Suicide Risk Assessment in Public Health Facilities: Counsellors' Experiences of Its Prevalence and Frequency in Bomet East Subcounty, Kenya

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Abstract
Globally suicide remains a significant public health concern, with greatest burden on low- and middle-income countries. In Kenya, despite the national Suicide Prevention Strategy Plan 2021–2026, limited research has examined frontline counsellors' experiences with suicide risk assessment (SRA) in rural settings. This qualitative phenomenological study tried to assess counsellors' experiences regarding the prevalence and frequency of suicide risk assessments in public health facilities in Bomet East Sub-County, Kenya. Data was collected through 14 in-depth individual interviews, two focus group discussions of 6 participants each, and document analysis was also done. Thematic analysis revealed that while counsellors frequently encounter suicidal clients, SRA is highly selective, case-based, and reactive rather than universal. Assessments are typically triggered by visible indicators such as depression, substance abuse, suicide attempts, or chronic illness. Key barriers include high workloads, staff shortages, limited counselling clinic days, poor client follow-up, stigma, and lack of institutional integration of SRA into routine care. Findings suggested that system barriers and sociocultural factors influence suicide risk assessment practices and therefore hinder effective early identification and intervention. The enhancement of human resources, establishment of routine screening procedures, improved follow up and addressing stigma through community outreach are recommended strategies for strengthening suicide prevention in low-resource settings.

Keywords: *Suicide risk assessment, counsellors' experiences, public health facilities, rural Kenya, suicide prevention*

Background Literature

Suicide continues to be a major global public health challenge, accounting for approximately 700,000 deaths per year. It is also identified as the fourth leading cause of death among the youth, a research done by the World Health Organization Africa experiences the highest age standardized suicide rate globally, estimated at 11.2 deaths per 100,000 people, followed by Europe at 10.5 per 100,000 and Southeast Asia at 10.2 per 100,000. In Kenya, the identified suicide mortality rate

stands at approximately 6.1 deaths per 100,000 populations. Although, this figure may not reflect the actual rate of the problem because suicide cases are believed to be lowly reported, majorly in rural communities where reporting systems are limited making it hard for correct data to be gathered. Suicide risk assessment (SRA) is a fundamental skill required of mental health professionals and represents an important first step in identifying individuals at risk and providing appropriate, targeted interventions (Oquendo & Bernanke, 2017; Ribeiro et al., 2013). A comprehensive SRA involved; systematically examining of risk factors such as previous suicide attempts, psychiatric history and access to potentially lethal means. It also considered protective factors including social support and coping abilities. The findings from this assessment will assist practitioners in determining the level of risk, developing a clinical formulation and selecting appropriate interventions (Silverman & Berman, 2014). Previous studies established that mental health practitioners in different settings encountered barriers when conducting those suicide risk assessments such as practitioner anxiety, inadequate privacy, limited time and insufficient training (Awenat et al., 2017; Regehr et al., 2016). In Kenya, the Ministry of Health launched the Suicide Prevention Strategy Plan (2021– 2026) emphasizing the integration of screening, assessment and treatment for suicidal behaviors in all levels of healthcare. Despite this strategy, evidence suggested that counsellors in rural facilities continued to face significant challenges including limited resources, shortages of staff and cultural stigma that hindered effective suicide risk assessment (Musyimi et al., 2017; Kwobah et al., 2021). Research on counsellors' experiences with suicide risk assessment in low and middle-income countries was scarce. In Uganda, (Rukundo et al. 2022) found that primary healthcare workers often encountered suicidal clients but faced challenges with assessment and management due to inadequate training, reliance on personal judgment instead of standardized tools and cultural beliefs that discouraged open discussion. Similarly, a study in Kenya's coastal region by Bitta et al. (2018) highlighted factors such as poverty, intimate partner violence, family rejection, stigma, chronic illness, and social isolation as contributing to suicidal behavior. However, none of these studies specifically investigated how counsellors in rural settings experienced and practiced suicide risk assessment.

