Cumberland Council

LIVERPOOL JOHN MOORES UNIVERSITY

NIHR | National Institute for Health and Care Research

The Big Question: Understanding Suicide in Cumberland

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Executive Summary

This report presents findings from the Cumberland Suicide Prevention Research Project, designed to explore local patterns of suicidal thoughts, self-harm, suicide attempts, and help-seeking across gender, age, and area. The findings aim to support Cumberland Council, NHS partners, and third-sector organisations in shaping targeted suicide prevention strategies.

Key Findings

1. High prevalence of distress:

- Over half of respondents reported **suicidal thoughts (56%)** and **self-harm thoughts (51%)**, while **28%** had self-harmed and **19%** had attempted suicide.
- These findings highlight the widespread nature of emotional distress among respondents in Cumberland.

2. Younger adults most at risk:

- People aged **18-40**, particularly those aged **18-25**, were **most likely to experience suicidal and self-harm thoughts and attempts**, underscoring the need for **early intervention, education, and accessible mental health support** for younger adults.

3. Older adults least likely to receive help:

- Adults aged **60-79** were **least likely to receive help** for self-harm, suicidal thoughts, or suicide attempts, suggesting barriers linked to stigma, service awareness, transport, and digital access.

4. Gendered patterns in distress and help-seeking:

- **Women were more likely to experience suicidal thoughts and attempts**, yet **less likely to receive follow-up or support** after disclosing them.
- **Men were less likely to receive help for self-harm thoughts or behaviours**, reflecting cultural barriers around help-seeking and emotional expression.
- Participants identifying as **'Other'** or **preferring not to say** reported **particularly high distress**, highlighting the need for **inclusive, identity-affirming services**.

5. Geographic variation in distress and support:

- **Carlisle, Workington, and rural Whitehaven** reported the **highest rates of suicidal thoughts; Cockermouth, Maryport, and Workington** showed **higher levels of self-harm**; and **rural Carlisle** had the **highest number of suicide attempts**.
- **Help-seeking** was **lowest in Cockermouth, Whitehaven, rural Carlisle, and Maryport**, revealing clear **inequalities in local access to support**.

6. Widespread suicide bereavement:

- Over **half of respondents (52%)** had been **bereaved or affected by suicide**, most commonly **older adults, women, and residents of Whitehaven and Carlisle**.
- Many had lost **friends, colleagues, or neighbours**, showing that suicide loss reaches **far beyond the immediate family** and calls for **community-wide postvention**.

7. **Knowledge strong, confidence weaker:**

- While most participants demonstrated **good awareness of suicide facts and warning signs**, many reported **uncertainty about how to intervene or where to refer someone for help**, pointing to the need for **practical, skill-based community training**.

8. **Service fragmentation and systemic barriers:**

- Qualitative findings reveal **rural isolation, long travel distances, poverty, and underfunded services** as recurring barriers.
- Many participants described being **turned away until in crisis, discharged without followup**, or **excluded due to neurodivergence or substance use**.

9. **Early help protects against crisis:**

- Across all analyses, people who **received help for suicidal thoughts were significantly less likely to attempt suicide**. This reinforces that **early, accessible, and compassionate support saves lives**.

Next Steps

The full report presents a detailed picture of suicidal distress across Cumberland, combining **quantitative survey data** with **in-depth qualitative insights**. It includes breakdowns of responses by age, gender, and area, statistical analyses of help-seeking and suicide risk, and rich first-hand accounts that illuminate the social, cultural, and service factors shaping people's experiences. Together, these findings provide a comprehensive evidence base to guide local suicide prevention work.

Introduction

Purpose and Context

Cumberland continues to experience some of the highest suicide rates in England, with the issue affecting individuals, families, and communities across the area. Suicide is a complex and multifactorial public health challenge shaped by personal, social, and economic circumstances, but it is also preventable. Understanding the experiences of local residents who have faced suicidal thoughts or behaviours is crucial to developing effective prevention and support strategies that meet the needs of our communities.

This report was commissioned to provide a local evidence base for suicide prevention in Cumberland. The aim is to move beyond national statistics and capture the lived experiences of people within our own localities, helping to identify patterns, service gaps, and opportunities for earlier intervention. Findings from this report will inform ongoing work under the Cumberland Suicide Prevention Strategy, supporting collaboration between the Council, NHS partners, voluntary and community organisations, and people with lived experience.

The project also responds to national priorities set out in the Government's Suicide Prevention Strategy for England (2023-2028), which calls for local data and community insight to underpin action. By analysing Cumberland-specific responses, this report contributes to that agenda, highlighting where prevention efforts are working well and where further action is needed.

About the Project

Between 2023 and 2024, a mixed-methods study was undertaken to explore experiences of suicidal thoughts, self-harm, suicide attempts, and access to support among people living in Cumberland.

A total of 894 residents took part in a local survey, with 782 valid responses included in the final analysis after data cleaning. Participants were asked structured questions about whether they had experienced suicidal thoughts, self-harmed, or attempted suicide, and whether they had received any form of help or support. Responses were examined by age, gender, and location, providing a detailed picture of local patterns in risk and help-seeking.

Survey data were analysed using descriptive statistics and Chi-square tests of independence in R to identify key demographic patterns and relationships between variables; for example, whether receiving help for suicidal thoughts was related to the likelihood of a suicide attempt.

To complement this, 27 in-depth interviews and 6 focus groups were conducted with individuals who had lived experience of suicidal distress, bereavement by suicide, or supporting someone in crisis. These qualitative data were analysed using Reflexive Thematic Analysis (Braun & Clarke, 2019), allowing the research team to identify and interpret recurring patterns, meanings, and lived experiences surrounding suicide in Cumberland.

Together, these analyses provide both a quantitative overview and a qualitative understanding of the social, cultural, and structural factors influencing suicide risk, help-seeking, and prevention in the region.

How to Read This Report

This report combines quantitative and qualitative insights to provide a comprehensive understanding of suicidal experiences, help-seeking, and service access across Cumberland. It is designed to balance data with narrative, making complex findings accessible to a wide audience including public health professionals, council officers, service providers, and community groups.

- The main sections of the report highlight the key statistical patterns and thematic insights that emerged from the survey, interviews, and focus groups.
- Selected charts, figures, and participant quotes are presented within the narrative to illustrate core findings and bring lived experiences to the forefront.
- A full set of data tables, statistical outputs, and supplementary figures is available in the Appendix for transparency and further reference.
- In some graphs, the label "did not respond" refers to participants who did not disclose their information; this wording has been retained for consistency across visuals.

Together, the quantitative and qualitative findings offer a nuanced yet readable overview of suicidal distress in Cumberland, providing robust evidence to inform future prevention strategies, commissioning decisions, and community initiatives.

Section 1: Patterns of Distress – Suicidal Thoughts, Self-Harm, and Suicide Attempts

Overview

Suicide attempts, thoughts and self-harm are common experiences among people living in Cumberland. Across all age groups, a significant proportion of respondents reported having experienced suicidal thoughts (56%), with many also describing thoughts of self-harm (51%), episodes of self-harm (28%) and suicide attempts (19%). These findings reflect the widespread emotional distress affecting respondents and underline the need for early and accessible mental health support.

Age Patterns

Figure 2. Distribution of responses by age to the question "Have you previously had any suicidal thoughts?"

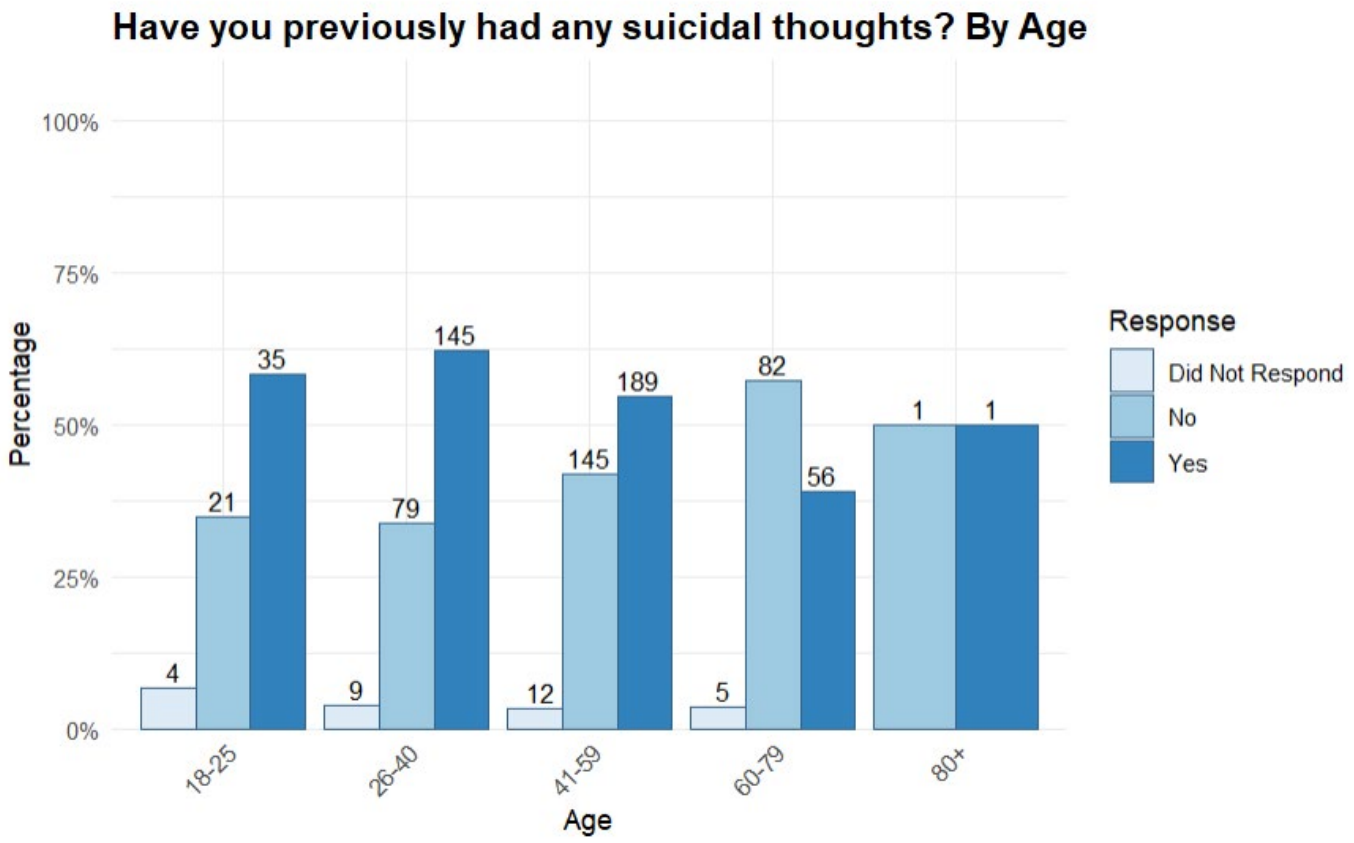


Figure 2 presents a breakdown of responses by age, showing that individuals in the younger age ranges of 18-25 and 26-40 were more likely to have experienced thoughts of self-harm. Self-harm analyses also showed similar results, with the most suicide attempts occurring in the 18-25 age range.

These findings highlight that younger adults are at greater risk of suicidal and self-harming ideation and behaviours, and that early intervention and mental health literacy are essential during this life stage.

Gender Differences

Figure 3. Distribution of responses by gender to the question "Have you previously had any suicidal thoughts?"

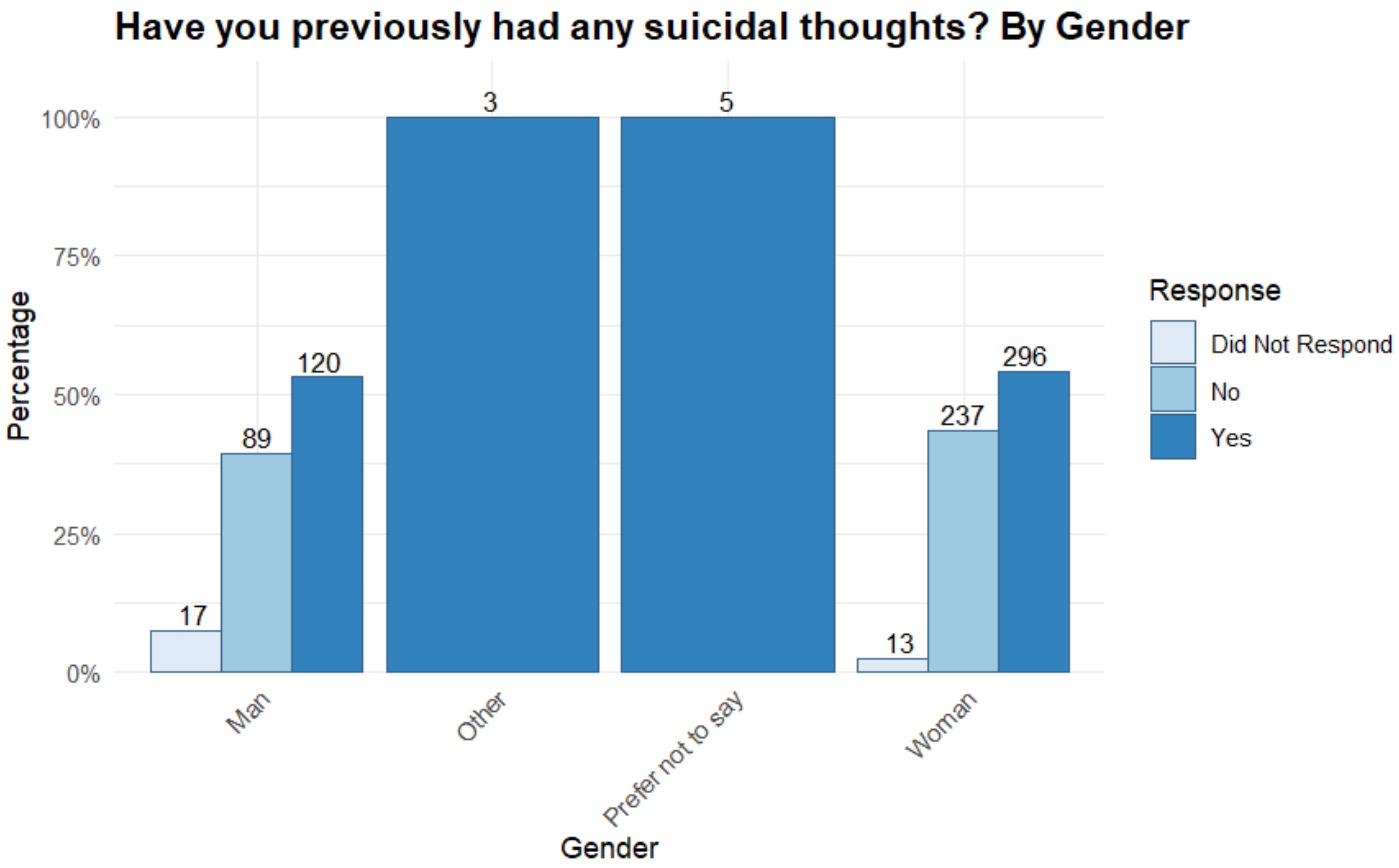


Figure 3 shows that men and women reported broadly similar rates of suicidal thoughts, with women slightly higher overall. Self-harm ideation was also marginally more common among women. All participants identifying as 'Other' and most who preferred not to say reported experiencing distress, while analyses of suicide attempts indicated that women were the most likely to report having attempted to take their own lives.

These patterns suggest that distress affects all genders but may be expressed or reported differently, shaped by social expectations, coping styles, and stigma. The particularly high levels among gender-diverse participants highlight the need for inclusive and identityaffirming support.

Geographic Variation

Figure 4. Distribution of responses by area to the question "Have you previously had any suicidal thoughts?"

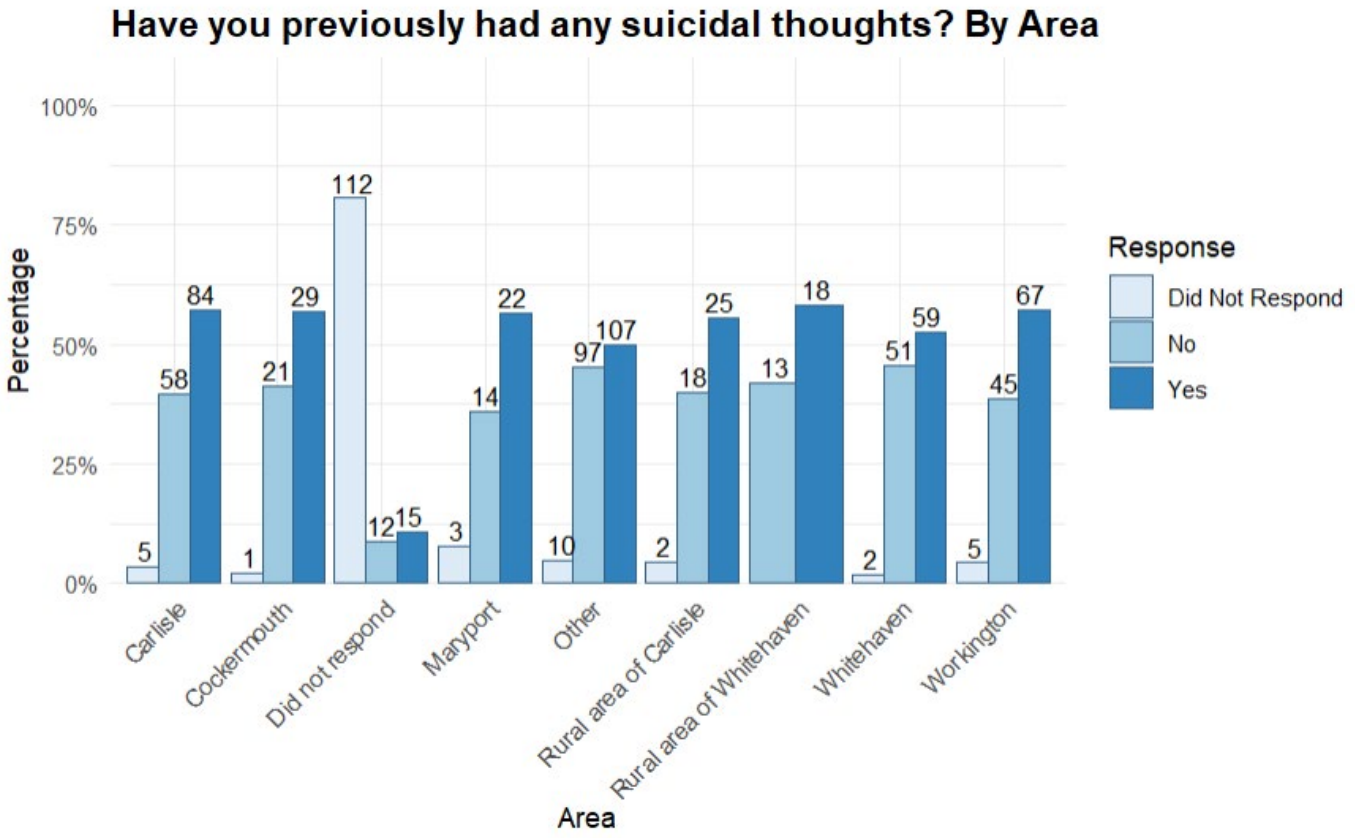


Figure 4 shows that reports of suicidal thoughts were broadly consistent across most areas, with slightly higher proportions in Carlisle, Workington, and the more rural area of Whitehaven. Self-harm was reported most often in Cockermouth, Maryport, and Workington, and suicide attempts were most reported in the rural area of Carlisle.

These variations suggest that both urban and rural communities experience high levels of distress, possibly influenced by deprivation, service access, social isolation, and population density. In some areas, higher awareness or willingness to disclose distress may also contribute to the pattern.

Key Takeaway

Suicidal thoughts, self-harm, and suicide attempts are common experiences among people living in Cumberland, reflecting widespread emotional distress across the population. Over half of respondents reported **suicidal thoughts (56%)** or **self-harm thoughts (51%)**, while **28%** reported episodes of self-harm and **19%** had attempted suicide.

Patterns varied by **age, gender, and location:**

- **Younger adults (18–40)** were most likely to experience suicidal or self-harming thoughts and behaviours, highlighting the need for **early intervention and mental health literacy during this life stage**.

- **Women** reported slightly higher levels of suicidal and self-harm ideation and were **most likely to have attempted suicide**, while **gender-diverse participants** showed particularly high levels of distress, underlining the need for **inclusive, identity-affirming support**.
- **Suicidal thoughts** were most reported in **Carlisle, Workington**, and the **rural area of Whitehaven**, while **self-harm** was highest in **Cockermouth, Maryport**, and **Workington**, and **suicide attempts** were most reported in the **rural area of Carlisle**.

Together, these findings show that **distress affects people across all communities**, shaped by **age, gender, geography, and social factors** such as deprivation, isolation, and access to care. Addressing these challenges requires **targeted, locally informed prevention** efforts that reach people earlier and in the places, they already live and work.

Section 2: Help-Seeking and Support Gaps

Overview

Although many participants reported experiencing suicidal thoughts or self-harm, fewer said they received help or support (45% did not receive help for self-harm thoughts, 60% for self-harm behaviours, 53% for suicidal thoughts, and 39% for suicide attempt). This gap highlights a major opportunity for early intervention, particularly among groups less likely to access mental health or community services. The findings below outline how help-seeking varies by gender and location, and how these patterns relate to suicidal thoughts, self-harm, and suicide attempts.

Age Patterns

Figure 6. Distribution of responses by age to the question "Did you receive any help following your self-harm?"

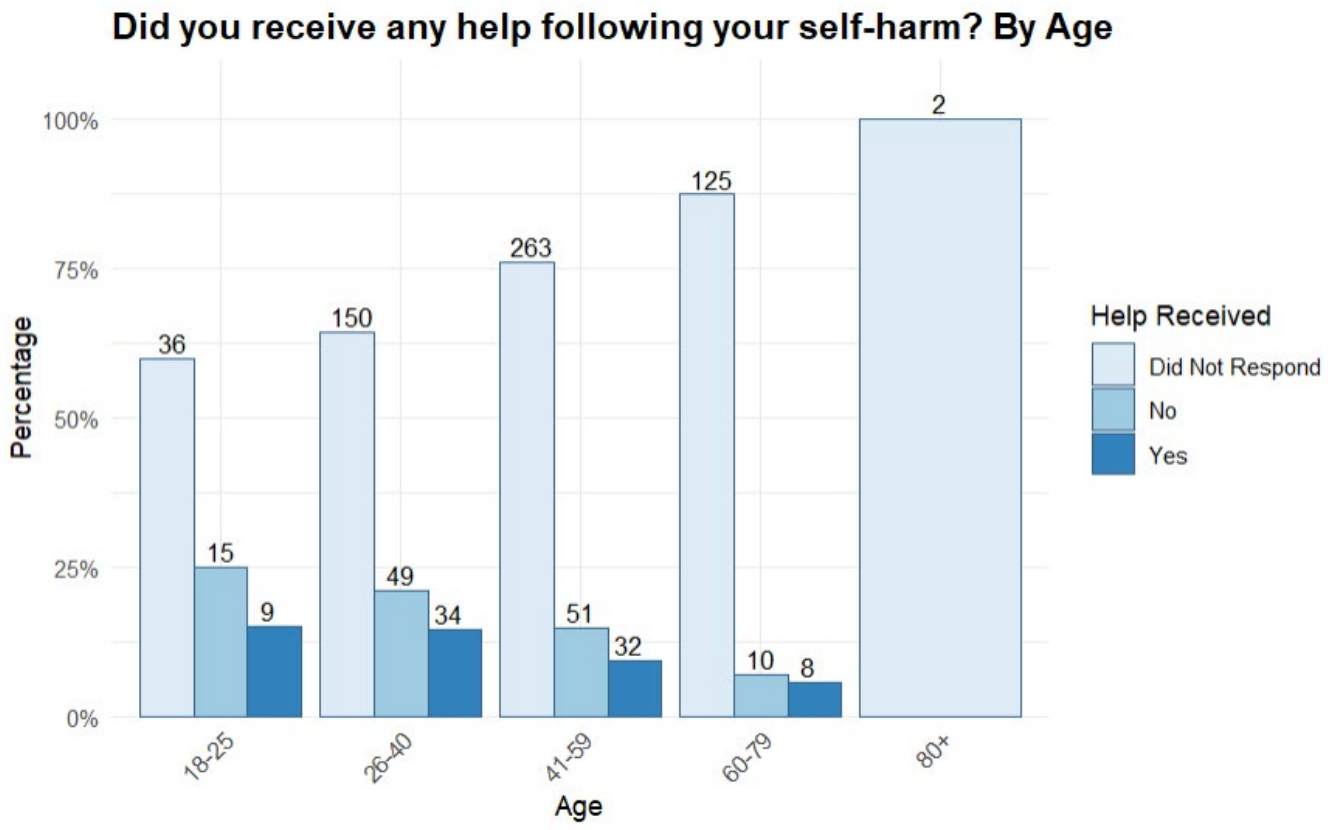


Figure 6 shows that adults aged 60-79 were the least likely to receive help after self-harm, followed by those aged 45-59. Older adults were also less likely to receive help after self-harm thoughts, suicidal thoughts, or a suicide attempt, suggesting that this age group may face particular barriers to accessing or being offered support.

Gender Differences

Figure 7. Distribution of responses by gender to the question "Did you receive any help following your self-harm?"

