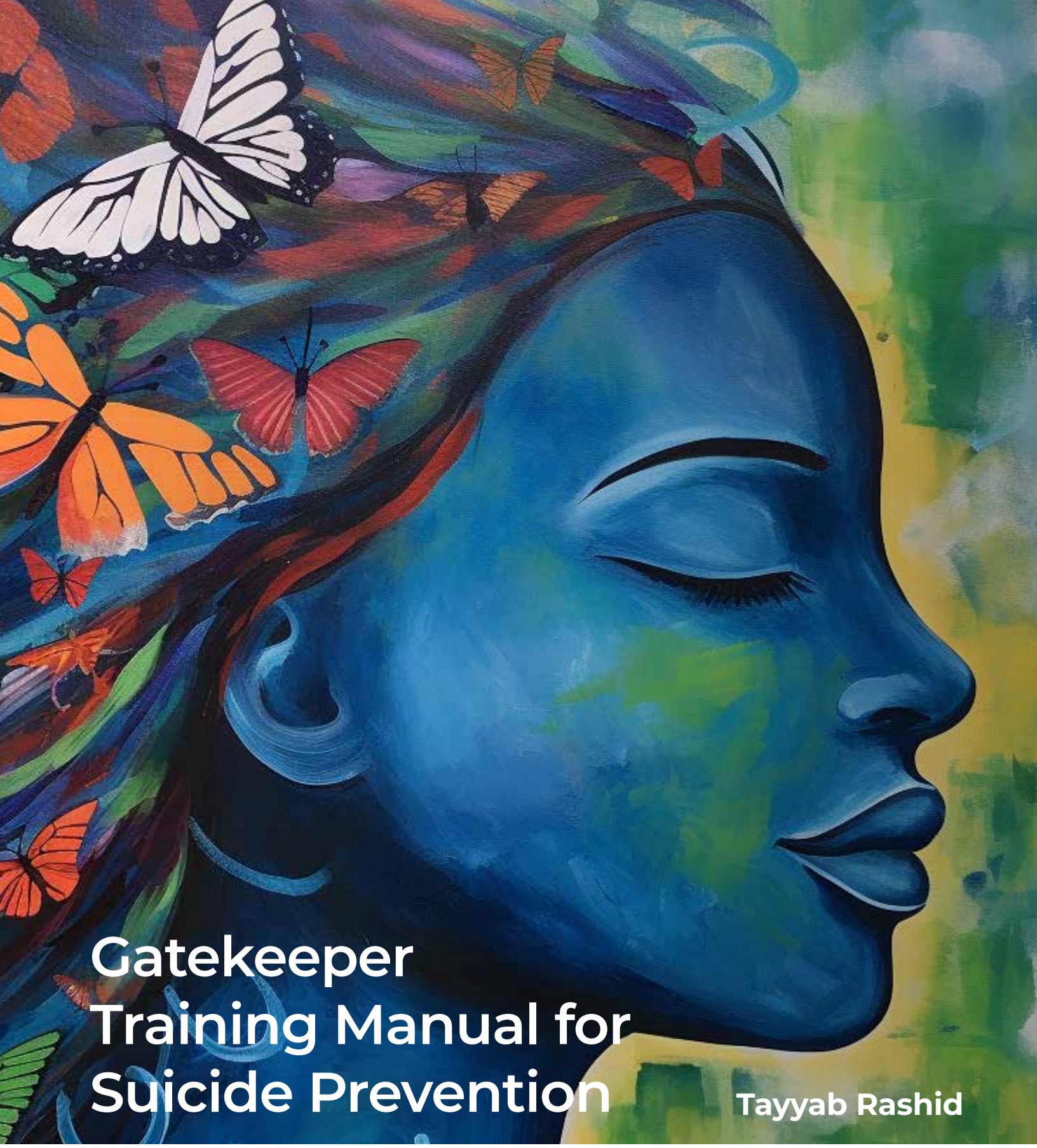


Gatekeeper Training Manual for Suicide Prevention

Tayyab Rashid

In partnership with Canada

IDRF GUYANA

MINISTRY OF HEALTH GUYANA

NATIONAL SUICIDE PREVENTION COMMISSION GUYANA

MINISTRY OF HEALTH MENTAL HEALTH UNIT

Gratitude

I extend my deepest appreciation to all involved in pioneering this Gatekeeper Training program for Guyana. Ruth Louden, your editorial acumen has been the keel of this project, sharpening the focus and building a cohesive narrative with editorial precision and care. Noman Siddiqui, your digital artistry has elegantly captured Guyana's spirit, endowing our online portal with cultural depth and aesthetic resonance. Dale Clark, through your design expertise, our training manual stands as a paragon of both beauty and utility. Finally, I'm thankful to Ryan Brudner for his diligence in researching the literature on suicide and organizing information regarding assessment tools.

To steadfast supporters: Nabil Ally, Anand Ally, Premika Benimadho, Mark Constantine, Kadija McClure, Abdul Mahinudin, Dr. Timothy Morgan, Dr. Mark Sinyor, Sabrina Neto, Lindsay Oades, Mahmood Qasim, Dan Loton, Shameena Haniff, Tariq Williams, and Dianne Vella Brodrick, your commitment has been critical to our progress. Your engagement has propelled this work forward and ensured that our collective effort resonates within the communities we intend to serve. Together, I hope we form a circle of empathy and distill knowledge and skills that will play a crucial role in the prevention of suicide and the nurturing of hope.

Colette Ault, Sarah Gopaul, Alan Hussain, Yolanda Howard, Faoud Mohamed, Celena Ramdeholl, and Sharon Rodrigues, please accept my profound gratitude. Your insights, grounded in cultural nuance, have significantly enriched the content and relevance of our Gatekeeper training, particularly in the context of Guyana. The thoughtful feedback and perspectives that each of you provided have enhanced our manual and will ensure that our training has a meaningful impact. This is crucial in supporting individuals facing suicidal crises and those who support them during these challenging times.

T.R.

Table of Contents

Introduction & Orientation

In this comprehensive five-module Gatekeeper suicide prevention training, Gatekeepers will acquire crucial knowledge and practical skills to address complex issues related to suicidal behaviour within the specific cultural and social context of Guyana. Here is an integrated overview of what Gatekeepers will learn:

In the first module, *Understanding Suicidal Behaviour in Guyana*, Gatekeepers will explore the complex landscape of suicide rates in Guyana and its sociocultural underpinnings. With the help of key facts and figures about suicidal behaviour, they will become informed about trends and learn to identify key factors that contribute to suicidal behaviour within their communities. This module sets the stage for Gatekeepers to understand their pivotal role in prevention efforts.

In the second module, Suicide & Psychological Disorders, participants will explore the intersection of suicide risk with major psychological disorders. They will learn to recognize the signs that may indicate an increased risk of suicide in individuals suffering from conditions such as mood disorders, emotional dysregulation, psychosis, and substance abuse, and will be equipped with strategies for timely intervention and support.

After setting the stage, the third module guides participants through a 5-step Suicide Risk Assessment and Safety Planning process. This assessment process equips Gatekeepers with a structured, evidence-based approach to assessing suicide risk, including identifying key risk and protective factors and warning signs, evaluating the seriousness of suicidal ideation and planning, and crafting an actionable safety plan. Hands-on role plays will reinforce the development of these assessment skills in real-world situations.

In this module, Gatekeepers will also be introduced to seven valid, reliable and concise assessment tools designed to evaluate crucial risk factors and symptoms such as depression, anxiety, and the presence of suicidal thoughts. This knowledge will aid in providing appropriate interventions and deepen Gatekeepers' ability to engage empathetically with those in crisis.

Module 4 considers the mental health and well-being of Gatekeepers as they navigate the complex emotions and responsibilities inherent in suicide prevention. It provides five broad strategies for self-care: stretch and relax, centering breathe, lovingkindness meditation, neck-down experiences and gratitude journal. Each strategy contributes to Gatekeepers' well-being, resilience and continued capacity to provide compassionate support. Gatekeepers can incorporate these strategies into their daily lives, and also before, during or after their interactions with people in crisis.

The final module examines postvention strategies to aid families and communities after a suicide, emphasizing the role of Gatekeepers in both postvention and broader community prevention efforts. It addresses the impact of stigma on suicide, highlights the critical role of media in shaping public perceptions about mental health and provides guidance on responsible reporting to further enhance community and national suicide prevention initiatives.

Upon completion, Gatekeepers will have a holistic understanding of suicide prevention, from individual crisis intervention to community-wide strategies, with a strong emphasis on cultural sensitivity, self-care, and responsible communication.

Suicide Prevention Training in Guyana

Suicide is a major public health challenge globally. It is not caused by any single factor, nor can its prevention be achieved by one single strategy or approach. Yet, the scale of this public health challenge is so substantial that all resources need to be deployed meaningfully to reduce gradually the number of people dying by suicide. This training is one such humble attempt.

As part of a concerted effort by Canada's International Development and Relief Foundation (IDRF) in collaboration with the Guyana Ministry of Health, we offer the *Gatekeeper Training Manual for Suicide Prevention* as a companion to training that addresses the suicide crisis in Guyana.

In suicide prevention, the term 'Gatekeepers' refers to individuals in our community who have face-to-face contact with many people in community settings. They can be trained to identify individuals at risk of suicide, refer them to treatment, and provide appropriate support services.

Visit: **idrfmentalhealthguyana.com** for the online portal

Suicide prevention efforts are more likely to be effective when developed based on the values, needs, and strengths of the groups for which the training is intended. These efforts should also be responsive and respectful of cultural norms, religious beliefs, and practices. Our training considers factors such as race, ethnicity, age, gender, sexual orientation, and socioeconomic status.

The manual is supplemented by an online portal which serves as a dynamic, scalable, and centralized hub for individuals who want to be trained as Gatekeepers. We have attempted to make this portal accessible, inclusive, and reflective of the diverse socio-cultural ethos of contemporary Guyanese society.

MODULE 1

Understanding Suicidal Behaviour in Guyana

The first module of this suicide prevention training program explores the complex landscape of suicide within Guyana, contextualized within the global health framework. Learners will review epidemiological data pointing to Guyana's high suicide rates, particularly among diverse cultural communities of Guyana. They will examine sociocultural factors that contribute to suicidal behaviour, including age, ethnicity, gender, religion, interpersonal conflict, health and trauma. Through this contextual lens, the module arms participants as Gatekeepers in their communities with culturally sensitive knowledge to inform effective suicide intervention within their communities.

Learning Outcomes

- **Describe** the multifaceted nature of suicide as a public health issue.
- **Explore** the complex landscape of suicide in the Guyanese context.
- **Review** evidence regarding who is most vulnerable to suicidal behaviour.
- **Receive** orientation to the key features of Gatekeeper training and the responsibilities of Gatekeepers in suicide prevention.

Guyana's Suicide Crisis

A report on suicide trends around the world by the World Health Organization (WHO, 2019) shows that 77% of global suicides take place in low and middle-income countries (LMICs), where most of the world's population resides. Suicide occurs throughout the lifespan and is the fourth leading cause of death among 15-29 year-olds globally (WHO, 2019). World suicide mortality trends between 2000 and 2019 show that age-standardized suicide rates have been declining (Ilic & Ilic, 2022). However, the impact of the COVID-19 pandemic on these trends needs to be explored.

Guyana is an anglophone country located on the northeast coast of South America, bordering Venezuela, Brazil and Suriname. Guyana's complex history is marked by slavery from West Africa and indentured labour from India, China and Portugal. After over two centuries of European colonization, including more than 170 years of British rule, Guyana gained independence in 1966 and became a republic in 1970.

Guyana is divided into ten administrative regions, with regions 1, 7, 8 and 9 interior, while regions 2, 3, 4, 5, 6 and 10 are along the coastline. Nearly 90% of the Guyanese population resides in coastal regions. The Guyanese population of over 800,000 is approximately 40% Indian origin (Indo-Guyanese), 29% African heritage (Afro-Guyanese), and 11% Indigenous (Amerindian). Nearly 20% of Guyanese people self-identify as mixed origin.

Guyana's chief economic assets are pristine rainforests, sugarcane plantations, rice fields, and gold reserves. Guyana has historically been one of South America's poorest countries despite these riches. However, the recent discovery of off-shore oil reserves has resulted in extraordinary economic growth. The Gross Domestic Production (GDP) increased from US $6,477 in 2019 to US $18,199 in 2022 (World Bank, 2024).

The suicide rate in Guyana has remained among the top ten globally for the past two decades. In 2019, Guyana's age-standardized suicide rate was estimated as 40.9 per 100,000, the highest rate for the country in nearly two decades and the second-highest rate in the world (WHO, 2021).

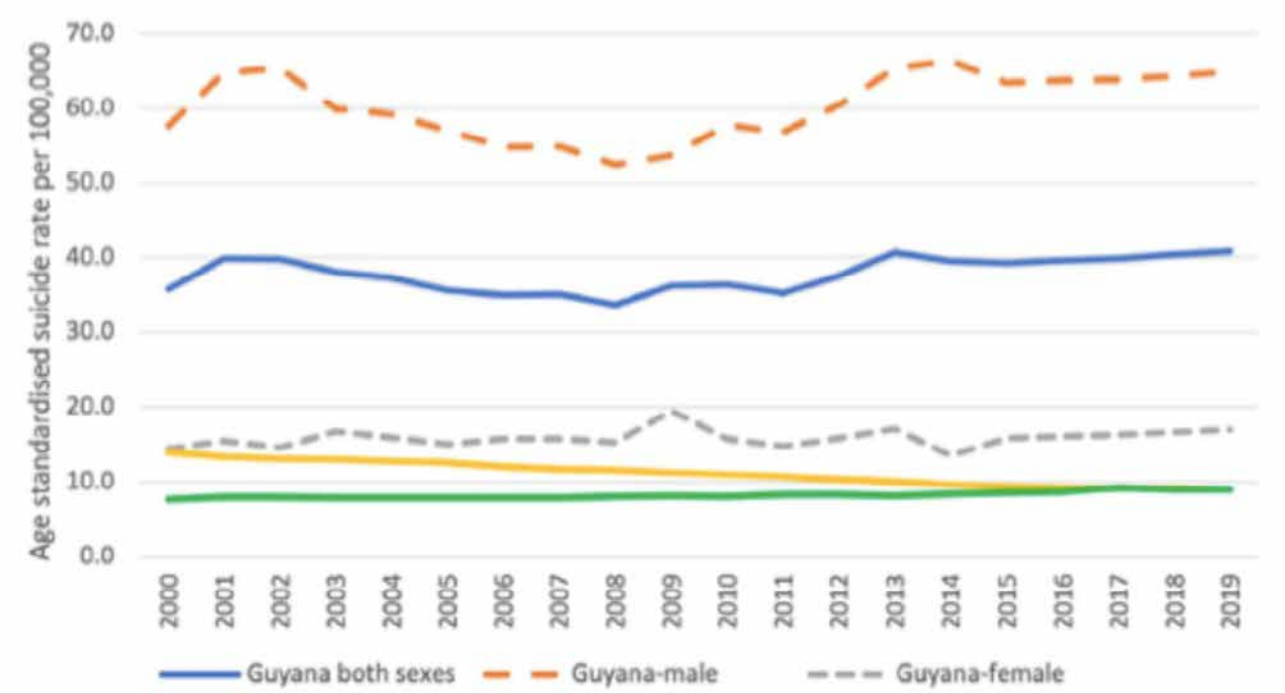
What are Key Facts and Figures Regarding Suicide in Guyana?

Prevalence: Guyana's estimated suicide rate of 41 per 100,000 is the 2nd highest in the world, according to World Health Organization's 2019 report. This report on suicide mortality around the world is issued every 5 years. There has been a 5% absolute increase in the suicide rate, from 2000 to 2019. This increase translates into 62,401 deaths by suicide in 2000 versus 97,339 deaths by suicide in 2019.

In addition to statistics by international organizations such as WHO, research has also explored the prevalence of suicide in Guyana. A recent systematic review of suicidal behaviour in Guyana (Peltzer & Pengid, 2022) explored the prevalence and correlates of suicidal behaviour among Guyanese adults. Their nationally representative sample of 2,662 participants included nearly 60% females. Indo-

Guyanese were 42% of the sample. Results indicated that in the past 12 months, 4.6% of those surveyed had suicidal ideation, 1.5% made suicidal plans, and 1.1% attempted suicide. In other words, approximately 1 in 20 (5,000 per 100,00 Guyanese adults) experienced suicidal behaviour, with approximately 1 in 100 (1,000 in 100,000) having attempted suicide.

Figure 1: Suicides in Guyana: Trends in the last two decades



Age-standardised rates of suicide (per 100,000) for Guyana based on WHO Global Health Estimates (2000-2019), with the Americas and global rate included for comparison. World Health Organization. Available from: https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates Accessed January 18, 2024.

There has been a 5% absolute increase in the suicide rate, from 2000 to 2019. This increase translates into 62,401 deaths by suicide in 2000 versus 97,339 deaths by suicide in 2019.

Ethnicity: Indo-Guyanese are disproportionately represented in the rates of death by suicide (~77-83%; Edwards, 2016; Shako, 2020). Research shows that people of Indian labour heritage are over-represented in suicides in Guyana (Shaw et al., 2023). This trend is not unique to Guyana as neighboring Caribbean countries show similar trends. Nobie and Hutchinson (2018) explored demographics associated with suicide in neighboring Trinidad and Tobago from 2000 to 2016. They found a 6 : 1 male-to-female ratio, with a mean age of 39.5 years, with Indo-Trinidadians accounting for 66% of suicide deaths. Poisoning was the most commonly used method, followed by hanging.

Graafsma and colleagues (2006), in an epidemiological study in Suriname, which shares a land border with Guyana, found a high rate of suicidal ideation (48 per 1000) and suicide attempts (207 per 100,000). The typical suicide profile of Surinamese includes being male and living in conditions of poverty, alcoholism, domestic violence, strict adherence to cultural expectations, accessibility of pesticides, and a sense of hopelessness.

Age & Gender: The majority of suicide deaths (~ 80%) are male (Shako, 2020). Among males, the suicide rate is the highest in the age range 25-37 years (97 deaths per 100,000), followed by males 45-54 years (87 deaths per 100,000). Among females, the rate is highest in the 15-24 age range, followed by the 35-44 age range. Although the suicide death rate is higher in males, suicidal ideation is higher in females (Pelzer & Pengpid, 2022). Suicide is still the leading cause of death among 15-24-year-old Guynese youth, accounting for 24.7% of deaths (Kolves & de Leo, 2017; WHO Mortality Database, 2013).

More recently, there have been significant changes in the age structure of persons of all ethnic groups who died of suicide in Guyana. Singh (2022) reports that in 2018, the age group 79+ had the highest rate (40.84 per 100,000); in 2019 the 65-69 age group had the highest rate (57.82 per 100,000); in 2020, the age group 70+ had the highest rate (44.93 per 100,000); and in 2021 the age group 65-69 had the highest rate (43.37 per 100,000).

Adolescents: Toney (2023) explored the suicidal behaviour among 10-17-year-old adolescents attending a psychiatry clinic in Guyana within a one-year span. The study found that such behaviour has a prevalence of 21% among pediatric patients, with an average patient age of 14.5 years and a higher occurrence in females. Most patients were of Indo-Guyanese ethnicity, Christian, and from Region 4, with no significant medical or psychiatric history and typically accompanied by their mothers to appointments. Poisoning was the most common method for suicide attempts.

ALTHOUGH THE SUICIDE DEATH RATE IS HIGHER IN MALES, SUICIDAL IDEATION IS HIGHER IN FEMALES.

Regions: Most cases of suicide are in Regions 2, 3, 4, 5, and 6. Region 6 has the highest rate, followed by Region 4 (Shako, 2020). Regions 9 and 10 have the lowest rates of suicide. Lange and colleagues (2023) examined contextual factors that could lend an explanation into why different regions/ countries have different suicide rates, though this is not Guyana

specific. Notable factors included health expenditure per capita, medical doctors employed per capita, homicide rate, intravenous drug use rate, alcohol use, education inequality, and unemployment.

Religions: Shako reports (as sited in Singh, 2022) that of the 101 suicide cases in which religious affiliation was identified, Hindus comprised 49.5%, Christians 35.6%, Muslims 8.9%, and Others 5.9%. The Hindu rate of 23.9 per 100,000 was 1.4 times higher than the Muslim rate of 17 per 100,000 and 1.5 times higher than the Christian rate of 15.5 per 100,000.

Means: Means of suicide included poisoning, firearm, drug poisoning, falls from high structures, use of a razor, knife or other sharp instrument, drowning, other). Of these, ingestion of poison is the most common method of suicide (65%; Shako, 2020).

Pelzer & Pengpid (2022) investigated the prevalence and factors associated with suicidal behaviour (SB) among adults in Guyana. Using data from the 2016 Guyana STEPS survey, the study found:

Prevalence: The SB prevalence among adults in Guyana was found to be 4.6%, with suicidal ideation at 4.4%, suicide plans at 1.5%, and suicide attempts at 1.1% in the preceding 12-month period.

Risk Factors: Several risk factors of SB were identified, including mixed and other ethnicities, childhood physical abuse, childhood sexual abuse, adult sexual abuse, experience of threats, exposure to violent injuries, and a history of heart attack, angina, or stroke.

Methods of Last Attempted Suicide: The major methods used in the last attempted suicide included poisoning with pesticides (e.g., rat poison, insecticides, weed killer), overdose of medication, use of a razor, knife, or other sharp instrument, and overdose on other substances such as heroin, crack, or alcohol.

Protective Factors: The study suggests that problem-solving skills may be protective against SB within different ethnic adult groups in Guyana. Having higher education was also found to be a protective factor.

The study emphasized the need for population-based suicide prevention strategies that consider psychosocial distress and cardiovascular disorders. The study provided important insights into the specific correlates and risk factors of suicidal behaviour among adults in Guyana, highlighting the need for targeted suicide prevention strategies that address these risk factors.

From facts and figures about suicide in Guyana, we now focus on what might be some of the underlying psychological reasons of suicidal behaviour in Guyana.

Suicide in Guyana at a Glance

Prevalence: Guyana holds the second highest global suicide rate in the world (41 suicides per 100, 000), with a 5% rise from 2000-2019.

Ethnicity: Indo-Guyanese have a higher representation in suicide rates.

Age & Gender: Male suicides are predominant, particularly in the 25-37 age group; suicidal ideation is more common in females.

Adolescents: There is a 21% prevalence rate among adolescents aged 10-17, with a female majority.

Regions: Region 6 reports the highest suicide rates.

Religions: Where identified, Hindu individuals show a higher rate compared to other religious groups (49.5%).

Means: Poisoning is the most common suicide method.

What Causes Suicide in Guyana?

What do psychological autopsies of suicide completers tell us?

A recent systematic review of suicidal behaviour in Guyana by Shaw and colleagues (Shaw et al., 2023) highlighted significant gaps in understanding suicidal behaviour in Guyana. The authors utilized a qualitative case study method, the Psychological Autopsy, to understand suicidal behaviour in Guyana. The lives of 20 Guyanese (14 males and 6 females, ages 10-74) who died of suicide were explored.

The study identified four major themes: Interpersonal Conflict, Trauma, Health, and Unknown Reasons.

1. **Interpersonal Conflict:** Many of the people who died by suicide were experiencing interpersonal conflicts within the family or in their intimate relationships. These interpersonal conflicts appeared to cause significant distress and to lack significant attempts to resolve them, which led to suicidal behaviour. Three subordinate themes were identified: Domestic Abuse, Marital Separation and Financial Disputes.

    a) **Domestic Abuse:** Some of the women were experiencing domestic abuse when they died by suicide. In some cases, the women sought police help, which proved temporary, as the abusive partner was let go after a brief lockup.

    b) **Marital Separation:** Some of the deceased men were estranged from their children after a marital separation, which led to relational distress. In some cases, their ex-partners had relocated or moved overseas without facilitating connection with their children. Some

males reported experiencing shame and embarrassment.

c) **Financial Disputes:** Financial disputes, including intergenerational distribution of wealth and assets, caused significant distress, which led to suicide. In a number of cases, individuals drank the pesticide impulsively directly during or soon after an argument, often in front of family members involved in the conflict. Almost all informants described a build-up of distress and agitation, which culminated in suicide.

2. Trauma: Some people who died by suicide had a history of experiencing significant trauma. This trauma could have been recent or historical, without adequate resolution. Untreated traumatic stress often leads to helplessness and hopelessness. Situational stressors exacerbate hopelessness and lead some to complete suicide.

3. Health: The health theme included subordinate themes of physical and mental health.

a) **Physical Health:** For some individuals, suicide was preceded by a protracted period of physical illness, including specific medical problems such as diabetes and neurological concerns. In numerous cases, individuals sought treatment but could not attain relief. Chronic pain often leads to frustration and the development of mental health concerns.

b) **Mental Health:** For some, death was precipitated by psychological illnesses such as severe and recurrent depression, self-harm, psychosis, and emotional dysregulation. Some also took medication but without much effect. In some cases, stigma towards mental health and lack of knowledge to recognize symptoms of mental health concerns worsened the situation. In others, a lack of access to treatment contributed to untreated mental illness or undertreatment (treatment terminated prematurely or treatments which did not address specific mental health issues.)

4. Unknown reasons: There are always some unique situations which contribute to or lead to suicide. In some cases, family members reported that everything appeared fine. Without any history of physical or psychological concerns, nor any prior history of suicidal ideation or attempt, the individuals completed suicide.

In a focus group with 15 mental health and educational professionals from all regions of Guyana, some of the unknown reasons mentioned by Shaw et al (2023) were unpacked as underlying factors contributing to the high rates of suicide. These include alcohol abuse, spiritual crisis, a lack of life purpose, struggles with sexuality and gender identity, the pressures of living with secrets, marrying outside one's faith or culture, peer pressure, cyberbullying, stigma, stress, and the emotional toll following the breakdown of relationships. These factors underscore the complexity of suicidal behaviour in Guyana (Rashid, 2024).

During Gatekeeper Training, we asked over 100 Gatekeepers in Region 6 their views on what might be some of the unknown reasons for suicidal behaviour in their region. Table 1.1 below summarizes their answers. Although we asked specifically about the category of "unknown reasons", we can assume their answers included both known and unknown reasons.

Table 1.1: Reasons for Suicidal Behaviour – Gatekeeper Perceptions

SOCIAL AND RELATIONSHIP CHALLENGES	PHYSICAL & MENTAL HEALTH, EMOTIONAL WELL-BEING & TRAUMA	CULTURAL, EDUCATIONAL, RELIGIOUS, AND FINANCIAL FACTORS
• Domestic violence • Toxic relationships • Sexual abuse and difficult partners • Unresolved personal disputes • Lack of trust • Rejection • Unfaithfulness • Living in denial • Disappointment and unrealistic expectations • Heartbreak • Relationship issues (especially among teenagers) • Betrayal and lack of trust • Teenage pregnancy • Family rejection • Family pressure • Involvement of in-laws in relationships • Marrying too early • Gender discrimination • Bullying • Cyberbullying • Absence of one or both parents • Peer pressure (general)	• Lack of self-expression/self-centeredness • Peer pressure • Depression • Health issues • Lack of communication within the home and work environment • Lack of family support • Lack of support or guidance • Self-image issues • Fear of discrimination when seeking help • Loss of self-worth and meaning • Not educated about mental health • Shame to seek help • Feeling insecure • Unable to speak • Rape	• Uneducated about mental health • Grades in school • Religious belief influencing behaviour (e.g., suicide as a means of rebirth) • Lack of support from religious communities • Cultural pressure (e.g., family disapproval of relationships) • Lack of support groups or trustworthy organizations • Marriage at an early age • Parents not approving of out of culture/religion marriage • Excessive involvement of inlaws • Social Media influence • Financial difficulties • Unemployment • High cost of living • Poverty • Financial and gambling issues • Lack of financial support

What Makes Indo-Guyanese Males Most Vulnerable?

The significantly higher rates of completed suicide among males in Guyana, one of the highest suicide rates in the world, can be attributed to several factors, similar to global trends but also influenced by local cultural, economic, and social dynamics.

Socioeconomic Challenges: The Indian community in Guyana, largely involved in agriculture, often faces socioeconomic challenges. Stress factors such as poverty, unemployment, and the pressure to provide for the family can lead to stress. Stress and mental health issues are strongly linked (Maharaj et al., 2019), with stressful life events a strong predictor for subsequent suicide (Fjeldsted et al., 2016). The socioeconomic stressor can exacerbate the risk of suicide, especially in the absence of adequate coping mechanisms or support systems (Platt et al., 2017).

Cultural Stigmatization: Guyanese men, especially those from Indo-Guyanese descent, may experience cultural pressures that discourage expressions of vulnerability or seeking help. The cultural stigmatization of mental health concerns and traditional gender roles that emphasize stoicism can prevent men from accessing support or expressing emotional distress, leading to more fatal outcomes (Bhugra et al., 2018; Rice et al., 2019). Expectations placed on men to be the main breadwinners and to maintain a particular social standing can create immense pressure, potentially leading to feelings of inadequacy and hopelessness in the face of financial or personal setbacks. The role of stigma in suicidal behaviour is further discussed in Module 5.

Alcohol Use: Alcohol abuse is a significant issue in Guyana and is often linked to suicidal behaviour. Men are more likely to use alcohol and engage in harmful drinking patterns, which can impair judgment and lower inhibitions, making impulsive or suicidal acts more likely (WHO, 2014).

Isolation: Men might experience greater social isolation due to the traditional gender roles in the community (Liu et al., 2020). This can contribute to the higher rates of suicide, as social isolation is a known risk factor (Motillon-Toudic et al., 2022).

Access to Means: The Indian community in Guyana may be more represented in rural agricultural communities for employment. Thus, they have more access to lethal means, especially pesticides, which are the most commonly used lethal means of suicide in Guyana (Shaw et al., 2023).

Lack of Mental Health Services: There is a scarcity of mental health resources and services in Guyana, which impacts the entire population but may particularly affect men who are less likely to seek help. This lack of services can prevent early intervention and treatment of mental health conditions that could lead to suicide (Mars et al., 2014).

Preventing Suicide through Gatekeeper Training

What is Gatekeeper Training? Gatekeeper training is an educational program designed to equip individuals who are not mental health professionals with the ability to recognize signs of suicidal ideation and the competencies to respond appropriately.

Who is a Gatekeeper? A Gatekeeper is an individual in a community who has face-to-face contact with a large number of community members as part of their usual routine. Gatekeepers are not necessarily clinicians but are trained to identify people experiencing suicidality and refer them to appropriate services.

The goal of Gatekeeper training is to provide individuals who would perform the role of "Gatekeepers" with the skills necessary to identify individuals at risk, provide initial support, and refer them to professional services. The training emphasizes the importance of early detection and intervention in suicide prevention strategies (Hawgood, et al.).

Effectiveness of Gatekeeper Training: A key belief to target in Gatekeeper training is the perceived barriers to action, on the part of Gatekeepers, which significantly predict Gatekeeper effectiveness. (Magness et al., 2023).

The effectiveness of Gatekeeper training varies depending on individual or organizational characteristics. Law enforcement and juvenile justice workers show the greatest increases in suicide prevention behaviours, while educators show the lowest increase, potentially due to the subtlety of suicide signs in school settings (Gryglewicz et al., 2023). Online Gatekeeper Training for teachers has been shown to increase beliefs and behavioural intentions to intervene, though it does not necessarily change suicide-prevention behaviours (Robinson-Link et al., 2020).

Gatekeeper Training for Agricultural Communities: For agricultural communities, the development of Gatekeeper comfort levels within the training, role-playing exercises, and identification of mental health resources are critical. Addressing the stigma of suicide through testimonials is also essential (Oldham et al., 2023).

Gatekeeper Training for Schools: School-based Gatekeeper training programs have shown potential in changing knowledge and skills, but there is a need to translate these improvements into behavioural change (Mo et al., 2018).

Gatekeeper Training in Guyana: Gatekeeper training has been implemented in Guyana. Persaud and colleagues (2019) designed a Gatekeeper training for Guyanese youth, designed to be culturally relevant and aimed at addressing the high rates of adolescent suicide in the region. Tailored to fit the specific cultural and social nuances of Guyana, the training equips teachers, community leaders, and peers with the skills to identify and respond to signs of suicidality, aiming to enhance knowledge, reduce stigma, and create sustainable mental health support within communities. In Guyana, culturally informed Gatekeeper training has been found to increase knowledge and attitudes and is considered culturally acceptable and implementable in school settings (Persaud et al., 2019).

In summary, while Gatekeeper training effectively increases knowledge and attitudes about suicide prevention, there is mixed evidence for increasing suicide prevention behaviours on the part of Gatekeepers, especially among educators. Training for educators should incorporate sensitivity to subtle signs and focus on perceived barriers to Gatekeeper action, (Magness et al., 2023). To date, there is only one study examining Gatekeeper training in Guyana, highlighting a lack of research in this area and the need for culturally tailored interventions (Persaud et al., 2019).

Guyana will benefit from a culturally responsive Gatekeeper Training Program aimed at accomplishing the following goals:

- **Cultural Adaptation:** Training ought to be tailored to reflect Guyana's cultural context, and recognize unique local attitudes toward mental health and suicide.
- **Community Engagement:** Training should empower community members to identify at-risk individuals and foster a proactive environment.
- **Education and Awareness:** Training should provide education on the signs of suicidal behaviour and the importance of early intervention.

GATEKEEPERS IDENTIFY INDIVIDUALS AT RISK, PROVIDE INITIAL SUPPORT, AND REFER THEM TO PROFESSIONAL SERVICES.

- **Building Support Networks:** Training should encourage the development of support networks to provide assistance to those in need.
- **Resource Accessibility:** Training should ensure participants know how to access local mental health resources and support services.

- **Building Support Networks:** Training should encourage the development of support networks to provide assistance to those in need.
- **Resource Accessibility:** Training should ensure participants know how to access local mental health resources and support services.

