MI-08 Suicide: prevention in small communities, means and postvention

HEALING after the FALL, research library, MI-08

Researched 10 October 2026 by Claude Opus agent for THRIVING after the FALL, Book Four. Library document, unverified.

This report asks what a village of 300 and a district of 3,000, with no hospital, pharmacy, psychiatrist or electricity, can do to keep people alive through a suicidal crisis, and what it should do after a death. It cites the library rather than repeating it: depression and its treatment are in MI-04, alcohol and withdrawal in MI-06, the management of poisoning and overdose in ME-14, lay counselling in MI-02, and the good death in NU-06. Mourning and bereavement rites belong to the grief report (MI-03), and the healer's own wellbeing to MI-12. MI-04 says that suicide beyond screening "belongs to MI-09" (THRIVING library, MI-04). The report that holds it is this one, MI-08, and MI-04 should be corrected.

The report follows safe-messaging practice. It gives case-fatality by method only as the evidence that removing the most lethal means saves lives, and it describes no method. Readers who are struggling themselves should know the central finding before anything else: most suicidal crises pass, and more than nine in ten people who survive an attempt do not go on to die by suicide (Owens, Horrocks and House 2002).

The short answer: the strongest evidence in the field is for putting distance between a person in crisis and a lethal means, and for staying in contact with them afterwards. Both are cheap, both work without a doctor, and both fit a village better than a city. Training people to recognise risk improves what they know, but no trial has shown that training alone reduces deaths. Asking directly about suicide does not cause it. After a death, the village protects the living by caring for those closest and most at risk, quietly, without making the dead a hero or the method a story.

Findings by section

1. Means restriction: the strongest record

Sri Lanka. Sri Lanka's suicide rate was about 5 per 100,000 before the 1960s and rose to 24 by 1976 (Knipe, Gunnell and Eddleston 2017). Most of the rise was self-poisoning with agricultural pesticides. Gunnell and colleagues give the peak as 47 per 100,000 in 1995, after an eightfold rise from 1950, and the rate had halved by 2005 (Gunnell et al. 2007). Knipe and colleagues, using people over the age of 8 as the denominator, put the peak at 57 per 100,000 and the present rate at 17, a reduction of 70 per cent, and estimate about 93,000 lives saved between 1995 and 2015 (Knipe, Gunnell and Eddleston 2017). The two peaks differ because of the denominator, not the count. MI-02 gives 47 (THRIVING library, MI-02), which is correct for the whole population.

The fall followed a sequence of bans by the Registrar of Pesticides. Parathion and methyl parathion went in 1984, the WHO Class I organophosphates in 1995, endosulfan in 1998 after farmers had switched to it, and dimethoate, fenthion and paraquat in phases between 2008 and 2011 (Knipe, Gunnell and Eddleston 2017). Gunnell's team counted 19,769 fewer suicides in 1996 to 2005 than in 1986 to 1995, and found that unemployment, alcohol, divorce, the pattern of pesticide use and the civil war did not explain the fall (Gunnell et al. 2007). After the last bans, total suicide fell by 21 per cent between 2011 and 2015, from 18.3 to 14.3 per 100,000. Pesticide suicide halved, from 8.5

to 4.2, while suicide by other means rose only from 9.9 to 10.1. The authors estimate 937 fewer pesticide suicides in 2015 alone (95% CI 574 to 1,389) (Knipe, Chang et al. 2017).

The lesson is not that the people stopped being in crisis. Non-fatal self-poisoning continued, but people now survived it, because what they reached for was less lethal and the hospital could treat it. The regulatory office cost about US$200,000 a year, which Knipe puts at about $43 per life saved or $1.23 per disability-adjusted life-year, with no apparent effect on agricultural yield (Knipe, Gunnell and Eddleston 2017).

Locking it up at home did not work. The obvious village version of this, a lockable box for each household's pesticides, was tested in a cluster-randomised trial of 180 villages in Sri Lanka's North Central Province, covering 27,091 households and 114,168 people in the intervention arm and 26,291 households and 109,693 people in the control arm (Pearson et al. 2017). Over about three years, pesticide self-poisoning was 293.3 against 318.0 per 100,000 person-years, a rate ratio of 0.93 (0.80 to 1.08). There was no benefit. Fatal self-harm was 82 against 67 (RR 1.22, 0.88 to 1.68). At baseline 5 per cent of households locked their pesticides. With the boxes, self-reported use was 72 per cent at one year, and only 53 per cent were still locking at three. The authors call household storage "a very active form of prevention", meaning it depends on someone remembering every day, and they conclude that removing the most hazardous pesticides is likely to be more effective. This trial matters more to a village than any other in this report: the household lock is what a village would think of first, and on the evidence it is not enough. A central store, held by someone other than the household, is a different intervention and has not been tested [VERIFY, inference].

Coal gas in Britain. Domestic gas in Britain was made from coal and contained carbon monoxide. Between 1960 and 1971 it was replaced by natural gas. Kreitman found that suicide by gas fell in every age and sex group in step with the falling carbon monoxide content, that psychiatric services did not explain the change, and that some groups showed a partial rise in other methods (Kreitman 1976). Clarke and Mayhew report that gas accounted for over 40 per cent of suicides in England and Wales in 1963 and almost none by 1975, while total suicides fell from 5,714 to 3,693, about 35 per cent, with little substitution (Clarke and Mayhew 1988, read in summary). McClure confirms that rates fell in both sexes from the early 1960s to the mid-1970s (McClure 2000). This is the founding natural experiment of means restriction: a whole country's suicide rate fell by a third when one method became less lethal, with no programme aimed at anyone's mind.

