The lived experience perspective of suicide: A rapid review

Factors contributing to suicidality and experiences of service and support

"I was grappling with what I can only describe as a cyclone in my head. My own self-talk and the external voice that only I hear were telling me to die. I also feel it (in) my body – It grabs you and you are consumed by it."

- Jackie Crowe, 2017, '*Preventing Suicide—It matters to me*'

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Statement from lived experience contributors

The research process underlying this report looked for the narratives of people who had lived through their own suicidal crisis and found relatively scant accounts in the suicide prevention literature. To us, individuals who have firsthand experience of suicidal thoughts and actions, this was not surprising. We have experienced stigma, discrimination, and lack of deep listening in both our efforts to get help when we needed it and in participating in the suicide prevention field, and we know the spotlight of research, for a multitude of reasons, has had limited reach.

It is extremely challenging to understand the complex phenomenon of suicide. The prevailing theories of suicide, briefly described in this report, help progress understanding and we see things in there that we can relate to in our own experiences. Similarly, the extensive knowledge base of risk and protective factors have relevance. But we ask that these are used with awareness of their limitations—they do not reflect every individual's experience of suicidal thoughts and behaviours. Our complex internal experiences and interactions with an equally complex external world cannot be reduced to variables. We do not all follow the same theoretical pathway from suicidal thoughts to actions. Even the category of 'suicide attempt' or 'suicide death' is a woefully inadequate reduction of our varied behaviours or deaths.

From our perspectives, we can see that the drivers of suicidal distress varies between individuals and within an individual over time–be it effects of childhood trauma, relationship challenges, situational problems, effects of medication on neurology, and so on. The specificity of each person's experience is not reducible to a dataset, and the existing research literature has barely scratched the surface. The 'solution' lies, not only in what will help people *stay alive,* but also in what will enable all people, regardless of disadvantage or disability, to *want to live*.

Finding this solution will require us all as individuals, as family members or friends, as professionals or academics, as community members and as a whole society, to face our most painfully intense feelings and genuinely reflect on how societal values are expressed. In the words of the late Jackie Crowe, National Mental Health Commissioner, "w*e turn a blind eye in order to feel safe, to avoid conflict, to reduce anxiety, and to protect prestige. But only greater understanding can lead to solutions."* (Crowe 2017, para 5). To create a genuinely effective, sustainable approach to suicide prevention we need to have the hard conversations, to really look at the how we live, how we communicate, and how we treat others, especially those who are vulnerable, and how our various systems—health, social, welfare, economic, education, and others—exacerbate or contribute to suicide.

In taking a narrower view of the research questions underlying this report, we offer this interpretation of the arising themes that resonated with our own lived experiences and the stories we have heard from our peers:

- *What contributes significantly to suicidal crisis?*

- Everything and anything that dehumanises, disempowers, invalidates feelings or perspectives, ignores or silences expressions of hurt and anguish, judges, or diminishes meaning.
- Being suicidal is exhausting and all-consuming. Most of the time, those who are suicidal are also trying to keep their and their family's day-to-day life afloat. Expectations on us to reach out, follow up, navigate siloed services and systems, chase referrals, do extra or self-advocate are grossly unrealistic.

- *What services are people accessing during their most vulnerable time?*
  - Services located everywhere and anywhere that might help deal with social, emotional, physical, financial, or spiritual problems or needs. From the grocery store to Centrelink, General Practitioner to Emergency Department, spiritual or religious supports to sports club.
  - We also encourage reflection on where those that we rely on for support—our family, friends, or other trusted support people—go to get the support they need to cope with times of crisis.
- *What's unhelpful?*
  - Unhelpful responses are any that create or exacerbate the contributors to suicidal crisis (see above). Sometimes these unhelpful responses come in the way we are spoken to or treated when we engage with a service and ask for help. Unhelpful responses also extend to a failure to give reasonable follow through or follow up, and often reflect a lack of accountability or responsibility within services or roles.
- *What's helpful?*
  - Helpful responses are those that see our humanity, offer time and a safe space to be deeply listened to and validated, provide genuine compassion, free of judgement and agendas. This empowers a person to find their own meaning and the answers to the problems in their own life.

We, the authors of this statement, have all experienced instances of 'help that helped'—but sadly, we recognise too many people have not been so lucky. So often the services that people turn to in their most desperate moments are embedded in complex, bureaucratic systems where barriers to helpful responses—despite the best intentions and frustrations of people who work within them—are entrenched in culture, scarcity, power dynamics, risk management, and fear. The emergency department is a prominent example, as is general practice.

We also know the desperate powerlessness that is inherent in feeling suicidal where the only option you think you have left is to end your own life. So much energy must go into healing one's self and building a

life worth living that challenging the stigma and discrimination that exists even in the field of suicide prevention is beyond any individual—let alone challenging the complex, entrenched systems that contribute to suicide. Reassuringly, the collective voice of those who have lived experience of suicide, standing on the shoulders of the giants who have fought for social justice, has finally gained traction and momentum, kindling the spark of hope for change. While we grapple with the larger questions about how our society deals with suicide and how to reduce barriers within these inflexible, depersonalising systems, we are encouraged to see the emergence of new service models, ones that offer compassion, understanding, and a safe space to get help, that helps.

- Dr Susanne Armstrong, Cassandra Heffernan, George Laggis and Jo Riley

Executive summary

Background

Existing research has identified associations between a variety of biological, psychosocial and environmental factors and elevated risk for suicide in different populations. These studies are usually quantitative and increase our understanding of the epidemiology of suicide. However, they are also limited in their capacity to explain *how* these factors operate to lead to suicidality. To expand on this knowledge and form a more complete picture, it is critical to directly study the perspectives of people with a lived experience of suicidal thoughts and behaviours. This rapid review aimed to investigate the following research questions:

1. What do people who have attempted suicide or been in a suicidal crisis report as the most significant contributing factors?
2. What were their experiences with health and non-health services (e.g., housing, employment) in the lead up to, during and following their suicide attempt or suicidal crisis?
    a. What services or which people were especially helpful or unhelpful with regard to the suicidal state that they experienced?

Methods

We conducted searches through PsycINFO and PubMed databases for peer-reviewed literature. For unpublished grey literature, we searched Google Scholar and contacted key informants and stakeholders working in the sector. These key informants and stakeholders included lived experience subject matter experts, suicide prevention organisations, health and welfare organisations, and academic researchers.

Manuscripts or reports were included in this review if they examined the experiences of people who have attempted suicide or experienced a suicidal crisis at any time in their lives and were published in English between 2010 and the search date (12 May 2020). Items were excluded if they were study protocols, focused solely on non-suicidal self-injury, or examined contributors to chronic suicidality or suicidal thoughts in general (e.g., fleeting thoughts of suicide). Data on population, number of participants, study

setting, study design, and key findings were extracted.

Findings

A total of 110 papers or reports were included in this review, 26 of which were from Australia. The majority were qualitative and examined individuals with direct experience of suicidal thoughts and behaviours. They focused on a variety of populations such as men, young people, older people, military veterans, LGBTQI, and cultural minorities. Though some experiences unique to these populations were identified, broadly, key contributors to suicide encompassed many different adverse life events. This included historic events such as early childhood trauma and adversity, which impacted vulnerability to later adverse life events, such as relationship breakdown, interpersonal conflict, employment difficulties, legal problems and mental or physical illness. The causes and impacts of these events occurred within the context of systemic factors like discrimination and stigma, and social and cultural norms. Individuals of minority groups, particularly those with intersecting identities, experience further sources of trauma and adversity. The culmination of these experiences and events can lead to feelings of low self-worth, loneliness, isolation, hopelessness, and subsequently, suicidality. For some, suicide was viewed as an escape and coping mechanism for the resulting emotional pain.

Contributing factors were reflected in people's accounts of their experiences with services. Generally, traditional services, particularly settings such as emergency departments and inpatient services, were viewed as unhelpful, restrictive, and dehumanising. While some negative experiences were a result of structural barriers to care (e.g., cost, time, unavailability of services), they were usually attributed to poor connections and negative interactions with health care providers. These negative interactions were characterised by demeaning, dismissive and stigmatising attitudes, and exclusion of patients or their family/carers from treatment decisions. Where there were positive experiences with traditional services, they emphasised the importance of genuine, kind, and empathetic human connection. A strong patient-provider relationship based on active listening, respect, and equal treatment facilitated self-disclosure, future help-seeking, and recovery. Similarly, other services such as online forums, helplines, respite centres, safe havens and peer support groups were valued for being places to connect with peer support workers or other people with a shared lived experience of suicide and mental illness. This helped to produce a more normalising and engaging environment where people felt safe to share without being judged, and feel listened to, heard, and understood.

Discussion

While systemic and structural factors contextualise people's experiences, which are indeed complex and vary depending on the individual and their circumstances, at the core of people's lived experience was the importance of connection (to society and to others). Positive interactions based on validating the person, not only built self-worth but also strong support systems for times when a person was in crisis. Conversely, negative interactions further isolated the person and led to feelings of disconnect from society, hopelessness and extreme emotional distress.

Gaps in the literature

It was clear that there was a need to address stressors relating to other aspects of a person's life such as employment, financial and legal issues, and housing. However, though we aimed to examine experiences of non-health services, there was a lack of research that addressed this. This is despite various government inquiries and reports identifying instances of suicide relating to unemployment claims, workers compensation claims, veterans' affairs, and detention and custody. However, as these reports were not focused on or did not examine the lived experience perspective, they were not included in this review.

Recommendations

Based on the findings of this review, we have identified the following recommendations for policy and practice:

1. A review of inputs to policy decision making that considers the impact of policies and policy settings on suicide, and investment in modelling of policies and their impact on suicide
2. Integration of lived experience perspective across all sectors and all levels involved in suicide prevention
3. Ongoing funding for alternative services to the emergency department and acute care teams

4. Health workforce development that is focused on therapeutic engagement rather than risk management, includes peer support workers, and recognises the role of complex trauma across a range of presentations.
5. Services that are structured and well-integrated to support broader psychosocial needs and ongoing follow up and support
6. Commission and fund research to improve the evidence base for integrating the peer and clinical workforces
7. Services that do not discriminate, are culturally appropriate, and available in languages other than English
8. Boosting and strengthening the capacity of community and family to provide effective support

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Background

The rate of suicide in Australia has remained relatively stable over the past 10 years, with 12.1 deaths per 100,000 people in 2018. It is the leading cause of death in people aged 15-44 (Australian Bureau of Statistics, 2019). Over the same period there has been a significant shift away from epidemiological research towards descriptive models of suicidal behaviour. This has been accompanied by growth in the visibility and activism of people with direct lived experience of suicide, contributing to increased focus on the needs of individuals experiencing intense emotional distress and the ability of services to meet these needs.

In recent years, several theories and models of suicide have emerged that explore the interactions between contributing factors, specifically delineating those that contribute to suicidal ideation from those that contribute to suicidal behaviour. One of the most well-known, Thomas Joiner's Interpersonal Theory of Suicide, posits that suicide involves three constructs: thwarted belongness (i.e., the unmet need of social connectedness/belonging), perceived burdensomeness (i.e. the belief that one is a burden on friends, family, or society), and the capability for suicide (i.e., lowered fear of dying, high pain tolerance) (Van Orden et al., 2010). Influenced by the Interpersonal Theory of Suicide, Rory O'Connor developed the Integrated Motivational-Volitional Model of Suicidal Behaviour (IMV). The IMV model further describes suicide in three stages: the pre-motivational phase (background factors and triggering events), motivational phase (development of ideation/intention), and volitional phase (suicidal behaviours). Transition between phases are moderated by a range of psychological, cultural and environmental factors (O'Connor, 2011). Another theory influenced by the Interpersonal Theory of Suicide is the Three-Step Theory (3ST). This theory suggests that there are three key steps to suicidal behaviour: (1) a combination of pain and feelings of hopelessness (that can be caused by a number of personal and environmental factors), (2) a lack of connectedness to people or a sense of purpose or meaning for living and (3) the capability for suicide (Klonsky & May, 2015).

Such theories or models can help us understand the key factors that contribute to suicidal behaviour and as a result, develop effective suicide prevention strategies. There is some evidence supporting the validity of these theories or models. A systematic review and meta-analysis found relationships between the three constructs of the Interpersonal Theory of Suicide and suicide attempts (Chu et al., 2017). Consistent with the pre-motivational phase of the IMV model, a large-scale longitudinal study found that adverse childhood events, specifically physical, sexual, and emotional abuse, parental incarceration, and a family history of suicide were significantly associated with an increased risk of suicide. This risk was further increased with cumulative adverse childhood experiences (Thompson et al., 2019). Social isolation has also been found to

be strongly related to suicide (Trout, 1980), while social support can act as a protective factor (Kleiman & Liu, 2013).

There is considerable research on suicide from an epidemiological perspective through studies investigating prevalence of suicide and variables associated with suicide risk. Reviews have examined risk factors in specific populations including young people (Beautrais, 2000), older people (Conwell et al., 2002), psychiatric outpatients (Brown et al., 2000), prisoners (Fazel et al., 2008), and those with bipolar disorder (Hawton, Sutton, Haw, Sinclair, & Harriss, 2005), depression (Hawton et al., 2013), or schizophrenia (Hawton, Sutton, Haw, Sinclair, & Deeks, 2005; Hor & Taylor, 2010). Factors associated with higher risk for suicide include the presence of a mental illness, previous suicide attempt, comorbid disorders and substance abuse, and being male. Certain groups, such as LGBTQI (National LGBTI Health Alliance, 2020) and Aboriginal and/or Torres Strait Islander people have been identified as having higher rates of suicide compared to the general population (Australian Bureau of Statistics, 2019). The focus on studying suicide in different populations demonstrates the complexity of suicide and its causes, but is also a result of the prevailing research methodologies. Much of this research is quantitative and consequently, is limited in the depth of information that it can provide. While they identify certain psychosocial and environmental variables to be associated with suicide, it is unclear how they interact and are experienced by individuals who engage in suicidal behaviour.

In order to work towards an understanding of suicide, it is critical that our research is informed by those who have a lived experience. Ensuring that the views of those who have experienced suicidality is highlighted in research is vital, and there is an ever-growing body of evidence which supports that this is particularly important when considering their mental health needs and wellbeing (Buston, 2002; Fallon et al., 2012; McAndrew et al., 2012). Studying the lived experience allows us to understand the motives for suicide garnered from first person accounts (Stewart et al., 2017). However, the subjective experience of those directly involved in suicidal acts has not been sufficiently explored to date (Biddle et al., 2013). To obtain these accounts, and subsequently gain greater understanding, using methods which allow them to provide a narrative account of their experience is a way to begin to understand the deeply personal aspects of the experience, and to address the limited suicide research using qualitative inquiry.

Positioning the lived experience narrative at the forefront of suicidology studies has the potential to more richly inform prevention and intervention efforts on a needs basis. Investigating participants' viewpoints, their lived experiences, and their interior worlds, can also be used to better understand the complexities of the suicidal experience (Hjelmeland & Knizek, 2010). This rapid review aims to investigate the experiences of people who have attempted suicide and the journey or pathway factors that were significant in the period prior to this point, with particular attention to ways in which suicide risk and protective factors operated in the person's life.

This review focuses on the following topic areas:

1. What do people who have attempted suicide or been in a suicidal crisis report as the most significant contributing factors?
2. What were their experiences with health and non-health services (e.g., housing, employment) in the lead up to, during and following their suicide attempt or suicidal crisis?
    a. What services or which people were especially helpful or unhelpful with regard to the suicidal state that they experienced?

Method

Searches for peer-reviewed published literature were conducted through PsycINFO and Medline databases using the following string: '(("suicid*" or "self harm" or "self-harm" or "self injur*" or "self-injur*" or "self poison*" or "self-poison*") and ("help seek*" or "help-seek*" or "health service" or "informal help" or "service*" or "peer*" or "social support" or "sociocultural*" or "social outcomes" or "psychosocial*") and ("experience*" or "perspective*" or "satisf*" or "self report" or "self-report"))'. Titles, abstracts, and keywords were searched.

Unpublished grey literature was identified through searches on Google Scholar and through contact with expert key informants. Two separate searches were conducted. The first focused on contributing factors to suicide attempt and crisis ("suicide" "attempt" "crisis" "lived experience" "causes" "contributors") and the second on services and support ("suicide" "lived experience" "help" "services" "support"). The first five pages of results for each search were downloaded for screening. Key stakeholders and informants working in suicide prevention were also contacted to identify unpublished or emerging research. These informants included lived experience subject matter experts, academic researchers, health and welfare organisations and suicide prevention organisations. Informants reported a range of 1-20 years working in the area of suicide prevention, though some had spent longer working more broadly in the mental health field.