Justification for the Study

The need to understand counsellors' experiences with the prevalence and frequency of suicide risk assessments emerges from the fact that counsellors are at the forefront line of suicide prevention in primary healthcare (Jackson et al., 2014), and the insight will highlight the disconnect between policies and practices. Bomet East Sub-County is a rural community whose residents engage in agriculture as the primary occupation, co-exist in ethnic groups that embrace a range of cultural beliefs, and lack adequate mental health resources. The area has reported multiple suicide attempts and cases of suicide (Ruto, 2023; Kenya News Agency, 2023). However, little is known about counsellors' experiences with assessing suicide risk in the area, and therefore this study seeks to contribute towards a holistic understanding of the entity. Previous studies on suicide risk assessment have revealed varied practices among counsellors, with most implementations being task-driven and taking place during critical moments (Atwoli et al., 2013). However, there is a need to reveal the influence of environmental factors on suicide risk assessment by asking whether the frequency is either case driven or routine and exploring the presenting features that necessitate the implementation. Additionally, the scarcity of qualitative studies on counsellors' experiences with suicide risk assessment presents a firm justification for the current research, as documenting the entity in a rural Kenyan community will add to the body of evidence that can be used to inform policies and enhance resources in mental health care.

Objective

The specific objective guiding this section of the study was: To assess the experiences of counsellors working in public health facilities regarding the prevalence of suicide risk assessments in Bomet East Sub-County.

Theoretical Framework

This study links two theoretical frameworks to explain counsellors' experiences of suicide risk assessment prevalence. The Constructivist Theory of Perception (Gregory) suggests that counsellors' perceptions on the frequency of suicide risk occurrence depend on their previous training, amount of work, and cultural background, resulting in selective and case-based assessments. The Stress-Diathesis Model, in turn, explains counsellors' responses to the identified stressors (staff shortages, high caseload, and stigma) as a manifestation of their limited ability to conduct regular risk assessments due to the lack of resources. Both theories help explain the counsellors' biased and situational approach to suicide risk assessment that leads to crisis intervention instead of regular monitoring.

Methodology

Study Design and Setting

This study used a phenomenological qualitative design to understand counsellors' lived experiences and perceptions in the context of mental health and suicide risk assessment practices. The study was conducted in Bomet East Sub-County in the Rift Valley region of Kenya. The sub-county is predominantly rural and hilly with communities engaging in subsistence agriculture as the mainstay. The area has a network of health facilities ranging from dispensaries to the County Referral Hospital. However, mental health services are limited.

Target Population and Sampling Procedure

The target population was all the counsellors (26) who provide mental health services and suicide risk assessment in the selected nine (9) health facilities in Bomet East Sub-County. These were Longisa County Referral Hospital (15 counsellors), Tegat Sub-County Hospital (4 counsellors), and Health centers/Dispensaries; Merigi, Irwaga, Chemaner, Mulot, Olokyin, Kembu and Kimuchul – each with one counsellor. A census approach was used for sampling since the target population was easily available and would offer a comprehensive view of the issue as opposed to using a sample.

Data Collection: Data was gathered through three methods: (a) semi-structured individual in-depth interviews with 14 counsellors, (b) two Focus Group Discussions (FGDs) with 12 counsellors (6 participants per FGD) and (c) document analysis of the facility records, assessment logs and policies. The interview and FGD guides had open-ended questions including but not limited to; How often do you encounter clients with suicidal behaviors? Under what circumstances do you conduct a suicide risk assessment? What presenting features bring about a suicide risk assessment? What are the barriers to conducting suicide risk assessments? Verbal consent was sought and interviews and FGDs were recorded and transcribed verbatim.

Data Analysis: Thematic data analysis was done by following Braun and Clarke's (2019) framework. In the first step, the researcher read and re-read the transcripts, identified initial codes,

generated preliminary themes and then collated similar themes into broader categories. Document analysis was done alongside interviews and FGDs.

Ethical Considerations: Ethical approval was obtained from Kisii University Ethical Review Committee and the National Commission for Science, Technology and Innovation (NACOSTI). Permission was secured from Bomet County Commissioner and County Health Department. Written informed consent was obtained from all participants, who were assured of confidentiality, the right to withdraw without penalty, and use of pseudonyms in reporting.

Findings and Discussion

Experiences of Counsellors Regarding the Prevalence and Frequency of Suicide Risk Assessments

The findings captured from the transcripts show that suicide risk assessment (SRA) is a common clinical practice but not consistently carried out as a routine practice in most public health facilities in Bomet East Sub-County. Instead of being equally offered to all clients, assessments are mainly selective, and only carried out when a case of a client shows up. This clearly shows that assessment is only done when a case shows up rather than being used as a procedure to every patient encountered.

