Understanding Suicide and Help-seeking in Urban and Rural Areas in Northern Ireland

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Executive Summary

A sizeable minority of people who take their own lives do so without any apparent warning or indication to others. Specifically, they do not contact their family doctor ot any other health professionals. However, most people who complete suicide are in contact with their family doctors in the preceding 12 months. A better understanding of the nature of these contacts

and the various pathways experienced by suicidal people should reveal the gaps and barriers to effective service provision. We also need better information about the dificulties experieced by family carers, both prior to the death and afterwards. We were commissoned by the R&D Division of the Northern Ireland Public Health Agency to address the gaps in our understanding of suicide in NI. We undertook a mixed methods study in which we examined help-seeking pathways of people who have died by suicide. We also undertook a detailed investigation of those bereaved by suicide to examine needs, coping strategies and use of support services. The findings produced by this study are intended to underpin recommendations targeted at primary and community services related to suicide prevention and support for the bereaved.

Background

Research suggests that as many as half of those suffering from some form of mental illness do not receive treatment from recognised psychiatric care (Reiger *et al.*, 1993). Psychological problems among single, isolated and unemployed people may be less detected because such problems impinge on few others. For those more socially connected, the family's response is often influenced by its own social and psychiatric problems, knowledge and access to resources and fear of community stigma (Cole *et al.*, 1995, Leavey *et al.*, 2007). In addition there is considerable variation in people's evaluation of distress and subsequent coping styles. For example, men are more likely to ignore or conceal their problems because it interferes with masculine self-image (Warren, 1983).

Of potential relevance to urban-rural differences in helpseeking, the 'tightness' of social support on offer to the individual within different communities may determine the length and type of containment of distress before professional involvement (Bott, 1957, Rogler and Cortes, 1993). Thus, the stronger the interconnectedness of social networks, the greater is the delay in contacting health professionals (Birkel and Respucci, 1983). The strength of social support within close-knit networks may obviate or lessen the need for professional services. Mental illness, including severe mental illness such as schizophrenia, has been strongly associated with urban living (Dohrenwend, 1980). Of course, urban and rural populations differ in a number of ways, especially in relation to physical and social environments. For example, access to private (shopping and leisure) and public (employment, education, transport and health) facilities (Levin, 2003, Shucksmith and Philip, 2000). These populations also differ considerably in terms of population settlement, community cohesion and activity. However, many rural communities in the UK and Ireland have experienced increasingly high levels of unemployment, homelessness and delinquency while social isolation remains a major feature of rural life (Nicholson, 2008). Relatively greater access to the means of lethality in rural environments (firearms and poisons) has long been associated with suicide among people in farming communities (Luoma *et al.*, 2002, Stack, 2000). There is some evidence that stigma related to mental illness tends to be greater among people in rural areas and may be compounded by relatively lower health service provision.

Main research questions and objectives

We aimed to address several, interrelated questions: (1) Are there differences in help-seeking behaviour for suicidal people and those affected by suicide between urban and rural areas? (2) Do people bereaved by suicide resident in urban and rural areas employ different coping strategies and support systems? (3) Are there differences in access to support services for those bereaved by suicide in urban and rural areas? (4) How might primary care and other services be best configured to accommodate the suicide related needs of people in urban and rural areas?

Objectives

1. To undertake a systematic detailed examination of help-seeking by people in Northern Ireland who have died by suicide over a two year period.

2. To examine help-seeking and coping strategies employed by suicidal people from the perspective of family and friends.

3. To assess the impact of suicide on people bereaved by suicide by exploring coping strategies and the provision (and uptake) of support services for the bereaved.

4. To explore the experiences and needs of GPs in caring for people who have died by suicide.

Study design and report structure

The study was undertaken in three stages and is therefore presented in the following sections.

(1) Coroner and general practice data: analysis of socio-demographic and situational data related to suicide, self-harm and contact with health and social care services.

(2) The perspectives of people bereaved by suicide: a qualitative study of suicide attributions, the impact of suicide on families and friends, help-seeking and use of services.

(3) General practitioners' experience of suicide: a qualitative study of suicidal patients and suicide in primary care.

Methodology

The study was undertaken using a mixed methods approach. Data were collected from four distinct sources as listed below. This approach was developed to provide a variety of perspectives relating to singular suicidal acts, in an effort to better understand the events that led to the suicide and to provide information to support the development of opportunities for prevention.

Data sources:

1. Records held by Coroner Service for Northern Ireland (CSNI) of the individuals who died by suicide occurring between March 2007 and February 2009 (n=403);
2. Records held by GPs of the individuals who died by suicide (n=360);
3. Qualitative interview data obtained from the next of kin of those who died by suicide (n=72); and
4. Qualitative interview data from GPs attending to a person who died by suicide (n=19)

Findings: Coroners and General Practitioner Records

- Males comprised 81% of the cohort, with suicide peaking among the 25-34 age group in men (n=80, 24.8% of deaths)
- Suicide in females peaked later in the 35-44 age groups (n=22, 28.2% of deaths)
- There were no significant differences for the incidence of suicide between urban-rural areas.
- Forty-one per cent of suicides had no prior mental health diagnosis
- Common mental disorders were recorded in GP records for 33% of suicides, serious mental illness in 12% and substance misuse in 14% of the cohort
- Attendance at the GP was recorded for 87% in the previous 12 months, 57% in the previous 3 months and 29% in the previous month

- 19% of the cohort had 10 or more visits in the 12 months before death.
- Living alone, professional status, no paid work, town locations and psychiatric diagnoses were particularly associated with increased attendance at the GP
- There were no significant differences in access to primary care services across rurality, with the exception of elevated attendance foe women living in towns
- 41% had contact with accident and emergency services in the previous 12 months, with 58% of these relating to a mental health crisis.
- 18% had contact with a social worker over the previous 12 months, with 92% of these contacts for mental health support
- 35% of the cohort had seen a psychiatrist in the previous 12 months and 29% had been supported by Community Mental Health Teams (CMHTs)
- Within the cohort, 76% died by hanging (78% of male suicides and 65% of female), 6% died by overdose (4% male and 15% of female) and 6% died by drowning (5% and 9% to males and females respectively).
- Previous suicide attempts were recorded for 39.7% (n=159) of the cohort
- Over a quarter of the cohort (27%, n=109) were in receipt of more than four prescription medications, with 38.5% (n=155) in receipt of a prescription for antidepressant medications (9.2% of these had no mental health diagnosis)

Findings: In-depth Family Interviews

Explanatory models and suicide attribution: How individual family members make sense of suicide may have an impact on their psychological wellbeing. Thus, we explored the participants' explanatory models of suicide.

Perhaps predictably, many of the deaths are understood as related to mental illness. In some cases, these are related to people with severe and enduring mental illness such as psychosis and for whom the explanation is contained within the diagnosis. However, for many others, the mental illness, generally described as an affective disorder, is very strongly associated by the participants as arising from recent life events and/or circumstances such as marital breakdown or a financial crisis. More distant life events such as childhood abuse were seen as contributing to a lifetime of problems. Suicide among older people is described as a resolution to pain and disability. Across many deaths, alcohol, helplessness and impulsivity were regarded as contributing factors.

Barriers to suicide prevention

Stigma:

The stigma of mental illness remains a major barrier to the disclosure of psychological problems, commonly featuring within participant narratives in relation to avoidance, late access and poor engagement with primary care and mental health services. This is compounded by particularly negative perceptions of psychiatric services.

Alcohol:

Alcohol appears to both mask and exacerbate long-standing problems. Substantial lifetime use of alcohol and/or recent and problematic increase in alcohol consumption was regarded as critical in the understanding of individual suicide cases and the inability to get appropriate and timely help.

GP training, recognition and management:

We found widespread acknowledgement that GPs are ill prepared for the management of mental illness. Too often, the pressure of patient waiting rooms and waiting lists compounds this. Manifested in the ‘ten-minute’ rule for consultation, high levels of demand ensures that people with complex psycho-social needs are afforded only the most superficial articulation of their problems.

Additionally, GPs suggest that formulaic approaches to suicide risk assessment act as a barrier to patient trust and engagement.

Information sharing, confidentiality and decision-making:

Families described their distress at being left with the responsibility of looking after a suicidal family member but lacking the skills and knowledge to do so effectively.

They report being excluded from the decision-making process, a process that was frequently perceived to lack ‘expert’ input from people who really understood the patient and his or her context.

Anti-depressant use and treatment options:

The issue of antidepressants is relatively neglected within the context of suicide prevention. Many relatives highlighted their dissatisfaction with medication. The following factors are highlighted: (a) perceived lack of assessment and consultation with family and patient; (b) inappropriate prescription; (c) failure to offer alternatives to medication; (d) fear of addiction; (e) side-effects; (f) the failure of clinicians to review; and (g) the perceived or felt ineffectiveness of medication.

Service Fragmentation:

GPs highlight the problems of long waiting lists for referral, delays to hospital admission and a general disconnection between primary care and psychiatric services.

Where a 'functional split' model has been adopted in mental health services, consultant psychiatrists are no longer responsible for patients across the range of treatment settings. For many GPs this lack of a central contact obstructs GP care of people with mental illness, on a range of levels and issues.

In other instances, some patients were described as being at increased risk because of transitional boundaries. For example, young people who having been seen in Child and Adolescent Mental Health Services (CAMHS) but were not transferred into adult care. When connections and relationships dissolved in these structures, so too did the continuity of care.

The impact of suicide on the family

Families are often deeply scarred by suicide. Participants report intense feelings of mental anguish related to guilt, rejection and betrayal. In general, participants, especially women with young children, used medication (e.g. sleeping tablets or antidepressants) to get through the early stages of bereavement. Other participants, reported longer-term depression and anxiety requiring treatment. In a few number of cases, hospitalisation for psychiatric treatment was necessary.

The response and provision of care by GPs and community-based organisations are highly variable with much criticism about the type and availability of care for families.

Recommendations

Recommendations emerging from the research can be grouped under five broad areas and we suggest that they should be considered as integral to a review of the suicide prevention strategy of Northern Ireland.

The five broad strands of service provision are:

1. **Public Health: tackling stigma**
2. **Primary Care: improving competencies in mental health and suicide prevention**
3. **The Voluntary Sector: integration and regulation**
4. **Mental Health Services: primary care liaison**
5. **Hidden suicide support needs: families first**

Public Health: tackling stigma

We need to change these culturally entrenched attitudes to mental illness as early in the lifespan as possible, ideally in schools. Tackling the stigma of mental illness and providing educational programmes on mental health literacy, defined as " knowledge and beliefs about mental disorders which aid their recognition, management or prevention"(Jorm *et al.*, 1997) should be adopted by schools within the Personal, Social, Health & Economic (PSHE) within schools.

Stigmatising attitudes and behaviour towards people with mental illness, those who attempt suicide and those with alcohol problems are sometimes casually propagated within our health and social care services, and may have devastating consequences for the recipients and their families. Training should be considered for all staff such as paramedics and those working in A&E.

There is a need to challenge the highly negative and commonly held beliefs about psychiatric services. The Royal College of Psychiatry in Northern Ireland and the Health & Social Care Trusts should be engaged in an understanding of, and resolution to this problem.

Primary Care: improving competencies in mental health and suicide prevention

We propose a strengthening of mental health resources within Primary Care. We understand that the RCGP in England is currently exploring new ways of working with other statutory and voluntary sector bodies such as the Royal College of Paediatrics and Child Health, the Royal College of Psychiatrists, and Young Minds. This may allow GPs and other specialists to train together and to work more effectively, particularly when caring for young people with mental health problems.

Primary care might benefit from the presence of mental health professionals – community psychiatric nurses and social workers, working within general practice. Extended community liaison roles (with voluntary sector providers) for trained counsellors working directly alongside GPs. The additional knowledge and experience offered by these roles may assist in achieving a better understanding of patient treatment preferences and a stronger therapeutic engagement.

The Voluntary Sector: integration and regulation

Among families and GPs alike, there is a notable lack of clarity about the role, function and effectiveness of community and voluntary sector organisations.

While the under-resourcing of mental health provision in primary care is a significant problem and can only be addressed at the macro-political level, there is much room for better-integrated care. It seems likely that the voluntary sector will increasingly assume the provision of psychological therapies. There is a need, therefore, for clear monitoring of patient outcomes and consistent reporting and feedback into primary care.

Improved outcomes-based reporting, from the variety of counselling and support services provided within the voluntary sector, would help to build the required level of trust and respect GPs need to refer individuals for support. This would also assist commissioners in allocating funding appropriately. It is possible that with the permission of voluntary sector clients, the GP should be notified and kept appraised of an individual’s mental health problems, progress and outcomes.

Mental Health Services: primary care liaison

The reported disjunction between primary care and mental health services requires attention. Effective, knowledgeable and most importantly, reachable key liaison contacts for GPs within mental health services are urgently required. In areas where the functional split model of mental health service provision exists, difficulties in GP-psychiatry relationships are likely to persist.

Again, improved integrated care will depend on building closer personal relationships between mental health professionals and general practitioners. There is a need for some degree of standardisation across NI Health and Social Care Trusts on the most efficient way to deliver integrated services, particularly in areas of contentious responsibility e.g. age determined mental health services.

Hidden suicide support needs: families first

Information sharing and decision-making

It is time to rethink how services can better engage with the ‘insider’ knowledge of families and usefully assimilate the views of families into the decision-making process. The suicide prevention strategy in England emphasises the need to improve information and support to families concerned about a relative who may be at risk of suicide. There is an acknowledgement also, that clinicians may too readily invoke the duty of confidentiality without consideration of the concerns and needs of family members. However, a recent consensus statement from the Department of Health and relevant partner organisations indicated that there are times when “practitioners may need to consider informing family and friends about aspects of risk and may need to create a channel of communication for both giving and receiving information that will keep the person safe” (Department of Health, 2014). The statement suggests that, “*If a person is deemed to be at imminent risk of suicide there may well be sufficient doubts about their mental capacity at that time*”. Further, “*if the purpose of disclosure is to prevent a person who lacks capacity from serious harm, there is an expectation that practitioners will disclose relevant confidential information, if it is considered to be in the person’s best interest to do so*”.

The impact that suicide may have on other people should be taken into account. Ultimately, while determining the immediacy of suicide risk and the timing and level of disclosure is a matter of professional judgement in each individual case, practitioners are nevertheless free to offer non-person specific information on crisis and other services.

Dealing with the impact of suicide on families

There seems to be no coherent strategy for looking after the needs of family survivors. While some people bereaved by suicide resolutely resist professional support and advice, others simply lack an understanding about what to expect, who to turn to, or have an awareness of useful coping strategies. This is especially striking in families with young children.

While each suicide and every family’s circurmstances are unique, there are many shared aspects of sucide within the family, and these should be acknowledged and made available through information and educational material. Research is needed on the scope, content and dissemination of such materials.

The Coroner’s Office was universally regarded as respectful and sensitive in dealing with the concerns and needs of families. Additional advisory and signposting resources located with personnel in the coroner’s office, could be made available to families at this earliest point of connection. Such additional investment in the services provided by Coroners Liaison Officers could improve awareness of the support landscape for many families.

Dealing with the impact of suicide on service professionals

Hidden suicide support needs also apply to service providers dealing with suicide. Patient suicide is distressing for GPs and appears to exact a heavy toll on their personal wellbeing and professional confidence. The Royal College of General Practitioners (RCGP) should consider mechanisms for better psychological and professional support for doctors who have experienced a suicide in practice.

Senior managers need to be mindful of the pressures that can complicate the aftermath of a suicide within teams of mental health professionals, such as the process of a Serious Incident Report investigation. Importantly, staff who are well supported through an efficient process are in a better position to engage with such processes and to meaningfully suport service user and family involvement.

Suicide in Northern Ireland: Help-seeking and Service Use in Urban and Rural Areas

Final report of a three-year study of help-seeking in relation to a cohort of suicides occurring in Northern Ireland (NI) over a two-year period

Introduction

Suicide is a major public health problem. In western societies, the major consistent factors known to influence suicide rates are: mental illness, gender, age, social class, employment, poor physical health, substance misuse and social isolation (Pitman *et al.*, 2012). Each year approximately one million people die from suicide around the world (WHO, 2014). Rates of suicide vary extensively across countries, with the greatest burdens in developing and western countries (Cantor, 2000, Hawton and van Heeringen, 2009). Within Europe, lower rates are reported in southern countries compared to northern countries, with the highest rates shown in Eastern Europe (Cantor, 2000, Hawton and van Heeringen, 2009). Worldwide the highest rate of suicides are in China, accounting for 30% of all deaths, and with rates three times higher in rural than in urban areas (Hawton and van Heeringen, 2009). While suicide rates in the western world have shown consistent patterns over time, in recent years there has been an increase of suicides in the 15-24 year-old group, specifically males (Cantor, 2000). These rises have been particularly noticeable in the United Kingdom (UK), Ireland, the United States (USA), Australia and New Zealand (Cantor, 2000). In the UK there were 6,045 suicides in 2011, an increase of 437 deaths compared to 2010.

In Western societies men are more likely to end their lives than women, a ratio that is constant at 4:1. A number of factors are associated with this. First, men tend to use more lethal methods, therefore, reducing opportunities for rescuing or resuscitation. Second, males are more prone to impulsivity and violence, as well as substance abuse. Third, the presence of higher co-morbidity of affective and substance abuse disorders in males than females. Fourth, males are less likely than females to seek help. Males also appear to be less resilient than women to the adverse effects of relationship breakdown and other stresses (Cantor, 2000).

Suicide has a strong association with mental health problems (Beskow, 1979, Cheng, 1995, Foster *et al.*, 1999). It has been argued that 90% of people who die by suicide are likely to have experienced a psychiatric disorder (Lönnqvist, 2000). Depression is the most common psychiatric disorder (Hawton *et al.*, 2013) noted in no less than 60% of cases, which may be also complicated by other disorders, such as alcohol abuse and personality disorders

(Centre for Suicide, 2012). In the UK, including NI, it has been reported that 15% of inpatient suicides between 2001 and 2011 had a dual diagnosis (Appleby *et al.*, 2013a).

Suicide in Northern Ireland

For most of the 20th century, both Northern Ireland and the Republic of Ireland had relatively low suicide rates, generally sitting midway in the suicide tables of Western societies (Lester *et al.*, 1997, Murphy *et al.*, 2015). The suicide rate in Northern Ireland in recent years, compared to those of other UK regions, is similar to that of Scotland but higher than rates in England and Wales. According to analysis undertaken by the Samaritans organisation (Scowcroft, 2015), NI has witnessed an increase in the overall rate, with substantial variations and a marked increase around 2005-2007. Thus, the male suicide rate in 2013 (25.5 per 100,000) was approximately double what it was in 1983 (13.3 per 100,000). In 2013, the female suicide rate was the same as it was in 1983 (Northern Ireland Statistics and Research Agency, 2013).

Urban and rural suicide

Suicide is often regarded as an urban phenomenon, with rural areas usually exhibiting better mental health and lower suicide mortality (Riva *et al.*, 2009). Hirsh (2007), in a review of the literature on rural suicide, outlines a general trend of increasing rural suicide when compared to urban areas, sustaining the view of either changing patterns or the more nuanced recognition of the developing problem of rural suicide. For example, an analysis of rural suicide in Australia, (Dudley *et al.*, 1997, Dudley *et al.*, 1998) shows that rural areas in the late 1990s experienced the steepest rises in suicide in young adults since the 1960s/1970s – a phenomenon possibly related to a relatively greater decline in the rural economy and its social sequelae such as family break-up and the impact of migration. An analysis of differences in rural mortality relative to urban mortality in England and (separately) Wales showed small differences in suicide levels: using mortality data from 2003-2004 and after adjustment for deprivation levels, English males living in rural areas recorded a significant 12% higher risk, while in Wales similarly defined females in rural areas recorded a 27% higher risk (Office for National Statistics, 2008).

A recent study on suicide in NI confirmed the well-known associations with indicators of social isolation and socio-economic disadvantage at both the individual and household levels (O' Reilly *et al.*, 2007). However, there is no robust epidemiological evidence to suggest that area deprivation or social fragmentation as stand-alone factors have an impact on suicide rates in NI, when analysed independently of personal and household characteristics. Nonetheless, rural dwellers may have stronger conservative and religious views than urban dwellers, factors generally considered to be protective, but taking individual and household characteristics into account those living in the least densely populated areas may experience a slightly higher risk of suicide when compared to those living in the most densely populated areas (O'Reilly *et al.*, 2008). Other contributory factors may include access to the means such as poisoning by pesticides, coupled with greater access to a private setting in which to carry out a suicide. However, the evidence for differences in urban-rural suicide rates in Northern Ireland is currently weak (O'Reilly *et al.*, 2008).

Current suicide prevention policies in the Republic of Ireland, England and Scotland incorporate specific recognition of and provision for tackling suicide and the impact of suicide according to geographic rurality. However, Northern Ireland's *Suicide Prevention Strategy and Action Plan 2006-2011* (DHSSPS, 2006) is somewhat weak in this dimension. Morbidity and mortality statistics on the NI population including general mental health are, on the whole, favourable towards rural areas (O'Reilly *et al.*, 2008). However deaths in younger people are on the increase in rural NI, partly because the suicide rate in rural NI has increased by a third since 2001 (Stewart *et al.*, 2007). This increase warrants further investigation to develop a better understanding of the mechanisms behind such a rise. This research directly addresses this need by providing an appropriate evidence base for creating geographically appropriate prevention and intervention plans to reduce suicide rates and to ease the impact of suicide in both urban and rural settings across NI.

Help-seeking and suicide

Although the experience of distressing psychological symptoms is the most powerful predictor of seeking help (Greenley *et al.*, 1987) many people meeting diagnostic criteria for mental disorders fail to reach care. A large cross-national, population-based survey revealed that most people with suicidal thoughts, plans or attempts do not receive mental health treatment in any form. The rate of treatment was especially low in middle- and low-income countries. However, receipt of care was positively associated with severe suicidality and among those with mood or anxiety disorders. The authors note that among suicidal respondents who did not receive any care, failure to seek treatment was predominantly related to low perceived need, followed by other attitudinal and structural barriers (Pollock and Grime, 2002). Indeed, other research suggests that as many as half of those suffering from some form of mental illness do not receive treatment from recognised psychiatric care (Reiger *et al.*, 1993). Of serious concern is the evidence that among the young people with a diagnosable mental illness, only one third of these ever receive professional help (Green *et al.*, 2005, World Federation for Mental Health, 2009). Even those with severe problems avoid seeking help or have considerable delays in getting appropriate help (Biddle *et al.*, 2006, Burns *et al.*, 1995, Goodman *et al.*, 2002). Thus, the costs incurred by late detection and untreated adolescent mental illness are likely to be considerable, impacting as they do on the individual, their families and communities. For people of all ages, symptoms more likely to be acknowledged as problems are those which are severe, numerous and impair role functioning in family relationships or in work settings, are more likely to be noticed, as are those which are more externally exhibited and obvious to others (Mechanic, 1978). Thus psychological problems among single, isolated and unemployed people may be less likely to be picked up because such problems impinge on few others. For those more socially connected, the family's response is often influenced by its own social and psychiatric problems, knowledge and access to resources and fear of community stigma (Cole *et al.*, 1995, Leavey *et al.*, 2007). In addition there is considerable variation in people's evaluation of distress and subsequent coping styles. For example, men are more likely to ignore or conceal their problems because it interferes with masculine self-image (Warren, 1983).

Of some relevance to urban-rural differences, the 'tightness' of social support on offer to the individual within different communities may determine the length and type of containment of distress before professional involvement (Bott, 1957, Rogler and Cortes, 1993). Thus, the stronger the interconnectedness of social networks, the greater is the delay in contacting health professionals (Birkel and Respucci, 1983). Rogler and Cortes (1993) speculate that in open networks, individuals are fairly detached from each other and more inclined or exposed to wider environmental information which includes alternative (non-normative) and other sources of health care, thus making professional treatment more likely. Conversely, in close-knit networks, the individual may experience greater pressure to accept normative beliefs which may be at variance with the culture of the health care providers, making professional consultation less likely. The strength of social support within close-knit networks may obviate or lessen the need for professional services.

Help-seeking in urban and rural areas

Mental illness, including severe mental illness such as schizophrenia, has been strongly associated with urban living (Dohrenwend, 1980). Of course, urban and rural populations differ in a number of ways, especially in relation to physical and social environments. For example, there is, commonly, considerable variation in provision of and access to private (shopping and leisure) and public (employment, education, transport and health) facilities (Levin, 2003, Shucksmith and Philip, 2000). These populations also differ considerably in terms of population settlement, community cohesion and activity. Thus, overcrowding, transience, crime and social fragmentation tend to be associated with urban life and conversely a quiet, settled conservatism are part of any characterisation of rural areas (Department of Agriculture and Rural Development, 2008). However, it is important to note that these ascribed typologies are not universally meaningful and ignore the social heterogeneity within rural communities. Certainly, many rural communities in the UK and Ireland have experienced increasingly high levels of unemployment, homelessness and delinquency while social isolation remains a major feature of rural life (Nicholson, 2008). Relatively greater access to the means of lethality in rural environments (firearms and poisons) has long been associated with suicide among people in farming communities (Luoma *et al.*, 2002, Stack, 2000). There is some evidence that stigma related to mental illness tends to be greater among people in rural areas and may be compounded by relatively lower health service provision.

Primary care and mental health services

Contact with primary care within the 12 months prior to suicide is common, with Luoma et al, (2002) reporting an average of 77% (range=57%-90%) and 45% (20%-76%) within one month of death. Generally, there is an age gradient of contact with primary care, significantly higher in older age. From the same review, approximately one-third of people are in contact with mental health services in the 12-month period. More specifically, Hunt et al examined a 4-year cohort of cases in contact with mental health services within 12 months of death. While contact with primary care data was not available, the study reveals a complicated picture in which people with schizophrenia and co-morbid drug dependence showing high levels of disengagement and non-adherence to treatment. Death within three months of discharge was common among patients with a personality disorder. Patients with drug and alcohol dependency were least likely to be followed up by services. People with schizophrenia were much more likely than other patients to die by violent means.

A recent study of suicide in rural Scotland (Stark *et al.*, 2012) showed that 52.5% of people who died by suicide had been in contact with at least one health service in the month before their death, including 18.6% with mental health services, and 46% with general practice. While no difference was found in general practice contact rates between rural and urban areas, differences were recorded with regard to contact to mental health services: those from rural areas were less likely to have had contact with mental health services in the year before their death and to have had lower recorded lifetime rates of mental health service contact.

In a Finnish study (Isomesta *et al.*, 1997) people who were diagnosed with psychiatric disorders in rural settings were more likely to be treated at the primary care level than those in urban settings. Inversely, urban dwellers were more likely to be in receipt of secondary or tertiary care at the time of suicide. In Wales, recent research highlighted the dearth of mental health service provision for young people in rural areas, particularly out of hours or assertive outreach programmes. Instead, they reported a reliance on general practitioners (GPs) for mental health promotion and treatment (Mind Cymru and Big Lottery Fund, 2008). Contact with primary care services prior to suicide is common, providing an opportunity for intervention for people recognised as vulnerable. In England, Pearson et al (2009) found that 91% of individuals had consulted their GP on at least once in the year before death; the median number of consultations was 7 (interquartile range = 3-10). A recent case control study of suicides in England over a 10-year period, revealed that risk of suicide was associated with an increasing frequency of GP consultations, particularly within three months prior to suicide; the highest risk was among patients who consulted with their GP more than 24 times in the final year. While approximately one-third of people who end their lives may be in contact with mental health services during the twelve-month period, mental health problems among many others was unrecognized and undiagnosed (Appleby *et al.*, 2013b).

Barriers to treatment and intervention

GP training

There is a strong international evidence for the effectiveness of suicide prevention policies that implement additional GP training in the recognition and treatment of depression (Mann, 2005). Currently, the Health Promotion Agency (HPA) is carrying out such training sessions for GPs in NI to improve recognition and appropriate treatment for tackling depression and suicide (DHSSPNI, 2006, Northern Health and Social Services Board, 2008). However, the evidence suggests that the barriers to recognition of suicidality and effective management are considerable. GPs acknowledge that their training in the identification and treatment of mental health may be lacking (Saini *et al.*, 2010).

At a very elementary level, suicide is a rare event while the risk factors associated with it are common and thus, lack any degree of sensitivity. Moreover, many people who would benefit from treatment for depression and other conditions, simply fail seek help. Thus, a significant proportion of young people are unlikely to contact their family doctor for mental health problems and don’t recognise the GP as having this role (Biddle *et al.*, 2006, Biddle *et al.*, 2007, Leavey *et al.*, 2011).

Stigma

The stigma associated with mental illness is one of the greatest deterrents to seeking help and although various agencies in the UK and elsewhere have campaigned to change attitudes and discriminatory practices, there is little evidence about the ability of their do so (Paykel *et al.*, 1998). The social rejection of people with mental illness appears to be strongly embedded within many cultures, influencing individuals to conceal their difficulties (Link *et al.*, 1999, Link *et al.*, 1992, Sandhu *et al.*, 2016). Moreover, stigma negatively impacts on engagement with treatment and satisfaction with services; it is also associated with poor clinical and social outcomes (Corrigan *et al.*, 2015). Converting emotional and psychological problems into a somatic presentation at GP surgeries appears to be one form of resolving the shame associated with mental illness problems, resulting in misrecognition of underlying affective disorders by GPs (Kirmayer and Robbins, 1996, Rosendal *et al.*, 2005).

Fragmentation of service provision

Although well-coordinated health and care of people is crucial to the effective treatment and management of mental health disorders, there is an increasing propensity in the design and structure of health services towards professional specialisms, departmental targets and discrete budget responsibility. While necessary for injecting a degree of discipline and accountability, there is a tendency to compartmentalise within health care (Plsek and Greenhalgh, 2001, Stange, 2009). For example, in the UK, the transition between Child and Adolescent Services and Adult Mental Health Services is commonly experienced as difficult (Singh *et al.*, 2010).

Impact of suicide on relatives and friends

On average, a single suicide directly affects at least six members of the nuclear family (Maple, 2005, Shneidman, 1969). However, it is estimated that each suicide affects intimately 60 people, including nuclear and extended family, friends, colleagues and classmates (Berman, 2011).

The death of a close relationship is one of the major stressors in life generally characterised by ‘normal’ grief reactions (Bonanno and Kaltman, 2001) that fade with the passing of time (Arnold *et al.*, 2005). For some, the death of a loved one can lead to a deep and long-term grieving process that could last for years (Bonanno and Kaltman, 2001, The Lancet, 2012). Some individuals may require medication or psychological treatment due to complicated grief; or may develop depression (The Lancet, 2012). Bereavement is associated with higher risks of mortality, suicide, physical health problems and illnesses, psychological symptoms, mental ill health, cognitive impairment and social isolation (Stroebe *et al.*, 2007). Certain themes or characteristics such as shame, guilt, blame, rejection and the question of ‘why?’

are more prominent in suicide bereavement than in other types of bereavement (Clark and Goldney, 1995, Jordan, 2001, Séguin *et al.*, 1995). The suicide bereaved have an increased risk of depression (Van Dongen, 1991) and suicide (Crosby and Sacks, 2002).

(Wilson and Clark, 2005).

Relatives have been found to experience 'suicide-specific' issues in coping with grief, such as difficulty finding meaning, strong feelings of guilt, higher levels of abandonment, shame and separation anxiety (Maple, 2005). Guilt can manifest in parents of the deceased as a perception that their closest acquaintances may blame them for the death. As a result, they may prefer to seek support from sources such as established support groups and specialist services, rather than their existing network of family and friends (Maple, 2005). It is assumed that access to health care services may be relatively limited in rural settings, and that there is lower utilisation of services in rural compared to urban settings (Nicholson, 2008). Support may be more informally provided through networks of family and friends, rather than social services, possibly due to increased fear of stigma in smaller communities (Middleton *et al.*, 2006).

Factors associated with negative outcomes

Young people as well as those bereaved by the suicide of a young person are at particular risk of experiencing negative effects. General population studies of suicide show significantly higher rates in families with a prior history of suicide, when compared with families experiencing deaths from other causes (Brent and Mann, 2005). Research has shown that suicide of a family member or close friend can increase suicidal behaviours in those individuals exposed to the death, particularly adolescents and vulnerable individuals (Burke *et al.*, 2010, Spirito *et al.*, 1989). Likewise, research has demonstrated that bereaved parents of a teenager suicide experience prolonged periods of social and psychological isolation, usually neglecting the needs of younger siblings in the family (Lindqvist *et al.*, 2008).

Main research questions and objectives

A substantial population within NI may be described as rural or living within rural areas. Some evidence suggests that people who live in urban and rural areas have differential access to health and social care. Thus, people from rural areas may be less likely to contact primary care services than their urban counterparts (Nicholson, 2008). GPs and other health professionals may require better training and support to assist recognition of people at risk of suicide and also to attend to the needs of bereaved family members. However, we know little about urban-rural differences in suicide-related help-seeking and the support provided to people bereaved through suicide. The examination of possible differences and their underlying causes is a central aim of the proposed research.

This study was funded to address the gaps in our understanding of suicide in NI and will provide useful information that will assist GPs and other services in recognising those at risk and supporting families. With the support and collaboration of general practice we undertook a mixed methods study in which we examined help-seeking pathways of people who have died by suicide. We also undertook a detailed investigation of those bereaved by suicide to examine needs, coping strategies and use of support services. The findings produced by this study are intended to underpin recommendations targeted at primary and community services related to suicide prevention and support for the bereaved.

We aimed to address several, interrelated questions: (1) Are there differences in help-seeking behaviour for suicidal people and those affected by suicide between urban and rural areas? (2) Do people bereaved by suicide resident in urban and rural areas employ different coping strategies and support systems? (3) Are there differences in access to support services for those bereaved by suicide in urban and rural areas? (4) How might primary care and other services be best configured to accommodate the suicide related needs of people in urban and rural areas?

Objectives

5. To undertake a systematic detailed examination of help-seeking by people in Northern Ireland who have died by suicide over a two year period.
6. To examine help-seeking and coping strategies employed by suicidal people from the perspective of family and friends.
7. To assess the impact of suicide on people bereaved by suicide by exploring coping strategies and the provision (and uptake) of support services for the bereaved.
8. To explore the experiences and needs of GPs in caring for people who have died by suicide.

Study design and report structure

The study was undertaken in three stages and is therefore presented in the following discrete sections, illustrated in Figure 1:

(4) Coroner and general practice data: analysis of socio-demographic and situational data related to suicide, self-harm and contact with health and social care services.

(5) The perspectives of people bereaved by suicide: a qualitative study of suicide attributions, the impact of suicide on families and friends, help-seeking and use of services.

(6) General practitioners' experience of suicide: a qualitative study of suicidal patients and suicide in primary care.

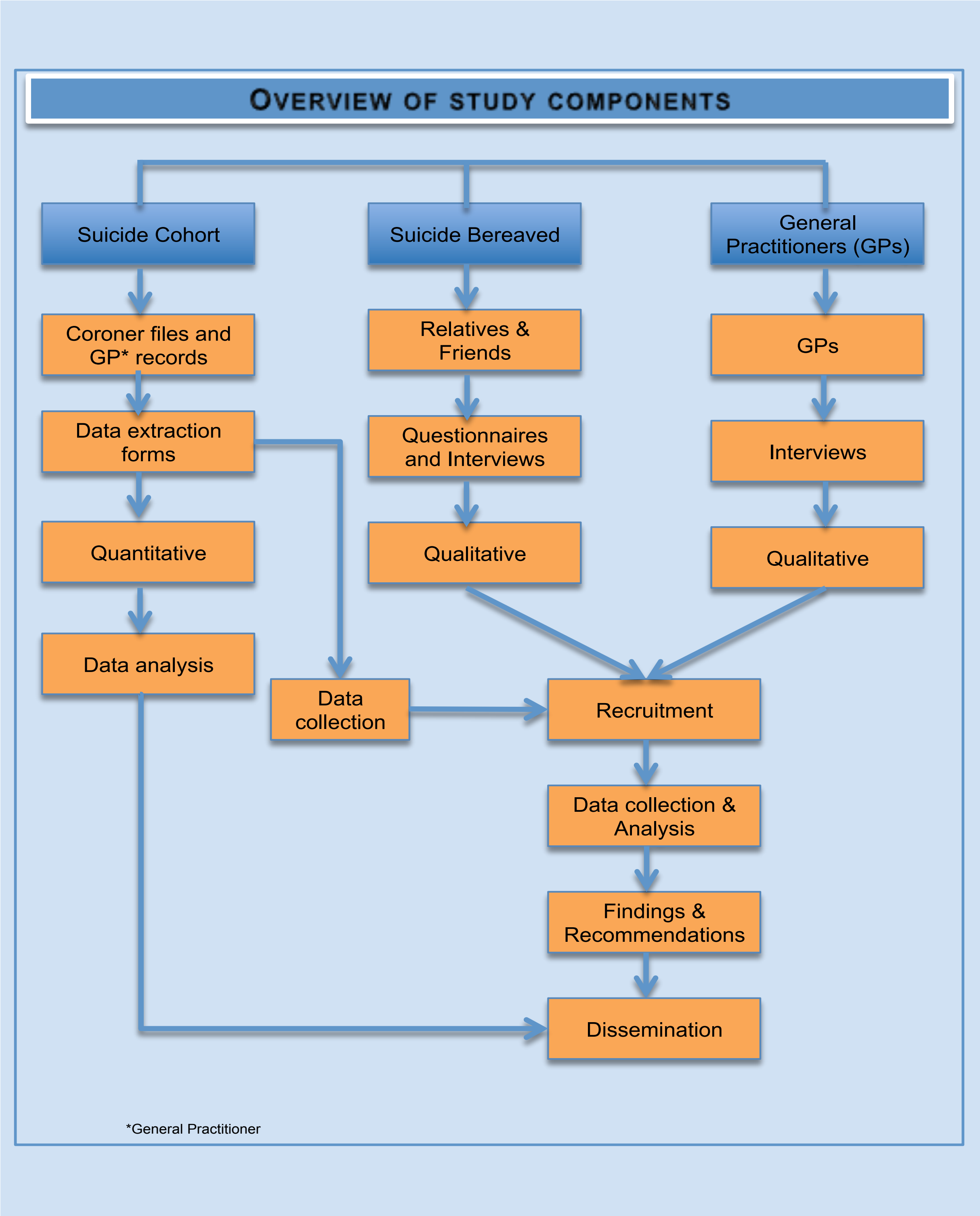

Figure 1. Overview of the components of the study

Methodology

The study was undertaken using a mixed methods approach. Data were collected from four distinct sources as listed below. This approach was developed to provide a variety of perspectives relating to singular suicidal acts, in an effort to better understand the events that led to the suicide and to provide information to support the development of opportunities for prevention.

Data sources:

5. Records held by Coroner Service for Northern Ireland (CSNI) of the individuals who died by suicide occurring between March 2007 and February 2009 (n=403);
6. Records held by GPs of the individuals who died by suicide (n=360);
7. Interview data from the next of kin of those who died by suicide (n=72); and
8. Interview data from GPs attending to a person who died by suicide (n=19)

Information about the participants, the data collection procedures and the analyses is presented in the respective sections below.

Participants

All accidental deaths that may have been by suicide (as classified according to ICD-10 codes X60-X84) occurring between March 2007 and February 2009 (N=405) provided the sampling frame for the study. Two cases were under the process of coroner's inquest at the time of data extraction, therefore it was not possible to extract data from those records. Two individuals resided in the Republic of Ireland at the time of their deaths and were subsequently withdrawn from the study. Data relating to all of the remaining 401 deaths were extracted from the records held by the Coroner Service for Northern Ireland (CSNI).

Medical records held by primary care practitioners (GP records) for each of the suicides were accessed from the Business Services Organisation (BSO). A number of the deceased (n=22) were not registered with a GP practice, with an GP records not available (n=19). This resulted in a sample of n=360 for which a full set of primary care data were available.

Inclusion and exclusion criteria

Accidental deaths occurring in NI between March 2007 and February 2009 were selected for examination. All those individuals who met agreed criteria for a suicide (according to ICD-10 codes X60-X84) formed the cohort. Deaths prior to 1st March 2007 and after 28th February 2009 were excluded from data extraction.

Up to three family members or friends listed as next of kin of the deceased as identified from the coroner's records in the cohort were eligible for interview. These individuals were excluded if there were notes on the records referring to difficult relationships maintained with the suicide prior to the death or issues of physical illness recorded. All GPs of the deceased also identified from the coroner's records were deemed eligible for interview. It was estimated that 80% of relatives would participate in the study. Similar published studies reported response rates for this group at 77% and 86% 53% (Foster *et al.*, 1997, Isometsa *et al.*, 1997).