Manuscripts and reports were included in this review if they met the following inclusion criteria:

- Examined experiences of people who have attempted suicide or experienced a suicidal crisis at any time in their lives
- Included participants of any age, gender and ethnicity
- Reported results/findings

- Published in English
- Published between 2010 and the search date (12 May 2020)
- Both quantitative and qualitative research
- Full text was available

Articles were excluded if they were:

- Study protocols
- Studies focusing only on non-suicidal self-injury (NSSI)
- Studies not including the perspective of a person with lived experience of suicide (e.g., prevalence, predictors of risk)
- Studies examining contributors to chronic suicidality or suicidal thoughts in general

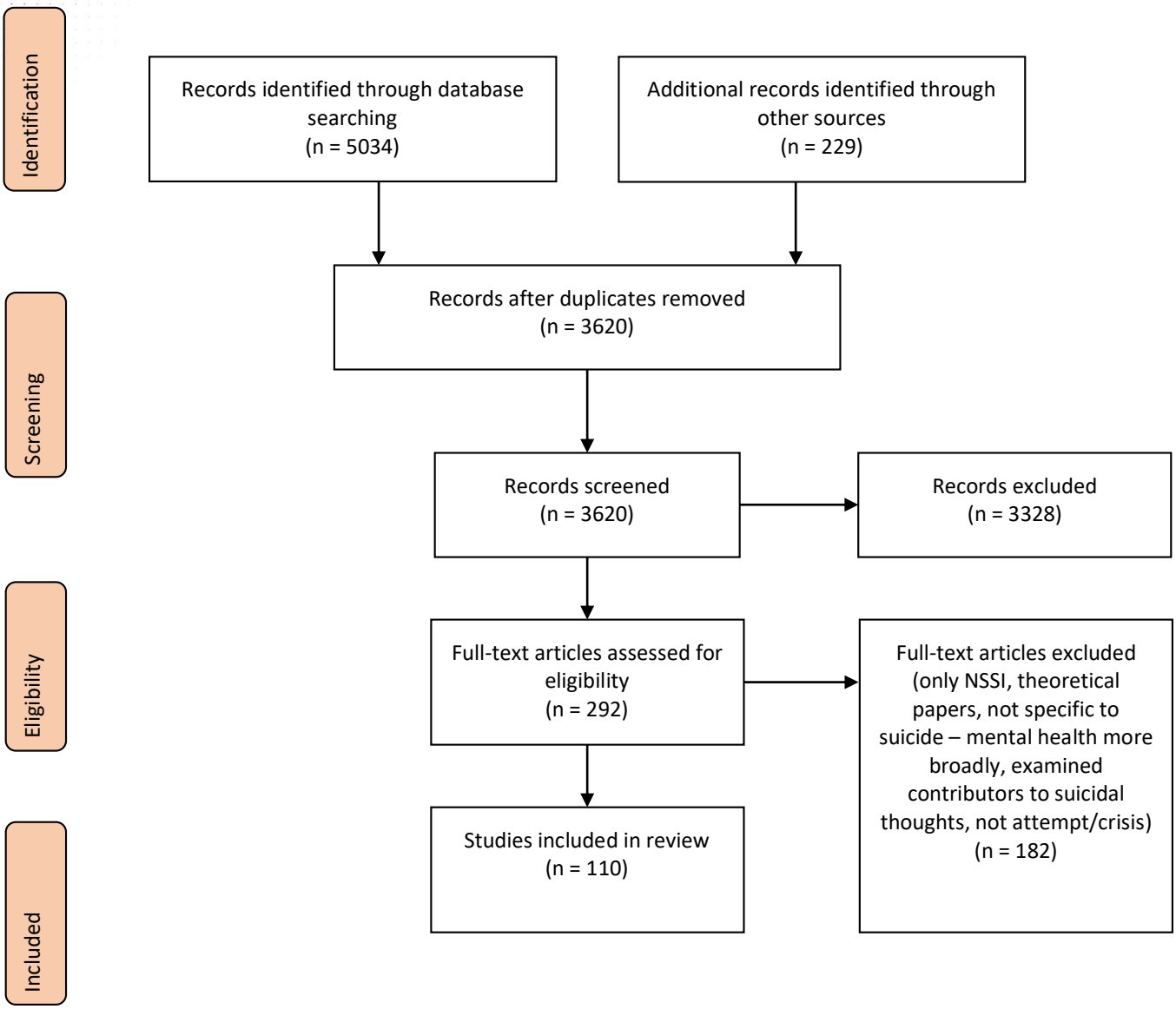

Figure 1. Search and screening process

Both international and Australian research was included. Figure 1 shows the flowchart of the screening process. For papers included in this review, information on participant group(s), number of participants, study design and setting, and key findings were extracted.

Results

Papers were primarily qualitative or used mixed methods approaches, and included a mix of peer-reviewed and grey literature. A summary of the study characteristics can be found in Table 1. Refer to Appendix A for the full results.

Table 1. Study characteristics

Characteristic	**n**
Location	
Australia	26
Asia	9
North America	32
South America	1
Africa	2
Europe	25
Multinational	5
Type of lived experience	
Suicidal thoughts/behaviours	83
Carer/bereaved by suicide	17
Study design	
Quantitative	6
Qualitative	72
Mixed methods	18
Review/inquiry	10
Analysis of coronial data	1

Note: *Does not include data that was missing or not captured*

Contributors to suicide attempt or crisis

Research was primarily international (n=74), and focused on a variety of populations including men (n=13), older people (n=6), migrants (n=4), refugees (n=1), Alaskan natives (n=1), Latina youths (n=4), military veterans or soldiers (n=2), prisoners (n=2), farmers (n=1) and gender and sexual minorities (n=2).

The below sections summarise key themes that emerged with respect to contributors to suicide, from environmental and systemic factors to more immediate individual factors. Some research found that individuals could not articulate clear reasons for suicidal behaviour, instead expressing ambivalent attitudes towards living and dying (Vatne & Naden, 2012; Zayas et al., 2010). Others, particularly young people, exhibited impulsivity in response to stress, which led to suicidal behaviour. This was further exacerbated by use of substances (Dougherty, 2011). However, as the reviewed research was focused on elucidating clear precipitators to suicide attempts or crisis, such factors did not appear prominently, despite links between ambivalence or impulsivity and suicide in the broader literature.

> *"Sometimes a suicide attempt is carefully planned, like the one that was interrupted by the fire. At other times, like my next attempt, it is a spur of the moment thing"*
>
> (Webb, 2010)

The following sections are not mutually exclusive and interact in complex ways to lead to suicidality. Systemic factors such as discrimination and cultural or social norms, along with the role of intersectionality, are important to contextualising the individual experience of suicidality. Further, distal or historic factors, such as early and chronic adversity can make people more vulnerable to proximal factors, such as relationship breakdown and loss of perceived value. An illustration of the complex interactions between these factors is shown in a study of the lived experience of suicide in young people on page 25.

Adverse or traumatic life events

A review of large psychological autopsy studies (at least 75 suicides) found that almost all suicide deaths experienced at least one (though usually more than one) adverse life event in the year preceding death (Foster, 2011). Indeed, other research showed that multiple adverse life events or compounding life events often preceded suicide (Heinsch et al., 2020; McTaggart, 2016). This could include historic events such as adverse childhood experiences, as well as current events. For example, many LGBTQI men who had survived a suicide attempt reported childhood sexual and physical abuse. This, along with struggles disclosing their abuse to others, was a significant source of trauma and impacted their relationships as adults, contributing to the development of mental health issues such as depression. Some felt a sense a

shame, perceiving their sexuality and not being 'masculine' enough as a potential reason for their abuse (Ferlatte et al., 2019).

> *"Within a few months we had fallen out of love and suicidality came rushing back into my life…*
> *I was broken-hearted and adrift, and also homeless and jobless"*
>
> (Webb, 2010)

Adverse life events could disrupt social structures that would normally provide a source of support, whether practical or emotional (Klevan et al., 2017). Some adverse life events were unique to particular groups. For veterans, this included difficulty returning to civilian life (e.g., substance misuse, loss of structure provided in military life), stressors caused by training (e.g., exposure to violence), multiple deployments, and lack of recovery time between deployments (Foreign Affairs Defence and Trade References Committee, 2017) and combat-related traumatic thoughts, including nightmares and flashbacks (Bryan & Rudd, 2012). In children and young people, suicidality was impacted by factors such as development of self-identity, bullying, body image issues, and neglect (Dougherty, 2011; Scott, 2016), while older people reported that self-harm was a way to end problems associated with chronic pain or physical ill health (Wand et al., 2018). An Australian inquiry report into suicide in immigration detention found contributing factors related to the detention environment itself, such as confinement, deprivation, loss of liberty, overcrowding, limited meaningful activities and exposure to others' self-harm/suicidal behaviour or mental illness (Neave, 2013).

While population-specific adverse events were identified, many were common across different populations. They included interpersonal conflict, relationship breakdown, being bereaved by suicide, physical health problems, legal problems, substance misuse, changes in family structure such as moving and divorce, intimate partner and family violence, sexual and physical abuse, and financial problems related to housing and employment (Barnes et al., 2016; Klevan et al., 2017; Rice & Tan, 2017; SANE Australia, 2015; Straiton et al., 2013). Differences emerged based on individual, social and environmental factors that interacted to influence the causes of these events, their manifestation, and how individuals responded to them.

Discrimination and stigma

Discrimination and stigma, whether towards a person's identity or towards their suicidality, could occur at both an individual and systemic level. For example, people identifying as gender and sexual minorities

experienced homophobic bullying, abuse, and violence (Ferlatte et al., 2019). For these people, this was a significant source of distress following coming out and caused some to conceal their identity and develop internalised stigma and self-hatred. This distress was further exacerbated by stigma directed towards their suicidality itself (Williams et al., 2018). In a rural village in Eastern Ghana, a sample of men who had attempted suicide reported stigma and social exclusion from their village and family following their attempt (Osafo et al., 2015). One participant in this study subsequently died by suicide following social taunting after a previous suicide attempt.

At an institutional level, discrimination can disadvantage people in various aspects of their lives and remove key protective factors. A government inquiry on Aboriginal suicides in Australia, based on submissions and input from individuals, organisations, researchers and Government agencies, identified clear links between the effects of colonisation and suicide (Education and Health Standing Committee, 2016). Racism and discrimination isolated and disempowered Aboriginal Australians, creating intergenerational trauma and preventing equitable access to resources and services. This resulted in health inequalities, homelessness and overcrowding, educational and employment disadvantage leading to socioeconomic disadvantage, lack of meaningful activities for young people due to geographical isolation, substance abuse, impulsive behaviour in relation to life stressors, children in care, overrepresentation in the justice system, and exposure to death or suicide. The cumulative effects of these factors created a sense of hopelessness and helplessness and consequently, suicidal crisis (Education and Health Standing Committee, 2016).

Those with intersecting identities experience combinations of these issues. For example, in a Canadian study of gay, bisexual and two-spirit men, an Indigenous participant discussed his experience with being removed from his Aboriginal culture and family by the government and placed in a residential school, where abuse and violence was common. After returning to his community, he found that he was now viewed as an outsider and ostracised. He experienced further abuse from his family, which was intensified when he came out (Ferlatte et al., 2019).

Restrictive cultural and social norms

Australian men who had survived a suicide attempt discussed the harm of unhelpful and restrictive conceptions of masculinity, where they felt expected to be emotionally ‘tough’ and to manage their own stress, rather than reach out others (Black Dog Institute, 2014; Player et al., 2015). Similarly, Chinese-born women living in Canada felt that gendered expectations led to coping strategies that focused on enduring distress, rather than relieving it (Andoh-Arthur et al., 2018; Zaheer et al., 2019). Societal pressures, especially expectations of individuals’ identities and their roles within the family, impacted the willingness to seek help and knowing how to communicate their problems to others. Some perceived their needs to

cope with distress and suicidal thoughts as being at odds with the needs of family. In a study in India of people who had attempted suicide, women explained feeling pressured to stay in an unhappy marriage due to expectations of their role as a wife and mother, and the potential negative impact on their parents' reputation if they were to leave (Lasrado & Young, 2017).

Sense of individual and societal value

The loss of a person's sense of value could also contribute to suicidality, and this was particularly apparent in older populations who often struggled with the loss of normal functioning and self-sufficiency as a result of aging. An increased reliance on others caused significant distress, both due to the feeling of losing autonomy and perceptions that this made them a burden on others. Some specifically cited the desire to avoid residential care as a reason for self-harm (Wand et al., 2018). Older people who self-harmed or attempted suicide also described their value in relation to their role in and contribution to society. Some felt a sense of 'completion' and being at the end of life, in that they had no more reasons to continue living. This was not always viewed negatively, where people felt that they had already lived a good and fulfilling life. Others felt disconnected from society from this loss of personal value. Sometimes this was related to work or financial difficulties, which were characterised by job loss (and therefore a loss of meaningful contribution to society) (Sales da Costa & Souza, 2017). Further, this could also be affected by cultural factors. For example, males from India and Ghana described the patriarchal pressures on men as the breadwinner and their distress when they could not fulfil this role (Andoh-Arthur et al., 2018; Zaheer et al., 2019).

Interpersonal conflict and relationship breakdown

In a number of studies, relationship problems were the most common reason given for suicidal behaviour. Conflict or relationship breakdown with peers, family members or partners was itself a source of distress, as well as removing a key source of support to whom individuals could communicate their suicidal thoughts (Anderson et al., 2012; Gulbas & Zayas, 2015; Nicolopoulos et al., 2018; Rice & Tan, 2017; Straiton et al., 2013; Wand et al., 2018; Wand et al., 2019; Zayas et al., 2010). Latina adolescents in the United States described how harmful family dynamics, influenced in part by cultural factors, prevented the formation of open and supportive relationships with their parents (Gulbas & Zayas, 2015). Relationship conflict characterised by abuse and violence were also contributing factors (Parkar et al., 2012; Wand et al., 2018), and were frequently reported in children and young people (Anderson et al., 2012; National Children's Commissioner, 2014; Zayas et al., 2010).

Loneliness and isolation

Loneliness and isolation were major precipitators to suicide and manifested in different ways across many different groups (Farrelly et al., 2015; Ferlatte et al., 2019; Fogarty et al., 2018; Gulbas et al., 2015; Rasmussen et al., 2018; Sturgeon & Morrissette, 2010; Van Orden et al., 2015; Wand et al., 2018; Williams et al., 2018). Though the reasons for loneliness and isolation were not always provided, they could be caused by the above factors, such as interpersonal conflict with peers and family members, disconnection from society due to lack of perceived value and low self-worth, loss of support networks, experience of stigma and discrimination, and isolating coping mechanisms.

> *"For whatever reason, life has become too difficult, too painful … and extinguishing this life force becomes a real possibility"*
>
> (Webb, 2012)

In other cases, isolation was caused by forced separation from support networks, commonly observed in refugees and migrants. Isolation was further exacerbated by acculturation stressors, such as a lack of access to key resources and services. Hagaman et al. (2016) interviewed close contacts of Bhutanese refugees in the US who had died by suicide and found that language barriers prevented access to employment and education. Korean-Canadian and Chinese-American migrants who had experienced suicidal thoughts and behaviours also reported difficulties, where education and work experience obtained in their home country was no longer valid (Han et al., 2013) or they were ineligible for government health or financial benefits (Chung, 2012). A report by the Commonwealth and Immigration Ombudsman on suicide and self-harm in immigration detention in Australia found that fears for family back home and isolation caused by language barriers and loss of family/other support systems were contributing factors (Neave, 2013).

"Sadly, this is a common occurrence in their lives, in our lives, as part of their condition is to attach symbiotically to the point of suffocation, and then to completely sever from those they love –close family members, partners, colleagues and friends, creating further isolation from those who love them. Sadly, this action excludes them from the much-needed love and support they require for their recovery"

(Oliver Armstrong, 2019)

For Aboriginal people, they not only experienced isolation through forced separation from culture, language and country, but were also often physically isolated in rural and remote areas (Education and Health Standing Committee, 2016). In general, geographical isolation can mean a lack of options for recreational activities or to connect with other communities (resulting in risky behaviours that lead to suicide) (Education and Health Standing Committee, 2016) or a lack of available help options (Creighton, Oliffe, Ogrodniczuk, et al., 2017; Creighton, Oliffe, Lohan, et al., 2017; Sturgeon & Morrissette, 2010).

