Prevention Information? What websites, what sources magazines, internet contacts, etc

Section: B Weakness

12. Do you see a need for some improvement in your program?

13. Are service providers asking questions for services you cannot provide?

14. What prevents your program from providing that service?

15. Other weakness_____

Section: C Opportunities

16. What are some aspects of your program that you can change to opportunities?

17. Are you aware of a new Suicide Prevention Programs?

18. Does your organization have any new Suicide Prevention Program opportunities?

19. Do you know about new technology opportunities in suicide prevention programs?

20. How can you take advantage of new technology?

21. Are the needs of any service provider not being met?

22. What do you see as some of the new requirements or desires of the clients?

23. Other Opportunities_____

Section: D Challenges

24. What are the most significant obstacles and challenges your program faces?

25. How does your organization's suicide prevention program address the following challenges?

(A) Political effects?

(B) the effects of the law?

(C) Development of information technology?

(D) the demands of the client?

(E) New technology, services, ideas?

(F) Significant Agreements and Cooperation?

(G) Maintaining the sustainability of internal capabilities?

(H) Sustainable financial condition?

(H) Other Challenges _____

26. How much does your program's client's risk-taking behavior look like?

(Eg, hurt oneself, attempt suicide and commit suicide).

(A) _____

(B) _____

(C) _____

Thanks for your help and feedback