Activity 1: Four Narratives

Objective: To develop a deeper understanding of suicide in Guyana by analyzing four representative narratives, examining the factors that contribute to suicide, and discussing potential prevention strategies.

Materials: See case stories of Devanand, Anita, Shamar and Rampaul.

Steps:

Break into Small Groups: Participants form small groups of 8-10 participants. Assign each group one case story each.

Individual Reading: Participants read their assigned case story individually, taking notes on key factors contributing to the crisis.

Group Discussion: In their groups, participants discuss the following questions:

1. In the narratives of Devanand, Anita, Shamar, and Rampaul, what common threads of Guyanese socio-economic factors and cultural context can be identified as factors that increase the risk of suicidal behaviour?
2. Across stories of these four individuals, how is suicide viewed and addressed within Guyanese communities?
3. Given the diverse challenges faced by Devanand, Anita, Shamar, and Rampaul, what might Gatekeepers do to create a supportive environment that enables these individuals to share their challenges easily?

Narrative-Specific Questions:

For Devanand: What specific factors in agricultural communities in Guyana make individuals like Devanand vulnerable to the risk of suicide?

For Anita: What role do socio-cultural factors play in Anita's suicide attempt? What are specific lessons for a Gatekeeper in her story?

For Shamar: What role do schools play in developing individual talents and enabling exploration of different paths to success?

For Rampaul: How does a Guyanese society, particularly among conservative families, deal with the challenges faced by Rampaul?

Narrative 1: Devanand – Despair in the Field

Devanand, an Indo-Guyanese rice farmer from the Yakusari area in the Blackbush community of Berbice, reminisced about the years when the region was celebrated as the breadbasket of the Caribbean. However, the area has recently been grappling with the aftermath of excessive rains, leading to flooding and devastation. His fields, once teeming with golden crops, lay in ruin, while slushy dams, nearly impassable roads, and an ailing infrastructure desperately needed attention.

The deluge left a significant mark not just on the land but also on Devanand's life. With his crops destroyed and livestock lost, the burden of the loan he took out for farm improvements seemed to grow heavier with each day. The rains washed away not just the fruits of his labour but also his vision for a prosperous season.

Living in a remote farming community, Devanand's social and recreational outlets were limited. The local bar was one of the few gathering places, where drinking often became the only respite from the day's toil. For Devanand, alcohol gradually turned into a solitary outlet, a way to drown the sorrows that the floods had intensified.

Isolated and with little access to comprehensive support services, the cumulative effect of his hardships, financial strain, and personal battles with addiction led Devanand to a place of deep despair. In an irreversible act of desperation, he turned to the very tools of his trade to end his suffering. The pesticide that once protected his crops became the means to his tragic end.

Narrative 2: Anita – Cycle of Abuse

Anita, a 26-year-old mother in a small Guyanese town, was entrenched in a cycle of abuse, married to a man much older than herself. His temper, exacerbated by alcohol, unleashed a torrent of violence that became a fixture in her life. The abuse was not only tolerated but sometimes dismissed by her in-laws, adding another layer to her entrapment. Cultural stigma about domestic issues and the fear of being shunned by the community left Anita voiceless, suffering in silence.

Repeatedly, Anita sought help, but the weak response from local authorities only emboldened her husband's wrath. The violence in their home often escalated to terrifying levels, with Anita's pleas for calm and safety for herself and her children falling on deaf ears. It was during one such intense altercation, when her husband's aggression turned towards their youngest child, that Anita reached her breaking point.

Overwhelmed by a combination of despair, fury, and profound helplessness, she took a drastic step. In the presence of her spouse, Anita retrieved pesticide from their shed. Consuming the lethal substance was a heart-wrenching act of desperation, a tragic culmination of her oppressive circumstances and a societal and systemic failure to offer protection.

Narrative 3: Shamar – Bouncing Back from Setbacks

Shamar, an Afro-Guyanese teenager raised in a foster home, faced an uphill battle in school, hindered by what seemed to be an undiagnosed learning disability that impaired his ability to read and keep up academically. This challenge seeded a profound sense of inadequacy within him, a self-stigma that grew like a shadow, darkening his perception of self-worth. His struggle with learning, made more burdensome by a growing addiction, seemed insurmountable, led him down a spiral of constant despair and multiple suicide attempts.

His belief of being fundamentally flawed because of his difficulties left Shamar isolated and misunderstood. He sought help from his guidance counsellor, but his meetings never seemed to address the root of his internal turmoil or offer the lasting change he so desperately needed.

Fortune smiled upon Shamar, however, when a community centre volunteer noticed his extraordinary agility and zest during a casual game of soccer. Seeing his potential, the volunteer encouraged him to join the local team, a move that sparked a transformative journey for Shamar. On the soccer field, he discovered a sense of belonging and achievement—precious commodities that had long evaded him in the academic setting. Soccer was not merely a sport for Shamar; it motivated him to rebuild his self-esteem and forge a new path in life.

Through this beautiful game, Shamar learned that success is not a one-size-fits-all measure, and talent can flourish outside the conventional confines of the classroom. His experiences underscored the importance of recognizing individual strengths and offering supportive environments where young people can escape the cycle of self-stigma and realize their true potential.

Narrative 4: Rampaul – To Be or Not To Be

Rampaul, the youngest son in a conservative Indo-Guyanese family, always felt like an outsider. Victim of peer bullying and ridicule by his cousins of a similar age, he was largely shielded by his mother. Stifled by his father's traditionalism, Rampaul's creative passions for the arts were suppressed in favour of the family's retail business. Seeking independence, he moved to Georgetown for an engineering degree, only to abandon it for the arts, defying his family's expectations. While working in media, he met David, an expatriate from the UK, and they formed a close bond that gradually evolved into romance.

In Rampaul's culture, dating someone of the same gender wasn't accepted. This meant he had to keep his relationship with David a secret. David invited Rampaul to start a new life together in the UK, but this meant coming out to his family, a daunting prospect for Rampaul given the potential for cultural backlash and familial rejection. Fearing the consequences, Rampaul hesitated, which led to a painful breakup with David. Overwhelmed by the loss and trapped by his circumstances, Rampaul resorted to self-harm and ultimately a suicide attempt, which landed him in the hospital.

His story is a stark reminder of the internal conflicts faced by those navigating cultural expectations, identity, and acceptance.

Module 1 Quiz

Each module ends with a quiz to test knowledge about key concepts in this module. The answer key is on the last page of this module.

1. Between 2000 and 2019, how much did the suicide rate increase in Guyana?

a. 12% **b.** 7% **c.** 5% **d.** Not listed **e.** 19%

2. What is Guyana's suicide rate per 100,000 people?

a. Approximately 11 **b.** Approximately 21 **c.** Approximately 31
d. Approximately 41 **e.** Approximately 51

3. By 2020, which three regions of Guyana have been identified as suicide hotspots?

a. Regions 1, 2, 7 **b.** Regions 1, 3, 6 **c.** Regions 2, 5, 6
d. Regions 4, 5, 6 **e.** Regions 5, 6, 7

4. Among Guyanese males, in which age range is the suicide rate the highest?

a. 26-37 years **b.** 15-24 years **c.** 45-55 years
d. 25-36 years **e.** 37-45 years

5. What is the most commonly used method of suicide in Guyana?

a. Hanging **b.** Firearm **c.** Drug overdose
d. Poisoning **e.** Jumping from high places

Summary

- The suicide rate in Guyana is among the highest in the world and has been in the top 10 over the last two decades
- Rates are highest in the coastal regions and among Indo-Guyanese males
- Suicidal ideation is more prevalent in females; suicide completion more prevalent in males
- Pesticide poisoning is the most common method of suicide in Guyana
- Psychological themes such as interpersonal conflict, trauma, and health play key factors in suicide in Guyana.
- The implementation of Gatekeeper training programs has been proven to be effective.
- Gatekeepers' roles are to identify individuals experiencing suicidality, intervene with them, and refer them to appropriate services.

Module 1: Quiz Answers

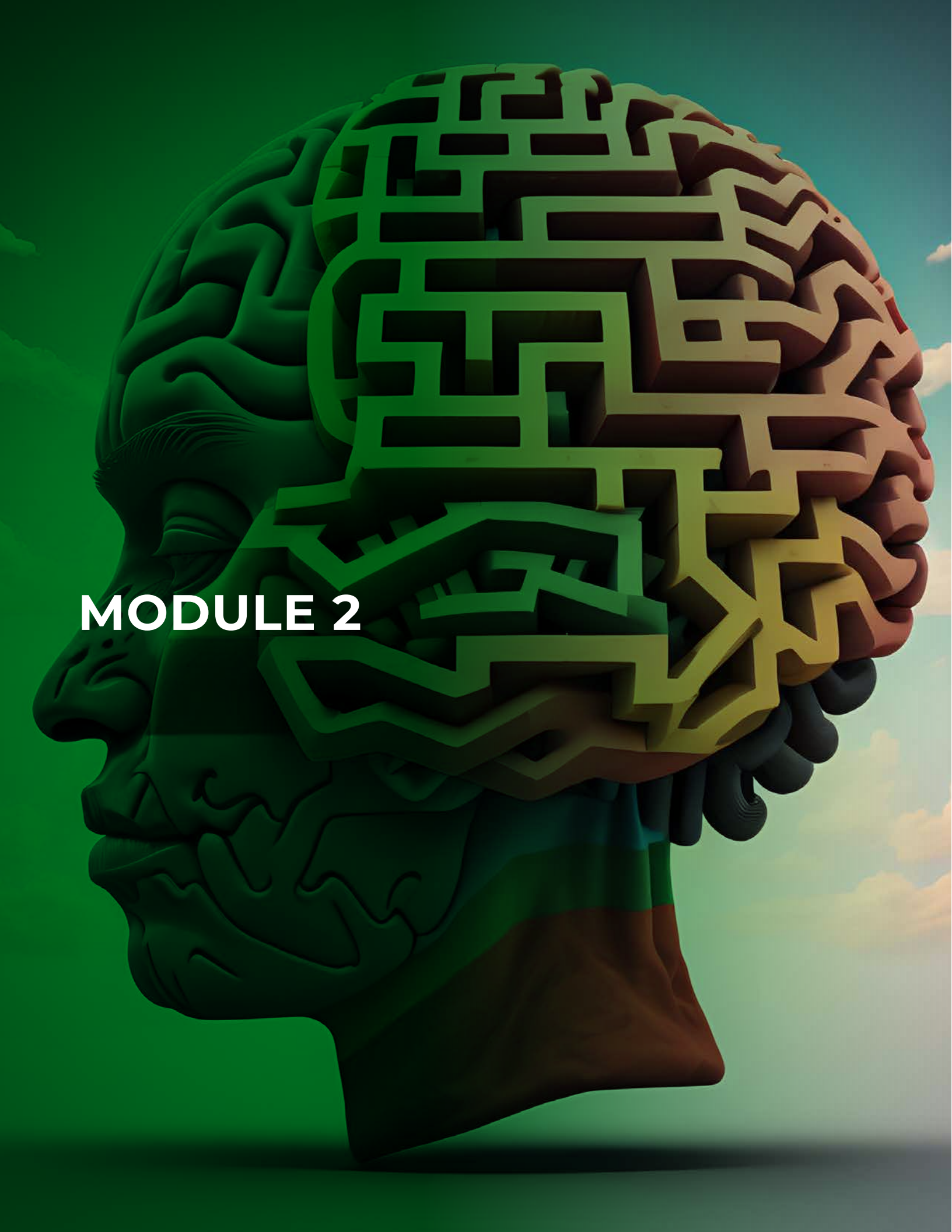
1. c: 5%. There has been a 5% absolute increase in the suicide rate in Guyana from 2000 to 2019, with the number of deaths by suicide rising from 62,401 in 2000 to 97,339 in 2019.

2. d: Approximately 41. Guyana's estimated suicide rate is 41 per 100,000 people, making it the second-highest in the world, according to the World Health Organization's 2019 report.

3. e: Regions 5, 6, 7. Regions 2, 5, and 6 have been identified as suicide hotspots in Guyana. Guyana Chronicle.

4. d: 25-36 years. Among Guyanese males, the highest suicide rate is observed in the age range of 25-36 years. Guyana Chronicle.

5. d: Poisoning. Poisoning is reported as the most common method of suicide in Guyana, according to multiple studies (Shaw et al., 2022).



MODULE 2

Suicide & Psychological Disorders

This module discusses major psychological disorders, explaining the most prevalent ones in relation to suicide, including depression, anxiety, emotional dysfunction, psychosis, and addiction. The module expands on how psychological disorders can amplify the risk of suicidal behaviour in order to equip Gatekeepers to identify individuals who may be in suicidal crisis.

Learning Outcomes

- **Identify** the increased suicide risk associated with specific mental health disorders, including mood disorders, borderline personality disorders, psychosis and substance abuse.
- **Recognize** observable signs in individuals with psychological disorders that require the need for suicide intervention and support.
- **Rehearse** the use of open-ended questions to encourage individuals in crisis to describe aspects of their psychological state in relation to suicidal intentions.

What is Mental Health, and How Does it Relate to Suicidal Behaviour?

The World Health Organization (WHO) defines mental health as a state of well-being that enables people to cope with the stressors of life, realize their abilities, learn and function well, and contribute to their community (WHO, 2022). Considering mental health a fundamental human right, WHO deems it essential for the personal, communal and socio-economic development of individuals and communities.

Attaining this state of mental health for much of the global population has been an enduring challenge, especially in recent decades. Those who are unable to achieve a state of well-being can become vulnerable to serious mental illnesses that can lead to suicidal behaviour and action.

While everyone experiences psychological distress from day to day, there's a significant difference between a person who feels temporarily stressed and someone diagnosed with a psychological disorder. Factors such as genetics, life challenges, and coping mechanisms significantly influence the progression of mental illness from feeling stressed to developing a mental health disorder (Hammen, 2005). Stressful life events like job loss, relationship breakdowns, or health issues can lead to feelings of anxiety and sadness. Without effective coping strategies, these feelings can intensify into more severe mental health problems. Without timely and effective support, mental health can deteriorate further.

Why is it Important to Understand Psychological Disorders?

Mental health disorders, also known as psychological disorders, are patterns of behaviour or psychological symptoms that impact multiple areas of life. These disorders create distress for the individual experiencing these symptoms and/or problems functioning in social, work, or family activities. The causes of psychological disorders are complex and multifaceted, involving a combination of genetic, biological, environmental, and psychological factors.

Recent studies and detailed reviews have confirmed these observations, showing how stress, the ways we deal with it, and the start of mental health issues are all interconnected (Li et al., 2020; Lorenzo-Luaces et al., 2021).

Psychological disorders contribute substantially to suicidal behaviour. According to the American Foundation for Suicide Prevention, approximately 90% of those who die by suicide have a diagnosable and potentially treatable mental health condition, though they might not have been aware of it or have received treatment (Bertolote & Fleischmann, 2002; Brådvik, 2018). However, it's crucial to understand that having a mental health condition does not inevitably lead to suicide, and most people with mental health conditions do not die by suicide.

Gatekeepers, such as mental health professionals, educators, community leaders, and even

laypersons trained in suicide prevention, play a critical role in identifying and helping individuals in suicidal crisis. Understanding psychological disorders is vital for Gatekeepers for several reasons:

Accurate Identification: Different psychological disorders have unique symptom profiles. Understanding these can help Gatekeepers identify underlying issues that may contribute to suicidal thoughts. For instance, the impulsivity associated with certain personality disorders might lead to rapid suicidal actions, which require immediate intervention.

Risk Assessment: Certain disorders carry a higher risk for suicide. Gatekeepers who are aware of these risks can better assess the level of danger and act promptly. For instance, understanding that major depressive disorder significantly increases suicide risk can prompt urgent action.

Focused Response: Knowledge of specific disorders allows Gatekeepers to tailor their approach when supporting someone in crisis. For example, individuals with anxiety disorders might require a different communication strategy than those with mood disorders.

Crisis Intervention: In acute situations, Gatekeepers with knowledge of disorders can use appropriate de-escalation techniques and crisis intervention strategies to manage the situation effectively until the individual can be referred to appropriate care.

Effective Referral: Gatekeepers with a broad understanding of psychological disorders are better equipped to refer individuals to the most appropriate resources and professional help, ensuring that they receive specialized care tailored to their needs.

Prevention Strategies: Understanding the spectrum of psychological disorders can inform the development of prevention strategies that address the specific needs of different groups, contributing to more effective community-wide suicide prevention efforts.

What are the Categories of Major Psychological Disorders?

Table 2.1 lists all major categories of psychological disorders in order of their statistical occurrence in most countries. It also provides examples of common types of disorder within the category.

Table 2.1
Categories of Major Psychological Disorders

DISORDER: SIGNS & SYMPTOMS	COMMON TYPES
Mood Disorders Mainly affect how you feel emotionally, like feeling really sad or swinging between feeling very happy and very sad	**Major Depressive Disorder:** Persistent sadness, loss of interest in activities, and inability to carry out daily activities for at least 2 weeks **Bipolar Disorder:** Episodes of mood swings ranging from depressive lows to manic highs, including Bipolar I, Bipolar II, and Cyclothymic Disorder
Anxiety Disorders: When someone feels really scared, worried, or nervous more than what seems normal, and these feelings get in the way of daily life	**Generalized Anxiety Disorder (GAD):** Excessive anxiety and worry occurring more days than not for at least 6 months, about a number of activities or events **Social Anxiety Disorder (Social Phobia):** Intense fear of social situations where others may scrutinize one **Panic Disorder:** Recurrent unexpected panic attacks, sudden periods of intense fear or discomfort **Specific Phobia:** Extreme fear or anxiety about a specific object or situation (e.g., flying, heights, animals)
Trauma- and Stress-Related Disorders: After someone goes through a scary or dangerous event, making them feel stressed or frightened even when they're not in danger anymore	**Post-Traumatic Stress Disorder (PTSD):** Distress and difficulty functioning after experiencing or witnessing a traumatic event **Adjustment Disorders:** Emotional or behavioural symptoms in response to an identifiable stressor occurring within 3 months of the stressor
Addiction/Impulse Control Disorders: When someone has difficulty resisting the urge to do things that could be harmful to themselves or others, like gambling too much or setting fires	**Substance-Related and Addictive Disorders:** Disorders related to the excessive use of substances like alcohol, caffeine, cannabis, etc., and behaviours such as gambling **Impulse-Control Disorders:** Disorders where there is a failure to resist an impulse, drive, or temptation to perform an act that harms the person or others (e.g., kleptomania, pyromania)

DISORDER: SIGNS & SYMPTOMS	COMMON TYPES
Eating Disorders: When someone has strong feelings about food and their body weight, leading to unhealthy eating habits	**Anorexia Nervosa:** Difficulty maintaining an appropriate weight, distorted body image **Bulimia Nervosa:** Eating a lot and then trying to get rid of the food through purging
Personality Disorders (PD): When the way someone thinks and behaves is different from what is usually expected, or it's hard for them to get along with others	**Borderline PD: (BPD):** A disorder characterized by a pervasive pattern of instability in interpersonal relationships, self-image, and emotions **Antisocial PD:** Characterised by frequent impulsive, irresponsible, and often criminal behaviour
Schizophrenia and Other Psychotic Disorders: When someone finds it hard to know what's real and what's not, affecting how they think and act	**Schizophrenia:** Seeing or hearing things that aren't there, believing things that aren't true
Neurocognitive Disorders: When someone has trouble remembering, thinking, or making decisions more than what is usual as they get older	**Alzheimer's Disease:** Characterized by a decline in memory, problem-solving, and other cognitive functions that affect daily life
Attention-Deficit/Hyperactivity Disorder (ADHD): When someone has a hard time paying attention, sitting still, or controlling their actions, more than others the same age	**Hyperactivity Type:** Difficulty sustaining attention in tasks, getting distracted and being restless **Inattentive Type:** Difficulty remaining focused, not being able to pay attention to details

Which Psychological Disorders are the Most Related to Suicidal Behaviour?

Understanding the connection between mental health and the risk of suicide is crucial. The Center for Disease Control (CDC) found that nearly half of the individuals who die by suicide have been identified with a mental health disorder. This shows a clear link between mental health challenges and the likelihood of someone taking their own life.

To dig deeper into this connection, researchers like Moitra and their team in 2021 looked closely at which specific mental health conditions are most linked to suicide. They found that individuals diagnosed with Major Depressive Disorder are roughly 7.6 times more likely to experience this event than those without the disorder. For people with Dysthymia, a milder form of depression, the likelihood is about 4.1 times higher. Those facing an Anxiety Disorder have a 4.9 times greater chance. At the same time, individuals with Schizophrenia are about 6 times more likely to encounter this event compared to individuals who do not have these conditions. Understanding these connections is key to offering the proper support and intervention to reduce the risk of suicide for those experiencing psychosis. Knowing their challenges, we can help them feel less alone, more understood, and supported through their journey.

In exploring the complex world of psychological disorders, it's vital to understand how conditions like depression, drug addiction, anxiety, and psychosis not only impact individuals' daily lives but also intertwine with serious risks, such as suicide. Depression often leads individuals into a deep, dark hole of despair, making it hard to see any light or way out. Substance abuse, whether it involves alcohol or drugs, can blur judgment and amplify feelings of hopelessness, significantly elevating the risk of suicidal thoughts or actions. Anxiety disorders trap people in cycles of worry and fear that can be paralyzing, while psychosis distorts reality to the point where one may feel utterly lost.

Table 2.2
Major Psychological Disorders & Suicide Risk

Table 2.2 lists the four disorders most closely linked to suicide risk (Brådvik, 2018). We examine each category below in terms of the degree of risk and common observable signs.

PSYCHOLOGICAL DISORDERS & SUICIDE RISK	COMMON OBSERVABLE SIGNS
Mood Disorders (Depression & Bipolar Disorder) 20.4% higher risk for suicide	• Hopelessness – Feeling and believing that no matter what one does, things will not improve • Feeling worthless – Believing one does not have important aspects or strengths • Impaired thinking and compromised decision-making – partly due to a lack of feeling and partly due to considering oneself negatively
Borderline Personality Disorder (BPD) Lifespan decreased by 9-17 years 20% die by suicide; 20-60% attempt suicide	• Impulsivity and acting without thinking • Feeling alone or misunderstood • Impulsive behaviour that often leads to self-harm and unstable interpersonal relationships
Psychosis Leading cause of early death Increased risk with symptom intensity and complexity 2- to 4-fold increase in suicide risk	• Stigma and isolation • Troubling symptoms like command hallucinations and persecutory delusions • Thinking difficulties • Severe psychotic episodes • Social withdrawal
Substance Abuse Disorders Complex relationship with genetics and alcohol use Higher risk for women and substance abuse Increased risk of suicide among those who abuse substances and also higher among those with childhood trauma	• Excessive drinking and substance use • Withdrawal symptoms • Life challenges like financial problems and relationship loss • Disinhibition from alcohol • Co-occurring psychological disorders

Suicide & Depression

Depression is one of the most common mental health disorders in Guyana (Pan American Health Organization, 2020). Depression has a very high risk for suicide at 20.4% (American Psychological Association, 2003). The severity of depression is directly linked to an increased risk of suicidal ideation and attempts.

The risk of a fatal outcome from a suicide attempt is significantly higher in individuals with bipolar disorder (BD) than in the general population, with the ratio of attempts to deaths being 3:1 for BD patients compared to 35:1 for the general public. Moreover, the presence of multiple mental health conditions, such as depression, coupled with anxiety or addiction, substantially elevates the likelihood of suicidal thoughts.

Below are three common signs of depression that are observable and can increase the risk of suicide:

Chronic Hopelessness: Feeling hopeless for a long time because of depression is a significant reason why some people might think about suicide.

Troubled Thinking and Difficult Decision-Making: People with depression often have trouble thinking clearly or making decisions, which can make them more likely to consider suicide, especially if they feel very hopeless.

Feelings of Worthlessness: Feeling like you're not worth anything is a common emotion in people with serious depression, and it can lead to thinking about suicide.

Understanding these connections between depression, how we think and feel, and the risk of suicide helps us see why it's so important to support those with depression, helping them find hope and healing.

Suicide & Borderline Personality Disorder (BPD) and Emotional Dysregulation

Personality disorders (PD) are common, chronic mental health conditions. Within personality disorders, Borderline PD and Antisocial PD are particularly associated with suicide-risk and self-injurious behaviour (McClellard & Cleare, 2022). BPD is when someone has strong emotions that they find hard to control. They might feel very unsure about who they are and have difficulty maintaining steady relationships. Individuals with Borderline Personality Disorder (BPD) have poor life experiences, which decreases their lifespan by about 9 to 17 years. Approximately 20% of individuals with BPD die by suicide and 20-60% attempt suicide

in their lifetime (Dome et al., 2019). This indicates that attempts by those with BPD are more likely to be fatal, highlighting the urgent need for specialized prevention efforts in this group.

It is common for people with a BPD profile to have symptoms of other psychological disorders such as addiction, Bipolar Disorder, or social anxiety. This amplifies the risk of suicidal behaviour.

Below are three common signs of Borderline Personality Disorder that are observable and can increase the risk of suicide:

Acting Without Thinking: Impulsivity, or acting without thinking, is common in BPD and can make someone more likely to try to harm themselves.

Struggles with Self-Harm: Many people with BPD harm themselves, engaging in habits like cutting, which can sometimes lead to more dangerous attempts at suicide.

Feeling Alone or Misunderstood: People with BPD might often feel alone, misunderstood, or rejected, which isn't mentioned often but is an important clue to their mental state. This is partly due to their challenges in handling tough emotions, which also cause interpersonal strife.

It's important for people with BPD to get the right help, like therapy, to learn better ways to handle their emotions, improve their relationships, and feel less alone. They can find healthier ways to cope with their struggles with the right support.

Suicide & Psychosis

When we talk about mental health, it's crucial to understand how different conditions can affect someone's risk of thinking about suicide or trying to end their own life. Psychosis, a mental health condition where people lose touch with reality, is one such condition that significantly increases the risk of suicide. Suicide is a leading cause of early death for those dealing with psychosis (Coentre et al., 2021). The risk of suicide increases due to the symptoms' intensity and complexity (Kugelmass, 2019). Furthermore, individuals experiencing psychosis also experience additional psychological challenges, such as depression or substance abuse, which place them at a heightened risk for suicidal behaviour (Pelizza & Ferrari, 2019).

Below are three common signs of psychosis that are observable and can increase the risk of suicide:

Stigma & Isolation: Dealing with psychosis can be incredibly isolating. The stigma, or negative judgments, that come with these conditions can make people feel alone and misunderstood, increasing their thoughts of suicide (Thompson et al., 2020).

Troubling Symptoms: Certain symptoms, like hearing voices that tell someone to harm themselves (command hallucinations) or believing that others are out to get them (persecutory delusions) are strong factors that can lead to suicidal thoughts and actions (Olfson et al., 2020).

Thinking Difficulties: Having trouble thinking clearly or understanding their own illness (cognitive impairment and poor insight) also play a role in why someone with psychosis might consider suicide (Radhakrishnan et al., 2021).

Suicide & Substance Abuse Disorders

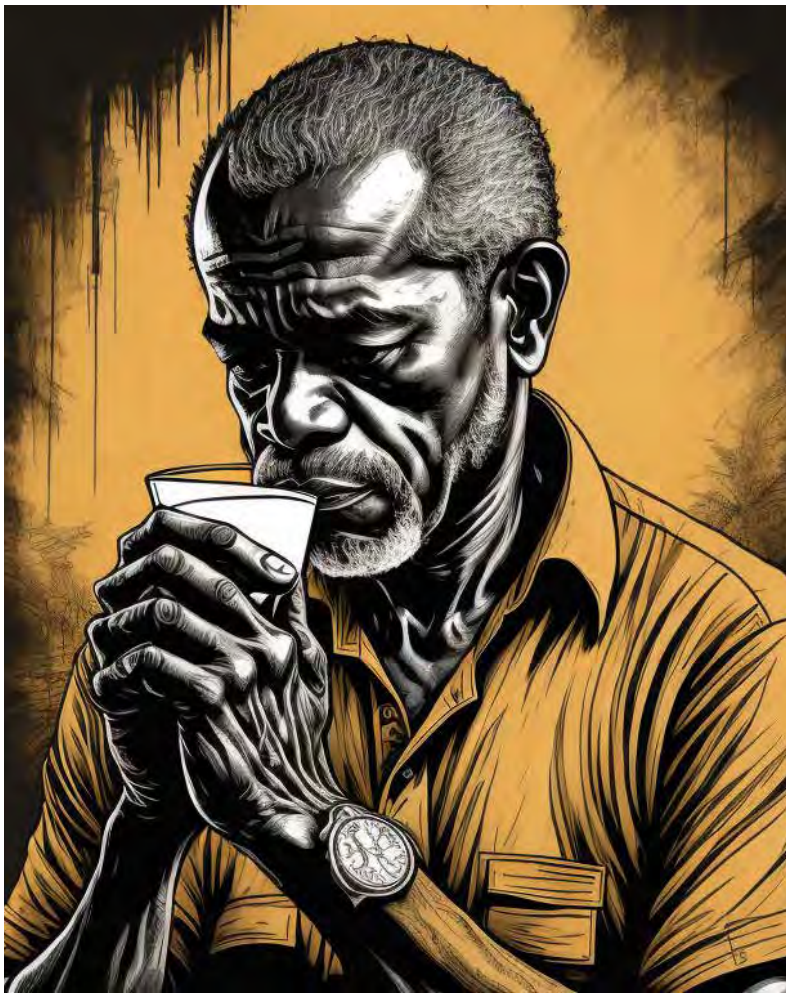
There's a complex relationship between genetics, alcohol use, and the risk of suicide. Some inherited traits can affect this relationship. For example, having certain psychiatric or psychological disorders like psychosis (losing touch with reality), mood disorders (like depression or bipolar disorder), and anxiety disorders, or being more sensitive to stress can raise the chance of someone engaging in suicidal behaviour. These same conditions can make someone vulnerable to alcohol usage, which in turn can impact mental health adversely. It's like a two-way street where mental health issues and alcohol use can negatively impact each other, leading to a higher suicide risk (Pompili et al., 2010). Research shows that women, tobacco users, and those using other substances experience a significantly higher risk of suicide, with variations in risk depending on the type of substance abuse - e.g., alcohol, tobacco, and other drugs (Korhonen et al., 2018; Lynch et al., 2020).

Below are three common signs of Substance Abuse Disorder that are observable and can increase the risk of suicide:

Excessive Drinking and Substance Use: Drinking too much alcohol or using drugs can make someone feel down, agitated, and less in control of their actions. This can lead to risky or impulsive behaviour, making it harder for them to think of better ways to handle tough emotions or situations. On the other hand, trying to quit or cut back from excessive usage of drugs and alcohol likely produces withdrawal symptoms that are so uncomfortable they make someone think about suicide.

Life Challenges: The financial problems, isolation, and loss of important relationships that often come with addiction can make someone more likely to think about suicide.

Disinhibition from Alcohol: Drinking too much can lower someone's fear of death, which might otherwise stop them from attempting suicide. It also can lead to feeling more disconnected and isolated from others.



Psychological Disorders and Suicide: Common Themes

Standing back from all four, we can conclude that psychological disorders contribute to suicidal behaviour in numerous ways including:

- Psychological disorders, especially depression, are strongly associated with suicidal thoughts and behaviours. Major depressive disorder, for instance, has been found to increase the risk of suicide significantly (Bostwick & Pankratz, 2000).
- Disorders such as schizophrenia and severe depression can impair judgment and reality testing, leading to distorted perceptions of one's life circumstances, which may contribute to suicidal ideation (Hawton et al., 2005).
- Psychological disorders can result in feelings of isolation and hopelessness, which are significant predictors of suicidal behaviour (Van Orden et al., 2010).
- The presence of comorbid psychological disorders and high-stress levels can increase suicide risk. For instance, the combination of depression and anxiety disorders has been shown to increase the risk of suicide attempts (Nock et al., 2009).
- Psychological disorders are often associated with impulsivity, lowering of behavioural inhibition, agitation and/or restlessness. These symptoms may render a person vulnerable to take risks. The risk-taking, in turn, can reinforce suicidal behaviour (Darke et al., 2012).

In conclusion, individuals living with specific mental health disorders can experience an increased risk of suicide. They exhibit specific and observable signs of distress, signaling the need for targeted support and intervention.

Activity 2: Recognizing the Signs of Psychological Disorders

Objective: Recall and notice observable warning signs of a psychological disorder that may increase the risk of suicidal behaviour and action.

Materials: Printed narratives (Rajesh, Tanya, Ahmed and Lisa)

Steps:

- Divide participants into small groups, assigning each group one of the vignettes.
- Have participants read their vignette and then discuss the questions below each one.
- Debrief by inviting a member of each group to share a summary of their discussion with the full group.

Narrative 1: Rajesh – Feeling Hopeless

Rajesh, a young man of 25, works at one of those big oil companies in Georgetown. For more than a year now, he's been feeling really down. Even though he works hard training expats, it seems that these same expats – though less qualified and experienced – get promoted and are given perks. It's not fair, and Rajesh feels that sting every day.

He used to love playing cricket on the weekends, laughing and joking with his buddies on the field, but these days, he just can't muster the energy to play. His relationships haven't been great either; a couple of serious girlfriends have come and gone, leaving Rajesh to wonder if he's good enough for anyone.

Decision-making feels like lifting heavy weights, and sometimes Rajesh gets caught in really dark thoughts, wondering if his family wouldn't be better off without him. He knows this isn't true, but the thought lingers, hard to shake off.

Discuss with your group two questions:

1. **In what ways is Rajesh struggling with some of the observable signs of a major depressive disorder?**
    - Chronic hopelessness
    - Troubled thinking and difficult decision-making
    - Feelings of worthlessness
2. **How can any of these signs alert you to the risk of suicidal behaviour and action?**
3. **What more would you like to know about Rajesh to assess suicide risk and provide support?**

Narrative 2: Tanya – Intense Emotional Ups and Downs

Tanya, a 28-year-old Afro-Guyanese woman, goes through intense ups and downs in her feelings. She finds it hard to keep steady relationships because she swings from loving people intensely to feeling like they're against her. Sometimes, she acts on impulse, like quitting her job without a plan, which she later regrets. To deal with her pain, she sometimes hurts herself, and she often feels no one truly gets her. Lately, she's been caught up in thoughts about whether life is worth living.