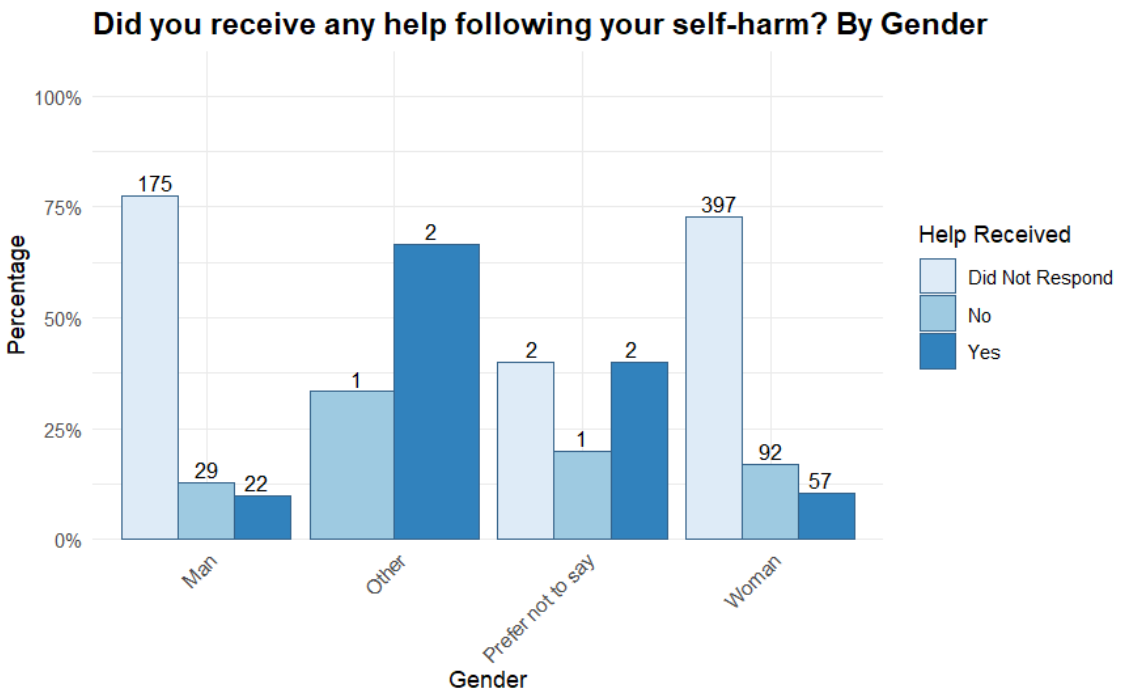


Figure 7 shows that men were least likely to receive help after self-harm, while women were less likely to receive help after suicidal thoughts and following a suicide attempt. These differences suggest that men may be less likely to seek or disclose help for self-harm, whereas women's suicidality may be under-recognised or not prioritised for follow-up support.

Geographic Variation

Figure 13. Distribution of responses by area to the question "Did you receive any help following your self-harm?"

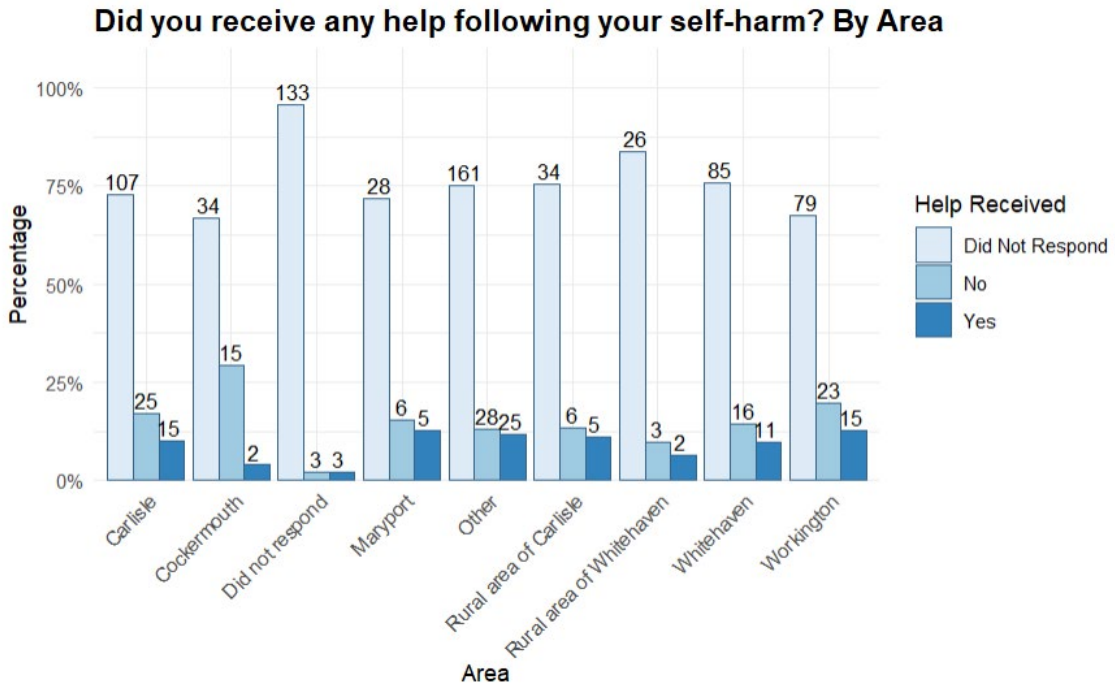


Figure 13 illustrates that help-seeking following self-harm was low across all areas, though slightly higher in Maryport and Workington compared to other localities such as Cockermouth and the rural area of Whitehaven. Cockermouth and Whitehaven were also among the least likely to receive help for self-harm thoughts, while the rural area of Carlisle and Workington showed lower support for suicidal thoughts, and Whitehaven and Maryport were least likely to receive help following a suicide attempt.

Key Takeaway

Many people who experience suicidal thoughts or self-harm do not receive help, with support lowest for **self-harm behaviours and suicidal thoughts**. This gap highlights a major opportunity for **early intervention and proactive outreach**, particularly among groups least likely to access formal services.

Help-seeking patterns varied by **age, gender, and location**.

- **Older adults (60-79)** were least likely to receive help across all measures, suggesting practical and social barriers to accessing support.
- **Men** were less likely to receive help after **self-harm**, while **women** were less likely to receive help after **suicidal thoughts** or a **suicide attempt**, indicating different points of vulnerability.
- By area, help-seeking was lowest in **Cockermouth and Whitehaven for self-harm thoughts**, in the **rural area of Carlisle and Workington for suicidal thoughts**, and in **Whitehaven** and **Maryport** following a **suicide attempt**.

Together, these findings show that **age, gender, and geography all shape access to support**, reinforcing the need for **targeted, inclusive, and locally tailored suicide prevention** across Cumberland.

Section 3: Bereaved or Affected by Suicide

Bereaved or Affected by the Death of Someone by Suicide

A total of 781 respondents answered the question:

"Have you been bereaved or affected by the death of someone by suicide?"

Over half of respondents (52%) indicated that they had been bereaved or affected by suicide; a striking finding that highlights just how widespread the ripple effects of suicide are across the Cumberland population. This means that for every two people surveyed, one has personally known someone who died by suicide. Figures 26-28 illustrate how these experiences vary across demographic groups.

Figure 26 presents the breakdown by age group, showing that suicide bereavement affects people of all ages, though older adults (60-79) reported the highest rates.

Figure 26. Distribution of responses by age for the question: "Have you been bereaved or affected by the death of someone who died by suicide?"

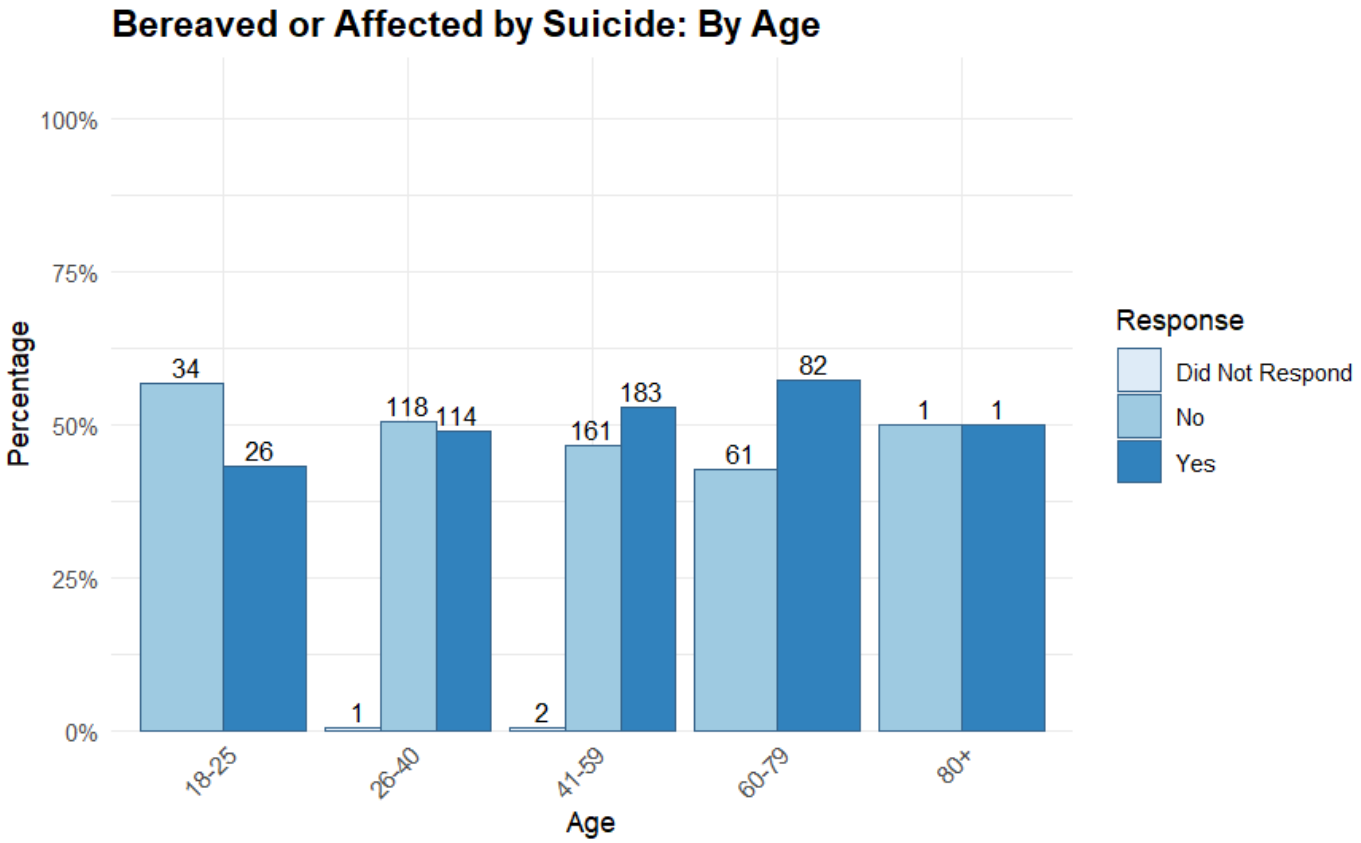


Figure 27 shows responses by gender, with women being bereaved by suicide the most.

Figure 27. Distribution of responses by gender for the question: "Have you been bereaved or affected by the death of someone who died by suicide?"

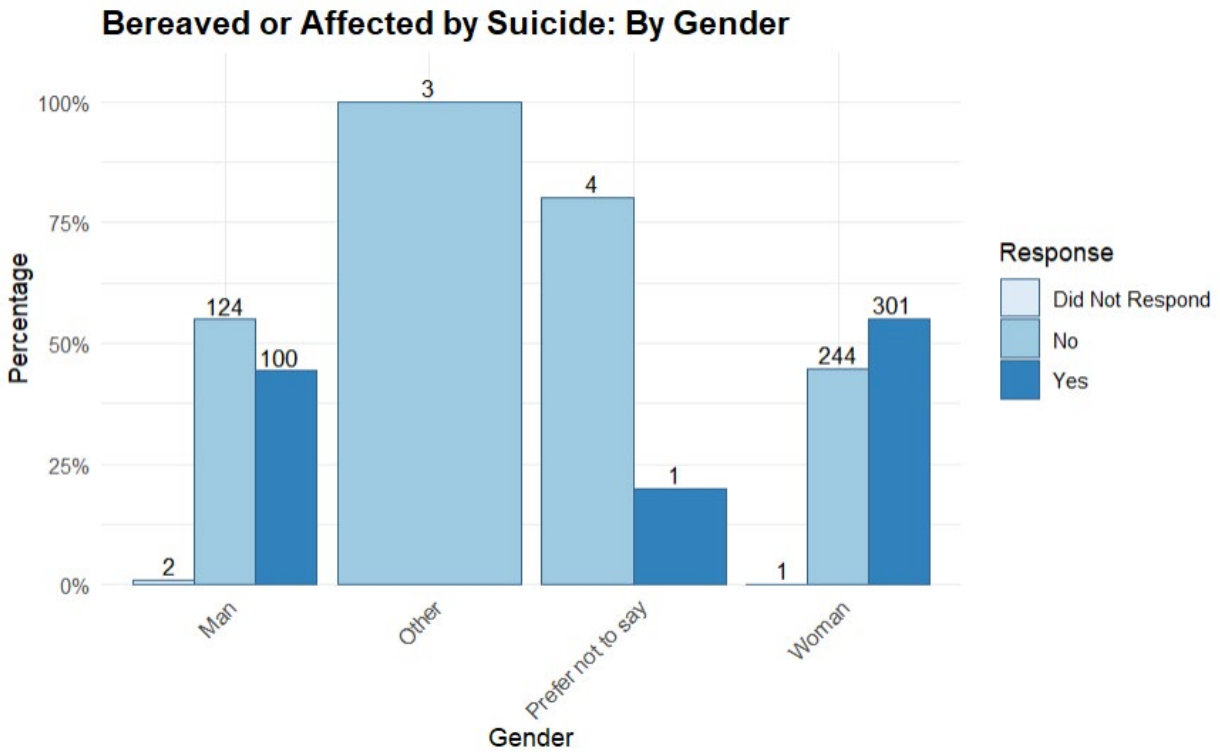
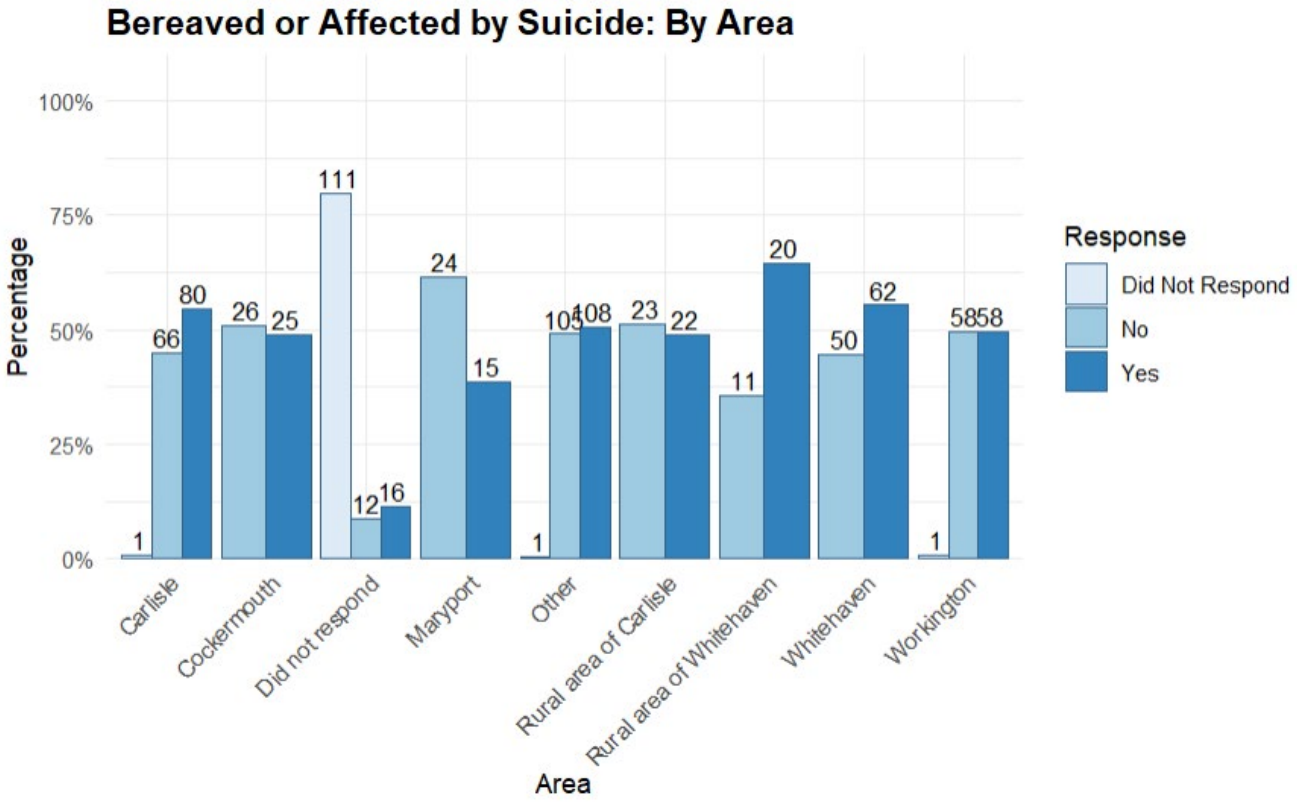


Figure 28 presents the breakdown by location, revealing slightly higher rates of bereavement in areas with known high suicide rates, such as Maryport and Workington.

Figure 28. Distribution of responses by area for the question: "Have you been bereaved or affected by the death of someone who died by suicide?"



Relationship to the Person Who Died by Suicide

There were 215 open-text responses describing respondents' relationships with the person who died. These ranged widely, indicating that suicide loss reaches far beyond the immediate family.

The most commonly mentioned relationships were:

- Friend – the single most frequent category, underscoring the social and peer-based dimensions of suicide bereavement.
- Family member, including parents, siblings, children, and extended relatives.
- Colleague, particularly in workplaces where a death by suicide had a lasting impact on staff wellbeing.
- Neighbour or acquaintance, reflecting the close-knit nature of some Cumberland communities.

These accounts illustrate the enduring emotional, social, and even occupational impacts of suicide bereavement. For many, the effects are long-term, shaping how they view mental health, relationships, and the availability of local support.

Postvention support must look beyond the family unit. Friends, workplaces, schools, and community networks also experience profound loss and may benefit from targeted outreach, education, and peer-led interventions.

Key Takeaway

Suicide bereavement is widespread in Cumberland, with the highest rates reported among **older adults (60-79) and women**, particularly in **rural Whitehaven, Whitehaven, and Carlisle**.

Open-text responses showed that suicide loss extends far beyond the immediate family. Many respondents had lost a **friend**, while others mentioned family **members, colleagues, and neighbours**, highlighting the broad social and community impact of suicide across the region.

These accounts reveal how suicide loss can have **lasting emotional and social effects**, influencing people's wellbeing, relationships, and trust in local support. **Postvention efforts should reach beyond families**, offering accessible, community-based support for **friends, workplaces, and neighbourhoods** affected by suicide.

Section 4: Knowledge, Self-Confidence, and Attitudes Survey

The Knowledge, Self-Confidence and Attitudes Survey explored respondents' understanding of suicide, their confidence in responding to someone at risk, and their personal beliefs about suicide and prevention. Findings indicate that while general knowledge levels are strong, there remains uncertainty and hesitation around direct conversations about suicide and assessing risk.

Knowledge

Most participants reported a good understanding of suicide and suicide prevention, with consistently positive responses across all knowledge items.

Understanding facts about suicide:

Over a third of participants (37.7%) rated their understanding of facts about suicide as high, while 31.2% were neutral and 14.1% reported very high understanding.

General understanding of suicide and prevention:

Similarly, 37.8% rated their general understanding as high, 31.7% as neutral, and 13.7% as low. This neutral proportion suggests that a significant number of people remain uncertain about their level of knowledge, which may reflect gaps in training or exposure to reliable information.

Recognising warning signs:

Participants generally felt confident in recognising warning signs of suicide; 42.4% rated their knowledge as high, 25.7% as neutral, and 14.1% as low.

Approaching someone at risk:

When asked about approaching or asking someone if they might be suicidal, 33% reported high understanding, while 23.5% were neutral and 18.6% low.

Getting help for someone at risk:

37.8% of participants rated their understanding as high, 24.9% as neutral, and 15.6% as very high.

Awareness of local resources:

Knowledge of local support services was more mixed. Around a third (32.4%) reported high understanding of where to find help, while 22% were neutral and 11.9% very high.

Encouraging help-seeking:

Finally, 42.7% said they understood well how to persuade someone to seek help, 25% were neutral, and 14.4% very high.

Self-Confidence

The self-confidence items assessed how comfortable participants felt engaging in conversations about suicide and supporting someone in distress.

Asking about suicide:

Around one-third (34.9%) disagreed or strongly disagreed with being hesitant to ask, suggesting many are comfortable asking directly. However, 25.3% agreed or strongly agreed that they would feel hesitant, and 16.9% were undecided, indicating lingering discomfort with initiating suicide-related discussions.

Assessing suicide risk:

Confidence dropped when assessing whether someone is suicidal. Nearly one-third (33%) were undecided, while 36.8% disagreed or strongly disagreed that they felt confident. Only 30% agreed or strongly agreed.

Supporting someone at risk:

Confidence improved when it came to supporting someone believed to be suicidal; 44% agreed or strongly agreed that they felt capable.

Making contact with someone in crisis:

Encouragingly, most participants (89%) agreed or strongly agreed that they would be confident in making contact with someone who may be suicidal, showing strong willingness to engage.

Beliefs about interference:

Responses to the statement "If someone wants to die by suicide, it is their business and we should not interfere" showed strong rejection of non-intervention: 82.7% disagreed or strongly disagreed, while 13.9% were undecided.

Duty to intervene:

Similarly, most participants (74.4%) agreed or strongly agreed that it is a human duty to try to stop someone from dying by suicide.

Attitudes

The attitudes items explored beliefs and misconceptions about suicide and those affected by it. Overall, the majority of respondents expressed compassionate and informed attitudes, though a minority held myths that could undermine prevention efforts.

Mental illness and suicide:

Most participants rejected the belief that suicide is always linked to depression or psychosis; 88% disagreed that everyone who dies by suicide is depressed, and 91% disagreed that suicide is always the act of a mentally ill or psychotic person.

Inherited or familial suicide:

The majority (83%) disagreed that suicidal tendencies are inherited or that suicide "runs in families".

Warning signs and secrecy:

For the statement that people who make plans to die keep their thoughts entirely to themselves, 40% agreed and 59% disagreed, indicating some uncertainty about the visibility of suicide warning signs.

Substance use and means restriction:

Most participants recognised the role of drugs and alcohol in suicide (85% disagreed with the statement that there is no relationship) and supported the idea that restricting access to lethal means can prevent suicides (86% disagreed that removal of means would not help).

Talking about suicide:

A large majority (85%) disagreed with the myth that people who talk about suicide do not die by suicide, showing good public understanding.

Complexity of causes:

Finally, 81% disagreed with the belief that one or two causes explain most suicides, reflecting awareness that suicide is multifactorial and influenced by a range of social, psychological, and environmental factors.

Key Takeaway:

Respondents in Cumberland show strong general awareness of suicide and its warning signs, but many remain **uncertain about how to intervene or where to refer someone for help**. Most people express empathy and a belief in the importance of supporting others, yet **lack confidence in identifying risk or starting conversations**.

These findings highlight the need to **move from awareness to action** through practical, skill-based community training such as **SafeTALK, ASIST, or Suicide First Aid**, alongside **targeted local awareness campaigns**.

While overall attitudes reflect compassion and understanding of suicide's complexity, **persistent myths** – for example, that suicide cannot be prevented or that warning signs are always hidden – reinforce the need for ongoing **education and stigma-reduction** efforts across Cumberland.

Section 5: Qualitative Results: "It Doesn't Just Happen" – Individuals' Perspectives on Suicide in Cumberland

This section draws on in-depth interviews and focus groups with 57 people living or working across Cumberland. Participants included professionals, community members, and those with lived experience of suicidal thoughts, bereavement, or caring for someone in crisis.

Their accounts offer powerful insight into the social, cultural, and structural realities shaping suicide risk in the area. Across all conversations, people described isolation, economic hardship, and gaps in support, but also shared stories of resilience, compassion, and hope for change.

Theme 1: Rurality and Geographic Isolation

Isolation – both physical and social – was described as a defining feature of life in Cumberland.

Participants explained that long distances, poor transport links, and a loss of local community networks leave many residents cut off from help at the moments they need it most.

"People can be miles and miles away from any support." – Participant 6

Public transport cuts were seen as a major barrier, particularly for people without cars, making even motivated help-seekers unable to reach services or connect socially. Many described how once-close rural communities have become fragmented, with fewer informal "check-ins" or spaces to notice when someone is struggling.

"You used to wander through the village, and everybody knew you… now there's just a lack of belonging." – Participant 8

Together, distance, disconnection, and the erosion of community bonds were seen as a "perfect storm" for loneliness and hidden distress.

Theme 2: Social and Economic Deprivation

Widespread financial hardship and inequality were seen as key drivers of distress. While a minority benefit from high-paid jobs at major employers in the region, many others face unemployment, low wages, and limited opportunities.

"People who work at [employer] are on very good money… and people who don't are on very poor money." – Participant 6

This economic divide was described as fuelling hopelessness across generations, where long-term unemployment and poverty have become normalised.

Participants also spoke of hidden harms, including domestic abuse, addiction, and emotional neglect; issues often minimised or ignored in the community. Men experiencing domestic abuse were said to be particularly overlooked.

"I encounter loads of men who need support… but they're invisible. That's contributing to the problem." – Participant 16

These intersecting hardships – poverty, trauma, and silence – create a backdrop of cumulative stress that heightens suicide risk across families and generations.

Theme 3: Male Attitudes and Cultural Norms

Rigid ideas about masculinity were repeatedly identified as barriers to emotional expression and help-seeking. Many men, participants said, feel they must "get on with it" rather than talk about feelings, leaving distress unspoken until crisis point.

