Suicide

Types & Clinical Assessment

[1]suicide *noun*

Merriam-Webster:

"THE ACT OR AN INSTANCE OF TAKING ONE'S OWN LIFE VOLUNTARILY AND INTENTIONALLY ESPECIALLY BY A PERSON OF YEARS OF DISCRETION AND OF SOUND MIND."

Oxford Dictionary:

"THE ACTION OF KILLING ONESELF INTENTIONALLY"

Dictionary.com:

"THE INTENTIONAL TAKING OF ONE'S OWN LIFE."

Each victim of suicide gives his act a personal stamp which expresses his temperament, the special conditions in which he is involved, and which, consequently, cannot be explained by the social and general causes of the phenomenon.

(Emile Durkheim)

TYPES OF SUICIDE

- Emile Durkheim classified different types of suicides on the basis of different types of relationship between the actor and his society.

1) Egoistic suicide:

According to Durkheim, when a man becomes socially isolated or feels that he has no place in the society he destroys himself. This is the suicide of self-centred person who lacks altruistic feelings and is usually cut off from mainstream of the society.

2) Altruistic suicide:

This type of suicide occurs when individuals and the group are too close and intimate. This kind of suicide results from the over integration of the individual into social proof, for example – hari-kari and Hindu wives' figurative suicide ritual.

3) Anomic suicide:

This type of suicide is due to certain breakdown of social equilibrium, such as, suicide after bankruptcy or after winning a lottery. In other words, anomic suicide takes place in a situation which has cropped up suddenly.

4) Fatalistic suicide:

This type of suicide is due to overregulation in society. Under the overregulation of a society, when a servant or slave commits suicide, when a barren woman commits suicide, it is the example of fatalistic suicide

The Werther Effect

Named after a German novel which influenced a number of copycat suicides, the Werther Effect describes a spike in suicides committed in a similar way.

In the 5 Months following news of Robin Williams' Suicides, studies say there was a **10%** increase in suicides.

Even more significant was a 32.3% spike in suicides by hanging (the same method Williams' used)

This likely affects people already contemplating suicide. It doesn't necassarily increase the amount of suicides, long-term, but simply encourages this "clustering".

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ANOMIE

Anomie in individuals and society is a condition of instability and disintegration. It stems from the breakdown of previously shared norms and values that regulated social (inter)actions.

EXAMPLES

1. People living in high-rise residencies feel disconnected from one another and struggle with loneliness.
2. People engage in organized theft because they do not have other ways of accumulating wealth.
3. Individuals resorting to criminal activities (e.g., looting) during times of war or military occupation.

CAUSES OF ANOMIE

1. Loss of one's sense of social belonging
2. Breakdown of social norms that keep people united

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Anomie

- Anomie is normlessness. if an individual or a group of people go against the socially accepted behavioral patterns, there can be an anomic situation.

Alienation

- Alienation can be defined as a situation where there is less integration among the people in a community and individuals do not feel connected to each other.

SUICIDE PACTS

The Importance of Sensitivity: *Responsible Reporting* on Suicide

ON THE BLOG

DO NOT USE THESE IMAGES
WHEN REPORTING SUICIDES IN THE MEDIA

- ✘ Photographs/ video footage of the **scene of suicide**
- ✘ Photographs/ video footage of the **person or the family from the scene of suicide**
- ✘ **Suicide notes, final text messages, social media posts or emails** from the deceased or their family members
- ✘ Dramatic or insensitive representational images such as **picture of a noose, person standing on a ledge etc.**

SUICIDE BY PERSONS ENGAGED IN FARMING OPERATIONS

5,318 Suicide by farmers/ cultivators

5,563 Suicide by agricultural labourers

A 2021 B

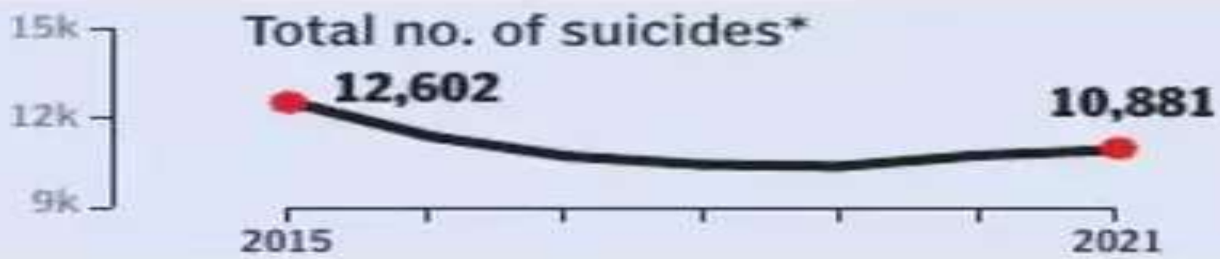
Total **10,881**

States/UTs with zero suicides of farmers/cultivators as well as agri labourers

Bihar, West Bengal, Jharkhand, Odisha, Tripura, Manipur, Arunachal Pradesh, Uttarakhand, Chandigarh, Lakshadweep and Puducherry

TOP FIVE STATES

INDIA YEAR-WISE



STATES THAT SAW MOST SUICIDES

FARMER/CULTIVATOR SUICIDES

State	2019	2020	%Chg
Maharashtra	2,680	2,567	−4.22
Karnataka	1,331	1,072	−19.46
Andhra Pradesh	628	564	−10.19
Telangana	491	466	−5.09
Madhya Pradesh	142	235	65.49
Punjab	239	174	−27.20
Tamil Nadu	6	79	1,216.67
UP	108	87	−19.44
Total	**5,979**	**5,579**	**−6.69**

AGRI LABOURER SUICIDES

States	2019	2020	%Chg
Maharashtra	1,247	1,439	15.40
Karnataka	661	944	42.81
Madhya Pradesh	399	500	25.31
Tamil Nadu	421	398	−5.46
Kerala	128	341	166.41
Andhra Pradesh	401	325	−18.95
Total	**4,324**	**5,098**	**17.90**

