VOLUME ONE: RESEARCH COMPONENT

SUICIDE PREVENTION: EXPLORING THE PROCESSES OF YOUTH HELP-SEEKING AND EVALUATING PEER SUPPORT INTERVENTIONS

By

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Thesis overview

This thesis consists of two volumes submitted towards the Doctorate in Clinical Psychology.

Volume one consists of three research chapters. The first presents a meta-analysis that combines the results of eight primary studies that researched peer support as an intervention to reduce suicide-related outcomes. The second chapter is a qualitative empirical research project that explores the processes of seeking help from a GP at a time when young people felt suicidal. The third chapter is two press release documents that provide an accessible overview of the meta-analysis and empirical component.

Volume two comprises of five clinical practice reports (CPR). The first presents the case of Danny[1], a 43-year old man experiencing low mood, physical health problems and suicidal ideation. His difficulties are formulated from two psychological models. The second CPR presents a service evaluation of how an adult community mental health team viewed and obtained service user feedback. The third CPR presents an integrated case study of Regina, a 16-year old adolescent who was seen in an inpatient setting following an increase in suicidal ideation. The fourth CPR presents a single case experimental design of Chester, a 71-year old who was seen in an inpatient setting following a suicide attempt. The fifth CPR presents an abstract for an oral presentation about Mohammed, a 30-year old man with a learning disability, who was referred for psychological support after he became mute following a stay in general hospital.

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[1] All names have been changed to maintain confidentiality.

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CHAPTER I

LITERATURE REVIEW

THE EFFECTIVENESS OF PEER SUPPORT AS A SUICIDE PREVENTION INTERVENTION: A META-ANALYSIS.

Abstract

Introduction

Peer support has the potential to be used as an intervention targeting suicide reduction by validating and normalising experiences, increasing supportive community based networks, and providing information on suicide prevention. However, at present there is uncertainty around the effectiveness of peer support on suicide-related outcomes.

Method

A systematic search of the literature was carried out using Embase, MEDLINE(R) and PsycINFO. 1744 records were screened for inclusion, with 8 studies included in the final systematic review and meta-analysis. All studies were assessed for bias and the quality of evidence described. Outcomes relating to suicide were extracted and included in the meta-analytic synthesis and a pooled estimate of the effect of peer-support on suicide-related outcomes is presented.

Results

A total of eight studies with 8912 participants investigated the effectiveness of peer support interventions in the treatment of suicidal behaviour and/or suicidal ideation. A random effects model was calculated using the generic inverse variance method and a small treatment effect was found.

Discussion

There is limited evidence to support the effectiveness of peer support as an intervention for suicide prevention. There are currently very few studies available and there is a large variability in how peer support is defined and implemented. Due to the

limited evidence, no confident conclusions can be made at present. Until the research base is developed, commissioners and clinicians need to be cautious about implementing peer support for individuals who are at risk of suicide. Where peer support services are available, it is recommended that they should only form part of a multi-tiered intervention alongside evidence-based interventions and should not be delivered as a sole intervention.

Introduction

Suicidal ideation and behaviour

In 2018, there were 6859 suicides in the United Kingdom (UK) and Republic of Ireland, with a significant increase in suicide from 2017 (Samaritans, 2019). However, there is a tendency in international data to under-report suicide (Tøllefsen, Hem & Ekeberg, 2012) and it is therefore possible there are many more suicide related deaths that are not included in these statistics. As such, the World Health Organisation has recognised suicide prevention as a global public health priority (WHO, 2014).

The WHO estimates 800 000 people die each year by suicide (WHO, 2019). For every suicide there are many more people who attempt suicide each year and even more who experience suicidal ideation. Both suicidal ideation and suicidal behaviour are major public health concerns that can have serious, long-lasting effects on individuals, families and communities (WHO, 2019).

Suicidal ideation can be defined as passive thoughts about wanting to be dead, or having active thoughts about killing oneself (Posner et al., 2007). The presence of suicidal ideation is a significant risk factor for a person to go on to make a suicide attempt (Schreiber, Culpepper & Fife, 2010). However, suicidal ideation does not necessarily mean there will be any accompanied suicidal behaviour. Suicidal behaviour includes death caused by self-directed injurious behaviour with any intent to die as a result of the behaviour. Suicidal behaviour can also include any behaviour that results in injury or the potential for injury to oneself (Crosby, Ortega & Melanson, 2011). Preparatory acts also fall under the definition of suicidal behaviour and include anything beyond thought of suicide. For example, preparing a method (e.g. collecting pills or buying a gun) or preparing a suicide note would be described as a preparatory act (Crosby, Ortega & Melanson, 2011; Posner et al., 2007).

A recent meta-analysis by Hofstra and colleagues (2019) has highlighted how current suicide prevention interventions such as community approaches, psychotherapeutic interventions, pharmacotherapeutic and multi-level interventions are effective in preventing completed suicides. However, barriers to supporting individuals at risk of suicide have also been identified. For example, stigma around discussing suicidal thoughts, long waiting lists for treatment, wishing to handle the problem alone and high costs related to treatment have all been highlighted as potential barriers preventing individuals at risk of suicide from accessing support (Alonzo, Moravec & Kaufman, 2017; Bruffaerts et al., 2011). It has been further suggested that most people with suicide ideation, plans and attempts receive no treatment at all (Bruffaerts et al, 2011). Clearly there is a growing need to explore further interventions and strategies that may be able to address some of the difficulties that suicidal individuals face when trying to access support. One such approach that has great potential is peer support. Peer support could offer a unique approach to supporting individuals that may be able to address some of the highlighted concerns regarding barriers to treatment, although at present it is under-researched.

Peer support

Peer support can be difficult to define, and across settings peer support may look and be implemented very differently. Generally, peer support refers to the use of individuals with lived experience of a mental health difficulty to provide support to others (Pentinnen et al, 2002). Peer support can come in many forms and can be found in a variety of clinical and community settings. It offers an opportunity for mutual support or unidirectional support that can be delivered individually, in groups, face-to-face, over the phone or online (Pentinnen et al, 2002). Peer support is often delivered through peer mentoring, reflective listening or counselling but it can also be delivered on a reciprocal basis (Mead, Hilton & Curtis, 2001).

Peer support may fall under a larger umbrella term of 'social support' but it is distinct in the sense that the source of the support has to involve a 'peer' with lived experience (Pentinnen et al, 2002). Within mental health services, peer support can be used alongside other interventions or as a sole intervention. It is suggested that peer support can help individuals at risk of suicide by building genuine, mutual and non-coercive relationships that can help improve hope and connectedness (Davidson et al., 2006). Whilst high costs and availability of mental health services have been highlighted as significant barriers to mental health services, peer support has the potential to be widely available at a relatively low cost (McCarthy et al., 2007; Steele, Dewa & Lee, 2007). Other barriers to mental health services such as transportation and scheduling may also be lower for peer support services, thus providing an opportunity to extend the reach of community interventions (Glasgow et al., 2001).

There are reports of peer support programs being developed across the UK, Canada, United States of America (USA), New Zealand and Australia (Forchuk et al., 2007; Lawrence, 2004; O'Donnell et al., 1999; Perkins, Buckfield & Choy, 1997; Rivera et al., 2007). Within the UK, a Recovery College has been set up in collaboration for and with individuals who have been affected by mental health difficulties. It trains peer support workers and offers a range of sessions to service users, carers, families and staff (Wilson, 2010). Peer support workers have also been used in services supporting individuals with severe mental illnesses, a population that is at increased risk of suicide (Ilgen et al., 2010). Peer support workers have been used to support high risk individuals discharged from psychiatric hospitals, to offer peer-run residential services as an alternative to hospitalisation and as callers to peer-run support lines (Dalgin, Maline & Driscoll, 2011; Shatell et al., 2014; Sledge et al., 2011).

Research on peer support has demonstrated favourable outcomes in terms of acceptability, potential cost savings and a reduction in the need for inpatient care (Trachtenberg, 2013). However, despite the uptake of peer support services nationally, there is currently little evidence that suggests peer support is associated with positive effects on overall symptoms or satisfaction with services (Lloyd-Evans et al., 2014). In particular, the effects on suicide-related outcomes have not yet been clearly described. Indeed, compared with the evidence base for other social support interventions such as supported employment programs and assertive community outreach programs, peer support has been highlighted as lacking an evidence base (Davidson et al., 2009). However, despite the lack of research around the use of peer support in suicide prevention, there is a growing professional belief that peer support workers do have a potential to play a significant role in suicide prevention, postvention and aftercare (Salvatore, 2010). Specifically, it is suggested that peer-support workers can draw on their own suicide-related experience, as well as learned recovery and support skills in supporting other people at risk of suicide (Salvatore, 2010).

Theoretical basis for peer support and suicide prevention

Peer support is often implemented to improve hopelessness and poor social connectedness, both of which are well-established risk factors for suicide and play important roles in the interpersonal theory of suicide (Van Orden et al., 2010). The association of poor social support with suicidal risk has been clearly demonstrated across a range of cultures, populations and with a range of clinical characteristics (Compton, Thompson, & Kaslow, 2005; Kleiman & Liu, 2013; Kotler, Iancu, Efroni, & Amir, 2001; Poudel-Tandukar et al., 2011). In general, there are very few evidence-based approaches that aim to explicitly address these risk factors as an intervention to prevent suicide (Zalsman et al., 2016).

It is possible that peer support workers may be able to target hopelessness by acting as examples for recovery, facilitating a process that service users can identify with and providing resources for recovery (Cook et al., 2012). Furthermore, peer support workers may improve an individual's sense of connectedness by providing emotional support, decreasing feelings of loneliness and stigma and improving relationships with others (van Gestel-Timmermans et al., 2012). The First National Conference for Survivors of Suicide Attempts (Litts D, 2008) suggested that peer support workers could help suicide prevention efforts by validating and normalising similar experiences, increasing supportive community-based networks, providing information on suicide prevention and supporting with follow-up and aftercare. Different conceptual models exist to explain how peer support may benefit individuals who are at risk of suicide. For example, Dennis (2003) describes mechanisms of peer support could work by decreasing isolation (direct effect), reducing the impact of stressors (buffering effect), sharing of self-management information (direct effect) and providing a positive role model (mediating effect).

At present, there has been no review that evaluates the current literature regarding peer support as an intervention specifically targeting suicide reduction. Although we know peer support may help improve outcomes that are associated with suicide, it is unclear whether peer-support has a direct effect on suicide-related outcomes, such as a suicidal behaviours or ideation. As no current review is available in this area, researchers, commissioners and clinicians should currently be cautious about any possible benefits of peer support. It is possible that peer-support may have no benefit on suicide-related outcomes or perhaps have negative outcomes for either service users or peer support workers.

Aim of meta-analysis

This systematic review aims to investigate the efficacy of peer-support interventions on suicide related outcomes such as suicidal ideation and suicidal behaviours. The ability to be able to draw clear conclusions around the effectiveness of peer support to improve outcomes related to suicide is important, particularly because of how serious the outcomes are and the impact suicide can have on individuals, families and the community. Even a small reduction in the number of suicides would be important in contributing towards the global public health priority for suicide prevention (WHO, 2014).

Methods

Search strategy

The literature was systematically searched on 02/08/2019 using Embase, MEDLINE(R) and PsycINFO. There was no date limit for identified articles, and only those in English language were considered. The reference sections of included articles were examined for further relevant publications. The search terms that were used to identify the two key areas (peer support and suicide), which were then combined, are outlined in Table 1.

For the purpose of the present review, peer support was defined as *"the provision of emotional, appraisal and informational assistance by a created social network member who possesses experiential knowledge*" (Dennis, 2003). Peer support is complex and it can be delivered in many forms, including phone calls, email exchange, face-to-face and through groups. Importantly, peer support can be delivered as a lone intervention, or perhaps more commonly, it can form part of a multicomponent intervention, which may include aspects of the intervention that are still delivered or co-delivered by healthcare professionals (Pentinnen et al, 2002). Each study was screened to ensure that it includes the involvement of a peer with 'lived experience' regardless of whether peer support was delivered as a sole intervention or whether it was part of a multicomponent intervention. The definition adopted for suicidal ideation includes passive thoughts about wanting to be dead, or having active thoughts about killing oneself (Posner et a., 2007). Suicidal behaviour is defined as death caused by self-directed injurious behaviour with any intent to die as a result of the behaviour and behaviour that results in injury or the potential for injury to oneself (Crosby, Ortega & Melanson, 2011).

Table 1: Search strategy for MEDLINE (R), PsycINFO and Embase

Number #	Search strategy for MEDLINE (R)	Search strategy for PsycINFO	Search strategy for Embase
1	exp Suicide/ or exp Suicide, Attempted/	exp Attempted Suicide/ or exp Suicide Prevention Centres/ or exp Suicide Prevention/ or exp Suicide/	exp Suicide/ or exp Suicide Attempt/
2	exp Drug Overdose/	exp Self-Inflicted Wounds/ or exp Self-Destructive Behavior/ or exp Self-Mutilation/ or exp Self-Injurious Behavior/ or exp Suicidal Ideation/	exp Automutilation/
3	exp Self-Injurious Behaviour/	exp Drug Overdoses/	exp Drug Overdose/
4	exp Self Mutilation/	exp Self-Injurious Behavior/	exp Suicidal Ideation/ or exp Suicidal Behavior/
5	exp Suicidal Ideation/	1 or 2 or 3 or 4	1 or 2 or 3 or 4
6	1 or 2 or 3 or 4 or 5	exp Peer Support	exp Peer Support
7	exp Peer Support	exp Social Support/ or exp Support Groups/ or exp Peer Relations/ or exp Peer Counselling/	exp Peer Group/
8	exp Self-Help Groups/ or exp Social Support/ or exp Peer Group/	exp Community Involvement/	exp Social Support/
9	exp Community Participation/	exp Psychosocial Rehabilitation/	exp Psychosocial Care/
10	exp Psychosocial Support Systems/	exp Client Participation/	exp Community Program/
11	7 or 8 or 9 or 10	6 or 7 or 8 or 9 or 10	exp Peer Counselling/
12	6 and 11	5 and 11	exp Voluntary Worker/
13	Limit 12 to (full text and English language)	Limit 12 to (full text and English language)	6 or 7 or 8 or 9 or 10 or 11 or 12
			5 and 13
14			Limit 14 to (full text and English language)

Inclusion Criteria

The full inclusion and exclusion criteria are described in Table 2. Criteria were kept as broad as possible as the research base for peer support is still in its infancy. The main inclusion criteria were that the studies were all intervention studies, with peer support either as part or all of the intervention and outcomes measured suicidal behaviour or ideation. No restrictions were placed on diagnosis, setting, age, time frame or type of control.

Study selection

The results from the systematic search strategy are presented in line with PRISMA guidelines (Moher et al, 2009) (Figure 1). Studies were screened for eligibility at title, abstract and full-text by the author. The search highlighted 3111 initial articles, with 1744 once duplicates had been removed. These articles were then screened by their titles and abstract using the inclusion/exclusion criteria. The most common reasons for removal based on title or abstract were: not an intervention study or not specifically relating to peer support. The remaining 47 articles were then assessed in more detail based on their full text. Eight studies satisfied the outlined criteria for the meta-analysis. No additional papers were found through screening of published systematic reviews exploring peer support for various outcomes or through backward screening of reference lists of included studies. A full outline of the eight included studies can be found in Table 3.

Table 2: Justification for the outlined inclusion criteria

Inclusion criteria	**Justification**
Nature of Peer Support intervention / study design.	
Interventions must include the involvement of a 'peer' with 'lived experiences'.	Peer support is often loosely defined and studies can vary in what they include under the term 'peer support'. To try and ensure that we are consistently comparing similar studies, the definition proposed by Dennis (2003) has been used, with the presence of 'lived experience' being a key criteria.
All included studies are intervention studies (research design may vary). Any geographical location or research setting will be included.	As the evidence base is still in its infancy, all intervention studies will be included in the present review. This will therefore include randomised and non-randomised trials, within participant and in-between participants designs. Any geographical location or research setting will be included as there is not yet sufficient evidence available to look at specific regions or types of peer support.
In order to reflect the broad landscape of peer support and the available literature, peer support may either be the sole intervention, or part of a multicomponent intervention.	This inclusion criterion is in place to reflect the heterogeneous nature of peer support and its use with different populations and through different modalities. For instance, many studies may include peer support as part of a wider intervention that also includes psychoeducation, gatekeeper training, other therapies and treatment as usual. Combination with other therapeutic elements will be accounted for in the quality criteria.
Participant characteristics	
All age groups and diagnoses will be included in the present review	This is to acknowledge that literature focussing on peer support is still in its infancy and suicide is trans-diagnostic and affects all age ranges. There is not yet sufficient literature to look at effectiveness within specific populations.

Inclusion criteria	**Justification**
Outcome data	
The studies are required to report either Means and Standard Deviations, or F- Test statistics, Odds ratios or Cohen’s d effect size or an r effect size.	To ensure that outcomes can be converted into an effect size. In any case, all efforts will be made to calculate an effect size from the data that is available.
Outcomes must measure either suicidal ideation or behaviour.	Suicidal ideation defined as passive thoughts about wanting to be dead, or having active thoughts about killing oneself. Suicidal behaviour includes death caused by self-directed injurious behaviour with any intent to die as a result of the behaviour and behaviour that results in injury or the potential for injury to oneself (including self-harm for this meta-analysis)
Type of article	
The following article types were excluded: meta-analysis/theoretical papers/ reviews/commentaries/ clinical guidance/non-outcome focused studies i.e. longitudinal/association studies/case studies/validation of psychometric scales/qualitative papers	The outlined article types do not provide outcome data that could be included in the present meta-analysis.
If a study does not present data for groups and instead only provides individual scores, they will also be excluded.	This is to ensure that an effect size can be calculated and increases methodological rigour of studies included.

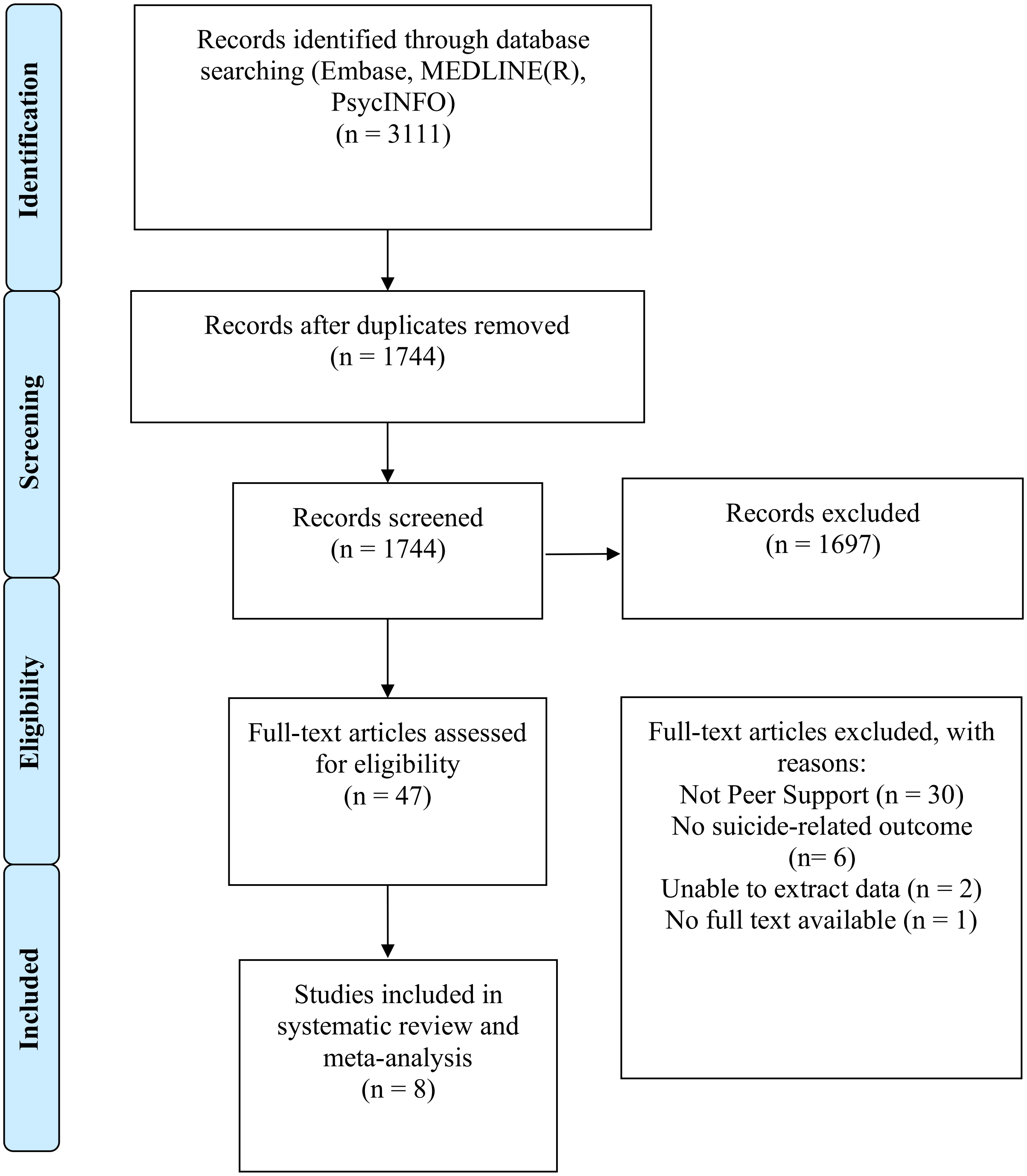


Figure 1: PRISMA flow diagram outlining the results of the systematic search strategy and the application of the inclusion criteria

Table 3: Outline and description of each included primary study

Study; Country;	Target population	Participants	Intervention description	Comparison condition	Suicide related outcome(s) assessed; follow-up period
Balaji et al (2011) India	Inclusion: All 16-24 year olds in the four-targeted communities Exclusion: Those with visual or hearing impairment or severe mental illness were excluded. Recruited from: two urban and two rural communities in Goa, India.	Baseline Rural communities: Total identified (N=2044). Total participated (N=1803). Baseline Urban communities: Total identified: (N=2431). Total participated: (N=1860). Follow up Rural communities: Total identified: (N=2304). Total participated: (N=1620). Follow up Urban communities: Total identified: (N=2976). Total participated: (N=1942)	A multi-component intervention comprising of educational institution-based peer education and teacher training, community peer education and health information materials.	One of each community type was wait-listed for the intervention. Any participant that reported suicidal behaviour were offered information and referred for further professional help.	Primary Outcome: Outcomes were measured through a structured interview that included: suicidal behaviour (considering, making plans for or attempting suicide).
Eggert et al (1995) United States of America	Inclusion: high risk of school failure: 1) below expected credits earned for current grade level; 2) in the top 25th percentile for days absent per semester; 3) grade point average (GPA) < 2.3 with a pattern of declining grades, or a precipitous drop in GPA > 0.7; 4) prior school dropout status, and 5) referral from school personnel for being in serious jeopardy of school failure or dropout. Recruited from: from five urban high schools, in grades 9-12.	Whole sample: N = 105 Intervention Group (PGCI): N=36 Intervention group 2 (PGCII) N= 34 Control group (assessment only) N = 35	Participant Growth Class (1 semester and 2 semester conditions) included: 1) small group work exchanged in group leader-to-student and peer-to-peer relationships, 2) weakly monitoring of targets, and 3) life skills training, PGCII also extended skills acquisition and transferring of skills to real life situations	The control group received a comprehensive assessment period conducted by a trained nurse/counselor.	Primary outcome: The Brief Suicide Risk Behaviour Scale (5-item scale). Follow-up: 5-month, and 10-month assessments

