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**SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA, LEGON**



**COMMUNITY PSYCHIATRIC NURSING SERVICES AND SUICIDE
RESILIENCE IN SELECTED COMMUNITIES IN THE GREATER ACCRA
REGION OF GHANA**

BY

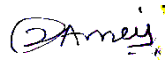
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**THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN
PARTIAL FUFILLMENT OF THE REQUIREMENT FOR THE AWARD OF PhD
IN PUBLIC HEALTH DEGREE**

DECEMBER 2023

DECLARATION

I, Abigail Ansere Buerthey, the writer of this thesis, hereby declare that this is my own PhD research work shepherded and written under the supervisions of Professor Emmanuel Asampong, Professor Lydia Aziato, Professor Phyllis Dako-Gyeke, and Dr. Franklin Glozah. I also declare that this thesis has not been submitted to any university, including the University of Ghana, Legon.



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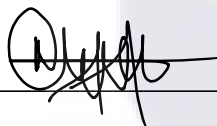
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DEDICATION

I consecrate this work primarily to the almighty God.

To my dearest husband, Pastor Benaiah Buerterey for your sacrifices, immense support throughout my academic pursuits. Your encouragement, and support in taking care of the children cannot be overruled.

To my children, Chacham Kofi Buerterey, Sagesse Kwame Ansere Buerterey, Klokhet Inshira Amea Buerterey and Charisma Adwoa Anointed Buerterey, thank you all for your inspiration and enormous support.

I would also want to appreciate my parents; Mr. Ernest Kojo Ansere and Mrs. Felicia Ansere for both their encouragements, financial and most importantly their prayer support. To my lovely siblings, Mrs. Mary Obeng, Mrs. Deborah Mensah and their families I say God bless you all.



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ABSTRACT

Background: Annually, 703,000 individuals end their own lives, with countless others attempting suicide. Each instance is a heart-breaking loss that deeply impacts families, communities, and nations, leaving lasting repercussions for those left behind. Several strategies can be implemented at the societal, sub-group, and individual levels to mitigate the occurrence of suicide and suicide attempts. Community resilience has been known and endorsed as a strategy for the management of suicide. However, not much is known about the use of community psychiatric nursing services as a strategy to promote community resilience against suicide. The aim of this study is to explore how to promote resilience against suicide in selected communities in the Greater Accra Region through community psychiatric nursing services.

Methodology: The study employed a qualitative descriptive exploratory design in five (5) districts; Ningo Prampram, Ledzokuku, Ga East, Weija Gbawe and Ga South in the Greater Accra region. A semi-structured interview guide was used to collect data from eighty-nine (89) purposively selected participants. A purposive sampling technique was used to select eighteen (18) Community Psychiatric Nurses (CPN), thirteen (13) suicide attempters', seven (7) attempters' family members, four (4) family members of completed suicide cases, five (5) Focus Group Discussions with 46 participants and 1 Key Informant Interviews for the study. The data were transcribed verbatim after it has been audio recorded digitally. The data was analyzed using thematic analysis with MAXQDA 20. Data triangulation strategy was used to present the qualitative findings of the study.

Results: The results showed that individuals who have attempted suicide in relation to precipitating factors included childhood experiences, psychiatric issues, mistrust, shame and disgrace, parental pressure, emotional breakdown, wasted resources, domestic violence, infidelity and difficult life pursuits. It was found that the response of suicide attempters'

families in relation to the general effects of the attempt on the family was Anger, shock, concern and solidarity. Also, the results showed that neutralizing the poison, inducing vomiting with the use of palm oil and crude oil, stoppage of bleeding, cutting down of noose, employing the services of skilled swimmers and calling of the police to be the means by which community members who almost lost/lost a member to suicide handled such cases. The results showed that Community Psychiatric Nurses have no laid down or specific guideline or policy in handling suicide cases. However, some of the strategies used by CPNs in the management of individuals and families of attempted and completed suicide cases were assessment, counselling and psychotherapy, medication, engaging the person/client in the area of interest, separating the person from the stressors, removing harmful items, physical monitoring and referral of cases that were beyond them to other health facilities. Furthermore, the results showed that the coping strategies used by families of suicide victims were through experience sharing and encouragement, relocating, social bonds, psyching oneself, acknowledging that tragedy may come to anyone, Word of God, Prayer and reliance upon God.

Conclusions: Suicide is a very complex problem in the society, and there is general ignorance about the triggers, signs and appropriate help seeking strategies. Inadequate knowledge therefore tends to make individuals and communities less resilient to suicide.

Community resilience to suicide can be significantly promoted if CPNs are provided with specific guidelines and retraining for the handling of suicide ideation and attempt. These guidelines and training coupled with provision of adequate funding and logistics, will enable the CPNs deliver high quality services to the suicide attempters, suicide attempter's family, suicide bereaved families and also to intensify the general public education on the proper handling of all suicide related matters. A substantial number of community members are not aware of the existence of CPNs and therefore do not utilize their services. It is therefore

imperative to create awareness about the existence and availability of CPNs through health education.

Definition of Key Term / Operational definition

Suicide resilience; is the inner ability of a person to fight against the tendency of attempting or taking ones life.



TABLE OF CONTENT

Content	Page
DECLARATION.....	i
DEDICATION.....	i
ACKNOWLEDGEMENTS	iii
ABSTRACT.....	v
TABLE OF CONTENT.....	viii
LIST OF TABLES	xii
LIST OF FIGURES	xiii
LIST OF ABBREVIATIONS	xiv
CHAPTER ONE	1
INTRODUCTION.....	1
1.1 Introduction	1
1.2 Background	1
1.3 Problem Statement	7
1.4 Research questions	11
1.5 Objectives of the study	11
1.5.1 General objective	11
1.5.2 Specific Objectives	11
1.6 Justification of the study	12
1.7 Theoretical Underpinnings and Conceptual Framework for the study	13
CHAPTER TWO	21
LITERATURE REVIEW	21
2.1 Introduction	21
2.2 The Global situation of suicide (epidemiology and burden).....	22
2.3 Causes of Suicide	25
2.4 Methods of suicide	26
2.5 Suicide prevention strategies worldwide and in Africa	28
2.6 Challenges and obstacles.....	29
2.6.1 Stigma and taboo	29
2.6.2 Data quality.....	29
2.7 Sample successful suicide prevention strategies.....	30
2.7.1 China.....	30

2.7.2 Ireland.....	32
2.7.3 Japan.....	33
2.7.4 Scotland.....	34
2.7.5 Namibia.....	35
2.8 Community based suicide prevention strategies.....	35
2.9 Suicide Prevention Initiatives In Ghana.....	39
2.10 Suicide Treatment(As A Mental Condition).....	39
2.10.1 Symptoms.....	40
2.10.2 Treatment.....	41
2.10.3 Psychiatric Medications.....	42
2.10.4 Electroconvulsive therapy.....	43
2.11 Psychiatry And Community Psychiatric Services In Ghana.....	44
2.12 Community Psychiatric Nursing and Suicide.....	45
2.13 Suicide and population growth.....	45
2.14 Factors that Precipitate Suicide in Attempters.....	46
2.15 The Response of Suicide Attempters' Families in Relation to the General Effects of the Attempt on the Family.....	50
2.16 The Views of Community Members that Almost Lost/Lost a Member to Suicide in Relation to how they Handled Such Cases.....	55
2.17 The Strategies used by Community Psychiatric Nurses in the Management of Individuals and Families of Both Attempted and Completed Suicide Cases.....	56
2.18 The Coping Strategies Used By Families Of Suicide Victims.....	58
CHAPTER THREE.....	65
METHODOLOGY.....	65
3.1 Introduction.....	65
3.2 Study design.....	65
3.3 Philosophical Underpinnings of the Study.....	66
3.4 Study Area.....	66
3.5 Sample Size.....	70
3.6 Sampling Procedure.....	70
3.6.1 In-depth Interview.....	72
3.6.2 Key Informant Interview.....	72
3.6.3 Focus Group Discussions.....	72
3.7. Data collection tools.....	73

3.8 Data analysis	73
3.9 Ethical Consideration	75
3.10 Methodological rigour	77
3.10 Quality Control	78
CHAPTER FOUR.....	79
RESULTS	79
4.1 Introduction	79
4.2 Socio-demographic characteristics of the study participants	79
4.3 The Experiences of Individuals Who Have Attempted Suicide.....	86
4.4 The general response of family members to the suicide attempt	95
4.5 How Community Members Handled Attempted and Completed Suicide Cases....	98
4.6 The Strategies Used by CPNs In The Management Of Individuals And Families Of Both Attempted And Completed Suicide Cases	102
Theme 4: Community Psychiatric Nurses response.....	102
4.7 The Coping Strategies Used by Families Of Suicide Victims	108
Theme 5: Positive coping	108
4.8 Conclusion.....	113
CHAPTER FIVE	115
DISCUSSION	115
5.1 Introduction	115
5.2 The Experiences of Individuals Who Have Attempted Suicide.....	115
5.3 The general response of family members to the suicide attempt	125
5.4 How Community Members Handled Attempted and Completed Suicide Cases.....	126
5.5 The strategies used by CPNs in the management of individuals and families of both attempted and completed suicide cases.	129
5.6 The Coping Strategies Used by Families of Suicide Victims	134
5.7 Limitations of the study.....	137
5.8 Strengths of the study	138
CHAPTER SIX	140
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS	140
6.1 Introduction	140
6.2 Summary of Findings	140
6.3 Conclusions	142
6.4 Contributions of the Study to Knowledge.....	144

6.5 Recommendations 145

 6.5.1 Recommendations for practice 146

 6.5.2 Recommendations for Future Research..... 147

 6.5.3 Recommendation for Policy makers..... 147

REFERENCES.....149

APPENDICES.....190

APPENDIX A: CONSENT FORM FOR DATA COLLECTION191

 APPENDIX B: IN-DEPTH INTERVIEW GUIDE FOR INDIVIDUALS WHO HAVE ATTEMPTED SUICIDE IN RELATION TO PRECIPITATING FACTORS228

 SEMI-STRUCTURED KEY INFORMANT INTERVIEW GUIDE FOR COMMUNITY PSYCHIATRIC NURSES 234

 SEMI-STRUCTURED IN-DEPTH INTERVIEW GUIDE FOR OPINION LEADERS AND STAKEHOLDERS236

 THEMES AND SUB THEMES238



LIST OF TABLES

Table 4.1: Socio-demographic Data of Suicide Attempters’ (SA), Suicide Attempters’ Family (SAF) and Suicide victims Family Members (SV).80

Table 4. 2: Socio-demographic Background of Community Psychiatric Nurses (CPNs), Community Members (CMs); Ledzokuku (CML), Ga East (CMGE), Weija/Mallam (CMWM), Ningo Prampram (CMNP), Ga South CMGS and a member of the Mental Health authority (MHA).....82

Table 4. 3:Main and Sub-themes84



LIST OF FIGURES

Figure 1: The Socio ecological Model..... 15

Figure 2: The Community Resilience Model..... 16

Figure 3: Conceptual framework for Community Resilience to Suicide Model..... 18

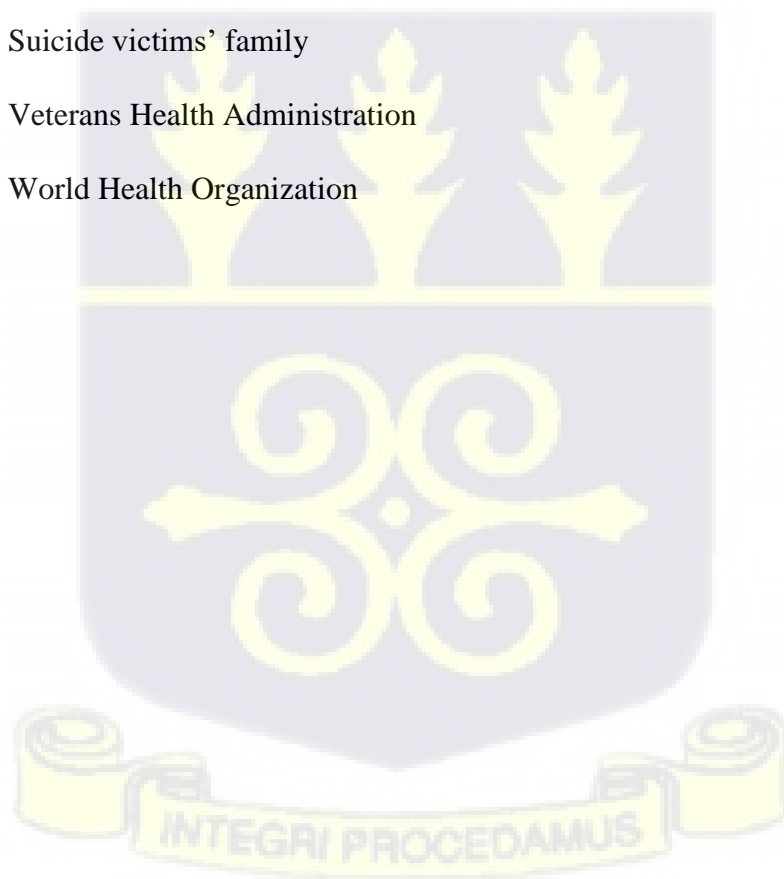
Figure 5: Map of Greater Accra with Study Districts Highlighted..... 70



LIST OF ABBREVIATIONS

CHO	Community Health Officer
CHPS	Community-based Health Planning and Services
CHW	Community Health Worker
CMHW	Community Mental Health Workers
CPNs:	Community Psychiatric Nurses
CPU:	Community Psychiatric Unit
CPS:	Child Protection Services
CRF	Community Resilience Framework
CPS	Community Psychiatric Services
CM	Community members
CMGE	Community members of Ga East
CMGS	Community members of Ga South
CML	Community members of Ledzokuku
CMNP	Community members of Ningo-Prampram
CMWM	Community members of Weija/Mallam
FGD	Focus Group Discussion
DVAM	Domestic Violence against Men
DV	Domestic violence
IDIs	In-depth Interviews
IPV	Intimate Partner Violence
KII	Key Informant Interview
LMICs	Low- and Middle-Income Countries
MHA	Mental Health Authority
MSE	Mental State Examination

MHMT	Municipal Health Management Team
OLs	Opinion Leaders
PI	Principal Investigator
PTSD	posttraumatic stress disorder
RJ	Romantic Jealousy
RMN	Registered Mental Nurse
SA	Suicide attempters
SAF	Suicide attempters family
SEM	Socio Ecological Model
SPS	Suicide Prevention Strategy
SVF	Suicide victims' family
VA	Veterans Health Administration
WHO	World Health Organization



CHAPTER ONE

INTRODUCTION

1.1 Introduction

This chapter provides a background to the study. It consist of the Community Psychiatric Nurses (CPNs) care rendered to patients on national and global levels. It seeks to Explore the experiences of individuals who have attempted suicide in relation to precipitating factors, describe the response of suicide attempters' families in relation to the general effects of the attempt on the family, examine the views of community members that almost lost/lost a member to suicide in relation to how they handled such cases, assess the strategies used by CPNs in the management of individuals and families of both attempted and completed suicide cases and identify the coping strategies used by families of suicide victims. It also provides an explanation of the theory adopted and the conceptual frame for the study.

1.2 Background

“Resilience is the capacity and dynamic process of adaptively overcoming stress and adversity while maintaining normal psychological and physical functioning” (Sher, 2019). Research indicates that resilience can reduce the chance of suicide. Research and prevention of suicide now emphasise resilience. In order to address this significant public health issue, years of suicide study have mostly concentrated on risk factors for suicidal behaviour while ignoring protective characteristics like resilience (Mclean, 2020); studies have focused on suicide risk screening tools, the Family Check-Up program (Emerging trends in adolescent suicide prevention research) whereas some concentrated on training primary care physicians in depression recognition and treatment, active screening for suicidal ideation, algorithm-driven electronic health record screening, internet-based screening, and smartphone passive monitoring (Mann, Michel, & Auerbach, 2021), and some considered prediction and

prevention according to demography, mental disorder, levels of psychiatric care as means to help curb suicide (Large, 2018).

It is essential that communities stay informed, accept interventions, and contribute to the success and continuation of programs through more meaningful engagement in public health management, as effective suicide control necessitates increased leadership and community participation in service delivery (King et al., 2019).

Suicide has in recent times taken a toll on different societies worldwide (Turecki et al., 2019). The phenomenon is quite complex due to the fact that no two suicides cases are completely identical, in terms of the motivation and trigger (O'Connor & Kirtley, 2018); though fundamental causes are generally known (Hogan & Grumet, 2016). The more complex and advanced life becomes, (technologically, economically and socially), mutual requirements and responsibilities that come along with development are multiplied (Hogan & Grumet, 2016). These do not only have positive effects but also some adverse effects that can serve as catalysts for suicidal behaviours (Davidson et al., 2018). "Suicide is the act of deliberately taking one's own life" (WHO, 2014). It is the 15th principal reason of death worldwide and more than 800,000 people die by suicide each year (WHO, 2014) Studies have revealed that majority of suicidal behaviour in Lower and Middle Income Countries (LMICs) are triggered by social, economic and cultural factors (Bantjes et al., 2016). Other suicides are spontaneous acts due to stress (such as from monetary or academic problems), harassment/bullying and relationship complications. (Chopko, Palmieri, & Facemire, 2014).

Suicide accounts for about 1.5% of all deaths globally (WHO, 2017), or about 12 deaths per 100,000 people (Navaneelan, 2012). Men commit suicide at a higher rate than women do overall; in the developing world, the rate is 1.5 times higher than in the developed world, at 3.5 times higher (Naghavi, 2019). Suicide is usually most common among those past the age of 70 (Stone et al., 2018) however, in some countries, those aged between 15 and 30 are at

the highest risk (Bachmann, 2018). In terms of region, Europe had the highest suicide rates in 2015 (Breuer, 2015). It is recorded that 10 to 20 million non-fatal suicides are attempted every year (Kinchin & Doran, 2017). Suicide attempts have the potential to cause harm and permanent disabilities (Geulayov et al., 2019; Kinchin & Doran, 2017). In the Western world, attempts are more common among the youth (Bilsen, 2018). People who have attempted suicide before are at a higher risk for future attempts (Mars et al., 2019).

Although there is lack of reliable data from sub-Saharan Africa (Cluver et al., 2015), information gathered shows that many African countries are also experiencing a rise in suicide rates and these trends are not easy to explain (Mars et al., 2014). In Africa one factor that runs through is the lack of professional assistance and research (Downs & Eisenberg, 2012; Muehlenkamp et al., 2012). About four (4) people die in the Eastern African country of Kenya daily from suicide (Fleischmann, 2016).

In Ghana, the scenario is similar to the general African situation; very little official records of data exist (Nii-Boye Quarshie et al., 2015), on the other hand, a prior subjective and journalistic report indicates that approximately 1556 individuals (or five per day) commit suicide in Ghana on a yearly basis (Oti, 2014). Victims of the suicides were mostly male (85.92%), with age ranging 10-86 years (Abdulai, 2020b). Commonly identified suicide methods included “self-hanging (67.94%), firearms (18.32%), and self-poisoning (8.93%)” (Abdulai, 2020b). Online news portals report an upsurge of suicides in Ghana in the last 3 years; “2017 saw the highest news coverage of 30 (21%) cases” (Abdulai, 2020b). Matrimonial or relationships and domestic difficulties commonly served as the reasons for the suicides; Also, “mental disorders, and monetary problems were also named as instant triggers of the suicides by close relatives of the victims” (Abdulai, 2020b).

Suicide prevention strategies have primarily focused on the individual and not on the general community (Naghavi, 2019). Strategies to combat suicide at the individual level include

treating mental disorders and substance abuse, as well as restricting access to tools of suicide, such as guns, drugs, and poisons. These strategies have not been able to significantly deal with suicide in the community because suicide risk is increased by certain environmental and cultural elements in the broader society (Kirmayer, 2022). The stigma attached to mental illness and seeking care, those who are at risk have easy access to deadly suicide methods, unsafe depictions of suicide in the media (Andriessen & Krysinaka, 2020). A variety of factors at the individual, relationship, community, and societal levels can prevent suicide, much like risk factors do. As a culture and as communities, we may take steps to help people and shield them from suicide thoughts and actions (Marraccini et al., 2022; Mueller et al., 2021).

Protective Factors in the Community such as encouraging social interactions reduce the risk of suicide: Having a sense of belonging to the community, school, and other social institutions
Accessibility of reliable, superior physical and mental health care. Protective factors in society such as environmental and cultural elements of the broader society reduce the likelihood of suicide: Decreased availability of deadly suicide methods for vulnerable individuals
Religious, cultural, or ethical objections to suicide (Al-Halabí & Fonseca-Pedrero, 2021).

The lack of a national suicide prevention strategy and resource limitations are two major obstacles to suicide prevention (Vorma, 2020). Lack of accurate suicide statistics, the lack of a national suicide prevention strategy, high stigma and low suicide awareness, and the low federal budget and priority given to mental health in general and suicide in particular were common cross-country issues (Ryan et al., 2020). In particular, many countries pointed to a shortage of human resources for suicide prevention initiatives as the reason for the discrepancy between policy and practice (Platt & Niederkrotenthaler, 2020; Wasserman et al., 2020).

However, the individual thrives within a society, as suggested by the famous age old saying that “No man is an Island”. People are therefore directly or indirectly affected and moulded

by their environment or community (Akotia et al., 2019). Therefore, improving Community Psychiatric Services could assist in building suicide resilience in the various communities. Because CPNs work closely with people who have mental illnesses, they are able to identify warning signs early (Buerthey, Attiogbe, & Aziato, 2020; Mensah, 2024). This means that suicidal patients are identified early, both in the community and in hospitals, and they can prevent suicide with the use of medication, counselling, psychotherapy, and health education (Spottswood et al., 2022). When they notice any warning signals, their approach should focus on keeping the patient safe, offering compassion and support, and making sure the patient gets the social and/or mental health assistance need to lower their risk (Menon et al., 2018). Integrated surveillance and monitoring systems, community involvement, and a life-course and multisectoral approach to suicide prevention are examples of contemporary suicide prevention techniques used by CPNs (Opare et al., 2020). Because suicide is a complex issue, prevention and treatment strategies must be multisectoral and life-course (Kirkbride et al., 2024; Pollock et al., 2020). CPNs with the help of Ghana Health Service (GHS) communicate with other health sectors, education, drivers, farmers, politicians, and the media to support comprehensive and integrated mental health service delivery, as CPNs continue to be the primary national policy that brings health services to the doorstep of mental patients (Buerthey, Attiogbe, & Aziato, 2020). An enhanced and economical approach to reducing the burden would be to better incorporate suicide prevention programs within CPNs' service offerings (Mensah, 2024).