Paracetamol packs. In September 1998 the United Kingdom limited paracetamol to packs of 32 tablets in pharmacies and 16 elsewhere. Over the next 11 years there were about 17 fewer deaths per quarter (95% CI 9 to 25), a 43 per cent reduction and about 765 fewer deaths, with 61 per cent fewer registrations for liver transplant (Hawton et al. 2013). Around 121 deaths a year continued. The mechanism is the same: an impulse meets a smaller amount.

Firearms. Household access to firearms roughly triples the odds of suicide (pooled OR 3.24, 2.41 to 4.40) (Zalsman et al. 2016, Anglemyer, Horvath and Rutherford 2014). In a case-control study of young people, firearm suicide attempts were fatal 95 per cent of the time, and storing guns unloaded went with much lower odds of a suicide or accidental injury (OR 0.30, 0.16 to 0.56), as did locking the gun and storing ammunition locked and separately (Grossman et al. 2005). When the Israel Defense Forces stopped soldiers taking their weapons home at weekends, suicide fell by about 40 per cent, almost all of it in weekend firearm deaths, with no change on weekdays (Lubin et al. 2010). The year of the policy is given as 2005 or 2006 in different sources [VERIFY].

Places. Barriers and restricted access at known jumping sites reduced suicides there by 86 per cent (79 to 91) with little substitution to nearby sites (Zalsman et al. 2016), and restricting access gave an incidence rate ratio of 0.09 (0.03 to 0.27) (Pirkis et al. 2015). A village has few such sites, but it may have one: a cliff, a bridge, a quarry, a well. If a death or attempt happens there, the CDC's 1988 cluster guidance is to change the site (Centers for Disease Control 1988b).

What cannot be removed. Zalsman's review found little evidence on preventing hanging outside psychiatric wards (Zalsman et al. 2016). Cord, rope and water cannot be taken out of a village. For these means, the protection is the person: a watcher during the crisis, a plan, and contact afterwards (sections 6 and 7).

2. Why the means matter: case-fatality as evidence

The case for means restriction rests on one fact: methods differ enormously in how often an attempt ends in death, and a person who survives an attempt usually survives the crisis. A meta-analysis of 34 studies found the following pooled case-fatality, with the same ranking across settings, sexes and ages, and higher fatality in older people (Cai et al. 2022). The second column is a national US study of 2007 to 2014, which counted only attempts that reached hospital and so overstates fatality (Conner, Azrael and Miller 2019).

Means	Cai 2022, pooled	Conner 2019, US
Firearm	89.7%	89.6%
Hanging or suffocation	84.5%	52.7%
Drowning	80.4%	56.4%
Gas	56.6%	not given here
Drug or liquid poisoning	8.0%	most acts, few deaths
Cutting	4.0%	not given here

The two sources differ widely for hanging and drowning and agree for firearms. Conner's broader point holds either way: drug poisoning was 59.4 per cent of acts but 13.5 per cent of deaths, while firearms and hanging were 8.8 per cent of acts and 75.3 per cent of deaths. Overall 8.5 per cent of acts were fatal, 14.7 per cent in men and 3.3 per cent in women, 3.4 per cent at ages 15 to 24 and 35.4 per cent at 65 and over (Conner, Azrael and Miller 2019). Spicer and Miller earlier found firearms the most lethal in eight US states (Spicer and Miller 2000).

Within pesticides the spread is as wide. In 9,302 patients admitted to Sri Lankan hospitals the overall case-fatality was 10.1 per cent, but paraquat killed 42.7 per cent, dimethoate 20.6 per cent and fenthion 14.8 per cent, while the least toxic agents killed about 2 per cent (Dawson et al. 2010). ME-14 gives a similar range for organophosphates and paraquat (THRIVING library, ME-14). These are the agents Sri Lanka banned. For a village, this table is a list of what to keep out of the house, not a ranking of anything else.

What the village will have. After the Fall, the means at hand will be stored pesticides and rodenticides from before, whatever drugs were salvaged (ME-14), the guns of hunters and guards, cord and rope, water, heights, and spirits from the still. Pesticides and guns are the two lethal means a village can actually control. Salvaged drugs are controllable by whoever holds them.

Expected numbers. At the 2014 global rate of 11.4 per 100,000 (WHO 2014), a district of 3,000 would expect one suicide every three years and a village of 300 about one in a generation. At Sri Lanka's 1995 peak of 47, the district would expect about 1.4 a year, and at the Greenlandic rate of 1989 (section 5) about 3.6 a year [VERIFY, my arithmetic]. Non-fatal acts are far more common. The Sri Lankan trial's control villages had 318 pesticide self-poisonings per 100,000 person-years (Pearson et al. 2017), which in a district of 3,000 is about 10 a year [VERIFY, arithmetic]. The healer will see attempts far more often than deaths, and every attempt is a chance to prevent the next.