Trauma, hopelessness and emotional suffering

The aforementioned factors, especially in combination, can culminate in trauma, hopelessness and extreme emotional distress. Individuals commonly described suicide as an escape and source of relief from these feelings when they became intolerable (Bryan & Rudd, 2012; Gulbas et al., 2015; Klevan et al., 2017; Straiton et al., 2013; Vatne & Naden, 2012). Some individuals who lacked alternative strategies to cope with distress engaged in strategies that led to suicidal behaviour. For instance, men with depression who had attempted suicide tended to self-isolate in response to distress, compared to men with depression who had not attempted suicide who instead reached out to friends and family (Oliffe et al., 2012). In other cases, suicidal behaviour was directly used as a method of coping. In a study which included people engaged in NSSI, participants who went on to attempt suicide stated that they did so because NSSI no longer provided sufficient emotional relief (Gulbas et al., 2015). Some also reported difficulties in verbalising their emotional distress to others, with suicidal behaviour representing their last resort method

"With hindsight I can now say that at the core of my suicidal dilemma was the question 'What does it mean to me that I exist?'. This question points to what is recognised as one of the key indicators of suicidality – hopelessness. For me, hopelessness arises from an absence of meaningfulness. If I feel that my life is entirely without any meaning and purpose, and no hope of it ever being otherwise (i.e. helplessness), then suicide becomes a progressively more and more logical and attractive option. Why put up with this pain when there is absolutely no point?"

(Webb, 2012)

of communicating the intensity of their distress and request for help (Holliday & Vandermause, 2015; Maple et al., 2019).

> *"Almost as some kind of negotiation with this 'voice' (telling me to ask for help) , I argued with myself that there was no-one I could turn to, that there was no-one and nothing that could help me"*
>
> (Webb, 2010)

Availability of methods

To a lesser extent than psychosocial and environmental variables, physical access to means also influenced suicidal behaviour. Biddle et al. (2012) interviewed a sample of adults who had made a near fatal suicide attempt and found that individuals learned about suicide methods from television and film, news stories, the Internet, and healthcare professionals (e.g., inappropriate dosage for medication). The Internet was also used as a way to secure these means. However, some participants also reported that this information could have a preventative effect, where information about what would happen if the method did not work discouraged them from using it.

A study of the complexity of suicide in young people (Nicolopoulos, 2020)

Findings from a recent doctoral thesis investigating the lived experience of suicide as per the narrative accounts of Australian adolescents and young adults, found a substantial level of dysfunction and disruption to interpersonal relationships and connections to be prominent among this population. These experiences were not only a risk factor for suicide, but also throughout the ideation and attempt phases of the experience. Participants' relationship with themselves was also found to be compromised throughout each phase of suicidality (risk, ideation and attempt phases) There was an ever-present representation of compromised identity, negative perceptions of self and inwardly directed self-loathing and blame.

Many themes – especially those which arose from childhood - pertained to factors outside of participants' control. Even though these seemed to be represented mainly as risk factors for suicide, there was significant reference to negative feelings, thoughts and emotions directly resulting from these childhood incidents throughout the ideation and attempt phase. Further, the lack of control over circumstances extended beyond the earlier experiences of many participants, and carried on into the ideation phase, and often, was reported in the attempt phase.

External factors, even those where participants did not report feeling a lack of control, played into each phase of suicidality. Aside from interpersonal relationship factors, there were also factors related to participants' socio-cultural environments, including unstable, unsupportive, and unsafe social environments.

Overall, environmental influence interacted with the network of interpersonal, social, and cultural risk factors. The importance of these social environments on participants, and the way in which they perceived the environment and were perceived by those in their social environment, was palpable. This had significant influence on not only their risk for suicide, but also the emergence of a negative inner dialogue during ideation and attempt phases.

Experiences with health services, non-health services and informal support

Research over the last two decades has described a common and distressing scenario where, precisely when people are highly distressed and in need of a compassionate response, our health system provides inadequate care that is lacking in empathy, focussed entirely on risk management, and disjointed (Black Dog Institute, 2015). This has led some help-seekers to disengage from health services, increasing their isolation and sense of mistrust towards a system that is meant to help them. In a recent study (Rosebrock et al., 2020) of people presenting to the emergency department for suicidal crisis, only one-quarter reported being willing to return to the ED for a future crisis. Their satisfaction with the care they received while in the ED was the strongest predictor of their willingness to return to the ED, and of their attendance at follow-up appointments. In an Australian data linkage study, only 41% of patients who had been admitted to hospital following a suicide attempt had any contact with a public health service after hospital discharge (Spittal et al., 2016). In an online survey of people who had made a suicide attempt, only one-third of participants who had presented to an ED had contact with another health service (Shand et al., 2018). Worryingly, dissatisfaction with health services was highest with the most common first points of contact (EDs and emergency services), and greater dissatisfaction was associated with lower willingness to disclose future suicidal thoughts (Shand et al., 2018). These studies describe only those people who have had contact with a hospital during a suicidal crisis. What is less clear is how many people come into contact with other health and non-health services before, during, or after a suicidal crisis, what support they have been able to access, and how helpful or unhelpful it has been.

> *"Well firstly, it all started with the emergency psych and the emergency ward. That was my first bad experience with psychologists that didn't help me at all. She [the psychologist] told my family things that were supposed to be confidential. So that really impacted my trust with psychologists and that, like off the bat."*
>
> Participant in Jackson et al. (2020)

"Critically at this time, I reached out to a nurse and counsellor for help, asking them to contact Child Services or police. I was denied, accused of lying, and my trauma was invalidated. I felt complete despair and entrapment. I attempted suicide for the first time soon afterward"

"These experiences individually and cumulatively lead to increased guilt, shame, worthlessness, and perceived burdensomeness, thereby compounding distress and increasing my immediate and future risk for suicide"

(Elwyn, 2020)

This review found that studies that examined experiences with services predominantly focused on health services. Reports were also identified that evaluated specific alternative services, including respite centres, safe haven drop ins, and a peer support group for suicidality, as well use of helplines and online services. EDs/hospitalisation were often associated with negative experiences while GPs and outpatient services were viewed more positively. Negative experiences were attributed to poor access to professional services, ineffective care that did not address patients' needs (e.g., complex mental health issues (Kjolseth et al., 2010)), lack of proper training for staff, and dismissive and stigmatising attitudes (Peters et al., 2013; SANE Australia, 2015; Shand et al., 2018). Positive experiences related to strong patient-provider relationship and peer support.

Lack of access to initial or ongoing care

Negative experiences with traditional services were commonly attributed to problems with accessing care. Australian adults who had previously attempted suicide described engagement with services as particularly important during the crisis stage, but that this help was often not available (Heinsch et al., 2020; Shand et al., 2018). Despite urgent needs and the presence of self-harm, individuals reported being turned away from services including psychiatric triage and inpatient care (Stokes, 2012). A number reported being rejected from services as their problems were seen as not being 'serious' enough (Coker et al., 2019; McKay & Shand, 2018; Peters et al., 2013; SANE Australia, 2015; Stokes, 2012). Other factors such as cost, time, remote location, high staff turnover and lack of resources resulted in no appointments or long appointment wait times, with

"When I came out of hospital, I was still suicidal, because like I was saying before you don't really change the circumstance overnight. It takes time … It is going back to your old place and your old life, and everyone is expecting you to be fine because you've been four weeks in the psych ward and therefore, there is nothing else to sort out. How wrong people can be?"

Participant in Jackson et al. (2020)

people having no access to alternative supports during this time (Abar et al., 2018; Finlayson-Short et al., 2020; Shand et al., 2018).

Additionally, confusing and difficult to navigate public health services in Australia, along with a lack of information about what to expect during the treatment process left individuals feeling scared, confused and not knowing what to expect (Abar et al., 2018; Heinsch et al., 2020; PLWSA Lived Experience, 2019; Shaw et al., 2019). In particular, poor integration and communication across services was described, leading to individuals having to tell their story multiple times to multiple health care providers, or decisions being made without consulting the other appropriate members of a person's health care team (Coker et al., 2019; PLWSA Lived Experience, 2019). At times, support provided was ineffective or insufficient, such as being discharged from hospital too soon, or lack of appropriate care for people with complex mental health issues (Kjolseth et al., 2010; McKay & Shand, 2018; Mental Health Council of Tasmania, 2019; Shand et al., 2018).

The period following discharge or initial contact with health services was also identified as a critical time for support (Cooper et al., 2011). Adults admitted to hospital with suicidal ideation or who had a lifetime history of suicidal behaviour reported feeling anxious at the prospect of discharge and how their long term needs would be met (Cutcliffe et al., 2012). However, both Australian and international research found that of individuals who had accessed health services for a suicide attempt, there was typically little to no follow up or information provided about follow up support options (Coker et al., 2019; Hunter et al., 2013; Jackson et al., 2020; Peters et al., 2013; SANE Australia, 2015; Shand et al., 2018). Shand et al. (2018) found that less than half of their participants believed that they had received enough help immediately after their attempt, after leaving the hospital or treatment facility, and in the 6 months following their attempt. Repeated negative experiences with health services led to feelings of hopelessness and suicidal behaviour (Furqan et al., 2019). With 12-month hospital re-presentation rates for self-poisoning of 15-30 per cent (Carroll et al., 2014), it is clear that consistent and high-quality follow-up care is needed.

Need for autonomy and agency in treatment

Many individuals described experiences of feeling disempowered and dehumanised through contact with traditional services. This occurred through interactions with staff, who did not appear to take them seriously, were dismissive, stigmatising and judgmental, and excluded patients and their friends and family from treatment decisions. Some viewed this as symptomatic of a lack of adequate training in suicide and mental health issues (Hom et al., 2020; Hunter et al., 2013; Rimkeviciene et al., 2015; SANE Australia, 2015; Shand et al., 2018; Wadman et al., 2018). Treatment that was imposed on patients was described as unhelpful, disappointing and humiliating (Rimkeviciene et al., 2015). While some felt that hospitalisation or institutionalisation kept them physically safe (Hom et al., 2020; Wand et al., 2018), such settings that involved detention and formal observation were seen by others as impersonal and restrictive (Lees et al., 2014). Fears of a loss of autonomy from these environments also discouraged people from seeking help and disclosing suicidality (Rimkeviciene et al., 2015).

> *"Other people start writing your life down as soon as you arrive and you know it's not true what they're writing but you're locked into that system with grand human emotions being viewed through narrow constrained and ultimately fiction through clinical lenses, whole journey based on that fiction"*
>
> Participant in Suicide Prevention Collaborative/ Roses in the Ocean co-design of Illawarra Shoalhaven Safe Space

Genuine, empathic relationships between patient and health care providers

Related to the need for autonomy and agency, it was clear that the relationship with health care providers was one of the most critical factors in people's various accounts of their experiences with health care services. Treatment based on active listening, empathy, compassion, trust, kindness and consistent care made patients feel understood, valued as an equal, and their experiences validated (Awenat et al., 2017; Klevan et al., 2017; Lees et al., 2014; McKay & Shand, 2018; SANE Australia, 2015; Signoracci et al., 2016; Vatne & Naden, 2018). A key component of a strong therapeutic alliance was the involvement of the patient in their own treatment, which helped to foster a sense of agency (Hausmann-Stabile et al., 2018; Hom et al., 2020; Shand et al., 2018; Vatne & Naden,

> *"A message I hear from so many mental health consumers and trauma survivors (some now sadly passed to suicide), about how the most important person is not the most qualified one, but the kindest one"*
>
> (Oliver Armstrong, 2019)

2012). Active involvement of patients in decisions about their care could also help to ensure that their unique needs were met. For example, Stokes (2012) noted that for Aboriginal Australians, Western conceptions of mental illness were unhelpful and could neglect specific needs caused by multiple levels of trauma.

A lack of interpersonal connection with health care providers was usually the reasoning for negative experiences, particularly in hospital and inpatient settings. In their systematic review of patient experiences of inpatient care, Berg et al. (2017) found that the relationship with the healthcare professional was especially important in situations of constant observation that were normally associated with a lack of privacy and freedom. People hospitalised for suicidality or self-harm reported unhelpful experiences where their emotional needs were not attended to or where they did not receive a mental health assessment (Hausmann-Stabile et al., 2018; Stokes, 2012). By comparison, in a UK study of experiences with psychosocial assessment following hospitalisation for self-harm, participants who found the assessment helpful stated that it legitimised their distress and gave them an opportunity to talk about their problems (Hunter et al., 2013). Indeed, positive experiences of hospitalisation or inpatient care included having health professionals show concern for the patient, connecting with health professionals, and having the sense of being cared for (e.g., being listened to) (Berg et al., 2017; Elliott et al., 2015). These positive relationships with health care providers facilitated self-disclosure and increased likelihood of future help seeking (Hagen et al., 2018; Wu et al., 2012).

Other services and support

The Internet was used as a source of information to find health care services (Idenfors et al., 2015), as well as a direct source of support. Greidanus and Everall (2010) and Hilton (2017) examined online suicide-related or self-harm-related posts and found that users not only sought help and support, but also provided it to others. Callers to a suicide prevention telephone helpline reported that they felt understood and listened to, and that they felt less alone, afraid and anxious and more hopeful, supported and wanting to live (Coveney et al., 2012). In a US study examining the impact of follow up calls for those who had contacted the National Suicide Prevention Lifeline, the researchers found that over half who had received a follow up call felt that it had saved their lives and kept them safe ‘a lot’ (on a scale of ‘not at all’ to ‘a lot’) (Gould et al., 2018).

> *"A few of us, would sit together (in the Child and Adolescent Unit) and talk about everything because we all had a history of sexual assault, we all had a history of all sorts of other things that we could share with each other and that really helped. We would get together in the games room in the beanbags, and chat and eat chocolates like a girlie sleepover. So, that felt really normal and at the same time helpful. You felt understood, which was a crucial point for me, in getting on with life."*
>
> – Participant in Jackson et al. (2020)

Evaluations of respite centre and safe haven services in the UK found that they improved mental well-being, made visitors feel less suicidal, provided them with a safe place to stay while in crisis, and helped save their lives (Briggs et al., 2016; Briggs et al., 2012; Griffiths, 2017). Visitors to the respite centre viewed the peer and practical support (e.g., providing people with food, a place to shower and sleep) as the most important aspects of the service and felt that they received more support compared to traditional services. The presence of peer support workers, who themselves had experience with mental health issues, helped to create an engaging and normalising environment (Briggs et al., 2016; Briggs et al., 2012). Similarly, visitors to the Way Back Support Service in the ACT and to a Safe Haven Café in Melbourne described the importance of supportive staff who made them feel safe, listened to and valued (Better Care Victoria, 2019; Woden Community Service, 2018). Just listening, rather than pushing the person to action, was particularly helpful and facilitated disclosure of experiences (Better Care Victoria, 2019). Additionally, these services also connected users to other health and support services (Woden Community Service, 2018).

Participants of an Australian suicide peer support group ('DISCHARGED') described feeling valued and able to safely speak without judgment or loss of autonomy, compared to public mental health services that they felt were punitive and dehumanising (Radford, 2019). The presence of peer support workers to facilitate discussion, along with being able to connect to others in the group was particularly helpful. Following their involvement, peer support group participants reported being more likely to open up to friends in the future about their distress, but still showed some distrust of traditional health services.

Dissatisfaction with these other services was uncommon, though some visitors to the respite centre felt unsafe due to it being a new environment and others felt that their stay was too short. Suggestions from users of the Safe Haven service included more staff, a more accessible location, and more effective dissemination of information (Griffiths, 2017). Individuals also reported feelings of sadness and anxiety over leaving and had doubts that they had the support needed for their long term needs, including both mental and social welfare (Briggs et al., 2016; Briggs et al., 2012). Visitors to the Way Back Support Service in the ACT also felt that their time with the service was too short (Woden Community Service, 2018). In a study of

individuals who had used crisis response teams in Norway, participants reported that support and information provided from staff made them feel safe, and that genuine, compassionate and kind treatment helped build self-worth (Klevan et al., 2017). However, they also felt that these teams were ill-equipped to provide practical support for structures relating to their daily lives (e.g., finances, housing, work, social roles). Australian men who had attempted suicide saw other services (e.g., welfare services) as having the potential to provide support that could not be obtained from other sources. However, there was often frustration towards and criticism of such services due to failures in supporting men at risk of suicide (Fogarty et al., 2018).

Family and/or friends

Family and/or friends or other informal support networks were cited as a major protective factor. They directly provided emotional support (Azizpour et al., 2019; Huisman & van Bergen, 2019; Lasrado et al., 2016; Lee et al., 2014; Reading & Bowen, 2014; Sturgeon & Morrissette, 2010; Zaheer et al., 2019) or helped facilitate the pathway to care (Bullock et al., 2012; Idenfors et al., 2015; Owens et al., 2016; Wu et al., 2012). Relationships with family and friends also helped prevent suicide indirectly, where thinking about their responsibilities to their family, the impact of suicide on family or friends, and reflecting on positive experiences with friends and family in the past helped to prevent suicidal behaviour (Owens et al., 2016; Roberts, 2019). In some cases, relationships with family strengthened following their attempt (Black Dog Institute, 2014). Women in Iran reported that their family offered more financial and emotional support, became more attentive and compassionate, and made considerable attempts to keep them safe following their suicide attempt (Azizpour et al., 2019). Family and friends could also play the role of an advocate in health care. However, a number of studies found that they were excluded from treatment plans or decisions, or blamed for the behaviour of the patient (PLWSA Lived Experience, 2019; Stokes, 2012).