Discuss with your group two questions:

1. **In what ways is Tanya struggling with some of the observable signs of a borderline personality disorder?**

    - Acting without thinking
    - Struggles with self-harm
    - Feeling alone or misunderstood

2. **How can any of these signs alert you to the risk of suicidal behaviour and action?**

3. **What more would you like to know about Tanya to assess suicide risk and provide support?**

Narrative 3: Ahmed – Struggling with Addictions

Ahmed, an Indo-Guyanese secondary school student, lived with his traditional family in the region of Berbice. While Ahmed respected his family's traditions, his heart led him down an unexpected path when he met Shanti, a girl of Indian Hindu descent, whose vibrant spirit and shared interests drew him in. Their bond deepened, and soon, they were in love, sharing dreams of a future together. However, their relationship did not stay hidden for long. When Ahmed's family discovered the affair, they were vehemently opposed. The pressure to conform to familial expectations—to marry within his caste and religion—was immense.

Feeling cornered by the mounting familial tensions, Ahmed sought solace in the fleeting escape of drugs. To his family and the outside world, he maintained the facade of a dutiful son, but internally he felt wounded. One fateful night at a party, the weight of his circumstances became too much to bear. Under the influence of drugs and at the height of emotional turmoil, Ahmed overdosed.

Discuss with your group two questions:

1. **In what ways is Ahmed struggling with some of the observable signs of a substance abuse problem?**
    - Excessive drinking and substance use
    - Conflict between family and love relationship
    - Disinhibition
2. **How can any of these signs alert you to the risk of suicidal behaviour and action?**
3. **What more would you like to know about Ahmed to assess suicide risk and provide support?**

Narrative 4: Lisa – Experiencing a Break from Reality

Lisa, a 30-year-old woman with a mixed racial background, has been going through a tough time where she feels disconnected from reality. She hears voices that no one else can, telling her she's not good enough or that others are plotting against her. These experiences make her feel extremely scared and alone as if she's living in a different world from everyone else. She's been struggling to keep up with her job and maintain relationships because she's often caught up in her own thoughts and fears. Recently, Lisa has found herself wondering if it would be easier not to wake up, indicating she's thinking about harming herself.

Discuss with your group two questions:

1. **In what ways is Lisa struggling with some of the observable signs of a psychotic disorder?**
    - Stigma and isolation
    - Troubling symptoms like hallucinations or delusions
    - Thinking difficulties like cognitive impairment and poor insight
2. **How can any of these signs alert you to the risk of suicidal behaviour and action?**
3. **What more would you like to know about Lisa in order to assess suicide risk and provide support?**

Module 2 Quiz

1. How does the WHO define mental health?

a. The absence of illness
b. A state of well-being
c. Characterized by emotional stability
d. The ability to experience positive emotions
e. Being free of psychological disorders

2. According to the American Foundation for Suicide Prevention, what percentage of individuals who die by suicide have a diagnosable mental health condition?

a. 50% **b.** 75% **c.** 90% **d.** 60% **e.** 80%

3. Which of the following is considered a Mood Disorder?

a. Social Anxiety Disorder
b. Borderline Personality Disorder
c. Panic Disorder
d. Post-traumatic Stress Disorder
e. Bipolar Disorder

4. Approximately what percentage of individuals with Borderline Personality Disorder die by suicide?

a. Approximately 10%
b. Approximately 18%
c. Approximately 12%
d. Approximately 20%
e. Approximately 15%

5. How much more likely are individuals diagnosed with Generalized Anxiety Disorder (GAD) to die by suicide compared to those without GAD?

a. Nearly four times more
b. Nearly five times more
c. Nearly three times more
d. Nearly seven times more
e. Nearly ten times more.

Summary

- Mental health disorders, also known as psychological disorders, are patterns of behaviour or psychological symptoms that impact multiple areas of life. These disorders create distress for the individual experiencing these symptoms and/or problems functioning in social, work, or family activities.
- Causes of psychological disorders are varied and complex, often involving an interplay of genetic, biological, environmental, and psychological factors.
- Mental health disorders most associated with increased risk for suicidal behaviour are mood disorders such as Depression, Borderline Personality Disorder, Psychosis and Substance Abuse.
- Individuals with psychological disorders are at an increased risk of suicidal thoughts and behaviours, have impaired perception and judgement, and experience feelings of isolation and hopelessness.
- Comorbidity of psychological disorders (a combination of more than one disorder) coupled with periods of high stress in an individual can increase their risk of suicidal behaviour.

Module 2: Opening Quiz Answers

1. b: A state of well-being. The World Health Organization (WHO) defines mental health as a state of well-being in which individuals can cope with the normal stresses of life, work productively, and contribute to their communities.

2. c: 90%. The American Foundation for Suicide Prevention reports that approximately 90% of individuals who die by suicide have a diagnosable mental health condition, potentially treatable, even if it was unrecognized or untreated at the time of their death.

3. e: Bipolar Disorder. Bipolar Disorder is classified as a Mood Disorder characterized by significant fluctuations in a person's mood, energy, and activity levels.

4. d: Approximately 20%. Research suggests that around 20% of individuals diagnosed with Borderline Personality Disorder may die by suicide.

5. b: Nearly five times more. Individuals diagnosed with Generalized Anxiety Disorder are nearly five times more likely to die by suicide compared to those without GAD.

MODULE 3

A 5-Step Model of Suicide Risk Assessment & Safety Planning

This module on crisis intervention aims to equip individuals with the knowledge and skills to identify suicide risk and intervene in cases of imminent self-harm. It covers a comprehensive and collaborative 5-step approach to assessing those in need, by evaluating risk and protective factors, identifying warning signs, and determining the seriousness of suicidal ideation and planning. The last step is the creation and implementation of a safety plan to support the person in crisis, depending on their level of risk. The module integrates practical narratives and sample questions to enhance understanding and application in real-world scenarios.

Learning Outcomes

- **Appreciate** the importance of a methodical, evidence-based suicide assessment.
- **Recall** the steps to assess and ensure the safety of individuals at risk of suicide.
- **Recognize** key risk factors, protective factors and warning signs associated with suicidal behaviour.
- **Through role play:**
    - Apply a 5-step suicide assessment process to be prepared for real-world events.
    - Practice skills to effectively and empathically communicate with someone at risk.
    - Apply skills to evaluate suicidal ideation and suicide plans.
    - Prepare a detailed safety plan.

The 5-step model of Suicide Risk Assessment & Safety Planning guides Gatekeepers through a methodical approach to gathering information about someone in crisis, and determining the most effective course of action. The approach is described in sequential steps for sake of simplicity and clarity. Although the steps are described in a linear progression, know that interacting with humans in crisis does not follow a sequential order. Be prepared to move back and forth between steps, depending on the circumstances and the individual you are supporting.

A 5-STEP MODEL OF SUICIDE RISK ASSESSMENT & SAFETY PLANNING

Through this approach, you will gather and consider information from many angles at each step to form a comprehensive picture of the person at risk. In the case study activity that concludes this module, you will work with a 2-page form to capture important details at each step step of the process. The completed form provides a big-picture understanding of the Gatekeeper's interaction with a person in crisis as it provides an at-a-glace understanding of the many complex ingredients of their crisis. As a result of considering relevant details, it enables one to stand back from a crisis and answer the questions:

- Is this person suicidal?
- Does the person have a specific plan?
- What do we as Gatekeepers need to do to provide appropriate support and effective referral?

Step 1: Establish A Trusting & Respectful Relationship

As a Gatekeeper, before you can intervene, establishing a meaningful connection with the person in distress is paramount. This foundational step ensures you build trust and understanding, which are essential ingredients for guiding the individual toward the necessary help. The process involves choosing an appropriate setting, being clear on your role, ensuring confidentiality, demonstrating empathy, communicating respectfully, and being sensitive to cultural elements.

The role of a Gatekeeper is paramount for suicide prevention. Gatekeepers are individuals trained to identify and respond to signs of suicidal ideation, and serve as vital connectors between vulnerable individuals and professional help. Establishing rapport, a fundamental aspect of effective gatekeeping, is not merely about building a bridge of communication; it is about creating a safe, trusting, and empathetic environment where individuals feel understood and supported.

Table 3.1 lists key factors which can facilitate a trusting connection. This includes essential strategies and principles for Gatekeepers to foster meaningful connections, emphasizing active listening, empathy, and non-judgmental support. By prioritizing these interpersonal skills, Gatekeepers can significantly impact suicide prevention, offering hope and guidance to those in their most critical moments of need.

One of the main goals is to establish a trusting relationship with the person in distress so they might be open to share the narrative of distress that is urging them to take extreme action. Your goal as a Gatekeeper is to create a safe, comfortable environment in which the person is able to make sense of the story they are telling themselves of their past, present and future. Early in this process, aim to ask questions in a compassionate way that uncovers specific events or experiences that are triggering their thoughts of suicide.

Table 3.1 Making a Meaningful Connection

FEATURES OF "CONNECTION"	WHAT DOES THAT LOOK LIKE?
Setting: Choose one that is safe and promotes openness and honesty.	☐ Make sure the environment is private and safe. ☐ Ensure it is quiet, distraction-free and comfortable.
Gatekeeper role: Clearly state it at the beginning.	☐ I'm not a clinician but . . . there to listen, understand. ☐ I'm not trained to counsel you but I can facilitate connection to or refer you to appropriate support
Confidentiality: Maintain dignity while prioritizing wellbeing.	☐ Explain confidentiality - i.e., you respect the confidentiality of details shared and will not compromise their privacy. ☐ Inform them of disclosure - i.e., you have a duty to disclose if the individual is in danger of causing harm to self or others.
Empathy: Ensure the individual feels seen and heard.	☐ Recognize and affirm feelings of person in crisis. ☐ Let person cry and vent (appropriately) if they want to. ☐ Use appropriate non-verbal cues (eye contact, head nods, leaning in). ☐ Show patient listening.
Respect & Dignity: Ensure the individual feels safe to open up.	☐ Maintain an open posture and create adequate personal space between you. ☐ Avoid words implying judgement or shame. ☐ Reassure person that suicidal behaviour is not their fault.
Curiosity: Invite the individual to share, but avoid interrogation and judgement.	☐ Ask open-ended questions about experiences and feelings. ☐ Avoid drawing simplistic conclusions.

Table 3.2 below includes sample scripts that show the difference between dialogue that shows caring, curiosity and respect rather than dismissive or disrespectful reactions. Review this table in preparation for working with someone in crisis.

Table 3.2: Sample Scripts to Avoid Dismissive or Disrespectful Dialogue

BE CARING, CURIOUS, RESPECTFUL	DO NOT BE DISMISSIVE, DISRESPECTFUL
It seems like you're going through a tough time. Would you like to talk about what's on your mind?	I know how you feel. (Assumes understanding of their unique experience)
I'm here to listen to you. Tell me what you're comfortable sharing.	It will get better, just give it time. (Dismisses their current feelings)
You're not alone in this. I'm here to help you find the support you need.	Have you thought about how your actions would affect your family? (May induce guilt or shame)
I genuinely care about your well-being and want to understand your feelings.	But things could be worse, right? (Minimizes their feelings)
Can you share with me what you're feeling right now, whatever you're comfortable with?	Just try to cheer up. (Oversimplifies the complexity of their feelings)
Guyanese Cultural Context Examples	Add during Training
Guyanese Cultural Context Examples	Add during Training

Step 2: Evaluate Risk & Protective Factors

Building upon the foundational first step of connecting with individuals in distress, Step 2 of Gatekeeper Training shifts the focus towards a more structured assessment of risk and protective factors associated with suicidal behaviour. This assessment is a critical component of the Gatekeeper's role, requiring a delicate balance between professionalism and empathy. Understanding and identifying risk and protective factors enable Gatekeepers to gauge the level of risk and to tailor their support strategies accordingly.

Risk Factors

A risk factor is an aspect of personal behaviour or lifestyle, an environmental exposure, or an inborn or inherited characteristic that has been shown to be associated with an increased occurrence of death by suicide. People possessing the risk factor are considered to be at greater potential for suicidal behaviour. Risk factors are not predictors or causes of suicide (Rimkeviciene et a., 2015). Helping a person in a suicidal crisis involves understanding risk factors and warning signs. In the context of suicidal behaviour, a risk factor refers to any characteristic, condition, or situation that increases the likelihood of a person attempting or committing suicide. Risk factors are indicative of whether an individual, a community or a population is particularly vulnerable to suicide.

Based on a synthesis of psychological autopsy studies, a systematic review and meta-analysis by Favril and colleagues (2022) offers a comprehensive analysis of various factors which elevate the suicide risk in adults. This analysis offers a thorough and critical understanding of the multifaceted aspects that may lead to suicide. These factors can be categorized into the following domains: clinical, history of self-harm, sociodemographic, family history, and adverse life events.

Clinical Domain: This includes any diagnosed mental health condition, such as depression, anxiety, or schizophrenia. Individuals with mental disorders are at a significantly higher risk of suicide, underscoring the importance of mental health support.

History of Self-harm Domain: This includes any previous intentional injury to oneself without suicidal intent. A history of self-harm is a strong predictor of future suicide attempts.

Sociodemographic Domain: This domain includes:

Social Isolation: Feeling disconnected from others and lacking a sense of social belonging or supportive relationships significantly increases suicide risk

Unemployment: Not having a job and the associated financial and psychological stresses can contribute to the risk of suicide.

Family History Domain: This domain includes:

Psychological Disorder in Family: Having a family member with a mental health disorder can increase an individual's risk of suicide, possibly due to genetic or environmental factors

Family History of Suicide: A history of suicide within the family is associated with a higher risk, which may reflect genetic predispositions or the impact of experiencing a family member's suicide.

Adverse Life Events Domain: This domain includes

Relationship Conflict: Conflicts in personal relationships, including with partners or family members, can significantly impact an individual's mental well-being and increase suicide risk.

Legal Problems: Encountering legal issues or interactions with the criminal justice system is associated with heightened suicide risk, likely due to stress and societal stigma.

Table 3.3 provides ten categories of risk, based on these five domains. It also lists associated behaviours and sample questions that Gatekeepers can ask individuals experiencing suicidal behaviour.

Table 3.3 Ten Categories of Risk

CATEGORIES OF RISK	BEHAVIOURS NOTICED	SAMPLE QUESTIONS
Mental Health Symptoms	• Severe mood swings or sadness • Feelings of hopelessness • Changes in appetite or sleep	Have you felt more down or anxious recently? Are there activities you used to enjoy that you're finding hard to do now?
Self-Harm Behaviours	• Cutting, burning, or self-injury • Preparations for suicide • Ongoing suicidal thoughts	Have thoughts of hurting yourself crossed your mind lately? Is there anything you've been doing to cope that you're concerned about?
Family History	• Anxiety about family health history • Discussing family mental disorders or suicide • Copying behaviours related to a family member's condition	Have you or your family sought professional help for mental health issues? Do you find yourself behaving in a similar manner to a family member who suffers mental health concerns?

CATEGORIES OF RISK	BEHAVIOURS NOTICED	SAMPLE QUESTIONS
Substance Use	• Increased use during stress • Risky behaviours under the influence • Using substances as a primary coping mechanism	Have you been turning to substances more often when feeling stressed? Do you feel like your substance use has changed or increased recently?
Behavioural Factors - Impulsivity & Aggression	• Impulsive actions without regard for consequences • Aggressive behaviour • Struggling to maintain stable relationships	Have you noticed any recent changes in how you react to things or make decisions? Has managing relationships been more challenging for you these days?
Life Stressors and Events	• Distress from divorce or job loss • Isolating after significant events • Feeling grief or overwhelm from recent events	What recent event has had the biggest impact on you? Do you feel like you're coping with these changes, or is it feeling like too much?
Health/Medical Conditions	• Fears of being a burden due to health conditions • Despair about prognosis • Withdrawing from activities due to limitations	How has your health condition been influencing your thoughts and feelings lately? Do you ever feel like your health concerns are a burden to others?
Social and Relational Conflicts	• Avoiding socializing, leading to isolation • Frequent conflicts with significant others • Feeling lonely even in company	Lately, do you find yourself wanting to spend more time alone than with others? How are your relationships with family and friends currently feeling to you?
Employment/ Financial Stress	• Constantly worrying about finances • Demonstrating lifestyle changes due to financial instability • Stress from unemployment	How are financial concerns affecting you right now? Has there been a change in your job situation that's been difficult?
Legal/Criminal Challenges	• Anxiety about legal proceedings • Isolation due to legal problem stigma • Expressing hopelessness about legal outcomes	How are you holding up with the legal issues you're facing?" Do these legal concerns make you feel more isolated or stressed?

Protective Factors

Conversely, protective factors play a crucial role in mitigating the risk of suicide. These factors, ranging from individual characteristics to broader social supports, can significantly reduce the likelihood of suicidal behaviour.

A protective factor against suicidal risk refers to a characteristic at the biological, psychological, social, or cultural level that can help to reduce the likelihood of an individual engaging in suicidal behaviour. These factors can enhance resilience and provide individuals with the resources and supports necessary to cope with life's challenges in a healthy manner (Fonseca-Pedrero et al., 2022).

These factors are crucial in suicide prevention efforts as they can mitigate the risk even in the presence of strong risk factors. Table 3.4 summarizes the top 10 protective factors and describes related features.

Table 3.4: Top 10 Protective Factors

TOP 10 PROTECTIVE FACTORS	WHAT DOES THAT LOOK LIKE?
1. Gender	While females may exhibit higher rates of suicidal attempts and ideation, they have a lower proportion of suicide deaths.
2. Education	Higher educational attainment is linked to better coping mechanisms and lower suicide attempts.
3. Coping and Problem-Solving Skills	Effective stress management and problem-solving skills can significantly reduce suicide risk.
4. Reasons for Living	Strong personal connections and responsibilities can offer a protective shield against suicidal thoughts.
5. Cultural Identity	A robust sense of cultural identity enhances resilience and well-being.
6. Connectedness and Support from Others	Emotional support from family and peers is vital in countering isolation and despair.
7. Connection to Institutions	Active participation in community and educational institutions can foster a sense of belonging.
8. Quality Healthcare	Access to comprehensive healthcare services can help address and mitigate risk factors.
9. Reduced Access to Lethal Means	Limiting access to means of suicide can prevent impulsive fatal acts.
10. Cultural/Religious Objections	Certain beliefs and values can act as deterrents to suicidal behaviour.

When evaluating risk and protective factors, Gatekeepers are encouraged to approach each conversation with sensitivity, non-judgment, and an open heart. The goal is not only to identify the presence of risk and protective factors but also to understand their impact on the individual's life. This understanding allows Gatekeepers to provide targeted support, connect individuals with appropriate resources, and potentially save lives.

The assessment of risk and protective factors is a process that requires Gatekeepers to listen attentively, ask thoughtful questions, and offer support without judgment. By carefully steering these conversations, Gatekeepers play a crucial role in the early identification and intervention for individuals at risk of suicide, ultimately contributing to the broader effort to prevent suicide in the Guyanese community and beyond.

Step 3: Identify Warning Signs

Building upon the foundational knowledge of connecting with individuals in distress (Step 1) and assessing risk and protective factors (Step 2), Step 3 of the Gatekeeper Training focuses on identifying and assessing warning signs of suicidal behaviour. Recognizing these warning signs is crucial for timely intervention and support.

Rudd and colleagues (2006) define warning signs as the earliest detectable signs which indicate an elevated or heightened risk for imminent suicide. Incorporating the self-perspective (i.e., those at risk for suicide) and informant-perspectives (i.e., those who observe individuals at risk for suicide), Rudd empirically tested dozens of warning signs and identified the following which are: suicide Ideation, substance abuse, purposelessness, anger, feelings of being trapped, hopelessness, withdrawal, anxiety, recklessness and mood changes.

Table 3.5 lists the top 10 warning signs integrating multiple lines of research (Tsai & Klonsky, 2023). The Table includes both a general category of warning sign and specific observable features in terms of a person's language or behaviour.

To effectively assess these warning signs, Gatekeepers should use a conversational approach that is empathetic and non-judgmental. The assessment should seek to understand the frequency, intensity, and context of these warning signs within the individual's current life situation.

WARNING SIGNS ARE DEFINED AS THE EARLIEST DETECTABLE SIGNS WHICH INDICATE A HEIGHTENED RISK FOR IMMINENT SUICIDE.

Table 3.5: Top 10 Warning Signs

TOP 10 PROTECTIVE FACTORS	WHAT DOES THAT LOOK LIKE?
1. Talking About Wanting to Die or Kill Oneself	Direct statements or insinuations about wanting to end one's life
2. Looking for a Way to Kill Oneself	Actively seeking means to commit suicide, such as searching online for methods or acquiring a weapon
3. Expressing Feelings of Hopelessness or Having No Purpose	Verbal expressions of having no reason to live or feeling trapped
4. Acting Recklessly or Engaging in Risky Behaviours	Increased engagement in dangerous activities, seemingly without consideration of the consequences
5. Withdrawing or Isolating From Others	Pulling away from family, friends, and society and increasing solitary behaviour
6. Showing Extreme Mood Swings; Expressing rage	Fluctuating from being very sad to very happy or from being even tempered to angry
7. Talking About Being a Burden to Others	Frequent mentions of feeling like an emotional or financial burden to friends or family
8. Increasing Use of Alcohol or Drugs	Noticeable escalation in substance use or new onset of heavy usage
9. Sleeping Too Little or Too Much	Significant changes in sleeping patterns, either insomnia or oversleeping
10. Showing Deterioration in Physical Health and Appearance	Neglecting personal hygiene or physical health, indicating a lack of self-care

Step 4: Assess Suicidal Ideation & Plan

This step builds on Step 1, establishing a connection, Step 2, assessing risk and protective factors and Step 3 identifying warning signs. From the insights gained in these three foundational steps, Step 4 proceeds to explore with the person in crisis the seriousness of their putting a suicidal intention into action. In other words, do they have a plan?

From observations and knowledge about an individual's risk and protective factors and warning signs, the Gatekeeper's role at Step 4 begins with a decision to explore suicidal ideation and planning. They need to embark on a methodical process of determining the individual's degree of suicide risk. Differentiating between an individual's intention to commit suicide and their suicide plan is crucial in determining the ultimate response on the part of the Gatekeeper.

This cohesive approach ensures a thorough understanding of the individual's current mental state and intentions before moving into intervention strategies which we discuss in Step 5. In order to assess the risk of suicide, the terms "suicidal ideation" and "suicide plan" are important to distinguish:

Suicidal ideation focuses on psychological and emotional aspects, including the desire to die, reasons for this desire, and the fluctuating intensity of these thoughts. Evaluation of ideation or their "intention to commit suicide" includes gaining an understanding of how serious and determined the person is to commit suicide. A **suicide plan** on the other hand focuses on the practical and logistical aspects, such as the specific methods, availability of means, and preparations for the act.

High-Risk individuals exhibit clear, persistent, and intense suicidal ideation with specific plans and means, requiring immediate safety interventions and ongoing monitoring. The focus here is on preventing the act through acute safety measures such as securing the environment and providing constant support to and active vigilance over the individual.

Low-Risk individuals may have fleeting or moderate thoughts of suicide without a detailed plan or means, allowing for a more preventative approach focused on counseling, support, and monitoring. The goal is to address underlying issues, enhance coping strategies, and strengthen protective factors.

Suicidal Ideation

Use Table 3.6 Suicidal Ideation to engage the individual in discussing their suicidal ideation - i.e., suicidal thoughts and related characteristics such as persistence, intensity, controllability, and acuity. Notice the difference between high risk and low risk characteristics. Sample questions can help you to initiate conversations. The notes box allows the Gatekeeper to summarize the individual's suicidal ideation and indicate the overall degree of risk. For additional notes, use a plain page.

Table 3.6: Suicidal Ideation

IDEAS & FEELINGS	
HIGH RISK	**LOW RISK**
Persistent/prolonged: Last for days	**Transitory/intermittent:** Fleeting and occasional
Intense: Highly distressing and overwhelming	**Moderate:** Present but not overwhelming, one can function reasonably well
Uncontrollable: Feel powerless to stop	**Manageable:** Able to manage and attend diverse things
Acute: Linked with a crisis or significantly triggered	**Not acute:** Always present but not immediate or driven by a crisis
Specific: Focused with greater specificity	**Vague:** Non-specific, unclear ideas
Constricted: Hard to express	**Expressable:** Relatively easier to express
Unbearable: Causing immense psychological pain	**Manageable:** Causing tolerable psychological pain

Sample Questions

1. What makes you feel or believe that life is not worth living?
2. If you were alone right now, would you kill yourself?
3. What makes you believe that you are no good?
4. How strongly do you want to die?
5. Why do you want to die?
6. Why do you want to die now?

Suicide Plan

Only if the individual's responses indicate High Risk suicidal ideation, and they have shared a specific means of suicide, proceed to Table 3.7: Suicide Plan. To facilitate your discussion about the plan, Table 3.8 lists specific markers of a suicide plan such as methods, access, and availability of means.

Table 3.7: Suicide Plan

SUICIDE PLAN	
PLAN DETAILS	**SAMPLE QUESTIONS**
Specific method of suicide in mind	• You mentioned having thoughts of ending your life. Have you thought about how you might do this? • Do you have access to the means to carry out this plan?
Specific date planned	• Do you intend to act on these thoughts? If so, have you thought about when you might do this? • Are these thoughts something you're experiencing constantly, or do they come and go?"
Specific steps planned (obtaining a firearm/pills, writing a suicide note, giving belongings away)	• It sounds like these thoughts have been quite distressing. Have you ever acted on these thoughts in the past? What happened? • It's important for us to understand your situation fully. Can you tell me if you've taken any steps toward making this plan a reality?
Availability of means	• Do you have everything you need to carry out your plan? Have you taken steps to secure these means
Guyanese Cultural Context Examples	Add during training

Step 5: Develop a Safety Plan & Implement

The fifth and final step focuses on devising a safety plan which outlines actions to keep the person in suicidal crisis safe in the long term. A Safety Plan is initiated by the Gatekeeper, but developed in collaboration with the person in crisis. It identifies triggers which the person can handle preemptively through adaptive coping behaviours, before they escalate into crisis. Although the Gatekeeper introduces the writing of the plan, the individual in crisis personalizes the content to ensure it contains accessible, and implementable actions, as well as supports, strengths and resources to keep them safe.

Safety Plan Overview

A. Recognizing and Responding to Warning Signs

Identify personal triggers: Clearly list situations, thoughts, or feelings that lead you to suicidal ideation.

Monitor warning signs: Regularly check in with yourself for signs of depression or thoughts of suicide.

B. Engaging in Positive and Safe Behaviours

Define coping behaviours: Write down specific actions you will take when experiencing suicidal urges (e.g., breathing exercises, physical activity).

Assess feasibility: Rate the likelihood of performing each behaviour and plan accordingly.

Identify obstacles: List potential barriers to these behaviours and strategies to overcome them.

Recognize supports: Identify supports such as people, services, technology, actions or beliefs that encourage positive behaviours.

Prepare resources: Gather necessary resources to enact coping strategies.

Leverage strengths: Document personal strengths and how they can be used during a crisis.

Have backup actions: List immediate, low-preparation activities to stay safe (e.g., listening to music or engaging in a hobby).

C. Seeking Support from People and Places

Create a support network: List names and contact information of individuals for each phase of a crisis.

Verify availability: Confirm each person's willingness and ability to provide support.

Identify comforting places: List locations that provide solace and detail how and when you can access them.

D. Contacting Support Services

List support services: Compile contact information for hotlines, text services, and counselling centers.

Remove barriers: Note any hesitations on your part to reach out and develop strategies to address them.

Keep information accessible: Ensure the list of support services is available in multiple formats and easily reachable.

E. Making the Environment Safe

Eliminate risks: Catalog all items that could be used for self-harm.

Limit access: Secure these items or entrust them to a supportive individual.

Discuss lethal means: Explicitly address your access to firearms or other methods and develop a plan to restrict access.

Guidelines to Refer High Risk Individuals

If the Suicidal Ideation and Suicide Plan indicate that the person is experiencing intense and urgent suicidal impulses, and also have a plan, follow these guidelines to ensure their safety:

1. **Ensure Safety:** Ensure that the person does not have access to any means (firearm, poison) through which they can harm themselves. Remove access. Involve the support of others and engage emergency services to support this removal. Throughout the removal process, ensure the person that you are acting to keep them safe.

2. **Communicate Calmly and Directly:** Inform the person of your actions, in a calm and non-judgemental manner, conveying your concern to keep them and others safe.

3. **Contact Emergency Services:** If the person is not cooperative or becomes irate, immediately contact professional emergency personnel at the nearest healthcare facility. Keep their contact information handy at all times.

4. **Facilitate Hospitalization:** If the person has strong suicidal ideation and a plan to execute, and is not cooperative or is unwilling to go to hospital voluntarily, call emergency services immediately. While the emergency services are on the way, do not leave the person alone.

    a) Explain to the person that their safety is the priority.

    b) Assure the person that you will share only relevant information with Emergency Services.

    c) If the person is willing, encourage them to contact someone they trust who could accompany them to hospital or support them in any way.

    d) Contact the health care facility where the person is most likely to be admitted.

    e) Share with the health facility information that is legally and ethically appropriate for the provision of appropriate services, and allowed within exceptions to confidentiality rules.

    f) If possible, provide to the person your Gatekeeper notes so they can share these details with the health care facility.

5. **Follow Up:** When and if the person is discharged from the health care facility, follow up with them to provide referrals to long-term psychological treatment if needed.

From the beginning of this process of referral, be aware of the legal framework regarding involuntary admission for mental health reasons in Guyana. In some cases, law enforcement may need to be involved if the person refuses care but is in imminent danger. Be mindful of cultural aspects that may influence the person's perception of suicide and their willingness to receive help. Finally, be aware of stigma that may interfere with the person's willingness to avail themself of services. See more about stigma in Module 5.

Suicide Behaviour Screening Tools

Gatekeepers can benefit from utilizing standardized assessment instruments that enable individuals to open up about their narrative of distress. These instruments enable a closer look at important risk factors such as drug and alcohol abuse, symptoms such as depression, anxiety, and stigma and steps in the assessment process such as suicidal ideation and plan. Participants gain additional tools to support their work with people in crisis and a means of enabling these individuals to be more open about their current reality.

These are relatively short, all free of charge (with the exception of one, Scale for Suicide Ideation ¶ and can be administered by a Gatekeeper, without extensive training in psychological assessment.

The following pages detail the seven instruments below. Appendix 1 contains the full questionnaire.

1. Beck Scale for Suicide Ideation (BSSI)

2. Columbia Suicide Severity Rating Scale (C-SSRI)

3. Alcohol Use Disorder Identification Test (AUDIT)

4. Drug Abuse Screening Test (DAST)

5. Patient Health Questionnaire-9 (PHQ-9)

6. Generalized Anxiety Disorder-7 (GAD-7)

7. Self-Stigma Against Seeking Help for Suicidal Ideation Scale (SASSHIS)

1. Beck Scale for Suicide Ideation (BSSI)

What is the BSSI:

- The BSSI evaluates the intensity of an individual's attitudes about living or dying, capturing their desire to die, the frequency of suicidal thoughts, their attitude toward living, and their personal control over suicidal thoughts.

Administration:

- The BSSI is a self-report instrument that can also be administered by a trained administrator, which may include Gatekeepers or paraprofessionals.
- It generally takes between 5 to 15 minutes to complete.
- The scale can be administered using paper and pencil or digitally on devices like iPads.

Scoring and Ranges:

- The BSSI consists of 21 items, each rated on a scale from 0 to 2, with total scores ranging from 0 to 42.
- The higher the score, the more severe the level of suicidal ideation.
- Scores of 9 or higher are considered indicative of significant suicidal risk and suggest the need for further evaluation.

Utility for Gatekeepers:

- Gatekeepers can use the BSSI as a quick screening tool to identify individuals who may be at risk for suicide.
- The scale's straightforward questions about the future and sense of hope can be a conversation starter about an individual's thoughts and feelings regarding suicide.
- BSSI provides a structured approach to quantifying and qualifying suicidal ideation, aiding Gatekeepers in determining the level of risk and the need for immediate intervention.

Key Research Reference

Beck, A. T., Kovacs, M., & Weissman, A. (1979). Assessment of suicidal intention: the Scale for Suicide Ideation. *Journal of consulting and clinical psychology,* 47(2), 343–352. https://doi.org/10.1037//0022-006x.47.2.343

2. Columbia Suicide Severity Rating Scale (C-SSRS)

What is C-SSRS:

- The C-SSRS is designed to measure the spectrum of suicidal ideation and suicide-related behaviours.
- It assesses the severity and immediacy of risk, providing categories for suicidal ideation, intensity of ideation, suicidal behaviour, and lethality of attempts.

Administration:

- The C-SSRS can be used for all age groups and is applicable in various settings, from clinical to research, and in school or community programs.
- It can be administered by professionals and trained paraprofessionals, including Gatekeepers.
- The scale can be conducted as a self-report or administered directly in an interview format.
- The time for administration can vary depending on the individual's responses and the setting, but typically ranges from several minutes to about 20 minutes.

Scoring and Ranges:

The C-SSRS includes a series of simple questions that lead to identifying the presence and severity of suicidal ideation and behaviour.

There isn't a numerical score like in the BSSI; instead, the responses categorize the level of suicidal ideation from "wish to be dead" to "active suicidal ideation with specific plan and intent."

Utility for Gatekeepers:

The C-SSRS provides Gatekeepers with a structured framework to evaluate and understand both the individual's past and any current risk for suicide.

It is a tool for identifying those at risk and can lead to timely interventions by helping to determine the level of support and monitoring required.

The scale's ability to assess the full range of evidence-based suicidality provides a comprehensive overview of an individual's risk status.