"There's a West Cumbrian male attitude… men have to be strong, tough, can't cry. They can't reach out for help." – Participant 12

While some male-focused groups (like men's sheds) were praised, others risked reinforcing stereotypes when vulnerability was dismissed or mocked.

These cultural norms were described as intergenerational, passed from fathers to sons, and reinforced in large workplaces in the region dominated by traditional or hyper-masculine values.

"The culture at [employer]… it's a microcosm of toxic culture. It's damaging." – Participant 24

Participants called for culturally sensitive suicide prevention, acknowledging that "talking therapy" alone may not reach men who have been socialised to stay silent.

Theme 4: Services – Failing Systems and Flickers of Care

Many described the local mental health system as underfunded, overstretched, and unresponsive.

People were often turned away unless in acute crisis, or faced months-long waits for appointments.

"I rang the crisis team and they said, 'Unless you're actively suicidal, we don't deal with you.' That's too late!" – Participant 14

Barriers were compounded for those with complex needs, such as trauma, substance use, or neurodivergence, who often found services inaccessible or dismissive. Staff shortages, empathy gaps, and poor coordination between NHS and third-sector providers left many feeling abandoned after discharge.

"He was discharged with no follow-up. They said he'd just been missed off the list." – Participant 2

Yet amid the frustration, participants recalled moments of excellence; encounters with compassionate GPs, paramedics, and community workers who listened, validated, and followed up. These experiences, though rare, demonstrated what effective care can look like when it is human, relational, and consistent.

Theme 5: What Helps in Practice

Participants praised several community-based initiatives that offered hope and connection, including:

- Every Life Matters, for suicide prevention training and bereavement support.
- The Lighthouse in Carlisle, valued for its calm, informal approach.
- The Baton of Hope campaign, which helped reduce stigma and honour those lost to suicide.

"Every Life Matters... that's where I refer a lot of people to." – Participant 10

While these efforts were appreciated, participants felt they need wider coverage, gender-sensitive adaptation, and stronger coordination with statutory services to maximise impact.

Theme 6: What Would Help – Building a Better System

Participants shared practical, evidence-informed ideas for reform:

- Faster access to crisis care, including digital options for remote areas.
- Early intervention and mental health education in schools.
- Human, empathetic communication; being listened to without judgment.
- Safe, discreet community hubs for informal support.
- Greater collaboration between NHS and third-sector services to end siloed working.
- Inclusive design, including sensory-friendly spaces for neurodivergent individuals.

"It's about listening without judgment... making sure people feel heard and safe." – Participant 7

Together, these ideas reflect a shared vision of a local system that meets people where they are: accessible, compassionate, and grounded in the realities of rural life.

Focus Group Insights: Shared Experience and Collective Burden

Focus groups reinforced and deepened the interview findings, highlighting the emotional toll on families, stigma, and the erosion of community life.

Participants spoke candidly about the exhaustion of caring for suicidal loved ones without professional backup, and the lifelong pain of suicide bereavement compounded by silence and shame.

"They say, 'Have you got somebody that can stay with you?' That's their duty done then. Even though we're not qualified." – Focus Group 5

Families described being left out of communication, unsupported after discharge, and given little or no postvention help following suicide loss.

"You're traumatised, and people just expect you to go back to work... but it doesn't go away." – Focus Group 3

Persistent stigma and silence were described as barriers across generations, particularly for men, farming families, and workers in high-pressure roles. Poverty, housing instability, and the closure of local spaces such as youth clubs, libraries, and drop-ins were seen as structural drivers of distress that leave communities without the infrastructure to care.

"Everything's gone… you used to be able to go to the community centre or the library and talk to someone. Now it's just forms online." – Focus Group 4

Summary of Qualitative Findings

Across interviews and focus groups, five consistent messages emerged:

1. Isolation and inaccessibility are structural risks; not just personal circumstances.
2. Poverty and intergenerational hardship deepen psychological distress.
3. Rigid gender and cultural norms silence emotional expression, especially among men.
4. Mental health services are seen as fragmented, reactive, and lacking empathy.
5. Community connection, compassion, and collaboration are the cornerstones of prevention.

Key insight: Suicide in Cumberland "doesn't just happen." It arises within a web of economic, cultural, and structural pressures, but communities also hold the insight and determination to drive meaningful change.

Section 6: Implications and Recommendations

Overview

This project shows that suicidal distress in Cumberland is widespread but preventable, affecting people across all ages, genders, and communities. Over half of respondents reported suicidal thoughts (56%) or self-harm thoughts (51%), and one in five had attempted suicide, highlighting the urgent need for earlier and more accessible support.

Younger adults (18-40) were most likely to experience suicidal or self-harm thoughts, while older adults (60-79) were least likely to receive help, suggesting age-specific barriers and stigma. Women reported higher rates of suicidal thoughts and attempts but received less follow-up, whereas men were less likely to receive help for self-harm. Gender-diverse participants reported especially high distress, underlining the need for inclusive and gender-sensitive approaches.

Geographically, distress and support vary: Carlisle, Workington, and rural Whitehaven show higher suicidal thoughts, Cockermouth, Maryport, and Workington higher self-harm, and rural Carlisle more suicide attempts. Access to help was lowest in Cockermouth, Whitehaven, rural Carlisle, and Maryport, pointing to clear inequalities between areas.

Over half (52%) of respondents had been bereaved or affected by suicide, most commonly women, older adults, and residents of rural Whitehaven, Whitehaven, and Carlisle. Many described losing friends, colleagues, or neighbours, not just family, highlighting the need for community-wide postvention.

Respondents show good knowledge of suicide facts and warning signs but limited confidence in intervening or referring others. Empathy is strong, but myths and stigma persist, reinforcing the need for practical training and public awareness to move from understanding to confident action.

Qualitative findings echo these gaps: rural isolation, poverty, and rigid gender norms combine with underfunded and fragmented services to leave many without timely support. Participants called for earlier, more human care, delivered locally, digitally, and collaboratively, to meet people where they are and prevent crisis before it occurs.

Cross-Cutting Principles

- **Local, accessible, and stigma-free:** Take support to where people are, through community, mobile, and digital routes, ensuring reach across both rural and urban areas.
- **Build confidence, not just awareness:** Move beyond knowledge to practical skills so residents feel able to ask, listen, and refer safely.
- **Gender- and age-responsive:** Design approaches that recognise the different needs of men, women, younger adults, and older people, including inclusive, identity-affirming support for gender-diverse residents.
- **Consistency and connection:** Ensure continuity of care through clear pathways, warm handovers, and reliable follow-up across NHS, council, and community services.

- Lived experience at the core: Involve people with lived experience of suicidal distress or bereavement in co-design, delivery, and evaluation to keep services grounded, compassionate, and effective.

1. Strengthen Early Intervention and Access to Support

Why: Younger adults (18-40) show the highest levels of suicidal thoughts, self-harm, and attempts, with women having the most suicidal ideation and attempts. Distance, transport barriers, and crisis-only thresholds delay access to help. Survey findings show many people know the warning signs but lack confidence in how to ask or refer.

Actions:

- **Target women with suicide-specific support**, including proactive follow-up after ideation or attempts, accessible counselling, and outreach through maternity, menopause, and family-care pathways.
- Expand **mobile "Wheels of Wellness" routes** to reach villages and estates, offering drop-ins, brief interventions, and signposting.
- Develop **discreet community hubs** (non-clinical, home-like spaces) open during evenings/weekends for early, stigma-free support.
- Build **digital fast lanes** (live chat, SMS, WhatsApp) for rapid connection and follow-up, with transport vouchers for in-person care.
- Embed early-help programmes in **schools, colleges, and youth settings**, targeting care-experienced and NEET young people.
- Deliver **short, practical micro-trainings** for public and frontline workers (GPs, libraries, housing, leisure) to boost confidence in asking, responding, and referring.

2. Address Gendered Patterns in Help-Seeking

Why: Men are less likely to receive help for self-harm thoughts or behaviours, while women are less likely to receive help for suicidal thoughts or after a suicide attempt. Qualitative findings suggest that rigid gender norms and service biases play a role: men may avoid disclosure due to stigma and masculine ideals, while women's suicidality is often under-recognised or deprioritised within services.

Actions:

- Develop **male-led, peer-based self-harm support programmes** in workplaces, trades, and sports clubs, centred on shared activity and informal conversation.
- Provide **gender-sensitive facilitator training** to challenge banter cultures, model vulnerability safely, and support men's disclosure of distress.
- Partner with major employers (e.g. nuclear, logistics, local government) to embed **on-site, confidential self-harm and wellbeing support** with protected time for staff.
- Strengthen **suicide-specific follow-up and crisis care for women**, ensuring timely post-attempt contact, active safety planning, and continuity of care.

- Run **targeted public campaigns** sharing local male and female voices, promoting help-seeking for self-harm among men and suicide-related support among women, to normalise action and demystify what happens after reaching out.

3. Older Adults: Visibility, Access and Outreach

Why: 60-79-year-olds were the least likely to receive help for self-harm thoughts, suicidal thoughts, or after an attempt, yet also the most likely to be bereaved by suicide.

Actions:

- Develop a dedicated **"Later Life Mental Health & Loss" outreach programme**, combining suicide prevention and bereavement support.
- Train primary care, community nurses, and voluntary groups (Age UK, Men in Sheds, WI, churches) to identify and refer older adults quietly at risk.
- Integrate **bereavement awareness and postvention** into older adult social care, befriending, and GP services.

4. Reduce Area-Based Inequalities (Workington, Maryport and beyond)

Why: Local disparities persist, with low help-seeking in **Maryport and rural Carlisle**, and low follow-up support in **Workington, Cockermouth, and Whitehaven**.

Actions:

- Conduct **90-day pathway audits** to map access and follow-up by town.
- Implement localised improvements:
    - **Workington:** 48-hour post-attempt follow-up and assertive outreach.
    - **Maryport:** primary-care-based early intervention for suicidal ideation.
    - **Cockermouth & Whitehaven:** targeted awareness and self-harm support.
    - **Rural Carlisle:** High-intensity post-attempt response, including guaranteed 48-hour follow-up, proactive outreach, and mobile/digital support pathways, given the highest rate of suicide attempts and low help-seeking.
    - Fund **community connector roles** to guide people through referrals and ensure warm handovers between services.

5. Make Post-Crisis and Aftercare Non-Negotiable

Why: Follow-up support after self-harm or suicide attempts remains very low. Qualitative findings show people discharged without contact and families left managing risk alone.

Actions:

- Standardise **48-hour post-discharge contact**, followed by a 7-day check-in and optional peer follow-up.

- Assign a **named coordinator** (NHS or VCSE) for up to six weeks to co-write safety plans with individuals and families.
- Introduce **real-time data sharing** from crisis teams to GPs and community hubs the same day.
- Commission a **bereavement and postvention pathway**, including 72-hour outreach, one-to-one and group support, and workplace/school postvention response.

6. Ensure Inclusive, Identity-Affirming Services (LGBTQ+, neurodivergence, substance use)

Why: Gender-diverse participants all reported suicidality; people with neurodivergence or substance use issues often face exclusion or stigma.

Actions:

- Embed **LGBTQ+ inclusive practice** across all services and strengthen referral links with trusted community organisations.
- Develop **neurodivergent-friendly options:** sensory-calming rooms, flexible appointments, and visual tools, linked to autism/ADHD pathways.
- Create **no-exclusion crisis routes** for those under the influence of substances, using harm-reduction and next-day review models.
- Routinely **monitor demographics and outcomes** to ensure equity across gender, sexuality, and neurodiversity.

7. Repair the Service Fabric (continuity, empathy, transitions)

Why: Participants described fragmented, reactive systems, poor empathy, and abrupt loss of care at the CAMHS-AMHS transition.

Actions:

- Deliver **empathy and trauma-informed training** across crisis, A&E, and primary care, with reflective supervision for staff.
- Introduce a **CAMHS-AMHS bridge**, ensuring joint reviews pre- and post-18 and "no discharge without next appointment."
- Improve **integration between NHS and third-sector services**, aligning local commissioning, outcomes, and shared protocols.

8. Strengthen Community Infrastructure and Practical Supports

Why: Poverty, transport cuts, and the loss of youth and community spaces were linked to distress and isolation. Families and carers often shoulder risk alone.

Actions:

- Provide **small grants** to reopen or extend youth clubs, libraries, and warm hubs as wellbeing touchpoints with suicide-alert training.

- Embed **money and housing advice** at community hubs with direct referral to hardship funds.
- Expand **family and carer support**, including education sessions, respite options, and a dedicated helpline for suicide risk.

9. Move from Awareness to Confident Action

Why: Respondents show good knowledge but neutral or low confidence in asking, assessing, or referring; myths persist.

Actions:

- Deliver **bite-size training (60-90 mins)** for community leaders, employers, and the public on:
    - How to ask about suicide
    - How to listen and respond safely
    - How to refer and follow up locally
        - Run **myth-busting communications** (e.g., talking about suicide saves lives; means restriction works).
        - Distribute a **Cumberland Help Card** (wallet and digital) with 24/7 crisis lines and local hub details.

10. Improve Safety and Design Safer Environments

Why: Participants raised concerns about bridge and railway access, while praising staff trained to recognise distress.

Actions:

- Work with rail and highways partners to install barriers, signage, Samaritan phones, and CCTV-triggered welfare checks at hotspots.
- Promote means safety through primary care and pharmacies, reviewing medication quantities and safe storage guidance.

Conclusion

This report presents one of the most comprehensive pictures to date of suicidal thoughts, self-harm, help-seeking, and suicide bereavement across Cumberland. The combined findings reveal that suicidal distress touches every age, gender, and community, but the ways people experience and access support are shaped by geography, culture, and circumstance.

More than half of respondents reported suicidal or self-harm thoughts, and one in five had attempted suicide. Younger adults (18-40) were most likely to experience suicidal and self-harm ideation, while older adults (60-79) were least likely to receive help, suggesting that both groups face distinct barriers. Women were more likely to experience suicidal thoughts and attempts yet less likely to receive follow-up, whereas men were less likely to seek or receive

help for self-harm. Across all genders, many people knew how to recognise distress but lacked confidence in how to intervene or refer someone for support.

Geographic inequalities persist: Workington, Maryport, Cockermouth, Whitehaven, and rural Carlisle each show different patterns of risk and support, shaped by distance, deprivation, and service access. Over half of respondents (52%) have also been bereaved or affected by suicide, most commonly women, older adults, and those in Whitehaven and Carlisle, demonstrating the far-reaching impact of loss across communities.

The qualitative findings add depth and humanity to these patterns, revealing how rural isolation, poverty, trauma, gender norms, and service fragmentation intertwine to create risk. Participants spoke of being turned away unless in crisis, struggling with poor continuity of care, and shouldering responsibility for loved ones alone. Yet they also described what helps: kindness, empathy, connection, and follow-up.

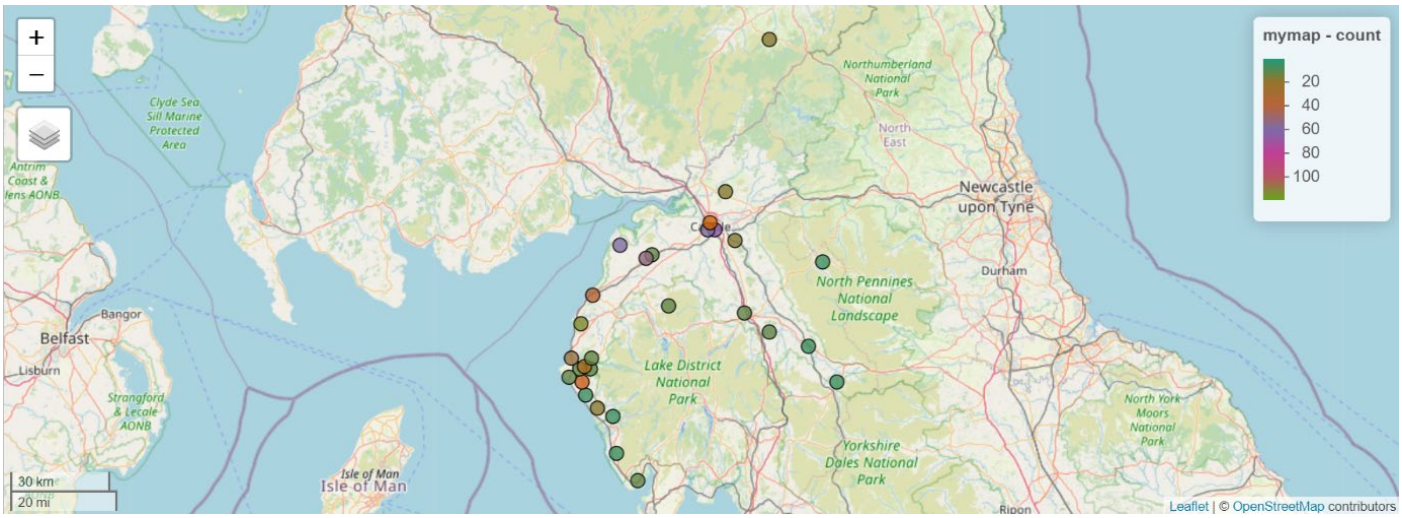
Together, these findings point to a clear truth: most people experiencing suicidal distress do not receive help, yet those who do are significantly less likely to attempt suicide. Suicide prevention in Cumberland must therefore prioritise early, equitable, and compassionate intervention; meeting people where they are, rebuilding trust in care, and turning awareness into confident, community-led action that saves lives.

Appendices

Quantitative Results: Survey Findings on Suicide, Self-Harm, and Help-Seeking Experiences

Data obtained from the survey were summarised using R (version 4.4.2). There was a total of 782 responses to the survey. In terms of location, the postcodes specifically focused on in this study are as follows: CA1, CA2, and CA3 (Carlisle); CA7 (rural area of Carlisle); CA22 (rural area of Whitehaven); CA28 (Whitehaven); CA13 (Cockermouth); CA14 (Workington); and CA15 (Maryport). The highest percentages of responses came from Carlisle (19.7%), Workington (15.7%) and Whitehaven (14.8%), based on postcode areas. Please see Figure 1 below.

Figure 1. Locations of participants based on Cumberland postcodes (Including LA18 and LA19 areas) in the survey.



Demographic Characteristics

The demographic information of the participants is summarised in Table 1 below. Results indicated that participants who took part were mostly aged 41-59 years, followed by the age ranges 26-40 and 60-79. More than twice as many women as men took part in the survey. Those who responded "Other" were Gender Questioning (AMAB) or Non-Binary. More than half of the participants were employed full-time. Those who responded "Other" were not in employment due to medical or health reasons, disability, or reported to be a housewife or homemaker. These respondents were collapsed into a 'Not in Work' category along with those Unemployed. Those who took part in the survey were mostly White/British. Please refer to the appendices for the graphical representations of the demographic characteristics.

Table 1. Demographics of Participants who took part in the Survey.

Characteristic	Survey	
	N	%
Age (years)		
18 – 25	60	7.67
26 – 40	232	29.67
41 – 59	344	43.99
60 – 79	143	18.29
80+	2	0.26
Did not respond	1	0.13
Gender		
Woman	545	69.69
Man	224	28.64
Prefer not to say	5	0.64
Other	3	0.38
Did not respond	5	0.64
Employment		
Employed full time	440	56.27
Employed part-time	129	16.50
Self-employed	38	4.86
Not in Work	58	7.42
Retired	100	12.79
Student	5	0.64
Prefer not to say	10	1.28
Did not respond	2	0.26
Ethnicity		
White British	755	96.55
White Other	10	1.28
Asian or Asian British	3	0.38
Black or Black British	1	0.13
Mixed or Multiple Ethnic Group	3	0.38
Prefer not to say	4	0.51
Other	7	0.26
Did not respond	4	0.51

Self-Harm

Thoughts about self-harm

768 participants responded to the question "Have you previously had any thoughts about self-harm?". Of those, 50.8% indicated that they had experienced thoughts of self-harm, while 49.2% reported that they had not. Figure 2 presents a breakdown of responses by age, showing that the largest difference between "yes" and "no" occurred in the 60-70 age group. However, individuals in the younger age ranges of 18-25 and 26-40 were more likely to have experienced thoughts of self-harm. Figure 3 presents the breakdown by gender, showing that women and men reported similar rates of self-harm thoughts, while all respondents identifying as 'Other' and most of those who preferred not to say reported having experienced such thoughts. Figure 4 illustrates the responses by location, showing that reports of self-harm thoughts were broadly consistent across areas, with slightly higher proportions observed in urban centres such as Carlisle and Workington compared to more rural areas.

Figure 2. Distribution of responses by age to the question "Have you previously had any thoughts about self-harm?"

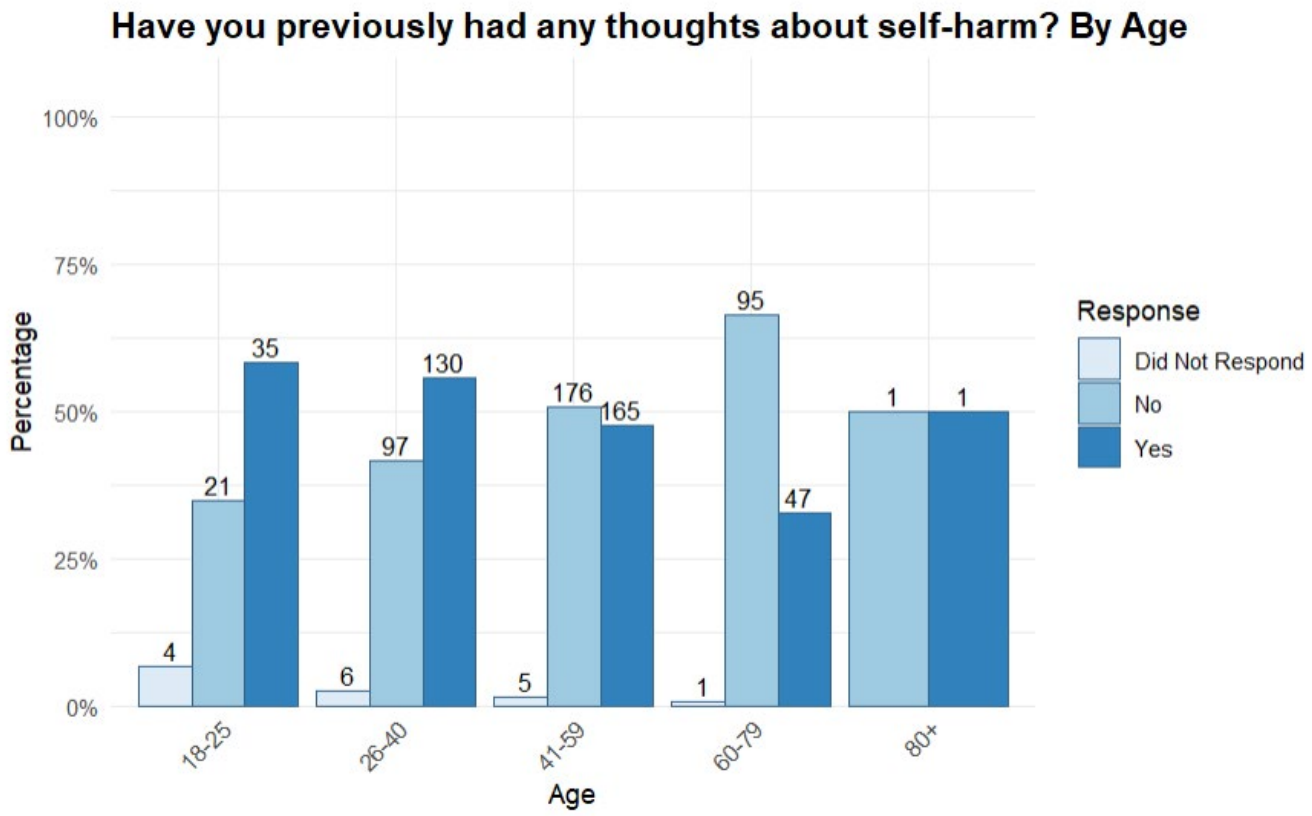


Figure 3. Distribution of responses by gender to the question "Have you previously had any thoughts about self-harm?"