Discussion

This rapid review identified significant diversity in people's lived experience of suicide. It was influenced by events at different points in a person's life, systems occurring at different levels of society, and individual identity and mental and emotional states. Some of the identified factors support existing theories of suicide, such as perceived burdensomeness, the need for connectedness and belonging, emotional pain

and different ‘stages’ of suicidality. The findings are also consistent with previous quantitative studies of risk factors and correlates, such as links between early childhood trauma and adversity and later suicide attempt (Ryan et al., 2020). The strength of this review, which primarily focused on people’s subjective accounts of their suicidality, is that it helps further our understanding of these factors and the interactions between them. Although these interactions are complex in nature, some common themes emerged. Broadly, they encompassed societal (structural and systemic factors), interpersonal (connection to others and society), and individual (self-worth and value) constructs. A summary of the relationships between these constructs and how they lead to or prevent suicide is shown in Figure 2.

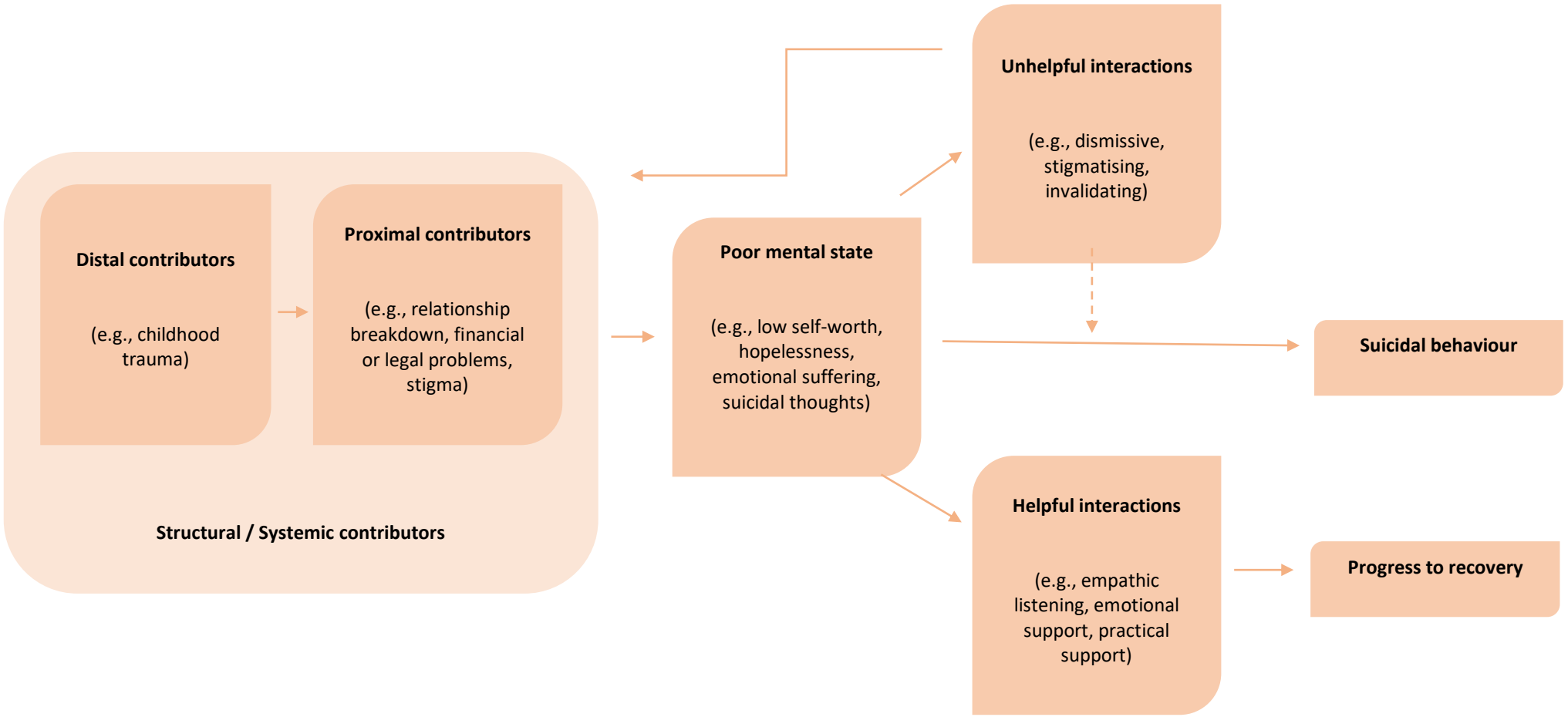

Figure 2. Relationships between factors contributing to suicidality

Structural and systemic factors

People experienced disadvantage at systemic levels that prevented access to key resources. Structural barriers such as time, cost, lack of integrated systems, confusing health care systems, and lack of service resources left individuals without mental health care support in critical times of need. Australians who had attempted to access care for suicidality or self-harm reported problems at stages of initial contact with health services (e.g., long wait time for an appointment), during contact (e.g., being discharged too soon, turned away due to not being 'serious' enough) and after contact (e.g., no follow up). A recent systematic review of aftercare services for suicide found that an effective model of care involves ongoing support comprising integrated coordinated clinical services and treatment with non-health and general support services (Shand et al., 2019).

There was also evidence that people's needs relating to aspects of their daily lives (e.g., housing, employment etc.) were not being met. While this could be due to unavailability of services and other structural barriers, institutional discrimination was also significant in preventing equitable access to services, particularly in minority groups and those with intersecting identities. The consequences of this, as shown in an inquiry on Aboriginal suicides, included poverty, homelessness, poorer health, financial problems due to lack of access to education and employment, increased substance abuse, and impulsive behaviours. This was a significant source of distress and could increase the likelihood for suicidal behaviour.

Connection to others

The importance of interpersonal connection and relationships to others was apparent in people's lived experience accounts of suicide. Relationship breakdown or interpersonal conflict were prominent precipitators to suicidal behaviour. The lack of connection to others or dissolved connections to others could lead to isolation and loneliness, which were also identified as significant contributors. Indeed, informal networks with friends, family, or other communities were cited as a major protective factor, either directly or indirectly.

In interactions with health services, it was clear that a strong patient-provider relationship determined how helpful people found the service. Kind, genuine, respectful and empathetic treatment reinforced the relationship between the patient and health care professional, as it validated their emotions, and made them feel understood and cared for. Settings such as EDs were seen as impersonal and unhelpful, as they tend to focus on immediate medical stabilisation rather than the emotional state of the individual (Hausmann-Stabile et al., 2018). Where individuals reported positive experiences with such settings, they were mainly attributed

towards having a connection with service staff. A meta-analysis found a consistent relationship between therapeutic alliance and therapeutic outcome (Martin et al., 2000)

The need for interpersonal connection was also clear in people's use of other services. This connection could be strengthened between people with shared experiences, which includes the shared experience of suicidality, as well as shared experience of identity (e.g., male, gender or sexual minorities). Online forums and peer support groups facilitated a type of mutual help giving and help receiving. Users of respite centres and safe havens felt comforted by being surrounded by other service users and staff, who were also experiencing suicidality or mental health problems. The presence of peer support workers with their own lived experience helped to create a more equal and normalising environment for visitors. These other services are particularly valuable considering structural and systemic barriers to traditional health care that may take considerable time to address. As a more immediate solution, these services are an important source of peer support and can offer help at critical times (e.g., during crisis, after discharge) where individuals may be unable to access traditional care.

Self-worth and value

People's experience of suicidality and services were sometimes framed in the context of their value to self and value to others. Individual stigma and discrimination, bullying from peers, and dismissive attitudes from health service staff could dehumanise individuals and lower their self-worth. In some cases, this also led to feelings of self-stigma or self-hatred. This negative treatment may be indicative of a lack of knowledge about mental health issues and suicide (Jorm, 2000). Education and training that improves suicide and mental health literacy might partially address discriminatory attitudes.

An important component of self-worth was having a sense of autonomy. A perceived loss of autonomy, such as increased reliance on others due to aging was a source of distress. Indeed, being a burden on others was a common reason for suicidal behaviour, particularly in older populations. People also reported negative experiences where there were power imbalances between patient and health care provider, where treatment was imposed on them and/or they were excluded from treatment decisions. By contrast, active involvement in a person's own treatment not only ensured appropriate tailored care, but also fostered agency and value in the patient.

Others described suicidality as related to a perceived loss of value to society or to family. This could be caused by specific events, such as job loss, where unemployment made people feel that they could no longer contribute to society or that they could not fulfil specific roles within their family (e.g., male expectations of being the breadwinner). Older individuals who had self-harmed described feeling disconnected from society,

a lack of meaning and purpose, and no reasons to continue living. Research suggests that societies that value older people and have more positive attitudes towards them are more likely to have lower rates of suicide in older people (Yuryev et al., 2010).

Emotional pain and hopelessness

Structural disadvantage, lack of connection to others and low internal self-worth could lead to trauma and extreme emotional pain in response to sources of distress, such as adverse life events. These events could compound from previous generations (e.g., intergenerational trauma) and early childhood (e.g., abuse or neglect) to the present. The cumulative effect of these events, as well as repeated negative experiences with help-seeking or reaching out (e.g., being dismissed, ineffective treatment), could lead to a sense of hopelessness. Across a number of studies reviewed, hopelessness was identified as a key contributor to suicide. Along with a lack of access to protective factors and alternative coping mechanisms, suicide provided relief from emotional pain through escape. Shneidman (1993) referred to this unbearable pain as 'psychache' and argued that to prevent suicide, we must seek to examine the sources of this pain and to alleviate it.

It is essential to note that the causes and impact of life stressors vary by people's age, gender and sexual identity, culture, and the intersections between these identifies. For example, contributors to suicide in young people often related to conflicts with parents and peers, while contributors to suicide in older people related to physical health problems. For Aboriginal Australians, multiple sources of trauma caused by colonisation and institutional oppression led to suicidality. Understanding intersectionality and suicide is particularly relevant for Australia's population, given the large culturally and linguistically diverse population, and the elevated rates of suicide in groups such as Aboriginal Australians (Dickson et al., 2019; Education and Health Standing Committee, 2016), men (Australian Bureau of Statistics, 2019), LGBTI (National LGBTI Health Alliance, 2020), and people in immigration detention (Hedrick et al., 2019).

Gaps in the literature

There was a notable lack of research that focused on non-health service experiences from a lived experience perspective. This is despite findings that a number of external stressors including financial, work, and legal problems contributed to suicidal behaviour. Individuals also directly expressed a need for support in these areas that was not being met by traditional health services. Various Australian government inquiries and reports have investigated issues in health and welfare systems that can increase the risk of suicide. For example, a NSW government inquiry into child and youth suicide reported that children under 18 with a child

protection history are at higher risk for suicide and that the number of child suicide deaths who were in contact with the Department of Family and Community Services (FACS) has increased in recent years (Joint Committee on Children and Young People, 2018). Other reports and inquiries have identified cases of suicide or self-harm relating to rural and remote mental health (Farmer et al., 2020), detention and custody (Ombudsman SA, 2019; Victorian Ombudsman, 2014), unemployment payments (Neave, 2016), workers compensation claims (Victorian Ombudsman, 2016), and disability services (Queensland Ombudsman, 2019). Additionally, cases of suicide linked to Centrelink debt have been reported in the media. These reports and inquiries were not included in this review as they were not focused specifically on suicide or the lived experience perspective, yet it is clear that they are areas requiring more attention. Related, the majority of the research identified was conducted internationally. Although some of these findings are relevant to Australian populations (e.g., the importance of appropriately trained health care staff, the value of a strong therapeutic alliance) it is necessary to further our understanding of service gaps and user needs in the Australian context.

Finally, compared to the body of quantitative research on suicide, qualitative research was limited. Therefore, the extent of historic, demographic, biological, clinical and psychosocial variables that have previously been identified as being linked to suicide in different populations may not be fully reflected in this review. This demonstrates the value of the combination of theoretical models, quantitative research and qualitative research in providing a more complete picture of suicidality.

Limitations

What is covered in this rapid review is not an exhaustive list of factors that influence suicide and experiences with services (nor will they be applicable to everyone due to the personal nature of these experiences), in part due to the research questions and review methodology. Ambivalence and impulsivity are often linked to suicidal behaviour, but they did not feature heavily in this review. In addition, it is likely that we missed some research and reports, given that many relevant papers were sourced from our key informants and stakeholders. Although this review identified studies on a variety of populations, there may have been perspectives of some groups missing. For example, recent studies have examined the prevalence of suicide in people with autism spectrum disorder (Hirvikoski et al., 2016) and the potential benefits of sensory interventions (e.g., quiet environment, soothing music, ambient lighting) in emergency departments (Bowman & Jones, 2016).

Studies of experiences of support and services included in this review focused on active help-seeking behaviour, and less is known about passive interactions with services and institutions. Further, there may be situations where a person is offered help and does not accept it. Understanding how to reach people who do not want help can aid suicide prevention efforts. Studies examining experiences of health services also usually involved face-to-face care. With the increasing use of technology-based care, it would be beneficial to understand people's experiences with non-face-to-face services.

Recommendations and conclusions

This review has summarised major themes and constructs emerging in people's accounts of the reasons for their suicidality and their experiences with services and support. However, much like existing theories of suicide, it is not a complete representation of the complexity of suicidality. Nevertheless, it is clear that there are interactions occurring between different factors at different levels, demonstrating the value of and need for qualitative research in enriching our knowledge of this process. Therefore, understanding a person's lived experience of suicide necessitates understanding their lived experience as a whole. With consideration for the fact that the experience of suicide is complex and unique to the individual, we have identified some key recommendations for policy and practice.

1. **A review of inputs to policy decision making that considers the impact of policies and policy settings on suicide, and investment in modelling of policies and their impact on suicide**

Many of the contributing factors to suicide identified in this review are beyond the remit of the health system and are aligned with the social determinants of health. There is good evidence that non-health policies have an impact on suicide (e.g. employment, alcohol availability, housing). A more universal approach to suicide prevention could be adopted through investing in impact and economic modelling to determine the policies and policy settings likely to produce the best outcomes for the least cost; reviewing policy decision making processes to allow for consideration of impact on suicide prevention, reviewing the policy 'suite' to identify gaps; and investing in research to evaluate the impact of policy changes. A process for considering health and suicide impacts of government policies is needed. Research conducted on behalf of Suicide Prevention Australia found that 71% of Australians want all government decisions to consider the risk of suicide and have clear plans in place to mitigate any negative impacts following from the decision (Suicide Prevention Australia, 2019).

2. **Integration of lived experience perspective within all sectors and all levels involved in suicide prevention**

If systems and services are to truly meet the needs of people experiencing suicidal thoughts, they require active involvement of lived experience at all stages, from research that aims to build the evidence base, government policy and program planning, service design and delivery, to program implementation and evaluation. This capacity should continue to be developed within Primary Health Networks and other health organisations. Various frameworks are available to guide this integration including the LifeSpan Framework for the engagement of people with lived experience in program implementation (Suomi et al., 2017), and the National Mental Health Commission's '*Sit beside me, not above me*' report (National Mental Health Commission, 2017b) and Consumer and Carer Engagement Practical Guide (National Mental Health Commission, 2017a). Investment is required to develop the skills, capabilities and cultures necessary to recognise and support equal partnerships and the value of lived experience perspectives.

3. Ongoing funding for alternative services to the emergency department and acute care teams

People in crisis often experience barriers to accessing care or sporadic, inconsistent care. Funding for a variety of services that complement and are integrated with traditional services ensures that individuals have a constant source of support. These services can also reduce the burden on existing health and welfare services. Following the launch of a safe haven service in the UK, there was a decrease in mental health-related calls to the police and in mental health-related police deployments in the surrounding areas. A cost-benefit analysis of a safe haven service in Melbourne found that it reduced ED presentations, improved patient experiences of care and improved social connectedness for vulnerable individuals (St Vincent's Hospital Melbourne, 2018). Therefore, there is also a need to evaluate these emerging services that goes beyond risk reduction to examine the experience of the service user, their long-term social and health outcomes, as well as health service outcomes such as impact on presentations to the emergency department and hospital admissions, using both quantitative and qualitative methods.

4. Health workforce development that is focused on therapeutic engagement rather than risk management, includes peer support workers, and recognises the role of complex trauma across a range of presentations.