Data extraction

Coroner's records

The Senior Coroner for NI granted the study a research exemption, under Section 33 of the Freedom of Information Act (The Stationery Office, 2000). The research team was granted permission to access all files from the coroner classified as 'accidental death'[1] that may have been by suicide over a two-year period, beginning on 1st March 2007 running to 28th February 2009, referred to as the two-year cohort in this study.

The study assesses help-seeking by the now deceased prior to taking their life, the help-seeking of those bereaved as a result (i.e. next of kin [NOK] as reported in the coroner's records), and the views, experiences and needs of GPs who have lost a patient to suicide. All the information extracted from these files is shown on Table 1.

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[1] Drugs, gunshot, volatile substances, hanging, drowning and other.

Table 1. Data extracted from the coroner's files.

Data extracted from coroner's files in relation to the next of kin and GP*	Data extracted from coroner's files in relation to the deceased[x]
Date of death	Reference number
Date of birth of the deceased	Date of death
Contact details of next of kin	Date death was reported
	Case closure/category
	Name and address
	Gender
	Age/date of birth
	Cause of death:
	Prior existing health condition
	What actually caused death and method used
	Occupation
	Place of death
	Initial report 'free text box' information
	Witness statements – green sheets (in light of emotional /physical state at the time of death, if reported/known)
	Autopsy report post-mortem
	Drug and alcohol information, if given
	GP details and report
	Police report
	Service use (including last contact) where provided

Information gathered to permit recruitment*

Information gathered to permit analyses[x]

The date of death and date of birth were recorded to ensure the research team was sensitive to anniversaries that are particularly emotive for the bereaved. Sensitivity was also paid to making contact at family times such as Christmas.

Primary care records

Quantitative data were collected through examination of primary care records of all those deemed to have died through suicide. These records, held by the BSO were systematically reviewed between March 2007 and February 2009. Identification of each case of suicide was obtained through the Coroner's Service for Northern Ireland. The Health and Care (H&C) number for each individual was used to match to the coroner's list. A data extraction form was designed to obtain data on various domains linked to suicidal behaviour and coping strategies, such as psychiatric illness, physical disorders, childhood history, life events and service usage. The content of the extraction form designed for these purposes is shown in Table 2.

Table 2. Content of data extraction form collecting clinical data from GP records

Clinical data collected from the GP records
a. Any history of emotional or psychiatric distress; this will include diagnosis, duration and dates, prescription(s)
b. Any history of physical long term/chronic conditions; diagnosis, duration and date, prescriptions(s)
c. All contacts with GP during 12 months prior to death: date(s), usual GP, presenting complaint(s) and any unusual features (e.g. accompanied by a significant other), recorded outcome of visit (prescription, investigation, referral, other)
d. Last contact with GP prior to death and indication of any future visits arranged
e. Contacts with other practice personnel e.g. nurse or counsellor
f. Notable comments by GP on the patient's wellbeing and social circumstances
g. Referrals during 12 months prior to death: date(s), secondary/tertiary agency
h. Ongoing secondary/tertiary care arrangements: last contact date prior to suicide
i. Continuity of care: repeatedly consulted the same GP, or different GPs within practice.

Recruitment and data collection

Identification of each case of suicide was achieved by using the records held at the Coroner's Service for Northern Ireland. We identified NOK of the deceased through the coroner's records and made contact by letter. With the support and assistance of the Royal College of General Practitioners we requested participation in in-depth interviews of the relevant GPs. All level of participants (NOK and GPs) was initially contacted by post and received a follow-up telephone call (where possible) to clarify queries and maximise response rates.

Bereaved family and friends

The purpose of interviewing family and friends was varied. First, we aimed to assess help-seeking behaviours and related health service needs in family members/friends using survey methods containing a series of validated measures related to physical health, psychological distress, social support, religion and spirituality and coping strategies. Second, we sought to further explore the experience of suicide and approaches to coping amongst the suicide bereaved by conducting semi-structured interviews with family members and/or friends. And finally, we examined help-seeking behaviour of the suicides from the family and/or friends' perspective, in an attempt to understand better what help was sought (if any), from whom and the satisfaction with statutory services and other agencies – the barriers and facilitators to care (pre-suicide help-seeking).

Having assessed each file from the coroner's office the research team created a database containing all the contact details for up to three relatives listed as next of kin of 405 suicides included in the two-year cohort relevant to the study. At the time of issuing invitation letters to potential participants two cases of suicide were excluded because the coroner's verdict was still pending. A total of 541 individuals listed as first, second and third next of kin (NOK) of 403 suicides was targeted for interview.

The latest statistical classification and delineation of settlements in Northern Ireland (Northern Ireland Statistics and Research Agency, NISRA, 2005) were used to classify the sample according to its urban-rural delineation. For the purposes of offering an even spread of rurality, in this study the eight bands used by NISRA (2005), have been collapsed into three single categories in which Bands A and B became the 'Urban' category, Bands C to E became the 'Town' category and Bands F to H were renamed as 'Rural'.

A total of 506 (93.5%) individuals were sent letters of invitation to participate in the study over a period of 18 months. The remaining 35 (6.4%) participants not invited for interview were not contacted due to factors such as, clashes with date of birth or suicide of the deceased, international or national component that prevented the researcher from travelling, incorrect contact details or sensitive issues (e.g. recent deaths in the family).

The contact process consisted of the following steps:

a) A letter of invitation also containing an information sheet, a reply slip accompanied by a self-addressed envelope (see Appendices 1 and 2) and a summary leaflet (see Appendix 3) about the research aims and objectives, was sent to the NOK giving them the opportunity to take part should they felt the research was relevant to them and their bereavement experience.

b) NOK was offered the opportunity to confidentially (indirectly) decline any further contact by entering a unique reference number via a dedicated page on the Niamh website [2], allowing them to opt out of any further contact without having to speak to a researcher, give their name or provide any further details.

c) As a reminder, and to clarify any queries, a follow-up telephone call was made to the individual two weeks after the letter was posted. This was outlined in the initial information sheet.

d) Individuals who declined further contact received a written acknowledgment within 21 days, in line with the fair processing of data requirements to confirm that their information had been removed from the database.

e) Those who opted in were given the chance to arrange a time and venue that best suited them to partake in the face-to-face interview.

f) NOK wishing to refer an alternative person who was close to the deceased to take part in the study were given the opportunity to do so at this stage.

g) Upon willingness to participate, the second person's eligibility was confirmed, then their contact details were gained and the invitation letter, reply slip and SAE were posted, thus repeating the recruitment procedures as above. Five participants in the study were recruited through this procedure.

At each stage of contact, potential participants were given the option to decline further contact; anyone agreeing to take part could withdraw from the research at any stage without explanation. As part of our duty of care, all those who took part in the study were provided with literature on bereavement and other support services. The research team made contact one month post-interview to ensure the welfare of participants and to enable the signposting onto relevant help agencies, with each participant being offered six free sessions of counselling provided in conjunction with Niamh's subsidiary, Carecall. Out of 77 participants, only two people used this service.

Seventy-two (14.2%) members of our sample agreed to participate in the research. Thus, 434 (85.7%) potential participants did not respond to the study. Over a quarter of the targeted sample (25.6%, n=130) contacted the researchers to provide their refusal either via reply slip or on the telephone (phoning the researcher or responding to their follow-up call). A high number of individuals (n=108), that is, 21.3% of the sample did not respond to the research nor did they return messages left by the researchers when making telephone follow-up calls on two occasions. It was not possible to have follow-up contact with a higher

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[2] Link of the Understanding Suicide Study available on the Northern Ireland Association for Mental Health website under the Compass section of the site: http://www.compasswellbeing.org/Understanding-Suicide-8420.html

number of potential participants (n=184) accounting for 42.3% who did not respond to the study and whose contact numbers (mobile or landline) were invalid or non-available. Through a substantial amendment approved by the research ethics committee, these latter individuals were followed-up through the electoral register in June 2013. However, this search, undertaken on 45% of this sample, revealed that nearly 53% of these individuals had never been registered at the addresses obtained for them from the coroner’s records. Given this outcome, further attempts to recruit bereaved family members were stopped. A comprehensive overview of recruitment and data collection process is presented in Figure 2.

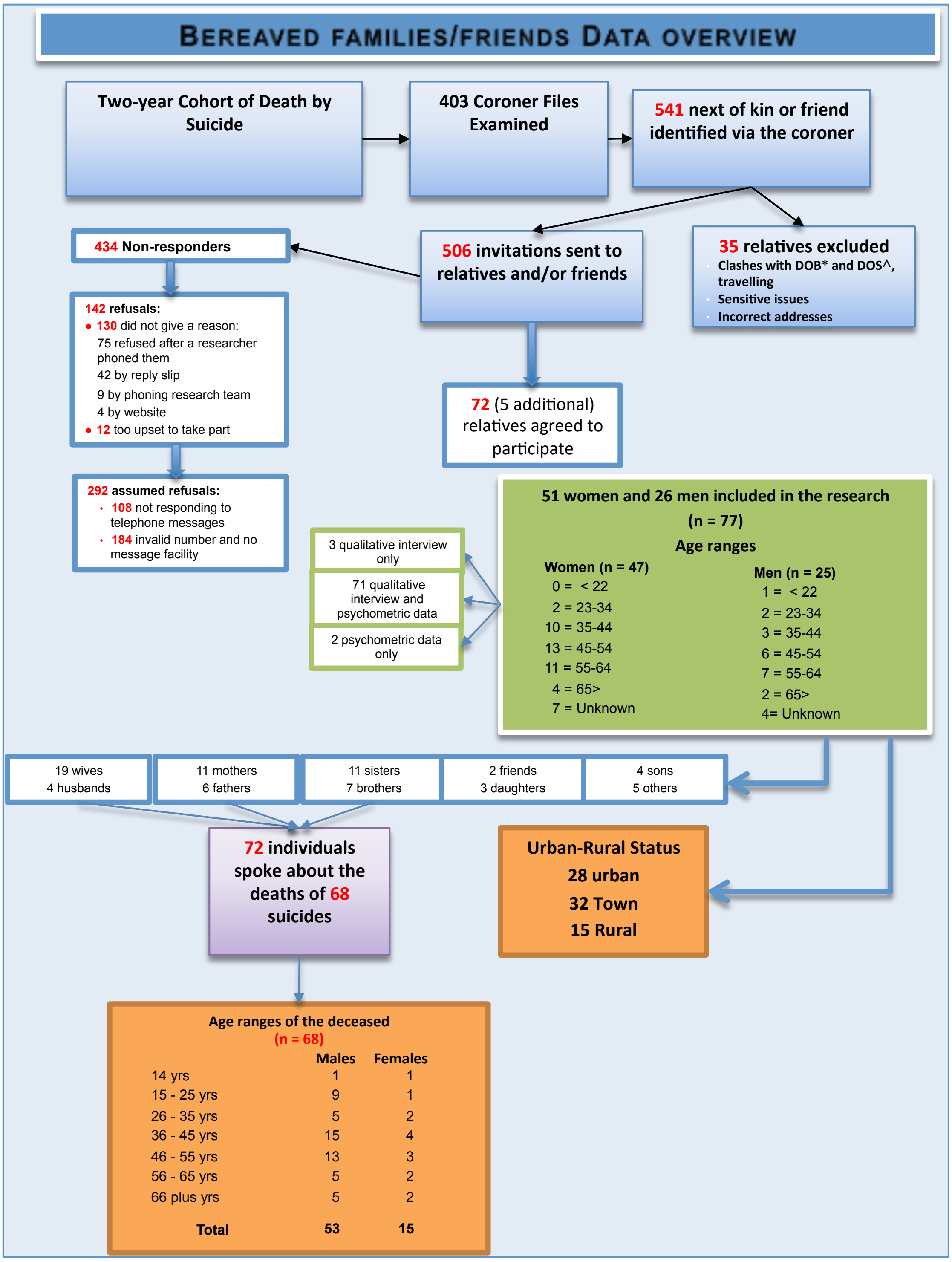

Figure 2. Overview of recruitment and data collection from bereaved families/friends

Data collected from the NOK included socio demographic characteristics: age, gender, accommodation, household profile, job and employment record, education, and relationship to the deceased. Data related to the families/friends' help-seeking behaviours and health and psychological needs were collected using a series of validated measures. These measures included the Hospital Anxiety and Depression (HAD) Scale, COPE questionnaire, close persons questionnaire, Royal Free interview (for religion and spirituality measures) and the Client Service Receipt Inventory (CSRI) (see Appendix 4).

Due to the low response rate, we decided against providing any statistical analysis

Qualitative in-depth interviews with relatives and friends

Based on the study questions, the research team constructed a topic guide which was piloted among four relatives and then refined (see Appendix 5). The definitive topic guide covered the following issues: (1) precursory events and explanatory causes; (2) family recognition of problem (if any); (3) timelines of help-seeking; (4) service contact and access; (5) response and satisfaction with services; (6) any contact with services prior to suicide; (7) a narrative of their lives following the death including impact on person and family along with satisfaction with services; (8) the community response and social support; and (9) personal coping strategies such as community involvement, family, religious and spiritual beliefs and connection to faith based organisations.

We examined in detail how the event impacted the bereaved relatives/friends' lives, the issue of stigma in the community, social capital and social exclusion, functioning and wellbeing, strategies for coping and resilience, the need for and response of statutory and public services (e.g. pastoral care, counselling, and other mental health services). The approach taken reflected the extensive experience of the research team, permitting flexibility in the structure and content of interviews, facilitating an exploration of individual circumstances and experiences in a way that is responsive to the accounts of individual respondents. Two researchers using digital audio recorders undertook the interviews which were then transcribed by a professional transcribing service.

Data analysis

We entered the qualitative data gathered through in-depth interviews with bereaved family members/friends into Atlas-ti 7; a software programme for the management and analysis of text data. The aims of this strand of the study were to obtain a better understanding of help-seeking in relation to the person who died by suicide and then, to examine the impact of suicide on the people who are bereaved by suicide, usually a close family member. Subsidiary areas related to these broad questions included: (a) an understanding of what families believed to have provoked suicide and what might have prevented it; (b) service provision to the deceased and also, the needs and access to services among bereaved families. In undertaking these qualitative interviews, we were not seeking to develop a specific theory, usually associated with grounded theory studies (Glaser, 1992), on help-seeking or the impact on bereaved relatives, but, rather, to offer a detailed, more ‘realist’ picture of relatives’ understanding of the events and experiences leading up to the suicide and a phenomenological grasp of what happens to individuals and their families in the aftermath of suicide. We recognise that this knowledge is always limited and contingent. The participants can only offer a personal view of events, or at times, assisted by the views and knowledge of others, as narrated to them. Nevertheless, the participants must be accepted as ‘close informants’ who knew the people who died by suicide, often intimately. Adopting a realist stance, we have not attempted to ‘interrogate’ their witnessing of the suicide circumstances. Nevertheless, where these emerge, we have sought to show the inconsistencies and paradoxes in the data. Importantly, we have attempted a systematic and comprehensive depiction of the experiences, issues and processes as presented by families without overlaying these accounts with too much intrusive interpretation.

As part of the analytical process, different members of the team examined copies of the first ten interviews and then met to develop a coding structure, which at first, loosely followed the topic guide in terms of the overall areas of interest and then proceeded to a more detailed thematic analysis of these areas. The codes (and coding frame) were revised at various stages throughout the indexing stage by the team, usually when ambiguities emerged. The 764 codes initially generated from reading and re-reading the interviews were systematized in conceptually clustered matrices (Miles and Huberman, 1994) as a ‘strategy for conducting thematic analysis to order and synthesise data’ (Pope and Mays, 2008). Wherever possible and without losing all meaning in the transcripts, we have completely removed all identifying characteristics of the people who died and the participants who provided these accounts. The data are mainly presented in a thematic analysis and therefore may be prone to a degree of fragmentation or disconnection between beliefs, attitudes, events and experiences, in which the ‘full narratives’ appear to get lost.

Interviews with General Practitioners (GPs)

In order to gather the experiences and perspectives of GPs on issues related to service provision, and recognition and referral of the suicidal individual, we interviewed a sample of 19 GPs. The interview schedule explored a number of areas including barriers and challenges relating to availability and knowledge of specialist services. GPs were invited to participate in the research by letter, with a follow-up phone call, according to the geographical location of their practice in order to represent any disparities between urban and rural areas. After a number of unsuccessful attempts to recruit GPs through traditional postal invitations, the 19 GPs who participated in the study were recruited through a snowball sampling approach with support from the Royal College of General Practitioners.

For the analysis of the in-depth interviews, we used a methodological approach similar to that for the family participant analysis, that is, our method was more consistent with a realist stance. To do so, we used a Framework (Gale *et al.*, 2013, Ritchie *et al.*, 2014) process for indexing and categorising our data. Several members of the team (GL, MR & JR) read samples of the transcripts. Following agreement on the main thematic areas, we developed a coding frame which we used to analyse and present the salient issues. Again, the themes, typically, mapped onto the areas followed within the topic guide. Accordingly, we were interested in how GPs who have experienced the death of a patient(s) by suicide, recognised and managed such patients, the impact of patient suicide on the GPs (personally and professionally), and on the bereaved families. Essentially, this work was constructed with the aim of understanding policy and practice, where these might be inadequate or failing and how they might be improved.

Ethical issues

The study was granted ethical approval on 20 December 2010 by the Office of Research Ethics Committees Northern Ireland (ORECNI), a branch of the National Research Ethics Service in the United Kingdom (REC reference: 10/NIR03/65).

Confidentiality and anonymity

The study qualified for research exemption under Section 33 of the Freedom of Information Act (The Stationery Office, 2000), commonly known as *the research exemption* since the data processing is strictly limited to research and met the following criteria:

- the data are not processed to support measures or decisions relating to particular individuals; and
- the data are not processed in such a way that substantial damage or substantial distress is, or is likely to be, caused to any data subject.

Furthermore, personal data were processed fairly and lawfully, meeting the conditions of the Data Protection Act (DPA), Schedules 2 and 3 (The Stationery Office, 1998). The data handling procedures firmly met the requirement to satisfy schedule 2, processed out of necessity for the exercise of functions of a public nature exercised in the public interest, funded with public monies by the Department of Health (DPA 1998, Schedule 2 subsection 5d). Data collection for this study meets the requirement of Schedule 3, being undertaken for philosophical purposes and not profit oriented (Schedule 3, subsection 4a), not disclosing personal data to a third party without consent of the data subject (Schedule 3, subsection 4d), and for the necessity of medical purposes undertaken by a person who owes a duty of confidentiality which is equivalent to that which would arise if that person were a health professional (Schedule 3, subsection 8b).

Data storage

All suicide data extracted from the coroner's office and the GP records were kept and analysed on encrypted laptops. Identifiers were removed from all transcripts and identity codes were assigned. Both datasets (quantitative and qualitative) were transferred into appropriate computerised software packages for analysis (SPSS, Stata and Atlas-ti). Personal details of all participants collated on databases were stored separately on encrypted pen drives kept in locked cabinets, which were accessed only by the data controller. Information for all potential participants who declined participation in the study was deleted from the database.

Summary

- Information was collected from the files within the Coroners Service for Northern Ireland from 405 suicides; all those occurring during the study period
- GP records of the individuals who died by suicide were examined. Data representing help-seeking behaviour prior to the suicide were extracted from 361 GP records
- NOK contact details were extracted from the coroner's files
- NOK were invited to participate in a research interview
- GPs were invited to participate in a research interview
- All data were anonymised for analyses
- All data were stored according to the ethical requirements.

Results from Coroner and General Practice (GP) Administrative Data

As a research domain, suicide is elusive and finding a balance between comprehending the intensity of suicide as a lived experience and its recognition as a social phenomenon (and a potentially avoidable cause of death[3]) is not easy to manage in research terms.

The analysis presented below, with its focus on the quantitative relationships associated with factors known to influence suicide behaviour, complements the detail of the accompanying qualitative findings: it provides both, a quantitative context for the suicides examined in the report and then tests the findings against the current literature, this lends some confidence in the generalisability of the report. While these results concern suicides from a single two-year period, given their inherent stability they will not differ markedly from immediately adjacent time-periods – certainly not in any significant way. Longer-term trends for NI since 2000 do show small increases in suicide numbers[4], and as the results presented here are for a point mid-way through the period, they can represent a snapshot of the social influences currently at play.

The major focus of the report concerns the degree to which locale may influence suicide levels in Northern Ireland.

Description of the cohort

The presentation shown below illustrates: (i) the age- and sex- specific proportions of suicides for the whole of NI; (ii) a series of figures depicting the proportions of suicides by standard area-level deprivation measures; (iii) the socio-demographic and socio-economic characteristics of the cohort, by locale; (iv) age and sex specific rates, by locale; (v) a series of tables outlining the extent of service access utilised by the cohort over time, by locale; (vi) the mean number of GP consultations visits, by standard socio-demographic characteristics; (vii) an examination of the factors influencing attendance at GP services for mental health issues; and finally (viii) an examination of the history of attempted suicides and the lethality of methods used in both the attempt and the eventual suicide.

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[3] In Wheller, Baker, Griffiths & Rooney (Trends in avoidable mortality in England and Wales, 1993-2005, *Health Statistics Quarterly 34 Summer 2007*), suicide is classed as preventable. They use a definition derived by Page, Tobias, Glover, Wright, Hetzel & Fisher (Australian and New Zealand Atlas of Avoidable Mortality, *University of Adelaide: Adelaide: PHIDU, 2007*) - defined as deaths occurring before age 75 from causes considered as preventable through (a) individual behaviour; or (b) public health measures limiting exposure to harmful substances, conditions or social interventions.

[4] A recent report from Manchester University ‘The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report’ (July 2013) recorded that, between 2001 and 2011 Northern Ireland recorded a small increase in suicide rates, rising from 12.7/100000 of the population to 14.7 between these periods. This latter was slightly higher than comparable rates recorded in either England or Wales, though lower than Scotland. However, all the three other jurisdictions recorded reducing suicide rates.

Table 3 shows that males were four times more likely to complete a suicide than females – 81% (323/401) and 19% (78/401) for males and females respectively. This pattern is broadly consistent over all age groups and also reflects the male/female ratios for suicide in the general population. Figure 3 shows the age-specific distribution of suicides for males and females: both show an overall consistent pattern – highest in younger age-groups and lowest in older groups – the proportions for male suicides peak at an earlier age than for females (25-34 and 35-44 respectively).

Table 3. Suicides in Northern Ireland from 1st March 2007 to 28th February 2009. Data represented in percentage and (numbers).

Completed suicides in Northern Ireland (March 2007 - February 2009) Age and gender							
	< 24	*25-34*	*35-44*	*45-54*	*55-64*	*65+*	*All*
Male	79.3 (65)	87.0 (80)	74.4 (64)	78.4 (58)	88.6 (31)	78.1 (25)	80.6 (323)
Female	20.7 (17)	13.0 (12)	25.6 (22)	21.6 (16)	11.4 (4)	21.9 (7)	19.4 (78)

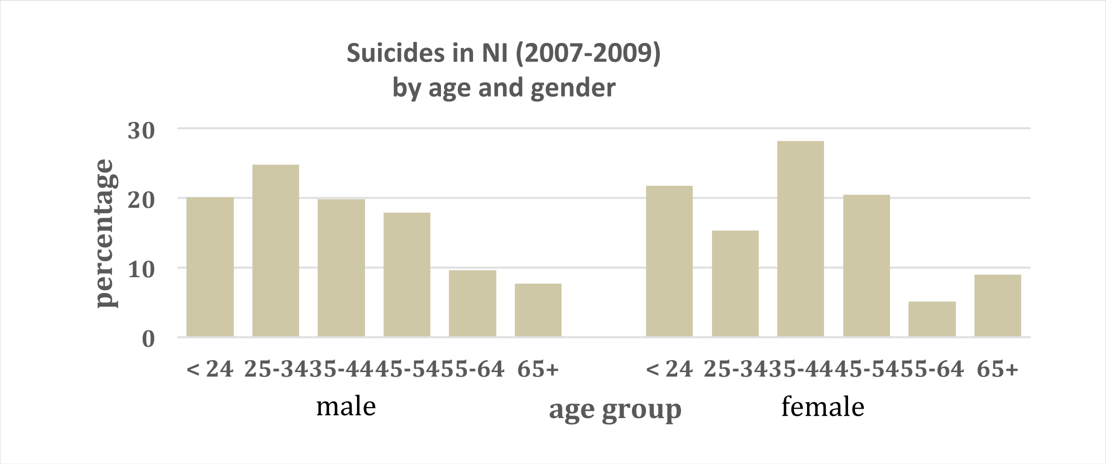

Figure 3. Suicides in Northern Ireland (2007-2009) by age and gender groups

Figure 4 below shows, for males and females separately, the distribution of suicides by selected measures of deprivation derived at small area level. These all follow a similar pattern: the uniform decline in the proportions of suicides from most deprived to least deprived areas. Again, this pattern follows normal expectation.

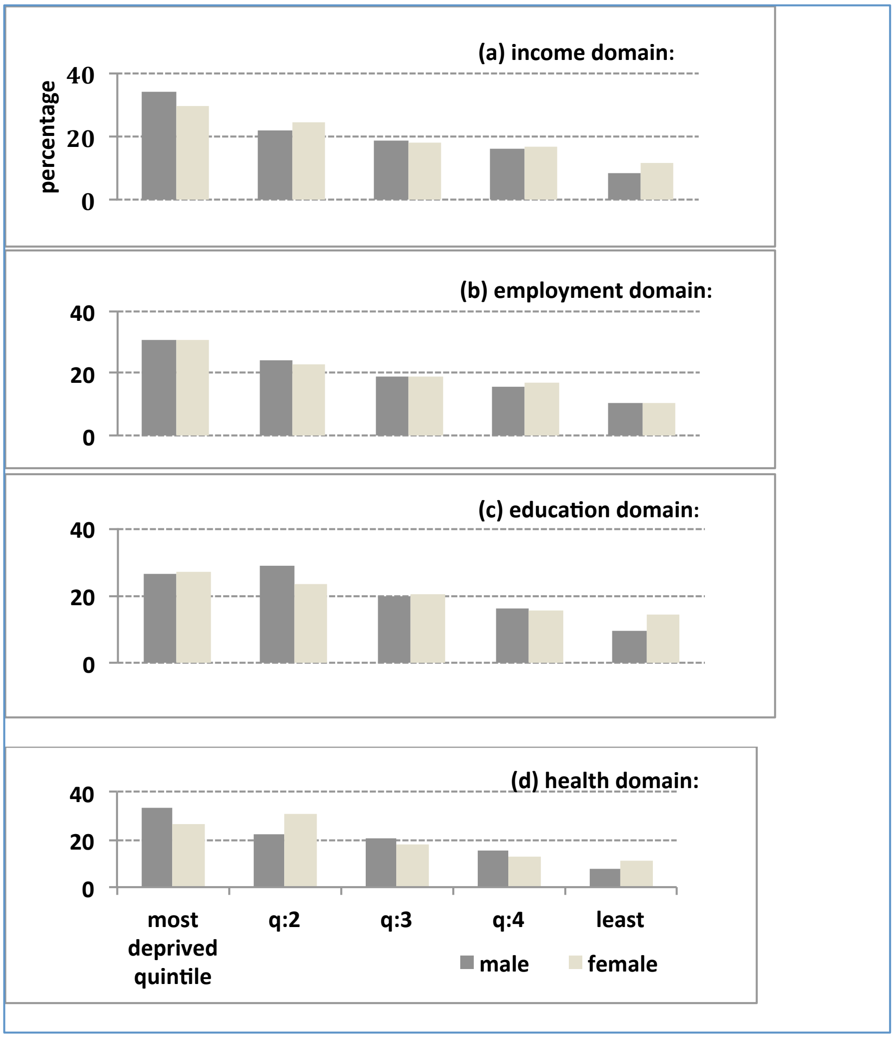

Figure 4. Completed suicide in NI by gender and quintile of deprivation[5]. Data represents the proportions of the (323 males and 78 females) suicides in ach quintile of deprivation[6].

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[5] The Northern Ireland Multiple Deprivation Measure (NIMDM) is a set of seven measures of material deprivation (plus an overall summary) derived at Super Output Area level (SOA) - an administrative small area geography of approximately 2000-2500 people designed to be relatively homogeneous in terms of deprivation. While periodically revised by the Northern Ireland Statistics and Research Agency (NISRA), these figures were derived in 2005. For further details see: *'Northern Ireland Multiple Deprivation Measure 2005'* - available at http://www.nisra.gov.uk/archive/deprivation/nimdm2005fullreport.pdf

[6] These are provided by NISRA as a ranking of SOAs from 1 (most deprived) to 890 (least deprived). For this exercise they have been summarised as quintiles.

Table 4. Suicides in Northern Ireland (March 2007 - February 2009). Distribution of the suicides by locale and the main parameters known to influence suicide

	Suicides in Northern Ireland (March 2007 - February 2009) Distribution of the suicides by locale and main risk factors				
	Urban	**Town**	**Village**	**Rural**	**All**
Proportion: males [1]	83 (77, 89)	78 (71, 86)	76 (58, 94)	82 (73, 91)	81 (77, 85)
Mean age: male [2]	37 (16.2)	39 (14.4)	36 (14.8)	45 (17.9)	39 (16.2)
: Female	35 (14.7)	42 (13.4)	35 (16.1)	45 (21.3)	39 (16.6)
Living alone: yes [1]	30 (22, 38)	38 (30, 47)	20 (3, 37)	24 (15, 34)	31 (26, 36)
In paid work: yes [1]	54 (46, 63)	59 (50, 68)	48 (27, 69)	72 (62, 82)	59 (54, 64)
Social class:					
Professional [1]	5 (3, 10)	7 (4, 13)	4 (0, 24)	6 (3, 14)	6 (4, 9)
Intermediate; semi-routine; routine	36 (29, 44)	42 (34, 51)	46 (28, 66)	46 (35, 57)	41 (36, 46)
Other (including retired)	59 (51, 67)	5 1 (42, 60)	50 (31, 69)	48 (37, 59)	53 (48, 58)
Prior mental health diagnosis:					
None recorded [1]	39 (31, 48)	42 (34, 52)	48 (28, 68)	41 (31, 53)	41 (36, 47)
Common mental disorders	38 (30, 46)	25 (18, 33)	28 (13, 50)	37 (27, 49)	33 (28, 38)
Severe mental illness	10 (6, 16)	15 (10, 33)	12 (4, 33)	11 (5, 20)	12 (9, 16)
Alcohol/drugs related	13 (8, 20)	18 (12, 26)	12 (4, 33)	11 (5, 20)	14 (10, 18)

1: numbers represent percentages and 95% confidence intervals
2: numbers represent mean age and standard deviation

Table 4 shows the distribution, by locale of the main factors known to influence suicide. Overall, 81% were to males. Age at suicide ranged from 11 to 83 years, with an overall mean of 39 years (SD=16.2) – with the mean age increasing from 37 to 45 years for males and 35 to 45 for females between urban and rural areas. Overall, 31% of the cohort was living alone at the time of their suicide, with highest rates recorded for the most urban areas. While the majority (59%) were in paid employment at the time of the suicide, the highest in employment levels were recorded in the most rural areas, and lowest in the 'smaller towns and villages'. No significant differences were recorded by locale. The patterning of suicide by social class shows the summary classifications derived directly from occupation are relatively homogeneous across all locales, with the majority of suicides located within the 'other' social class group, an amalgam of categories (including the retired) derived on a basis other than occupation. Finally, the distribution of prior diagnosis of mental health problems: overall, 41% of those who died had no prior diagnosis of a mental health problem recorded, with the remaining recording common mental health problems (33%), severe mental illness (12%) and drugs and alcohol problems (14%). Again, these proportions are relatively homogeneous across the locales, signifying no differences in the distribution of these mental health problems across the locales.

Table 5 records crude age- and gender- specific suicide rates (per 100,000 of the population) by the type of locale the person lived in at the time of the suicide[7]. Looking first at the marginal totals: for both males and females the highest rates are recorded for the larger towns; followed by the Belfast and Derry urban areas; then small towns; with lowest rates recorded for the most rural areas. However, for those aged sixty-five or more the highest rates were recorded in rural areas. The highest rates were recorded in (larger) towns, followed by urban areas. Generally, while the lowest rates were recorded in the most rural areas the highest rates for older people were also recorded in the most rural areas (18.5 and 4.1/100000 – based on fifteen deaths). Overall, the highest suicide rates were recorded for males (aged 16-39) living in urban areas and larger towns, or males aged 40-64 living in larger towns (36.9, 34.5 and 33.5 respectively). For females aged 16-59, rates were more evenly spread through the different locales.

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[7] The initial dataset comprised suicide deaths only for the two year period. For this table a population-base derived by the Northern Ireland Statistics and Research Agency (NISRA) was linked to this initial data. These comprised estimates of the Northern Ireland population in 2008, by settlement band. These had been derived by NISRA for internal purposes and were used with permission. The non-standard age-groups used in the table was determined by the population age-groups required by NISRA for their internal purposes.

Table 5. Suicide in Northern Ireland (March 2007 - February 2009). Age-specific crude rates per 100,000 of the population – suicide by gender, age group and locale

Suicide in Northern Ireland (March 2007 - February 2009).
Age-specific crude rates
per 100,000 of the population

	Age groups				
	Less than 16	16 to 39	40 to 64 (males) 40 to 59 (females)	65 plus (males) 60 plus (females)	All Northern Ireland
Males					
Urban	0.7 (1)	36.9 (84)	17.6 (34)	13.6 (11)	20.4 (130)
Large towns	1.0 (1)	34.5 (53)	33.5 (46)	5.5 (3)	23.2 (103)
Small towns & villages	8.7 (3)	18.7 (9)	19.4 (9)	0.0 (0)	14.3 (21)
Rural	1.7 (2)	14.2 (24)	19.7 (32)	18.5 (11)	13.6 (69)
Total	**1.8 (7)**	**28.4 (170)**	**22.4 (121)**	**11.8 (25)**	**18.5 (323)**
Females					
Urban	0.7 (1)	6.9 (16)	7.3 (13)	0.7 (1)	4.5 (31)
Large towns	2.1 (2)	5.1 (8)	11.7 (14)	2.0 (2)	6.6 (26)
Small towns & villages	3.1 (1)	6.1 (3)	7.8 (3)	0.0 (0)	4.1 (7)
Rural	0.0 (0)	3.8 (6)	3.1 (4)	4.1 (4)	2.8 (14)
Total	**1.1 (4)**	**5.6 (33)**	**7.3 (34)**	**1.8 (7)**	**4.3 (78)**
Persons					
Urban	0.7 (2)	21.8 (100)	12.7 (47)	5.1 (12)	12.0 (161)
Large towns	1.5 (3)	19.7 (61)	23.4 (60)	3.3 (5)	14.1 (129)
Small towns & villages	6.0 (4)	12.4 (12)	14.1 (12)	0.0 (0)	9.4 (28)
Rural	0.9 (2)	9.2 (30)	12.3 (36)	9.6 (15)	8.3 (83)
Total	**1.4 (11)**	**17.0 (203)**	**15.4 (155)**	**5.4 (32)**	**11.3 (401)**

Note: mid-year population estimates for 2008 provided by NISRA[+]. These rates were generated using as the population base small-area-specific population estimates derived by NISRA for 2008 - these had been derived as a special exercise for internal NISRA purposes and were used with permission.

Urban and rural access to services

The putative lack of services and presumed associated deficits in rural areas are often cited as problematic for those rural residents affected by mental health issues. This study examines the distribution of service access across this cohort in the twelve months before death. However, it can, say nothing about the actual availability of services in rural areas[8].

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[8] This issue has been discussed in more detail in a forthcoming paper entitled, Suicide rates in urban and rural areas: factors associated with suicide in Northern Ireland including contact with health and social care services in the twelve-month period prior to suicide. Leavey G, Rosato M, Galway K, Hughes L, Mallon S, Rondón J

Tables 6 to 8 are similar in structure – they show, by locale, the proportions of the cohort accessing available services, firstly for GP services over time and, secondly for other health service providers.

Those attending at GP services in the twelve months, three months and one month periods prior to the suicide recorded attendance levels of 87% (297/341), 57% and 39%, respectively for the whole of NI. The associated breakdown by locale for each of these time periods shows that the proportions do not vary greatly across the different locales. The second set of figures in each row, recording attendance with mental health problems, shows a similar homogeneity of contact with other available services in the twelve months prior to the suicide (Tables 7 and 8): 41% (140/341) had contact with Accident and Emergency services, with 58% (81/140) of these for mental health issues; 18% (61/341) were in contact with social workers, with 92% (56/61) of these for issues related to mental health; 29% (101/341) attending community services; and finally 35% (128/341) were recorded as having seen a psychiatrist. Again, the breakdown of these figures by locale shows a reasonable homogeneity. Ultimately, from the experience of this cohort, it is unlikely that there were systematic differences in their access to services by locale.

Table 6. Suicides in NI (March 2007 - February 2009). Attendance at general practice services in the 30 days, 90 days and 12 months before death, by locale. Data represent the proportion attending, followed by the proportion of those attending for mental health issues.

	Suicides in NI (March 2007 - February 2009). Attendance at General Practice services in the 30 days, 90 days and 12 months before death, by locale.				
	Urban % (n/p)	**Town % (n/p)**	**Village % (n/p)**	**Rural % (n/p)**	**All % (n/p)**
GP: attended within 30 days of suicide	39 (51/132)	38 (43/112)	48 (12/25)	36 (26/72)	39 (132/341)
GP: of those attending, proportion with mental health issues	86 (44/51)	91 (39/43)	83 (10/12)	88 (23/26)	88 (116/132)
GP: attended within 90 days of suicide	56 (74/132)	57 (64/112)	60 (15/25)	58 (42/72)	57 (195/341)
GP: of those attending, proportion with mental health issues	86 (64/74)	91 (58/64)	80 (12/15)	86 (36/42)	87 (170/195)
GP: attended within 12 months of suicide	85 (112/132)	90 (101/112)	84 (21/25)	88 (63/72)	87 (297/341)
GP: of those attending, proportion with mental health issues	73 (82/112)	72 (73/101)	43 (9/21)	71 (45/63)	70 (208/297)

Table 7. Suicides in Northern Ireland (March 2007 - February 2009). Data represent the percentage (%) of the suicides who attended at Accident & Emergency services within 12 months of the suicide, by locale

Suicides in Northern Ireland (March 2007 - February 2009). Percentage (%) of those attending Accident & Emergency services within 12 months of suicide					
	Urban	Town	Village	Rural	All
Visits to Accident & Emergency	44 (58/132)	40 (45/112)	40 (10/25)	38 (27/72)	41 (140/341)
A&E: proportion of those attending with mental health issues (within 12 months)	59 (34/58)	67 (30/45)	60 (6/10)	41 (11/27)	58 (81/140)

Table 8. Suicides in Northern Ireland (March 2007 - February 2009). Data represent the percentage (%) of the suicides who attended for other health or social services within 12 months of the suicide, by locale

	Suicides in Northern Ireland (March 2007 - February 2009). Percentage (%) of the suicides who attended for other health or social services within 12 months of the suicide, by locale				
	Urban	**Town**	**Village**	**Rural**	**All**
Contact with social worker: within 12 months of suicide	18 (24/132)	21 (23/112)	12 (3/25)	15 (11/72)	18 (61/341)
Contact with social worker: of those attending proportion with mental health problems (within 12 months)	92 (22/24)	91 (21/23)	67 (2/3)	100 (11/11)	92 (56/61)
Community services: those attending with mental health problems	28 (37/132)	36 (40/112)	5 (4/25)	28 (20/72)	29 (101/341)
Contact with psychiatrist: within 12 months	36 (47/132)	46 (52/112)	24 (6/25)	32 (23/72)	35 (128/341)

Table 9. Suicides in Northern Ireland (March 2007 - February 2009). Mean number of consultations at general practice services for mental health issues in the 12 months before the suicide. Data represent the mean (95% confidence intervals)

Suicides in Northern Ireland (March 2007 - February 2009). Mean number of consultations at general practice services for mental health problems in the12 months before the suicide (95% confidence intervals).