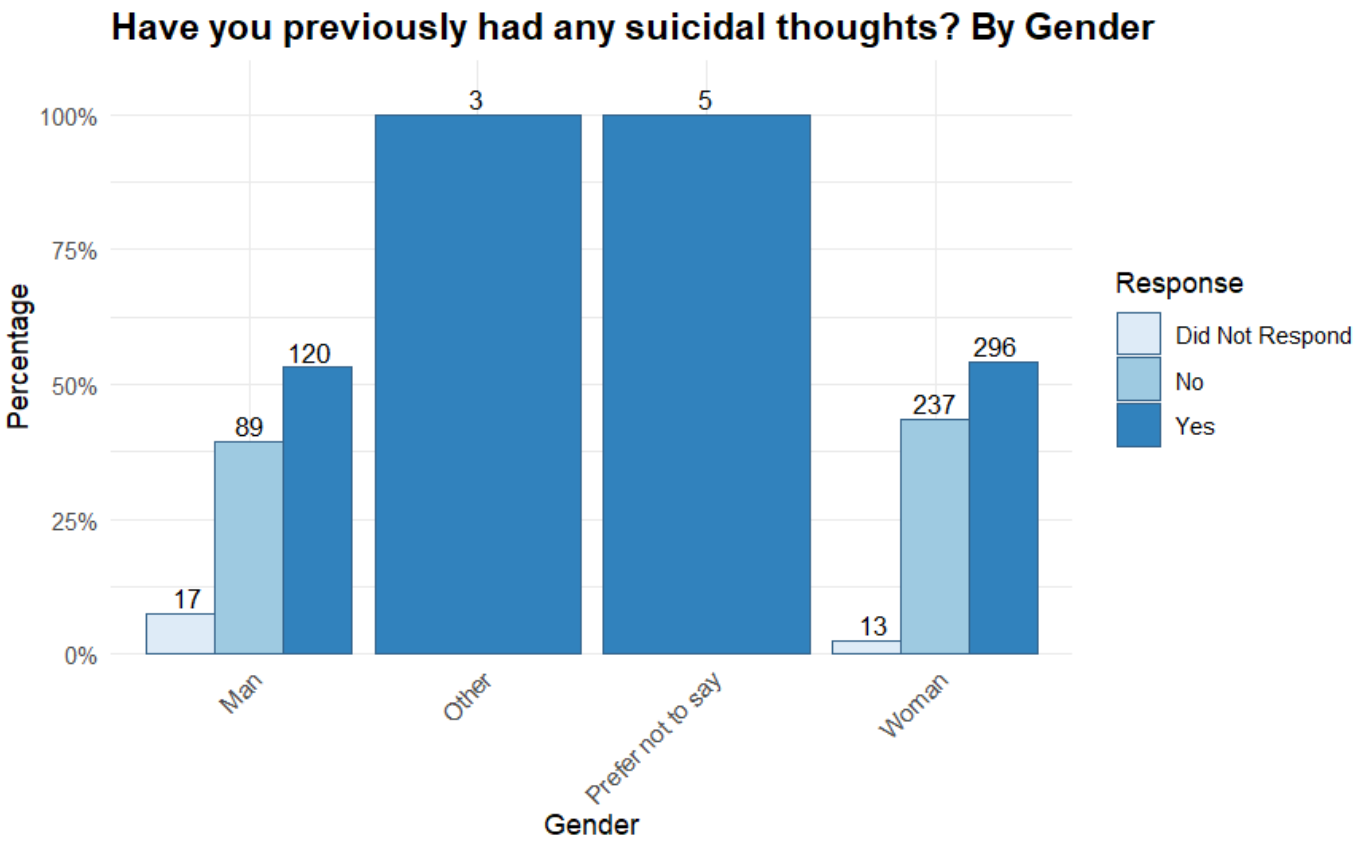
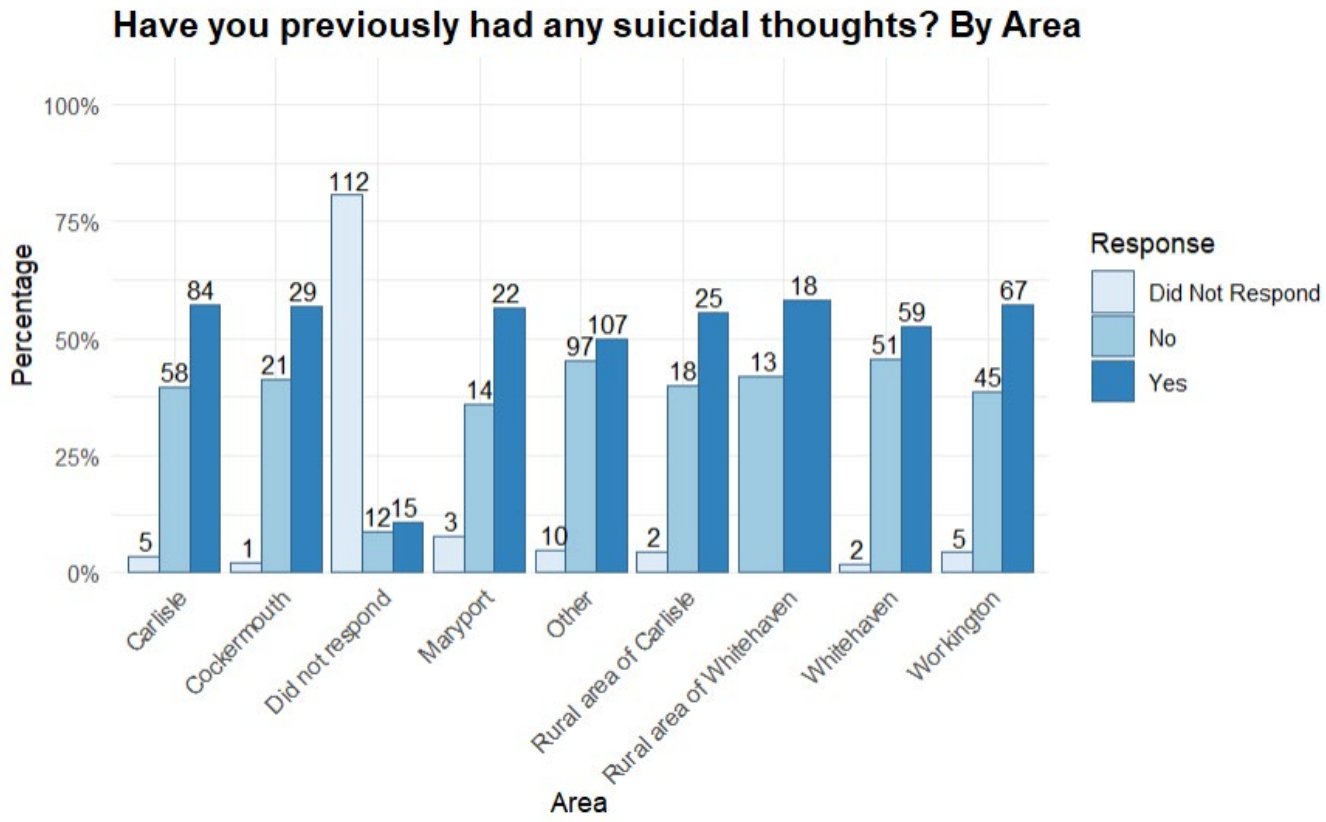


Figure 4. Distribution of responses by area to the question "Have you previously had any thoughts about self-harm?"



When asked whether participants had received help for their thoughts (n=370), 55% indicated that they had, while 45% reported that they had not. Figure 5 shows a breakdown of responses by age, showing that younger age groups, including 18-25 and 26-40, were the most likely to have received help. Participants in the 41-59 age group were also more likely to have received help than not. Figure 6 presents the breakdown by gender, showing that women were more likely than men to have received help for thoughts of self-harm, although similar proportions of men and women reported not receiving support. All participants identifying as 'Other' reported receiving help. Figure 7 illustrates the responses by location, showing that help received was broadly consistent across areas, though slightly higher proportions were observed in Workington and Whitehaven compared to other localities such as Maryport and Cockermouth.

Figure 5. Distribution of responses by age to the question "Did you receive any help for your thoughts?"

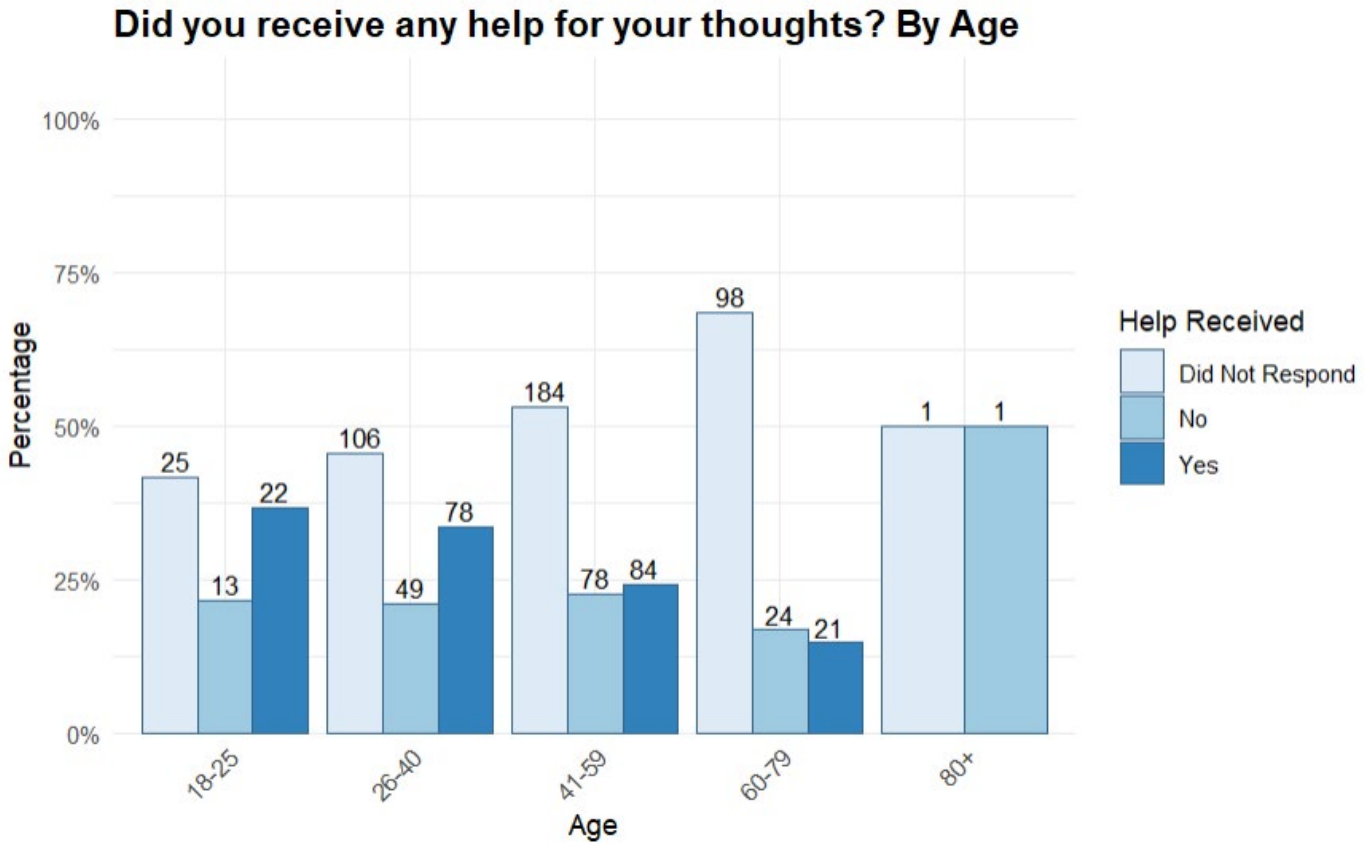


Figure 6. Distribution of responses by gender to the question "Did you receive any help for your thoughts?"

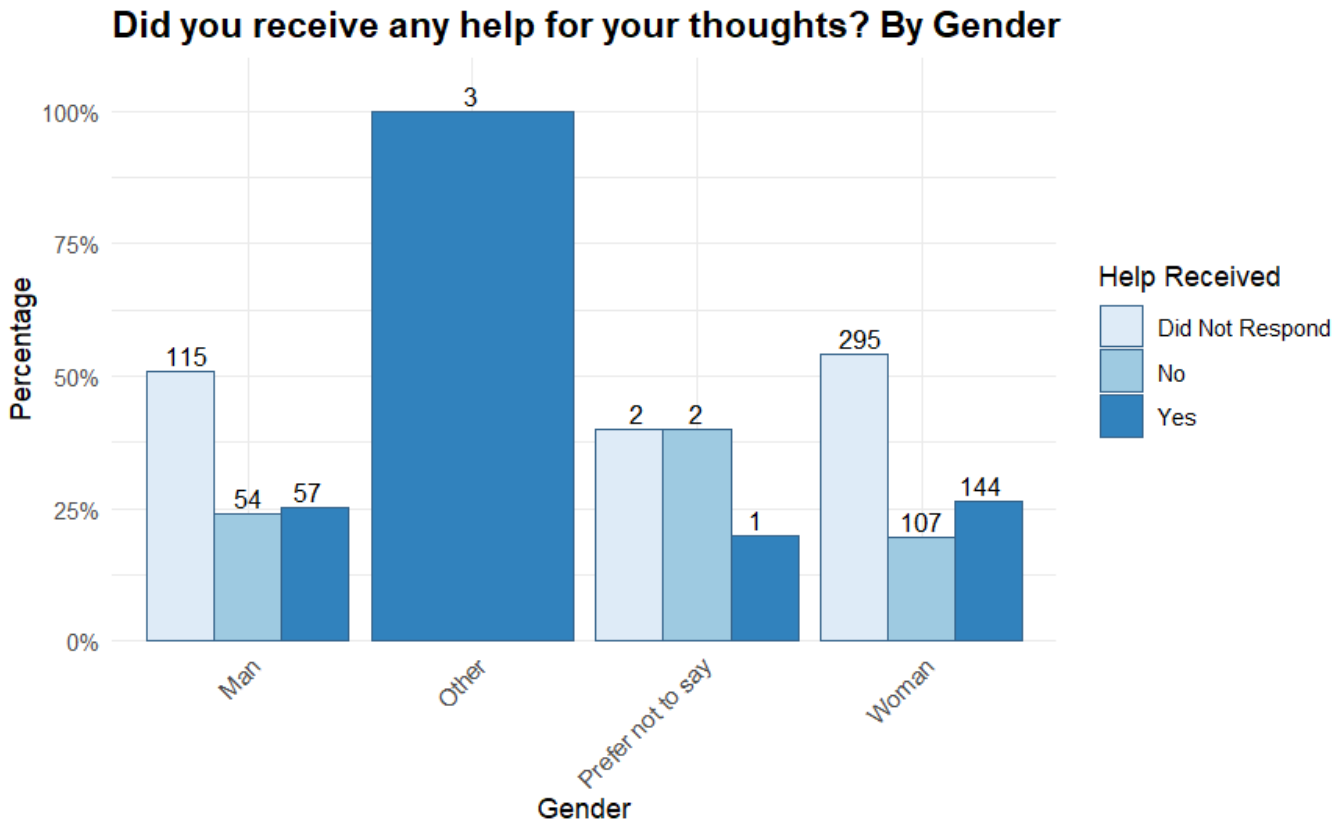
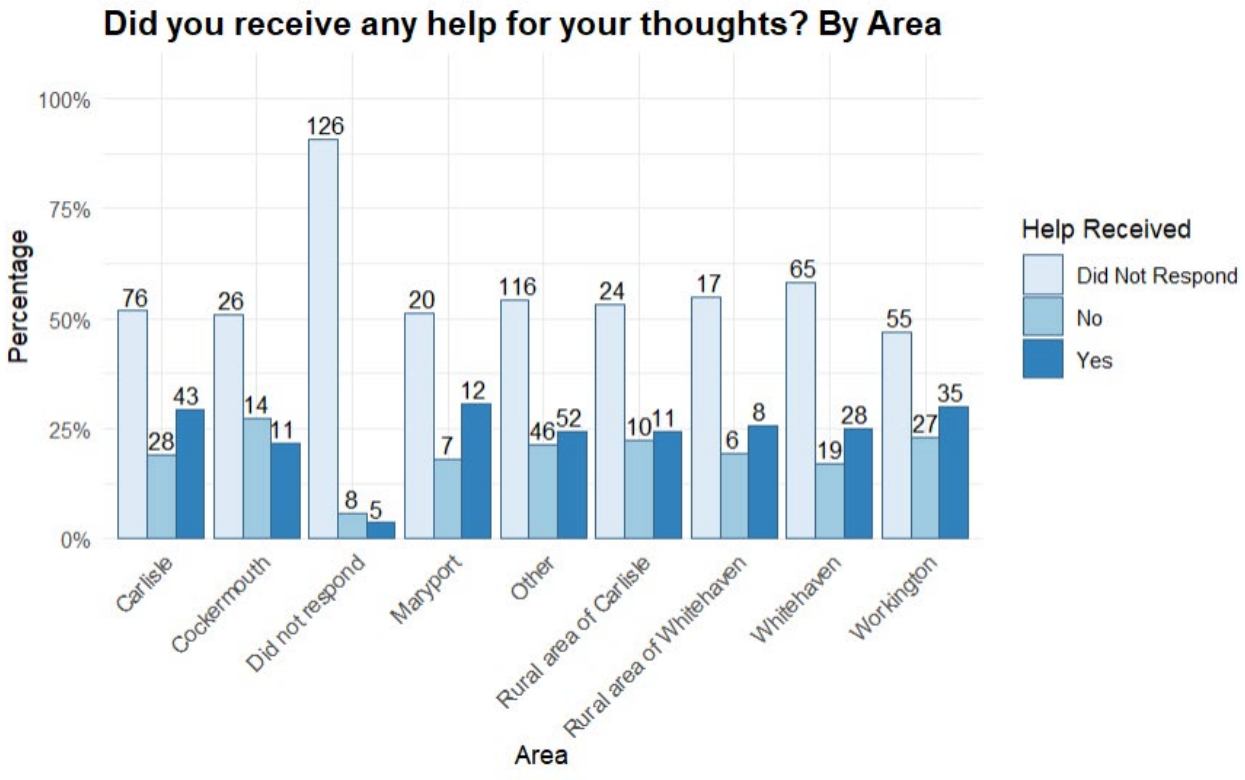


Figure 7. Distribution of responses by area to the question "Did you receive any help for your thoughts?"



Experiences of self-harm

In response to the question, "Have you previously self-harmed?", 72% of participants (n=756) reported that they have not self-harmed, while 28% indicated that they had. Figure 8 shows the breakdown of respondents by age, indicating that participants in all age groups were less likely to have not self-harmed than to have self-harmed. Figure 9 shows the distribution of responses by gender, indicating that women were more likely than men to report having previously self-harmed, though both groups showed notable proportions of respondents reporting such experiences. All participants identifying as 'Other' reported having selfharmed, while smaller proportions were observed among those who preferred not to disclose their gender. Figure 10 shows the distribution by location, indicating broadly consistent patterns across areas, with slightly higher proportions of self-harm reported in Workington, Whitehaven, and rural areas of Carlisle compared to other localities such as Cockermouth and Maryport.

Figure 8. Distribution of responses by age to the question "Have you previously self-harmed?"

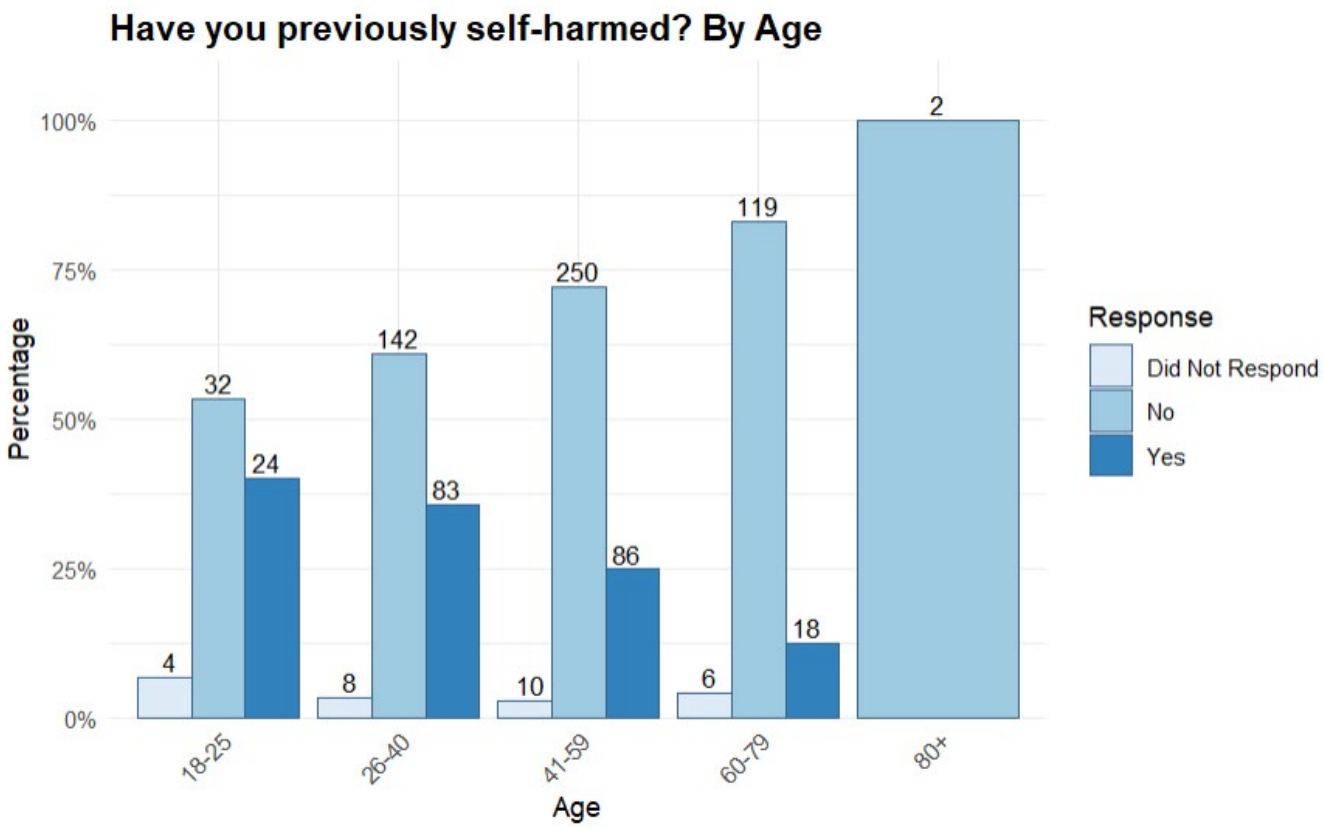


Figure 9. Distribution of responses by gender to the question "Have you previously self-harmed?"

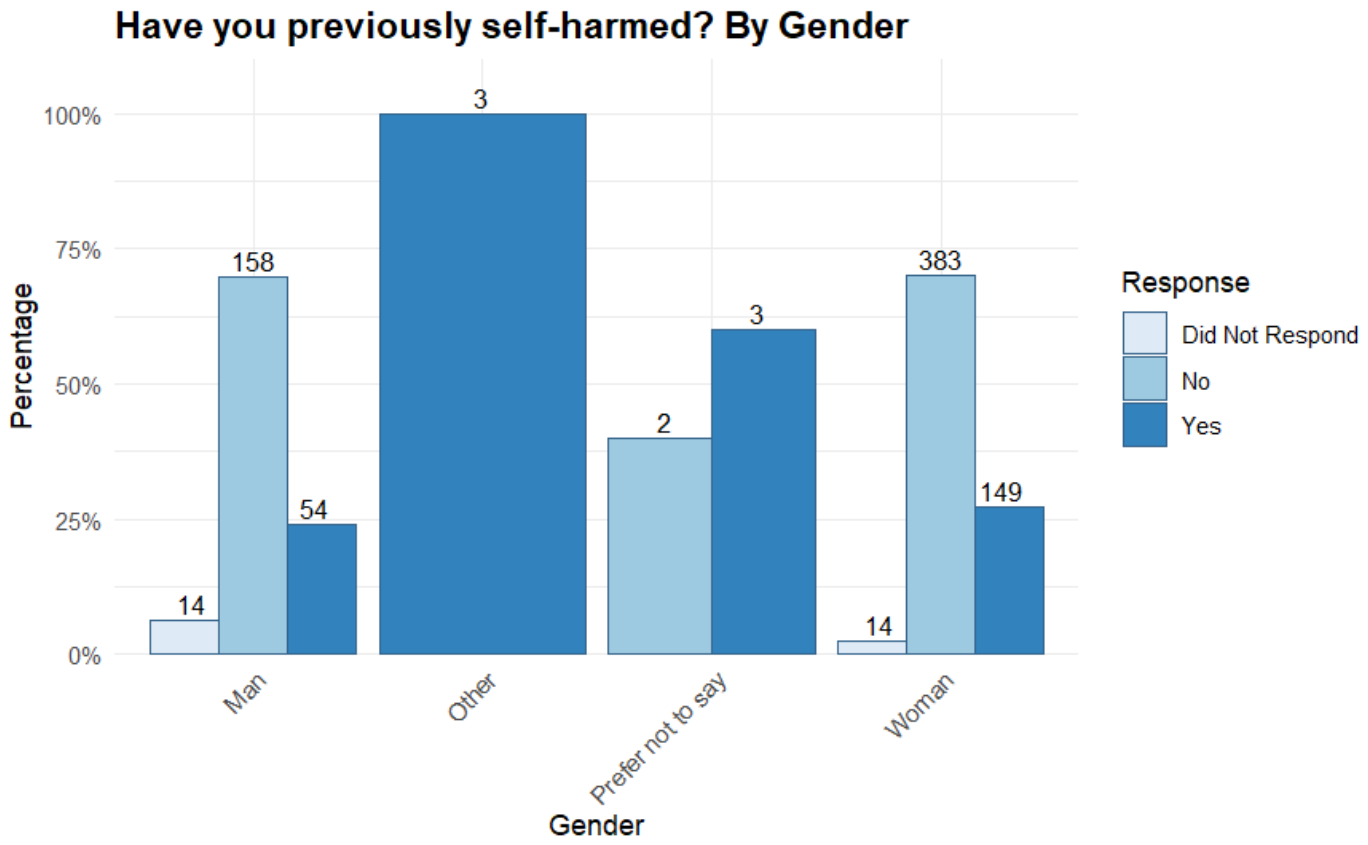
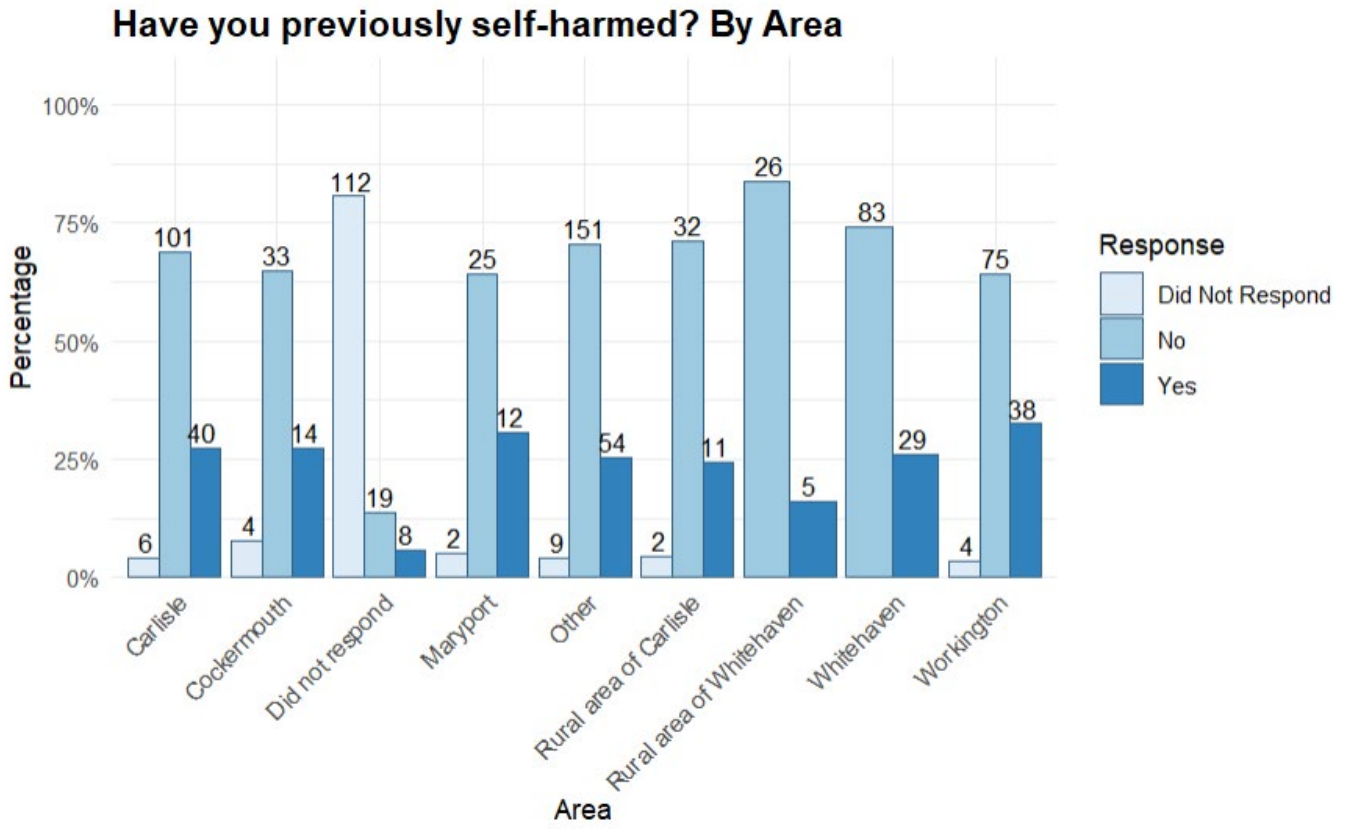


Figure 10. Distribution of responses by area to the question "Have you previously self-harmed?"