The need for existing health systems to reform their culture and practice will remain, even when alternatives are available. Currently, health and other related professionals are required to complete separate training for a range of presentations, many of which are overlapping (e.g. suicidality, domestic violence, substance use) and require the same capacity for active listening, empathy, and compassionate care**.** Traditionally, suicide prevention training has focused only on suicide risk and not on the needs of the person. Newer models of suicide prevention training (e.g. CAMS, Connecting With People, SRAM-ED, SafeSide) emphasise the importance of a collaborative and therapeutic relationship. This approach is supported by research which shows that, compared to treatment modality, the therapeutic alliance is often a stronger predictor of

treatment outcomes. Training must be supported by cultural change and systems changes that support the use of newly learned skills.

Workforce development must extend to the peer workforce, as well as including peer support workers in training for clinicians in order for them to treat the whole person, recognising that many people who present in crisis do so because of complex trauma. Training that focuses on supporting the person's sense of agency and power to the fullest extent possible, i.e. where possible including the person in decision making about their care, is also likely to be of benefit.

5. **Services that are structured and well-integrated to support broader psychosocial needs and ongoing follow up and support**

People who experience suicidal crisis often require a range of services, and yet this is a time when many are left to navigate several complex and difficult systems (disability support, income support, housing, health). Care coordination is generally carried out by aftercare services such as the Way Back Support Service, but this represents only a small proportion of people presenting in crisis (e.g. it is often restricted to people who have already made an attempt). Because of the siloed nature of care even within a single hospital, there is often little accountability for ensuring continuity of care within and across services. The role of care coordination or case management must therefore be well resourced and have decision making power and authority. With growing evidence for the utility of services such as safe havens, integration and coordination of care must also involve new and emerging services in order to fully address people's long-term needs.

6. **Commission and fund research to improve the evidence base for integrating the peer and clinical workforces**

There are now several Australian organisations that have implemented an integrated peer support and clinical model, and many more that are trying to understand how best this can be achieved. We recommend a study that captures best practice and lessons from those organisations already experienced in this area, supported by a knowledge sharing strategy so that new organisations can benefit from this expertise. Further, we recommend investing in ongoing mixed methods evaluation and quality improvement in this field.

7. **Services that do not discriminate, are culturally appropriate, and available in languages other than English**

Equitable access to health and welfare services for Australia's diverse population is key to preventing suicide. This includes upskilling workers to ensure that they are culturally competent, and diversity in hiring of staff. Where there are language barriers, translators should be made available. Providing detailed information online and in person about staff and available services (e.g., languages spoken, training undertaken by staff),

as well as clear statements of support for vulnerable populations (e.g., LGBTQI, Aboriginal and/or Torres Strait Islanders) can help people feel safe and welcomed.

8. Boosting and strengthening the capacity of community and family to provide effective support

Family and other informal sources of support are the most frequently preferred first point of contact or disclosure of suicidality. For some, the role of being a support person is an ongoing one with its own limited support, and many people in a support role feel ill-equipped. While there are carer support groups in most jurisdictions, along with other resources such as 'Guiding Their Way Back', many support people are unaware of these resources. Training in how to support a suicidal family or community member/colleague etc., such as Mental Health First Aid, could and should be integrated into standard workplace training practices as part of a strategy to ensure reach/exposure to these skills at a population level. At a broader level, an effective communications strategy to the community about help options and available resources is needed, along with examination and development of the other support resources required.

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Appendix A: Full data extraction tables

What do people who have attempted suicide or been in a suicidal crisis report as the most significant contributing factors?

Authors (year)	Participant group (n)	Study setting	Study design	Key Findings
Australia				
Black Dog Institute (2014). Player, M. J., J. Proudfoot, A. Fogarty, E. Whittle, M. Spurrier, F. Shand, H. Christensen, D. Hadzi-Pavlovic and K. Wilhelm (2015).	Interviews: • Men who had survived a suicide attempt aged 18-67 (n=35) • Friends and family of men who had survived an attempt aged 19-65 (n=45) Online survey • Men aged 18-73 (n=176)	Australia	Mixed methods	• Four core traits or experiences common in suicidality – depressed mood, unhelpful conceptions of masculinity, social isolation/ineffective coping strategies, life stressors (e.g., employment, relationships, involvement in family court system) • Key factors interrupting or preventing an attempt: male bonding, physical activities, normalising distress, 'sanctuary' or safe space for men, direct intervention from family and friends, sense of responsibility to family members, accessing professional services, not wanting family or friends to feel that it was their fault • Importance of persistence of offers of help in face of rejection
Fogarty, A. S., Spurrier, M., Player, M. J., Wilhelm, K., Whittle, E. L., Shand, F., ... & Proudfoot, J. (2018).	Men who had made a suicide attempt aged 18-67 (n=35), family and friends of men who had made a suicide attempt aged 19-65(n=47)	Australia	Qualitative	Contributors: period of depressed or disrupted mood, unhelpful conceptions of masculinity, social isolation and use of avoidant coping strategies, personal stressors, unable to acknowledge disturbed mood, normalised distress and thoughts of suicide • Factors that interrupted attempts: distraction, seeking professional help, family, practical help, talking to others and receiving support
Foreign Affairs, Defence and Trade References Committee - The Constant Battle: Suicide by Veterans		Australia	Inquiry report	• Difficulty returning to civilian life (e.g., relationship problems, mental illness, substance misuse, employment problems, bereavement, loss of routine and structure in military life), and reluctance to seek help • Stress caused by training (e.g., exposure to violence) • Multiple deployments, limited recovery time between deployments

Authors (year)	Participant group (n)	Study setting	Study design	Key Findings
Heinsch, M., D. Sampson, V. Huens, T. Handley, T. Hanstock, K. Harris and F. Kay-Lambkin (2020)	Adults aged 30-62 (n=6)	Australia	Qualitative	• Lack of access to affordable service, lack of awareness about services • Difficult to access services when in unfamiliar location • Adverse life events, compounding life events preceded suicide attempt • Desire for escape • Most critical need for service engagement and support was during initial crisis stage but sufficient support was not always provided at this time
Joint Committee on Children and Young People (2018)		Australia	Government inquiry	Vulnerable groups of young people: • Children and young people with a child protection history, Aboriginal and Torres Strait Islander children, young men, children and young people living in rural and remote areas, LGBTI young people,
Maple, M., L. M. Frey, K. McKay, S. Coker and S. Grey (2019)	Adults aged 19-72 (n= 31)	Australia	Qualitative- semi-structured interview	mes centred around 1) Internal factors impacting disclosure (the way individuals experienced revealing their thoughts and behaviours and 2) Others' interpretations or reactions that impacted disclosure. me 1) Internal factors (*3 sub* themes) • *Hard to reach*- being too far in the suicidal space to reach out even if it was noticed by family/friends • *needing to find the words* – experience of intense emotions (pain, disconnect, hopelessness) leading up to attempt that they were unable to verbalise what was going on. For some also sense of internalised stigma and fear of rights being removed • *Sharing from a distance* – writing and online platforms (Facebook) provided an outlet. Helped process their experiences and provide connection and help to others Theme 2) Others' interpretations or reactions (4 *sub* themes) • *Attention seeking*- upon disclosure experiencing negative reactions indicating the person wasn't serious/attention seeking. Lead to less disclosure • *Harsh judgement* –on disclosure to friends/family/professionals verbally being criticised/blamed/ called names • *Stigma*- general mental health stigma related or not related to them impeded disclosure

Authors (year)	Participant group (n)	Study setting	Study design	Key Findings
				• Finding a lifeline – having at least one person who was available and served as a buffer to others' negative reactions
McTaggart, O. (2016).		Australia	Inquiry report	Factors influencing suicide death include: • History of depression • Substance use • Relationship breakdown • Work problems • Physical health problems • Death of family • Individuals often experienced multiple of these problems
Milner, A., Maheen, H., Currier, D., & LaMontagne, A. D. (2017)	Male suicide deaths aged 15-69 (n=34)	Australia	Qualitative analysis of coronial data	• Possible stressors included transient work experiences, workplace injury, financial difficulties, legal problems, relationship problems (most common), substance abuse
National Children's Commissioner (2014)		Australia	Inquiry report	Proximal risk factors included • Emotional distress, diagnosed mental and physical health concerns, grief and loss, physical and emotional abuse, familial conflict, body image issues, school pressures Distal risk factors: • Mental health problems, alcohol and drug abuse, child abuse, adverse family experiences, previous suicide attempts, communicated suicidal attempt, intentional self-harm
Neave, C. (2013).		Australia	Inquiry report	Factors contributing to suicide/self-harm in immigration detention • History of torture and trauma (e.g., violence in home countries) • Fears for family • Isolation (e.g., language barriers, lack of family/support systems at home) • Children in immigration detention

Authors (year)	Participant group (n)	Study setting	Study design	Key Findings
				• Confinement, deprivation, loss of liberty, isolation and hopelessness caused by detention environment • Exposure to other self-harm/suicidal behaviour or mental health issues • Limited meaningful activities • Overcrowding
Peters, K., Murphy, G. & Jackson, D. (2013)	Immediate family survivors (n = 10), bereaved between 2 and 20 years	Community (Australia).	Qualitative narrative inquiry design. Interviews.	Key events in weeks prior to suicide as reported by immediate family survivors • Purposeful indication of intent to end life (i.e. verbalisation, prior attempt) • Disappointment with health services (participants did not feel their concerns taken seriously) Exclusion of family members from treatment information
SANE Australia (2015)	Adults aged 19-72 (n=31)	General community, Australia	Qualitative	• Psychosocial influences at time of attempt – presence of symptoms of mental illness, lack of professional support and life stressors relating to work, bereavement, substance misuse, sexual assault, relationship problems, physical health problems • Internal feelings of hopelessness, depressed, overwhelmed, feeling like a burden
International				
Abar, B., E. Greener, V. DeRienzo, S. Botelho, T. Wiegand and K. Conner (2018).	Adults, mean age 29.83 (n=18)	Medical centres, United States	Quantitative	• Majority reported more than one barrier to care • Most common barrier was transportation
Anderson, J., M. Hurst, A. Marques, D. Millar, S. Moya, L. Pover and S. Stewart (2012).	Young people aged 9-16 (n=23)	Child and Adolescent Mental Health Services, UK	Qualitative	• Sexual abuse • Ill sibling • Multigenerational issues • Depressed parent
Andoh-Arthur, J., B. L. Knizek, J. Osafo and H. Hjelmeland (2018)	Close contacts aged 22-80 (n=43) of men who died by suicide aged 19-56 (n=12)	Ghana	Qualitative	• Loss of economic control • Breach of patriarchal norm • Threats to sexual competence

Authors (year)	Participant group (n)	Study setting	Study design	Key Findings
Barnes, M. C., D. Gunnell, R. Davies, K. Hawton, N. Kapur, J. Potokar and J. L. Donovan (2016)	Adults aged 19-56 (n=19)	UK	Qualitative	• Employment and financial difficulties (e.g., debt) • Co-existing or historical vulnerabilities (e.g., childhood trauma, bereavement) • Need for clear, practical help for economic difficulties or counselling for co-existing/historical vulnerabilities
Biddle, L., D. Gunnell, A. Owen-Smith, J. Potokar, D. Longson, K. Hawton, N. Kapur and J. Donovan (2012).	Adults aged 19-60 (n=22)	UK	Qualitative	Sources of information about method • Television and film • Internet • Information found about methods could be preventative (i.e., prompted people to think about what would happen if the method didn't work) • Internet used to access materials • News stories • Healthcare professionals (e.g., ideas about appropriate dosage)
Brownson, C., D. J. Drum, S. E. Smith and A. B. Denmark (2011).	College students (n=1321)	Colleges, US	Quantitative	• Females more likely to report problems with family, sexual assault, relationship with violence, relief from pain, communicating pain to others as contributors to crisis • Females more likely to report disappointing others, support from others, religious/moral beliefs and plans for future as protective factors
Bryan, C. J., & Rudd, M. D. (2012).	Soldiers aged 19-44 (n=72) reporting at least one suicide attempt in the past month	Military, United States	Secondary analysis of quantitative data	• Most frequent contextual factors occurring in 24h prior to suicide attempt were emotional experiences (e.g., feeling depressed, overwhelmed, isolated), external events (e.g., interpersonal conflict, financial problems), and traumatic thoughts (e.g., combat, nightmares, flashbacks)
Chung, I. (2012).	Chinese immigrants (n=31)	Mental health clinics, US	Qualitative	• Interplay of acculturation stressors, negative life events and negative help-seeking • Interplay of mental illness, help-seeking behaviour and social resources (e.g., lack of mental health services and government entitlements) • Ineligibility for health and financial benefits
Creighton, G., J. Oliffe, J. Ogrodniczuk and B. Frank (2017).	Close contacts aged 23-71 (n=15) of male suicides aged 15-39 (n=6)	Rural town, Canada	Qualitative	• Conceptions of masculinity, particularly within rural setting led to hiding depression and its causes and self-medicating

Authors (year)	Participant group (n)	Study setting	Study design	Key Findings
Creighton, G. M., J. L. Oliffe, M. Lohan, J. S. Ogrodniczuk and E. Palm (2017)	Close contacts aged 22-57(n=6) of a male suicide aged 17 (n=1)	Rural town, Canada	Qualitative	• Rural town limited self-expression • Narrow conceptions of masculinity
Dougherty, P. A. (2011).	Female adolescents aged 14-17 (n=7)	Hospital, US	Qualitative	• Estrangement and alienation from adolescent's two major support groups: parents and peers • Lack of self-identity to cope with stressful experiences • Non-supportive communication with parents • Rejection and ridicule from peers • Impulsivity of youth
Elliott, M., D. E. Naphan and B. L. Kohlenberg (2015).	Adults aged 19-54 (n=16)	State facility for people unable to pay for treatment, US	Qualitative	• Disappointment with others • Extreme financial strain • Lack of mental health care or medications • Relationship problems • Benefits of being hospitalised – being removed from adverse situations, access to care, loved ones and staff showing concern for them
Farrelly, S., D. Jeffery, N. Rusch, P. Williams, G. Thornicroft and S. Clement (2015)	Adults aged 20-65 (n=58)	UK	Mixed methods	• Treated unfairly or differently due to mental health problems/diagnosis • Isolation • Negative feelings about themselves
Ferlatte, O., J. L. Oliffe, T. Salway, A. Broom, V. Bungay and S. Rice (2019)	Gay, bisexual and two-spirit men aged 23-71 (n=21)	Canada	Qualitative	• Adverse childhood events/trauma • Financial problems • Lack of belonging/isolation • These factors interacted with homophobia/stigma
Furqan, Z., M. Sinyor, A. Schaffer, P. Kurdyak and J. Zaheer (2019).	Suicide notes (n=36)	Canada	Qualitative	• Negotiating personal agency in context of mental illness • Illness as biological • Conflict between self-identity and illness

Authors (year)	Participant group (n)	Study setting	Study design	Key Findings
				• Multiple attempts at treatment that led to sense of hopelessness • Treatment failure viewed as personal failure • Suicide as exertion of personal autonomy
Foster, T. (2011).	N/A		Review of psychological autopsies (international)	• Almost all suicides experienced at least one adverse life event within a year of death • Life events particularly common prior to young, male, impulsive, personality disordered and substance misusing suicides, though there were some differences across cultures • Interpersonal conflict greatest risk • Relationship breakdown, legal problems, physical illness, employment/financial problems and bereavement more common in men • Interpersonal conflicts, rejections, legal problems, unemployment/financial problems more common in younger suicides • Differences also found in suicides with personality disorders and substance misuse
Gulbas, L. E., Hausmann-Stabile, C., De Luca, S. M., Tyler, T. R., & Zayas, L. H. (2015)	Latina adolescents aged 11-19 who: • Attempted suicide (n=29) • NSSI and attempted suicide (n=8)	Hospitals, mental health services, clinics, community agencies, New York City, US	Mixed method longitudinal project from 2005-2010	• Motivations include feelings of powerlessness, loneliness, lack of self-worth, lack of alternative coping mechanisms for emotional suffering • Participants engaged in NSSI attempted suicide after NSSI no longer provided relief for emotional distress
Gulbas, L. E., & Zayas, L. H. (2015)	Latina adolescents attempted suicide (n=10), mean age 15.7	Hospitals, mental health services, clinics, community agencies, New York City, US	Mixed method longitudinal project from 2005-2010 – Analysis of qualitative data	• Motivations include subjective distress, interpersonal discord (within family), and emotional isolation • Culture impacted interpersonal familial conflict and ability to form meaningful, supportive relationships (individualist vs collectivist)
Hagaman, A. K., Sivilli, T. I., Ao, T., Blanton, C., Ellis, H., Lopes Cardozo, B., & Shetty, S. (2016)	Family/close contact of 16 Bhutanese refugees who died by suicide (n=14)	United States	Mixed methods psychological autopsy study 2009-2012	• Bereaved by suicide, language barriers to accessing employment and education and contributed to sense of hopelessness, separation from family in home country, lack of resources to support refugee transition, difficulty maintaining cultural and religious traditions
Han, C. S., Oliffe, J. L., & Ogrodniczuk, J. S. (2013)	Korean immigrants aged 20-62 (n=15)	General community, Vancouver, Canada	Qualitative, individual interviews	• Academic and work pressures to meet familial expectations (influenced by Korean cultural values), cultural clash (individual identity, relationship with family)