Study; Country;	Target population	Participants	Intervention description	Comparison condition	Suicide related outcome(s) assessed; follow-up period
Goodwin et al (2018) United States of America	Inclusion: (1) PHQ-9 score of 8 or above, (2) age 18 or older, (3) visited a primary care clinic in the previous 6 months, and (4) Internet access for the next 4 weeks, been on the Internet at least three times, and has used e-mail by himself or herself. Exclusion: 1) rejects all treatment for depression, (2) viewed or posted on any ISG more than once in the previous month, (3) symptoms of mania/ hypomania/diagnosed with bipolar disorder, (4) history of psychiatric hospitalization, (5) history of attempting suicide, (6) PHQ-9 suicidal ideation item score of 1 or above Recruited from: self-referral from six primary care offices	Within participant design: Total N: 34 Mean age: 32.53 (SD: 16.10)	Participants were given access to Psycho-babble, an online mental health peer support group for 6 weeks	At baseline participants had not accessed any Internet Support Group in the last month.	Primary outcomes: Hopelessness, Self-harm ideation and thoughts of death as measured on the PHQ-9 Follow-up: 6-weeks
Hom et al (2018) United States of America	Inclusion: aged 18 years or older, lifetime history of at least one suicide attempt and fluent in English. Exclusion: mental or physical statues requiring hospitalisation, presence of medical or psychiatric symptoms that would prevent participation in an outpatient group (e.g. responding to internal stimuli) Recruited from: the Didi Hirsch Mental Health Services suicide prevention crisis line and referrals from local providers	Whole sample: (N = 92) Mean age: 41.61 (SD = 13.53)	8-week Survivors of Suicide Attempts (SOSA) support group, facilitated by a licensed mental health clinician and a peer co-facilitator with lived experience (e.g. personal suicide attempt history).	This study used a within-participants design. At baseline: 72 participants reported current psychiatric medication use and 53 reported engaging in other psychological treatment. At post treatment, 70 reported psychiatric medication use and 65 reported engaging in other psychological treatment.	Primary outcomes: Beck Scale for Suicide Ideation (BSS) Suicidal desire and suicidal intent (1-5 scale). Beck Hopelessness Scale (BHS) Follow-up period: 8-weeks

Study; Country;	Target population	Participants	Intervention description	Comparison condition	Suicide related outcome(s) assessed; follow-up period
Johnson et al (2018) United Kingdom	Inclusion: been on the crisis resolution caseload for at least a week, had capacity and were willing to give written informed consent to participate, and consented to enter the trial within a month of discharge from the crisis resolution team. Exclusion: people who presented such a high risk to others that the crisis resolution team judged it unsafe for peer support workers. Those discharged outside the catchment area, and those who could not understand the intervention when delivered in English. Recruited from: six crisis resolution teams in England	Whole Sample: N = 439 Intervention Group: N = 221 Mean age: 40 (SD: 13) Control Group: N=218 Mean age: 30 (SD: 12)	Participants in the intervention group were offered up to ten sessions with a peer support worker who supported them in completing a personal recovery workbook, including formulation of personal recovery goals and crisis plans + Treatment as usual.	The control group received the personal recovery workbook by post. + Treatment as usual	Primary outcome was readmission to acute care Follow-up: within 1 year
King et al (2006) United States of America	Inclusion: 12-17 years of age, suicide attempt or significant suicidal ideation/intent during past month, a score of 20 or 30 on the self-harm subscale of the CAFAS, one completed baseline measure. Exclusion: Youths were excluded if they were severely or profoundly mentally retarded or presented with incapacitating psychosis. Recruited from: Psychiatric hospitals	Whole sample: N: 289 Mean age: 15.8 (SD: 1.5) Treatment group (TAU+YST-1): N: 151 Mean age: 15.4 (SD: 1.5) Control group (TAU): N: 138 Mean age: 15.2 (SD: 1.4)	Treatment as usual plus Youth-Nominated Support Team-Version 1 (YST-1). YST-1 provides psychoeducation for support persons whom youths nominate from within and outside their family, and it facilitates the supportive weekly contact of these support persons with the suicidal adolescent.	TAU consisted of psychotherapy (100%), psychoactive medication (96.8%), alcohol/drug treatment (13.4%), partial hospitalisation (18.0%) and community services (8.5%).	Primary outcomes: The suicidal Ideation Questionnaire-Junior (SIQ-JR). Suicide attempts (recorded as a % during the 6 month period) Secondary outcomes: The Spectrum of Suicide Behaviour Scale Follow-up period: six month follow up assessment.

Study; Country;	Target population	Participants	Intervention description	Comparison condition	Suicide related outcome(s) assessed; follow-up period
Pfeiffer et al (2018) United States of America	Inclusion: 1) Medical recorded documentation of suicidal ideation or suicide attempt; 2) BSSI score of 5 or more. Exclusion: 1) determination by the inpatient psychiatry attending physician that the patient was not suitable for peer support due to cognitive impairment, unstable psychosis, or severe personality disorder; 2) Cognitive impairment; 3) Living more than 50 miles away from peer specialists, 4) Receiving ECG, 5) already receiving peer support, 6) no reliable access to a telephone. Recruited from: Two participating inpatient psychiatric units.	Whole Sample: N = 70 Intervention Group (PREVAIL): N = 34 Mean age: 34 (SD:14) Control Group (TAU): N= 36	Peers for Valued Living (PREVAIL) peer support intervention, which was provided in addition to usual care: incorporating components of motivational interviewing and psychotherapies targeting suicide risk into recovery-based peer support.	Treatment as usual	Secondary outcomes: Suicide attempts Suicidal ideation (Beck Scale for Suicidal Ideation) Follow-up: 3-month and 6-month assessment.
Simpson et al (2014) United Kingdom	Inclusion: Diagnosed mental illness; approaching discharge/extended leave' age 18-65 Exclusion: Considered a serious risk to others; alcohol or drug dependent or primary diagnosis of substance use; serious personality disorder; pregnant or caring for children. Recruited from: four mental health wards.	Whole sample: N: 46 Treatment group (Peer support + TAU): N: 23 Mean age: 34.13 (SD: 10.27) Control group (TAU): N: 23 Mean age: 23.36 (SD: 10.15)	Peer support workers to provide peer support for four weeks to patients discharged from four mental health wards.	Patients in control condition received treatment as usual from community mental health teams.	Primary outcome: Suicidal risk was measured using the Beck Hopelessness Scale (BHS) Follow-up period: one and three-months post-discharge

Data Extraction

The author was responsible for all data extraction. The full text of each study that met the inclusion criteria was read and then quality rated. Any data relevant to methods, participants, intervention or outcomes were extracted. To increase the reliability of the selection process and data extraction, the included studies were cross-validated by a second rater. The second-rater was either a trainee clinical psychologist or a researcher tutor at the university. If there was any disagreement between the two raters, any subsequent discussions have been documented. For any outstanding issues in regards to data extraction, the authors of the studies were contacted where possible.

As the present review is investigating intervention studies, it was anticipated that treatment outcomes would be reported either as a mean or mean difference with a standard deviation and sample size for the treatment and control groups. Where a standard deviation has not been reported, then the pooled standard deviation has been used instead. If studies have reported a sample size but they have not reported a mean or standard deviation, then student t or F statistics have been transformed into estimates of Cohen's d. Where summary statistics, nor t or F statistics are reported, then effect sizes as calculated within the primary study have been considered within the present review. In some cases where percentages or raw figures have been reported, these have been converted into odds ratios and then transformed into estimates of Cohen's d.

Effect sizes as reported within primary studies are often calculated from data that has been adjusted for the association with one or more covariates. As a result, effect sizes reported from adjusted data may emphasise the idiosyncratic nature of the reported effect, which may lead to a dissimilarity compared with the effects reported in other primary studies. Where problematic heterogeneity is identified within the random effects model, the overall heterogeneity has been examined empirically to assess the contribution of the adjusted effect size.

It was also anticipated that some studies would have reported multiple measures that would fall under the same concept. For example, a study may have used a psychometric measure to report suicidal behaviour, but they may also have reported a percentage of participants who demonstrated suicidal behaviour. In the cases where primary studies have reported multiple measures of the same outcome, where possible the effect sizes has been combined into a single quantitative effect using the procedures described by Borenstein and colleagues (2009). As suicidal behaviour and suicidal ideation are measuring different but related concepts, these outcomes have not been combined into a single effect size and instead have been reported separately as multiple effects. The inclusion of such studies may result in a reduction in confidence intervals for the random effects model, as the sample size of the primary study would be included within the meta analysis twice. However, providing an effect size for behaviour and ideation separately allows the efficacy of peer support to be evaluated on each outcome, as well as an overall combined outcome.

Risk of Bias Assessment

To assess the risk of bias within the identified literature, a set of quality criteria were developed. The created quality criterion was based on existing frameworks from: the Risk of Bias Assessment Tool for Nonrandomised Studies (RoBANS) (Kim et al., 2013) and the Cochrane Collaboration Risk of Bias Tool (Higgins et al., 2011). The quality criteria reflect six domains: *selection bias, performance bias, treatment fidelity, detection bias, statistical bias, reporting bias, and generalisability*. The author rated each domain as either being low, unclear or high risk (Table 4). Each primary study was rated on each of the six domains and given a score to reflect the possibility of bias within each domain. An outline of the reported biases in the primary studies can be found below as well as a summary of the applied quality criteria in Figure 2.

Selection Bias

Five studies were rated low risk and three were rated high risk. The main reason for studies to be rated as high risk was for the use of a within-participants design (Goodwin et al., 2018; Hom et al., 2018) or there was no randomisation process (Eggert et al., 1995). The other five studies used some form of randomisation process: randomly allocated using a random numbers table (King et al., 2006), randomly allocated using a lottery method (Balaji et al., 2011), randomly allocated using distance randomisation (Simpson et al., 2014), randomly allocated using an online minimization tool that balanced groups based on gender and suicide attempt history prior to admission (Pfeiffer et al., 2018) or randomised by an unmasked data manager (Johnson et al., 2018).

Performance Bias

Of the eight included studies, none were rated low risk for performance bias and four were rated as high risk. Two of the studies were rated as high risk due to the use of a within-participants design (Goodwin et al., 2018; Hom et al., 2018) and the other two were rated high risk, as peer support was part of a multi-component intervention (Balaji et al., 2011; Eggert et al., 1995). The other four studies were rated as unclear risk because all of the studies included treatment as usual for both the control group as well as the intervention group. It was therefore unclear if any treatment effect would be the result of peer support, or simply increased contact with a treatment condition (Johnson et al., 2018; King et al., 2006; Pfeiffer et al., 2018; Simpson et al., 2014).

Treatment Fidelity

Six of the studies were rated as low risk of bias because they described procedures to ensure, monitor or evaluate treatment fidelity. Three of the studies used either a treatment manual or workbook and provided training for the peer support workers (Hom et al., 2018; Johnson et al., 2018; King et al., 2006). Supervision to monitor treatment fidelity was also provided in three of the studies (Balaji et al., 2011; King et al., 2006; Pfeiffer et al., 2018). Two studies used recorded data to monitor treatment fidelity: Eggert et al (1995) used observational recordings and Pfeiffer et al (2018) used a treatment fidelity scale. One study was given an unclear risk, as there was no mention of any procedures relating to treatment fidelity (Simpson et al., 2014). One study was given a high-risk rating, as the study used an online peer support message board with no guidance provided on how the message board should be used and the reported usage of the message board varied greatly between participants (Goodwin et al., 2018).

Detection Bias

Four of the studies were given an unclear risk because there was no mention of any blinding procedures (Eggert et al., 1995; Johnson et al., 2018; Pfeiffer et al., 2018; Simpson et al., 2014;). The reasons given for a high-risk rating were the use of a within-participants design (Goodiwn et al., 2018; Hom et al., 2018) and the use of an un-masked assessor to code structured interviews into binary outcomes (Balaji et al., 2011). King et al (2006) was given a low risk rating because it was a randomised controlled trial that clearly described how outcomes were collected to ensure there were no differences between groups in how the outcomes were assessed.

Statistical Bias

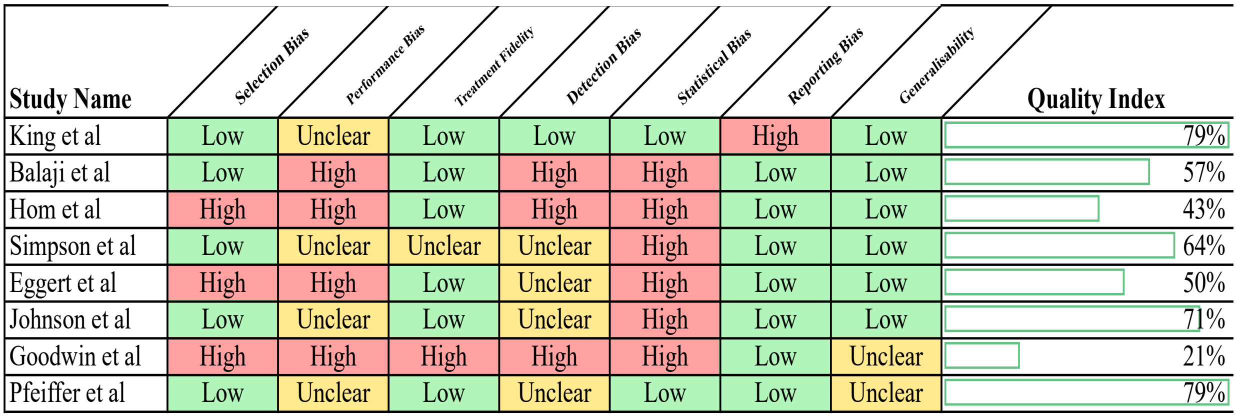
For the present review, studies were either given a high risk rating for statistical bias for the use of a 'completer analysis' (Balaji et al., 2011; Eggert et al., 1995; Goodwin et al., 2018; Hom et al., 2018; Johnson et al., 2018; Simpson et al., 2014) or a low risk rating for statistical bias for the use of an 'intent to treat analysis' (King et al., 2006; Pfeiffer et al., 2018).

Reporting Bias

Only one study was given a high risk for reporting bias, this was because scores were reported for girls and boys separately rather than a combined overall score (King et al., 2006). The other seven studies were given a low risk of bias because they reported the outcomes that were outlined in the method.

Generalisability

Six studies were given a low risk for generalisability because all of these studies had a sufficient sample for generalisation and were representative of their target population. Two studies were given an unclear risk of generalisability because of their use of an overly specific inclusion criteria that resulted in a large proportion of their initially identified sample being excluded (Goodwin et al., 2018; Pfeiffer et al., 2018).



Study Name	Selection Bias	Performance Bias	Treatment Fidelity	Detection Bias	Statistical Bias	Reporting Bias	Generalisability	Quality Index
King et al	Low	Unclear	Low	Low	Low	High	Low	79%
Balaji et al	Low	High	Low	High	High	Low	Low	57%
Hom et al	High	High	Low	High	High	Low	Low	43%
Simpson et al	Low	Unclear	Unclear	Unclear	High	Low	Low	64%
Eggert et al	High	High	Low	Unclear	High	Low	Low	50%
Johnson et al	Low	Unclear	Low	Unclear	High	Low	Low	71%
Goodwin et al	High	High	High	High	High	Low	Unclear	21%
Pfeiffer et al	Low	Unclear	Low	Unclear	Low	Low	Unclear	79%

Figure 2: Summary of applied quality criteria. Red indicates high risk of bias, Amber represents an unclear risk of bias and green represents a low risk of bias.

Table 4: Quality framework applied to assess risk of bias

Risk of Bias	Low Risk of Bias	Unclear Risk of Bias	High Risk of Bias
Selection Bias	The characteristics of the sample population are clearly outlined and without evidence of bias. There are no systematic differences between the intervention and control Participants were randomly allocated to either control or intervention group.	The characteristics of the study population are not clearly reported. It is unclear if there are differences between the intervention and control group. Participants were pseudo-randomised to either control or intervention group.	Characteristics of the target population are systematically different to the study sample. There are systematic differences between the intervention and control group prior to experimental manipulation. Participants were not randomised to either control or intervention group.
Performance Bias	There are no clear differences between intervention and control conditions other than the intervention that is being compared. Peer support is the sole intervention. There is effective blinding to ensure both groups receive a similar amount of attention, ancillary treatment and diagnostic.	It is unclear if there are any differences between intervention and control condition other than the intervention that is being compared. Unclear if peer support was part of a multi-treatment package. Blinding may be in place but is not clearly described	There are clear differences between intervention and control conditions other than the intervention that is being compared. Peer support has been combined with another treatment or has no protocol. There has been no efforts to put blinding in places
Detection Bias	There are no systematic differences between groups in how the outcomes are determined Where needed, blinding of outcome assessors has been implemented and clearly described	Any differences between groups in how the outcomes are determined have not been clearly outlined or described Where needed, blinding of outcome assessors may be in place but it has not been clearly described.	There are clear systematic differences between groups in how the outcomes are determined Where needed, blinding of outcome assessors is not in place.
Statistical Bias	Intention to treat analysis was conducted Appropriate statistical treatment of data clearly outlined and described	Unclear if completer analysis or intention to treat analysis was used Unclear if appropriate statistical treatment of data was used. Not clearly outlined or described.	Completer analysis was conducted. Not appropriate statistical treatment of data.
Reporting Bias	Reported all results of measures as outlined in the method	Not all descriptive and / or summary of statistics are presented	Not reported full outcome measures that are stated in the method section / reported only a subsample of results / only significant results.
Generalisability	Sufficient sample for generalisation and representative of target population (>20)	Sufficient sample for generalisation but with some idiosyncratic features (>20 per group)	Small sample with or without idiosyncratic feature (<20 per group).

Summary

Overall, the level of bias across the primary studies was mixed. Only one study was not rated to have any high risk of bias in any domain (Pfeiffer et al., 2018). Statistical bias, detection bias and performance bias resulted in the majority of the studies receiving high or unclear risk of bias, which was often the result of a within participant design, completer analysis or a lack of clarity surrounding blinding procedures. It should also be noted that the delivery of peer support was varied between studies and it was used as both the sole intervention and also as part of a multi-component intervention. It is therefore suggested that the results of the present meta-analysis should be interpreted with some caution.

Data Analysis Strategy

The data analysis strategy follows the guidelines for the Centre for Applied Psychology, University of Birmingham and is paraphrased below. The full procedures were not possible in the present meta-analytic synthesis due to the limited number of included studies and therefore only strategies that were used are outlined

Handling of data that violates analysis assumptions

When a sample size is small, the absolute value of the Standardised Mean Difference (SMD) is systematically overestimated by Cohen's d (Borenstein, 2009). To remove this bias, Cohen's d is transformed into an unbiased estimate known as Hedge's g

(Hedges, 1981) that is then used for the calculations, before being back transformed into Cohen'd for the reporting and interpretation of figures and tables.

Normalisation and variance stabilisation

The simplest and most widely used method for calculating the between studies variation (tau) for fitting the random effects model, is the DerSimonian and Laird method (DerSimonian & Laird, 1986). The DerSimonian and Laird method comes with the assumption that the random effect is normally distributed in the population and therefore within the primary studies the reported effect sizes should also approximate a normal distribution. To test for the assumption of normality, the primary study effects were plotted on a QQ-chart. Where the QQ-chart shows non-normality, then the variation between studies were then calculated using the restricted maximum likelihood estimator, a method that has been shown to be robust to violations of the normality assumption.

The omnibus test

The fixed effects model or the random effects model can be used to calculate the omnibus test. Utilising the fixed-effects model, there is an assumption that the true effect size for all the reported studies would be identical. The only reason there would be variation within the effect sizes for the reported studies would be due to a sampling error (an error in estimating the effect size). When assigning weights to each of the studies, information in the smaller studies can therefore be largely ignored as we have better information about the same effect size within the larger studies.

In the current group of studies there will likely be different levels of methodological strengths and weaknesses. Therefore, it would also be unlikely that each study is functionally equivalent. Within each study, the participants and intervention would differ in ways that would impact the results that are gathered and therefore it would not be appropriate to assume a common effect size. In these cases, the random-effects model is better justified than the fixed-effects model.

Handling problematic variance

If a study effect varies from the meta-analysis synthesis and the variation cannot be attributed to true variation in the way participants responded to treatment, then the effect is considered to be heterogeneous. Heterogeneity can result from a number of methodological variations between the reported studies, uncontrolled individual factors within the reported literature or measurement errors. To measure heterogeneity, Higgins I^2 is usually used. The more variation in an effect that cannot be attributed to the true variation in the distribution effect, the greater the I^2 value. As the reported primary studies used to calculate the meta-analytic synthesis show a considerable variation in methodologies; heterogeneity has been defined by Higgins as problematic at an I^2 value greater than 75% (Higgins et al., 2003).

Estimation of unexplained variance due to methodological factors and uncontrolled covariates

Where heterogeneity is defined as problematic, then a ‘leave-one-out analysis’ was used to identify primary studies that exert a disproportionately influential effect on the overall meta-analytic synthesis. Where a study is identified to have a disproportionate influential effect, then it has been reviewed with the possibility to exclude on the basis of risk of bias. Subgroup analyses and meta-regression have also been considered in addition to the ‘leave-one-out analysis’ in an attempt to identify the sources of problematic heterogeneity. The subsequent attenuated estimate of the synthesis has then been reported.

Identifying Influential Studies

A ‘leave-one-out analysis’ was used to examine whether any studies were exerting a disproportionately high influence on the overall meta-analytic effect. The ‘leave-one-out analysis’ observes the impact of removing each study in turn, to identify studies with a disproportionate influence on the quantitative synthesis. If influential and discrepant studies are identified then they have been reviewed for risk of bias with a view to removing them from the meta-analytic synthesis.

The quality effects model

Within the random effects model, the precision of an effect is usually estimated as a function of the studies sample size. However, the quality effects model (Doi & Thalib, 2008) builds on the random effects model by also including methodological quality ratings in addition to the sample size in the estimation of precision. For the present review, the risk of bias ratings reported in Figure 2 has been used to calculate the random effects model. The quality effects model can then be interpreted, as the meta-analytic synthesis that would have been generated should all the studies have had the same methodological quality as the best reported study in the review. The quality effects model therefore provides a measure of attrition to attributable to methodological variation.