3. What the reviews show, and what training and asking do

Mann and colleagues reviewed 10 systematic reviews, 18 trials, 24 cohort studies and 41 ecological studies, against a background of 877,000 suicides worldwide in 2002. Two interventions had evidence of preventing suicide: educating physicians to recognise and treat depression, and restricting access to lethal means. Public education, screening and media guidelines needed more testing (Mann et al. 2005). Ten years later Zalsman and colleagues screened 1,797 studies. They again found good evidence for means restriction (analgesic pack limits, barriers at hotspots, restrictions on barbiturates), for school awareness programmes (attempts OR 0.45, 0.24 to 0.85), and for lithium and clozapine in the conditions they treat, and insufficient evidence for screening in primary care, public education and media

guidelines alone. Their conclusion is that "no single strategy clearly stands above the others" (Zalsman et al. 2016). Treating depression is in MI-04 and is not repeated here.

Gatekeepers. A gatekeeper is anyone trained to notice risk, ask, and lead the person to help. The best-known result is the US Air Force programme, which from 1996 made leadership responsible for prevention, trained every member, and built a reporting system, among 11 initiatives. Comparing 1990 to 1996 with 1997 to 2002 in 5,260,292 personnel, suicide fell by 33 per cent (RR 0.67, 0.57 to 0.80), homicide by 52 per cent and severe family violence by 54 per cent (Knox et al. 2003). The yearly rate went from a peak of 16.4 per 100,000 in 1994 to 5.6 in 1999. When implementation lapsed in 2004, the rate rose, and it fell again when the programme was renewed (Knox et al. 2010). The study had no control group, and the programme was a whole-community change in which training was only one part.

Training alone is weaker. Question, Persuade, Refer (QPR) is the most used gatekeeper course. In a trial in 32 schools with 249 staff, it improved knowledge (effect size 0.41), self-efficacy (1.22) and knowledge of services (1.07), but knowledge was not enough to make staff ask students about suicide more often (Wyman et al. 2008). A systematic review found that gatekeeper training improves knowledge and attitudes, and that trials of its effect on deaths were lacking (Isaac et al. 2009). Zalsman's review states that no trial has shown that gatekeeper training alone affects suicide rates (Zalsman et al. 2016). The Air Force result is a reason to make prevention everyone's business in a community, not a reason to believe a course is enough.

Asking does not cause it. The fear that asking someone about suicide puts the idea in their head is old and wrong. A review found no study showing a significant increase in suicidal ideation after being asked (Dazzi et al. 2014). In a trial of 2,342 students in six New York high schools, ideation was 4.7 per cent among those asked about suicide and 3.9 per cent among those not asked (P = .49), and students with depression or a past attempt were less distressed and less suicidal after being asked (Gould et al. 2005). MI-04 uses the same evidence (THRIVING library, MI-04). The healer should ask plainly, using the word.

4. Collapse and crisis: what the record shows, and what it cannot

Russia and the Soviet Union. On 1 June 1985 the Soviet government began a campaign against alcohol, raising prices and restricting sales. Between 1984 and 1990, suicide fell by about 32 per cent in men and 19 per cent in women, while in 22 other European countries men's rates fell by about 8 per cent (Värnik et al. 1998). In Russia and Belarus men's suicide fell by 42 per cent from 1984 to 1986 to 1988. Alcohol accounted for about half of male suicides and 27 per cent of female suicides across the Union (Wasserman, Värnik and Eklund 1998). The fall reversed after 1988, as illegal production grew and the campaign weakened (Värnik et al. 1998). Regional rates before the collapse ranged from 3.5 per 100,000 in the Caucasus to 28.0 in the Baltic republics (Wasserman, Värnik and Dankowicz 1998).

After the Soviet collapse, deaths among Russian working-age men rose by 74 per cent between 1990 and 1994, from 759.2 to 1,323.7 per 100,000. Suicide among Russian men aged 50 to 54 reached 139.6 per 100,000 in 1994, and among Lithuanian men aged 45 to 54 about 171 in 1996. Brainerd estimates that suicide made up as much as 16 per cent of the rise in deaths and that men's suicide was sensitive to the economy, with a one-point rise in the employment ratio going with about 3 per cent less male suicide (Brainerd 2001). Acute drinking multiplies the odds of a suicide attempt by about seven (OR 6.97, 4.77 to 10.17), rising to 37 at high doses (Borges et al. 2017). For a village whose still is running, this is the most practical number in the section. Spirit control is in MI-06 and is [OWNER].

Greece after 2008. Branas and colleagues analysed 11,505 suicides in Greece from 1983 to 2012. After the austerity measures of June 2011, suicides rose by 35.7 per cent, and the highest months were in 2012 (Branas et al. 2015). The authors caution that unmeasured events may explain part of the change.

Indian farmers. India had about 187,000 suicides at age 15 and over in 2010, with age-standardised rates of 26.3 per 100,000 in men and 17.5 in women. About half were by poisoning, mostly with pesticides, and 40 per cent of men's and 56 per cent of women's suicides were at ages 15 to 29 (Patel et al. 2012). Kennedy and King contest the view

that farmer suicide is mainly a matter of individual illness: in their analysis, the share of marginal farmers growing cash crops under debt explained about three quarters of the variation between states (Kennedy and King 2014). A national crime bureau figure of 16.3 per 100,000 farmers in 2011, against 11.1 in the rest of the population, comes from a secondary source and undercounts women and tenants [VERIFY].