CPNs are at the forefront of creating and putting into practice strategic suicide prevention plans to suicide through education (Procter et al., 2023). It is essential that communities stay informed, accept interventions, and contribute to the success and continuation of suicide prevention programs through more meaningful engagement in the management of public health initiatives, as effective suicide control necessitates increased leadership and

community participation in service delivery. So, the CPNs teach the community to be interested in and take part in suicide prevention activities. Otherwise, any preventative effort may be undermined by the community's perceived lack of urgency to fully combat suicide. Once more, CPNs with the help of GHS participatory organisation links communities, mental health services, healthcare practitioners, and other stakeholders to help identify and address mental health issues like suicide (Buertey, 2022a).

Combating suicide and attempted suicides requires early discovery, communication, therapy, and care for clients with mental and drug use disorders, chronic pain, and acute emotional distress (Chiles & Roberts, 2018) . However, Ghana and other nations throughout the world struggle with a dearth of trustworthy suicide statistics (Andoh-Arthur, 2023; Asare-Doku, Osafo, & Akotia, 2019; Quarshie et al., 2021). When it comes to providing reliable and nationally representative data on suicide trends, rates, features, and methods, as well as following up with vulnerable populations for referral and treatment, CPNs can be of great assistance (Andoh-Arthur et al., 2018).

Suicide and attempted suicide represent serious problems for many nations (Bachmann, 2018). We believe that a dynamic window of opportunity to envision durable solutions to suicide in Ghana can be created through the appropriate integration of suicide prevention programs with community-based initiatives with the assistance of CPNs (Ross, 2021). Mass media participation(using technology for educational campaigns and support systems, including mobile apps and online resources), community health professionals' capacity building, and additional research on the psychological causes and remedies of suicide could all help significantly to deal with suicide and attempted suicide (Mann, Michel, & Auerbach, 2021) .

The study shifts from the traditional concept of handling suicide which seeks to confront risk factors and rather focuses on protective factors such as resilience which tends to tackle suicide

from the roots (Al-Halabí et al., 2021). A derived model based on the three foundational underpinnings of this study clearly depicts how community psychiatric services can utilize innovative strategies to build community resilience to suicide.

1.3 Problem Statement

Records reveal that “79% of suicides took place in low and middle income countries” (Uddin, Burton, Maple, Khan, & Khan, 2019). Suicide has over the years taken many lives, ranging from adolescents to adults (Abuabara, Abuabara, & Tonchuk, 2017). It is also an established fact that the issue of suicide is not limited to any particular race, people, colour, ethnic group, religious body or nation (Wong, Maffini, & Shin, 2014). There has been traumatic deaths worldwide which have had series of negative impacts on families as a unit and communities as a whole (Arensman, Scott, De Leo, & Pirkis, 2020). Even though suicidal patients are sometimes not appropriately identified in health care settings by community psychiatric nurses (Stuber & Quinnett, 2013) there are no widespread existing strategies to help CPN’s strengthen community resilience because of the existence of low official data (Buerthey, Attiogbe, & Aziato, 2020). Existing strategies have proven inadequate to strengthen community resilience to suicide. Though past studies have helped increase knowledge, there is no study that has tackled CPS and suicide resilience in selected communities in the Greater Accra region of Ghana.

“Decades of suicide research have mostly focused on risk factors for suicidal behaviour while overlooking protective factors such as resilience that may help to address this important public health issue” (Sher, 2019). The data gotten from the various Community Psychiatric Nurses in the districts shows that in the year 2021. The number of males and females who attempted suicide were 26 and 65 respectively. The district with the highest attempted suicide cases were Korle Klottey: 8 Male and 16 Female Attempt. The district with the smallest attempted suicide

case was Accra Metro with 1 attempted male suicide case with no female suicide attempted cases. The districts with no cases of suicide and attempted suicide cases were ; Ablekuma Central, Ablekuma North, Ada West, Ashaiman, Ayawaso Central, Ayawaso East, Ayawaso West, Ga Central, Kpone-Katamanso, La-Dade-Kotopon and Okai Koi North. Many community dwellers do not know about community psychiatry services CPS (Buerthey, Attiogbe, & Aziato, 2020). The few that know about CPS feel it is meant for the mentally retarded or so called 'mad' people (Buerthey et al., 2020).

The suicide rate in Ghana for 2019 stood 6.60, there was no increase from 2018. Which indicates that Ghana's suicide rate for 2018 was also 6.60. This shows a "5.71% decline from 2017". Ghana suicide rate for 2017 was 7.00, which designate a 2.78% drop from 2016. The decline of Ghana's suicide rate from 2015 was a 1.37%, and that of 2016 was 7.20. Data from some previous research also highlight the need for more study to help curb the suicide menace in Ghana (Quarshie et al., 2021).

One attempted suicide and 29 suicides among children aged 8–12 years were reported in the Ghanaian media between January 2000 and March 2022. Twenty-two of the 29 suicides were boys, and hanging was the reported method of all the suicides. Another study found that parents and caregivers reported subtle or no warning signs of their young children's suicides (Addai et al., 2018).

Results from other research again indicated higher levels of food insecurity and suicidal tendencies among unemployed graduates compared to employed graduates. There was a definite relationship between food insecurity and suicidal tendencies as well as years of unemployment and suicidal tendencies.

Suicide continues to be a serious public health issue in Ghana and the West African sub-region, claiming the lives of both the young and old (Abdulai, 2020a). A significant number of the suicides are attributable to psychological distress which results from various life's

pressures. There is the pressing need for members of the community to be equipped with knowledge and skills to better handle such stressors. This calls for an extension of community psychiatry services to the doorsteps of members of the community in order to help build resilience. A lack of psychological resilience makes people crumble in the face of adversity (Akotia et al., 2020a). The ensuing helplessness makes many a person see suicide as the only escape route (Abuabara, Abuabara, & Tonchuk, 2017). Suicidal activity is prohibited in Ghana's sociocultural environment, which has major consequences for those who have survived suicide attempts and their families (Andoh-Arthur & Quarshie, 2021; Osafo, Asare-Doku, & Akotia, 2023). Understanding the perspectives of attempt survivors' families and how they deal with the fallout from the attempt is lacking in our communities when it comes to the lived experiences of individuals who have attempted suicide and their families (Quarshie et al., 2024).

Up until now the causes of suicide in Ghana have been many (Abdulai, 2020a) ranging from loss of loved ones, to financial problems, relationship breakdowns, chronic physical illness, however research has shown that the root cause of most suicide was the lack of mental resilience to handle the aforementioned life stressors (Asare-Doku, 2015).

A psychologically distressed person would rather be carried by the average family to either a hospital emergency or a 'spiritualist for treatment (Akotia et al., 2019). People are generally not informed or knowledgeable about the purpose of CPS in the community. Knowledge, they say, is power; so knowing who to consult in a psychiatric emergency is half the solution to the problem (Andoh-Arthur et al., 2019). Possible precipitating factors exist within the community. These difficult problems in one's community increase risk of suicide; Inability to obtain healthcare, a spate of suicides in the neighbourhood, acculturation stress, violence in communities, past trauma discrimination and social risk (Akotia et al., 2020b). Risk is increased by certain environmental and cultural elements in the broader society and these

include the stigma attached to mental illness and seeking care, those who are at risk have easy access to deadly suicide methods and unsafe depictions of suicide in the media (Akotia et al., 2020b). Personalised spiritual coping, avoidance, and social support were among the specific coping resources (Akotia et al., 2020b).

The majority of original writings and documents urge staff training and education for health service providers, which was the first significant component of Suicide Prevention Strategy (SPS) . Thus, educational intervention is the first step and intervention for putting suicide prevention initiatives into action. The second tactic involved screening and evaluating the general public or the at-risk group for suicide risk. Reports from organisations like the WHO and the National Action Alliance for Suicide Prevention Executive Committee, as well as the majority of the original studies that were included, expressly emphasised this tactic. The third aspect of SPS in PHC identified in this analysis was managing mental illnesses and symptoms of depression. Handling suicide attempters was the fourth key element of suicide prevention tactics. This review offered trustworthy data to support the development of health systems. In summary, primary health care practitioners that is CPNs who are keen to offer quick and efficient contact interventions for patients at risk of suicide include: (1) educating and training healthcare providers; (2) screening and suicide risk assessment; (3) managing mental disorders and depression symptoms; (4) managing suicide attempters and at-risk cases; and (5) prevention strategies for the general public.

As suicide cases continue to escalate in Ghana, it is imperative to address mental health concerns by putting policies into place that have been demonstrated to lower suicide rates, such as improving socio ecological factors that have a direct negative bearing on the people in the community, proper exploration and utilization of community capitals to build adaptive capabilities within the citizenry, as well as easy accessibility to CPS and making mental health care for people living in the various communities of the Greater Accra Region, which in the

long run help improve the communities resilience to suicide. There is therefore the need to know the experiences of individuals who have attempted suicide in relation to precipitating, the experiences of suicide attempters' families regarding the effect of the suicide attempt on the family, the experiences of community members who have almost lost/lost a member to suicide, and also strategies currently used by Community Psychiatric Nurses in the management of individuals and families of both attempted and completed suicide cases, as well as coping strategies used by families of suicide victims, all in an attempt to improve CPS that will create an enabling environment to build suicide resilience in our communities. This therefore underscores the crucial nature of Community Psychiatry Services to the average citizen.

1.4 Research questions

1. What are the experiences of individuals who have attempted suicide in relation to precipitating factors ?
2. What are the experiences of suicide attempters' families regarding the effect of the suicide attempt on the family?
3. What are the experiences of community members who have almost lost/lost a member to suicide ?
4. What strategies are used by Community Psychiatric Nurses in the management of individuals and families of both attempted and completed suicide cases in order to improve community resilience to suicide?
5. What are the coping strategies used by families of suicide victims?

1.5 Objectives of the study

1.5.1 General objective

The general objective of this study is to explore community psychiatric nursing services and suicide resilience in selected communities in the Greater Accra Region of Ghana.

1.5.2 Specific Objectives

1. Explore the experiences of individuals who have attempted suicide in relation to precipitating factors.
2. Describe the responses of suicide attempters' families in relation to the general effects of the attempt on the family.

3. Examine the views of community members that almost lost/lost a member to suicide in relation to how they handled such cases.
4. Assess the strategies used by Community Psychiatric Nurses in the management of individuals and families of both attempted and completed suicide cases in order to improve community resilience to suicide.
5. Identify the coping strategies used by families of suicide victims.

1.6 Justification of the study

Among those aged 15 to 29, suicide is currently the second most common cause of death. Every year, almost 800,000 people commit suicide throughout the world. Approximately there is the occurrence of one death every 40 seconds. There are numerous people who attempt suicide for every suicide that occurs. One of the biggest risk factors for suicide in the general population is having attempted suicide before. It is estimated that 77% of suicides globally take place in low- and middle-income nations.

Among the most popular ways to commit suicide worldwide are hanging, ingestion of pesticide, and the use of firearms. It is an irrevocable damage which finally leads to death. Right now, suicide ranks fourth globally among the main causes of death for people. It is a very challenging issue to address in mental health care.

The outcome of the study will provide basis for communities to determine new ways in dealing with and overcoming suicide. The communities through the findings of this study alongside the help of CPNs will build adaptive capacity against suicide.

World health organization 2021 shows that Suicide is the fourth leading cause of death among 15–29 , Media reports that is statistics gotten from police and newspapers in Ghana show an increasing trend (Azasu, 2024; Quarshie, Asante, & Andoh-Arthur, 2021). Suicide attempts have only received attention from families and communities after the person has attempted it (Maple et al., 2020; Maple, McKay, & Sanford, 2019). Health personnel have also focused mostly on treating suicide attempt patients only after a victim has attempted suicide (Hom et

al., 2021). Suicide have received limited attention from the communities and families (Mueller et al., 2021; Wasserman et al., 2020).

The focus of attention for health personnel is after the attempt. CPNs work in the communities but do not have what it takes to tackle it. To achieve no increase in suicide cases and decrease 1/3 of premature death associated with suicide since Goal 3 of the SDGs is to: Ensure healthy lives and promote well-being for all at all ages. Target 3.4 is: By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being. Within Target 3.4, suicide rate is an indicator (3.4.2) .

This study would therefore pre-empt a new leaf of tackling suicide from its roots through the CPNs promotion of massive public education and knowledge dissemination from basic education levels to the general adult populace, and thus promoting psychological resilience which will in turn bring down the number of suicide attempts in the community. This study will help CPNs tackle massive public education and knowledge dissemination.

1.7 Theoretical Underpinnings and Conceptual Framework for the study

“Research is based on theoretical frameworks which forms the foundation for the statement of the problem, the significance, the research questions, and make available a basis for the literature review, the research methods and plan for analysis of the study” (Babale & Lawal, 2021; Lynch et al., 2020; Osanloo & Grant, 2016). The role of Community Psychiatric Nursing Services for suicide resilience can be explained by several theories. This study is guided by the socio ecological model, Community Resilience Model and Orlando's Theory of the deliberative Nursing Process.

The socio-ecological model (Kousoulis & Goldie 2021) was developed to help visually elucidate individual, family, organization, community, and societal factors that affect individual mental health and well-being. It reveals what we know from the research

concerning the way people's mental health is affected both positively and negatively at all points. The socio-ecological model was created as a means to show that persons are affected by a varied and diverse group of social influences and nested environmental interfaces. This model remains as one that is in constant evolution because it takes cognisance of the fact that factors that determine psychological well-being can intersect at numerous points. The levels of influence include:

1. Individual: People are born every day. How they influence and are influenced by the world around them; examples: age, personality, skills, race/ethnicity, sexual orientation, education/knowledge, economic status, geographic location
2. Relationships: formal and informal social supports; examples: family, friends, neighbours, teachers, co-workers, service providers
3. Organizations: the relationship between public, private, and non-profit organizations; examples: schools, workplaces, agencies, businesses, healthcare, childcare, faith groups.

Communities: the broad social setting in which relationships occur; examples: neighbourhoods, cultural groups. Cultural factors also affect the individual especially in African settings and particularly in Ghana. Because most African societies have cultural entrenched practices, it tends to affect the lives of those living within their domain.

4. Policy: laws and policies that regulate and support health behaviours; examples: workplace, local, state, federal, international.

The individual within the Socio Ecological Model (SEM) relates to the suicide attempter within this study, around whom the other factors revolve to determine their wellbeing or otherwise. The relationships level of the SEM represents the attempter's family in the study, whose action or inaction can affect the suicide attempter positively

or negatively before and after the attempt. Organizations in the SEM stand for survivor or left behind families. Their proper handling or coping skills in the event of the loss of a family member to suicide goes a long way to help avert suicide contagion within the family. Furthermore, communities as shown within the SEM links to the selected communities with which the study was conducted and for which the study seeks to promote resilience. Finally, the policy portion of the SEM symbolizes the CPN and CPN services within the selected communities of the study. Proper deployment and harnessing of CPN services will go a long way to improve community resilience to Suicide.

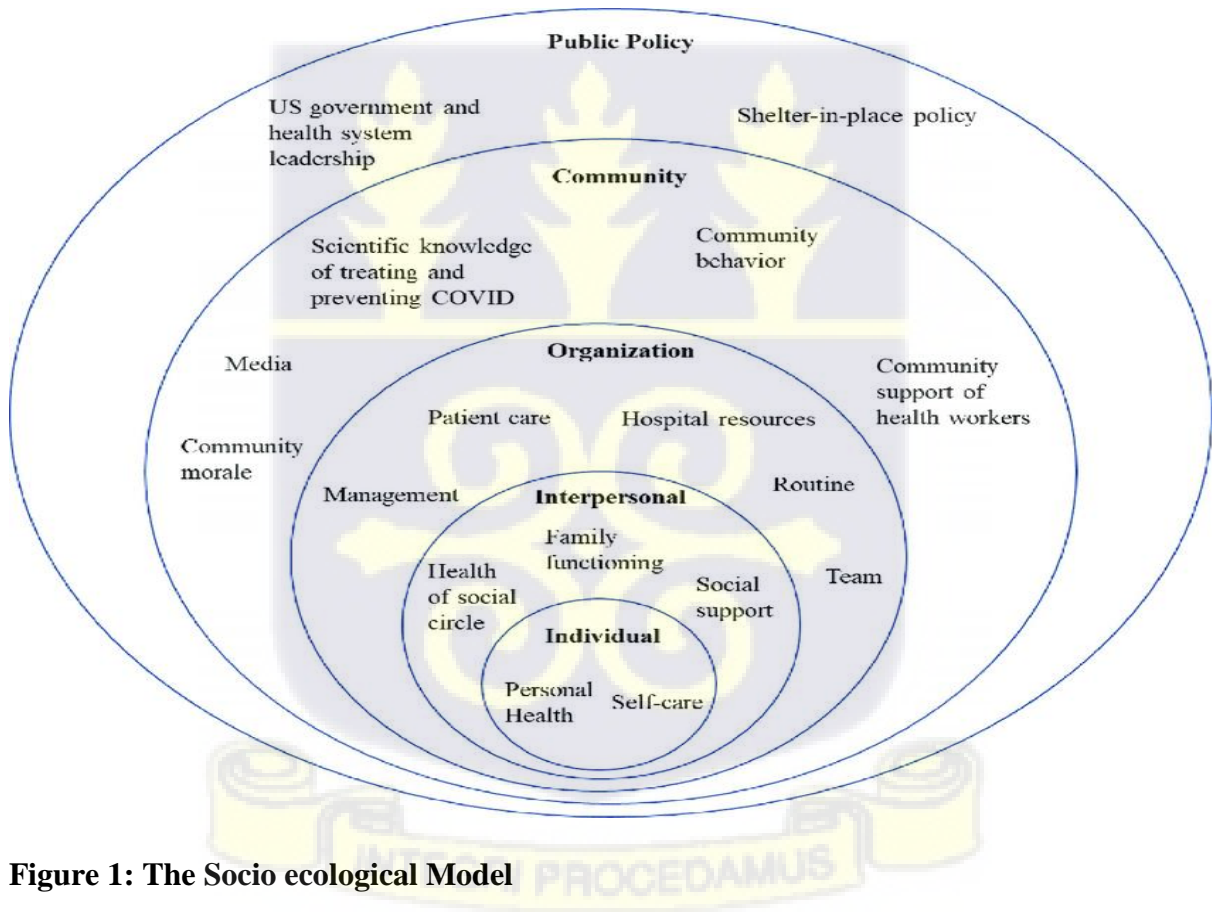


Figure 1: The Socio ecological Model

Source: Reupert, 2017

The community resilience framework (CRF) is the second model that also guided this study. The CRF was carved out of the Sustainable livelihoods approach and the Community Capitals framework. The Community Resilience Framework was created with specific emphasis on

community development practice. In a drive to build resilience two potential methodologies can be paired with the framework to engage communities and inform policy. The combination of the Sustainable Livelihoods Approach and Community Capitals Framework proved most appropriate to address critical concerns in the current community resilience literature. One concern was the need for better flexibility to account for the wide variety of actors within a community system. A second concern—the pre-eminence of only four major outcomes (nutrition security, food security, environmental sustainability, and economic security) — ignores other important system-level capacities. A third issue in the literature is the normative dialog within resilience. Finally, existing literature overemphasizes specific resilience rather than general resilience. The Community Resilience Framework was therefore developed with a particular emphasis on community development practice to address these issues.

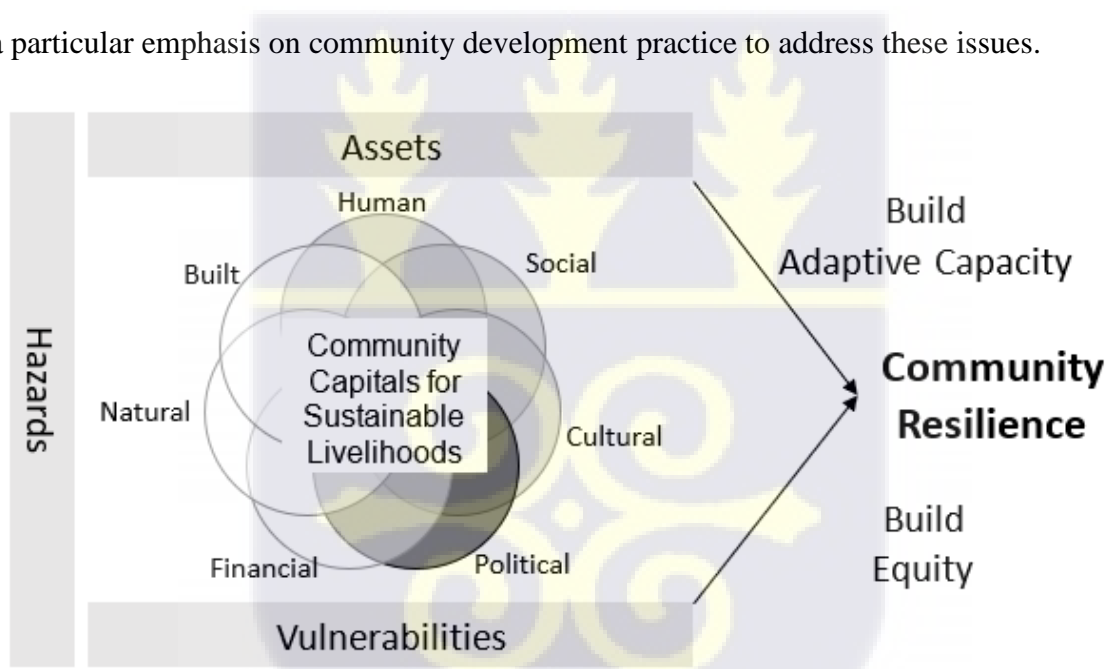


Figure 2: The Community Resilience Model.

Source: Cafer, Green, & Goreham, 2019

The goal of the community resilience model (Cafer, Green, & Goreham, 2019) is to help local communities become more resilient to shocks and crises. In order to help communities adopt risk-informed, comprehensive approaches to address their underlying vulnerabilities, this model seeks to direct and support community efforts. It promotes the adoption of people-

centred, demand-driven strategies by communities to strengthen their resilience. Endorsing the necessity of maintaining ties with communities and being accessible to all in order to stop and lessen suffering among people. Resilience has played a major part in conceptualizing the usual world since 1970s (Cafer, Green, & Goreham, 2019). Various conceptual frameworks have been applied to determine the resilience of communities towards numerous hazards (Almutairi, Mourshed, & Ameen, 2020).

In order to determine how a community is resilient toward suicide certain basic factors must be considered. The resilience of a community towards suicide is determined by the types of systems employed by leadership to minimize suicide ideation and attempt (Zuromski et al., 2019). It is also determined by the various assets the community has invested into, in order to strengthen its capacity and populace in multiple ways so as to avert suicide (Aitsi-Selmi et al., 2015; Tyler & Moench, 2012). These may include infrastructural, educational, social, religious and health investment. The community needs to prepare against various types of hazards in order to determine its resilience. Preparedness, in summary, will make any given community more resilient to suicidal behaviours.

The community Resilience framework depicts community assets to include the human capital, built infrastructure, natural resources, financial reserves, social and cultural development as well as political leadership. These assets, if properly harnessed will lead to the building of equity and adaptive capacity that will afford members of the community sustainable livelihoods. Such a resilient community can overcome vulnerabilities and hazards such as suicidal behaviours that rise within it from time to time. Resilience therefore is a product of the proper harnessing of the various factors represented.