Results

The omnibus test

A total of eight studies (Balaji et al., 2011; Eggert et al., 1995; Goodwin et al., 2018; Hom et al., 2018; Johnson et al., 2018; King et al., 2006; Pfeiffer et al., 2018; Simpson et al., 2014) with 8912 participants investigated the effectiveness of peer support interventions in the treatment of suicidal behaviour and/or suicidal ideation. Of the included studies, three studies used samples of young people with ages ranging from 12 to 24 years old (Balaji et al., 2011; Eggert et al., 1995; King et al., 2006) and five studies used adult populations, with ages of 18 years old or above (Goodwin et al., 2018; Hom et al., 2018; Johnson et al., 2018; Pfeiffer et al., 2018; Simpson et al., 2014). Furthermore, five studies were conducted in the USA (Eggert et al., 1995; Goodwin et al., 2018; Hom et al., 2018; King et al., 2006; Pfeiffer et al., 2018), two studies in the UK (Johnson et al., 2018; Simpson et al., 2014) and one study in India (Balaji et al., 2011). Two studies also used peer support as part of a multi-component intervention (Balaji et al., 2011; Eggert et al., 1995).

A random effects model was calculated using the generic inverse variance method. Using the random effects model, there is a standardised mean difference of 0.24 ($z = 2.46$, $p = .01$) and a 95% Confidence Interval (CI) of 0.05 to 0.43. A treatment effect of this magnitude would be considered small (Cohen, 1977). The treatment effects for suicidal ideation and behaviour have also been analysed separately, to explore the efficacy of peer support on each outcome. For suicidal ideation, using the random effects model there is standardised mean difference of 0.16 ($z = 1.65$, $p = .10$) and a 95% CI of -

0.03 to 0.34. For suicidal behaviour, using the random effects model there is a standardised mean difference of 0.25 (z = 1.95, p = .05) and a 95% CI of 0.00 to 0.50. The reported effect sizes for both suicidal ideation and suicidal behaviour would also be considered small (Cohen, 1977).

The treatment effects are presented in a forest plot described in Figure 3. The participants who received peer support showed a reduction in suicidal behaviour and ideation compared to those who did not. Although the treatment effects are small, any treatment that reduces suicide related outcomes should be considered to be important and worth exploring further. However, caution is warranted as the confidence intervals are shown to cross the line of null effect and therefore requires further investigation and the study by King and colleagues suggests there was an increase in suicidal behaviour following the peer support intervention.

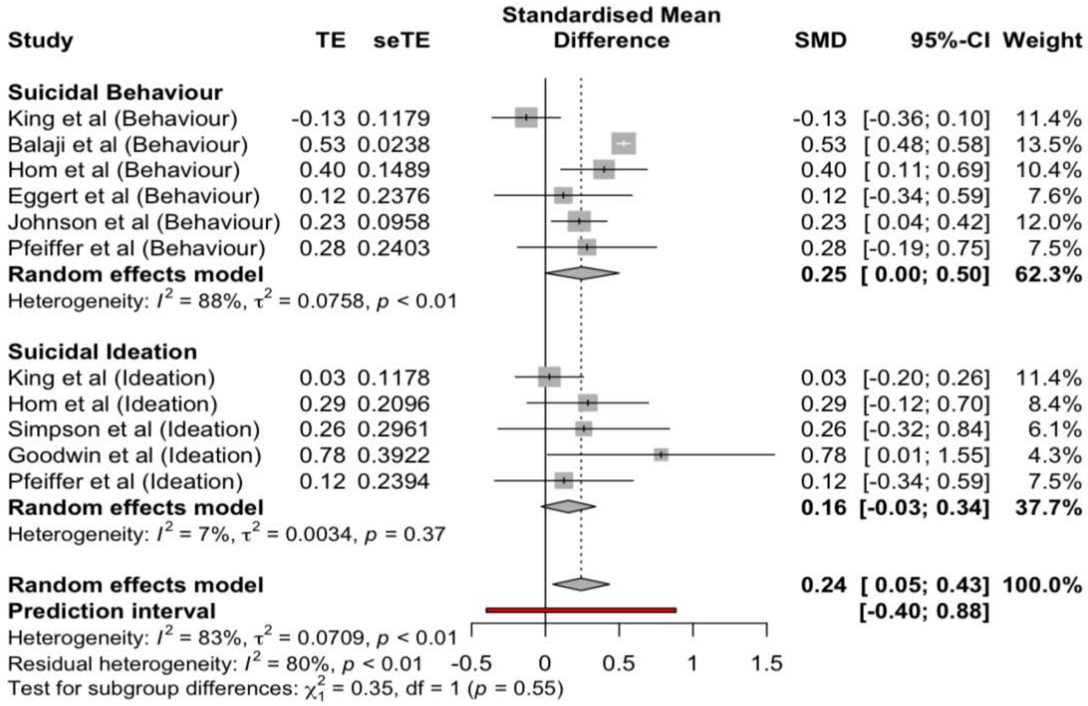


Figure 3: A forest plot detailing the treatment effect for peer support on suicidal behaviour and ideation

Further exploration of the results is detailed below. However, due to the small number of primary studies available in the literature, it was not possible to explore sub-group analyses. When more primary studies are available, it would be important to complete further analyses to better understand the effectiveness of peer support in suicide prevention.

Quantifying and Exploring Heterogeneity

There was an acceptable level of heterogeneity observed in the primary studies reporting suicidal ideation ($\tau^2 < .01$, Higgin's $I^2 = 7\%$; $Q = 4.28$, $p = .37$) but an unacceptable level of heterogeneity observed in the primary studies reporting suicidal behaviour ($\tau^2 = .08$, Higgin's $I^2 = 88\%$; $Q = 41.338$, $p = <.0001$). However, I^2 has been shown to have a substantial bias in meta-analyses that have a small number of primary studies. The estimate of I^2 in the present review should therefore be interpreted cautiously and the reported confidence intervals should be used to supplement the I^2 estimate (von Hippel, 2015). Furthermore as the number of included studies was small, it was not possible to use meta-regression to identify whether unexplained variation in effect sizes could be attributed to uncontrolled methodological factors. It is therefore suggested that the present review should be used to indicate preliminary results for the use of peer support but the outcomes should be taken with caution. It is also possible that the combined effect sizes presented could be biased by the presence of uncontrolled or confounding variables.

Identifying influential studies

The impact of disproportionately influential studies has been assessed using a ‘leave-one-out’ analysis. The leave-one-out analysis calculates the random effects model with each of the primary studies removed in turn. A forest plot depicting the results of this procedure for suicidal ideation and behaviour are presented in Figure 4 and 5.

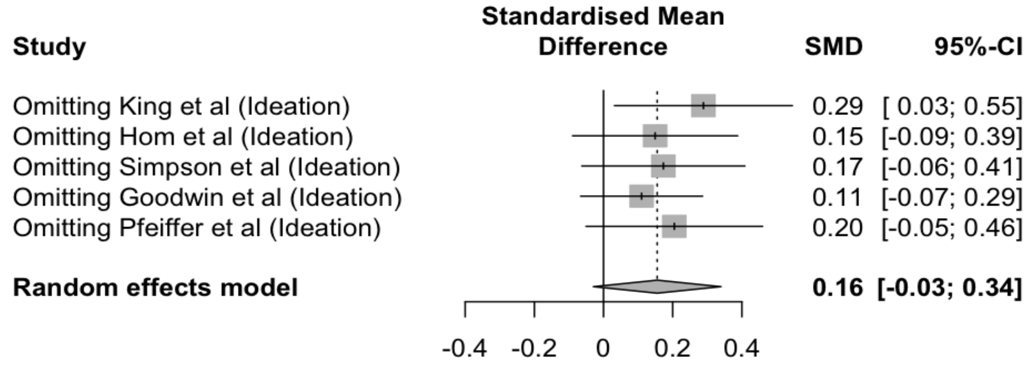


Figure 4: A forest plot depicting the leave-one-out analysis for suicidal ideation

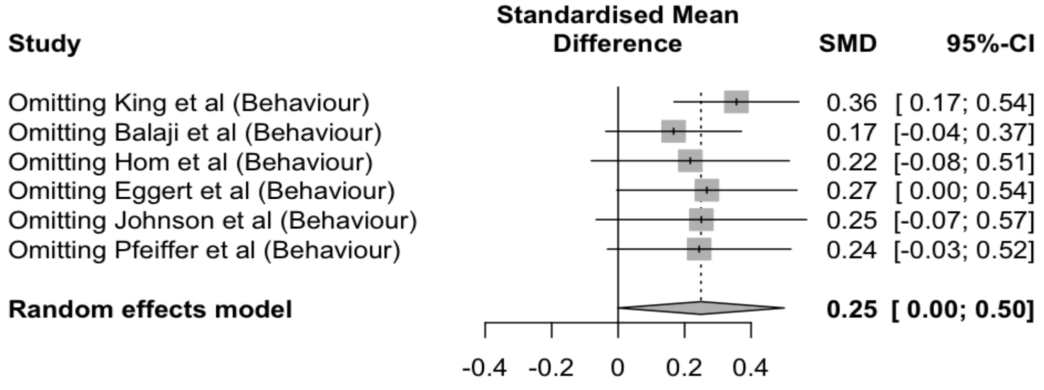


Figure 5: A forest plot depicting the leave-one-out analysis for suicidal behaviour

The leave one-out analysis did not identify any study whose omission would result in a quantitatively different conclusion to the meta-analysis. However, it should be noted that the omission of King et al., (2006) from the suicidal ideation dataset resulted in a relatively large increase in the estimate of the effect from the meta-analytic synthesis and so this paper was reviewed for risk of bias with a view to removal from the meta-analysis. As no additional or substantial risk of bias could be identified the study by King et al., (2006) was retained in subsequent analysis.

A quality effects model was calculated, weighted by methodological quality, as reported in Figure 2. The quality effects model should be interpreted, as the result of the meta-analytic synthesis that would be obtained should all the studies have been of the same methodological quality as the best reported study. The back-transformed quality effects model for suicidal ideation and behaviour are presented as forest plots in Figure 6 and Figure 7.

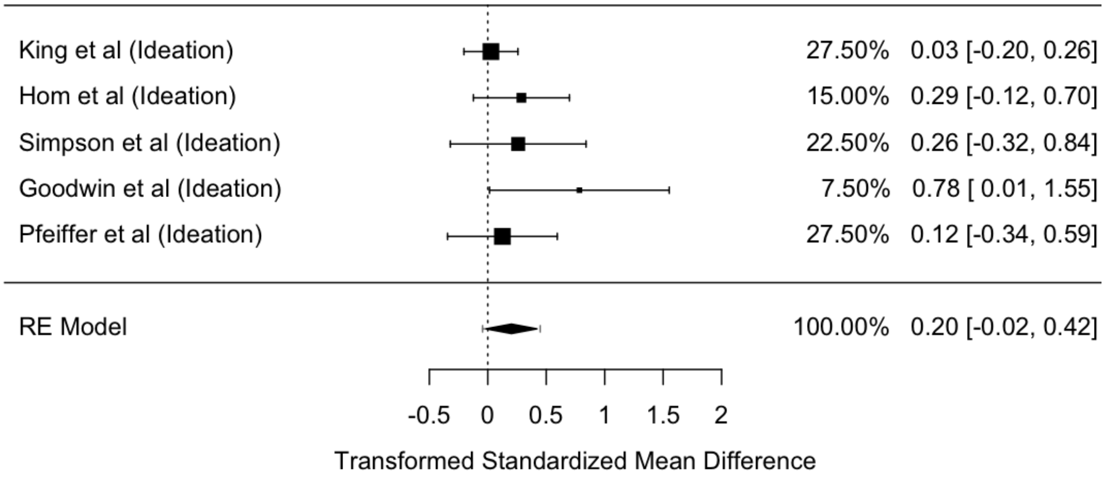


Figure 6: The back-transformed quality effects model for suicidal ideation

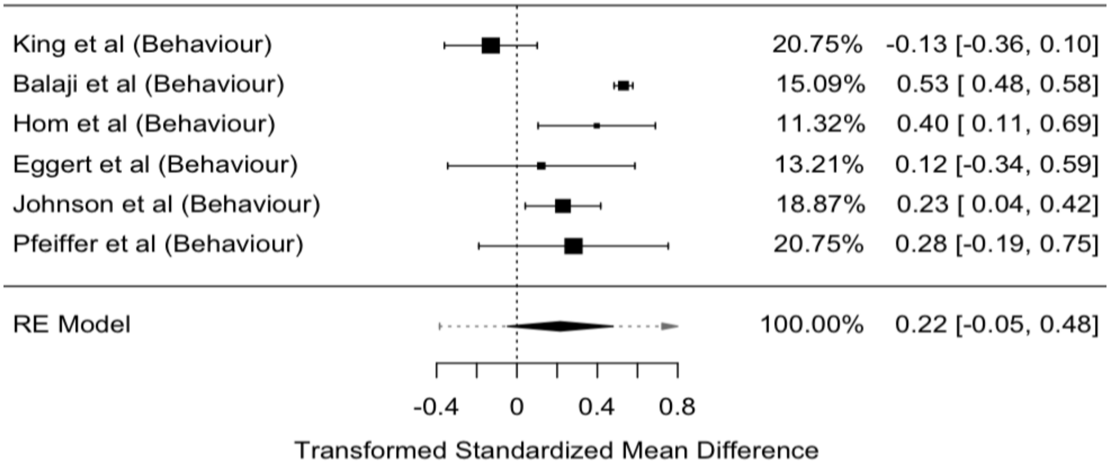


Figure 7: The back-transformed quality effects model for suicidal behaviour

The quality effects model suggests that, for suicidal ideation there is a small increase in the estimate of the effect from the meta-analytic synthesis and for suicidal behaviour there is a small decrease. However it should be noted that neither quality effects model changes the substantive conclusion of the meta-analysis.

Identifying the Impact of Methodological Bias

In order to assess the impact of methodological variation upon heterogeneity, a series of subgroup analyses were conducted on the prevalence rates of low, unclear and high risk of bias for each of the outlined types of methodological bias. Table 5 outlines the impact of methodological bias for suicidal behaviour. There were no significant results for the impact of methodological bias on suicidal ideation.

Table 5: Impact of methodological bias on the suicidal behaviour outcome. N/A is recorded when no studies received this rating. -- is recorded if an I^2 value could not be calculated.

	Low risk	**Unclear risk**	**High risk**	**Q**	**P**
Selection bias	I^2 = 92.2% SMD = 0.23	I^2 = N/A SMD = N/A	I^2 = 0.0% SMD = 0.32	0.16	0.6865
Performance bias	I^2 = N/A SMD = N/A	I^2 = 67.7% SMD = 0.10	I^2 = 45.4% SMD = 0.45	4.10	0.0429*
Treatment fidelity	I^2 = 87.9% SMD = 0.25	I^2 = N/A SMD = N/A	I^2 = N/A SMD= N/A	0.00	--
Detection bias	I^2 = -- SMD =-0.13	I^2 = 0.0% SMD = 0.22	I^2 = 0.0% SMD = 0.53	40.30	<0.0001*
Statistical bias	I^2 = 57.7% SMD = 0.02	I^2 = N/A SMD = N/A	I^2 = 76.1% SMD = 0.36	2.28	0.1313
Reporting bias	I^2 = 70.2% SMD = 0.36	I^2 = N/A SMD = N/A	I^2 = -- SMD = -0.36	10.23	0.0014*
Generalisability	I^2 = 90.2% SMD = 0.49	I^2 = -- SMD = 0.28	I^2 = N/A SMD = N/A	0.02	0.8918

Performance bias, detection bias and reporting bias evidenced statistically significant estimates of prevalence for the suicidal behaviour outcome. For performance and detection bias, studies rated as low risk of bias tended to report lower standardised mean difference, and conversely for reporting bias, studies rated at low risk of bias tended to report higher standardised mean differences. However, the number of primary studies involved in the present meta-analysis limits any further exploration or handling of the available data. There is a clear need for more high quality literature to be published in this field.

Peer support in the context of the wider literature

To understand how the results of the meta-analysis fit with the wider suicide prevention literature, a comparison of effect sizes between different interventions for suicide prevention is reported in Figure 8. All effect sizes have been taken from published meta-analyses (Cipriani et al., 2013; Hofstra et al., 2019; Milner et al., 2015; Pirkis et al., 2013; Tarrier et al., 2008) and the results were transformed into Cohen's-d as described earlier in the methodology section. Meta-analyses were selected that evaluated suicide prevention strategies highlighted as best practice for suicide prevention and/or commonly used within mental health services. The National Institute for Health and Care Excellence (NICE) Guidance for preventing suicide (2019) and the Department of Health's suicide prevention strategy for England (2012) highlighted the need for multi-level interventions (Hofstra et al., 2019), telephone, text messaging, email or letter contact (Milner et al., 2015), liaison with building planners at suicide hotspots (Pirkis et al., 2013) and interventions that target associated mental health difficulties such as depression (Cipriani et al., 2013; Tarrier et al., 2008).

For the purpose of this comparison, the overall combined effect size of suicidal behaviour and ideation has been used, this is in line with Tarrier et al (2008). Figure 8 indicates that out of the included meta-analyses, currently the most effective interventions are lithium and CBT that both have a moderate effect size. The tentative results from the present review fall in line with other interventions, such as brief contact and structural interventions, which have a small effect size. Importantly, the current literature supports national guidance that multi-level interventions is the most effective approach to reducing suicide, and peer support is well suited to be part of a multi-level intervention. Within the present review, there were three studies that all included peer support as part of a wider intervention program (Balaji et al., 2011; Eggert et al., 1995) and a further four studies that provided peer-support alongside treatment as usual (Johnson et al., 2018; King et al., 2006; Pfeiffer et al., 2018; Simpson et al., 2014).

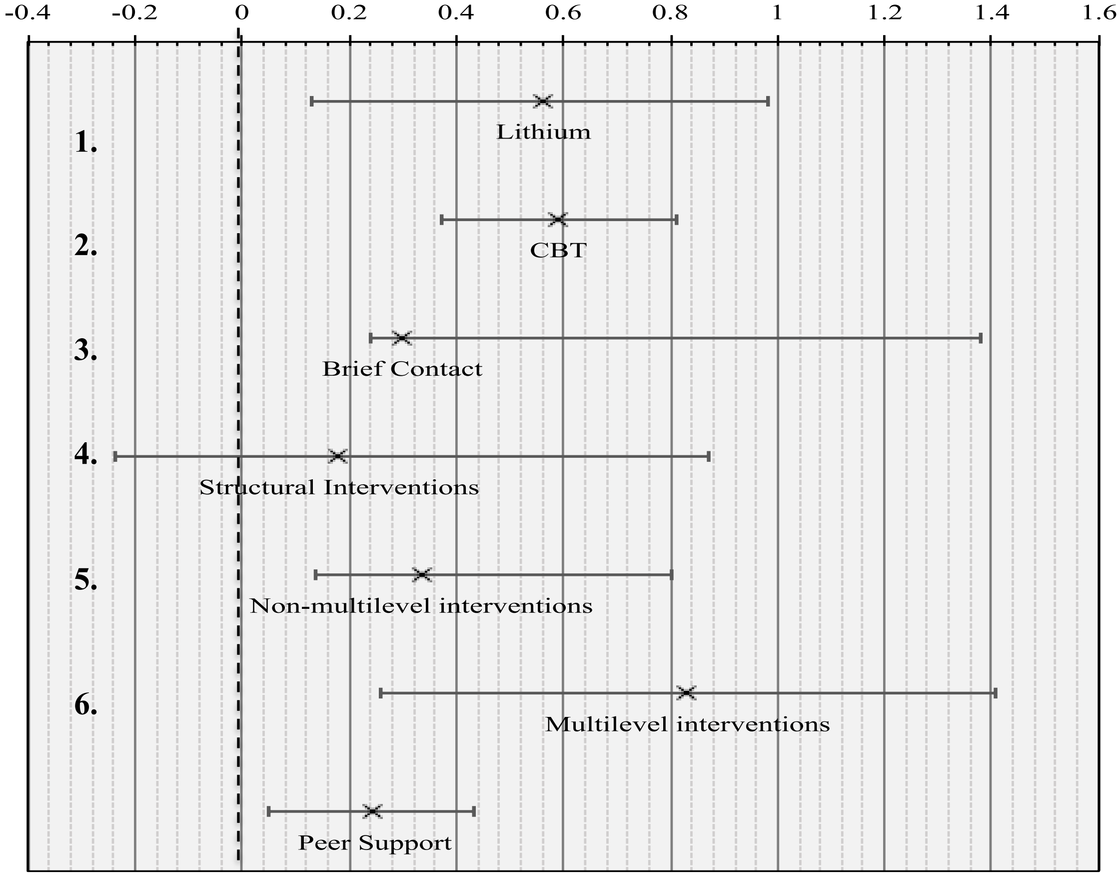


Figure 8: A comparison of published treatment effects for different interventions targeting suicide reduction. 1. Cipriani et al (2013) Lithium vs. Placebo in unipolar depression (Suicidal Deaths); 2. Tarrier et al (2008) Cognitive Behaviour Therapy vs. Treatment as usual (Suicidal Behaviour and Ideation); 3. Milner et al (2015) Brief Contact Interventions: Letters, green cards, telephone calls and postcards (Suicidal behaviour); 4. Pirkis et al (2013) Structural Interventions: barriers and safety nets at suicide hotspots (Suicide attemps); 5. Hofstra et al (2019) Non-multilevel intervention: Community approaches, psychotherapeutic interventions, pharmacotherapeutic vs. Treatment as Usual (Suicide attempts); 6. Hofstra et al (2019) Multilevel interventions vs. Treatment as Usual (Suicide attempts).

Discussion

Summary of main findings

This is the first meta-analysis of peer support interventions for reducing suicidal ideation and suicidal behaviour. The findings of this review suggest there is limited evidence to support the effectiveness of peer support as an intervention to prevent suicide-related outcomes. There are currently very few studies available, and even fewer high quality controlled trials. Of the included studies, all but one was rated to have some serious risk of bias and there was also a noted large variability in how peer support was defined and implemented. Furthermore, some studies delivered peer support as a sole intervention and others included peer support as part of a wider multi-tiered intervention. However, from the available literature, a small effect size was found. For an outcome that is as serious as suicide, even a small effect size should be taken as promising and highlights the need for further controlled trials in this area. This is particularly important as peer-support interventions have the potential to reduce costs to services, reduce needed clinician time and can be easily implemented as part of a multi-tiered intervention.

Comparison with existing literature

At present, there is limited high quality evidence to support the large-scale implementation of peer-support interventions for suicide-related outcomes. Lloyd-Evans and colleagues (2014) highlights that many conclusions from previous reviews may overestimate the effectiveness of peer-support as an intervention and it is equivocal to other interventions at best. However, Gillard (2019) highlights that one of the issues with the current research base is that as researchers, we may not actually be reviewing what it is that peer-support workers actually do. It has been suggested that the literature should focus more on how peer support brings about change, the values that underpin peer-support and how peer-support may actually offer something different (and effective) to mental health services that could supplement the work delivered by mental health professionals (Gillard, 2019).