	Mean number GP consultations relating to mental health problems		
	Male	Female	All
All GP consultations (for any reason)	5.92 (5.61, 6.25)	9.71 (8.96, 10.52)	6.74 (6.45, 7.05)
and for Mental Health problems only	5.75 (5.38, 6.15)	8.68 (7.85, 9.57)	6.45 (6.10, 6.82)
Age: **<35**	5.17 (4.57, 5.83)	3.90 (2.77, 5.33)	4.97 (4.43, 5.55)
35-54	5.64 (5.10, 6.21)	10.90 (9.64, 12.17)	7.06 (6.55, 7.60)
55+	7.23 (6.23, 8.34)	7.60 (5.99, 9.51)	7.33 (6.48, 8.27)
Living alone: no	5.10 (4.66, 5.57)	8.39 (7.43, 9.44)	5.94 (5.53, 6.37)
yes	6.94 (6.25, 7.69)	9.36 (7.82,11.10)	7.45 (6.81, 8.13)
Paid work: no	6.35 (4.66, 5.57)	8.25 (7.28, 9.30)	7.06 (6.51, 7.64)
yes	5.42 (4.96, 5.90)	9.6 (8.10, 11.30)	5.98 (5.54, 6.45)
Social class:			
Professional	9.88 (7.81, 12.31)	5.25 (3.25, 8.03)	8.33 (6.78, 10.14)
Intermediate, semi-routine/routine	4.68 (4.15, 5.25)	6.00 (4.64, 7.63)	4.88 (4.38, 5.41)
Other	6.09 (5.55, 6.66)	10.03 (8.96, 11.19)	7.49 (6.95, 8.06)
Locale type: Urban	5.05 (4.50, 5.65)	6.63 (5.42, 8.01)	5.38 (4.87, 5.93)
Town	7.00 (6.29, 7.77)	12.59 (10.96, 14.39)	8.42 (7.74, 9.14)
Villages and rural areas	5.25 (4.65, 6.01)	6.28 (5.04, 7.74)	5.4 (4.06, 7.04)
Prior suicide attempts: no	5.79 (5.22, 6.40)	8.08 (6.60, 9.78)	6.16 (5.63, 6.74)
yes	5.73 (5.23, 6.26)	8.91 (7.93, 9.97)	6.64 (6.19, 7.13)
Prior diagnosis: none	3.22 (2.66, 3.86)	7.57 (5.67, 9.90)	3.93 (3.36, 4.57)
Common metal health problems	5.78 (5.17, 6.43)	8.70 (7.62, 9.89)	6.71 (6.17, 7.29)
Serious mental illness	5.10 (4.16, 6.19)	9.63 (7.60, 12.03)	6.39 (5.49, 7.40)
Alcohol/drugs	8.65 (7.69, 9.69)	8.00 (5.4.7, 11.29)	8.58 (7.67, 9.56)

Table 9 shows the mean number of contacts with primary care services. Highest frequencies are found among men and women from larger towns with female contact with GPs, almost double that of women in urban and rural areas. Similarly, women older than 35 years recorded higher attendance levels than younger women. There are also significant differences with regard to social class and type of substance misuse. Thus, male professionals compared to the other classifications recorded higher levels of GP contact, while conversely, women in 'other' classifications attended more frequently than their female professional counterparts. We also noted significantly higher contact among people with drug and alcohol problems than those without. Men living alone had significantly more contact with GPs than men living with others.

In Table 10 below we addressed the question of the type of factors that influenced consultations with a GP in this cohort. The table comprises a series of fully adjusted models testing for differences in the likelihood of consulting with a GP over the three time-periods: (a) for all consultations and (b) for those concerning mental health problems only. Thus:

- Gender: while for females (compared to males) there was a greater than twofold difference in *all* consultation rates at all time-periods, this disparity either disappeared or was substantially reduced when tested against mental health related consultations only;
- Age-group: while for *all* consultations those in older age-groups attended more than younger, with attendance for mental health consultations those aged 35-54 were much more likely to attend;
- Living alone: while for *all* consultations at all time periods those living alone where less likely to attend than those living in families, for mental health consultations those living alone were more likely to attend in the one month and three months before death, with the odds ratios (OR) associated with the twelve-month period reverting to the pattern associated with *all* consultations;
- Paid work: while for *all* consultations at all periods those not in employment were less likely to attend (than those employed), for mental health consultations those not in employment were more likely to attend in the early time-periods (with the likelihood reverting to pattern associated with all consultations);
- Occupational social class: while for *all* consultations (at all time periods) those in professional social classes were most likely to attend, for mental health consultations those in semi-routine or routine social classes or those whose status was defined in a way other than by occupation were more likely to attend (again this attenuates at twelve months);
- Locale: at all periods and for *all* consultations those from larger towns were more likely to attend than the other groups;
- Prior attempts: for all time periods those with a history of prior attempts were more likely to attend, while for those attending for mental health consultations only were (significantly) more likely to attend; and finally

- Compared to those with no prior diagnosis of a mental health problem those with a pre-existing diagnosis were more likely to attend at the GP – while all groups recorded higher likelihoods, those with common mental health problems and substance abuse problems were highest.

Table 10. Suicides in Northern Ireland (March 2007 - February 2009). Attendance at general practice services (plus attendance for mental health issues only) in the 30 days, 90 days and 12 months before death together with the main risk factors associated with suicide. Data represents odds ratios and (95% confidence intervals)

Suicides in Northern Ireland (March 2007 – February 2009). Attendance at GP services (plus attendance for mental health issues only) in the 30 days, 90 days and 12 months before death and the main risk factors associated with suicide ORs and (95% confidence intervals)

	Attendance at GP services prior to suicide: one month		Attendance at GP services prior to suicide: three months		Attendance at GP services prior to suicide: twelve months	
	All (n=333)	**Mental health (n=132)**	**All (n=333)**	**Mental health (n=193)**	**All (n=350)**	**Mental health (n=288)**
Gender: male	1.00	1.00	1.00	1.00	1.00	1.00
Female	2.00 (1.08, 3.71)*	1.11 (0.24, 5.12)	2.63 (1.36, 5.51)*	1.13 (0.35, 3.67)	2.37 (0.92, 6.10)	1.91 (0.76, 4.81)
Age: <35	1.00	1.00	1.00	1.00	1.00	1.00
35-54	1.81 (1.04, 3.14)*	47.39(3.60,623.84)*	1.30 (0.76, 2.25)	13.02(3.24,52.38)^{x}	0.70 (0.35, 1.38)	3.29 (1.43,7.55)*
55+	2.95 (1.44, 6.00)*	4.15 (0.81, 21.16)	2.45 (1.17, 5.15)*	4.29 (1.13, 16.33)*	2.04 (0.72, 5.83)	1.11 (0.44, 2.78)
Living alone: no	1.00	1.00	1.00	1.00	1.00	1.00
yes	0.83 (0.49, 1.40)	1.21 (0.30, 4.89)	0.74 (0.44, 1.24)	2.47 (0.74, 8.30)	0.80 (0.41, 1.55)	0.60 (0.28, 1.29)
In paid work: yes	1.00	1.00	1.00	1.00	1.00	1.00
no	0.65 (0.35, 1.22)	3.09 (0.46, 20.35)	0.71 (0.39, 1.32)	2..61 (0.66, 10.33)	1.05 (0.47, 2.31)	0.88 (0.38, 2.03)
Social class:						
professional	1.00	1.00	1.00	1.00	1.00	1.00
(semi) routine	0.86 (0.30, 2.47)	4.84 (0.24, 97.34)	0.59 (0.19, 1.78)	3.44 (0.65, 18.20)	0.67 (0.17, 2.72)	1.20 (0.28, 5.08)
other	0.80 (0.27, 2.39)	6.87 (0.31, 154.95)	0.56 (0.18, 1.78)	3.19 (0.52, 19.60)	0.53 (0.12, 2.24)	2.51 (0.56, 11.30)
Locale: urban	1.00	1.00	1.00	1.00	1.00	1.00
Large towns	0.94 (0.53, 1.65)	1.40 (0.29, 6.74)	1.03 (0.69, 1.82)	1.46 (0.44, 4.79)	1.36 (0.66, 2.80)	1.03 (0.46, 2.32)
Large villages/rural	0.90 (0.50, 1.62)	1.12 (0.26, 4.91)	0.93 (0.52, 1.68)	0.80 (0.27, 2.40)	1.01 (0.49, 2.08)	0.48 (0.21, 1.10)
Prior attempts: no	1.00		1.00		1.00	1.00
yes	1.40 (0.85, 2.31)		1.37 (0.83, 2.27)		1.82 (0.94, 3.56)	4.14 (2.04, 8.39)*
Prior diagnosis: none	1.00		1.00		1.00	1.00
Common mental disorders	1.75 (0.97, 3.15)		2.15 (1.20, 3.88)*		2.41 (1.12, 5.51)*	6.32 (2.89, 13.83)*
Serious mental illness	0.91 (0.39, 2.17)		1.25 (0.55, 2.83)		1.35 (0.50, 3.66)	20.26 (4.07,100.8)*
alcohol/drugs	1.72 (0.80, 3.70)		2.82 (1.29, 6.19)*		5.42 (1.47,20.01)*	11.26 (3.31,38.27)*

***: p-value at least <0.05**

Suicide, attempted suicide and method of suicide

Table 11 below shows the distribution of methods used in the completed suicides, by both gender and locale. Of the 401 suicides in the cohort, 76% died by hanging (78% of male suicides and 65% of female), 6% died by overdose (4% male and 15% of female) and 6% died by drowning (5% and 9% to males and females respectively). Death by firearms comprised only a small proportion of suicides. However, by locale there are some differences of note. While hanging is in the main distributed evenly across locales, higher proportions of females in urban areas (81%) and of males in villages (100%) died by hanging; and while females in towns recorded the lowest proportions for hanging (42%), they also recorded higher levels of drugs overdose.

Table 11. All suicides recorded in Northern Ireland (March 2007 - February 2009). Relationship between method used in the completed suicide and settlement band, by gender. Data represent column percentages (all columns sum to 100%)

	All suicides recorded in Northern Ireland (March 2007 – February 2009). Relationship between method used in the completed suicide and settlement band, by gender (columns sum to 100%)														
	All in NI			**Urban**			**Town**			**Village**			**Rural**		
	All	**M**	**F**	**All**	**M**	**F**	**All**	**M**	**F**	**All**	**M**	**F**	**All**	**M**	**F**
Hanging	76	78	65	78	78	81	70	76	42	93	100	71	76	78	65
Drugs overdose	6	4	15	6	5	10	11	6	31	4	0	14	6	4	15
Firearms	5	5	1	2	2	3	5	7	0	0	0	0	5	5	1
Drowning	6	5	9	6	6	3	6	5	12	4	0	14	6	5	9
Other methods	7	8	10	8	9	3	8	6	15	0	0	0	7	8	10

Table 12 below explores the relationship between the methods used in both prior attempts and the subsequent suicide[9]. Here the method used has been dichotomised into two categories, either lethal or non-lethal[10], where lethal methods include hanging, gun-shot and jumping and less-lethal methods include drugs overdose, poisoning, drowning, cutting and asphyxiation by gassing. Of the 401 suicides, 159 had recorded at least one prior attempt (117 males and 42 females). Of the attempts,19.5% (21/159) were classed as lethal, with

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[9] This is treated in more detail in a recently published paper: 'Patterns of presentation for attempted suicide: analysis of a cohort of individuals who subsequently died by suicide'. Mallon S, Rosato M, Galway K, Hughes L, Rondon J, McConley S & Leavey G. *Suicide and Life Threatening Behaviour* (2014).

[10] The methods used in the suicides and the prior attempts have been re-classified into lethal or less-lethal types – this draws mainly on the Harvard assessment of lethality (Harvard School of Public Health. Lethality of Suicide Method - http://www.hsph.harvard.edu/means-matter/means-matter/case-fatality/). Generally, we have taken a pragmatic view and in aggregating the specific methods used included wider elements of intent, lethality and prospective finality or fatality in the classification.

80% classed as non-lethal. However, by the time of the actual suicide itself these proportions had reversed.

Table 12. Completed suicides in Northern Ireland (April 2007 - March 2009). Characteristics of the type of method used (more lethal vs. less lethal) in both, the completed suicide and its immediately prior attempt

Completed suicides in Northern Ireland (April 2007 - March 2009). Type of method used in both, the completed suicide and its immediately prior attempt				
	Last prior attempt (n)	Last prior attempt classed as lethal % (n)	Suicide classed as lethal %(n)	Change in method: Less lethal to lethal %(n)
Males	117	20.5 (24/117)	82.1 (96/117)	61.5 (72/117)
Females	42	17.1 (7/42)	66.7 (28/42)	50.0 (21/42)
Persons	159	19.5 (31/159)	80.0 (124/159)	58.5 (93/159)

This is to be expected: an individual persisting with less lethal methods over a history of attempts would be expected to survive more, while a shift to a lethal method like hanging would be more likely to precipitate the death. This switch between non-lethal and lethal methods is explored in some depth in Table 13 which quantifies the likelihood of: (i) the use of non-lethal methods in the overall 401 suicides under examination, and (ii) the *persistence* of the use of non-lethal methods into the suicide by those who have previously recorded a previous attempt. Models 1 to 3 show the population groups most likely to use non-lethal methods in the suicide (females, older age-groups, those not living alone, and those with a prior diagnosis of mental illness). The final model in the sequence (4) also shows these likelihoods, but this time for those with a history of prior attempts. For this group, while females remain more likely to use non-lethal methods than males, the difference between the two is now no longer statistically significant; the remaining population groups show a similar profile as previously. However, the additional variables included in the model do show noteworthy results. Those recording two or more attempts were (significantly) more likely to persist, and those whose last prior attempt was classed as non-lethal were three times more likely to die using a method classed as non-lethal (this however, while indicative, was not statistically significant). Apart from data on the actual suicide, analysis of this sort is based entirely on data available on an ongoing basis – and given more detailed analysis of these and other data, including the GPs' implicit knowledge of both the area and the patients, to refine mechanisms to signal a developing immediate problem.

Table 13. Completed suicides in Northern Ireland (March 2007 - February 2009). The persistence of use of less lethal methods for suicide attempts, when compared against those who use more lethal methods, by selected known risk factors and indicators of prior suicidal behaviour. Data represent ORs (95% confidence intervals) from logistic regression analysis quantifying the ORs associated with the use of less lethal methods in the completed suicide

	Completed suicides in NI (March 2007 - February 2009). The persistence of use of less lethal methods for suicide attempts, when compared against those who use more lethal methods, by selected known risk factors and indicators of prior suicide behaviour. ORs (95% confidence intervals)			
	M1 **gender & age, over the whole cohort**	**M2** **M1 + socio-demographic characteristics**	**M3** **M2 + diagnosis**	**M4** **M3 + characteristics of final prior attempt (over 159 subjects recording a prior attempt)**
Gender				
Male	1.00	1.00	1.00	1.00
Female	2.19 (1.16, 4.14)*	2.36(1.17, 4.77)*	2.15(1.03, 4.48)*	1.71 (0.62, 4.71)
Age group				
<34	1.00	1.00	1.00	1.00
35-54	2.56(1.27, 5.16)**	2.28(1.11, 4.69)*	2.10 (0.99, 4.47)	3.23 (1.07, 9.73)*
55+	3.82(1.72, 8.52)**	3.28(1.44, 7.47)**	2.95 (1.25, 6.97)*	3.75 (1.19, 19.05)*
Living alone				
Yes		1.00	1.00	1.00
No		2.76(1.52, 5.02)**	2.47(1.34, 4.59)**	3.02 (1.20, 7.60)*
In paid employment				
Yes		1.00	1.00	1.00
No		1.20(0.64, 2.23)	0.94 (0.48, 1.81)	0.82 (0.33, 2.04)
Mental health problem diagnosed: type				
No			1.00	1.00
Common MH problems			1.92(0.86, 4.25)	3.68 (0.83, 16.30)
Severe mental illness			4.98(1.98,12.49)**	7.88 (1.58, 39.43)*
Alcohol/drugs			1.38(0.49, 3.86)	2.02 (0.41, 9.95)
Final prior attempt Lethal method used				
Yes				1.00
No				3.21 (0.79, 13.07)
Final prior attempt				
Less than 1 year before				1.00
One or more years before				1.08 (0.44, 2.66)
Number of prior attempts				
One only				1.00
Two or more				2.77 (1.06, 7.23)*

Prescription medications and polypharmacy

Administrative data collected from the coroners files included medications prescribed at the time of death. The deceased's general practitioner supplied this information directly to the CSNI. In line with the reports of some bereaved family members, prescription medications were a significant part of life for many people within the cohort. It is important that the potential role of polypharmacy in suicide is explored and considered, particularly in relation to the psycho-active chemicals used in psychiatry, which affect the state of a person's emotional and cognitive functioning at the time of a suicide attempt[21]. In this cohort high levels of psychiatric polypharmacy were observed. In brief, 27% of the cohort (n=109) were being prescribed four or more separate prescription medications, with 5% (n=28) currently in receipt of eight or more prescription medications. Across 207 people with a mental health diagnosis, 163 (79%) were in receipt of at least one prescription, with 112 (54%) in receipt of three or more prescription medications. Worryingly, 45% (n=40) of those prescribed a variety of painkillers were also being prescribed benzodiazepines; a well-known toxic mix. Polypharmacy is currently being examined in a separate analysis.

Focusing on mental health related prescriptions, the data revealed that 38.5% (n=155) of the cohort was being prescribed anti-depressants of various types at the time of their death; interestingly 34% (n=36) of those prescribed an anti-depressant had no MH diagnosis. Furthermore, 9.5% (n=13) of those prescribed an antidepressant were experiencing social problems (but had not received a mental health diagnosis).

Self-poisoning is a common method of suicide and often involves ingestion of antidepressants. Information on the relative toxicity of antidepressants is therefore extremely important. Tricyclic antidepressants are toxic in overdose; therefore caution is advised in prescribing guidelines(National Institute for Health and Clinical Excellence (NICE), 2009). Of those who died, 8.2% (n=33) were in receipt of tricyclic antidepressants and 23.5% (n=95) were in receipt of SSRI prescriptions.

Benzodiazepam medications were being prescribed for 22% (n=88) of the cohort. Of these, 20% (n=15) were being prescribed for people with no mental health diagnosis and a 21% (n=16) were being prescribed for people with chronic or acute drug or alcohol problems.

Examination of neuroleptic prescription frequencies indicated that 14% (n=56) of the cohort were being prescribed these medications, broken down by diagnosis into: schizophrenia and psychosis (n=18), depression and/or anxiety disorder (n=5) acute/chronic alcohol and/or drug abuse (n=8), personality disorder (n=6) bi-polar disorder (n=3), phobic reaction (n=2), other (n=14).

Summary

Males comprised 81% of the cohort, with suicide peaking in the 25-34 age group in men (n=80, 24.8% of deaths)

- Suicide in females peaked later in the 35-44 age groups (n=22, 28.2% of deaths)
- 59% of the cohort were in paid employment at the time of death, and 41% had no prior mental health diagnosis
- Common mental disorders were apparent in 33%, serious mental illness in 12% and substance misuse in 14% of the cohort
- Attendance at the GP was recorded for 87% in the previous 12 months, 57% in the previous 3 months and 29% in the previous month
- The mean number of consultations in the previous 12 months was 6.74 (SD 6.45, 7.05) overall, with a mean number of consultations for mental health problems of 6.45 (SD 6.10, 6.82)
- Living alone, professional status, no paid work, town locations and psychiatric diagnoses were particularly associated with increased attendance at the GP
- There were no significant differences in access to primary care services across rurality, with the exception of elevated attendance amongst females living in towns
- 41% had contact with accident and emergency services in the previous 12 months, with 58% of these relating to a mental health crisis.
- 18% had contact with a social worker over the previous 12 months, with 92% of these contacts for mental health support
- 35% of the cohort had seen a psychiatrist in the previous 12 months and 29% had been supported by Community Mental Health Teams (CMHTs)
- Within the cohort, 76% died by hanging (78% of male suicides and 65% of female), 6% died by overdose (4% male and 15% of female) and 6% died by drowning (5% and 9% to males and females respectively).

- Previous suicide attempts were recorded for 39.7% (n=159) of the cohort
- Over a quarter of the cohort (27%, n=109) were in receipt of more than four prescription medications, with 38.5% (n=155) in receipt of a prescription for antidepressant medications (9.2% of these had no mental health diagnosis)
- Initial analyses indicate that the role of polypharmacy in suicide should be examined in more detail

Family Attributions of Suicide

The participants

This section of the report is derived from seventy-two audio recorded, in-depth interviews with bereaved relatives or friends of people who took their own lives. In this section we will explore the relatives and friends' explanatory models of suicide; that is, their understanding of the events, circumstances and causal attributions related to the suicide of 68 relatives. The participants discuss in detail the suicide of 53 males and 15 females. As shown in Table 14, we interviewed a wide range of participants, including wives, husbands, mothers, fathers, brothers, sisters, sons, daughters, friends and other relatives.

Table 14: Kinship relationships of participants

Kinship (n)	
Wife	19
Mother	11
Sister	11
Friends/Other	7
Brother	7
Father	6
Husband	4
Son	4
Daughter	3
Total	**72**

Explanatory models: introduction and rationale

It is often considered that suicide is a challenge to reason and in common with other traumatic events, 'shatters our assumptive worlds' (Leavey *et al.*, 2008). Suicide often has a powerfully destructive impact on those left behind, exacerbated by the apparent meaningless of the action. For some people, suicide may come as a 'bolt out of the blue' but then rendered, over time, 'understandable' or predictable with 'hindsight', contextualised perhaps, by a long-term illness or a series of difficult life events. For others, it will always remain a struggle to explain. In many cases, there is an externalisation of the explanation, a need to allocate responsibility and blame. For a few people, the suicide of a relative may be seen as almost unavoidable or a release from suffering while for a few, suicide is even seen regarded as 'deserved', a self-punishment for misdeeds. Nevertheless, in most cases, family members spend substantial time in attempting to uncover the ultimate reason or reasons why their father or mother, brother or sister died by suicide.

How people come to explain the death of a family member through suicide may have considerable importance to their own mental health and that of other family members. Their beliefs about the death may assist in healthy coping, allowing, over time, people to come to terms with the suicide. In addition, the attributions they give to the suicide may also determine if, from whom and when, they seek help or support. Their understanding of the suicide may impact on close family and wider community relationships. Thus, such narratives can reveal a great deal about the influence of stigma attached to the circumstances and life events, in addition to the stigma of suicide itself as an event. They allow us to consider the problematic relationships in the personal lives of suicides and with the professionals who have tried and failed. In this sense, narratives also reflect the problematic relationships of some survivors as they seek to apportion blame and seek retribution.

During these interviews, we sought to obtain from the participants, their narratives relating to the circumstances of death and what each person understood to be the direct or contributing factors leading to the suicide. Commonly, but not in all cases, such factors tend to distil into some form of mental illness or emotional distress accompanied with, and often provoked by, a range of life events that were related as recent or historical. In some cases, family members can find no explanation for the suicide; that is, there were no satisfactory, tangible circumstances or behaviours that were noticed or explain why it happened.

The concept of an explanatory model has been useful in various health settings to illustrate the meanings and beliefs that lay people attach to their problems, how it affects their lives, relationships and wellbeing and, among other things, how their beliefs influence help-seeking. In contrast to physical or medical explanatory models, which attribute illness to a disruption of a biological process, sociocultural or psychosocial explanatory models are understood within a framework that comprehends a health event as related to thoughts or emotions, and is influenced by cultural and social factors.

We have adopted Arthur Kleinman's concept of an explanatory model of illness (Kleinman *et al.*, 1978) in order to assist in the analysis of the family understanding of the suicide. However, it is important to acknowledge that explanatory models of illness or an event such as suicide do not always form a linear pathway in a narrative; quite often, they may be contradictory or lacking coherence. Often too, while these are personal accounts of family suffering, they point to wider, externalised social complaint (Good, 1986, Leavey *et al.*, 2007). However, what matters most, is that explanatory models are an attempt to give a meaning to the event.

In the following section we describe the participants attributions for suicide; the perceived causes and life circumstances according to common themes and patterns found in the data. In most cases, life events form the most substantial element of the bereaved participants' narratives, providing meaning as to why they became distressed or developed a mental health problem. We will provide an overview of the issues and events, historical and recent, that are discussed by participants as most salient to the "why" question and show how these may condense into various types of explanatory model of suicide.

All proper names have been changed and all identifiers removed from the text to protect the identity of the participants and the suicides.

Mental illness

The onset or initial diagnosis of clinical depression or severe mental illness appeared to be directly linked to some suicides. Many of the relatives recounted of how the deceased has been treated for a mental health problem that had been diagnosed within a year or less prior to the suicide. Participants described their relatives struggle to come to terms with the diagnosis, mentioning continuous changes in medication and rejection of proposed treatment. These difficulties were accompanied by feelings of inadequacy, particularly among men. However, while relatives tended to suggest that suicide followed relatively soon after onset and diagnosis of a mental health illness, their narratives also suggested that such problems may have been undiagnosed for some time. This was indicated in some cases by increasing social isolation and disengagement from work or education.

Parents of young adults with recent mental health diagnoses more clearly attributed the suicide to mental illness. For example, this mother, describes how her son ended his life within weeks of receiving a diagnosis for a mental illness:

> I think he did what he did because he was ill. […] He just didn't want to live his life with [the mental illness] and he wanted to have an exciting great life and he felt that he couldn't possibly with a severe mental illness. So that's why [he ended his life] (P20, Mother).

Here, a father, whose young-adult daughter had been treated for depression in the 12 months prior to her suicide, states:

> It seems very fatalistic, but I think that she couldn't see that her illness could have been cured. […] But I do think that what she saw as insurmountable problems, from what I know of them, and again I'm guessing, I think that she could have been treated and treated successfully (P3, Father).

Loss and deterioration: ageing and physical health problems

At the other end of the life span those describing suicide among older relatives described how they had experienced a deterioration in their physical health and this led to a slow dissent into depression underpinned by a sense of hopelessness. This son described his mother's plight:

> She fell and broke her hip about probably [number of years] years ago, before she died, and from that day onwards she seemed to slowly but surely get depressed. She couldn't do the same things that she used to do (P73, Son).

The curtailment of normal activities was a common feature in causing depression among this group. The sense was that this lady could not go about her normal daily activities. Later, in his interview, this son also revealed that these activities were crucial to his mother because she was the main carer for his father who was suffering from a terminal illness:

> He started to deteriorate and that's when all the problems really started. Then she actually said to me, oh, I'm sure four, possible five, six times that she couldn't cope with the whole thing. His illness and the way she felt with her legs and she couldn't do the same things and my father was starting to steadily get worse (P73, Son).

It is potentially significant here, that shortly before her suicide this woman had begun to communicate her sense of hopelessness in relation to both her deterioration and that of her husband whom she cared for. She had not been known to previously express such desires and had never been formally diagnosed with any mental illness.

Other cases reveal the close association between physical pain, depression and hopelessness among this group:

> The other thing I should say is that in her latter years she was going through a process of being diagnosed with [chronic illness]. She thought it was [that]. Just before she died it was diagnosed as [illness name]. So, she was in a lot of pain with that, physical pain in her hands and her feet and was taking medication for that (P31, Sister).

As suggested by this participant, it sometimes took a long time for a diagnosis to be made, thus creating delays in setting up effective pain management. For example, one daughter described how in her opinion the lack of '*proper pain relief*' had directly led to deterioration in her father's mental health:

> I think that they needed to have done the pain relief sooner because by the time the depression had kicked in towards the end, I don't think you'd have had a chance to help him. And I think they really need to listen to people (P12, Daughter).

This daughter believed that at the end of his life, her father's depression was unmanageable and she stressed the need for medical professionals to manage the pain effectively from the onset of the condition.

Impulsivity

Impulsive behaviour, particularly in relation to young males, was a feature of several parents' accounts. Such behaviour helped explain the event; parents often felt that they could have done more to contain their children. As this father explains, his son's suicide could be explained as the result of momentary aggression:

> He was impulsive […] your mind works very quickly and before you know it you've done it and you didn't mean to do it […]. You're just pissed off. I guess he just couldn't face it any longer […]. You just wish there was something you could have done to delay that moment by one second because when anybody commits suicide, at that moment, another moment later they may have changed their mind, they may have stepped back from the brink, and I just wish I had been able to do something to delay that moment … (P36, Father).

One mother described her son as being impulsive from an early age but now questions the possibility that this was an early sign of mental illness:

> I was always was a little bit concerned about him, in that he was very impulsive, didn't think first, got into some scrapes, but just made me laugh … But looking back, was that a sign of mental illness? I remember the first time going over to see him in [his new home]. He was really, really high, but I didn't know whether he was just excited, […]. Was he perhaps a bit manic then? I don't know (P20, Mother).

Relationship break-ups

The break-up of a relationship, associated mainly with an impulsive suicide, seemed prevalent amongst the young males in our sample. Frequently, the participants (usually a mother or a sister) described these relationships as volatile, unsettled and littered with arguments or quarrels. In some cases the quarrels occurred on the day of the suicide or shortly before it. However, while the participants emphasised the break-up with the girlfriend as the 'trigger' for the suicide, it is important to note that these narratives also reveal, in most cases, a series of life events or other adverse circumstances that have impacted on the lives of these young and middle-aged men.

> When his relationship with his ex [girlfriend] was starting to break up, I think that's when things started to fall apart. He was being treated by his doctor for depression, and I suppose anxiety goes with that too (P25, Sister).

> [The deceased had an accident] and couldn't get work, he divorced from his second wife, [he] was married twice, he had [children] from his marriages […] After the divorce he fell in with this girl, who was no good for him. She had problems of her own. She drank a lot, which didn't help him, and it was just a downhill roll from there on. […] [It was a] very volatile relationship […] I didn't live with him in that relationship but I don't know if he would have been a violent [man]. There was a row had and she phoned the police and the police just came and took him away. […] And he came out [and three days later] he died (P10, Sister).

For example, some of these men grew up in families where one of the parents abused alcohol or suffered from a mental illness.

> [My son] was very moody all his life. Very bad tempered, moody, if he didn't get his own way that was it. If he was happy, he was happy, if he was down in the dumps, he was down in the dumps. I've tried to commit suicide and one thing and another and I wanted to get my son help, but he wouldn't listen to me; just wouldn't hear of it. […] About four weeks before [significant date] he was down in the dumps. He took tablets. I got him into the [hospital]. Then four weeks after [that date] he committed suicide. Before he died he went down to [see his girlfriend] and that's when she told him she was engaged to another fella. Her and [the deceased] were engaged. She didn't actually tell him, it was the fella's sister that told him and handed him back the ring and all that. So it just went to [the deceased's] head. All that week he just cried sore … (P14, Mother).

In other cases, these men had been underachievers and had been bullied in school; others had committed criminal offences in their teenage years, had been expelled from school or had been alcohol or drug abusers. They were described as prone to low self-esteem, poor problem solving skills and lacking in natural coping mechanisms:

> [My son] had I think third year in [name of school] when he was like 13 he had a really bad year that year in terms of bullying and decided he never was going back to school again, but he did. […] Life was good from he working and he had younger people working with him and you know … and he seemed to be very outgoing and successful and had his girlfriend […] They were arranging their wedding and getting engaged. […] There was a party […] and they [the deceased and his girlfriend] had words but it wasn't serious, but they never did have words, you see, so what happened, I don't know. And she still maintained that her wedding was still going to be on (P70, Mother).

In other more poignant cases, parents simply appeared to be resigned to the suggestion that the hurt of unrequited young love could have been the only explanation for the suicide of their offspring:

> We don't know why … from the coroner's report it came out eventually that it [the suicide] was over his girlfriend that fell out with him (P9, Mother).

> That was about the girl [friend], obviously we feel that [our son's] suicide was through emotion **[…]** it was an emotional, first time love [thing] (P66, Father).

Life events

From the relatives' narratives there was evidence of high levels of intrapersonal stress among the majority of the deceased individuals. Participants talked, particularly, about the anxiety states, guilt and shame experienced by many of the deceased males as a result of the series of life events, as previously described, chronic or acute, taking place in their lives. Many of these individuals have been overwhelmed with feelings of hopelessness, burdensomeness and low self-esteem. These features, more noticeable in males than females, may be conceptualised in two ways. First, it was linked to these men's need to be a provider and breadwinner for their family. And second, it was linked to status within the community. Therefore, it is very important for the male suicides not to appear weak or irresponsible before their families and communities.

> And work, now definitely, I would say had an impact on his life because he was a big believer, you know, in providing. Like that was one thing about him, all his

> money went on our kitchen table, regardless, regardless. It's not that, you know what I mean, he wasn't one of these men that hid money or kept money, he didn't need money to get drink, do you understand me? (P54, Wife).

This wife is keen to highlight that the reason money was important to her husband was because of his desire to provide for his family. This is seen as a traditional position among older generations both in Northern Ireland and wider communities. However, we also found evidence of this as a contributory factor in the deaths of younger men. We also found resistance from men when women challenged the notion that men had to be provider:

> He said he was thinking to himself lying in bed, '*What kind of man am I? I can't even get up and go to work.*' He said, '*That's a man thing, you need to protect everybody and work and pay for stuff. That's just something that … it's the man's job to be the provide*r' (P55, Wife).

This man's statement that it was the '*man's job to be the provider'* does much to contextualise the significant sense of loss, guilt and being a burden experienced by these men when they are unable to fulfil this role. In some cases, leaving work as a result of physical ill health had the same impact. These men were described as following a typical downward spiral as indicated in the following cases:

> He had an operation on his arm […] and he was losing the power in parts of his hand […] and that started a downward spiral with him really because he never ever got the full use of the hand again. He was unable to work, carry out his job (P24, Brother).

> He was a manual worker all his life and then he lost his job. He fell and he broke his foot and he lost his job, and to me, that was the be all and end all of him, when he couldn't work. He couldn't get any work anywhere else (P65, Sister).

Of importance perhaps, the physical condition was considered to be highly significant in terms of the longer-term effect because it was to these men '*the be all and end all of him'*. However, the same effect was found in isolated cases of females. This daughter talked about the impact of ill physical health on her mother and the typical sense of loss identified throughout the interviews:

> … when she was [younger] she had a motor bike accident which then medically retired her from work and so she became unemployed and I think that was part of the problem then because she became a lot more isolated and didn't have the

> job that she loved. She was quiet, she kept herself to herself and she lived for her family, more or less (P6, Daughter).

Role loss and change

Transition points are associated with changing roles at work or more general life transitions, such as getting married or changing career. For the older adults the pressures of changing roles at work and feeling unable to cope or perform in the way they thought it was expected of them, appeared to trigger anxieties and worries which then spiralled into depressive moods that led to the suicide. In the following, a relative explained how her sister had difficulties coping with changes at work, which impacted on her wellbeing. She said that:

> She worked [type of work] and she was there for about [number of years], I would say, and not one day did she miss. That was how loyal she was to her work. Then all of a sudden, just the changes, new boss, things just got to her, getting on, she just couldn't accept the changes and it just went gradually downhill. She was maybe there for a couple of months and then she'd be off a couple of weeks and this kept going (P49, Sister).

Some older adults, male or female, came to see themselves as not being needed anymore. Thus, facing redundancy was disturbing, not necessarily due to the financial loss, but because it was experienced as a rejection and for the void it threatened. For example, two widowed participants talked about the circumstances of their spouses' redundancy and the accompanying losses in these terms:

> … you see, she looked after her grandchildren and then they got bigger and she sort of didn't have to look after them and she kind of thought I suppose that she wasn't needed. I don't know. I think the problem was she maybe hadn't enough to do, sort of thing, and then she didn't drive and she couldn't … she was depending on me to get anywhere she wanted to go. […] Probably … right enough, when we came down to the bungalow she would have got a bit depressed, when she left the farm. But I don't know what was the reason for that … (P39, Husband).

> … it was a whole combination, just a whole lot of things. I really think that's what happened him. I think everything just got too much and he felt worthless. He was a [name of profession] for [many years]; when he wasn't [in that role] that was a big part of his life over. …. And he was [number of years] years old … At that time they [the employers] were chatting about them going into the bigger

> [business] so he thought his time was come. He didn't drive, so he said, '*I'm not moving to [city's name]. I'll just come out then.*' So he was thinking that was ending too, and the [sports] club, that job ended and he probably … and the children had all moved on out of the house (P57, Wife).

Addictions

Issues deemed unresolvable were noted as stemming from two sources. First, in some cases of young males, financial difficulties are linked to debts gained by sustaining an addiction. Second, given the timing of our study, it is not surprising that the recession was repeatedly mentioned in relation to the suicide. One woman's emphatic assertion was that her son's financial problems led to the suicide; he could no longer support his expensive drug habit. She found comfort in the knowledge that he was not prepared to deal drugs. She explained that:

> … That was why he took his life. It was financial. I don't really want to go into too much detail. Thanks be to God, he might have taken [drugs] but his morals would never let him sell it, and that is the one thing that I am grateful for, that he would not inflict that on someone else's family (P22, Mother).

For other young males, gambling was a problem that led to the accumulation of considerable debt and criminal behaviour (e.g. fraud). Two young female partners of these individuals explained their circumstances as follows:

> … it wasn't until maybe two years into the relationship that I would have become aware that he had a gambling addiction, which wasn't evident to me at the start. […] I suppose prior to the suicide he had gone into business and was in business for probably a year, two years, before. It was really difficult because he had gone and had run up debts … and wrote cheques fraudulently … and he had fraudulently taken out a lease on vans for the business in my name (P71, Partner).

> … it was really about his gambling; that was out of control. He had a really bad credit score and he was struggling with budgeting. […] I got a loan to pay off his […] and we made a plan of what the money would go on and who he needed to pay off. […] So he did pay off the majority of people. […] And he had a small business with a partner and he went on a gambling spree with the takings one day. [...] They fell out, his business partner and him … and he was getting pressure there … there was a lot of conflicting issues there (P47, Partner).

Similarly, this account provides an insight into the association between the recession and an increase in alcohol consumption as this man, feeling under pressure to provide for his family, also struggles to cope with his increasing sense of anxiety.

> He would have been working a lot. He had a night shift work and he'd have been working that night shift and then he'd have come home here and then he'd to work during the day and he just seemed to be obsessed with working and trying to make a living, and as I say, just the recession and the line of business he was in, it didn't sort of work out. And he probably would have drunk a bit more alcohol than normally. He never really would have drunk much, but he drank, and that's, I suppose, another depressive as well (P63, Wife).

Financial problems associated with the recession

Recession and associated financial problems were mentioned in relation to a number of male suicides. Notably such issues were entirely absent from interviews in relation to female suicide. It was suggested that job loss contributed to a general deterioration in emotional health as this daughter describes:

> So obviously then when he came out of work he had more time on his hands and gradually got more and more depressed about it, and then that was really it (P12, Daughter).

There were also many instances where the recession was linked to anxiety about debt as the following quote illustrates:

> I think it was work and debt; the recession probably would be the main things. He had lost his job, and he was self-employed and he wasn't really getting any work, and work he did, he didn't get paid for and he was in a lot of debt and he just had become depressed for probably a few years (P63, Wife).

Many women shared the view that these men felt significant pressure to provide financially for their families. In some cases, this was, at least in part, anticipatory in nature in that men became worried about dwindling offers for work. The association between the recession and the impact on emotional wellbeing was further conveyed in the repeated reports we encountered of disrupted sleep patterns. The impact of these issues often presented itself late at night when the couple went to bed:

> Then he would be telling me, he'd be going to sleep and then he'd say, 'Now I have money to buy nothing, there's no money for nothing.' And I'd say, 'Look,

> forget about it.' He'd say, 'The whole thing's over, you see. The economy's wrecked.' He'd be sitting up at night doing sums and he'd be sorting out all that old bank crisis to see ... with a pen. And I said, 'What about it? Sure the boys and I are fine! I'm working away and you're working away. What odds, let it go ... Sleep darling, sleep.' Not at all! (P58, Wife).

It was noticeable in all these cases that although these men often had close support networks in the form of family and friends, they nevertheless believed that they bore the burden of financial concerns alone. There was a sense of protectiveness or gender-based responsibility attached to these issues by these men. In some cases, this extended to a sense of concern about how the wife might financially cope after the apparently planned suicide:

> But I didn't pick up on it at that stage, you know. It was wee subtle wee things and I didn't pick up on what he actually meant. You know, he used to say, '*You brought up these children on your own anyway. You could cope on your own.*' And … '*Do you think if you needed to get more hours at work could you get more hours at work?*' In other words, he was trying, I suppose, to feel that if he wasn't here anymore that I would be able to survive on my own … (P74, Wife).

A brother describes a recession-based event identified as a short-term trigger to the suicide. Again, as was typical of the narrative nature of many of the accounts recounted to us by relatives, this brother describes this event as '*the last straw'*,' suggesting it was contributory in nature rather than directly causal of the suicide:

> … now the day that my brother died was a day that a bailiff was to come … so he maybe felt that this was the last straw, this was the end of life as he had hoped and planned and set out and that everything had fallen apart, that was the last straw. So maybe that came into it. (P73, Brother)

It is difficult to determine whether or not the impact of the financial downturn on job status was the main issue on some men's lives; or whether their greatest concern was dealing with their mental health problem, as there was usually a conflation of several issues in the suicides. Again, the stigma of failure and mental illness are interwoven. Thus, participants commonly indicated increasing secrecy, avoidance and withdrawal from close relatives:

> The business was … as the financial crash happened his business got into trouble. We didn't realise the extent of the trouble. We knew he was experiencing difficulties but we didn't realise it was having an effect on his actual

> wellbeing. Subsequent to his death we found that he had been treated for depression. Now, in the week leading up to his death, I would have seen him every week (P73, Brother).