Key Research Reference

Posner, K., Brown, G. K., Stanley, B., Brent, D. A., Yershova, K. V., Oquendo, M. A., . . . & Mann, J. J. (2011). The Columbia–Suicide Severity Rating Scale: initial validity and internal consistency findings from three multisite studies with adolescents and adults. *American journal of psychiatry,* 168(12), 1266-1277

3. Alcohol Use Disorders Identification Test (AUDIT)

What is AUDIT:

- AUDIT is a questionnaire that helps to identify people who are at risk for developing alcohol problems.
- It looks at how much and how often a person drinks, as well as the consequences of their drinking.

Administration:

- The AUDIT can be self-administered or conducted by a staff member or healthcare provider.
- It can be filled out on paper, electronically, or given verbally, making it flexible for different settings.
- It takes only a few minutes to complete, typically between 5 to 10 minutes.

Scoring and Ranges:

- The test has 10 questions, each with a score range from 0 to 4.
- The total score can range from 0 to 40, with higher scores indicating a greater risk for alcohol problems.
- A score of 8 or more in men (and sometimes 7 in women) suggests hazardous drinking.
- Scores of 13 or more for women and 15 or more for men indicate likely alcohol dependence.

Utility for Gatekeepers:

- The AUDIT is an effective tool for Gatekeepers and healthcare providers to screen for potential alcohol use disorders, providing a quick and reliable way to assess and address alcohol-related risks.
- Gatekeepers can use AUDIT to quickly assess whether a person might need further evaluation for alcohol use problems.
- It can guide discussions about drinking habits and the need for potential interventions or referrals.

Key Research Reference

Higgins-Biddle, J. C., & Babor, T. F. (2018). A review of the Alcohol Use Disorders Identification Test (AUDIT), AUDIT-C, and USAUDIT for screening in the United States: Past issues and future directions. The American journal of drug and alcohol abuse, 44(6), 578–586. https://doi.org/10.1080/00952990.2018.1456545

4. Drug Abuse Screening Test (DAST)

What is DAST:

- The DAST assesses the degree of consequences related to drug use, rather than the quantity or frequency of use.
- It helps to identify problematic drug use patterns and the potential need for more comprehensive assessment or intervention.

Administration:

- The DAST can be self-administered on paper or electronically, or administered by an interviewer in person or over the phone.
- It is a quick screening tool, often taking less than 10 minutes to complete.

Scoring and Ranges:

- The original DAST has 20 questions, with each affirmative answer scoring one point.
- The total score can range from 0 to 20, with higher scores indicating more severe drug-related problems.
- There are also shorter versions like the DAST-10.

Utility for Gatekeepers:

- For Gatekeepers, the DAST provides a simple method to assess whether an individual's drug use might be problematic.
- It can help determine if there is a need for a referral to specialized services for substance use issues.

Key Research Reference

Shirinbayan, P., Salavati, M., Soleimani, F., Saeedi, A., Asghari-Jafarabadi, M., Hemmati-Garakani, S., & Vameghi, R. (2020). *The Psychometric Properties of the Drug Abuse Screening Test*. Addiction & health, 12(1), 25–33. https://doi.org/10.22122/ahj.v12i1.256

5. Patient Health Questionnaire-9 (PHQ-9)

What is the PHQ-9:

- The PHQ-9 specifically targets the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).
- It consists of 9 questions that inquaire about the frequency of symptoms of depression experienced over the past 2 weeks.

Administration:

- The PHQ-9 can be self-administered or conducted by a healthcare provider.
- It typically takes a few minutes to complete, making it a quick tool for screening in clinical settings.

Scoring and Ranges:

- Each of the 9 items is scored from 0 (not at all) to 3 (nearly every day), with a total score ranging from 0 to 27.
- Scores of 5, 10, 15, and 20 represent cut-off points for mild, moderate, moderately severe, and severe depression, respectively.

Utility for Gatekeepers:

- Gatekeepers can use the PHQ-9 to quickly assess depressive symptoms in individuals, guiding decisions about further evaluation or intervention.
- It can facilitate discussions about mental health, helping to identify those who may benefit from mental health services.

Key Research Reference:

Kroenke, K., Spitzer, R.L., & Williams, J.B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16(9), 606-613.

6. Generalized Anxiety Disorder-7 (GAD-7)

What is the GAD-7:

- The GAD-7 assesses the frequency of anxiety symptoms experienced over the past 2 weeks, focusing on core features of generalized anxiety disorder as outlined in diagnostic criteria.
- It asks about feelings of nervousness, inability to stop worrying, and physical symptoms related to anxiety, among others.

Administration:

- The GAD-7 can be completed by patients in clinical settings, research, or as part of routine screening for anxiety symptoms.
- It is designed for adults and can be filled out on paper or electronically, usually taking less than 5 minutes.

Scoring and Ranges:

- Scores for each of the 7 items range from 0 (not at all) to 3 (nearly every day), with total scores ranging from 0 to 21.
- The severity of anxiety is categorized as minimal (0-4), mild (5-9), moderate (10-14), and severe (15-21).

Utility for Gatekeepers:

- Gatekeepers, including primary care providers and mental health professionals, can use the GAD-7 to quickly screen for anxiety disorders, identify the severity of symptoms, and monitor changes over time.
- It aids in the decision-making process for referrals to mental health services or the initiation of treatment.

Key Research Reference:

Spitzer, R.L., Kroenke, K., Williams, J.B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of Internal Medicine*, 166(10), 1092-1097.

7. Self-Stigma of Seeking Help Scale (SSOSH)

Please note that Gatekeeper Training in Guyana will use an adapted version of this tool, called, Self-Stigma Against Seeking Help for Suicidal Ideation Scale (SASSHIS). See Appendix A for sample.

What is SSOSH:

- The Self-Stigma of Seeking Help Scale (SSOSH) is designed to measure the extent to which individuals hold negative beliefs about seeking psychological help.
- It assesses self-stigma, which can be a barrier to individuals accessing mental health services.

Administration:

- The SSOSH is a self-report measure that can be administered in a variety of settings, including clinical, research, and community environments.
- Typically, the scale is quick to complete, often requiring only a few minutes.

Scoring and Ranges:

- The scale usually consists of a series of statements related to seeking help, to which individuals respond on a Likert-type scale.
- Scores are totaled to give an overall measure of the degree of self-stigma associated with seeking help, with lower scores indicating greater self-stigma.

Utility for Gatekeepers:

- Gatekeepers, such as healthcare providers, counselors, and educators, can use the SSOSH to identify levels of self-stigma in individuals who may be reluctant to seek help for mental health issues.
- It can inform strategies for addressing stigma in mental health education and intervention programs.

Key Research Reference:

Vogel, D. L., Wade, N. G., & Haake, S. (2006). Self-Stigma of Seeking Help Scale (SSOSH) [Database record]. *APA PsycTests.* https://doi.org/10.1037/t00524-000

Activity 3: Five-Step Model Role Play

Objective: Groups will demonstrate understanding and application of the Five-Step Suicide Assessment and Safety Planning Model through a role-play of one of the provided narratives (Rajesh, Tanya, Ahmed, and Lisa). The role-play will incorporate the use of standardized assessment tools at appropriate steps.

Materials Needed:

- Blank Suicide Risk Assessment & Safety Plan on pages 82-83
- Narratives of Rajesh, Tanya, Ahmed, and Lisa
- Screening tools: C-SSRS, PHQ-9, GAD-7, AUDIT, DAST, and SASSHIS
- Illustration of 5-point model

Group Setup:

- Groups of 5-7 participants
- Each group selects one narrative to focus on
- Roles assigned within each group for the character (Rajesh, Tanya, Ahmed and Lisa), the gatekeeper(s), and observers

Preparation:

- **Familiarize:** Groups read and understand the assigned narrative and the Five-Step Model.
- **Study Tools:** Participants familiarize themselves with assessment tools
- **Scripting:** Groups develop a script for the role-play, determining how Gatekeeper intervenes
- **Rehearsal**: Practice the role-play, ensuring accurate portrayal and use of the screening tools.

Role-Play Execution:

- **Step 1:** Start the role-play by establishing trust between the gatekeeper and the character.
- **Step 2:** Evaluate stressful events, triggers and stigma, as well as risk and protective factors. Apply where appropriate C-SSRS (Suicidal Severity, PHQ-9 (Depression), GAD-7 (Anxiety), AUDIT (Alcohol), and DAST (Drug abuse) to evaluate risk and protective factors, documenting scores on the flow diagram.
- **Step 3:** Discuss with group members warning signs as well as information from relevant tools to understand the person's narrative of distress.
- **Step 4:** Assess suicidal ideation and plans based on the narrative and the results of screening tools

- **Step 5:** Develop a safety plan using the gathered information and considering the character's support network.

Presentation:

- **Showcase:** Each group presents their role-play to the larger assembly, demonstrating the application of the Five-Step Model and the assessment tools.
- **Visual Aids:** Display the completed flow diagram to guide the audience through the assessment process.

Debriefing:

- **Reflective Questions:** After each presentation, discuss how the use of screening tools informed the role-play and the development of the safety plan.
- **Feedback:** Observers and facilitators provide feedback on the role-play's effectiveness and adherence to the model.

Scenario Specific Check Points

Rajesh's Scenario:

Step 1 - Trust:

- Confirm the gatekeeper demonstrates empathy for Rajesh's work issues and a sense of fairness.
- Ensure the gatekeeper's interactions convey nonjudgmental support.

Step 2 - Risk & Protective Factors:

- Verify the accurate portrayal of Rajesh's workplace stress using screening tools.
- Identify Rajesh's support system, including his relationship with his mother, as a protective factor.

Step 3 - Warning Signs:

- Highlight Rajesh's withdrawal from cricket and his change in personal care as warning signs.
- Connect Rajesh's feelings of worthlessness to potential risk factors in the role play.

Step 4 - Suicidal Ideation:

- Assess the depiction of the severity of Rajesh's suicidal thoughts using C-SSRS.
- Examine the discussion around Rajesh's thoughts on his family's well-being without him.

Step 5 - Safety Plan:

- Evaluate the customization of the safety plan to Rajesh's lifestyle and emotional support from his mother.
- Check for the inclusion of follow-up steps and professional help referrals.

Tanya's Scenario:

Step 1 - Trust:

- Confirm the gatekeeper responds appropriately to Tanya's emotional state.
- Check for the portrayal of a supportive and understanding approach.

Step 2 - Risk & Protective Factors:

- Ensure Tanya's history of suicide attempts is considered in the assessment.
- Confirm the role-play demonstrates the use of different screening tools to assess Tanya's emotional state.

Step 3 - Warning Signs:

- Identify how Tanya's impulsive actions are addressed as warning signs.
- Check for a nuanced discussion on her mood swings and their potential risks.

Step 4 - Suicidal Ideation:

- Evaluate how the gatekeeper explores Tanya's suicidal ideation and planning.
- Check for an assessment of the implications of Tanya's life choices on her mental state.

Step 5 - Safety Plan:

- Ensure Tanya's safety plan includes specific strategies for managing her impulsive behaviour.
- Verify the inclusion of accessible support and resources.

Ahmed's Scenario:

Step 1 - Trust:

- Check for a respectful discussion of Ahmed's cultural and familial expectations.
- Confirm the portrayal of a sensitive gatekeeper approach towards Ahmed's religious values.

Step 2 - Risk & Protective Factors:

- Verify the role-play reflects Ahmed's substance use using AUDIT and DAST.
- Ensure Ahmed's secret relationship is explored as both a risk and protective factor.

Step 3 - Warning Signs:

- Identify Ahmed's behavioural changes post-family conflict as potential warning signs.
- Assess the gatekeeper's recognition of the escalation in Ahmed's drug use.

Step 4 - Suicidal Ideation:

- Confirm a detailed assessment of Ahmed's suicidal ideation after his arrest.
- Check for an understanding portrayal of Ahmed's internal conflict and shame.

Step 5 - Safety Plan:

- Ensure the safety plan is culturally sensitive and tailored to Ahmed's unique challenges.
- Verify the inclusion of strategies for coping with substance use.

Lisa's Scenario:

Step 1 - Trust:

- Check for a gatekeeper approach that validates Lisa's feelings of detachment.
- Confirm an understanding atmosphere is created for Lisa to discuss her uncertainties.

Step 2 - Risk & Protective Factors:

- Ensure Lisa's depressive symptoms are assessed with the PHQ-9.
- Confirm the role-play shows Lisa's healthy lifestyle and strong family connections as protective factors.

Step 3 - Warning Signs:

- Highlight Lisa's moments of intense loneliness as warning signs in the role play.
- Assess the gatekeeper's response to Lisa's doubts about the purpose of life.

Step 4 - Suicidal Ideation:

- Evaluate the sensitive exploration of Lisa's suicidal thoughts using the C-SSRS.
- Check for a conversation around her mental toolkit and coping strategies.

Step 5 - Safety Plan:

- Confirm the safety plan incorporates Lisa's daily routines and positive habits.
- Verify that the plan includes proactive and preventive measures that are aligned with her lifestyle.

On pages 82-83 is an example of a blank Suicide Risk Assessment & Safety Plan. Depending on the environment, a form such as this is a common protocol that all Gatekeepers follow. After the Gatekeeper has collaborated with the person in crisis to complete this form, it becomes a tool for both the Gatekeeper and the person in crisis to observe the individual's thoughts and behaviours and monitor their safety.

Narrative 1: Rajesh – From Hopelessness to Helplessness

Rajesh, a young man of 25, has been navigating a challenging period in his life while working at one of the big oil companies in Georgetown. Over the past year, his morale has hit an all-time low, a situation exacerbated by observing expatriates, seemingly less qualified and experienced, leapfrogging him in promotions and receiving benefits he feels are out of reach. This constant sense of unfairness has been gnawing at him, affecting his sense of self-worth and belonging.

The joy and camaraderie Rajesh once found in playing cricket with his friends during weekends have diminished. Now, finding the energy to engage in what was once his favorite pastime feels like an insurmountable task. His social life has also seen better days. A series of relationships have ended, leaving him questioning his value and compatibility. These personal setbacks have contributed to a pervasive sense of loneliness and isolation.

Decision-making, once a straightforward process, has become a daunting ordeal for Rajesh, with even minor choices feeling overwhelming. Sometimes, his thoughts take a dark turn, leading him to question his importance to his family and whether they would be better off without him. Although a part of him recognizes these thoughts as untrue, they persist, making it hard for him to see his own value.

Throughout this period, Rajesh has inadvertently withdrawn from his social circles, including close family and friends, further deepening his sense of isolation. Changes in his behaviour, such as his withdrawal from cricket and social activities, hint at a significant internal struggle. Additionally, his diminished attention to personal care might be signaling a deeper issue that goes beyond mere disappointment or fatigue.

Despite these challenges, Rajesh still maintains a loving relationship with his mother and whenever he can, accompanies her to the temple. The emotional support he receives from his mother is a lifeline, reminding him that he is not alone, even when the shadows of doubt loom large.

Narrative 2: Tanya – Anger and Ambivalence

Tanya, a 28-year-old Afro-Guyanese woman, goes through intense ups and downs in her feelings. She finds it hard to keep steady relationships because she swings from loving people intensely to feeling like they're against her. She has a fierce love for her folks and her friends—they're her rock, the people who can make her laugh, even when it seems like there's not much to smile about. That said, when they criticize her, she responds with intense anger and bitter words.

Sometimes, Tanya can be a bit of a thrill-seeker, testing the waters just to see how far she can go. But it's her reasons for sticking around—those unspoken promises and the sense of belonging—that keep her from drifting too far out. Her life is like a dance with the ever-changing tides. She's often found lost in thought, making major decisions on a whim that don't always make sense to her later on. These decisions can cause conflict with family and friends. She struggles especially with making wise decisions about money and barely manages to stay afloat. Sometimes, she acts on impulse, like quitting her job without a plan, which she later regrets.

She has a lot on her plate, juggling these highs and lows, and sometimes, the pressure seems like it's just too much - to the point where she has in the past made suicide attempts, requiring hospitalization in one case. Lately, she's been caught up in thoughts about whether life is worth living. But Tanya's smart—she's got a solid head on her shoulders from her years in school, which helps her think twice and gives her a fighting chance when the going gets tough.

Narrative 3:
Ahmed – Navigating Family Expectations

In the gentle coastal breeze of his hometown, where traditions are as much a part of life as the air one breathes, young Ahmed found himself at a crossroads. He had always walked the path laid out by his conservative Muslim family, but his heart had started to carve a new trail, one that led to Shanti, whose laugh was as bright as the Diwali lamps.

Love, as it often does, didn't knock before it entered. It just swept Ahmed off his feet. Their secret meetings were filled with talks of tomorrows they dreamed of spending together. Yet, such dreams were fragile, and when his family's eyes were opened to his secret, the dreams began to crack under the weight of expectation.

Ahmed, the boy who had always been the pillar of duty, felt the strain of an invisible battle. He began to rebel against the pressures at home and strict religious and cultural expectations. Ahmed sought solace in the fleeting escape of drugs. On the outside, he kept up appearances, but inside, he struggled to assert himself as a 21st century urban Guyanese teenager.

Then came the night where everything seemed too heavy. At a party, where alcohol and drugs were in abundant supply, Ahmed's drug use resulted in conflict with a fellow student, for which he was ultimately arrested for battery and property damage charges. The intense shame he felt at having his parents learn of his arrest caused strong suicidal thoughts.

Narrative 4:
Lisa – Holding on to Threads of Hope

Lisa, an Indo-Guyanese 30-year-old, often feels like she's floating, untethered from the world around her. The whispers of uncertainty can sometimes be loud in her head, making her question what's real and what's not. Yet, her schooling has given her a sort of mental toolkit. She uses it to challenge those whispers, to sort the helpful thoughts from the harmful ones.

Her family's stories and the traditions they've passed down to her are like an anchor. They don't erase the doubts, but they give her a sense of belonging that's stronger than the voices. Support from her loved ones might not always be with words; often, it's just a look, a touch, or just being there. It's subtle but steady, like the heartbeat of a drum in the distance.

Her factory work gives her a rhythm to her days, connecting her to something bigger. It's not just about the paycheck; it's about feeling useful, about contributing to something that helps her see beyond herself.

Even on days when it seems hard to care, her habits of healthy living — like choosing a salad over fast food or taking a brisk walk instead of watching TV — are her safety nets.

Lisa's life isn't loud or flashy. Sometimes she feels intensely alone and that there is no purpose to her life. This prompts her to wonder what's the point of living.

SUICIDE RISK ASSESSMENT

Name: _____ Age: _____ Referred by: _____

Date: _____ Time: _____ Location of meeting: _____

Have you assured the individual of confidentiality? ☐ yes ☐ no

Is the individual aware of the limits to confidentiality (i.e., requirement to disclose)? ☐ yes ☐ no

RECENT STRESSFUL EVENTS OR TRIGGERS

STIGMA (personal or social disapproval or perceived disgrace)

RISK FACTORS

- ☐ History of Suicide attempts
- ☐ Alcohol & drug usage
- ☐ Recent/historical trauma or loss
- ☐ Hopelessness
- ☐ Psychological disorder
- ☐ Bullying or discrimination
- ☐ Chronic medical conditions
- ☐ Impulsivity/aggression
- ☐ Criminal/legal issues
- ☐ Financial issues
- ☐ Other

INSIGHTS FROM ASSESSMENT TOOLS

Score

- ☐ Suicidal ideation (BSSI)
- ☐ Suicide severity (C-SSRS)
- ☐ Alcohol Use (AUDIT)
- ☐ Drug Abuse (DAST)
- ☐ Depression (PHQ-9)
- ☐ Anxiety (GAD-7)
- ☐ Stigma SASSHIS

WARNING SIGNS

- ☐ Significant increase in alcohol/drug usage
- ☐ Talking about wanting to die
- ☐ Looking for ways to kill oneself
- ☐ Engaging in risky behaviours
- ☐ Isolating from others
- ☐ Experiencing extreme mood swings
- ☐ Talking about being a burden to others
- ☐ Sleeping too much or too little
- ☐ Neglecting personal hygiene
- ☐ Experiencing agitation (emotional urgency to do something)
- ☐ Other

SUICIDAL IDEATION	LOW	MED	HIGH	SUICIDAL PLAN	
Severity				How – means	
Intensity				Access to means?	
Acuteness				How - steps	
Specificity				When	
Persistence				Where	
Notes:					

PROTECTIVE FACTORS

- ☐ Religious/spiritual beliefs & practices
- ☐ Female gender
- ☐ Education
- ☐ Coping & problem-solving skills
- ☐ Readily available support from others
- ☐ Connection to community
- ☐ Quality health and mental health care
- ☐ Strong cultural identity
- ☐ Reduced access to lethal means
- ☐ Reasons for living
- ☐ Other

Extent to which person wants to live: 1 2 3 4 5 6 7 8 9 10

Extent to which person wants to die: 1 2 3 4 5 6 7 8 9 10

Level of cooperation: 1 2 3 4 5 6 7 8 9 10

SAFETY PLAN

A. DRAFT THE CRISIS NARRATIVE

Brief summary of details from Page 1, highlighting risk factors and warning signs that signal risk of suicide and plan to execute.

B. COPING ADAPTIVELY THROUGH POSITIVE AND SAFE BEHAVIOURS

Define coping behaviours:

List supports (people, services, technology, actions, beliefs):

List obstacles and strategies to overcome obstacles:

List personal strengths and how they support coping behaviours:

List immediate, low-preparation safety actions and habits:

C. SUPPORT NETWORK

List support contacts:

List comforting locations and access times:

D. CONTACTING SUPPORT SERVICES

List support services:

E. MAKING THE ENVIRONMENT SAFE

List lethal means and specific ways to limit access:

Module 3 Quiz

1. Alcohol & drug usage, recent or historical trauma, recent loss or bereavement, psychological disorders, and financial issues are all examples of:

a. Warning signs **b.** Triggers **c.** Risk factors
d. Symptoms & signs **e.** Protective factors

2. The earliest detectable signs indicating an elevated risk of imminent suicide are called:

a. Vulnerabilities **b.** Triggers **c.** Risk factors
d. Symptoms & signs **e.** Warning signs

3. What is the first and foundational step in the 5-Step Model of Suicide Risk Assessment & Safety Planning?

a. Identifying Warning Signs **b.** Assessing Suicidal Ideation & Plan
c. Developing a Safety Plan **d.** Establishing a Trusting Relationship
e. Evaluating Risk & Protective Factors

4. During which step does a Gatekeeper explore the seriousness of an individual's suicidal intention and plan?

a. Step 1: Establish a trusting & respectful relationship
b. Step 2: Evaluate Risk & Protective Factors
c. Step 3: Identify Warning Signs
d. Step 4: Assess Suicide Risk
e. Step 5: Develop & Implement Safety Plan

5. According to research, which warning sign is most commonly reported by individuals contemplating suicide?

a. Feeling hopeless
b. Sleeping too little or too much
c. Being anxious or agitated; behaving recklessly
d. Expressing feelings of being trapped or in unbearable pain
e. Making a will or giving away personal possessions

Summary

- This module outlined a 5-step approach to identify individuals at risk of suicide and intervene in cases of imminent self-harm.
- The first step prepares Gatekeepers to cultivate a trusting relationship with people in crisis so that they are able and willing to share their narrative of distress.
- It provides tools to recognize risk and protective factors, identify warning signs, and evaluate the seriousness of suicidal ideation and planning.
- The Safety Plan is the fifth step in the process. This document is a collaborative activity initiated by the Gatekeeper, but completed with high-risk individuals to manage their ongoing suicidal thoughts, behaviours and actions.
- The module also provides Gatekeepers seven standardized assessment tools which help them assess specific suicidal risk factors, warning signs and related mental health issues.
- The module integrates practical application through role plays and sample questions to enhance understanding and application in real-world scenarios.

Module 3: Quiz Answers

1. c: Risk factors. Alcohol & drug usage, recent or historical trauma, recent loss or bereavement, psychological disorders, and financial issues are all risk factors for suicide.

2. e: Warning signs. The earliest detectable signs indicating an elevated risk for imminent suicide are known as warning signs (Rudd et al., 2006).

3. d: Establishing a Trusting Relationship. The first and foundational step in the 5-Step Model of Suicide Risk Assessment and Safety Planning is establishing a trusting and respectful relationship.

4. d: Step 4: Assess Suicide Risk. In the 4th step of the 5-step model, a Gatekeeper explores the seriousness of an individual's suicidal intention and plan.

5. a: Feeling hopeless. Expressing hopelessness is the most commonly reported warning sign among individuals contemplating suicide (Tsai & Klonsky, 2023).

Additional Module 3 Quiz

1. The GAD-7 assesses symptoms of which psychological condition?

a. Depression **b.** Drug addiction **c.** Alcohol abuse
d. Anxiety **e.** Suicide

2. Suicidal Ideation is assessed by:

a. Beck Signs and Symptoms Inventory (BSSI)
b. Beck Suicide Scale and Inventory (BSSI)
c. Beck Survey of Symptoms and Inventory (BSSI)
d. Beck Scale for Suicide Ideation (BSSI)
e. Beck Survey of Suicide Ideation (BSSI)

3. The Patient Health Questionnaire (PHQ-9) is used to assess:

a. Anxiety **b.** Depression **c.** Health Status
d. Attentional Deficit **e.** Depressive Symptoms

4. Which measure assesses Alcohol-related disorders?

a. DAST **b.** PH-Q **c.** GAD **d.** AUDIT **e.** BSSI

5. Which measure screens for the presence of drug abuse?

a. DART **b.** DAST **c.** BSSI **d.** AUDIT **e.** PHQ-9

Additional Module 3: Quiz Answers

1. d: Anxiety. GAD-7 (Generalized Anxiety Disorder) is a 7-item, self-report questionnaire that screens for symptoms of anxiety.

2. d: Beck Scale for Suicide Ideation (BSSI). Suicidal ideation is assessed by the Beck Scale for Suicide Ideation, a 21-item self-report scale.

3. e: Depressive Symptoms. The Patient Health Questionnaire (PHQ-9) is used to assess symptoms of depression.

4. d: AUDIT (Alcohol Use Disorders Identification Test). AUDIT is used to identify individuals with hazardous and harmful patterns of alcohol consumption.

5. b: The Drug Abuse Screening Test (DAST). DAST is a self-report instrument designed to screen for the presence of drug abuse or drug-related problems.

MODULE 4

Self-Care for Gatekeepers

Module 4 underscores the importance of self-care for Gatekeepers as they are often at the frontlines of others' crises. The module offers five specific self-care strategies Gatekeepers can build into their daily lives – stretch and relax, centering breath, lovingkindness meditation, neck-down experiences and gratitude journaling. Engaging in these activities not only offers a positive distraction or respite for Gatekeepers, but can also build their resilience and wellbeing. Moreover, they can transfer to people in crisis some of the lessons learned about the value of self-care.

Learning Outcomes

- **Acknowledge** one's risks and limits as a Gatekeeper to buffer against burnout
- **Recognize** the value of developing healthy habits of self care in order to achieve balance and foster resilience
- **Practice** stretching and deep breathing to regulate nervous system response
- **Achieve** emotional balance through practicing LovingKindness meditation
- **Identify** personally meaningful low-prep "below-the-neck" activities to lower daily stress
- **Foster** a positive outlook by appreciating good things in everyday life

Why is Self-Care Important?

Self-care is not just a personal luxury but a necessity, especially for Gatekeepers who shoulder the crucial responsibility of supporting individuals in crisis. Gatekeepers are often on the front lines, providing the first layer of support and guidance to those in distress, making their own safety and well-being paramount not only for their health, but also for the effectiveness of their work.

Benefits of Self-care

Engaging in self-care practices offers a number of benefits that extend beyond mere stress reduction, ensuring that Gatekeepers can maintain their emotional, physical, and mental health in the face of challenging work environments. Some of these benefits are:

- **Buffer against burnout:** Implementing self-care strategies can be particularly effective in creating a buffer against burnout for Gatekeepers and offering those in crisis a way to momentarily step back and find solace and joy amidst their struggles. By encouraging mindfulness, physical activity, creative expression, and social connection, individuals are equipped with a holistic toolkit for managing stress and enhancing their capacity to cope with life's challenges.
- **Positive Distraction:** Engaging in these activities can offer a respite or a positive distraction from the immediate pressures and challenges. Such a distraction can provide a new perspective which might have escaped the Gatekeeper's understanding thus far.
- **Cultural Understanding:** Guyana is culturally diverse. Self-care helps Gatekeepers recharge and rejuvenate. This can, in turn, facilitate the understanding and appreciation of diverse cultural perspectives underlying suicidal crisis, including family values, stigma, gender roles, and culturally informed notions of mental health, normality, and mental illness. Cultural understanding can further help Gatekeepers communicate with the person facing crisis in an empathic and compassionate manner.
- **Resilience:** By integrating self-care into their daily routines, Gatekeepers can enhance their resilience and ensure they remain compassionate, attentive, and effective in their roles. Enhanced resilience means that Gatekeepers can offer long-term support to the community.
- **Emotional Stability:** Self-care activities can improve mood and mental clarity, foster a sense of connection and support through interpersonal activities, rejuvenate the body and mind through nature and leisure activities, and offer therapeutic companionship through interactions with animals.
- **Appreciation of the Present:** Self-care helps Gatekeepers stay focused and appreciate the present moment. This is important for calmly and skillfully helping people through tough times.

Therefore, it's imperative for Gatekeepers to prioritize their self-care, not only for their well-being but as a cornerstone of their professional capacity to aid those in need.

For Gatekeepers in Guyana, self-care is crucial given the unique cultural and societal context influencing mental health and suicide prevention efforts. Implementing self-care involves regular mental health training tailored to Guyana's specific needs, building robust support networks within the community, and accessing supervision to navigate the complex emotions and responsibilities inherent in suicide prevention roles. Emphasizing work-life balance, mindfulness, and professional development can help maintain Gatekeepers' wellbeing and enhance their capacity to effectively support individuals at risk, reflecting the importance of culturally informed practices in suicide prevention. Table 4.1 lists some specific strategies for Gatekeepers' self-care (Citation).

Table 4.1: Self Care for Gatekeepers

STRATEGY	DESCRIPTION
Personal Care Activities	Maintain healthy lifestyle habits, diversify workload, and ensure regular breaks for mental health.
Safety & Support Needs	Choose the right setting (group or individual) for safe discussion post-crisis.
Planning & Preparedness	Develop structured plans for post-suicide support within organizational policies.
Education & Training	Pursue ongoing education on occupational hazards and training on coping with suicide and attempts.
Defining Personal Limits	Limit the number of severely suicidal clients to manage workload and reduce stress.
Informational Resources	Utilize resources like first-hand therapist accounts for learning and coping strategies.
Formalized Supervision	Establish a supervisory relationship for case-by-case support to reduce anxiety and self-doubt.
Understanding Limits	Acknowledge the realistic impact you can have on preventing client suicide while avoiding self-blame.

Five Self-Care Activities

We've outlined five self-care activities in the following pages. This variety of activities ensures that Gatekeepers can explore the ones that are personally beneficial to them, create a tailored approach to nurturing their resilience and enhance the quality of support they provide.

Self-Care Activity 1 : Stretch & Relax

Objective: To provide participants with simple, effective techniques to calm and centre the body that can be utilized before, during or after stressful encounters with individuals in crisis.

Steps Read the instructions below. Read slowly and create space between each instruction to ensure a relaxed experience for participants.

1. Alignment (1 Minute)

- Imagine a line connecting your head, neck, and chest in an upright, yet relaxed posture.
- Sit with your back straight and shoulders relaxed.
- Place your feet flat on the floor, knees pointing forward and gently place your hands close to your kneecaps.
- Take a deep breath in, slowly exhale, and focus on entering a state of relaxation.

2. Head & Neck (1 Minute)

- Inhale and turn your head to the right; pause, then exhale and return to the centre.
- Inhale and turn your head to the left; pause, then exhale and return to the centre.
- Inhale and bring your right ear to your right shoulder; pause, then exhale and return to the centre.
- Inhale and bring your left ear to your left shoulder; pause, then exhale and return to the centre.

3. Shoulders (1 Minute)

- Bend your arms, placing your fingers on your shoulders.
- Rotate your arms clockwise, stretching out and then bringing your elbows together in front and then high above, enhancing chest expansion.
  - Do several rotations in both a clockwise and counter-clockwise direction.
  - Envision your arms creating larger circles as you rotate them, stretching the shoulders and expanding the chest.

4. Legs & Below the Waist (1 Minute)

- Lift your left leg, flex your toes away from the ankle, then tighten your whole leg. Hold it for a few seconds.
- Gradually relax and lower it.
- Lift your right leg, flex your toes away from the ankle, then tighten your whole leg. Hold it for a few seconds.
- Gradually relax and lower it.
- Tighten everything below the waist, then relax and feel the difference.

5. Focused Breathing (1 minute)

- Focus on your breathing and aim to go deeper, wider and longer with each breath cycle.
- On the inhalation, take a deep breath to expand through the abdomen.
- Continue the inhalation as you widen through your ribs.
- Exhale long, emptying all of the air from ribs to abdomen.
- Repeat two more times.

Conclusion

Conclude the session by encouraging participants to take a moment to notice the overall relaxation in their body and the calmness of their mind.

Self-Care Activity 2: Centering Breath

This mindfulness exercise is designed to be an integral part of your self-care and professional practice, helping you navigate the emotional complexities of suicide crisis intervention with greater resilience and compassion.

Objective: Prepare you as a Gatekeeper, mentally and emotionally, before facing a crisis, maintain your focus and compassion during the crisis intervention and facilitate emotional decompression and reflection after the event.

Materials: Journal or notebook

Steps: Before Handling a Suicide Crisis

Centering Breath: Find a quiet space. Take three deep, slow breaths. With each inhale, envision drawing in calmness and clarity. With each exhale, release tension and preconceived notions.

Intention Setting: Quietly set an intention for the interaction. It might be something like, "May I offer presence and hope," emphasizing your role as a guide and support.

