ISSN: 2951-6641 (paper)
https://doi.org/10.54790/rccs.6

CENTRA Journal of Social Sciences
| 2022 | vol. 1 | no. 1 | pp. 81-102

ARTICLES/ARTÍCULOS

Caring for People at Risk of Suicide in the Andalusian Health Service: A Qualitative Study of the Institutionalisation Process

Atendiendo a la persona en riesgo de suicidio en el Servicio Andaluz de Salud: un estudio cualitativo del proceso de institucionalización

Patricia S. Sánchez-Muros Lozano
University of Granada, Spain
sonsoles@ugr.es

Received/Recibido: 4/2/2022
Accepted/Aceptado: 18/5/2022

ABSTRACT

Suicide continues to be the main external cause of death in Spain. Andalusia is the region with the highest number of suicides in the country. It is important to address its prevention. Here we describe how people who have attempted suicide access and are treated by the Andalusian Health Service. A qualitative study was conducted exploring public health care and its assessment. Data were collected through in-depth interviews with health professionals, patients, family members and relatives. This search was complemented with ethnographic information, all of which was explored following a combined strategy of analysis in line with the grounded theory assumptions. The results reveal setbacks in access to the health system, and stigmatised representations among professionals. At the same time, limitations due to lack of training and uncertainties in risk management were identified. Finally, strong difficulties were found among family members and patients, as they face stigmatisation and taboos that lead to profound vulnerability, especially in areas with fewer resources. All of this hinders early detection and reduces the capacity for prevention.

KEYWORDS: suicide attempted; health service; medical records; referral and consultation; patient care; family caregivers.

HOW TO QUOTE: Sánchez-Muros Lozano, Patricia S. (2022). Atendiendo a la persona en riesgo de suicidio en el Servicio Andaluz de Salud: un estudio cualitativo del proceso de institucionalización. *Revista Centra de Ciencias Sociales, 1*(1), 81-102. https://doi.org/10.54790/rccs.6

La versión original en castellano puede consultarse en https://centracs.es/revista

RESUMEN

El suicidio continúa siendo la principal causa externa de muerte en España. Andalucía es la región con mayor número de suicidios del país. Es importante abordar su prevención. Aquí se describe cómo las personas que han sufrido tentativas de suicidio acceden al Servicio Andaluz de Salud y son atendidas en este. Se realizó un estudio cualitativo explorando la asistencia sanitaria pública y su valoración. Se recabaron datos mediante entrevistas en profundidad, tanto a profesionales de la sanidad como a personas afectadas y familiares de estas. Esta búsqueda se complementó con información etnográfica. Todo ello se analizó siguiendo una estrategia combinada de exploración atendiendo a los presupuestos de la teoría fundamentada. Los resultados revelan contrariedades en el acceso al sistema sanitario y representaciones estigmatizadas entre profesionales. Al mismo tiempo, se identificaron limitaciones por la falta de capacitación y las incertidumbres en la gestión del riesgo. Finalmente, se comprobaron fuertes dificultades en familiares y supervivientes, pues hacen frente a la estigmatización y a los tabúes con profunda vulnerabilidad, especialmente en las zonas con menos recursos. Todo ello lastra la detección temprana y resta capacidad de prevención.

PALABRAS CLAVE: intento de suicidio; Servicio de Salud; registros médicos; derivación y consulta; atención al paciente; familiares cuidadores.

1. Introduction and background

A person dies from suicide every 40 seconds. According to the WHO, suicide, with a global rate of 10.5 cases per 100,000 inhabitants, poses a grave public health problem and it is now even included as one of the objectives of the 2030 Agenda for Sustainable Development — Indicator 3.4.2 — published by the United Nations (World Health Organization [WHO], 2021). The rate is 1.8 times higher among men than it is women. This is particularly the case in European countries (WHO, 2019). Moreover, for each suicide, there are estimated to be up to 20 suicide attempts, with this proving to be the greatest risk factor and the key area for improving its prevention (WHO, 2014). The issue does not affect just the victims; rather, it has an impact on the entire social environment: relatives, loved ones and friends. For each suicide, it is estimated that between six and fourteen people are severely affected (Clark and Goldney, 2008; Jordan and McIntosh, 2011).

In Spain, suicide continues to be the number one external cause of death — with a rate of 7.5 suicides per 100,000 inhabitants — making it deadlier than traffic accidents, homicide and gender-based violence combined in terms of deaths recorded (Spanish National Statistics Institute [*Instituto Nacional de Estadística, INE*] 2019). This seems to be a continuing trend, with no great variation experienced over the past twenty years (Sáiz and Bobes, 2014), with the greatest suicide rate coming in 2014 (8.4) and the lowest in 2010 (6.8). Despite these alarming figures, Spain does not have a national suicide prevention plan, and as such, it is an ongoing issue that has yet to be resolved (Sáiz and Bobes, 2014).

At first glance, suicide would seem to depend on a series of personal factors. However, as discovered by Durkheim (2012), by focusing not on the individual incident, but instead on the overall impact — the suicide rates in each society, group or social category — we can see that it is littered with consistencies. A quick look at the historical figures on the suicide rate in Spain (Barricarte et al., 2017) tells us that Durkheim's almost two-centuries-old hypotheses still ring true (*Semi-*

nario de fundamentos clásicos de la sociología ["Lectures on Classic Fundamentals of Sociology"], 1999). In fact, and by way of example, the suicide rate in France has historically been double that of Spain. Another constant that can be seen is the decrease of the suicide rate during socio-economic crises and its increase during boom years. This goes some way to explaining what happened with suicide rates during the global Covid-19 pandemic (Pirkis et al., 2021). This has been coined the "good health paradox in pandemics" (INE, 2021), something that has been observed globally (see also the analysis in "*Surprisingly, suicide has become rarer during the pandemic,*" 24 April 2021).

The fact that these consistencies continue to occur helps transform suicide from an event that has "its own unity, individuality and consequently its own nature [...] into a dominantly social event" (Durkheim, 2012: 5). As such, it is subjected to real forces that impose themselves on it: "the individual is dominated by a moral reality greater than himself: namely, collective reality" (*ibid.*: 6).

In modern society, people who have committed self harm (whether or not resulting in death) or who have or have had suicidal thoughts are considered mentally sick, and they are referred for specialist care in specific healthcare establishments (psychiatric hospitals, mental health units, etc.). If we take Goffman's (2001/1961) definition, they can to a certain degree be considered "total institutions", as they are settings for supervision and re-socialisation (with rigid rule structures in place) which force a person to transform their own image, although they do not quite stretch as far as coercive organisations (with closed doors, bars in the windows, security, etc.). Continuing with Goffman, each society fosters special ways in which service providers and clients interact with one another, with those deemed a suicide risk being represented by healthcare professionals in the public healthcare system, who must deal with "the client", in other words the affected parties, their family and loved ones.