> A key theme identified from the focus group discussions is that counsellors face a number of challenges in carrying out universal suicide risk screening, mainly due to heavy workloads, limited time and inadequate resources within the health facility. They also emphasized that assessing every client is not realistic, leading them to prioritize individuals who show clear signs of high risk of suicide. Therefore, due to this suicide assessment is only done considering to the client's condition rather than being carried out to all patients. "It is not possible to assess every client because of high workload… Suicide risk assessments are only done to those patients who present with mental problems such as depression, suicide attempts, and anxiety, and in some cases those with chronic illnesses." (FGD participant)

The data show that the counsellors are mainly relying on diagnostic cues which are mostly observable in clients at risk of suicide. Although this may be efficient in a busy clinical setting, it may neglect clients whose suicide ideation may be masked or not overt. Participants further highlight that the SRA is mainly conducted in clients presenting psychosocial and Behavioural risks including substance abuse and chronic illness. This highlights that counsellors are not utilizing the systematic screening for all patients, but instead using presenting complaints and referrals as starting points.

> "Mainly clients with mental health problems such as alcohol and drug abuse are subjected to SRAs… also patients admitted in the wards with chronic illnesses such as HIV and cancer are always assessed and counselled because they are traumatized and may think of committing suicide." (Another participant)

Also counselling services are reported to be unavailable in most facilities and sometimes only available on specific clinic days hence reducing chances of assessment since most people don't receive the services.

> "Counselling clinics is done every Tuesday only, this leads to a high number of clients and reduces the likelihood of suicide risk assessment." (Key informant)

The above factors create time pressures and crowded services forcing counsellors to focus on more urgent matters. As a result, although suicide risk may be suspected it is not thoroughly assessed.

Another key reason is the presence of systemic barriers such as high number of patients, staff shortages, and follow-up systems which reduces the likelihood of suicide risk assessment. Counsellors explain that the number of clients they receive is high than the available time hence making it difficult to carry out comprehensive evaluations for all clients.

> "Shortage of staff in some facilities makes it hard to integrate counselling services into the health system." (Respondent)

This highlights a great resource gap, since shortage of counsellors makes it difficult to integrate suicide risk assessment into routine practice. The findings further show challenges with client retention and follow-up which reduces the chances of follow-up assessments. Since suicide risk assessment is a dynamic process follow up visits are important in order to ensure proper adherence to the process but poor follow up adherence leads to increased likelihood of missing suicide risk cases.

> "Most clients do not come back for follow-up after initial contact, therefore may escape being assessed or screened for suicide risk." (FGD discussant)

This shows that although some patients are assessed during first contact, chances of thorough assessments are overlooked. The findings further highlight that there is lack of routine assessment services for suicide risk. Counsellors unanimously agreed that SRA is not a routine service. The reasons cited includes a range of structural, cultural and organizational barriers that prevent its routine use.

> "No… due to stigma, limited space, and increased workload with few counsellors." (Multiple respondents)

This finding further supports the idea of larger underlying systematic problems that institutional environments are not adequately prepared for routine mental health screening, specifically for suicide. Limited space may hinder confidentiality, stigma discourage disclosure of suicide ideation and increased workload pressures reduce the ability of counsellors to conduct comprehensive assessments. Moreover, stigma not only affects the patient, but also is a challenge to delivery of services, influencing the willingness of clients to disclose suicidal ideation and the willingness of counsellors to thoroughly investigate this matter within low-finance area.

Overall, the findings reveal that, although counsellors in Bomet East Sub-County regularly meet clients that present with suicidal behaviors, use of this type of assessment is inconsistent among various patients interacted. Practice of suicide risk assessment is influenced by clinical judgments, lack of resources, organizational structures and sociocultural factors, resulting in a largely reactive approach to suicide prevention. An analytical perspective reveals a resource-limited mental health service delivery model that focuses on high-risk cases rather than universal screening. Though this approach may be necessary in the constrained setting, raises questions about timely identification and equitable access as well as the possibility of missing those at risk without obvious signals.