Note: Total won't match as all states haven't been included
Source: Accidental Deaths and Suicides in India 2020 and 2019 report

March 27, 1997

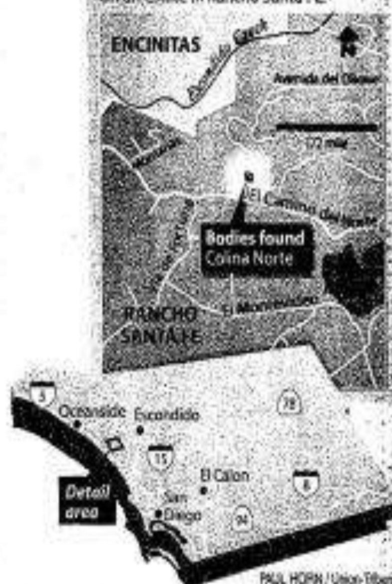
Union-Tribune.

35¢
Tax included

"I've never seen anything like this in my life."

LT. JERRY LIPSCOMB, *homicide detective*

Mansion of death yields 39 bodies



PAUL HORN / Union-Tribune

■ Members of religious group discovered dead in Rancho Santa Fe
■ Deaths appear to be a mass suicide, according to sheriff's deputies

By Ruth L. McKinnie
STAFF WRITER

RANCHO SANTA FE — At least 39 members of a religious group, who referred to themselves as angels, were found dead yesterday inside a rented million-dollar-plus estate.

Sheriff's investigators, who began searching the house only late last night, said the deaths appeared to be a mass suicide. If so, it would be one of the largest such incidents in U.S. histo-

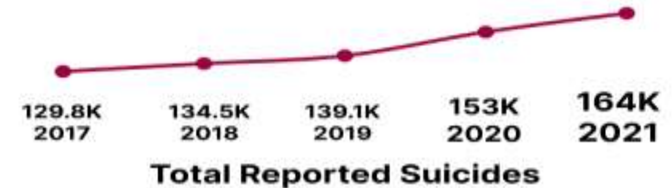
Reported Suicides in India Per 1 lakh Population, 2021

India Average **12.0** Reported Suicides per 1 lakh population

- 39.7 AN Islands
- 39.2 Sikkim
- 31.8 Puducherry
- 26.9 Kerala
- 26.9 Telangana
- 26.4 Chhattisgarh
- 24.7 Tamil Nadu
- 20.6 Goa
- 19.5 Karnataka
- 18.9 Tripura
- 17.8 Maharashtra
- 17.6 Madhya Pradesh
- 15.4 DNHDD
- 15.3 Andhra Pradesh
- 13.7 West Bengal
- 13.7 Delhi
- 12.5 Gujarat
- 12.5 Haryana
- 12.3 Odisha
- 12.0 Himachal
- 12.0 null
- 10.4 Arunachal
- 10.4 null
- 9.9 Chandigarh
- 9.3 Assam
- 8.6 Punjab
- 8.1 Mizoram
- 7.0 Rajasthan
- 6.9 Meghalaya
- 6.3 Uttarakhand
- 4.7 Jharkhand
- 3.7 Ladakh
- 2.6 Uttar Pradesh
- 2.0 Nagaland
- 1.8 J&K
- 1.5 Manipur
- 1.5 Lakshadweep
- 0.7 Bihar

3.7 LA
1.8 JK
12.0 HP
8.6 PB
6.3 UK
12.5 HR
13.7 DL
7.0 RJ
2.6 UP
0.7 BR
39.2 SK
10.4 AR
9.3 AS
2.0 NL
6.9 ML
1.5 MN
4.7 JH
13.7 WB
18.9 TR
8.1 MZ
12.5 GJ
17.6 MP
26.4 CG
12.3 OD
15.4 DH
17.8 MH
26.9 TS
20.6 GA
19.5 KA
15.3 AP
31.8 PY
39.7 AN
26.9 KL
24.7 TN
1.5 LD