Stigma was noted as a significant issue in rural communities where men ran their own businesses. These men saw the need to keep appearances within the community where a "sound reputation" was identified as being of critical importance to the continued success of the business. One wife described her husband situation as follows:

> … He didn't want to be the farmer that had the depression. Although since his death, so many of my neighbours' wives have said, 'You know, he [my husband] suffers badly with it but doesn't want anybody to know.' And I thought, 'Mmh, that's unhelpful.' But he didn't want to be that … (P60, Wife).

Another wife said:

> Yes, and he was afraid … as a businessman he used to say he would never be able to hold his head up again if people thought he'd had a breakdown and he was very embarrassed by that and proud (P59, Wife).

These and other quotes highlight the problem of stigma within professional circles.

Northern Ireland conflict

Several participants linked the suicide of their relatives to the Northern Ireland conflict. This connection was noted in two ways. Firstly, relatives suggested that the deceased experienced difficulties in adapting when their paramilitary activities had ended. Loss of identity, role and sense of purpose were described as important. Some relatives noted that it was difficult to live up to the image of '*the hard man*' when this had been a crucial part of who they were perceived to be in their communities:

> My brother got involved in paramilitary activity when he was a teenager. He spent six or seven years in prison and when he got out he got more and more involved in that kind of criminality. […] He was some kind of hard man, or had that persona, although in his older stages he couldn't live up to that and he found that difficult (P19, Brother).

In the context of what is often referred to as a 'post-conflict' society, their prior 'conflict' identities were revealed to be fragile.

Secondly, there were a number of individuals who had threats posed to their lives apparently by paramilitary groups at the time of their death. In these cases, due to the sensitive nature of the issues, families were cautious about discussing the circumstances but made a clear connection between the suicide and threat. It is the case, that politically motivated violence had changed into something more resembling gang violence and some of the suicides had been caught up in this. One participant described it as follows:

> There were things happening that we didn't know about until after he died. […] This is what happened to him. There were events that were going on that we didn’t know about and he was getting bullied by certain factions in the town that we knew nothing about. They were supporters of a paramilitary group. But it was to do with something that happened apparently years ago but we didn’t know anything about it (P64, Brother).

Previous exposure to suicide

Relatives frequently mentioned previous exposure to suicide by family members or friends, or more generally within the community, as an important factor in the connection with the death of their relative. The time since the suicide and type of exposure varied considerably. On some occasions the connected suicide had taken place just weeks before:

> He was away on holiday and there was a guy that he grew up with, took his own life. I had to go and tell him when he came back from holiday that [his friend] had taken his own life. So [his friend] did that in summer and he did it in the autumn, but two weeks prior to it, another good friend did the same thing (P24, Brother).

It was remarkably common to have participants recalling the deceased expressing his/her views on the suicide of another member of their community:

> It was so out of the blue, it really was, because he had a friend who did this about four years before it happened to [the deceased] and he was so shocked at that happening. It was a fellow up from [town name] and he was really close with him and he just couldn’t believe that that had happened. So that's why I know that he didn’t plan this. Something has come over him and it’s just happened (P10, Wife).

Another form of connection was that made between the suicide of a family member, even where it had occurred many years before. This quote reveals an insight to impact of a personal exposure to suicide within the family:

> My granda was in the army […] when he came out he just couldn't cope and he gassed himself . My daddy found him at 13 and he said to me, ‘*It was horrific*.’ […] And then when I think about it as well, I’m sure his head was melted, because when the depression set in that must have just constantly … To me, that has to have been with him obviously, because I know what it’s like and then when you’re really depressed, that whirling around in your head as well, and you've never had any help (P12, Daughter).

This daughter believed that her father had been traumatised by his own father’s suicide and that he may have been ruminating on this event in the midst of his depression. Most participants were aware of the additional risk of suicide for those participants with a history of suicide in their family. One participant remembers how the family made sure that this message was echoed to her brother, when they were attending a relative’s funeral:

> … We had a cousin who committed suicide […]. It nearly killed his mummy and daddy; we were down [to the funeral], it was about a year probably before he done it and we were saying, ‘*Don’t be doing no things like that. You've seen who’s left behind and what it’s caused and everything else*.’ And he said, ‘*No, I’ll not be doing nothing like that.*’ So, he knew because there was a lot of heartache from before. But I suppose like when you get it into your head, that's just it (P18, Sister).

Despite giving assurances that he would never kill himself, this brother ended his life a year after that death. Similarly, other participants recounted instances of the deceased condemning suicide.

> I know the young fella across the road took his life just about maybe a year before that [the suicide]. But the only thing she [the deceased] did say, she thought it desperate and she said, ‘*I think if ever I felt like that I would put you and the family first.*’ (P39, Husband).

For these participants the shock, bewilderment and/or condemnatory statements of the act had been a reassurance that placed an additional bewilderment in their search for an explanation. In some cases the young people in our study, had been exposed to the suicides of relatives, school friends or other young people in their communities. Some participants described it thus:

> I know there was an awful lot of suicides going on […] There were ones that she [the deceased] knew […], my neighbours have lost somebody themselves (P40, Mother).

> I mean, exactly a year before [my young sister] died, exactly almost to the day, my cousin's son killed himself [in the same manner]. He lived just down the street (P67, Brother).

Exposure to suicide clusters

Another type of exposure to suicide mentioned by participants concerned the vulnerabilities of young people and the effects of copycat suicides or 'clusters' involving youths from the same towns. In many of cases of young suicides in our study, these individuals have been exposed to the suicides of relatives, school friends or other young people in their communities. Implicit in these narratives, is the possibility that each preceding suicide provided a 'permission' to people who followed:

> I know there was an awful lot of suicides going on […] There were ones that she [the deceased] knew […], my neighbours have lost somebody themselves (P40, Mother).

> The day before [my brother] died, my wife's sister-in-law's brother jumped off the [bridge]. He was walking along with his sister, over the side. At that stage I think there was three suicides in one week (P34, Brother).

> He [the deceased] was only a child […] only 14 years of age. […] There were two other young fellas [who killed themselves], and he was the third one in the school within a period of two months or three months. …. There was a first year student, in [spring] of that year there was a third year and then [my son]. Now, they didn't know each other but they were at the same school (P66, Father).

No apparent reason for the suicide – 'No idea'

Our interviews with families often followed a clear pattern. Our opening question specifically asked relatives to recount the circumstances that, in their view, led to the suicide of their relative. In the majority of cases the participant set the scene for the eventual suicide, immediately recounting an event or events which had taken place many years ago (life events) or one specific event (acute stressors) which had triggered the death. For a number of family members there was no apparent reason for the suicide of their relative. One mother described how she …

> …I looked for reasons; I couldn't find any (P9, Mother).

While a sister reported:

> … It just baffles me, the whole thing, why she did it (P48, Sister).

Where this happens, participants consulted other family members and close friends. For most, the incomprehension remained. In some cases, there were no indications at all that the person who died was experiencing any form of emotional distress; the suicide occurred in the absence of any signs that anything was wrong, as the following quote illustrate:

> Nobody saw it coming. If someone had said to me, '*I'm going to line up ten of his friends and you pick two that you think could maybe go towards suicide*,' he would have been the last one I would have picked from that row. He would have been the last one (P22, Mother).

Again, the suicide appears to happen in the midst of domestic ordinariness –even though there may be an allusion to some friction, this appears quite trivial:

> On the night that she killed herself […] her and my mum had had a bit of an argument. I don't think it was anything major but basically what had happened was she [was] grounded […] So, my younger brother was out and it was just my mum and [the deceased] in the house together, and they sat and had their dinner together and she went up the stairs to watch TV for an hour, and whenever my younger brother came into the house mum had said to [him], '*Run up and check on her and see how she is.*' And when he went up the stairs; he found her (P67, Brother).

Two other fathers found no plausible explanation either:

> No, everything seemed real normal, that's why we just can't get to the bottom of it. She came home from school, […]; that evening when I came down and made the tea we talked and I said, '*Look, I haven't bought you anything for your birthday, but tomorrow when you get home from school I'll take you down the road and buy you a new computer. You can pick whatever you want.*' [My son] came down that night, and gave her tickets for this big show in [town]. She was over the moon about going, she called about four people that night to see if they wanted to go with her. […] And the next morning she was dead (P72, Father).

> [My son] was 14, it happened out of the blue, hadn't been going to a doctor or anything, that's actually a photo of [him] on the Friday; he died on the Sunday

> evening. He had been at a summer camp all week and this is him [in the picture]. His photo on the day that he was actually buried, there's two photos of him that was in the paper, because he had played [a match] on Thursday night and his photo was in the paper actually on the morning that he was buried. So here was a young lad who wasn't being treated for anything, he wasn't going anywhere … (P67, Father).

> .... And nobody knows. When I came back at 9 o'clock, he was happy and his friends were staying in my house … My son was playing with his friends, talking on the phone and everything …[and a little later] I went to the room … Then I went near him, I touched him and then I felt he was dead. (P2, Father).

Where the suicide appears to be without any history of mental illness the participants' conceptualisation of suicide is that the suicide either sinks rapidly into a despondent mood or that they act in an impulsive, unthinking manner. Crucially, for these relatives, the lack of communication in these final moments of life and the lack of any obvious cause, conclude that suicide was not preventable:

> He was as large as life ... played with the kids, everything. Everybody went to bed, he couldn't sleep properly because of headaches and whatever … and he then decided that that was it. He had had enough. […] He had no downer, no nothing, nobody seen anything different in him at all (P24, Brother).

> … and nothing shocks me now; nothing shocks me. I know that this is a part of life, all the work you're doing and everything, it's just a part of something else we have to go through and you have to deal with it when it happens (P16, Husband).

In general, these suicides appear to have agreeable, extroverted, conscientious personalities. They have an active social life, do well at school or are successful in their jobs. Many of these parents indicated that they will never recover from the death. Moreover, in some cases, their lives have changed to the point that they are unable to hold a job due to depression and depend on antidepressant medication to help them cope. Other parents, still deeply affected by the suicide simply refused to take part in the study and so indicated to the researchers when contacted for interview.

Barriers to Suicide Prevention

Introduction

The data from the Coroner's Office and from GP records showed that most people who later died by suicide had been in contact with their GP in the 12 months prior to their death, and 50% had seen a GP in the last month. Others had been in contact with psychiatric services. In section 4 we provided evidence about the type and frequency of contacts with heath care services made by people in the year prior to their deaths. While these data are invaluable, such statistics are unable to tell us much about the nature of these contacts, the level of engagement with treatment, the quality of the patient-GP relationship and the challenges faced by patients, families and the health and social care services in the care of the suicidal family. Only a few people had not had some kind of contact with primary care. Indeed, many people had frequent contact with multiple agencies and professionals.

In this section, we provide a finely grained picture of help-seeking and service contacts of the suicidal person. We present the experiences and perceptions of participants and the different challenges to service access. Many of the bereaved families were instrumental in seeking help and support for a family member. In various ways, families may play a crucial role in recognising and defining the nature of the problem, seeking and negotiating appropriate treatment, providing support, monitoring warning signs and symptoms, and prompting emergency intervention when necessary.

Evidence suggests that looking after a depressed and suicidal relative is challenging in emotional, health, relationship and financial terms (Heideman *et al.*, 2005, NHS centre for Reviews and Dissemination, 2002). Moreover, people bereaved by suicide have an elevated risk of depression and suicide. In recognition of this, we believe that families' experience of services, albeit with varying degrees of contact, is crucial to building a better understanding of suicide and how to better target our suicide prevention strategies. In short, caregivers will have an acute understanding of the weaknesses and limitations of the healthcare system and how these might be improved. Importantly too, families' experience of health and social care may also play a determining role on how they come to terms with the suicide in the weeks and years that follow.

A healthcare system may be regarded as the totality of agencies, relationships and meanings that people assign to health and illness in which, 'the medical encounter is but one step in a more inclusive sequence' (Kleinman *et al.*, 1978). In relation to the resolution or attenuation of mental health problems and suicidal behaviour, the first step in this sequence is the recognition by the person with problems and available family members, and the belief or desire that help is possible. Perhaps surprisingly, many people do not acknowledge that they have a mental health problem or minimise its extent (Biddle *et al.*, 2004, Pollock and Grime, 2002). A complex constellation of factors, often interrelated, determine the type of help sought, the level of engagement, satisfaction and outcome of such interventions. Thus, it is not just the availability of and access to, medical and community resources; the beliefs and attitudes of individuals, families and communities towards mental illness also contribute to service contact and problem resolution.

In qualitative research, the aim is to obtain an understanding of the types of attitudes, beliefs, experiences that are associated with a particular phenomenon as viewed from particular perspectives. The aim should be to try to elucidate why things occur in the way they appear to do so. However, while qualitative studies will generally avoid quantification or calculate the probability of occurrences, there remains an obvious concern to highlight patterns and commonly occurring experiences. Our analysis, in this respect, draws upon a remarkably large sample size for qualitative research, providing greater assurance as to patterns of events and experiences relayed by the participating family members. Throughout this report we have been mindful of the need to understand and report the complexity of help-seeking and health service contacts in order to highlight the critical weaknesses and failures of the system. In this section, we have restricted our focus to the views of family members; their experiences and perceptions related to seeking help and their contact with the healthcare system.

This report section has been divided into four main areas. To a considerable extent, the issues examined in these sections are interwoven but permit a presentation of the main concerns and recommendations for suicide prevention.

1. **Stigma, recognition and referral:** in this section, we highlight the problems experienced by individuals as they seek care. The stigma attached to mental illness was regarded as playing a major factor in deterring people from seeking help. We explore the challenges to caregiving when family members conceal their mental health problems and/or any contact they might have with services. We also examine the various sources of stigma.

2. **Primary care:** general practitioners are crucial to the recognition and management of people with mental illness, assessing suicidality and arranging specialist care. In this section we examined the issues of recognition and care at the primary care level. In particular we detail the family members' concerns that the risk of depression and suicide was missed by primary care.

3. **Mental health and other services:** psychiatric and hospital based services are considered in this section. In particular, participants' narratives are occupied, to a considerable degree, by inadequacies of treatment and treatment options.
4. **Family support and engagement in care:** in this section, we detail the challenges faced by families in caregiving. Key determinants of satisfaction with services relate to consultation and advice, shared decision-making, monitoring and continuity of care. We also describe the loss of hope witnessed by family members.

Stigma, recognition and referral

No knowledge of treatment

In only a few cases, participants were unaware of health service contact prior to the suicide of a family member and therefore could say little about treatments offered or received. These tend to be people where there is some level of estrangement in the family or where the suicide had a history of being "shut-off". For example, they commonly describe the deceased, as a very private person, prone to concealing his or her feelings, never disclosed health concerns:

> He kept very much to himself. […] He was attending the doctor beforehand [prior to the suicide]. […] I wasn't aware of this at the time. It was only after [the suicide] that I was aware of it. […] I think the doctor said it could be one of two or three things, which I think cancer was one of them. So he said they would do tests and send them off for analyses (P4, Son).

> I'm not exactly sure what he was doing or what he was attending. I really don't know. I don't know. You see, I don't even know if he would admit that he had an alcohol problem. There's a lot that I don't know. I would have liked to have spoken to the GP but I didn't. Sometimes you don't know what to do for the best, because when the person's gone it's too late anyway and I didn't realise that …I mean, you don't know that this is going to happen (P59, Sister).

Similarly, for those participants who felt that they had a close and trusting relationship with their deceased relative, it was surprising to find out that they had been kept in the dark about some of the most pressing issues, which in their view, directly impacted on the suicide. This brother, in this statement, illustrates the lack of trust that the deceased demonstrated:

> Subsequent to his death we found that had been treated for depression. Now, in the week leading up to [his] death, I would have seen him every week, either I

> would have gone to his house or he would have come here, and we had a usual just a normal brotherly brother relationship. If there was an issue, generally, I was there for him and he was there for me […], but he had never hinted that there was anything (P73, Brother).

Emotional and mental health literacy

A poor 'mental health literacy' among some of the people who took their own lives was noted in several narratives. Thus, a lack of awareness and understanding about feelings, distress and mental health issues were regarded as being the main barriers to seeking help. This father of a young man, for example, pointed out that such help seeking requires identification that what they are going through is a mental health problem:

> But this is why then I have always said that I think you sometimes need to change the wording. There's no point in talking about mental health because whatever way he was on that day or whatever it was, he would not have identified himself as having a mental health problem and lifted the phone to ring anybody (P66, Father).

In other cases, it was believed that the deceased individuals, perhaps because of poor education, were unable to recognise their feelings and seek appropriate help. For some, the issues were confused. This participant explains how she was not sure if her husband was unable to express his feelings, or if he did not want to reveal his intentions:

> So when we went up […] and I sat down and he held my hand, I said to him, again just the same thing, '*What is wrong with you?*' He didn't know what was wrong with him, he couldn't answer it or did he know and he didn't want to say? (P62, Wife).

This was typical of many cases in which participants were aware that there was emotional distress in the deceased relative, but they were unaware of the significance. Another participant describes these signals as '*alarm bells*':

> But the alarm bells were coming to me, but only two days before he died. There was something wrong. But I would never have dreamt suicide, never in a hundred years (P57, Wife).

> I think it's very challenging if they don't have an understanding of it [mental health] or an awareness of it. Maybe if they don't have a great educational

> background or don't talk about their feelings as part of their everyday life, it’s very hard for people who don’t talk about their feelings in general to start to talk about them (P67, Brother).

For others, the family member never acknowledged their mental health conditions, however serious they might be. As this mother explained, despite a diagnosis of severe mental illness in early adulthood and years of treatment, her daughter struggled to understand it:

> As I say, mental illness is in our family, it’s a family thing, and she developed it when she was [very young]. […] She had the symptoms of schizophrenia. She never really came to terms with her illness herself, she always thought that there was demons inside her, that these demons were there and that was what she thought her problem was. She never would have said she had a mental illness; she was always in denial. […] She called it the demons, the demons that were inside her. She really thought there were demons in there and she had gone different places to get rid of these demons (P43, Mother).

Masculinity and mental health

The failure to discuss distressing feelings either to significant others or health professionals, dominates many of the narratives about male suicides. Although male reticence to disclose emotional problems is well documented, the issue is raised again here because of its prominence with participants’ narratives and to illustrate some of the salient issues associated with service contact. In this extract, one woman described how her husband dealt with his feelings of anxiety:

> When he was a little boy [there was an accident] […] a little boy died […] and the police came and took a statement and there was an inquest, all of which he attended but nobody ever thought to explain to him why he was going or what it was about. So he actually thought that he was going to go to jail […] and [so he] learned to deal with anxiety by just don't tell anybody, put your head down and get on with it, don't talk about it, because there were other incidents, minor things where he maybe was anxious but he never talked about it, and he wasn’t good at talking about feelings, so maybe those things (P59, Wife).

These incidents were described as ‘*minor*’ but the implication is that perhaps they may have contributed to the suicide because they were never talked about. The failure of some men to communicate their feelings blocked many forms of informal support. As this participant recollected, her husband was unable to establish a trusting relationship with those close to him, including his wife:

> And then people said, but he must have been depressed, '*Why didn't you call us? These are friends, we could have helped him*.' I said, '*Nobody could have helped him. My husband was a private person, he didn't open up. And if he couldn't open up to me, and I know he loved me and he knows I loved him …*' (P61, Wife).
>
> As I said, he would have gone to the doctor no problem if he had anything physically wrong with him. He wasn't the type of man that if he had bleeding through the back passage or something […], he wasn't shy about his body or anything like that, but obviously, he was about his mental health (P57, Wife).

Similarly, other participants suggested that their husbands had rejected psychiatric treatment on the grounds that this would have dented their sense of masculinity and made them look as a failure:

> He just had episodes, sort of sporadic episodes of feeling really bad. […] But he just wasn't going to comply with getting any help, or, I don't know. I think he just saw it as a failure, if he went on antidepressants or you know, I don't know. It's just this man thing. I don't know, I don't understand what it was but he didn't (P63, Wife).

Closed emotions and alcohol

An inability to talk about feelings was linked to the development of maladaptive forms of coping with distressing feelings, which may have been associated with other factors contributing to the suicide, specifically, alcohol dependence. One participant describes her husband's attitude as:

> I just wish men would come forward and express themselves, you know. They normally turn to alcohol and that's wrong; that is wrong, that is wrong. […] He had alcohol issues; basically from the day I met him. He would have gone on binge drinking (P54, Wife).

As we showed in the previous section on *Family Attributions of Suicide*, alcohol misuse was salient in the conceptualisation of some of these deaths. However, it was pointed out that male attitudes regarding privacy and what needs to be concealed could be ambivalent and illogical. One participant, described her brother's inconsistency towards issues of concealment:

> He was a man; he just didn't want anybody to know that there was something wrong with him. He didn't care that people thought he was an alcoholic but he didn't want anybody to know that he was depressed (P65, Sister).

Thus, while the stigma attached to mental illness prevents help seeking, it appears to be more socially acceptable for a man to admit to alcohol problems. Others rejected any contact with health services and this was noted in cases where alcohol was a problem. In this kind of situation participants were constantly under the pressure of having to deal with critical episodes during the course of the deceased's life:

> But the last month, after he had been taken to the [hospital] twice in an ambulance, the first time, the lady doctor who was on duty that night phoned me when I got home to make sure I was all right. She was all right and she tried to put him, as it were, in the system. But there again, when he was sober he didn't want to be in the system (P1, Wife).

Female stoicism

Although the lack of communication of distressing feelings was mainly discussed in relation to males, it is worth noting that female reticence was observed in a more positive way. Thus, the concealment of distress was often regarded as a positive aspect of female identity, a protective stoicism through which, family members are shielded from problems and anxieties. Accounts from a father and a daughter illustrate this point:

> She was a very kind and caring person but she was also … She kept things to herself, as we all do, and I thought that maybe she had been suffering from depression for a longer time and didn't want to annoy us as parents (P3, Father).

> No, to be honest, she didn't burden anyone else with her problems and her worries. She kept to herself. […] And she sort of let people walk all over her to avoid confrontation and to avoid any ill feeling or anything like that (P6, Daughter).

Physical health and pain

In the causal attributions section we noted that the narratives pertaining to the suicide of older relatives, were often characterised by descriptions of stoic pride in the midst of increasing dependence, the endurance of long-term illness and/or chronic pain:

> The other thing I should say is that in her latter years she was going through a process of being diagnosed with arthritis. She thought it was arthritis that she had. Just before she died it was diagnosed as [name of illness]. So she was in a lot of pain with that, physical pain in her hands and her feet and was taking medication for that. She would have been on morphine patches (P31, Sister).

For other people, there was a gradual awareness, or in some cases, a realisation that continuous, complex and unresolved symptoms may have had an underlying depression and anxiety. They acknowledged that GPs may have struggled with the inability of these individuals to express the real nature of the problem and regrettably missed the warning signs:

> He wouldn’t have said he was suffering with depression. He was going up to see his GP with pains in his legs; he was going up with pains in his arms. […] He lost that much weight. He was a very small eater at the best of times, and that's when I took the bull by the horns and went. I think it was about a fortnight afterwards, [the doctor] landed here and after he was gone I came in then and she said he has always suffered with depression but the fall at his work has brought it to a surface. And he started on tablets then (P17, Wife).

The following quote reveals something of the confusion on the part of the husband and the GP. It also suggests that communication between the GP and family may be absent:

> My wife had all these physical symptoms. The GP was explaining them as stress. […] Eventually the GP got her treated for scabies […], I went through the treatment too. […] Until then the biggie, she headed off and didn’t come back for three days, and I was going frantic; I hadn’t a clue where she was. […] I was phoning [her GP] and he was basically saying he had referred her to [the mental health hospital] and there was nothing more he could do (P28, Husband).

Similarly, this participant recounted how his elderly relative, despite obvious problems, rejected any offers of help. Later during the interview, this participant admitted to have acknowledged this suicide as a rational decision of an elderly person who was not prepared to become a burden to anybody when one’s quality of life has deteriorated:

> After [his wife] had died he accepted no help, certainly from myself and my wife. He was diagnosed with some form of cancer in his lung. Anytime we would have offered to go out or take him shopping or do any of those things it was, ‘*No, no.*

> *I've got everything that I need.*' I knew from my knowledge of him and his quietness and his gentleness there was no necessary need to push that. […] That would have been going too far. […] They recommended that he go into a nursing home for some recovery and I took him down to the nursing home and I realised that this is going to be a big upheaval for him (P46, Nephew).

Antipathy to health professionals

An inability of individuals to disclose worries or emotional problems extended to health care professionals. However, we noted that in some cases, relatives also shared this anxiety about professional healthcare. For example, one participant who, despite being aware of the high suicide risk of her sister, indicates a level of agreement with the deceased's decision not to approach health professionals; or at least, a considerable ambivalence about the effectiveness of medication. We also note that relatives admit to underestimating the depth of the problem:

> We knew that she was feeling suicidal; she had said that. I asked her about going to the GP and getting medical help and all that, but she didn't want that and I didn't push it, because I guess, […] she had no faith in the medical profession, which is quite driven by medical intervention, clinical, they put you on tablets. […] She didn't want that, and I knew, yes, she was very down, I was very worried about her, but I thought it was a blip (P31, Sister).

Similarly, psychiatry was regarded with a degree of contempt. In the following quote, the deceased individual maintained that doctors lacked a genuine care for the individual; rather, they were motivated solely by financial gain:

> I had a talk with her [to get help]. I begged her. She said, '*Don't tell them ones* [psychiatrists] *anything about me because they don't care. They only care about their wages for their pocket. They don't care about anybody.'* That's what she said, for the psychiatrists. She said that they were only there for the money (P40, Mother).

Stigma and community

For others, the stigma attached to mental illness posed a substantial threat to reputation, position or role; again, leading to concealment of mental health problems and/or failure to seek appropriate help. Such fears appear to extend to close family members and spouses:

> She was actually taken to [the local mental health hospital] that day and got her stomach pumped. She just got out of there again immediately. She said she was scared they would offer her psychiatric help because she said if they did '[my husband] *would never take me back again if there was any way that I was ever treated for mental health problems*.' So she said, '*I can't stay in here any longer than necessary*.' So whether they offered her treatment from the [mental health hospital] or whether they didn't, I don't know but she didn't get any (P15, Sister).

Likewise, others feared community rejection following discharge from inpatient mental health services. The following account reveals the presence of deeply stigmatising attitudes towards mental illness within the local community. Of interest in the following quote, the full weight of stigma may emerge following the voluntary admission and contact, deterring further contact:

> After a suicide attempt he went into a [psychiatric hospital] voluntarily. […] I think from his point of view, the stay in [the hospital] was detrimental to his mental health because when he left there he felt that the stigma attached to that was unbearable, and given the mindset of the community that he lived in […] there was such stigma attached to that … (P19, Brother).

> No, I'm not going over to that place … Sure the whole of [town name] will know there's something wrong with you (P10, Sister).

Refusal to seek help

We also noted in some cases that although people had communicated their suicidal intentions, directly or indirectly, they nevertheless refused to seek professional help, leaving the family member(s) distressed and isolated. The following accounts reveal something of the anxiety, uncertainty and obstinacy within family dynamics. They also reveal a lack of knowledge or at least, clarity, about risk, hospitalisation and the process of getting emergency help. To some degree, families feel locked in a 'stalemate':

> We knew that she was feeling suicidal; she had said that. But she did not want … I asked her about going to the GP and getting medical help and all that, she didn't want that and I didn't push it (P31, Sister).

> So the alarm bells were ringing. […] But at that stage, he was in line to see a psychiatrist. At the time, I was attending a counsellor, […] for depression, so I phoned her and asked her what should I do; could I get a doctor to sign him into

> [the psychiatric hospital] because I was a bit worried, and she said we'd have real problems to get a doctor to actually sign him in unless he goes willingly. So, we tried to persuade him to go willingly to [the hospital]. He wasn't having any of that so it came to a stalemate. (P34, Brother).

Stigma and psychiatric institutions

Relatives attributed some of this behaviour to a stigma associated with mental health institutions generally. In other cases, there was a concern about specific psychiatric hospitals. Northern Ireland is comprised of small, highly networked communities. This perception of proximity and transparency appears to exacerbate the degree and impact of stigma. To some degree, it is unclear in some of the narratives whether the 'fear' of psychiatric institutions is historical, that is, embedded in the folk memory of the asylum, or perhaps, are provoked by a more current familiarity:

> He didn't particularly avail of the adult mental health service route […]. Probably part of it was because I was working within that environment, within adult mental health and a number of years back the team that he would have been referred to, would have been the team that I was involved in (P17, Partner).

> The family that I came from would be a well-known family who would know everybody around the area, and he had it in his head that because of that, everybody knew that he had been up there [the inpatient psychiatric unit], and to be honest, I have yet to hear anybody mention it. There is nobody outside of our family I've ever heard even mention it, apart from his close friends (P19, Brother).

Family reluctance

Perhaps surprisingly, an opposition to psychiatric hospital admissions by families was noted, as was the case of one sister:

> But he actually went into [the local hospital], which I didn't agree because the things that goes on inside that hospital is not … it's not right (P18, Sister).

In some cases, family members intervened to block a referral to hospital. In the following excerpt, we note a vehement rejection of hospitalisation in a psychiatric unit:

> She said, '*I'm going into hospital.*' '*Right,*' I said, '*That's okay.*' So, I went down and phoned my brother and said to him and he came down and in her own house and they had a fallout and he told her to get a grip of herself and pull

> herself together and this was stupid, her going into [name of hospital] (P49, Sister).

Another brother and a friend refused to consider the option of a psychiatric hospital to deal with their relatives or friends' psychological or psychiatric problems:

> Well, I think if there's people like that I think it's up to the GP to refer to maybe more specific … but there are, like in this town, the medical unit for psychological problems and mental problems is [name of unit], and there's a stigma attached to [that hospital] and attached to the name of [name of psychiatric unit] (P73, Brother).

This brother participant begins by suggesting that the GP should refer to specific psychological services but with a caveat attached, highlighting the stigma associated with this particular establishment. In this case, this man and his brother lacked any direct personal experience of the hospital. Similarly, although described in harsher terms, this friend does not consider the option of inpatient psychiatric treatment as viable because he would find the treatment of patients in these institutions as inhumane:

> There is nowhere for people to go with mental health problems. [The mental health hospital], as I say, when you get into [there], you wouldn't put your dog in it. Have you ever been down around there? (P8, Friend).

Rejection of psychological treatments

It is worth mentioning that there were considerable barriers to engagement in talking therapies by those who were offered them. Men were particularly unwilling to engage in talking therapies. In some cases, this barrier was absolute in that these individuals refused to go for therapy at all. Participants offered various reasons for this but primarily these were distilled into a fear of disclosing private and distressing information:

> I don't honestly think there would have been anything because he was not a talker. He wouldn't let people know his business (P17, Wife).

> She was never one for talking therapies. I've never known her really to have gone to counsellors or therapists. She didn't have a lot of time for that (P31, Sister).

> Anyway, he said he didn't want to go to the counselling because it was dragging all that up and there was no use and whatever. So he didn't [continue] the counselling (P21, Sister).

There also appeared to be a pervasive sense that talking was an ineffective or in some cases damaging form of treatment.

> He had counselling after that but I don't think … he didn't feel that it was doing any good and he stopped going. He just wouldn't go (P25, Sister).

> He went to counselling with them [voluntary sector organsation] once a week, which he said was no help but I think he was doing it more for me. He said that it was bringing things up from his past that were making him feel actually worse (P32, Partner).

Primary care

The prevention of suicide often depends on a delicate collaboration between multiple agents and agencies in which availability and timing, knowledge and communication, relationships and trust, all contribute. In this section we examine these relationships from the perspectives of family participants. Families, while not universally reproachful of health services, raise important concerns about the recognition and management of suicidal risk in patients. The most fundamental of these was: (a) the failure of clinicians to fully engage with the patient; (b) to misattribute or fail to notice critical signs; (c) to exclude families in the decision-making process with regard to treatment and care; (d) to place responsibility of care on unprepared and ill-informed families. We begin however, by highlighting aspects of GP care that attracted satisfaction from families.

Compassionate care

The positive aspects of primary care contact were those in which the GPs appeared to demonstrate a genuine interest in the person and his or her life, maintaining regular contact, providing appropriate treatment, and encouraging and supporting those more vulnerable individuals in their further treatment. Thus, compassion was demonstrated by GPs who offered more than just medication; they showed understanding and a flexible approach in their practice, encouraging regular consultations, the involvement of relatives, and making domiciliary visits if requested. Therefore, families felt reassured by the interest shown by GPs in their relative and the close monitoring of the consultations:

> But he was on medication and his GP asked him, you know, wanted him back again and asked me also to come back, you know, I suppose to monitor and see how things were at that stage. So yes he did have the support then (P53, Wife).

> The GPs were very good to her, so they were; they took good care of her. When she needed an appointment she got it. They even came out to see her a time or two, the doctor had been there to get her blood counts (P38, Husband).

Continuity and contexts of care

For relatives it was important that consultations were undertaken by the same GP. This, in turn, strengthened the trusted relationship with the patient, which, for participants, was another valuable characteristic of the support provided by many GPs. This was critical because those GPs who appeared to have established a trusting relationship with their patients and their next of kin were more aware of the patient's and family needs in relation to their specific contexts and environments:

> Yeah, he [the GP] would have been quite proactive. He had a good relationship with the GP and actually spoke at length with the GP, yeah, because he had the same GP throughout and he would have spoken quite highly of his GP (P71, Wife).

> Her GP … tried to help her a lot and was very, very good to her. When her husband would go to him and try to find out if she was on different medication or what he was doing, I'm not sure but he told her that the husband had been with him and that he would give him no information. […] She] really thought a lot of him [the GP]. He was actually the GP that came down the night that she had to go to the hospital to get her stomach pumped and he knew the build up to it and knew her circumstances and knew everything. … Possibly she had told Dr. [name of doctor] the whole story and he knew what was happening. So he maybe tried to keep the husband at a distance (P15, Sister).

In this last quote, we get an indication of the fine balance that GPs are obliged to preserve; keeping family members involved (some of whom may have contributed to the patient's problems) while securing patient confidentiality.

Patient concealment

Participants, generally, acknowledged the challenges for GPs in assessing risk in a person who was not able or willing to fully communicate their emotions to them during a consultation. As this sister expressed:

> But no, when you're dealing with people who are depressed, they're good at covering up, and whether or not she [the deceased] told him how she was feeling, I don't know (P31, Sister).

However, in some cases, it was considered that while the consultation had been, in some ways, cloaked in nature, the GP had failed to recognise the significance of an unusual visit to his/her practice. A typical example is the recognition by a wife or close relative of a change in the family member's behaviour or mood. Subsequently, they persuaded their relative to contact the GP to ask for help in relation to the problem. One such case is illustrated in the following extract from a wife who had persuaded her husband to attend his GP:

> I honestly can say I could count on one hand the amount of times my husband would have been at his GP, and I know certainly now, the GP has spoken to me and he said he learnt lessons out of it that he should have realised. This man came out of the blue to him (P60, Wife).

As this and other interviews illustrated, these relatives believed that the GP was somehow culpable in failing to recognise the significance of the consultation and ultimately, given the suicide, the seriousness of the situation. In the above case, families wanted an acknowledgment that lessons would be learnt in the future. However, we also noted that when families identified a sense of risk in relatives which they felt was not being directly communicated to the GP, they responded by attending the consultation with their relative:

> I used to go with him to the GP appointments because I had got to the stage that I believed he was, … hiding something here, something to do with work or whatever, so I used to go along so that I could hear what was being said (P59, Wife).

The involvement of family members during consultation was not unusual among people treated only by the GP. The difficulty of talking about emotional distress was directly witnessed and commented on by some of those families who had attended the consultation:

> But I think it was only about two weeks before he died he had to go back to the doctor's for his pain relief and he really needed them upped but the doctor gave him his usual prescription, and he had said to them about being quite down about it all and the doctor had … because my mum always went with him, and the doctor had said, '*Well, are you as depressed and down as you would harm yourself?*' And my daddy just shrugged his shoulders. But then again, I don't

> think my mummy realised. It's like all of us. But then the doctor said, '*Well, there's your pain relief and make another appointment and we'll deal with your depression*.' So to me, if somebody shrugs that should be enough. That doesn't mean, '*No, I'm fine.*' And then, I think it was only about two weeks after that that he did what he did (P12, Daughter).

Recollections from these shared consultations are very revealing as they demonstrate some of the subtle ways in which these consultations may have failed to identify the risk of suicide in some of those who are vulnerable. In relating her father's shrug of the shoulder, this daughter succinctly conveys her father's ambivalence to the idea of harm. These families showed a notable degree of understanding of the complexity that faced GPs in recognising suicidal risk. However, there was a pervading and fundamental sense that they had disappointed by the medical profession's inability to recognise risk. Such cases were particularly noticeable among individuals who presented at GP surgeries with pain or physical complaints. This daughter, for example, believes that the failure to manage on time the intense pain suffered by her father led to his deep depressive state and subsequent suicide:

> Dad took arthritis quite bad and it just got worse and the place that he was working in, [number of years] he was in the job, it was closing. But that really didn't bother anybody at the time, but I think as the pain got worse and he didn't get the proper pain relief and the attention that he should have got, then depression set in, because to me, if you're in pain constantly you don't really want to do very much or whatever. […] I think that they needed to have done the pain relief sooner because by the time the depression had kicked in towards the end, I don't think you'd have had a chance to help him (P12, Daughter).

Similarly, one participant believed that her sister was failed by her doctor who missed the signs of depression manifested in regular somatic presentations at the surgery. She said that:

> She definitely was mentally disturbed. […] To me, the doctor or some of them should have noticed it. She was in the doctor's maybe twice a day. She'd have phoned him in the morning and then she'd have phoned him at night and then she maybe would have been up on the Monday, then she'd been there a couple of times on the Wednesday, then maybe again on Friday, Saturday or else Sunday, one or other at least. […] She was neglected, pure neglect, wasn't given the appropriate treatment or assessed right or anything, and I do blame

> the GP. The root of it is the GP, he's the primary care here for her and he should have seen that (P49, Sister).

Brief consultations: "the ten-minute rule"

In the extract above, a participant recollected how her father was encouraged to make another appointment in order to deal with his depression, despite the fact that her father had attended the consultation with regard to physical pain, which in turn was causing the depressed mood. We can only speculate here, but it is possible that this request was made because the GP was responding to time pressures and the need to keep appointments running to schedule (see section on GP interviews). Participants identified the amount of time allowed for consultation with the GP as a key barrier to communication about mental health by other participants in this study:

> Doctors are ten minutes and you're out and it's not easy for anybody to go, there's always the stigma of mental health problems … (P37, Father).

Noted here are the particular difficulties of dealing with mental health problems in such a short time compounded by the associated stigma. This suggests it should be possible to book an extended appointment for those wishing to discuss sensitive issues. This issue was by no means isolated to the primary care system and we return to this theme in later sections of the report.

The close involvement of family members in relation to primary care permitted a close-hand perspective of the failings of the primary care system in providing a space in which risk could be communicated and identified. In some cases, however, the GP was held responsible for not detecting the signs of mental illness, as shown in this example:

> And, you know, my only fault with my husband's [case] is to do with the doctor. I just can't understand how the doctor didn't pick up that there was something mentally wrong (P62, Wife).

Here, the use of the word fault hints at a sense of culpability. In some cases, the level of blame directed towards the GP led to significant and persistent anger.

Dealing with trauma

As discussed previously, trauma experiences were recognised by some participants as a life event that impacted on the psychological an emotional wellbeing of the deceased. Mainly, these traumatic events were related to childhood physical or sexual abuse. However, a more recent case of a deceased individual having been the victim of violence in the months previous to the suicide was reported to a GP. The family considered this traumatic experience to be inadequately addressed by the GP. With hindsight, the participant pondered on the possible impact of that experience on the fatal outcome. This is the case of a widow who recounted:

> [The deceased] was robbed in the shop. […] He was in hospital; they shaved the back of his head, stitched him up and sent him home basically. […] But after that I actually think he had lost a bit of his … I don't know what way to put that, his confidence had gone and I think that was all part of what eventually … because he didn't like going out on his own at night in the dark, there was a lot of things. […] He went to the doctor's about that and they said that's all natural. This is a traumatic thing that has happened to you and it's normal but you'll learn to live with it and deal with it. But now when I look back, he definitely lost a part of himself there … (P55, Wife).

Mental health services

In this section we will outline service related difficulties associated with mental health and social care provision for people referred into psychiatric inpatient treatment and who also received care by community mental health teams. Commonly, these are people who have been diagnosed with a severe mental illness such as schizophrenia or bipolar disorder.