Despite the limited evidence to support the use of peer support for suicide related outcomes, the small effect size found in the present meta-analysis is similar to those found for suicide prevention by brief contact interventions (Milner et al., 2015) and structural interventions (Pirkis et al., 2013). Furthermore, the present literature also highlights that the most effective suicide prevention interventions are those that are multi-level (Hofstra et al., 2019). It is important to consider that peer support has the potential to be widely available at a relatively low cost (McCarthy et al., 2007; Steele, Dewa & Lee, 2007) and other barriers to mental health services such as transportation, available clinician time, stigma and scheduling may also be lower for peer support services. Furthermore, peer support it is an intervention that has also been positively appraised in qualitative literature and is seen as both acceptable and feasible to patients (Coarsworth-Puspoky et al., 2006). Therefore, peer support could add value to a multi-level approach (Pentinnen et al, 2002).

Implications for policy, future research and practice

Peer support interventions are popular interventions that have already been implemented at a national level (Wilson, 2010). However, the lack of evidence for peer-support interventions in treating severe mental illness (Lloyd-Evans et al., 2014), as well as suicide-related outcomes, should be taken into consideration when developing or implementing peer support services. Clinicians and commissioners should be wary that the popularity of peer support and the current pressures on mental health services does not lead to the development of services that focus on peer support for suicide prevention. Furthermore, where peer-support is being delivered locally, service planners should regularly monitor the outcomes of interest and offer regular support and supervision from qualified staff to ensure that treatment goals are aligned. As the evidence base grows, more confident recommendations as well as a clearer definition of how peer-support can be best implemented will be possible.

At present, it is suggested that peer support workers can offer a meaningful role in suicide prevention, alongside other interventions by:

- Sharing, normalising and validating similar experiences
- Increasing supportive recovery networks
- Providing information around suicide risk and prevention
- Developing self-help plans
- Being aware of signs of crisis and signposting for additional support

Future research should focus on conducting more high quality trials investigating the effectiveness of peer support as an intervention for suicide prevention. This is particularly relevant for certain populations, such as young people, who first and foremost turn to friends and peers as informal sources of help-seeking when in distress (Rickwood et al., 2020). Furthermore, for commissioners and mental health services to support interventions that aim to reduce suicide with confidence, they should have evidence that they can reduce hard outcomes such as suicidal behaviour and not just psychological process variables such as hopelessness. However, until there are more high quality studies measuring these outcomes, it could be helpful to systematically review the effect of peer support on psychological process variables as it is anticipated that there will be a greater number of studies available for review. Research should also consider exploring the mechanisms that peer support uses and how it can be best implemented within services (Gillard, 2019). Indeed, with a greater body of literature available, more in depth analyses will be possible, such as sub-group analyses exploring the effectiveness of peer support across different populations, regions and methods of delivery.

Strengths and limitations

A significant limitation of the present review is the small number of included studies. To try and widen the scope of the review, outcomes were included relating to both suicidal behaviour and suicidal ideation. However, the inclusion of both of these outcomes still resulted in a small number of studies for review. It is possible that at present peer-support intervention studies are not measuring explicit outcomes related to suicide, but instead measuring outcomes associated with suicide, such as hopelessness and isolation. The decision was made to focus on specific outcomes measuring explicit suicide related outcomes to try and better understand the efficacy of peer support as a direct intervention for preventing suicide.

There are also further issues related to the limited number of studies available for review. For example, the present review included both randomised and non-randomised trials. The inclusion of non-randomised trials means that the quality of evidence available for review is limited. Furthermore, the present review has included studies that have used peer support as a sole intervention, as well as studies that involved peer support as part of a multi-tiered intervention. Inclusion of peer support as part of a multi-tiered intervention reduces the confidence in which conclusions can be drawn around peer support as an effective suicide prevention intervention. Furthermore, each study has implemented peer support in various ways such as phone calls, email exchange, face-to-face and through groups. It is therefore unclear if there are certain forms of peer support that may be more effective for suicide prevention than others. Indeed, it is hard to make any confident conclusions with the available literature.

Despite these limitations, this review has several strengths. As peer support is already being used across voluntary and national health services, a strength of the present review is that it provides the first overview of the current state of the literature for this area. Furthermore, the present review has made all efforts to convert outcomes into a common effect size so that all relevant studies could be implemented into the analysis. Important recommendations for clinical practice, research and policy have also been outlined.

Conclusion

Although peer support has become a popular intervention and it is currently delivered nationally, evidence for its use to reduce suicide-related outcomes is limited. The present review highlights the methodological problems with defining peer support, its varied use and high levels of methodological bias in the extant literature. There is a clear need for future research in this area and until the evidence base is further developed, policy makers and mental health services should ensure they have a clear justification for the use of peer support within their services, particularly for individuals that are suicidal.

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CHAPTER II

EMPIRICAL PAPER

EXPLORING THE PROCESSES INVOLVED IN SEEKING HELP FROM A GP FOR YOUNG PEOPLE WHO HAVE BEEN AT RISK OF SUICIDE

Abstract

Introduction

General Practitioners (GPs) are in a good position for the early identification and management of suicide risk in young people. However, little is known about the processes involved in how, when and why a young person decides to seek help from their GP.

Method

A qualitative study using semi-structured interviews to explore the processes of help-seeking from a GP at a time when young people felt suicidal. Eight participants (2 males, 6 females) aged 17-23 took part in this study and the data was analysed using framework analysis.

Results

The analysis identified three main themes and seven sub themes that reflect young people's processes of help-seeking. The main themes explored are: *'Understanding when to seek help from a GP,' 'Barriers and facilitating factors at the GP consultation,'* and *'Help-seeking as a fluid process.'*

Discussion

The findings suggest that the processes involved in how, when and why young people seek help are dynamic and fluctuates over time. Prior to the first GP consultation, there was an emphasis on how a young person comes to understand and articulates their distress, the importance of their informal support networks and their perception of the GP as a potential source of help. During a GP consultation, willingness to seek help was

influenced by how safe and supported the young person felt to disclose their distress. Perceived GP training, verbal and non-verbal communication and validation were seen to be important factors to help facilitate this process. Subsequent help-seeking was then largely influenced by prior experience of GP consultations and the availability of alternative support.

Introduction

Suicide in young people

Suicide, defined as a fatal self-injurious act with some evidence that there was an intention to die (Turecki & Brent, 2016), is the leading cause of death for young people, aged 10 to 24 years old, in the United Kingdom (UK) (Office for National Statistics, ONS, 2019). Worldwide, suicide is the second leading cause of death among 15 to 29 year-olds, accounting for 8% of all deaths (World Health Organisation, WHO, 2019). Furthermore, there has been a recent increase in the rates of suicide for young people across the UK. In 2018, 730 young people, aged 10 to 24 years old, died by suicide; this is the highest recorded number since the year 2000 (ONS, 2019). The WHO (2019) also estimates that for each person who dies by suicide, there is a further 20 people who would have made a suicide attempt. Suicide attempts, suicidal ideation and deliberate self-harm are also very high in this age group and are associated with completed suicide (Hawton, Saunders & O'Connor, 2012).

Self-harm refers to any act of self-injury carried out by a person, irrespective of their motivation (The National Institute for Health and Care Excellence, NICE, 2012). Self-harm has been demonstrated to be the single greatest predictor of suicide, with 50% of young people who died by suicide having previously self-harmed (The National Confidential Inquiry into Suicide and Safety in Mental Health, NCISH, 2017). Further documented risk factors include the presence of an underlying mental health difficulty, a history of suicide attempts, a genetic predisposition and difficulties within the family (Bilsen, 2018). Furthermore, the collected data around suicide and self-harm are poor, and it is suggested that the actual statistics are significantly higher than what is reported (Samaritans, 2019).

Suicide behaviours are complex; there are often many explanations that can be attributed to why someone died by suicide. For example, adolescence and early adulthood is a period of increased risk for young people due to significant cognitive, biological, social and emotional changes (Arnett & Ranner, 2006). These changes are also in combination with a range of external pressures such as school, college or university, difficulties with employment and the associated pressures from social media (Pelkonen & Marttunen, 2013). It is also a period of time where young people can be vulnerable to adverse experiences such as experiencing poverty, bereavement, domestic violence or abuse (Pelkonen & Marttunen, 2013). Alongside all of the above, roughly half of all lifetime mental disorders start by the mid-teens and three quarters by the mid-20s (Alonso et al., 2004). Young people therefore have been highlighted as being at a particularly high risk for developing mental health difficulties and at a higher risk for suicide (WHO, 2019).

Preventing suicide: A global priority

Given the size and scale of youth suicide and the impact suicide can have on individuals, families and communities; the reduction of suicide for young people has been highlighted as a global health target (WHO, 2014). Indeed, the reduction of deaths by suicide is now a priority for the WHO in their mental health action plan (2013-2020) and it has also been highlighted as an indicator of progress in the United Nations Sustainable Development Goals (UN, 2016). To achieve this target, it has been suggested that a comprehensive and coordinated response to suicide prevention is needed, with the timely registration and regular monitoring of suicide forming the main component of the prevention strategy (WHO, 2014). This recommendation is further highlighted in the national strategy for the prevention of suicide in England, where it states the importance of early identification and management of young people who are deemed 'at risk of suicide' (Department of Health, 2014).

Within the UK, around two thirds of people who have completed suicide have not been in contact with mental health services in the year before they die (NCISH, 2018). However, many were found to have visited their GP in the months before their death. The UK National Confidential Inquiry into Suicide in Children and Young People (2017) found that around 60% of young people who completed suicide were known to services, with 40% of those in recent contact. However, in only 26% of cases was this in mental health care. Importantly, young people who completed suicide were found to have had increased rates of contact with their General Practitioner (GP) one to three months prior to their death (Appleby, Amos & Doyle, 1996; Luoma, Martin & Pearson, 2002), with 91% of individuals who completed suicide visiting their GP at least once in the year before their death (Pearson et al., 2009). Indeed, increasing frequency of GP consultations has been associated with rising suicide risk, with the highest risk among patients who consulted their GP over 24 times during a 12-month period (NCISH, 2014).

GPs have therefore been identified to be in a good position for the early identification and management of suicide.

Role of GP in suicide prevention

Both the NHS and the UK government have committed to improving mental health care and the management of suicide risk (NHS England, 2016). At present, the Royal College of Psychiatrists (2016) estimates that around 90% of people with mental health difficulties are being treated under primary care services. Furthermore, approximately 40% of all GP appointments are now related to mental health, with GPs often fulfilling the role of a 'gatekeeper' to further mental health support (Mind, 2016). GPs therefore are highlighted to play a vital role by providing the appropriate assessment and management of suicidal risk. Having an awareness of risk factors, conducting a thorough risk assessment and knowing how to offer appropriate support can enable a GP to make appropriate clinical decisions that can prevent an individual dying from suicide (Department of Health, 2012). Risk management skills through supplementary training and liaison with local psychiatrists have been highlighted as important in ensuring that GPs are prepared to support in this capacity (England, Nash & Hawthorne, 2017).

Despite the identified role for GPs in mental health care, the Royal College of General Practitioners has highlighted that many GPs feel underprepared for practice, especially in child and adolescent psychiatry (Mind, 2016). This finding is demonstrated in practice, with young people, compared with older populations, being offered fewer interventions and fewer referrals to mental health services in the 3-months preceding their suicide attempt (Younes et al., 2013). Furthermore, many GPs have highlighted that they find suicide risk assessment an area that they find particularly challenging (Michail & Tait, 2016).

The standard allocated 10-minute GP consultation slot, combined with limited training and confidence in dealing with mental health difficulties have been highlighted as significant barriers to the assessment and management of suicidal risk in primary care (Saini et al., 2010). However, barriers also exist in relation to GP's attitudes and beliefs towards suicide. For example, GPs believed that young people were unwilling to reveal the true extent of their distress and if they were 'truly' suicidal then they would not seek help at all (Michail & Tait, 2016). The variation in attitudes and understanding of suicide risk amongst GPs has subsequent implications about how GPs perceive risk and how it should be assessed. Indeed, it has been found that GPs can rationalise self-harm as attention seeking (Herron et al., 2001) and rely on risk measurement tools or checklists that may not adequately capture the emotional, psychological and social mechanisms that underlie self-harm and other risk factors (Michail & Tait, 2016).

Young people's perceptions of the GP role

Bidle et al., (2006) explored a sample of young adults' perceptions of GPs as a source of support for mental distress. It was found that young people did not value or recognise that the GP could be a source of help for mental health difficulties. Often, GPs were seen as a source that could only provide help for physical health difficulties and therefore young people did not want to discuss difficulties relating to mental distress. Young people also thought that the most likely outcome from attending a GP consultation would be a prescription of antidepressants and that they were unable to provide 'talking therapies'. Indeed, research highlights that young people are least likely to endorse the GP as a source for support in relation to mental distress (Barker, et al., 1990; Oliver et al., 2005).

Young people and help-seeking

'Help-seeking' typically refers to the active behaviour of seeking help from others. Specifically, help-seeking is often used to describe the process of an individual seeking help from health services in the case of severe and serious mental health issues, including depression, substance misuse and suicide (Barker, 2007). Help-seeking can be broken down into formal help-seeking from professionals, and informal help-seeking from friends and families (Rickwood et al., 2005). There are a number of theoretical frameworks that have attempted to explain the process of help-seeking for those at risk of suicide. However, help-seeking research is often adult-orientated and less is known about the direct relevance of many frameworks in our understanding of help seeking in young people (Murray, 2005)

For young people, behavioural models have suggested that help-seeking is an internal process within the individual that moves through recognition, identification of sources of help and subsequent willingness to disclose risk (Rickwood et al., 2005). However, these models may not reflect the reality of help-seeking in young people. The difficulty with many models of help-seeking is that they often follow static or a sequential process that may not take into account any potential fluctuating and dynamic influences that may be contributing to a young person in relation to if, when and how they seek help (Rickwood et al., 2005).

An alternative model to help-seeking in young people was presented by Murray (2005), building on the model proposed by Rickwood et al., (2005). This model emphasises the perception of the problem by the young person and how their prior experience of help-seeking pathways can alter their perception that something can be done to help and consequently affects their motivation to seek help. Other models of help-seeking further highlight a pathways-based extension to existing theories, suggesting that the process of help-seeking is influenced by a person's mental health literacy and perception of stigma (Best et al., 2016). Alternatively, Biddle et al., (2007) offers an insight into why young people may not seek help, suggesting a cycle of avoidance that seeks to normalise how the young people are feeling through their life experiences in an attempt to avoid acknowledging that they are in real distress. This research further highlights that increased need does not always lead to increased help-seeking.

There is also potentially a large role for family, tutors, peers and employers in understanding help-seeking behaviours of young people. It has been suggested that initial sources of help may have a significant influence on subsequent help-seeking behaviour and can deter or facilitate presentation to services (Klineberg et al., 2013). However, the proportion of young adults who access mental health support by their own decision and those that access support facilitated by others is still largely unknown (Mitchell, McGillian & Hagan, 2017). Furthermore, there is also a growing evidence base that suggests that young people show a preference for informal help-seeking and many do not seek any professional help, even in cases where an overdose has been taken (Michelmore & Hindley, 2012).

A systematic review exploring perceived barriers and facilitators to mental health help-seeking in young people identified 13 barriers and 8 facilitating factors (Gulliver, Griffiths & Christensen, 2010). Important barriers included: poor mental health literacy, preference to be self-reliant, and a concern about stigma. The most important facilitating factors were previous positive experience with help-seeking and social support that aids in the help-seeking process. However, despite a good understanding regarding barriers and facilitating factors for help-seeking, little is known about the underlying process of how, when and why young people seek help when they are feeling suicidal. If we wish to improve the quality and outcomes of mental health care further then it is important that we know more about the processes involved in how, when and why young people seek help, as well as how identified barriers interplay with the help-seeking process (Mitchell, McGillian & Hagan, 2017).

Aims of the project

The principal research objective is to understand how, when and why young people seek support from their GP when they are feeling suicidal, or in some cases, what is happening when young people do not present at their GP. By gaining in-depth knowledge of the processes that young people employ in regards to seeking help for suicidal ideation, future educational interventions for GPs may be better tailored to the young people's experience and needs. Furthermore, additional support can be put in place to improve access for young people to receive appropriate care that takes into account their views and experiences of seeking help for suicidal ideation.

Method

Ethical approval

Ethical approval for the project was granted from the University of Birmingham's Ethics Committee and the National Health Service's Health Research Authority (NHS HRA, REC reference: 19/WM/0104). The letter of ethical approval, participant information sheet and consent form can be seen in Appendices 1, 2 and 3. Ethical considerations around consent, confidentiality and anonymity were taken into account, as well as ensuring participants felt they were safe to participate, and that participation did not cause distress.

Although talking about sensitive issues such as a past suicide attempt could potentially be upsetting for the participants, there is no evidence to suggest that it could increase risk or harm (Crawford et al., 2011). A review of the literature by Dazzi and colleagues (2014) found no statistically significant increase in suicidal ideation or behaviour in adolescents and adults in the general populations and in at-risk groups as a result of being asked about their suicidal thoughts. Furthermore, young people taking part in self-harm research reported they were happy to take part in such research and cited important benefits (Lockwood et al., 2018).

Study design and setting

This is a qualitative study using semi-structured interviews (Appendix 4) with young people who were under the care of a local children, young people and families service. This service provides specialist input for young people in a community setting. The use of a semi-structured interview ensured relevant topics were covered, but it also enabled the collection of flexible and open responses from the participants (Kvale & Brinkman, 2009). The study is conducted in line with the consolidated criteria for reporting qualitative research (COREQ; Tong, Sainsbury & Craig, 2007) and the completed checklist can be found in Appendix 5.

Sample and recruitment

The definition of 'young people', in regards to strict age ranges, varies by country and over time (Furlong, 2014). However, most research uses the term 'young people' to cover the school-age range (7-12), adolescents (13 – 20), and young adults (up to 24) (King, 2001). The present study recruited young people between the ages of 16-25 to fit the definitions of existing literature and to reflect age ranges at local services.

The current study used a volunteer sample. Multidisciplinary team meetings were attended at local children, young people and families service hubs and care-coordinators were approached directly about the research. Care coordinators then approached young people on their case load, giving information about the research and seeking consent to be contacted by the researcher if they expressed an interest to take part. The researcher also met with and advertised the research through the service's Youth Advisory Group, on social media and a snowball sampling strategy was also employed to encourage further participation in the research.

Inclusion criteria for participation were as follows:

- Aged 16 – 25 years old
- History of suicide attempts in the past three years (excluding a period of six months before the interview).
- Participants must be registered with a GP in the local area and be under the care of the local children, young people and families service
- Participants must be able to provide informed consent
- Participants must have sufficient command of English.

In total, eight participants were recruited and took part in the semi-structured interviews and no participants withdrew from the study. However, two potential participants expressed interest but did not satisfy the inclusion criteria. All participants were given a pseudonym to protect confidentiality. Six participants identified as female and two participants identified as male. Participants were aged 17 to 23 years old and had received various mental health diagnoses such as bipolar disorder, depression, anxiety and autism spectrum disorder. No further information was collected about the participants as it was not necessary for the present study. The study aimed to recruit a sufficient and diverse number of participants to reach data saturation, whilst also taking into account timeframe restrictions and the nature of the project (Trotter, 2012). There was no restriction on current diagnosis because suicide is a transdiagnostic experience and the present research is more interested in the processes involved in help-seeking, rather than understanding the experiences of a person's suicidal ideation.

Material

The semi-structured interview was developed initially by researching the existing evidence base around young people, help-seeking and primary care. The initial interview questions were then reviewed in supervision with the author's research supervisor. The refined interview schedule was then sent to a Youth Advisory Group, allowing young people to suggest adjustments to ensure that the questions were meaningful to them. However, no adjustments were made by the Youth Advisory Group.

Data collection

Each participant took part in a semi-structured interview that lasted approximately one hour; with a follow-up debrief session offered with a Clinical Psychologist. A flexible schedule of open-ended questions was used to guide the interviews, which allowed for further exploration, clarification and probing where appropriate. All interviews took place at the young person's local children, young people and families service hub. Each interview was conducted, audio recorded, transcribed verbatim and checked for accuracy by the author. Participants were made aware that they could withdraw from the research before, during or after data collection. All participants chose to be interviewed alone and there were no repeat interviews.

Reflexivity

It is important in qualitative research to consider both personal and epistemological reflexivity. Personal reflexivity refers to how the researchers own values, life experiences and beliefs could have influenced the research process. Whereas, epistemological reflectivity refers to how theoretical assumptions and perspectives can influence the research (Willig, 2013).

Important characteristics of the author relate to his occupation as a Trainee Clinical Psychologist, with an interest in child and adolescent mental health and suicide prevention. The author had received teaching in qualitative methodologies and received regular research supervision throughout the project. The author is male and at the time of interview, he was only a few years older than some of the participants. It was made clear that the research was conducted with the intention to fulfil the partial requirements of Doctor in Clinical Psychology and that by taking part in the research, they would be contributing to the understanding of the help-seeking processes young people use and this could have important future clinical implications. As part of their training, the author also had experience of working in a child and adolescent mental health setting. However, there had been no prior contact with any of the participants. The impact these qualities could have on the research was monitored through a reflective journal, supervision and strategies to establish methodological rigor. Framework analysis was chosen as the method of data analysis, which is not aligned with a particular epistemological, philosophical or theoretical approach. Rather, it is a methodology that has a flexible, structured and transparent approach to generate themes (Gale et al., 2013).

Data analysis

Data were analysed using a thematic framework method (Ritchie & Spencer, 1994). The framework method is an approach to qualitative data analysis that allows themes to be derived from the narratives of the participants as well as from the research question (Pope et al., 2000). It is a pragmatic approach to analysis and is increasingly common in healthcare research settings (Furber, 2010). Framework analysis was chosen as the most appropriate methodology as it as an approach that is useful when there is a specific research question and a narrow time frame for the project to be completed (Strivastava & Thomson, 2009). Furthermore, the present research aimed to illicit the participant's 'story' of seeking help, taking into account context, experience and process issues. Framework analysis has been highlighted as being a helpful approach for this type of research as it emphasises how both a priori issues and emergent data driven themes guide the development of the analytic framework (Parkinson et al., 2016). Other methodologies would not have been as appropriate in trying to understand the process of help seeking as a whole as they may not capture the situational, social and experiential factors that all contribute to understanding if, when, why and how a young person may seek help when they are feeling suicidal.