The WHO announced that it was imperative to adopt urgent suicide prevention measures (WHO, 2019) and the strategies required to implement them, prioritising the need to properly register, monitor and locate people at risk of suicide in the public health system (PAHO, 2018). Prevention is possible, and it begins by training primary care healthcare professionals to detect suicide risks, as 83% of people who die from suicide seek assistance in this setting in the year prior to their death, and even 66% during the month prior (Giner and Guija, 2014; Luoma et al., 2002). The next step is being able to correctly classify the severity of the risk, thus enabling the person affected to access the most suitable tools and level of care (WHO, 2000). Finally, in each case, personalised records must be kept containing information on previous suicide attempts or on any other details related to cases of self-harm.

In order to effectively implement this prevention plan, the Spanish autonomous communities have drawn up their own action plans. Andalusia, the country's most populated region, is one of the areas with the highest number of deaths by suicide each year (Chishti et al., 2003; Córdoba-Doña et al., 2014), and it has devised several directives on caring for people at risk of suicide and drawn up a number of guides containing practical recommendations for healthcare professionals (Basaluzzo Tamborini et al., 2010; Rueda López, 2010). These guides come to the conclusion that people who are at risk of committing suicide are generally not currently on the most suitable care pathways, and this inhibits their adequate monitoring. It draws our attention in particular to those who have not been admitted to institutions specialising in mental health. All of this is clear proof that the real risk run by people with the intention of committing suicide is not being considered (Oquendo and Mann, 2008).

In this regard, the general objective of this study is to describe how people at risk of suicide access the National Health System in Andalusia (NHS-A), how they are cared for and how this information is recorded. In addition, its specific objectives focus on gathering the opinions of family members and friends, as the impact that the suicide of a loved one has on them is another risk factor that must be corrected (PAHO, 2018). This research forms part of the EUREGENAS (European Regions Enforcing Actions Against Suicide) project, which aims to bolster suicide prevention actions (Euregenas Project, 2012).

2. Theoretical context

In this investigation of suicide, going beyond Durkheim's perspective, the biomedical model of public health has taken priority, although, from a sociological point of view, this fails to fully consider the micro and macro view of the fundamentals of the sociological approach to suicide research (Wray et al., 2011). Here we see an attempt to address the issue from this perspective, which suggests dealing with the process of "institutionalisation" of the survivor, or the person at risk of suicide, and the ensuing social "stigma".

The process through which one becomes a "man", in the terms used by Berger and Lukmann, "takes place in an interrelationship with an environment" (2003: 66). Therefore, the environment in the social construction of humans is of utmost importance. As such, life around suicide is constructed socially, and in it the institutions where this process occurs play a fundamental role.

The institutionalisation process entails integrating oneself into this environment. In order for this integration to come about, habituation is a must, something that is a precursor to any institutionalisation process. All human activity is subject to habituation, meaning that people give meaning to their everyday activities and legitimise the daily order of their lives.

It is at this point when it becomes necessary to explain the greater part of the process of institutionalising the person at risk of suicide, which takes place in healthcare establishments, and which involves socially objectifying the solution to the problem, in addition to performing legitimised routine actions in these institutions.

The concept of stigma, on the other hand, is a challenging one as Goffman's concept reduces it to a mere "attribute that is deeply discrediting" and which reduces the bearer "from a whole and usual person to a tainted, discounted one" (1963: 3). However, this concept has evolved, and authors such as Link and Phelman, complementing the definitions put forth by others (Jones et al., 1984), and particularly applying it to the context of mental health, propose a conceptualisation that is of fundamental use to this work, as they understand that stigma exists when five interrelated components come together: "In our definition, stigma exists when elements of labelling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows these processes to unfold" (Link and Phelan, 2001: 370).

Both labelling and stereotyping are part of our cognitive processes, which Susan Fiske (1998) tells us must be connected with the social context, and which are the precursor to our tendency towards behaviour that can be expressed as prejudice, discrimination and exclusion (Augoustinos and Walker, 2001).

Given this context, our general objective here is to describe the healthcare received by people who have survived a suicide attempt and accessed the Andalusian Health Service (SAS)'s mechanisms. Our specific objectives are identifying the processes of stigmatisation and institutionalisation that occur behind this access to the system as well as the dynamics of healthcare, describing the discourse of professionals and exploring the assessment of this care by the people affected and their families.

3. Methods

The social context in which this investigation is conducted focuses solely on the 2008 financial crisis, which further heightened the socio-economic factors most associated with poor mental health (poverty, low levels of education, social fragmentation and inequality and unemployment). Back then, the SESPAS report (Gili et al., 2014) recorded a dramatic increase of mental health disorders in primary care settings.

This investigation is limited to the two Andalusian provinces of Málaga and Jaén, whose high suicide mortality rate is above the regional average (Institute of Statistics and Cartography of Andalusia [*Instituto de Estadística y Cartografía de Andalucía*, IECA], 2017), and where the proven link between the prevalence of people who suffer from mental illnesses and the impact of inequality on a financial level, as well as in terms of the quality of social relationships and the differentiation of status in societies, is most obvious (Pickett and Wilkinson, 2010).

3.1. Data sampling and collection

In order to tackle this objective, a qualitative methodology was adopted, combining ethnographic work with discourse collection (Krippendorff, 1990), for which purpose in-depth, semi-structured interviews were conducted, alongside observation in both the institutional (healthcare professionals) and private spheres (people at risk and their families and/or loved ones). In this sense, we took on a more participatory role as "social assistants" when dealing with survivors of suicide and their families, while when faced with healthcare professionals it was an "investigative" role. Thanks to these two different roles, we were able to record discourse and note down observations in the field diary simultaneously, allowing the observations to be interpreted later *a posteriori* (Guasch, 2002).

The study centred around three levels of analysis and their corresponding units of observation:

1) Access to the Andalusian Health Service (hereinafter, SAS) by the person at risk. In this case, the units of observation are the healthcare services, which we can further subdivide into institutional structures (and three levels of healthcare) in order to observe them in more detail:
    a. Primary care (health centres and rural practices, from now on HC and RP, respectively).
    b. Mobile (ambulances) emergency care services (from now on MECS).
    c. Hospital accident and emergency departments (from now on A&E).
    d. Specialised hospitals with high treatment success rates (from now on SH).
2) Care given. In this case, the units of observation are healthcare professionals, also broken into three different levels:
    a. General practitioners (from now on GPs).
    b. Emergency healthcare professionals.
    c. Mental health specialists (psychiatry/neurology).
3) Assessment of the care given by the people affected. The units of observation are the people who have attempted suicide, as well as their families and loved ones.