Overall counsellors' experiences indicate that suicide risk assessment is perceived as an integral part of mental health care and is frequently required. However, it is not always incorporated into all client contacts, it is selective and dependent on clinicians' risk perceptions, time availability and institutional capacity. This corresponds closely to the study's conceptual framework which emphasizes the role of support mechanisms like staffing levels, service organization and infrastructure, and contextual factors like stigma and workload. These factors inform the frequency and consistency of suicide risk assessment practices as well as the effectiveness of suicide prevention.

The findings indicate that although suicide risk assessment is common in public health facilities in Bomet East Sub-County, its practice is inconsistent. Current practices are largely selective, case

specific and reactive rather than routine and universally applied. This is in line with the evidence from low- and middle-income countries (LMICs), where mental health services including suicide prevention initiatives are often inadequately integrated into primary health systems and are more likely to be implemented in the face of apparent clinical needs than through standardized screening procedures (WHO, 2014; MOH, 2020).

A literature analysis indicates that suicide risk assessment (SRA) is an essential process which plays a pivotal role in preventing suicide cases as suggested by Empirical scholarship frames suicide risk assessment (SRA) as a fundamental clinical practice in prevention, requiring systematic identification of risk and protective factors, structured evaluation and ongoing monitoring (Oquendo & Bernanke, 2017; Silverman & Berman, 2014). However, the current findings depict a deviation from this model where counsellors primarily carry out SRA with clients exhibiting overt mental health concerns such as depression, substance misuse and previous suicide attempts. This reflects a targeted screening approach which is clinically justifiable for high-risk groups but problematic when influenced by contextual limitations rather than standardized protocols. As Ribeiro et al. (2013) caution, suicidal ideation is often hidden and may not present through obvious psychiatric symptoms, risking the systematic overlooking of those at risk.

The findings depict how system shortages within the health system greatly impact suicide risk assessment (SRA) practices. Heavy caseloads, shortage of trained counsellors and restricted service availability make it difficult to maintain routine screening. This aligns with (Kiri 2015) and Schmidt (2016) who highlight workforce gaps, time pressures and lack of institutional backing as barriers to effective suicide risk screening. National reports (MOH, 2020) further highlight that Kenya's mental health services are underfunded and poorly integrated into primary healthcare. (Kwobah et al. 2021) further note that mental health care in Kenya is often deprioritized compared to other health needs limiting the adoption of preventive measures such as routine suicide risk assessment. The study highlights major gaps in continuity of care and follow up, which limits the effectiveness of suicide risk assessment (SRA). As suicide risk is fluid, repeated evaluations are needed to capture changes in ideation, intent and protective factors over time (Ryan & Oquendo, 2020). Yet, the observed pattern of poor follow-up with many clients failing to return after initial contact limits opportunities for monitoring. This finding relates to the work of Musyimi et al. (2017) in that the study identifies weaknesses in the follow-up systems and a general lack of client retention as challenges which limit the effectiveness of mental health service delivery in LMICs. The absence of such systems renders SRA as a one-day event.

The findings illuminate the role of sociocultural factors such as stigma and cultural beliefs on the practice and effectiveness of suicide risk assessment (SRA). Stigma associated with suicide and mental illness reduces the likelihood of seeking and accessing help as well as disclosing thoughts of suicide (Jackson et al., 2014; Spillane, 2018). In the findings, stigma manifested itself at the client level in terms of limited disclosure and at the service level in the discouragement of suicide related dialogues during consultations. Moreover, cultural beliefs which attribute suicide to curses and wrongdoing act as a deterrent to formal and informal assessment.

When interpreted through the lens of theory, the findings may be understood within the Constructivist Theory of Perception and Stress-Diathesis Model of Suicidal Behavior. The constructivist theory focuses on the role of personal experiences, expectations and context in the interpretation process (Gregory). In practice, counsellors employ heuristic "risk schemas" which prioritize clients who present with known risk factors such as mental illness and substance use disorders. In the context of limited resources, such an approach may be considered an effective triage. However, by relying on these "schemas", counsellors are bound to use selective assessment

frameworks and operate from biased perspectives thus failing to identify and respond to diverse suicidal presentations. The lack of uniform assessment tools exacerbates the problem by allowing subjectivity to guide practice.