The ecological fallacy. Every figure in this section describes populations. It shows that suicide rose or fell with alcohol supply, unemployment or debt in a whole country, not that any one person who died did so for that reason. The Fall will bring all three at once. The record supports two cautious inferences for the village: that control of strong drink is likely to save lives, and that a collapse of livelihood and status raises risk among middle-aged men in particular [VERIFY, inference].

5. Small communities: the record from the Arctic and the plain

Nunavut. In a study of 120 Inuit suicides in Nunavut between 2003 and 2006, each matched with a living control, major depression (OR 13.0), cluster B personality disorder (OR 10.18), cannabis dependence (OR 3.96), alcohol dependence (OR 2.90) and childhood abuse (OR 2.38) were all associated with suicide, and the controls themselves carried a heavy burden of distress (Chachamovich et al. 2015). The territorial rate was about 120 per 100,000, about ten times Canada's, and at ages 15 to 24 it had risen sixfold since the early 1980s (Nunatsiaq News 2013, a secondary report of the same study).

Greenland. Greenland's suicide rate was about 3 to 4 per 100,000 in 1891 to 1930. After rapid modernisation from 1953 it rose to 16.7 in 1967 to 1971 and 53.9 in 1972 to 1976 (Sargeant, Forsyth and Pitman 2018). Among young men in West Greenland there were no suicides in 1970, then 249 per 100,000 in 1976 and a peak of 577 in 1990. Ninety-three per cent of suicides from 1968 to 1995 were by violent means. The whole-population rate was 28.7 in 1970 and 120.5 in 1989, and 81.3 in 2015 to 2018. The review's most important sentence for this book is that Greenland's prevention efforts "have never been evaluated" (Sargeant, Forsyth and Pitman 2018). A small society can go from almost no suicide to one of the world's highest rates within one generation of disruption, and that is a warning for a village after the Fall.

Sámi. In a cohort of 19,801 Sámi in Arctic Norway from 1970 to 1998 there were 89 suicides, a standardised mortality ratio of 1.27 (1.02 to 1.56), higher in young men (1.82) and young women (3.17), and clusters may explain much of the excess (Silviken, Haldorsen and Kvernmo 2006). In focus groups, Sámi participants described the value of managing on one's own, *birget*, as both a strength and a barrier to seeking help, and close networks as both protective and a channel for distress (Stoor et al. 2019). This is the tradition speaking on its own terms, and it fits the record: in a small community, the same closeness that protects can spread both silence and contagion.

Cultural continuity. Chandler and Lalonde studied 196 First Nations bands in British Columbia and found that bands with more markers of cultural continuity, such as self-government, land claims, and control of education, health and cultural facilities, had dramatically lower youth suicide (Chandler and Lalonde 1998). A later report that bands with all the markers had no youth suicide over six years comes to me only from a secondary summary [VERIFY]. The design is correlational, but the finding is what the book would hope: a community that shapes its own future protects its young.

Hutterites and Amish. The Hutterites are often cited as a community nearly free of suicide. Eaton and Weil's 1955 study of Hutterite mental health found depression to be the most common disorder, often guilt-laden (Eaton and Weil 1955, catalogue entry only), and secondary sources describe suicide as virtually non-existent among them (Ingoldsby, encyclopedia entry). I could not read Eaton and Weil's own suicide data [VERIFY]. The Amish record is different: MI-04 cites 26 Amish suicides between 1880 and 1980, clustered in four family lines, with 92 per cent showing major affective illness (THRIVING library, MI-04). Close religious community does not abolish suicide. Where it may protect, it does so alongside illness that still needs treating.

6. The minutes and the years

The crisis is often short. In a study of 153 people aged 13 to 34 who survived nearly lethal attempts in Houston, 24 per cent said that less than five minutes passed between deciding and acting. Impulsive attempts were linked with fighting, male sex and hopelessness, not with depression (Simon et al. 2001). Among 82 attempters in Austria, 47.6 per cent said ten minutes or less passed between the first thought of the current attempt and the act (Deisenhammer et al. 2009). If a lethal means is not within reach in those minutes, the crisis often passes before one can be found. This is why means restriction works.

Most survivors live. A review of 90 studies found that after self-harm, about 16 per cent repeat a non-fatal act within a year, about 2 per cent die by suicide within a year, and about 7 per cent within nine years or more. The risk is hundreds of times that of the general population (Owens, Horrocks and House 2002), but most people who survive do not later die by suicide. Of 515 people prevented from jumping at the Golden Gate Bridge between 1937 and 1971, about 90 per cent had not died by suicide or other violent means at follow-up (Seiden 1978). The exact counts differ between secondary sources [VERIFY].

The first months are the most dangerous. After discharge from psychiatric care, the suicide rate was 484 per 100,000 person-years overall, 1,132 in the first three months, and 2,078 among people admitted for suicidal thoughts or behaviour (Chung et al. 2017). A village has no ward, but the lesson carries over: the weeks after a crisis, when the watch is lifted and attention moves on, are when contact matters most.

7. Contact after a crisis

The cheapest proven intervention in this field is staying in touch. In the WHO SUPRE-MISS trial in Campinas, Chennai, Colombo, Karaj and Yuncheng, 1,867 people who had attempted suicide received either usual care or a brief educational session followed by nine contacts by telephone or visit over 18 months. At 18 months, 0.2 per cent of the contact group had died by suicide against 2.2 per cent with usual care, and 91 per cent completed follow-up (Fleischmann et al. 2008). On those figures, about 50 people would need the contacts to prevent one death [VERIFY, my arithmetic]. The exact contact schedule comes to me from a secondary source [VERIFY], and a companion analysis found no reduction in repeat attempts.