Authors (year)	Participant group (n)	Study setting	Study design	Key Findings
Holliday, C., & Vandermause, R. (2015).	Adolescents aged 15-19 (n=6)	US	Qualitative cross-sectional	• Suicide attempt as a method to communicate emotional suffering • Feeling unconnected and alone – isolated from peers and health professionals
Klevan, T., Karlsson, B., & Ruud, T. (2017)	Crisis response team service users aged 25-70 (n=14)	Norway	Qualitative	• Crises triggered by loss of social structures relating to financial problems, poor housing, social roles, family situation • Loss of self-worth • Suicide thought as a way to cope or escape from mental health crises
Lasrado, R., & Young, A. (2017)	Survivors of attempted suicide (n=15), mental health professionals (n=8), traditional healers (n=8) aged 18-44	Southern India	Qualitative	• Struggle with cultural norms and pressures particularly in relation to gender expectations and family structures • Presence of intimate partner violence, family member violence
Lim, M., S.-W. Kim, Y.-Y. Nam, E. Moon, J. Yu, S. Lee, J. S. Chang, J.-H. Jhoo, B. Cha, J.-S. Choi, Y. M. Ahn, K. Ha, J. Kim, H. J. Jeon and J.-I. Park (2014)	Suicide attempters presenting to hospital aged 13-87 (n=367)	Hospitals, Korea	Secondary analysis of quantitative data from national survey of suicide	• Psychiatric symptoms, stress (most commonly interpersonal problems followed by financial problems) • Stress due to interpersonal problems as a reason most common among reasons in all age groups, but more common in younger attempters • Older age groups more likely to cite financial stress as reason • Media coverage and suicide-related Internet sites not the direct cause
Rasmussen, M. L., K. Dyregrov, H. Haavind, A. A. Leenaars and G. Dieserud (2018)	Data from young men aged 18 – 30 who died by suicide (n=10) Information from closely connected individuals, i.e. parents, siblings, girlfriends (n=61; 4-8 per suicide) and suicide notes	Community, Norway	Qualitative, Interpretative Phenomenological Analysis. Interviews and analysis of suicide notes. Suicides occurred between 2005 and 2009.	Self-esteem issues as predominant theme leading to suicide where transition to adulthood was experienced as period of personal defeat: • Striving to find viable path to life as adult man • Experiencing sense of failure according to own standards • Emotional self-restriction in relationships Strong feelings of loneliness and rejection of self

Authors (year)	Participant group (n)	Study setting	Study design	Key Findings
Nicolopoulos, A., K. Boydell, F. Shand and H. Christensen (2018)		International	Systematic review (children and young people aged 12-25)	Reasons for suicide: • Intrapersonal conflicts and challenges (e.g., negative emotions, emotional state, control, desperation and escape) • Sociocultural factors (e.g., access to support, socioeconomic adversity, rejection, expectations) • Interpersonal conflict • Historical factors
Oliffe, J. L., Ogrodniczuk, J. S., Bottorff, J. L., Johnson, J. L., & Hoyak, K. (2012)	Men who self-identified (n=13) or were formally diagnosed with depression (n=25) aged 24-50	Canada	Qualitative interviews	• Things that prevented suicide included connecting with others, recognising the need for treatment for their depression • For individuals who had engaged in suicidal behaviours, a desire for escape led to self-isolating and self-destructive behaviours
Osafo, J., Akotia, C. S., Andoh-Arthur, J., & Quarshie, E. N.-B. (2015)	Suicide attempters, men, aged 30-41 (n=10)	Rural village in Eastern region of Ghana	Qualitative interviews	• Motivations included social taunting/mocking, hopelessness (related to employment problems, chronic illness), perceived partner infidelity • Stigma/exclusion from family and community following suicide attempt unhelpful
Parkar, S. R., Nagarsekar, B. B. Weiss, M. G. (2012	Close contacts of n = 50 suicides: 1. Closest surviving first-degree relative (1 per suicide) 2. More distant relative (1 per suicide)	Low income community Mumbai	Mixed method sociocultural autopsy study from 2003-2004. Interviews.	Specific relationships with the deceased shape survivor views. Series-level (agreement within one group of participants) and case-level (agreement within two participants of one suicide case) findings agreement did not always correspond. Motivations as reported here include perceived causes for suicide as well as reasons for distress. Most frequently reported motivations based on both high series-level and case-level agreement: • Marital problems • Financial problems • Alcohol

Authors (year)	Participant group (n)	Study setting	Study design	Key Findings
				Most frequently reported motivations based on highest case-level agreement: • Desertion • Substance abuse • Bereavement • Marital problems • Physical and verbal abuse • Alcohol
Rice JL & Tan TX (2017)	Youth hospitalised for suicidality aged 13-17 (n=220)	Inpatient child and adolescent unit of one psychiatric hospital, metropolitan area of a southern region of the US.	Qualitative. Thematic analysis of de-identified psychiatric medical records incl. therapy session notes, psychosocial assessments and psychiatric evaluations. Data collected in 2014.	Life events precipitating suicidal crisis: • Changes in family structure (e.g. death, divorce, remarriage, moving, birth of new sibling) • Exposure to familial trauma (severe emotional pain coupled with lack of support to cope) • Family conflict • Parental instability (e.g. parental mental illness, substance abuse, history of trauma, incarceration)
Rivlin A, Ferris R, Marzano L, Fazel S & Hawton K (2013)	Male prisoners aged 18-57 (n=60)	19 male prisons near Oxford, UK incl. 3 Young Offenders Institutes, 3 Cat. A prisons, 12 Cat. B prisons, 1 Cat. C prison	Qualitative study. Semi-structured Interviews conducted within 4 weeks of attempt.	Attempts were made because (5-category typology) • Unable to cope in prison (suicide attempt attributed to combination of past abuse, ongoing prison related troubles and other serious problems outside prison) • Psychotic symptoms • Instrumental motives (intent was not to die even though a serious attempt was made) • Unexpected by prisoners themselves (suicide attempt as out of characters, precipitated by a series of adverse events inside and out of prison) • Drug withdrawal
Sales da Costa, A. L. and M. L. P. d. Souza (2017)	Family members aged 19-76 (n=11) of older	Brazil	Qualitative	• Health-related losses • Work-related losses

Authors (year)	Participant group (n)	Study setting	Study design	Key Findings
	suicides aged 60-74 (n=8)			• Lack of social security to retire/economic difficulties • Family conflicts
Scott, D. (2016)		International	Review – government report	• Published literature and CDRT reports show fatal neglect linked to child suicides • For suicide, this may involve medical neglect (parents exhibiting signs of distress and parent failing to help find effective care)
Shaw JL, Beans JA, Comtois KA & Hiratsuka V (2019)	Alaska Native and American Indian people aged 15-56 with self-reported histories of suicidality (n=15)	Alaska Native-owned and operated healthcare organisation, US	Qualitative study. Semi-structured interviews. Interpretative phenomenological analysis.	Experiences that contributed to suicide risk: • Trauma and related health problems • Loss and exposure to suicide • Substance misuse • Lack of effective behavioural health resources (they did not exist, were not accessible or ineffective) Stigma related to suicidality and behavioural healthcare preventing the person to seek help
Signoracci GM, Stearns-Yoder KA, Huggins JA, Janoff EN & Brenner LA (2015)	AIDS infected male veterans (n=20)	Urban Veterans Administration Medical Centre, US	Qualitative study. Semi-structured interviews. Descriptive approach.	Perceived indicators of elevated risk included drug and alcohol relapse, avoiding everyone except other drug/alcohol users, not taking medications, missed appointments, poor hygiene, not answering the phone. Participants expressed desire for healthcare providers to reach out to them and to do what it takes to keep them safe incl. involuntary hospitalization. Lack of social support, poverty, depression.
Straiton M, Roen K, Dieserud G & Hjelmeland H (2013)	Young Norwegian adults who have self-harmed (n=122)	Community, Norway	Mixed methods. Sub-sample of a larger quantitative study (n=522). Thematic analysis of open-ended survey items related to description of self-harm	What leads to self-harm: • Social influences (vague life events, bullying, violence, separation, bereavement, family problems) • Emotions: distress, anger, low mood, despair, frustration, low self-esteem, homesickness. Only one male participant reflected on emotions.

Authors (year)	Participant group (n)	Study setting	Study design	Key Findings
				Specific triggers: Intoxication, conflict, period of social isolation
Sturgeon R & Morrissette (2010)	Manitoban farmers (n=29) with concerns around suicide. Current SI = 16; past SI = 8; third-party callers = 5.	Canadian rural and farm population. Data collected between 2003 and 2008.	Qualitative conventional content analysis of encounter forms of calls to the Manitoban Farm and Rural Stress Line. Encounter forms are written accounts of call, not a verbatim transcription, suicide risk assessment is included when applicable)	Triggers for call to crisis line: • Financial concern (for >55%). Financial distress also leading to or co-occurring with strained family relationships. • Physical and MH concerns (ongoing fatigue, high blood pressure, stress-related physical illness, depression, anxiety, negative feelings) • Uncontrollable events (almost all related to farm yield) Family stress
Van Orden, K. A., Wiktorsson, S., Duberstein, P., Berg, A. I., Fässberg, M. M., & Waern, M. (2015)	Older patients aged 70 years and older (n=101)	Hospitals, Sweden	Mixed methods longitudinal	• Reasons for suicide attempt include escape, loss of normal functioning and autonomy, psychological problems, somatic problems and pain, perceived burden on others, feelings of loneliness/isolation
Vatne M & Naden D (2012)	Persons after suicidal crisis aged 21-52 (n=10)	Emergency psychiatry/crisis resolution, Norway	Qualitative. Gadamerian hermeneutic approach to data analysis of interviews.	Participants' reflections about suicide attempt: • Losing touch with the world • Relationship between suicidal accident and life history (life events e.g. inter-relational problems, substance abuse, physical injuries, psychological problems, excessive workload, loss of meaningful tasks) • Struggling for death and life (feeling ambivalent about survival) • Open door as consolation (being able to put an end to one's suffering) • Feeling shame (not being able to cope with one's own life) and guilt (related to hurting others) Suicidality as struggle between longing for escape from suffering and longing for love, safety and dignity in life. Suicidal accidents to happen when suffering becomes intolerable.

Authors (year)	Participant group (n)	Study setting	Study design	Key Findings
Wand APF, Peisah C, Draper H & Brodaty H (2018)	Older people aged 80 and over who self-harm (n=30), Suicidal intent n=20	Two teaching hospitals and associated community services	Qualitative study. Narrative enquiry of in-depth interviews.	Reasons for SH: • Enough is enough: Sense of life completion/lack of meaning, desperate wish to avoid residential care • Loneliness • Disintegration of self • Being a burden • Cumulative adversity • Hopelessness and endless suffering: depression, physical illness and pain • Helplessness with rejection: feeling invalidated by practitioners • Untenable situation: family conflict, abuse, perceived betrayal Consequences of SH: • Becoming engaged with or distanced with family • Problem was solved • Gaining control • Worse off now • Rejection by health professionals • Tension in the role of the inpatient clinical environment: hospitalisation experienced like being in a prison but some felt safe
Wand APF, Draper, B, Brodaty H & Peisah C (2019)	Older people aged 80 and over who had self-harmed (n=19), 5 had repeated SH, 8 had a persistent wish to die Also GPs and carers (not reported on here)	Two teaching hospitals and associated community services	Qualitative study. Narrative enquiry of in-depth interviews.	Factors contributing to SH persisted at follow-up. Patients felt that nothing could be done for them, felt like a burden and felt mistrusted and invalidated by clinicians. Some 'felt heard' after SH.

Authors (year)	Participant group (n)	Study setting	Study design	Key Findings
Williams SM, Stage DRL & Cerel J (2018)	Gender and Sexual Minorities (GSM) suicide attempt survivors aged 19-59 (N=25). Time since most recent attempt ranged from 1-31 years.		Part of the 'Live through this' project collecting stories of suicide attempt survivors. Qualitative interpretative phenomenological analysis of interviews data.	Factors contributing to suicidality: • Intersecting identities of multiple stigmatized groups shaping their experiences (i.e. GSM and attempt survivor identities). GSM identity leading to social isolation and distress (e.g. negative reactions when coming out) and eventually to suicidality. Gendered expectations. • Identity concealment because of negative reactions of others causing emotional distress and anxiety around GSM identity. • Internalised stigma and self-hate • Social environment, e.g. interpersonal difficulties contributing to suicidality. o Identity-based stigma and discrimination o Importance of positive social support. Enhancing coping capabilities o Family of origin dynamics, both positive support helping to resist suicidality and lack of support contributing to suicidality o Chosen family support • Importance of peer support (=ability to learn from and share with other individuals). 'Natural understanding' to occur. Both peer support for MH and for GSM important. Participants' wish to peer support others as well. Findings emphasize the need for peer support for GSM suicide attempt survivors.
Yamaguchi T, Fujii C, Tsujino N, Takeshi K & Mizuno M (2015)	Individuals with schizophrenia who were admitted to ED after near-fatal suicide attempt (n=7)	ED, Toho University Medical Centre Tokyo (Japan)	Pilot study. Qualitative study. Grounded theory approach to analysis of semi-structured interview data.	Factors related to suicidality: • Psychotic symptoms • Depressive state Only low level or no help-seeking behaviour displayed by participants.
Yang S (2012)	Korean Adolescent girl who attempted suicide, aged 16 at start of study (n=1)	Korea	Qualitative case study Life History Research approach (one single,	Life history as struggle between independence and autonomy and freeing herself from social stigmatisation. Life stressors:

Authors (year)	Participant group (n)	Study setting	Study design	Key Findings
			accessible, distinctive individual as representative of culture) including 24 interviews.	• Stigma due to growing up in a single-parent family. Controlling and oppressive attitude of mother (taking on the role of authoritarian father rather than affectionate mother) • High academic pressure
Zaheer J, Shera W, Tsang AK, Law S, Fung WLA, Eyan R, Lam J, Zheng X, Pozi L & Links PS (2016)	Chinese-born women living in Canada with history of suicidal behaviour within the prior 12 months (n=10), aged 19-51	Psychiatric care setting, Canada	Qualitative study. Constructivist grounded theory approach to data analysis of interviews.	Triggers for suicidal behaviour: • Build-up of stress and pressure • Restricted patterns of emotional communication, lack of agency, recurrent patterns of victimization and oppression and gendered expectations contributing to a coping style focused on 'endurance' of distress, in turn leading to negative self-view, physical manifestations of distress, worsening depressive symptoms and feelings of hopelessness and eventually leading to a breaking point. Precipitating incidents were reported perceived as causally linked to development of distress (incl. work, financial or educational distress, marital/romantic conflict, divorce/break-up, family conflict, illness/death of a parent)
Zayas LH, Gulbas LE, Fedoravicius N, Cabassa LJ (2011)	Young Latinas aged 11-19 (n=27) who had attempted suicide	Social Service and Mental Health agency, psychiatric outpatient, inpatient and emergency services, US	Qualitative thematic analysis of interview data. Data collected 2005-2007	Why they attempted: • Intent of dying • Management of emotions • Ambivalence Four main sources for patterns of distress: • Changes in family structure • Parental conflict • (Zayas et al., 2010) • Bullying Triggering events occurring within pattern of distress: • Familial conflict (often fight with mother)

Authors (year)	Participant group (n)	Study setting	Study design	Key Findings
				Suicide attempt as a consequence of continuous escalating stress. Struggle between traditional Hispanic gender socialisation with insertion in modern Western society.

What were their experiences with health and non-health services (e.g., housing, employment) in the lead up to, during and following their suicide attempt or suicidal crisis?