Figure 3 below is a representation of the community resilience model that has been adapted and will be utilized for the study.

This study utilized the “Community Resilience Framework for community development practitioners, building equity and adaptive capacity” as a guide. The framework portrays community assets to include the human capital. It also acknowledges that the level of built infrastructure in given communities affect the quality of life of inhabitants; furthermore, natural resources alone do not by themselves ensure citizenry are living well but rather it is the proper harnessing and utility of these resources that will ensure better living standards, again the framework reiterates sufficient financial reserves as another factor that contributes to community resilience; then social and cultural development was as well noted as an essential component. Finally, political leadership is given the mandate to pull all these resources together to better the lives of the people in the community and the nation as a whole and thereby promoting resilience to suicide.

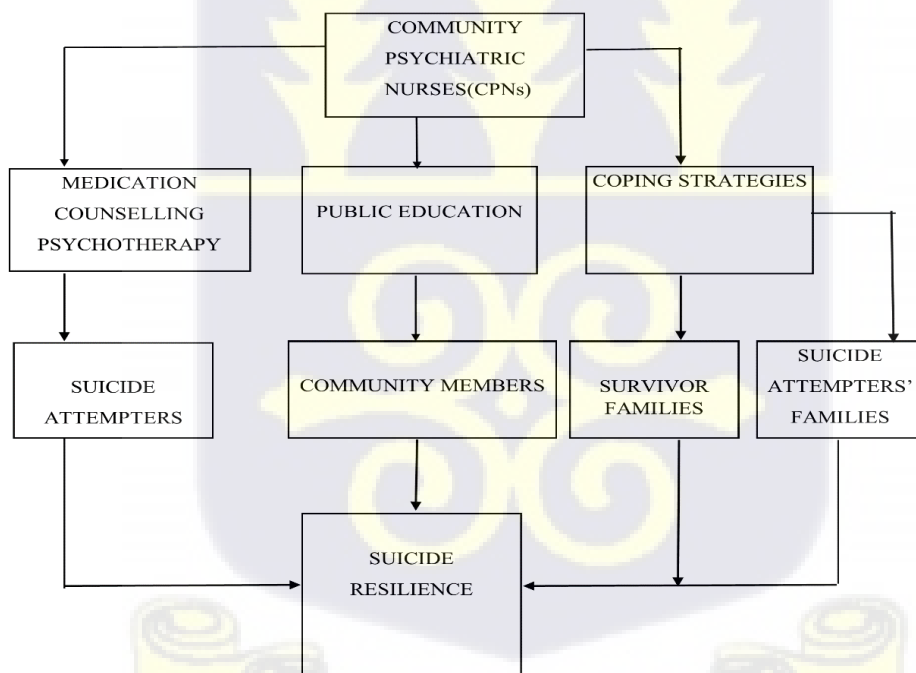


Figure 3: Conceptual framework for Community Resilience to Suicide Model

The above adapted model shows how Community Psychiatric Nurses will utilize the relevant information gathered from suicide attempters’ and families of completed suicide victims, the Attempters themselves and the community to improve Community Psychiatric Nursing

service delivery which will eventually help reduce the number of suicide cases in our homes, communities, and the nation.

Theoretical frameworks form the foundation of research studies in terms of the research question, the significance of the study, statement of the problem, methodology and analysis, basis for the literature review (Kivunja, 2018). Community resilience against suicide can be clarified by multiple of theories but this particular research is directed by the Community resilience and the Orlando Deliberative Nursing Process.

Orlando Deliberative Nursing Process Theory places a strong emphasis on the nurse-patient relationship, validating the patient's perceptions, and applying the nursing process to achieve desired results or patient improvement. Her theory consents to nurses creating effective nursing care plan that can similarly be improved if any difficulties arise with the patient.

It includes interacting with the patient's and finding out his/her instantaneous needs for assistance. The Orlando Deliberative Nursing Process is sensitive to people who are vulnerable or who fear becoming vulnerable. It focuses on the approach to care in a momentary encounter. It is particular with providing direct assistance to a patient in whatever setting they are found to diminish, relieve, avoid, curing the patient's weakness and vulnerability to ensure the patient needs are met. To ensure the purpose of nursing has been achieved, it is vital that the patient instant needs for assistance is ascertained and met especially patient's difficult circumstances. The nurse discovers the patient's immediate need for assistance through the patient's presenting behaviour. The nurse is able to achieve this by first identifying the challenging situation. Irrespective of how the presenting behaviour appears, it is likely to signify a cry for help from the patient. The nurse automatically responds internally to the stimulus. The patient's presenting behaviour and the patient responds in kind. The nurse's response may be automatic (determined for purposes other than the patient's

immediate need) or deliberate (determined after determining a need and then meeting this need).



CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Suicide is a serious social and medical issue (Andoh-Arthur et al., 2019). Research on suicide has primarily concentrated on risk factors for suicidal behaviour for decades, ignoring protective characteristics like resilience that could aid in addressing this significant public health concern (MacDonald et al., 2013; Sher, 2019). Resilience is the ability to adaptably overcome stress and adversity while preserving normal psychological and physical functioning (Horn, Charney, & Feder, 2016). Research carried out in the last ten to fifteen years indicates that resilience serves as a safeguard against the risk of suicide (Sher, 2019). Research and prevention on suicide are increasingly centered on resilience (Sher, 2019). Interventions for suicide prevention that are universal, targeted, and recommended should include resilience building. Building resilience may lower the risk of suicide in high-risk individuals, at-risk groups, and the general population. Increasing resilience among the general public may lower the prevalence of disorders linked to stress and, in turn, lower the rate of suicidal thoughts and actions. Every psychiatric patient's treatment plan ought to include building resilience. Mental health providers who actively focus on boosting patients' stress resilience will most likely have the greatest success in lowering the risk of suicide in psychiatric patients.

Suicide is a complex phenomenon that has affected and continues to negatively affect individuals worldwide (Arensman et al., 2020). The indirect effects are far reaching and diverse and is not limited to the individual who loses his or her life but also takes a toll on nuclear families, extended families, communities, nations and on the world as a whole (Osafo, Asante, & Akotia, 2020). Presently all attention is on the adverse effects of suicidal behaviour on the individual and their immediate families, such as shame, stigma, disability, loss of

income, family support and orphans amongst others (Biffu et al., 2021; Hawton et al., 2021). There is however limited knowledge on the effect suicides and attempted suicides have on the larger community and beyond.

It is for the above reason that this chapter is dedicated the review of existing literature on suicide; taking the objectives of the study into account, through the following search engines, Google, PubMed, Hinary, Cochrane, Science Direct, Google Scholar, and Medline ` , among others, to obtain information on various literature related to this research. It covered suicide situation on the global level, in Africa, in Ghana and various suicide prevention strategies. It searched existing literature on the experiences of individuals who have attempted suicide in relation to precipitating factors, the opinions of suicide attempters' families in relation to the general effects of the attempt on the family, the views of community members that almost lost/lost a member to suicide in relation to how they handled such cases, the strategies used by community psychiatric nurses in the management of individuals and families of both attempted and completed suicide cases and the coping strategies used by families of suicide victims.

2.2 The Global situation of suicide (epidemiology and burden).

Suicide mortality actualy turns out to be a global public health problem, approximately 800 000 persons die because of suicide each year, this represents one individual each 40 seconds (Ping & Panirselvam, 2019). Of all deaths worldwide suicide represents 1.4%, thus making it the 18th foremost reason for an persons death in recent times (Jokinen et al., 2018). Estimates reveal that 79% of suicides currently take place in the low and middle-income countries (Uddin et al., 2019). There are signals that show that for each adult who died by suicide there is the likelihood that 20 more others might have attempted it (Gritsenko et al., 2020; World Health Organization, 2020). It is also revealed through reearch that suicide in recent years have taken a principal place among cases of violent death (Elov, 2022).

Suicidal behaviour was deliberated to be an occurrence that pertains to a specific country, Nation or province (Elov, 2022) . On the contrary the issue of suicide is not unique to any particular race, people, colour, ethnic group, religious body or nation for that matter (Klonsky, Saffer, & Bryan, 2018; Lawrence, Oquendo, & Stanley, 2016; Linde et al., 2017). Recently, the number of suicide cases have increased worldwide and it is the leading cause of death between the ages of 15-34 years (Elov, 2022). Statistics show that 3 thousand persons die by suicide daily, and attempted suicide cases is 10 times greater than completed suicide cases and in reality actual occurrences of suicide cases are more than reported suicide cases (Elov, 2022).

Evidence-based and effective mediations can be employed by individual levels, population and sub-population to prevent suicide attempts and suicide (Azizi et al., 2020; Begum et al., 2017; Page et al., 2018). The improvement in mental health services, introduction of extra safer psychotropics (including anti-depressants) and effective psychotropics (including anti-depressants) and, some countries have systematically and successfully reduced the incidence of suicide over the years (Turecki & Brent, 2016). Certain countries like Scotland and Finland reported a substantial decrease in suicide rates, as well as Australia, Sweden and Norway (Lewitzka et al., 2019).

Inspite of the gains some countries have made in terms of suicide reduction, global suicide rates continue to rise (Gysin-Maillart et al., 2016). “The answer can partly be that although there have been some improvements in suicide prevention in developed countries, there are also reported upsurge in suicides in numerous developing countries, such as China and India” (McLoughlin, Gould, & Malone, 2015).

“While suicide prevention is receiving increased attention in many developed countries, it remains largely ignored in developing countries, where a number of factors” such as poor social attitude and criminalization impede the implementation of successful preventive

programmes (Mulenga et al., 2017). The incidences of suicide are usually reported as rates per 100 000 (McMahon et al., 2014). Therefore, countries with rates of more than 30/100 000 (e.g. Sri Lanka, Lithuania, Latvia) are considered high rates nations (Lappi-Seppälä & Lehti, 2014); individuals with rates between 10–29/100 000 (e.g. China, Slovenia, Japan) as middle rates countries and those with rates less than 10/100 000 (e.g. Egypt, Jordan) as low rates countries. However, rates don't always accurately depict how serious a problem is (Fountoulakis et al., 2014). For instance, China has a moderate suicide rate of roughly 25 per 100,000 people, but it also has the highest annual suicide rate (287 000) (Wang, Chan, & Yip, 2014; Zhang, 2019; Zhong, Chiu, & Conwell, 2016).

Similarly, “India has a rate of 10–11/100 000 but is second only to China in the actual number of people (110 000) who kill themselves” (Imtiaz, Ali, & Ali, 2015; Simon et al., 2013). To put this into perspective, the total number of suicides in India is more than the total number in the four top-ranked European nations—Lithuania, Latvia, Estonia, and the Russian Federation. (Bachmann, 2018; Milner, McClure, & De Leo, 2012; Värnik & Wasserman, 2016). In Brazil, “suicide rates increased by 21% between the years 1980 and 2000 and is currently at 4/100 000 (similar to most South American countries) which in real numbers is almost 8000 individuals” (Colombo-Souza et al., 2020; Machado, Rasella, & Dos Santos, 2015). Pakistan, which an Islamic country with traditionally few suicides, has seen a dramatic increase in suicide incidences over the last few years, from a few hundred to more than 3000 in 2003 (Malakouti et al., 2015). However, neither national suicide statistics nor WHO reports are gathered by the nation. As a result, Pakistan is rarely considered when compiling global suicide statistics or planning prevention programs (Khan, 2005).

Even though data from African countries are lacking, there are isolated reports which indicate that suicidal behaviour occurs in these countries as well. Studies have been published from Tanzania, Nigeria, Zimbabwe, Uganda, Egypt, and Ethiopia (Asante et al., 2017; Mars et al.,

2014). HIV/AIDS is one of the newer factors contributing to suicidal behavior in African nations, this requires adequate attention to enable effective management (Osafu et al., 2017). More than 50 states with a predominately Muslim population—including those with populations of more than 100 million, like Bangladesh, Pakistan, and Indonesia—are among the nations with no suicide reports (Bachmann, 2018). “Suicide also occurs in all these countries but, due to a variety of religious, legal and cultural factors, data collection and reporting is largely neglected” (Hirsch & Cukrowicz, 2014; Say et al., 2014).

2.3 Causes of Suicide

Mental disorder is a major risk factor for suicide (Andoh-Arthur et al., 2020; Oquendo & Baca-Garcia, 2014). It is well known that more than 90% of suicide victims had a mental illness diagnosis at the time of their demise (Bertolote & Fleischmann, 2002). While high-income countries are aware of the connection between mental disorders—specifically, depression and alcohol use disorders—and suicide, many suicides occur on their own during times of crisis when a person's capacity to cope with life's stresses, such as financial hardships, chronic pain or illness, or the breakdown of a romantic relationship, collapses (Adamczyk & Hayes, 2012).

Furthermore, experiencing conflict, disaster, violence, abuse, or loss and a sense of loneliness are strongly linked with suicidal behaviour (Brake et al., 2017). Likewise suicide rates are high amongst vulnerable groups who face discrimination, such as refugees and migrants; indigenous peoples; lesbian, gay, bisexual, transgender, intersex (LGBTI) persons, as well as prisoners (Elze, 2019). But prior suicide attempts seem to be the strongest risk factor for suicide (Chu et al., 2018; Kar et al., 2021; Rezaeian, 2018; Shoib & Arafat, 2021).

In Ghana, findings show that a wide range of issues, including a lack of support, guilt, abandonment, life's challenges, and supernatural causes, are contributing factors to suicidal behaviour. (Akotia et al., 2019). The reasons were also chronic in nature, which is to

say that they represent crises the attempters have struggled with over a long period of time (Osafo et al., 2011).

Researchers in other LMICs have had similar findings (e.g., Alem et al., 1999; Gunathileke, 2001; Khan, 2005; Kinyanda, Hjelmeland, & Musisi, 2004; Knizek et al., 2010; Knizek et al., 2011). “In an interdependent society, such as Ghana, the importance of interrelated values and good social support systems cannot be overemphasized” (Triandis, 2000). For this reason, “social disconnection, loss of meaning, a deep sense of despair and a host of other sociocultural factors can lead to serious consequences, including suicidal behaviour” (Akotia et al., 2019).

On the other hand teen or adolescent suicide attempters have also given several other reasons for attempting to take their own lives (Gulbas et al., 2015). These include stress due to parental pressure for academic laurels. Inability to obtain such laurels makes these youngsters feel they have disappointed their parents and themselves; this can lead them to attempt suicide (Holliday & Vandermause, 2015). Another reason is bullying and peer pressure in senior high schools at the hands of seniors (Addy et al., 2021; Shayo & Lawala, 2019). In its extreme forms, some youngsters feel worthless and see taking their lives as an escape route (Lachal et al., 2015).

Emotional neglect, domestic abuse, sexuality confusion, sexual abuse, divorce and mental disorders are further reasons why other teens attempt to take their own lives in Ghana (Abdulai, 2020b; Dzokoto et al., 2018).

2.4 Methods of suicide

Any way by which an individual decides to take their own life is considered a suicide method. Suicide attempts can leave the victim with severe physical harm, long-term health issues, and brain damage, but they do not necessarily end in death.(Koo, Kőlves, & De Leo, 2019). In order to develop effective prevention strategies, such as limiting access to means of suicide,

it is crucial to have knowledge of the most popular suicide methods (Wu, Chen, & Yip, 2012). Pesticide self-poisoning is thought to be the cause of 20% of suicides worldwide, with the majority of these cases occurring in rural agricultural areas of low- and middle-income nations (Gunnell et al., 2017; Lee et al., 2021). Other common methods of suicide are hanging and firearms. In totality, the differences in the suicide methods used in different countries are noteworthy. Three methods that is hanging, pesticide and firearm suicide were commonly used because they dominate country-specific suicide patterns (Bojanić, Pitman, & Kapur, 2021). Plunging from a height and other poisoning techniques (primarily drug poisoning) are occasionally mentioned as significant substitute techniques (Dogan & Toprak, 2015). According to the analysis, when there is no other viable major method, hanging is the most common suicide method. When the use of firearms or pesticides rises, the percentage of hangings usually falls. In developing Asian nations, pesticide suicide has been identified as a serious public health issue. It has long been known that the prevalence of suicide is influenced by firearms, with firearm suicide being more common in several American and European countries. In nations where private households commonly own firearms, firearm suicide is a common occurrence (Anglemyer, Horvath, & Rutherford, 2014; Kposowa, Hamilton, & Wang, 2016).

In Korea, “the most frequently used methods of suicide were different in the two groups of attempters and completers” (Lim, Lee, & Park, 2014). The most frequently used method in suicide attempters was drug poisoning was, whereas hanging was the most common method among suicide completers (Joo et al., 2016). When compared to other suicide techniques, drug poisoning, stabbing, and other chemical poisoning were found to be relatively non-lethal. Based on the classification of the method's lethality, about 70% of suicide attempters employed comparatively non-lethal techniques, while nearly all suicide completers used

lethal techniques. Males were more likely than females to use more deadly suicide techniques (Lim, Lee, & Park, 2014).

2.5 Suicide prevention strategies worldwide and in Africa

Suicides are preventable (Large & Nielssen, 2012; Trueland, 2014; Walter & Pridmore, 2012). “There are a number of measures that can be taken at population, sub-population and individual levels to prevent suicide and suicide attempts” (Page et al., 2018). Among them are lowering the availability of suicide tools (such as weapons, pesticides, and some prescription drugs) (Gunnell et al., 2017); the implementation of alcohol policies to prevent the harmful use of alcohol; school-based interventions; responsible media coverage; training of non-specialized health workers in the assessment and management of suicidal behaviour; follow-up care for individuals who have attempted suicide and community support; early identification, treatment, and care of individuals with mental and substance use disorders, chronic pain, and acute emotional distress (Barber & Miller, 2014; Betz & Anestis, 2020).

Suicide prevention efforts necessitate coordination and collaboration among various sectors of society, including the health sector and other sectors like education, labour, agriculture, business, justice, law, defence, politics, and the media, because suicide is a complex issue (Charankumar et al., 2020). Since suicide is a complex issue, no one approach can effectively address it on its own; therefore, these efforts must be comprehensive and integrated (Galynker, 2023).

WHO recognizes suicide as a public health priority (Abuabara, Abuabara, & Tonchuk, 2017). The 2014 release of the first WHO World Suicide Report, *Preventing Suicide: a Global Imperative*, aims to raise awareness of the importance of suicide and suicide attempts for public health and to prioritize suicide prevention on the global public health agenda. Additionally, it seeks to support and encourage nations in strengthening or developing all-encompassing suicide prevention plans using a multisectoral public health approach.

The WHO Mental Health Gap Action Programme (mhGAP), which was introduced in 2008 and offers evidence-based technical guidance to scale up service provision and care for mental, neurological, and substance use disorders in countries, lists suicide as one of its priority conditions. WHO Member States have committed to working toward the global goal of reducing the suicide rate in countries by 10% by 2020 in the WHO Mental Health Action Plan 2013 to 2020. Furthermore, target 3.4 of the Sustainable Development Goals—which calls for promoting mental health and well-being and reducing premature mortality from noncommunicable diseases by one-third by 2030—is indicated by the suicide death rate (Bennett et al., 2020; Bennett et al., 2018; Izutsu et al., 2015).

2.6 Challenges and obstacles

2.6.1 Stigma and taboo

Many people who are contemplating suicide or who have attempted suicide do not seek help and, as a result, do not receive the help they require because of stigma, especially in relation to mental illnesses and suicide. (Micheltore & Hindley, 2012). Due to the taboo nature of openly discussing suicide in many societies and the lack of awareness of suicide as a serious public health issue, the prevention of suicide has not received enough attention (Pompili, 2012). Just 38 countries claim to have a national suicide prevention strategy, and only a small number of nations have made suicide prevention one of their top health priorities to date (Zalsman et al., 2016). For countries to make progress in preventing suicide, it is imperative that they break down social taboos and increase community awareness.

2.6.2 Data quality

Globally, data on suicide and suicide attempts is not readily available or of high quality. Suicide rates can only be explicitly estimated from 80 Member States with high-quality vital registry data. (Dückers et al., 2019). Although suicide is not the only cause of poor-quality mortality data, given its stigma and the fact that suicidal behavior is prohibited in some

nations, it is a particularly sensitive issue. Underreporting and misclassification of suicide are probably bigger issues than they are for the majority of other causes of death (Glenn et al., 2020).

Suicide prevention strategies that are effective must include improved surveillance and monitoring of suicide and suicide attempts. Suicide patterns vary across countries, and variations in rates, features, and methods of suicide draw attention to the necessity for every nation to enhance the timeliness, comprehensiveness, and quality of its suicide-related data. This includes hospital-based suicide attempt registries, vital registration of suicide, and nationally representative surveys that gather data on self-reported suicide attempts (Azra et al., 2023; Ivey-Stephenson et al., 2022; Nielsen et al., 2023).

2.7 Sample successful suicide prevention strategies

2.7.1 China

China has had a dramatic shift from having one of the highest suicide rates in the 1990s to having one of the lowest in 2016 (Platt, 2016). This is attributable to certain positive factors which include the following.

Fast economic development: The general standard of living of the population in China appreciated remarkably leading to the reduction of frustration, anger and mental agony and a reduction in suicidal behaviour.

Migration to urban areas: Majority of suicidal behaviour was in the rural areas but as people migrated to work in the cities, they left behind the conditions that predisposed them to suicide.

The change in social values: Economic development came along with Western ideologies that countered most traditional Chinese social values. Many young women who were at the highest risk of suicidal behaviour, in rural areas where Confucian teachings were entrenched became more liberated as they moved to the cities where liberal Western ideas dominated.

Reduced family sizes: Forty years ago China's policy of having one child per family, preferably male children, led to a sex imbalance. There were now about 33 million more males than females by year 2000. Given that most of the suicidal behaviour was by young women. The phenomenon was drastically reduced by reduction in their population.

Surveillance based counselling: Suicide among college students are far lower than that of non college students of the same age because the students are closely monitored and counselled against suicidal behaviours.

The control of the media by government: China's media is controlled by the government and it does not allow the broadcasting of undesirable news and occurrences such as suicide in order to avoid copy cat behaviour by the youth.

According to recent studies, China has been a huge success story in recent decades, contributing significantly to the global decline in suicide-related deaths, even though suicide prevention is still a challenge that affects everyone (Lew et al., 2020) .

The Asian country is the best at preventing suicide, according to a study that was published in the British Medical Journal (BMJ). Over the course of 27 years, there was a 64 percent decrease in these deaths. According to the study, this had a significant role in the 33 percent drop in the suicide rate worldwide during that time. The study revealed that while the global suicide death toll rose by 6.7% from 762,000 in 1990 to 884,000 in 2016, the suicide death rate decreased from 16 per 100,000 people to 11.2 during the same time period.

Approximately 17% of all suicides worldwide occurred in China in 2016 (Chu et al., 2018; Zhong, Chiu, & Conwell, 2016). China's suicide rate in 2016 was 9.7 per 100,000, one of the lowest in the world and significantly lower than its suicide rate in the 1990s, which was over 20 per 100,000 (Maris, 2019).