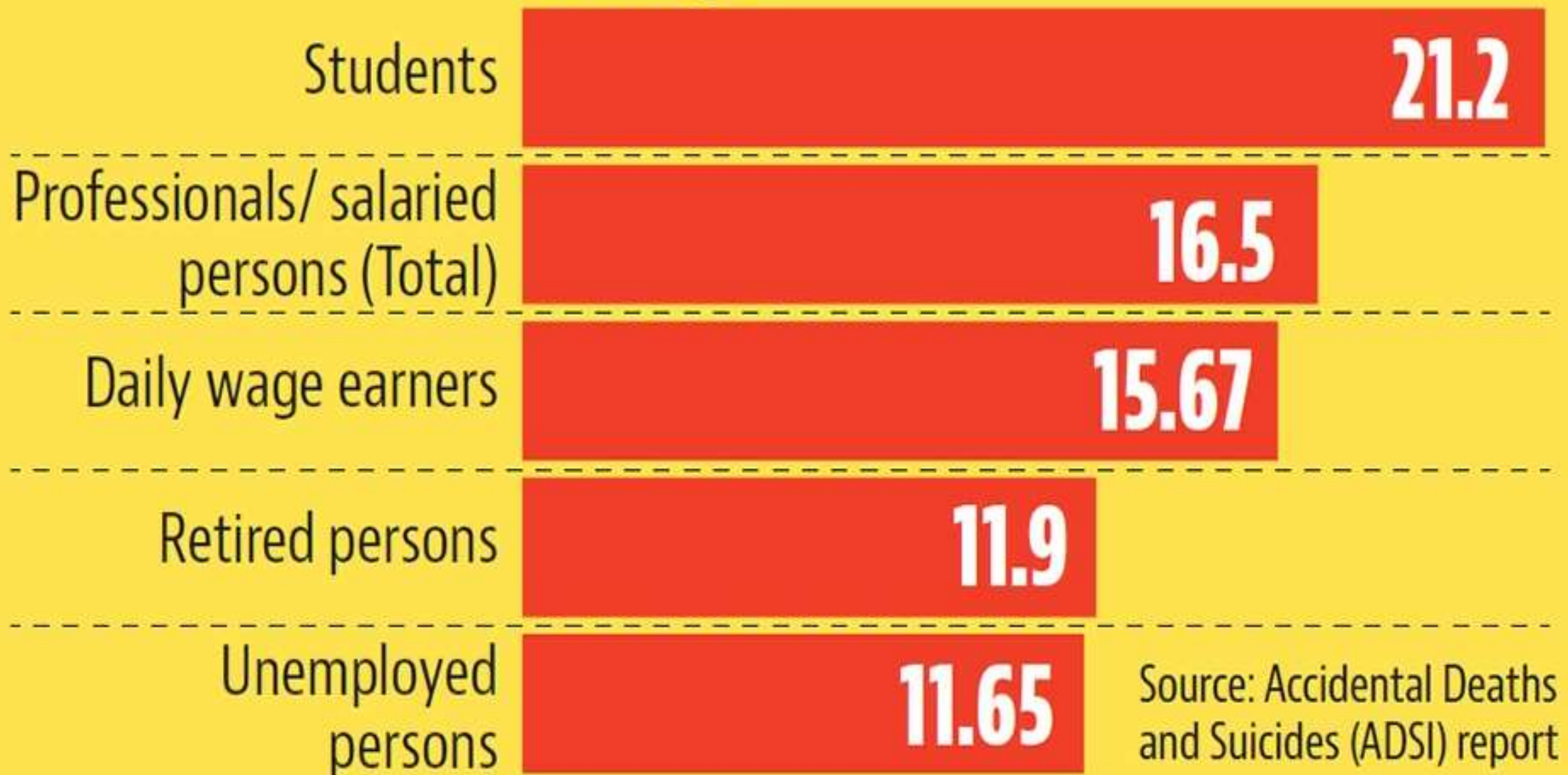
statsofindia.in
Source: NCRB 2021



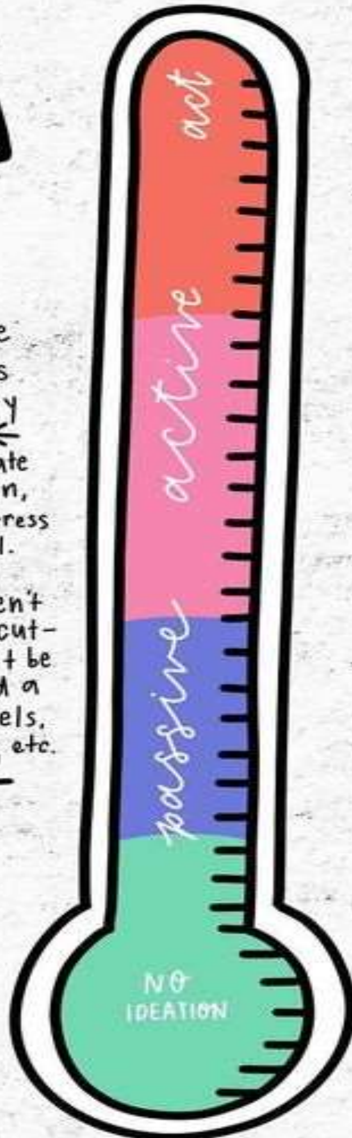
In pandemic year

NCRB data shows big jump in deaths by suicide among students

% change



THERE ARE DIFFERENT TYPES OF SUICIDAL IDEATION



NOTE

ALL of these types + levels of suicidality are ⇛VALID⇚ & doesn't dictate the level of pain, intensity, & distress you may feel. ♥

These also aren't always clear cut- someone might be moving around a few, "skip" levels, fall in between, etc.

SUICIDE ATTEMPT
attempts to kill self, either initiating made plan or impulsively

SUICIDAL with PLAN & INTENT
has a specific plan (how, when, where) and intends to carry it out → Ex. "I am going to overdose tomorrow at home."

SUICIDAL INTENT (no plan)
intends to kill self but doesn't have a specific plan → Ex. "I think I'm going to kill myself, but not sure when."

SUICIDAL THOUGHTS (method, no plan or intent)
has an idea of how they would do it, but no specific plan or intent → Ex. "I've thought about overdosing, but I'm not going to."

SUICIDAL THOUGHTS (no intent/plan)
thinking about killing self, but no details & no intention to act → Ex. "I should just kill myself." "I wish I could just kill myself."

THOUGHTS OF MORBIDITY
thinking about own death & dying, but not specifically by self → Ex. "I wish I wouldn't wake up" "I wish I were dead."

RANDOM INTRUSIVE THOUGHT*
passing thought, curiousity → Ex. "What if I just jumped?" when waiting for train *different if person has chronic suicidality

NO THOUGHTS

SOURCED FROM lived experience & columbia-suicide severity rating scale

@ALYSERURIANI

Shneidman's Ten Commonalities of Suicide (1985)

1. The common stimulus is unendurable psychological pain (i.e., psychache).
2. The common stressor in suicide is frustrated psychological needs.
3. The common purpose of suicide is to seek a solution.
4. The common goal of suicide is cessation of consciousness.
5. The common emotion in suicide is hopelessness-helplessness.
6. The common internal attitude toward suicide is ambivalence.
7. The common cognitive state in suicide is constriction.
8. The common interpersonal act in suicide is communication of intention.
9. The common action in suicide is egression (i.e., escape).
10. The common consistency in suicide is with life-long coping patterns.