Framework analysis uses several inter-related distinct stages (Rabiee, 2004) that allow for both theme-based and case-based analysis utilising the development of a framework matrix. Framework analysis adheres most closely to the ontological position of subtle realism (Snape & Spencer 2003), which suggests that the social word exists independently of an individual's subjective understanding. However, the social world is only accessible in qualitative research through the subjective understanding of the research participants, which are then further interpreted by the researcher (Hammersley & Atkinson, 1995). One of the biggest strengths of framework analysis is that it is a straightforward and transparent process with clear stages (Johnston et al., 2013) that also provides a clear audit trail of the analytical process (Flick, 1998). The present research followed the stages described within the 'illustrative example of the use of the framework method' (Gale et al., 2003) and the seven stages are summarised in Table 6. Strategies were employed throughout this process to establish methodological rigor (Leal et al., 2015), these have been summarised in Table 7.

Table 6: The seven stages of framework analysis (Gale et al., 2003).

Framework analysis stage	**Description**
Stage 1: Transcription	Interviews were transcribed verbatim independently by the author, with only long pauses, interruptions and nonverbal communication (such as laughter) included in the text. Due to time limitations, the transcripts were not returned to the participants for checking. However, regular summaries of what was being discussed during interview were provided to check the interviewer understood the young person.

Stage 2: Familiarisation with the interview	The author familiarised themselves with the interview by re-reading the transcripts and listening again to the audio-recorded interviews. During this stage, initial thoughts or impressions were noted along the margin of the transcript.
Stage 3: Coding (Appendix 5)	The author coded the first two transcripts independently, highlighting interesting segments of text and applying a label or code (in the left margin) along with more detailed ideas and notes (in the right margin). A second researcher also followed this process independently from the author.
Stage 4: Developing a working analytical framework (Appendix 6)	The author and second researcher met to discuss the codes and labels that had been applied to each transcript. Although at times, different words or phrasing were used, the same areas of text had been highlighted. If there was anything highlighted by one researcher and not the other, we met to discuss and come to an agreement. The codes and labels were then sorted and the first analytical framework was developed. The researchers then met again to discuss this process and refine the analytical framework.
Stage 5: Applying the analytical framework	The analytical framework matrix was then applied to each of the eight transcripts. Interesting and meaningful passages of text were highlighted and attached the appropriate code or sub code from the framework matrix.
Stage 6: Charting data into the framework matrix	Once all eight of the transcripts had been coded using the analytical framework. The researcher summarised the data in the matrix for each code and sub code, utilising a column per code and a row per participant on Microsoft Excel. This process

(Appendix 7)	allowed large sections of data to be sorted and summarised in a manageable way that allows for both in-between and within participant comparisons. At this stage, the codes tend to be neutral summaries and will highlight positive and negative responses to the questions at hand.
Stage 7: Interpreting the data (Appendix 8)	Reviewing and summarising the framework matrix and making connections both within and between participants and categories generated themes and subthemes. This process is influenced by the original research question as well as by new concepts that are generated inductively from the data. At this stage, an interpretive process is applied, going further than the descriptions of individual cases and towards possible explanations for what was happening with the wider data. Ideas were explored and developed in consultation with the second researcher and the author's research supervisor. A summary of the results was also returned to participants with the possibility for them to make comments or corrections.

Table 7: Strategies employed to establish methodological rigor (Leal et al., 2015)

Strategy employed	Description
1: Transparency	The process of data analysis followed a systematic and visible staged process that provided transparency in data analysis as well as a clear audit trail.

2: Researcher Triangulation	After the author had familiarised themselves with the data and identified initial codes and sub codes, a second researcher independently reviewed the transcripts and developed their codes and sub codes. These codes were then reviewed together.
3: Discussion, refinement of thematic framework and interrelatedness	The author and second researcher worked closely together at each stage to discuss the development of the framework and emerging themes to ensure that there was consistency and accuracy between integration of data and the interpretations.
4: Credibility	The findings were presented and discussed with the second researcher, author's supervisor and a research tutor at the University to ensure that assertions were supported by the data and that the framework encompassed the majority of the available data.
5: Use of quotes	Participant's quotes were used and provided as examples of particular themes and the relationship between the thematic frameworks and the interpretative stage.
6: Comparison with research literature	Results from the present research have been compared with existing literature to confirm and expand upon the studies findings.

Results

The results section has been split into three main themes with seven subthemes (Table 8). The overarching themes cover the process of help-seeking from a GP; starting with the process of when young people first considered seeking help, the process when they tried to seek help, and how the process changed following their GP consultations. All participants contributed to each theme (Table 8), however, any commonalities or variations within each theme have been highlighted in the text. As the focus for this study was not about quantifying the outcomes, quasi-statistical claims using ‘some’, ‘many’ and ‘others’ are generally made. Further quantifying of the findings may be misleading, given the parameters and aims of the present study (Maxwell, 2010).

1. Understanding when to seek help from a GP

All participants had attended a consultation with their GP that involved discussing their suicidal experience. In understanding how the participants came to attend their first GP appointment, three subthemes were identified: difficulty with understanding and articulating internal distress, arranging and accessing a GP consultation and preconceptions of the GPs role. The three sub themes are outlined below.

Table 8: Structure of themes and example quotes from contributing participants

Theme	**Subtheme**	**Contributing participants and example quotes**
1. Understanding when to seek help from a GP	*1.1 Difficulty with understanding and articulating internal distress*	***Prisha:*** *"I didn't make the link between being kind of depressed and having lots of issues and it being to do with health."* ***Connor:*** *"I didn't even know what depression was"* ***Hayley:*** *"I didn't even know depression existed"* ***Sarah:*** *"There is such a depth to my struggles that I didn't quite have the words to explain."* ***Mia:*** *" [Because] I had on going therapy, very good therapy during the time when I sought help from a GP – I think I had good insight into why I felt so low"* ***Sophia:*** *" […] I was scared, I didn't know what the hell was going on"* ***Olivia:*** *"I didn't know what anxiety was, I didn't really understand mental health as a concept"* ***Liam:*** *"I didn't understand my mental health in general growing up, I find it hard to talk about things".*
	1.2 Arranging and accessing a GP consultation	***Prisha:*** *"[…] [The police] told my parents to take me to the GP. And so, my parents took me to the GP the next day".* ***Connor:*** *"[…] Then my mom said, 'okay, I am going to take you to the doctors and we are going to see what is going on'"* ***Hayley:*** *"my friend noticed something wasn't right. I said 'I don't want to be alive' basically. I don't think I actually said that, but that is what I meant. That is what triggered going to the GP."*

	Sarah: *" I thought I was coping all right. Everyone around me was well aware that I wasn't. So I was dragged off [to the GP]".* **Mia:** *"I did try and seek help on my own accord in January, then my parents noticed that I wasn't going back to see the GP. They suggested I change GPs."* **Sophia:** *She [Mum] freaked out and she said 'we have to get you to the doctor. This is not normal.'"* **Olivia:** *"[My friend] said 'that is social anxiety'. I googled it and was like 'oh god, that really makes sense' I went to the GP and I said, 'I have this thing and I don't know what to do''"* **Liam:** *"They [A&E] were not too helpful because I didn't show any signs of self-harm. Didn't show anything like that. It was the case of 'go speak to your GP.'"*
1.3 Preconception of the GP's role	**Prisha:** *" I never really associated it [mental health] with something you would go to the GP with"* **Connor:** *"I think I would have just hoped that they would make my better, just because I didn't know what it was until she [the GP] actually said it"* **Hayley:** *"'Why am I here? I am not coughing or sneezing.' I had lots of internalised stigma without knowing it"* **Sarah:** *"It was very much not knowing who else to turn to aside from my GP – I hadn't looked into any other help, so it was easiest to go to"* **Mia:** *"In order to access alternative forms of support, and in my opinion better forms of support, you have to go through the GP first"*

		Sophia: *“There was concerns about what they would say, what will they do? Will I have to take tablets?”* ***Olivia:*** *“I know for a fact that they are not going to help me, they can’t do anything. I viewed them as a stepping stone to get into something that could [help].”* ***Liam:*** *I didn’t really know, I didn’t know if I was going to be thrown in hospital or put on medication or whatever else”*
2. Barriers and facilitating factors at the GP consultation	*2.1 Facilitating factors to help-seeking at the GP consultation*	***Prisha:*** *“I didn’t feel safe to open up because they [parents] were there. I think it really helped that my GP told them to leave the room”* ***Connor:*** *“I just trusted the GP and I took the medicine until the other mental health place took over.”* ***Hayley: “*** *[what was helpful] was just straight up him [the GP] turning around and asking me that direct question after listening […] I knew that he was listening. He was active listening”* ***Sarah:*** *“[Having mum there to say]: ‘No, she needs help. She needs something.’”* ***Mia:*** *“[The GP] was immediately like ‘come in,’ and then made eye contact with me. That made huge difference. The subtleties of body language can tell you a lot about someone’s empathy.”* ***Sophia:*** *“[The GP] took care of me because she was talking to my mum and me about how were both feeling about it. She was very attentive […]”* ***Olivia:* “***[If they know you] a doctor is going to be able to pick up on body language, how they dress and whatever and think ‘they are not doing too well, I have a reason to worry here.’”*

		Liam: *"having my Dad there was good because he could then say 'yes, they have not said enough, or was quite rude, or you haven't said enough yourself.' Or, whatever else."*
	2.2 Barriers to help-seeking at the GP consultation	***Prisha:*** *"I think barriers would be that GP's only have 10 minutes and some are really rushed. […] They don't always have the time to talk and that, you know, open space"* ***Connor:*** *"He was saying some people have it worse than me, some people's families are dying and stuff like that. I already felt terrible anyway"* ***Hayley:*** *"You can understand why it might be difficult [for GPs] to switch from something very physical to something very mental."* ***Sarah:*** *"For someone who feels like they are burdening them [GP], or is maybe reluctant or unsure. I feel there needs to be an understanding about how they present at a surface level, there is more to that."* ***Mia:*** *"[The GP] was cold in manner. It felt like she was rushing me, like she didn't want to take the time to really talk to me about what happened. […] She just shrugged her shoulders and said 'I can up the dose.'"* ***Sophia:*** *"If someone comes to a GP and says 'I have been self-harming.' They look at the cuts, and they are like it is not worthy of my time. If that is the case, they are going to go away and practice, and get worse until they have a gaping hole in their arm."* ***Olivia:*** *"When you realise what their limitations are, and their lack of confidence, it is even more scary for you."*

		Liam: *"There were barriers in a way because I didn't want to keep going to the doctors about my mental health. […] I didn't want to be labelled as a mental health patient."*
3. Help-seeking as a fluid process	3.1 Changing support networks	***Prisha:*** *"I have got a really good kind of support package now. So, I would go to probably my manager of my supported living place."* ***Connor:*** *"I have not come seen a GP again for my mental health. I always come here [mental health service], whether it is a psychiatrist or duty worker. I don't have CPN anymore, but it would have been her."* ***Hayley:*** *"My care coordinator books appointments with me. […] I would go to her because I know she has the resources to 'fix me'."* ***Sarah:*** *"I am very open with him [new partner]. I tell him everything. He is aware of my history, all my struggles. It was like having another me, but with more insight."* ***Mia:*** *"[I speak to] The care coordinator I have had since I was discharged from hospital […] I was already in counselling. It was very good, so I didn't necessarily need that. I just needed intensive support."* ***Sophia:*** *"I save all my mental worries for when I see the care coordinator. So, I don't really go to the GP now."* ***Olivia:*** *"I still rely on people picking up cues. I make them easier for people to find now and when I am feeling more well, I tell people what the cues are so when I am not well I can use them and know that they already know what they are."*

		***Liam:** "The people that I do have close are through hospital or have got mental health problems themselves. It has taken a while to find healthy relationships."*
	3.2 Drawing on past GP consultations	***Prisha:** "I think now, now that quite a few years have passed, I can understand more about the GP's role and that they are like a stepping stone."* ***Connor:** "I think now a GP is not an option maybe anymore to get help from them in terms of mental health."* ***Hayley:** "I don't think the GP's are the be-all-end-all. Some people may see them that way, so they should treat their patients that way."* ***Sarah:** "I was expecting to be turned away. I was expecting to be shunned"* ***Mia:** "Each time I visit the GP, I would have a massive anxiety attack, because they are an authority figure and because they had been so cold and unhelpful."* ***Sophia:** "It is hit and miss. It depends on their personality and the day you catch them on, and everything. There are so many factors involved, but fortunately, I have quite good experiences."* ***Olivia:** "One problem that happens with people who regularly feel the way [suicidal] is that you tend to present a lot of times and it is just natural whoever you see each time, the seriousness diminishes. They don't believe it as much or whatever."* ***Liam:** "They will only really properly help me unless I do it [make a suicide attempt] and I am still trying to commit suicide, or something like that."*

1.1 Difficulty with understanding and articulating internal distress

For all eight of the young people interviewed, the development of their suicidal experience was described to have started at a young age, usually in their early teens. Young people attributed their developing difficulties to various levels of adverse childhood experiences. For example, participants described experiencing verbal and physical abuse as well as difficulties with school transitions, bullying and relationship or family breakdowns.

However, although the young people were explicit in their descriptions of what was happening to them during these years, there was a general confusion or difficulty in understanding and making sense of their internal emotional state. Participants were aware that something was not quite right in how they felt but did not feel they had the words to describe their experience to others.

> *"I was a kid, I was scared. I didn't know what the hell was going on. My childlike instinct was screaming inside of me 'this ain't right, you should be scared.' I guess deep down, below my mental health demons, deep down, I really did want to be helped, and I wanted that support." (Sophia)*

> *"To me, it was almost like an overflowing cup. A cup, which kept getting full, filling up, and then there was just one night and – Again, I can't actually say what happened, it was just too much (Sarah)"*

In the quote above, Sarah uses the metaphor of a cup that was steadily filling up, and alludes to how in one night it overflowed. In this way, we can understand some of the sense of what may have happened that night, even though she is not describing the events. This illustrates how difficult it is to put into the words the experience of the suicide attempt and yet still conveys some of the meaning. Furthermore, the quote by Sophia highlights that even when it is difficult to make sense of how she was feeling, she still wanted help. Sophia described this period of her life to be scary and how the idea of help-seeking was supressed by what she described as her 'mental health demons.' The description presented here perhaps further highlights what a scary experience this was for a child to be experiencing and also some of the complexities young people face when trying to describe or explain how they are feeling.

Given some of the difficulties in finding the right words to explain their internal experience, participants often used physical symptoms to try and make sense of and explain what was happening to them. However, it was difficult to link this experience to their developing suicidal feelings or mental health difficulties.

> *"I just had this horrific anxiety, but I didn't know what it was. I didn't really understand mental health as a concept. Then I described to my friends that before we were going to go out, I just had this feeling of being sick or not being able to go" (Olivia)*

In general, all participants used different language and ways of talking about their difficulties, which is likely influenced by their individual culture, family upbringing and exposure to others with mental health difficulties.

> *"They [parents] were very religious and they didn't understand that much about how they behaved. […] They never really understood why I would cry so much and why I was so sensitive. My parents made me go through two exorcisms and the first was when I was 11, and that was quite traumatic for me." (Prisha)*

> *"I didn't understand my mental health in general growing up. I find it hard to talk about things. I know my Dad grew up around it, not necessarily had it himself, but I have got my older sister who he has been looking after […] My sister has got scars all over her arms and she never told me why. Obviously because I was a child at the time, I thought she just cut it on a fence or whatever she says." (Liam)*

In the quotes above, Prisha speaks about a significant traumatic experience in her younger years that she believes was linked to her families' lack of understanding around mental health difficulties. She attributed her experience to her family's religion and how they perhaps believed that Prisha was possessed. Liam on the other hand alludes to a family where mental health difficulties are very present, however this didn't mean that they were spoken about openly. As a child, he was protected from understanding what was happening with his family, as far as believing that his sisters scarred arms were a result of cutting them on a fence. It is possible Liam couldn't find the words to explain his own feelings because these feelings were not spoken about within his family. These quotes perhaps also further highlight how young people may struggle to understand their internal experience based more broadly on external factors such as family and religion.

As the young people found it challenging to make sense of their difficulties and had trouble finding the words to articulate their internal experience, this had a direct consequence on the process of seeking help. Some participants were very explicit in their worry that they would be dismissed because they couldn't clearly describe how they were feeling.

> *"I think there is such a depth to my struggles that I didn't quite have the words to explain. I didn't want to be turned away because I was explaining it in a light-hearted manner" (Hayley)*

Hayley summarises this subtheme in the above quote. She didn't believe she had the words to be able to articulate the severity of how she was feeling. She speaks about describing her struggles in a 'light-hearted' way and as a result is concerned she would not be understood or taken seriously. In Hayley's example it is clear that her ability and confidence in describing her distress was preventing her from seeking help at this point in her life.

1.2 Arranging and accessing a GP consultation

For those participants that had a supportive network, there was a general consensus that it was their support network that first identified that something was wrong and that help was needed. Some families and friends were able to draw on their knowledge or experience of mental health difficulties or their own life experiences to understand what might be happening. However for others, their support network were as confused as the young person. Sometimes families really did not know what to do and felt that the GP was the natural contact that would help make sense of the presenting difficulty.

> *"My mum was concerned because she didn't know what was going on, we had been the perfect family. She didn't understand what was going on because I was the oldest child in the family, we hadn't had any run-ins with mental health thus far, and so it was scary for her. I think she was hoping that it (contacting the GP) would change things and that I would get better. She was concerned and she felt out of her depth I guess." (Sophia)*

In the quote above, Sophia illustrates how mental health difficulties can present even in a 'perfect family.' She alludes to how scary this situation can be for not only the young person but also for the family. For Sophia, it felt that the process of consulting a GP was driven by her mum in a desperate attempt to help Sophia get better. The quote further suggests a sense of panic that can underlay the first contact with a GP and also gives us an idea of how bad the situation could have been. This further highlights how difficulties with mental health literacy can also extend to the support network and how this can impact why or how the GP was first contacted.

Seven out of the eight participants described being taken to the GP by either their family or friends at least once. At the first consultation, there was a mix of feelings around this for the young people. One participant described feeling hopeful that something might change and that they may begin to feel better.

> *"People are not just made better by nothing, you have to actually do something. I remember before going to the GP, I kept asking my mum if we could go to the pharmacy, to see if we could buy something to help with my anxiety or help with my mood. My mum took me straight to the GP" (Connor)*

However, for other young people, there was a worry that they were not ready to open up how they were feeling, or they were worried that by explaining what was happening, it would take away the legitimacy of their suicidal experience. There was a sense that the internal struggle that the young people were battling with, would be minimised or not taken seriously.

> *"I was not ready to deal with anything, I didn't want to talk to the GP and go through everything, but when I was younger, my parents just carted me up to the GP " (Sarah)*

> *"If you keep it to yourself, it remains a valid attempt, a valid experience." [...] "It is such a serious decision to make [to act on suicidal feelings], that if you try and seek help and you get like a 'you are doing this on purpose for a different reason, or for attention' it makes a mockery of what you were feeling" (Olivia)*

In the quotes above Sarah is talking about being taken to the GP based on the concerns of others. However there is a clear worry that at that point she was not ready to talk about her difficulties, it perhaps felt like she was forced to attend. In the second quote by Olivia, she is talking perhaps more about the idea that if she did attend the GP consultation, she may be mislabelled as attention seeking, and this changes the nature of her feelings and of the suicidal act. In her words, it is only a 'valid' suicide attempt if you 'keep it to yourself'.

For participants who did not feel they had a supportive network, one participant went to the GP alone, whilst others had experience of bypassing the GP and going straight to A&E or were taken into psychiatric inpatient units first. Two participants described police involvement, when it became apparent that they were actively suicidal. In general the young people that were interviewed did not have a sense of when they should access the GP and often intervention by others was required to ensure they received proactive support.

1.3 Preconceptions of the GP's role

One of the most important factors that influenced young people in regards to seeking help from their GP was the perception that the GP could not offer any help. For many of the young people, they could not understand what was happening to them, others around them could not make sense of it either, so there was little hope a GP would be able to offer any support. It was often the case that participants saw GPs as dealing only with physical health difficulties and as such they could not understand why they needed to access a GP for support.

> *"I remember sitting in the waiting room, and that was not pleasant because people were coughing and sneezing, and I was like 'why am I here? I am not coughing or sneezing' I had lots of internalised stigma about the GP, without really knowing it" (Hayley)*

Hayley talks about her experience of sitting in the GP waiting area, feeling confused why she was there and comparing herself to people who are physically unwell. She suggests that it was only at a later date that she realised she had such a strong preconception around the role of the GP. However at the point when she needed help around her mental health difficulties, she did not see a role for the GP. This view appears more based on Hayley's understanding on the GP's role within a mental health context, rather than viewing the GP as not competent.

Other participants felt that the GP might not be able to help, but they saw them as a gatekeeper to better support. There was a hope that by talking with a GP, the young people would be either given medication or therapy to help with their difficulties.

> *"They filter out who needs the care. It is a cruel process, but I feel they are the first point of call for support. They are a bouncer to the mental health club" (Sophia)*

Sophia makes the comparison to entering a club and how you have to get past the bouncer before you enter. She describes the process as cruel, alluding to the idea that some people will go without support; in the same way a bouncer would reject some individuals from the club. However, she also suggests this to be necessary to get the right support and if we took the metaphor further, it perhaps is about ensuring the club does not reach capacity. Depending on how participants viewed their GP, this sub theme highlights how some participants showed a reluctance to approach a GP and have to discuss their difficulties, whilst others show almost an acceptance, seeing the GP as a hoop to jump through to better support.

2. Barriers and facilitating factors at the GP consultation

All participants at the point of interview had experienced more than one GP consultation, many with different GPs. One participant had entirely positive experiences with their GP, whilst most participants had mixed experiences. Throughout the interviews it was clear that prior experience of GP consultations was one of the most important factors that would mediate whether young people would consider the GP in their process of seeking help for future suicidal feelings. The subthemes relating to facilitating factors and barriers at the GP consultation are detailed below.

2.1 Facilitating factors to help-seeking at the GP consultation

Participants spoke about the importance of the GP's approach in enabling them to feel safe enough to talk about their difficulties. Overwhelmingly, participants found that if they were met with a GP who was welcoming, attentive and willing to build up a rapport, then the young person felt more able to disclose how they were feeling and hopeful that they would receive good care.

> *"She took care of me because she was talking to my mum and me about how we were both feeling about it. She was very attentive and although she wasn't my main doctor, she is one of my favourites personally because I just feel really looked after whenever I go to see her" (Sophia)*

> *"The other Dr I saw the year before, who was immediately like 'come in,' and then made eye contact with me. That made a huge difference. The subtleties of body language can really tell you a lot about someone's empathy for you when you are having a mental health crisis" (Mia).*

Sophia describes that even when a GP is unfamiliar to you, a warm and caring approach can go a long way. In her quote she talks about how attentive the GP was to both her needs and the needs of her mother. This is very important as we established that many participants attended their GP with a parent or friend. Mia further summarises the importance of the general approach a GP takes as being a significant factor. She speaks about the GP 'immediately' speaking with her and making eye contact and this approach helped her feel like the GP would be able to empathise with her. We get the sense that the GP had created an open and safe space in which someone's difficulties could be talked about and heard.