2.7.2 Ireland

The Irish government's strategy is called “Connecting for Life: Ireland’s National Strategy to Reduce Suicide 2015–2020” (Platt, Arensman, & Rezaeian, 2019). "Reach Out," the first national suicide prevention strategy from 2005 to 2014, served as its guidance. This tactic increased awareness of suicide prevention efforts and directed activities in this field. "Reach Out" outlined a goal and tenets for preventing suicide. In that time frame, 96 actions with designated lead agencies were described (O'Donnell & Richardson, 2020). Significant advancements have been made in the fields of suicide prevention research, policy, and service delivery since "Reach Out." (O'Neill & O'Connor, 2020). Reach Out serves as a major foundation for the new 2015–2020 Connecting for Life strategy (Dublin, 2016) .

Implementation: Five advisory groups covering research, policy, practice, engagement, and communications/media were appointed to assist in the development and execution of the strategy. The evidence-based approach used in the strategy's development and knowledge of best practices for policies and services served as the foundation for its execution. Four incremental stages, each requiring a different set of conditions and tasks, were developed for an efficient implementation. Planning and resource allocation, operationalizing and executing, investigating and getting ready, and complete implementation were these. The strategy included a number of interventions that were supported by evidence. Plans for communication and resource allocation were developed to assist with the strategy's execution. Coordination between government departments and agencies is essential to Connecting for Life. The key components of an efficient implementation are clearly defined roles and responsibilities in capacity development, budgetary management, evaluation frameworks, and formal accountability. Having strong implementation structures in place helps monitor activities and establishes a clear decision-making process for government strategies with short implementation timelines. This prevents decisions from being made hastily without defining

accountability and consequences. The five main Connecting for Life implementation structures serve as a representation of the various stakeholder groups involved in the program's delivery, offer forums for participation, encourage clear monitoring and decision-making, and are made to maximize the use of already-existing structures to guarantee effective operation (Malone et al., 2017).

2.7.3 Japan

In 2017 the Japanese Cabinet Decision called Realising a society in which no one is motivated to take their own life: the general principles of suicide prevention policy was created. (Yamauchi et al., 2017).

In the year 2005, suicide was recognised as a social issue in Japan, which led to tangible measures (Yamaoka et al., 2020). The Minister of Health, Labour, and Welfare pledged to address the issue of suicide at the symposium on suicide countermeasures held in May 2005, where NGOs and some Diet members submitted urgent proposals for comprehensive suicide prevention (Okamura et al., 2021). Subsequently, Japan's Basic Act for Suicide Prevention was signed into law in June 2006 (Okamura et al., 2021; World Health Organization, 2018). After this, the Cabinet Office took over as the main driving force behind suicide prevention, replacing the Ministry of Health, Labour, and Welfare. As a result, suicide prevention became a multi-ministerial government policy. In an effort to stop suicide and help survivors, the General Principles of Suicide Prevention Policy were implemented in 2007 (Shimpo, 2018). These broad guidelines were updated in 2012 with a focus on supporting youth and individuals who have attempted suicide in the past (De Choudhury et al., 2016). Establishing the roles of the national government, local public entities, associated organizations, private-sector entities, companies, and the Japanese people, as well as encouraging collaboration and coordination among them, was how the implementation was ensured (Kuroki, 2010).

2.7.4 Scotland

In 2002, Choose Life, a national suicide prevention strategy and action plan in Scotland, was introduced with the goal of lowering the suicide rate by 20% by 2013 (Harkess-Murphy, MacDonald, & Ramsay, 2012). Scotland had seen a rise in suicide rates, with men accounting for 27 per 100,000 deaths in 2001 (women's rates were 9 per 100,000) (Palmer, 2014). A national public mental health program called Choose Life was created and put into action as a part of larger Scottish policy commitments to address inequalities, advance social justice, and improve population health (Gask, Coupe, & Green, 2019). This makes it possible to carry out work on suicide prevention within a larger framework of policy goals and initiatives that all have the general objective of enhancing the mental health of the populace (Palmer, 2014; Robinson, Braybrook, & Robertson, 2014), but did not tackle community resilience against suicide which included the individual, family and the community.

The Scottish Government spent £20.4 million from 2002 to 2006 to put the "Choose Life" strategy into action (Mackenzie et al., 2007) . A nationwide network of agencies spanning multiple sectors worked together to create educational materials and set up an execution plan. The development of multi-professional training programs, multi-sector coordination of suicide prevention, and provision of funding for community-based interventions were the three main goals that all local authorities concentrated on.

Scotland had an 18% decrease in the suicide rate between 2000–2002 and 2010–2012. In 2012, an assessment of "Choose Life" was finished (Gask, Coupe, & Green, 2019); nevertheless, it is challenging to identify whether the decrease is related to the program overall or to any specific components of it (Stephany, 2017).

More recently, "United to Prevent Suicide" was introduced as a component of Scotland's National Suicide Prevention Action Plan. Co-managing this movement are Public Health Scotland and SAMH (Murphy, 2016).

2.7.5 Namibia

In Africa Namibia instituted the 2011 strategic plan of the Namibian Ministry of Health and Social Services, called “National Strategic Plan on the Prevention of Suicide in Namibia 2012–2016”(Arensman et al., 2020) .

A national SWOT analysis conducted prior to the strategy's implementation showed that Namibia was beset by a high degree of stigmatization, governmental fragmentation, and a shortage of infrastructure and training. The fundamental knowledge from this analysis served as Namibia's direction in addressing the issue of suicide and its prevention. The first nation in Africa to implement a national suicide prevention strategy was Namibia (Quarshie, Waterman, & House, 2020; Vadis, 2016). Multi-professional teams now have the chance to address the issues through suicide prevention programs, workshops, training sessions, counseling, and other awareness-raising campaigns, thanks to Namibia's National Strategic Plan on the Prevention of Suicide. In cooperation with all parties involved in suicide prevention, the National Strategic Plan was created (Vijayakumar & Phillips, 2016).

2.8 Community based suicide prevention strategies

According to data analysed from five extensive community-based initiatives carried out in the US, Canada, Australia, and Europe, each of these initiatives employed a multi-level strategy that integrated several integrated suicide prevention techniques (Snijder et al., 2020). Each one was founded on a great deal of research, which included community engagement, expert consultation, and literature reviews. Furthermore, all of these programs are theoretically sound, and available evaluation results show that the programs were successful in lowering suicide deaths and/or attempts, even though some of them are still undergoing evaluation (the Australian program was only recently launched).

The United States was the site of the first two programs. A well-known example of a comprehensive, community-based suicide prevention program that has been successful is the U.S. Air Force Suicide Prevention Program (AFSPP), which was established in 1996. The program, which brought together eleven primary initiatives to strengthen social support, encourage the development of coping skills, and alter policies and norms to support help-seeking behaviors, was created in response to an increase in suicide rates within the U.S. Air Force. According to program evaluation, Air Force personnel had a one-third lower risk of suicide as a result of the program. In addition, reductions in homicide, family violence (including severe family violence), and accidental death were associated with program participation. These negative outcomes share risk factors with suicide.

The second program, the Model Adolescent Suicide Prevention Program, was created in response to a rise in youth suicide attempts in the small American Indian tribe of the Western Athabaskan Tribal Nation, located in rural New Mexico. The program included a number of integrated suicide prevention strategies, including community education, surveillance, school-based activities, and the use of "natural helpers," or neighborhood volunteers of various ages who offered peer training, advocacy, referrals, and counseling (in coordination with professional mental health staff). The program was informed by extensive consultation with community members and various key stakeholders. The results of the evaluation show that the number of suicide attempts fell from an average of 19.5 per year prior to the program's start (1988–1989) to 4 attempts in 2002. (Deaths from suicide remained stable during this time period, at 1 to 2 per year.)

Help for Life, a Canadian initiative to prevent suicide that was launched in Québec in 1998 to carry out the province's suicide prevention strategy, is another illustration of a comprehensive program. The five-year strategy, which was created after a thorough consultation process involving nearly 40 organizations, prioritized seven suicide prevention tactics, such as crisis

management, training, and limiting access to lethal means. This program led to the establishment of a provincial hotline, the creation of suicide prevention centers across the province, enhanced mental health services and follow-up for individuals who attempt suicide, the installation of barriers on important bridges and railroad trestles, and improved training for youth protection agency staff. The program is acknowledged for helping to lower the province's suicide rate from 22.2 per 100,000 in 1999 to 13.7 per 100,000 in 2012. The European Alliance Against Depression (EAAD) is the most widely used suicide prevention program in Europe. Its dual goals are suicide prevention and depression treatment. Established in 2004 with support from the European Commission, the Nuremberg Alliance Against Depression (EAAD) drew upon the achievements and insights gained from its predecessor. With the help of programs that use a four-level approach to address gatekeeper training, public awareness campaigns, primary care provider training, and support for affected individuals and high-risk groups, the European Alliance Against Depression aims to improve the treatment of depression and prevent suicide. Since its initial implementation in 17 European nations, EAAD has spread throughout many European regions (Bazemore & Schiff, 2015).

A suicide prevention program was developed using the EADD approach and was implemented in four European regions between 2008 and 2013. The European Commission started the five-year Optimizing Suicide Prevention Programs and their Implementation in Europe (OSPI-Europe) study in 2008 to find out more about the best combination of suicide prevention tactics. The study was carried out in Germany, Hungary, Ireland, and Portugal. The intervention included the four EAAD strategies and added a fifth strategy addressing access to lethal means, all of which were informed by a thorough review and consultation process. Lessons learned from the process evaluation have been presented in recent papers and can be helpful in the planning of new community-based suicide prevention programs, even though findings regarding the primary outcomes (deaths and attempts) are not yet available.

The LifeSpan Program in Australia's New South Wales was the most recent international project that was examined. The program is built upon an integrated framework for suicide prevention that was unveiled in August 2015 and places a strong emphasis on a systems-based approach to the problem. The National Health and Medical Research Council (NHMRC) Centre for Research Excellence in Suicide Prevention (CRESP) and the nonprofit Black Dog Institute developed the framework for the NSW Mental Health Commission. The framework was developed after extensive consultation with partners from across the health and medical sectors. With funding from the Paul Ramsay Foundation totaling \$14.7 million, the program combines nine evidence-based strategies that will be implemented concurrently. These include crisis care, high-quality treatment, training, school programs, communication campaigns, media guidelines, and means restriction. In October 2016, implementation got underway in Newcastle and will be spread over two and a half years to three other regions.

Only three nations—Algeria, Congo, and Madagascar—were in the process of creating any kind of suicide prevention strategy at the time of this survey, out of the eighteen countries in the African region examined by Osafo, Asante, and Akotia (2020). Of the eighteen AFRO countries, four had official national suicide statistics available, and two published national figures on suicide attempts. There were only four countries offering general practitioners' or mental health professionals' training programs on suicide assessment and interventions. Four countries have at least one non-governmental organization (NGO) devoted to suicide prevention, and one country has a national center specifically for suicide research or prevention. Three AFRO countries offered postvention bereavement support to families impacted by suicide. Suicide is not an admissible cause of death in more than half of the nations. In all 18 of the AFRO countries, statistics on suicide and suicide prevention are not well tracked. Given the current state of suicide prevention in the area, cross-country initiatives

that create a critical mass of support will be necessary to advance suicide advocacy and the establishment of national prevention strategies in the area.

2.9 Suicide Prevention Initiatives In Ghana

Increasing the capacity of nonspecialist healthcare providers and increasing the capacity of specialists are the two approaches for creating a workforce in mental health with the appropriate combination of skills. Community and primary health care workers can be trained to carry out a range of tasks under proper supervision in low- and middle-income countries. Identifying and referring cases, providing psychosocial therapies, and assisting with medication adherence are some of these responsibilities. For instance, two courses have been developed by the Kintampo Project in Ghana to train two new cadres of community mental health officers. Through this project, 296 new practitioners who operate throughout Ghana have been trained as of 2012. As a result, from 2011 (67,792 people) to 2013 (154,322 people), there was a more than 200 percent increase in the number of people in Ghana receiving treatment for mental health issues. Though the above is a step in the right direction towards suicide prevention in Ghana, there still remains a lot to be done to ensure strengthening community resilience to suicide which is the primary objective of this study; more so these strategies are individually focused, and not population or community based and framed from purely biomedical perspectives.

2.10 Suicide Treatment(As A Mental Condition)

In addition to being a symptom of major depression and the type of depression associated with bipolar disorder, suicidal ideation can also happen to people who do not have any mental illness at all. The rate is much higher for those with mental health disorders. Although the precise numbers are unknown, suicidal ideation is far more common in these populations because it is a symptom of mental health conditions like major depression and bipolar disorder (Soomar, Ali, & Minaz, 2019).

In assessing and managing suicide risk, primary care physicians, nurse practitioners, and other healthcare professionals are crucial. 75% of suicide victims are thought to have spoken with a primary care physician in the year prior to their death, and 45% do so within a month of taking their own lives. Conversely, only 20% of these patients had a mental health consultation in the month before (HHS, Control, & Prevention, 2012) It is clear from the above that most key factors of suicide lie outside biomedicine and hospitalization; the promotion and maximization of all the components of the Community Resilience Framework will serve as a strong alternative to biomedicine.

It has been demonstrated that enhancing the mental health skills of clinicians to identify and address suicide risk factors can lower the number of patients who experience suicidal thoughts. Primary care intervention was found to reduce suicidal ideation in the Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT). According to studies, 70% of elderly people who killed themselves visited a primary care physician within a month of passing away. These findings highlight the possible benefits of screening and intervention techniques centered in primary care (Gould et al., 2015).

2.10.1 Symptoms

Salient warning signs exist that show that you or a loved one are thinking about or contemplating suicide; these signs include; isolating one's self from loved ones, a feeling of hopelessness or being trapped. Individuals who exhibit these traits often discuss death and suicide and readily part with their belongings. Substance abuse, mood swings, anger, rage, and/or irritability are also on the rise. Some people who take risks, such as having unprotected sex. Others seem to passively enquire from unsuspecting people the means to kill one's self, such as medication, drugs, or a firearm. Some also display extreme anxiety and behave as though they are saying goodbye to people. Ask if a loved one is considering suicide or is

preparing to do so. The idea that you'll inspire someone else to take their own life is untrue. Asking demonstrates care and concern for the other person.

Suicidal ideation that is passive, meaning it is not as serious as active suicidal ideation; it can occur when someone wishes they could die while they are sleeping or in an accident instead of by their own hand. It has a blend of active and passive components, and it can become active quickly.

2.10.2 Treatment

Fully engaging the components of the Community Resilience Framework to build a resilient society will have therapeutic effects on the populace and ameliorate suicidal behaviours. These components include proactive political leadership, a solid financial reserve and good fiscal policies, properly developed human capital, a rich cultural heritage, well developed infrastructure, exploited natural resources and social development.

Political leadership: The importance of good political leadership cannot be overemphasised. Major national decisions rest within the authority of political leaders, and the effects of such decisions are far reaching; trickling down to the last person in any given community. When good policies are successfully implemented it works to help strengthen community resilience against suicide (Thornley et al., 2015).

Financial reserves and good fiscal policies: Diversification of the economy can lead to increased revenue generation and appreciated national reserves. Such reserves serve as a strong foundation upon which many good things within the community can be established, including strengthening community resilience against suicide. Good intentions do not materialise without the financial base to implement them. The execution of excellent fiscal and economic policies can aid in the realization of community resilience to suicide.

Properly developed human capital: A community's most essential asset is the human capital. If the people in the community are equipped with the right knowledge, information and skills, they become invaluable in the promotion of community resilience to suicide.

Rich cultural heritage: The culture of a society is the way of life and belief systems they uphold. Culture is developed over a long period of time and handed over from generation to generation. Fine tuning and accentuating the positive aspects of culture can help establish the community on a strong foundation that will help strengthen the communities resilience to suicide.

Social development: the interaction between community dwellers and the general set up of the community goes a long way to promote resilience to suicide. A well knit society carries the capability to withstand shocks that might break down members of the society. The strong societal fabric will not easily break under pressure.

Built infrastructure: A well developed infrastructural system in the community will help solve one of the basic and crucial needs of the people, namely, shelter. Most human activity take place in shelters for example places of residence, schools, work, places of worship, recreation and entertainment. When all these sectors have good infrastructural development it leads directly and indirectly to improvement in the general well being and quality of life for members of the community that helps strengthen its resilience to suicide.

Lifestyle changes, including managing stress, improving sleep, eating, and exercise habits, building a solid support network, and making time for hobbies and interests help to ease and divert the attention of a suicidal person.

2.10.3 Psychiatric Medications

Medications for any underlying depression that's driving the suicidal thoughts. These could include anxiety-reducing drugs, antipsychotics, or antidepressants.

Managing underlying mental disorders and the risk of recurrent or more dangerous self-directed violence may benefit greatly from pharmacologic intervention. To guarantee safe and effective treatment without unfavorable drug interactions, all medications—prescription, over-the-counter, and supplements—used by patients who are at risk of suicide should be reviewed. Prescribers should take into account the toxicity of their drugs when giving them to individuals who self-harm in order to prevent overdose, restrict the amount given or made available, and/or designate a different person to be in charge of obtaining medication access. Adverse event monitoring and follow-up are necessary and should be addressed (Maryan et al., 2019)

Patients with mood disorders treated with lithium, neuroleptics, and antidepressants have a lower long-term suicide rate, despite the paucity of evidence linking psychiatric medications to a reduction in suicidal thoughts and behaviors (Pompili & Goldblatt, 2012). In addition to medication, psychosocial interventions should be provided to individuals with psychiatric and substance use disorders (Cleary et al., 2008).

Lithium and clozapine are the only two evidence-based drugs that have been demonstrated to reduce suicidal thoughts and actions. These drugs take some time to reach therapeutic levels, though. Until a behavioral health assessment can be completed, anxiolytics, sedative/hypnotics, and short-acting antipsychotic medications can be used to treat agitation, irritability, psychic anxiety, insomnia, and acute psychosis. If the patient is suspected of being impaired by alcohol, illegal drugs, or prescription or overdose medication, the kind and quantity of medication must be carefully selected and titrated.

2.10.4 Electroconvulsive therapy

Additional treatments should be used if the depression is very severe, does not respond to treatment, or if psychotic symptoms manifest. The most traditional and well-researched is electroconvulsive therapy, which can be administered as an outpatient or an inpatient

procedure but necessitates anesthesia and the application of a tiny electric current to the brain. Although it can have some side effects, which doctors are trying to minimize, it is incredibly effective. Transmagnetic stimulation (TMS) is a comparable but possibly less successful treatment. Lastly, in addition to other treatments, the doctor may recommend light therapy for patients with seasonal mood disorder (Ougrin et al., 2015).

2.11 Psychiatry And Community Psychiatric Services In Ghana

Ghana, home to about 30 million people, was a lower middle-income nation in 2011. There was legislation, a plan, and a mental health policy in place. The laws pertaining to mental health were out of date and did not follow best practices. With only 1.4% of health spending going toward mental health and a strong bias towards urban areas, services were severely underfunded. This is significantly less than what would be expected given Ghana's economic situation: there were 123 mental health outpatient facilities, 3 psychiatric hospitals, 7 community-based psychiatric inpatient units, 4 community residential facilities, and 1 day treatment center. Most patients received their care in psychiatric hospitals and outpatient clinics, with the latter providing the majority of the inpatient beds. Of the estimated 2.4 million people with mental health issues in 2011, 67,780 (or 2.8% of the total) received treatment. In the field of mental health, there were 18 psychiatrists, 1,068 Registered Mental Nurses, 19 psychologists, 72 Community Mental Health Officers, and 21 social workers employed. This is an imbalanced number of professionals, with an unequal emphasis on nurses relative to expectations.

The existence of a long-standing service with employees working across the nation in outpatient clinics and hospitals was the primary strength of the mental health system. The primary shortcoming of the system was the extremely low level of government funding allocated to mental health, with the majority of the limited services concentrated in the nation's

capital, leaving a large portion of the rest of the country virtually unserved. Nurses predominated in providing services; few other professional groups were present.

2.12 Community Psychiatric Nursing and Suicide

Suicides among nurses employed in psychiatric wards and hospitals are common. An investigation into post-suicide stress in nurses as well as the accessibility of mental health resources and education related to suicide was carried out. 531 psychiatric nurses were given the Impact of Event Scale-Revised and an anonymous, self-reported questionnaire to complete in order to gather information about their experiences with inpatient suicide. 55.0% of nurses reported having dealt with patient suicide. 11.4% was the average Impact of Event Scale-Revised (IES-R) score. 13.7% of respondents were considered to be at high risk for post-traumatic stress disorder (PTSD) (≥ 25 on the 88-point IES-R score). Only 15.8% of respondents, however, said they had access to programs for mental health treatment following suicide. The survey also showed that a low percentage of nurses (26.4% and 12.8%, respectively) reported attending in-hospital seminars on mental health care for nurses or suicide prevention. These findings showed that nurses who witness inpatient suicide experience severe psychological distress. However, it is concerning that there are few systematic post-suicide mental health care programs available for these nurses, as well as that there are few initiatives for suicide education and mental health care for nurses. The circumstances are probably connected to the lack of official protocols for recognizing and assessing the psychological ramifications of patient suicide in nurses as well as the pressures resulting from the public's view of nurses as providers rather than patients (Hagen, Knizek, & Hjelmeland, 2017).

2.13 Suicide and population growth

This study examines how modernization affects suicide globally using recently collected data on suicide rates and economic development indicators for 60 countries. The findings

corroborate, albeit slightly modify, the theory that high suicide rates are associated with modernization. In multiple regression analyses with all other factors controlled, the population growth factor is a much better predictor of suicide rates than the quality of life factor, despite the fact that suicide is positively correlated with quality of life indicators and negatively correlated with population growth indicators. This result is valid for both developed and developing nations when the two subsamples are examined independently. The population increase theory of suicide is emphasized as a possible explanation for global suicide rates (Zhang, 1998).

2.14 Factors that Precipitate Suicide in Attempters

A study on predisposing and precipitating factors for suicide among alcoholics by (Ciupercă & Duică, 2023) showed that alcoholism is a significant risk factor for suicide. Therefore, attempts to prevent suicide should focus on alcoholics (Edwards et al., 2020). This article reviews the literature on suicide among alcoholics and provides a model that may inform research, clinical work, and prevention efforts (Richardson, Robb, & O'Connor, 2021). They proposed in their model that "The main risk factors for suicide among alcoholics are hopelessness, extreme alcoholism, and aggression/impulsivity." "Stressful life events, especially interpersonal difficulties, and major depressive episodes are key precipitating factors, they propose. They also integrate these constructs in a model that argues that many alcoholics' suicides can be seen as reactive aggressions carried out in the midst of distress over a relationship that has been lost or is in danger (Richardson, Robb, & O'Connor, 2021). Yuodelis-Flores and Ries (2019) in their study found that "suicidal behavior is a significant problem for people with co-occurring disorders seeking addiction treatment". In addition to personality traits and mental illnesses, a number of predisposing and precipitating risk factors, including disruptions in marriage and interpersonal relationships, financial and occupational stressors, recent heavy substance use and intoxication, and a history of previous suicide

attempts and sexual abuse, combine to increase the risk of suicidal behavior in addiction patients. Major depression, borderline personality disorder, bipolar disorder, and post-traumatic stress disorder are especially associated with suicidal behavior in people with addictive disorders (Lasota et al., 2020).