Mindful Acknowledgment: Acknowledge your feelings without judgment—recognize the weight of what you're about to do and reassure yourself of your training, skills, and capacity to help.

During the Crisis

Listen Mindfully: Stay fully present with the individual, focusing intently on their words, tone, and body language. Let this mindfulness ground you, preventing emotional overwhelm and burnout.

Use Your Breath as an Anchor: If you find your emotions rising, gently focus on your breath to maintain your calm and presence. This helps to stay centered without becoming overwhelmed by the client's emotions.

Compassionate Detachment: Practice compassionate detachment, in other words being emotionally invested yet sufficiently detached to offer effective, objective support.

After Handling a Suicide Crisis

Mindful Decompression: Step away to a private space. Engage in brief mindful walking or sitting, focusing on your breath, to help transition from the high-intensity scenario.

Reflective Journaling: When ready, reflect on the experience in writing, focusing on what you learned and how you felt. This can be a therapeutic process and a valuable learning tool.

Gratitude and Release: End with a moment of gratitude for your ability to provide support and release the emotional burden of the crisis. Visualize placing any residual stress or emotion into a balloon and letting it float away.

Maintaining Practice

Daily Mindfulness: Incorporate brief mindfulness exercises such as these into your daily routine to enhance your emotional resilience and preparedness for crisis situations.

Peer Support: Regularly engage in peer support sessions where you can share experiences and strategies for handling emotional stress in a supportive environment.

Professional Supervision: Ensure you have access to professional supervision where you can discuss and reflect on your experiences in a structured, supportive setting.

Self-Care Activity 3: LovingKindness Meditation

Objective: To provide emotional and mental support to Gatekeepers and reduce the risks of burnout through the practice of lovingkindness meditation.

Preparation:

- Find a quiet, comfortable space where you won't be disturbed.
- Choose a time before your shift begins to set a positive intention for the day or after your shift to release any emotional weight and recharge your body battery.

Steps:

Find Comfort and Presence

- Sit or lie down in a comfortable position, ensuring your back is straight but not strained.
- Close your eyes or fix your gaze at a stationary point near the floor or carpet, and take deep, slow breaths. Focus on being present in your body and environment.

Acknowledge Your Role and its Importance

- Reflect on your role as a Gatekeeper and the importance of your work. Acknowledge the strength it takes to be present for others in their moments of crisis.

Cultivate Self-Compassion

- Place your hand over your heart. Feel its beat and warmth, reminding yourself of your humanity and compassion.
- Recall a time or situation when you felt truly appreciated or supported, either by a loved one, colleague, or even a pet. Let this feeling fill you with warmth and gratitude.

Offer Lovingkindness to Yourself

- Whisper or think gently to yourself:
  - May I be held in lovingkindness.
  - May I navigate my challenges with strength and wisdom.
  - May I find moments of joy and peace amidst my work.
- Repeat these wishes three times, allowing yourself to fully receive these intentions.

Extend Lovingkindness to Those You've Helped

- Think of individuals you've supported. Without focusing on specific outcomes, wish them safety, peace, and well-being.
- This step serves as a release, acknowledging your role in their journey without carrying the weight of their outcomes.

Widen the Circle of Compassion

- Extend your thoughts of lovingkindness to colleagues, emergency responders, and others in the field. Recognize the collective effort in supporting those in crisis.

Embrace Universal Lovingkindness

- Finally, allow your compassion to extend outward in ever-widening circles, to all living beings, recognizing our shared desire for peace and well-being.

Return to the Present

- Gently bring your attention back to the present moment. Take a few deep breaths and slowly open your eyes.
- Conclude with a gesture of gratitude—a bow, hands in prayer, or a simple moment of silence.

When to Practice: This meditation can be a daily practice, ideally at the beginning or end of your workday. It can also serve as an emergency tool when feeling overwhelmed, providing a quick mental and emotional reset.

Note: We have adapted this lovingkindness meditation from Sharon Salzberg's work (1994).

Self-Care Activity 4: Neck-Down Experiences

For Gatekeepers working with individuals facing crises, and for those individuals themselves, finding effective ways to manage stress, regain a sense of peace, and maintain mental well-being is crucial.

Table 4.2 lists 20 simple low-prep activities that offer positive distractions for those in stressful situations and yield positive self-care benefits. The table serves as a guide for Gatekeepers to integrate self-care into their daily routines. By engaging in these activities, Gatekeepers can maintain their resilience, compassion, and effectiveness, ensuring they can continue to provide the best support possible to those in crisis.

Table 4.2: 20 Low-Prep Self-Care Activities

ACTIVITY	DESCRIPTION	SELF-CARE BENEFITS
Individual		
Discover Quiet Joy Without Digital Gadgets	Spend time away from technology, to find peace.	Enhances mindfulness and reduces digital overload
Do 5 Minutes of Stretching	Integrate simple stretching exercises during your day.	Releases physical tension and improves circulation
Savor Local Fruits Mindfully	Enjoy local fruits like mango, focusing on flavors and textures.	Enhances present-moment appreciation and mindfulness
Breathe Deeply	Practice deep breathing exercises.	Enhances mental clarity and emotional balance
Interpersonal		
Laugh Uproariously	Share local jokes or amusing stories with others.	Stimulates endorphin release for mood improvement and stress reduction
Invite a Loved One to Snuggle	Seek comfort in snuggling with a loved one.	Increases oxytocin, enhancing feelings of safety and connection
Engage in Community Storytelling	Participate in storytelling sessions celebrating local culture.	Strengthens social bonds and cultural connection for emotional support
Express Gratitude	Express gratitude for simple joys and natural beauty.	Fosters a positive outlook and resilience by appreciating life's good aspects

ACTIVITY	DESCRIPTION	SELF-CARE BENEFITS
Nature		
Dance or Be Playful in the Rain	Dance or be playful in the rain to rejuvenate your spirit.	Engages body and mind for a joyful break, reducing stress
Walk in Nature	Replace hurried activities with walks in nature.	Boosts mood and mental well-being with exposure to natural beauty
Enjoy the Water	Take short swims or walks by the water to refresh the mind and body.	Utilizes soothing effects of water for mind and body refreshment
Star Gaze	Observe the stars, connecting with the universe's vastness.	Offers peace and grounding, reducing feelings of overwhelm
Leisure		
Explore Local Tastes	Savor local delicacies like Potato Pancake or Hot Chocolate.	Provides a comforting break
Rediscover your Childhood	Revisit childhood activities like flying kites or playing traditional games.	Awakens nostalgia and simplicity, offering a mental break and rekindling joy
Tune into The Power of Music	Play relaxing or uplifting music.	Calms one down, reduces stress, and boosts focus
Get to Know your Neighbourhood	Discover new paths or areas for walks to discover and rediscover your local area.	Invigorates the body and refreshes the mind with physical health and adventure
Animal Interaction		
Pat a Pet	Spend time with domestic animals or wildlife, enjoying their companionship.	Facilitates calming interaction, reducing stress hormones
Feed a Stray Animal	Connect with a community pet or friendly animal by offering food.	Offers a sense of peace and grounding through simple joys
Let Animals Entertain You	Watch YouTube videos of the strange and wonderful things animals do	Reduces stress, improves mood, releases endorphins from laughter
Bird Watch	Sit outside and tune into the sights and sounds of local birds.	Improves mental wellbeing, connects you to nature

Self-Care Activity 5: Gratitude Journal

A gratitude journal can be a powerful tool for Gatekeepers working with individuals in suicidal crisis. It serves as a daily reminder of the positive impacts of their work, reinforcing their sense of purpose and the importance of their role. By regularly documenting moments of gratitude, Gatekeepers can shift focus from the stresses and emotional burdens of their work to the positive outcomes and support they provide. This practice not only enhances their own well-being but also contributes to a more compassionate and effective approach to helping others. Acknowledging the good in their lives helps to build resilience, fosters emotional stability, and encourages a mindset that appreciates the present, all of which are essential qualities in challenging and emotionally charged work environments.

As a Gatekeeper working on the front lines of crisis intervention, cultivating a habit of gratitude can be especially grounding. Here's a guide for maintaining a gratitude journal that can help Gatekeepers acknowledge and appreciate the unique aspects of their role:

- **Be specific:** Detail the exact moments of support and breakthroughs with those you're helping, recognizing the individual impact you make.
- **Aim for depth, not breadth:** Focus on in-depth reflections about key experiences or people who uplift you, rather than a long list of generalities.
- **Value personal connections:** Prioritize gratitude for relationships and personal interactions that sustain you in your challenging role.
- **Honour your contribution:** Contemplate the difference your work as Gatekeeper makes and the value of your presence in others' lives.
- **Recognize your gifts:** See the positive outcomes and successful interventions as gifts in your work, enhancing your sense of accomplishment.
- **Relish surprises:** Cherish the unexpected positive turns or moments of gratitude from those you aid.
- **Reflect deeply:** When revisiting similar themes, delve into different aspects to keep your perspective fresh and grateful.

Gratitude Journal Worksheet for Gatekeepers

Day 1: Good Things at Work

Theme: Positive Events at Work

Sample Specific Event: Managed to de-escalate a crisis situation with a client.

Sample Reflection: Seeing their relief and gratitude reminds me why I chose this profession; it's incredibly fulfilling to be able to make such a direct impact.

Specific Event: _____

Reflection: _____

_____

Day 2: Good Things from Family

Theme: Better Relationships

Sample Specific Event: Received an encouraging text from my spouse during a tough moment.

Sample Reflection: This gesture reinforced my sense of support, showing me the strength of my family ties and how much I can lean on them.

Specific Event: _____

Reflection: _____

_____

Day 3: Good Things from Colleagues

Theme: Helping Others

Sample Specific Event: A colleague shared an insightful approach to a common challenge we face.

Sample Reflection: I'm grateful for the collaborative spirit among my colleagues; it not only helps me grow professionally but also enhances our collective work.

Specific Event: _____

Reflection: _____

_____

Day 4: Good Things Recalled from the Past

Theme: Slower Adaptation

Sample Specific Event: Remembered the first successful intervention I led.

Sample Reflection: Reflecting on where I started and the progress I've made fills me with pride and gratitude for my journey.

Specific Event: _____

Reflection: _____

_____

Day 5: Good Things Happening in the World

Theme: Fewer Negative Comparisons

Sample Specific Event: Read about a former client who started a community support group.

Sample Reflection: It's heartening to see the ripple effect of the work we do, spreading further than we can see.

Specific Event: _____

Reflection: _____

Day 6: Good Things about Yourself

Theme: Self-Worth & Self-Esteem

Sample Specific Event: Successfully applied a new technique from recent training in a session.

Sample Reflection: Each new skill I acquire boosts my confidence in my abilities and the valuable service I offer.

Specific Event: _____

Reflection: _____

Day 7: Good Things from Strangers and Pets

Theme: Coping with Stress

Sample Specific Event: A stranger complimented my approach with a client they observed at the park.

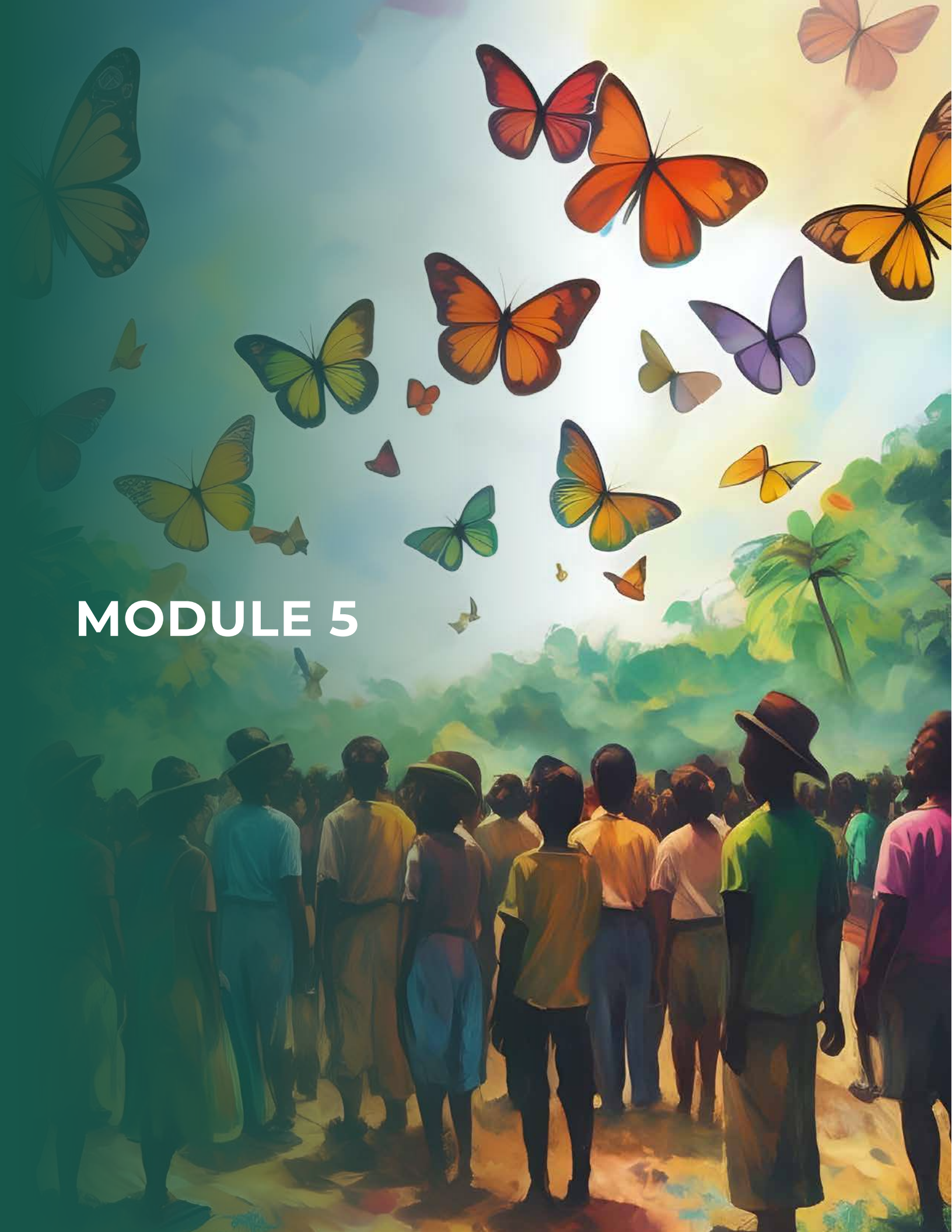
Sample Reflection: This unexpected validation from an outsider was uplifting and reinforced the positive impact of my presence.

Specific Event: _____

Reflection: _____

Summary

- This module discussed self-care as one of the most important responsibilities of gatekeeping.
- It presented five strategies Gatekeepers can use before, during and after dealing with a suicidal crisis and in their daily lives.
- The module emphasized multiple benefits of self care activities which can be a buffer against burnout, provide positive distraction, invite cultural understanding, cultivate resilience and emotional stability and enhance appreciation of the present.



MODULE 5

Suicide Postvention and Prevention

Module 5 examines postvention, which supports families and communities to heal following a suicide as well as prevention on a broader community level. Whereas postvention deals with the loss of an individual, prevention aims to reduce the losses across entire communities. As stigma is a barrier to action on the part of both people who are suicidal as well as those who might intervene, the module discusses forms of stigma as well as its impact on individuals and communities. In order to elevate suicide prevention to a broader community and national level, the role of Media's in combatting stigma is also discussed.

Learning Outcomes

- **Define** postvention and its importance in suicide prevention
- **Discuss** key postvention strategies for supporting the bereaved, and explain how these strategies can help prevent suicide contagion and support community healing.
- **Gain** an understanding of the various forms of stigma and learn effective approaches for challenging and reducing stigma.
- **Understand** the roles and responsibilities of media in suicide prevention, including how reporting on suicide can influence public perceptions of suicide and mental health.

Postvention for Families & Communities

Postvention refers to interventions conducted after a suicide to support the bereaved or affected individuals, helping them cope with the loss and preventing further suicides. It includes strategies like providing counseling services to those affected, creating support groups for survivors of suicide loss, and educating communities about grief and the impact of suicide. Effective postvention acts as prevention for future crises by addressing the immediate needs of those impacted and promoting healing (Andriessen et al., 2019).

Postvention in the context of suicide completion refers to the support and intervention strategies implemented after a suicide has occurred. It involves actions taken to address the aftermath of a completed suicide, supporting those affected by the loss and minimizing the potential negative consequences within a community or organization. Postvention is crucial for several reasons:

- **Support for Survivors:** Postvention helps provide emotional support for the family, friends, and loved ones of the individual who completed suicide. It aims to help them cope with the grief, guilt, and other emotions that may arise.
- **Prevention of Contagion:** Postvention efforts also focus on preventing the "contagion" or the increased risk of suicidal behaviour within a community or social group following a suicide. This involves providing resources, counseling, and support to individuals who may be at risk.
- **Educational Opportunities:** Postvention provides an opportunity for education and awareness about mental health issues, suicide prevention, and available resources. This can contribute to reducing stigma and increasing understanding within the community.
- **Crisis Intervention:** Postvention involves crisis intervention strategies to help those who may be deeply affected by the suicide, such as individuals at risk of self-harm or suicide.
- **Memorialization and Remembrance:** It involves facilitating healthy memorialization processes to honor the memory of the deceased individual, while also ensuring that such remembrances do not inadvertently romanticize or glorify suicide.

Who is involved in postvention?

Family and Friends: Those closest to the individual who completed suicide are directly involved, and they require support to cope with their grief.

Mental Health Professionals: Counselors, therapists, and mental health professionals play a crucial role in providing support and intervention for both the immediate family and the broader community.

Community Leaders and Organizations: Local community leaders, schools, workplaces, and organizations may be involved in implementing postvention strategies, offering resources, and supporting affected individuals.

Government and Public Health Agencies: These entities may provide funding, resources, and guidelines for postvention efforts at a broader level.

Postvention aims to minimize the traumatic impact of a suicide on individuals and communities. By addressing the aftermath effectively, postvention can help prevent the occurrence of suicide clusters or contagion. Postvention supports the healing process for those affected, helping them navigate the complex emotions and challenges that arise after a suicide. It provides an opportunity to educate communities about suicide prevention, mental health, and available resources, contributing to long-term prevention efforts.

In summary, postvention is a critical component of a comprehensive suicide prevention strategy, addressing the needs of those affected and working to prevent further instances within a community.

Postvention for Gatekeepers

Working with individuals who might be experiencing suicidal behaviour, especially in the acute phase, places significant emotional and psychological stress on Gatekeepers. Moreover, if the individuals who Gatekeepers support die by suicide, this increases the psychological toll on Gatekeepers. Therefore, it is important for Gatekeepers to participate in self-care activities discussed in Module 4 and postvention practices.

Organizations that employ Gatekeepers need to ensure there are accessible services to support their employees who are on the front lines of suicide prevention. Some examples of ways organizations can support their staff include:

Peer Support Groups: Participation in support groups for professionals can offer a space to share feelings and coping strategies (Schernhammer & Colditz, 2004).

Professional Counseling: Seeking individual therapy can help professionals process grief and prevent burnout (Jacobson et al., 2012).

Mindfulness and Self-Care: Engaging in mindfulness and self-care activities can reduce stress and improve resilience (Raab, 2014).

Supervision and Debriefing: Regular supervision and debriefing sessions can provide emotional support and practical advice after a client's death (Cerel et al., 2006).

Continuing Education: Ongoing education on coping with loss and grief can help professionals better understand personal reactions and professional responsibilities (Scurfield & Platoni, 2013).

Stigma and Suicide

Stigma, in the context of mental health, is a social construction that embodies negative attitudes, beliefs, and behaviours towards individuals with mental illness (Corrigan, 2002). Stigma often results from lack of understanding, fear, and misinformation. Stigma against mental health and suicide is a multifaceted concept that encompasses negative attitudes, discrimination, and stereotypes directed towards individuals experiencing mental health issues or exhibiting suicidal behaviour. For example, suicidal individuals are often perceived as weak, unable to cope with their problems, or selfish. Those who attempt suicide are subject to processes of stigmatization and "social distancing." This stigma can manifest in various forms.

Forms of Stigma

Self-Stigma: Self-stigma is a process in which a person with a mental illness internalizes stigmatizing attitudes and beliefs held by the public. Individuals who see themselves as a burden may believe themselves to be shunned (either by others or themselves), and those who are socially isolated may assume that their condition either results from or contributes to an undesirable social status. Self-stigma operates internally but also internalizes societal stigma, leading to feelings of shame, low self-esteem, and a reluctance to seek help (Link & Phelan, 2001). Those experiencing suicidal ideation often internalize societal attitudes, leading to feelings of shame and a reluctance to discuss their struggles (Johnson, 2021). Self-stigma can exacerbate feelings of worthlessness and hopelessness, further entrenching suicidal thoughts.

The above-mentioned factors regarding suicidal behaviour and especially suicidal ideation and suicide attempts, can keep people feeling ashamed and embarrassed, and reluctant to seek timely help. This stigma manifests in various forms, including societal misconceptions, self-stigmatization, and institutional biases (Brown & Jones, 2020; Corrigan & Rao, (2012).

Societal Stigma & Discrimination: Societal stigma refers to collective negative beliefs and reactions towards people with mental health issues or those who have attempted suicide, often leading to ostracism and social exclusion (Corrigan & Watson, 2002). Societal stigma often stems from a lack of understanding and fear about mental health issues. People experiencing suicidal thoughts might be viewed as weak, attention-seeking, or morally flawed (Evans-Lacko et al., 2012; Smith et al., 2019). This external stigma can lead to discrimination, where individuals are treated differently or unfairly because of their mental health status.

Structural Stigma: Institutional policies and societal structures that result in limited opportunities and access to resources for those with mental health challenges or a history of suicidal behaviour, reinforces the cycle of stigma and discrimination (Hatzenbuehler et al., 2013).

Institutional Stigma: Institutional stigma refers to the policies and practices within organizations that inadvertently discriminate against those with mental health issues. For example, inadequate mental health coverage in insurance policies or workplace discrimination can deter individuals from seeking help (Williams & Patel, 2020).

Stigma, Suicide & Gender

Gender is both a risk factor as well as a potential source of stigma. Why?

Women are more likely to attempt suicide, but men are more likely to complete it due to various factors including the methods chosen and socialization patterns. Women often use less lethal means for suicide attempts, such as self-poisoning, which allows for the possibility of intervention and medical treatment, whereas men typically resort to more lethal methods like firearms or hanging, resulting in higher suicide completion rates. Additionally, societal norms often encourage women to be more expressive and to seek help, leading to higher reported rates of attempts, while men might adhere to norms of stoicism and self-reliance, which can result in more lethal, less communicative (Canetto & Sakinofsky, 1998; Cleary, 2012) behaviours.

In terms of coping with stress, women and men are socialized to handle emotional distress differently. Women are more likely to utilize social support networks and emotional expression as coping mechanisms, which can serve as a buffer against the impacts of stress (Oquendo et al., 2014). Men, on the other hand, often engage in problem-focused coping and are more likely to use substances as a means of escape, potentially exacerbating the situation and reducing the likelihood of seeking help. Furthermore, men's adherence to stoic norms and less open communication about their distress can lead to a delay in seeking help, exacerbating the risk of a fatal outcome (Oliffe et al., 2019; Siu et al., 2020). These gendered coping strategies reflect broader societal expectations and can significantly influence mental health outcomes and behaviours related to suicide (Rice et al., 2019; Oliffe et al., 2019).

Stigma, Suicide & Culture

A myriad of factors such as interpersonal violence, childhood abuse, trauma, and a host of socioeconomic problems such as poverty, unemployment, interpersonal violence, and intergenerational trauma interact to elevate the risk of suicide. However, all of these factors are created and manifest through a particular cultural context, which includes its values, norms, practices, institutions and expectations. The act of taking one's life, or thinking about it, is understood and executed within the meaning provided by the immediate culture in which the individual is embedded. Hence, it is important to understand the role of cultural stigma about suicide. Below are a few illustrations of stigma's association with suicide in various cultures:

Shame among Cuban Adolescents: Schneider et al. (2022) explored the suicidal behaviour among Cuban adolescents. They found that a strong association of suicidality with the experience of shame, linked to socialization of youth in schools and within the family, may intensify the experience of shame.

Shame & Loss of Face or Status Among East Asian Families: In East Asian families (e.g., Japanese, Korean, Chinese), shame may be emotionally painful especially when it involves a loss of face or status. Shame is associated with many forms of self-harm (Sheehy et al., 2019). Shame may be more

closely linked than guilt to suicidal ideation, even in individualistic societies like US (Crowder & Kemmelmeier, 2018).

Shaming on Social Media: Social media has changed the dynamics of shame, by creating new areas of interpersonal violence (cyberbullying) and shaming in ways that can be catastrophic (Dorol-Beauroy-Eustache & Mishara, 2021). Unfortunately we have seen a number of suicides recently due to shaming on social media.

Filial Piety in Asian Cultures: In most collectivist cultures, family plays a pivotal role in an individual's life. Hence family piety is strongly inculcated. Hong Lam and colleagues (2022) examined the role of filial piety in suicidality among women in China. The ability to fulfill family role obligations reduced stress and was a protective factor for suicidal behaviour, whereas failure in familial piety resulted in harsh self-judgment and a pervasive sense of shame and despair. Mental illness is considered a personal failure and the fear of bringing shame or dishonour to the family can prevent individuals from seeking help for suicidal thoughts or behaviour (Garcia & Lopez, 2021).

THE RELUCTANCE TO SEEK HELP DUE TO STIGMA CAN LEAD TO A DETERIORATION IN MENTAL HEALTH CONDITIONS.

Suicidal Risk Among Forced Migrants: The experiences of forced migration and resulting loss of loved ones, exposure to violence, prolonged detention, uncertainty over one's refugee status, and a pervasive sense of powerlessness in the face of social structural and bureaucratic hurdles all seem to increase the risk of suicide (Forte et al., 2018).

Religious & Spiritual Beliefs: Religious beliefs can also influence perceptions of suicide. In some religions, suicide is considered a sin, which can add to the stigma and prevent individuals from seeking help (Patel & Jones, 2019). Most religions offer a sense of purpose and meaning which can be a protective factors against suicidal thoughts. Religious practices such as prayers, meditation, chanting, fasting and such provide concrete behaviours which can be positive coping mechanisms. Many religions explicitly teach that suicide is morally wrong and offer ways to cultivate hope and future mindedness. Together religious and spiritual practices can encourage individuals to deal with suicidal behaviour in a positive and affirmative manner.

Suicide and Indigenous Communities: Suicide in Indigenous communities is often intertwined with complex socio-cultural factors. Stigma associated with mental health is a significant barrier that maintains and worsens the crisis of suicide in Indigenous communities. Research (Kiremayer, 2022; Wexler et a., 2014) has indicated seven key themes as causes of suicide among indigenous adolescents. These are:

1. Cultural norms inhibiting interpersonal or professional help-seeking (e.g., cultural value of self-sufficiency, avoidance of talk about suicide, concerns about confidentiality)
2. Loss of culture due to rapid change in ways of life and disruption of intergenerational

transmission from Elders

3. Geographic isolation and small highly interconnected communities
4. Lack of alternatives in navigating problematic relationships intensifying a sense of there being “no way out” of personal and family quandaries
5. Lack of vocational and recreational opportunities
6. Frequent exposure to suicide by others (including relatives and friends)
7. Exposure to other traumas including domestic violence, and substance abuse (especially alcohol)

The above list was adapted from Kiremayer’s notion of cultural mediators of social factors that contribute to suicide (Kiremayer, 2022).

Addressing the stigma and discrimination associated with suicide is vital in encouraging individuals to seek help in a timely manner. Efforts to reduce stigma through public awareness, education, and policy changes are essential to creating a more supportive environment for those experiencing suicidal ideation (Taylor & Robinson, 2023).

Stigma’s Impact on Help-Seeking Behaviour

Stigma’s Impact on Suicidal Individuals: The stigma associated with suicidality (self, societal, and structural) often exacerbates the feelings of self-blame and isolation in those experiencing suicidal thoughts. This heightened sense of alienation can worsen their mental health condition, potentially increasing the risk of suicide. The stigma contributes to a vicious cycle where the individual feels trapped and unable to seek the necessary support, further intensifying their distress.

Secondary Stigma–Effect on Families: Families dealing with a member’s suicidality often encounter secondary stigma. This additional burden manifests as emotional stress and societal judgment, which can significantly hinder their ability to provide effective support to the suicidal individual. The stigma faced by families can lead to isolation and a lack of understanding from their community, exacerbating the family’s emotional distress and complicating the dynamics of care and support.

Hindrances to Seeking Help: Stigma erects formidable barriers to seeking help for suicidal ideation, significantly delaying access to vital mental health care. This delay can lead to a worsening of the individual’s condition, as the stigma associated with mental health issues and suicidality often discourages people from reaching out for the help they need, due to fear of judgment or misunderstanding.

Delaying or Avoiding Treatment: The impact of stigma on help-seeking behaviour is profound. Individuals grappling with suicidal ideation often delay or avoid seeking help due to fear of

judgment or repercussions (Lee & Kim, 2022). This delay can be detrimental, as early intervention is crucial in addressing suicidal ideation effectively.

Barriers to Seeking Help: Stigma is one of the major barriers that can prevent individuals from seeking help, which can exacerbate the risk of suicide (Gulliver, Griffiths, & Christensen, 2010). Stigma creates a significant barrier to accessing mental health services. Concerns about confidentiality, being misunderstood by healthcare providers, and fear of being judged are common reasons individuals refrain from seeking help (Davis, 2021).

Worsening Mental Health Conditions: The reluctance to seek help due to stigma can lead to a deterioration in mental health conditions. Without support and treatment, individuals may find their suicidal thoughts intensifying (Martinez, 2022).

Increased Risk of Crisis Situations: Stigma can result in individuals with suicidal ideation not seeking help until they are in a crisis situation. The lack of earlier intervention means that when they do seek help, it is often under more severe and urgent circumstances. This increased severity can challenge the efficacy of treatment and places additional strain on emergency and mental health services. It also increases the risk of harm to the individual and others around them (Robinson & Lee, 2024).

Compounded Stigmatization in Vulnerable Groups: Certain groups, such as those belonging to minority communities or with specific cultural backgrounds, may face compounded stigmatization. This intersectional stigma can further dissuade individuals from seeking help for suicidal behaviour. The fear of facing discrimination not just for mental health issues but also for their identity (like racial, gender or sexual identity) can significantly hinder access to necessary care and support (Gonzalez & Patel, 2023).

Stigma & The Role of Media

Media representations play a critical role in shaping public perceptions and attitudes towards suicide. Often, the media can reinforce negative stereotypes and misinformation about suicidality, contributing to the stigma surrounding it. This can result in a skewed public understanding of suicide hindering effective communication and support for those struggling with suicidal thoughts.

The World Health Organizaton (WHO, 2017) in order to enlist the media in their effort to prevent suicide, has outlined guidelines for best practices in media reporting on suicide. These guidelines are summarized as Do's and Don'ts in Table 5.1.

The Media can play an important role in suicide prevention efforts.

The Role of Media in Stigma Reduction: Mass media campaigns can contribute to reducing the stigma associated with suicidal ideation and mental illness, which is vital for encouraging help-seeking behaviours among at-risk individuals. Media portrayals that focus on individuals overcoming crises (the 'Papageno effect') may have a protective influence, encouraging help-seeking and alternative coping strategies. Likewise, media can highlight the benefits of getting trained in helping someone in crisis through approaches like Gatekeeper training.

Reporting of Suicides: Given the significance of media reporting on suicide, media outlets in Guyana can adopt reporting guidelines from international agencies or national guidelines from other countries. These guidelines should focus on avoiding the depiction of suicide methods and ensuring that stories on suicide include information on available support services. By adhering to these evidence-based practices, media can play a responsible role in suicide prevention, potentially reducing imitative behaviours and providing resources to those in need (Creed & Whitley, 2016). For example, The Canadian Psychiatric Association's 2017 policy paper provides updated guidelines for media reporting on suicide to minimize harm and prevent contagion effects. The guidelines emphasize the role of health reporters in covering suicide, recommend avoiding details of suicide methods, and stress the importance of including emergency resources in reports ((Sinyor et al., 2017).

Coverage of Suicide-Related Content: Suicide-related content should be covered by health reporters, not crime reporters, to ensure appropriate context. Reports should generally avoid details of suicide methods, especially those that are unusual or novel (Sinyor et al., 2017). Emergency resource links should be included in all articles and mentioned in media reports (Sinyor et al., 2017).

Suicide Prevention

Whether suicidality is treatable is answered affirmatively by the evidence supporting the Zero Suicide model (Brodsky et al., 2018). The Zero-Suicide model assumes that systematic, comprehensive approaches are embedded within the health and mental healthcare systems. The model describes ten steps to develop the competence of healthcare professionals in dealing with suicidal behaviour. Table 5.1 presents 10 steps of the model, which are further divided into three phases: assessment, intervention, and monitoring.

Table 5.1: Suicide Prevention: Zero-Suicide Model

Theme	Step	Description
Assess	1	Ask explicitly about suicidal ideation (current and history)
	2	Identify risk factors and assess suicidal ideations
	3	Devise, implement and maintain a Safety Plan
Intervene	4	Develop a collaborative safety plan
	5	Initiate coping strategies
	6	Connect with suicide-specific treatment
Monitor	7	Offer service with contact flexibility
	8	Increase monitoring during high-risk phase
	9	Involve family, friends and community resources
	10	Consult with experts

The Zero-Suicide model provides Gatekeepers with an overview of suicide treatment and prevention and recognizes their pivotal role—what they can do and how to use others' services to provide a multilevel and comprehensive treatment and prevention strategy. A number of steps in the model are consistent with the 5-step model outlined in Module 3.

Overall, the Zero Suicide model provides a structured and evidence-based framework for treating suicidality, demonstrating that with the right approaches and interventions, suicide is preventable.