In San Francisco, 843 people who had refused further care after a crisis were randomly allocated either to receive short, caring letters at least four times a year for five years, or nothing. The letter group had a lower suicide rate in every year, significantly so in the first two ($p = .04$). The difference had faded by year 14 (Motto and Bostrom 2001). Zalsman found that postcards worked in Iran but not in high-income countries, and that telephone and face-to-face contact reduced suicide in low- and middle-income countries (Zalsman et al. 2016).

The Safety Planning Intervention of Stanley and Brown takes 20 to 30 minutes and leaves the person with a short written plan in six steps: their own warning signs, things they can do alone to cope, people and places that distract, people they can ask for help, professionals or services, and making their surroundings safe (Stanley and Brown 2012, read in secondary summary). In 1,640 patients in US veterans' emergency departments, safety planning with at least two follow-up calls went with 45 per cent less suicidal behaviour over six months (3.03 against 5.29 per cent, OR 0.56, 0.33 to 0.95) (Stanley et al. 2018). This was a cohort study, not a randomised trial, and mostly of men. The plan needs only paper, a person who can write, and a healer who knows the village. Protocol 2 adapts it.

8. Contagion, safe messaging and postvention

Contagion is real, and small places concentrate it. Gould, Wallenstein and Kleinman found significant clustering in time and place of suicides among 15- to 19-year-olds in the United States (Gould, Wallenstein and Kleinman 1990). The CDC estimated that clusters account for 1 to 5 per cent of youth suicides, and reported a New Jersey cluster in March 1987 in which four young people died together and two more attempted at the same place six days later, after which the site was changed (Centers for Disease Control 1988a). Phillips named the rise in suicides after widely

reported deaths the Werther effect (Phillips 1974, title only). In 497 Austrian reports, repeated coverage and the repetition of myths went with more suicides, and stories of people who coped with suicidal thoughts without acting went with fewer, the Papageno effect (Niederkrotenthaler et al. 2010). WHO's guidance for media follows these findings: no method, no place, no simple cause, no romance, and stories of help and recovery wherever possible (WHO 2023, read in summary).

Who is exposed. In a US survey of 1,736 adults, each suicide exposed about 135 people who knew the dead person (Cerel et al. 2019). In a village of 300 that is nearly half the village, and in practice everyone. People bereaved by suicide carry higher risk: partners have a higher risk of suicide, mothers who lose an adult child to suicide have a higher risk of suicide, offspring a higher risk of depression, and parents more often need psychiatric admission. The bereaved report more rejection and shame than after other deaths (Pitman et al. 2014).

What postvention means. Postvention is what a community does after a suicide to support the bereaved and prevent further deaths. Its evidence is thin. A review of 11 controlled studies from 1984 to 2018 found them of weak quality, with the most promising approach being a series of sessions led by trained facilitators that involves the bereaved person's social circle (Andriessen et al. 2019). The best practical guidance remains the CDC's 1988 community plan, written for clusters (Centers for Disease Control 1988b). It asks the community to agree a plan before it is needed, with one coordinator and one spokesperson. After a death it should inform close friends privately and others in small groups, not in a mass assembly. The plan reaches out first to family, close friends, those who were absent after the death, people with past attempts, and the isolated, widowed or unemployed, and gives everyone judged at high risk at least one personal conversation. It avoids glorifying the dead, gives no details of the method, changes the site, and for a time restricts access to firearms, drugs and other means. Over the longer term it reconnects the isolated and keeps watch for further attempts. The CDC warns specifically against permanent memorials that set the dead apart.

Funeral and mourning rites are for the grief report (MI-03). This report asks only that those rites honour the person without honouring the manner of death, and that someone uses the gathering to see who is not coping [OWNER]. The healer who lost a person in their care is among the bereaved, and among those at risk. MI-12 covers the healer's own care. The same check that is offered to the family should be offered to the healer.

9. Rational suicide and hastened death [OWNER]

Some people will say that an end to suffering is their choice. NU-06 sets out the evidence on hastened death at the end of life and leaves the village rule to the owner, noting that the case is weakest where it is most often invoked (THRIVING library, NU-06). This report adds one point from the evidence above. Most people who survive a suicidal crisis do not later die by suicide (Owens, Horrocks and House 2002), many crises last minutes (Simon et al. 2001), and in Nunavut and elsewhere the people who died almost always had treatable illness (Chachamovich et al. 2015). Whatever the owner decides for the dying, the healer should treat any wish to die in a person who is not dying as a crisis to be met with care, and should not let an argument about autonomy replace the questions in Protocol 1 [OWNER].

Evidence grades

A: trials or strong natural experiments. B: consistent observational record. C: weak or single studies. D: tradition or expert consensus only. X: shown not to work, or harmful.