Participants of 242, 952 in a prospective cohort research on the general population's risk factors for completed suicide (Nie et al., 2021). It was found that in order to better identify individuals at risk, and develop effective prevention strategies at the population level, a comprehensive understanding of the biological, psychological and social risk factors is required. 180 suicide-related deaths occurred over the course of the 242, 952 individuals' follow-up, which lasted an average of 6 years. Eight of the 18 risk factors had correlations with suicide that could be found. These were: Individuals with a higher risk of completed suicide included those who had never been married, currently smoked, currently drank, individuals in significant psychological distress, and those with a history of cancer, liver disease, kidney disease, or emphysema (Nie et al., 2021).

According to a systematic review and meta-analysis of psychological autopsy studies, “clinical factors had the strongest associations with suicide, including any mental disorder” (Favril et al., 2022). In contrast, effect sizes were lower for other domains including family history, sociodemographic status, and unfavorable life events.

In conclusion they found that “a wide range of predisposing and precipitating factors are associated with suicide among adults in the general population, but with clear differences in their relative strength” (Favril et al., 2022).

Even though research has identified interpersonal, intrapersonal, and achievement-related factors that precipitate suicide attempts (SAs), how these factors vary by race/ethnicity is unknown (Rosario-Williams et al., 2022). Rosario-Williams et al. consequently looked at racial/ethnic variations in the factors leading up to suicide attempts in a sample of young

adults (YAs) with a history of SA who were diverse in terms of race and ethnicity. Intrapersonal factors were the most common cause of SAs, followed by interpersonal factors. According to the study, YAs who identify as Hispanic, Asian, or Biracial are more likely than Black YAs to report interpersonal precipitants (Rosario-Williams et al., 2022).

Additionally, a study looked at the relationship between suicidality and the social issue of discrimination as well as the particular behavioral manifestations of suicidality in Black adolescents and young adults living in inner cities (Talley et al., 2021). This systematic review investigates high-risk behaviors in this community, which might be interpreted as indicators of suicide risk, intent, and conduct, using a culturally sensitive approach. The authors also go beyond the conventional suicide method, which involves killing oneself on purpose, to investigate the cultural role of another type of suicide called victim-precipitated homicide, in which victims actively or passively contribute to their own death by engaging in violent or self-destructive behavior or self-harm. This review aims to investigate the elements that sustain the psychological conditions that drive the behavior, rather than sticking with the victim-centered perspective of victim-precipitated homicide. The purpose of this review was to provide light on the social and cultural factors that contributed to Black adolescents' and young adults' increased risk of self-harm. More significantly, this review examined the need for enhancements in the identification, detection, and prevention of suicidality in this population, which may be characterized as high-risk or aggressive behaviors that result in violent death (Talley et al., 2021).

According to a multistate population-based qualitative study carried out in the US, mental health, past suicidal behavior, trauma, and problems with family or peer relationships are among the many risk factors linked to childhood suicide. The majority of suicides in this age group involve hanging or suffocation in the victim's bedroom. In the situations where comprehensive information was available, all of the children who committed suicide did so

by obtaining firearms that were kept in a dangerous manner within their family (Ruch et al., 2021).

Participant recruitment from community clinics in three countries (the United States, Canada, and Ireland) was used to conduct a qualitative analysis of 85 interviews with transgender kids regarding their experiences of suicidality between 2010 and 2014 (Hunt, Morrow, & McGuire, 2020). The study's findings identified a number of variables, such as gender dysphoria and rejection based on gender identity, that led to participants' suicide attempts. Due to medical practitioners' ignorance of transgender issues and their fear of being victimized again, transgender youth may be afraid to seek medical attention. Suicidality can be better understood as a logical decision-making process in reaction to stress, which could open up new intervention options and explain why people try suicide (Hunt, Morrow, & McGuire, 2020).

A common risk factor for suicide thoughts and actions is insecure attachment. His emerging evidence base suggests that a variety of predisposing, precipitating, and crisis-state factors may mediate the association between attachment security and suicidality. The current systematic review aimed to evaluate empirical evidence that has investigated the role of psychosocial mechanisms within this relationship in order to increase our understanding of this distal association (Green et al., 2020). Research that looked into moderating factors did not discover any noteworthy results, and it is still unknown how psychiatric disorders function as a mediating component. Moreover, the excessive dependence on cross-sectional designs and self-reported data constrains this developing body of research. In order to confirm the causal relationships and find out if trait vulnerabilities combine with acute stresses to raise the risk of suicide, longitudinal and experimental designs are needed. Lastly, disordered attachment has received insufficient attention thus far and needs more attention in the future (Green et al., 2020).

A significant study on suicide contagion showed that suicidal behavior is the result of the interaction between the individual's predisposing factors and precipitating factors (Walling, 2021). A recognized precipitating factor is the knowledge of the suicidal act of another, termed suicide contagion. Another precipitating factor is the physiological impact of an acute inflammatory response to disease, for example that seen in patients with COVID-19 (Walling, 2021). One of the main objectives of medical care is to identify patients who are more likely to act suicidally so that preventive steps can be taken (Walling, 2021).

Lafer and Oquendo (2020) posited that “most suicidal behavior (thoughts, attempts and completion) occurs in the context of a psychiatric illness, of which bipolar disorder (BD) is associated with the highest risk for suicide. Several studies and meta-analyses have shown that 34 to 50% of individuals with bipolar disorder have a lifetime history of suicide attempts”. According to epidemiological research, suicide accounts for 10–15% of deaths in BD. Lastly, compared to the general population, the standardized mortality ratio for suicide fatalities in BD has been observed to be 10- to 30-fold higher. Gender (males have higher completion rates and females have higher attempts), past suicide attempts, family history of suicide, rapid cycling, bipolar type I, early onset, aggression, impulsivity, stressful life events, drug and alcohol abuse/misuse disorders, comorbid anxiety disorders, Axis II comorbidities, and child abuse and maltreatment are some of the most significant predisposing and precipitating individual risk factors for suicidal behavior in bipolar disorder (Lafer & Oquendo, 2020).

2.15 The Response of Suicide Attempters' Families in Relation to the General Effects of the Attempt on the Family

Three superordinate themes were identified in a qualitative study by Spillane et al. regarding the experiences that follow a suicide bereavement and how it affects family members' physical and mental health: co-occurrence of grief and health reactions; disparity in supports after suicide and reconstructing life after deceased's suicide (Spillane et al., 2018). They found that

“initial feelings of guilt, blame, shame and anger often manifested in enduring physical, psychological and psychosomatic difficulties”. They further found that “support needs were diverse and were often related to the availability or absence of informal support by family or friends” (Spillane et al., 2018).

In conclusion it was established that “healthcare professionals’ awareness of the adverse physical and psychosomatic health difficulties experienced by family members bereaved by suicide is essential; thus, proactively facilitating support for this group could help to reduce the negative health sequelae because the effects of suicide bereavement are wide-ranging, including high levels of stress, depression, anxiety and physical health difficulties” (Spillane et al., 2018).

Other research showed suicide affects millions of persons internationally leaving a devastating impact on family members left behind, herein referred to as survivors (Kuramoto et al., 2013).

Offspring who experience parental suicide prior to young adulthood are at increased risk for suicide and hospitalization for suicide attempt as compared with those who experience a parent's death by other means. Young offspring who survive parental suicide have received special research attention because they lost a caregiver during a critical developmental period and may be more vulnerable to suicide attempt and suicide. The risk in offspring who lost a parent to suicide or an unintentional injury during childhood surpassed the other age groups' risk approximately 5 years after the origin and, for the youngest group, continued to rise over decades, the study noted. These offspring had higher levels of anger and depressive symptoms than those who lost a parent through other means. The risk decreased with time for offspring who lost a parent during adolescence or early adulthood, peaking one to two years following the parent's passing. Compared to offspring who lost a parent to an unintentional injury, those who lost a parent to suicide in their childhood and early adulthood began hospitalizing for

suicide attempts earlier. The study concluded that children who lose a parent early in life had a different hospitalization risk for attempting suicide than those who lose a parent later in life. The findings point to crucial periods for vigilant surveillance and intervention regarding the likelihood of suicide attempts, particularly in the first two years following the death of a parent for older age groups and throughout several decades for children surviving parental death (Kuramoto et al., 2013).

Findings from the Avon Longitudinal Study of Parents and Children (ALSPAC) Birth Cohort indicated that while maternal suicide attempt was unrelated to self-harm without intent, it did raise the risk of suicidal thoughts and self-harm with intent in offspring. Paternal suicide attempt results were less clear-cut and did not reach statistical significance. Maternal SA poses a significant risk for mental morbidity in their offspring, even if it may go unnoticed by medical specialists (Geulayov et al., 2014).

However, the study also looked at the potential relationship between parental suicide attempts and offspring internalizing, externalizing, and attention/hyperactivity problems in both childhood and adolescence. Parental suicide attempts and offspring mental health problems in childhood and adolescence confirmed that the relationship between parental suicide attempts and offspring suicide risk had been established (Ortin-Peralta et al., 2023). The study looked at the relationship between parental suicide attempts and adolescent offspring mental health issues and how it was mediated by childhood mental health issues.

Throughout the study period, parental suicide attempts over a lifetime were linked to internalizing, externalizing, and attention/hyperactivity issues in their teenage children. Behavioral issues in their youth were linked to parental suicide attempts prior to the childhood assessment. According to the mediation models, parental suicide attempts prior to the childhood assessment had a noteworthy indirect impact on the externalizing and

attention/hyperactivity issues that arise in adolescence, through the behavioral problems that the children experienced during their early years.

According to their findings, children with behavioral problems should ask their clinicians about their parents' history of attempted suicide, as these children may have externalizing and attention/hyperactivity problems in adolescence as a result of familial vulnerability to suicide. These findings also emphasize the significance of evaluating and tracking mental health issues in children whose parents have been hospitalized for attempting suicide (Ortin-Peralta et al., 2023).

Numerous negative behavioral and health effects have been connected to childhood exposure to suicidal behavior by parents. The prevalence of SUDs among individuals who were exposed to parental suicide attempts as children was compared using data from the National Epidemiologic Survey on Alcohol and Related Conditions. The results showed that there was no correlation between exposure to parental suicide attempts as a child and an increased risk of developing alcohol, cannabis, or cocaine use disorders. On the other hand, there was a substantial increase in the likelihood that people who witnessed a parent attempt suicide as a kid would later meet the criteria for stimulant, sedative, tranquilizer, and opiate use disorders. Regarding the strength of the association between exposure to parental suicide attempts and the risk of SUD in men and women, no discernible gender differences were found. Childhood exposure to parental suicide attempts is a vulnerability factor for low prevalence illicit drugs (such as stimulants, sedatives, tranquilizers, and opioids), but not for more widely used substances, even after adjusting for a variety of sociodemographic, parental, mental health, and childhood adversity confounds (Ortin-Peralta et al., 2023).

According to the multivariate models, the offspring of a parent who attempted suicide were more likely to attempt suicide themselves, but not to die by suicide. Offspring exposed after birth had a greater chance of trying suicide than offspring not exposed, particularly if the

parent attempted during the children's youth, adolescence, or early adulthood (O'Brien et al., 2015). An initial motherly SA elevated likelihood of suicide attempt among kids, independent of date

Depending on the timing and gender of the parent who attempted suicide, the effect of a parental SA on the offspring's chance of attempting suicide varied, indicating that both genetic and environmental factors may contribute to the transmission of suicide risk (Ortin-Peralta et al., 2023).

There exists an association of family factors, including high family conflict and low parental monitoring, with suicidality and self-injury in children (DeVillie et al., 2020)

A sizable section of the community experiences suicide loss, and although with its widespread occurrence, suicide death is still stigmatized. Health practitioners should be aware of how suicide stigma affects friends and family members who have survived so they can respond appropriately and offer helpful assistance. Survivors of suicide said they felt condemned, blamed, and ashamed. They felt that the suicide was often uncomfortable and embarrassing, which added to the secrecy and avoidance. Suicidality, self-harm, depression, and overall psychological distress were all correlated with higher levels of perceived stigma (Evans & Abrahamson, 2020).

Bereavement by suicide poses a risk for negative consequences pertaining to bereavement, social functioning, mental health, and suicidal thoughts and actions. As a result, postvention, or suicide bereavement care, has been recognized as a crucial suicide prevention tactic.

Numerous intervention modalities, study populations, control groups, and outcome measures relating to mourning, psychological issues, and suicide were used in these investigations.

Overall, the research' quality was subpar. While there was some evidence supporting the efficacy of therapies for simple sorrow, there was not enough data to support the effectiveness of interventions for complex grieving. Based on the limited evidence available, therapies that

appear to hold promise include those that engage the social surroundings of the bereaved, entail therapeutic, educational, and supportive methods, and consist of a series of sessions facilitated by qualified professionals.

More study across the lifespan is necessary to avoid mourning and its negative effects on mental health because individuals who have lost a loved one to suicide are more likely to experience unfavorable grief, mental illness, and suicidal behavior (Andriessen et al., 2019).

2.16 The Views of Community Members that Almost Lost/Lost a Member to Suicide in Relation to how they Handled Such Cases

The modified instructions included measures unique to the Chinese context in addition to being comparable to those for English-speaking nations, in some Chinese communities they resorted to the removal of the means of suicide that potential attempters might use to harm themselves (Lu et al., 2020).

In an effort to combat suicide attempts, some towns train volunteers who might work more closely in the community and serve as "gatekeepers," as well as members of educational institutions and the workplace. The mental health community has been working to raise awareness in the community for the past few decades, but increasing the number of mental health professionals and resources is likely to come via training gatekeepers and considering them "partners" in the delivery of mental health care (Sagar & Pattanayak, 2016).

Suicidal behavior, both deadly and non-fatal, and depressive disorders remain significant mental health concerns. It is possible that preventive measures that enhance care and optimize therapy for depressed individuals would lead to a decrease in suicide acts because of the strong correlation that exists between depression and suicidal behavior. The Nuremberg Alliance against Depression, a two-year, four-level community-based intervention program linked to a 24% reduction in suicidal acts (completed and attempted suicides combined) compared to a baseline year and a control region, demonstrated how effective certain community strategies

have been in handling suicide in Germany. This concept has been implemented as a model project in over 100 regions throughout Germany and Europe to date (Hegerl et al., 2013).

2.17 The Strategies used by Community Psychiatric Nurses in the Management of Individuals and Families of Both Attempted and Completed Suicide Cases

According to research conducted in Spain, nurses used a variety of approaches to address suicide-related concerns in various settings. For instance, compared to the baseline year, the telephone management program postponed suicide attempts in the intervention group. In comparison to the prior year, the intervention decreased the number of patients in the experimental population who made another attempt at suicide. The amount of time that passed between a patient's first and subsequent suicide attempt, as well as variations in the annual percentage of patients who tried suicide again between the intervention year and the year before (Cebrià et al., 2013).

According to Slemon et al.'s research, the language on safety has influenced how people with mental illness are cared for both institutionalized and in contemporary psychiatric nursing practices. Safety was the driving force behind confinement: fear for public safety, social stigma, and the altruistic but paternalistic desire to keep people from harming themselves. Safety is upheld as the primary value in today's psychiatric inpatient settings, and risk management forms the basis of nursing care. The safety discourse legitimizes and upholds practices that align with this goal, even in the face of evidence that contradicts their effectiveness and patient perceptions that indicate harm. This growing concern in mental health nursing care is exemplified by four risk management methods used in psychiatric inpatient settings: close observations, isolation, door locking, and defensive nursing practice. The application of these tactics shows how viewpoints on risk and safety in nursing care must change. Nurses re-evaluate the risk management culture that gives rise to and justifies harmful

behaviors while providing tailored, flexible care that incorporates safety precautions in order to re-center meaningful support and treatment for clients (Slemon, Jenkins, & Bungay, 2017). Suicide is a prevalent occurrence in primary health care settings in Uganda, and since the COVID-19 pandemic began, there has been a sharp rise in the number of suicide attempts. Because poisoning suicide is a prevalent occurrence, proactive measures like pesticide and herbicide management are used here to prevent suicide among community members, particularly during pandemic conditions (Kaggwa, Rukundo, et al., 2022).

Since many suicides in the US have taken place in psychiatric settings, one of the main responsibilities of inpatient psychiatric facilities is to ensure patient safety. Guidelines for evidence-based care, environmental safety, suicide risk assessment, milieu observation and monitoring, psychotherapy interventions, and documentation have all been implemented throughout the years to guarantee inpatient suicide-specific safety. The United States' Veterans Health Administration (VA) has been acknowledged as a model suicide prevention system. To demonstrate the operationalization of a culture of suicide-specific safety, a VA inpatient psychiatric institution is utilized (De Santis et al., 2015).

A narrative investigation on the experiences and management of caregivers in Northern Thailand revealed some caregivers discussing their encounters with challenging circumstances, the coping mechanisms they used, and the stress they went through following a patient's attempted suicide. First, they use external variables like indulgence, modifying family rules, and strict supervision to prevent recurrent suicide attempts. Next, they use internal elements like *plong* and *Thum-jai* to help patients accept and comprehend their suffering (Sukmak et al., 2023).

Studies on how mental health nurses identify and address suicidal behavior or self-harm, as well as manage the emotional difficulties associated with caring for potentially suicidal inpatients, revealed techniques like being aware of patients' suicidal cues, easing

psychological discomfort, and igniting hope. Suicidal behavior evokes a range of feelings. In order to take proper care of patients and themselves, mental health nurses appear to control their emotions and emotional expressions as well as their involvement and distance from the situation (Hagen, Knizek, & Hjelmeland, 2017).

According to Awenat et al.'s research, staff attitudes, behaviors, and practices are significantly impacted by suicide behavior in psychiatric hospitals. Employees were ill-prepared to handle such actions, which had negative effects on both patients and staff members. There is insufficient organizational support. Training and assistance should go beyond risk assessment to enhance staff members' abilities to create therapeutic relationships with suicidal in-patients (Awenat et al., 2017).

2.18 The Coping Strategies Used By Families Of Suicide Victims

A study by Čepulienė et al. (2021) found that “a loved one’s loss to suicide can be a traumatic experience and trigger a difficult grief process, identity changes, a loss of the sense of meaning and a spiritual crisis”. Spirituality and/or religiosity (S/R) can be an important resource during suicide bereavement. five major coping resources related to S/R during suicide bereavement were found, these include: “the need to be helped by the religious community without being judged; S/R-related experience of the deceased as a figure who continues to exist; S/R experienced without a conscious choice; conscious reach towards S/R themes; not relating to S/R during suicide bereavement”. These results suggest that S/R plays a complicated and varied role during suicide bereavement, ranging from offering support to causing suffering. Hence, “practitioners and religious communities should be mindful of the S/R themes during suicide bereavement” (Čepulienė et al., 2021).

Additional study indicates that there is a comparatively increased incidence of mental diseases, including suicide, among people who have lost a loved one to suicide. It's frequently challenging to have a conversation about sorrow because of the social stigma around suicide.

For those who have lost a loved one to suicide, participating in online forums can be helpful in locating self-help techniques, grieving processes, and experiences using medical services. It was shown that the communications most frequently included sharing personal experiences, frequently together with tearful feelings of loss. Other common self-help strategies included offering guidance, expressing sympathy or support, and universality (recognition). In contrast, experiences with health care providers showed that suicide survivors rarely shared more intimate details and conversed with others. Therefore online forums appear to have important additional value as a platform for talking about grief and finding support (Schotanus-Dijkstra et al., 2014).

Suicide survivors are a significant demographic in terms of postvention, and those who have experienced suicide frequently seek out peer support groups. In Ireland, surveys were sent out to all members in August 2020 and June 2021 to assess changes in wellbeing, depressive symptoms, and bereavement emotions. New members were also assessed at three- and six-month intervals. Mixed linear regression models and descriptive statistics were used to analyze the results. The majority of the 75 participants were female, and compared to the general population, they had worse overall wellbeing scores and a higher frequency of depressive symptoms and suicide thoughts. The participants also indicated significant levels of mourning emotions and challenges with social adjustment, with the latter being more evident in those who had lost a loved one recently. After correcting for the amount of time after the loss, a notable improvement in wellbeing and a decrease in mourning symptoms were observed at the follow-up. According to the participants, the groups foster a feeling of safety, belonging, and hope. “Notwithstanding the small number of participants at follow-up, these findings underline the enduring mental health challenges for those bereaved by suicide and provide further evidence for the role of peer support in postvention” (Griffin et al., 2022).

The "men in grief" phenomena was discovered to consist of three coping mechanisms in a study involving ten Chinese men in Hong Kong who had lost their wives or children to suicide. These strategies included processing grief-related guilt, understanding concealed sadness, and eliminating the stigma associated with grieving as a man (Chan & Cheung, 2022).

In Queensland, Australia, a longitudinal study on suicide bereavement included interviews with parents at six, twelve, and twenty-four months following their loss. Three major themes were found in previous analyses and were further explored through the use of thematic analysis: seeking meaning and purpose, coping mechanisms and support, and seeking solutions and sense-making. Findings at 24 months showed a more distinct difference between the tactics used by fathers and mothers. Anger and guilt had given way to depressive sentiments. There is a division between parents who have moved toward sense-making and those who are still prone to brooding and rumination. The latter expressed a more upbeat outlook on life and acceptance of their loss, whereas the former more frequently reported signs of depression. Consistent with the dual-process model, parents managed to reach acceptance after oscillating between sense-making and meaning making (Entilli et al., 2021). Another coping strategy that proved helpful to those who had lost a loved one to suicide was effective social support. According to this research, it entails making meaningful connections with people who share similar values and prioritizes creating a safe space for genuine self-expression to support the maintenance of personal relationships. Not wanting to burden loved ones due to judgement, and a lack of understanding was the mechanisms that influenced support seeking included: (Adshead & Runacres, 2022).

Spiritual encounters can also be significant life-affirming events or coping techniques for the challenges of surviving a suicide loss. According to this study, those who have lost a loved one to suicide frequently maintain their relationships through spiritual experiences. Based on

four distinct prompts, a total of 1301 people who had lost a loved one to suicide submitted 2443 free answers regarding their spiritual experiences, which were then examined using an inductive methodology. Nine common themes were identified, selected for interest, and reported: a helpful sense of comfort; a helpful sense of connection with the deceased; intense sadness evoked by the spiritual experiences; (4) confusion regarding the spiritual experiences; (5) negative reminders of the deceased or negative meanings of spiritual experiences; (6) evidence of an afterlife; (7) general importance of the spiritual experiences' meaning; (8) impact of and on religious beliefs; and (9) "others' responses to disclosure of suicide or spiritual experiences. For the overwhelming majority of participants, spiritual experiences such as a sense of presence have deep meaning and are often regarded as a positive source of healing and transformation after a suicide death (Jahn & Spencer-Thomas, 2018).