When observing these units, a strategic, non-probabilistic sample was taken, "whose selection of sample units meets subjective criteria, in line with the objectives of the investigation" (own translation, González and D'Ancona, 1997: 200). In order to achieve this, three types of sample units were determined: healthcare services, professionals and people affected. These three levels were confined to the local health areas of Jaén-Sur and Málaga-Valle Guadalhorce.

The following inclusion criteria were used when selecting healthcare professionals: 1) those who have been working in the same establishment and role for at least two years, and 2) those who have treated patients at risk of suicide, or even those who have died of suicide. This selection was made by the Mental Health Clinical Management Units (hereinafter, MHCMU) of both health areas. These units were responsible for choosing and personally contacting both the healthcare professionals who met the inclusion requirements and the people affected.

A minimum of 10 interviews was considered necessary for each area, and attempts were made to keep the number of interviews in proportion in terms of the gender of the healthcare professionals and the healthcare services where they worked. Interviewees were sent a letter outlining the objectives of the study and a consent form by their corresponding MHCMU. A total of 17 healthcare professionals, 4 suicide survivors and 4 of their family members and/or loved ones participated, resulting in a sample size of 25 individuals. No healthcare professionals or interviewees refused to collaborate in our investigation. Table 1 shows the distribution of the sample of healthcare professionals who participated.

Table 1

Healthcare professionals by service type, health area and gender

	Jaén-Sur		Málaga-Valle Guadalhorce		Total
Participants and services	Male	Female	Male	Female	
PC doctors (health centre)	1	1	1	1	4
PC doctors (rural practice)	1	1	1	1	4
MECS doctors*	1	1	-	1	3
A&E doctors*	3	1	1	1	6
Total	6	4	3	4	17

Note: * A&E: Hospital accident and emergency department; MECS: Mobile emergency care services (ambulances).

Table 2 contains the distribution by gender and health area of the survivors and their families and/or loved ones. The underrepresentedness of male family members was due to the pre-selection performed by the MHCMU based on the willingness to participate in the study, authorisation by means of informed consent and the availability of people fitting this profile.

Table 2

People who have attempted suicide and their family members by health area and gender

	Jaén-Sur		Málaga-Valle Guadalhorce		Total
	Male	Female	Male	Female	
Patient	1	1	1	1	4
Family member	-	2	-	2	4
Total	1	3	1	3	8

Once the participants were selected, a field diary was kept in which the data collected for each health area were recorded. The data were collected from the practices and at the homes of the participants of the study. The audio of all of the interviews was recorded, each lasting a maximum of 70 minutes, and simultaneous observation was performed, with all of the notes being kept in a diary. The fieldwork was carried out during the month of April 2011, during which time the framework of Strategy 3 "Mental Health and Gender" of the II Comprehensive Mental Health Plan of Andalusia (PISMA) was adopted (Del Pino López, 2013). This plan was followed by III PISMA 2016-2020, which continues to propose the design of a specific region-wide suicide prevention plan, led by the MHCMU.

3.2. Analytical categories

The content of the interviews was based on a review of the literature, the attainment of this study's specific objectives, the adaptation of the WHO's tool for suicide prevention for general practitioners (WHO, 2000) and the recommendations for detecting people at risk of suicide and acting accordingly aimed at Andalusian healthcare professionals (Huizing et al., 2016). The script was written to help achieve the objectives of the investigation and it structures the guided observation in accordance with the aspects referred to in Table 3.

Table 3

Guide to analytical categories

Block	Categories of analysis
I. Access to the healthcare network	The person's ways of reaching the health system
	Community officers involved
	Circumstances around their access to healthcare
	Interventions aimed at family members
II. Risk assessment	Who assessed the risk in the initial stage
	How it was assessed, depending on the health service accessed
	Where the risk assessment was performed
III. Referrals	Referral types by risk classification
	Referral protocol employed in each case
	Actions taken depending on the risk type and healthcare service
IV. Recording of information	Information recorded about the person affected (risk/healthcare service)
	Who wrote the clinical report
	The medium on which the report is recorded
	Who the information was passed on to
V. Professional barriers	Difficulties of professionals in detecting and treating the person at risk
	Professionals' willingness to undergo training
VI. Family intervention	Intervention with loved ones
	Opinion of families and people who have attempted suicide on the healthcare received
	Main demands on the public health system

3.3. Analysis

This is a cross-sectional investigation which uses a strategic sample for descriptive purposes. The analysis methodology used has followed the grounded theory (Strauss and Corbin, 2002). This strategy bases itself on the idea that every analysis must go beyond merely describing the social reality being investigated, recognising its subjectivity. Its goal is to lay bare the points of view and perspectives of the subjects of the investigation. For this reason it is coded in three stages — open, selective and theoretical coding — in which the information is fragmented and checked for regularities, linked categories are promoted, and a proposal for a fundamental and latent social process is made, respectively.

In order to carry out this process, a collaborator transcribed the material and a researcher performed a pre-analysis, identifying the categories that appear in Table 2. These were contrasted with those of other researchers who were participating in the project. During this phase, the categories were evaluated in order to explore their relevance and adapt them to the data obtained. Once they were validated, all of the interviews were codified, fragmenting the categories by job role, healthcare service and health area. In order to describe the type of information gathered at each level of care, the results were graphed using CAQDAS CmapTools (v6), which was developed to organise and display findings in a concept map (Lee and Fielding, 1991). A graph was created for each level of care so that they could all be later joined together in a single graph which would display all the types of access, interventions, referrals, procedures and monitoring. In order to explain the possible family interventions, as well as the barriers or obstacles faced by the professionals, a category analysis was performed which explored their opinion of the clinical practice and the main difficulties the professionals found when managing these cases, in addition to the opinion of suicide survivors and their family or loved ones of the healthcare. This information is presented as text.