Out of the total number of participants (n=208) who answered the question, "Did you receive any help following your self-harm?", 60% reported not receiving help, while 40% indicated they had. Figure 11 shows the distribution of responses by age, indicating that participants in all age groups were more likely to have not received help than to have received help. Figure 12 shows the distribution of responses by gender, indicating that most men and women who had self-harmed did not receive help afterwards, with slightly higher proportions of women reporting support. All participants identifying as 'Other' reported receiving help. Figure 13 shows the distribution by location, suggesting that help-seeking following self-harm was relatively low across all areas, though slightly higher in Maryport and rural areas of Carlisle compared to other locations such as Whitehaven and Workington.

When compared with Figure 5, which illustrates help received for self-harm thoughts, Figure 13 shows that even fewer individuals received support after an act of self-harm, highlighting a significant gap in follow-up care and access to services.

Figure 11. Distribution of responses by age to the question "Did you receive any help following your self-harm?"

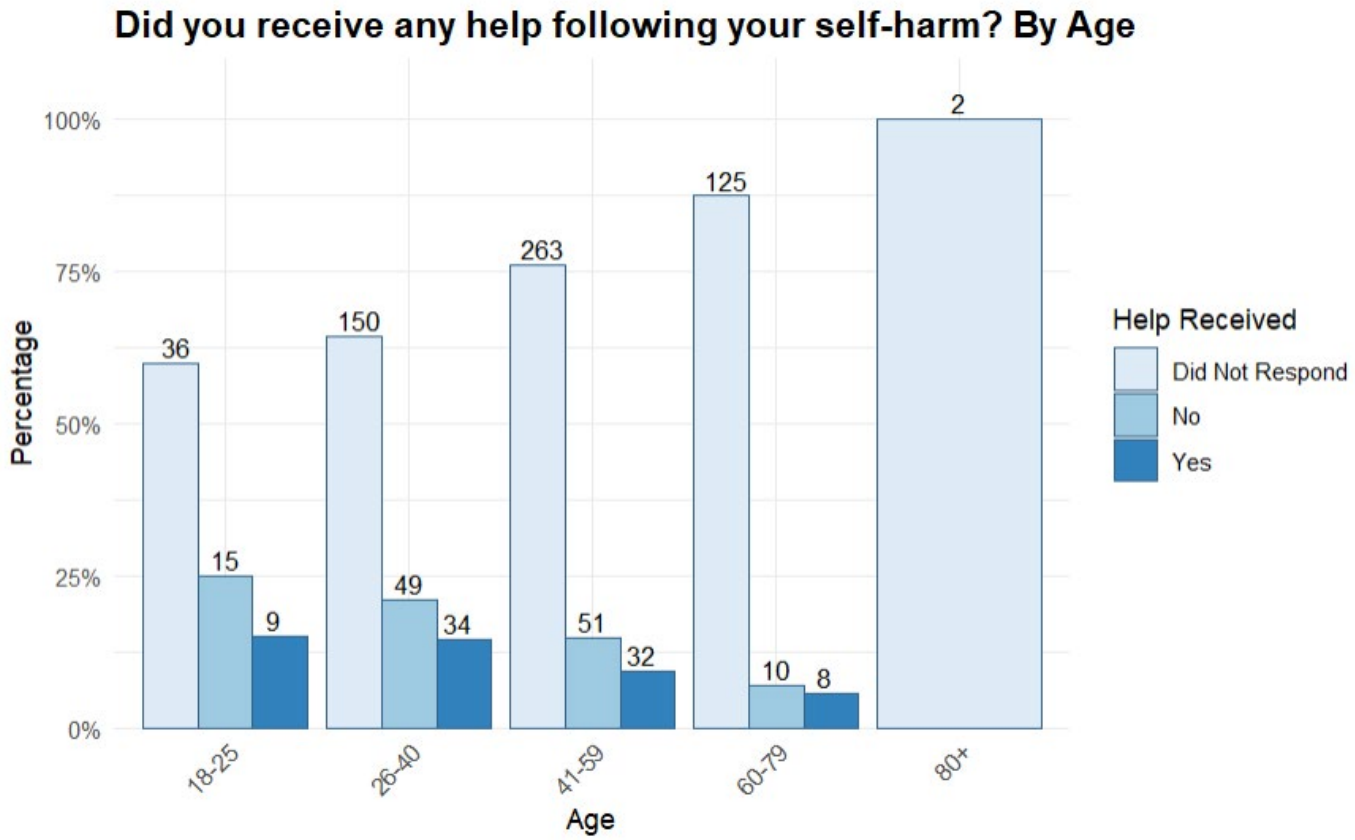


Figure 12. Distribution of responses by gender to the question "Did you receive any help following your self-harm?

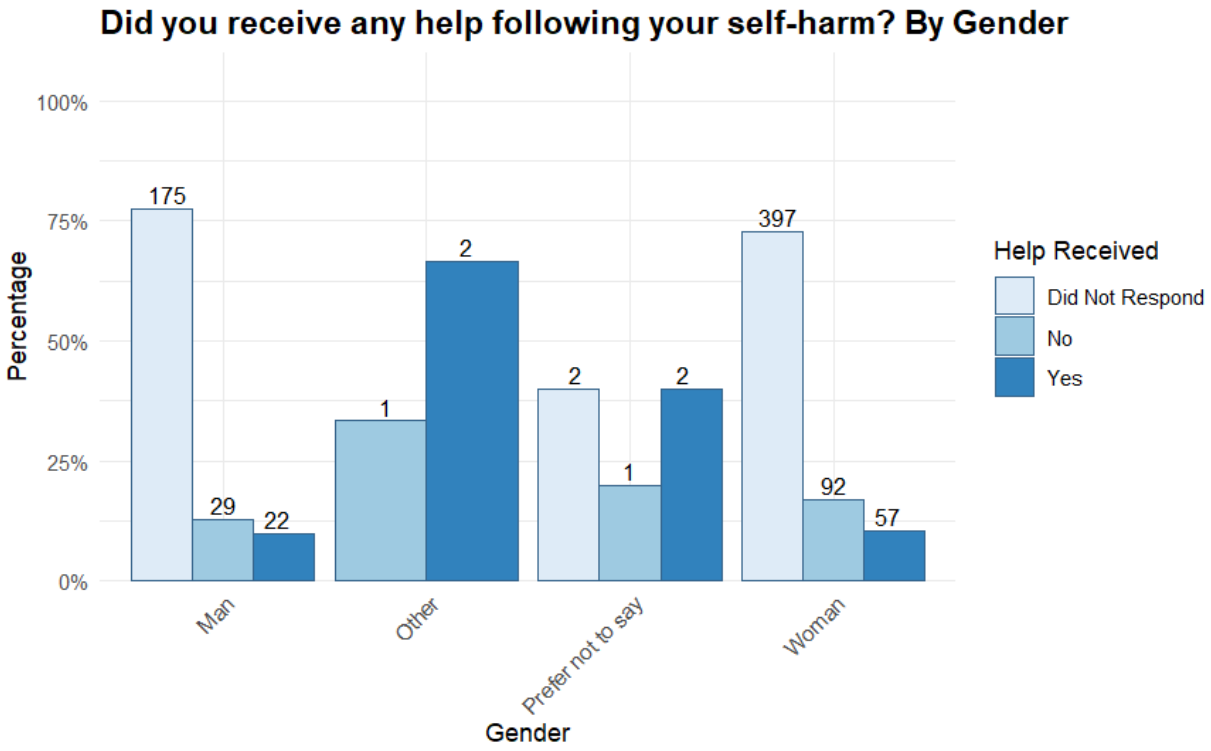
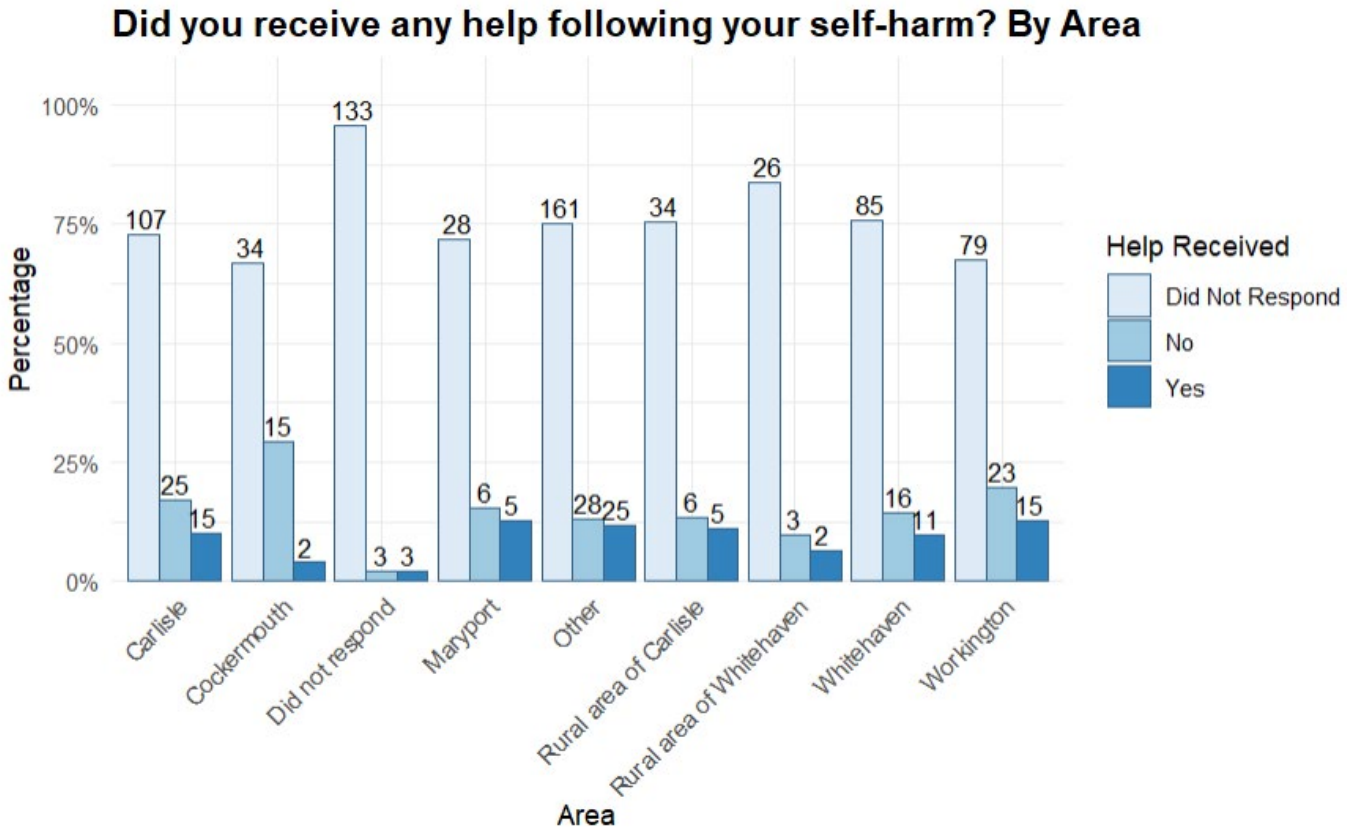


Figure 13. Distribution of responses by area to the question "Did you receive any help following your self-harm?"



Relationship between help received and self-harm behaviour

A chi-square test of independence was performed to examine the relationship between responses to the question "Did you receive help for your thoughts about self-harm?" and "Have you previously self-harmed?". The relation between these variables was not significant, $X2(1, N=365) = 0.52$, $p=.47$. This suggests that there was no association between receiving help for thoughts relating to self-harm, and subsequent self-harming behaviours.

Suicide

Thoughts about Suicide

755 participants responded to the question, "Have you previously had any suicidal thoughts?". Among those, 56% indicated they have experienced suicidal thoughts. Figure 14 presents the breakdown of responses by age, showing that individuals aged 26–40 were the most likely to have experienced suicidal thoughts, followed by those aged 41–59 and 18–25. Additional breakdowns are provided in Figure 15 by gender and Figure 16 by location. Figure 15 shows that women were slightly more likely than men to report having had suicidal thoughts, while all respondents identifying as 'Other' and those who preferred not to say reported experiencing them. Figure 16 shows that reports of suicidal thoughts were broadly consistent across areas, with slightly higher proportions observed in Workington, Whitehaven, and rural areas of Carlisle compared to other locations such as Cockermouth and Maryport.

Figure 14. Distribution of responses by age for the question: Have you previously had any suicidal thoughts?

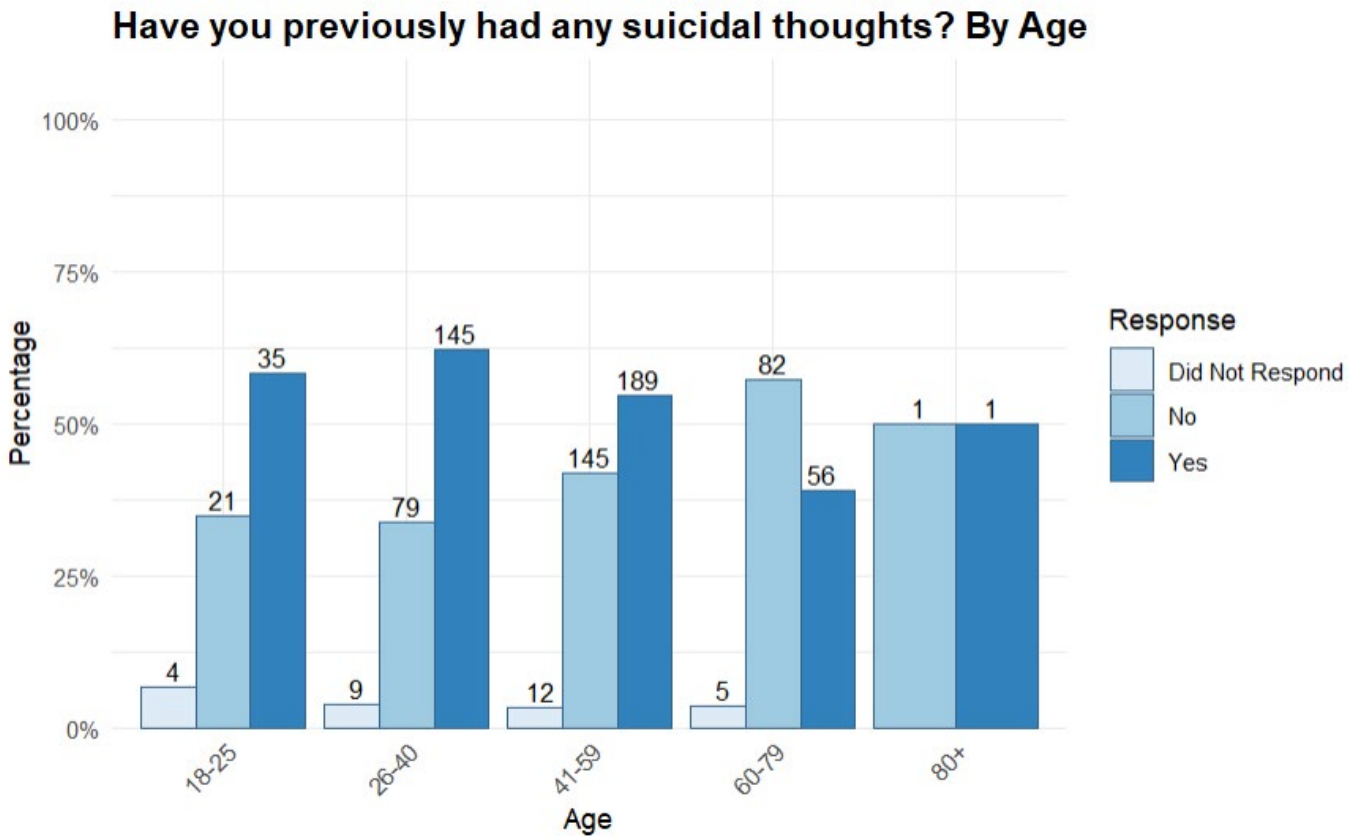


Figure 15. Distribution of responses by gender for the question: Have you previously had any suicidal thoughts?

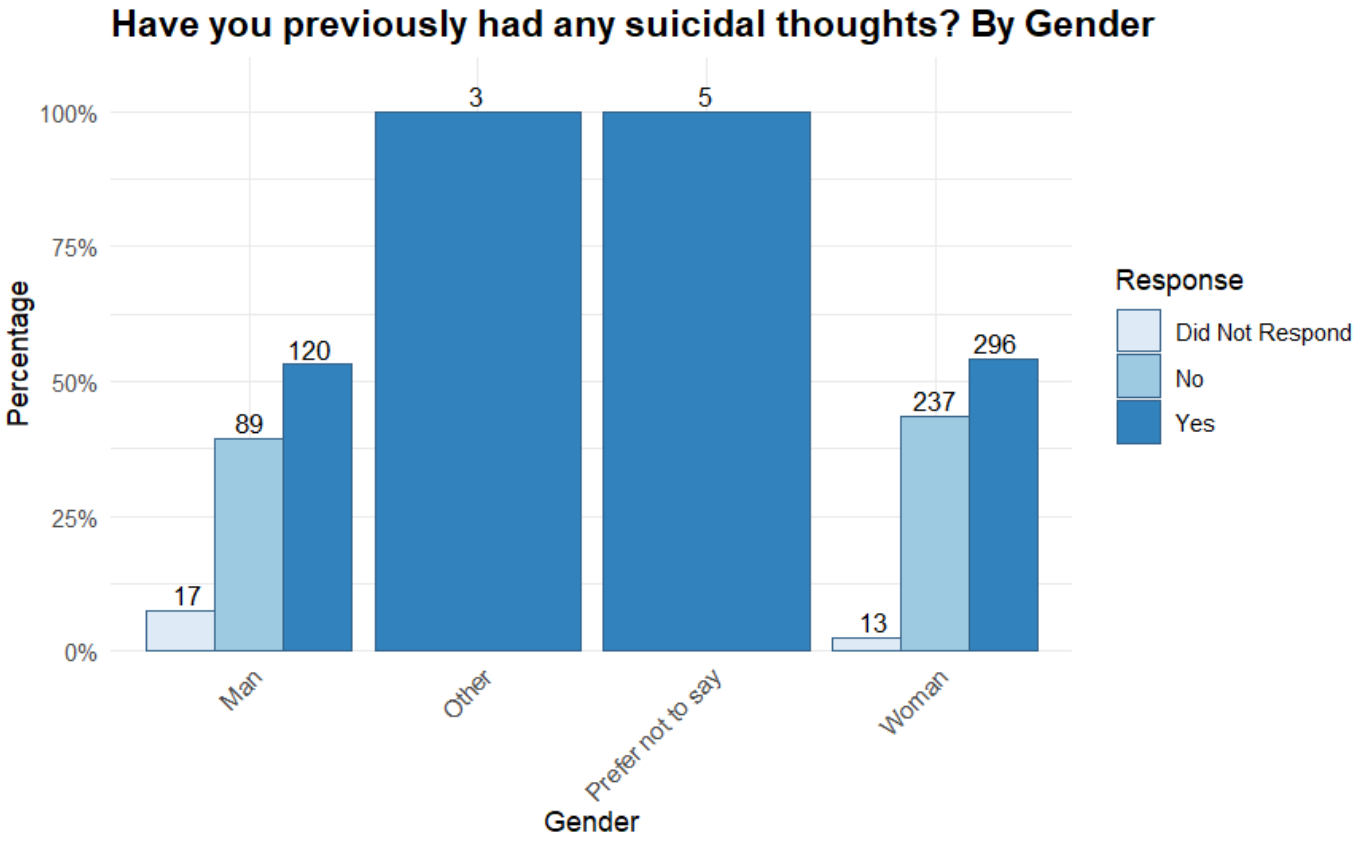
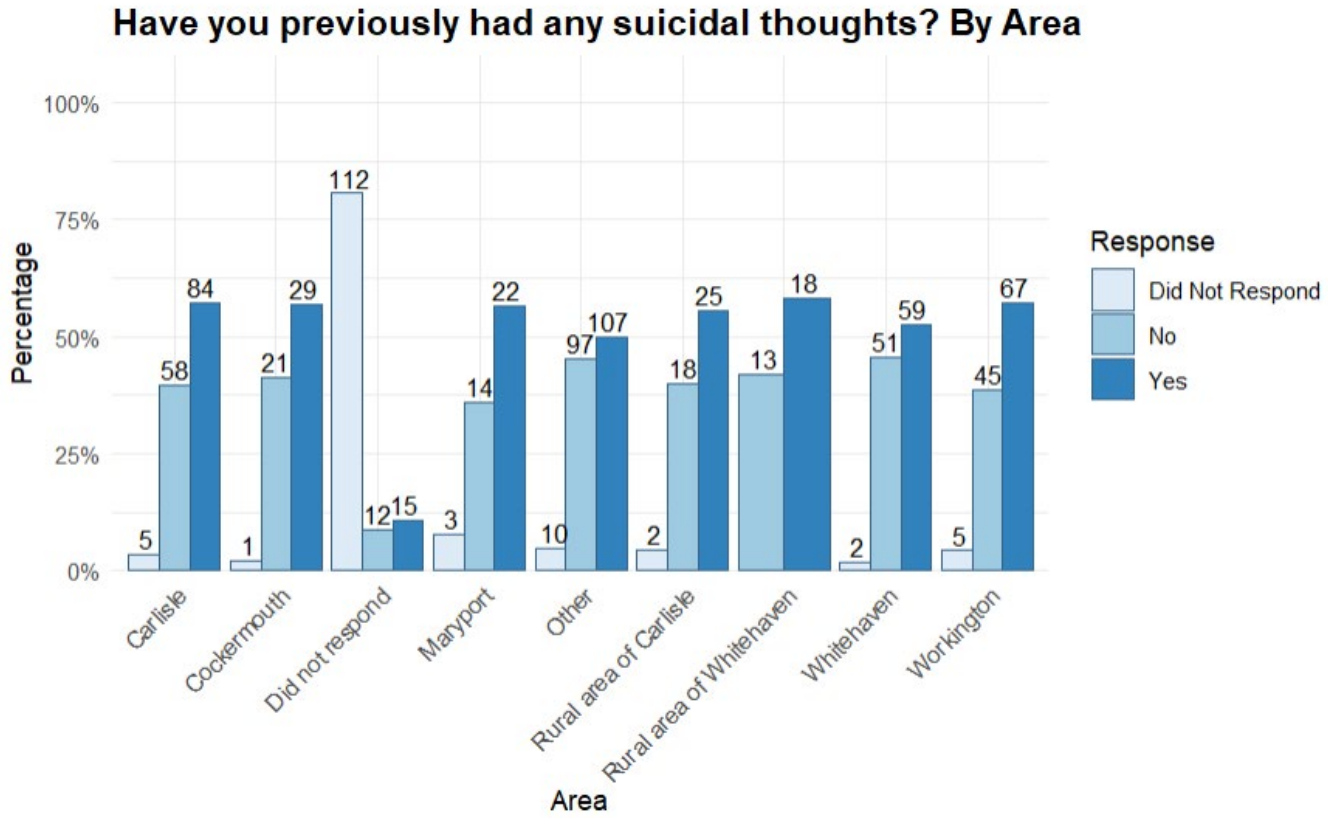


Figure 16. Distribution of responses by area for the question: Have you previously had any suicidal thoughts?