Emergency admissions and treatment

The participants indicated that they had been providing care and support to their relative for a long time, but frequently felt their capabilities as caregivers had been exceeded and that, in some cases they could have been jeopardising the safety of their relative. At such times, they were relieved that psychiatric services were available for emergency admissions and ensuing sustained treatment.

> He had had a couple of attempts at killing himself. And that's where it started […] and because the psychiatrist was seeing him, I actually had that relief because it was taken off me onto someone else … (P60, Wife)

> So they had to immediately medicate him. He was very heavily medicated, Haloperidol and oh my goodness, the names of all the things! He was never very happy about that but then he rang me one day and said, “Mum, I have agreed to start Lithium.” So he began to start Lithium. I didn't know anything about all these medications; I just put my trust in [them] (P20, Mother).

Similarly, participants who experienced the sectioning of their relative also note this sense of relief and safety provided by hospitalisation and psychiatric treatment:

> I know when he was released he got a lovely letter from his advocate. He was actually quite content in [the hospital], although he was sectioned. And then he was allowed out back and forward and he had his bike, so he would have cycled off. And his dad went over and I went over and some of his friends were still there and would have come and taken him out to the beach and things like that (P20, Mother).

Nonetheless, when the crisis subsided adherence to treatment and medication after discharge became challenging for the majority of the families. This is detailed in the following subsection.

Treatment adherence and medication

The failure to engage in treatment at psychiatric units was exacerbated by the deceased's reluctance to medication, mainly antidepressants. Concerns about antidepressant medication are extensively covered in the academic literature. However, it may be helpful to consider some of these issues for two reasons. First, this topic consumed a considerable part of the interviews. Second, the issue of antidepressants appears to be relatively neglected within the context of suicide prevention. We have categorised the reasons highlighted by relatives for their dissatisfaction with medication. The following factors are highlighted: (a) perceived lack of assessment and consultation with family and patient; (b) inappropriate prescription; (c) failure to offer alternatives to medication; (d) fear of addiction; (e) side-effects; (f) the failure of clinicians to review; and (g) the perceived or felt ineffectiveness of medication.

a) Perceived lack of assessment and consultation with family and patient

A dominant source of concern was the perception that antidepressants were frequently prescribed by doctors without appropriate assessment, regardless of the circumstances and with little or no explanation to the patient or their family about their efficacy or side-effects. In many cases this simply meant that treatment prescribed was not complied with:

> But to me, they're too easy handing out the antidepressants (P62, Wife).

> She was given medication but she didn't want to take it, didn't take it … (P38, Husband).

For some participants there were lost opportunities of assessment and consultation while the patient was receiving psychiatric care. Many of these families were simply left ‘trying to manage the best’ they could, as put by this wife:

> … psychologists and the doctors that talked to him [the deceased] during the week [he was in hospital] they didn't want to talk to me at any time, didn't want to ask me what things were like at home, how we found him, how we were dealing with it. I had two sons here at the same time and we were trying to manage it as best we could, trying to keep an eye on him, to keep him from going out in the car and killing not only himself but maybe somebody else (P1, Wife).

b) Inappropriate prescription

While there was consensus about the need for psychiatric treatment, relatives expressed considerable conflict related to the appropriateness of the prescribed medication and its maintenance. In some instances, the participants complained of ineffective drug treatments and that health professionals disregarded their observations and concerns:

> Because they put her down for bi-polar and this and that and put her down to different things, and they gave her this medication and that medication and she might as well have been taking goat’s pills (P40, Mother).

> She spent nearly a year in [psychiatric hospital], you know, on and off. But they had her, ... she was on an awful lot of drugs, you know, I don’t know, the drugs seemed just to make her like a zombie, you know, you have this ECT, you know, the electric shocks ... She was quite OK for a while but she never was herself (P38, Husband).

c) Failures to offer alternatives to medication

There was a sense of disappointment amongst some participants that their relative’s prescription did not come with other forms of therapeutic intervention:

> I’m not sure, I don’t think giving all these drugs helps, you know. I thought with the psychiatrist, they have to come and talk to you and try and sort out what the problem was. But they come and they talk to you and we’ll give you this medication, we’ll give you that medication, another drug and we’ll give you another one and another one. My wife was on about four or five different medications (P38, Husband).

Polypharmacy was particularly unwelcome in the absence of other form of therapeutic intervention. In some cases families felt the need to discuss with the psychiatrists other types of intervention. In the following quote, a participant discusses a family request for cognitive behavioural therapy:

> Well, I think what the psychiatrist was saying, we would have asked about CBT, you know, about the cognitive behavioural therapy, because I thought that would be good for him, somebody talking to him and that, but the psychiatrist was saying, '*He's not really ready for that. You know, that's training your thoughts and trying to rethink your thoughts again*.' […] and he said he [the deceased] was nowhere near at the level to be able to even do that, that he needed to get his medication right (P74, Wife).

Similarly, this other participant recounted her considerable difficulties with access to the GP to explain her husband's difficulties with the medication and her own desperation in trying to cope:

> I went in to [the surgery], I wanted an appointment to see the doctor and asked the receptionist, I said, '*I'm here about* [my husband]. *Could you do it* [give me an appointment]?' '*No need*,' she said '*at all, there's another prescription*.' And she said, '*That's your appointment*.' My appointment was two days. […] My husband was given different types of … sleeping tablets, tranquilizers. I said, '*What do I do with the rest of them? He'll not take them; that is why I want to see the doctor. He thinks I'm drugging him*.' […] I was at the end of my tether. (P58, Wife).

Other participants felt that their relative needed more specific attention. For example, this daughter pointed out that one-to-one counselling was a form of treatment that could have benefited her deceased mother for whom medication and other forms of talking therapy had been unsuccessful:

> She was diagnosed with depression, anxiety, OCD, […] and I found that the last few self-harm, attempted suicides, whatever you want to call them, were more … they weren't as superficial. […] To be fair there probably could have been other ways of dealing with it and there could have been something else done, I don't know what, I don't even know if there is anything else possible but there could have been other avenues explored, like counselling, for example. She never received counselling. […] She was offered group support, but obviously because that wasn't sort of her deal she was never offered anything else like that. But

> group support, I don't suppose you can talk very openly anyway really (P6, Daughter).

d) Fear of addiction

The use of the term '*reluctant*' came up a lot in interviews in relation to antidepressants. It was interesting that the attitude was described as reluctance rather than refusal. It is worth stressing that reluctance was based on a 'common knowledge' belief by the suicidal person that antidepressants are ineffective, or worse, addictive. This reluctance to take medication was also described by a mother who recalls how her son avoided medication even when he was receiving inpatient treatment:

> He [the deceased] didn't like taking them so he stopped taking them for whatever reason. He should have been taking them maybe. There's a lot of people don't like taking them because they think, '*I'm hooked on these things now forever*' (P8, Friend).

> He [the deceased] was very, very against these medications. He was convinced that these medications would kill him and all the rest of it. He was very, very against them but I believe he did take them for a while. There did seem to be an improvement during those 53 days and then I think things reached a plateau. […] He had started to hide the meds then. […] He used to hide them in his mattress, we didn't know then … (P20, Mother).

e) Side-effects

Additional concerns relate to the side-effects of antidepressants and other psychiatric medication. In some cases this was limited to the physical impact of the drugs:

> But she was out and into a mental hospital […] a good few times and was on all different types of medication but she was reluctant to take her medication on a regular basis because the medication made her fat, and for different reasons. […] She would have said that all these drugs affected your organs and whatever and she wasn't going to be taking them. So she never took them, what you would call on a regular basis and she was always sick, quite a lot, quite a lot (P43, Mother).

A major concern for men in particular was the changes in their sexual performance, which resulted from the medication itself:

> We went into the doctor together and the doctor put him on antidepressants and sleeping tablets. […] He took the medication on the Friday night, all day on the Saturday, and on the Sunday. And on the Sunday night, when me and him went to bed he couldn't get an erection for the first time ever that I was with him. […] And he turned round and he goes, '*No way!* He said, *'If that medication is going to do that to me, I'm not taking it no more.*' So, he never took it after that (P62, Wife).

f) Failure to review

It was also stated by various participants that poor review systems contributed to this situation:

> … if you're given antidepressants or whatever nobody ever … unless you make an appointment to go back to see your GP, which you mightn't necessarily do if you have a mental health issue because you wouldn't be thinking logically, they just leave you on that dosage. To me, there was no system for review (P35, Daughter).

A lack of effective monitoring and uncertainty with relation to the need to have review appointments with GPs, combined with a strong fear of '*addiction*' added to the tendency towards non-compliance. A perceived lack of review extended to long-term users of medication attending psychiatric services, sometimes described by relatives as '*being fed*' medication. One of the many criticisms of antidepressants was that they were offered without consideration of any other form of treatment. This can be summed up in the following quote:

> The only treatment … he was on anti-depressants; […] and what we didn't know, he had opted to stop taking them without medical advice. How long he had stopped taking them, I'm not aware even at this stage. I presume it would probably … it could be months, it could be a year, I don't know. But he had elected himself to stop taking them (P19, Brother).

g) Perceived or felt ineffectiveness of medication

However, a commonly held explanation for non-adherence to medication was a lack of effectiveness. In the following passage this wife describes how emphatic her husband's attitude was about the uselessness of antidepressants:

> He was very reluctant to take medication because he felt, I think, that the medication didn't always work and people went on this medication and it took ages for it to work and it kind of didn't always work (P13, Wife).

> But she went and she got medication when she was suffering from post-natal depression, but she didn’t really take it when she should have been taking it, […] she would say that going to seek help would not be the answer to her problems because it was within the marriage and no matter how much medication she took it wasn’t going to help her (P15, Sister).

While medication could have alleviated the symptoms of this woman’s post-natal depression, it is clear that its effectiveness is questionable as her mental health problem is clearly compounded with other serious social issues related to her unhappy marriage. Nonetheless, the interview revealed that those issues, in her case, were never discussed with any health professional.

The issue of perceived ineffectiveness of medication and/or side effects, led some of the suicidal individuals or their relatives to request alternative medications. However, families became disenchanted with psychiatric treatment when changes in medication failed to have the desired effects:

> The [month] before she died, you know, I could see her slipping back again and she’d one of her appointments with the psychiatrist. And there were two of them there. [She said], ‘*But this medication’s doing no good, you know, could you not try something else?*’ They thought about it but then said, ‘*We need to wean* [you] *off this other one and just wean* [you] *on to this other one again.*’ And then they just said, ‘*No, we’ll just take* [you] *off that one, straight on to this other one.*’ I can’t remember if that was before […] or after [that month] but it just seemed to, just have the opposite effect it was supposed to have on her. She just lived for nothing, you know, just a zombie, you know (P38, Husband).

However, some of the people who killed themselves were also receiving talking therapies, mainly counselling or CBT. Although psychological therapies were regarded as ineffective by patients, participants appeared to be satisfied with this kind of provision arranged either by GPs or psychiatric services alongside the medication. In a few cases, participants mentioned how mental health professionals ruled out the option of alternative therapies for their relative. As this wife explained, she thought that CBT could have been helpful for her husband, but his psychiatrist clearly explained why this kind of treatment would have been ineffective:

> Well, I think what the psychiatrist was saying, we would have asked about CBT, because I thought that would be good for him [the deceased], somebody talking to him and that. But the psychiatrist was saying, '*He's not really ready for that*.' You know, that's training your thoughts and trying to rethink your thoughts again, and all the rest, and he said, he was nowhere near at the level to be able to even do that, that he needed to get his medication right (P74, Wife).

Suicide risk: pre-admission and post-discharge

What was distressing for many families was that suicide can occur despite all help-seeking and in the midst of potential positive resolution. Thus, some of the deaths occurred immediately after the families had succeeded in gaining psychiatric services, obtaining a referral for admission or further assessments. A husband and a father, respectively, recounted their experiences:

> She asked to go back into [the psychiatric hospital] again. So [her doctor] said, '*OK, we'll take you in again.*' That was on the Tuesday. Then we went to see the psychiatrist [later that week], and they phoned me and said, '*Just watch her and we'll see what we can do* [about the admission].' But come Friday evening it was too late. I went away that day and I had to work in Belfast - came home and I found her (P38, Husband).
>
> So, I was about to phone her and the next thing she phoned my mobile, and I said, '*Where are you*?' She said, '*I'm not feeling very good. I've gone down to* [the mental health clinic] *and they've directed me up to* [A&E at another main hospital] *so I'm sitting in* [here].' […] And I said, '*Right*, *I'll be over now*.' […] They then discharged her and they had made a follow up appointment for the Tuesday. I said to her, '*Are you happy enough at that?*' and she said that she was (P3, Father).

His daughter killed herself the day before her next appointment. There was no indication of her intentions; his description of the events and domestic context was that of ordinary, busy, family life. Likewise, the shock of witnessing the suicide of their relative after a psychiatric inpatient admission was evident for some participants who appeared to trust in the effectiveness of psychiatric treatment and who were unaware of the elevated risk of suicidal individuals recently discharged from hospital. One daughter talked about her father's case:

> Obviously he’d just tried to take his own life so he wasn't jumping for joy, but he was fine and he was still taking his medication, and I think, stupidly I presumed, because he had been let out of hospital that whatever they had given him or whatever, that there was a plan in place and that I didn’t need to be unduly worried. So that was fine. I got through the rest of the week and he was out with mum and he was out walking again … (P35, Daughter).

Suicides also occurred when the suicidal individual discharged him/herself from hospital. As this wife recounted:

> He wasn't in hospital; he was out. […] As far as I know, he had signed himself out of hospital and again, it’s part of the whole trauma of suicide for everybody involved … (P13, Wife).

In other cases, there is a sense of disbelief at how the vulnerable individual could be repeatedly admitted to, and discharged, from hospital within a short period of time prior to the suicide without evidence of a sustained form of treatment or intervention that could have changed the outcome. More precisely, this mother explained that:

> … a month before she took her life, she went three times in the one month into [the psychiatric inpatient unit]; out in two days, in again maybe at the end of that week, out again in a couple of days (P40, Mother).

Community Mental Health Team (CMHT)

Participants commonly indicated that Community Mental Health Services responded in a helpful and professional manner. Staff, usually psychiatric nurses, who visited the individuals at risk at home, paid attention to the families concerns and patients appeared to positively engage with them in order to facilitate treatment. There were numerous examples in which participants described the positive relationships that have been established between the CMHTs, the deceased and themselves. This is illustrated in the following quotes:

> … They [psychiatric services] got the home treatment team to come and visit him every day and they were doing that. He [the deceased] rang them in the morning that he tried to say that he was a bit busy, could he leave it to the following day, which was fair enough (P20, Mother).

> … it was a Friday evening and he [the doctor] was a bit fearful for him [the deceased], so he would send out the mental health team to have a wee word with him later on, which he did, and they came out and they told him to take his

> tablets over the weekend and they were there if he needed them and that type of thing (P74, Wife).

The experience of Accident and Emergency (A&E) settings

Many participants were aware of their relative's previous suicide attempts and their contact with Accident and Emergency (A&E) services; indeed, some had accompanied their relative. Commonly, families' satisfaction with this service was poor. Specifically, dissatisfaction was related to perceived problematic attitudes, skills and knowledge of staff:

> [After the suicide attempt] … We went in to A&E that time, and even the paramedics coming up in the ambulance that time didn't want to know … (P65, Sister).

Thus, criticism of A&E departments was dominated by an experience of judgmental attitudes towards people with mental health problems and/or those who self-harm, deemed as a '*waste of space by A&E staff'. Such* attitudes emerge from, and also reinforce the stigmatisation of mental illness as not a 'real' illness. Individuals with mental illness merely consume time and resources that should be given to more deserving physical health problems. Other issues, related to the indifference of A&E staff and ambulance paramedics who become desensitised and impervious to the potential serious needs of people who have made several suicide attempts – who assume the status of 'regulars'. These issues are compounded by a view that A&E is a particularly untherapeutic setting for dealing with mentally distressed individuals:

> I just sometimes sit back and listen [at work]. Oh yeah, and that's in the caring profession. Mental health and suicide, '*Waste of spaces.*' We would get a lot of '*regulars*.' We would get them in every day. And one girl [member of staff] in particular, when I went back, it wasn't early days but I think she had forgotten [about the suicide], and there was a fellow in that had come in, I don't know what age, he took an overdose or something, and her words to me were, '*He should take a rope and hang himself*.' And I didn't answer back. I felt like smacking her! (P23, Wife).

> [It was] about maybe a year previous to [the suicide] he had tried … He had taken an overdose, he had slit his wrists a couple of times, and this was, I think this was a third time he had tried. […] A&E didn't want to know, basically. […] The nursing staff don't have time for nothing. I know they're short staffed and all that, but at the same time he's a person and he has needs and needed help, and

> to me, nobody cared. He was sitting there in A&E with me and my son […], and even the paramedics coming up in the ambulance that time didn't want to know, because this had happened before and because it was [him] going in an ambulance again, '*Oh, that's* [him] *again. What has he done this time?*' And especially one ambulance man in particular, […] I was so angry with him, and I wish I had done something or said something at the time, but I didn't because I was occupied with [the deceased] (P65, Sister).

Other participants felt that emergency rooms do not offer a private and comforting environment, leaving the individual exposed, insecure and unprotected. This father recalls his experience as follows:

> When you are feeling suicidal A&E is not the place to go. […] I happened to be there with [the deceased] on a Sunday morning, a fairly lax time, but I can imagine that if you were suicidal on a Saturday night and somebody sent you to A&E at 10 o'clock at night you're going to be surrounded by people who have been drinking and whatever and you're going to be triaged and you're going to be put sitting there, and when your mind is in absolute chaos, I know if it was me and I was being put there in a queue that I might be seen in two or three hours and that I was so agitated, I'd walk out the door. I wouldn't sit there (P3, Father).

Family management of mentally ill or suicidal members

Families provide most of the care and support for people with mental health problems. For example, they assume the responsibility for monitoring the health and social care needs of family members, initiating help-seeking, arranging appointments and accompanying patients. They take time off work and other duties. Social and leisure activities disappear. However, what appears to provoke the greatest distress was the persistent fear of relapse and suicide coupled with an exclusion from the decision-making process.

Caregiver responsibility: anxiety

Relatives described their sense of isolation in attempting to prevent their relative from ending their life. One person described how he was left in sole care of his wife after she was released from hospital despite her known suicide risk. In his view, this man was simply left to get on with it:

> … I was brought in [to the consultants' meeting in hospital] and told like a bad child, '*Here, we've done this and this is how she's going home with you.*' […] And we weren't scheduled to have a meeting for two weeks and all of a sudden the

> meeting was called on the Friday morning. I said [to my wife], '*You are coming home with me, guaranteed you're going to be sent home.*' And true enough. That was the worst part […] it was the isolation, the complete feeling of, '*She's your problem*' (P28, Husband).

Similarly, this mother described her anxiety at the ever changing levels of risk she felt she was carrying, most of all, because she was not trained or skilled to deal with this type of situation:

> They [the hospital] deemed he was well enough to be released home here. Good days, bad days. From one hour to the next it could change. […] I was a wreck. Just worried, just constant worry […] I think I maybe could have done with a bit of help then, or I could have maybe done with somebody saying to me, '*Do you know how serious this is? Do you actually know that there is a huge risk that your son could kill himself?*' I actually wish somebody had said that to me (P20, Mother).

Monitoring illness

Similarly, when participants are unable to secure hospital care, they were obliged to take time off work in order to invigilate and prevent suicidal behaviour. The need to provide surveillance was often undertaken by family members with minimal support from services:

> That night she rang us and said she was going to hospital [the following morning] […] but they rang and they said that they did not have a bed for her […] I know she should have been admitted [to hospital]. […] Now that was the whole aim, to get her in, for I knew if she was in at least she was safe. […] So anyway, I got in the car, flew down the road and into her house, and I sat with her. I had to phone work and say, '*Look, I can't get back in because she's in that bad a state'* (P49, Sister).

Family engagement, decision-making and communication

A recurrent concern or criticism was the perception that health care professionals exclude families from the healthcare management of the individual, that is, to engage with family members or to accommodate their opinions and concerns. Families felt they were not properly informed on the developments of the care of the patient and health professionals appeared to be dismissive, unhelpful and disregarding.

The issue of communication and information sharing with families has been contentious; we give it coverage here because in addition to be a constant source of frustration and anxiety for relatives, we feel that there are several issues that need further consideration. Families insisted that they should have been involved in consultations with the health care team; in some cases this was linked to a suspicion that the ill relative was concealing information from the clinical team that was relevant to their care. This wife described her frustration at not knowing what was being shared:

> But then, did he tell the doctors [about his problems]? I don't know and nobody ever really said to me, '*What do you think?*' (P32, Wife).

Family members showed a high degree of sensitivity with regard to the sharing of confidential information. Complaints about the lack of involvement in care plans, relate to the frustration of not being asked '*what do you think*' rather than relating to a lack of sharing of information:

> Each case is different. There are no, I can't see any guidelines, only that people who come out to speak to the person should also listen to the people who are closest to them and who live with them to get the truth or to get another side of it, and then make up their mind … I know their job's very difficult because they're hearing all sorts of things, like you do, they shouldn't discount the person who's living in the same bubble (….) how do they get a whole picture from one person, who's telling them what they think they want to hear so that they're off the hook? That to me is very, very important. There should be input from the people who are closest (P61, Wife).

Repeatedly stressed, is the principle that those who live with the suicidal individual may be able to provide health care professionals with valuable information about the patient's context and a truer picture of their mental health; information which may assist in determining appropriate healthcare. This wife shows a high level of understanding about the varying perspectives that care teams may have to take account of and respond to. Two reasons are offered here, she suggests that her husband's account was likely to be both partial and attuned to his desire to conceal the true nature of his distress because he wanted to be discharged, or in her words be let '*off the hook'*. These reasons reflect those offered by a range of participants. The desire for input, rather than information from the care team should also be noted:

> I think they [the doctors] have to sit down and they have to listen a wee bit more, because I know of people that it has happened to, where they've said, '*No,*

> *you're not really that sick, you can't be*' or whatever. The parents know, and even the brother or sister, you know when your brother's not well or your sister's not well and I think they definitely have to be listened to ... (P18, Sister).

A common perception among participants was that healthcare professionals' blocked engagement with families by exploiting '*patient confidentiality*' as a pretext. In doing so, professionals were thought to have missed vital warning signs. Again, families found it difficult to reconcile the unbending adherence to confidentiality in the midst of suicidality:

> She was in and out of [the psychiatric unit]. We used to go up and visit her and I used to say, '*Look, please don't let her out.* […]. *Can you not keep her in and get her more sustained help? Because she is obviously not well.*' And they just said, '*Look, we can't talk to you. It's patient confidentiality and we can't tell you anything.*' I think it was a legal thing. There's patient confidentiality and there's patient confidentiality. At the end of the day, the person matters in the end. (P16, Husband)

While in the main, participants were keen to help to watch over their relatives, they were alarmed about not being fully informed about the condition of their relative, even in the midst of clinical concerns:

> With regard to the assessment [at A&E] then, I wanted to know what they had felt and they did feel that she wasn't at any great risk of suicide. They felt that it was perfectly safe for her to go home because there was going to be somebody with her and they were also going to contact her by phone on the [day] with regard to her appointment for [the following day]. I subsequently learned that although the mental health nurse had attempted to contact her on a number of occasions, she hadn't answered, and again, I raised questions. I wasn't aware at the time that she was supposed to contact or that anybody was contacting her. When I said about contacting me they said, '*Oh, but we've got patient confidentiality*,' and I said, '*Right, I can accept that, except that there was a mild danger. You were releasing her into my custody, into my care and yet I wasn't aware what the situation was* … (P3, Father).

As this father suggests, he was left in an impossible situation in that his daughter was released into his care but information regarding her situation, in particular, her risk of suicide was not divulged to him because of the need to protect '*patient confidentiality*'.

The frustration of families at not being consulted, or perhaps perceived as being excluded, in the decision-making process was exacerbated by an assumption by clinicians that families would assume responsibility of care once these vulnerable individuals were discharged into their care. In some instances, it was noted that families struggled to cope with their caring responsibilities. This wife describes how she was excluded from all the consultations that took place with her husband:

> But the last month, after he had been taken to the [hospital] twice in an ambulance, […] I took him flip flops and tracksuit trousers and a wash bag and told the nurse on the ward that if they let him have a shower and put clean clothes on, he would be much more amenable. And she looked at me as if to say, '*Who do you think you're talking to?*' I was only trying to be helpful. I was only telling her that if you let him get up out of bed, have a shower, put clean clothes on he'll feel so much better in himself that anything you want him to do, he'll do. I was irrelevant. '*Your opinion really doesn't count.*' The psychologists and the doctors that talked to him during the week didn't want to talk to me at any time, […] nobody wanted anything from me, my opinion was totally irrelevant as to what he was like as a person or anything else and not once did the psychologist at the hospital ask to speak to me during that week and when I phoned on the Friday and they said they were going to send him home and I suggested that this was the worst place to send him because this was where all his problems were, he should not come here, it was too soon, I was told this time would be different because there was a consultant psychologist dealing with his case and they would be monitoring him over the weekend. The monitoring involved two phone calls (P1, Wife).

As noted here, there is a major divergence between services and families as to what purports to be 'monitoring'. The perceived failure to listen to the close relative was stated by some as the key reason why psychiatric care failed. Perhaps predictably, these negative experiences and perceptions of health services prior to the suicide, fuelled resentment and blame in the aftermath. For example, one woman recalls the anger and frustration she felt when immediately after the suicide of her sister, she met with her GP, whom she blames for the death due to his reluctance to obtain a mental health assessment. Her narrative provides an explanation for some of the long-term impacts on relatives' mental health:

> [On the day of the suicide] somebody phoned his doctor. It definitely wasn't me but somebody phoned the doctor and he came down, and I'll never forgive him till the day I go to my grave, and he said to me, '*Well now, I didn't think it would come to this*.' I don't know where I got the strength but I said to him, '*Well, I *** told you and I'm so annoyed with this, and I pleaded with you.*' And I said, '*Look,*

> *the symptoms were there*.' And I'm not qualified but I said, '*You have a lot to answer for*.' And he stood there and he tried to help me and I was so annoyed with him I just said, '*Don't even come near me!*' And I was angry with him. It wasn't just the one off; I rang him in work. The ones in work were saying to me, '*Are you on with that GP again?*' It was as if I was going bananas! Behind [the deceased's] back I was ringing him; I was making appointments with the health centre. I'm not even a patient of the health centre, going behind her back, and I said to him, '*Look, something has to be done*' (P49, Sister).

Another woman, realising that her husband's mental health was deteriorating and possibly suicidal, described her attempts to convey the seriousness of his condition to services but was left distraught at the inability of health professionals to accurately assess him; to get beyond her husband's disingenuous responses:

> There was no point in me going every other day to a doctor that was giving me more and more tablets, and I couldn't wait to the following Wednesday. […] So, eventually, between begging and asking […] I got this hospital appointment. We went there. [My husband] sat and looked at me and, I started to talk; I said to him, '*Tell the doctor that you're up at night*.' '*Ah! I was waken last night, surely. You think about the family and you think about the fellas* [that have died], *but sure that's the way it goes.*' And I said, '*Yes,* […] *but you were being sick*.' And he was raging at me. I come out and as I say, I shut up then because her [the doctor] and him were talking about whatever, '*You're tired … ah, this farming is hard at the moment. Yes, yes …*' I came out, I was crying. […] We were out in 10 15 minutes […] I wasn't making a noise, the tears were running down my cheeks, because I knew I was going home to start again. [The doctor] didn't say I'll see you again. […] I came on out and I thought, '*I don't want to be getting him into an awful state until I get him home*.' […] I didn't know what the next turn was. […] And I knew I was no better, and [the deceased] came home and shot himself that night (P58, Wife).

Inadequate professional support

A major contributing factor to the isolation experienced by relative carers was the inability to identify or obtain support services. Bureaucratic procedures and unsympathetic health professionals added to the frustration in what was deemed to be a suicidal crisis:

> Yeah, and there was nowhere to go. She phoned the hospital and she had to get referred by such and such, and it was procedural, whereas I think there needs to be more of an emergency [service] (P35, Daughter).

Those who rang the out of hours GP service reported being fobbed off with medication:

> The out of hours doctor just said, '*Take two Diazepam and sit in front of his room*.' That's not helpful, not helpful for a family or not helpful for the person that's suffering. (P9, Mother).

The accessibility of mental health services or more specific services for vulnerable individuals was also discussed. Although scant, some of the criticisms pointed to deficits in rural areas. In this sense, the opinions were varied. Participants either asserted that mental health services have never been readily available in rural areas or considered that the provision have been negatively impacted by the financial recession of recent years:

> I think the whole medical system in this area, and in all rural areas probably in Northern Ireland and the UK as a whole, are hugely disappointing. And the way they're making the cut backs at the moment to save money, to keep unemployed and the unemployable to a level that they're happy with, that the working class people and the people in rural areas who need the same services as people in cities and towns, they're paying the price for other areas that should be cut, I think (P51, Son).

This lack of resources within mental health services meant that some participants felt an added burden in their care duties for their relative because they were unable to offer the specialist care which a hospital admission or close surveillance by the appropriate staff could have provided. As this father explains, shortages of beds prevented the admission into hospital of his son, thus he had to resort to the extreme measure of taking him to work in order to be able to watch him constantly:

> It's well known, well documented, the whole mental health field is completely under funded, it's easy to see holes in it. I'm not being critical of the mental health system, you know, I think there's a lot of issues with it. […] The issues to do with the mental health system [in my son's case] certainly if you look back on it […] when he was discharged and he relapsed again there was just no beds … he was just … at that time to try and keep some stability in his life I had to keep a close eye on him, bring him into work with me, give him a job in my

> place, if it was that bad I just took time off to be with him because he certainly was suicidal for a long time (P37, Father).

Ultimately, the inability to obtain the required and desired services for the suicidal relative led to feelings of exasperation and frustration in some of the participants, such as this husband who pleaded for the hospitalisation of his wife and resignedly stated that:

> When the suicide attempts were on a regular basis I asked to keep her in and give her more sustained help; […] you know somebody is that sick and you've seen the pattern develop and you know something is going to happen, […] there was frustration all round. And they [services] can only do so much as well. […] So yeah, frustration. Simply because you just know something's going to happen sooner or later, and people can only do so much. The services are stretched probably to their limits (P28, Husband).

The challenges of children and young people's services

Similarly, there was an argument that services were patchy and fragmented and that GPs were unable to fill in those gaps, therefore, some individuals found it difficult to know were to turn to for help. This was particularly evident in relation to Child and Adolescent Mental Health Services (CAMHS), which were perceived as neglecting the needs of the individual and letting young people 'fall through the safety net.' A mother whose young adult son had alcohol problems had exceeded the age to be treated in adolescent services explained this difficulty. This is a considerable problem for young and very vulnerable people:

> The Thursday before he died, he went down to the doctor's and he was totally [in despair]. He rang me up and asked me to make a doctor's appointment for him and I rang up and [the doctor] said, '*And what's wrong?*' And I said, 'I don't know, he just wants an appointment.' […] So I got an appointment and he saw [the doctor] and all he did was hand him a phone number because he was over 18 and it wasn't an adolescent thing, it was adult now. So he rang this number up and it was like a five-week waiting list and then the next thing we know he's done what he's done on Sunday. So there needs to be better communication between drugs and advice and counselling for older ones. That was the only time I ever saw him cry. He really cried like a baby, because I remember thinking, '*He really does need help*' (P44, Mother).

Continuity of care

Treatment failures also ensued when case notes and previous psychiatric histories were not reviewed. Thus, this participant found that his wife's condition could have been better managed if notes on previous hospital admissions had been thoroughly read:

> She was just in [hospital], and they go, '*Right, we'll diagnose you*,' instead of opening the file and going back 10 pages and saying, '*Four years ago she was being paranoid, she was depressed. There's the medication, it worked, let's try it again*.' I never got them [any answers] in writing. […] And when you're dealing with somebody's life and somebody's health, to me, […] … I don't know, but I just felt they weren't there, is the best way of putting it. I felt it was me and my wife who were left to get on with it. '*We've made our decision and that's it*,' which to me is so sad, considering it's somebody's life you're talking about (P28, Husband).

Premature discharge from hospital and a subsequent lack of continuity of care was also noted. In the following excerpts two widows described almost identical situations:

> I think maybe he was released a wee bit early out of hospital, after ten days. He was clearly still very ill, and when the mental health team came for the fortnight after he got out it was more or less it was different people we were seeing every day, it wasn't the same continued, and that was … I could see that was a problem at the time, you know, because new people were coming all the time, they were introducing themselves, and, you know, he had to go through the whole thing with them again. That used to irritate him, you know (P74, Wife).

This issue was not only observed within community mental health settings, but was also an occurrence typical of psychiatric services, as this daughter explained:

> [The mental health service] was useless. Because she found, she was under [a doctor] for the mental health team […] and every time she had an appointment […] it was a different junior house doctor, every time. And these junior house doctors, okay they're busy, but they didn't have the time to even flick through her notes and get a general idea of what was going on or even her most recent [visit]. They'd come in and want her to start from the beginning. So, every time she was going in she was starting from the beginning again, therefore she wasn't progressing anywhere (P6, Daughter).

Hopelessness which follows failed help-seeking

Among those who had sought help for their mental health problems, we identified an additional theme of hopelessness. This is consistent with the general literature on suicidal ideation. However, in this section of the report we aimed to explore the issue of hopelessness associated with failed efforts at help-seeking and ineffective treatment.

In some of these narratives, participants conveyed a profound lack of belief in recovery among their ill relatives. One brother described his sibling’s treatment under the NHS:

> I don't know whether the National Health Service could have done anything more for him … they explained it to me, and basically he said that everything that could have been done was done for him as far as the National Health Service could do (P24, Brother).

One man described how his daughter had complied with all the treatment offered but came to:

> I think that she couldn't see that her illness could have been cured (P3, Father).

Many of those who at first complied with treatment then began to believe that recovery was not possible. In most cases, it should be highlighted that it was not a lack of engagement that prevented recovery, for example some people sought additional private treatment:

> That was private but through his GP. By this time he was attending the GP who knew how he was feeling. So he’s had the counselling, then the next thing was about a year before he died, he was very bad that summer and he went back to his GP and we went privately to a consultant psychiatrist, which he attended every Saturday for months. But he didn't get that. He used to come home and say, ‘*I don't even know what she’s trying to do.*’ He wanted a miracle cure and it wasn't coming quick enough for him (P59, Wife).

For others, there was a lack of understanding about the therapeutic process and the length of time over which recovery would take place:

> There was not much that could have been done, to be honest with you, because he wasn't very conducive to any treatment. He was on antidepressants for quite a while, but again, he didn't really rate that much so he came off those. There was help offered to him, it was there and he didn't really take up on it. But I think that's just his nature, his personality. It wasn't that it wasn't offered (P21, Sister).

One participant described how her husband, despite engaging with all the psychiatric services offered to him never appeared to show any improvement:

> But he never really picked up, you know … Yes, there were times that you thought he's a wee bit better, he's sleeping a wee bit better and things like that, but he never came back to the same person, if you know, what I mean. So they kept him on the same medication for months and months and months, and that was so slow, you know, and in between times he was thinking … he kept saying to me '*Oh I can't cope. I need to get rid of the sheep. I need to get rid of the cattle and I'm not going to be able to work and I'm not going to be able …*' He thought this was long term. I kept saying, '*This is depression. Everybody takes depression at some stage in their life. You know, you will get better from this.*' And he said, '*No, no you don't understand, this is long term*.' So, he never thought he was going to get any better. This went on just for months and months (P74, Wife).

Some participants recalled how their relative described mental illness as a form of '*cancer*', underscoring a fatalistic belief that this was a chronic condition from which there was no recovery:

> He seemed to sort of get resigned to this is the way that he was going to be and I know now, looking back, that he was probably planning his exit from that on, you know, because he used to say, '*This is like a cancer in my head. I'm not going to get any better. This is long term*.' … I remember saying to the psychiatrist about that and he said, '*Well the very fact, that he thought he wasn't going to get any better was detrimental to him getting any better*' (P74, Wife).

The use of the term cancer is significant in highlighting this man's perception that there will be no recovery from this depression. This wife describes how she thinks this led to planning the suicide. This desire to return to the life, which had been enjoyed prior to the onset of the mental illness, was a common theme. The fear that life would never be the same again:

> He just didn't want to live his life with bipolar and he wanted to have an exciting great life and he felt that he couldn't possibly with a severe mental illness. […] He would have said [to the CPN], '*Can I go back to university in September*?' And they were saying, '*Well, maybe after Christmas*.' So, nobody was saying that's it. Nobody was saying that's it. But it must have been horrific for him thinking '*Oh my God, am I going to be stuck here? As much as I love my mum, I*

didn't think at 22 I'd be waiting for her to come in from work to take me to the supermarket' (P20, Mother).

Services at Time of Suicide

In sections five to six we reported on the experiences of family members prior to their relatives' deaths. In this section, we turn our attention towards their experiences in the aftermath of the suicide.

Specifically we report on the respondents' views on the role of the formal institutional and legal organisations involved – the Police Service of Northern Ireland (PSNI) and the Coroners Service for Northern Ireland (CSNI) – in the immediate aftermath of the suicide. The consistent nature of assistance from the coroner's office was considered particularly valuable. However, we also need to convey some of the more challenging aspects of institutional response to death by suicide. These are associated, predominantly, to the return of evidence to participants and public awareness of circumstances relating to the death.

Background: role of the PSNI and NICS

All sudden, violent or unnatural deaths are referred to a coroner, whose role is to determine the facts of the reported deaths. The coroner classifies a death as suicide. In England and Wales this is determined during a formal inquest, where the coroner considers both the intent with which an act was undertaken and the intention with which the individual must have undertaken this action (Atkinson, 1978). The approach taken in Northern Ireland to determine suicide is different to England and Wales: a suspected suicide in Northern Ireland does not automatically require a formal inquest – the Coroner's Office in Northern Ireland has determined that the Human Rights Act affords families of the deceased a right to privacy which supersedes the right of the State to hold a public inquest. Cases of suspected suicide are referred to the coroner and are subject to the same initial investigative process as elsewhere in the UK (e. g. a post-mortem examination, witness statements and medical reports are gathered by police and coroners' officers). However, on receipt of the post-mortem and relevant toxicology reports, the coroner reviews the evidence, establishes the cause of death and only proceeds to hold an inquest on the family's request or if he considers that it is in the public interest to do so. This makes the service provided in NI unique in the UK. Relatively few studies have explored how those bereaved by suicide experience the official processes involved in concluding that the death was a suicide (Clark and Goldney, 1995, Wertheimer, 2001). To our knowledge, no previous study has examined the area within the specific context of Northern Ireland.

Experience and role of the PSNI

Our review of the response of the PSNI to the 68 deaths, indicated that the majority of police officers who attended the scene, responded professionally and with a high degree of sensitivity to the delicacy of the situation. In cases of suspected suicide in NI, police officers are bound by the Service Procedure on Police Investigations into Unexpected, Unexplained or Suspicious Deaths (Policy and Support, 2007). This provides guidance on how they should proceed in the investigation of those deaths where the cause of the death is not immediately known. The responsibility of the first officer at the scene of confirmed suspicious deaths is to summon a doctor to pronounce death, maintain the scene, establish the facts and circumstances surrounding the death and ensure the death has been reported to the coroner. The family of the deceased is also spoken to as a priority in order to obtain vital information surrounding the death.

Officers were described by participants as bringing a '*sense of calm*' to what was regarded by many, as a chaotic and bewildering situation. We identified areas of good practice related to the immediate needs of the relatives in the aftermath of suicide. These included responding in a manner that acknowledged the emotional distress of the relatives; helping to manage and guide the bereaved in their early decisions in relation to the death and guiding how best to contact other members of the family. There were a number of cases were individuals described and welcomed being given structured advice on what steps do next:

> The only thing the policeman asked me to do was to sit down a minute, gather my thoughts, that was the only thing the policeman did. They were really nice (P33, Brother).

We found no regional or community based variations in the way in which participants felt they were responded to and we were struck by the positive manner in which the input of the PSNI was welcomed within all communities in NI. There was an acknowledgement that the police response represented a shift in their attitudes towards the service:

> The police were extremely good, extremely good, dealt with things, I thought, in a very humane way. I never felt that they were intrusive … I thought at the time I was amazed by the police's performance because I felt that they had come a long way from what I had remembered in past experiences and had made a conscious effort in a systemic way to do the thing that was necessary and to be sensitive (P36, Father).

For some participants, the initial police contact was considered sufficient. Some welcomed follow up visits shortly after the funeral had taken place:

> [We were not offered any support]. Not really at the time, but the police were very good, in fairness. They were really nice and they did call back to see us about a week later (P35, Daughter).