Authors (Year)	Participant group (n)	Study setting	Study design	Findings
Australia				
Better Care Victoria (2019)	Visitors to Melbourne Safe Haven service	Australia	Qualitative feedback survey	• Visitors felt a sense of hope, felt valued, heard and seen • Just listening, rather than being pushed to action, was important, • Felt safe and in control • Made connections with others
Black Dog Institute (2014) Player, M. J., J. Proudfoot, A. Fogarty, E. Whittle, M. Spurrier, F. Shand, H. Christensen, D. Hadzi-Pavlovic and K. Wilhelm (2015).	Interviews: • Men who had survived a suicide attempt aged 18-67 (n=35) • Friends and family of men who had survived an attempt aged 19-65 (n=45) Online survey • Men aged 18-73 (n=176)	Australia	Mixed methods	• Problems with welfare or health service supporting men at risk • Perceived failures of these services related to psychological assessment, scope or quality of intervention, extent of communication with family members • External service sometimes helped generate a community to help suicidal and isolated men • Relationships with family and friends strengthened following attempt

Authors (Year)	Participant group (n)	Study setting	Study design	Findings
Coker,S., Wayland,S., Maple, M., Hartup, M., Lee-Bates, B., & Blanchard (2019).	Survey • Adults (n=758) Interviews • Adults (n=30)	General community, Australia	Mixed method approach	Carers identified following issues with healthcare (from semi-structured interviews) • Difficulty accessing appropriate support due to issues related to geographic availability in rural and regional locations, not enough services available in general, the help seekers 'incident' not being deemed serious enough • Lack of post-discharge communication from service about the help seekers follow up support • Lack of coordination between teams within a service or between services which impact quality of care for help seeker i.e. being discharged without proper psychiatric consultation. • Positive experiences provided by carers were related to perceived supportive working relationships between help-seekers health professionals and the carer themselves
Finlayson-Short, L., S. Hetrick, K. Krysinska, M. Harris, C. Salom, E. Bailey and J. Robinson (2020).	Adults (n=175)	Queensland, Australia	Quantitative	• Compared to other lived experience groups, people who attempted suicide more likely to use face-to-face resources and telephone resources, but less likely to find them helpful • People who attempted suicide more likely to report that they could not find appropriate support, not have the energy to find support, accessed support that was not helpful, did not deserve support, problems with transportation, childcare, scheduling, scared of being hospitalised
Fogarty, A. S., Spurrier, M., Player, M. J., Wilhelm, K., Whittle, E. L., Shand, F., ... & Proudfoot, J. (2018).	Men who had made a suicide attempt aged 18-67 (n=35), family and friends of men who had made a suicide attempt aged 19-65 (n=47)	Australia	Qualitative secondary analysis	• Need for privacy vs vigilance in risk monitoring • Difficulties in differentiating normal vs risky behavioural change • Familiarity vs anonymity in risk monitoring • Respecting autonomy vs imposing restraints • Dependence on vs perceived failures of community services • Men expressed frustration at welfare/health services but had capacity to support them in a way that informal networks could not
Jackson, K. P., Welch, A., & Hopkinson, S. (2020).	Individuals aged 18-64 (n=8)	General community, Australia	Qualitative	• Positive experiences – hitting 'rock bottom' was a turning point to recovery, spending time with other patients • Negative experiences – breaches in confidentiality (information shared with parents), lack of guidance and support from health professionals

Authors (Year)	Participant group (n)	Study setting	Study design	Findings
				• Little to no follow up • Some prescribed medication with little explanation that limited their normal functioning
Lees, D., Procter, N., & Fassett, D. (2014)	Mental health nurses with recent experience of caring for someone in suicidal crisis, mean age 48 (n=11), consumers who had received care for recent suicidal crises, mean age 41 (n=9)	Hospital and community setting, Australia	Qualitative interviews	• Need for access to care, physical care and safety, treatment of psychiatric symptoms and strong patient-provider relationship • Nursing care most prominently involved detention, formal observation, medication – lacked interpersonal engagement • When there was interpersonal engagement, some of the most helpful components were active listening, empathy, compassion and trust
McCosker, A., & Hartup, M. (2018). Turning to Online Peer Forums for Suicide and Self-Harm Support.		Beyondblue suicide and self-harm online forums, Australia	Mixed methods analysis of forum posts	• Reasons for posting include: not coping, relationship problems, feeling lost, hopeless, suicidal thoughts, needing help • Forum members discussed personal histories, work, employment and education pressures, mental health problems • Positive experiences in terms of source of one-to-one personal contact, community of support, way to access expertise and knowledge related to mental health issues, personal advice, resources for coping strategies
McGill, K., Hackney, S., & Skehan, J. (2019)	People who had attempted suicide (n=22), friends and family of someone who had attempted (n=9), both someone who had attempted and knew someone who had attempted aged 18-79 (n=6)	Australia	Qualitative	• Need for information to address stigma, mental health and suicide literacy following attempt to support recovery
McKay, K., & Shand, F. (2018)	Individuals with previous suicide attempt aged 19-56 (n=20)	Australia	Qualitative	• Lack of integrated care (e.g., for complex mental health problems), not 'serious' enough to receive services • Feelings of fear and confusion during hospitalisation, uncertainty over what to expect • Need for advocate to facilitate care following attempt

Authors (Year)	Participant group (n)	Study setting	Study design	Findings
				• Private care better than public • Participants considered themselves lucky to receive appropriate care • Consistent care most helpful • Empathetic, kind staff helpful • Support of family and friends helpful
Peters, K., Murphy, G. & Jackson, D. (2013)	Immediate family survivors (n = 10), bereaved between 2 and 20 years	Community, Australia	Qualitative narrative inquiry design. Interviews.	Immediate family survivors reported negative experiences with health services in weeks preceding suicide: • Not having their concerns taken seriously • Early discharge after attempt • Health services focussing on immediate physical threat • No effective psychiatric assessment or follow-up • Immediate family survivors were made to feel like part of the problem rather than part of the solution • Little knowledge of how to deal with suicidal person • Negative experiences reported with both public and private health system • Exclusion of family members from treatment information (fam members being assured that their loved ones would be safe with the loved ones continuing suicidal behaviour at home right after discharge) • Lack of support from health professionals re strategies to keep their loved ones safe
PLWSA Lived Experience (2019)	Parents and grandparents who have lost loved ones to suicide, aged (n=42)	Australia	Qualitative survey	• Lack of compassion and not being heard – contributed to negative outcomes • Lack of involvement of caregivers • Cost was a barrier to accessing service • Overburdened service and lack of follow up • Lack of service coordination/integration – multiple types of funding/payment models was confusing • Staff turnover affected continuity of care

Authors (Year)	Participant group (n)	Study setting	Study design	Findings
				• Health system and police not equipped to deal with people with complex needs Children dealt with bullying prior to death
Radford, K. W., E; Martin, R (2019)	DISCHARGED peer support group participants (n=6)	Alternatives to suicide peer support group, Australia	Qualitative co-design interviews	• Felt valued and that they could speak without judgment or loss of autonomy, unlike their experiences with mental health services • Felt listened to • Welfare checks instigated by clinicians was viewed as disempowering • Public mental health services described as dehumanising and punitive • Had opportunity to explore their own trauma • Peer support workers/facilitators provided a safe, engaging environment • Trans participants felt safer in DISCHARGE – lack of safety in mental health services • Connection with others • Following involvement, participants felt more willing to open up to friends, were cautious about opening up to practitioners
Rimkeviciene, J., Hawgood, J., O'Gorman, J., & De Leo, D. (2015).	Eight adults (6 women, 2 men) aged 27-55 years being treated for suicidality	Outpatient clinic that specialises in treatment of suicidal individuals, Australia	Qualitative, individual semi-structured interviews	• Experiencing receiving clinical treatment that was deemed inadequate (too limited) or disempowering (too intrusive) led participants to feel stigmatised. • Inadequate care; when it was perceived that clinicians deemed suicide attempts as not serious (like other medical issues) participants felt discriminated against • Disempowering care: when rights and basic freedom was more intrusive and controlling than participants felt was necessary – in cases this was perceived as unhelpful, disappointing and humiliating. This threat of 'too intrusive' led to a lack of disclosure from participants for fear of "being locked up" • Both themes were linked to perceived stigma) perceived attitudes of others) and experienced stigma (encounters with discriminatory behaviour)
SANE Australia (2015).	Individuals aged 19-72 (n=31)	General community, Australia	Qualitative	• Difficulties accessing professional support experienced by majority of participants • Most who were hospitalised described negative experiences (80%) – not taken seriously, affected by other patients who were severely unwell, little follow-up • About half described positive experiences with hospitalisation – private much better than public

Authors (Year)	Participant group (n)	Study setting	Study design	Findings
				• Participants sought help from professionals including GPs, psychologists, psychiatrists, mental health case managers, mental health nurses, counsellors and telephone helplines • Positive experiences – developing strong relationship with professional • Negative experiences – stigmatising or dismissive attitudes • Professional support, access to effective and affordable treatments, support from family and friends, learning coping mechanisms most helpful to recovery
Shand FL, Batterham PB, Chan, JKY, Pirkis, J, Spittal J, Woodward A & Christensen H (2018)	People who made a suicide attempt aged 18-59 (n=112)	Health system, Australia	Mixed methods cross-sectional design. Online survey.	• Less than half believed they had received enough help (1) immediately after SA, (2) after leaving hospital/treatment facility, and (3) in the 6 months following the SA • Staff attitudes were perceived as poor • Satisfaction with GPs was rated highest, satisfaction with EDs and crisis teams was rated lowest • Reasons for low satisfaction: poor staff attitudes, inadequate staff knowledge about suicide, being discharged too rapidly, no FU after discharge, not having their emotional distress attended to • Majority of patients who were involved in treatment decision making found this helpful. Of those who were not involved, the majority would have liked to be involved.
Stokes et al. (2012)		Australia	Mixed methods	• Could not access services (psychiatric triage) • Lack of psychiatric assessment in ED • Lack of attention to physical needs when in mental health care • Not taken seriously • Patients felt alone during admission • Need for youth-specific recovery and rehabilitative groups • In young people, inappropriate information sharing with parents – parents blamed, not wanting parents to know everything • System complex and difficult to navigate • Carers excluded from decisions about discharge

Authors (Year)	Participant group (n)	Study setting	Study design	Findings
				Aboriginal people have specific needs and multiple levels of trauma – conceptions of mental illness from a Western perspective can be unhelpful
Woden Community Service (2018)	Users of Wayback service (n=54)	Australia	Qualitative feedback survey	• Staff were supportive and easy to talk to, providing an individual and tailored response • People found activities helpful • Connected people to other services and helped them access them • Some felt that time was too short. Staff turnover affected relationship building
International				
Awenat, Y. F., E. Shaw-Nunez, J. Kelly, H. Law, S. Ahmed, M. Welford, N. Tarrier and P. A. Gooding (2017).	Adults aged 17-46 (n=8)	England	Qualitative	• Value of therapeutic alliance • Helped to ameliorate suicidal thoughts and actions • Increased willingness to discuss suicidal thoughts following therapy • Taking control • New ways of thinking • Created recovery-focused plans • Improved social confidence and self-care
Azizpour, M., Taghizadeh, Z., Mohammadi, N., & Vedadhir, A. (2019).	Women aged 20-37 (n=7)	Hospitals, Iran	Qualitative interviews	• Felt more support from family following attempt by not leaving them alone, family became more compassionate and attentive, provided more emotional and financial support
Berg, S. H., K. Rortveit and K. Aase (2017)			Systematic review	• Connection with health care professionals important to patient recovery and safety • Sense of being cared for (listening, providing basic needs e.g., food, hygiene, sleep) • Need for validation of feelings • Being treated as an equal • Lack of freedom and privacy under constant observation • Constant observation could be life-saving • Relationship with care providers was important while under constant observation

Authors (Year)	Participant group (n)	Study setting	Study design	Findings
Bullock, M., L. Nadeau and J. Renaud (2012)	Young people aged 14-18 (n=15)	Psychiatric hospital, Canada	Mixed methods	• Religious community members acted as a bridge to mental health services
Briggs, S., H. Linford and A. Harvey (2012)	Maytree guests (casenotes n=50, interviews n=12)	Respite centre, UK	Qualitative interviews and analysis of casenotes	• Diverse mix of staff and volunteers created an engaging and normalising environment • For some, staying at Maytree prompted recovery even after guests had left • Guests felt sadness and anxiety about leaving
Briggs, S., J. Finch and R. Firth (2016)	Place of Calm guests (n=11)	Respite centre, UK	Mixed methods cross-sectional	• Majority of guests agreed that staying at Place of Calm improved mental health and well-being, made them feel less suicidal at the time, saved their lives • Peer support and practical support (providing them with a place to rest) rated as most important • Safety/wellbeing plan and practical support (signposting, contact with services) also rated as important • Guests valued support they received but felt worse when they had to leave • More support at Place of Calm. Hospital too impersonal • Found it helpful that peer support workers also had mental health issues • Some felt stay was too short (people with long term needs), not safe because it was a new environment
Cooper, J., C. Hunter, A. Owen-Smith, D. Gunnell, J. Donovan, K. Hawton and N. Kapur (2011).	Adults (n=11)	Hospitals, England	Qualitative	• Period immediately after discharge particularly important – need for support and intervention Thoughts on contact-based interventions • Genuine, caring treatment viewed positively • Information on services useful • Intervention via phone favoured due to immediacy of contact • Level of contact needed differed by individual
Coveney, C. M., K. Pollock, S. Armstrong and J. Moore (2012)	Helpline callers (n=1396)	UK	Mixed methods	• Helpline callers felt positive after contact, felt listened to and understood • Felt less alone, afraid and anxious and more hopeful, supported and wanting to live after contact

Authors (Year)	Participant group (n)	Study setting	Study design	Findings
				• Suggestions for improvement include incorporating new technologies (e.g., webchat), reduce cost, improved training
Cutcliffe, J., P. Links, H. Harder, Y. Bergmans, K. Balderson, R. Eynan, M. Ambreen and R. Neibaum (2012).	Adults (n=20)	Canada	Qualitative	• Angst at prospect of discharge – how will long term needs be met? • Not feeling ready to leave • Feeling like a burden to loved ones and mental health professionals – not worthy of support • Hospital place of safety
Deering, K., C. Pawson, N. Summers and J. Williams (2019).		International	Systematic review	Factors important to risk management • Interpersonal relationships and communication • Patient agency and autonomy
Gould, M. S., Lake, A. M., Galfalvy, H., Kleinman, M., Munfakh, J. L., Wright, J., & McKeon, R. (2018)	Individuals aged 18-78 (n=550)	General community, United States	Quantitative cross-sectional	• Majority (53.8%) felt that follow up calls stopped them from killing themselves 'a lot' (scale of 'a lot' to 'not at all') • Majority (59.6%) felt that follow up calls kept them safe 'a lot' (scale of 'a lot' to 'not at all')
Greidanus, E., & Everall, R. D. (2010)	Adolescents	Online suicide prevention community	Qualitative analysis of online posts	• Participants wrote about suicidal feelings, self-harm behaviours, and reasons for seeking help • Community members not only sought help but played role of help-provider by offering support to other members
Griffiths, A. G., K (2017).	Safe Haven service users (n=79)	Drop in safe haven, UK	Quantitative feedback survey	• Main reasons for attending include maintaining their wellbeing during a difficult time, seeking a safe haven during crisis • For activities, most people socialised with others at the Safe Haven, and talked to a staff member about how they were feeling • Safe Haven helped users to stay alive, cope in crisis, have a safe space and talk to others, manage their condition, receive specialist help and advice, and have somewhere to go • Majority felt that the staff had treated them with dignity, respect, warmth and compassion • Areas for improvement include more staff, private space, more accessible location, more effective dissemination of information

Authors (Year)	Participant group (n)	Study setting	Study design	Findings
Hagen, J., Knizek, B. L., & Hjelmeland, H. (2018)	Patients previously hospitalised in psychiatric wards for suicidality (suicide attempt or close to suicide attempt) aged 33-54 (n=5)	Acute psychiatric wards, outpatient psychiatric units, Norway	Qualitative study using individual semi-structured interviews	• Connection/relationship with health care provider facilitated or prevented disclosure • Individualised treatment made patients feel valued • Positive support received from mental health care workers prompted seeking additional supports for their recovery process following treatment • Some negative experiences with mental health care reported
Hausmann-Stabile, C., Gulbas, L., & Zayas, L. H. (2018)	Latina adolescents aged 11-19 (n=68)	Medical and mental health services, United States	Mixed methods cross-sectional	• Adults and peers often initiated request for services • Only a fifth had positive experiences with inpatient care/care in restrictive settings • Outpatient talk therapy or behavioural services more helpful • Positive experiences related to clinicians understanding context of teens' everyday lives, reducing mental health stigma, normalising experiences, fostering agency, improving family interactions • Negative experiences related to mismatch between expectations of care and care provided (e.g., ER focus on medical stabilisation), fear of stigma associated with hospitalisation and mental health care, feelings of lack of agency in their own care and recovery
Hilton, C. (2017).		Twitter	Qualitative analysis of online posts	• Individuals offered and received support from others • Discussed personal experiences with help-seeking
Hom, M. A., Albury, E. A., Gomez, M. M., Christensen, K., Stanley, I. H., Stage, D. R. L., & Joiner, T. E. (2020)	Suicide attempt survivors aged 16-69 (n=96)	United States	Qualitative unstructured interviews	• Most participants used mental health services including outpatient individual treatment, outpatient group treatment, medication, intensive services (e.g., ER, inpatient) • Most (88.9%) reported at least 1 positive experience with MH services • Most (82.2%) reported at least 1 negative experience with MH services • Positive experiences related to hospitalisation providing a safe environment, continuity of care, effective follow-up care following discharge, effective treatments (mediation and therapy) that helped them develop practical coping skills, frequent sessions, positive social support to engage in treatment, peer-support from people with lived experience