Recommendations for Suicide Prevention

In Guyana, where community and culture deeply influence daily life, tailoring suicide prevention strategies to fit these local contexts is crucial. Recognizing the diverse lifestyles, beliefs, and available supports in the community is essential for implementing effective suicide prevention measures. Here's how tailored plans can make a meaningful impact:

1. **Suicide Crisis Lines:** Hotlines can be pivotal in preventing suicides. It's crucial to train responders in cultural nuances and ensure they're comfortable directly addressing suicide risks with callers (Baldacare et al., 2023; Hoffberg et al., 2020).

2. **Environmental Strategies:** Reducing access to common means of suicide, like modifying access

to poison used in farming and household gas and enforcing stricter gun laws, can save lives by altering the environment (Florentine & Crane, 2010).

3. **Limiting Public Exposure to Methods and Means:** Limiting public exposure to suicide methods and changing perceptions of suicide through responsible media reporting can help. Implementing educational campaigns and media guidelines are vital steps in this strategy (Florentine & Crane, 2010).

4. **Community-Based Approaches:** Designing comprehensive plans that address specific community needs, including awareness campaigns and training for community gatekeepers, can foster a supportive environment for mental health (Robinson et al., 2018).

5. **Youth-Oriented Interventions:** Programs in schools and clinics aimed at reducing self-harm and suicidal thoughts among young people are crucial. Providing appropriate support for their unique challenges is key (Robinson et al., 2018).

6. **Religious and Spiritual Involvement:** Religious support, ethical guidance, and a sense of purpose are significant protective factors. Engaging these communities is vital in crisis support (Lawrence et al., 2016).

7. **Agricultural and Rural Focus:** In rural areas, where resources may be scarce, it's important to train local leaders and adapt suicide prevention strategies to fit cultural contexts, offering targeted support (Oldham et al., 2023).

8. **Educational Sector Engagement:** Educating school staff to recognize and assist at-risk students, with consideration for cultural factors, can lead to more effective interventions (Persaud, Rosenthal, & Arora, 2019).

9. **Suicide Resilience:** Enhancing resilience against suicidal thoughts through promoting positive thinking and social support is critical in prevention efforts (Osman et al., 2004; Wang et al., 2022).

10. **Digital and Social Media Interventions:** With the rise of online platforms, identifying and addressing suicide risks in digital spaces has become increasingly important. Training individuals to notice distress signs and using personal stories for peer support is essential (Corbitt-Hall, Gauthier, & Troop-Gordon, 2019).

11. **Institutional Collaboration:** Collaboration between community centres, schools, and hospitals ensures comprehensive support for individuals in crisis, from assessment to post-hospitalization care (Rockland-Miller & Eells, 2008).

12. **Machine Learning to Predict Suicide:** Advanced models using machine learning to identify high-risk individuals can lead to more personalized intervention strategies (Lin, Tseng, Tung, Hu, & You, 2022).

When infused with an understanding of Guyanese cultural and community dynamics, these recommendations can ensure that all individuals, regardless of their background, can access practical and compassionate support during challenging times.

Activity 5: Uncovering Resilience Amid Adversity

Objective: Understand resilience in overcoming challenges and its connection to suicide prevention.

Materials Needed:

- Revised Narratives from earlier module (see below)

Group Size: Suitable for any number

Activity Steps:

- **Introduction (3 minutes)**
  - Divide participants into at least four groups, each receiving a unique scenario (Devanand, Anita, Rampaul, Tanya).
  - Explain the activity's purpose: understanding resilience in overcoming challenges and its connection to suicide prevention.
- **Reading Narratives**
  - A participant from each group reads their scenario aloud. Encourage attention to challenges and resilience factors highlighted in the stories.
  - Rampaul's Narrative: A young man grappling with his sexual orientation feels conflicted by the weight of traditional cultural expectations.
- **Individual Reflection**

  Participants consider:

  - **Actions of resilience:** What specific actions demonstrated resilience?
  - **Support systems:** How did support from others aid in overcoming challenges?
  - **Cultural/spiritual beliefs:** What role did these beliefs play in resilience?

Small Group Discussion

Groups discuss their reflections, focusing on:

- **Resilience actions:** Specific actions that showcased resilience
- **Role of support:** How community, friends, or institutions contributed
- **Cultural and spiritual contributions:** The impact of beliefs on resilience
- **Reaching out for help:** Moments when seeking help was pivotal
- **Suicide prevention strategies:** Their application or absence in these stories

Large Group Share and Debrief

- **Share insights:** Each group presents a key insight from their discussion.

- **Facilitator-led conversation:** Discuss how these insights relate to effective suicide prevention.

Closing

- **Summarize insights:** Emphasize the importance of community support and reaching out in times of adversity.

Narrative 1: Devanand – Seeds of Hope

Devanand, a farmer from Yakusari, faced a tough year when non-stop rain destroyed his fields. He felt lost and overwhelmed with heavy debts and the weather against him. During a village meeting, someone mentioned that a phone call could offer hope. Feeling a bit braver, Devanand made that call and got some excellent advice on small steps he could take to start fixing things.

He also turned to his community and faith for comfort. Talking with the village priest helped a lot. The priest gave him wise and practical advice, making Devanand feel stronger. He followed old religious practices and joined in prayers, which gave him a sense of belonging and support.

Devanand began to see his problems as just part of life's ups and downs. He focused on what he could do, like planting new seeds for the future. Along with his neighbours, who also faced their own losses, he helped others recover. This brought everyone closer and strengthened their faith even more. As time went on, Devanand's f arm began to show signs of life again. This showed everyone that they could get through tough times by working together and supporting each other.

Narrative 2: Anita's New Dawn – Breaking Free from the Storm

Anita, a young mom in a small town in Guyana, was in a tough spot. She was married to a man much older than herself, a man who struggled with alcohol and often became angry. His outbursts of rage, usually worsened by his drinking, filled their home with fear and uncertainty. Anita felt trapped. Her family offered no support and she feared the judgement of her neighbours if she sought help.

The situation at home became even more tense, reaching a breaking point one day when her husband directed his anger toward their youngest child. Feeling completely lost and without options, Anita remembered

something about a support line designed to help people in her situation.

Mustering all her courage, Anita made the call. The person on the other end offered a kind and understanding ear, something Anita hadn't experienced in a long time. They talked to her about finding a safe place for her and her children, away from the fear and pain they were enduring. Together, they planned for Anita to leave her dangerous environment and start fresh.

This call marked the beginning of a new chapter for Anita. News of her situation spread throughout the community, and people slowly offered support. This wave of community assistance was something Anita had never anticipated. It gave her and her children not just a way out but hope for a better future.

Transitioning to this new life was by no means easy, but Anita no longer felt alone. She found friends and allies who stood by her, offering support in various forms. This journey from a place of despair to one of hope was a testament to the strength that comes from reaching out for help and the incredible impact of a supportive community. Anita's story is a reminder that, no matter how dire the situation may seem, there is always a chance for a new beginning and the opportunity to break free from the storm.

Narrative 3: Rampaul's Leap - Embracing His True Colors

Rampaul was the youngest in a traditional family in Guyana. He felt different, especially when others made fun of him, and only his mom stood up for him. His dad wanted him to work at their store, but Rampaul loved art and dreamed of doing his own thing. So, he went to the city to study but soon left his classes to follow his heart into the art world.

While working, he met David, who came from far away, and they became very special to each other. But Rampaul was worried. Where he came from, people didn't accept having a boyfriend, and he didn't want his family to be upset with him.

David wanted Rampaul to come live with him in another country where they could be together without hiding. Rampaul feared what this would mean—telling his family the truth about who he loved. This fear made him say no to David, and they split up, which greatly hurt Rampaul.

Feeling lost and alone, Rampaul hurt himself and ended up in the hospital. But this low point became a new beginning. It made him see that he had to be honest about his identity, even if it was tough.

Rampaul's journey reminds us that being yourself can be hard, but it's worth it. His story gives hope to others finding their way through tough times, showing that it's okay to be who you are and love who you love.

Narrative 4: Tanya's Path to Serenity - Harmony in the Whirlwind

Tanya's journey is one of rediscovery and resilience. She's a vibrant soul who has always felt the world intensely, but sometimes, her emotions would swing wildly, and her relationships suffered. In moments of impulse, she made decisions like quitting jobs that later filled her with regret. Pain became a shadow she couldn't shake off, often leading her to harm herself with a silent scream for help.

But then, Tanya found a lifeline. It began with a phone call to a hotline, where the voice at the other end understood the dance of her emotions. This was more than a call; it was a connection to someone who spoke her language, who asked the right questions, enabling her to answer without fear of judgement.

Her community, too, started to change. Conversations about mental health and support echoed in the streets and fields of her town. The local schools, where she once felt alone, became places where teachers watched out for students like her, offering a word of comfort or advice just at the right time.

Online, Tanya discovered communities where people shared their stories—stories that mirrored her own. The strength in those shared experiences told her she wasn't alone.

The spiritual guidance she found in her ancestors' traditions provided a steady rhythm to her life. Prayers and rituals, once just part of her heritage, became her refuge. They gave her moments of peace and a sense of belonging that she cradled close to her heart.

In this world, where every eye is trained to see and every ear to listen, Tanya learned to weave a tapestry of her own story, where every thread is a step towards healing. She discovered the power of letting go of what she can't change and nurturing hope for what she can.

Module 5 Quiz

1. Postvention refers to:

a. Strategies implemented before a suicide occurs
b. Strategies implemented during the suicidal crisis
c. Strategies implemented after the suicide occurs
d. Strategies for community support amidst suicidal crisis
e. Strategies to support a person going through trauma

2. A process through which a person with a stigma related to mental illness internalizes stigma-related attitudes aand beliefs held by others is known as:

a. Institutional Stigma **b.** Societal Stigma **c.** Structural Stigma
d. Self-Stigma **e.** Self-bias

3. Regarding Suicide and Gender

a. Women are more likely to think about suicide. Men are less likely to think about it.
b. Women are more likely to attempt suicide. Men are less likely to attempt it.
c. Women are more likely to complete suicide. Men are more likely to just attempt it.
d. Women are more likely to die by suicide than men.
e. Women are more likely to attempt but men are more likely to die by suicide.

4. Which of the following is probably not accurate about potential causes of suicide in indigenous communities, according to research?

a. Loss of culture due to rapid change in ways of life
b.Geographic proximity within interconnected communities
c. Lack of alternatives in navigating problematic relationships intensifies a sense of there being “no way out” of personal and family quandaries
d. Lack of vocational and recreational opportunities
e. Frequent exposure to suicide by others (including relatives and friends)
f. Exposure to other traumas including domestic violence, and substance abuse

5. In the context of Suicide and Media, the Papageno Effect refers to:

a. Accurate portrayal of suicide which has a positive impact on public perception
b. Inaccurate portrayal of suicide which has a mixed impact on public perception
c. Realistic portrayal of overcoming suicidal crises which may have a protective effect
d. Provocative and sensationalized portrayal which may have a negative impact
e. Pessimistic portrayal of suicides which may have a negative impact

Summary

- This module focused on supporting those grieving after a suicide, with strategies like counseling and community education to prevent further crises and promote healing.
- The module also discussed the importance of self-care for Gatekeepers, and presented strategies Gatekeepers can use before, during and after dealing with a suicidal criss.
- Stigma towards suicide and mental health continues to pose a barrier, both for those needing support and those hesitant to intervene.
- Addressing self-, societal, structural and institutional stigma as well as gender and cultural forms of stigma can reduce barriers to support and treatment and prevent the high rate of suicide.
- Finally the module highlighted the role of media in shaping perceptions of suicide, advocating for responsible reporting that avoids sensationalism, and follows guidelines to support suicide prevention efforts and the need to reduce stigma.

Module 5: Quiz Answers

1. c: B

2. d: Self-Stigma. Self-stigma is the process through which a person with a stigma related to mental illness internalizes stigma-related attitudes and beliefs held by others.

3. e: Women are more likely to attempt but men are more likely to die by suicide. Research indicates women are more likely to attempt suicide, but men are more likely to die by suicide.

4. b: Geographic proximity within interconnected communities. Geographic isolation, not proximity, within indigenous communities is actually considered a potential cause of suicide.

5. c: Realistic portrayal of overcoming suicidal crises which may have a protective effect. The Papageno Effect refers to the beneficial impact of media portrayals that show realistic ways of overcoming suicidal crises, which may encourage self-help and have a protective effect on the public.

Glossary

Alcohol Use Disorder Identification Test (AUDIT): A screening tool developed by the World Health Organization (WHO) to identify individuals with hazardous and harmful patterns of alcohol consumption.

Assessment: The process of evaluating or estimating the nature, ability, or quality of something.

Beck Scale for Suicide Ideation (BSSI): A self-report tool measuring an individual's attitudes, behaviours, and plans related to suicidal ideation.

Columbia Suicide Severity Rating Scale (C-SSRS): A scale for evaluating the severity of suicidal ideation and behaviour, providing categories for ideation, behaviour, and lethality of attempts.

Contagion: In the context of suicide, the phenomenon where exposure to suicidal behaviours influences others to consider or commit suicide.

Crisis Intervention: Immediate and short-term psychological care aimed at assisting individuals in a crisis situation to restore balance to their biopsychosocial functioning and to minimize potential for long-term psychological trauma.

Cultural Competence: The ability of Gatekeepers and health professionals to understand and respect the values, beliefs, and practices of the community they serve.

Drug Abuse Screening Test (DAST): A self-report instrument for identifying drug abuse or related problems, focused on consequences rather than frequency of use.

Empathy: The ability to understand and share the feelings of another, crucial for establishing trust and rapport.

Gatekeeper: An individual trained to identify signs of suicidal ideation or crisis and to direct them to appropriate help.

Gatekeeper Training: Educational programs designed to train non-mental health professionals to identify and respond to signs of suicide risk.

Generalized Anxiety Disorder-7 (GAD-7): A questionnaire for screening the severity of generalized anxiety disorder symptoms.

High-Risk: Descriptor of an individual who will likely engage in suicidal behaviour imminently due to intense suicidal ideation, a specific plan, and means.

Impulsivity: A tendency to act on a whim, displaying behaviour characterized by little or no forethought, reflection, or consideration of the consequences.

Interventions: Actions taken to improve a situation, especially a medical disorder or a social problem.

Low-Risk: Descriptor of an individual who does not have a specific plan or means to commit suicide and therefore are at a lower immediate risk for suicidal behaviour.

Mindfulness: A mental state achieved by focusing one's awareness on the present moment, often used as a therapeutic technique to manage stress and emotional regulation.

Papageno Effect: A positive effect that media coverage can have on individuals by portraying individuals overcoming psychological crisis. The Papageno effect can encourage help-seeking behaviour and alternative coping strategies.

Patient Health Questionnaire-9 (PHQ-9): A clinical tool for identifying and measuring the severity of depression.

Peer Support: Emotional and practical support provided by and for individuals with shared experiences, particularly in mental health contexts.

Postvention: Strategies implemented after a suicide has occurred, aiming to support the bereaved, reduce the risk of further suicides, and facilitate community healing.

Prevention Strategies: Planned measures and interventions aimed at stopping mental health issues from developing or worsening, thereby reducing the incidence of suicide.

Protective Factors: Characteristics or conditions that promote resilience and decrease the likelihood of an individual engaging in suicidal behaviour.

Psychological Autopsy: A research method used to study cases of completed suicide by reconstructing the deceased individual's psychological state before death.

Psychological Disorders: Clinical conditions characterized by disruptive patterns of thought, behaviour, and emotions that impair daily functioning.

Referrals: Directing of someone to a different place or person for information, help, or action.

Risk Assessment: The process of identifying and evaluating factors that could contribute to a person's potential for suicide.

Risk Factors for Suicide: Characteristics or conditions that increase the likelihood that a person may consider, attempt, or die by suicide. Can include previous suicide attempts, history of mental health conditions, substance abuse, access to lethal means, significant life changes or trauma, and a family history of suicide

Role Play: An educational activity in which individuals simulate a situation or perform a role to practice responses and interventions to potential real-life scenarios.

Safety Plan: A personalized, practical plan that outlines strategies for individuals at risk to cope with distress and control the immediate environment to prevent suicide.

Self-Stigma: The internalization of negative stereotypes, prejudices, and discrimination related to seeking help for mental health issues, which can act as a barrier to accessing support and care.

Self-Stigma of Seeking Help Scale (SSOSH): A measure that assesses the degree to which individuals internalize negative beliefs about seeking psychological help.

Stigma: A mark of disgrace or infamy; a sign of severe social disapproval of personal characteristics or beliefs that are against cultural norms.

Suicidal Behaviours: Acts of self-harm with some intent to end one's life, often associated with mental health conditions.

Suicidal Ideation: The consideration or planning of suicide, ranging from thoughts that life is not worth living to formulated plans to end one's life.

Suicide: A major public health issue characterized by the intentional act of causing one's own death.

Suicide Assessment: A systematic approach to identifying the likelihood that a person will engage in self-harm or suicidal behaviour.

Suicide Plan: A person's formulated intent and method for ending their own life, including the timing, means, and circumstances of the planned suicide.

Suicide Resilience: Refers to the perception and competence to use one's resources in regulating suicidal feelings and thoughts. Suicide resilience includes not only suicide risk but also factors that protect an individual from suicide.

Warning Signs of Suicide: The earliest indicators that suggest an individual may be thinking about suicide - can include behaviours like talking about wanting to die, looking for ways to kill oneself, expressing hopelessness, withdrawing from others, and showing dramatic mood changes.

References

Albright, G. L., Davidson, J., Goldman, R., Shockley, K. M., & Timmons-Mitchell, J. (2016). Development and Validation of the Gatekeeper behaviour Scale. *Crisis*, 37(4), 271–280. https://doi.org/10.1027/0227-5910/a000382

American Psychiatric Association (2003). Practice Guidelines for the Assessment and Treatment of Patients with Suicidal behaviour. Pp. 30-41.

Andriessen, K., Rahman, B., Draper, B., Dudley, M., & Mitchell, P. B. (2019). Prevalence of exposure to suicide: A meta-analysis of population-based studies. *Journal of Psychiatric Research, 113,* 115-130.

Anestis, M. D., Soberay, K. A., Gutierrez, P. M., Hernández, T. D., & Joiner, T. E. (2014). Reconsidering the link between impulsivity and suicidal behaviour. *Personality and Social Psychology Review: An Official Journal of the Society for Personality and Social Psychology, Inc*, *18*(4), 366–386. https://doi.org/10.1177/1088868314535988

Armoon, B., Griffiths, M. D., Mohammadi, R., & Ahounbar, E. (2023). Suicidal behaviours and Associated Factors Among Individuals with Gambling Disorders: A Meta-Analysis. Journal of gambling studies, 39(2), 751–777. https://doi.org/10.1007/s10899-023-10188-0

Armoon, B., SoleimanvandiAzar, N., Fleury, M. J., Noroozi, A., Bayat, A. H., Mohammadi, R., Ahounbar, E., & Fattah Moghaddam, L. (2021). Prevalence, sociodemographic variables, mental health condition, and type of drug use associated with suicide behaviours among people with substance use disorders: a systematic review and meta-analysis. *Journal of addictive diseases, 39*(4), 550–569. ttps://doi.org/10.1080/10550887.2021.1912572

Bachmann S. (2018). Epidemiology of Suicide and the Psychiatric Perspective. *International journal of environmental research and public health*, *15*(7), 1425. https://doi.org/10.3390/ijerph15071425

Bagge, C. L., Littlefield, A. K., & Lee, H.-J. (2013). Correlates of proximal premeditation among recently hospitalized suicide attempters. *Journal of Affective Disorders*, *150*(2), 559–564. https://doi.org/10.1016/j.jad.2013.02.004

Bagge, C. L., Littlefield, A. K., Wiegand, T. J., Hawkins, E., Trim, R. S., Schumacher, J. A., Simons, K., & Conner, K. R. (2023). A controlled examination of acute warning signs for suicide attempts among hospitalized patients. *Psychological Medicine, 53,* 2768–2776. https://doi.org/10.1017/S0033291721004712

Baldaçara, L., Weber, C. A. T., Gorender, M., Grudtner, R. R., Peu, S., Teles, A. L. S., Passos, I. C., Quevedo, J., & da Silva, A. G. (2023). Brazilian Psychiatric Association guidelines for the management of suicidal behavior. *Part 3. Suicide prevention hotlines. Revista brasileira de psiquiatria (Sao Paulo, Brazil : 1999)*, 45(1), 54–61. https://doi.org/10.47626/1516-4446-2022-2536

Barber, C. W., & Miller, M. J. (2014). Reducing a Suicidal Person's Access to Lethal Means of Suicide: A Research Agenda. *American Journal of Preventive Medicine*, *47*(3, Supplement 2), S264–S272. https://doi.org/10.1016/j.amepre.2014.05.028

Bhatt, M., Bhatt, S., & Tompkins, D. A. E. (2017). Impact of reduced heroin supply on demographic characteristics and overdose of opioid users. *Journal of Substance Abuse Treatment, 81,* 74-80.

Bhugra, D., Ventriglio, A., & Kato, T. A. (2018). Suicide in men: A complex challenge for psychiatry. *Psychiatry and Clinical Neurosciences, 72*(8), 565-566.

Bostwick, J. M., & Pankratz, V. S. (2000). Affective disorders and suicide risk: A reexamination. American Journal of Psychiatry, 157(12), 1925-1932.

Bertolote, J. M., & Fleischmann, A. (2002). Suicide and psychiatric diagnosis: a worldwide perspective. *World psychiatry : official journal of the World Psychiatric Association (WPA), 1*(3), 181–185.

Brådvik, L. (2018a). Suicide Risk and Mental Disorders. *International Journal of Environmental Research and Public Health*, *15*(9), 2028. https://doi.org/10.3390/ijerph15092028

Breet, E., Goldstone, D., & Bantjes, J. (2018). Substance use and suicidal ideation and behaviour in low- and middle-income countries: a systematic review. *BMC public health, 18*(1), 549. https://doi.org/10.1186/s12889-018-5425-6

Brodsky, B. S., Spruch-Feiner, A., & Stanley, B. (2018). The Zero Suicide Model: Applying Evidence-Based Suicide Prevention Practices to Clinical Care. *Frontiers in psychiatry,* 9, 33. https://doi.org/10.3389/fpsyt.2018.00033

Brokke, S. S., Landrø, N. I., & Haaland, V. Ø. (2022). Impulsivity and aggression in suicide ideators and suicide attempters of high and low lethality. *BMC Psychiatry*, *22*(1), 753. https://doi.org/10.1186/s12888-022-04398-w

Brown, S., & Seals, J. (2019). Intimate partner problems and suicide: Are we missing the violence? *Journal of Injury and Violence Research*, *11*(1), 53–64. https://doi.org/10.5249/jivr.v11i1.997

Carpiniello, B., & Pinna, F. (2017). The Reciprocal Relationship between Suicidality and Stigma. *Frontiers in Psychiatry*, *8*. https://doi.org/10.3389/fpsyt.2017.00035

Castellví, P., Miranda-Mendizábal, A., Parés-Badell, O., Almenara, J., Alonso, I., Blasco, M. J., Cebrià, A., Gabilondo, A., Gili, M., Lagares, C., Piqueras, J. A., Roca, M., Rodríguez-Marín, J., Rodríguez-Jimenez, T., Soto-Sanz, V., & Alonso, J. (2017). Exposure to violence, a risk for suicide in youths and young adults. A meta-analysis of longitudinal studies. *Acta Psychiatrica Scandinavica*, *135*(3), 195–211. https://doi.org/10.1111/acps.12679

CDC. (2022). Suicide Prevention Resource for Action: A Compilation of the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Chen, X., & Li, S. (2023). Serial mediation of the relationship between impulsivity and suicidal ideation by depression and hopelessness in depressed patients. *BMC Public Health*, *23*(1), 1457. https://doi.org/10.1186/s12889-023-16378-0

Cleare, S., Wetherall, K., Clark, A., Ryan, C., Kirtley, O. J., Smith, M., & O'Connor, R. C. (2018). Adverse Childhood Experiences and Hospital-Treated Self-Harm. *International Journal of Environmental Research and Public Health*, *15*(6), 1235. https://doi.org/10.3390/ijerph15061235

Coentre, R., Fonseca, A., Mendes, T., Rebelo, A., Fernandes, E., Levy, P., Góis, C., & Figueira, M. L. (2021). Suicidal behaviour after first-episode psychosis: results from a 1-year longitudinal study in Portugal. *Annals of General Psychiatry*, *20*(1), 35. https://doi.org/10.1186/s12991-021-00356-0

Coimbra, B. M., Hoeboer, C. M., Yik, J., Mello, A. F., Mello, M. F., & Olff, M. (2022). Meta-analysis of the effect of racial discrimination on suicidality. *SSM - Population Health*, *20*, 101283. https://doi.org/10.1016/j.ssmph.2022.101283.

Corbitt-Hall, D. J., Gauthier, J. M., & Troop-Gordon, W. (2019). Suicidality disclosed online: Using a simulated Facebook task to identify predictors of support giving to friends at risk of self-harm. *Suicide and Life-Threatening Behavior,* 49(2), 598-612. https://doi.org/10.1111/sltb.12461

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry, 1*(1), 16-20.

Corrigan, P. W., & Rao, D. (2012). On the self-stigma of mental illness: stages, disclosure, and strategies for change. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, *57*(8), 464–469. https://doi.org/10.1177/070674371205700804.

Creed, M., & Whitley, R. (2016). Assessing Fidelity to Suicide Reporting Guidelines in Canadian News Media: The Death of Robin Williams. *The Canadian Journal of Psychiatry*. https://doi.org/10.1177/0706743715621255

Crowder, M. K., & Kemmelmeier, M. (2018). Cultural differences in shame and guilt as understandable reasons for suicide. *Psychological Reports, 121*(3), 396–429. https://doi.org/10.1177/0033294117728288

Darke, S., Kaye, S., McKetin, R., & Duflou, J. (2012). Major physical and psychological harms of methamphetamine use. *Drug and Alcohol Review, 31*(3), 253-262.

Dazzi, T., Gribble, R., Wessely, S., & Fear, N. T. (2014). Does asking about suicide and related behaviours induce suicidal ideation? What is the evidence? *Psychological Medicine*, *44*(16), 3361–3363. https://doi.org/10.1017/S0033291714001299.

Dome, P., Rihmer, Z., & Gonda, X. (2019). Suicide Risk in Bipolar Disorder: A Brief Review. *Medicina (Kaunas, Lithuania)*, *55*(8), 403. https://doi.org/10.3390/medicina55080403

Dorol-Beauroy-Eustache, O., & Mishara, B. L. (2021). Systematic review of risk and protective factors for suicidal and self-harm behaviours among children and adolescents involved with cyberbullying. *Preventive Medicine, 152* (Part 1), 106684. https://doi.org/10.1016/j.ypmed.2021.106684.

Edelstein, B. A., Heisel, M. J., McKee, D. R., Martin, R. R., Koven, L. P., Duberstein, P. R., & Britton, P. C. (2009). Development and psychometric evaluation of the reasons for living--older adults scale: a suicide risk assessment inventory. *The Gerontologist*, *49*(6), 736–745. https://doi.org/10.1093/geront/gnp052

Edwards, A. C., Ohlsson, H., Mościcki, E., Crump, C., Sundquist, J., Lichtenstein, P., Kendler, K. S., & Sundquist, K. (2021). On the Genetic and Environmental Relationship Between Suicide Attempt and Death by Suicide. *American Journal of Psychiatry*, *178*(11), 1060–1069. https://doi.org/10.1176/appi.ajp.2020.20121705

Edwards, D. C. (2016). Suicide in Guyana: A Parsonsian corrective to Durkheim's theory of suicide. *Canadian Journal of Latin American and Caribbean Studies / Revue Canadienne Des Études Latino-Américaines et Caraïbes*, *41*(2), 197–214. https://doi.org/10.1080/08263663.2016.1189650

Ehlers, C. L., Yehuda, R., Gilder, D. A., Bernert, R., & Karriker-Jaffe, K. J. (2022). Trauma, Historical Trauma, PTSD and Suicide in an American Indian Community Sample. *Journal of Psychiatric Research*, *156*, 214–220. https://doi.org/10.1016/j.jpsychires.2022.10.012

Esang, M., & Ahmed, S. (2018). A Closer Look at Substance Use and Suicide. *American Journal of Psychiatry Residents' Journal*, *13*. https://doi.org/10.1176/appi.ajp-rj.2018.130603.

Evans-Lacko, S., Brohan, E., Mojtabai, R., & Thornicroft, G. (2012). Association between public views of mental illness and self-stigma among individuals with mental illness in 14 European countries. *Psychological Medicine*, *42*(8), 1741–1752. https://doi.org/10.1017/S0033291711002558

Favril, L., Yu, R., Uyar, A., Sharpe, M., & Fazel, S. (2022). Risk factors for suicide in adults: systematic review and meta-analysis of psychological autopsy studies. *Evidence-based mental health, 25*(4), 148–155. https://doi.org/10.1136/ebmental-2022-300549

Fazel, S., Ramesh, T., & Hawton, K. (2017). Suicide in prisons: An international study of prevalence and contributory factors. *The Lancet. Psychiatry*, *4*(12), 946–952. https://doi.org/10.1016/S2215-0366(17)30430-3

Fazel, S., & Runeson, B. (2020). Suicide. *The New England Journal of Medicine*, *382*(3), 266–274. https://doi.org/10.1056/NEJMra1902944

Florentine, J. B., & Crane, C. (2010). Suicide prevention by limiting access to methods: A review of theory and practice. *Social Science & Medicine, 70*(10), 1626–1632. https://doi.org/10.1016/j.socscimed.2010.01.029

Fonseca-Pedrero, E., Al-Halabí, S., Pérez-Albéniz, A., & Debbané, M. (2022). Risk and Protective Factors in Adolescent Suicidal

Behaviour: A Network Analysis. *International Journal of Environmental Research and Public Health*, *19*(3). https://doi.org/10.3390/ijerph19031784

Forte, A., Trobia, F., Gualtieri, F., Lamis, D. A., Cardamone, G., Giallonardo, V., Fiorillo, A., Girardi, P., & Pompili, M. (2018). Suicide risk among immigrants and ethnic minorities: A literature overview. *International Journal of Environmental Research and Public Health, 15*(7), 1438. https://doi.org/10.3390/ijerph15071438.

Franklin, J. C., Ribeiro, J. D., Fox, K. R., Bentley, K. H., Kleiman, E. M., Huang, X., Musacchio, K. M., Jaroszewski, A. C., Chang, B. P., & Nock, M. K. (2017). Risk factors for suicidal thoughts and behaviours: A meta-analysis of 50 years of research. *Psychological Bulletin*, *143*(2), 187–232. https://doi.org/10.1037/bul0000084.

Frey, L. M., Fulginiti, A., Lezine, D., & Cerel, J. (2018). The Decision-Making Process for Disclosing Suicidal Ideation and behaviour to Family and Friends. *Family Relations*, *67*(3), 414–427. https://doi.org/10.1111/fare.12315

GBD 2019 Mental Disorders Collaborators (2022). Global, regional, and national burden of 12 mental disorders in 204 countries and territories, 1990-2019: a systematic analysis for the Global Burden of Disease Study 2019. *The Lancet. Psychiatry*, *9*(2), 137–150. https://doi.org/10.1016/S2215-0366(21)00395-3.

Gonzalez, L., & Patel, V. (2023). Intersectional stigma and its impact on mental health treatment in minority populations. *Cultural Diversity and Mental Health*, 27(2), 89-104.

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry, 10*(1), 113.

Guyana (2024): https://www.britannica.com/place/Guyana; accessed January 2024. Hammen, C. (2005). Stress and depression. *Annual Review of Clinical Psychology*, 1, 293-319. https://doi.org/10.1146/annurev.clinpsy.1.102803.143938

Harrison, D. P., Stritzke, W. G. K., Fay, N., Ellison, T. M., & Hudaib, A.-R. (2014). Probing the implicit suicidal mind: Does the Death/Suicide Implicit Association Test reveal a desire to die, or a diminished desire to live? *Psychological Assessment*, *26*(3), 831–840. https://doi.org/10.1037/pas0000001.

Hawgood, J., Woodward, A., Quinnett, P., & De Leo, D. (2022). Gatekeeper training and minimum standards of competency: Essentials for the suicide prevention workforce. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 43(6), 516–522. https://doi.org/10.1027/0227-5910/a000794

Hill, N. T. M., & Robinson, J. (2022). Responding to Suicide Clusters in the Community: What Do Existing Suicide Cluster Response Frameworks Recommend and How Are They Implemented? *International Journal of Environmental Research and Public Health*, *19*(8), 4444. https://doi.org/10.3390/ijerph19084444

Hoffberg, A. S., Stearns-Yoder, K. A., & Brenner, L. A. (2020). The Effectiveness of Crisis Line Services: A Systematic Review. *Frontiers in public health,* 7, 399. https://doi.org/10.3389/fpubh.2019.00399

Holt, M. K., Vivolo-Kantor, A. M., Polanin, J. R., Holland, K. M., DeGue, S., Matjasko, J. L., Wolfe, M., & Reid, G. (2015). Bullying and Suicidal Ideation and behaviours: A Meta-Analysis. *Pediatrics*, *135*(2), e496–e509. https://doi.org/10.1542/peds.2014-1864.

Hong Lam, J. S., Links, P. S., Eynan, R., Shera, W., Tat Tsang, A. K., Law, S., Alan Fung, W. L., Zhang, X., Liu, P., & Zaheer, J. (2021). I thought that I had to be alive to repay my parents: Filial piety as a risk and protective factor for suicidal behaviour in a qualitative study of Chinese women. *Transcultural Psychiatry*. https://doi.org/10.1177/13634615211059708

Hawton, K., Sutton, L., Haw, C., Sinclair, J., & Harriss, L. (2005). Suicide and attempted suicide in bipolar disorder: A systematic review of risk factors. *Journal of Clinical Psychiatry, 66*(6), 693-704.