In *Making Sense of the Unique Pain of Survivors*, Berardelli, Erbuto et al concluded that grief, guilt, abandonment, anger, shame, and rejection are the most common feelings experienced by suicide survivors, who differ from other bereaved individuals for the intensity of these feelings. Furthermore, those who have lost a loved one to suicide are more likely to suffer from psychiatric diseases linked to suicidality and to be at risk for suicide. Considering the intricacy and ramifications associated with a loved one's suicide, quick action is required. Psychoeducation is one of the many tactics used by medical professionals that has been shown to be helpful for a number of mental illnesses and suicide grief. It is a therapeutic technique designed to help manage the illness and help people see linkages in the social environment by identifying and comprehending the psychological characteristics linked to the mental anguish of suicide survivors. Psychoeducation's primary objectives were to support survivors, normalize their reactions, help them lessen their mental anguish and suicidal thoughts, look into the possibility that they may be at risk for suicide, put prevention measures into place, and help them integrate the loss of a loved one. By enabling people to connect with others

going through similar experiences, the psychoeducational method provided to suicide survivors helps them get back on track and puts the death of a loved one in a larger context (Berardelli et al., 2020).

Research on the effects of suicide bereavement indicate that compared to the general population, there is an increased risk of drug and alcohol use disorders, psychiatric illnesses, suicide, and suicide attempts. After 346 British adults between the ages of 18 and 40 had their data analyzed, three major patterns emerged that explained how alcohol or drug use and suicide bereavement are related: control over drug or alcohol use, the perceived purpose of using drugs or alcohol, and the attribution of drug or alcohol misuse to external factors. Overlying these themes were dimensions of control and of awareness of potential harms. This study highlights that “increased use of drugs and alcohol after suicide bereavement may form part of a bereaved person’s coping strategies, and that sensitive approaches are needed when judging whether and when to intervene” (Eng et al., 2019).

One of the most agonizing experiences in life is losing a loved one to suicide, according to a different study on suicide bereavement and complex grieving. Suicide survivors frequently face feelings of guilt, uncertainty, rejection, shame, rage, and the aftereffects of stigma and trauma that compound the sentiments of loss, sadness, and loneliness that accompany any death of a loved one. In addition, those who have survived a suicide loss are more likely to have complicated grief, a protracted type of grieving that lasts longer than expected, significant depression, and suicidal thoughts and actions. The significant stigma, which can prevent survivors from accessing resources for recovery and much-needed support, adds to the burden. In order to deal with their loss, survivors may need special supportive measures and focused treatment (Tal Young et al., 2012).

About seven people commit suicide in Australia each day, meaning that thousands of survivors will need support for their particular grief each year. A phenomenological study of

14 suicide victims was carried out in order to better understand the lived experiences of those who have lost someone to suicide. The study identified two major themes: immediate and ongoing supports. Survivors did not always receive information about available assistance or were matched with service providers. Suicide survivors' grieving journeys were impacted by the reactions of first responders and other professionals, and their lived experiences varied from being empathetic to being distant. To guarantee that the resources available can satisfy the requirements of individuals mourning after a suicide, postvention is essential. "Such efforts may help avert complications associated with the suicide of a loved one" (McKinnon & Chonody, 2014).

In comparison to grieving following sudden and predicted death types, a study looked at the extent to which suicide survivors can grow in the wake of suicide loss, as well as the significance of self-disclosure and coping mechanisms in stress-related growth (SRG) among suicide survivors. One hundred forty-five bereaved people, ranging in age from 18 to 73, answered questions about their coping mechanisms, self-disclosure, and SRG. It was discovered that there was a significant connection between self-disclosure and death types, with low self-disclosure suicide survivors exhibiting the lowest level of SRG in comparison to other categories. Results indicated that discussing private information with others can help as a coping mechanism when dealing with a suicide issue in the family (Levi-Belz, 2016).

Due to the multifaceted nature of suicide, and it not having an conventional animal model and culturally not tolerated in most countries, suicide has an exclusive status among other public health problems. This unusual status causes diverse methodological problems which jeopardise suicide research worldwide, particularly in developing countries where suicide rates seem to be rising during recent years. Nevertheless, these do not interpret into a sense of hopelessness around suicide studies. On the other hand, more well-thought-out and

cosmopolitan studies are needed to shed light on this anomalous phenomenon especially in the Ghanaian context (Rezaeian, 2012).



CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter describes the research design and setting, study population and area, sample size and sampling technique, tool for data collection, procedure for data collection, methodological rigour, data analysis procedure, data management and ethical considerations.

3.2 Study design

A qualitative descriptive exploratory design was used to select participants, using a purposive sampling technique. Thus for data collection and analysis a phenomenological approach was used to document the lived experiences of the suicide attempters in relation to precipitating factors, the responses of suicide attempters' families in relation to the general effects of the attempt on them, the views of community members that almost lost/lost a member to suicide in relation to how they handled such cases, the strategies used by Community Psychiatric Nurses in the management of individuals and families of both attempted and completed suicide cases and to identify the coping strategies used by families of suicide victims.

This approach is normally used when the information available is not sufficient about a phenomenon (Tubaishat, 2019). It is used by researchers to gain background information and is used to clarify research problems (Thomas & Lawal, 2020). This assisted in giving an in-depth analysis of the research problems and ensured that the data results were well clarified in detail with the information gathered. Therefore, the research was gathered from both primary and secondary sources through in-depth interviews, key informant interview and focus group discussions. This type of design was used because the researcher's interest does not lie in quantifying the phenomenon under study but rather to have an in depth understanding of the experiences of suicide attempters', their families, suicide completers' families, community members and CPNs.

3.3 Philosophical Underpinnings of the Study

The philosophical underpinnings of this study served as the basis upon which this study was carried out. The two philosophical subjects that was considered in designing this study were ontology and epistemology (Vogl, Schmidt, & Zartler, 2019). Ontology refers to the nature and form of the reality the researcher explored and how this reality was measured. Epistemology scrutinizes the association between what is being researched and the researcher (Al-Ababneh, 2020). Often, they impact the methodology that was used to attain the information that the research sets to explore and the design of the study.

Qualitative study designs observe reality as individualistic and numerous, as perceived by participants in the study and functions on the interpretivist philosophy (Garner, Wagner, & Kawulich, 2016). These interpretivists take on approaches that decreases the distance between what is being studied and him/herself. Based on these philosophical underpinnings, it was observed that the most appropriate ontological and epistemological position for this study should be the interpretivist (qualitative method). The ontological opinion concerning Community Psychiatric nursing services and suicide resilience in the selected communities is that the reality could vary between individuals as experiences may vary and be shaped by families and the communities one lived in. Also, the interpretivist epistemological approach brought me closer to the individual participants of the study so I could better understand their reality and draw valid conclusions in the process.

3.4 Study Area

The study was conducted in the Ningo Prampram, Ledzokuku-Krowor municipal, Ga East, Weija Gbawe municipal and Ga South municipal all in the Greater Accra region of Ghana. This is because the Community Psychiatric Nurses in-charges confirmed both attempted and completed suicide cases. A phenomenological approach; a qualitative approach that aims to

understand the universal nature of a phenomenon by exploring the views and experiences of those who have encountered it (Iser, 2022).

Ningo Prampram District in 1988 was formerly part of the Dangme West District. It is one of Ghana's twenty-nine districts that make up the Greater Accra Region. It was formed on June 28, 2012, from the remnants of the former Dangme District Council. The southern portion of the district was then divided off to form Ningo-Prampram District, and the remaining portion was renamed Shai-Osudoku District. Prampram serves as the capital city of the district assembly, which is situated in the eastern portion of the Greater Accra Region. Shai Osudoku District borders the district to the north; Ada West District borders it to the east; the Gulf of Guinea borders it to the south; and Kpone Katamanso District borders it to the west. The total area of the district is 622.2 square kilometers. According to the 2010 census, the population of the district is 70,923, with 33,514 males and 37,409 females. The current population based is 87,393 by Ghana Statistical Service record.

The Community Mental Health Units of Prampram Polyclinic was established in June 2012 with client population of nine (9); and two Mental Health staff. As at mid-year 2021, the client's population was 274 consisting of 144 males and 130 females. Some of the clients have relocated. The Unit seeks to provide easily accessible, affordable, and quality mental health services within its catchment area and to reduce the burden of clients and their careers travelling long distances to access mental health care. Ultimately, the units seek to improve the community understanding of mental health to help influence a positive attitude towards mental illness and its treatment.

The mission of the unit is to improve the community understanding of mental health, Advocate for improved support for people living with mental illness, provide education and opportunity for individuals to identify early warning signs of mental illness and seek treatment and the vision is to create additional mental health units at the various sub-unit.

For Ledzokuku municipal the Community Psychiatric unit began work in the year 2010 at the Opec Clinic with three newly posted staff who use to work under a canopy outside, like other units. Later that year staff became four and were moved to continue work inside LEKMA hospital after its completion and inauguration. The work of the unit covered Ledzokuku-Krowor until it was divided into 2 municipalities. Currently the work at the unit covers just Teshie North sub district. The population of the Municipality according to 2010 population and housing census stands at 217,304 with 106,099 males and 111,205 females. LeKMA to step enforcement of sanitation bye-laws (GSS, 2014a, 2014b).

The Ga East Municipal of Greater Accra Region of Ghana comprises of 140,015 males and 143,364 females with a total population and housing census of 283,379. The Ga East Municipal Assembly is located at the northern part of the Greater Accra Region. The Administrative capital of the Municipality is Abokobi. The Municipality shares boundaries with the Ga West Municipal to the west, the La Kwantanang Municipal to the east, Accra Metropolitan to the south and the Akwapim South District to the north. It is one of the fastest growing shantytown areas in the nation. The area is covered by 166 square kilometres individuals. Abokobi, Taifa, Dome and Haatso are the four sub-municipals in the municipality. Abokobi, Taifa, Dome and Haatso are mainly peri-urban settlements largely occupied by rural-urban migrants who settle in the Ga East Municipal due to its closeness to the country capital, Accra. Poverty is predominant in the three northern regions of Ghana which also happens to be the main migrants. Some of the ethnic groups in the municipality from the southern part of Ghana are the Fantis, Gas, Ewes, and Akans; and from the northern part we have Grushie and Dagombas. Forty-two (42) communities and sixteen (16) operational areas exist in the sub-municipals. The Municipal Health Management Team (MHMT) is responsible for overseeing the delivery of health services in the municipality. However, the municipality lacks public health facilities, with only six (6) of the thirty-nine

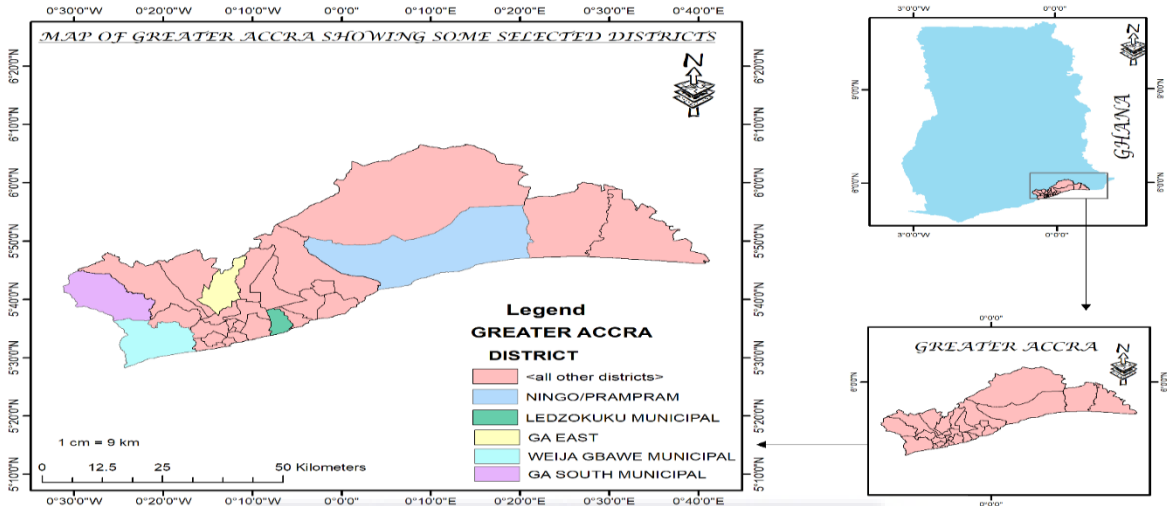
(39) active health facilities in the area being private facilities. In the peri-urban settlements of Dome and Taifa, there are currently fifteen (15) Community-based Health Planning and Services (CHPS) zones that offer basic healthcare services to the community members through outreach programs and house visits. The municipality's four primary economic sectors are industry, commerce, agriculture, and service delivery; nonetheless, a sizable portion of the labor force is unemployed, underscoring the high rate of poverty that exists there.

The total land area of the Ga South Municipality is estimated at 517.2 sq km with about 362 communities; the current population based on Ghana Statistical Service records is 507,192. The Ga South Municipality was carved out of Ga West in 2009. It is bounded by Awutu to the west, Ga West to the north, Weija - Gbawe to the East and the Gulf of Guinea to the South. The municipality has seven (7) public health facilities and twelve (12) private facilities. It also has a total population of 304,500 with 488 schools and has its capital as Ngleshie Amanfro. It has five (5) sub districts. Namely Amanfro, Aplaku, Bortianor, Kokrobite and Obom. The aims and objectives of the unit is to conduct home visits, give health talks, conduct durbars and to conduct effective school health services.

Ga South has twenty-four (24) Community Psychiatric Nurses and four (4) Community Mental Health Officers. Ga South in-charge reported of having four (4) attempted suicide cases being recorded within the last year under review, one male and three female.

Ga West Municipal District borders the Weija Gbawe Municipal District on the north and west, Accra Metropolis District borders the district on the east, and Ga South Municipal District borders the district on the south. The district has a total area of 48.997 square kilometers. As of the 2010 census, there are 117,220 people living there, with 57,321 men and 59,899 women. Accra is multi-ethnic because about 44% of inhabitants are migrants with their unique ethnic features; Accra therefore has a mixed culture. Other languages spoken in

Accra include Fante, Ewe, Twi, and Dangme apart from the original Ga language of the indigenes. There are numerous health facilities in Accra, both public and private, and these provide the necessary healthcare services for the general population here.



Source- Department of Geography, University of Ghana

Figure 4: Map of Greater Accra with Study Districts Highlighted

3.5 Sample Size

In order to ensure full engagement with the participants the sample size was determined by saturation ((Saunders et al., 2018). That was the threshold where data redundancy was reached and provision of relevant new information by participants ended. (Guest, Namey, & Chen, 2020).

3.6 Sampling Procedure

Sampling was done using a Maximum Variation Purposive Sampling technique in the Ningo Prampram, Ledzokuku municipal, Ga East Municipal Weija Gbawe Municipals and Ga South Municipal all in the Greater Accra. Thirteen (13) individuals who have attempted suicide (3 each from 4 districts and 1 from Ningo Prampram), Seven (7) of the family members (one from each district and three from Ledzokuku. Four (4) completed suicide cases families (from

4 districts except Prampram) were retrieved from the various CPNs reports who agreed to be interviewed, five (5) FGDs: One from each district.

In-depth interviews, focus group discussions and key informant interviews were used in gathering data qualitatively. Data were collected from 89 participants using a digital audio recorder. These interviews started on the 15th of September 2022 and ended on the 28th of April 2023. Thirteen (13) individuals who have attempted suicide, seven (7) of the family members and four (4) completed suicide cases families were retrieved from the various CPNs reports from each of the five selected districts in the communities. Twenty-four of the suicide attempters', attempters' family and completed suicide cases families were contacted through telephone calls and an agreed date and time was set for each interview.

Inclusion Criteria

Individuals who have attempted suicide, the family members of both attempted and completed suicide cases, within the last ten (10) years. CPNs and individuals or community members residing for at least three (3) years in the five selected communities (Ningo Prampram, Ledzokuku-Krowor municipal, Ga East, Weija Gbawe municipal and Ga South municipal) all in the Greater Accra Region and were between the ages of 16 years and 68 years participated in the study because it is the age range that has one of the highest activities and willingness to participate. KII who have cared for individuals who have attempted suicide, the family members of both attempted and completed suicide cases, CPNs and community members working or residing in the five selected communities for at least three (3) years

Exclusion Criteria

CPNs and individuals who were not willing to take part in the study.

Persons who did not provide informed consent including KII.

3.6.1 In-depth Interview

An in-depth Interview is a qualitative data collection technique that is used to determine rigorous individual viewpoints concerning the issue under discussion.

This involves interviews with respondents that explored their standpoints on a particular topic under investigation that could improve community suicide resilience.

In-depth interviews were carried out with particular persons, including elderly community members, to solicit information were purposively selected while opinion leaders were selected randomly. In-Depth interviews were also gathered at the community level in all the selected districts in the Greater Accra Region of Ghana.

In-depth telephone interviews with CPNs in the five districts in the Greater Accra, were conducted using a semi-structured interview guide. Due to the outbreak of COVID-19 the above procedure commenced whilst observing all necessary protocols to safeguard everybody involved in this study. The participants in the IDIs were different from the FGDs in that the the IDIs were individualized and FGDs were in groups.

3.6.2 Key Informant Interview

People who have knowledge of the issues and situations in which the researcher is interested were interviewed. This was achieved through discussions with a member of the Mental Health Authority who was also the national mental health coordinator on the guidelines used by CPNs in the care of persons with attempted suicide cases.

3.6.3 Focus Group Discussions

This conveyed the opinions of groups in the community. Focus Group discussions (FGDs) conducted among indigenous persons of the selected districts, helped highlighted their various opinions and perceptions on suicide. Five FGDs were conducted with ten people participated in each district except Ningo Prampram where six (6) people participated.

3.7. Data collection tools

A semi-structured interview guide (Appendix III) was utilized to undertake in-depth face-to-face interviews with CPNs, community members, suicide attempters, attempters' family members and completed suicide cases family members. This comprises open-ended questions designed based on the objectives of the study and from clues sourced from literature. The interview guide had two sections. Section A is on demographic characteristics of participants. This contains the age, marital status, religion and employment status. Section B looked at the experiences of individuals who have attempted suicide in relation to precipitating factors, the response of suicide attempters' families in relation to the general effects of the attempt on the family, examine the views of community members that almost lost/lost a member to suicide in relation to how they handled such cases, assess the strategies used by Community Psychiatric Nurses in the management of individuals and families of both attempted and completed suicide cases and identify the coping strategies used by families of suicide victims. Semi structured IDI and FGD guides were used. Face to face and telephone calls and an agreed date and time was set for each interview. Interviews and FGDs were conducted by the PI and trained research assistants. All interviews and FGDs were audio recorded.

There were guiding questions and investigations to augment additional exploration into the phenomenon under study.

3.8 Data analysis

Data was managed and organized using the MAXQDA 20. The outcomes of the analysis were triangulated to enable drawing valid conclusions. This would assist in taking decisions that will help improve community psychiatric services in strengthening community resilience against suicide not just in the districts of Greater Accra but in Ghana as a whole. The data gathered were under key and lock.

Interviews and discussions were analyzed using thematic content analysis (Wen, Yu, & Goh, 2019) after it has been transcribed and coded. The thematic content analysis used to analyze data through preparation, organisation and reporting of results as described by (Wen, Yu, & Goh, 2019). This was done inductively or deductively with the help of literature reviewed and the interviewing of the participants making it more comprehensive. In the preparation stage, data gathered, was read over several times to make sense of it and to determine whether to apply inductive or deductive analysis. Inductively, the groundwork phase involves coding, categorisation and abstraction of data (Elo et al., 2014). The transcripts were read over and over again to enable in the development of a codes.

Coding encompasses the use of words as labels to denote a particular text. Categorisation involves grouping of codes that are linked both inductive and deductive approaches in context or content. In the organization phase, the content of the data was reviewed and coded to represent identified categories in the data deductively (Polit & Beck, 2013). Categorisation of data was considered valid if the classifications actually epitomize the concept being studied (Schreier, 2012). The results were then defined based on the content of the categories that describe the phenomenon under study in the reporting phase. This was done either inductively or deductively.

In this study, data analysis was carried out alongside with on-going interviews. This was to help the investigator to know when data becomes redundant with no new information emerging. The principles of content analysis were employed to develop themes that emerge from the data. All interviews were transcribed verbatim. The audio recordings of the interviews in “Twi” were transcribed in English and again to ‘Twi’. Interview transcriptions were then be read several times to attain full understanding of participants’ accounts.

Coding was carried out, after going through the data a number of times to make sense of the data as part of the preparation phase. This was followed by categorisation in the organization

phase. Data from field notes were reviewed and added up to the results to enhance the meaning of the information gathered. Interpretations from the data was then discussed to ensure that themes are completely developed. Segments of data that best suit the themes identified were sorted out appropriately and used to support findings.

This was based on the constructs and themes of the community resilience model. And the socio ecological model. Field notes were taken during the interview which served as a form of additional information. Thus for data collection and analysis a phenomenological approach was use to document the lived experiences of the suicide attempters in relation to precipitating factors, the opinions of suicide attempters' families in relation to the general effects of the attempt on them, the sentiments of community members that almost lost/lost a member to suicide in relation to how they handled such cases, the approaches used by Community Psychiatric Nurses in the management of individuals and families of both attempted and completed suicide cases as well as identify the coping strategies used by families of suicide victims.

3.9 Ethical Consideration

Permissions: Ethical approval to carry out the study was obtained from the Ghana Health Service Ethics Review Committee (GHS-ERC:013/07/22) and the Greater Accra Regional Health Director for the Ghana Health Service through the School of Public Health, College of Health Sciences, University of Ghana. Permission to collect data was sought by sending introductory letters to the Accra Metropolis Health Director.

Consent: Information sheets describing the purpose, procedures and benefits of the qualitative studies was provided to participants. Written consent was also obtained for participation and audio recording of the studies.

Confidentiality procedures: To ensure anonymity, codes or pseudonyms were used instead of names of participants. All interviews were scheduled at a time and place of convenience to

all participants. Interviews were carried out privately to ensure privacy. To ensure confidentiality, all audio recordings of interviews and transcribed data were kept safely under lock and key on a password protected computer. This will only be made accessible to the researcher and the supervisors.

Risks and benefits: The study poses no serious risks. However, participants may feel sad or upset during the interview. If this happens, the participant was told they will be referred to a qualified counsellor for counselling and reassurance. One may also be exposed to COVID-19, however, strict adherence to all COVID-19 protocols were observed to ensure participant and researcher safety.

The study provided no direct benefits but indirectly, the findings would provide information that will inform the planning of interventions that will improve CPSs to support individuals, communities, opinion leaders and CPNs in the Greater Accra Region of Ghana.

COVID-19 protocols: All COVID-19 protocols were also be observed. Thus, social distancing of at least 2 metres were always maintained between the researcher and the participants. Participants were provided with nose masks and hand sanitizers to use. Both participants and the researcher wore nose masks throughout the period of interaction.

