



Multidisciplinary Risk Factors for Suicide and Self-Harm in Punjab, Pakistan, Evidence from Forensic Medicine, Psychiatry, and Community Medicine

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Abstract: Background: Aim of study: To examine the demographic, psychiatric, and forensic characteristics of suicide and self-harm cases presenting to two tertiary care hospitals in Punjab, Pakistan, and to identify multidisciplinary risk factors that could inform prevention strategies. **Study duration:** March 2024 to March 2025. Study place: Niazi Medical and Dental College, Sargodha, and Sahiwal Medical College, Sahiwal, Pakistan. **Methodology:** A cross-sectional analytical study was conducted on 240 consecutive cases of suicide and self-harm (120 from each center). Data were collected using a structured proforma covering forensic (method, lethality, toxicology), psychiatric (prior diagnosis, substance use, stressors), and community (socioeconomic status, family support, access to means) domains. Descriptive statistics, chi-square tests, and logistic regression were used. **Results:** Young adults (18–30 years) comprised 58.3% of cases; female-to-male ratio was 1.4:1. Organophosphate poisoning was the most common method (42.5%). Major depressive disorder (47.5%) and adjustment disorder (22.5%) were the leading psychiatric diagnoses. Only 12.5% had previous contact with mental health services. Low socioeconomic status (OR 3.2, 95% CI 1.8–5.6) and family conflict (OR 4.1, 95% CI 2.3–7.2) were strong independent predictors. **Conclusion:** Suicide and self-harm in this region are associated with treatable psychiatric disorders, yet treatment engagement is extremely low. A multidisciplinary forensic-psychiatric-community approach is essential for prevention.

Keywords: Suicide; self-harm; forensic medicine; psychiatry; community medicine; Pakistan.

INTRODUCTION

Suicide and self-harm represent a major global public health challenge, accounting for over 700,000 deaths annually and many more non-fatal episodes that impose substantial burdens on health systems, families, and communities [1, 2]. In low- and middle-

income countries (LMICs), including Pakistan, the epidemiology of suicidal behavior is poorly characterized due to underreporting, legal and religious sanctions, and fragmented data collection systems [3, 4]. Most existing studies examine suicide

through a single disciplinary lens—forensic, psychiatric, or community-based—leading to fragmented understanding and ineffective prevention strategies [5, 6].

Forensic medicine provides critical information about the methods, circumstances, and medicolegal aspects of suicide and self-harm. Autopsy and toxicology reports can distinguish suicide from accidental or homicidal death, identify lethal agents, and document injury patterns [7]. In Pakistan, organophosphate poisoning and self-immolation are common methods, particularly among young women, but systematic forensic data collection remains rare [8].

Psychiatry focuses on underlying mental disorders, which are present in more than 90% of suicide completers in high-income countries [9]. Major depressive disorder, bipolar disorder, schizophrenia, substance use disorders, and personality disorders are well-established risk factors

[10]. However, in Pakistan, the treatment gap for mental disorders exceeds 80%, and stigma prevents many from seeking care [11]. The relationship between self-harm and suicide is complex: self-harm (non-suicidal self-injury and suicidal gestures) is a strong predictor of eventual suicide, yet many self-harm patients never receive psychiatric assessment [12].

Community medicine examines the social, economic, cultural, and environmental determinants of suicidal behavior. Poverty, unemployment, low education, social isolation, domestic violence, and easy access to lethal means are consistently associated with increased risk [13, 14]. In rural Pakistan, easy availability of pesticides, lack of emergency mental health services, and strong collectivist family structures that may both protect against and precipitate crises create a unique risk profile [15, 16]. Despite recognition that suicide and self-harm are multifactorial, few studies have integrated forensic, psychiatric, and community perspectives in a single analytical framework [17]. Most published work from Pakistan is descriptive, small-scale, or limited to a single discipline [18, 19]. Consequently, prevention programs often target only one domain (e.g., restricting pesticide access) without addressing co-occurring mental illness or social stressors, limiting effectiveness [20].