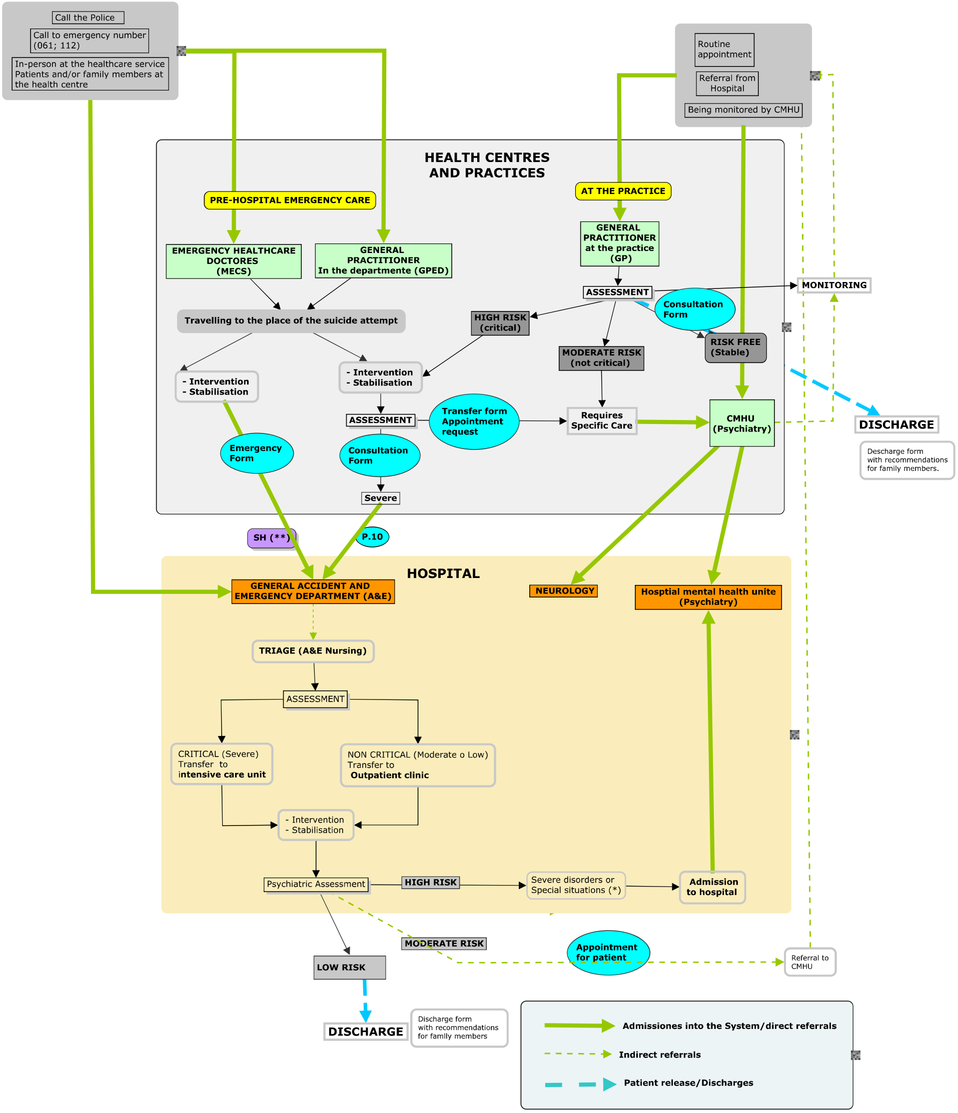
4. The institutionalisation of people at risk of suicide

4.1. Constructing stigma: institutional structures and professional discourses on people at risk of suicide

The results are shown in a flowchart (Figure 1), which describes how people who have attempted suicide enter and leave the different services and levels of healthcare. Alongside this are the procedures, types of referrals between healthcare levels depending on the level of suicide risk (serious, moderate, low/no risk), the type of professional who treated them (GP, emergency doctor, etc.) and the information that was recorded.

Figure 1

Healthcare circuit for people at risk of suicide in the SAS



Three different ways of accessing the health network have been observed, depending on the risk level and the time and place of the suicide attempt.

First is access to non-hospital emergency care. This may be by calling the emergency services and/or community officers (Local Police or Civil Guard). The way of gaining access to the healthcare network differs depending on whether the attempt occurs in an area with no nearby or open public health centres, or whether it has resulted in death or serious injury. In these cases, the officers visit the place where the suicide attempt has occurred and notify the MECS. The ambulance's emergency medical team performs a first assessment and intervention *in situ* depending on the level of risk of death presented: if the risk is moderate or severe, they perform interventions in order to stabilise the patient and transport them to the nearest hospital (or SH). The patient continues to receive care in A&E. If there is a low risk of death, they perform interventions in order to emotionally stabilise the patient, before referring them to their GP for continued care at their practice.

Information on this primary care is recorded on paper on an "Emergency Form", which contains the date, time, place and reason for care (ICD-10 codes X60-X84), without specifying the type of suicidal intention (ideation, repetition, gesture, etc.). The interventions performed are also recorded here. This sheet is given to the person who attempted suicide, if they are conscious, so that they can hand it over to the staff when they reach the hospital.

In this scenario, the healthcare professionals create their own discourse about the "client". As such, on the one hand, MECS professionals are able to indicate the difficulties they have faced when treating a person at risk of suicide. They categorise situations as "aggressive" when the person they are caring for does not want to be treated. In addition to these interpretations of the situation, they also add any restrictions experienced in accessing clinical information from different care levels.

> I don't know why, but in out unit, we need authorisation from the patient or their family, or from the chip, and not all diagnoses, unless they are admitted, are entered in their Diraya record[1] (male, GP-RP-J07)[2].
>
> [If we don't see previous information] we don't know what's happened (female, MECS-M13).

Another common interpretation is that they are obliged to pass on information. Time and again they claim it is counter-productive to inform the person affected, and especially their family, of all of the observations performed by professionals, especially when family conflicts are detected as a cause:

> [Regarding the clinical report] the patient shouldn't be able to get their hands on it [...] As a doctor, it's not something I think the patient should be able to see, but it is absolutely necessary that they know who the next professional who's going to treat them is (male, GP-RP-J07).

Secondly, the person affected is transported to a hospital or health centre in order to be treated. Once again this depends on proximity and availability, and they may be taken to a HC, RP or hospital. In this case, the emergency healthcare professional evaluates the risk level and assesses whether they should be referred to a different level of healthcare. If the person affected goes to a HC, the primary care professional is responsible for assessing the risk level. If they deem the patient to be high risk (or if they have a special condition), they request referral and emergency transfer to a hospital (by filling in the P-10 referral form). The patient may be transferred by ambulance or taken by a family member. If the risk level is low or moderate, the primary care health professionals may refer the person at risk of suicide to the community mental health unit (hereinafter, CMHU) or, if there is a long waiting time, to A&E. This information is recorded in the "Consultation Form" and added to the SAS' Diraya digital system. This form includes family history and past suicide attempts, as well as possible causes, regular medication and accessibility to lethal means. If they are transferred to the hospital, a physical copy of this form is given to the person who attempted suicide.