When asked if they received help following these thoughts (n=413), 47% reported receiving help, and 53% stated they had not received help. Figure 17 shows the breakdown of responses by age, indicating that individuals aged 28–40 were the only age group more likely to have received help than not, compared to other age groups. Additional breakdowns are presented in Figure 18 by gender and Figure 19 by location. Figure 18 presents the distribution of responses by gender, showing that men were less likely than women to have received help for suicidal thoughts, suggesting possible gendered differences in help-seeking behaviour. Figure 19 illustrates the distribution by location, showing variation across areas, with particularly low levels of reported support in Maryport compared to other locations such as Whitehaven and Workington.

Figure 17. Distribution of responses by age for the question: Did you receive any help for your suicidal thoughts?

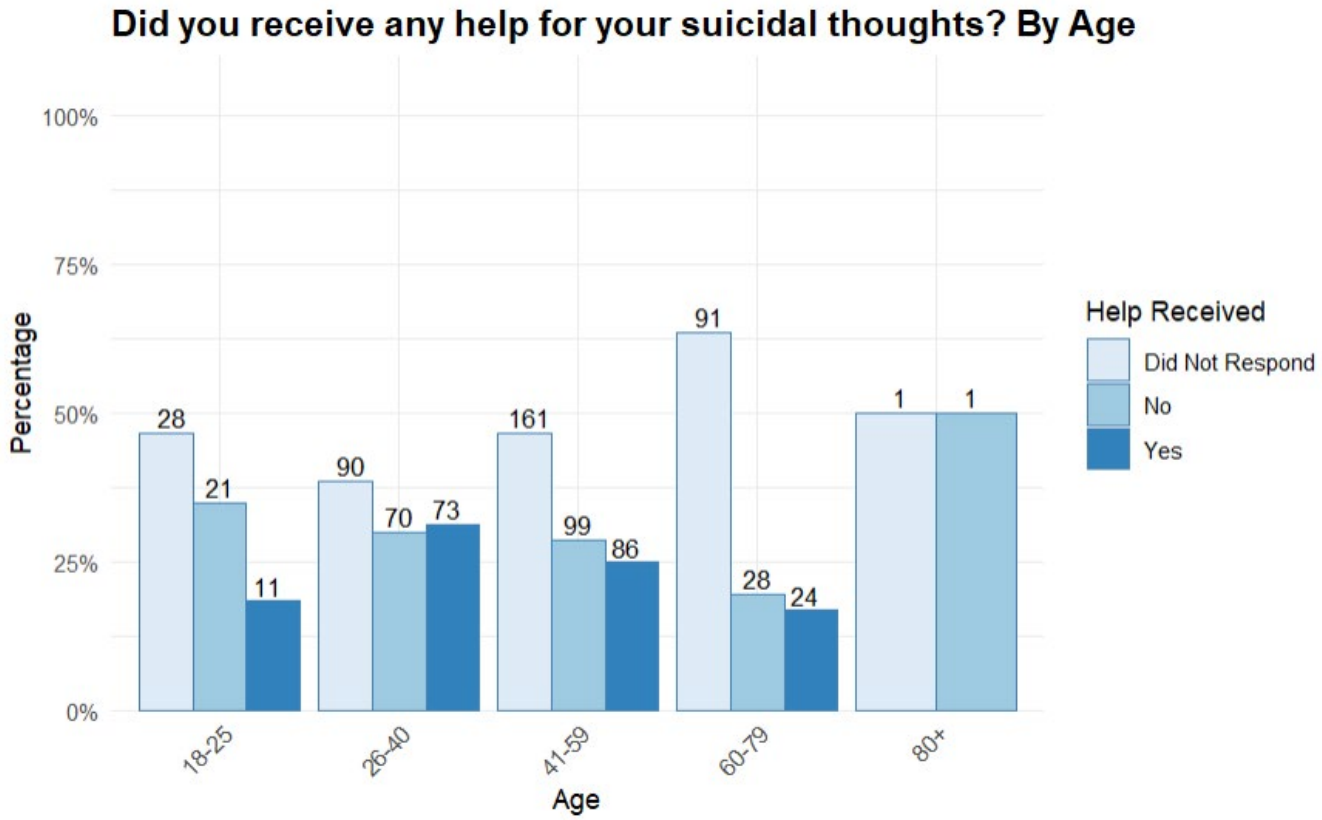


Figure 18. Distribution of responses by gender for the question: Did you receive any help for your suicidal thoughts?

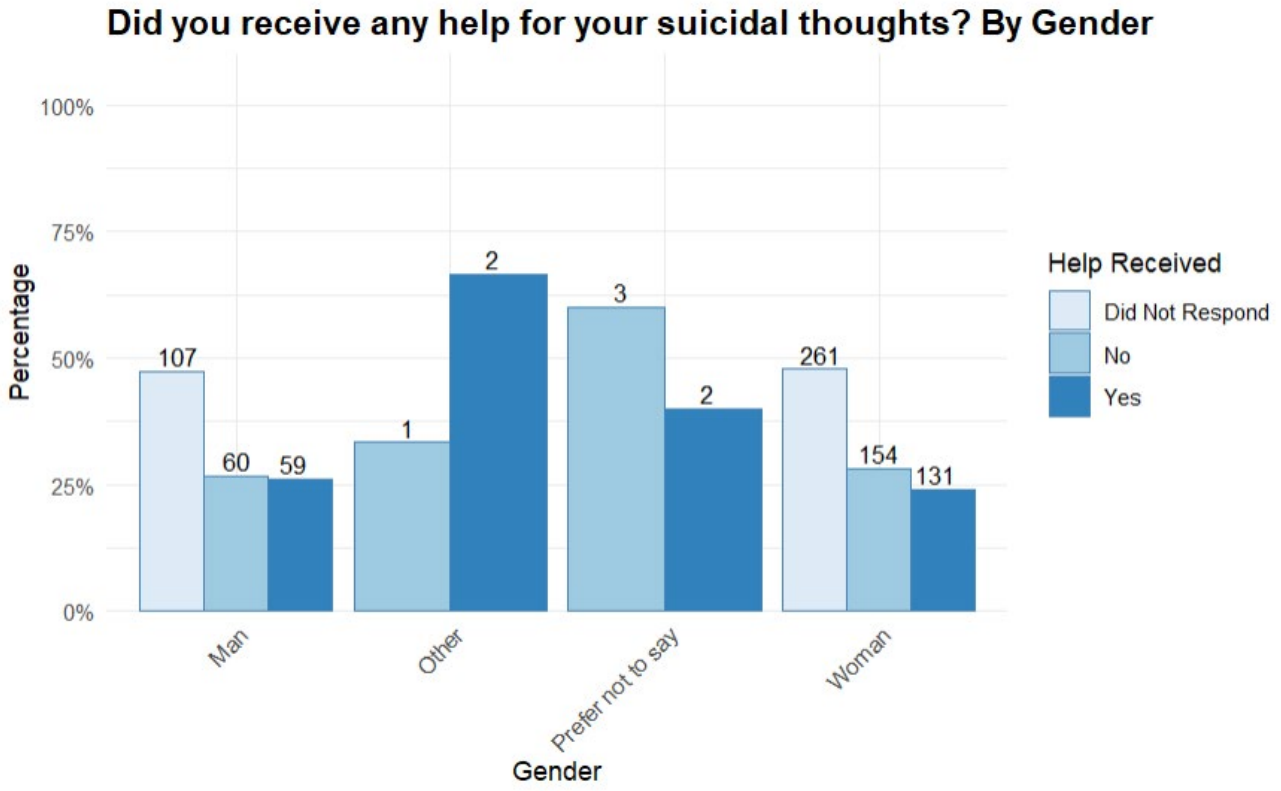
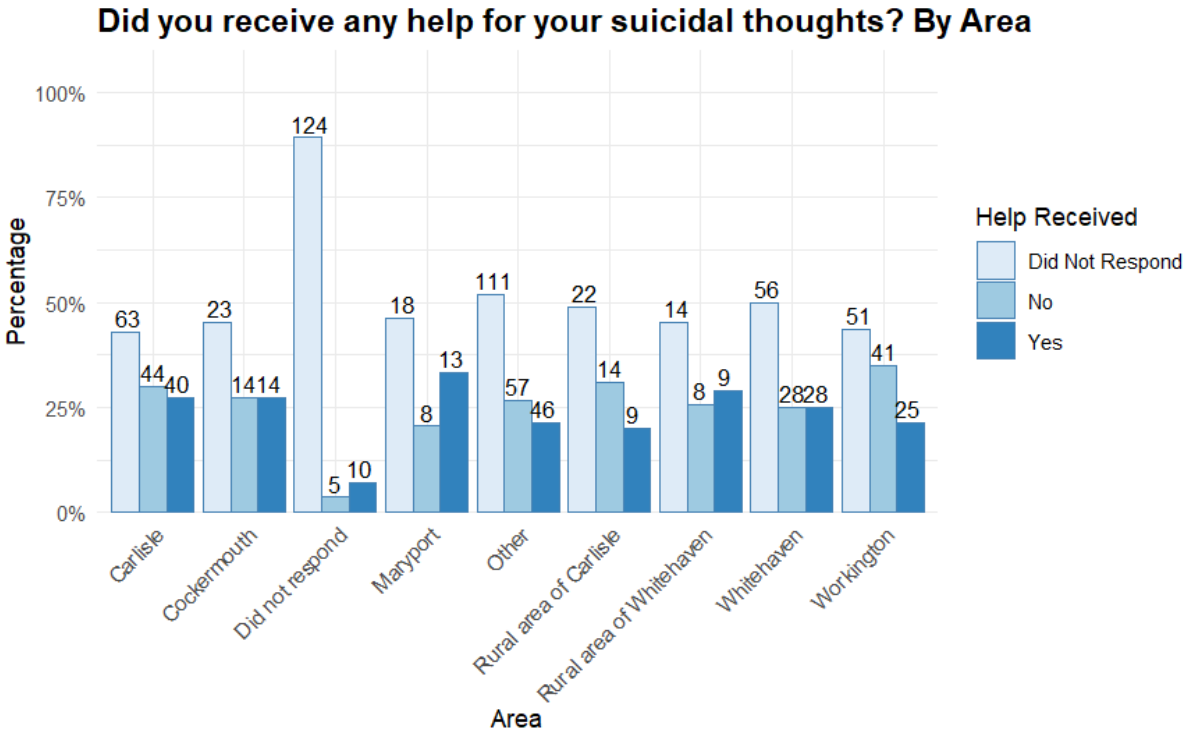


Figure 19. Distribution of responses by area for the question: Did you receive any help for your suicidal thoughts?



Suicide Attempts

743 participants responded to the question, "Have you previously had any suicide attempt?". Among those, the majority (81%) reported that they had not made any previous suicide attempts, while 19% indicated that they had. Figure 20 presents the distribution of responses by age, Figure 21 by gender, and Figure 22 by location, revealing consistent results across all demographic groups.

Figure 21 presents the distribution of responses by gender, showing that men and women reported similar proportions of previous suicide attempts, reflecting a pattern consistent with earlier findings on self-harm thoughts. All respondents identifying as 'Other' also reported a history of suicide attempts, while those who preferred not to say were less likely to provide a response. Figure 22 presents the distribution of responses by location, showing broadly similar patterns across areas, though the proportion of respondents reporting previous suicide attempts was notably higher in Workington relative to its population size. This finding may indicate concentrated need or higher reporting rates in that locality compared with other areas such as Whitehaven or Cockermouth.

Figure 20. Distribution of responses by age for the question: Have you previously had any suicide attempt?

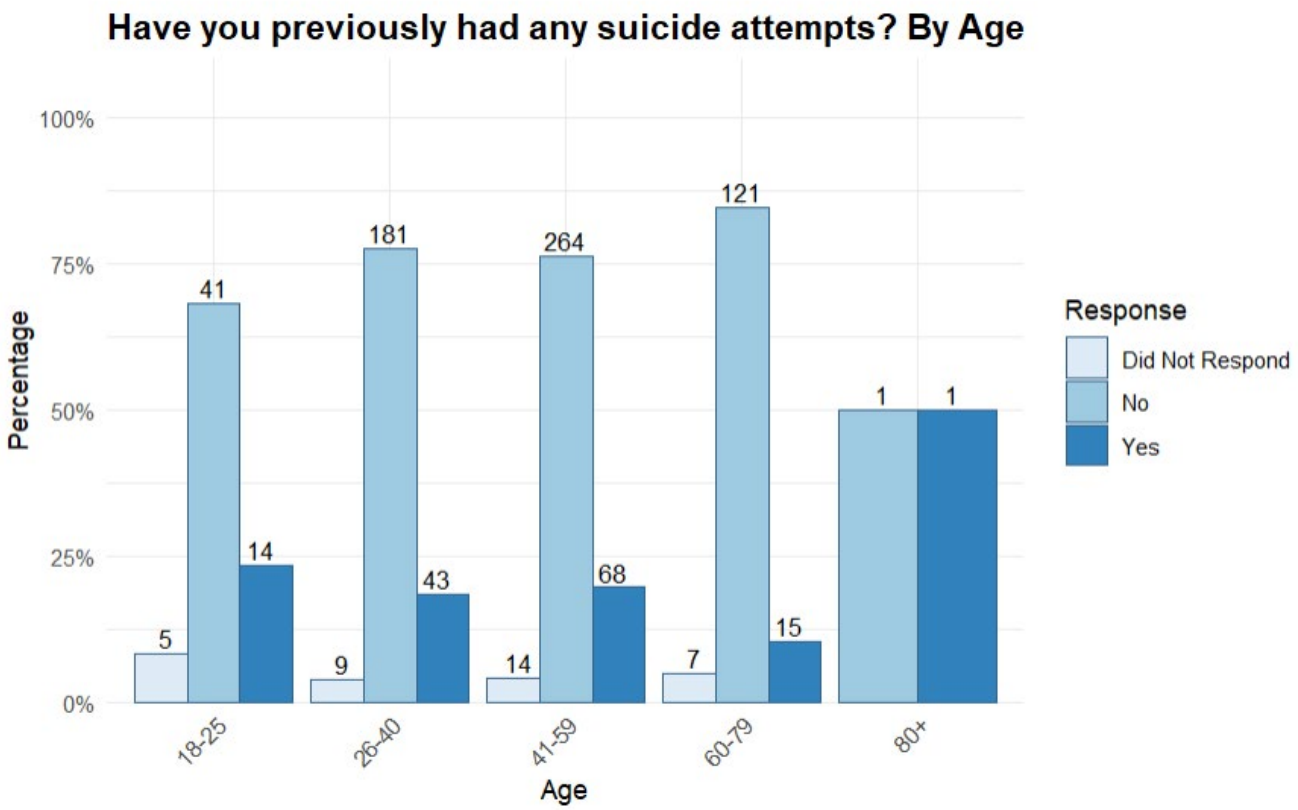


Figure 21. Distribution of responses by gender for the question: Have you previously had any suicide attempt?

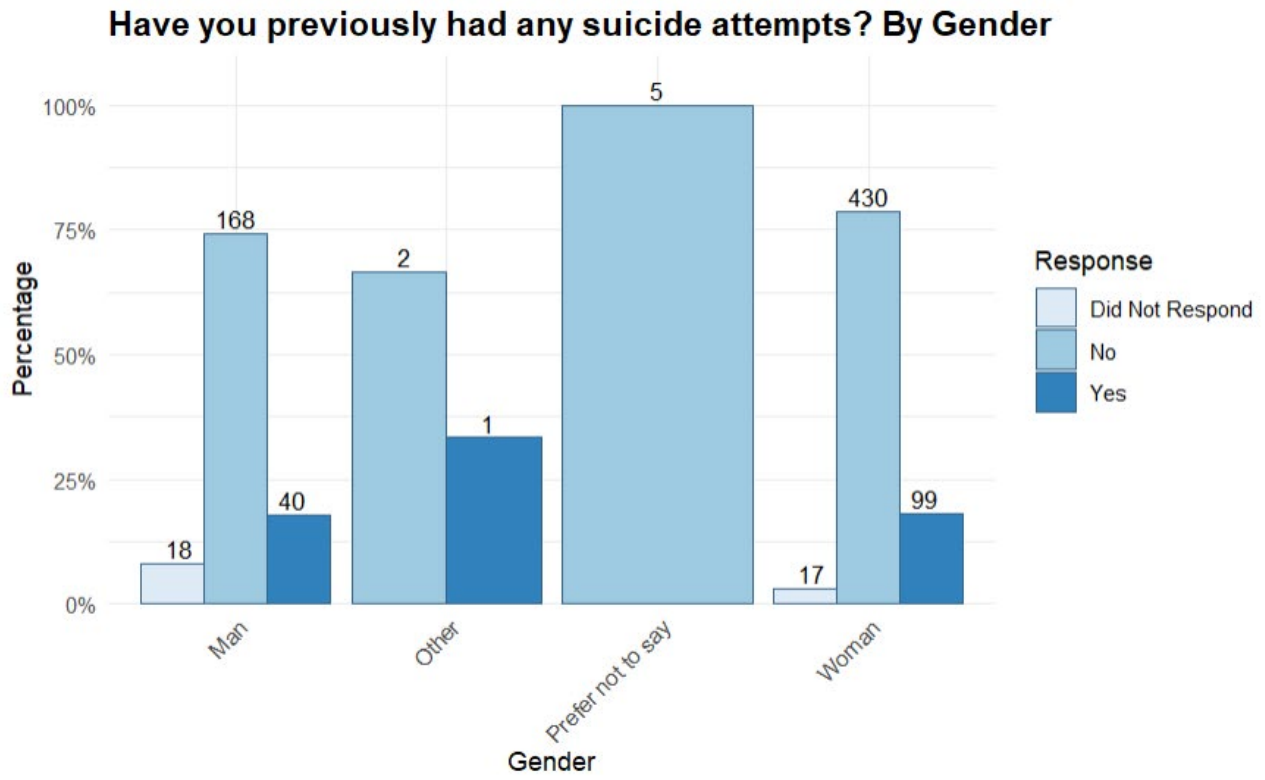
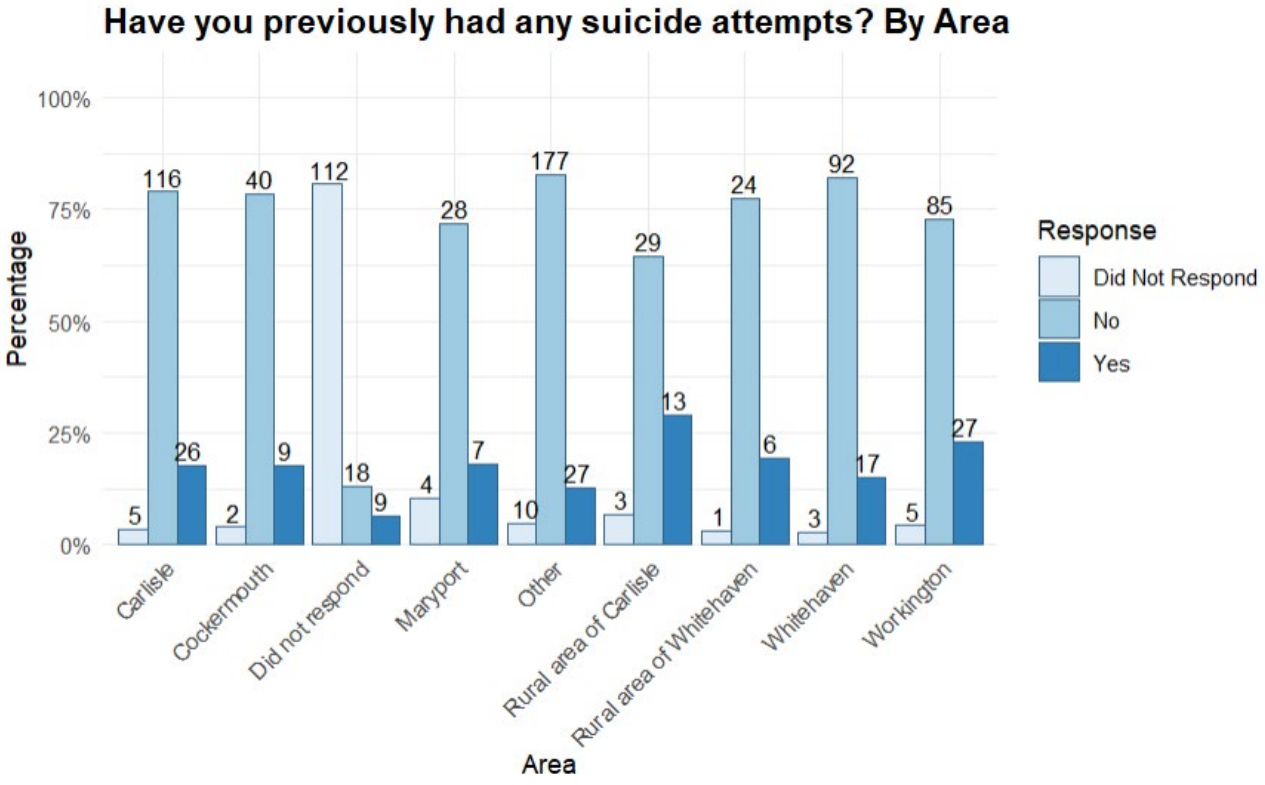


Figure 22. Distribution of responses by area for the question: Have you previously had any suicide attempt?



A significant portion of respondents who answered the follow-up question (n=131) indicated that they had received help following their attempt (61%), while just over a third (39%) reported not receiving any help. Figure 23 shows the distribution of responses by age, indicating that in all age groups, receiving help was more likely than not receiving help. Figure 24 shows the distribution of responses by gender, while Figure 25 displays the distribution by location.

Figure 24 presents the distribution of responses by gender, showing that men were considerably less likely than women to have received help following a suicide attempt. This pattern reflects the broader trend across earlier figures, where men consistently reported lower levels of help-seeking for suicidal thoughts and self-harm. Figure 25 presents the distribution of responses by location, showing low levels of help received following a suicide attempt across all areas. Notably, this pattern differs from earlier findings (see Figure 19), with Maryport showing a slightly higher proportion of respondents who received support, while rates in Workington were comparatively lower, suggesting possible variation in post-attempt service access between localities.

Figure 23. Distribution of responses by age for the question: Did you receive any help following your suicide attempt?

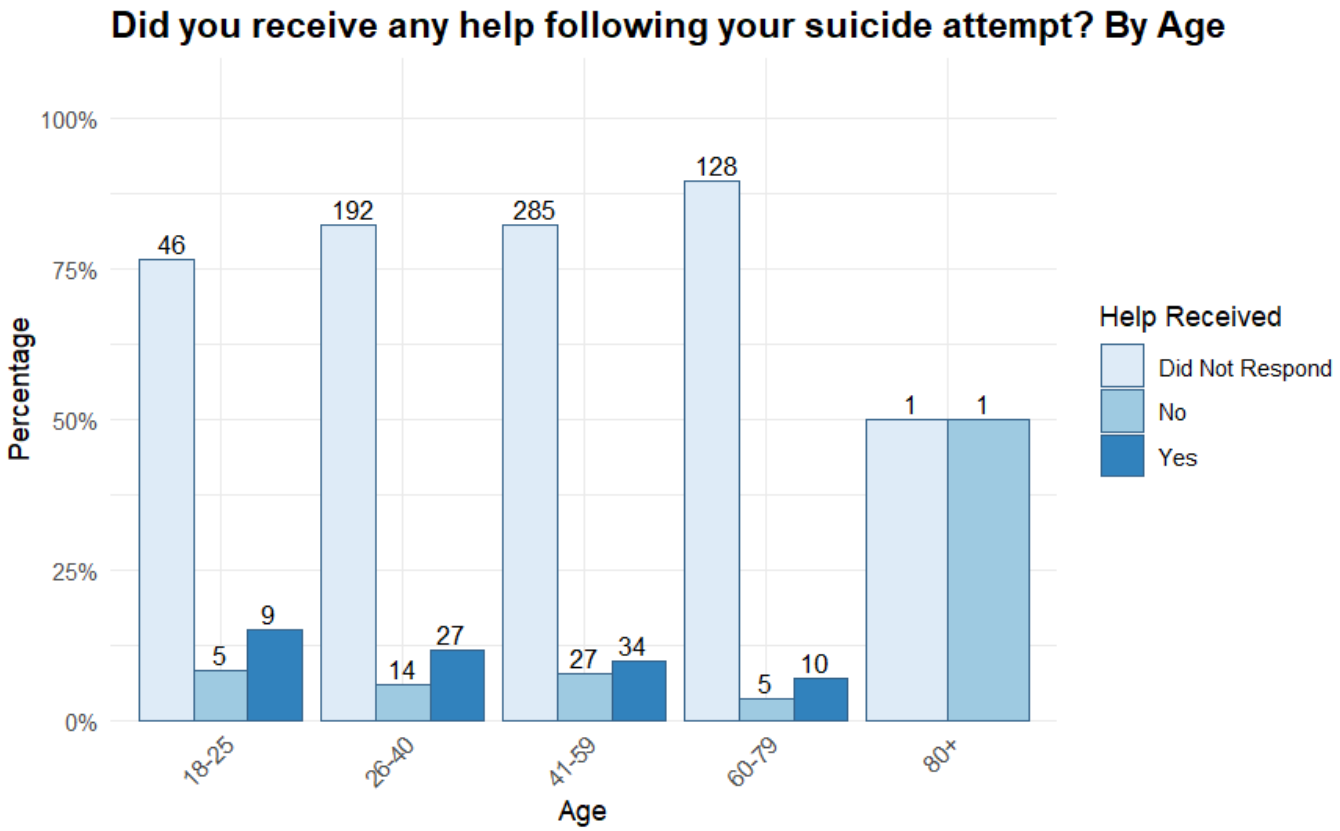


Figure 24. Distribution of responses by gender for the question: Did you receive any help following your suicide attempt?