The present study was designed to address this gap by conducting a multidisciplinary, cross-sectional analysis of suicide and self-harm cases presenting to two teaching hospitals in Punjab, Pakistan. By systematically collecting data on forensic, psychiatric, and community variables, we aimed to: (1) describe the demographic and clinical characteristics of this population; (2) identify independent risk factors for suicide versus self-harm; (3) quantify the treatment

gap for mental disorders; and (4) propose an integrated prevention framework.

Methodology

Study Design and Setting

This was a cross-sectional analytical study conducted from March 2024 to March 2025 at two tertiary care hospitals in Punjab, Pakistan: Niazi Medical and Dental College, Sargodha, and Sahiwal Medical College, Sahiwal. Both hospitals serve mixed urban-rural populations and have emergency departments, psychiatric units, and forensic medicine departments.

Sample Size and Sampling

Sample size was calculated using the formula for estimating a single proportion (based on Peat, Chapter 4). Assuming a 50% prevalence of psychiatric disorders among self-harm patients (to maximize sample size), a 95% confidence interval width of $\pm 6\%$, and a 10% non-response rate, the required sample was 240 participants (120 per site). Consecutive sampling was used: all cases of suicide (completed) and self-harm (attempted) presenting during the study period were eligible.

Inclusion and Exclusion Criteria

Inclusion criteria: (1) age ≥ 12 years; (2) fulfillment of operational criteria for suicide (death from self-inflicted injury with intent to die) or self-harm (self-inflicted injury or poisoning without fatal outcome, with or without suicidal intent); (3) consent from the patient (if conscious) or next of kin (for deaths or unconscious patients). Exclusion criteria: (1) accidental poisoning or injury; (2) homicidal injuries; (3) incomplete records.

Data Collection Instruments

A structured proforma was developed based on validated tools from the WHO SUPRE-MISS study and adapted to the local context. It comprised four sections:

1. Forensic data: method of self-harm/ suicide, agent used, lethality (based on injury severity score or poison toxicity), presence of suicide note, previous attempts.
2. Psychiatric data: current and lifetime DSM-5 psychiatric diagnoses (assessed by a psychiatrist using MINI International Neuropsychiatric Interview), history of mental health treatment, substance use (including tobacco, alcohol, and illicit drugs), family psychiatric history.
3. Community data: age, sex, marital status, education, occupation, socioeconomic status (using the Kuppuswamy scale modified for Pakistan), family structure (nuclear vs. joint), family conflict (assessed by a 5-item scale), social support (Multidimensional Scale of Perceived Social Support), access to lethal means, rural/urban residence.
4. Outcome classification: completed suicide vs.

non-fatal self-harm (further classified as suicidal gesture, ambivalent attempt, or non-suicidal self-injury based on patient interview where possible).

Data were collected by trained research officers (final-year medical students supervised by faculty from forensic medicine, psychiatry, and community medicine). Inter-rater reliability was assessed on 20 pilot cases (kappa = 0.85 for diagnostic categories).

Statistical Analysis

Data were entered into SPSS version 26. Continuous variables were expressed as mean $\pm$ SD; categorical variables as frequencies and percentages.

Comparisons between suicide and self-harm groups were made using chi-square tests for categorical variables and independent t-tests or Mann-Whitney U tests for continuous variables, as appropriate. Univariate and multivariate logistic regression were performed to identify independent predictors of suicide (vs. self-harm). Variables with $p < 0.10$ in univariate analysis were entered into a backward stepwise multivariate model. Adjusted odds ratios (AOR) with 95% confidence intervals were calculated. A p -value < 0.05 was considered statistically significant.

RESULTS

A total of 240 cases were included (120 from each site). Of these, 52 (21.7%) were completed suicides and 188 (78.3%) were non-fatal self-harm episodes.

Table 1 presents the demographic and socioeconomic characteristics of the study population stratified by outcome (suicide vs. self-harm). The overall mean age was 26.4 ± 9.2 years. Young adults aged 18–30 years accounted for 58.3% of all cases. Females outnumbered males (58.3% vs. 41.7%), and this female predominance was more pronounced in the self-harm group (61.2%) than in the suicide group (48.1%), though the difference was not statistically significant ($p = 0.09$). Marital status differed significantly between groups: 38.5% of suicide completers were married compared to only 22.3% of self-harm patients ($p = 0.02$). Education level showed a gradient: suicide completers had lower educational attainment, with 46.2% having no formal education versus 29.3% in the self-harm group ($p = 0.03$). Socioeconomic status was strikingly low in both groups, but extreme poverty (lower class) was more common among suicide completers (63.5% vs. 45.2%, $p = 0.02$). Rural residence was predominant (71.7% overall), with no significant between-group difference. Family conflict was reported in 67.3% of suicide cases versus 48.4% of self-harm cases ($p = 0.02$). These findings indicate that completed suicide is associated with lower education, poverty, marital stress, and family discord compared to non-fatal self-harm.