Some Important
RISK FACTORS
for suicide
PREVIOUS suicide ATTEMPTS
History of SUBSTANCE ABUSE
Physical DISABILITY or ILLNESS
RELATIONSHIP PROBLEMS
Losing a FRIEND or FAMILY MEMBER to SUICIDE
ACCESS to HARMFUL MEANS
Ongoing EXPOSURE TO BULLYING behavior
Recent DEATH of a FAMILY MEMBER or a CLOSE FRIEND
History of a MENTAL HEALTH CONDITION
DE SOUSA FOUNDATION

Suicide WARNING SIGNS

NEGATIVE VIEW of SELF

A sense of HOPELESSNESS

OR NO HOPE for the FUTURE

ISOLATION or FEELING ALONE

MAKING SUICIDE threats

SUBSTANCE abuse

AGGRESSIVENESS and IRRITABILITY

GIVING things AWAY

Possessing LETHAL MEANS

Making funeral ARRANGEMENTS

FEELING LIKE A BURDEN to others

ENGAGING in "risky" BEHAVIORS

SELF-HARM

like CUTTING behaviours

FREQUENTLY TALKING about DEATH

DRASTIC changes in MOOD and BEHAVIOUR

Classical Crisis Concept

DSM Concept

Suicidal Behavior Associated with Mental Disorders

Suicidal Behavior Disorder

Suicide-Specific Syndromes

ASAD

Acute Suicidal Affective Disturbance

SCS

Suicidal Crisis Syndrome

ASAD	SCS
A. A drastic increase in suicidal intent over the course of hours or days, as opposed to weeks or months B. One (or both) of the following: marked social alienation (e.g., social withdrawal, disgust with others, perceptions that one is a liability on others) and/or self-alienation (e.g., self-hatred, perceptions that one's psychological pain is a burden) C. Perceptions that one's suicidality, social alienation, and self-alienation are hopelessly unchangeable D. Two (or more) manifestations of overarousal (i.e., agitation, irritability, insomnia, nightmares)	A. Persistent or recurring feeling of entrapment and urgency to escape or avoid a perceived inescapable and unavoidable life situation. Although death may appear as the only escape, explicit suicidal ideation need not be (though may be) present B. Affective, behavioral, and cognitive changes associated with the experience of entrapment, including at least 1 item from a to d: a. Affective disturbance b. Loss of cognitive control c. Disturbance in arousal d. Social withdrawal

Suicide as a symptom? Suicide as a syndrome?

Past suicidal behavior predicts future suicide risk better than a psychiatric disorder

Psychiatric Disorders

Suicidality Dimension

Suicides

Suicide as epiphenomenon of depression or of a psychiatric disorder?