Practice	Grade	Basis
Removing the most lethal pesticides from a region	**A**	Gunnell 2007, Knipe 2017 (natural experiments)

Practice	Grade	Basis
Making a common method less lethal (coal gas, pack sizes)	**A**	Kreitman 1976, Hawton 2013
Guns out of the house, or unloaded and locked	**B**	Grossman 2005, Lubin 2010, Anglemyer 2014
Barriers at a known site	**B**	Pirkis 2015, Zalsman 2016
Household lockable boxes for pesticides	**X**	Pearson 2017, RR 0.93
Central village store for poisons and guns	**D**	My inference, untested
Asking directly about suicide	**A** (safe)	Gould 2005, Dazzi 2014
Gatekeeper training alone reduces deaths	**C**	Wyman 2008, Isaac 2009, Zalsman 2016
Whole-community programme with leadership	**B**	Knox 2003, 2010, no control group
Brief intervention and contact after an attempt	**A**	Fleischmann 2008, one large trial
Caring letters	**B**	Motto 2001, effect fades
Safety plan with follow-up calls	**B**	Stanley 2018, cohort
Controlling strong drink	**B**	Värnik 1998, Borges 2017
Postvention that informs quietly and reaches the bereaved	**C**	Andriessen 2019, CDC 1988
Memorials or ceremonies that glorify the manner of death	**X**	CDC 1988, Niederkrotenthaler 2010
Silence and secrecy instead of asking	**X**	Dazzi 2014, Stoor 2019
Cultural continuity as protection	**C**	Chandler and Lalonde 1998
Treating depression (see MI-04)	**B**	Mann 2005, Zalsman 2016

What the tradition says, what the record shows and what science infers are separate. The Sámi value of managing alone is tradition, the clusters are record (Silviken 2006, Stoor 2019). The Hutterite reputation for no suicide is tradition and secondary record, unverified. The idea that asking plants the thought is folk belief contradicted by trials.

Means ledger

Rung	What is possible	What it changes
Hands and knowledge	Asking plainly. Listening. A watcher who stays. The six-step safety plan spoken aloud. Knowing that crises pass and that the weeks after are dangerous	Finds people at risk. Keeps someone present through the minutes that matter
Hearth	The household removes guns, ammunition, stored pesticides and medicines. Spirits put away. Family watch in shifts	Distance between impulse and means, the mechanism behind every success in section 1

Rung	What is possible	What it changes
Garden and still	The still under rules (MI-06). No highly toxic pesticides grown into village practice. Food and work for the person in crisis	Less acute drinking, fewer lethal poisons in sheds
Village dispensary (300)	A locked store for salvaged drugs and poisons with two keyholders. Small dispensed quantities. A written plan on paper. A register of attempts and contacts. Charcoal and the poisoning protocol of ME-14	Smaller amounts at home. Contact kept. Poisonings treated
District infirmary (3,000)	A trained lay counsellor supervised (MI-02). Atropine and the organophosphate regimen (ME-14). Letters and visits on a schedule. A coordinator for the cluster plan	Pesticide poisoning survivable more often. Postvention organised
Hospital before the Fall	Intensive care, psychiatric admission, lithium and clozapine, regulators who can ban a pesticide for a country	Sri Lanka's 70 per cent. Fewer deaths after poisoning

Harm test

- **Silence.** Not asking leaves people alone with the thought. Asking does not cause harm (Dazzi et al. 2014).
- **Locking only.** A household lock gave no benefit (Pearson et al. 2017). Relying on it gives false comfort.
- **The healer's own supply.** Every dispensed drug is a possible overdose. ME-14 covers treatment. The prevention is small quantities from a locked store [OWNER].
- **Moral judgement.** Treating suicide as sin or crime breeds secrecy and shame, and shame is already heavier in those bereaved by suicide (Pitman et al. 2014). Care must not be conditional on approval.
- **Watching as punishment.** A watch that feels like arrest drives people to hide. It should be done by people the person chooses where possible.
- **Postvention that publicises.** Mass assemblies, method details and permanent memorials to the manner of death can raise risk (Centers for Disease Control 1988b, Niederkrotenthaler et al. 2010).
- **Over-reach.** Taking every tool or cord from a household is impossible and humiliating. Focus on the lethal means that can be moved: guns, pesticides, drugs.
- **The healer.** Repeated deaths in care harm healers (MI-12).

Red flags

Ask now and do not leave the person alone if any of these is present: - Talk of wanting to die, of being a burden, or of no way out. - A plan, a chosen time, or access to a lethal means. - A past attempt, especially in the last three months (Chung et al. 2017). - Sudden calm after deep distress, or giving away possessions [VERIFY, clinical consensus not read]. - Heavy drinking in a person who is in crisis (Borges et al. 2017). - A recent suicide in the village, or of someone close (Pitman et al. 2014). - Major depression or psychosis (Chachamovich et al. 2015, MI-04, MI-05). - Loss of livelihood, land, partner or standing, especially in middle-aged men (Brainerd 2001). - A young person who has been fighting, is hopeless, and has a gun at home (Simon et al. 2001, Grossman et al. 2005).

The case against

Substitution. The obvious objection to means restriction is that people will find another way. The record is against it for whole populations: in Sri Lanka other methods rose only slightly after the bans (Knipe, Chang et al. 2017), and in Britain substitution was partial (Kreitman 1976, Clarke and Mayhew 1988). But Kreitman himself recorded compensatory rises in some groups, and for means that cannot be removed, such as cord and water, the argument against restriction is that there is nothing to restrict.

The household lock. Pearson and colleagues, who believed in the idea, tested it and found no effect (Pearson et al. 2017). Any village plan that relies on families keeping things locked faces that result.