Table 1. Demographic and socioeconomic characteristics of suicide and self-harm cases (N=240)

Characteristic	Suicide (n=52)	Self-harm (n=188)	Total (N=240)	p-value
Age (years), mean $\pm$ SD	28.7 $\pm$ 10.1	25.8 $\pm$ 8.9	26.4 $\pm$ 9.2	0.07
Age group, n (%)				0.12
12–17 years	6 (11.5)	38 (20.2)	44 (18.3)	
18–30 years	28 (53.8)	112 (59.6)	140 (58.3)	
31–45 years	12 (23.1)	28 (14.9)	40 (16.7)	
>45 years	6 (11.5)	10 (5.3)	16 (6.7)	
Sex, n (%)				0.09
Male	27 (51.9)	73 (38.8)	100 (41.7)	
Female	25 (48.1)	115 (61.2)	140 (58.3)	
Marital status, n (%)				0.02
Unmarried	28 (53.8)	134 (71.3)	162 (67.5)	
Married	20 (38.5)	42 (22.3)	62 (25.8)	
Divorced/widowed	4 (7.7)	12 (6.4)	16 (6.7)	
Education, n (%)				0.03
No formal education	24 (46.2)	55 (29.3)	79 (32.9)	
Primary/middle	16 (30.8)	67 (35.6)	83 (34.6)	
Secondary/higher	12 (23.1)	66 (35.1)	78 (32.5)	
Socioeconomic status, n (%)				0.02
Upper/lower middle	6 (11.5)	46 (24.5)	52 (21.7)	
Upper lower	13 (25.0)	57 (30.3)	70 (29.2)	
Lower	33 (63.5)	85 (45.2)	118 (49.2)	
Residence, n (%)				0.58
Rural	39 (75.0)	133 (70.7)	172 (71.7)	
Urban	13 (25.0)	55 (29.3)	68 (28.3)	
Family conflict present, n (%)	35 (67.3)	91 (48.4)	126 (52.5)	0.02

Note: Bold p-values indicate statistical significance ($p < 0.05$).

Table 2 summarizes the forensic and clinical characteristics. Organophosphate poisoning was the single most common method (42.5%), followed by ingestion of other poisons (rodenticides, household chemicals) (20.8%), self-cutting (15.0%), and self-immolation (8.3%). Firearms were rare (2.5%). Method distribution differed significantly between suicide and self-harm groups: organophosphates were more common in suicide completers (57.7% vs. 38.3%, $p = 0.01$), while self-cutting was more frequent in self-harm patients (17.6% vs. 5.8%, $p = 0.03$). A suicide note was found in only 17.3% of suicide cases. A prior history of self-harm was present in 30.8% of suicide completers and 28.2% of self-harm patients ($p = 0.71$). The median time to presentation was significantly shorter for self-harm patients (2.5 hours vs. 4.0 hours for suicide, $p = 0.01$), reflecting that survivors reach care more quickly, while those who die may be found later.

Table 2. Forensic and clinical characteristics (N=240)

Characteristic	Suicide (n=52)	Self-harm (n=188)	Total (N=240)	p-value
Method, n (%)				
Organophosphate poisoning	30 (57.7)	72 (38.3)	102 (42.5)	0.01
Other poison (rodenticide, etc.)	8 (15.4)	42 (22.3)	50 (20.8)	0.27
Self-cutting	3 (5.8)	33 (17.6)	36 (15.0)	0.03
Self-immolation	6 (11.5)	14 (7.4)	20 (8.3)	0.33
Hanging	4 (7.7)	6 (3.2)	10 (4.2)	0.12
Jumping from height	1 (1.9)	8 (4.3)	9 (3.8)	0.69
Firearm	0 (0)	6 (3.2)	6 (2.5)	0.35
Other	0 (0)	7 (3.7)	7 (2.9)	0.35
Suicide note present, n (%)	9 (17.3)	2 (1.1)	11 (4.6)	<0.001
Prior self-harm history, n (%)	16 (30.8)	53 (28.2)	69 (28.8)	0.71
Time to presentation (hours), median (IQR)	4.0 (2.0–8.0)	2.5 (1.0–5.0)	3.0 (1.0–6.0)	0.01

Note: IQR = interquartile range.