Biological changes or endophenotypes of suicidality in adolescents

Genotype

Phenotype

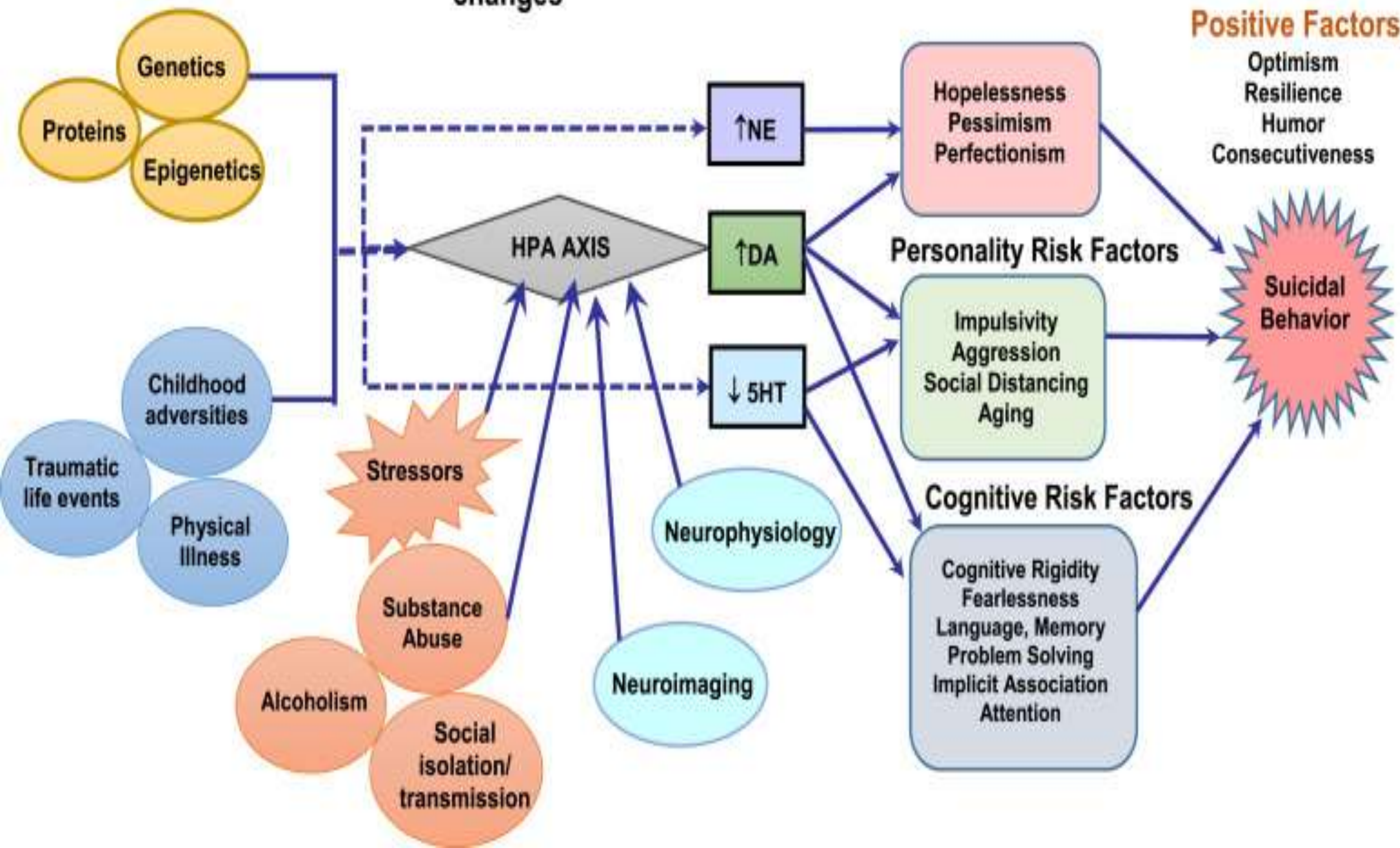
Neurodevelopmental

Neuroendocrine changes

Neurochemical

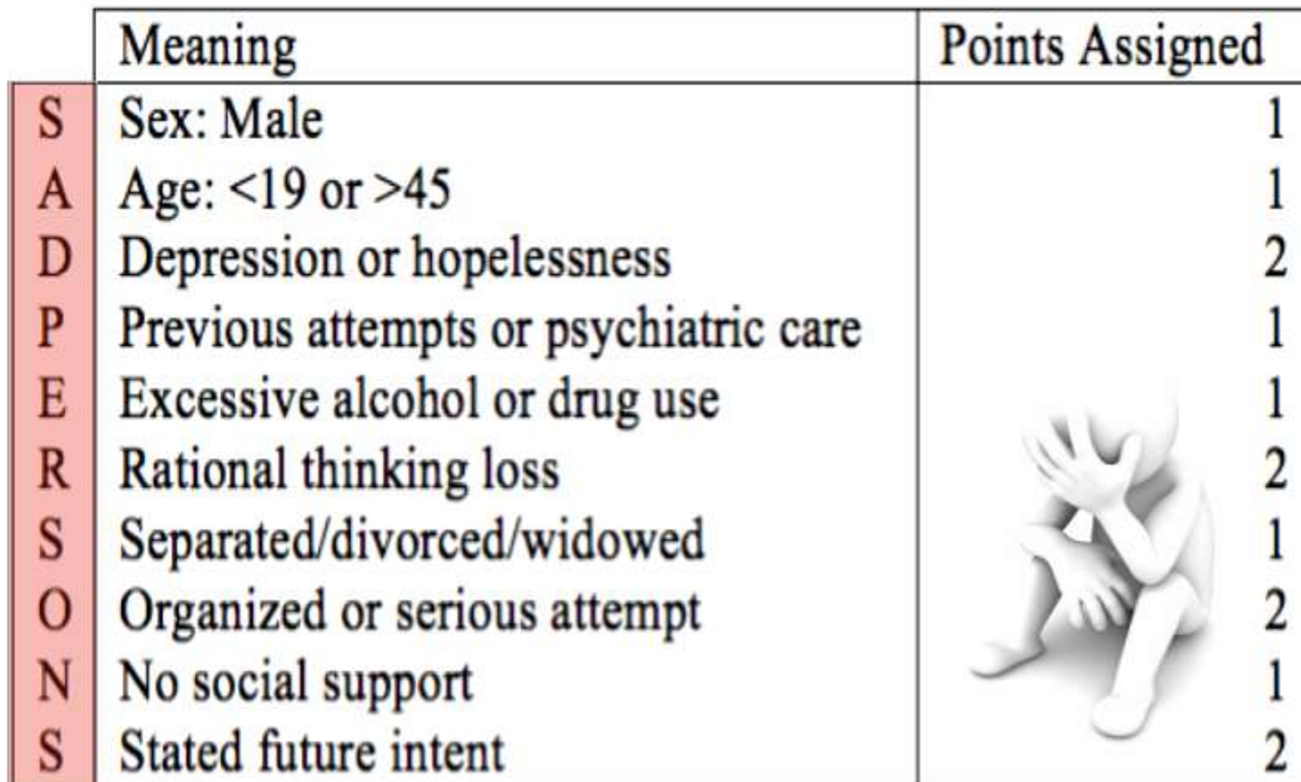
Clinical Features

Behavior



EMNote

The modified SADPERSONS score



	Meaning	Points Assigned
S	Sex: Male	1
A	Age: <19 or >45	1
D	Depression or hopelessness	2
P	Previous attempts or psychiatric care	1
E	Excessive alcohol or drug use	1
R	Rational thinking loss	2
S	Separated/divorced/widowed	1
O	Organized or serious attempt	2
N	No social support	1
S	Stated future intent	2

Score ≥ 6: high suicide risk, need psychiatry directed hospitalization

@ jackcfchong

Table 1

Imminent warning signs of suicide: IS PATH WARM

I	Suicidal **I**deation
S	Increased **S**ubstance abuse
P	**P**urposelessness
A	**A**nxiety, agitation, sleep disturbance
T	Feeling **T**rapped
H	**H**opelessness
W	**W**ithdrawal
A	**A**nger
R	**R**ecklessness
M	**M**ood changes

Source: Adapted from Reference 1

Universal interventions
- Restricting access to means
- Media strategies for better reporting
- Suicide awareness campaigns

Selective interventions
- Pharmacological interventions
- General practitioner education programmes
- Development of treatment guidelines