Howarth, E. J., O'Connor, D. B., Panagioti, M., Hodkinson, A., Wilding, S., & Johnson, J. (2020). Are stressful life events prospectively associated with increased suicidal ideation and behaviour? A systematic review and meta-analysis. *Journal of Affective Disorders*, *266*, 731–742. https://doi.org/10.1016/j.jad.2020.01.171

Kafka, J. M., Moracco, K. (Beth) E., Taheri, C., Young, B.-R., Graham, L. M., Macy, R. J., & Proescholdbell, S. (2022). Intimate partner violence victimization and perpetration as precursors to suicide. *SSM - Population Health*, *18*, 101079. https://doi.org/10.1016/j.ssmph.2022.101079

Kearns, M., Muldoon, O. T., Msetfi, R. M., & Surgenor, P. W. G. (2015). Understanding help-seeking amongst university students: The role of group identity, stigma, and exposure to suicide and help-seeking. *Frontiers in Psychology*, *6*. https://www.frontiersin.org/articles/10.3389/fpsyg.2015.01462.

Kessler, R. C. (1997). The effects of stressful life events on depression. *Annual Review of Psychology*, 48, 191-214. https://doi.org/10.1146/annurev.psych.48.1.191

Kirmayer, L. J. (2022). Suicide in cultural context: An ecosocial approach. *Transcultural Psychiatry*. https://doi.org/10.1177/13634615221076424

Klonsky, E. D., Saffer, B. Y., & Bryan, C. J. (2018). Ideation-to-action theories of suicide: a conceptual and empirical update. *Current Opinion in Psychology*, *22*, 38–43. https://doi.org/10.1016/j.copsyc.2017.07.020

Koenigsberg, H. W., Fan, J., Ochsner, K. N., Liu, X., Guise, K. G., Pizzarello, S., ... & Siever, L. J. (2021). Neural correlates of using distancing to regulate emotional responses to social situations. *Neuropsychopharmacology, 46*(5), 1073-1080.

Koller, G., Preuss, U., Bottlender, M., Wenzel, K., & Soyka, M. (2002). Impulsivity and aggression as predictors of suicide attempts in alcoholics. *European Archives of Psychiatry and Clinical Neuroscience*, *252*, 155–160. https://doi.org/10.1007/s00406-002-0362-9

Kõlves, K., & de Leo, D. (2017). Suicide methods in children and adolescents. *European Child & Adolescent Psychiatry*, *26*(2),

155–164. https://doi.org/10.1007/s00787-016-0865-y

Kõlves, K., & Leo, D. D. (2014). Suicide rates in children aged 10–14 years worldwide: Changes in the past two decades. *The British Journal of Psychiatry*, *205*(4), 283–285. https://doi.org/10.1192/bjp.bp.114.144402

Kõlves, K., & Leo, D. D. (2016). Adolescent Suicide Rates Between 1990 and 2009: Analysis of Age Group 15–19 Years Worldwide. *Journal of Adolescent Health*, *58*(1), 69–77. https://doi.org/10.1016/j.jadohealth.2015.09.014.

Korhonen, T., Sihvola, E., Latvala, A., Dick, D. M., Pulkkinen, L., Nurnberger, J., Rose, R. J., & Kaprio, J. (2018). Early-onset tobacco use and suicide-related behaviour - A prospective study from adolescence to young adulthood. *Addictive behaviours*, *79*, 32–38. https://doi.org/10.1016/j.addbeh.2017.12.008

Ku, B. S., Li, J., Lally, C., Compton, M. T., & Druss, B. G. (2021). Associations between mental health shortage areas and county-level suicide rates among adults aged 25 and older in the USA, 2010 to 2018. *General Hospital Psychiatry*, *70*, 44–50. https://doi.org/10.1016/j.genhosppsych.2021.02.001.

Kugelmass, H. (2019). Suicide risk among individuals with psychotic disorders: A systematic review. *Schizophrenia Research, 208*, 25-33.

Kuhlman, S. T. W., Walch, S. E., Bauer, K. N., & Glenn, A. D. (2017). Intention to Enact and Enactment of Gatekeeper behaviours for Suicide Prevention: An Application of the Theory of Planned behaviour. *Prevention Science*, *18*(6), 704–715. https://doi.org/10.1007/s11121-017-0786-0.

Lange, S., Cayetano, C., Jiang, H., Tausch, A., & Souza, R. O. e. (2023). Contextual factors associated with country-level suicide mortality in the Americas, 2000–2019: A cross-sectional ecological study. *The Lancet Regional Health – Americas*, *20*. https://doi.org/10.1016/j.lana.2023.100450.

Lawrence, R. E., Oquendo, M. A., & Stanley, B. (2016). Religion and Suicide Risk: A Systematic Review. *Archives of suicide research : official journal of the International Academy for Suicide Research*, 20(1), 1–21. https://doi.org/10.1080/13811118.2015.1004494

Li, S., Wang, Y., Xue, J., Zhao, N., & Zhu, T. (2020). The impact of COVID-19 epidemic declaration on psychological consequences: A study on active Weibo users. *International Journal of Environmental Research and Public Health*, 17(6), 2032. https://doi.org/10.3390/ijerph17062032.

Lin, I. L., Tseng, J. Y., Tung, H. T., Hu, Y. H., & You, Z. H. (2022). Predicting the Risk of Future Multiple Suicide Attempt among First-Time Suicide Attempters: Implications for Suicide Prevention Policy. *Healthcare (Basel, Switzerland)*, 10(4), 667. https://doi.org/10.3390/healthcare1004066

Link, B. G., & Phelan, J. C. (2001). Conceptualizing Stigma. *Annual Review of Sociology, 27,* 363-385. doi: 10.1146/annurev.soc.27.1.363.

Lorenzo-Luaces, L., Keefe, J. R., & DeRubeis, R. J. (2021). Cognitive-behavioural therapy: Nature and relation to non-cognitive behavioural therapy. *Behaviour Therapy*, 52(4), 1000-1012. https://doi.org/10.1016/j.beth.2020.09.004.

Lynch, F. L., Peterson, E. L., Lu, C. Y., Hu, Y., Rossom, R. C., Waitzfelder, B. E., Owen-Smith, A. A., Hubley, S., Prabhakar, D., Keoki Williams, L., Beck, A., Simon, G. E., & Ahmedani, B. K. (2020). Substance use disorders and risk of suicide in a general US population: a case control study. *Addiction Science & Clinical Practice*, *15*(1), 14. https://doi.org/10.1186/s13722-020-0181-1

Maharaj, R. G., Motilal, M. S., Babwah, T. J., Nunes, P., & Brathwaite, R. (2019). Suicide in Guyana: rates and aetiology. *West Indian Medical Journal, 68*(5), 462-467.

Mann, J. J., Michel, C. A., & Auerbach, R. P. (2021). Improving Suicide Prevention Through Evidence-Based Strategies: A Systematic Review. *American Journal of Psychiatry*, *178*(7), 611–624. https://doi.org/10.1176/appi.ajp.2020.20060864

Maremmani, A. G. I., Bacciardi, S., Gehring, N. D., Cambioli, L., Schütz, C., Jang, K., ... & Maremmani, I. (2015). Substance use among homeless individuals with schizophrenia and bipolar disorder. *Journal of Nervous and Mental Disease, 203*(5), 356-360.

Mars, B., Burrows, S., Hjelmeland, H., & Gunnell, D. (2014). Suicidal behaviour across the African continent: a review of the literature. *BMC Public Health, 14*, 606.

Martinez, R. (2022). The effect of stigma on worsening mental health conditions. *International Journal of Psychology and behavioural Studies*, *29*(1), 45-59.

Mathieu, S., Treloar, A., Hawgood, J., Ross, V., & Kõlves, K. (2022). The Role of Unemployment, Financial Hardship, and Economic Recession on Suicidal behaviours and Interventions to Mitigate Their Impact: A Review. *Frontiers in Public Health*, *10*, 907052. https://doi.org/10.3389/fpubh.2022.907052.

McClelland, H., & Cleare, S. (2023). Suicide Risk in Personality Disorders: A Systematic Review. *Current Psychiatry Reports*, *25*(9), 405-417. https://doi.org/10.1007/s11920-023-01440-w

McGuffin, P., Rijsdijk, F., Andrew, M., Sham, P., Katz, R., & Cardno, A. (2003). The heritability of bipolar affective disorder and the genetic relationship to unipolar depression. *Archives of General Psychiatry*

Ministry of Public Health Guyana (2014). *National suicide prevention plan 2015-2020*. Retrieved January 12, 2024, from https://extranet.who.int/mindbank/item/6321

Mo, L., Li, H., & Zhu, T. (2022). Exploring the Suicide Mechanism Path of High-Suicide-Risk Adolescents—Based on Weibo Text Analysis. *International Journal of Environmental Research and Public Health*, *19*(18), 11495. https://doi.org/10.3390/ijerph191811495.

Moitra, M., Santomauro, D., Degenhardt, L., Collins, P. Y., Whiteford, H., Vos, T., & Ferrari, A. (2021). Estimating the risk of suicide associated with mental disorders: A systematic review and meta-regression analysis. *Journal of psychiatric research*, *137*, 242–249. https://doi.org/10.1016/j.jpsychires.2021.02.053.

Monroe, S. M., & Simons, A. D. (1991). Diathesis-stress theories in the context of life stress research: Implications for the depressive disorders. *Psychological Bulletin*, 110(3), 406-425. https://doi.org/10.1037/0033-2909.110.3.406

Motillon-Toudic, C., Walter, M., Séguin, M., Carrier, J.-D., Berrouiguet, S., & Lemey, C. (2022). Social isolation and suicide risk: Literature review and perspectives. *European Psychiatry*, *65*(1), e65. https://doi.org/10.1192/j.eurpsy.2022.2320

Nafilyan, V., Morgan, J., Mais, D., Sleeman, K. E., Butt, A., Ward, I., Tucker, J., Appleby, L., & Glickman, M. (2023). Risk of suicide after diagnosis of severe physical health conditions: A retrospective cohort study of 47 million people. *The Lancet Regional Health - Europe*, *25*, 100562. https://doi.org/10.1016/j.lanepe.2022.100562

Näher, A.-F., Rummel-Kluge, C., & Hegerl, U. (2020). Associations of Suicide Rates With Socioeconomic Status and Social Isolation: Findings From Longitudinal Register and Census Data. *Frontiers in Psychiatry*, *10*. https://www.frontiersin.org/articles/10.3389/fpsyt.2019.00898

Nguyen, M.-H., Le, T.-T., Nguyen, H.-K. T., Ho, M.-T., Nguyen, H. T. T., & Vuong, Q.-H. (2021). Alice in Suicideland: Exploring the Suicidal Ideation Mechanism through the Sense of Connectedness and Help-Seeking behaviours. *International Journal of Environmental Research and Public Health*, *18*(7), Article 7. https://doi.org/10.3390/ijerph18073681

Niederkrotenthaler, T., Fu, K., Yip, P. S. F., Fong, D. Y. T., Stack, S., Cheng, Q., & Pirkis, J. (2012). Changes in suicide rates following media reports on celebrity suicide: A meta-analysis. *J Epidemiol Community Health*, *66*(11), 1037–1042. https://doi.org/10.1136/jech-2011-200707/

Niederkrotenthaler, T., Reidenberg, D. J., Till, B., & Gould, M. S. (2014). Increasing help-seeking and referrals for individuals at risk for suicide by decreasing stigma: the role of mass media. *American journal of preventive medicine, 47*(3 Suppl 2), S235–S243. https://doi.org/10.1016/j.amepre.2014.06.010

Nobie, M.J., & Hutchinson, G. (2018). Demographic Factors Associated with Suicide in Trinidad and Tobago: An Analysis of Completed Suicide 2000-2026. *Caribbean Journal of Psychology*, *10*(1).

Nock, M. K., Hwang, I., Sampson, N., Kessler, R. C., Angermeyer, M., Beautrais, A., ... & Williams, D. R. (2009). Cross-national analysis of the associations among mental disorders and suicidal behaviour: Findings from the WHO World Mental Health Surveys. *PLoS Medicine, 6*(8), e1000123.

Oexle, N., Waldmann, T., Staiger, T., Xu, Z., & Rüsch, N. (2018). Mental illness stigma and suicidality: the role of public and individual stigma. *Epidemiology and psychiatric sciences*, *27*(2), 169–175. https://doi.org/10.1017/S2045796016000949

Oldham, C., Guffey, K., Link, K., Sampson, S., McQueen, T., & Stanton, A. (2023). Measuring Gatekeeper Instructor Comfort to Inform Suicide Prevention Train-The-Trainer Recruitment & Training in Agricultural Communities. *Journal of Agromedicine, 28*(4), 689–702. https://doi.org/10.1080/1059924X.2023.2215249

Olfson, M., Wall, M., Wang, S., Crystal, S., & Gerhard, T. (2020). Suicide after deliberate self-harm in adolescents and young adults. *Pediatrics, 145*(4), e20193634.

Oliffe, J. L., Rossnagel, E., Bottorff, J. L., Chambers, S. K., Caperchione, C., & Rice, S. M. (2019). Community-based men's health promotion programs: Eight lessons learnt and their caveats. *Health Promotion International, 35*(5), 1230-1240.

Oquendo, M. A., Baca-Garcia, E., Mann, J. J., & Giner, J. (2014). Issues for DSM-V: Suicidal behaviour as a separate diagnosis on a separate axis. *The American Journal of Psychiatry, 161*(11), 1383-1384.

Orsolini, L., Latini, R., Pompili, M., Serafini, G., Volpe, U., Vellante, F., Fornaro, M., Valchera, A., Tomasetti, C., Fraticelli, S., Alessandrini, M., La Rovere, R., Trotta, S., Martinotti, G., Di Giannantonio, M., & De Berardis, D. (2020). Understanding the Complex of Suicide in Depression: From Research to Clinics. *Psychiatry Investigation*, *17*(3), 207–221. https://doi.org/10.30773/pi.2019.0171.

PAHO/WHO | Pan American Health Organization. (2022). Guyana moves to address Mental Health more vigorously to secure the health of the population. Retrieved from https://www.paho.org/en/news/18-7-2022-guyana-moves-address-mental-health-more-vigorously-secure-health-population.

Pelizza, L., & Ferrari, A. (2019). Suicidality in early psychosis: A systematic review. *Early Intervention in Psychiatry, 13*(2), 208-221.

Peltzer, K., & Pengpid, S. (2022). Correlates of suicidal behaviour among adults in Guyana. *Journal of Psychology in Africa, 32*(4), 407-412. https://doi.org/10.1080/14330237.2022.2075581.

Persaud, S., Rosenthal, L., & Arora, P. G. (2019). Culturally informed gatekeeper training for youth suicide prevention in Guyana: A pilot examination. *School Psychology International,* 40(6), 624–640. https://doi.org/10.1177/0143034319879477

Perez, S., Marco, J. H., & Cañabate, M. (2020). Emotional dysregulation and non-suicidal self-injury in individuals with borderline personality disorder. *Personality and Individual Differences, 160,* 109921.

Platt, S., Niedzwiedz, C., & Arevalo, M. A. (2017). Suicidal behaviour and psychosocial problems in a post-conflict setting: Evidence from a national survey in Guyana. *Conflict and Health, 11*(1), 5.

Pompili, M., Serafini, G., Innamorati, M., Dominici, G., Ferracuti, S., Kotzalidis, G. D., Serra, G., Girardi, P., Janiri, L., Tatarelli, R., Sher, L., & Lester, D. (2010). Suicidal behaviour and alcohol abuse. *International journal of environmental research and public health*, *7*(4), 1392–1431. https://doi.org/10.3390/ijerph7041392

Poorolajal, J., Haghtalab, T., Farhadi, M., & Darvishi, N. (2016). Substance use disorder and risk of suicidal ideation, suicide attempt and suicide death: A meta-analysis. *Journal of Public Health, 38*(3), e282-e291.

Qin, P., Agerbo, E., & Mortensen, P. B. (2002). Suicide risk in relation to family history of completed suicide and psychiatric disorders: A nested case-control study based on longitudinal registers. *The Lancet*, *360*(9340), 1126–1130. https://doi.org/10.1016/S0140-6736(02)11197-4

Quinlan-Davidson, M., Sanhueza, A., Espinosa, I., Escamilla-Cejudo, J. A., & Maddaleno, M. (2014). Suicide Among Young People in the Americas. *Journal of Adolescent Health*, *54*(3), 262–268. https://doi.org/10.1016/j.jadohealth.2013.07.012.

Radhakrishnan, R., Guloksuz, S., Ten Have, M., de Graaf, R., van Dorsselaer, S., Gunther, N., ... & van Os, J. (2021). Interaction between environmental and familial affective risk impacts psychosis admixture in states of affective dysregulation. *Psychological Medicine, 51*(2), 268-277.

Rashid, T. 2024. *Suicide Prevention Gatekeeper Training*. Regional Mental Health Leads. International Development Relief Fund. February 2024, Georgetown, Guyana.

Rehm, J., & Shield, K. D. (2019). Global Burden of Disease and the Impact of Mental and Addictive Disorders. *Current Psychiatry Reports*, *21*(2), 10. https://doi.org/10.1007/s11920-019-0997-0.

Reynders, A., Kerkhof, A. J. F. M., Molenberghs, G., & Van Audenhove, C. (2015). Help-seeking, stigma and attitudes of people with and without a suicidal past. A comparison between a low and a high suicide rate country. *Journal of Affective Disorders*, *178*, 5–11. https://doi.org/10.1016/j.jad.2015.02.013.

Rice, S. M., Aucote, H. M., Parker, A. G., Alvarez-Jimenez, M., Filia, K. M., & Amminger, G. P. (2019). Men's perceived barriers to help seeking for depression: Longitudinal findings relative to symptom onset and duration. *Journal of Health Psychology, 24*(1), 12-23.

Rihmer, Z. (2001). Can better recognition and treatment of depression reduce suicide rates? A brief review. *European Psychiatry: The Journal of the Association of European Psychiatrists*, *16*(7), 406–409. https://doi.org/10.1016/s0924-9338(01)00598-3.

Rimkeviciene, J., O, G. J., & De Leo, D. (2015). Impulsive suicide attempts: A systematic literature review of definitions, characteristics and risk factors. *Journal of Affective Disorders, 171*, 93–104. https://doi.org/10.1016/j.jad.2014.08.044

Rizk, M. M., Herzog, S., Dugad, S., & Stanley, B. (2021). Suicide Risk and Addiction: The Impact of Alcohol and Opioid Use Disorders. *Current Addiction Reports*, *8*(2), 194–207. https://doi.org/10.1007/s40429-021-00361-z

Robinson, A., & Lee, M. (2024). The role of crisis in mental health: Consequences of stigma in suicidal behaviour. *Emergency Mental Health Review*, 12(3), 301-318.

Robinson, J., Bailey, E., Witt, K., Stefanac, N., Milner, A., Currier, D., Pirkis, J., Condron, P., & Hetrick, S. (2018). What Works in Youth Suicide Prevention? A Systematic Review and Meta-Analysis. *EClinicalMedicine*, 4–5, 52–91. https://doi.org/10.1016/j.eclinm.2018.10.004

Rockland-Miller, H. S., & Eells, G. T. (2008). Strategies for Effective Psychiatric Hospitalization of College and University Students. *Journal of College Student Psychotherapy*, 22(3), 3–12. DOI: 10.1080/87568220801960670.

Rudd, M. D., Berman, A. L., Joiner, T. E., Nock, M. K., Silverman, M. M., Mandrusiak, M., Orden, K. V., & Witte, T. (2006). Warning Signs for Suicide: Theory, Research, and Clinical Applications. *Suicide and Life-Threatening behaviour*, *36*(3), 255-262. https://doi.org/10.1521/suli.2006.36.3.255

Salzberg, S. (1995). *Lovingkindness: The revolutionary art of happiness*. Shambhala.

Sarchiapone, M., Mandelli, L., Iosue, M., Andrisano, C., & Roy, A. (2011). Controlling Access to Suicide Means. *International Journal of Environmental Research and Public Health*, *8*(12), 4550–4562. https://doi.org/10.3390/ijerph8124550.

Schneider, B. H., Sanz Martinez, Y., Koller, S. H., D'Onofrio, P. A., Puricelli, D., Lalota, G., & Lu, R. (2022). Hopelessness and shame in relation to suicide attempts by Cuban adolescents. *Transcultural Psychiatry, 59*(1), 28–36. https://doi.org/10.1177/1363461520963924.

Scott, K. M., Lim, C., Al-Hamzawi, A., Alonso, J., Bruffaerts, R., Caldas-de-Almeida, J. M., Florescu, S., de Girolamo, G., Hu, C., de Jonge, P., Kawakami, N., Medina-Mora, M. E., Moskalewicz, J., Navarro-Mateu, F., O'Neill, S., Piazza, M., Posada-Villa, J., Torres, Y., & Kessler, R. C. (2016). Association of Mental Disorders With Subsequent Chronic Physical Conditions: World Mental Health Surveys From 17 Countries. *JAMA psychiatry*, *73*(2), 150–158. https://doi.org/10.1001/jamapsychiatry.2015.2688

Shah, A. (2012). Suicide rates: Age-associated trends and their correlates. *Journal of Injury and Violence Research*, *4*(2), 79–86. https://doi.org/10.5249/jivr.v4i2.101

Shako, K. (2020). Sociodemographic Factors, Culture, and Suicide in Guyana. *Walden Dissertations and Doctoral Studies*. https://scholarworks.waldenu.edu/dissertations/8650

Shaw, C., Stuart, J., Thomas, T., & Kõlves, K. (2022). Suicidal behaviour and ideation in Guyana: A systematic literature review. *The Lancet Regional Health - Americas*, *11*, 100253. https://doi.org/10.1016/j.lana.2022.100253.

Sher, L., Fisher, A. M., Kelliher, C. H., Penner, J. D., Goodman, M., & Zalsman, G. (2020). Adolescents with borderline personality disorder, a high-risk population for suicidality: A review of neurobiological and other risk factors. *Journal of Affective Disorders, 265,* 279-283.

Sher, L. (2019). Resilience as a focus of suicide research and prevention. *Acta Psychiatrica Scandinavica*, 140(3), 169–180. https://doi.org/10.1111/acps.13059.

Skewes, M. C., Gameon, J. A., Grubin, F., DeCou, C. R., & Whitcomb, L. (2022). Beliefs about causal factors for suicide in rural Alaska Native communities and recommendations for prevention. *Transcultural Psychiatry, 59*(1), 78–92. https://doi.org/10.1177/1363461520963869.

Sinyor, M., Schaffer, A., Heisel, M. J., Picard, A., Adamson, G., Cheung, C. P., ... & Sareen, J. (2017). Media guidelines for reporting on suicide: 2017 update of the Canadian Psychiatric Association policy paper. *Canadian Psychiatric Association*.

Song, Y., Rhee, S. J., Lee, H., Kim, M. J., Shin, D., & Ahn, Y. M. (2020). Comparison of Suicide Risk by Mental Illness: A Retrospective Review of 14-Year Electronic Medical Records. *Journal of Korean Medical Science*, *35*(47). https://doi.org/10.3346/jkms.2020.35.e402

Sorensen, C. C., Lien, M., Harrison, V., Donoghue, J. J., Kapur, J. S., Kim, S. H., Tran, N. T., Joshi, S. V., & Patel, S. G. (2022). The Tool for Evaluating Media Portrayals of Suicide (TEMPOS): Development and Application of a Novel Rating Scale to Reduce Suicide Contagion. *International Journal of Environmental Research and Public Health*, *19*(5), 2994. https://doi.org/10.3390/ijerph19052994.

Thompson, E., Kline, E., Reeves, G., Pitts, S. C., & Schiffman, J. (2020). Psychotic-like experiences and suicidal ideation in a community sample of adolescents. *Early Intervention in Psychiatry, 14*(1), 58-66.

Tomko, R. L., Trull, T. J., Wood, P. K., & Sher, K. J. (2020). Characteristics of borderline personality disorder in a community sample: Comorbidity, treatment utilization, and general functioning. *Journal of Abnormal Psychology, 129*(7), 739-751.

Tsai, M., & Klonsky, E. D. (2023). Warning signs for suicide attempts in psychiatric inpatients: Patient and informant perspectives. *General hospital psychiatry*, *85*, 207–212. https://doi.org/10.1016/j.genhosppsych.2023.11.005

Turner, B. J., Chapman, A. L., & Layden, B. K. (2020). Intrapersonal and interpersonal functions of non-suicidal self-injury: Associations with emotional and social functioning. *Borderline Personality Disorder and Emotion Dysregulation, 7*(1), 1-12.

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner Jr, T. E. (2010). The interpersonal theory of suicide. *Psychological Review, 117*(2), 575-600.

Vigo, D., Jones, L., Atun, R., & Thornicroft, G. (2022). The true global disease burden of mental illness: still elusive. *The Lancet. Psychiatry*, *9*(2), 98–100. https://doi.org/10.1016/S2215-0366(22)00002-5

Vigo, D., Thornicroft, G., & Atun, R. (2016). Estimating the true global burden of mental illness. *Lancet Psychiatry, 3*(2), 171-178.

Wang, X., Lu, Z., & Dong, C. (2022). Suicide resilience: A concept analysis. *Frontiers in Psychiatry*, *13*, 984922. https://doi.org/10.3389/fpsyt.2022.984922.

Weber, A. N., Michail, M., Thompson, A., & Fiedorowicz, J. G. (2017). Psychiatric Emergencies: Assessing and Managing Suicidal Ideation. *The Medical Clinics of North America*, *101*(3), 553. https://doi.org/10.1016/j.mcna.2016.12.006

Wexler, L., Chandler, M., Gone, J. P., Cwik, M., Kirmayer, L. J., LaFromboise, T., Brockie, T., O'Keefe, V., Walkup, J., & Allen, J. (2015). Advancing suicide prevention research with rural American Indian and Alaska Native populations. *American Journal of Public Health, 105*(5), 891–899. https://doi.org/10.2105/AJPH.2014.302517.

Wilcox, H. C., Kuramoto, S. J., Lichtenstein, P., Långström, N., Brent, D. A., & Runeson, B. (2010). Psychiatric morbidity, violent crime, and suicide among children and adolescents exposed to parental death. *Journal of the American Academy of Child and Adolescent Psychiatry*, *49*(5), 514–523; quiz 530. https://doi.org/10.1097/00004583-201005000-00012.

World Health Organization. (2017). *Preventing Suicide: A Resource for Media Professionals* (Update 2023). World Health Organization.

Yuodelis-Flores, C., & Ries, R. K. (2015). Addiction and suicide: A review. *American Journal on Addictions, 24*(2), 98-104.

Zheng, Y., Molassiotis, A., Tyrovolas, S., & Yip, P. S. F. (2022). Epidemiological changes, demographic drivers, and global years of life lost from suicide over the period 1990-2019. *Suicide & Life-Threatening Behaviour*, *52*(3), 439–451. https://doi.org/10.1111/sltb.12836z

Resources

Literature

Books

Don't F*cking Kill Yourself: A Memoir of Suicide, Survival, and Stories That Keep Us Alive - Jeff Romig, 2021

In Don't F*cking Kill Yourself, Jeff Romig details his own battles against anxiety, depression, and suicidal ideation while sharing his stories about the people, passions, and experiences that have kept him alive through mental illness, divorce, alcoholism, cancer, and the legacy of his father's Suicide. This book shares two potentially life-saving ideas: 1) that we can reduce the stigma around suicidal ideation by sharing our stories and 2) that we can push through our darkest moments of suicidal thoughts by connecting our minds with the passions, people, and experiences that define the best parts of our lives.

Reasons to Stay Alive - Matt Haig, 2016

Reasons to Stay Alive is an inspiring account of how, minute by minute, Haig overcame the disease of depression with the help of reading, writing, and the support of his loved ones. And eventually, he learned to appreciate life all the more for it.

The Noonday Demon: An Atlas of Depression - Andrew Solomon, 2015The Noonday Demon examines depression in personal, cultural, and scientific terms. Drawing on his own struggles with the illness and interviews with fellow sufferers, doctors and scientists, policymakers and politicians, drug designers and philosophers, Solomon reveals the subtle complexities and sheer agony of the disease. He confronts the challenge of defining the illness and describes the vast range of available medications, the efficacy of alternative treatments, and the impact depression has had on various demographic populations around the world and throughout history.

Suicide Notes - Michael Thomas Ford, 2019

Suicide Notes is a darkly humorous novel from award-winning author Michael Thomas Ford that examines that fuzzy line between "normal" and the rest of us. It examines mental health and suicide.

Toolkits and Handbooks

Transforming communities: Key elements for the implementation of comprehensive community-based suicide prevention. National Action Alliance for Suicide Prevention (2017)

National Action Alliance is a US-based organization to enhance suicide prevention. This resource is a useful tool for policymakers as it presents seven key elements for comprehensive community-based suicide prevention, all aimed at helping communities create policies, programs, and services that reduce suicide and improve individual, family, and community health.
https://theactionalliance.org/resource/transforming-communities-key-elements-implementation-comprehensive-community-based-suicide

Practice Guideline for the Assessment and Treatment of Patients With Suicidal behaviours. American Psychiatric Association. (2006)

This APA publication provides an overview and guidelines based on the current scientific literature on suicide prevention, assessment, and treatment. Part A outlines assessment, treatment, and risk management recommendations. Part B outlines background information and a review of the available evidence. Part C outlines where future research should be directed.
https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/suicide.pdf

CAMH suicide prevention and assessment handbook. Centre For Addiction and Mental Health (2011).

The Centre for Addiction and Mental Health is a mental health hospital located in Toronto, Canada. This handbook provides healthcare personnel some tools and guidelines in suicide prevention and assessment. It provides key clinical information, current CAMH tools and resources, and further population-specific resources.
http://www.antoniocasella.eu/salute/CAMH_2011.pdf

Suicide Prevention Resource for Action. Centers For Disease Control and Prevention (CDC, 2022).

The CDC's Suicide Prevention Resource for Action (Prevention Resource) details the strategies with the best available evidence to reduce suicide. The Prevention Resource can help states and communities prioritize suicide prevention activities most likely to have an impact. The programs, practices, and policies in the Prevention Resource can be tailored to the needs of populations and communities.
https://www.cdc.gov/suicide/resources/prevention.html

Suicide Prevention: The Family & Youth Institure Community Action Guide. The Family & Youth Institute.

This Community Action Guide provides stories from survivors, guidelines for community leaders, and information regarding suicide. It can be a helpful resource for Gatekeepers, community leaders, policy-makers, or anyone struggling with suicidal thoughts or mental health issues.
https://thefyi.org/suicide-prevention-community-guide/

IASP Policy Position on National Suicide Prevention Strategies. International Association for Suicide Prevention. (2023)

The IASP puts forth a policy position recommending that every country should adopt, or make progress towards the adoption of a national suicide prevention strategy aimed at reducing rates of suicidal behaviour.
https://www.iasp.info/2023/10/06/iasp-policy-position-on-national-suicide-prevention-strategies/

Suicide Postvention Resources for Canadian Communities. Mental Health Commission of Canada. (2017)

The Mental Health Commission of Canada puts forth this document of a collection of resources in Canada for postvention (people affected by suicide after a suicide behaviour, whether it is bereavement or someone who has made an attempt).
https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2021-01/Postvention_Catalogue_eng.pdf

Multimedia

Websites about Suicide Support

Suicide Prevention Resource Centre
This U.S. Funded Organization advances the U.S. national strategy for suicide prevention. It contains many resources regarding information about suicide, suicide risk, warning signs, and suicide prevention strategies.
https://sprc.org/

National Action Alliance for Suicide prevention
This U.S. organization advances the U.S. national strategy for suicide prevention. It contains resources on suicide prevention strategies, stories from those with lived experience, and advocacy.
https://theactionalliance.org/,

The Zero Suicide Tool Kit
Zero Suicide, is a revolutionary approach aimed at health and behavioural health care systems, grounded in the principle that suicides among those receiving care can be prevented. It offers both an ideal goal of eliminating suicide deaths and a practical strategy for achieving systemic changes to enhance the safety and care for individuals at risk of suicide.
http://zerosuicide.sprc.org/toolkit

Guyanese helplines
Consult this ist of helplines for various services and aid, including the Suicide Prevention Help Line (592) 600-7896.
https://findahelpline.com/countries/gy

Websites For Survivors of Suicide who have Lost Loved Ones to Suicide

Alliance of Hope

This organization helps survivors who have lost loved ones to suicide. It provides worldwide support in an online forum, virtual consultations, and grieving programs.https://allianceofhope.org/

Friends for Survival

This organization provides suicide bereavement support and offers virtual meetings for those who have lost a loved one to suicide.
https://friendsforsurvival.org/

After A Suicide Resource Directory: Coping with Grief, Trauma, and Distress

This is an online directory of suicide bereavement resources, including other websites, books, and services.
http://www.personalgriefcoach.net/

Stories from Survivors - Live Through This

This online Catalogue of stories from Suicide Attempt survivor is curated by an organization whose mission is to change public attitudes about suicide.
https://livethroughthis.org/

Suicide Risk Reduction Project

The Pew Charitable Trusts' suicide risk reduction project aims to make suicide risk assessment and care a part of routine health care in the U.S. and to fill gaps between people at risk of suicide and the care they need by empowering hospitals and health systems to expand the use of evidence-based screening and interventions.
https://www.pewtrusts.org/en/projects/suicide-risk-reduction-project

Suicide Prevention Program: Western Michigan University

This website from Western Michigan University's Campuswide Suicide Prevention Program offers useful information about suicide and as how one can may be able to prevent suicide.
https://wmich.edu/suicideprevention

American Foundation for Suicide Prevention (AFSP)

Established in 1987, AFSP offers valuable resources to all those affected by suicide.
https://afsp.org/

Jack.org

Jack.org is a Canadian organization which trains and empowers young leaders to revolutionize mental health through Jack Chapters and Jack Summits throughout Canada. The website offers a wide variety of mental health resources.
https://jack.org/Home

Kids Help Phone:

Kids Help Phone is Canada's only 24/7 e-mental health service, which offers free, multilingual and confidential support to young people.
https://kidshelpphone.ca/ 1-866-668-6868 Text 686868

Naseeha
Naseeha, a Canadian organization, provides confidential mental health support over the phone and chat from 12 pm - 3 am. It also offers educational programs to raise awareness against stigma towards mental illness.
https://naseeha.org/
1-866-627-3342

YouTube Clips

Movies and tv clips can be helpful resources to explore how common people work effectively to help someone who is suicidal.