If the person affected is taken straight to the hospital, the nursing staff perform triage in order to complete an early assessment of the risk level. If the risk is deemed to be high, the person affected is referred to the intensive care unit (ICU). If the risk is low or moderate, they are sent to the outpatient clinic. In either case, the emergency healthcare professionals at both locations perform the necessary diagnostic tests and studies and stabilise the person affected both physically and emotionally. Once they have been stabilised, if there is still a high risk, an emergency psychiatric specialist is asked to perform another assessment and they may discharge the patient, request that the patient be admitted to the hospital's mental health unit or refer them to the CMHU for follow-up. When the patient is discharged, they are transferred to primary care for follow-up. The care received in the hospital is recorded digitally in an "Emergency Form", which includes the data from the "Consultation Form", the interventions performed at the hospital's A&E department, and a psychiatric assessment, if applicable.

If we apply the definition of "stigma" proposed by Link and Phelan (2001), in the first notes made and the emergency healthcare professionals' discourse records, we can already see the use of labels, barely hidden beneath metaphors, which are clear proof of how this type of "client" is treated differently:

> There are some patients who... it's easier to talk to a brick wall than it is to them (male, A&E-J01).

Sticking with Link and Phelan, the second component, the link between the label and negative stereotypes ("they don't collaborate", "they deny having an illness", "they refuse care"), is somewhat reactive:

> The family may be asking for a lot, but if the patient doesn't collaborate, [in other words] if they deny they have an illness, they refuse to go to the doctor's for even five minutes... (male, GP).

The social cognition process occurs when the labelling and associating of the behaviour with negative attributes justifies the display of negative attitudes towards this kind of patient. Their rejection becomes legitimised as it is implied that repeated attempts are the "fault" of the person at risk of suicide, resulting in the following kind of scenario:

> [...] You can see that they repeat this behaviour, that nothing changes [...] It annoys you. You stop caring about them so much. You'd like to be able to take control of the situation. And be able to manage the family. And in A&E we use resources that shouldn't be used for this kind of patient (male, doctor in A&E-J09).
>
> [...] They've already passed through a pain threshold due to recurrence, and they visit the practice with a certain amount of apathy, indifference even (male, GP-HC-M14).

From this point of view shared by emergency healthcare professionals, the work that carry out is always being questioned. They feel obliged to legitimise their actions and they therefore need a cause which justifies observation, diagnosis and treatment. This establishes the "standards" that people who use the health service "must" follow. Add to that an institutional structure that doesn't grant healthcare professionals the physical space and time needed to properly care for people in this situation:

> [We need spaces] that aren't shared by so many people and so loud, as well as spaces that allow us to properly observe the patient (male, A&E-J01).

Finally, it is possible to access the health system by requesting an appointment, through referral from another service or if follow-up is required for specific sequelae (such as of the throat or neck as a result of hanging or the ingestion of toxic products). In these cases, there are also significant barriers in terms of the information recorded. The first barrier is the fact that the professionals are restricted to a single ICD code that does not differentiate between gestures, ideation or repetition, something that is made up for in the interview at the practice. A&E departments do not have access to the assessments performed by mental health departments, and MECS professionals underscore the importance of this gap in gaining a better understanding of the situation and that of the people affected. GP professionals, for their part, also highlight the significance of a lack of information and the obstacle that it poses, as it limits their involvement to pharmaceutical prescription, and in the event of a new suicide attempt this propels the "counter-referral" dynamic and multiplies the risk.

> If you see that you have a patient who is insistent, one who is showing clear signs of problems (they're not sleeping, they are very anxious, etc.), they need to be referred to psychiatry [hospital mental health unit], or you have to take them yourself to the mental health clinic [CMHU] (female, GP-RP-M17).

4.2. Constructing stigma trajectories in families and loved ones

Each suicide survivor displays their pain in a different manner, though all families affected share the same opinion: "The biggest scare of my life"[3] (F.2. Female. Málaga).

The shocking testimony of a young female survivor of several suicide attempts, which uncovers the thought process involved in that crucial moment, reveals how the first recourse of healthcare seems like the only way out:

> I was a very active and open person [...] As I've already attempted it [before], I know that all it takes is one minute. One minute during which you forget about your family, you forget that you have children [...] It's such a fleeting moment that... [Pause] that when you're thinking about it, before that moment is even over, you tell yourself "I need help" [...] You already know that it's just a matter of days, or even hours (S.1. Female. Jaén).

She even specifies to what extent healthcare serves as a "lifeline":

> Your body gets used to treatment. So, every certain amount of time, you need for them to change your treatment. You have the intention of harming yourself. But there [the acute medical unit], you know that you're going to be watched closely day and night (S.1. Female. Jaén).

The discourse of patients and their families leaves little room for doubt of the role played by healthcare, or lack of, in their lives. All of the healthcare professionals involved, on the other hand, consider the family members and loved ones to be main players, thanks to being both key sources of information and the people responsible for providing special care for the person affected from the moment they are discharged from the healthcare service.

However, the total lack of basic resources for those affected (such as guides, catalogues or directories) which may meet their needs, particularly those for vulnerable collectives such as minors and groups at risk of social exclusion, is completely overlooked. This is a key issue for the families:

> I'd like for there to be a place where you can go and talk to people... People going through similar things, even if there's no doctor present. A type of meeting for people who are facing the same problems (F.2. Female. Málaga).

Neither professionals nor families mention any type of specific assistance, consolation or social support service for this purpose. Particularly glaring is the lack of specific initiatives for young children of people who attempt suicide, with this demographic being completely ignored.

Family members, meanwhile, partially represented by the women selected for this study by the MHCMU, whether mothers, wives or daughters, are the ones who must act as informal carers. The immense pressure that this implies, adding to the emotional impact of the situation, reflects the distress and constant fear of further suicide attempts. This mainly occurs in families that have already witnessed previous episodes and seen similar cases in the town where they live. They live in a state of trepidation that there may be a contagion effect, described as the Werther effect (Niederkrotenthaler *et al.*, 2010), which results in the use of the dichotomous labels of "us"/"them". In this sense, factors such as the linking of negative stereotypes associated with rejection, discrimination, status loss and exclusion once again converge, especially if this occurs in a rural setting. This is how one carer expressed her fear:

> I've lived in X [rural village] for 26 years, and I could tell you about 30 people. In other words, at least one person a year who has committed suicide [and did they manage it?] Yes, yes. As well as others who attempted it. I could give you names and numbers [...] Every time one happens, I record it. I could almost tell you the order in which they happened (F.1. Female. Málaga).