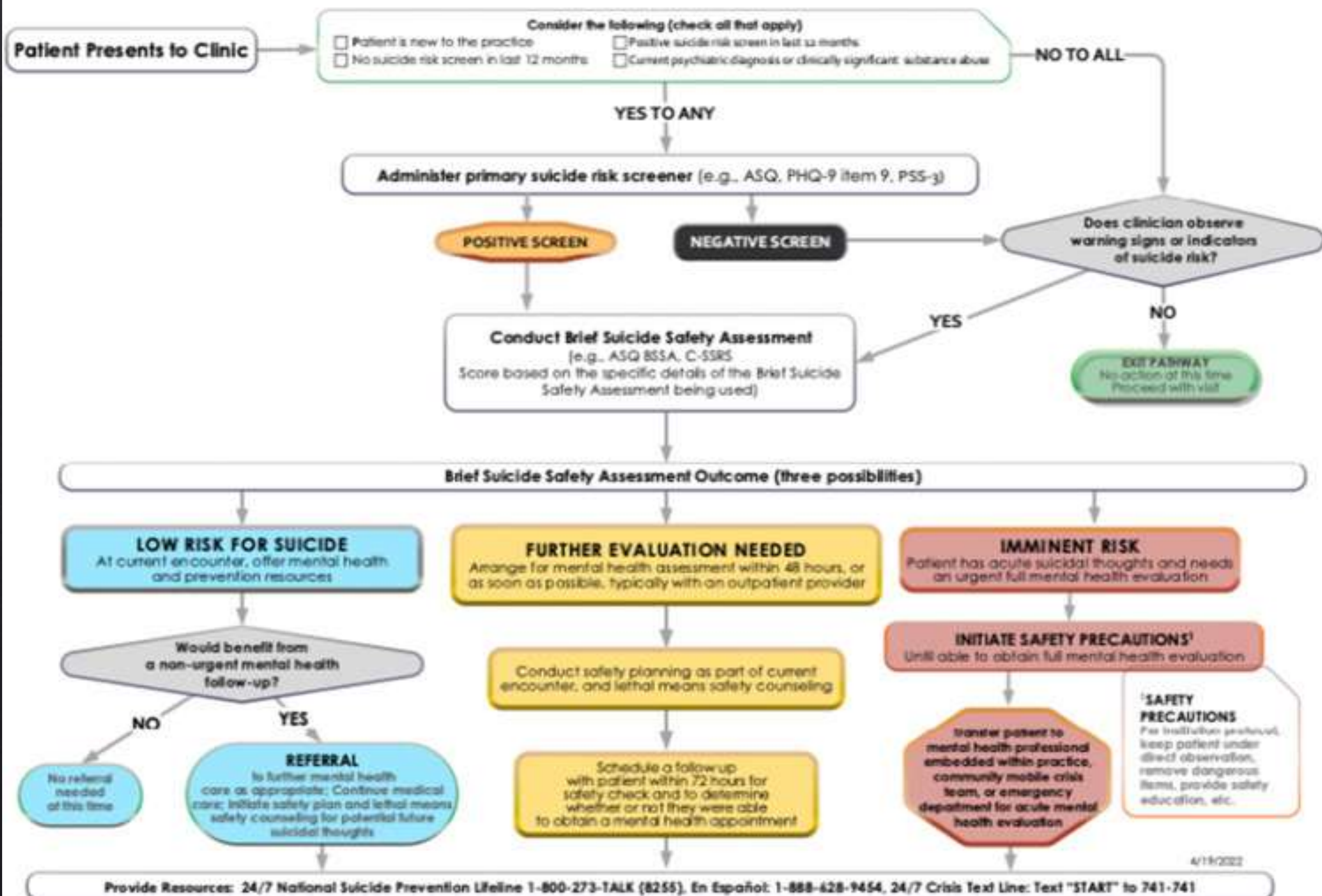
Indicated interventions
- Psychological interventions
- Social approaches
- Crisis services and helplines

Assessment of suicide risk
- Takes place in ED or primary care settings
- Computerized adaptive tests
- Analysis of electronic health records

Mental illness
- Affective disorder (such as MDD or BD)
- Substance use disorder
- Schizophrenia
- Cluster B personality disorder

Behavioural and psychological traits
- Anxiety
- Impulsivity and/or aggression
- Neuroticism
- Hopelessness

Risk factors	Protective factors
INDIVIDUAL-LEVEL	
Prior suicide attempt(s)	Problem-solving skills
Mental disorders (Axis II diagnosis)	Frustration tolerance
Trauma or abuse history	Self-control
Hopelessness	Reasons for living and optimism
Stressful life events	Perceptions of positive health
Self-harm	Participation in sporting activities
Prior psychiatric hospitalization	–
Family history of suicide	–
Chronic illness and pain	–
Personality traits	–
Biomedical/physical determinants	–
SOCIAL-LEVEL	
Job or financial loss	Family relationships
Socio-economic disadvantage	Partnership
Relationship conflict, discord or loss	Social relationships and social support
Disaster, war and conflict	Religious or spiritual beliefs
Acculturation stress	Employment



ADULT SUICIDE RISK SCREENING PATHWAY
OUTPATIENT PRIMARY CARE
Patient Presents to Clinic
Consider the following (check all that apply)
Patient is new to the practice
No suicide risk screen in last 12 months
Positive suicide risk screen in last 12 months
Current psychiatric diagnosis or clinically significant substance abuse
NO TO ALL
YES TO ANY
Administer primary suicide risk screener (e.g., ASQ, PHQ-9 item 9, PSS-3)
POSITIVE SCREEN
NEGATIVE SCREEN
Does clinician observe warning signs or indicators of suicide risk?
YES
NO
EXIT PATHWAY
No action at this time
Proceed with visit
Conduct Brief Suicide Safety Assessment
(e.g., ASQ BSSA, C-SSRS
Score based on the specific details of the Brief Suicide Safety Assessment being used)
Brief Suicide Safety Assessment Outcome (three possibilities)
LOW RISK FOR SUICIDE
At current encounter, offer mental health and prevention resources
Would benefit from a non-urgent mental health follow-up?
NO
YES
No referral needed at this time
REFERRAL
to further mental health care as appropriate; Continue medical care; Initiate safety plan and lethal means safety counseling for potential future suicidal thoughts
FURTHER EVALUATION NEEDED
Arrange for mental health assessment within 48 hours, or as soon as possible, typically with an outpatient provider
Conduct safety planning as part of current encounter, and lethal means safety counseling
Schedule a follow-up with patient within 72 hours for safety check and to determine whether or not they were able to obtain a mental health appointment
IMMINENT RISK
Patient has acute suicidal thoughts and needs an urgent full mental health evaluation
INITIATE SAFETY PRECAUTIONS[1]
Until able to obtain full mental health evaluation
Transfer patient to mental health professional embedded within practice, community mobile crisis team, or emergency department for acute mental health evaluation
[1]SAFETY PRECAUTIONS
keep patient under direct observation, remove dangerous items, provide safety education, etc.
4/19/2022
Provide Resources: 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255), En Español: 1-888-628-9454, 24/7 Crisis Text Line: Text "START" to 741-741

Social context: lack of social cohesion and environmental factors

- Geographical location
- Sociocultural norms
- Disruption to social structure or values
- Economic turmoil
- Social isolation
- Media reporting
- Access to lethal means
- Poor access to mental health services