It was also noted that participants felt that it is important that the GP takes what they are saying at face value and will adapt to how the young person is presenting. Some participants felt that if they are able to talk and explain themselves, they should be given that chance to do so. However, sometimes the young person might feel unable to find the words or are too emotionally suppressed that they do not feel able to talk. In these cases, it was helpful for the GP to take a more direct approach to their assessment.

> *"It is important for the GP to be an active listener, being open, and looking like they are interested in the human that is in front of them, because you are human. It may not feel like it at the time, but you are. The GP needs to take charge when they need to, not when they want to" [...] " I think if someone is 'able' like in my first appointment, if they can engage in conversation with the GP about how they*

> *feel, they need to go with what they are saying. Get what they need from them, with what they are saying. If someone is not able to talk and they are quiet, then ask direct questions. They need to use their training" (Hayley)*

Most participants found it easier to talk about and disclose information relating to their suicidal experience after getting to know their GP. The young people that were interviewed felt that it took a lot of bravery to talk about their difficulties to a GP and they had to feel safe to be able to do this. It sometimes took more than one GP consultation before the full picture had been disclosed and the right support was offered. It is possible that young people were withholding information based on their experience with their GP, but it is also possible that young people were finding it difficult to know what was important to disclose, or find the right words to convey how deeply affected they were by their internal difficulties. Sophia describes the value of having a good relationship with her GP and she alludes to how it can be helpful to have someone follow your mental health journey from start to end. The positive rapport they built up together allowed her to feel that she had someone who was rooting for her, and this actually helped with her journey towards recovery.

> *"She has been with me from the beginning of the bad times, to coming out of my mental health problems, and it felt really nice to have closure with her" […] "She referred me to CAMHS and got me into that, it made me feel quite proud of myself and everything that I had achieved" (Sophia)*

All participants spoke about the value of taking family or friends to the GP consultation in regards to their ability to seek help from a GP. Participants found it helpful to have someone available to articulate and explain how they were feeling, when perhaps they could not find the words themselves. Furthermore, participants described a sense that the GP would take the assessment more seriously if the young person had support during the consultation. A few participants also described the value of their GP giving time for the individual to speak alone as well as time to discuss their difficulties, supported by a family a friend.

> *"If I had a supportive caregiver around, Mother or Father, somebody else, then I probably would have asked them to come with me, and maybe speak a bit on my behalf. At least it would have been helpful for them to speak initially, and then when I had calmed down, because I used to get very anxious, because of how I had been treated by GP's, then I would have felt able to chip in with more information for them later on in the consultation" (Mia)*

> *"My mum pushed for my help, which otherwise, if I had gone on my own, downplaying everything, I would have been sent away" (Sarah)*

The quote by Sarah clearly illustrates a worry that without her mum, she might not have got the right support. There is a suggestion that the GP might not understand the difficulties or take it as seriously without a parent present. Mia, who was the only participant who attended her first GP appointment on her own, still spoke about how she would have valued having someone with her to talk about her difficulties. This perhaps highlights the significance of other people in the processes of help-seeking from a GP.

2.2 Barriers to help-seeking at the GP consultation

All of the interviewed participants spoke about barriers that they experienced at the GP consultation, some of which were internal to them, and others that were attributed to their experience at consultation. The 10-minute consultation time came up across all participants, and it felt that this was not sufficiently long enough to be able to disclose and talk about their mental health difficulties. Furthermore, participants did not feel that GPs had received adequate training on mental health difficulties and how to assess for suicidal risk. Multiple participants talked about how GPs should have wider training that taught them how to just be around someone who was experiencing mental health difficulties, because often they found the GP consultation to be a very invalidating experience.

> *"I feel like they need to be taught a process of how to actually be with somebody who is saying all that (disclosing suicidal thoughts), because if you are sitting at your keyboard, not looking at them, part of that training has to be how to sit with and be with that person" (Olivia)*

> *"From my experience with certain GPs, I think they are like the police force. They get a 10-minute lecture on mental health and that is it. But the GPs, I don't know if they are that interested" (Hayley)*

> *"If they had more training into what to look out for and signs and symptoms that definitely say 'yes, this person needs to be in services. This person needs extra help.' I think that would be very helpful." (Sarah)*

The three quotes above by Olivia, Hayley and Sarah all talk about their experience or perception that their GPs had not received the right training. Olivia speaks about a need for general training about how to be with a patient in distress whilst Sarah talks more about specific training around assessment, diagnosis and management of mental health difficulties. The quote by Hayley alludes to a perception that she feels GPs do get training, but they just aren't interested in it. There is a sense that this view may link up with the perception that many young people hold, that a GP is someone who works in physical health, and perhaps doesn't play a role in mental health.

In some cases, the GP had made unhelpful comments or had been dismissive of the young person entirely. This fuelled the young person's suicidal experience, and multiple participants either increased their self-harm, or made a suicide attempt that they attributed to a sense of hopelessness following the GP consultation. Mia spoke about how she had felt able to disclose an incident where her ex-boyfriend raped her and the GP minimised this experience:

> *"I think it is very significant, negatively, that she [the GP] attributed my low mood to a 'relationship breakdown', which was a complete misunderstanding of what had happened to me" (Mia)*

Another participant attributed blame to the GP for the increase in his suicidal experience, and felt that it would have been their fault if he had died:

> *"It would have been their fault [the GP], because it wouldn't have been my decision to do that [to kill himself]. I understand about not giving me medication because I am complex, but the things that he said like 'other people are worse off', he didn't have to say that at least" (Connor)*

It was often the case that participants got a sense of whether they would feel able to disclose their feelings and seek help from their GP based on the first few minutes of the consultation.

> *"You would get a sense as soon as you walked into the room of whether it was going to be helpful or not. Because, it was how quick they ushered you to the seat, quickly got into their keyboard, typing really fast as you were talking, not even looking at you. You get that sense of nothing is going to happen here" (Olivia)*

Olivia clearly describes the ‘sense’ you get from the moment you walk into the room for a GP appointment. However she also went on to speak about how barriers to getting the right support can be internal to the young person. Sophia describes how her suicidal experience was a private experience and she was worried about seeing her family GP, in case the GP disclosed information to her family. Other decisions to withhold information from the GP by other participants were made around not wanting to burden the GP, not wanting to waste the GP’s time or a fear the young person will be labelled as a ‘mental health patient’.

> *“I felt really uncomfortable going to the GP, knowing that he has treated me, in theory all my life, and that they knew my mum. I knew that they were professional standards and that they had to have confidentiality, but I thought to myself like ‘being a family GP, I don’t actually trust that the next time he is not going to be like, how is Olivia finding the medication?’ or something that assumed I had told my mum. I always had a funny feeling about that. (Olivia)*

In the above quote Olivia talks about the fear of disclosing information to her GP. There is a sense that perhaps there is some shame, or at least secrecy around her suicidal experience. She alludes to the idea that perhaps it is more painful or worrying to disclose her internal distress to a familiar GP and it would have perhaps been easier to talk to a professional who was unfamiliar to her and her family. This is a contrasting view to other young people who spoke about the value of having a GP who is familiar to them and knows them well. Perhaps the key difference here is that the GP knew Olivia before her suicidal feelings developed, and the GP has a good relationship with her whole family. However, there were general concerns raised that the GP could make assumptions based on what they thought they knew of the young person.

> *"They asked me 'are you getting suicidal thoughts? Are you suicidal?' and when I said 'yes'. Especially this one Dr, I wont name names, but he was like 'you wouldn't do it anyway'" (Liam)*

> *"If you are sat there explaining you are struggling and you need help, then they should listen and not be like 'you are just having a bad week' kind of thing" (Sarah).*

> *"The GP said, when I went into my low mood, he was like 'You have got a really nice supportive family so you are going to be okay'. I was just thinking ' you don't know anything'. He not only made that assumption, but he introduced that concept in the room. I had nowhere to go." (Olivia)*

The above quotes by Liam and Sarah are also talking about examples where the GP has perhaps assumed they knew better than the young person based on prior knowledge of them. In Liam's case this was despite very clearly answering yes to the questions assessing for suicidal risk. The final quote above is again by Olivia, who summarises the danger of making assumptions when assessing risk and the impact it had on her. She talks about how not only did her GP assume that she had a supportive family, she then felt like she perhaps could not challenge this assumption any further, and felt stuck without further support from her GP. It is perhaps significant when the GP gets involved with a young person and if a GP does know somebody prior to the development of any mental health concerns, they should still be taken at face value.

In general, participants who had experienced barriers at their GP consultation were less likely to open up or seek help from their GP. At times, it made their suicidal feelings a lot worse and their experience reinforced some of their previously held beliefs around GPs not being in a position to offer help, and that nobody could understand or offer support for their internally held difficulties. Some participants felt very uneasy during the consultation and tried to drop 'hints' about how they were feeling, or presented with very physical symptoms. It is possible that this approach is seen as the safest route to seeking help, but it relied on the GP picking up these clues, reading the young person's notes and asking the right questions. It is also possible that if young people view a GP as somebody who only works with physical health difficulties, and if the young person has been taken to see their GP, this could prime them to talk about physical symptoms rather than their emotional experience.

> *" I think that if a person doesn't come in to a GP appointment for their mental health, and they only talk about their physical health, you should still ask about their mental health, because you are a general practitioner. The mind is included in that general bit. I think if someone has pre-existing or pre-diagnosed mental health conditions comes in to your practice with a physical health condition, don't*

> *assume that it is to do with their physical health, because it probably isn't. Sometimes maybe, but probably not. Just be holistic is my speech of the day." (Hayley)*

Hayley summarises this point, and indeed the complexity of the barriers that are at play during a GP consultation. She is speaking about the importance of a holistic assessment as young people may have internally held barriers to disclosing their distress. She suggests that it is the responsibility and part of the role of a GP to ensure that they assess for mental health difficulties, particularly if there is a prior history or evident risk factors. However, as discussed, the internally held barriers that young people hold may also interplay with environmental barriers at the GP consultation such as the 10-minute consultation slot, as well as internal barriers that the GP's may hold. The interplay of these different barriers presents a significant challenge to the process of seeking help for young people who are feeling suicidal.

3. Help-seeking as a fluid process

In contrast to thinking about help-seeking as a linear process, all participants referred to the process of help-seeking as being more of a fluid and dynamic process. The processes involved in seeking help from their GP seemed to change and evolve each time the young person required to seek help and this process was mediated by different factors. Of particular importance were the two subthemes around changing support networks and prior experiences of GP consultations. These subthemes are outlined further below.

3.1 Changing support networks

The participants' support networks heavily influenced the process of seeking help from a GP. However, support networks changed frequently across the participants' experience of seeking help. For many participants after going through the GP consultation and getting into specialist mental health services, they described how the process in which they would now seek help had changed because their support network had also changed. For many, this was a positive experience and they felt better supported than ever before. Nearly all the participants had access to a Community Psychiatric Nurse (CPN) and they spoke about a strong preference to be seen by their CPN, or duty worker, as they preferred to talk to someone who knew them and were mental health trained.

> *"That is what they (CPN) specialise in; it is obviously not just depression. There is a whole wide range of people here that has lots of different mental health problems. I feel because the people that work here are trained in some way in mental health, that is why I feel safer to come here." (Connor)*

In the quote above Connor has a strong preference to speak to someone whom he trusts and who is trained in understanding and supporting people with mental health difficulties. Of particular importance is how Connor describes knowing that the staff are trained, helps him to feel 'safe'. Indeed, he uses the word 'safer', referring to feeling safer than going to a GP.

Some participants met other young people with mental health difficulties through the services they had gone through, such as inpatient stays, or met partners that they felt more able to disclose their mental health difficulties with. There was an emphasis on how participants had a shared experience with their newly built support network that was a valuable source of support.

> *"I don't have many friends anymore because of my mental health. The people that I do have close are through hospital or have got mental health problems themselves. It has taken me a while to find healthy relationships, although they have mental health problems too, they won't use you and affect my mental health. It has helped a lot to speak to people" (Liam)*

> *"I am very open with him (partner). I tell him everything. He is aware of all my history, all my struggles. It was like having another me, but with more insight." (Sarah)*

Liam describes the close relationship he had built up with other young people that have shared experiences with him. He met these people through services that he accessed through his GP. In Liam's case it may be that the process of seeking help from a GP will come further down the line as he has a stronger support network in place now. In Sarah's quote she describes having a new partner that she feels she can trust and talk openly with about her difficulties. This is a stark contrast to how she had previously held her difficulties to herself and did not feel able to seek help. This is important again for two reasons. Firstly, she has someone she feels is like her, to whom she can talk and use as a source of support. Secondly, she also has someone else who can monitor for risk factors, signs of relapse and someone who can support if another GP consultation is required.

However, some participants spoke about a reliance on the new support that was not always permanent. A lot of services can only provide support for a specified amount of time. Participants found that they can at times become reliant on the support that is put in place and can then relapse when it is taken away.

> *"I would get attached to these staff because they would be giving me positive support, and then when I was better, I came out of feeling suicidal. Then it would be like, because I was doing well, it felt like they didn't care anymore, so then I would be suicidal again. It was a bit of a cycle." (Prisha)*

Participants were often reluctant or frustrated about having to go back through the GP. However, after going through services multiple times already, many participants had developed more confidence or assertiveness around telling their support network or GP what they needed.

> *"I still rely on people picking up cues. I make them easier for people to find now and when I am feeling more well, I tell people what the cues are so when I am not well I can use them and know that they already know what they are." (Olivia)*

Olivia describes how the process for seeking help for her is still very similar to before in that she relies on other people to pick up the cues. However when she is feeling well she now communicates to people what they should look for, this in turn would change the whole dynamic of the help-seeking process and perhaps suggests that there is less shame to what was previously described. It is also possible that through the support that she has received, and indeed that the other participants received, there is now an improved mental health literacy that allows for better communication of their difficulties.

In some cases being assertive was very helpful, however in other cases this felt like it could develop into conflict when trying to assert what they need with a GP. This potential confrontation had the potential to cause further reluctance or frustration with the help-seeking process.

> *"You try and tell them (the GP) what they have to do, in a way, they don't like it. They just see it as "I have been studying this for ten years, I have qualifications right here." Me, personally, I know personal experience is the best qualification for mental health" (Liam)*

In general, what young people were describing is how they were now drawing on newly built support networks or their greater understanding of their mental health difficulties and this changed the process in how they go about seeking help, if at all, from their GP. Some participants also received various diagnoses across their mental health journey, and found that they were better able to communicate their needs to a GP with a diagnosis. This shift in the help-seeking process highlights how fluid the process is and how the process appears to be influenced by a number of factors.

3.2 Drawing on past GP consultations

The experience at the GP consultation didn't just affect the help-seeking process during that consultation, but it also had long-lasting effects for any future help-seeking attempts. Overwhelmingly, where participants had bad experiences, these stuck with the young people and affected their decision to seek help moving forwards. For some participants this gradually built up with each consultation:

> *"There was a growing hopelessness. There was a concern that I would get worse, become more distressed, more suicidal, maybe make an attempt. (Mia)*

Other participants had such bad experiences that they completely disregarded the GP as an option for any future help:

> *"I think a GP is not an option anymore, to get help from them, in terms of my mental health. Because, it has happened with two separate GPs, I think it will happen again with another one" (Connor)*

For each GP consultation that the young people found unhelpful, participants appeared to use this as a growing personal evidence base that they shouldn't seek help from the GP again. If at this point, the young people didn't have alternative access to support (such as a CPN), it was often the case that their suicidal risk would increase until they ended up in specialist services, bypassing the GP. This is particularly evident for the participants who also felt let down by the support that was offered.

> *"That is the scary thing, nobody can do anything, apart from you being sectioned or whatever. This normally wouldn't happen until you have tried to kill yourself. I feel like there is nothing that anyone can really do, other than give time to somebody, sit and listen to them and reassure them. But, this services barely exists to anyone who hasn't already tried to kill themselves" (Olivia)*

> *"Each time I visit the GP, I would have a massive anxiety attack, because they are an authority figure and because they had been so cold and unhelpful." (Mia)*

> *"I was expecting to be turned away. I was expecting to be shunned" (Sarah)*

Olivia talks about how scary it can be thinking that there is nothing that can be offered unless you try and kill yourself. There is a sense that the support that is desperately needed is not available until a crisis situation. Mia further highlights that previous bad experiences had a direct impact on her ability to attend future consultations, bringing on anxiety attacks at each visit. Finally, Sarah summarises this sense of growing hopelessness suggesting that her experience has led her to expect to be let down, to be ‘turned away’.

However, although it only took one bad experience in some cases to change the way a young person would seek help from a GP, other participants drew on positive experiences to also give them hope. This again is particularly evident where young people knew they could see the same GP, and speak to someone who knew them. In the quote below, Olivia speaks about the contrast of seeing a familiar and unfamiliar GP but asking for the same support:

> *“At times, I know that the only option to help me is through a crisis team. So there have been times where I have gone to my GP and said ‘look, can you call them and tell them what is happening’ and the GPs that do not know me would be like ‘why? You can ring them?’ and I cant explain to them that I just can’t. The one that knows me though, she knows the drill, she knows my problems and she will do it.” (Olivia)*

Sophia goes on to highlight how unpredictable the GP consultations can be. Many young people don’t get to see the same GP, particularly if it is an emergency appointment. Furthermore, even if they do see the same GP, there are many other factors at play. Fortunately for her, her experiences indicate that she would perhaps take a gamble at having a positive GP consultation. However, for those who have had bad experiences, they may be less willing to take a gamble for a positive GP consultation.

> *"It is hit and miss. It depends on their personality and the day you catch them on, and everything. There are so many factors involved, but fortunately I have had good experiences." (Sophia).*

The participants who were interviewed did not speak about one process of seeking support from the GP; it was an ever-changing and evolving process. What is apparent is how prior experience was one of the most important factors to these young people in choosing whether they would seek help again in the future. It is clearly important to remember the significance of each interaction with a young person who may be feeling suicidal.

Discussion

In this study, the l processes of help-seeking from a General Practitioner (GP) at a time when young people felt suicidal were explored through semi-structured interviews and framework analysis. The findings build on the current evidence base by offering an original contribution to our understanding of how, when and why young people seek help. Furthermore, the research offers important clinical implications around how our understanding of the assessment and management of suicidal risk for young people in primary care could be developed.

Help-seeking was described as a fluid process that changed over time and related to a number of changing factors. Prior to the first GP consultation, there was an emphasis on how a young person comes to understand and articulates their distress, the importance of their informal support networks and their perception of the GP as a potential source of help. During a GP consultation, willingness to seek help was influenced by how safe and supported the young person felt to disclose their distress. Perceived GP training, verbal and non-verbal communication and validation were seen to be important factors to help facilitate this process. Subsequent help-seeking was then largely influenced by prior experience of GP consultations and the availability of alternative support.

Initial stages of help-seeking

Rickwood et al., (2005) described how the first stage of help-seeking starts with how a person has to become aware of their symptoms and decides that they have a problem that could benefit from intervention. In the present research, the young people were not necessarily struggling to become aware of their symptoms; they all knew something was wrong with how they felt. However, they struggled to understand what could be done with their symptoms and it was not always clear as to who could help them with how they were feeling. This may go someway to explaining why so many young people have shown a preference to seek help from their informal support network (Michelmore & Hindley, 2012). Furthermore, as Klineberg and colleagues (2013) had suggested, the informal support network also played an important role in when and how the young person attended a GP consultation. Participants suggested that the experience, knowledge and availability of their support network affected the process leading up to the first GP consultation.

Previous research has also highlighted that young people and GPs both feel that primary care health professionals are not sufficiently trained in the assessment and management of suicidal ideation (Bidle et al., 2006; Michail & Tait, 2016; Mind, 2016). It has also been found that medical professionals can hold negative beliefs regarding help-seeking for suicidal ideation, rationalising behaviours as attention-seeking and not viewing the young person as ‘truly suicidal’ (Herron et al., 2001; Michail & Tait, 2016). In the present study, young people often did not consider the GP as a source of help; assuming that they could not help with mental distress and that they were not sufficiently trained to help. Importantly, some of the participants were also worried about the stigma of attending a consultation; they were worried about being mislabelled as attention-seeking. This finding suggests that young people may be aware of the negative attitudes that GPs can hold, and had come to accept and internalise these attitudes, believing that if they sought help, then their experience would no longer be valid. These results support and highlight the significance of beliefs, attitudes and stigma on the early stages of help-seeking (Best et al., 2016; Gulliver, Griffiths & Christensen, 2010).

Help-seeking during a GP consultation

The following stages of help-seeking in the model proposed by Rickwood et al., (2005) suggest that once a problem has been identified, the person then needs to be able to articulate or express their internal stress in a way that can be understood by others. This was a stage that the present study highlighted as being particularly difficult for the young people. It was often described that young people could not find the right words to articulate their distress, and they sometimes used physical symptoms or metaphors to try and explain how they felt.

This model of help-seeking also implies that help-seeking will only occur when the young person is able to articulate how they feel (Rickwood et al., 2005). However, it was not always necessary for the young person to be able to articulate their distress to their GP, as many participants relied on their informal support network to understand and articulate the distress on their behalf. Furthermore, in the present research, young people presented to their GP sometimes in silence or sometimes gave hints or clues to how they felt, hoping that the GP would help make sense of this experience and offer the right support. There was also a sense that the young person should not necessarily have to be able to articulate how they feel, it was the job of the GP to help with this process by asking direct questions and unpicking the experience. It is possible therefore that some of the proposed stages of help-seeking are not actually discrete stages and that they can blur and overlap.

Furthermore, barriers and facilitating factors to help-seeking at consultation have been highlighted as being important in understanding when, how and why people seek help. Gulliver, Griffiths & Christensen (2010) suggested important barriers included: poor mental health literacy, preference to be self-reliant, and a concern about stigma. The present research further highlights the importance of good positive verbal and non-verbal communication and creating a space where the young person can feel safe and able to disclose risk. The alternative model of help-seeking (Murray, 2005) highlights how help-seeking can be influenced by the perception that something can be done about the problem. However in the present research young people acknowledged that sometimes not much could be done to help, but being heard, validated and taken at face value were as important, if not more important, to their willingness to disclose how they felt.

Subsequent help-seeking following a GP consultation

For a young person to access help successfully, it is suggested that once they are able to articulate how they feel, the source of help must then be available and the help seeker must be willing to disclose their internal distress (Rickwood et al., 2005). In the present study, young people were put off wanting to seek help as they were aware of long waiting times for interventions, 10-minute GP consultation slots and a sense that they could burden the GP with their distress. However, whilst this suggests there are practical aspects of the GP consultation that limit availability, it also further highlights the significance of how young people had interpreted and made sense of the available help-seeking pathway.

Alternative models of help-seeking to the model proposed by Rickwood and colleagues (2005) stress the importance of pathways-based extensions. It has been suggested that a young person's perception of stigma, understanding of mental health difficulties, understanding of what support is available and prior experience of help-seeking are important moderators (Best et al., 2016; Murray, 2005). Indeed, it was found that the most important factor for a lot of young people was their prior experience with a GP. Many of the young people interviewed had negative experiences at GP consultations and therefore were reluctant to seek help again. For some, the experience was so negative that it actually exacerbated their self-harming or suicidal behaviour following consultation.