A profound discourse of the survivors and their affected families gradually emerges, which reveals how having experienced a suicide attempt (whether or not the person affected survived) makes them feel a "social force" that pushes them little by little towards isolation and loneliness. And although they do not say as much, they do know that the suicide of a family member is taboo in their shared social spaces, which further strengthens this invisible line that separates "us" and "them".

> Just having someone to talk to who knows what it's like, who understands the fear that you have, because it's really scary (S.2. Male. Málaga).
>
> [...] we start to cry [whenever we talk about it], so the less we talk about it, the better (S.2. Male. Málaga).

The difficulties are compounded in rural areas, where families experience these feelings with a greater intensity, given that the increased social isolation and greater distance from specialist services do nothing to help reduce this feeling of stigma. The lack of specialised mental health services, particularly emergency psychiatric services, as well as the lack of awareness regarding support resources[4], all increase this sense of isolation. Here it is worth further highlighting the particular lack of resources available to vulnerable collectives.

In this sense, community professionals in rural areas point towards the need to improve shared GP practices and the available ICT resources for preventing suicide.

5. Discussion and conclusions

The analysis of this information suggests people at risk of suicide are institutionalised in the Andalusian public health system. In other words, on the one hand, institutionalised structures are constructed and, on the other, scenarios and discourses are generated that provide evidence of a difficult attitudinal climate. Consequentially, families are also becoming integrated into this process, which results in increasingly more stigmatising trajectories as it progresses. This process is also propagated in the media when talking about suicide among adolescents (Sánchez-Muros and Jiménez-Rodrigo, 2021).

The institutionalisation process begins with admission to the healthcare service. This first point of the system differs depending on when the attempt occurs and its severity. The person at risk and their family members follow a care pathway that puts up barriers preventing them from receiving correct and proper treatment, thus inhibiting the prevention of suicide.

The discourse on rejection seen across all the levels of care analysed contributes to the process by creating specific professional jargon which justifies — whether due to a lack of specific training, necessary resources, ability or communication — the inability to provide correct care. This issue coincides with other investigations (Saunders et al., 2012), and these barriers are similar to those already found in other investigations which indicate the need to focus both on early detection (Bajaj et al., 2008; Hawton and Van Heeringen, 2009) and on necessary training for primary care, emergency and mental health healthcare professionals (Muñoz-Sánchez et al., 2018). Institutionalisation complicates the sound assessment of the risk and the determination of the specific care that should be given for the risk posed by the person affected, a topic that has also been dealt with in other studies (Gensichen et al., 2010).

Properly recording information on the person who has attempted suicide and who is seeking care from the public health service takes on more or less importance depending on how the institutions and professionals construct the scenario and its discourse regarding the event that has occurred in a social context. Both the recording of information of each case and access to the clinical history can vary according to the way in which the person at risk accesses the system. Health services do not uniformly record information, nor do they access this information in the same way, and this variation results in the delayed detection of risks as it impedes the anticipation of the severity of an attempt (Gotsens et al., 2011). The methods used to record information on each case of suicide or attempted suicide, and its transfer to and level of accessibility between the different care levels that the person at risk passes through, do not meet the WHO's recommendations (2018) designed to prevent a person from committing repeated suicide attempts and self-harming. This problem is also corroborated by other investigations that outline at least seven quality indicators that are only met in less than a third of clinical reports (Miret et al., 2010). Overall, this procedure leads to "information vacuums" that healthcare professionals tend to make up for through interviews with the survivors and/or their family members, thus giving way to a certain level of bias that proves to be an obstacle to providing the right level of care required at each moment.

Finally, the lack of health and social support for populations that are particularly vulnerable only further consolidates stigmatised trajectories. The dearth of information on resources or services designed to support family member or friends affected by a loved one's suicide attempt results in a lack of interventions for these people. Non-existent suicide prevention in these groups only further aggravates the risk. There is considerable demand for support groups to help care for people at risk of suicide, although the scarcity of information makes these possible initiatives a non-starter. The findings coincide with those of studies on the satisfaction of suicide survivors and their family members with this type of healthcare, as well as the claim that primary care is the healthcare service and level that is best suited to disseminating this information (Triañes Pego, 2014).

It is of vital importance to point out that families, particularly the women, are ultimately left to perform the role of informal carer of the person at risk of suicide, as they are the main custodians of the clinical reports, essential companions and carers on constant alert, which increases their anxiety. These carers not only experience the suicidal attempt or ideation, but they are also subject to a deep sense of pressure and stigma, especially in smaller towns and villages, and they demand increased contact with peer groups, highly rating initiatives designed to start up mental health support groups for families. These same family members call for health and social workers to provide them with adequate information on guidance and support resources and/or services aimed at people who have suffered irreparable damage.

It is also essential to underline the limitations of this investigation, namely its small sample size and ambition, which make it impossible to obtain conclusive results, although we can take away suggestive findings. The structure and discourse analysis helps overcome the limitations of the qualitative methodology, shedding light on the processes of social construction by extracting discursive components and structural dynamics, thus helping create initiatives and policies that provide a solution to this problem.

Overall, the way in which people at risk come into contact with the healthcare network, the procedure for recording case information and the shortcomings in the healthcare received all play a vital role in the institutionalisation process of the person at risk of suicide. Meanwhile, these factors foster the convergence of the components of stigma, shrouding those affected by suicide risk and their family and/or loved ones in it, which ultimately severely inhibits the prevention of suicide.

Acknowledgements

This investigation was possible thanks to the support of a number of people and institutions that I would like to thank: Evelyn Huizing (SAS), Berta Moreno Küstner (UMA), Rafael del Pino (PISMA), Daniel Gutiérrez Castillo (SAS), Israel Codina Fuillerat (SAS) and Almudena Millán Carrasco (EASP).

Notes

1 “System used in the Andalusian Health Service as a digital medium for storing medical records. It contains all of the health information of every person cared for at health centres, ensuring that it is available whenever and wherever it is needed in order to treat them, while it is also used to manage the healthcare establishment” (Diraya, n. d.).

2 Key: Gender of the professional (binary: male or female); acronyms used for healthcare professionals (A&E: doctors in hospital emergency departments; GP: general practitioner, primary care doctors); acronyms used for healthcare services (HC: health centre; RP: rural practice); first letter of the health area (J: Jaén; M: Málaga) and the identification number of the person interviewed.