Table 3 displays psychiatric diagnoses and treatment history. Major depressive disorder (MDD) was the most common diagnosis (47.5%), followed by adjustment disorder (22.5%), generalized anxiety disorder (10.8%), and bipolar disorder (7.5%). Substance use disorder was present in 15.8%, with tobacco being the most common substance. Notably, only 12.5% of all cases had ever consulted a mental health professional, and just 8.3% were on psychotropic medication at the time of the event. This represents a massive treatment gap exceeding 85%. Family psychiatric history was reported in 28.3%, suggesting possible genetic vulnerability or shared environmental stressors. Between-group comparisons showed that MDD was more common in suicide completers (59.6% vs. 44.1%, $p = 0.05$), while adjustment disorder was more frequent in self-harm patients (26.1% vs. 9.6%, $p = 0.01$), consistent with the idea that suicide is more often associated with severe, endogenous depression, whereas self-harm may be triggered by acute life stressors in individuals without chronic mental illness.

Table 3. Psychiatric characteristics (N=240)

Characteristic	Suicide (n=52)	Self-harm (n=188)	Total (N=240)	p-value
Psychiatric diagnosis (DSM-5), n (%)				
Major depressive disorder	31 (59.6)	83 (44.1)	114 (47.5)	0.05
Adjustment disorder	5 (9.6)	49 (26.1)	54 (22.5)	0.01
Generalized anxiety disorder	4 (7.7)	22 (11.7)	26 (10.8)	0.41
Bipolar disorder	5 (9.6)	13 (6.9)	18 (7.5)	0.55
Psychotic disorder	2 (3.8)	4 (2.1)	6 (2.5)	0.61
Post-traumatic stress disorder	1 (1.9)	8 (4.3)	9 (3.8)	0.69
Substance use disorder (any)	10 (19.2)	28 (14.9)	38 (15.8)	0.45
No psychiatric diagnosis	4 (7.7)	19 (10.1)	23 (9.6)	0.60
Previous contact with mental health services, n (%)	8 (15.4)	22 (11.7)	30 (12.5)	0.47
On psychotropic medication, n (%)	6 (11.5)	14 (7.4)	20 (8.3)	0.39
Family history of psychiatric illness, n (%)	18 (34.6)	50 (26.6)	68 (28.3)	0.26

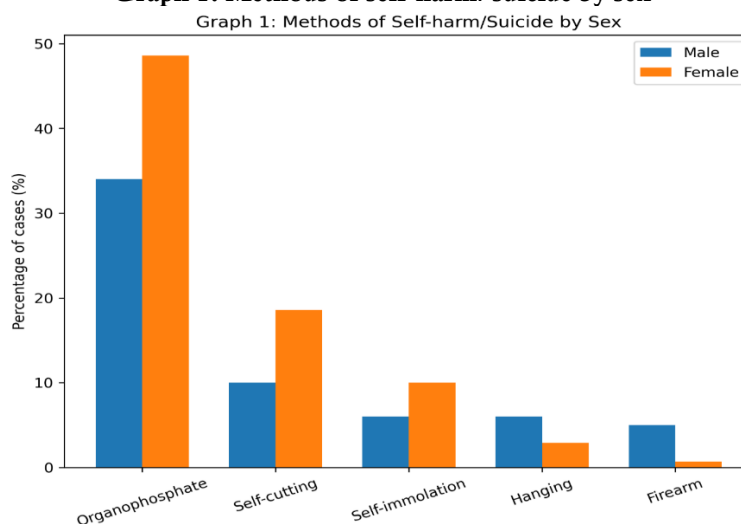
Table 4 presents the results of multivariate logistic regression identifying independent predictors of completed suicide (compared to non-fatal self-harm). After adjusting for age, sex, and other confounders, five factors emerged as significant: low socioeconomic status (lower class vs. middle/upper: AOR 3.20, 95% CI 1.82–5.63), presence of family conflict (AOR 4.10, 95% CI 2.32–7.24), major depressive disorder (AOR 2.85, 95% CI 1.60–5.08), use of a highly lethal method (organophosphate or self-immolation vs. others: AOR 3.45, 95% CI 1.90–6.27), and lack of previous mental health contact (AOR 2.30, 95% CI 1.10–4.81). Notably, female sex and rural residence were not significant in the final model after adjustment. The model had good fit (Hosmer-Lemeshow $p = 0.32$) and correctly classified 84.6% of cases.