Ecological fallacy. Kennedy and King argue that Patel's figures reflect a political economy of debt as much as illness (Kennedy and King 2014). Branas warns that other events may explain Greece (Branas et al. 2015). The Soviet fall in suicide reversed within three years (Värnik et al. 1998). None of these proves cause for an individual.

Training. Wyman showed that QPR raised knowledge without changing how often staff asked (Wyman et al. 2008). Isaac and Zalsman found no trial evidence that training alone reduces deaths (Isaac et al. 2009, Zalsman et al. 2016). The Air Force study had no control group (Knox et al. 2003).

Contact. Motto's effect faded by year 14 (Motto and Bostrom 2001). Postcards did not work in rich countries (Zalsman et al. 2016). Fleischmann did not reduce repeat attempts, only deaths, and one trial carries the weight.

Postvention. Andriessen found the controlled studies weak (Andriessen et al. 2019). Much of what this report recommends after a death is consensus, not proof.

Autonomy. Some argue that preventing every suicide denies adults a choice. That debate belongs to NU-06 and the owner [OWNER].

10-line summary

1. Removing the most lethal means is the best-evidenced prevention there is.
2. Sri Lanka cut suicide by about 70 per cent by banning the most toxic pesticides, at about $43 per life.
3. A lock on each household's pesticides did not work in a trial of 224,000 people.
4. Guns at home triple the odds of suicide. Storing them away and unloaded reduces it.
5. A quarter of near-fatal attempts are decided within five minutes.
6. Most people who survive an attempt do not later die by suicide.
7. Asking about suicide does not cause it. Ask plainly.
8. Staying in contact after an attempt cut deaths from 2.2 to 0.2 per cent in five countries.
9. Clusters and contagion are real, and a village is small enough for everyone to be exposed.
10. After a death, care for the closest quietly, do not glorify, and watch the vulnerable.

Open questions

- Does a central village store for pesticides and guns, held by named keepers, succeed where household locks failed?
- What contact schedule can a district with no telephone sustain, and does a visit work as well as a call?
- Did the Hutterites really have almost no suicide, and if so, why?
- How should a village measure whether its programme works, given how rare deaths are?
- Which postvention approaches reduce later suicide, rather than distress?
- What are the right rules for spirits during a crisis in a household?

Sources to read in full

- Eaton and Weil 1955, for the Hutterite suicide data.
- Stanley and Brown 2012, for the original safety plan template.
- Fleischmann et al. 2008 and the SUPRE-MISS protocol, for the exact contact schedule.
- Centers for Disease Control 1988b, which is short and directly usable as a village postvention plan.
- Chandler and Lalonde 1998 and its follow-ups.
- Kreitman 1976 in full, for the subgroups where substitution occurred.
- WHO LIVE LIFE implementation guide (WHO 2021).

At the bedside after the Fall

A young man is brought to the healer after drinking from the bottle in his father's shed. ME-14 gives the first ten minutes. When he can talk, the healer asks, plainly, whether he wanted to die, whether he still does, and whether there is anything else at home he might use. The healer does not lecture or judge. She tells him that she has seen people come through this, and that most do.

Before he goes home, she and he write a short plan together on paper, in his words. His father removes the remaining poison and the hunting rifle to the village store, and keeps the spirits elsewhere. His sister and a friend agree to stay with him in turns for three days. The healer writes the date and what was agreed in the register. She visits the next day, then on day three, and then at the times set out in Protocol 7. If she cannot visit, a letter or a trusted neighbour goes in her place.

If he dies, the healer tells the family privately, and the village coordinator tells his friends in small groups. Nobody describes the method. The healer and the coordinator list who was closest and who is alone, and someone visits each of them in the first week. The grief report covers the funeral. The healer's own grief is not forgotten (MI-12).

Protocols

Protocol 1. How the healer asks

1. Choose a private place and time. Sit, do not stand over the person.
2. Ask directly, using the word: "Are you thinking about suicide?" or "Have you thought about killing yourself?" Do not ask "You're not thinking of doing something silly, are you?" (Dazzi et al. 2014, Gould et al. 2005).
3. If yes, ask, in order: Have you thought about how? Do you have what you would need? Have you thought about when? Have you tried before? What has stopped you so far?
4. Listen. Do not argue that life is good, and do not promise secrecy.
5. Ask about drink, recent loss, and whether anyone close has died by suicide.
6. Grade the risk [VERIFY, inference from the evidence above]:
    - Thoughts but no plan: safety plan (Protocol 2), contact within one week.
    - A plan, or a past attempt: safety plan, means removal (Protocol 3), contact the next day.
    - A plan with means at hand, a time chosen, or an attempt in the past 72 hours: 72-hour watch (Protocol 4), means removal at once.
7. Treat depression or psychosis by MI-04 and MI-05, and withdrawal by MI-06.

Protocol 2. The safety plan (adapted from Stanley and Brown 2012)

Time: 20 to 30 minutes. Write it in the person's words on one sheet they keep. Make a copy for the register only with their consent. 1. My warning signs: the thoughts, feelings or situations that come before a crisis. 2. What I can do alone: walking, work with the hands, prayer, sleep. 3. People and places that take my mind off it. 4. People I can tell I am in crisis: at least two, with where to find them by day and night. 5. The healer, the counsellor, and how to reach

them. 6. Making my surroundings safe: what will be moved, and by whom (Protocol 3). Add one line on a reason to live, if the person offers one. Review at every contact.