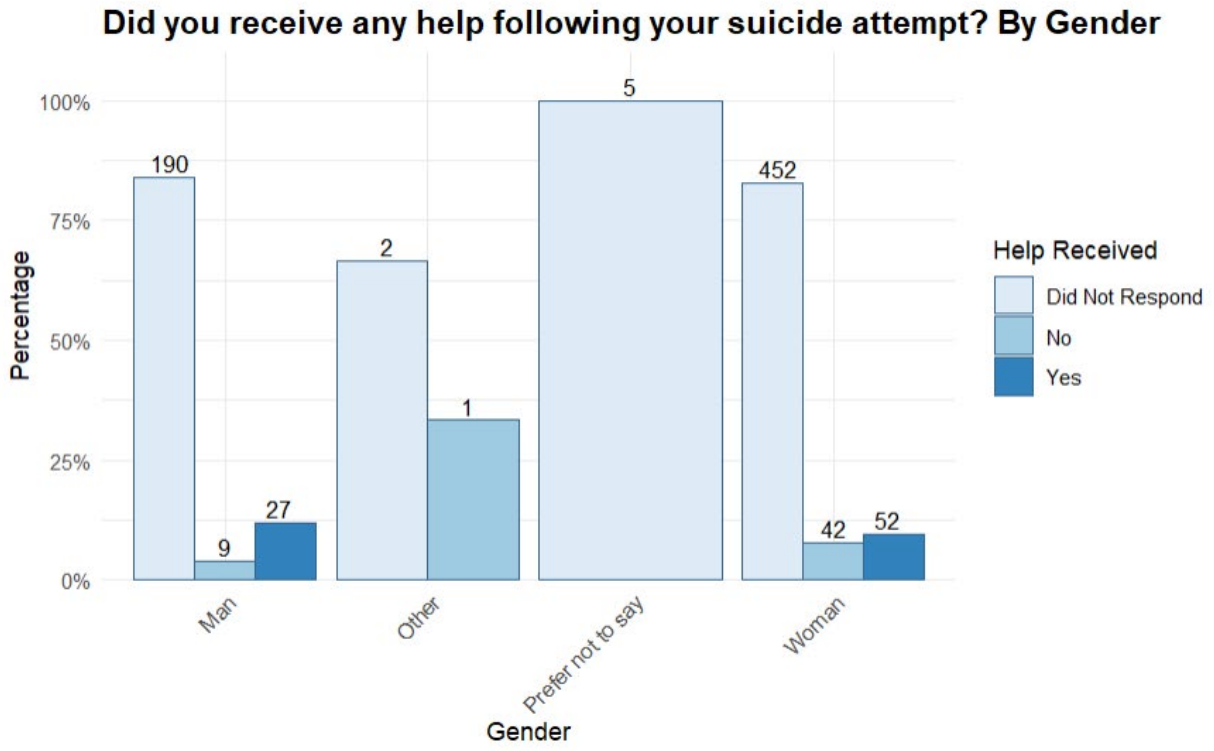
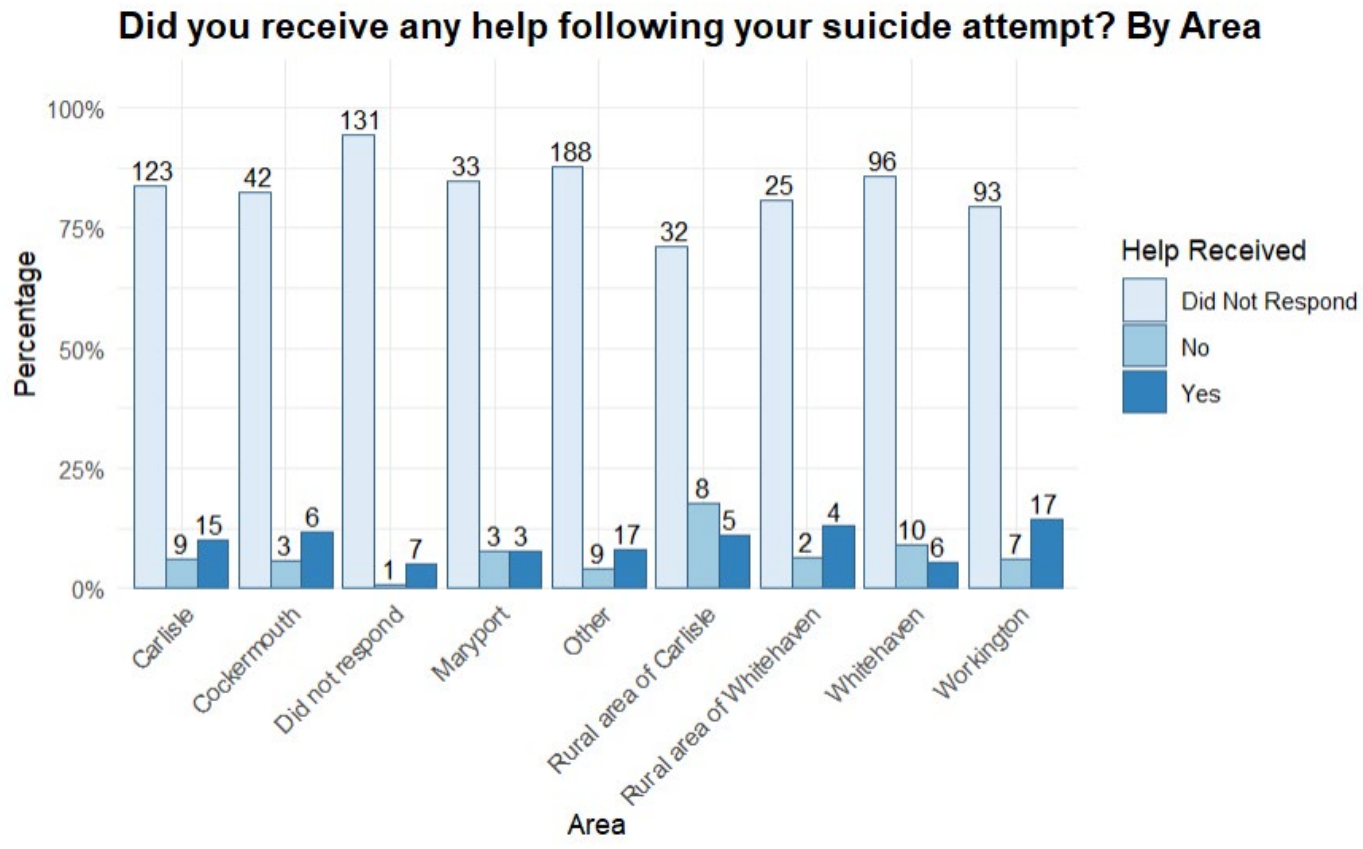


Figure 25. Distribution of responses by area for the question: Did you receive any help following your suicide attempt?



Relationship between help received and suicide attempt

A Chi-square test of independence was performed to examine the relationship between responses to the questions "Did you receive help for your suicidal thoughts?" and "Have you previously had any suicide attempts?". The association between these variables was significant, $X^2(1, N = 410) = 11.51$, $p < .05$. This indicates that individuals who did not receive help for their suicidal thoughts were significantly more likely to report a previous suicide attempt than those who had received help. In other words, accessing support for suicidal thoughts appeared to be associated with a lower likelihood of having made an attempt, highlighting the potential protective role of timely intervention.

Bereavement/Affected by Suicide

Bereaved or affected by the death of someone by suicide

There were 781 respondents to the question "Have you been bereaved or affected by the death of someone by suicide?". 52% of the sample said that they have been bereaved by suicide. Figure 26 shows the breakdown of responses by age, while Figure 27 presents the distribution by gender and Figure 28 by location.

Figure 26. Distribution of responses by age for the question: Have you been bereaved or affected by the death of someone who died by suicide?

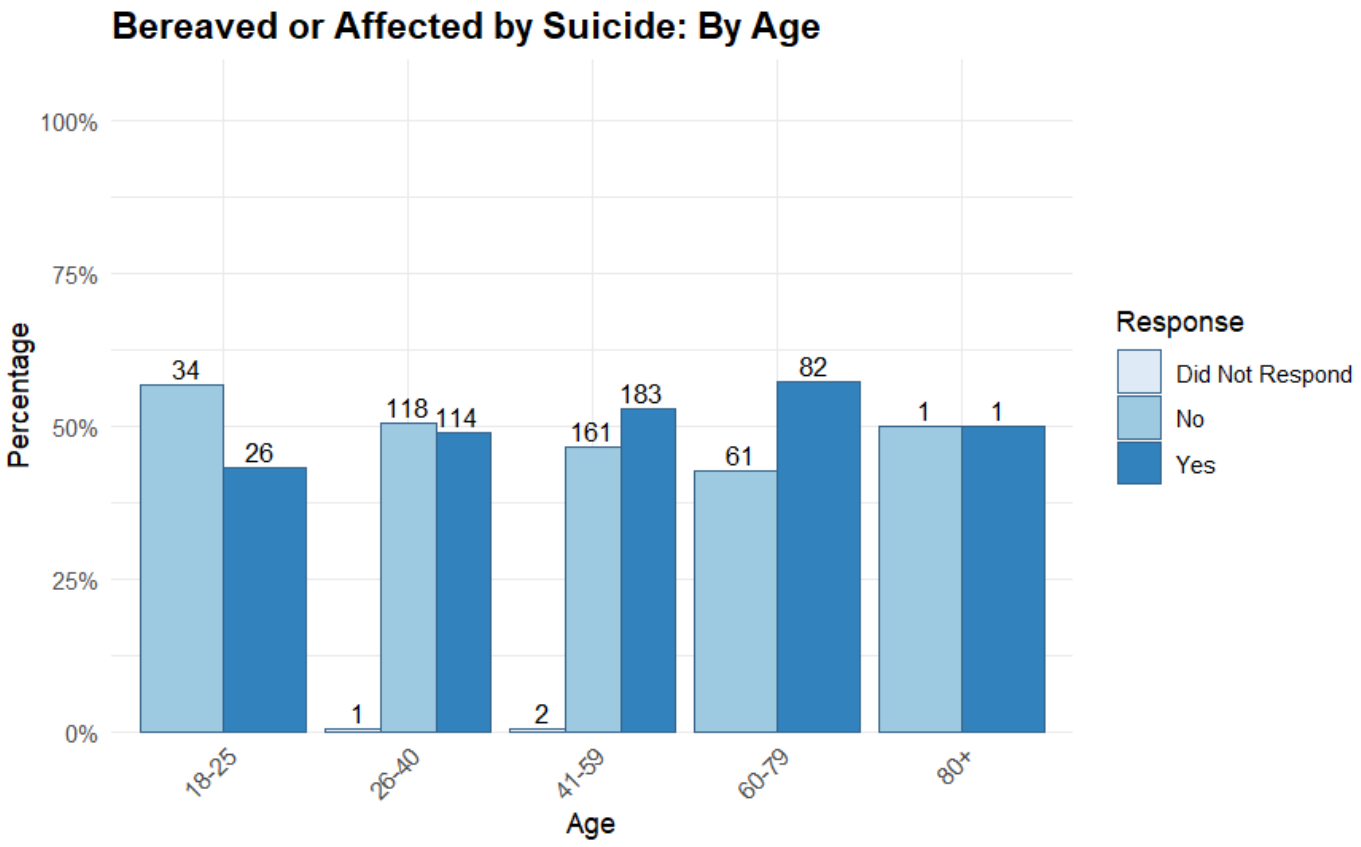


Figure 27. Distribution of responses by gender for the question: Have you been bereaved or affected by the death of someone who died by suicide?

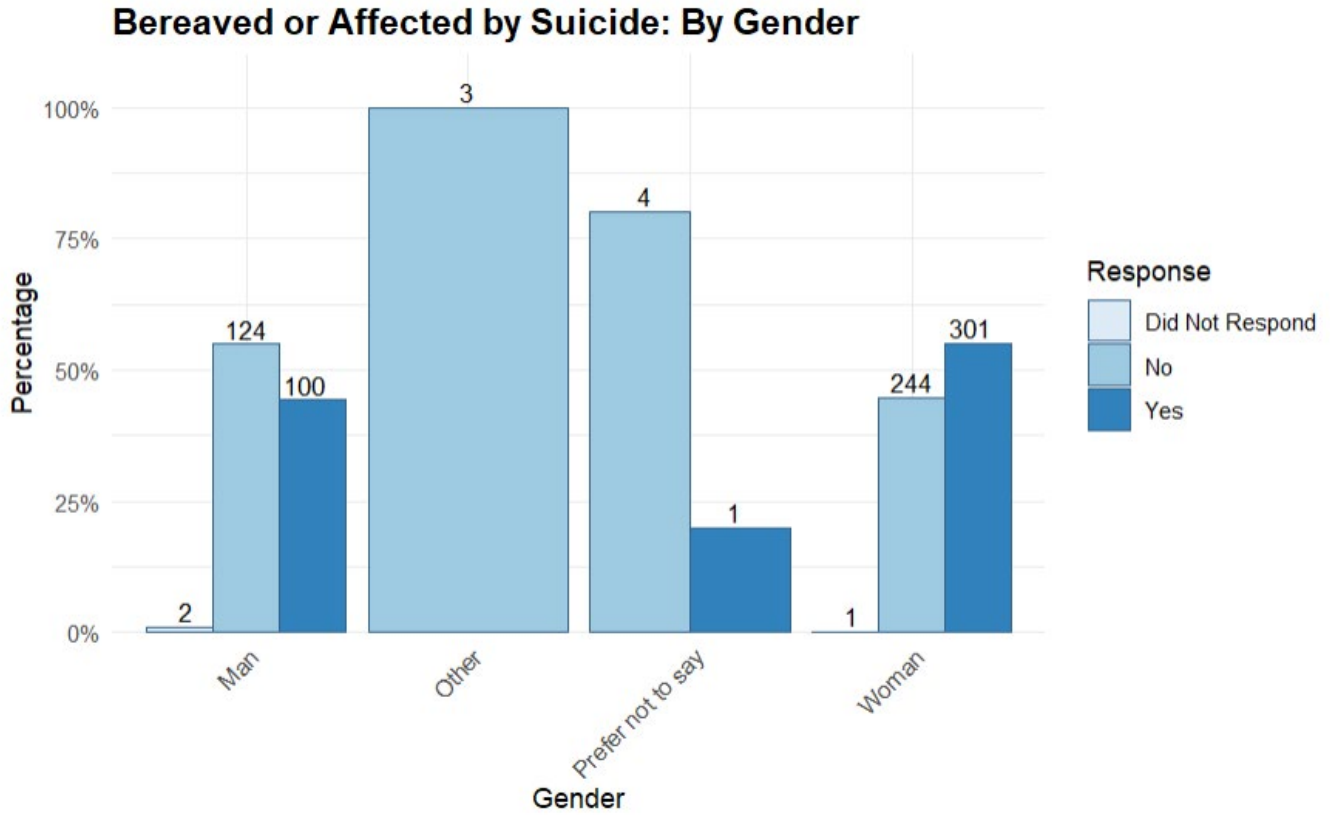
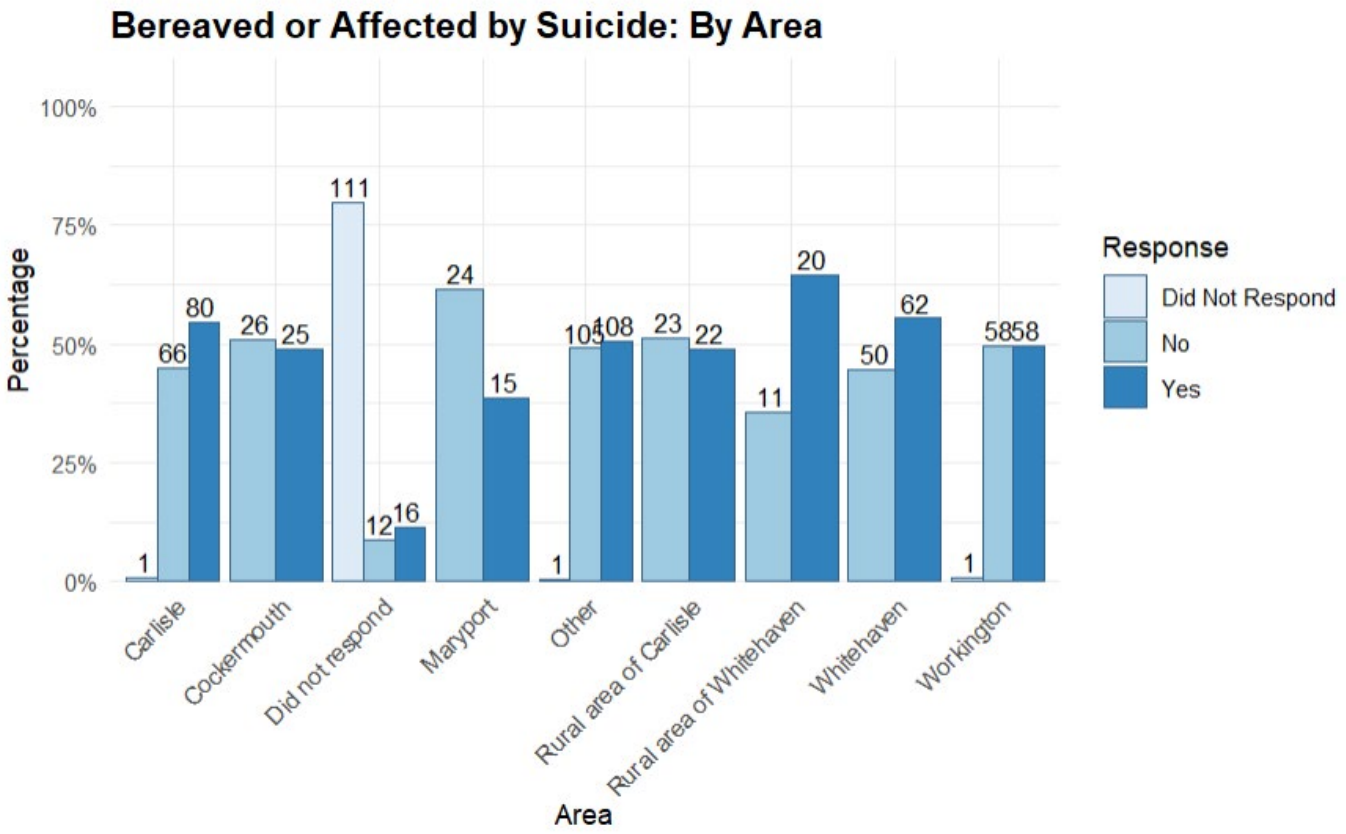


Figure 28. Distribution of responses by area for the question: Have you been bereaved or affected by the death of someone who died by suicide?

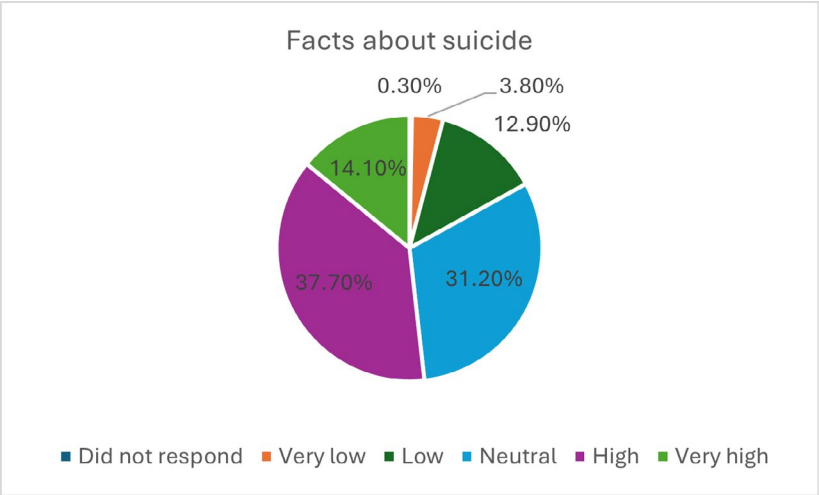


Knowledge, SelfConfidence, and Attitudes Survey

Knowledge

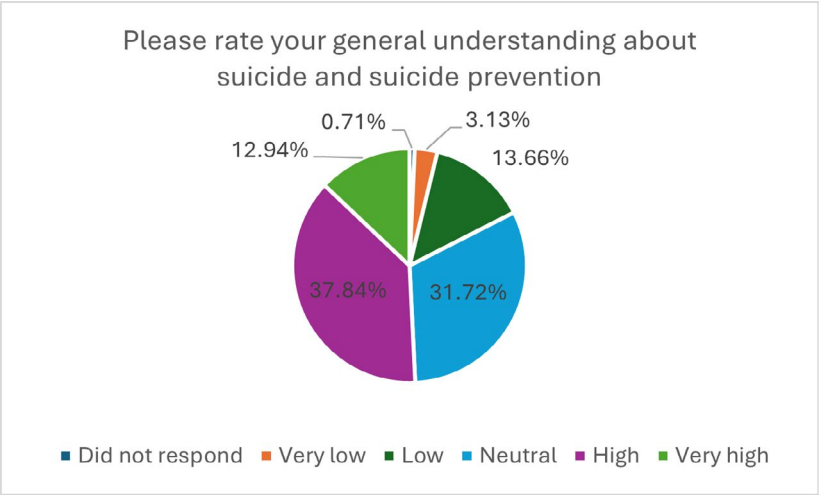
Most participants reported a strong understanding of suicide and suicide prevention, and this finding was consistent across all items in the Knowledge subscale. Regarding facts about suicide, 37.7% of participants reported a high understanding, followed by 31.2% who rated their understanding as neutral, and 14.1% who rated it as very high.

Figure 29. Understanding of facts about suicide.



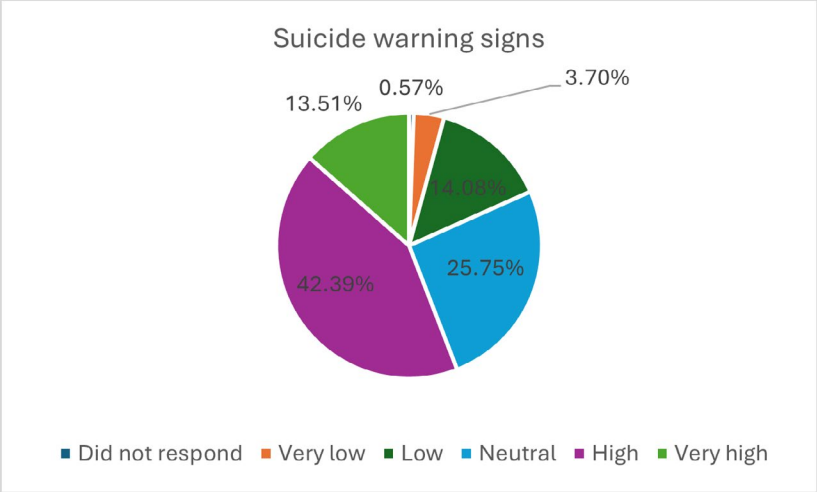
For general understanding of suicide and suicide prevention, 37.8% of participants rated their understanding as high, followed by 31.7% who rated it as neutral, implying uncertainty or a lack of confidence in their knowledge, and 13.7% who rated it as low.

Figure 30. Understanding suicide and suicide prevention.



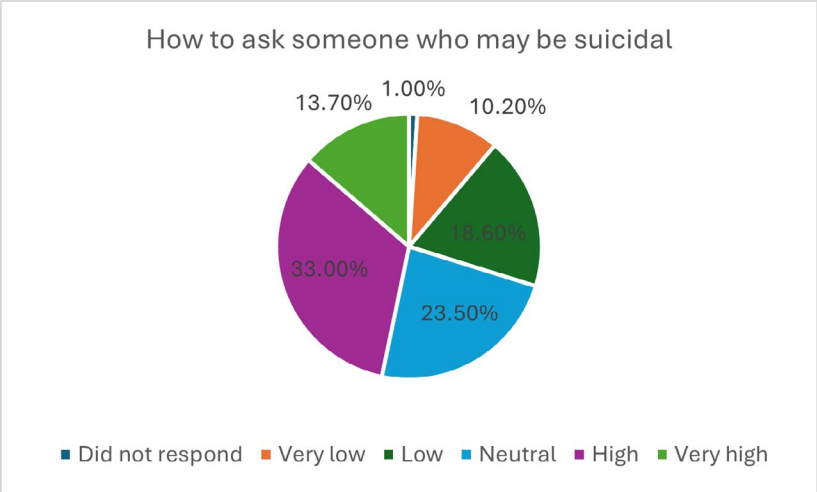
The majority also rated their understanding of suicide warning signs as high, with 42.4% indicating their knowledge as high, followed by 25.7% who rated it as neutral, and 14.1% who rated it as low.

Figure 31. Understanding suicide warning signs.



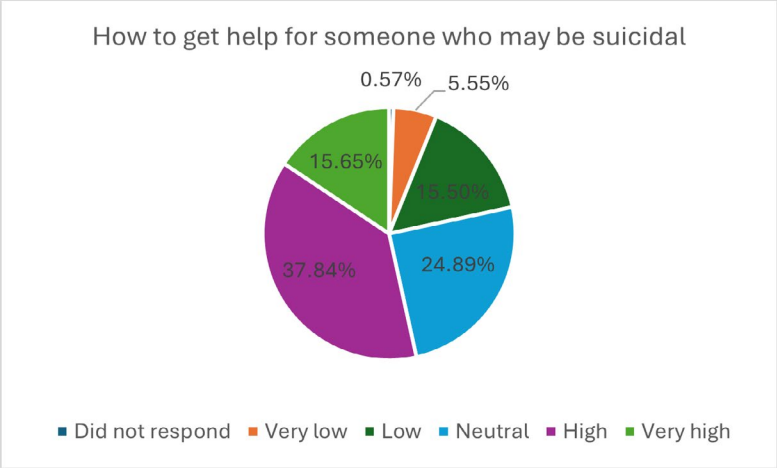
In response to items related to seeking help for others, most participants indicated a strong understanding of how to approach someone who may be suicidal, with 33% reporting a high level of understanding, followed by 23.5% who rated their understanding as neutral and 18.6% who rated it as low.