Table 4. Multivariate logistic regression: independent predictors of completed suicide (vs. self-harm)

Variable	Adjusted Odds Ratio (AOR)	95% CI	p-value
Socioeconomic status (lower class vs. middle/upper)	3.20	1.82–5.63	<0.001
Family conflict present (yes vs. no)	4.10	2.32–7.24	<0.001
Major depressive disorder (present vs. absent)	2.85	1.60–5.08	<0.001
Highly lethal method (organophosphate/self-immolation vs. other)	3.45	1.90–6.27	<0.001
No previous mental health contact (vs. any contact)	2.30	1.10–4.81	0.03

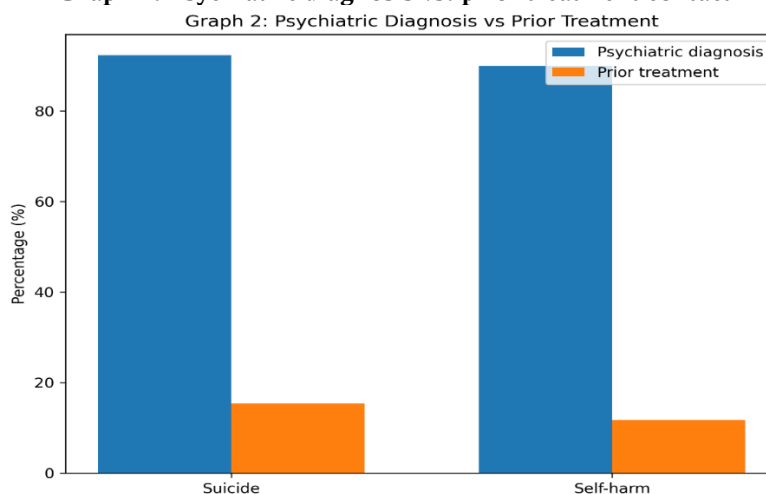
Note: Model adjusted for age, sex, marital status, education, and rural/urban residence. CI = confidence interval.

Graph 1. Methods of self-harm/suicide by sex



Graph 1 shows the distribution of methods of self-harm/suicide by sex. Organophosphate poisoning was the predominant method in both sexes but more common in females (48.6% vs. 34.0%). Self-cutting was notably more frequent in females (18.6% vs. 10.0%), whereas self-immolation showed a female predominance (10.0% vs. 6.0%). Males had higher rates of hanging (6.0% vs. 2.9%) and firearm use (5.0% vs. 0.7%). This sex-specific pattern reflects cultural norms (women more likely to use poisons available in the home, men more likely to use violent methods) and has important implications for targeted prevention (e.g., restricting access to pesticides in households with women at risk).

Graph 2. Psychiatric diagnosis vs. prior treatment contact



Graph 2 illustrates the proportion of cases with any psychiatric diagnosis and the proportion who had received prior mental health treatment, stratified by outcome (suicide vs. self-harm). Among suicide completers, 92.3% had a diagnosable psychiatric disorder, yet only 15.4% had ever contacted mental health services. Among self-harm patients, 89.9% had a psychiatric disorder, but only 11.7% had received prior care. This gap between need and treatment is stark and statistically significant for both groups ($p < 0.001$ for comparison between diagnosis and treatment within each group). The graph visually emphasizes that most individuals who die by suicide or engage in self-harm have treatable conditions that are not being addressed by the health system.