The researcher ensured interviews were conducted at places that were convenient for the participants. This included an appropriate place suggested by the researcher, through telephone calls or in the office of the community psychiatric nurses in the selected municipalities. Each interview lasted between 15 to 45 minutes. Observations made during the interviews were also recorded in the field notes. This was carried out until no new theme emerged from the interviews.

3.10 Methodological rigour

Assurance of methodological rigour were ensured by employing the trustworthiness criteria recommended by Lincoln and Guba (1985). This includes credibility, transferability, dependability and confirmability.

Credibility comprises processes to guarantee that results are accurate by the participants (Polit & Beck, 2013). This safeguarded through data triangulation. Secondly, through lengthy engagement in the subject matter and through member checking by means of taking the concluding report back to the participants to determine whether they feel that it is accurate (Creswell & Plano Clark, 2011).

Confirmability covers ways of making sure that data collected is accurate and valid and assisted in drawing conclusions and recommendations made from the study. Combination of field notes and interviews that is triangulation of the methods and keeping of audit trail were ensured.

Transferability symbolizes the ability to apply the study elsewhere. This signifies that other researchers can utilize the findings of this research on participants in a similar scenario. To ensure this, detailed explanations were made as presented by the participants (Lincoln & Guba, 1985). This covers adequate contextual data about the fieldwork to allow the reader to make such a transfer. Accessibility to in depth description of methods, the research setting and the type of persons that were made available to participants in the study.

Dependability is certifying that satisfactory measures and processes have been followed to establish credibility of the study (Brink et al., 2012). To achieve this, detailed reporting of the processes involved in the study were provided. This incorporated a description of the research design and how it was executed; detailed explanation of the data gathering process and explaining what was done on the field. Independent co-coding of data was carried out.

3.10 Quality Control

Before the commencement of the data collection, five community psychiatric nurses were trained by the principal investigator to assist in the data collection. There was pretesting of the interview guide at the Ga East Municipal Hospital. The in-charge Patience Adjavon was very instrumental and helpful in that regard. Based on that, changes were made to the various interview guide.



CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter presents the results from the study. It starts with a presentation of the socio-demographic characteristics of study participants. Descriptions and explanations are given on the experiences of individuals who have attempted suicide in relation to precipitating factors, the general effects of this suicide attempt on family members, how community members handle attempted and completed suicide cases, the approaches used by Community Psychiatric Nurses in the management of individuals and families of both attempted and completed suicide cases and the coping strategies used by family members of suicide victims. In highlighting and describing the experiences of the participants, pseudonyms were used instead of their actual names. Also, the conceptual framework and the objectives of the study were taken into consideration in the analysis process.

4.2 Socio-demographic characteristics of the study participants

A total of 89 participants were involved in the study as shown in table 4.1 below. The demographic characteristics of the participants included age, gender, marital status, number of children, level of education, religion, place of work, years, or duration of work. Five of the suicide attempters were between 18 -28 years of age. The study indicates that the principal means through which the participants attempted to take their lives was through the ingestion of rat poison. Again the demographic characteristics of the seven (7) suicide attempters' family study participants also showed that majority (4) of their family members resorted to the ingestion of rat poison. In addition, four (4) suicide victims' family members were also interviewed as shown in the table 4.1 below.

Table 4.1: Socio-demographic Data of Suicide Attempters' (SA), Suicide Attempters' Family (SAF) and Suicide victims Family Members (SV).

Variables	Suicide Attempters' (SA)	Suicide Attempters' Family (SAF)	Suicide victims Family Members (SV)
Age (years)			
<18			1
18-28	5	2	1
29-39	6	3	
40-50	2	2	1
51-61			1
Sex			
Male	8	2	2
Female	5	5	2
Marital Status			
Married	8	6	2
Unmarried	4	1	1
Divorced	1		1
Number of Children			
None	8	2	1
1-3	4	4	1
4-6	1	1	2
Level of Education			
No Formal Education		2	
Primary	3		1
JHS/Middle School	2	2	1
SHS	3		1
Tertiary	5	3	1

Religion

Christian	13	5	4
Moslem			
Non-religious		2	

Occupation

Unemployed		1	1
Government Employed		2	1
Self employed		4	2

Mode of attempt/Mode of attempt of the family member

Rat poison, Axe	7	4	3
Insecticide, Overdose of sleeping tablet, strips of Panadol, Gebedol and a cough mixture	4	2	1
Stabbing of lower abdomen	1		
Slitting/cutting of the wrist	1	1	

Relation with attempter/ relation with victim

Brother		2	1
Sister		3	2
Mother		1	
Father		1	
Husband			1
Total	13	7	4

Community Psychiatric Nurses from table 4.2 below show that they had first-hand experience because each nurse had been working for at least 1 year and for others close to 16 years. Forty-six (46) community members were successfully interviewed from Ledzokuku, Ga East,

Weija/Mallam, Ningo Prampram and Ga South. They came from varying demographic backgrounds. Their socio-demographic characteristics are summarized in Table 4.2 below.

Table 4. 2: Socio-demographic Background of Community Psychiatric Nurses (CPNs), Community Members (CMs); Ledzokuku (CML), Ga East (CMGE), Weija/Mallam (CMWM), Ningo Prampram (CMNP), Ga South CMGS and a member of the Mental Health authority (MHA).

Variables	CPNs	CML	CMGE	CMWM	CMNP	CMGS	MHA
Age (years)							
18-28	3		1	4	1	3	
29-39	14	3	7	6	4		
40-50	1	3	1		1	5	1
51-61		2				1	
>61		2	1			1	
Sex							
Male	2		5	1	1	5	
Female	16		5	9	5	5	1
Marital Status							
Married	15	5	3	5	3	5	
Unmarried	3	5	7	5	3	2	
Divorced						2	
Widowed						1	1
Number of Children							

None	3	2	5	6	2	2	
1-3	11	3	5	3	3	4	1
4-6	4	4		1	1	3	
>6		1				1	

Level of Education

No Formal Education		2				2	
Primary					4	4	
JHS/Middle School		3	1	1	2	2	
SHS		3				1	
Tertiary	18	2	9	9		1	1

Religion

Christian	18	10	9	10	6	9	1
Moslem						1	
Zionite			1				

Occupation

Unemployed			1	3			
Government	18		4	3			1
Employed							
Self Employed		10	5	4	6	10	

Years/Duration of

Work

<4	4						
4-10	11						
11-16	3						1
Total	18	10	10	10	6	10	1

Table 4. 3:Main and Sub-themes

Study Objective	Main Themes	Sub-themes
Explore the experiences of individuals who have attempted suicide in relation to precipitating factors	Suicide precipitating factors	Childhood experiences, psychiatric issues, mistrust, shame and disgrace, parental pressure, emotional breakdown, wasted resources, domestic violence, infidelity, difficult life pursuit (Financial challenges and academic demands
	Methods used for attempted suicide	Use of rat poison
		Overdose of medication, use of an axe
	Post attempted suicide experience	Feel of regret
Describe the response of suicide attempters' families in relation to the general effects of the attempt on the family.	Family response	Anger
		Shock
		Concern and solidarity
Examine the views of community members that almost lost/lost a member to suicide in relation to how they handled such cases.	Remedies for suicide attempt	Neutralizing the poison, Induce vomiting with the

		use of palm oil and crude oil, Stoppage of bleeding, Cutting down of noose, Skilled swimmers, Calling of the police.
Assess the strategies used by Community Psychiatric Nurses in the management of individuals and families of both attempted and completed suicide cases.	CPNs response	Assessment, Counselling and psychotherapy, Medication, Engage the person in the area of interest, Separation from stressors, Removal of harmful items, Physical monitoring and Referral.
Identify the coping strategies used by families of suicide victims	Positive coping	Experience Sharing and Encouragement, Relocation, Social bonds, Psyche Yourself, Acknowledging That Tragedy May Come to Anyone, Word of God, Prayer, Reliance upon God

4.3 The Experiences of Individuals Who Have Attempted Suicide

The first objective of this study explored the experiences of individuals who have attempted suicide in relation to precipitating factors. These factors included childhood experiences, psychiatric issues, mistrust, shame and disgrace, relationship challenges, parental pressure, difficult life pursuits. Suicide is a very complex phenomenon, and the findings of this study have buttressed that before the participants decided to attempt suicide there had been a build-up of events. One such factor was childhood experiences. The following themes and sub-themes were derived from the data of the research:

Theme 1: Suicide precipitating factors

Childhood experiences as precipitating factors

In sub-theme 1, some of the participants recounted how they had been badly treated way back when they were very young children; one participant said:

“My stepfather told my mum that he cannot look after me and my two other siblings. He claims that he did not have enough money to look after someone else’s children but then my step siblings were well catered for. It was clear and without doubt that my step siblings were his favourites” (35-years, SA 12)

“I think the kind of relationship parents create between themselves and the children... let’s say 4 out of the 5 children and the parents have a favourite... so most of the problem comes from childhood, I think I was neglected since childhood” (37-years, SA 4).

Other participants witnessed a spill over of their father’s anger and battering of their mother and themselves as kids as well as being used as under aged labourers among other painful childhood experiences by the same father. The ordeal was described as such:

“My stepfather did not abuse only mum but also us the children. We had to drop out of school due to many unfavourable events. Dad used us as assistants at the various construction sites he worked at even though we were under aged. At home he sometimes beat us to pulp. At one time he beat my younger brother severely and

smashed his head into a wall. He ended up with a bloodied face and facial wounds. At a certain point we could not take the maltreatment anymore, so without informing mum nor our stepfather, we absconded. We went to live with our Aunties and Uncles at a neighbouring town.” (35-years, SA 12)

It is noteworthy that most of the negative childhood experiences recounted as precipitating factors were perpetrated by the fathers. A misbehaviour or failure on the part of any father goes a long way to negatively affect the young minds of the children and can lead to lifelong mental health issues as expressed by the following respondent:

“I witnessed some of the episodes of my father battering my mom; I was seven years old I did not want to speak with my father even on the phone. I used to be a very active student in class, and I even won two awards for being the most active student, but I stopped participating in class activities and was always detached and often did not want to mingle with my mates.” (21-years, SA13)

Suicide Attempts Precipitated by Psychiatric Issues

The second sub-theme of the study showed that some participants’ suicide attempt was precipitated by psychiatric issues. The kind of psychiatric issue experienced include auditory hallucination that normally occurs in conditions like Parkinson's, post-traumatic disorders, schizophrenia, borderline personality disorder, bipolar disorder, and dementia; it involves the hearing of strange voices without seeing anyone around. These voices instructed them to take their lives. Some of these psychiatric issues are endogenous (the kind that people are born with) and others are exogenous which are triggered by environmental factors. Once a person begins to hear voices, they almost always lose control of their will power and seem to be at the mercy of these voices as seen in the following participants’ statements:

“I work with a security agency and my problem is that anytime I am on duty I feel like shooting myself. I hear voices that tell me to shoot myself. I feel like I want to die that is why I tried using the gun on myself. I can’t tell you the details what makes me want to kill myself. (32-years, SA 3)

“I was having problems with my mind since childhood. I once heard a voice that told me to kill myself with an axe. So, I told some of my family members that I hear voices that says I should use an axe to kill myself.” (31-years, SA 11)

On other occasions, while they were alone and quiet, these voices made them feel defeated and because they were tired of hearing these voices, they decided to end their lives in order to silence the voices. This participant confessed:

“Honestly it all started when I began hearing these voices, it was like some people were talking to me even when I was quiet and alone, thinking about something better for my life. These voices said things like they have won, and you have lost. I was always trying to do what they said, and thinking about how I will perform their commands. I was very sick and tired of hearing these voices. Even when sleeping, I could still hear them; so, I was like why won't I end my life and all these things will be cut off. So, I decided to commit suicide.” (26-years, SA 5)

Mistrust as a precipitating factor

Sub-theme 3 of this study shows that false accusation also contributed to some study participants suicide attempt; an expression of a lack of trust coupled with being accused of theft made some participants feel like they had to prove their innocence by taking their own lives and thus putting their accusers to shame. One described it this way:

“I was wrongly accused. I think this was not the first time I was accused of doing something. So, I think the feeling that you can accuse me of doing something I never did... I wanted to end it all. And some of the issues or the feelings you have come from the fact that people don't trust you, you feel the accusation so much and you want to end it all.” (37-years, SA 4)

False accusation also manifested in the marriage of some participants. Some spouses accused their partners without any concrete evidence but just based on suspicion. When trust is lost in a marital union and suspicion and false accusation take its place, the spouse at the receiving end goes through serious distress that can sometimes trigger suicide thoughts and attempt. One spouse narrated her experience thus:

“One time he was struggling with me; he wanted to take my phone and I refused to give it to him. He claimed I had been talking to someone he suspects was my newfound lover. It was not true; the truth is about a year or some months into the marriage, he stopped chatting with me altogether and everyone was living their own life so I converse with my friends on phone and on WhatsApp. I once jokingly told a friend that it been a long time since I went to the beach and that I will like to go to the beach. I afterwards plugged my phone to charge it; but unknown to me anytime I tried talking

to friends he hangs around to listen to our conversations. He took the phone from charging and hid it.” (31years SA 6)

The participants said to be accused of something they had not done was so painful and they felt like ending it all to put their accusers to shame.

Shame and disgrace as precipitating factors

Sub-theme 4 revealed that other respondents who attempted suicide did not do so to put their accusers to shame but rather sought to avoid shame and disgrace, they felt they were being discussed, which made them feel embarrassed and therefore wanted to end it all. Certain participants felt shattered when private family life information that was supposed to be kept secret leaked and got into the public domain. For a man financial struggles and sexual challenges are issues that are very sensitive and can kill a man’s ego and public image, it was not surprising when some participants made statements like:

“I felt they were discussing my issue which kept me embarrassed within and very disturbed. I didn’t want disgrace so I wanted to end it...I was very tired and felt embarrassed when I heard people discussing my issue” (46-years, SA 2).

“Can you imagine how I feel, you will not wish any loved one of yours to go through what I experienced. It takes away my dignity and self-worth. It was so painful and disgraceful. I kept it all to myself and made me feel ending it all.” (22-years, SA 7)

Elsewhere, participants who entered relationships against the will of their families could not go back for solace from the same family they discarded in the event of a relationship problem with their spouse, in such stranded scenarios many a victim will begin to contemplate suicide to avoid the upcoming shame and disgrace as in the participant who said:

“Can you imagine how I feel, you will not wish any loved one of yours to go through what I experienced. It takes away my dignity and self-worth. It was so painful and disgraceful. I kept it all to myself and made me feel like ending it all.” (22-years, SA 7)

Parental pressure as precipitating factors

Some of the participants were also invigorated to attempt suicide because of parental pressure which manifested as sub-theme 5. This pressure was brought to bear on them at the very onset of their amorous relationship with their partners; attempters felt that the general pressure that emanates from their day-to-day interaction with parents concerning everyday life issues was too much to bear so they felt they could slip out of the parental pressure through suicide. This participant said:

... “you know how our local parents behave at times...the kind of problems they will give you at home. So, it is like if I sleep and I don't wake up Charlie it is better off than to go through so much stress.” (33-years, SA 9)

Other suicide attempters also engaged in the act due to this same parental pressure, but it was a pressure concerning something different. Their pressure stemmed from academic demands. Parents spend fortunes in the education of their wards and the least these parents expect in return for all their investments is good academic performance to show that they have not wasted their resources; when these wards are not able to meet the expected academic expectation of their parents due to several factors like peer influence, laziness, inappropriate choice of courses, substance abuse and other social vices, it puts a lot of pressure on these students who then begin to contemplate suicide, especially nearing the completion of the course when the day of reckoning nears, as their only source of escape. A student who experienced this said thus:

“It is not easy to make money nowadays, so when parents pay expensive fees for you the least they expect from their ward is good academic performance...the parents have spent a lot from Kindergarten to University. My parents are telling me I need to get my grades right and this has brought a lot of pressure on me; I feel like when I am no more the pressure will cease” (20-years, SA 10)

Some parents were also completely against the unions of these participants, but some of the participants fought their way through and went ahead with the relationship, in this current

situation where the relationship has gone belly up, it is absolutely difficult to return to the same parents and admit they were right, so considering their reaction and the excessive pressure that it will bring, the only route left for these participants seemed to be suicide as expressed by this attempter:

“I was going out with a certain guy and my parents were not in support at all, they warned me seriously to keep away from this guy. I disobeyed my parents however and moved on with this guy. Instead of him showing me love for all my sacrifices he rather maltreated me. I couldn't go back to my parents because they warned me about this relationship, and I did not listen to them. I run away from home with this boy. So I don't know how I can go back to my parents with this pregnancy.” (22- Years, SA 7)

Apart from the shame and disgrace that some relationships brought, the findings of the study revealed other relationship issues that also triggered suicidal thoughts and suicide attempts, these included emotional breakdown, wasted resources, domestic violence and infidelity.

Emotional breakdown as a precipitating factor

Some of the participants said they sometimes broke down emotionally and got confused because of the way their family behaved towards them. Some also expressed the feeling of rejection from both their partners and families that made them shocked, shattered, and depressed which at the end made them want to take their lives and this represented sub-theme 6 .The following illustrative quotes buttress these assertions:

“It doesn't matter, I don't feel loved neither by my parents or family. Love is based on trust and since my own people don't trust me clearly shows there is no love here and they don't want me around. I will be better off dead. Depression is not enough to describe that feeling.” (37-years, SA 4)

“...I was really disturbed and having a lot of thought and wished I was not alive. I was confused and felt shattered and did not know what to do.” (22-years, SA 7)

“It is a feeling that comes, you feel rejected. No one understands you.” I have been through that situation before where I wanted to take my life.”(27-years, SA 8)

Wasted resources as a precipitating Factor

Within relationship issues, the study also uncovered that some partners felt they had wasted their resources on their spouse, this represented sub-theme 7. They felt that all their sacrifices were in vain, whereas others felt their partners were ingrates, they had spent a great deal of their resources in terms of time, energy, financial resources among others, all on a person who tramples it under foot and in turn behave as if nothing had been done for them; some believed they lost great opportunities in life all because of this unthankful partner. The cumulative pain caused them to start contemplating suicide. The following illustrative quotes illuminate these assertions:

“My wife doesn’t buy any dress. I provide everything even if I go to town I buy anything she wants, even her panties. I haven’t been able to build a house. If I look at the money I have spent on her, it is not a small amount at all. I have really suffered.”
(46-years, SA 2)

“Can you believe what I have been through for this guy? I have lost a lot because of him; I wasted my money, my time and even the relationship with my parents. I couldn’t go back home because of the way I left. I couldn’t tell anyone because it was so painful.”
(22-years, SA 7)

Domestic violence as precipitating factors

Sub-theme 8 further showed some of the participants that felt they had wasted their resources on their partners also suffered intimate partner violence (IPV) or domestic violence (DV) at the hands of these same ungrateful partners; some participants experienced bitterness in their relationships as a result of this domestic violence; participants narrated how their partners will verbally abuse them by passing very hurtful comments. They were mostly maltreated by these partners despite their sacrifices for them. One male respondent lamented:

“At times she can say very hurting comments and she will tell you she is saying what is in her mind.” (46-years, SA 2)

Another female participant revealed that:

“Instead of showing me love for all my sacrifices he started maltreating me; several times when my boyfriend was maltreating me.” (22-years, SA 7)

Infidelity as precipitating factor

Sub-theme 9 of this study also showed that in some cases the spouses that were ungrateful after all the resources spent on them were not only subjecting their partners to IPV or DV but were also into infidelity. Most of the participants believed that their partners were unfaithful, and so because of their newfound love, nothing their current partners did could please them. They could deduce that through many things these spouses did including the phone calls that they made and how they spoke to the person at the other side of the call; these calls were suddenly ended when a partner approaches. One male participant said:

“I also felt there was something going on. Whenever my wife is on phone and sees me she cuts the line. So I became very suspicious. When she gets a call and I pick hello the person will never speak. I once saw a message and I confronted her but she denied and I never complained. (46-years, SA 2)

Another female participant added:

“My boyfriend started misbehaving towards me. He was not like that from the beginning; among other things I suspected he was cheating on me and he has seen another girl, when I die then he will be free to do whatever he likes.” (31-years, SA 6)

The cumulative effect of the painful relationship issues made these partners feel that they would be better dead than to live through such excruciating experiences.

Difficult life pursuits as precipitating factors

Sub-theme 10 depicts a scenario where academic demands arise from the fact that some parents want to use their wards to settle a score with another person or group of persons, therefore a parent might force the child to offer a course that will make the parent look good or overstretch themselves to attain certain heights in their academics. This form of parental pressure led many an innocent student to contemplate and attempt suicide because of its negative effects on the mind just as one student said:

“My mum has always tried to use me to prove a point to her previous husband. She has always been pressurizing me to do well in my academics just to make a strong statement. I do not like the course I am doing but she forced me. I keep getting Ds and Fs. I just could not bear it and therefore felt it will be better to end my life than disappoint her.”(21-years, SA13)

Other adverse life situations also served as a trigger for suicide attempt as was found by the study. Participants shared how their plans and expectations were crushed by unexpected events. Such negative surprises had the tendency of disorganizing the individual mentally; some of the participants related how they had lost their source of livelihood, run into debt and were being pursued by debtors others experienced broken hearts when relationships and partners they had invested so much into break away suddenly; some of the respondents put it this way:

“Hmm life is not easy at all. I remember how one Christmas occasion I had so many things to sew but all got burnt and people were on me demanding for their materials and advance payments. Hmm there was no way out for me. Some people even said I intentionally burnt the materials, hmm.”(46-years, SA 2).

“There are certain life situations that will eat you up. I had a girlfriend, you have gone through so many hard times with the person, spent a lot of money and now one day the person wakes up and is like I am done with you. It is not easy, let’s say you are not in good terms with your parents because of this same lady. You have spent a lot. Most of your life savings have gone to her and at the end of the day out of the blue decides I am done with you. I tell you, you won’t take it easy.” (33-years, SA 9).

Financial challenges that stem from several factors including adverse life circumstances also served as a trigger for some attempters. Many a home broke down and partners left the relationship because the breadwinner could not afford to cater for the family anymore, whereas arguments about money have also brought so much strife into families; some participants had this to say:

“We are in hard times and things are difficult. At times I do even cry and I also thank my family for supporting me even when things were not right for me. My goat farm was not functioning well due to the epidemic around Christmas but I am trying my best because of my wife. My mother died when I was at the age of 12years so when I saw my wife, she resembled my mum and decided to live with her for the past 22-23

years now. So it was a shock to me when I went through such an experience.” (46-years, SA 2)

“I was wrongly accused, just because of money. My own parents think I am a thief. If your own parents don't trust you with money then who will? I feel useless.” (37-years, SA 4)

4.4 The general response of family members to the suicide attempt

The second objective describes the general response of the suicide attempter's family to the suicide attempt.