The Stress-Diathesis Model offers further understanding of the mechanism by which the suicidal behavior emerges through an interaction of the potential vulnerabilities and the environmental stressors. From this perspective, the selective and inconsistent practice of suicide risk assessment (SRA) represents a missed opportunity to identify the individuals with the hidden vulnerabilities which may be triggered by the biopsychosocial events, such as illness, social conflict and economic hardship. Moreover, the staffing shortages, heavy workloads and deficient infrastructure pose as the stress-inducing factors which affect not only the number of assessments but their quality as well.

Overall, the findings of the study contribute to a body of evidence which confirms that the suicide risk assessment (SRA) in the context of the limited resources is non-systematic, reactive and influenced by the structural and sociocultural pressures. The restricted capacity of the institutions, the stigma and the counsellors' reliance on their perceptions determine the extent of the assessments which are conducted, affecting the capacity to detect the suicide risk in the clinical populations. These findings inform the need for system level reforms in suicide risk assessment (SRA). The study suggests that the improvements in practice could be actualized through embedding the routine screening protocols into primary healthcare, expanding the mental health human resources and designing the culturally appropriate tools. In addition, the enhancement of the follow up systems and community-based approaches to reduce the stigma are critical to augment the disclosures and support the continuity of care. Unless these system level reforms are initiated, the SRA will remain selective and episodic in nature, restricting its capacity to serve as an effective prevention strategy.

Conclusion.

This study sought to determine counsellors' experiences with suicide risk assessment (SRA) in public health facilities in Bomet East Sub-County, Kenya. The results indicate that while counsellors frequently encounter suicidal behaviours, SRA is not conducted as a routine or universal screening but rather selectively and situationally, initiated by specific signs or symptoms such as depression, substance abuse, suicide attempts, and chronic illness. Counsellors practice SRA on an individual basis due to the high client load, insufficient staff, and limited operational hours, making it a responsive measure triggered by perceived risk levels. Structural factors such as inadequate human resources, lack of privacy, stigma, and poor follow-up mechanisms profoundly affect SRA performance, rendering it intermittent and dependent on counsellors' discretion. Overall, counsellors do not have standardized SRA procedures, increasing the likelihood of overlooking suicidal thoughts, especially when clients do not display overt warning signs. At the same time, limited client retention and follow-up measures render SRA a one-time intervention, which is inadequate for identifying and responding to suicide risks effectively.

Recommendation.

1. **Instituting routine suicide risk screening**. The Ministry of Health and County Health departments should institutionalize and enforce routine suicide risk screening of all patients coming for any form of service at public health facilities. The screening should be done by brief validated instruments and should be culturally adapted to be sensitive and easily understood by the local population.

2. **Enhancing human resources**. The national and county governments should enhance human resources by recruiting more counsellors and mental health nurses at the facilities such as Bomet East Sub-County in the rural areas. This will free up counselors' time in institutions allowing them to do more thorough suicide risk assessments (SRA). Additionally, there is a need to have continuous training of the existing officers on topics such as suicide risk assessment, use of the standardized tools and culturally appropriate communication skills.

3. **Improving follow up and continuity of care**. Facility managers should come up with ways of reminding patients to come back for check-ups after their initial consultation. Methods such as sending reminders by phone or SMS and home visits could be considered. There is also a need to involve community health promoters in follow-up activities including providing support between clinic visits.

4.Address Stigma and Cultural Barriers. The Ministry of Health, working with community leaders, should implement sensitization campaigns to reduce stigma around suicide and mental illness, encourage help-seeking, and promote open disclosure. Counsellors should be trained in culturally adapted assessment techniques that respect local beliefs while enabling accurate risk identification, such as indirect questioning and involving trusted family members.

5. Develop and Adapt Assessment Tools. Research institutions and the Ministry of Health should collaborate to adapt and validate existing suicide risk assessment tools (e.g., PHQ-9, C-SSRS) for rural Kenyan communities. Locally tailored tools would improve accuracy and reduce stigma-related non-disclosure.

6.Strengthen Institutional Support and Supervision. County health departments should provide regular clinical supervision and case review meetings for counsellors, with input from mental health specialists, to enhance skills and reduce professional isolation. Clear policies and standard operating procedures for SRA should be developed, disseminated, and monitored across all public health facilities.