3 Identification codes for interviewees: F (family member) or S (suicide survivor), plus their identification number. This is followed by their gender and province.

4 Both the specific mental health care services: children and adolescent mental health services, mental health therapeutic communities, mental health rehabilitation units (MHRU), mental health day hospitals (MHDH); and the community and social support services: residential programmes (care homes, supervised residences, respite care, home care), employment programmes (workshops, employment training courses, social enterprises), leisure and free-time programmes (permanent spaces/social clubs, leisure and free-time activities), programmes promoting and supporting mentorship schemes, mutual support programmes for families and service users (mutual support initiatives, awareness-raising, managing social support programmes, fostering the participation of collectives), care programmes for inmates with severe mental illnesses.

References

Augoustinos, M. and Walker, I. (2001). *Social Cognition. An integrated introduction.* SAGE.

Bajaj, P., Borreani, E., Ghosh, P., Methuen, C., Patel, M. and Crawford, M. J. (2008). Screening for suicidal thoughts in primary care: The views of patients and general practitioners. *Mental Health in Family Medicine*, *5*(4), 229-235.

Basaluzzo Tamborini, S., Benito Riesco, O., Calvo Azpeitia, M., Cantarero Villanueva, M., Cerezo Camacho, I., Corredera Guillén, M. Á., González Almendros, E. M., López Narbona, M., Perea Baena, José Manuel, Pérez Costillas, L., Rodríguez Marín, E. M., Rueda López, F., Ruiz Ramos, M. and Zafra Jiménez, R. (2010). *Recomendaciones sobre la detección, prevención e intervención de la conducta suicida.* Servicio Andaluz de Salud.

Berger, P. L. and Luckmann, T. (2003). *La construcción social de la realidad.* Amorrortu.

Chishti, P., Stone, D. H., Corcoran, P., Williamson, E. and Petridou, E. (2003). Suicide mortality in the European Union. *European Journal of Public Health*, *13*(2), 108-114. https://doi.org/10.1093/eurpub/13.2.108

Clark, S. E. and Goldney, R. D. (2008). The impact of suicide on relatives and friends. En Hawton y Heeringen (Eds.), *The International Handbook of Suicide and Attempted Suicide* (pp. 467-484). Wiley & Sons, Ltd. https://doi.org/10.1002/9780470698976.ch26

Córdoba-Doña, J. A., San Sebastián, M., Escolar-Pujolar, A., Martínez-Faure, J. E. and Gustafsson, P. E. (2014). Economic crisis and suicidal behaviour: The role of unemployment, sex and age in Andalusia, Southern Spain. *International Journal for Equity in Health*, *13*(1). https://doi.org/10.1186/1475-9276-13-55

Del Pino López, R. (2013). *II Plan Integral de Salud Mental de Andalucía 2008-2012* (E. Gómez de Lara, Ed.). Junta de Andalucía. Consejería de Salud.

Diraya (s. f.). Servicio Andaluz de Salud. Retrieved on 4 February 2022, https://https://www.sspa.juntadeandalucia.es/servicioandaluzdesalud/profesionales/sistemas-de-informacion/diraya

Durkheim, É. (2012). *El suicidio: Estudio de sociología y otros textos complementarios*. Miño y Dávila.

Euregenas (25 April 2014). Euregenas en español. *Euregenas*. https://www.euregenas.eu/espanol

Fiske, S. (1998). Stereotyping, prejudice, and discrimination. En D. T. Gilbert (Ed.), *The Handbook of Social Psychology*. McGraw Hill.

Gensichen, J., Teising, A., König, J., Gerlach, F. M. and Petersen, J. J. (2010). Predictors of suicidal ideation in depressive primary care patients. *Journal of Affective Disorders*, *125*(1-3), 124-127. https://doi.org/10.1016/j.jad.2009.12.008

Gili, M., García Campayo, J. and Roca, M. (2014). Crisis económica y salud mental. Informe SESPAS 2014. *Gaceta Sanitaria*, *28*, 104-108. https://doi.org/10.1016/j.gaceta.2014.02.005

Giner, L. and Guija, J. A. (2014). Número de suicidios en España: Diferencias entre los datos del Instituto Nacional de Estadística y los aportados por los Institutos de Medicina Legal. *Revista de Psiquiatría y Salud Mental*, 7(3), 139-146. https://doi.org/10.1016/j.rpsm.2014.01.002

Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity.* Prentice Hall.

Goffman, E. (2001). *Internados: Ensayos sobre la situación social de los enfermos mentales*. Amorrortu.

González, R. A. and D'Ancona, M.ª A. C. (1997). Metodología Cuantitativa. Estrategias y técnicas de investigación social. *Reis*, *80*, 240. https://doi.org/10.2307/40183928

Gotsens, M., Olmo, M. M., Rodríguez-Sanz, M., Martos, D., Espelt, A., Pérez, G., Pérez, K., Brugal, M. T., Barbería, E. and Borrell, C. (2011). Validación de la causa básica de defunción en las muertes que requieren intervención medicolegal. *Revista Española de Salud Pública*, *85*, 163-174. https://doi.org/10.1590/S1135-57272011000200005

Guasch, Ó. (2002). *Observación participante*. CIS.

Hawton, K. and Van Heeringen, K. (2009). Suicide. *The Lancet*, *373*, 9672, 1372-1381. https://doi.org/10.1016/S0140-6736(09)60372-X

Huizing, E., Gutiérrez Castillo, D., Pérez Costillas, L. and Moreno Küstner, B. (2016). *Recomendaciones sobre la detección, prevención e intervención de la conducta suicida. Resumen para Atención Primaria.* (A. Millán Carrasco, Ed.). Andalusian Health Service.

IECA (2017). *Estadística de Condiciones de vida, consumo y bienestar social. Estado de salud de la población: Tasas de suicidio por provincia.* Indicadores sociales en Andalucía. https://www.juntadeandalucia.es/institutodeestadisticaycartografia/indsoc/indicadores/791.htm

INE (2019). *Defunciones según la Causa de Muerte, Año 2018. Principales causas de muerte por grupos de enfermedades 1.*

INE (2021, January). La salud mental en la pandemia: Lo que dicen las encuestas. *Boletín Informativo del Instituto Nacional de Estadística*, *1*-6.

Jordan, J. R. and McIntosh, J. L. (2011). Grief after suicide: Understanding the consequences and caring for the survivors. En *Grief after Suicide: Understanding the Consequences and Caring for the Survivors*. Routledge. https://doi.org/10.4324/9780203886045

Krippendorff, K. (1990). *Metodología de análisis de contenido. Teoría y práctica.* Paidós.