It is important to note that in cases of sudden death, the police are required to secure the scene of death and treat it as a potential crime scene for forensic examination. This requirement presents a conflict for police in situations where relatives are present; here the police must negotiate a challenging set of competing needs between sensitivity and care for the relatives and regarding them as potential suspects.

In cases of sudden death, the police are required to secure the scene of death and treat it as a potential crime scene for forensic examination. However, police behaviour relating to the handling of the deceased's body was an area of specific dissatisfaction. Some participants considered the body of their relative was left in situ at the scene of the death for an unnecessary extended period of time:

> There is no nice way of saying to somebody, '*Your son has died*.' … But to get a phone call, '*You need to come to the park*.' … I don't know why nobody came to the house to tell us why – it was a funny phone call [from the police]. I was angry at the way [the deceased] was treated, that he wasn't covered, that the park wasn't closed on time … I do remember seeing people in the park still walking around with their dogs and my son … in full view of everybody (P9, Mother).

Experience of Coroners Service

There is a single Coroners Service in Northern Ireland and consequently a degree of uniformity of care is to be expected in relation to the official processes in the aftermath of a suicide. Respondents described their appreciation of the clear instructions provided by the coroner's office on the initial procedures and any delays in releasing the bodies. They understood the legal imperative to ascertain the facts of the death:

> I knew we had to go through [the coroner's process], but I thought it was dealt with sensitively (P36, Father).

The removal of key pieces of evidence from the scene of the death was noted as one area requiring improvement in. Relatives' concerns focused on items which they believed could aid their own understanding of why the deceased died. Most focus was on mobile phones and laptops, and in cases, the suicide note:

> And obviously they had to take away the note … and the note, I never got back again, and that's another thing I find difficult. Now going back on the note, that policeman said to me, we have to take this note because it's evidence, …, but he would make sure that I would get it [back]. And about, maybe a couple of weeks later, he brought me a photocopy of the note, personally he brought it over to me, and he said it was very important that I got that. So that's all I got, was a copy, as I say, I've never got the original (P53, Wife).

The importance of the suicide note to the coroner's determination that the death was suicide is clear. Participants appreciated clear communication in relation to the removal and return of these items.

The coroner's decision not to hold an inquest into the death was mostly welcomed by participants who felt that an inquest was unnecessary and potentially distressing as the circumstances of the death were so clearly apparent:

> No, because what would an inquest do? Just opened up the wounds, they just told me the death was by hanging, which we knew because I found her (P49, Sister).

For a minority, while a formal inquest was understood to be unnecessary, there was also a belief that this sort of process could provide information about the circumstances of the death:

> She spoke to me two or three times, asked me did I want an inquest, I said, '*No*.' I didn't want an inquest, I didn't want all that but I wanted answers (P28, Husband).

Those who felt their relative had been neglected by services were particularly keen for the death to have a public hearing:

> They [the Coroner's office] were happy enough for the case to be closed and I said, '*No, I'm not happy enough for the case to be closed because there's things that I think should have been done and there's things that I think were handled wrongly'* (P6, Daughter).

However, opinion on this varied among our participants. In some of these cases, while there was a desire to have the circumstances surrounding the death examined, they also the desire to do this in a closed setting:

> But it was the liaison officer said, '*You know, you can have a meeting just with a doctor in the coroner's office or in a local police station rather than go to a court.*' And I said, '*I would prefer that. I don't want to go to court and hear all that and members of the public being there and what not. I would prefer a closed* [meeting]' (P65, Sister).

There was a general lack of understanding with regard to the purpose of an inquest. However, staff who worked within the coroner's office were seen to have an advisory role with regard to official processes; they were described as approachable and a valued source of information:

> They were brilliant and I would advise anybody to keep in contact with them because they're very knowledgeable (P59, Wife).

It was apparent that written information provided by the coroner was welcomed by most family members who could then refer to again it at later stages. The official role of the coroner's office meant that participants strongly valued the documentation provided by his staff. They often retained this information in the years after the death and at times referred to it when making decisions about help seeking:

> I had lots of little leaflets that must have come through the coroner's office. Somewhere I had little leaflets. I kept everything … (P59, Wife).

Despite precautionary messages from staff about the graphic content of the post mortem report, copies were requested by some families who thought that it would provide additional information about the circumstances. They were often disappointed at the medical nature of the detail contained within it. However, it was apparent that written information provided by the coroner was welcomed by most family members who could then refer to again it at later stages. The official role of the coroner's office meant that participants strongly valued the documentation provided by this agency. They often retained this information in the years after the death and at times referred to it when making decisions about help-seeking:

> I had lots of little leaflets that must have come through the coroner's office. Somewhere I had little leaflets. I kept everything … (P59, Wife).

Help-seeking for Emotional Problems

Informal care from family and friends were the most commonly reported source of support for the bereaved. However, at times participants also sought assistance from formal agencies such as their GPs, mental health professionals, voluntary or community organisation and, occasionally from faith-based groups. In this section, we discuss the formal and informal sources of support accessed by participants in the aftermath of the suicide.

Informal sources of support

Family and friends

A substantial number of participants undertook no formal help-seeking and described relying on support from their social network of friends and family to help cope with the aftermath of the suicide. For the majority of these participants, this support was invaluable.

Interviewees described how grateful they were for the reassurance of having someone available to whom they could turn to for both emotional support and for help with practical issues. Practical support varied from day-to-day household tasks such as cooking and shopping, to looking after the children and to offering major support with financial difficulties (e.g. paying debts accrued by the deceased). The following quote provides an illustration:

> I had good support from my family and my close friend, she was really supportive … My family paid off a lot of the debts for me from the credit cards, because he [the deceased] had just taken everything financially ... That was massive. I wouldn't have survived without that, I wouldn't have survived … because even just to come in and take charge with the practical things like putting on the washing for the [children] or even making food sometimes and just tidying round and stuff, just being there listening to you or [minding the children] where I could just even go and have a bath. Just the basics, I think (P73, Wife).

A number of participants reported that they did not approach their GPs or any other health care professional after the suicide. These individuals mainly relied on the support provided by family members, friends, voluntary sector organisations or simply, did not avail of support at all. As the following quote demonstrates, for many the support they received from friends and family members, meant they did not feel the need for any outside assistance:

> No, I didn't even feel the need for [seeking help]. The kids were great and [my husband] was great and they listened and they were sympathetic … They were supportive and still are (P21, Sister).

Friends, colleagues or acquaintances

There was a general sense that survivors benefited the most from the support received from friends, colleagues, or acquaintances when this support was perceived as being genuine and unconditional. Participants valued friends who made regular contact, offered a listening ear and who were empathic and non-judgmental in their approach. This widow emphasised this by saying:

> I had a couple of very good friends that I was able to talk to, and I will put my hand up and say I did say some awful things and they just disregarded them and let me carry on (P1, Wife).

She continues by explaining how appreciative she was of her colleagues' discretion when she returned to work:

> And between [my friends] and the support I got from [my employer] when I went back to work, because nobody asked any questions, nobody said, apart from, '*Nice to see you back, how are you?*' I got through it and the boys and I got through it and we picked our lives up (P1, Wife).

It was evident that this type of support was insufficient for some participants, who found there were limitations to what friends and colleagues could do to help. This was especially the case if they had not experienced a family suicide or were not connected with the deceased. These participants found themselves isolated in their loss, as this excerpt illustrates:

> My work colleagues were excellent with me, not on top of me but there if I needed them. But there's nothing really I can say to them. They didn't know him and there's nothing that they can say to me (P26, Sister).

Additionally, for the majority of participants the support from friends and acquaintances diminished almost immediately after the funeral. Some participants, welcomed the peace and quiet that came after the funeral rites were over, others were left feeling isolated:

> Family and friends and that came when it [the suicide] happened, but then when everything's over, they all just disappear (P14, Mother).

> I don't really see many friends, well nobody. [Friends] called at the beginning, but, you know, everybody dwindles away so you don't really see them. […] I can go to the shop. I get my hair done every week now and if I do go up shopping, I usually see [people] that I know, but that is all … (P17, Wife).

Formal sources of support

Numerous participants reported seeking help from formal sources in relation to their bereavement. Some reported attending only their GP in relation to the suicide, others used community organisations only, while another group reported attending both their GP and a community organisation.

General Practitioners (GPs)

We have grouped the different responses of GPs' suicide bereavement care into four main categories. Two of these categories contain elements of a proactive approach in the provision of bereavement care and are listed under the headings: (a) *a presence and a source of support* and (b) *medication and counselling*. Those elements identifying the GPs who, according to our participants, were reactive in their practice are listed under the headings: (c) *referral and signposting* and (d) *disconnection*.

It is important to note that a number of participants reported that they did not approach their GPs or any other health care professional after the suicide. These individuals mainly relied on the support provided by family members, friends, voluntary sector organisations or simply, did not avail of support at all.

a) A presence and a source of support

There were a few examples in the data of GPs who responded in a proactive manner after the suicide by visiting the bereaved in their homes shortly after the death. On these occasions participants welcomed GPs who were able to respond to queries they had about the circumstances of the death. The home visits formed an early connection between professionals and the bereaved. They were often followed-up with telephone calls and/or surgery appointments to help GPs better monitor vulnerable individuals:

> My GP did call in here on the day [the deceased] died … and I think the GP was having me come back [to the surgery] just to see if I was okay. That's the impression I was getting (P11, Wife).

> My GP came to see me, and he would phone me up. So yes, I had their [support], they were great. I have to say they were brilliant (P59, Wife).

The reassurance provided by these GPs seemed to help the bereaved deal with initial feelings of guilt:

> My GP was very good at speaking to me and trying to make me realise that it wasn't my fault, because you do think, '*Yes, it must have been something I did, it was my fault*' (P69, Sister).

Interviewees described feeling reassured about the normality of the emotions they were going through at the time and at times felt empowered to progress into other treatments, such as counselling:

> After [the deceased] died my doctor called one night, and it was lovely. He came in and he just gave me a big hug […] He's a lovely, lovely man … And he arranged for me to go to counselling and I had the most wonderful counsellor (P22, Mother).

b) Medication

Many participants were offered medication (mainly antidepressants and/or sleeping tablets) by their GPs. For some, medication had helped overcome the initial physical symptoms of bereavement. Others found that medication was helpful in the longer term, helping them move on and continue with their lives. However, the majority of participants who made contact with their GP looking for support felt that medication alone would not resolve their problems:

> I had plucked up the courage to go to the GP and … he wanted to throw antidepressants at me. When I went in there with a plan, I had asked him, I had said, '*Look, antidepressants, I'm willing to take but I want to go down a therapeutic route as well. I don't want just the medical model*' … and lucky enough I got a GP who was willing to listen to what I was saying and I believe I got the right treatment that I needed at that time (P19, Brother).

Some of the participants rejected the medication for fears of becoming addicted to it:

> My doctor, yes, my doctor came out that day [in the aftermath of the suicide] but I would not take anything. He gave me tablets and I said, '*No.*' That was not the answer, tablets … I knew once you get on antidepressants, you'll probably end up, you have to get on them, you have to stay on them, you know, and I didn't want that (P41, Mother).

Some participants who were prescribed antidepressants reported that the medication made them feel worse or did not have an effect on them at all and no alternative treatments where provided:

> I did go to the doctor that time [when the suicide occurred] about it and he said, '*Well, we could start you on something mild because you may be suffering from just like a mild depression*.' So, he gave me these, I don't know if it was, Prozac or something, and after about four or five days, oh my God, they gave me such an anxiety feel, such a feeling of anxiety, I should say, in my chest. It was like heart palpitations, I don't know what they were, and I thought, '*I don't like the feeling of these tablets*.' And I stopped them then and that was it (P74, Wife).

c) Referrals and signposting

Some of the participants who contacted their GP for support were offered counselling and therapies to complement medication or as an alternative to medication. GPs referred or signposted individuals to counselling and therapies or suicide specific services within the statutory health service or the community (e.g. support groups, Suicide Prevention Unit). A small number of participants required referral to community mental health services were they needed specialised treatment. In only a few cases, counselling was offered through counsellors attached to the practitioner's surgery; but generally, participants were referred to either statutory or voluntary (e.g. CRUSE) services. These referrals to counselling services had a mixed reception, however, in general, the intervention was welcomed and participants appreciated the opportunity they had with the counsellors to offload and work out their personal feelings and emotions:

> … it had come to the stage where I was unbearable to live with. I was snapping; everything was a problem. So, then I went to the doctor. I couldn't sleep, … I was irritated … [The doctor] got me in touch with a phone number with a bereavement counsellor … So, I phoned him and got an appointment and discussed and then he put me on a six-week course (P64, Brother)

d) Disconnection

A small number of participants in this study felt a lack of response from their GPs and this led to a disconnection from these professionals. The main causes of the disconnection were the perceived negative attitudes of these professionals. These participants felt that they were treated with indifference by their GPs or in a patronising manner. Given the sudden and traumatic nature of the death, these participants perceived their GPs as indifferent to their needs because they did not make contact with them (either in person or by telephone) after the suicide. Instead it was left to the bereaved individuals to seek their GPs' help and support. When participants made contact with their GPs, they found it difficult to establish a meaningful, therapeutic relationship. In particular, participants reported the all too evident lack of confidence of their GP in dealing with the subject:

> When I hit the third time with the doctor she should have picked up that I was in trouble, because I was at the end of my tether. I'm not blaming anybody or trying to blame anybody, but she should have seen it and say, '*We need to get you on tablets* [the deceased's name]. *Will you go to the hospital?*' Sure, if he didn't need it, let him home in two days (P58, Wife).

In some cases, participants felt strongly that GPs could have done more to appropriately treat the suicides' mental health problems. In all these cases, participants argued that GPs failed to recognise the degree of deterioration of the mental health of the suicide. Instead, they felt that their opinions were disregarded and they were burdened with care responsibilities for which they did not feel adequately equipped:

> [My GP] never contacted me when [the suicide happened] to say, '*Here, come on in till I see you or I'll call out and see you.*' There was no communication. And [the deceased's] GP only lives up the road there and if he was passing down now, I mean, I just hate the sight of him, and I don't care who knows that. I wouldn't be looking at him, because he could have done more for [the deceased] and he certainly could have helped me. Nor did he even call… (P49, Sister).

Finally, there was a voluntary disconnection from a considerable number of participants from their GPs. These individuals argued that GPs were subject to their own constraints of time and workloads. They did not contact their GP for two reasons: fears that they would waste their time and the belief that bereavement care is beyond the scope of GPs' responsibilities, therefore they should not be burdened with it. While they agreed that GPs should be the first port of call for the suicide bereaved, these participants saw their support role as providing advice on appropriate care pathways and other services or agencies:

> There needs to be another service that you're referred to from your GP. I don't think the GP has the time or the capacity to do it. I think there probably needs to be a dedicated team for [suicide] in terms of mental health. I don't know. There needs to be someone you can go to (P35, Daughter).

Counselling and its role

Certainly not all survivors sought or needed counselling, but amongst those who did, opinion was fairly divided about its effectiveness. Some people sought counselling within weeks following the death while others sought talking therapies months, or even a year, later. However, counselling did not work for everyone.

> I talked to a counsellor on a couple of occasions but I found myself just thinking at the time, '*Well, I don't know whether this is going to help me. It might help me, but really all I want is* [my son] *to come back*' (P70, Mother).

Counselling did not work either for the following participant. He appeared to experience considerable feelings of guilt due to his inability to prevent his friend's suicide. His recollection of his counselling experience was that:

> I went for counselling [with the voluntary sector] … The second or third time here's me saying, '*Look, if you don't mind me telling you, this isn't doing me any good because when I leave here I'm walking out more depressed than I have ever been because you're bringing up hard things.*' I said, '*You can't really do anything for me*' (P7, Friend).

Conversely, other participants, specifically survivor spouses, felt that counselling helped their children overcome the various psychological problems they experienced after the suicide: fear and anxiety, loss of sleep and appetite.

> [My son] just locked himself, shut himself away, everything to do with his father in the bin, wouldn't eat, wouldn't sleep, it was terrible. Again, I got on to the school and he got his counselling done through the school, which was very, very good (P54, Wife).
>
> A year later [after the suicide] [my eldest daughter] developed a real heightened anxiety about everything, … so she went for weeks to this [counsellor] on a one-to-one, and that was great. It was about knowing the difference between feeling a bit frightened and feeling really terrified and feeling anxious and feeling excited and sorting feelings out and helping her to calm. And that was brilliant for her. She did get the chance to talk about her daddy (P59, Wife).

Finally, many of the participants who engaged in counselling commented on the widespread practice of the six-session model of counselling. The general view was that this number of sessions was insufficient. Some participants stated that:

> I would recommend they go to counselling or some of them supportive organisations, even if it is only to talk, because talking about it helps … It maybe wouldn't be for five or six weeks but longer (P49, Sister).

> I went to New Life[11], it lasted six weeks. You only get six sessions with them, which is stupid, to me. In six weeks it doesn't change anything. In six weeks they expect you to talk about your problems and after six weeks everything's hunky dorey! It doesn't work like that! (P14, Mother).

Other objections to this model concerned the expected outcomes held by the counsellors, which for some participants were an imposition. More structured forms of counselling may be more appropriate in complicated grief:

> I went to one counsellor, early on I went to one counsellor and I couldn't stand him…. And he was insisting you signed up for six weeks and you had to do six weeks and he expected this, that and the other, and I said, '*Nah, it's not for me. Don't give me a list of expectations.*' I was given the privilege of paying for it so it wasn't really … But I didn't feel that was much use (P33, Brother).

Voluntary Sector Organisations (VSOs)

Surprisingly, the majority of participants were unaware of the existence of community or voluntary sector organisations available in their area to provide suicide-specific services for the bereaved.

> I wouldn't have been looking for anything. But there again, it could be word of mouth. Like we went to a place, forget the name of it, [my daughter] and myself, in [a town near here] in the new golf club. There was a seminar on there one Saturday … Well, I knew it from [a neighbour]. She had a son done the same thing years ago (P17, Wife).

However, those who were approached by this type of organisation or who decided to contact such groups were not entirely satisfied with their approach. For a small number of participants the high profile attached to some of the community or voluntary organisations offering specific suicide bereavement interventions acted as a barrier to engagement. Some participants scathingly described their antipathy towards these as groups as "pity parties":

> I don't like the cheesy support groups that somebody's set up. I don't like the pity parties and I just imagined everybody would be sitting around in a room

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[11] New Life Counselling is a voluntary sector counselling organisation in NI

> going, '*Oh, my story's much more tragic than yours and I feel so sorry …*' (P27, Wife).

The manner in which commemorations and sympathy messages were distributed en masse provoked dissatisfaction among families, who described this approach as impersonal and distant rather than inviting and compassionate. They found it painful to receive a bouquet of flowers on the anniversary of the suicide.

> We've one [suicide prevention group] in [our town] now. […] But nobody came near us […] Nothing! They post a letter through the letterbox now and again saying, '*We're having a remembrance service for all those who committed suicide or are bereaved by suicide*.' […] I went to one group in the Church and I felt like an outsider. It was a remembrance at Christmas and you made a ball and put it on the tree and all, and I felt like a total outsider (P44, Mother).

It is clear that however well-intentioned such gestures may be, they run counter to personal ideals of private grief and remembrance and may, in fact, be counterproductive, reinforcing the sense of loss and isolation.

> I contacted them [suicide prevention groups]. I contacted as many people as I could myself, that I could get to know. But I've never gone back to any of the [sessions they organise]. I went to a series of talks the first time … but then I found wee things … I think on the anniversary of [the deceased's] death they [the group] sent out a bouquet of flowers which was lovely in one sense, but I found that quite hard as well. It was like a slap in the face reminding you and yet I know why they do it, because they want to say, '*We haven't forgotten your loved one.*' So, I don't know if anybody else would say that. I wasn't sure if that was such a good thing (P13, Wife).

General bereavement services, such as CRUSE and Barnardo's became known to the majority of participants, through word of mouth or via a GP or social services referral. Mostly, the availability of these services came through concerns of survivor female participants about their children. These organisations were instrumental in supporting children and young people through their grief and bereavement and advising and supporting parents who were struggling to find the appropriate manner and moment to tell their children that their father had taken his own life. Some excerpts from female participants illustrate this:

> I did get counselling through CRUSE and my daughter … I had to refer her. She was firing questions to me like … she was being very sore on me and I got her

> referred and she went and she came back to me a different girl, which was good (P55, Wife).

> My main concern was our daughter. My main concern was to get [her] some counselling. And I've a very good friend at work as well and she said to me about CRUSE, so I contacted them quite early. I spoke to [my daughter] about it and she said, yes, she would go for counselling. And we got her to CRUSE (P53, Wife).

> I contacted Barnardo's because they do bereavement for children. I was more concerned about talking to them about what had happened. It was fine. A girl came out to me a couple of times and we just talked through about how I should explain what had happened to the children (P11, Wife).

Faith-based Organisations (FBOs)

Numerous participants reported that they upheld religious or spiritual beliefs that provided comfort to them in the aftermath of the death. Participants reported that clergy showed compassion and sympathy throughout all the ceremonies and funeral rites. The response from religious or spiritual leader or community was important because of their need to feel that the deceased was at peace. However, in the longer term some were disappointed at the lack of further involvement of the clergy in the provision of support.

> Whenever the funeral and all is over they [the clergy] don't know how to deal with … the Reverend, a perfectly good man, he didn't want any bother. I go to Church every Sunday … I believe in God faithfully. … It wasn't for me that I felt let down by the church, it was for my boys. Because I'm old enough and thick skinned enough to not worry about people, and to know that people don't make God's love, but if you have children that are honourable they'll pick up on it and think, '*Well, he didn't give us much*' (P58, Wife).

Some of the participants felt their spiritual needs were poorly responded to by their religious leaders. Families felt disappointed and, worse still, rejected by their churches. Worryingly, participants tended to think this lack of response may have been linked to the perception that suicide is considered by some religious members as a sinful act. In some cases the lack of response added an extra burden to the participants. One female partner, described it thus:

> … I had no support really from the parish, which was actually quite disappointing and caused a bit of consternation because [the deceased's] family would have

> been quite well known within the church setting and had very close relations with the church, as such. My sense of things was that because myself and [the deceased] weren't married, in the eyes of the Church we were sinners. Maybe that's me just making an assumption but there was no follow up at all, … I struggled with it. Yeah, I did struggle with that initially and probably one of the factors why I didn't probably go to [Church] initially. I've got over that now. But yeah, it was hurtful at the time (P71, Partner).

Alternative forms of spirituality

A number of participants looked for alternative forms of spirituality. This group of participants visited mediums or spiritualists who claim to provide them with the ephemeral contact with their loved one that could reassure them the deceased was in a better place. Maintaining this spiritual connection was an important coping mechanism:

> I went to see a medium. She told me everything. She said to me [the deceased] … '[He] *is showing me the scar right down from his chest to his stomach.*' And she told me [he] said he was happier (P42, Mother).

Impact of Suicide on the Family

In this section we present the specific problems and needs that the bereaved participants and their families experienced following the suicide. We report on four domains of need: (1) psychological; (2) financial; (3) practical; and (4) social. These various and overlapping impacts include the guilt experienced, financial and legal burdens, the negotiation of complex family dynamics and dealing with community attitudes and behaviours. While we examine the range of needs that arise from such problems, also covered are the views of people who resist any external advice and support.

Help not necessary

When people are faced with a major loss, including suicide, informal help and support from others is often required. However, in our study, a small group of survivors considered that help from external, non-family resources was not needed. This response is unusual but notable. The need to find their own solutions, their own way through their grief, is stressed; accepting help from outsiders or resorting to professional support may be disempowering. In other cases, it can be more negatively regarded as deriving from shame.

Our analysis produced the following key features:

a) **The impact of suicide on the bereaved is considerable but should not be regarded as different to any other death**

It was recognised that the death would have an adverse effect, however, any bereavement is difficult and suicide is not different:

> I know now when I cry, and if I'm having a bad day and I'm crying I know it will last for whatever time it will last, usually half an hour, an hour, and then I have to say, '*Right, let's go.*' And always take that as that's her [the dead relative] letting us know that she's still around. But I think we've coped well, certainly after the first year (P3, Father).

b) **Suicide is regarded as a release from suffering for the individual; it is regarded as a relief for survivors**

For this wife, her husband had finally found '*peace*' after a life of distress and suffering:

> I just got through it [the suicide] myself. At the time I felt I lost him six months before he died anyway. That's the way I saw it. And I found once I got acceptance, '*No, he is gone, he's in a better place*.' And I thought, '*He's never*

> *going to get over his childhood and stuff and he's probably in a better place because he's at peace*' (P56, Wife).

c) Personal self-evaluation as a 'strong person'. Sufficient internal coping resources to manage grief in their own way

It was important to accept the normality of bereavement and respond to it in a flexible and adaptive manner akin to other major life event:

> I took a month off [work] because I felt [the grief] … You go through the process of bereavement and anger and sadness and why and all that, very strongly. When I went back to work, they offered me counselling. But I said, '*No',* I was fine. I'm a strong person. … So I said, '*No, I'll battle through this*.' And I never took the offer up (P65, Sister).

d) Grieving is a natural process, requiring a passage of time and should not require medical intervention

The passing of time was crucial for many respondents who found that after a period away from normal activities they were able to return to work:

> [After the suicide] I stopped and I didn't do anything for a whole year. I didn't join any societies or clubs, I pottered and probably wasted my time; and at the end of that year I allowed myself to go back to work […] I think it was then I began to recover (P1, Wife).

For another brother, medication was not an option, for him time was a healer, and he decided to let time pass, rather than associating himself with '*tablets to help* him *sleep'*:

> I got, maybe, tablets to help me sleep and I never took them. I looked at them and I thought, '*No, just let's not do that for a wee while'* and I got passed it. But I don't spend hours worrying about what happened … or thinking about [the suicide of my brother]. You go through life, as time goes by things get easier (P33, Brother).

e) Acceptance that the participant had done all they could to help the family member

Some described how they felt they had done as much as they could to help the deceased, thus to allow their recovery they went through a process of grieving, acceptance and reconciliation with their new life:

> I just got through it [the grief] myself. At the time I felt I lost him six months before he died anyway. … That's the way I saw it. … And I found once I got acceptance, no, he is gone - he's in a better place. And I thought, 'He's never going to get over his childhood and stuff and he's probably in a better place because he's at peace (P56, Wife).

f) Acceptance that services had done all they could to prevent suicide

> He just got to the stage where he needed more help than we could give him … and [he] wouldn't accept a lot of help from [the doctor] … he was astute enough to be able to give them the answers that they wanted to hear (P1, Wife).

However, while such cases suggest a reasonable adjustment to the suicide, other, more problematic rejection of support arises through the presence of guilt and stigma. For example, one man described how his young son killed himself while the family was out enjoying a weekend away with an elder sibling who lived in a different town:

> My daughter is here … she is not prepared to talk … she feels very guilty because she is the one booked the ticket. The whole family was supposed to go, so she feels guilty that because of her he was left alone and this has happened. So she won't talk. I don't want to disturb her mind because she is [in a demanding job] (P2, Father).

In this case, family discussion about suicide was avoided because of a concern that talking about the event may make it worse. This particular family is of non-western European origin, thus, there is a possibility of cultural differences in dealing with suicide. However, it is worth noting that the participant emphasised later in the interview that his own community had offered all the social support the family needed at the time.

Psychological impacts[12]

For a number of participants guilt was associated with a persistent feeling among that they “could have done more.” Therefore, intense feelings of self-recrimination have prevented them from seeking help, making their grief all the more difficult to resolve. This man struggled with the guilt he felt because he thought the family could have been more supportive of his elderly mother:

> The brother lived quite close to my mummy … him being so close, he could have been in more often and seen how they were getting on. … I called in as often as I could but my problem is I was calling in for 15, 20 minutes. I hadn’t time to sit for an hour, and that's terrible saying that now and that's why I feel so guilty about it too (P68, Son).

The early period of bereavement for many survivors was marked by intense feelings of mental anguish related to guilt, rejection and betrayal. In general, participants, especially women with young children, used medication (e.g. sleeping tablets or antidepressants) to get through the early stages of bereavement. However, a group of participants, parents and wives, in particular, reported longer-term depression and anxiety requiring treatment. In a few number of cases, hospitalisation for psychiatric treatment was necessary.

Depression and anxiety

Many participants were currently using antidepressants or sleeping tablets since the suicide between five and six years ago. The majority of these participants were women, although a few male cases described their need to take antidepressants to help them through the day:

> We’re on antidepressants at the minute, the both of us [mother and father]. I have to say I don't think I’d like to come off it and I’m not on a very high dose (P66, Father).

> I was on antidepressants, I tried three different ones, I couldn't get anywhere, and then the sleeping tablets are just Diazepam just to try and relax, keep calm and stop freaking out (P9, Mother).

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[12] In qualitative research it is unusual to quantify the occurrence of behaviours or events. However, given the large sample of participants we feel that it is important to highlight the considerable prevalence of distress experienced within this group. From our interviews we noted that seventeen participants (24%) had been treated for anxiety and depression; ten participants (14%) had described how they had contemplated suicide and nine others (13%) had attempted suicide.

In many such cases, the suicide of a teenage child and/or the absence of an explanation for the death, were associated with clinical depression and medication:

> When she [her daughter] died I had another bout [of depression] but I wasn't hospitalised or anything but I have been on medication since (P43, Mother).

In a few number of cases, hospitalisation for psychiatric treatment was necessary:

> I took a nervous breakdown, actually. I was in hospital for seven months and that's where I got help. […] Just talking to psychiatrists. And while I was in the ward you had your nurse; I talked to her. […] I still go to the day hospital. It's only now that I'm getting to feel I'm myself again because my thoughts were wrecked with guilt (P42, Mother).

Suicidal behaviour

There was a particular concern among many participants that other members of the family may now also take their own lives. Siblings worried about their own children after the suicide of their brother or sister, and wives and mothers also worried about the safety of the surviving bereaved offspring after the death of their fathers or siblings.

This increased awareness of the suicide vulnerability among family members made wives and mothers, foe example, fearful about another suicide in the family and unsure about how they would cope:

> My big fear would be of it happening again, you know, and God, it would just be… you think, yes, people say I was a strong person and I know myself I'm a strong person, but you just think if that was to happen again within this family, you know, I just don't know how I would cope, I just don't know (P74, Wife).

The heightened awareness of increased family suicide risk encouraged a level of overprotectiveness, for self and others. As this man recounted after his brother's suicide:

> That was my main concern […] because I had known that families become more at risk of suicide, and that's why I was trying to encourage people to seek some kind of help and then presented them with options of what was available. […] And also, I was acutely aware of my own mental health problem, difficulties that I had experienced before and I was very hypersensitive. I was like, '*Right, I've got to watch out for my own warning signs here because nobody else is going to*.' And I also felt that I had to look out for other members of my family too (P19, Brother).

Some participants, related this hypervigilance about suicide risk to the presence of family history of suicide:

> There is a fair history of suicide in my family. Two years after [my brother killed himself], my cousin, who only lived a few doors down the road, committed suicide. […] It makes me fear for my own sons (P25, Sister).

Wives worried about the genetic link to suicidal behaviour and the fear that the suicide gene had been 'transmitted' to their children. Occasionally during the interviews they attempted to gain information about this from the researchers:

> The only one [of my children] I would worry about is [my daughter]. She depends on me emotionally more than the other ones. I do mind the children. […] But my son, he would be more … I would worry about him more. Obviously it's a thing … have you found does it run in families? (P23, Wife).

Suicidal ideation

A number of participants struggled with suicidal thoughts. In a few cases, participants reported having attempted suicide. Wives were the group most likely to disclose suicidal thoughts following the suicide of a husband. In these cases, children acted as a strong protective factor:

> I thought about suicide a lot, […] I thought about it 24/7 and thought, '*Right, if I was going to do it …*' […] It might have been a different story if I hadn't had the kids. I probably was that grief stricken I would have. But I had the kids and that just wasn't an option (P27, Wife).

There was considerable fear about such feelings and about the pain that would be inflicted on other family members, both of which pushed participants to seek help:

> I didn't want to be here anymore and I didn't want to put my granny through that again, and I was scared of myself. I don't know what made me do it. So I think I sort of went then to the doctor [and said], '*Listen, I'm not coping. I can't deal with this*.' (P6, Daughter).

One man described how he did not want to leave behind a similar 'trail of destruction' as that which ensued from the suicide of his brother:

> I did have suicidal thoughts whenever he took his own life, […] But whenever I sat down and thought about it for myself, the trail of destruction it has left behind

> and the hurt it has caused throughout the family, why would I want to inflict that on anybody else? It would have been a very selfish thing for me to have taken on board just because of [guilt] just for my own ease of mind. Why would you do that and leave my two children the same way? (P24, Brother).

Attempted suicide

Other participants, all female had attempted suicide in the aftermath of the death of their relative. These women included mothers, wives/partners of the deceased and one sister. Mothers appeared to be overwhelmed by guilt. One mother, in particular, who had a history of self-harm, blamed herself directly for her son's death because she thought it was learned behaviour. She explained that:

> I have tried to commit suicide. […] And after he died, because I tried to commit suicide so many times, I went to the self-harm team. […]. There is not a day that goes past or a minute goes past that I don't blame myself. I blame myself for trying to commit suicide so many times. That's probably where he got the idea from (P14, Mother).

Wives tended to report loneliness and feelings of dread when contemplating a life without their companions:

> You wanted it over, '*Please, please!*' And you're just thinking, '*How am I going to live without him? How am I going to live?*' […] I knew him longer than I knew my parents. It's just yourself now (P57, Wife).

> I would say for the first two years I was suicidal myself. I did try to kill myself a few times. I tried to hang myself. And like there was nights, you know, being totally honest, there was nights when I did start to go out […] and went out to that shed [where the body was found] and sat out there half the night. And I used to come in and walk the dogs round here at maybe four o'clock in the morning and I couldn't have cared if somebody had murdered me out there or attacked me because it would have been an easier way to die, you know what I mean? (P62, Wife).

Financial problems

In those cases where a spouse or partner took all responsibility for household finances, the surviving partner was left to 'pick up the pieces' but without the knowledge or skills to do so:

> He took all the decisions, about money, about everything. And all of a sudden I was on my own, I panicked, I thought, '*What am I going to do? How do I do this, this, that and the other?*' (P61, Wife)

Financial difficulties were a major concern for some women in the aftermath of the suicide. Some women referred to the struggles caused by legal and insurance matters:

> The life insurance didn't pay out, battling for that (P27, Wife).

Others were worried about how they were going to earn a living and support their household:

> I mean, when [the deceased] died my income was gone (P10, Wife).
>
> But the biggest pressure I suppose now is just really getting the financial end of it sorted, and now that we've sold off all the stuff there is no real income coming in from the farm. So, it's trying to sort ourselves out financially (P60, Wife).

Other women had to take extreme measures to survive financially and declared bankruptcy:

> I had to make the decision to go bankrupt because [the deceased] had left me in debt and I had my own debt. I gave up my house, I lost the house, I was made redundant from my job. […] His family couldn't help me pay his bills because they didn't have any money. (P47, Partner).

Practical and social issues

In the section on *Services at the Time of Suicide*, previously discussed, we noted the generalised view of participants on the outstanding achievement of the coroner's office in providing valuable advice and information, and also on the excellent service provided by the PSNI. However, in this section we highlight the difficulties that the participants encountered outside the arena of the formal and legal procedures. The practical issues highlighted here relate to the lack or availability of sources of support to help participants deal with the immediate practicalities after the death such as dealing with undertakers, telling the children about the suicide, and interacting with other family members and those in their communities.

Dealing with the funeral

Participants resented not having someone in a supportive role who could have given them appropriate advice and information. One mother simply said:

> The only other thing I have to say that I think people should get help with is funeral direction, because we hadn't a clue (P9, Mother).

Others found this lack of information adding to the stress:

> I was only [age] and the undertaker was here saying, *'Do you want a family plot?* […] That question rings in my head still and I keep thinking, *'Oh God!'* […] And I'm like, '*I can't believe I'm not old enough for all this c***!* I don't know the answers to these questions.*'* (P27, Wife)

Interacting with other family members

Talking about the suicide within the family was often felt to be challenging. Dealing with one's personal grief while managing the grief of others was complex and difficult. Individual members were acknowledged as being at different stages in processing their grief:

> It was good that [my daughter] was at home. It was good for her. Difficult though … It was hard for her because some days I might have been really, really down while she was feeling a bit up and then other days I might have been laughing about something and I could see her looking at me thinking, '*What is she laughing for? How can she laugh?*' So, there was a bit of friction there too (P20, Mother).

Most surviving adult relatives with young children recognised the need to tell them about the death and the circumstances surrounding it. Commonly, they enlisted the support of well-known charities such as Barnardo's or CRUSE. We noted the desires, often contradictory, of families to protect their children from the hurtful details of suicide, while simultaneously, appreciating the need to provide an explanation. They described their relief when they were able to talk openly about the suicide with the children:

> The children are not told any lies, they're told the truth but in a very simple way (P62, Wife).
>
> Yes, Barnardo's told them [the children]. I wanted them to know that their father had taken his own life but … and I wanted to know that they knew and were safe (P63, Wife).

Other female participants, specifically widows, found they had to protect their own parents or their parents in-law from further distress. In the early days these women felt it was difficult to engage in any conversation about the suicide because it could bring up to the surface distressing feelings for the grieving parents:

> In those very raw days … I couldn't put it on his mum because she just can't cope with it. And then she goes to his brother and cries and roars around there and then he'll come onto me and say, '*What the hell did you say to her? You're better just pretending, pretend you're all right.*' (P59, Wife).

In other cases, in order to avoid upsetting their relatives these widows pretended that everything was all right. As this wife said about her own mother:

> Even my mum, she doesn't know that I'm on antidepressants. She would have known that I was in bad form but I never said … But anytime she comes I'd be all upbeat with the children and would just not … because I don't want her worrying about me then as well (P63, Wife).

Family conflict

While one strategy was pretence of normality in order to hold the family together, in many cases, families pulled apart; unable to find appropriate ways to help each other they disagreed on what were the best way to support deeply affected members of the family; the young, in particular. This widow recalled the negative impact of this in her family when she said that:

> What happened after [the suicide] was [my sister] and I kind of had a fall out because my daughter was going to her and then she was becoming [upset] … And I said [to my sister], '*Don't try and tell me how to deal with her. I'm doing this my way.*' '*But you're not doing it right.*' [She would say]. […] and then she said, '[…], *she needs to go and see somebody.*' The whole family just got uprooted and started arguing and bickering with each other (P55, Wife).

There were also instances of strain and fracture within family relationships because wives or girlfriends were blamed for the suicide. The majority of these women, as expressed by this wife, were 'hated' by their in-law relations:

> But what I found the hardest was the hatred from his family members. Everybody needs to blame somebody and I was the scapegoat for his sister. … What I would have liked would have been a mediator to come in at the time and be able to sit everybody down and say, '*Look, this is a tragic accident and nobody's to blame*', because up until last year she was still phoning me and calling me a murderer (P27, Wife).

Public impact of suicide

In general, participants stated that the reaction of their community to the suicide was sympathetic towards them. Where the deceased individual or his/her family had played a prominent role in the community, the death was deeply felt. In these instances, funerals were well attended and participants welcomed the sympathy and support offered by friends, neighbours and acquaintances in those initial moments in the aftermath of the suicide. However, in some instances, the visibility of family grief left some participants feeling vulnerable within their communities and may have delayed recovery. There was a heighted sense of exposure and being the object of unsolicited attention, particularly when the suicides were highly publicised in the media.

The negative impact of the media coverage was particularly associated with young suicide. These deaths were sometimes given prominent coverage within local and regional newspapers, and described in a sensationalistic and romanticised way. This media coverage caused additional stress to families who became worried about suicide contagion amongst other vulnerable youths. One father expressed his worries by saying that:

> There was a couple of big headlines in the front of the paper and stuff like this, […]. So he was becoming a hero and we were afraid that some of the other young fellas would mimic (P66, Father).

Small communities, as this wife stated, were left in '*shock*' with the death, and people became more aware of suicide:

> Yeah, well I think it's opened a lot of people's eyes. This is a small community up here […] and people were very, very shocked, you know, when [my husband] died, very, very shocked. And they would have seen him out still at his day's work and everything looked okay … (P74, Wife).

Community gossip

While the support of the community may be considered as helpful, paradoxically, the community focus could, in cases, exacerbate varying feelings of shame and responsibility. For some of the participants, the difficulties of dealing with the suicide were compounded by rumours and speculation. Communities were described as attempting to forge an explanation for the death. As this widow explained, the conjectures made by her husband's close relatives impacted on her relationships with the whole community:

> But [his sister] and her husband have really put their story about and had even said that [the deceased] was having an affair and I found out the night before he killed himself. I mean, that is just so … you know, unbelievable. So the community has been very much poisoned (P10, Wife).