7. **Future Research**. There is a need to conduct a long-term study to assess the effectiveness of the intervention, including suicide mortality data collection. Additionally, future researchers could use mixed-methodological approaches to demonstrate the efficacy of the proposed strategy. There is also a need for a comparative study between different sub-counties to reveal factors that may contribute to heterogeneity. This information will be vital in creating effective strategies for reducing suicides at the national level.

References

Awenat, Y., Peters, S., Shaw-Nunez, E., Gooding, P., Pratt, D., & Haddock, G. (2017). Staff experiences and perceptions of working with in-patients who are suicidal: Qualitative analysis. The British Journal of Psychiatry, 211(2), 103–108. https://doi.org/10.1192/bjp.bp.116.191817

Bitta, M. A., Bakolis, I., Kariuki, S. M., Nyutu, G., Mochama, G., Thornicroft, G., & Newton, C. R. (2018). Suicide in a rural area of coastal Kenya. BMC Psychiatry, 18, Article 267. https://doi.org/10.1186/s12888-018-1855-z

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. Qualitative Research in Sport, Exercise and Health, 11(4), 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Jackson, J., & Saini, P. (2014). Suicide risk assessment and management in primary care. Crisis, 35(6), 408–417.

Kenya Ministry of Health. (2021). National suicide prevention strategy 2021–2026. Ministry of Health.

Kwobah, E., Jaguga, F., Robert, K., Ndolo, E., & Kariuki, J. (2021). Efforts and challenges to ensure continuity of mental healthcare service delivery in low-resource settings during the COVID-19 pandemic: A case of a Kenyan referral hospital. Frontiers in Psychiatry, 11, Article 588216. https://doi.org/10.3389/fpsyt.2020.588216

Musyimi, C. W., Mutiso, V. N., Ndetei, D. M., Unanue, I., Desai, D., Patel, S. G., Musau, A. M., Henderson, D. C., Nandoya, E. S., & Bunders, J. (2017). Mental health treatment in Kenya: Task-sharing challenges and opportunities among informal health providers. International Journal of Mental Health Systems, 11, Article 45. https://doi.org/10.1186/s13033-017-0152-4

Oquendo, M. A., & Bernanke, J. A. (2017). Suicide risk assessment: Tools and challenges. World Psychiatry, 16(1), 28–29. https://doi.org/10.1002/wps.20396

Ribeiro, J. D., Bodell, L. P., Hames, J. L., Hagan, C. R., & Joiner, T. E. (2013). An empirically based approach to the assessment and management of suicidal behavior. Professional Psychology: Research and Practice, 44(5), 332–341. Rukundo, G. Z., Wakida, E. K., Maling, S., Kaggwa, M. M., Sserumaga, B. M., Atim, L. M., Atuhaire, C. D., & Obua, C. (2022). Knowledge, attitudes, and experiences in suicide assessment and management: A qualitative study among primary health care workers in southwestern Uganda. BMC Psychiatry, 22, Article 605. https://doi.org/10.1186/s12888- 022-04244-z

Ryan, E. P., & Oquendo, M. A. (2020). Suicide risk assessment and prevention: Challenges and opportunities. Focus, 18(2), 88–99. https://doi.org/10.1176/appi.focus.20200011

Schmidt, R. C. (2016). Mental health practitioners' perceived levels of preparedness, levels of confidence and methods used in the assessment of youth suicide risk. The Professional Counselor, 6(1), 76–88. https://doi.org/10.15241/rcs.6.1.76

Silverman, M. M., & Berman, A. L. (2014). Suicide risk assessment and risk formulation Part I: A focus on suicide ideation in assessing suicide risk. Suicide and Life-Threatening Behavior, 44(4), 420–431. https://doi.org/10.1111/sltb.12065

Spillane, A., Matvienko-Sikar, K., Larkin, C., Corcoran, P., & Arensman, E. (2018). What are the physical and psychological health effects of suicide bereavement on family members? An observational and interview mixed-methods study in Ireland. BMJ Open, 8(1), Article e019472. https://doi.org/10.1136/bmjopen-2017-019472

World Health Organization. (2014). Preventing suicide: A global imperative. World Health Organization.
World Health Organization. (2019). Suicide worldwide in 2019: Global health estimates. World Health Organization.
World Health Organization. (2021). Suicide worldwide in 2021: Global health estimates. World Health Organization.