Lee, R. M. and Fielding, N. G. (1991). Computing for qualitative research: Options, problems and potential. In N. G. Fielding y R. M. Lee (Eds.), *Using Computers in Qualitative Research* (pp. 1-14). Sage Publications.

Link, B. G. and Phelan, J. C. (2001). Conceptualizing Stigma. *Annual Review of Sociology*, 27(1), 363-385. https://doi.org/10.1146/annurev.soc.27.1.363

Luoma, J. B., Martin, C. E. and Pearson, J. L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *American Journal of Psychiatry*, *159*(6), 909-916. https://doi.org/10.1176/appi.ajp.159.6.909

Miret, M., Nuevo, R., Morant, C., Sainz-Cortón, E., Jiménez-Arriero, M. Á., López-Ibor, J. J., Reneses, B., Saiz-Ruiz, J., Baca-García, E. and Ayuso-Mateos, J. L. (2010). Calidad de los informes médicos sobre personas que han intentado suicidarse. *Revista de Psiquiatría y Salud Mental*, *3*(1), 13-18. https://doi.org/10.1016/S1888-9891(10)70003-3

Muñoz-Sánchez, J. L., Sánchez-Gómez, M. C., Martín-Cilleros, M. V., Parra-Vidales, E., De Leo, D. and Franco-Martín, M. A. (2018). Addressing suicide risk according to different healthcare professionals in Spain: A qualitative study. *International Journal of Environmental Research and Public Health*, *15*(10), 1-17. https://doi.org/10.3390/ijerph15102117

Niederkrotenthaler, T., Voracek, M., Herberth, A., Till, B., Strauss, M., Etzersdorfer, E., Eisenwort, B. and Sonneck, G. (2010). Role of media reports in completed and prevented suicide: Werther v. Papageno effects. *British Journal of Psychiatry*, *197*(3), 234-243. https://doi.org/10.1192/bjp.bp.109.074633

OPS (2018). *Manual de prácticas para el establecimiento y mantenimiento de sistemas de vigilancia de intentos de suicidio y autoagresiones*. World Health Organization. https://iris.paho.org/handle/10665.2/49120

Oquendo, M. A. and Mann, J. J. (2008). Suicidal Behavior: A Developmental Perspective. *Psychiatr Clin North Am*, *31*(2), xiii-xvi. https://doi.org/10.1016/j.psc.2008.03.001

Pickett, K. E. and Wilkinson, R. G. (2010). Inequality: An underacknowledged source of mental illness and distress. *British Journal of Psychiatry*, *197*(6), 426-428. https://doi.org/10.1192/bjp.bp.109.072066

Pirkis, J., Shin, S., Mres, A., Dwyer, J., Spittal, M. J., Delpozo-Banos, M., John, A., Arya, V., Analuisa-Aguilar, P., Appleby, L., Arensman, E., Bantjes, J., Baran, A., Bertolote, J. M., Borges, G., Brečić, P., Caine, E., Castelpietra, G., Chang, S.-S., ... Spittal, M. J. (2021). Suicide trends in the early months of the COVID-19 pandemic: An interrupted time-series analysis of preliminary data from 21 countries. *Articles Lancet Psychiatry*, *8*, 579-588. https://doi.org/10.1016/S2215-0366(21)00091-2

Rueda López, F. (2010). *Guía sobre la prevención del suicidio para personas con ideación suicida y familiares*. Andalusian Health Service. https://web.sas.junta-andalucia.es/servicioandaluzdesalud/publicaciones/guia-sobre-la-prevencion-del-suicidio-para-personas-con-ideacion-suicida-y-familiares-anexo-la

Sáiz, P. A. y Bobes, J. (2014). Suicide prevention in Spain: An uncovered clinical need. *Revista de Psiquiatría y Salud Mental*, 7(1), 1-4. https://doi.org/10.1016/j.rpsm.2014.01.003

Sánchez-Muros, P. S. and Jiménez-Rodrigo, M. L. (2021). Digital Media and Youth Suicide: Analysis of Media Reporting on «Blue Whale» Case. *Communication & Society*, *34*(3), 117-133. https://doi.org/10.15581/003.34.3.117-133

Saunders, K. E.; Hawton, K.; Fortune, S. and Farrell, S. (2012). Attitudes and knowledge of clinical staff regarding people who self-harm: A systematic review. *Journal of Affective Disorders, 139*, 205-2016. https://doi.org/10.1016/j.jad.2011.08.024

Seminario de fundamentos clásicos de la sociología. (1999). Centenario de *El suicidio*, de Émile Durkheim. *Papers. Revista de Sociologia*, 57, 39-72. https://doi.org/10.5565/rev/papers/v57n0.1966

Strauss, A. and Corbin, J. (2002). *Bases de la investigación cualitativa: Técnicas y procedimientos para desarrollar la teoría fundamentada*. Universidad de Antioquía.

The Economist (24 April 2021). «Surprisingly, suicide has become rarer during the pandemic». https://www.economist.com/graphic-detail/2021/04/24/surprisingly-suicide-has-become-rarer-during-the-pandemic

Triañes Pego, Y., Senra-Rivero, C., Seoane Pesqueira, G., Álvarez Ariza, M., De las Heras, E. and Atienza Merino, G. (2014). Satisfacción y utilidad percibidas por pacientes y familiares acerca de la información sobre prevención de suicidio. *Revista de Calidad Asistencial*, *29*(1), 36-42. https://doi.org/10.1016/j.cali.2013.09.004

WHO (2000). *Prevención del Suicidio. Un instrumento para médicos generalistas*. World Health Organization, 1-19. https://apps.who.int/iris/bitstream/handle/10665/75428/WHO_MNH_MBD_00.1_spa.pdf?sequence=1&isAllowed=y

WHO (2014). *Preventing suicide: A resource for non-fatal suicidal behaviour case registration*. World Health Organization. https://apps.who.int/iris/handle/10665/112852

WHO (2019). Suicide in the world. Global Health Estimates. En *World Health Organisation* (p. 32). CC BY-NC-SA 3.0 IGO. https://doi.org/10.1201/b14713-3

WHO (2021, junio 17). *Suicide. Key facts.* World Health Organization. https://www.who.int/news-room/fact-sheets/detail/suicide

Wray, M., Colen, C. and Pescosolido, B. (2011). The Sociology of Suicide. *Annual Review of Sociology*, *37*, 505-528. https://doi.org/10.1146/annurev-soc-081309-150058