People within the community instigated other “stories” about the death and, again, the widows became the object of gossip and speculation about the reasons for the death. This wife explained that:

> Everybody talking about you; and the rumours … It was, money, it was, I was having an affair; I’d been caught having sex on the sofa. And people come out and tell you, ‘*Oh, I heard this …*’ Narrow minded people (P27, Wife).

Caught within the community gaze, perceived or real, survivors sometimes found it hard to return to ‘normality. While isolation and stigmatisation within communities was a common experience, we also noted a degree of self-stigma and marginalisation. Social existence becomes limited to contacts with other suicide survivors. One participant describes the new status that survivors may adopt:

> … and you’re landed in this limbo and that’s it for the rest of your days. It’s like being in a strange club. You get to know more people. I’ve seen more people that are suicide victims now than I actually speak to in the general public. Your friends nearly become the same … you know, I would have friends, lots of people that I could have lifted the phone and said hello and talk to about things. But then afterwards your life changes, you don't go out, and other than that then there’s, you become friends with, or acquaintances with people likeminded. So you’re in the one big limbo club (P70, Mother).

Some of the participants reported that members of their family did not want to discuss the suicide with friends or acquaintances. Instead they resorted to ambiguous stories, as explained by this son:

> But if someone asked, ‘*Where’s your dad?*’ Mummy wouldn’t tell them that he committed suicide. Say someone asked, ‘*Where is your husband?*’ She'd say, ‘*He passed away a few years ago*.’ And if they say how, she quickly changes the topic (P52, Son).

Others experienced the community as avoidant. This husband, for example, talking about his experience with friends and acquaintances, in the early days of the suicide, said that:

> I would say about 75% of people, maybe more, actually physically nearly ran away (P28 Husband).

Similarly, other participants found it hard to cope with expressions of pity:

> I think sometimes when I do open up to people they don’t know how to react to it, so it’s pity, ‘*Oh my God, how terrible!*’ Well, I don't want that (P6, Daughter).

Interviews with General Practitioners (GPs)

The majority of individuals who die by suicide have commonly had contact with their doctor (Luoma *et al.*, 2002, NCISH, 2014, Pearson, 2009). It is also estimated that 30% of all GP consultations are for mental distress (Bebbington *et al.*, 2003). Primary care is thus commonly regarded as a crucial site for suicide prevention and various national strategies highlight the pivotal position of primary care in suicide prevention strategies (Mann, 2005, O'Connor *et al.*, 2013).

Currently in the UK, GPs routinely screen patients who present with mental health problems for suicidal ideation and while the identification of risk has improved in recent years, it nevertheless remains problematic. Some of the reasons for this relate to evidence that many of the risk factors for suicide are highly prevalent in society and they tend to be unalterable (Beautrais *et al.*, 2005, Bertolote and Fleischmann, 2002). For example, suicide has been linked to being male, a particular age, divorced, having made a previous suicide attempt or having a family history of suicide (WHO, 2014). Acute symptoms and behaviours that signal potential suicide may be of more assistance to the GP in identifying risk; these include, anxiety, insomnia, a sense of hopeless, social isolation and increasing or excessive use of alcohol or drugs; all of which may be identified and potentially addressed.

Some studies have indicated that training for GPs on depression and suicide-related behaviour may be lacking (Feldman *et al.*, 2007, Hepner *et al.*, 2007, Sudak *et al.*, 2007). A number of training and education interventions designed to reduce suicide have been developed, but there is little evidence of their sustained effectiveness (Gilbody *et al.*, 2003). Despite their perceived pivotal role, few studies have directly examined the challenges experienced by GPs in the recognition and the management of suicidal patients, nor the impact of suicide on their professional and personal wellbeing (Saini *et al.*, 2010).

Our study indicates that 87% of people had some contact with their GP in the year prior to suicide. Therefore, in order to better understand the challenges to identifying suicidal risk in primary care we undertook qualitative interviews with GPs working in Northern Ireland during the time frame for this study.

Method

In-depth interviews were carried out with GPs working in Northern Ireland who had experienced the suicide of at least one patient in their care. The sample was recruited through the Royal College of General Practitioners. We developed a topic guide based on the study questions and literature relevant to the topic. GPs were asked to base their answers on their involvement with patients who died by suicide. The digitally recorded interviews lasted an average of 60 minutes. They were professionally transcribed and anonymised. Three members of the research team developed an indexing and coding framework (Miles and Huberman, 1994) for the transcripts, based on the Framework approach (Ritchie *et al.*, 2014: 269-345). The topic guidelines provided the initial thematic framework on which the emerging themes were then placed.

Sample

In total, 19 GPs; 11 women and 8 men participated in the interviews. They were located in a range of primary care settings, serving diverse socio-economic and urban and rural populations. The participants were all long-serving practitioners, sharing between 15 and 30 years experience in practice. Each had been involved in the care of more than two suicides, with several GPs indicating they had knowledge of more than ten cases. Within the interviews, three doctors also acknowledged a personal connection with suicide outside of their professional role. These deaths are likely to have influenced their views on suicide and their professional engagement with suicidal people.

Findings

The findings are presented under four thematic headings each of which has a series of related subheadings:

1. Barriers to the recognition and management of suicidal people.
2. Liaison and communication with mental health services.
3. Responding to families after suicide.
4. Professional and personal impact of patient suicide.

Barriers to the recognition and management of suicidal people

> “I think that we need more time with patients. The demand is the problem, accident and emergency is on its knees. It is not a problem about GPs, it is a problem of impossible demand.”

Level of contact

It is important to bear in mind that some patients, particularly men, who take their own lives are not in regular contact with primary care and may be living in areas beyond the surgery boundary. Commonly, GPs had been in regular contact with such patients and were aware of their histories of poor mental health. If they don't attend surgery, GPs do not follow them up to see if they are not well; the default assumption is that they are well. It is not that they are uncaring but rather, the volume of patients that consume attention:

> By and large the others that we have had, when you reflect on what could you have done differently that might have had an impact, most of them you couldn't. They shoot themselves, they hang themselves; they mostly hang themselves. We've had one not that long ago did it. He drank weed killer. He lived about six hours, and regretted doing it before he died (GP5).

Mental illness stigma

> I think that we are quite good at reaching the patients with a mental illness and who have been diagnosed but there are a lot of people out there who don't have mental illness or don't appear to but are still very desperate but don't say anything (GP8).

Up to 30% of GP consultations are related to a mental health problem. Suicide is still a rare event and GPs are unable to identify, with any degree of certainty, which patients with a mental health problem are likely to kill themselves:

> You could argue that mental health is a little bit different than say something like dermatology, in the sense that we live in a spectrum of very much well to pretty poor and I guess that you are confronted with a lot of mental health problems in general practice (GP13).

However, the stigma of mental illness remains a significant barrier to providing appropriate treatment. Even in those cases where mental illness is clearly indicated, GPs find it difficult to ensure treatment:

> One of the other suicides that we had in the practice was a young man about thirty who we knew had mental health problems and he denied it and didn't want to have anything to do with Psychiatric services, I had arranged an urgent psychiatric appointment for him and he was quite annoyed with me that I had done this and he was convinced that he had physical problems, but was quite obstructive with any attempts we made referring him, which we actually done two or three times, within about six months he had walked out in front of a train and killed himself and that was somebody we were very clear that his problem was psychiatric problem and that he was at risk (GP13).

One GP, working in an inner-city area with a long history of deprivation, drug abuse and gang violence, described herself as being overwhelmed by the demand for sick notes and psychiatric medication. While acknowledging that a considerable proportion of this demand may have been justified, in many instances, it wasn't. On several occasions, she was confronted by patients who "demanded diazepam or they would kill themselves."

> A lot of people sick, mentally ill, and a lot of people pretending to be mentally ill to get disability living allowance (GP9).

Stigma and patient concealment

> He wasn't good at sort of ventilating his feelings, although he had good eye contact and he did answer questions but it's made me certainly a lot more [wary] ... if I have a younger person in consultation now I am looking at the mental health issues (GP12).

Our participants commonly note the inability to discuss mental health problems. We noted that GPs covering rural areas feel that the stigma of mental illness is a particular problem:

> I think rural people in general will not seek help as readily as people who are town-based; that is my experience here. Out in farming communities in particular, people are very … they pride themselves in being very robust, and men in particular don't seek help unless it's something quite seriously wrong with them, be it on a physical level, and often you don't see people who are farmers with mental problems unless they are brought in by other relatives. They often don't come on their own bat; they come because they have been forced to; by families who have thought, '*I must get help for him*.' So your traditional farmer in the local community would pride themselves in not seeking help for this sort of thing. It would be seen as unmanly […] if you have to come in and tell the doctor that you're depressed or you're not coping or whatever (GP1).

However, it was also noted by GPs outside the main cities, working in small town practices that patients also feel very stigmatised by mental illness. In a place where everybody knows each other, there is a hypervigilance about being seen

> It's a wee town, so things are publicized more easily. The other problem is how do you get someone to [attend psychiatric services]. I have a patient who comes in regularly but [refuses] to see the Community Psychiatric Nurse – she said, '*Everyone will know what I'm going for*' (GP4).

Assessment for suicidality

> If you know somebody is at risk, those are the easy ones to deal with, they really are. t's the ones that just do it in an entirely unpredictable fashion. So if you were looking for something positive, raising awareness among relatives that someone's not at themselves and are potentially at risk, like the guy who told the ex-partner what the kids should wear at his funeral. That is definitely a sort of key clue and intervention might have stopped that one. The problem is the more subtle things, somebody who seems in bad form, not at themselves, a bit withdrawn or whatever, that describes most of us at some stage of the year. What do you do? (GP5)

GPs are now required to ask patients deemed to be depressed, questions related to potential suicidality. GPs do not always feel comfortable about asking these questions; for some patients the questions are considered counterproductive, provoking an acute defensiveness. One GP described patients "bristling' or getting upset; asking, "*Do you think I'm mad!"* Some participants commented that they find "more sensitive" ways of determining suicidal thoughts among patients.

A commonly held perspective suggests that GPs find the suicide protocol as a barrier to a true therapeutic engagement with patients; that something in the bureaucratic management of healthcare, precludes an 'opening up' of how patients are truly feeling:

> They come in to talk about their mood and by the time we have asked them all these questions, they probably think that this is not what the doctor wants to hear – that my world is really crap at the minute and I can't see a way out (GP10).
>
> You need someone who has natural empathy, who can sit and listen. One thing would annoy me would be if someone was following a protocol – if you see someone following a tick sheet (GP7).
>
> I don't know if it is a female thing. I don't know. Sometimes you are afraid to probe and ask those really hard questions. We sort of skirted around those things. (GP7)
>
> You have to ask them about their alcohol and their social history and their debt and their family support, and stuff you did anyway but never actually ticked boxes, especially if you actually print it out and sit in front of the patient and do it, that totally depersonalises somebody, because '*Why does the doctor want to know how much I earn or whether I've got any credit card debt?'* (GP3)

> It’s all about the illness and all about reporting the illness and asking the questions, and I get that that's about assessing risk for doctors who are not very good at it and having a template helps you do it, but if you sit and go through it automatically it has the opposite effect of what it’s intended to do. It’s thought up by people who aren’t thinking about the person in the middle of this and it’s getting increasingly difficult to practise as a GP who remembers that it’s 3,500 people I have, not 3,500 sets of illness (GP8).

Of concern to some GPs is that general practice is currently dominated by a concern for suicide rather than mental illness. One view is that many people who contact the GP declaring that they are suicidal, are unlikely to be so.

> And there are lots of people who say ‘*I feel suicidal*’ or ‘*I feel life isn’t worth livin*g’, and I can't think of anybody who has actually said that who has gone on to commit suicide (GP17).

The suicidal declaration is regarded as an emerging form of presentation, in which the patient, because of current adverse events or circumstances, is finding life very difficult; interpreted by some, as a strategy to rouse medical care. In the next quote, the GP indicates something of a cultural response to personal problems.

> I suppose the problem is that the people who come in saying they’re suicidal are then I suppose taking up work ... they take up quite a considerable amount of work, and there are one particular family going through here at the minute who have had three or four people from the same family, girls perhaps one or two years older than each other, presenting with the same suicidal ideation over the last few weeks, which takes up a considerable amount of time for CPNs. So the lag then that you see is people who perhaps aren’t perceived as being suicidal but have acute mental health problems that probably need dealing with but the system’s stretched trying to deal with people that are presenting with these crises situations (GP14).

Nevertheless, we also noted that although GPs suggest a degree of awareness that the patient may have other things on their mind but these never get expressed and there is often little opportunity to explore these issues further.

The “ten-minute rule”

As noted previously, the stigma of mental illness and patient reticence to discuss ‘personal’ problems often inhibits any meaningful intervention by GPs. Patients often require gentle encouragement to reveal their difficulties. The issue of GP limited time was universally noted as a significant barrier to the recognition and management of any underlying mental health or emotional problems:

> Personally, I ... if somebody needs to talk, they need to talk and the waiting time goes out the window, and my patients tend to know that and my reception staff are very good at saying 'she's running a bit behind today' (GP5).

Few GPs were as relaxed about the ten-minute rule as the GP above. She suggests that it is an acknowledged dimension of her professional care, supported by practice staff. As illustrated in the following quote, patients often begin to discuss the 'true' presenting problem as their ten minutes come to an end, leaving the GP with difficult choices to make:

> You have to start all over again and that may take half an hour; and there is a waiting room full of people. I know that I can't spend 30 minutes with this person, so you end up saying, '*Come back and see me next week and we will talk abut it'* (GP8).
>
> I don't know how you train someone in that. But then you sometimes confront the patient or you ask them and you bring it up or you say something noncommittal and then they come out with it. I don't know what I do … and you just pick up something … and suddenly you're half an hour behind, 40 minutes behind, and you've ruined your day! (GP4)

In the following relatively extended quote, the participant relates that an important quality of a GP's profession is being eroded partly by work overload and partly by a steadily bureaucratic systemisation of their practice. From this perspective, GPs are no longer able to provide the humane and compassionate aspects of primary care.

> And yes, you have to look after the illnesses but sometimes a person just wants to tell you that their dog has died and are feeling very sorry for themselves and they're not really interested in what their diabetes blood results are, or what their peak flow is for their asthma. They just want to have a moan about how bad they feel right now. I find that that's because something I do a lot and do well, that's the bit of my job that I'm facing now, general practice is changing, my job is changing, that little bit of counselling I do as I go through my job, there's not time for it anymore. I have to pass that onto somebody else. What I'm finding it a bit of a struggle to state some of the things I do well, there's not time for this anymore; that's becoming someone's else's job, whether my patients want it to

> be or not or whether I want it to be or not. I can't keep doing my job and say sane and do all of this anymore because there's just not time (GP8).

Suicide as unpredictable

> He wasn't on drugs, he didn't drink, he had friends, he hadn’t had a relationship bust up; there was nothing that you could point other than his cousin did it (GP5).

In the above quote, the GP reflects that the only explanation for this young man’s suicide was that he was following the behaviour of a cousin who took his own life. The unpredictability of suicide among patients was a recurrent issue. GPs remarked on the heterogeneity of the suicide, in terms of the patient characteristics, social contexts and presenting problems. The considerable variation of the suicides related within these interviews was obvious.

> I worked in psychiatry for a year but my training now is redundant. I’ve got some experience but ... I don't know, I just feel so many of them are unpredictable and there's nothing we could have ... probably more the relatives might have seen the signs than us, because they weren’t coming to us (GP15).

Of greater relevance here is the degree of ambiguity and unpredictability in the contact with primary care. The unpredictability arises in various ways:

Somatic presentation

Patients may have attended surgery for some time but show no indication that they may be depressed or suicidal. These contacts with primary care are often for physical health problems and are common among older patients, some of who have been managing chronic, complex conditions.

> She had had a chronic illness and struggled with for many years. She coped and managed to balance working and relationships and all the rest very well but had relapses. No history of mental illness and we were all quite taken aback (GP8).

> No, he never ever presented with any psychiatric illness. Even in the bad times when there were assassinations going on and all sorts of things where he really was at risk, he never sought any help with anxiety, depression, nothing. There were things, he might have had a pain in his chest or a chest infection, the sort of things that people come to GPs with, run of the mill acute self-limiting illness and things like that, or things they were slightly worried about. I knew him on that basis. […] So I knew him reasonably well and he didn’t use drugs, he took a

> drink but not to excess. He was not predictable; I could never have spotted him for suicide, no way (GP3).

In other cases, the presenting problems seemed minor or non-existent:

> One lady came to see me with a lump on her neck. I examined her and I couldn’t feel anything that I was worried about but I picked up that she was worried. I referred her to the ENT clinic. I heard that she drowned herself two weeks later (GP13).

> The day I saw him, for example, he was more concerned about how he looked rather than basically ... and I sort of said what is actually bothering you and he said the spots on his face. He didn't sort of have any ... it didn't seem to be a body image problem and we did explore other sort of symptoms. I did ask about sleep, appetite and his general enjoyment of things, and he certainly didn’t seem unkempt or anything like that. He seemed a typical sort of young person (GP12).

Paradoxical presentations

GPs note that the patients who have been treated for depression are often those who kill themselves in the midst of ostensibly positive signs and outcomes. Thus, they appear to be responding well to treatment, returning to work, engaging with community; in short, they present as if all is well:

Other suicides occur following a recent visit when all seemed well. In the following case, a woman saw the GP and reported that her “life was on-track”; she had a new job and a new house and her partner was fine.

> She s said, ‘*Doctor, everything is fine …*’ And then, two days later, the police walked in; she had been on the booze and hanged herself. What do you do about that? (GP 9)

> I last saw him in December. Again, he described his mood as great, energy levels, motivation, everything was much better and we’d arranged for a review early in the New Year (GP 2).

Continuity of care and poor engagement

In various narratives, it was suggested that suicides occur despite a high level of attention by services, both statutory and voluntary. The following case is that of a young man who had been seen by a GP over a couple of years. His history of poor engagement with mental health services was echoed elsewhere in the interview:

> Two or three months prior to his suicide he consulted with a couple of the different doctors and we changed his anti-depressants and we'd brought him back for review. He didn't keep the review dates and when he did come in it was about some other health problem. He denied any self-harm and he denied any sort of suicidal tendencies. He did display some anger management problems, which we'd referred him to men-to -men project and also to a counsellor. He had been seen also by Lifeline and then prior to his committing suicide he actually had been seen in A&E but we didn't get the letter until after his demise. So, he'd actually been seen by Crisis Response Team (GP12).

The problem of poor engagement noted by this GP was balanced against the issue of continuity of care. She reported that one patient had deliberately sought the assistance of different GPs and had been offered a range of support:

> He didn't engage; I don't know why these patients don't – they request help and you get them help but when they are provided with service they don't use it (GP3).

Family interference and concealment

Continuity of care was also influenced by family behaviour. For example, in one case, the GP reported that the family had "protected" their son for a considerable time before seeking treatment. When they did so, they also tried to obtain care from a private healthcare who she described as a "disaster; they didn't have a psychiatrist, only a counselor." It was noted that the family had failed to convey to the GP their son's various indicators of suicidal intent. These were revealed only after his death.

Alcohol and drug use

GPs described the lives of some patients who died by suicide as chaotic and in which alcohol plays a significant role, either as self-medication when depression hits or as a precursor factor in the loss of job, family and contact with the criminal justice system. The presence of alcohol is regarded as obscuring diagnosis and hindering treatment.

> But then again, this is on a background of someone who was still taking alcohol. He had managed to abstain for periods of time over the last 10 years but he

> always went back to binge drinking and that seemed to be when his mood dropped. I think he was drunk the night that he hung himself, so …(GP5).
>
> There's been a few who are almost regulars where you just don't know are they really suicidal or is it a cry for help, and there's been a few repeated ones would take overdoses who we're all aware of, or maybe the odd cut wrist and stuff, but more tentative wounds. But mostly overdoses, quite often tied in with drugs, or alcohol particularly (GP15).

As noted in previous sections, alcohol is associated in the general literature and in the GP narratives, with aggressive and impulsive behaviour.

Referral to and engagement with psychiatric services

GPs' relationships with mental health services were variable, shifting from complementary and highly satisfied to the fractious and deeply concerned. We noted that the variance may be partly determined by locale and the structural organization of psychiatric services. We also noted that many GPs had excellent relationships with local mental health services and were very complementary about crisis intervention and home treatment teams. Nevertheless, there appears to be considerable gaps and failures located within the community care of people with severe depressive disorders. While GPs acknowledge that many suicides appear unpreventable, they point to instances when suicide should not have been the outcome.

In brief however, the dominant issues documented by GPs regarding mental health services relate to the following:

1. Perceived inadequate assessment.
2. Delays to hospitalization.
3. Inadequate or absent follow-up in the community.
4. Lack of communication with primary care.
5. Absence of shared knowledge and expertise. [13]

There is a strong perception among GPs that, in some cases at least, mental health services reject their professional judgment or tend to minimize the GP's assessment of the urgency of

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[13] Other, perhaps more minor points that were mentioned in the interviews relate to concerns about the long waiting lists and the refusal of mental health assessment teams to see people who are intoxicated or have taken drugs.

the problem. One GP felt that the ‘One-point referral’ system established in her area was exceedingly negative, structured solely in order to avoid dealing with suicidal patients:

> They usually say, ‘*What’s the forensic history? What drugs are they on? The whole thing is resistance, resistance, resistance*’ (GP7).

In the above case, the GP had failed to have a patient admitted who then attempted suicide. Mental health services refused to attend to the man because the GP was acting on behalf of a housing association and had not directly interviewed the patient.

In other instances, patients appear to be only briefly assessed and then discharged with minimal or no safeguarding measures put in place. In the following case, the GP felt that sufficient warning signs had been raised but that the arrangement for a proper assessment had been “dragging on for days”. She argued with psychiatry that she knew the patient very well, much better than mental health services, and knew “what they were normally like”.

> I was very upset because I felt that if he had been sectioned, he would have been alive and we could have worked through the issues he had (GP1).

Also commonly expressed, was the difficulty of trying to arrange a psychiatric assessment via the telephone when the patient is sitting in the surgery and wanting to leave. In some cases, the GPs found it impossible to convince the clinician on the other end of the phone that the patient required admission. This was regarded as a major barrier to suicide prevention.

In other, more complicated cases differing clinical judgments are made about the patient’s mental state and the assessment of risk. In the following case, a female patient was observed to have had an appalling personality change and was acting violently. Because of her age, just over 65 years, she appeared to fall between adult mental health and old age psychiatry. Clinicians disagreed as to her mental state and capacity. This participant was deeply concerned about the patient’s wellbeing (and that of the patient’s family) strove to obtain an intervention. In the end, there was a failure to respond:

> So in a way, her presentation was very unusual. A private psychiatrist […] thought that she was definitely psychotic. So she was presenting with psychotic depression but the NHS consultant didn't think she had it. So then I had to organise a third party to do an independent assessment and unfortunately he didn't get that done that week that he said he would and it was that weekend that she committed suicide (GP11).

> After his discharge from hospital into the care of the home treatment team, he was due to have daily reviews […]. The day after his discharge, they [home treatment team] reviewed by home and decided with him that they didn't need to see him the next day. So the first contact with [services] was to downgrade his review and the next day he killed himself (GP13).

The same GP argued that psychiatric services tend to neglect people who are severely depressed, concentrating on severe and enduring disorders instead. In several cases, concerned about their deterioration, he referred patients with a severe depression to psychiatric services, only to be told, '*We don't think this is our problem, could you send the patient to some of the voluntary services*'. He stated that it was not reasonable for a GP to undertake outreach for people with severe depression and who may be suicidal.

> And so it's not the GP's and it's not psychiatry dealing with it so I wonder who is? (GP13)

Communication and liaison with psychiatric services

We noted that the organisation of mental health services in different areas of Northern Ireland had undergone considerable change in recent years. While some GPs were satisfied with service provision, a commonly held perspective is that psychiatric services, in some areas at least, had become fragmented into different specialist sectors (for example, recovery, addiction, emergency). Participants complained of having to decide on which team was most appropriate.

> They would overlap and you'd have the difficulties of getting the right person; people would get lost between the cracks. But the actual individual, when you got them, was super. I felt that there was a loss of continuity. The GP is the only person, really, that had any picture of continuity (GP6).

Moreover, sectorisation appears to remove a valued, direct and personal connection with consultant psychiatrists. This mutually beneficial connection was valued because advice or concern about a patient's mental state could be quickly resolved by a relatively quick phone call to someone whose opinion the GPs trusted. When this conduit was removed, GPs felt that mental health services may not be operating in the best interests of the GP or the patient.

The suspicion that mental health services are "off-loading" was noted elsewhere. There is some concern that the voluntary sector is expected to fill in the gaps but this is becomes part of a 'revolving door' scenario:

> I think it’s interesting, sometimes you get people who have been assessed by the community psychiatric services and they have given them their Lifeline card if they do become suicidal and encourage them to phone that. But they actually come into us when they do feel bad. I don't know whether they prefer to be seen by someone but […] the card is almost like, ‘*Well sure, I've given you the card; my duty’s done*’ (GP15).

The disjunction between primary care and mental health services had deeper implications and GPs welcomed the development of closer liaison and knowledge sharing:

> Probably a greater appreciation for each other’s roles and what we can do (GP14).
>
> Greater co-operation between the services, at present I have no contact with the psychiatric services at all. There is no personal contact, it would really help if we had more regular meeting or case discussions with them that would be a learning opportunity for us; we might be able to fill them in on some of the pressures (GP13).
>
> Easy access to somebody who is in the mental health team who is more practiced than us; that can help us make an assessment. If we have somebody to help us make that decision, say if they weren’t that seriously depressed we would be happy enough following it up ourselves, it would be good to have help making the decision and backing up your choice (GP2).

Referral to the voluntary sector

The presence of the voluntary sector was noted across all the interviews, often with variable perceptions about their value. Predominantly, the sector is generally recognised as ‘filling a gap’ in skills and in levels of service provision. Therefore, GPs will describe their knowledge and skills in mental illness as limited. For many, mental illness is not a branch of medicine in which they feel competent of confident. Moreover, the waiting list for counselling in primary care was reported as lengthy, often extending beyond six months. While feedback on the voluntary sector was general favourable, we noted a number of strong caveats. Concern about the involvement of voluntary sector organisations relates to: (1) the level of skills and qualifications of counsellors; (2) lack of feedback or communication about patients; (3) uncertainty about the aims and objectives of some ‘suicide-specific’ organisations; (4) voluntary sector publicity about suicide; (5) potential overreliance by statutory agencies and the risk of inappropriate referrals to this sector:

> It would often take six months to get an appointment [with the counsellor]. I would often recommend Lifeline and CRUSE (GP13).
>
> They’re difficult in that anything where you use a community and voluntary sector or you recommend them, the fact that most of the time you don't do a formal referral and most of the time you don't receive any feedback, you’re at times unsure if anything has ever actually happened. This is the problem. We don't get formal feedback from community and voluntary sector providers unless there’s a crisis. Unless they’ve been down and they’ve said they’re suicidal then we might get a letter through to say it might be worthwhile referring this man to psychiatry. But generally you don't get a lot of feedback from them (GP14).

Dealing with bereaved families

As we have described in a previous section, the impact on families who have lost a family member through suicide can be immense. For example, we know that people bereaved by suicide are more likely to develop anxiety and depression and have an elevated risk of suicide. Despite these risks, as far as we aware, in Northern Ireland, there are no formal policies or procedures for dealing with bereaved families in the primary care setting. We discerned no standard approach to engaging with such families nor did we find evidence that GPs have been offered advice or guidance on how to handle families in the context of suicide.

GPs contact with families is influenced by the following factors: (1) Familiarity and knowledge of the family. In cases where the GP knows the family well (quite usual in the smaller towns), this can either encourage or inhibit contact by family members. Suicide continues to provoke disapproval and shame. In other cases, the deceased may not have the same GP and contact with them would be unlikely; (2) Dispute with services. Families may hold the GP, alone or with other services, responsible for the death by failing to prevent it. This often results in protracted conflict with the family [14]. (3) Other contextual factors. For example, where a GP has knowledge of causal influences and continues to be engaged with the family. (4) Standard practice policy: GPs contact relatives following any type of death in the family. This is unusual and often part of a more general proactive stance by a large practice.

Generally too, GPs do not feel confident in dealing with bereavement and several GPs suggested that they would benefit from such training:

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[14] Several GP participants and/or their practice colleagues, have faced or currently facing a tribunal or litigation.

> We would always try and make contact with the family after any death. We would always let them know that they can come and see us anytime they need (GP13).
>
> They are seeking answers. They say, '*Why did this happen?*' And it is often a rhetorical question. There are no definite answers but you have to use your skills as a counsellor and as a professional, to try to alleviate some of their distress. I'm not very well equipped to deal with the fall-out from suicide (GP11).
>
> By and large the families do attend, because it's a terrible grief that they go through and they do tend to come to us afterwards. Sometimes you'll engage immediately at the time of the suicide if we're called out and sometimes it'll be later (GP16).

There is little evidence that GPs deliberately seek out bereaved families. In some cases, again, in close communities, GPs attended the funeral. If bereaved family members consult the GP and describe low mood following the suicide, the GPs will usually refer them to the relevant voluntary sector or to in-house counselling. However, it is worth mentioning that GPs are not generally aware of the quality of such services. Moreover, in the case of the voluntary sector, once referred, the GP has scant information or feedback about the outcome of such referrals.

> In relation to those suicides of the teenagers there is a specialised team from [name of town] who set up a counselling type service and had asked for names of people who wanted to be seen by them, who felt affected by those, but I think they had direct involvement with the families and made it known that they were available and therefore our involvement, we were by-passed to a large degree (GP17).

Again, the belief among GPs is that the voluntary sector may now be in a position to give the kind of support that is no longer available in primary care, with the caveat that GPs will pick up the pieces where necessary.

> Lifeline I think is tremendously useful, because you've got to understand, what can we offer them? We can offer them ten minutes of our time in the middle of a surgery and perhaps a relationship, and perhaps not a relationship, perhaps we haven't built up a relationship and so they might as well have three quarters of an hour or an hour of someone who's specifically trained to deal with their issues and deal with their concerns and is able to give them another hour next week and another hour next week, and that's where I find Lifeline with their little card

> that says we're trained counsellors and yes, you can see us if there is an issue with anxiety and depression (GP15).

Professional and personal impacts of patient suicide

It is unusual to hear that a GP is unaffected by a suicide in practice. All of the GPs in this study appeared to be negatively affected by a patient's death through suicide. As noted earlier, most of the participants had been in practice more than 20 years and had knowledge of multiple suicides. The impact of a suicide was variously described by GPs as 'devastating' or 'very painful', highlighting a common response of rumination that they had acted correctly in each case. Several admitted that they had experienced periods of depression and had witnessed colleagues being "destroyed" in the aftermath of a suicide. Several participants became distressed during these interviews.

Even years after the event, the participants experienced the suicide as a painful memory. There are several factors that were associated with the GP distress: (1) Avoidable deaths. These are regarded by GPs as people who might still have been alive had services acted more swiftly or were better coordinated; (2) Missed signs: Suicides that had been signalled by the patient but that the GP recognised only in hindsight; (3) Valued patients; the suicide of patients, usually of long-standing, who have coped with chronic illness with cheerful stoicism; (4) Apparent improvement: Suicides that occur despite apparent improvement in mood and social functioning; (5) Family complaint: the GP feels scapegoated by the family for not preventing the suicide.

In cases where there is a long history of self-harm, alcohol or substance misuse, poor engagement with services and impulsive behaviour, the GPs indicate that while these suicides are not individually anticipated, they are not shocking. In the other, more distressing cases, a compassion for the individual and their families is apparent. Importantly too, these suicides deeply attack the GPs' sense of professional identity. When suicides occur in practice, there is no particular expectation on GPs to be provided with any level of counselling support and we found no instance where GPs had sought this for themselves. Responses to suicide in primary care vary. In most instances, the participants referred to an informal level of peer-support, and felt reasonably supported and protected by their colleagues. Many participants remarked on a 'macho' culture within general practice, which tends to produce a collective expectation of perseverance while dealing with unremitting human suffering.

> Everyone loves bashing GPs. We actually do a reasonable job most of the time and it's not just as easy as you think it is. You do get involved. We pretend we

> don't. I'm saying this to you now but we do get involved, we do worry about people and you do wake up at 3:00am with a sudden idea […] we do it all the time but few of us would ever admit it to anyone, even to each other (GP4).
>
> I'm not saying GPs don't need it, I'm saying that GPs don't access it, and the reason I think they don't access it is twofold. I suppose GPs feel that I'm big enough, I can … '*I'm strong enough, I don't need counselling*'. And second of all, there's an embarrassment issue of having to seek help yourself as someone who gives help to others. I think there is a difficulty there. Doctors in general I think don't seek help for anything like this often and they just absorb it. Yes, we're fortunate in our practice in that we have three doctors that are all of the same age and the same general outlook of things. So therefore we would help and support each other through difficult cases, be they patients who are difficult to manage generally, or if someone dies, the impact of that on the doctor. So we would feel that that's fairly robust in itself, but I think there still could be a role for, for example, psychology services to be available to doctors when they have experienced something traumatic, to go over things with them and counsel them a bit and just help them, because I think otherwise what happens is the GP goes home and takes it out on family or- (GP1)

Nevertheless, GPs try to insulate themselves as best they can from the psychological, and sometimes, professional, consequences, of a patient death by suicide. One strategy is self-reassurance of competency, in which GPs return to the case notes, examining all encounters to make sure that all procedures were correctly followed, noting the patient's consultations and any referrals that ensued. In the following quote, the GP revealed an overarching strategy for self-assurance in which he informs all patients that the objective to get better can only be achieved in partnership. This forms the basis for a contract that is considered broken if the patient fails to adhere to medication or disengages from care.

> GPs could do with more training, but how do you go about that? It's so easy with diabetes heart disease; there are NICE guidelines. There just isn't a NICE guideline on dealing with suicide (GP3).
>
> … it does definitely knock your confidence a bit.. a lot of our out-of-hours would be psychiatry … and dealing with patients you don't know … So, I think since this happened I do take a lot more time with these types of patients because you just can't be sure (GP12).

I usually give the same, not sermon but the same discussion with everybody whenever we’re starting them on antidepressants, so when we’re looking at a mental health problem I’ll always say, ‘*This only works if we’re both engaged with it***.’** So we’re here to prescribe, to refer, to monitor the mood, to respond to the changes, but the person has the responsibility to firstly be compliant with medication if it’s started and also to have at hand sources of help**.** So again, one of the things I would always do, especially if someone is high risk, I would always say, ‘*This is when your next review is. If there are problems in the meantime I can be contacted and then there's these other organisations such as Lifeline, Samaritans …*’ (GP2).

Summary and Recommendations

Introduction

Suicide rates in Northern Ireland have increased over the past decade, shattering families and engendering a sense of bewilderment and anxiety in many communities. The explanations behind the suicide act and the increased rates are multifactorial and mutable. Nevertheless, while it is difficult to imagine the eradication of suicide, there are opportunities, at both population and individual level, to reduce the rates of suicide. Evidence from studies, including ours, show the majority of people who take their own lives have been in contact with primary care and other health and social service agencies in the months prior to their death. Our overall aim was to examine these contacts and other aspects of help-seeking in the context of suicide in Northern Ireland. In doing so, we provide information that we hope to will contribute to a revision of policy and practice in suicide prevention.

However, within this, the issue of suicide in urban and rural areas was of particular interest. It has been argued, in Northern Ireland and elsewhere, that geography may play a role in the distribution of suicides, partly determined by cultural issues but perhaps also related to inequalities in service provision and access. By combining data from the coroner's office with data held on each person within general practice records, we were able to provide a detailed and definitive account of the individuals' contacts with primary care and other services. We were also able to examine the suicide rates by different urban and rural locales and to analyse any potential associations between rurality and service contacts.

In addition, by undertaking in-depth interviews with a wide range of family members who had been bereaved by suicide, we have examined the complexities of seeking help and the challenges of engaging with services. These interviews enriched our understanding of such services and the barriers to managing and caring for depressed and suicidal people. Moreover, we obtained from close family members, detailed accounts of their experiences following suicide; the social and psychological impacts of suicide in the family and how they coped with this distressing event.

The final intersecting aspect of this research programme was the general practitioners' views and experiences of suicide and its impact within the primary care context. When combined, these various strands of the study provide a strong body of evidence upon which to draw conclusions about the pathways to suicide in Northern Ireland and upon which to develop a set of recommendations for suicide prevention and postvention.

Rurality and suicide

Although evidence suggests that rural suicide rates in Western countries are increasing (Hirsch, 2006) and may, in some countries have overtaken those of urban areas (Beeson, 2000, Crombie, 1991), our findings do not support this for NI where rates remain higher in more urban areas. However, it should be noted that our analysis of urban-rural locale was based on a four-fold classification, allowing a more nuanced urban-rural gradient to become apparent. Unexpectedly, the highest suicide rates were found among middle-aged people (aged 40-64 years) in towns. Explanations for this excess are currently lacking. We have no evidence that socio-economic problems are worse in towns relative to other locales or that service provision is poorer (Northern Ireland Statistical Agency (NISRA), 2010). It may be that towns have a relatively underdeveloped mental health provision, specifically, within the voluntary and private sectors. Our data did not suggest a differential prevalence of mental illness across locales and in this cohort only slight differences were noted for GP-recorded diagnosis. Again unexpectedly, we found a signifcantly higher level of primary care contact among people living in towns; particularly so among women, which suggests, perhaps, a higher level of need and a lack of alternative psychological support or provision.

Contact with services

Consistent with other studies, we found the majority of people who died by suicide were in contact with primary care within twelve months prior to death. The likelihood of contact was increased among women, older people and those with mental health problems, especially patients identified as having substance misuse problems (NCISH, 2014). This study offers an enriched understanding about GP contact in that we were able to distinguish mental health consultations and their frequency in the final twelve-month period (for some this amounted to more than twice a month). Additionally, levels of recorded mental health diagnoses were similar to that described elsewhere (NCISH, 2014). Perhaps worryingly, only 2% of patients appeared to be in receipt of counselling services. However, it is possible that some people sought such services outside the NHS, independently from their GP. Certainly, we know from our GP interviews that patients sometimes consult private professionals. The findings certainly suggest that risk remains poorly recognised in the primary care setting and that too many people remain vulnerable to suicide despite seeking help in relation to mental health problems.

A minority of people who take their own lives appear not to make contact with medical professionals of any type and apparently complete the suicide at the first attempt (Mallon *et* *al.*, 2014). These suicides, are often impulsive and may be the least amenable to intervention. However, for the majority of patients, every contact with professional health services represents a potential opportunity for recognising suicidality. Our findings suggest that contact with services among the majority of suicides may be considerable and, consonant with other research, we suggest that frequent attendance can be a marker for risk, as can receiving different kinds of medication for mental health problems (NCISH, 2014). Families may play a large part in seeking help and engaging services. Our own in-depth interviews illustrate the barriers in contacting services and their role in trying to deal with these. Even then, such barriers are compounded by the patient's diagnosis, their willingness to engage with available treatments, and family dynamics and attitudes towards mental illness, as well as many other factors.

Neverthless, suicide remains a rare event and screening for suicide among high-risk patients may not be a cost-effective suicide prevention strategy (Mann, 2005, O'Connor *et al.*, 2013). The restriction of access to lethal methods and training primary care physicians to evaluate suicide risk have had some impact on suicide rates but the evidence base for suicide prevention programmes, generally, remains poor (Pitman and Osborn, 2011). Pitman and Osborn (2011) argue that because suicidality is a behaviour with diverse underlying aetiologies, not a discrete diagnosis, no single intervention will be appropriate or effective for a plurality of people and contexts. In the following sections, we reflect on this position by summarising some of our key findings in relation to service access and engagement across our two-year cohort of deaths by suicide.

General practice and mental health services

Families, while not universally reproachful of health services, raise important concerns about the recognition and management of suicidal risk in patients. The most fundamental of these were: (a) the failure of clinicians to fully engage with the patient; (b) to misattribute or fail to notice critical signs; (c) to exclude families in the decision-making process with regard to treatment and care; (d) to place responsibility of care on unprepared and ill-informed families. Intrinsic to these concerns, was the perceived lack of time given to patients and their families. On occasion, this led GPs to minimise or ignore potentially significant behaviour changes, and to fail to pursue potentially important follow up appointments.

The brevity of the GP consultation itself may be a critical barrier to recognition and treatment of mental illness. For example, bearing in mind that the stigma of mental illness in many cases had consistently delayed any contact with services, families were therefore particularly distressed when, despite all their exertions to achieve help, GP's appeared to accept the patient's misleading presentation of the problem. In such cases, suicides sometimes occurred shortly after contact or in the midst of being treated for other chronic, physical health conditions.