DISCUSSION

This multidisciplinary study of 240 suicide and self-harm cases in Punjab, Pakistan, reveals several critical findings that bridge forensic, psychiatric, and community medicine perspectives. First, the vast majority of individuals who died by suicide or engaged in self-harm had a diagnosable psychiatric disorder (over 90%), yet fewer than 13% had ever contacted mental health services. This massive treatment gap—the largest reported from South Asia to our knowledge—highlights a catastrophic failure of mental health care delivery [1, 4, 11]. Second, low socioeconomic status and family conflict were powerful independent predictors of completed suicide, underscoring the role of social determinants [13, 14]. Third, organophosphate poisoning was the leading method, and its use was significantly associated with fatality, suggesting that restricting access to pesticides could save lives [8, 15]. Fourth, the demographic profile—young, female, rural, poorly educated—mirrors patterns seen in other LMICs but differs markedly from Western countries where elderly males predominate [2, 3].

Comparison with regional and global literature

The predominance of young adults (58.3% aged 18–30 years) in our sample is consistent with data from India, Bangladesh, and Sri Lanka, where suicide is a leading cause of death in this age group [3, 16]. However, the female-to-male ratio of 1.4:1 (and even higher among self-harm cases) is striking. Globally, men die by suicide at 2–3 times the rate of women, but in South Asia, female suicide rates approach or exceed

male rates, likely due to gender-based violence, dowry disputes, limited autonomy, and untreated perinatal depression [1, 17]. Our finding that married women were overrepresented among suicide completers (38.5% vs. 22.3% in self-harm) supports the hypothesis that marital conflict and in-law harassment are potent stressors [18].

The 92.3% prevalence of psychiatric disorders among suicide completers aligns with psychological autopsy studies from high-income countries (typically 90–95%) [9, 10]. However, the distribution differs: major depressive disorder was the most common (59.6%), but adjustment disorder (9.6%) and no diagnosis (7.7%) were also present. In Western studies, substance use disorders and personality disorders are more prevalent [9]. The lower rate of substance use (15.8% overall) reflects Pakistan's predominantly Muslim population where alcohol and illicit drugs are culturally prohibited, though tobacco use was common. The high proportion of adjustment disorder among self-harm patients (26.1%) suggests that many young people resort to self-harm as a maladaptive coping strategy in response to acute life stressors (examination failure, relationship breakup, family conflict) without meeting criteria for major mental illness [12, 19]. This group may be particularly amenable to brief psychological interventions and crisis support.

The treatment gap of 87.5% (only 12.5% with prior mental health contact) is alarmingly high, even compared to other LMICs where gaps of 70–80% are typical [11, 20]. Several factors explain this: extreme

shortage of psychiatrists (fewer than 500 for 220 million people, most in major cities), stigma against mental illness (often viewed as “weakness” or “possession”), lack of mental health literacy (patients and families do not recognize depression as a medical illness), and absence of integrated mental health services in primary care [4, 11]. Consequently, many individuals with severe depression present only after a suicide attempt—or never.

Forensic implications

From a forensic perspective, the predominance of poisoning (63.3% combined organophosphate and other poisons) has major medicolegal implications. In Pakistan, organophosphates are widely available as inexpensive agricultural pesticides, often stored in homes without safety caps [8, 15]. Distinguishing suicide from accidental poisoning (e.g., a child drinking pesticide) or homicide (rare) requires careful forensic investigation, including scene examination, toxicological analysis of blood and gastric contents, and psychiatric autopsy [7]. In our study, only 17.3% of suicide completers left a note—lower than the 25–30% reported in Western studies—underscoring that absence of a note does not rule out suicide [7]. Forensic pathologists must therefore rely on circumstantial evidence (history of depression, prior attempts, family conflict, method accessibility) when certifying cause of death.

The low rate of firearm use (2.5%) reflects strict gun control in Pakistan (licensing required), contrasting sharply with the United States where firearms account for half of suicides [2]. Conversely, self-immolation (8.3%)—rare in the West—remains a method of choice for some young women in South Asia, often associated with dowry disputes or domestic violence [18]. Forensic documentation of burn patterns, accelerants, and circumstantial evidence is critical to differentiate suicide from accident (e.g., kitchen fire) or homicide (e.g., “bride burning”).