Authors (Year)	Participant group (n)	Study setting	Study design	Findings
				• Negative experiences related to inadequate assessment, stigmatising attitudes, poor therapeutic alliance, lack of provider training, lack of access to care, lack of continuity of care, ineffective treatment
Hom, M. A., Bauer, B. W., Stanley, I. H., Boffa, J. W., Stage, D. R. L., Capron, D. W., Schmidt, N. B., & Joiner, T. E. (2020)	Individuals who have survived a suicide attempt (n=329)	Community members, United States	Mixed method cross-sectional	• Strengthening patient-provider relationships (e.g., no stigmatising, validating and empathising) • Offer variety of treatment options (therapy and medications) • Involving patient in their own care • Holistic approach to treatment • Care that is trauma-informed and culturally competent • Equip patients with coping skills • Address structural barriers to care (e.g., emergency care, hospitalisation)
Hunter, C., Chantler, K., Kapur, N., & Cooper, J. (2013).	Individuals who had self-harmed (n=13)	Hospitals, UK	Qualitative interviews	• Psychosocial assessment legitimised their distress • Talking to health professional during assessment helped relieve distress and regain sense of self-worth • Psychosocial assessment Inspired hope for change – the start of recovery • Some felt shamed and judged by staff • Referral to services previously used by patients increased hopelessness • At times felt staff did not listen • Unclear about arrangements for follow up • Lack of follow up or change in their circumstances • Interactions with staff influenced future help-seeking intentions • Need for tailored care
Huisman, A., & van Bergen, D. D. (2019)	Peer specialist workers aged 26-66 years (n=20)	Mental health care services, Netherlands, United States	Qualitative, cross-sectional	• Family, friends, other care users and sometimes clinicians contributed to recovery
Idenfors, H., Kullgren, G., & Salander Renberg, E. (2015)	Individuals aged 16-24 (n=10)	Hospital, Sweden	Qualitative	• Family and friends helpful in facilitating access to care

Authors (Year)	Participant group (n)	Study setting	Study design	Findings
				• Medication for mental health problems not helpful for some • Some health services did not provide adequate help • Used Internet to find information about health care services, though information was often not useful or relevant
Jordan, J., McKenna, H., Keeney, S., Cutcliffe, J., Stevenson, C., Slater, P., & McGowan, I. (2012)	Young men (n=36)	General community, clinical and community mental health services, Northern Ireland	Qualitative	• Strong relationship between patient-provider, need for greater outreach of services specifically for men (e.g., social networking sites, text messaging, email), connection with other men with same experiences to reduce feelings of isolation
Kjolseth, I., Ekeberg, O., & Steihaug, S. (2010).	Close contacts (relatives n=34, GPs n=17, home-based care nurses n=12) of elderly suicide deaths (n=23)	Norway	Qualitative psychological autopsy	• Distrust of health services, fear of institutionalisation, poor connection/ communication between patients and health care providers, inadequate or unavailable care for complex problems (physical and mental health problems)
Klevan, T., Karlsson, B., & Ruud, T. (2017)	CRT service users aged 25-70 (n=14)	Norway	Qualitative	• Need for addressing loss of social structure relating to housing, employment etc. • CRTS had little experience in providing practical or structural support • Available support and information from CRTs helped clients feel safe • Genuine, compassionate, empathetic treatment helpful for building self-worth
Lasrado, R. A., Chantler, K., Jasani, R., & Young, A. (2016).	Survivors of attempted suicide (n=15), mental health professionals (n=8), traditional healers (n=15) aged 18-44	Southern India	Qualitative	• Most did not seek psychological help, went to hospital for medical intervention relating to attempt • Informal sources (family, friends, religious leaders) were their source of support • Traditional healers and mental health services used in conjunction
Lee, S.-H., Tsai, Y.-F., Chen, C.-Y., & Huang, L.-B. (2014)	Elderly psychiatric outpatients aged 65-84 (n=24)	Medical centre/hospital, Taiwan	Qualitative	• Reasons for not attempting suicide include support from family and friends, psychological treatment
Owen, R., Gooding, P., Dempsey, R., & Jones, S. (2015)	Individuals diagnosed with bipolar disorder (n=20) aged 26-60	General community, Manchester, UK	Qualitative interviews	• Social relationships prevented suicidal behaviour either directly (intervention by loved ones) or indirectly (reflecting on past positive social experiences). More effective for mild suicidal thoughts but less effective for severe suicidal thoughts • Lack of perceived social support, negative comments worsened suicidal thoughts

Authors (Year)	Participant group (n)	Study setting	Study design	Findings
Peterson DHM & Colling SC (2015)	People with experience of mental illness and suicidality aged early 20s – mid-70s (n = 27). Most had attempted suicide in the past.	Community (New Zealand)	Qualitative. Interviews.	People who made an active decision to self-manage their suicidality for one of the following reasons: • Disagreement with aspects of mental health system (e.g. therapeutic approach to suicidality) • Desire to be independent • Fear of being subject to compulsory treatment when disclosing suicidality • No other option through lack of access to MH services • **Peer support:** Accessed on person's own terms, LE of peer-support person
Reading L & Bowen (2014)	Male prisoners (all serving a life sentence due to opportunity sampling) aged 30-58 (n=8, with one interview being discontinued and data excluded due to participant distress)	Male Category B Prison in HM Prison Service Estate (UK)	Qualitative study. Interviews. Thematic analysis based on guidelines from Braun & Clarke (2006), essentialist/realist approach	How was suicidality overcome: • Sense of self • Presence of meaning incl sense of fulfillment (e.g. employment, giving back to others through voluntary listener support role), goal setting (most goals related to employment), father role (incl personal relationships and commitment to others) • **Connectedness** (closeness and caring from significant others) incl spiritual connections, shared experience, feeling wanted, support systems (i.e. family, friends and professional): **Professionals** included wing staff, personal officers, drug workers, intervention facilitators, psychologists, MH workers, psychiatrists, listeners and were described as 'supportive', 'being there', being 'good listeners', 'genuine', 'trustworthy', 'open', 'empathic', 'taking an individualized approach to care'. • Shift of perspective • Re-establishing control
Rice JK (2015)	College students (N=26,451) 4 randomly selected subsamples (n=15 each) out of subgroup of participants with 12-month SI (n=1371) were analysed:	College student data from 70 campuses, US	Mixed method quantitative-to-qualitative design using archival survey data. Qualitative study: Thematic analysis and Constant Comparison of two open-ended survey items utilising	Most helpful to resolve suicidal crisis: • Social support • Coping behaviour and skills, e.g. talking • Loved ones • Only 10% reported MH services as most helpful thing Least helpful:

Authors (Year)	Participant group (n)	Study setting	Study design	Findings
	• Has never received MH services, no suicide attempt • Has never received MH services, had suicide attempt • Has received MH services, no suicide attempt • Has received MH services, had suicide attempt		an essentialist/realist framework.	• Unhelpful feedback from others (e.g. shaming, minimization of their emotional state) • Social isolation • Lack of support from others
Roberts ML (2018)	People aged 21-50 (n=32), M age of first onset of SI = 14.4	Community, US	Qualitative study. Thematic analysis (Braun and Clarke, 2006) of anonymous self-report questionnaires.	Why did participants not act on suicidal thinking during adolescence: • Social support, professional help • Positive live event • Responsibility/purpose (e.g. caring for someone, obtaining a job, sparing family the pain of losing a loved one) • Religious/spiritual experience Recovery was motivated through a positive emotional-perceptual shift towards resiliency via connectedness, hope and love. 22 participants reported to experience post-traumatic growth.
Sellin L, Asp M, Wallsten T & Gustin W (2017)	Psychiatric patients (n=14), suffering from suicidality, depression, anxiety and/or crisis	Psychiatric clinic (Sweden)	Qualitative study. Interviews. Phenomenological approach (i.e. lifeworld research approach).	Recovery = reconnecting with oneself whilst struggling between life and death: • **Being in an expressive space and giving voice to oneself**, e.g. to professional caregivers who listen and pay attention to the person behind the suicidality. Being able to create a personal narrative provides basis for self-understanding and attribution of meaning in life.

Authors (Year)	Participant group (n)	Study setting	Study design	Findings
				• **Regaining dignity through nurturing connectedness =** becoming aware of one's own worth through engagement with both professional caregivers and supportive relatives. Sense of 'being see' and 'taken into account' Finding balance in the tension between life and death
Shaw JL, Beans JA, Comtois KA & Hiratsuka V (2019)	Alaska Native and American Indian people aged 15-56 with self-reported histories of (n=15)	Alaska Native-owned and operated healthcare organisation, US	Qualitative study. Semi-structured interviews. Interpretative phenomenological analysis.	What kept people safe: • Informal support • Formal support incl. crisis intervention, speciality case management, therapy (feeling cared for and understood, gaining useful skills), medication management, residential and outpatient substance use treatment, primary care, youth programming, Careline (Alaska's statewide crisis hotline), Denaa Yeets (=the tribal health system's specific suicide prevention program) • Self-support Factors central to acquiring resilience: • Meaningful and consistent social connection • Awareness how one's suicide would negatively affect loved ones • Knowledge and utilization of available health services
Signoracci GM, Stearns-Yoder KA, Huggins JA, Janoff EN & Brenner LA (2015)	AIDS infected male veterans (n=20)	Urban Veterans Administration Medical Centre	Qualitative study. Semi-structured interviews. Descriptive approach.	Helpful: • VA appointments incl. group therapy sessions as these were facilitating social interactions • Relationships with HIV/AIDS providers were perceived as important and valuable (listening and keeping them safe) • Higher power/belief system/religion
Simon GE, Specht C & Doederlein A (2016)	People with depression or bipolar disorder (n=611), 96% reported ever having thoughts about suicide	Depression and Bipolar Support Alliance (education, advocacy and support organisation). Data collected in 2013.	Cross-sectional design. Anonymous online survey	• MH services most frequently used and most favourably rated • Peer supports less frequently used but also favourably rated • ED rooms and crisis lines were used less frequently and rated less favourably • Most frequently used self-care strategies included distracting/social activities, positive affirmations, exercise and personal spiritual practices

Authors (Year)	Participant group (n)	Study setting	Study design	Findings
				• 49% of people with SA rated talking to primary care physicians as not helpful or harmful compared to 29% of those without SA • 56% of those with SA rated talking to family as not helpful/harmful compared to 40% without SA
Sturgeon R & Morrissette (2010)	Manitoban farmers (n=29) with concerns around suicide. Current SI = 16; past SI = 8; third-party callers = 5.	Canadian rural and farm population. Data collected between 2003 and 2008.	Qualitative conventional content analysis of encounter forms of calls to the Manitoban Farm and Rural Stress Line. Encounter forms are written accounts of call, not a verbatim transcription, suicide risk assessment is included when applicable)	• Family support/family tie as reason for not going through with suicide. • Use of mood medications as most common coping mechanism to deal with farm life related stressors – potentially reflecting help seeking with GPs rather than MH professionals. • Farm culture to inhibit help seeking while promoting stressful reactions (feelings of pride, geographical/social isolation, lack of support, 'outside people' would not understand, feeling misunderstood by counsellor, fear of reactions of community members)
Surrey and Borders Partnership Foundation NHS Trust (2015).	Community members who had seen the Safe Haven service advertised in various communications as an alternative to A&D. No further			Reasons for attending included • Alternative to A &D • Maintain wellbeing during crisis • To talk to someone and/or get advice about their mental health • To socialise Attendees reported being able to • Talk about how they are feeling and their mental health • Be in a 'safe' space during their crisis • Spend time socialising • Receive advice about their mental health If the safe haven was not open, participants would have

Authors (Year)	Participant group (n)	Study setting	Study design	Findings
				• Not have sought help (35%) • May have escalated their crisis (38%) • Would have attended casualty (2%) • Phoned a crisis line or sought (12%) support from friends or family (13%) The service resulted in a reduction in admissions to the A&D for mental health crisis over three months
Vatne M & Naden D (2018)	Persons after suicidal crisis aged 21-52 (n=10)	Emergency psychiatry/crisis resolution (Norway)	Qualitative study. Gadamerian hermeneutic approach to data analysis of interviews.	What is perceived as meaningful help after suicidal crisis in care and treatment situations: • Experiencing hope through encounters (feeling understood through empathic listening by health professionals, importance of body language displayed by health professionals, being perceived as a whole human being) • Experiencing hope through atmosphere of wisdom (experiences with different caring cultures, staff's attitudes making them feel to be valuable human being with potential in life, positive atmosphere in healthcare environment) • Experiencing a ray of hope through taking back responsibility (being helped to develop alternative coping strategies, crisis plans, written/verbal agreements) • Dialogue and cooperation to create patients' safety and ability to cope with suffering and as such hope and will to struggle for life.
Wadman R, Armstrong M, Clarke D, Harroe C, Majumder P, Sayal K, Vostanis P & Townsend E (2018)	Looked-after young people who self-harm aged 14-21(n=24)	Social Services, clinical services, community (UK)	Qualitative study. Interpretative Phenomenological analysis of semi-structured interview data.	Experience of clinical services (Child and Adolescent Mental Health Services), a relational mixed bag with focus on interactions with individual clinicians: • Feeling patronized • Not listened to • Nothing being done • Comfortable/able to talk (attributed to having a positive relationship with clinician involved) Reliance on self-help (developing coping skills, e.g. music, art etc)

Authors (Year)	Participant group (n)	Study setting	Study design	Findings
Wadman, R, Vostanis P, Sayal K, Majumder P, Harroe C, Clarke D, Armstrong, J M & Townsend E (2018)	Young women aged 13-18 (n=14) who had self-harmed in the previous 6 months (had never lived in foster care)	Various clinical settings as well as community (UK). Data collected in 2014.	Part of a larger UK-based study of self-harm in young people with and without experience of living in foster care/residential homes. Qualitative interpretative phenomenological analysis of interview data	Clinical supports (Child and Adolescent MH Clinical Services): Systemic limitation in service provision experienced as personal rejection • Both, positive and negative experiences • Empty promises, feeling personally let down by clinical services – waiting lists, being dismissed, being turned away Difficulties talking about self-harm and Impact on help-seeking (e.g. through emotions shaped by others – shame, regret and feeling stupid to self-harm) contributing to stressors and the way support is experienced. **Parents and peers play key role in precipitating self-harm and supporting young people.**
Wu, CY, Whitley R, Stewart R & Liu SI (2012)	People who presented to ED for self-harm aged 18-55 (n=20).	Emergency Departments (Taiwan) Study conducted 2005-2006) People who SH in Taiwan have access to any medical service or speciality (Taiwan's universal National Health Insurance program)	Qualitative. Participants recruited from an earlier quantitative study. Content analysis of qualitative in-depth interviews. Interviews were conducted within 1 month of SH index episode.	Supportive attitudes and continuous care from formal and informal sources of help facilitated help-seeking. Negative influences from close friends or relatives triggered SH. Pathways to MH care included friends, family, healthcare staff and their own initiative. Help-seeking experience: • Physician-patient relationship as very important ○ Positive experience: Confidential relationship built on continuing care and active inquiry. MH professionals seen as trustworthy/caring leading SH individuals to be open and disclose their problems. ○ Negative: Limitations of medical service, e.g. doctors perceived as not to be able to help participants with their problems. Unsatisfactory past medical advice resulted in negative help-seeking attitudes. • Non-adherence to medical contact, e.g. irregular medication consumption, doctor shopping Social support

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Zaheer J, Shera W, Lam JSH, Fung WLA, Law S & Links PS (2019)	Chinese-born women living in Canada with history of suicidal behaviour within the prior 12 months (n=10), aged 19-51	Canada, psychiatric care setting	Qualitative study. Constructivist grounded theory approach to data analysis of interviews.	Factors related to short-term recovery: • Accessing culturally sensitive MH care • Social and instrumental support Factors related to long-term recovery: • Developing an explanatory framework with healthcare provider • Narrative reflection and prioritizing self-care • Interdisciplinary care team support • Support from family and friends • Spiritual and existential supports • Goals for future and sense of mastery