Many families struggle with the care of individuals with a mental illness (Baronet, 1999, Leavey *et al.*, 2004), particularly when there were concerns that the person may harm themselves. The struggle to care and to cope, was worsened by families' lack of confidence in services and poor communication about the illness by health professionals – for example what to look out for, what to do, who to call (Leavey *et al.*, 1997). Care cannot be truly considered as 'coordinated' when families are not consulted or adequately prepared to cope with a family member who is at risk of suicide; the absence of communication should not be disguised as patient confidentiality. Family participants were remarkably understanding about the need to maintain confidentiality and their distress was largely directed towards their exclusion about the decision-making process, a process which was frequently perceived to lack 'expert' input from people who really understood the patient and his or her context.

General practitioners provided an alternative but sometimes, complimentary perspective, to that of the family participants. Theirs was a complicated and uncertain position in which the overarching narrative insists that suicide prevention in primary care is, generally speaking, unpredictable and unknowable. This position is linked to their belief that the factors associated with suicide are ubiquitous and the event itself, so rare, that the assessment of risk is imprecise. Moreover, even when individuals are diagnosed with a mental disorder, are considered at risk and treated appropriately, their expected pathway to recovery can still be abruptly interrupted by suicide.

Although, GPs assert the complexity of risk-assessment, there is an acknowledgement too, that some suicides may have been preventable. Commonly, these 'failures' are regarded as either a lack of personal competency or a systemic failure, generated by poor liaison and decision-making. With regard to the former, we found widespread acknowledgement that GPs are ill prepared and lamentably unequipped in their management of mental illness, compounded by the pressure of patient waiting rooms and waiting lists. Manifested in the 'ten-minute' rule for consultation, a high level of demand ensures that people with complex psycho-social needs are afforded a relatively superficial articulation of their problems. Additionally, obliged as they are, to ask 'pro-forma' questions about an individual's suicidal ideas and behaviours, GPs suggest that such formulaic approaches act as a barrier to patient trust and engagement. Moreover, as the findings from our family participants' interviews demonstrate, the pressure of time and low confidence in mental health care, appear to push GPs into an overreliance on pharmacological treatment, leaving little or no room for patient preference.

Access to psychological treatments, for many individuals, was considered to be lacking even when the patients complained about the ineffectiveness of their antidepressant medication and/or ceased taking it. While, some GPs presented the notion of patient-GP partnership, a psychological contract with obligations and responsibilities on both sides, the dominant approach, albeit for pragmatic reasons, appears to be, ‘take it or leave it’. This is contrary to current demands for patient-centred care and patient self-management (Kelly *et al.*, 2014, Mueser *et al.*, 2013), and is hugely wasteful in economic terms as well as human suffering. As noted in the participant interviews, many of those who died by suicide were unhappy with the medication and simply stopped using it. From this, it might be argued that a proportion of suicidal people were not provided with appropriate treatment prior to their deaths. This should be deeply worrying to the health care community and to government.

GP concerns about systemic failures, relate predominantly to communication failures between primary care and psychiatry. It is important to stress that these failures or lapses of communication are not universal, nor are they insurmountable. In various instances, we found that problems encountered by GPs in referral to psychiatry were historical and are now rectified. Although we avoid naming particular areas and services, we briefly comment on service characteristics that provoked the most concern, and these tend to fall into the split between the traditional approach, that is, a sectorised model and a more recent, functional split model (Laugharne and Pant, 2012). In the former, a single consultant provides both hospital and community care within a designated geographical catchment area. In the functional split model, various other specialist teams are established such as recovery, crisis resolution and home treatment teams. Where this model has been adopted, consultant psychiatrists are no longer responsible for patients across the range of treatment settings. For many GPs this lack of a central contact is a challenge to GP care of people with mental illness, on a range of levels and issues.

Sectorisation was commonly regarded by GPs as permitting the development of ‘social capital’ among health professionals; the added value of useful, interdisciplinary perspectives and professional relationships, out of which, GPs might more easily seek advice from a consultant psychiatrist and the latter might seek deeper understanding of the patient’s social and personal context. With the introduction of the functional split model, these relationships disappeared, replaced by a virtually anonymous, and sometimes impenetrable, interface. GPs complained of desperately attempting on many occasions to convince the psychiatric gatekeepers of the need for an emergency referral[15]. In other instances, some patients were described as being at increased risk because of transitional boundaries. For example, young people who having been seen in Child and Adolescent Mental Health Services (CAMHS) but were not transferred into adult care. When connections and relationships dissolved in these structures, so too did the continuity of care and some GPs felt that some people might still be alive today had these barriers to communication and referral not existed.

Stigma, mental health services and masculinity

Based on our interviews with family members, we know that many people who experience some form of mental disorder, and are evidently suicidal, are unwilling to acknowledge their illness and/or seek professional help. The stigma of mental illness is a major barrier to the access of appropriate help. However, while the issue of stigma associated with mental illness has been well publicised, nationally and regionally(Corrigan, 2000), there is little evidence to suggest the effectiveness of public awareness campaigns in challenging stereotyped views and reducing discrimination. Likewise, there is little evidence that people who develop mental health problems are now more comfortable about revealing their illness or any less inclined to make destructive moral self-assessments. As highlighted by our findings, the stigma of mental illness appears to be as potent as ever. The concern about being recognised by one's community as having a mental illness is often entwined with life and business in small towns and rural communities. In the family narratives, the participants described a sense of dread, of "being trapped" – the loss of credibility, business and social, should "people find out about being mentally ill". However, in some instances, it is difficult to disentangle the concern about being recognised as having a mental illness from the low regard in which psychiatric services and particular institutions are held. Again, it is not clear as to the reality of service provision in particular areas, but the perception among the people who died by suicide and their families was, at best, that anyone admitted into psychiatric care would be very badly treated.

Rusch et al (Rusch *et al.*, 2014) have recently argued that the relationship between suicide and stigma is acknowledged for other stigmatised groups, ethnic or sexual minorities for example, but has relatively little attention for people with mental illness. There are different dimensions of stigma. It has been well argued that stigma is simply another form of discrimination, differential and negative treatment applied to people with a specific characteristic (Sayce, 2000, Social Exclusion Unit, 2004). Sometimes described, as *public stigma* it comprises reactions of the general public towards a group based on stigma about

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[15] The issue of alcohol use by patients was mentioned as a barrier to emergency referral. Again, given the association between alcohol use and suicidal behaviour, the rejection of such people by emergency services seems to be contrary to suicide prevention.

that group. At another level, *self-stigma* refers to the reactions of individuals who belong to a stigmatised group and who internalise the associated negative or stigmatizing attitudes and attributes (Dinos *et al.*, 2004, Link *et al.*, 1999). In this latter dimension, stigma is strongly associated with shame. However, while both dimensions, undoubtedly, combine to deter help-seeking, there is also a determination by stigmatized individuals to defend something deeply valued. For example, we noted above, the defence of business or social reputation seemed paramount to some individuals. However, more centrally, masculine identity dominated many of the family members' narratives and their explanations for the respective suicide and the rejection of help. The inability of many men to 'open up' about their feelings, to discuss the source of their distress to either families or health professionals was regarded as key to understanding suicide.

Alcohol, help-seeking and services

Alcohol plays a significant role in suicide and suicidal behaviour in multiple and intricate ways (National Institute for Health and Clinical Excellence (NICE), 2009). Suicide completers have high levels of blood alcohol, and intoxicated people are more likely to attempt suicide using more lethal methods. Individuals with alcohol dependence have a 60–120 times greater suicide risk than the non-psychiatrically-ill population (Galway *et al.*, 2016). As age increases, correspondingly, mood disorder increasingly predicts suicide among problem drinkers. Middle-age and older men with alcohol dependence and mood disorders are at particularly high risk (Galway *et al.*, 2016). Impulsivity and aggression are associated with alcohol misuse and also strongly implicated in suicidal behaviour and within different psychiatric conditions such as personality disorders (Owens *et al.*, 2005).

The causal relationship between social factors, life events, alcohol use and mood disorders tends to be problematic. Importantly, epidemiological studies of the relationship between alcohol use and suicide in different national contexts indicate a significant influence of multiple sociocultural and environmental factors. For example, it is not easy to determine if heavy alcohol use leads to social isolation or whether the isolation leads to increasing alcohol dependency. In the context of Northern Ireland, these, more universal factors, are overlaid with localized issues from which, we can only assume that the conflict has influenced masculine (and, correspondingly feminine) identity and behaviour. Thus, forty years of political and sectarian inspired violence is likely to have shaped communal and personal attitudes, beliefs and values about how males, and to a certain extent females, ought to behave and how they should cope with adversity. If negativity, aggression and impulsivity are features of political discourse and action in NI, it is worth asking; to what extent such responses are reified or reflected at a broader cultural and community levels.

Again, the family interviews reveal what are strongly characterised as maladaptive, and deeply intractable, male responses to emotional and psychological problems in which alcohol appears to both mask and exacerbate long-standing problems. Substantial lifetime use of alcohol and/or recent and problematic increase in alcohol consumption was regarded as critical in the understanding of individual suicide cases and the inability to get appropriate and timely help. Certainly, the views of general practitioners underscore a belief that some people, who later complete suicide, put themselves beyond help, through alcohol-fuelled, impulsive behaviour outside the service context, and commonly in immediate response to some setback or other.

However, the response of a range of health services to people with addiction problems and/or those who were brought into A&E having harmed themselves, sometimes accompanied by alcohol use, is worrying. We acknowledge that staff in emergency services are increasingly under-resourced and under pressure; they may be protective of this resource and in doing so, need to prioritise or triage patients according to need. At another, more morally influenced level, staff may designate cases as either deserving or undeserving. Historically, people who harm themselves in apparent suicide attempts, with or without alcohol consumption have been regarded as a nuisance, as “time wasters” and this appears to be an enduring attitude. Our findings chime with other evidence about the response of services to people experiencing a mental health crisis (CQC, 2015). If, as research suggests, that alcohol use is a maladaptive form of coping and is associated with mental illness and suicidal behaviour, our findings should provoke profound concern about the attitudes, behaviour and training needs of health professionals. This maybe particularly important given our findings that such people may eventually switch to more violent methods. We therefore suggest that suicide prevention initiatives should pay attention to how young people especially are managed by emergency services.

The needs of families after suicide

In the immediate aftermath of a death by suicide, families may experience a range of feelings, from emotional numbness to anger and grief. When making funeral, legal and financial arrangements they may also feel confused, isolated and lost. For many family members this period presents a considerable challenge. While, the coroner’s office and the police service were commended for the generally sensitive manner in which they dealt with proceedings after the suicide[16], for many people there is an absence of advice and guidance about practical matters.

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[16] The delay in returning personal effects was the single problematic issue that caused distress to some families.

We have detailed the social and psychological consequences of suicide within families. The evidence suggests that families of people who take their own lives are exceptionally vulnerable to stress, mental health disorders and suicide. For example, Crosby and Sacks (2002) reported that people who had known someone who died by suicide within the past year were three times more likely to have suicidal plans, and almost four times more likely to have made a suicide attempt than those who did not. Our findings provide a detailed but disturbing account of the varied responses to these deaths and the family and social dynamics post-suicide. For some, there is a struggle to comprehend the reasons behind the suicide, when no reasons are obvious and no one is able to offer an explanation. For others, there had been a draining struggle to seek help, to provide support and to be hyper vigilant, this contributed greatly to feelings of isolation and guilt at having 'failed'; and/or anger and distress that services had failed.

Despite the burden borne by these families following the suicide, many were uncertain of their own mental health needs and from whom they might seek help. Many experienced problems holding the family unit together. Mothers particularly, reported needing help to explain the suicide to their children, and care for their emotional needs, sometimes at the cost of processing their own grief in an appropriate manner. There is also the heightened anxiety of further suicides in the family which places further stress on parents and children alike.

Suicide may also provoke painful and destructive recrimination among family members as they respectively attempt to attribute or deflect blame. Again, these, often protracted, disputes are likely to lead to psychological and emotional problems. We were unable to detect any coherent, standardized service provision to support whole families in the aftermath of suicide. Counselling and advice services are based on individual need and local availability and this tends to be patchy and inconsistent. Participants who lived in towns and rural areas frequently expressed the view that there was an unequal distribution of services within Belfast. It was felt in particular, that those living in the city benefited from a more developed statutory and voluntary sector. Moreover, although some voluntary sector organisations were considered helpful, many other participants, GPs and family members alike, found the provision within the voluntary sector bewildering and/or undesirable; some were concerned about the development of 'victim's clubs'. Certainly, we noted some confusion about the specific aims and activities of voluntary sector organisations.

Recommendations

Recommendations emerging from the research can be grouped under five broad areas and we suggest that they should be considered as integral to a review of the suicide prevention strategy of Northern Ireland.

The five broad strands of service provision are:

6. **Public Health: tackling stigma**
7. **Primary Care: improving competencies in mental health and suicide prevention**
8. **The Voluntary Sector: integration and regulation**
9. **Mental Health Services: primary care liaison**
10. **Hidden suicide support needs: families first**

Public Health: tackling stigma

Stigma associated with mental illness must be regarded as a major barrier to suicide prevention. Combined with inflexible attitudes towards masculine identity and maladaptive ways of coping, stigma results in many people failing to seek appropriate treatment when they are experiencing emotional distress. We need to change these culturally entrenched attitudes to mental illness as early in the lifespan as possible, ideally in schools.

Tackling the stigma of mental illness and providing educational programmes on mental health literacy, defined as “ knowledge and beliefs about mental disorders which aid their recognition, management or prevention”(Jorm *et al.*, 1997) should be adopted by schools within the Personal, Social, Health & Economic (PSHE) within schools.

Stigmatising attitudes and behaviour towards people with mental illness, those who attempt suicide and those with alcohol problems are sometimes casually propagated within our health and social care services, and may have devastating consequences for the recipients and their families. Training should be considered for all staff such as paramedics and those working in A&E.

With limited evidence of the effectiveness of large-scale public health advertising campaigns to reduce stigma, it is prudent to reserve judgment on the cost-effectiveness of investment in this specific area. However, there is a need to challenge the highly negative and commonly held beliefs about psychiatric services. The Royal College of Psychiatry in Northern Ireland and the Health & Social Care Trusts should be engaged in an understanding of, and resolution to this problem.

Primary Care: improving competencies in mental health and suicide prevention

Our research suggests there is a need for investment in the primary care provision of mental health expertise, care and support. First, many GPs lack confidence in responding to the emotional and mental health problems; a problem exacerbated by limited exposure to mental health training and psychiatric professional support. In addition, the current pressure on primary care services leaves insufficient time and space to deal with such patients appropriately and sensitively. Treatment with anti-depressant medication for many patients seems haphazard and futile.

We propose a strengthening of mental health resources within Primary Care. We understand that the RCGP in England is currently exploring new ways of working with other statutory and voluntary sector bodies such as the Royal College of Paediatrics and Child Health, the Royal College of Psychiatrists, and Young Minds. This may allow GPs and other specialists to train together and to work more effectively, particularly when caring for young people with mental health problems.

Primary care might benefit from the presence of mental health professionals – community psychiatric nurses and social workers, working within general practice. Extended community liaison roles (with voluntary sector providers) for trained counsellors working directly alongside GPs. The additional knowledge and experience offered by these roles may assist in achieving a better understanding of patient treatment preferences and a stronger therapeutic engagement.

The Voluntary Sector: integration and regulation

Among families and GPs alike, there is a notable lack of clarity about the role, function and effectiveness of community and voluntary sector organisations.

GPs currently have little knowledge of the quality and outcomes of therapy provided by the voluntary sector. Thus, at this key level of care provision, there is little transparency and no mechanism for feedback. In order for this to improve, both primary care and the voluntary sector need to recognise the need to reach out to each other for mutual gain.

While the under-resourcing of mental health provision in primary care is a significant problem and can only be addressed at the macro-political level, there is much room for better-integrated care. It seems likely that the voluntary sector will increasingly assume the provision of psychological therapies. There is a need, therefore, for clear monitoring of patient outcomes and consistent reporting and feedback into primary care.

Improved outcomes-based reporting, from the variety of counselling and support services provided within the voluntary sector, would help to build the required level of trust and respect GPs need to refer individuals for support. This would also assist commissioners in allocating funding appropriately.

It may also be important to maintain the option of separate services at an individual level, for patients who prefer not to directly involve their GP in their psychological care. However, the development of strong professional liaison between voluntary sector-run psychological services and primary care should be explored. It is possible that with the permission of voluntary sector clients, the GP should be notified and kept appraised of an individual's mental health problems, progress and outcomes.

Mental Health Services: primary care liaison

The reported disjunction between primary care and mental health services requires attention. Effective, knowledgeable and most importantly, reachable key liaison contacts for GPs within mental health services are urgently required. In areas where the functional split model of mental health service provision exists, difficulties in GP-psychiatry relationships are likely to persist.

Again, improved integrated care will depend on building closer personal relationships between mental health professionals and general practitioners. There is a need for some degree of standardisation across NI Health and Social Care Trusts on the most efficient way to deliver integrated services, particularly in areas of contentious responsibility e.g. age determined mental health services.

Hidden suicide support needs: families first

Information sharing and decision-making

The maintenance of patient confidentiality is an important principal of care but so too is family involvement in decision-making. Families provide the greatest proportion of care and carry the greatest burden. Therefore, the relationship between services and family caregivers requires much more respect and consideration.

It is time therefore, to rethink how services can better engage with the 'insider' knowledge of families and usefully assimilate the views of families into the decision-making process. The suicide prevention strategy in England emphasises the need to improve information and support to families concerned about a relative who may be at risk of suicide. There is an acknowledgement also, that clinicians may too readily invoke the duty of confidentiality without consideration of the concerns and needs of family members. However, a recent consensus statement from the Department of Health and relevant partner organisations indicated that there are times when "practitioners may need to consider informing family and friends about aspects of risk and may need to create a channel of communication for both giving and receiving information that will keep the person safe" (Department of Health, 2014). The statement suggests that, "*If a person is deemed to be at imminent risk of suicide there may well be sufficient doubts about their mental capacity at that time*". Further, "*if the purpose of disclosure is to prevent a person who lacks capacity from serious harm, there is an expectation that practitioners will disclose relevant confidential information, if it is considered to be in the person's best interest to do so*". The impact that suicide may have on other people should be taken into account. Ultimately, while determining the immediacy of suicide risk and the timing and level of disclosure is a matter of professional judgement in each individual case, practitioners are nevertheless free to offer non-person specific information on crisis and other services.

Dealing with the impact of suicide on families

Familes in the aftermath of suicide endure multiple, interwoven difficulties with an increased risk of family break-down, mental health problems (including suicide) and financial crises. However, there seems to be no coherent strategy for looking after the needs of family survivors. This is not an easy task, not least because it is difficult for professionals to determine who has been impacted by suicide, exactly; in many cases this may be people other than the immediate family. Furthermore, while some people bereaved by suicide resolutely resist professional support and advice, others simply lack an understanding about what to expect, who to turn to, or have an awareness of useful coping strategies. This is especially striking in families with young children.

While each suicide and every family's circurmstances are unique, there are many shared aspects of sucide within the family, and these should be acknowledged and made available through information and educational material. Research is needed on the scope, content and dissemination of such materials.

The Coroner's Office was universally regarded as respectful and sensitive in dealing with the concerns and needs of families. Additional advisory and signposting resources located with personnel in the coroner’s office, could be made available to families at this earliest point of connection. Such additional investment in the services provided by Coroners Liaison Officers could improve awareness of the support landscape for many families.

Dealing with the impact of suicide on service professionals

Hidden suicide support needs also apply to service providers dealing with suicide. Patient suicide is distressing for GPs and appears to exact a heavy toll on their personal wellbeing and professional confidence. The Royal College of General Practitioners (RCGP) should consider mechanisms for better psychological and professional support for doctors who have experienced a suicide in practice.

Senior managers need to be mindful of the pressures that can complicate the aftermath of a suicide within teams of mental health professionals, such as the process of a Serious Incident Report investigation. Importantly, staff who are well supported through an efficient process are in a better position to engage with such processes and to meaningfully suport service user and family involvement.

Limitations

In our proposal we outlined several work strands, one of which was an examination of the differing coping strategies and use of services by families bereaved by suicide. This was intended as a quantitative survey of needs using standardised measures. Despite our best efforts and keeping within the protocol agreed by the Office of Research Ethics Northern Ireland (ORECNI), we were unable to recruit a sufficiently large sample to address our hypothesis. To compensate, we sought in-depth interviews from all those individuals who took part in the survey, giving us substantially more breadth than is usually found in qualitative studies. Thus, we were able to obtain a much broader span of participants, in terms of age, gender and relationship to the deceased and, of course, the characteristics and experiences of the latter. The findings obtained from these data will permit a more sophisticated or nuanced analysis of suicide and its impact on families, specifically because we will be able to more narrowly focus on questions related to particular characteristics and circumstances.

Nevertheless, however large the participant sample, we can make no claims for representativeness. The people who agreed to offer their views and experiences may differ significantly in various ways to those whom we were unable to contact or who refused to participate. Their reluctance may betoken greater distress or stigma, or an inability to talk about the suicide. In all research methods, qualitative or quantitative, validity is a concern. Are we able to capture that most awkward and elusive of properties – truthfulness? This may be particularly true of subject areas that are difficult, painful and perhaps, stigmatised in some way. People, as we recorded in great detail, often reveal a great deal of hurt, shame and guilt about the death of a family member or good friend. However, while there are certain things that may be concealed or forgotten by participants, the narratives of our participants seldom appear censored. As might be imagined, the events surrounding suicide are remembered vividly. More cautiously, we suggest that in the aftermath of suicide, families generally seek an explanation and in some cases, these may be only partially revealed due to family estrangement or the suddenness of death.

As noted previously, rural environments vary considerably ensuring that international comparisons are problematic; the population, socio-economic issues, geography and culture within Northern Ireland may differ considerably from other settings. While the more detailed classification used here can help tease out differences in NI, it may make comparisons with other studies more difficult. In any case, we are unable to address the 'life-history' transition of people from one locale to another. A limitation of studies such as this is that we lack an appropriate comparison group. Although we cannot say whether this population differed substantially in their contact with services than the general population, they appear to have visited their GP much more often (Galway *et al.*, 2007). Although we were unable to obtain GP records for 9.5% of the suicides, these are unlikely to have significantly affected the overall findings. Lastly, while our study benefits from the additional more finely grained data from GP records, rather than those from coroner's records only, missing data on contact with other services for which the GP is not a gatekeeper, remains a possibility.

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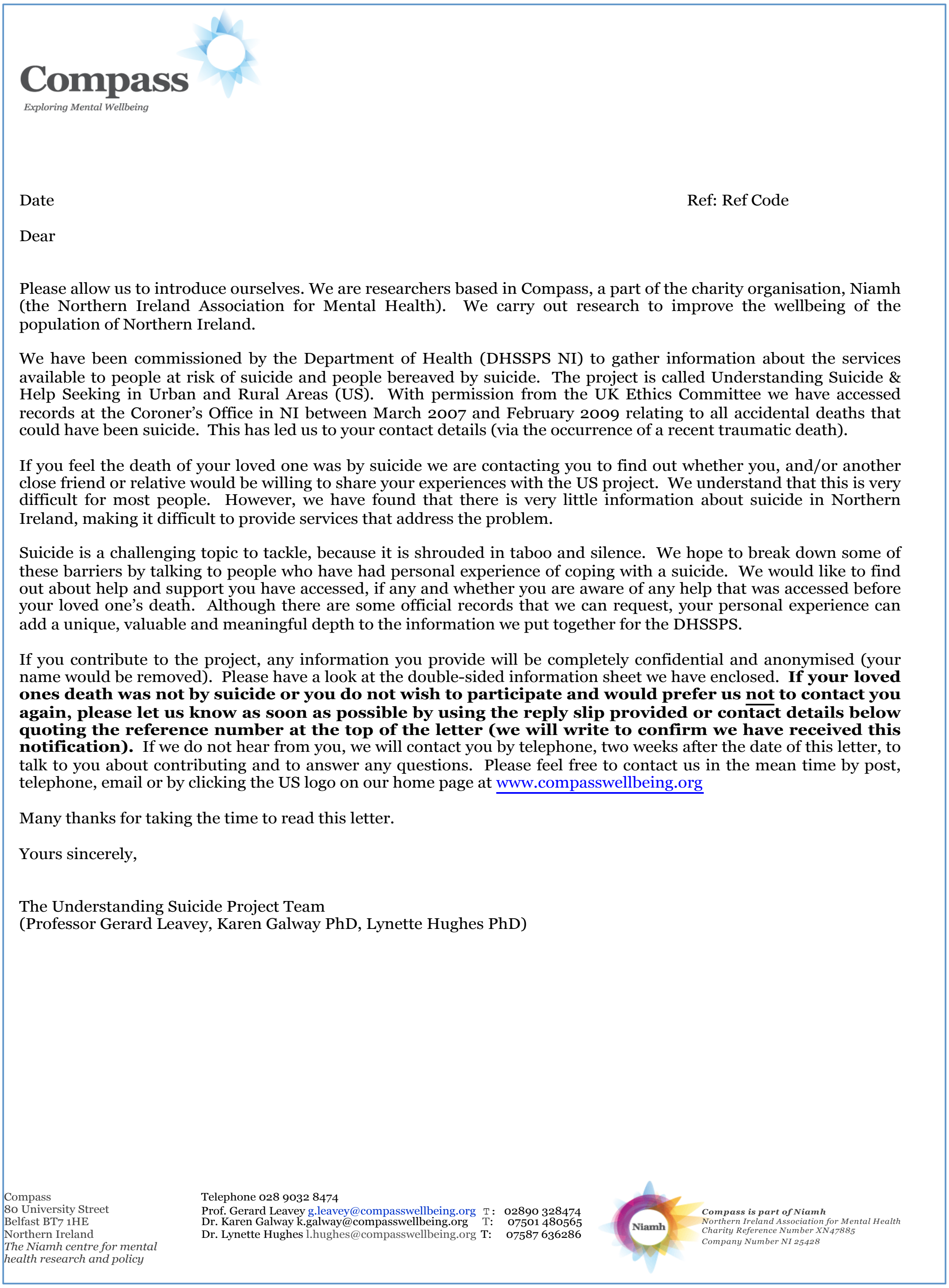
Appendices

Appendix 1. Invitation letter



Compass
Exploring Mental Wellbeing

Date Ref: Ref Code

Dear

Please allow us to introduce ourselves. We are researchers based in Compass, a part of the charity organisation, Niamh (the Northern Ireland Association for Mental Health). We carry out research to improve the wellbeing of the population of Northern Ireland.

We have been commissioned by the Department of Health (DHSSPS NI) to gather information about the services available to people at risk of suicide and people bereaved by suicide. The project is called Understanding Suicide & Help Seeking in Urban and Rural Areas (US). With permission from the UK Ethics Committee we have accessed records at the Coroner's Office in NI between March 2007 and February 2009 relating to all accidental deaths that could have been suicide. This has led us to your contact details (via the occurrence of a recent traumatic death).

If you feel the death of your loved one was by suicide we are contacting you to find out whether you, and/or another close friend or relative would be willing to share your experiences with the US project. We understand that this is very difficult for most people. However, we have found that there is very little information about suicide in Northern Ireland, making it difficult to provide services that address the problem.

Suicide is a challenging topic to tackle, because it is shrouded in taboo and silence. We hope to break down some of these barriers by talking to people who have had personal experience of coping with a suicide. We would like to find out about help and support you have accessed, if any and whether you are aware of any help that was accessed before your loved one's death. Although there are some official records that we can request, your personal experience can add a unique, valuable and meaningful depth to the information we put together for the DHSSPS.

If you contribute to the project, any information you provide will be completely confidential and anonymised (your name would be removed). Please have a look at the double-sided information sheet we have enclosed. **If your loved ones death was not by suicide or you do not wish to participate and would prefer us not to contact you again, please let us know as soon as possible by using the reply slip provided or contact details below quoting the reference number at the top of the letter (we will write to confirm we have received this notification).** If we do not hear from you, we will contact you by telephone, two weeks after the date of this letter, to talk to you about contributing and to answer any questions. Please feel free to contact us in the mean time by post, telephone, email or by clicking the US logo on our home page at www.compasswellbeing.org

Many thanks for taking the time to read this letter.

Yours sincerely,

The Understanding Suicide Project Team
(Professor Gerard Leavey, Karen Galway PhD, Lynette Hughes PhD)

Compass
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Niamh
Compass is part of Niamh
Northern Ireland Association for Mental Health
Charity Reference Number XN47885
Company Number NI 25428

Appendix 2. Information sheet

Understanding Suicide

Participant Information Sheet for family and friends

1. Study Title
Understanding Suicide Help Seeking in Urban and Rural Areas (US)

2. Invitation
You are being asked to take part in a project about suicide help seeking in urban and rural areas in Northern Ireland (NI). Before you decide whether or not to take part, it is important that you understand what the project is about and what you will be asked to do. Please read the following information and ask questions about anything you do not understand, before you decide what to do. Thank you for taking the time to think about this.

3. What is the study for?
The aims of the study are to answer the following questions:
(1) Are there any differences in help-seeking behaviour for suicidal people and those affected by suicide between urban and rural areas? (2) Do people in urban and rural areas employ different coping strategies and support systems? (3) Are there any differences in access to support services for those bereaved by suicide in urban and rural areas? (4) How might primary care and other services be best configured to accommodate the suicide related needs of people in urban and rural areas?

4. Why have I been chosen?
To answer the research questions, we need to gather the views of people who have experienced a suicide. We have accessed the Coroner's records of accidental deaths in NI between March 2007 and February 2009. Through these records, we have identified you as a close 'significant other' in the life of a person who has died by accidental death which may have been through suicide. That is why we have chosen to contact you about the Understanding Suicide project.

5. Do I have to take part?
It is up to you to decide whether you want to be involved in this project. If you do decide to take part, you will be given this information sheet to keep and you will also be asked to sign a form. However, even if you do agree to take part, you can change your mind at any time and leave the study without giving a reason.

6. What will happen to me if I do take part?
You will be invited to meet an experienced, trained researcher who will ask you questions from a number of questionnaires and fill in your answers on a computer. We are interested in any details that will help us learn about providing the right support to prevent suicide and help people cope with a suicide when it occurs. This will take about 25 minutes.

We would also like to talk to about 40 people in more detail about their experience of suicide. We would like to digitally record our conversation to help us listen to what was said later as it would be difficult for the researcher to remember everything. No one, apart from the researchers, will be able to listen to this recording. After the information in the recording has been typed into a document, it will be destroyed. This will take about 45 minutes.

7. What do I have to do?
Simply agree to meet a researcher and answer some questions. We will ask everyone who agrees to complete a set of questions, with the researcher there to ask and to enter your responses on a computer. You can chose whether you would like to also discuss your experience in more detail. We are able to meet you in your own home, at a neutral location, or at our premises. We are happy to discuss this and make suitable arrangements, including paying for any travel expenses you may incur.

8. Risks/disadvantages
You will not be at any risk if you take part in this project. However, we understand that this may be a difficult topic to think about and discuss. We want you to feel that you are in control of the process. You

can refuse to answer any questions that you do not wish to answer and you can end the meeting at any time, without giving a reason.

9. Are there any possible benefits in taking part?

Research has found that sharing experiences of suicide can have a healing effect for some people. The main benefit of taking part is that you can share your experience for the benefit of others.

10. What happens when the study ends?

The research team will use statistical methods to analyse all the combined answers given in the questionnaires. The research team will also listen to the tapes of the conversations and type out what has been said, then read the typed notes carefully to find out the main themes discussed, which will then be written up as the findings of the study. We hope to send you a copy of these findings. You can read them and make comments if you wish.

11. What if something goes wrong?

It is very unlikely that anything will go wrong, as there is very little risk associated with the project. However, Compass and Niamh do have ways of dealing with things if they do go wrong. Any complaints will be taken seriously and should be made directly to the Chief Investigator, Professor Gerard Leavey (contact details below) who will advise you further. We will also provide contact details for local support services in your area.

12. Will taking part in the study be kept confidential?

Any information will be held securely and in confidence, in a locked filing cabinet or on a password protected computer. Only the researchers will know who you are and have access to the information held.
The only exception to this rule is that if the researcher thinks that something you say might somehow lead to harm to you or someone else, then by law they have to tell others about this. You will not be identified in any report that will be published as a result of this study.

13. What will happen to the results of the study?

We will write a report for the Research and Development Office for NI (DHSSPS NI). The results will be based on a summary of our findings and will not include any information that could identify individuals. We will share the results of the project with other professionals working the area of suicide prevention and support. We will also publish the findings in peer-reviewed academic journals, in order to reach a wide audience and make the best possible use of the information you provide.

14. Who is organising and funding the research?

The research is being organised by Compass, which is the centre for research and policy within Niamh (NI Association for Mental Health). The Research and Development Office for NI have funded the research.

15. Who has reviewed this study?

The study has been reviewed by other researchers who have expertise in this area, to help the Research and Development Office for NI decide which research to fund. US has been also been reviewed and approved by the National Research Ethics Service (NRES) and is supported by the Royal College of General Practitioners NI.

16. Please contact us for further information

Name	**Address**	**Tel/Email**
Professor Gerard Leavey Chief Investigator US Project	Compass, Niamh 80 University Street Belfast BT7 1HE	Tel: 0280 328474 g.leavey@compasswellbeing.org
Karen Galway PhD Senior Research Officer		Tel: 07501 480565 k.galway@compasswellbeing.org
Lynette Hughes PhD Senior Research Associate		Tel: 07587 636286 l.hughes@compasswellbeing.org

Please enter your unique Reference Code (as per letter) below:

Ref. Code: ________

Please tick one of the three boxes below to indicate whether or not you are willing to take part in the research project.

☐ I am willing to take part in the study

Please tick three suitable days (morning, afternoon or evening). Please give a telephone number at which we can contact you if possible

	Mon	Tues	Wed	Thurs	Fri	Sat
Morning						
Afternoon						
Evening						

☐ I am not willing to take part in this research study and request no further contact to be made

☐ I am unsure and would like further information prior to making a decision*

*Please provide a contact number for the research team to contact you

Telephone:______________________

Signature: ______________________ Date: ________________

Please send your responses using the self-addressed envelope provided to the research team as soon as possible.

Appendix 3. Summary leaflet

Understanding Suicide

Understanding Suicide is a project run by Compass, the research and policy centre in Niamh (Northern Ireland Association for Mental Health)

The aim of Understanding Suicide is to make sure the right help is available for people who experience suicidal thoughts and people who are bereaved through suicide

Have you lost someone to suicide?

Would you be willing to share your story to improve help and support for others?

- **Everyone's story is unique**
- **All stories will help us learn more about providing help and support**
- **You can help others by sharing your experience**
- **Please consider donating your story**

We would like to invite you, a family member or a close friend to:

Talk to US

If you have lost someone through suicide between March 2007 and February 2009, please get in touch via our contact details below.

We will respect your privacy and wishes at all times. We will also ensure that you get the support you need, if appropriate.

Research Team; Professor Gerry Leavey, Karen Galway PhD and Sharon Mallon PhD
T: 02890 328474 or M: 07501 480565
E: k.galway@compasswellbeing.org E: s.mallon@compasswellbeing.org
W: www.compasswellbeing.org

Understanding Suicide & Help-seeking in Urban and Rural Areas

The Understanding Suicide Project has been funded by The Department of Health Social Services and Public Safety Northern Ireland (DHSSPS NI), through the Research & Development Office for NI.

Appendix 4. Validated Measures Used with Bereaved Family Members or Friends

Hospital Anxiety and Depression (HAD) scale

This is a self-screening questionnaire for depression and anxiety consisting of 14 questions, seven for anxiety and seven for depression. Although it was designed for hospital general medical outpatients, it has been extensively used and validated in primary care and other health related settings.

Coping Strategies

The COPE enjoys wide use among coping researchers. The state measure of the COPE is completed by respondents with respect to a specific stressor, designated either by the respondent or by the researcher (in this case the specified stressor bereavement by suicide). An additional advantage of the COPE is the fact that a reliable and validated brief form exists (Carver, 1997). In the "statelike" version, respondents rate the degree to which they use each coping strategy to deal with a particular stressful event. The measure has good psychometric properties and strong evidence of discriminant and convergent validity, with constructs such as hardiness, optimism, control, and self-esteem.

Religion and Spirituality

The Royal Free interview for religious and spiritual beliefs assesses the nature and strength of spiritual beliefs and practice (King et al., 2006). It has high reliability and concurrent validity. A spiritual scale consists of questions in visual analogue format about the beliefs held. High scores indicate strongly held beliefs that play a major part in a person's life. Strength of spiritual belief is considered independently.

Client Service Receipt Inventory (CSRI)

Services use was measured using the Client Service Receipt Inventory (CSRI) which is a questionnaire for collecting information about use of health and social care services, other economic impacts (such as time off work due to illness) and socio-demographic information. It has now been used in over 150 health and social care economic evaluations, each time being tailored to suit the data requirements and broad approach to data collection for individual studies. The variant used in this study was designed to collect retrospective data on service utilisation for the previous six months. It covered the following domains: GP consultations, practice nurse visits, inpatient stays, outpatient episodes, social worker contacts, counselling contacts and therapy contacts. Participants were also asked about the duration of these contacts and any costs incurred for private treatment.

Appendix 5. Topic guide for qualitative interviews with relatives and friends

Understanding suicide help seeking in urban and rural areas

Bereaved Interview Schedule

Brief introduction to the study:

“I want to begin by reassuring you that the project aims we are focusing on today are to support those bereaved by suicide and its consequences (expand as you see fit). In order to do this we are trying to obtain as wide a range of views and experiences as possible from family and friends bereaved through suicide. The interviews will be recorded but everything discussed will be confidential; all the transcripts and any other material from the project will be completely anonymised. I understand this subject is difficult for you to talk about and I am so grateful to you for deciding to donate your story so as to help others in the future. If at any stage you wish to stop or take a break please feel free to do so. If you wish to listen back to your interview at the end and change or omit anything, please feel at liberty to ask to do so.”

“We are looking for the *individual* views and experiences of those bereaved by suicide- so we would hope you can be as open as possible about this subject.”

Brief Biographical details:
We have learnt about your NAME death from our analyses of coroner and medical reports in an attempt by us to see what help if any is sought by those feeling suicidal. Our aim is to reduce suicide deaths and build greater help for those in distress and those bereaved by suicide.

Background of the community in which they live:
Can we begin by asking:
Prior to NAME’s death were there any other deaths by suicide in your area?
Obtain something of the socio-economic mix of the community/ particular problems and difficulties (employment, deprivation, experience of violence) or whether fairly stable and solid.

Tell me about NAME? (Lindqvist et al., 2008)

Are you aware of any help he/she sought from any source prior to taking his/her life?
- If so from whom? Talking to significant others
- If not, why do you think this is?

“Through our own experience in research in many cases there were significant life events prior to an individual taking his/her life.” In reflection were there any events prior to NAME’s death that in your view may have contributed to his/her decision to take his/her life?

Explore:
- Stressful life events: lost job, financial worries
- Lost relationship/ lack of relationships (isolation)
- Previous suicide attempt/ family history of suicide
- Recently released from care/ diagnosis of critical illness

"Through our own experience from research in many cases there were small, subtle changes in the behaviour/moods or personality of an individual prior to taking their life." In reflection could you say anything had changed about NAME?

Explore:
- Moods
- Social interaction- family/ friends/ hobbies
- Indication of intent or risky behaviour (substance use, driving, unsafe sex)
- Making preparation: visiting friends, family, tidying up loose ends

How do you feel about the circumstances of NAME's suicide?

- Could it have been avoided?
- What could people have done?
- What would help prevent, or at least reduce suicide risk?
- Satisfaction with statutory services and other agencies

Bereaved help-seeking

What about you? I'd like to ask you about life since the death of NAME and about any support that exists for those bereaved by suicide.

How has life been for you since NAME's death?

Explore:
- Have you been able to talk about what happened with family/ friends?
- What do you think of the support options available to those bereaved by suicide?
- Do you think support would be/is of value?
- Who or what has helped you to cope with your loss? Personal strategies/ other?
- Who do you turn to for support?
- What role has your GP played in supporting you and your family in the circumstances?
- How satisfied have you been with the support you have received following the death of NAME by suicide?

How easy or challenging do you think it is for someone bereaved by suicide to ask for or receive help themselves following the death of a family member or friend?

Explore:
- Stigma: within community or perceived from other sources
- Knowledge and availability of support services
- Faith-based connection: has it increased or decreased since the death

Given your own experience, what type of support do you think would most benefit those bereaved by suicide?

Do you want to tell me anything else that we have not talked about?
What did you think of the interview? (Linqvist et al., 2008)