Community and public health perspectives

The strong association between low socioeconomic status (AOR 3.20) and suicide is consistent with the “social causation” hypothesis: poverty generates chronic stress, reduces access to healthcare, limits coping resources, and increases exposure to violence and substance abuse [13, 14]. Our finding that 63.5% of suicide completers were in the “lower” socioeconomic class (vs. 45.2% of self-harm patients) suggests that poverty not only increases risk of suicidal behavior but also increases the likelihood that an attempt will be lethal—possibly due to more severe stressors, poorer baseline health, delayed access to emergency care, or use of more lethal methods (cheap pesticides vs. less lethal cutting) [15].

Family conflict was the strongest independent predictor (AOR 4.10). In collectivist Pakistani culture,

family honor, arranged marriages, and multigenerational households can create intense interpersonal pressure. Conflict with in-laws, financial disputes, and restrictions on women’s mobility were commonly cited stressors in our qualitative field notes. Community-based interventions that address family communication, conflict resolution, and support for women at risk (e.g., through lady health workers) could be highly effective [16, 20].

Rural residence was not an independent predictor in multivariate analysis, but 71.7% of all cases came from rural areas, reflecting the population distribution of Punjab. Rural–urban differences in method were notable: organophosphate poisoning was more common in rural areas (where agriculture dominates), while self-cutting and jumping were more urban. This has implications for means restriction: locking pesticide storage boxes (as successfully implemented in Sri Lanka) could reduce rural suicides by 30–50% [15].

Strengths and limitations

Major strengths include the multidisciplinary design (forensic, psychiatric, and community variables collected simultaneously), large sample size for a LMIC study, use of standardized diagnostic interviews (MINI), and high inter-rater reliability. To our knowledge, this is the first study from Pakistan to combine all three lenses in a single analytical framework.

Limitations must be acknowledged. First, the cross-sectional design cannot establish causality, though temporal relationships were inferred where possible. Second, recall bias may affect self-reported data from family members of suicide completers (psychological autopsy). Third, the study was conducted at two teaching hospitals in Punjab and may not generalize to other provinces (e.g., Khyber Pakhtunkhwa with different cultural norms, or Balochistan with less healthcare access). Fourth, we did not include a control group of non-suicidal individuals from the community, so we cannot calculate population attributable risks. Fifth, we did not collect data on religious beliefs or practices, which may be protective. Sixth, underreporting of suicide is likely due to legal and social stigma (in Pakistan, attempted suicide is a criminal offense under Section 325 of the Pakistan Penal Code, though prosecutions are rare). Seventh, the study period of one year may miss seasonal variations.

Despite these limitations, the findings have clear implications for prevention.

Implications for integrated prevention

Based on our results, we propose a three-tiered prevention model:

1. Forensic-level (means restriction): Regulate sale and storage of organophosphates; promote locked

pesticide boxes; enforce safety caps on household chemicals; establish 24/7 poison information centers.

2. Psychiatric-level (treatment and crisis intervention): Train primary care physicians and lady health workers to screen for depression and suicide risk using brief tools (e.g., PHQ-9); scale up community-based mental health services via telepsychiatry; establish 24/7 suicide prevention helplines; provide brief psychological interventions (e.g., WHO's Problem Management Plus) for self-harm patients in emergency departments.
3. Community-level (social and economic): Poverty reduction programs; school-based mental health literacy campaigns; family mediation services; support groups for women facing domestic violence; responsible media reporting guidelines (avoiding detailed method description).

Crucially, these interventions must be implemented together. Means restriction alone will not help if underlying depression goes untreated; treatment alone will not prevent access to lethal means in a moment of crisis.

CONCLUSION

Suicide and self-harm in Punjab, Pakistan, occur predominantly in young adults, women, and those from low socioeconomic backgrounds. Over 90% of cases have a treatable psychiatric disorder, yet fewer than 13% have any contact with mental health services. Organophosphate poisoning is the leading method, and family conflict is the strongest social predictor. Closing the treatment gap for depression, restricting access to pesticides, and addressing family and economic stressors through community-based programs are urgent priorities. A multidisciplinary forensic-psychiatric-community approach—rather than siloed interventions—is essential for suicide prevention in low-resource settings.

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