Survivors Talking about their Suicide Attempts
https://www.youtube.com/watch?v=BW_FcyqQPb4

Video about How to help someone with suicidal thoughts
https://www.youtube.com/watch?v=B7dKgg4Z9tg

Role-Play on Assessing Suicidal Ideation
https://www.youtube.com/watch?v=Na3YzSE0XoI

Real Suicide Hotline conversation
https://www.youtube.com/watch?v=tBcOSo6A__k

Survivor's story about calling a helpline
https://www.youtube.com/watch?v=Va85sL3BLT8

Survivors Go through Myths and Facts about Suicide
https://www.youtube.com/watch?v=ppSAlO9pmPA

TEDTalks: On Suicide or Related Topics

Kevin Briggs - The Bridge Between Suicide and Life
Kevin Briggs worked patrolling the southern end of the San Fransisco's Golden Gate bridge, a popular site for suicide attempts. He shares stories of talking to people who were contemplating suicide and provides advice to those with loved ones struggling with suicidal thoughts.
https://www.ted.com/talks/kevin_briggs_the_bridge_between_suicide_and_life?referrer=playlist-let_s_end_the_silence_around_s&autoplay=true

JD Schramm - Break the Silence for Suicide Attempt Survivors
Schramm encourages everyone to speak out and tell someone how you are feeling. Often survivors have unshared pain that is buried deep within. This hidden pain can often lead to a suicide. attempt.
https://www.ted.com/talks/jd_schramm_break_the_silence_for_suicide_attempt_survivors?referrer=playlist-let_s_end_the_silence_around_s&autoplay=true

Gus Worland - Is Someone You Love Suffering in Silence?
Worland is a mental health advocate. He shares how a grieving experience of his own sparked his advocacy for suicide prevention. He shares how you can take simple steps to helping your community and how a little goes a long way.
https://www.ted.com/talks/gus_worland_is_someone_you_love_suffering_in_silence_here_s_what_to_do

Andrew Solomon - Depression: The Secret We Share
Solomon shares stories of his darkest moments when he battled depression. He shares his experience talking with hundreds of others with depression and how they wanted to share their stories as well.
https://www.ted.com/talks/andrew_solomon_depression_the_secret_we_share

Podcasts

There are many podcasts online that feature experts discussing suicide in accessible language and sharing suicide survival stories.

Podcast on Suicide by the creators of *Live Through This* website
Podcast episodes explore suicide with experts and people with lived experiences.
https://suicide-n-stuff.com/

Before you kill yourself: a suicide prevention podcast
Leo Flowers interviews other mental health experts, comedians and best-selling book authors as they destigmatize mental health and teach you how to thrive
https://www.leoflowers.com/podcast

Understanding Suicide
This podcast interviews specialists, survivors, and individuals who have a story to tell. Themes include: grief, warning signs, risk factors, contagion, youth, and most importantly, what can be done to prevent suicide.
https://www.understandsuicide.com/

Suicide Survival Stories
This podcast gives a voice to suicide survivors. Episodes outline their stories and lived experience.
https://open.spotify.com/show/2PUW4UcFuEL32Wnnnpmpak
https://www.suicidesurvivalstories.org/

The Suicide Cultures Podcast
This podcast opens up a space to talk about suicide in diverse ways. In each episode, hosts talk to a special guest with a link to or expertise in suicide, as well as draw on their own experiences of researching this issue in a range of different communities across Scotland.
https://blogs.ed.ac.uk/suicide-cultures/suicide-cultures-podcast/

Thoughts of Suicide
Through conversations about suicide, the goal is to stop the stigma and provide support.
https://open.spotify.com/show/6wo43aRxOYJdr9G8BH51kO

Appendices

Appendix 1: Standardized Assessment Tools

Demogaphic and Pesonal Information

Date of Form Completion: _____

(When was form completed? Alternatively, today's date):

Full Name: _____ Date of Birth:_____

Sex: ☐ Male ☐ Female ☐ Gender (if different from sex):_____

Ethnicity

☐ Indo-Guyanese ☐ Afro-Guyanese ☐ Amerindian/Native American

☐ European ☐ Portuguese ☐ Chinese

☐ Other

Occupation: _____ **Occupation Sector:** _____

Education Completed

☐ Primary School Secondary School
☐ Vocational/Technical Institute
☐ University

Please select the Region you reside in

☐ Region 1 - Barima-Waini
☐ Region 2 - Pomeroon-Supenaam
☐ Region 3 - Essequibo Islands-West Demerara
☐ Region 4 - Demerara-Mahaica
☐ Region 5 - Mahaica-Berbice
☐ Region 6 - East Berbice-Corentyne
☐ Region 7 - Cuyuni-Mazaruni
☐ Region 8 - Potaro-Siparuni
☐ Region 9 - Upper Takutu-Upper Essequibo
☐ Region 10 - Upper Demerara-Berbice

Beck's Suicide Intent Scale

The Beck Suicide Intent Scale (BSSI) is a proprietary and copyrighted assessment instrument. The content provided here offers only a general overview of its items for educational purposes. To administer BSSI, please obtain and use an original, legally purchased copy in accordance with copyright laws.

#	STATEMENTS	0	1	2
1	Isolation	Someone present	Someone nearby or in contact	No one nearby or in contact
2	Timing	Intervention probable	Intervention not likely	Intervention highly unlikely
3	Safeguards	No precautions	Passive precautions	Active precautions (locked door)
4	Actions to Get Help	Notified helper about attempt	Contacted but didn't notify	Didn't contact or notify
5	Specific Date	None	Thought about arrangements	Made definite plans
6	Preparations	None	Minimal to moderate	Extensive
7	Suicide Note	Absent	Note written but torn up	Present
8	Expressed Verbally	None	Equivocal communication	Unequivocal communication
9	Purpose	Manipulate, get attention	Components of "0" and "2"	To escape, solve problems
10	Expectations	Death was unlikely	Death was possible, not probable	Death was probable or certain
11	Method	Less than lethal thought	Unsure of lethality	Exceeded lethal thought
12	Severity	Did not seriously attempt	Uncertain about seriousness	Seriously attempted
13	Reasons for Living	Did not want to die	Mixed feelings	Wanted to die
14	Attempt to Get Medical Attention	Unlikely to die if aided	Uncertain of medical outcome	Certain of death even if aided
15	Premeditation	Impulsive	Contemplated < 3 hours	Contemplated > 3 hours
16	Reaction to Attempt	Regrets attempt	Accepts attempt and failure	Regrets failure
17	Visualization of Death	Life-after-death	Never-ending sleep	No thoughts about death
18	Number of Previous Attempts	None	One or two	Three or more
19	Alcohol Usage	Some intake, not related	Enough to impair judgment	Intentional to facilitate attempt
20	Drug Usage	Some intake, not related	Enough to impair judgment	Intentional to facilitate attempt

Name: _____ _____ **Date Completed:** _____

_____**Scoring: 0 to 10** = Low Risk; **11 to 19** = Medium Risk **20 to 30** = High Risk

Columbia Suicide Severity Rating Scale (C-SSRS) - Columbia Protocol

Date of Form Completion: _____

Full Name: _____ Date of Birth:_____

I. In the past month, have you wished you were dead or wished you could go to sleep and not wake up?

☐ Yes ☐ No

CSSRS 1 Notes: _____

2. Have you actually had any thoughts about killing yourself?

☐ Yes ☐ No

CSSRS 2 Notes: _____

3. Have you been thinking about how you might do this?

☐ Yes ☐ No

CSSRS 3 Notes: _____

___

4. Have you had these thoughts and had some intention of acting on them?

☐ Yes ☐ No

CSSRS 4 Notes: _____

5. Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?

☐ Yes ☐ No

CSSRS 5Notes: _____

6. Have you done anything, started to do anything, or prepared to do anything to end your life? (e.g collect pills, obtain a gun, give away valuables, wrote a suicide note)

☐ Yes ☐ No

CSSRS 6 Notes: _____

Please note timing of any preparatory acts (in the past 3 months?)

_____

_____

_____

C-SSRS Scoring and Interpretation:

Basic Clinical Scoring Guide for the C-SSRS Ideation Severity Subscale

SUBSCALE	SCORING & INTERPRETATION
Ideation Presence	· Score yes/no for presence of any suicidal ideation · Questions 1 & 2 are screening; if both "no", skip to "Suicidal Behaviour" section
Ideation Severity	· The most severe type of ideation (1-5) endorsed becomes the score
Optional Description	· “If yes, please describe” for notes

Intensity of Ideation Subscale (Referring to the most severe ideation)

INTENSITY ITEMS	SCORING & INTERPRETATION
Frequency, Duration, Controllability, Deterrents, Reasons for Ideation	· Add the highest numbers endorsed - Score range: 2 to 25
Overall Intensity Score	· Assign 0 or N/A if no ideation on Severity Subscale- No “cut off” score; used to inform clinical judgment and assess change

Risk Ratios Based on Intensity Score

INTENSITY SCORE RANGE	RISK RATIO OF SUICIDE BEHAVIOUR
Moderate (6-10)	11x increased risk
Mod. Severe (11-15)	13x increased risk
Severe (16-20)	Very Severe (21-25)
Very Severe (21-25)	34x increased risk

\

Alcohol Screening Tool (AUDIT)

Date of Form Completion: _____

Full Name: _____ Date of Birth:_____

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks".

This is one unit of alcohol: Half a pint of regular beer or lager or cider. 1 small glass of wine. 1 single measure of spirits. 1 small glass of sherry. 1 single measure of aperitif

These are more than one unit of alcohol: Pint of regular beer/lager/cider. Pint of premium beer/lager/cider. Alcopop or can/bottle or regular lager. Can of premium lager or strong beer. Can of super-strength lager. Glass of wine (175ml). Bottle of wine.

1. How often do you have a drink containing alcohol?

☐ Never ☐ Monthly ☐ 2-4 times per month ☐ 2-3 times per week ☐ 4+ times per week

2. How many units/drinks of alcohol do you drink on a typical day when you are drinking?

☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10+

3. How often do you have 6 or more drinks in one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

5. How often in the last year have you failed to do what was normally expected from you because of your drinking?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because of your drinking?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

9. Have you or somebody else been injured because of your drinking?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

AUDIT Scoring and Interpretation Table:

Scoring the AUDIT

- The columns in the AUDIT are scored from left to right.
- Questions 1 to 8 are scored on a five-point scale from 0, 1, 2, 3, and 4.
- Questions 9 & 10 are scored on a three -point scale from 0, 2 and 4.
- Record the score for each question in the "score" column on the right, including a zero for questions 2 to 8 if 'skipped'.
- Record a total score in the "TOTAL" box at the bottom of the column. The maximum score is 40.

Consumption score

- Add up questions 1 to 3 and place this sub-score in the adjacent single box in the far right column (maximum score possible = 12). A score of 6 or 7 may indicate a risk of alcohol-related harm, even if this is also the total score for the AUDIT (e.g. consumption could be over the recommended weekly intake of 28 for men and 14 for females in the absence of scoring on any other questions).
- Scores of 6 to 7 may also indicate potential harm for those groups more susceptible to the effects of alcohol, such as young people, women, the elderly, people with mental health problems and people on medication. Further inquiry may reveal the necessity for harm reduction advice.

Dependence score

- Add up questions 4 to 6 and place this sub-score in the adjacent single box in the far right column (maximum score possible = 12). In addition to the total AUDIT score, a secondary 'dependence' score of 4 or more as a subtotal of questions 4 to 6, suggests the possibility of alcohol dependence (and therefore the need for more intensive intervention if further assessment confirms dependence).

Alcohol-related problems score

Any scoring on questions 7 to 10 warrants further investigation to determine whether the problem is of current concern and requires intervention.

AUDIT Alcohol Screening Tool Scoring and Interpretation Table

SCORE	LEVEL OF RISK	INDICATED ACTION
0 - 7	Low Risk	Alcohol education
8 - 15	Risky or Hazardous	Simple advice on reducing drinking
16 - 19	High Risk	Simple advice plus brief counseling and continued monitoring
20 - 40	Possible Dependence	Referral to specialist for diagnostic evaluation and treatment

Note: The above scores and actions are indicative. Gatekeepers may adapt actions based on the situation/context.

Drug Screening Questionnaire (DAST)

Date of Form Completion: _____

Full Name: _____ Date of Birth:_____

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Which of the following drugs have you used in the past year? (Select all that apply.)
Methamphetamines (speed, crystal)

☐ Cannabis (marijuana, pot)
☐ Inhalants (paint thinner, aerosol, glue)
☐ Tranquilizers (Valium)
☐ Cocaine
☐ Narcotics (Heroin, oxycodone, methadone, etc.)
☐ Hallucinogens (LSD, mushrooms)
☐ Other (please list below

1. How often have you used these drugs?
☐ Monthly or less ☐ Weekly ☐ Daily or almost daily

2. Have you used drugs other than those required for medical reasons? ☐ No ☐ Yes

3. Do you abuse more than one drug at a time? ☐ No ☐ Yes

4. Are you always able to stop using drugs when you want to? ☐ No ☐ Yes

5. Have you ever had a blackout or flashbacks from drug use? ☐ No ☐ Yes

6. Do you ever feel bad or guilty about your drug use? ☐ No ☐ Yes

7. Does your spouse (or parents) ever complain about your involvement with drugs? ☐ No ☐ Yes

8. Have you neglected your family because of your use of drugs? ☐ No ☐ Yes

9. Have you engaged in illegal activities to obtain drugs? ☐ No ☐ Yes

10. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?
☐ No ☐ Yes

DAST Scoring and Interpretation Table:

SCORE	ZONE OF USE	INDICATED ACTION
0	I – No Risk	None
1 - 2 **(Meeting Specific Criteria)**	II – Risky	Offer brief education on the benefits of abstaining from drug use. Monitor at future visits.
1 - 2 **(Without Meeting Criteria)**		Brief intervention
3 - 5	III – Harmful	Risk of health problems related to drug use and a possible mild or moderate substance use disorder. Brief intervention.
6+	IV – Severe	Risk of health problems related to drug use and a possible moderate or severe substance use disorder. Brief intervention (offer options that include treatment).

Patient Health Questionnaire (PHQ-9)

Date of Form Completion: _____

Full Name: _____ Date of Birth:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

0 = Not at all 1 = Several Days 2 = More than Half the Days 3 = Nearly Every Day

1. Little interest or pleasure in doing things

☐0 ☐1 ☐2 ☐3

2. Feeling down, depressed, or hopeless

☐0 ☐1 ☐2 ☐3

3. Trouble falling or staying asleep, or sleeping too much

☐0 ☐1 ☐2 ☐3

4. Feeling tired or having little energy

☐0 ☐1 ☐2 ☐3

5. Poor appetite or overeating

☐0 ☐1 ☐2 ☐3

6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down

☐0 ☐1 ☐2 ☐3

7. Trouble concentrating on things, such as reading the newspaper or watching television

☐0 ☐1 ☐2 ☐3

8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual

☐0 ☐1 ☐2 ☐3

9. Thoughts that you would be better of dead or of hurting yourself in some way

☐0 ☐1 ☐2 ☐3

PHQ-9 Scoring and Interpretaion Table

PHQ-9 SCORE	LEVEL	PROPOSED ACTIONS
0 – 4	None-minimal	No action required
5 – 9	Mild	Monitoring and watchful waiting
10 – 14	Moderate	Consider mental health support, such as counselling or referral to a mental health professional
15 – 19	Moderately Severe	Engage in psychotherapy, counselling, and/or consider pharmacotherapy
20 – 27	Severe	Immediate initiation of pharmacotherapy and/or psychotherapy and counselling

Generalized Anxiety Disorder (GAD-7)

Please read each statement and record a number 0,1, 2, or 3 which indicates how much the statement applied to you over the past two weeks. There are no right or wrong answers. Do not spend too much time on any one statement. This assessment is not intended to be a diagnosis. If you are concerned about your results in any way, please speak with a qualified health professional.

0 = Not at all 1 = Several Days 2 = More than Half the Days 3 = Nearly Every Day

1. Feeling nervous, anxious or on edge

☐0 ☐1 ☐2 ☐3

2. Not being able to stop or control worrying

☐0 ☐1 ☐2 ☐3

3. Worrying too much about different things

☐0 ☐1 ☐2 ☐3

4. Trouble relaxing

☐0 ☐1 ☐2 ☐3

5. Being so restless that it is hard to sit still

☐0 ☐1 ☐2 ☐3

6. Becoming easily annoyed or irritable

☐0 ☐1 ☐2 ☐3

7. Feeling afraid as if something awful might happen

☐0 ☐1 ☐2 ☐3

GAD-7 Scoring and Interpretation Table

GAD-7 SCORE	ANXIETY LEVEL	SUGGESTED ACTIONS
0 – 4	None to Minimal	Usually none; routine clinical care
5 – 9	Mild	Watchful waiting; repeat assessment as clinically indicated
10 – 14	Moderate	Active treatment with psychotherapy, pharmacotherapy, or both
15 – 21	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or distress is present, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

Self-Stigma Against Seeking Help for Suicidal Ideation Scale (SASSHIS)

#	STATEMENT	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
1	Getting help would show I'm brave, not weak.	1	2	3	4	5
2	If I talk to someone about wanting to end my life, it means I'm serious about finding help.	1	2	3	4	5
3	Seeking help would make me appear less intelligent.	5	4	3	2	1
4	Seeing a mental health professional (e.g., therapist or counsellor) is a good idea if I'm thinking about suicide.	1	2	3	4	5
5	It's okay to need support from others when things get really tough.	1	2	3	4	5
6	Asking for help is a smart move, not a sign of failure.	1	2	3	4	5
7	I would still be proud of myself if I got help for my suicidal thoughts.	1	2	3	4	5
8	Talking to a professional means I'm crazy or losing my mind.	5	4	3	2	1
9	I am showing strength when I fight for my life by seeking help, not weakness..	1	2	3	4	5
10	My family and friends would think I'm doing the right thing by getting help.	1	2	3	4	5

SASSHIS Scoring and Interpretation:

TOTAL SCORE RANGE	LEVEL OF SELF-STIGMA	INTERPRETATION	SUGGESTED ACTIONS
10-20	Very Low	Feels okay about seeking help.	Encourage to maintain open communication and seek help when needed.
21-30	Low	Some hesitation but generally open.	Discuss the importance of help-seeking and provide mental health resources.
31-40	Moderate	Mixed feelings about getting help.	Engage in conversations to dispel myths about mental health and promote support-seeking.
41-50	High	Significant concerns about seeking help.	Intervention through counselling to address self-stigma and emphasize the importance of mental health.
51-60	Very High	Strong negative feelings towards seeking help.	Consider crisis intervention and provide immediate support and resources.

Screening Tools: At a Glance Summary with Scoring Ranges

CATEGORY	C-SSRS (SUICIDAL IDEATION)	PHQ-9 (DEPRESSION)	GAD-7 (ANXIETY)	AUDIT (ALCOHOL USE)	DAST (DRUG USE)
None to Minimal	0 (No ideation)	0-4 (None-minimal symptoms)	0-4 (Minimal anxiety)	0-7 (Low-risk drinking)	0 (No reported drug use)
Mild	1-2 (Ideation without intent)	5-9 (Mild symptoms)	5-9 (Mild anxiety)	8-15 (Moderate drinking)	1-2 (Low level of problems)
Moderate	3-4 (Some plan formation)	10-14 (Moderate symptoms)	10-14 (Moderate anxiety)	16-19 (Hazardous drinking)	3-5 (Moderate level of problems)
Severe	5 (Active suicidal planning)	15-19 (Moderately severe symptoms)	15-21 (Severe anxiety)	20-27 (High-risk drinking)	6-8 (Substantial drug abuse issues)
Extreme / Very Severe	Not applicable (extreme risk typically not scored)	20-27 (Severe symptoms)	Not applicable (scale only to 21)	28-40 (Possible dependence)	9+ (Severe drug dependence issues)

Appendix 2 : A Comprehensive Summary & Protective Factors

A risk factor is an aspect of personal behaviour or lifestyle, an environmental exposure, or an inborn or inherited characteristic that is associated with an increased occurrence of death by suicide. People possessing the risk factor are considered to be at greater potential for suicidal behaviour. Risk factors are not predictors or causes of suicide (Rimkeviciene et a., 2015). Helping a person in a suicidal crisis involves understanding risk factors and warning signs. In the context of suicidal behaviour, a risk factor refers to any characteristic, condition, or situation that increases the likelihood of a person attempting or committing suicide. Risk factors are indicative of whether an individual, a community or a population is particularly vulnerable to suicide.

Risk & Protective Factors: A Global Perspective

Individual Risk Factors

Previous Suicide Attempt: Previous attempts significantly increase the risk of future attempts (Beghi, et al., 2013; Lin et al., 2022).

History of Mental Illnesses: This includes depression and other disorders that elevate risk (Bradvik, 2018).

Serious Illness: Chronic pain and other severe conditions contribute to risk. (Nafilyan et al., 2023)

Criminal/Legal Problems: Legal issues can increase stress and vulnerability (Fazel et al., 2017).

Job/Financial Problems: Economic stress is a known risk factor (Mathieu et al., 2022).

Impulsive/Aggressive Tendencies: These tendencies can lead to suicidal behaviours in stressful situations.(Brokke et al., 2022).

Substance Misuse: Substance abuse aggravates risk and may impair judgment (Rizk et al., 2021).

Adverse Childhood Experiences: Prior trauma can have long-term impacts on mental health (Cleare et al., 2018).

Sense of Hopelessness: A strong predictor of suicidal ideation is a sense of hopelessness (Chen & Li, 2023; Franklin et al., 2017).

Violence Victimization/Perpetration: Exposure to violence can increase suicide risk (Fazel et al., 2017).

Relational or Interpersonal Risk Factors

Bullying: The experience of bullying can lead to isolation and depression. It impacts suicidal ideation and attempts (Holt et al., 2015).
Family History of Suicide: Genetic and environmental influences may play a role. (Edwards et al., 2021; Qin et al., 2002)

Loss of Relationships: Breakdown of significant relationships can lead to despair (Thornton et al., 2019).

High Conflict/Violent Relationships: Intimate relationship problems precipitate suicide (Brown and Seals, 2019).

Social Isolation: Lack of social support can lead to loneliness and depression (Motillon-Toudic et al., 2022).

Communal/Community Risk Factors

Lack of Healthcare Access: Lack of access can prevent individuals from receiving needed help (Ku et al., 2021).

Suicide Cluster in Community: When suicide is common in a community, this may normalize suicide or desensitize suicide risks (Hill & Robinson, 2022).

Acculturation Stress: Cultural adjustment can be stressful and isolating (Kastelvi et al., 2016).

Community Violence: Exposure to violence can lead to trauma (Ehlers et al., 2022).

Historical Trauma: Collective historical experiences can affect current risk (Coimbra et al., 2022).

Societal Risk Factors

Stigma of Help-Seeking: Stigma may prevent people from seeking necessary help (Kearns et al., 2015; Reynders et al., 2015).

Access to Lethal Means: Access to lethal means increases the likelihood that attempts will be fatal (Barber & Miller, 2014; Sarchiapone et al., 2011).

Unsafe Media Portrayals: The media can glamorize or normalize suicide, leading to increased risk (Niederkrotenthaler et al., 2012; Sorensen et al., 2022).

Protective Factors

Gender: Females account for a much lower proportion of suicide deaths, but this protective factor reverses when examining suicidal attempts and ideation, where females account for more of these behaviours (Barrigon & Cegla-Schvartzman, 2020). Although being female can protect against death by suicide, it is a risk factor for non-lethal suicide behaviours.

Education: Higher education levels can offer better coping mechanisms, social support, and access to mental health resources, reducing suicide risk. Higher educational attainment has been causally linked to lower suicide attempts (Rosoff et al., 2020).

Coping/Problem-Solving Skills: Learning stress and adversity management skills can help people cope (Larasati et al., 2021).

Reasons for Living: Having more reasons to live can protect against suicidal ideation. These reasons for living can include family, friends, pets, and responsibilities and can provide a sense of joy and purpose. (Christensen et al., 2020; Edelstein et al., 2009).

Cultural Identity: A strong sense of belonging enhances resilience. A strong sense of cultural identity has been linked to better well-being and lower levels of mental health issues (Kent & Bhui, 2003; Sirin & Gupta, 2012).

Connectedness and Support from Others: Emotional support helps to counter feelings of isolation. Strong relationships act as a support network during crises. Strong familial and peer support has been associated with lower levels of suicidal ideation and depression (Harris & Molock, 2010; Sharaf et al., 2009). Family support has also been shown to play a large role in the relationship between loneliness and suicide (Chang et al., 2017).

Connection to Institutions: Schools and community groups offer a sense of belonging. Involvement in extracurricular activities agave been associated with lower levels of suicidal ideation (Armstrong & Manion, 2013; Boone et al., 2023).

Quality Healthcare: Good healthcare access helps to mitigate risk factors. (Ku et al., 2021).

Reduced Access to Lethal Means: Limiting access to lethal means can prevent fatal impulsive acts. (Boggs et al., 2020; Barber & Miller, 2014).

Cultural/Religious Objections: Certain beliefs discourage suicide, acting as a deterrent (Lawrence et al., 2016).

Risk & Protective Factors: A Guyana Perspective

We found two studies which explored risk and protective factors related to Guyanese individuals. Pelzer and Pengpid (2022) sampled 2,662 Guyanease adults, ages 18-69 years, (females 60%; East Indian 42.3%; median age 37.4 years). They identified ethnic background, childhood and adult abuse, exposure to violence, family history of suicide attempts, and health conditions. Thornton, Asnabe and Denton (2017) explored the suicidal ideation and previous attempts of suicide among 184 youth, aged 11-21, separated from biological parents at the time of assessment, in South Africa and Guyana. This study identified somatization, psychological pain or hopelessness, feeling disconnected and absence of community support as risk factors. We have listed below the risk factors, specifically identified for Guyanease context.

Individual Risk Factors

Somatization: Sometimes individuals especially adolescents are unable to articulate their psychological stress and pain in words due to stigma and lack of self-awareness. They describe their psychological distress, through physical symptoms that have no medical basis. This tendency is known as somatization. Somatization was found to be significantly associated with suicidal ideation among Guyanese adolescents. Hence, attention must be paid to psychosomatic symptoms is important in assessing suicide risk.

Psychological Pain and Hopelessness: Guyanese adolescents who are orphans or separated from their biological parents showed a higher likelihood of suicidal behaviour. This risk factor, along with other symptoms of depression, makes adults vulnerable to suicide as well.

Ethnic Background: Certain ethnic groups such as Indo Guynese males were found to have higher vulnerability due to various socio-cultural or genetic factors. Mixed-ethnicities had the highest risk.

Interpersonal or Relational Risk Factors

Family History of Suicide Attempts: Knowledge of or direct exposure to a family member who attempted or completed suicide, posed a significant risk for suicidal behaviour
Childhood Abuse: Experience of childhood abuse (physical and/or sexual) tend to produce long-term psychological trauma, affecting mental health and increases suicide risk.

Adult Abuse: Experiences of abuse in adulthood, especially among females, can contribute to mental health disorders and a sense of hopelessness, increasing suicide risk.

Absence of Communication and Social Support: The lack of open communication about thoughts of suicide, distress, and hopelessness, especially among vulnerable youth who are orphan or are separated from their biological parents

Communal or Community Risk Factors

Social Stress: Those who endorsed suicidal ideation, also reported social stress which included troubled interpersonal relationship as well as lack of support especially during times when one needs it.

Exposure to Violence: Exposure to violence was also found to be a potent risk factor. This exposure included violence witnessed in person or exposure by secondary means, including media. Exposure to violence was also found a contributing factor to trauma and together, these two increase the likelihood of suicidal behaviour.

Feeling Disconnected: Feelings of being disconnected and not fitting in, along with perceived personal failure and associated shame were found to be risk factors. Feeling disconnected from communal resources, or feeling that one did not having these resource in the first place was found to be associated with higher suicidal risk.

Societal Risk Factors

Health Conditions: Cardiovascular disorders can be linked to depression and a decreased quality of life, potentially increasing suicide risk.

Key Protective Factors:

Gender: Being female protects against death from suicide in Guyana, as approximately 80% are completed by males (Shako, 2020, Shaw et al., 2023). Although being female protects from death by suicide, suicidal ideation is higher in females (Pelzer & Pengpid, 2022).

Education: Higher education levels can offer better coping mechanisms, social support, and access to mental health resources, reducing suicide risk. Education levels have been directly associated with lower levels of suicidal behaviour in Guyana (Pelzer & Pengpid, 2022).

Positive Social Support: Social support serves as a protective factor against suicide among youth (Arora et al., 2020; Pelzer & Pengpid, 2022).

Community Involvement: Involvement in community activities is noted as a protective factor in Guyana (Arora et al., 2020).

In a training session, 82 participants were asked to rank the most common signs of suicide risk using an app. They focused on what's happening in their community (Region 6, Berbice, known for high rates of suicide in Guyana). Here's the list they put together, starting with what they see as the most significant concern:

1. Alcohol and Drug Abuse
2. Past Suicide Attempts
3. Feeling Hopeless
4. Big Changes in Life
5. Going Through Trauma
6. Being Bullied or Discriminated Against
7. Having Ongoing Legal or Criminal Issues
8. Being Impulsive or Aggressive
9. Mental Health Issues
10. Ongoing Physical Health Issues

This ranking shows the community's main risks and can help guide support and prevention efforts in the area.

Appendix 3 : Sample Scenarios

Each Gatekeeper training cohort is divided into several groups for activities. For the most important activity, Role Play of 5-Step Model (Module 3), groups are formed based on geographical regional affinity. Each group is asked to give themselves a name which represents their region's culture. The following are three narratives created by a Gatekeeper Cohort.

Shanta – Created by Gatekeeper Training Group Breadbasket

Shanta is a 15-year-old girl with Amerindian and Indo-Guyanese roots, standing alone on a bridge, scared and confused. She's just found out she will have a baby and doesn't know what to do. In her Indo-Guyanese culture, having a baby so young is often seen as a big problem, and people can be very harsh about it. But for her Amerindian side, it's not seen the same way; it's more accepted.

Lately, Shanta feels like everything is too much. She keeps hearing these nagging voices, making her feel worse. To try and calm these thoughts, she keeps moving things around in her room, trying to make everything perfect, hoping it will help her feel better inside.

Not long ago, during a school talk about tough times and feeling down, Shanta couldn't hold back her tears. The school counsellor saw this and asked her what was wrong. Shanta tried to brush it off, saying she was "fine," because talking about such personal stuff is hard, especially when people around you might not understand.

But after a week of carrying this secret and feeling alone, Shanta was brave enough to go back to the school counsellor and tell her about the baby. Opening up about something that's really tricky in her community, especially when you're young, was a big step for Shanta. Now that the secret's out, she can get the help and understanding she needs to figure out what's next.

Vince – Created by Gatekeeper Training Group Indigenous Warriors

Vince, a young Afro-Guynease man in his late twenties from Georgetown, is facing a tough time. He's been with his girlfriend for 2 years, but things are rocky. Vince lives with his mom, taking care of her and earning the money they both live on. His mom is always busy, and Vince often feels lonely. He wanted someone to be close to, and when he started dating his girlfriend, he got very attached to her—maybe too much.

His girlfriend felt crowded by how much attention he wanted, and it caused some trouble between them. To deal with his hurt feelings, Vince started drinking a lot. One night, after too many drinks, Vince argued with his girlfriend, and she broke up with him. Vince felt deeply hurt and abandoned. Feeling dejected, he harmed himself. He didn't do much damage, but it was a cry for help. This scary moment made his girlfriend return to him, but it didn't fix everything. Their relationship stayed up and down, and now she's thinking of leaving for good.

With all this going on, Vince feels depressed and anxious. He thinks about giving up and doesn't know how to improve things. It's a lot for anyone to handle, and Vince needs help finding his way through it.

Poonam – Created by Gatekeeper Training Group West Siders

Poonam is a smart and popular girl from a middle-class Indo-Guyanese family. She gets excellent grades and is active in school activities. At a Christmas party, she meets Adonis, a student from a higher grade, and they hit it off, spending lunch hours together and taking after-school walks.

However, when Poonam's parents learn about the relationship, they're not pleased because Adonis comes from a different cultural background. They confront Poonam with a harsh choice: leave school or end the relationship. If she doesn't, they say she must move out.

Poonam goes back to school but feels haunted by her parents' ultimatum. She's torn between her family and her feelings for Adonis. Not wanting to share her troubles for fear of ridicule, Adonis becomes her only comfort.

Caught in this emotional tug-of-war and feeling increasingly trapped, Poonam tries to end her life. She survives but is taken to the hospital. The news deeply affects Adonis, who falls into depression, his grades plummet, and he loses the will to attend school.

About the Author

Dr. Tayyab Rashid, a licensed clinical and school psychologist in Toronto, Canada, holds esteemed positions at Harvard's Human Flourishing Program and its TH Chan School of Public Health. With nearly 2 decades of experience, Dr. Rashid specializes in strengths-based clinical psychotherapy, tackling complex mental health issues, fostering resilience, and encouraging posttraumatic growth.

He is the lead clinician and researcher for the mental health initiative in Guyana, in partnership with the International Development Relief Fund (IDRF) and Global Affairs Canada. He has trained professionals and educators in over 25 countries. His co-authored book with Martin Seligman, "Positive Psychotherapy," has expanded positive psychology's reach, being translated into several languages.

In partnership with Canada

IDRF GUYANA

MINISTRY OF HEALTH GUYANA

NATIONAL SUICIDE PREVENTION COMMISSION GUYANA

MINISTRY OF HEALTH MENTAL HEALTH UNIT