Distal factors

Early-life adversity
Epigenetic changes
Genetics
Family history

Lasting alterations to gene expression

Developmental factors

Personality traits

Genetic and epigenetic factors
Chronic substance misuse
Impulsive aggression
Negative affect
Cognitive deficits

Increased vulnerability to stress

Proximal factors

Life events
Psychopathology
Biological, psychological, genetic and epigenetic factors

Depressed and dysregulated mood
Hopelessness and entrapment

Acute substance abuse

Behavioural disinhibition

Thoughts about death
Acts of self-harm with intent to die
Death

Table 2. Questions to Ask in the Assessment of Suicidal Intent

Are you currently thinking about or have you recently thought about death or harming yourself?
Have you thought about how you would harm yourself? What is your plan?
Do you have access to the method (e.g., gun and bullets, poison, pills)?
What has kept you from acting on these thoughts?
Do you have any intention of following through with the thoughts of self-harm?
What are your plans for the future?
Have you or a family member ever attempted suicide in the past?
Have you or a family member ever been diagnosed with or treated for anxiety, depression, or other mental health problems?
Are you currently using alcohol or drugs (illicit or prescription)?
Have there been any changes in your employment, social life, or family?
Do you have friends or family with whom you are close? Have you told them about these thoughts?
Do you tend to be impulsive with your decisions or behavior?

Information from reference 10.

Questions to Ask in the Assessment of Suicidal Intent

Are you currently thinking about or have you recently thought about death or harming yourself?

Do you have access to the method (e.g., gun, bullets, poison, pills)?

Do you have any intention of following through with the thoughts of self-harm?

Have you or a family member ever attempted suicide in the past?

Are you currently using alcohol or drugs (illicit or prescription)?

Do you have friends or family with whom you are close? Have you told them about these thoughts?

Have you thought about how you would harm yourself? What is your plan?

What has kept you from acting on these thoughts?

What are your plans for the future?

Have you or a family member ever been diagnosed with or treated for anxiety, depression, or other mental health problems?

Have there been any changes in your employment, social life, or family?

Do you tend to be impulsive with your decisions or behavior?

Columbia-Suicide Severity Rating Scale (C-SSRS)

Name: Nathaniel Emery

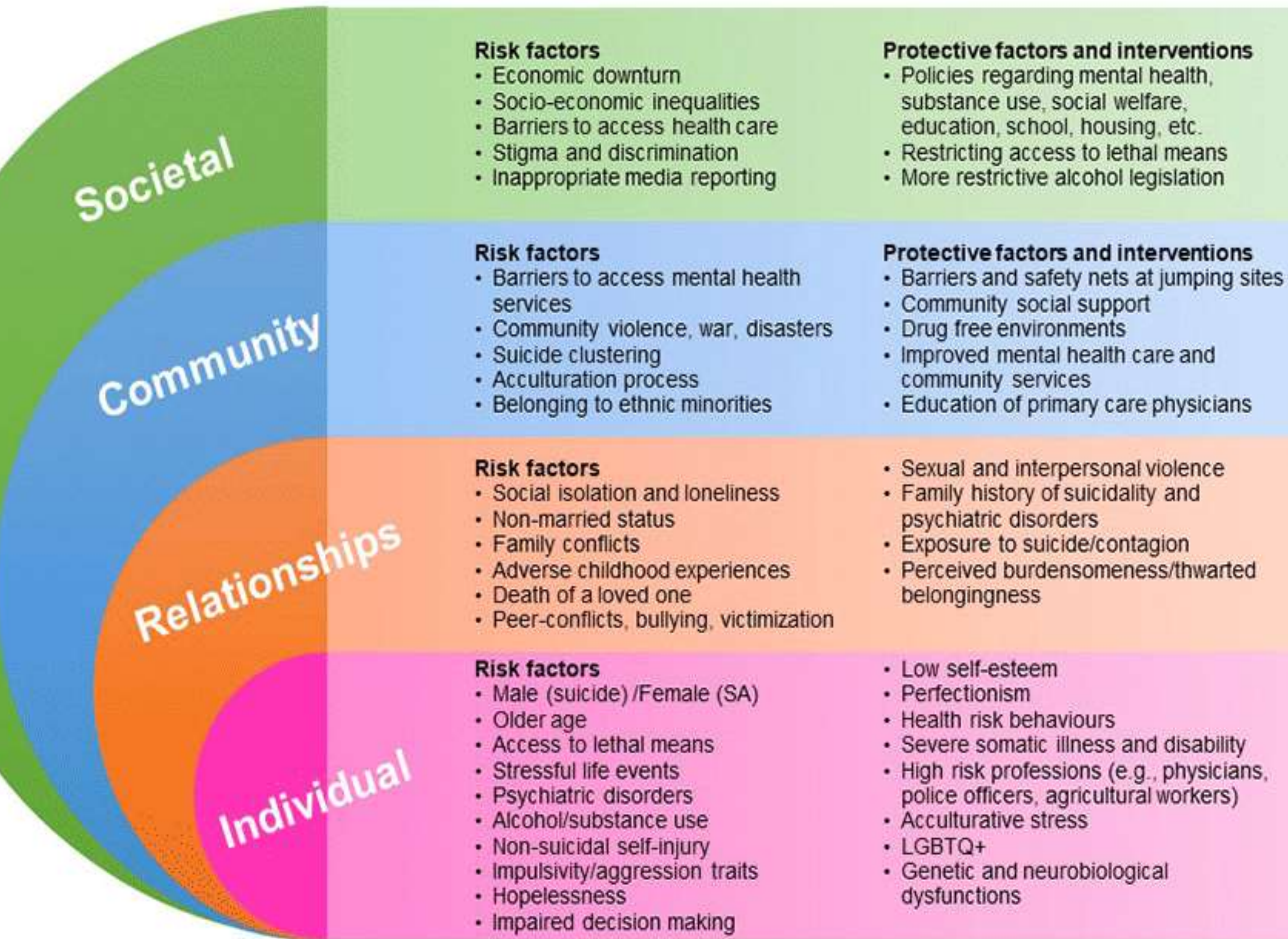
SUICIDAL IDEATION	
Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.	**Since Last Visit**
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you thought about being dead or what it would be like to be dead?*** ***Have you wished you were dead or wished you could go to sleep and never wake up?*** ***Do you wish you weren't alive anymore?*** If yes, describe: ______	**Yes** ☐ **No** ☑
2. Non-Specific Active Suicidal Thoughts General, non-specific thoughts of wanting to end one's life/commit suicide (e.g., "I've thought about killing myself") without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you thought about doing something to make yourself not alive anymore?*** ***Have you had any thoughts about killing yourself?*** If yes, describe: ______	**Yes** ☐ **No** ☑
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, "I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it....and I would never go through with it." ***Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)? What did you think about?*** If yes, describe: ______	**Yes** ☐ **No** ☑
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do? This is different from (as opposed to) having the thoughts but knowing you wouldn't do anything about it.*** If yes, describe: ______	**Yes** ☐ **No** ☑
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you decided how or when you would make yourself not alive anymore/kill yourself? Have you planned out (worked out the details of) how you would do it?*** ***What was your plan?*** ***When you made this plan (or worked out these details), was any part of you thinking about actually doing it?*** If yes, describe: ______	**Yes** ☐ **No** ☑