Figure 32. Understanding of how to ask someone if they are suicidal.



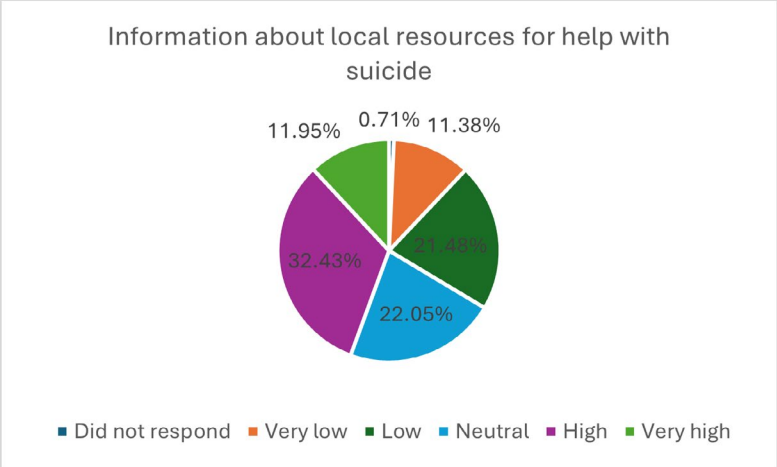
For understanding how to help someone who may be suicidal, 37.8% of participants rated their understanding as high, followed by 24.9% who rated it as neutral and 15.6% as very high.

Figure 33. Understanding of how to get help for someone who may be suicidal.



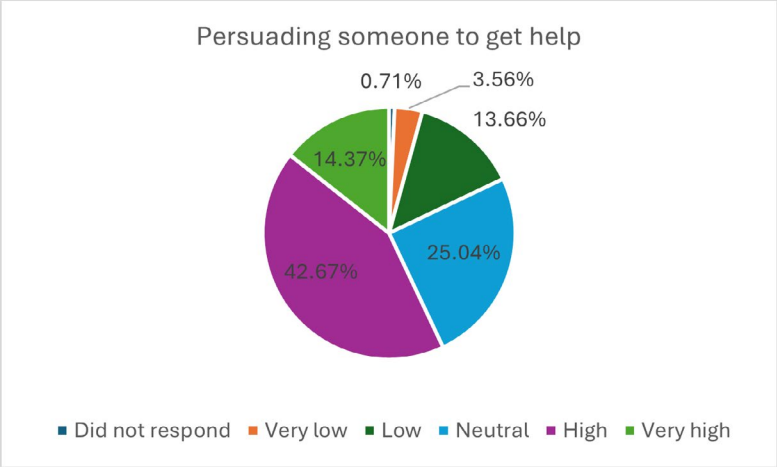
Participants rated their understanding of local resources as high, with 32.4% suggesting a high level of understanding and an awareness of support options in the local area, followed by 22.0% who rated it as neutral and 11.95% as very high.

Figure 34. Understanding of the local resources for suicide prevention.



Finally, regarding persuading someone to get help, 42.7% of participants rated their understanding as high, followed by 25% who rated it as neutral, and 14.4% who rated it as very high. In general, participants showed confidence in their ability to encourage someone to seek help.

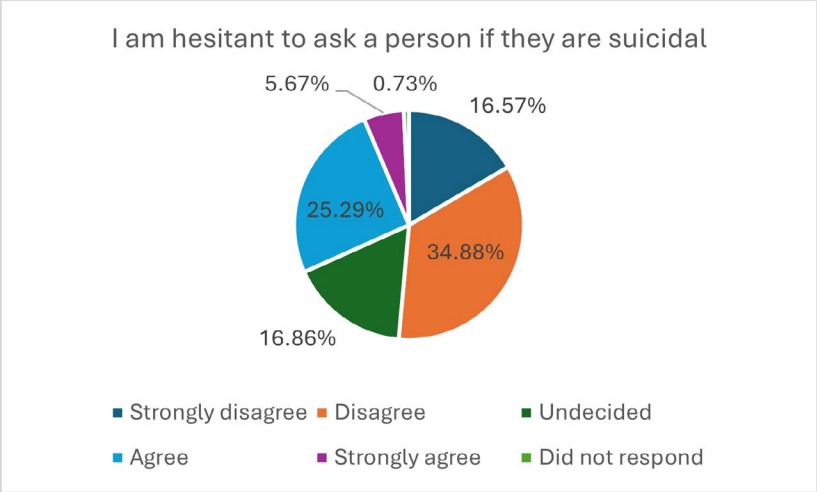
Figure 35. Understanding of how to persuade someone to get help.



3.5.2 Self-Confidence

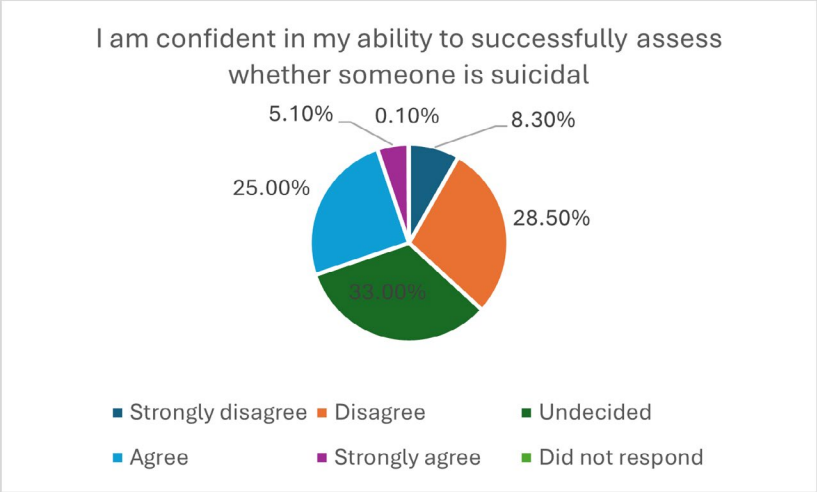
Participants showed a mix of feelings about asking someone if they are suicidal. While 34.9% disagreed or strongly disagreed with the statement, indicating that they are not hesitant to ask, 25.3% agreed or strongly agreed, suggesting that a quarter of respondents feel unsure or hesitant to bring up the topic of suicide. 16.9% were undecided, which highlights some uncertainty about the question.

Figure 36. Confidence in asking a person if they are suicidal.



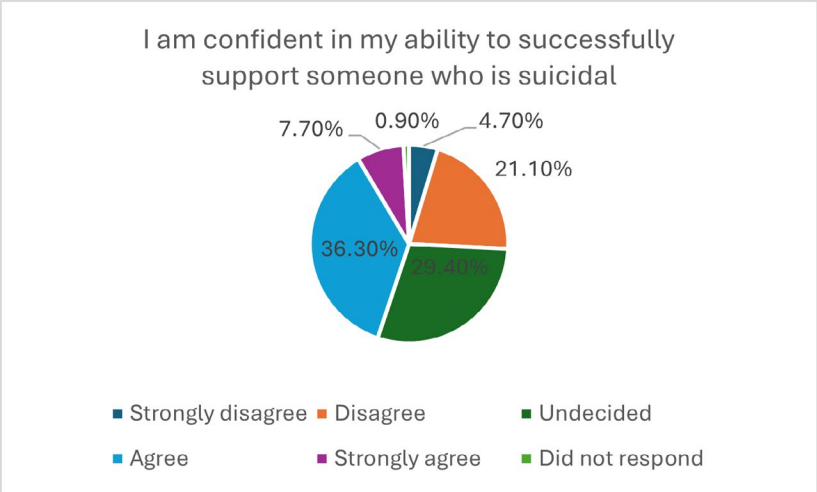
For the statement, "I am confident in my ability to successfully assess whether someone is suicidal," 8.3% strongly disagreed, 28.5% disagreed, and 33% were undecided. Meanwhile, 25% agreed, 5.1% strongly agreed, and 0.1% did not respond, suggesting a general lack of certainty in regards to accurately assessing whether someone is suicidal.

Figure 37. Confidence in assessing whether someone is suicidal.



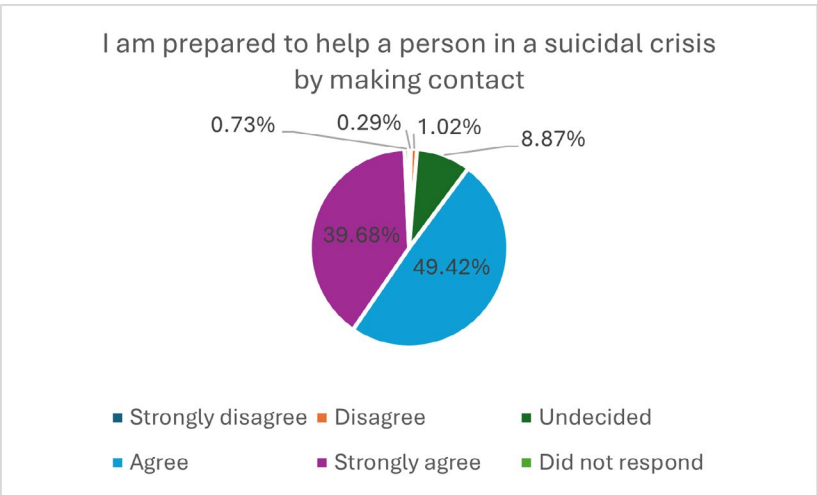
In contrast, participants demonstrated greater confidence in their ability to support someone who may be suicidal, with 4.7% strongly disagreeing, 21.1% disagreeing, and 29.4% undecided, while 36.3% agreed, 7.7% strongly agreed, and 0.9% did not respond.

Figure 38. Confidence in supporting someone who is suicidal.



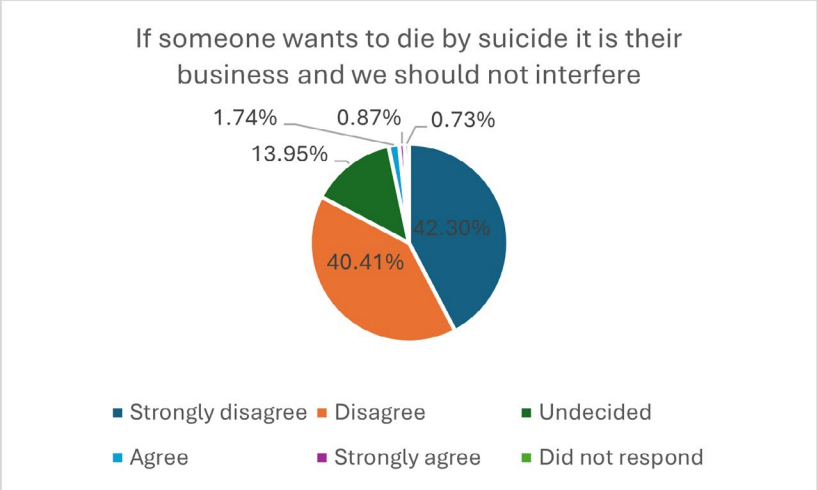
A significant proportion of participants reported that they were confident in making contact with someone who may be suicidal, with 39.7% strongly agreeing and 49.4% agreeing, indicating that they are prepared to help by making contact. A small percentage (1.02%) disagreed with the statement, and only 0.29% strongly disagreed.

Figure 39. Confidence in helping a person who is suicidal by making contact.



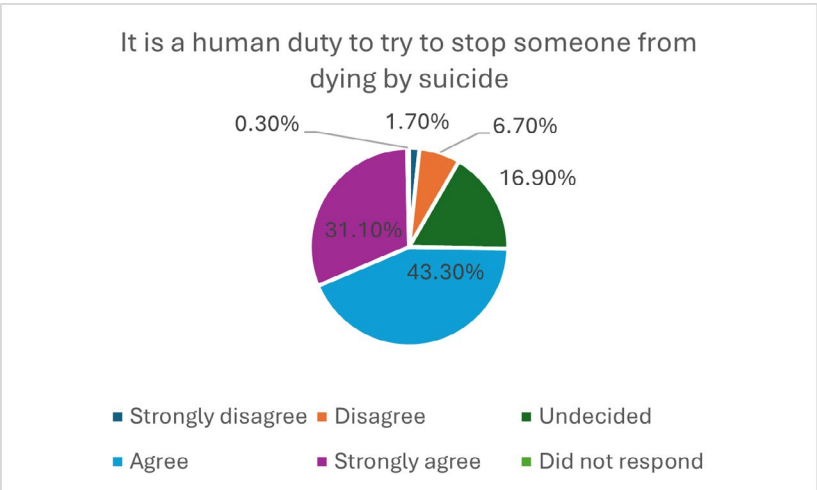
The findings for the statement, "If someone wants to die by suicide, it is their business and we should not interfere" show strong opposition to the idea of non-interference. The majority of participants, 42.3%, strongly disagreed with the statement, indicating that they believe intervention is necessary when someone expresses suicidal intentions. An additional 40.41% disagreed, further supporting the view that suicide should not be treated as a private matter. Meanwhile, 13.95% were undecided, reflecting some uncertainty or lack of a clear stance on the issue.

Figure 40. Responses to "If someone wants to die by suicide, it is their business, and we should not interfere."



The findings for the statement, "It is a human duty to try to stop someone from dying by suicide," show strong support for the idea of intervention. The majority of participants, 43.30%, agreed with the statement, indicating that they believe it is a human duty to intervene in suicide situations, 31.10% strongly agreed, and 16.90% were undecided.

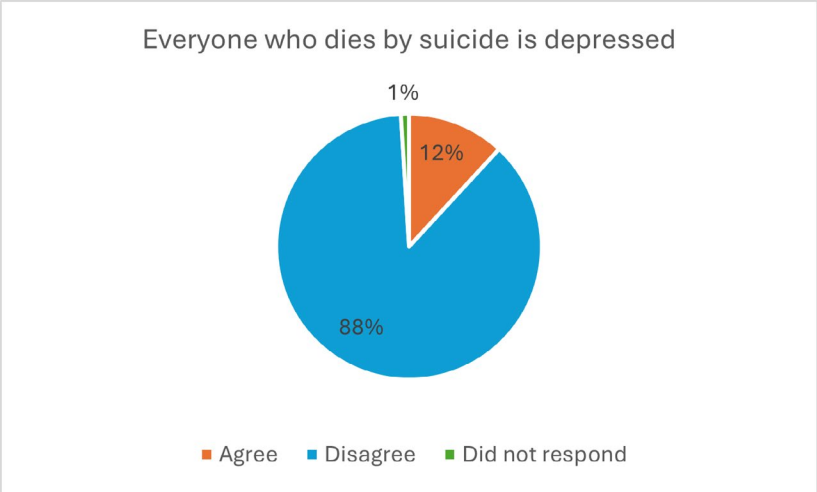
Figure 41. Responses to "It is a human duty to try to stop someone from dying by suicide."



Attitudes

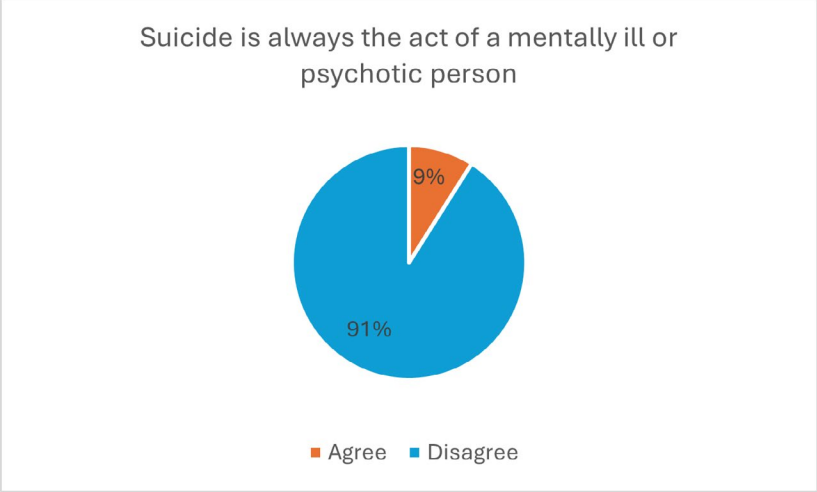
The survey responses revealed differing opinions regarding the relationship between mental health and suicide. For the statement that everyone who dies by suicide is depressed, 12% agreed, 88% disagreed, and 1% did not respond.

Figure 42. The belief that suicidal individuals are depressed.



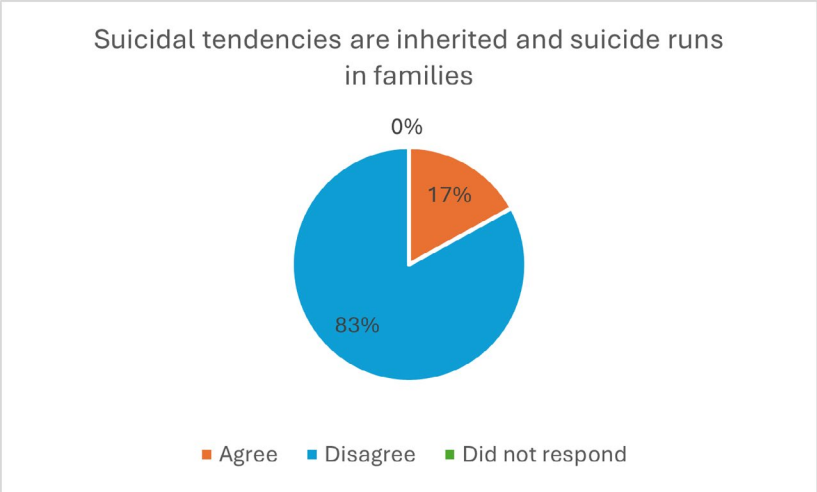
Similarly, when considering the idea that suicide is always the act of a mentally ill or psychotic person, 9% agreed, while 91% disagreed.

Figure 43. The belief that suicide is related to mentally ill or psychotic person.



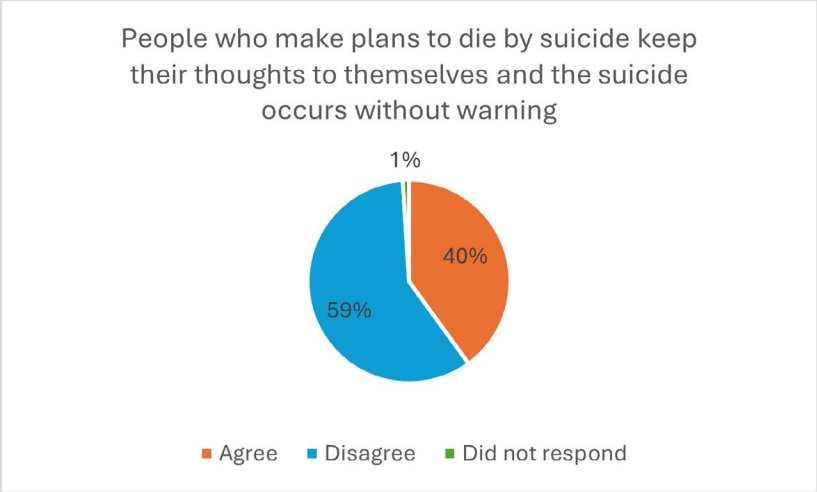
Regarding the belief that suicidal tendencies are inherited and that suicide runs in families, 17% agreed and 83% disagreed, with no participants choosing not to answer.

Figure 44. The belief that suicide runs in the families.



Participants also expressed varied views on suicide prevention and public understanding of warning signs. Regarding the idea that people who make plans to die by suicide keep their thoughts to themselves, 40% agreed, 59% disagreed, and 1% did not respond.

Figure 45. The belief that people who make plans to die by suicide keep their thoughts to themselves and the suicide occurs without warning.



For the statement that there is no relationship between drugs, alcohol, and suicide, 14% agreed, while 85% disagreed, and 1% did not respond. On the topic of removing the means of suicide (such as handguns and poisons) to prevent suicides, 13% agreed, 86% disagreed, and 1% did not respond.

Figure 46. The belief that removing the means of suicide would prevent many suicides.

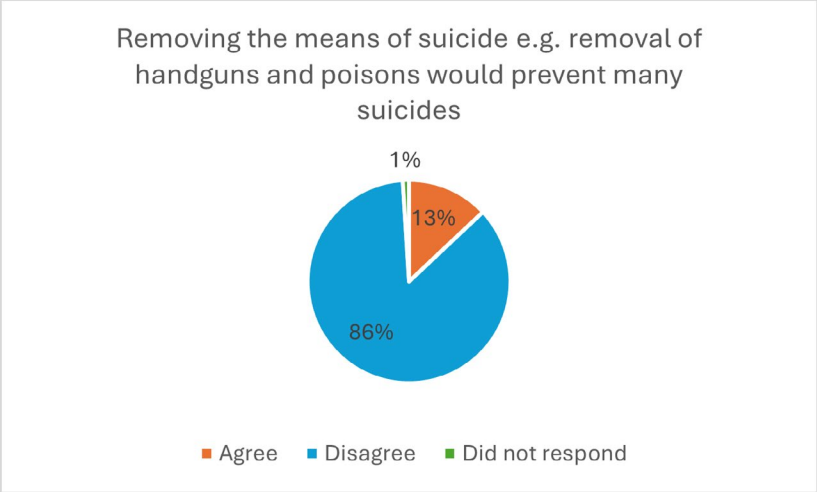
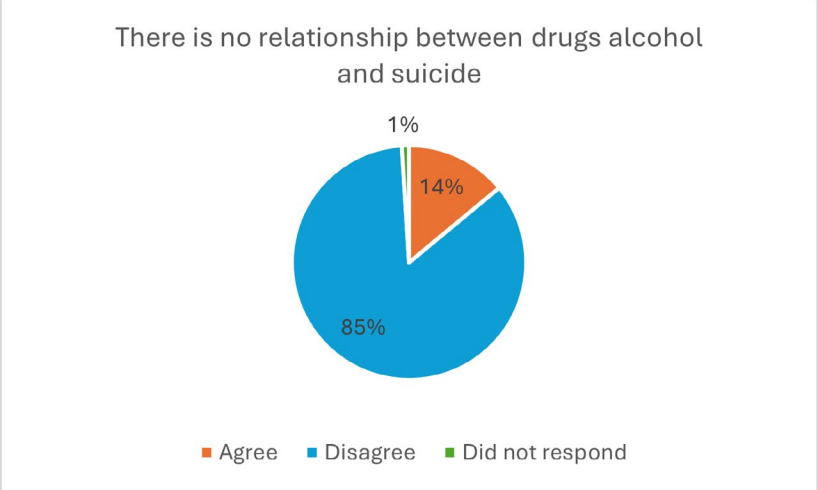
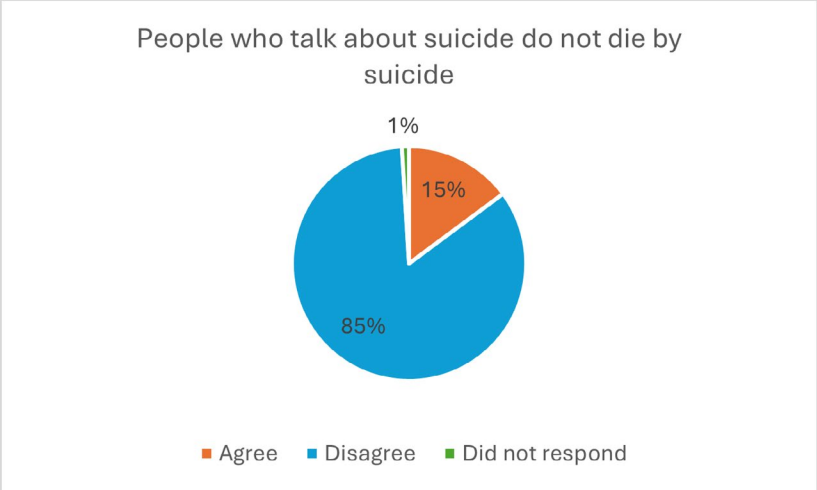


Figure 47. The belief that there is no relationship between drugs, alcohol, and suicide.



Regarding whether people who talk about suicide do not die by suicide, 15% agreed, 85% disagreed, and 1% did not respond.

Figure 48. The belief that people who talk about suicide do not die by suicide.



On the belief that there are one or two causes or motives that explain most suicides, 18% agreed, 81% disagreed, and 1% did not respond.

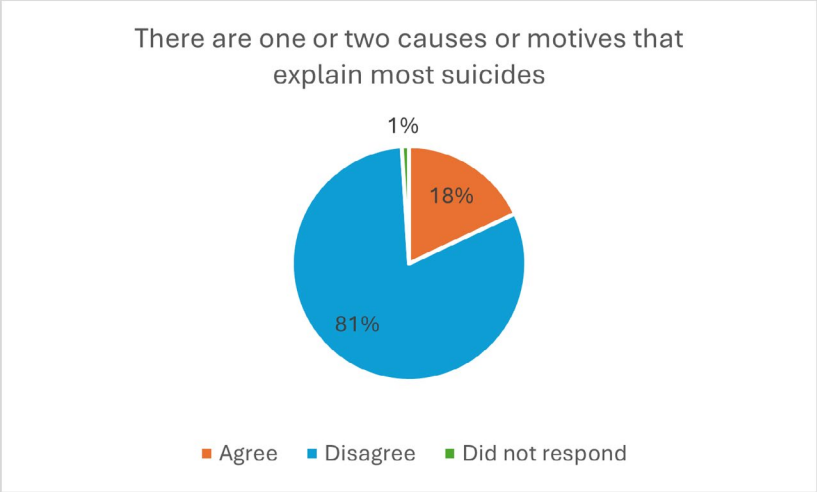



Figure 49. The belief that there are one or two causes or motives that explain most suicides.