Where an increase in suicidal behaviour was described, participants typically also described a growing sense of hopelessness. However, some participants also felt that they needed to escalate their behaviour to match their internal state before they would be taken seriously. For example, where a GP minimised the suicidal experience of a young person, there were examples described where the young person increased their self-harm, by cutting more 'deeply', to try and demonstrate that they needed-help and that they were not ‘attention-seeking’. These experiences may have confirmed prior beliefs held by the young people around the stigma mental health professionals may hold towards help-seeking for self harm (Herron et al., 2001) and the perception that GPs are not a source of support for mental distress (Bidle et al., 2007). Moreover, these experiences may also offer another explanation as to why young people first and foremost turn to friends and peers as informal sources of help-seeking when in distress (Rickwood et al., 2020).

Strengths and limitations

There has been little exploration of help-seeking amongst suicidal young people. A strength of the present research is the inclusion of a sample of young people who have all made suicide attempts and have all had multiple GP consultations. This allowed for between and within comparisons as well as a consideration of what happens when help is not used or where the help was not beneficial. Using a framework analysis approach allowed for a rigorous and clear research audit trail for other researchers to follow. The use of the second researcher for cross validation enhances the credibility of the results that have been presented. Taking a qualitative approach more generally has allowed for participants to express their experiences, beliefs and ideas more openly and naturally. Indeed, this is the first study to offer an in-depth exploration of the processes involved in seeking help from a GP when young people have felt suicidal.

As with all qualitative studies, there are limitations around the generalisation of any findings and the possible influence of the researcher. These limitations have attempted to be minimised by interviewing young people that the researcher has had no prior contact with and by using the data to offer possible explanations rather than data to extrapolate. Furthermore, as the research relied on a volunteer sample, it is possible that only young people who felt passionate to take part, or had a clear view or agenda to discuss may have volunteered. This may explain why nearly all the participants had negative experiences of their GP consultations. With that said, all participants still identified facilitating factors to help-seeking at their GP consultations and appeared motivated to help future young people, rather than using the interview as an opportunity to highlight their negative experiences. However, even if this were the case, the present research highlighted how GP consultations can make individuals more suicidal, and even if this is in the minority of cases, it should be taken very seriously. Furthermore, despite the richness of the data collected, there are practical constraints such as using local children, young people and families service hubs for the research interviews that put a time limit on the interviews that may have influenced the depth of the discussion and interaction.

Implications for research and clinical practice

Models of help seeking should continue to be researched and developed so that the available evidence base can be integrated and used to support young people who are at risk of suicide. Specifically, future models of help-seeking for young people may want to focus more on trying to capture the dynamic and fluctuating processes, such as past experiences of help-seeking, available support networks and ability to articulate internal distress. Furthermore, research should also consider how these models apply in particular contexts, such as help-seeking in primary care, as it is likely that the process of seeking help will vary based on the problem and support pathway.

Prior research has suggested that professionals working in primary care require additional training in the assessment and management of suicidal risk (Michail & Tait, 2016; Mind, 2016; Rickwood et al., 2005). The present study suggests that this training should not just focus on understanding mental health difficulties, but it should incorporate a wider scope of how to sit and be with a young person in distress. Young people highlighted the importance of the GPs' verbal and non-verbal communication. They valued eye contact, the GP moving away from their computer and giving time to listen and understand the young person. Warmth, compassion and validation are all seen to be helpful in this process, not just for the assessment at that consultation, but to support young people to feel able to access help in the future. Furthermore, the assessment of suicidal risk should not be seen as a discrete process, it should be seen as an ongoing process that may take a number of consultations to fully understand a young person's suicidal risk.

There is also an important implication around the involvement of family, but with a significant warning not to make assumptions about the young persons life or available support. It is therefore important for any professional to offer time with and without the young person's friends and family. The concept of confidentiality and its limits also needs to be clearly explained. The young person may also need to be routinely reminded and reassured. Young people may not always be able to find the right words to explain how they are feeling, and therefore professionals should also be aware of physical symptoms of mental health difficulties and there should be a focus on building a safe and containing relationship with the young person.

In general, to help young people access the right support, more information needs to be disseminated to young people, families and schools to help normalise mental health difficulties, improve people's understanding of mental health difficulties and to help identify the GP as a source for support. An ongoing difficulty appears to be how a GP consultation can assess and manage suicidal risk given barriers such as the 10-minute time slot and the pressures of working with a large caseload. Future research may want to focus on this area further and also consider youth outreach support, particularly as there are still a number of young people who are choosing not to present to their GP for mental distress (Rickwood et al., 2005). Furthermore, although these clinical implications have been discussed in the context of primary care, GPs are just a part of a wider, multi-agency healthcare system for young people and the underlying principles around how to assess and support suicidal young people are applicable to any professional working with that individual. For example, nurses, clinical psychologists and psychiatrists should also consider their approach, attitudes and beliefs towards working with young people who are at risk of suicide.

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CHAPTER III

PRESS RELEASE

SAVING LIVES THROUGH LIVED EXPERIENCE

‘GPs ARE THE BOUNCERS TO THE MENTAL HEALTH CLUB’ - WHAT GPs CAN LEARN FROM SUICIDAL YOUNG PEOPLE

University of Birmingham

Press Release

Saving lives through lived experience

The World Health Organisation estimates that 80,000 people die each year by suicide. There has also been an increase in suicides in the UK and Republic of Ireland over the past few years. The Samaritans reported that there were 6,589 deaths by suicide in 2018, a significant increase from 2017. With rising pressure on our NHS there are understandable concerns around what more we can do to support people who are feeling suicidal.

Researchers at the University of Birmingham have conducted a meta-analysis exploring the potential of using peer support to help prevent any further increase in suicides. Eight published studies were reviewed and their results analysed to assess whether peer support could be a beneficial approach.

Peer support involves people who have a lived experience of feeling suicidal sharing and supporting others in their journey to recovery. Peer support can help individuals at risk of suicide by building relationships that are genuine, mutual and non-coercive, and that can help improve hope and connectedness.

The available evidence suggests that peer support has the potential to help those who are feeling suicidal and that it could fit well alongside other treatment approaches. Peer support could also alleviate some of the pressure on our NHS, as it has shown to have potential cost-saving benefits and could provide quicker support for those who are waiting for treatment.

Peer support is not here to replace other treatments and should not be seen in that way. However, the evidence suggests there is value in including those with lived experience in the treatment and support offered to others. Nobody should underestimate the importance of bringing people together with shared experiences to support one another and provide a space in which someone can feel accepted and understood.

If you are experiencing suicidal thoughts or are worried about someone you know, remember you can access help through the following channels:

- Samaritans (for everyone): Call 116 123
- Campaign Against Living Miserably (for men) Call 0800 58 58 58
- Papyrus (for people under 35) Call 0800 068 41 41
- Childline (for children and young people under 19) Call 0800 1111
- Alternatively, talk to someone you trust, contact your GP or call NHS 111.

Notes to editors:

The University of Birmingham is ranked amongst the world’s top 100 institutions. Its work brings people from across the world to Birmingham, including researchers, teachers and more than 6,500 international students from over 150 countries.

University of Birmingham

Press Release

‘GPs are the bouncers to the mental health club’ - What GPs can learn from suicidal young people

Suicide is the leading cause of death among young people in the UK. The UK’s Office for National Statistics has found that suicide accounts for 14 per cent of all deaths in 10-19 year olds and 21 per cent of all deaths in 20-34 year olds. There are many possible reasons why the statistics are so high for young people. For example, young people are at a point in their lives where there are periods of cognitive, social and emotional development, as well as a period in which they have to adjust to physical changes in their bodies. It is a very complicated time in their lives.

It was found that young people who had died by suicide had increased rates of contact with their GP one to three months prior to their death. People with the highest risk of suicide were also found to have contacted their GP over 24 times during a 12-month period. It has therefore been suggested that GPs are in a good position for the early identification and management of suicide risk. To help understand this process further, researchers at the University of Birmingham, interviewed eight young people about their experience of seeking help from a GP when they felt suicidal.

Young people felt that GPs were not adequately trained in managing mental health difficulties and, in some cases, the consultation made them feel more suicidal.

To assist with the process of getting help, young people felt they needed back up from friends and family and more information about what to expect at the consultation. There was a general feeling that they needed the GP to really listen to what they were being told, and that they should take everything at face value. Young people acknowledged that the GP was a gatekeeper to future support, but could be put off from seeking further help if they have had prior bad experiences.

The research suggests that we can help young people to get better support when they feel suicidal by providing specialist training for GPs in the assessment and management of youth suicide. Importantly, involving young people in the development of this training could help to ensure that it is meaningful and informative. Although there has been much work done globally to lower the stigma around mental health difficulties, there is also a clear need to focus on providing further information to young people around who they can talk to and what support they should expect to receive. One young person helpfully summarised the situation, seeking help shouldn't feel like you are 'confronting a bouncer' to enter 'the mental health club.'

If you are experiencing suicidal thoughts or are worried about someone you know, remember you can access help through the following channels:

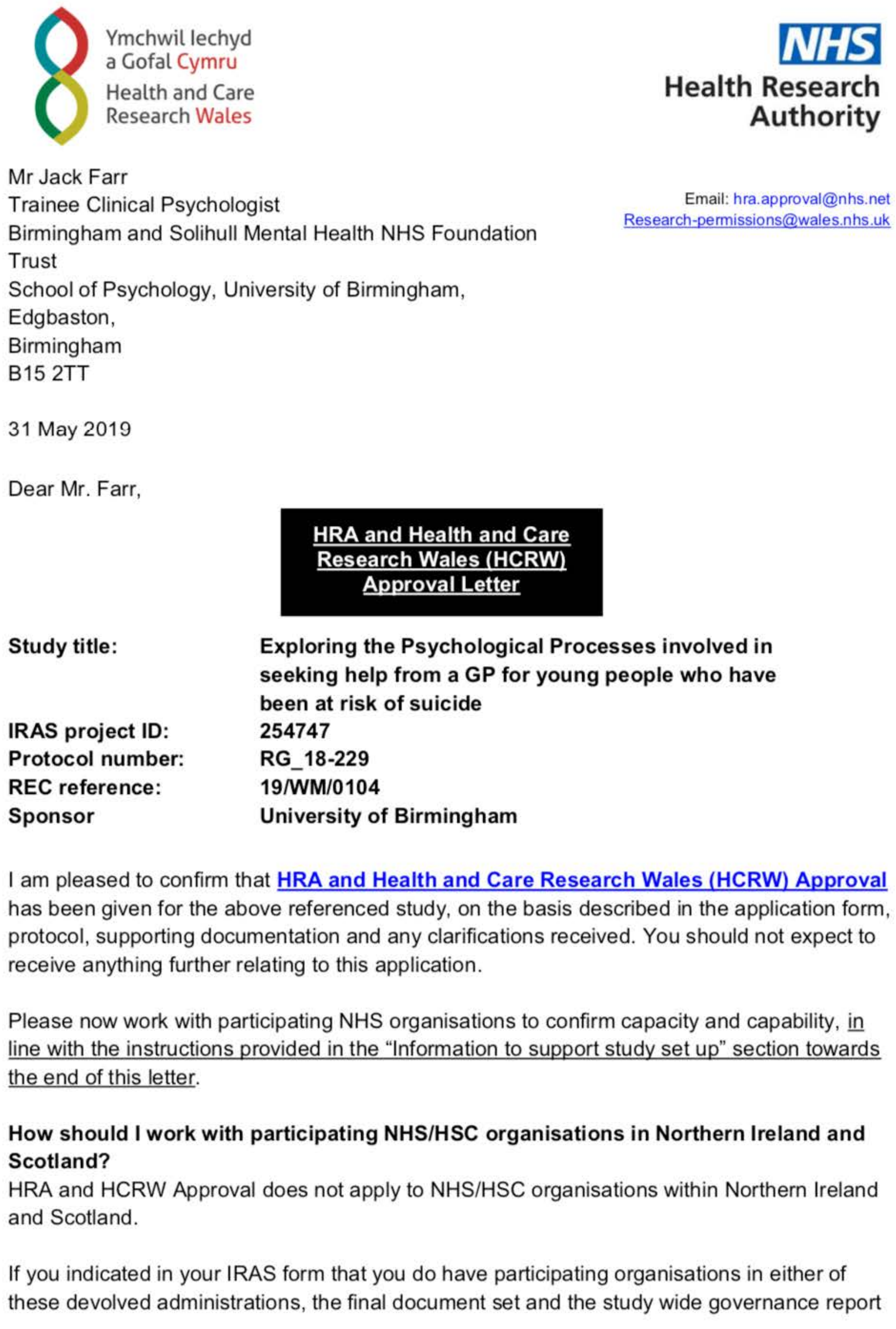
- Samaritans (for everyone): Call 116 123
- Campaign Against Living Miserably (for men) Call 0800 58 58 58
- Papyrus (for people under 35) Call 0800 068 41 41
- Childline (for children and young people under 19) Call 0800 1111
- Alternatively, talk to someone you trust, contact your GP or call NHS 111.

Notes to editors:

The University of Birmingham is ranked amongst the world’s top 100 institutions. Its work brings people from across the world to Birmingham, including researchers, teachers and more than 6,500 international students from over 150 countries.

Appendices

Appendix 1: Letter of ethical approval



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

Mr Jack Farr
Trainee Clinical Psychologist
Birmingham and Solihull Mental Health NHS Foundation Trust
School of Psychology, University of Birmingham,
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B15 2TT

31 May 2019

Dear Mr. Farr,

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Exploring the Psychological Processes involved in seeking help from a GP for young people who have been at risk of suicide**
IRAS project ID:	**254747**
Protocol number:	**RG_18-229**
REC reference:	**19/WM/0104**
Sponsor	**University of Birmingham**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **254747**. Please quote this on all correspondence.

Yours sincerely,
Laura Greenfield

Approvals Specialist

Email: hra.approval@nhs.net

Copy to: *Dr Birgit Whitman [Sponsor Contact]*

Appendix 2: Participant information sheet

PARTICIPANT INFORMATION SHEET

Title of project :

Exploring the processes involved in seeking help from a GP for young people who have been at risk of suicide.

Researchers: Jack Farr (Trainee Clinical Psychologist).
Supervised by: Dr Maria Michail (Senior Birmingham Fellow), Dr Andrew Surtees (Clinical Psychologist).

You are being invited to take part in a research study, which is being completed as part of a Doctorate in Clinical Psychology at the University of Birmingham. Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

- Part 1 tells you the purpose of this study and what it will involve if you wish to take part.

- Part 2 gives you more detailed information about how the study will be conducted.

If there is anything that is not clear or if you would like more information, please ask the researcher named above. Take time to decide whether or not you wish to take part.

PART 1:

What is the purpose of this research?

Every year in the UK several hundred young people die by suicide. Many more vulnerable young people harm themselves and may contemplate suicide. It is important that young people who, for whatever reason, are at risk of taking their lives are provided with the right help and support. General Practitioners (GPs) are usually the first professionals we contact about health issues.

The aim of this study is to explore, though interviews, young people's views and experiences of seeking help from a GP at a time they felt vulnerable and what happened during their consultation.

Why have I been invited to take part?

You have been invited to take part in this study because you are a young person aged 16-25 and are under the care of (Local mental health service). It is hoped that by listening to your experiences and views of seeking support through your GP, you can contribute to our understanding of the processes involved when seeking help from GPs for young people who have been at risk of suicide. We are inviting 10 participants like you to take part.

PART 2:

What will happen to me if I agree to take part?

If you agree to take part in this study, you will be given a consent form to sign. Once you have understood what is being asked of you and have given your consent, you will be invited to take part in a short interview that will last approximately one hour. During this interview you will be asked questions relating to seeking support from your GP when you felt vulnerable; any support or help you might have received from your GP; whether you are happy with the help and support you received and any problems you might have encountered with accessing help.

The interview can be stopped at any point and you can refuse to answer any questions you do not want to. This will not affect any treatment that you are currently receiving. The researcher will be available to answer any questions you may have. It is ok to pause the interview and then continue when you feel able to.

The interviews will be recorded using an encrypted Dictaphone and will only be accessed by the researcher or their supervisors. The recordings will then be transcribed by the researcher and the original recordings will be deleted from the device. Each participant will be given a unique pseudonym. Their name and other identifiable information will not be recorded on the transcripts. Common themes will then be drawn from across all the recorded interviews and will then be written up with the intention to publish the research as well as to include it in the researcher's thesis. All participants will remain anonymous throughout analysis and in the final write up.

If you give consent, your GP will be contacted to inform them that you will be taking part in the study. The GP involvement will only involve them knowing that you are taking part in a study and they will not be privy to anything that is said during the study. The purpose of informing your GP that you are taking part in the study is to provide you with another source of support should you wish to discuss anything with them. This is entirely optional and can be discussed with the researcher before your decision is made.

It is entirely up to you whether you take part in the study and you have the right to withdraw from the study at any point without having to provide a reason and with no consequences to your treatment. If you wish to have a friend or family member present during the interview, this is also ok. You may also request to receive a feedback report following the completion of the study that can be posted or emailed to you.

If you are happy to take part, and are satisfied with the explanations from the research team, you will be asked to sign a consent form. You will be given a copy of the signed information sheet and consent forms to keep for your records.

What will happen if I do not want to carry on with the study?

Nothing will happen if you choose not to take part in this research study. You will continue to receive the same level of care that you were receiving before you were approached about this research study. Participation is completely voluntary.

If you decide to withdraw from the study before themes have been drawn from the data then your data will be completely removed from analysis and the final report. However, as the process of identifying emerging themes is an ongoing process, if you wish to withdraw your data once this process has started it may be impossible to fully withdraw your influence on the data. However in the final write up any quotes from your interview will be fully removed. It won't be possible to withdraw your data once the study has been submitted for publication.

What are the possible disadvantages of taking part in this study?

The interview will include questions about when you sought help from your GP in relation to your suicide attempt and therefore you may find the interviews upsetting. If this does happen and you feel that you do not want to continue with participation in the research, you can withdraw at any time. If you wish to stop the interview but then decide to carry on, this is also ok. The researcher is also a Trainee Clinical Psychologist and will be able to discuss with you where to access support or any other questions or concerns you may have.
The interviews will last approximately one hour of your time and you will be given the opportunity to contact the research team and discuss any concerns you have at any stage during the research period.

What are the possible benefits of taking part in this study?

It is hoped that your involvement will provide an insight into the processes involved in seeking support for suicide from young people. In relation to this, future training for GPs should take into consideration the findings of the present research and will therefore contribute to supporting future young people who face similar difficulties to what you have experienced. If requested you will also receive a copy of the final report.

What will happen to the results of the research study?

The research study is due to be completed by September 2020. The themes that emerge from the interviews will be written up for the purpose of publication in a peer-reviewed journal and for submission for the researcher's ClinPsyD thesis. As it can take time for research papers to get published, we can circulate a report containing the results to everyone that participated in the study prior to this. There will be no personally identifiable information published within the report.

What will happen with my data?

The University of Birmingham is the sponsor for this study based in the United Kingdom. They will be using information from you in order to undertake this study and will act as the data controller for this study. This means that they are responsible for looking after your information and using it properly. The University of Birmingham will keep identifiable information about you for 10 years.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we may keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally identifiable information possible.

The University of Birmingham will keep your name and contact details (email address) confidential and will not pass this information to any other organisation. The University of Birmingham will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded to oversee the quality of the study. Certain individuals from regulatory organisations may look at these research records to check the accuracy of the research study. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact information.

You can find out more about how the University uses your information by contacting a member of the research team and by reading the Data Protection Essentials document that will have also been provided for you.

Who will see my information?

All personal data and research data will be stored separately so that no one can be identified by their research data. Only the researcher and their supervisors will have access to that data. All information and data will be kept confidential and stored securely. Audio-recorded interviews will be backed up on NHS servers and then anonymously transcribed. Following transcription, audio recordings will be deleted from all devices / servers and the anonymous transcripts and notes from interviews will be securely saved on the University of Birmingham server. Any identifiable data will be removed from the transcripts and/or any notes from the interviews. Computer held data including the study database will be held securely and password protected. Access will be restricted by user identifiers and passwords (encrypted using a one way encryption method)

How will the study manage any distress I may experience?

You will have been given a participant invitation letter that requests the researcher has access to your risk assessments. If you have given consent, the researcher will ensure to read your risk assessments so that the researcher will know how best to manage any disclosure of risk or distress. If you were to disclose any potential risk either to yourself or somebody else then this information will be shared with your clinical team. This will involve breaking confidentiality to ensure that your clinical team can help you feel safe. When information is deemed appropriate to share with your clinical team, it will be first discussed with you at the time and will be done to ensure that you receive the right support. The researcher is also a Trainee Clinical Psychologist and understands that this research can be emotive in nature, they will be able to answer any questions you may have and can signpost you to additional support. If an accompanying friend or family member becomes distressed, they will also be given the chance to discuss their experience with the researcher and will be signposted to further support.

Should you wish to discuss any concerns about the study and you are not satisfied with discussing this with the researcher you can also contact the Patient Advice and Liaison Service (local PALS) who can help answer your queries and help resolve any concerns you might have. (Contact information has been removed to maintain confidentiality)

What happens if I have any further concerns?

If you would like to discuss any aspect of this research or have any concerns you would like addressing then please do not hesitate to contact the researcher using the details below.

You will also be provided with the contact information for your local patient advice and liaison service in case you would like to discuss the study with somebody who is independent to this process.

Ethical approval

A Research Ethics Committee within the National Health Service (NHS) has reviewed the present study and it has been given a favourable opinion.

I would like to thank you for taking the time to read this information sheet and I hope that you consider taking part in this research study.

Appendix 3: Participant consent form

UNIVERSITY OF BIRMINGHAM

Research site: ....

Participant Identification Number:...............

CONSENT FORM

Title of Project: Exploring the Processes involved in seeking help from a GP for young people who have been at risk of suicide
Researchers: Jack Farr (Trainee Clinical Psychologist).
Supervised by: Dr Maria Michail (Senior Birmingham Fellow), Dr Andrew Surtees (Clinical Psychologist).

Please initial box

1. I confirm that I have understood the information sheet dated 27/04/19 (version 4) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that relevant sections of my medical notes and data collected during this study may be looked at by individuals from regulatory authorities, sponsor representatives and / or the trust, where it is relevant to my taking part in this research. I understand that this information will be held in a confidential manner. I give permission for these individuals to have access to my records. ☐

3. I wish for my GP to be contacted and made aware that I am participating in the present research. ☐

4. I understand that my participation is voluntary and that I am free to withdraw at any time during the research study period, without giving any reason, without my care or legal rights being affected. ☐

5. I understand the process of data collection and analysis will involve the interviews to be audio recorded and then transcribed. ☐

6. I understand that the data collected during this study will be looked at by the researcher and relevant others at the University of Birmingham to ensure that the identified themes from the interviews are a reasonable representation of the collected interviews. Parts of the data may also be made available to the NHS team responsible for my care should I disclose current issues of risk. ☐

7. I agree to take part in the above study. ☐

8. I wish for a summary of the report to be sent to me following the completion of the study ☐

Email address that I wish the research summary to be sent to:

____

....	....	....
Name of participant	Date	Signature
....	....	....
Name of researcher	Date	Signature

One copy will be provided for the participant, one copy for the researcher and one copy for the participant's medical records.