TABLE 2

ASSESSMENT TOOLS FOR LATE-LIFE SUICIDE RISK IN OLDER ADULTS[a]

Assessment Tool	Explanation
Comprehensive psychosocial assessment form	This form should be adapted to the older adult and cover all areas of risk and protection.
Mini Mental State Exam (MMSE)	A widely used screening tool to assess cognitive functioning of older adults. It contains items that assess orientation, attention and calculation, immediate and short-term recall, and language and ability to follow simple written and verbal commands. The MMSE is designed to be administered by a clinician. It yields a maximum score of 30 and a minimum score of 0. A score of ≤23 indicates the presence of dementia. The MMSE has demonstrated high sensitivity and specificity (Folstein, Folstein, & McHugh, 1975). This tool is useful as dementia, especially newly diagnosed, is a risk factor for suicide.
Montreal Cognitive Assessment (MOCA)	A widely used screening assessment for detecting cognitive impairment. It is a brief 30-question test that takes approximately 10 to 12 minutes to complete. It was published in 2005 by a group at McGill University working for several years at memory clinics in Montreal, Canada. It was validated in the setting of mild cognitive impairment and has subsequently been adopted in numerous other clinical settings (Nasreddine et al., 2005).
Patient Health Questionnaire 2 (PHQ-2)	A two-item tool based on the PHQ-9 that asks two *yes/no* questions: During the last 2 weeks have you been bothered by: (1) having little interest in doing things? (2) feeling down, sad, or hopeless? If the client answers yes to either question, the provider should administer the full PHQ-9 (Pfizer, 2005).
Geriatric Depression Scale–Short Version (GDS-15)	A 15-item tool to assess presence of depression in older adults. The advantages of the tool are that it can be self- or clinician-administered and it is brief (usually taking less than 10 minutes to complete) (Sheikh & Yesavage, 1986).
Geriatric Depression Subscale for Suicide Ideation (GDS-SI)	A 5-item subscale of the GDS-15. Client scores of ≥1 on five selected items (3, 7, 11, 12, and 14) have been strongly correlated with positive suicidal ideation. All items are generally related to increased feelings or perceptions of hopelessness, worthlessness, emptiness, and reduced happiness in life (Friedman, Heisel, & Delavan, 2005; Heisel, Duberstein, Lyness, & Feldman, 2010; Heisel & Flett, 2006).
Cornell Scale for Depression in Dementia (CSDD)	Commonly used to detect depression in adults with mild to severe dementia. It is a 19-item instrument that relies on interviews with clients and nursing staff and is based on behavioral observation. It can be used in hospital, outpatient, and nursing home settings, and may be useful for assessing clients with dementia for depression (Alexopoulos, Abrams, Young, & Shamoian, 1988).
Nurses' Global Assessment of Suicide Risk (NGASR)	Can be used to augment the psychosocial assessment form and GDS-SI to further assess risk factors (Cutcliffe & Barker, 2004).

[a] *The clinician should start with a basic psychosocial assessment and follow up with more specific tools that assess depression, cognitive impairment, and suicide risk.*



Societal
Risk factors
• Economic downturn
• Socio-economic inequalities
• Barriers to access health care
• Stigma and discrimination
• Inappropriate media reporting
Protective factors and interventions
• Policies regarding mental health, substance use, social welfare, education, school, housing, etc.
• Restricting access to lethal means
• More restrictive alcohol legislation
Community
Risk factors
• Barriers to access mental health services
• Community violence, war, disasters
• Suicide clustering
• Acculturation process
• Belonging to ethnic minorities
Protective factors and interventions
• Barriers and safety nets at jumping sites
• Community social support
• Drug free environments
• Improved mental health care and community services
• Education of primary care physicians
Relationships
Risk factors
• Social isolation and loneliness
• Non-married status
• Family conflicts
• Adverse childhood experiences
• Death of a loved one
• Peer-conflicts, bullying, victimization
• Sexual and interpersonal violence
• Family history of suicidality and psychiatric disorders
• Exposure to suicide/contagion
• Perceived burdensomeness/thwarted belongingness
Individual
Risk factors
• Male (suicide) /Female (SA)
• Older age
• Access to lethal means
• Stressful life events
• Psychiatric disorders
• Alcohol/substance use
• Non-suicidal self-injury
• Impulsivity/aggression traits
• Hopelessness
• Impaired decision making
• Low self-esteem
• Perfectionism
• Health risk behaviours
• Severe somatic illness and disability
• High risk professions (e.g., physicians, police officers, agricultural workers)
• Acculturative stress
• LGBTQ+
• Genetic and neurobiological dysfunctions

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