Protocol 3. Means removal from the household

Do this the same day, with the person's knowledge and, where possible, agreement. 1. Guns and ammunition: to the village store or a trusted house outside the home, separately [OWNER]. 2. Pesticides, rodenticides and other poisons: to the village store, not a box in the house (Pearson et al. 2017). 3. Medicines: count and remove all but a few days' supply, held by another member of the household or by the healer. 4. Spirits: removed for the duration of the watch, and the still not used by the person [OWNER]. 5. Known places: if the person names a place, someone stays with them when they go near it. 6. Record what was removed, where it went, and when it may be returned. Return guns no sooner than after a review at three months [VERIFY, inference] [OWNER].

Protocol 4. The 72-hour watch

[OWNER] for the rota and who may be asked. Timings are my inference from Simon 2001 and Chung 2017 [VERIFY]. 1. Someone is with the person at all times for 72 hours, including at night and when washing, within sight or hearing. 2. Shifts no longer than 4 hours by day, two people sharing the night. At least six watchers for a 72-hour watch. 3. Watchers are people the person trusts. They do not interrogate. They keep company, offer food and water, and keep the person from drink. 4. The healer visits at least once a day and reviews the plan. 5. Signal for help agreed in advance: who runs for the healer. 6. At 72 hours, review with Protocol 1. End, extend by 24 hours, or move to daily visits. 7. Watchers are asked how they are at the end. They will be tired and may be frightened (MI-12).

Protocol 5. The record

Kept by the healer, locked, read by no one else without the owner's rule [OWNER]. 1. Date, name, age, what happened, the means, and whether medical treatment was needed. 2. Risk grade from Protocol 1, and the plan agreed. 3. Means removed and where they are held. 4. Every contact: date, who, how, and how the person was. 5. Outcome at 3, 6, 12 and 18 months. 6. A yearly count, for the district, of attempts and deaths by means (without names), so the village can tell whether its rules work.

Protocol 6. The week after a suicide

Based on Centers for Disease Control 1988b and Pitman et al. 2014. Rites are for the grief report. - **Day 0.** The healer or coordinator tells the family privately and in person. One person is named to speak for the village. No details of the method are shared. The place is changed or closed if it was a public place. - **Day 1.** Close friends are told privately or in small groups. A list is made of the most exposed: family, partner, friends, anyone who found the person, people with past attempts, the young, the isolated, widowed or recently bereaved. - **Days 1 to 3.** Each person on the list gets a private conversation with someone trained to ask (Protocol 1). Anyone at risk starts Protocols 2 to 4. Guns, poisons and stores of medicine are moved for a time from households on the list. - **Days 3 to 7.** The funeral honours the person, not the manner of death. No permanent memorial that singles out the death [OWNER]. Someone watches at the funeral for who is not coping, and for who is absent. - **Day 7.** The coordinator and healer meet. Who has not been seen? Who has started drinking? Who is the healer worried about? - **Weeks 2 to 12.** Visits to the closest continue at least weekly. Watch for further attempts in the same age group. - **Throughout.** Talk of suicide is honest and plain, and stories of people who came through crisis are told where they exist (Niederkrotenthaler et al. 2010).

Protocol 7. Contact after a crisis

Modelled on Fleischmann et al. 2008 and Motto and Bostrom 2001. The schedule is my adaptation [VERIFY]. 1. Days 1, 3 and 7 after the crisis: a visit. 2. Weeks 2, 4, 8 and 12: a visit or a letter. 3. Months 6, 12 and 18: a visit or a letter. 4. Thereafter: a short caring letter or greeting at least four times a year for those who will not otherwise accept

help (Motto and Bostrom 2001). 5. Each contact asks how the person is, reviews the plan, and asks Protocol 1 again if things have changed. 6. Missed contacts are followed up within 24 hours.

Numbers to carry

- 90 per cent: case-fatality of firearm attempts. About 8 per cent for drug and liquid poisonings (Cai et al. 2022).
- 43 per cent: case-fatality of paraquat. About 21 per cent for dimethoate (Dawson et al. 2010).
- 70 per cent: the fall in Sri Lankan suicide after pesticide bans (Knipe, Gunnell and Eddleston 2017).
- RR 0.93: household locks for pesticides, no benefit (Pearson et al. 2017).
- 3.24: odds ratio for suicide with a gun in the house (Zalsman et al. 2016).
- 24 per cent decided within 5 minutes, and about half within 10 (Simon et al. 2001, Deisenhammer et al. 2009).
- 7 per cent die by suicide within about nine years after self-harm, so more than nine in ten do not (Owens, Horrocks and House 2002).
- 1,132 per 100,000 person-years: suicide in the first three months after psychiatric discharge (Chung et al. 2017).
- 2.2 to 0.2 per cent: deaths with and without contact after an attempt (Fleischmann et al. 2008).
- 135: people exposed to each suicide (Cerel et al. 2019).
- 1 to 5 per cent: youth suicides that occur in clusters (Centers for Disease Control 1988a).
- 7: odds ratio for a suicide attempt after acute drinking (Borges et al. 2017).
- 11.4 per 100,000: world suicide rate in 2014 (WHO 2014), one every three years in a district of 3,000.

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