Appendix 4: Interview schedule

Introductions:

My name is XXX.
Thank you for agreeing to participate.

Purpose:

- Who we are, and what we are trying to do
- What we will do with the information
- Why you were asked to participate

Interview Questions:
I understand that about X [insert number] months/years ago, things in your life got a bit too much and you found yourself at a very vulnerable place. This must have been very hard and stressful both for yourself and your family. I'd like to ask you a few questions about the services and support you received during that difficult period in your life.

1. Can you tell me briefly about your experience of attempting to end your life?
   Prompts: what was happening at this time? How did you understand what was happening for you at this time? What sense did you make of this?

2. Who did you first contact to seek help and support?
   Prompts: If GP, what was the reason you chose your GP to talk to first?
   If not the GP, did you consider contacting your GP at that point?

3. If you found yourself in the same position, who and why would be the first person you would contact to ask for help?
   prompts: what is your reasoning for this? *Why do you think this is? Do you have any other coping strategies? What was your support network like before/ now? Isolation? Physical Health?*

4. Why did you choose to seek support at this time?
   prompts: was there anything you noticed about yourself or how you were feeling? Was anybody else involved in suggesting you should access support?

5. How did you find your experience visiting your GP?
   Prompts: Did you go by yourself or did someone come along with you? If someone came along was that helpful?

6. Did you have any hopes or concerns before visiting your GP?
   prompts: did these hopes or concerns play a role in deciding whether you

would seek support? What did you think the outcome would be?

7. What services were offered to you?
   Prompts: how happy/unhappy were you with what was offered?

8. Do you think that GPs are the first point of contact for mental health issues? If not, who do you think is?
   Prompts: Did this play a part in deciding whether to talk to your GP about your difficulties? What do you think the GPs role is in regards to mental health difficulties

9. Could you talk me through the process you went through from your suicide attempt to seeking support, what was important to you?
   Prompts: Could you highlight anything that felt significant to you?

Thank you for taking part in this interview. Is there anything else you can think of that we have not covered?

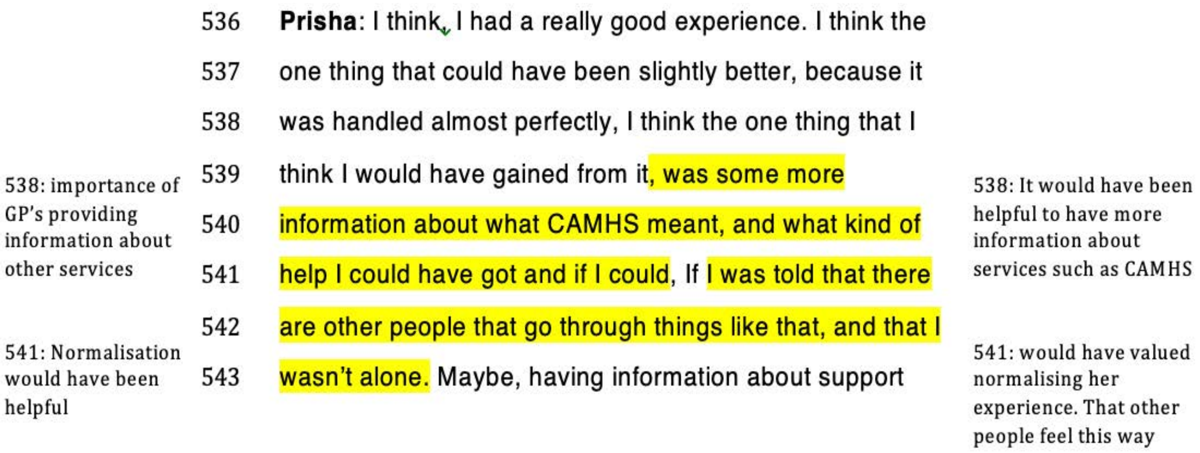
Appendix 5: Completed COREQ Checklist

No.	Item	Description	Section #
Domain 1: Research team and reflexivity			
Personal characteristics			
1.	Interviewer/facilitator	Which author/s conducted the interview or focus group?	Page 69
2.	Credentials	What were the researcher's credentials? *E.g. PhD, MD*	Page 70
3.	Occupation	What was their occupation at the time of the study?	Page 70
4.	Gender	Was the researcher male or female?	Page 70
5.	Experience and training	What experience or training did the researcher have?	Page 70
Relationship with participants			
6.	Relationship established	Was a relationship established prior to study commencement?	Page 70
7.	Participant knowledge of the interviewer	What did the participants know about the researcher? *E.g. Personal goals, reasons for doing the research*	Page 70
8.	Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? *E.g. Bias, assumptions, reasons and interests in the research topic*	Page 70
Domain 2: Study design			
Theoretical framework			
9.	Methodological orientation and theory	What methodological orientation was stated to underpin the study? *E.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis*	Page 70-75
Participant selection			
10.	Sampling	How were participants selected? *E.g. purposive, convenience, consecutive, snowball*	Page 68
11.	Method of approach	How were participants approached? *E.g. face-to-face, telephone, mail, email*	Page 68
12.	Sample size	How many participants were in the study?	Page 68
13.	Non-participation	How many people refused to participate or dropped out? What were the reasons for this?	Page 68
Setting			
14.	Setting of data collection	Where was the data collected? *E.g. home, clinic, workplace*	Page 69
15.	Presence of non-participants	Was anyone else present besides the participants and researchers?	Page 69

16.	Description of sample	What are the important characteristics of the sample? *E.g. demographic data, date*	Page 68
Data collection			
17.	Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	Page 69
18.	Repeat interviews	Were repeat interviews carried out? If yes, how many?	Page 69
19.	Audio/visual recording	Did the research use audio or visual recording to collect the data?	Page 69
20.	Field notes	Were field notes made during and/or after the interview or focus group?	Page 70
21.	Duration	What was the duration of the interviews or focus group?	Page 69
22.	Data saturation	Was data saturation discussed?	Page 68
23.	Transcripts returned	Were transcripts returned to participants for comment and/or correction?	Page 72
Domain 3: analysis and findings			
Data analysis			
24.	Number of data coders	How many data coders coded the data?	Page 72
25.	Description of the coding tree	Did authors provide a description of the coding tree?	Page 72
26.	Derivation of themes	Were themes identified in advance or derived from the data?	Page 73
27.	Software	What software, if applicable, was used to manage the data?	Page 73
28.	Participant checking	Did participants provide feedback on the findings?	Page 73
Reporting			
29.	Quotations presented	Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? *E.g. Participant number*	Page 76-109
30.	Data and findings consistent	Was there consistency between the data presented and the findings?	Page 76-109
31.	Clarity of major themes	Were major themes clearly presented in the findings?	Page 76-109
32.	Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	Page 76-109

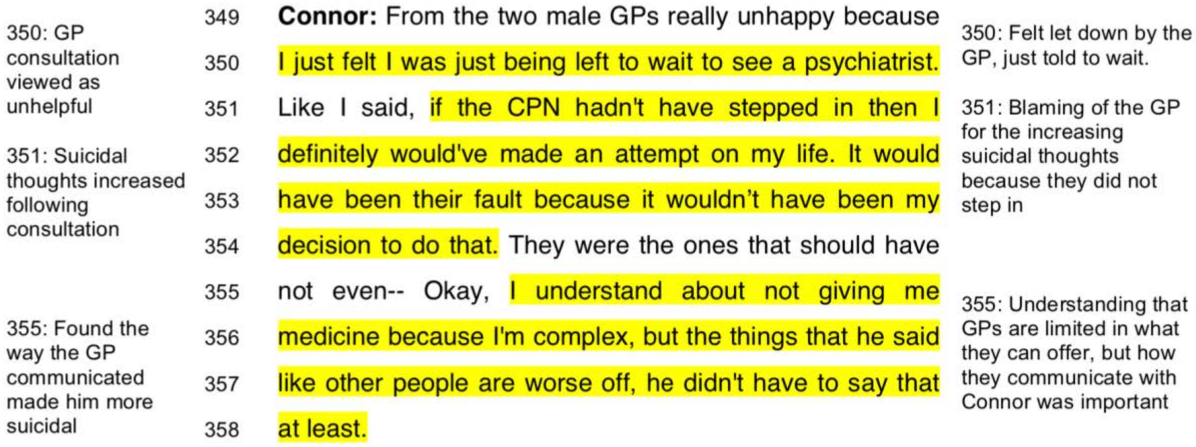
Appendix 6: Example of coding

Example from Transcript 1 (Prisha):



	536	**Prisha**: I think I had a really good experience. I think the	
	537	one thing that could have been slightly better, because it	
	538	was handled almost perfectly, I think the one thing that I	
538: importance of GP's providing information about other services	539	think I would have gained from it, was some more	538: It would have been helpful to have more information about services such as CAMHS
	540	information about what CAMHS meant, and what kind of	
	541	help I could have got and if I could, If I was told that there	
541: Normalisation would have been helpful	542	are other people that go through things like that, and that I	541: would have valued normalising her experience. That other people feel this way
	543	wasn't alone. Maybe, having information about support	

Example from Transcript 2 (Connor):



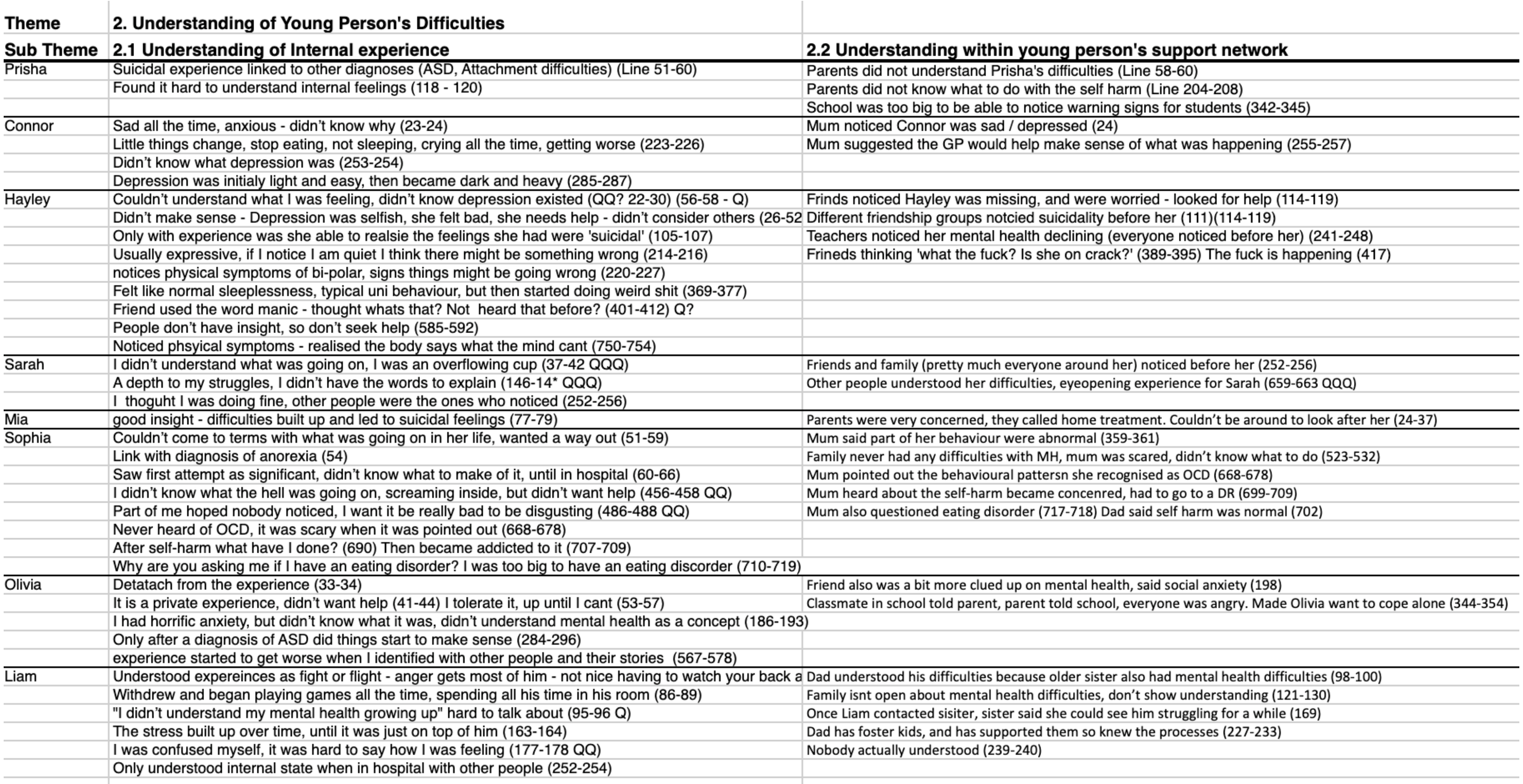
	349	**Connor:** From the two male GPs really unhappy because	
350: GP consultation viewed as unhelpful	350	I just felt I was just being left to wait to see a psychiatrist.	350: Felt let down by the GP, just told to wait.
	351	Like I said, if the CPN hadn't have stepped in then I	351: Blaming of the GP for the increasing suicidal thoughts because they did not step in
351: Suicidal thoughts increased following consultation	352	definitely would've made an attempt on my life. It would	
	353	have been their fault because it wouldn't have been my	
	354	decision to do that. They were the ones that should have	
	355	not even-- Okay, I understand about not giving me	355: Understanding that GPs are limited in what they can offer, but how they communicate with Connor was important
355: Found the way the GP communicated made him more suicidal	356	medicine because I'm complex, but the things that he said	
	357	like other people are worse off, he didn't have to say that	
	358	at least.	

Appendix 7: The Framework matrix

Theme / Subtheme	**Description**
1.Young person's early experiences	
1.1 Development of suicidal thoughts / behaviour	Description of how the young persons suicidal thoughts or behaviour developed. This could include the age this started, what they noticed, what method(s) were used or the frequency of these behaviours or feelings.
1.2 Description of support network	Description of the young persons support network at the time their suicidal thoughts or behaviour was developing. This could include their friends or family and a description of what the support might have looked like.
1.3 Adverse childhood experiences	This is a description of any adverse childhood experiences that may have occurred. This could include difficulties at home or school and covers different types of abuse and trauma the young person may have been subjected to.
2. Understanding of young person's difficulties	
2.1. Understanding of internal experience	This is how the young person made sense of their difficulties, their understanding of mental health difficulties and the language used to explain their internal state.
2.2 Understanding within young person's support network	This is how other people around the young person made sense of the young person's difficulties. This could include significant others such as family, friends or school staff.
3. Seeking support from a GP	
3.1 Young person's view of GP role	This is the perception the young person has of the GP, what they could offer, their hopes and concerns.
3.2 Process leading up to GP consultation	This is the process that led up to the first GP consultation. Did they go directly to the GP? Did they go alone, or with someone? Was it the first point of contact, or were other forms of support used first?

3.3 Drawing on past experiences of GP consultations	This describes how young people draw on past experiences of GP consultations to inform future help-seeking choices.
3.4 Presenting at other medical settings	This is a description of where the young person came into contact with services if the GP was not their first contact. Examples include A&E or Psychiatric inpatient units.
4. Description of GP consultation	
4.1 What support was offered	This is a description of what was offered following the GP consultation. For example, were they referred on for further support? Did they receive medication?
4.2 The young person's experience of the GP consultation	This is the young person's personal experience of the GP consultation, how they felt during the consultation and what they took from the visit.
4.3 Facilitating factors at the GP consultation	This is the young person's view of what factors helped at the GP consultation. This could include anything that helped them feel heard, understood and able to communicate their difficulties.
4.4 Barriers at the GP consultation	This is the young person's view of what factors may have made the GP consultation less helpful. This could include anything that prevented them to feel heard, understood or able to communicate their difficulties.
5. Post GP experience	
5.1 New sources of support	This is a description of how the young person's source of support may have changed since their GP consultation. This could mean that if relapse happens they now have a support network.
5.2 Reasons for relapse	The reasons provided why a young person relapsed or required further help from mental health services.

Appendix 8: Example of charting data into the matrix



Theme	2. Understanding of Young Person's Difficulties	
Sub Theme	**2.1 Understanding of Internal experience**	**2.2 Understanding within young person's support network**
Prisha	Suicidal experience linked to other diagnoses (ASD, Attachment difficulties) (Line 51-60)	Parents did not understand Prisha's difficulties (Line 58-60)
	Found it hard to understand internal feelings (118 - 120)	Parents did not know what to do with the self harm (Line 204-208)
		School was too big to be able to notice warning signs for students (342-345)
Connor	Sad all the time, anxious - didn't know why (23-24)	Mum noticed Connor was sad / depressed (24)
	Little things change, stop eating, not sleeping, crying all the time, getting worse (223-226)	Mum suggested the GP would help make sense of what was happening (255-257)
	Didn't know what depression was (253-254)	
	Depression was initialy light and easy, then became dark and heavy (285-287)	
Hayley	Couldn't understand what I was feeling, didn't know depression existed (QQ? 22-30) (56-58 - Q)	Frinds noticed Hayley was missing, and were worried - looked for help (114-119)
	Didn't make sense - Depression was selfish, she felt bad, she needs help - didn't consider others (26-52	Different friendship groups notcied suicidality before her (111)(114-119)
	Only with experience was she able to realsie the feelings she had were 'suicidal' (105-107)	Teachers noticed her mental health declining (everyone noticed before her) (241-248)
	Usually expressive, if I notice I am quiet I think there might be something wrong (214-216)	Frineds thinking 'what the fuck? Is she on crack?' (389-395) The fuck is happening (417)
	notices physical symptoms of bi-polar, signs things might be going wrong (220-227)	
	Felt like normal sleeplessness, typical uni behaviour, but then started doing weird shit (369-377)	
	Friend used the word manic - thought whats that? Not heard that before? (401-412) Q?	
	People don't have insight, so don't seek help (585-592)	
	Noticed phsyical symptoms - realised the body says what the mind cant (750-754)	
Sarah	I didn't understand what was going on, I was an overflowing cup (37-42 QQQ)	Friends and family (pretty much everyone around her) noticed before her (252-256)
	A depth to my struggles, I didn't have the words to explain (146-14* QQQ)	Other people understood her difficulties, eyeopening experience for Sarah (659-663 QQQ)
	I thoguht I was doing fine, other people were the ones who noticed (252-256)	
Mia	good insight - difficulties built up and led to suicidal feelings (77-79)	Parents were very concerned, they called home treatment. Couldn't be around to look after her (24-37)
Sophia	Couldn't come to terms with what was going on in her life, wanted a way out (51-59)	Mum said part of her behaviour were abnormal (359-361)
	Link with diagnosis of anorexia (54)	Family never had any difficulties with MH, mum was scared, didn't know what to do (523-532)
	Saw first attempt as significant, didn't know what to make of it, until in hospital (60-66)	Mum pointed out the behavioural pattersn she recognised as OCD (668-678)
	I didn't know what the hell was going on, screaming inside, but didn't want help (456-458 QQ)	Mum heard about the self-harm became concenred, had to go to a DR (699-709)
	Part of me hoped nobody noticed, I want it be really bad to be disgusting (486-488 QQ)	Mum also questioned eating disorder (717-718) Dad said self harm was normal (702)
	Never heard of OCD, it was scary when it was pointed out (668-678)	
	After self-harm what have I done? (690) Then became addicted to it (707-709)	
	Why are you asking me if I have an eating disorder? I was too big to have an eating discorder (710-719)	
Olivia	Detatach from the experience (33-34)	Friend also was a bit more clued up on mental health, said social anxiety (198)
	It is a private experience, didn't want help (41-44) I tolerate it, up until I cant (53-57)	Classmate in school told parent, parent told school, everyone was angry. Made Olivia want to cope alone (344-354)
	I had horrific anxiety, but didn't know what it was, didn't understand mental health as a concept (186-193)	
	Only after a diagnosis of ASD did things start to make sense (284-296)	
	experience started to get worse when I identified with other people and their stories (567-578)	
Liam	Understood expereinces as fight or flight - anger gets most of him - not nice having to watch your back a	Dad understood his difficulties because older sister also had mental health difficulties (98-100)
	Withdrew and began playing games all the time, spending all his time in his room (86-89)	Family isnt open about mental health difficulties, don't show understanding (121-130)
	"I didn't understand my mental health growing up" hard to talk about (95-96 Q)	Once Liam contacted sisiter, sister said she could see him struggling for a while (169)
	The stress built up over time, until it was just on top of him (163-164)	Dad has foster kids, and has supported them so knew the processes (227-233)
	I was confused myself, it was hard to say how I was feeling (177-178 QQ)	Nobody actually understood (239-240)
	Only understood internal state when in hospital with other people (252-254)	

Appendix 9: Example of how the data was summarised at the start of the interpretative stage

1.1 Understanding of internal experience

There was a general theme across the participants around having difficulties understanding and making sense of their internal feelings. Many of the participants were aware that something was not right, but they talked about having a lack of understanding around mental health difficulties and this made it more difficult to talk about and seek help for their difficulties.

To me, it seems it was almost like an overflowing cup. A cup, which kept getting full, filled up, and then there was just one night and – Again, I can't say what happened, it was too much. (Sarah, Page 2, Line 38)

Some participants tried to use the physical symptoms to be able to make sense of what they were feeling.

I just had this horrific anxiety, but I didn't know what it was. I didn't really understand mental health as a concept. Then I described to my friends that before we were going to go out or before we were going to do something, I just had this feeling of being sick or not being able to go. (Olivia, Page 7, Line 191)

One participant summarised this experience by saying:

The body tells you what the mind can't (Hayley, Page 27, Line 751)

Each participant used different language and ways of describing their experience; the commonality was that at the time they didn't feel they had the right words or language to explain their experience.

When it first started, it was, this sounds bad, but it was easy and it wasn't intense. It was light, if that makes sense. But when it came to trying to end my life, it was so dark and so heavy. (Connor, Page 10, Line 285)

I think there is such a depth to my struggles that I didn't quite have the word to explain. I didn't want to be turned away because I was explaining it in a lighthearted manner (Sarah, Page 6, Line 147)

Some participants used diagnoses to help make sense of their experience (such as ASD, Anorexia or OCD). Others talked about only understanding their difficulties when they were older and had gone through services, and some talked about truly understanding when they had met others who were experiencing similar difficulties.

I didn't really understand until I got put in hospital around patients with mental health difficulties, that I really, truly, understood what was going on (Liam, Page 9, Line 252)