The general response of the family to the attempt was both negative and positive. The negative responses were anger and shock, while the positive responses were concern and solidarity. The relatives included a father, a mother, two brothers and three sisters. They were all staying with their immediate relative, but these relatives were not around at the time of incidence. The anger and shock were short to medium term, while concern and solidarity were medium to long term responses.

Theme 2: Family Response

Anger, as a response of family members to the suicide attempt

Sub-theme 1 which is anger, was described by participants as the way they felt after a relative had attempted to take their life. This anger was seen as short to medium term. The study showed that many family members asked a lot of questions as to why their family member would attempt to do such a disgusting thing and the pain increased when they considered how much investment in terms of time, food, clothing, care, education, money among other things that was going to go down the drain if the victim had completed the suicide and the future potential the suicide attempter carried. Another thing that also angered the family members was the good name of the family that was going to be dragged in the mud because of this suicide attempt. Which shows that the anger was expressed by the immediate family who believe that people will ask questions like what the family members did to the victim to push

him/her to this extreme, and all sorts of rumours will be circulated. Beyond that it casts a slur on the family name, in the African culture communities become like an extended family and many discussions are made concerning different families; when you ask about any particular family name in the community, you will quickly be given the family's background information, without even asking for it, therefore in the future whenever someone wants to either marry or make some good investment into the suicide attempter's family, the people in the community will tell the potential investor that it is a family of good for nothing suicide attempters and that will most definitely discourage many an investor. This stigma will not easily be taken away from the family.

The following illustrative quotes of some angry family members:

“It is humiliating and demoralizing. I really got annoyed. Sometimes I see him to be a useless boy. He should appreciate us hmmm. ” (45-years old father, SAF 1)

“It is infuriating. At times I feel very sad, other times I feel ashamed and ask myself why and how did this happen? At times it makes me very angry” (35-years old sister, SAF 4)

“I was so angry. How can David do such a thing? After all the love we have shown him, hmm. “This is very painful and annoying considering the fact that the image of the family was permanently tarnished in the eyes of outsiders” (38- Years old brother, SAF 2).

Shock as a response of family members to the suicide attempt

Shock was sub-theme 2. Other immediate family members were so shocked to hear that a trusted family member could attempt such a despicable thing. In the event where there existed prior signs and comments from the attempter, the family are usually not too shocked or surprised about the attempt but where the person in question had no obvious issues, the family gets really jolted in the wake of the event. This shock was seen as short to medium term.

One of the participants said:

“Everybody who knows David will be shocked that he tried such a thing. With his education, intelligence and smartness, we didn't expect that from him at all, so with the least notice and prompting everybody came around to verify what had happened; to take that tool and attempt suicide? No! That was not the David we knew. I think

they were equally surprised the same way I was. Yeah” (38- years old brother, SAF 2).

Another participant responded:

“Ooooooh she likes making friends and she is not very quiet, she is playful, she is at peace with everyone, so I am really shocked at what happened, not in my wildest thoughts could I imagine my sister doing this.” (32 years old sister, SAF 3)

Concern and solidarity as a response of the family members to suicide attempt

Concern and solidarity was sub-theme 3. Despite the fact that many family members were angry and shocked, they could not help but show concern for their loved ones, and they imagined this victim might have really suffered because of both physical and emotional injuries the attempter has received. It also brought solidarity; unity, togetherness and mutual support within the nuclear family as well as the extended family; many family members that had not been together for a long time were brought together by this event and they brought in encouragement for the victim.

The following quotes elucidate the above point:

“That very moment everybody came around, you know here in our society, we are like an extended family, so when one person encounters a problem, you have people in the neighbourhood trooping to the house to see what had happened. It is sometimes even not about money o! They just want to show you that they are with you, the solidarity is there paa. I think they were equally concerned the same way I was, seriously I was amazed the way they were all worried about what had happened, you could see they felt the pain we were feeling as a nuclear family, those who were not able to come here physically would actually call and ask about how we were faring” (38-years old brother, SAF 2)

“They were actually worried about the situation when it happened, they would ask questions like, how are things now; is there anything we can do to help you and they would often tell me-we are praying with you” (46-years old mother, SAF 6).

“Everyone was concerned because we have lost both parents. So, we only have each other. The pain of losing even one parent was not easy, talk of losing both. They kept saying, o why would he try such a thing when he knows that you don’t have any other family but yourselves” (28-years old sister, SAF 7).

4.5 How Community Members Handled Attempted and Completed Suicide Cases.

Theme 3: Remedies for suicide attempt

The third objective of this study examined the views of community members that almost lost/lost a member to suicide in relation to how they handled such cases.

The result of the study showed that community members handled attempted suicide cases by the use of palm oil in neutralizing the poison and to induce vomiting; they also use other methods to stop bleeding. They cut down the nooses of those who attempt suicide by hanging and engage the services of skilled swimmers to rescue those who attempt suicide by drowning.

In the case where suicide is completed for all the above modes of suicide attempt, the community members will usually call the police to the scene before conveying the body to the morgue in order to avoid implicating themselves. It is also worthy of note that the most effective method used in the community in handling attempted suicide cases was the stoppage of bleeding by rubbing in the herb Acheampong or cassava dough and applying pressure to the affected area with the help of a piece of cloth before conveying the person to the hospital.

Neutralizing the poison and inducing vomiting with the use of palm oil and crude oil by community members

Sub-theme 1 showed that suicide attempters within the various communities employed different methods in a bid to end their lives, for those who attempted suicide by the ingestion of toxic substances like rat poison, insecticides, weedicides, and other drug overdoses. Many participants expressed that the sure way of handling such cases was through neutralizing the poison and inducing vomiting with the use of palm oil and crude oil. A considerable amount of red palm oil is orally administered to the victim and participants were of the belief that this will make the person vomit the poison. A rather novel method of neutralizing toxic substances was put forth by one respondent, which is the use of crude or automobile oil. He claimed in

their community, when a person is found to have taken in anything toxic, they administered a few drops of crude oil orally and this also makes the victim throw up and expel the poison.

This participant said that:

“When we realize that someone has taken in some toxic substance like weedicide, we usually give them red palm oil to take so it can neutralize the poison and also induce vomiting.” (68- Years, CML 10)

“A few drops of crude oil administered orally to the suicide attempter to induce vomiting of the toxic substance sometimes help.” (66-years, CMGS3)

Stoppage of bleeding by community members

In sub-theme 2, other suicide victims in the communities’ resort to other suicide attempt methods that cause them to bleed to death like those who have been diagnosed with conditions that carry heavy stigma such as HIV. The victim usually feels like it will be better to end it all than to live through the condition, some of them cut their wrist or throat with a sharp object; others who are likely to also attempt suicide this way are those who have had a broken heart in a relationship or lost large sums of money among other reasons; when such a victim is found, community members apply pressure to the affected area and also tie up the wounded area or bleeding place with a piece of cloth to stop the blood flow before the victim is carried to a health facility for further treatment. On other occasions they use an herb called Acheamong or cassava dough on the bleeding area. The narratives that follow buttress these methods:

“For those who cut themselves with sharp objects to end their lives when we discover them in time, what we sometimes do is to apply pressure to the affected arrear and also tie the wound up with cloth/dress. We then rush the person to the hospital.” (30-Years, CMGE 7)

“Sometimes we apply certain herbs like the Acheamong weed or we place some cassava dough on the wound to stop the bleeding and tie it up with some shredded piece of cloth to stop the bleeding.”(35-years, CMWM5)

Cutting down of the noose by community members

In the community people also attempt suicide by hanging themselves. When someone is found to have hang him/herself, members of the community said they usually attempted to save the person by cutting down the noose of the hanging material which is sub-theme 3. This will however be effective if the attempter is found in good time before they get strangled by the rope; otherwise, it will just be cut to carry the corpse to the morgue with the help of the police.

The following illustrative quotes illuminate these assertions:

“When we find out someone was trying to end their life by hanging what we do is we cut off the rope that holds up the person or we place a chair or a table under the feet to decrease the tension in the noose this gives us the opportunity to rescue the person.” (36-years, CMGE 8).

“It’s very sad o! The rope hanging method is very fast so most of the time you see that the persons neck break because the weight of the body is too much, so if we don’t see them fast by the time we cut the rope, they already die.” (40 years, CMGS 5)

Community Members Engaging Skilled Swimmers as Rescuers

People who have lost the will to live because of previously discussed factors sometimes deliberately throw themselves into water bodies so they will drown and supposedly end their troubles; Community members also said they strategized to use the best swimmers (sub-theme4) in the community to save such lives provided they are spotted early enough. However, in some cases they were unsuccessful because they ended up losing those swimmers as well; they also expressed shock and the inexplicable resurfacing of the dead bodies on the third day. The following interviews shed some light on this:

“When someone attempts suicide in a community by drowning, we look for a very good swimmer around to enter the water and help save the victim.” (44- Years, CMGS 9)

“Someone trying to kill himself by drowning has happened twice but in all cases the person trying to save them died. I remember the second person who tried to save the person was an epileptic patient and had an episode of fit whiles trying to save the

drowning person; so, he also ended up losing his life in the process because there was no other person around who could swim to rescue both of them.” (66-years, CMGS3)

Calling of the police by community members

When all the preceding methods outlined by community members to rescue suicide attempters fail and the person actually completes the suicide, the only option left open for the community members is reporting the case to the police (sub-theme 5) to ensure proper investigation of the case to prevent implicating themselves and for the bodies to be carried away to the morgue.

These points are supported by the following quotes:

“When we find out someone has committed suicide, to avoid implicating ourselves we inform the police first, so they come and investigate and carry the body.” (50-years, CMNP 1)

“The amazing thing is that those who commit suicide by drowning always resurface after three days. Then we call the police.” (66-years, CMGS3)

After family members and the people in the community have done all, they can help a suicide attempter, they usually seek external assistance to help the victim recover. They usually bring the person to a health facility where healthcare professionals utilize their expertise to help the attempter recover. One pivotal group of healthcare professionals in the recovery journey of suicide attempters in a health facility are the community psychiatric nurses. In the delivery of their services, they ensure that the wellbeing of the victim is well attended to; their work extends beyond the ward into the various communities where they undertake home visits and ensure the attempters are following their treatment regimen. The study made evident that the following are some of the strategies utilized by community psychiatric nurses (CPNs) in their work with suicide attempters and their families to help in recovery and ultimately promote suicide resilience.

4.6 The Strategies Used by CPNs In The Management Of Individuals And Families Of Both Attempted And Completed Suicide Cases

Theme 4: Community Psychiatric Nurses response

The fourth objective of the study assessed the strategies used by Community Psychiatric Nurses in the management of individuals and families of both attempted and completed suicide cases. The participants (CPNs) of the study from all the selected districts stated emphatically that there was no laid down guideline or strategy for handling suicide attempt cases, both in the community psychiatric facilities and in the communities. But then depending on the situation and experience, CPNs used one of the following: assessment, counselling and psychotherapy, medication, engaging the person in an area of interest, separation from stressors, removal of harmful items, physical monitoring and then referral; this assertion was confirmed by the national coordinator for mental health and a member of the Mental Health Authority.

Assessment as a strategy used by Community Psychiatric Nurses

When a suicide attempter is brought to the health facility, they are treated for any medical emergencies and injuries after which they are brought to the mental health department here, one of the first things that CPNs do is assessment of the patient (sub-theme 1). The CPNs undertake a mental status examination to determine the cause of the attempt so it will guide them to know the best way to assist the attempter overcome the psychological challenge that led them to undertake the attempt. It is the first step of any interaction between the nurse and any mental patient and is performed before any other form of intervention. These are illustrated by the narratives below:

“How to open up to you the health worker is a big challenge, but you know since it is our field we are able to communicate with them and know what really prompted them to attempt suicide; so when they come you have to show them emotional care, extra

love. You shouldn't be judgmental; you should have a listening ear.... Have a listening ear to the person, let the person come out with what prompted him or her, what triggered the attack for him to attempt that suicide, you should also find out from the family whom the person is staying with, the environment, you should also find out from them whether maybe it is coming from the community, the family members and any other person around the person."

(35- Years, CPN 14)

"Mostly when we have suicidal cases with mostly depressive clients and mostly when they come and we are assessing them you realize that as part of our assessment, we are supposed to find out whether they have any suicidal thoughts or ideations and then as to whether they've attempted, and I remember there was this client who had suicidal ideations recently it's not even up to a month we had a case, she said she was fed up with the world, she felt that if she dies it's okay and then she even attempted suicide according to the mother she took in insecticide and then she was rushed to our facility; that is the recent experience with suicidal behaviour" (32-years,CPN 15)

Counselling and Psychotherapy as a strategy used by Community Psychiatric Nurses

After examining the attempter mentally, the CPN then engages the suicide attempter in counselling and some psychotherapy (sub-theme 2). After the CPN gets the patient to open up and share their experiences and what triggered the attempt, the psychiatric nurse now determines the most appropriate counselling to take the patient through and also the best psychotherapy to apply to ease the patient's psychological issues. The CPNs at this point sometimes work hand in hand with psychiatrists and clinical psychologists to whom they refer patients whose condition require their services, and this is evident by the following statements by CPNs:

"When they are brought at the first time if you are not able to talk to them in a good tone they can even hurt you the health worker around him at that time you have to reassure them, you have to let the patient know that he is in good hands and you will be able to help him or her come out with the situation he or she finds themselves at that particular time. You let the patient have a seat in a comfortable position. the patient is anxious, so you have to reassure the patient to allay his or her fears or anxiety. You can take the patient through deep breathing exercise to come out with the anxiety or fear, then you can take the patient through, we have this cognitive behavioural therapy. It is a therapy that is designed to make a patient come out of any stressful event they are going through." (35- Years, CPN 14)

"Like I said it is through counselling depending on the stressor, the recent one she had the depression as a result of a broken heart. Apparently, she got pregnant for a guy and the guy refused to accept the pregnancy and then he broke up with her. And

that was the main cause of depression. We tried to encourage her and let her feel that that was not the end of the world that there is a bright future. So, she shouldn't worry and we also involved the relatives in the counselling” (32-years CPN 15)

“There was this man that came with money issues and marriage issues. The wife left him, took the children away but he still had the chance to go to them, he felt he was useless, he wasn't doing anything so he attempted it the first time, and when he attempted it he came to the hospital and they referred him to us and so we were attending to him and he was fine, we did counselling and all that...” (30-years, CPN 18)

Medication as a strategy used by Community Psychiatric Nurses

After counselling and psychotherapy most patients get better, but during the mental status examination, the CPNs sometimes realize that the victim needs to receive some psychotropic medication (sub-theme 3) to handle any underlying psychiatric conditions that might cause the patient to attempt the suicide again. Some of the participants (CPNs) confirmed that antipsychotics help handle hallucination, which can pre-empt suicidal ideation. This strategy used by CPNs as far as caring for the mental patients was concerned can go a long way to help the patients in terms of recovery.

This participant said that some patients were given antipsychotics, like Olanzapine and Modecate to treat the hallucination. Some CPNs said:

“...She was hallucinating as well so we put her on antipsychotics, to her we gave Olanzapine and modecate....” (32 –years, CPN15)

“Then we put you on medication and most of the time if somebody wants to take his or her life, it means, the person has come to their wits end and the person is also depressed and there are antidepressants we put the patients on and if it is psychosis, we put the patient on anti-psychotic drugs.” (37 years, CPN 16)

“When they hear suicide they don't know they have to treat the medical side first so they call us, so when we get to the ward, if its ward or the emergency ward, then we meet with the doctor and maybe we let the doctor help us with the medical aspect, if its infusion and all that then he prescribes the needed medication and everything” (30 years, CPN 18)

Engage the person in the area of interest as a strategy used by Community Psychiatric Nurses

The results of the study also showed that the CPNs realized from experience that engaging the patient in meaningful activities of their interest (sub-theme 4) really helped to speed up

the healing process. In-depth interviews held with community psychiatric nurses confirmed this. Activities like watching of football, skipping ropes, singing, sewing, drawing and painting or any other interests really helps us is highlighted by the narratives below:

“If the person has interest in football, you may ask the person who is taking care of them....to bring them around the television. If there are players that they admire in the current football match, encourage them to come and watch, and also mention the players’ names and the exciting part they are playing in the game to get the drive back” (40-years, CPN 1)

“There was also this another therapy where you try to engage the client where he is interested in. I realized she loved dress making. Ahaaa I intentionally said if she can sew my dress. She smiled and said oh she has not learnt how to do male dresses. Then I will bring my wife measurement, so you saw for them I also have two girls. So, these things I did brought some life into her.” (36 years, CPN4)

Separation from stressor and removal of harmful items as a strategy

The CPNs through their interview of psychiatric patients and conduction of mental state examinations realize that for many of the attempters there were some things in their lives that triggered the attempt. They therefore realized that it was absolutely necessary to separate them from these stressors (sub-theme 5) using all the avenues available and also engage the family and make them know the role they had to play to help this family member recover fully; by this the family will be admonished to ensure they don’t become one of the stressors of the patient if they are to assist them in recovery. CPNs sometimes utilized the technique in addition to medication and counselling of and this helped to ameliorate the attempter’s mental status. This is evident from the following interviews.

“If there is a stressor, you either take the stressor away or take her away from the stressor. The mere sight of certain things can spark serious episodes of stress within the long term could lead to suicide ideation. Therefore, it is only proper to keep previous attempters away as much as possible from a repetition or from any factors that will make the attempter re-live the bad experience. (40-years, CPN 1)

“Mostly we think that it is psychosocial stressors that make people attempt to take their lives. So, when we see that there are psycho stressors we do a lot of the psychotherapy, in order to relieve the client of the stress and speed up recovery.” (37 years, CPN 16)

The CPNs also apply the strategy of removing any harmful items from the immediate environment of the attempters because it could serve as an equipment for the reattempt of suicide so to ensure the safety of the clients, the community psychiatric nurses as a way of managing patients, make sure there are no sharp objects that can endanger the life of the patient and therefore all the sharp objects and any potentially harmful things are removed. Beyond the ward, family members are also encouraged to do their best to remove any dangerous item from the home environment. The quotes below illustrate these points:

“If the person is suicidal then you have to be on the watch out especially the room, they live in. if there is a fan there you might have to remove the fan. If there are things like a rope or sharp and pointed things like knives, forks, blades or a metallic loose object you might have to remove all of them. Ahhaa, make sure they don’t get access to these blades, sharp knives etc. because they can re-attempt the suicide with these. You remove all of them and make sure poisonous substances like weedicides, insecticides and other toxic household items are kept out of sight” (40-years, CPN 1).

“Make sure that all sharp objects, anything that the patient can reach out to harm him/herself are taken out” (35-years, CPN 14).

Physical monitoring as a strategy used by Community Psychiatric Nurses

In sub-theme 5: Physical monitoring of suicide attempters while at the health facility is also crucial for the prevention of any negative surprises on the part of the attempter. Results from the study showed that Community Psychiatric Nurses use physical monitoring as one of the strategies in the management of suicidal patients. These nurses provide care by close observation and monitoring, in an open ward close to the nurse’s station. CPNs would also counsel family members to also keep an eye on the patient at home to help prevent a reattempt. The narratives that follow illustrate these factors mentioned.

“They are managed in an open ward close to the nurses’ station, so that there will be monitoring and observation and sometimes if they are to be kept in a room it should be in the company of other patients” (35-years, CPN 14).

“Then we make their relatives aware, because with attempted suicide we don’t keep confidentiality for them. Probably the person will be going back with their relatives and if we don’t make them in the known, they could be harmful to themselves. So we

involve relatives to be watchful as much as possible they should have people around them at any point in time because no one knows when they will try it again. So when we do that we have to make the family members be involved in their treatment.” (37-years, CPN 16)

Referral as a strategy used by Community Psychiatric Nurses

After the CPNs have utilized all the above-mentioned strategies to help suicide attempters in recovery, there are sometimes instances where they realize there is the need to refer particular patients to other facilities that have additional facilities not available at the local healthcare center so they can receive better care and quicker recovery. The participants described various scenarios where cases brought to them seemed to be out of their domain therefore, majority of the nurses especially the young ones professed that for suicidal cases they quickly refer (sub-theme 6) to higher facilities.

“For me if I get those cases I refer them. I wasn’t managing them directly. If a case is brought in and we assess it here and our facilities and skills level don’t match up to the case, we don’t hesitate at all to refer to some of the higher institutions with more logistics and know how. A delay in referral could jeopardize a client’s life and ultimately render the goal of nursing care useless” (36-years, CPN 7)

“What we normally do at our district is, when they come to the hospital, they are referred to us, so we see them and attend to them. We work in collaboration with the clinical psychologist. We involve them and where there is the need for counselling we also refer to the clinical psychologist.” (36-years, CPN 4)

“I have come across a lot of suicidal attempts and behaviour in the community. Recently I came across a case at my facility, a gentleman attempted suicide and then upon probing like he was opting for mercy killing. He needed something that will take his life silently without pain. So, we tried to convince him to let him know that suicide is not an option but we tried so many times. We made him write a letter to really make sure he will not commit suicide, but he wrote the letter stating that he gives consent to take his life and we realized that he was so much at risk of attempting or committing suicide; so, we needed to refer because we realized keeping such a person in the house was very risky. So, such a client needs admission, so we referred him to our higher facility that is the Accra psychiatric hospital for further and proper care.” (29-years, CPN 5,)

4.7 The Coping Strategies Used by Families Of Suicide Victims

Theme 5: Positive coping

The fifth objective of the study identified the coping strategies used by families of suicide victims. In spite of the utilization of the various strategies by the CPNs to help suicide attempters recover, some still lose their life because of post suicide attempt complications; while others also lose their life through a reattempt of the suicide; also, not all suicide attempters even make it to the health facility to receive help; some lose their life in the first attempt. When a family loses a loved one through any of the ways mentioned, it leaves devastating effects like stigma, depression, pain, anger, and other psychiatric issues on the family; some of these effects could even trigger other suicide attempts within the family. Professional help is usually needed to help the suicide bereaved family cope under such circumstances, however in Ghana many families do not seek for the services of certified counsellors, clinical psychologists, CPNs among others, because the phenomenon carries heavy stigma in local settings so the victim's death is usually referred to in local parlance as "atorfu wuo" meaning: tragic or premature death; and they are usually not given befitting burials, which is seen as a destruction of the family image. The study results showed that these suicide bereaved families had developed their own ways and means of coping with the loss. Some of these strategies included experience sharing and encouragement, relocation, social bonds, psyching of oneself, acknowledging that tragedy may come to anyone, the word of God, prayer and reliance upon God. They were made up of a husband, a brother and two sisters.

Experience Sharing and Encouragement as Coping Strategies Used by Families of Suicide Victims

Certain participants said, what helped them deal with the situation was experience sharing and encouragement from others (sub-theme 1); the bereaved family received well-wishing

neighbours who will share their own painful experiences with this family and encourage them to know that they were not alone in this predicament. The idea of having someone who can relate to what they were experiencing helped ease the mental agony. The receipt of such encouraging words could not have come at a more appropriate time than this. The following are quotations from participants of experiences shared by neighbours and friends which helped them through with the situation:

“...before my naked eyes at the Trust Towers a lecturer fell down from the last floor of the storey building because of the frustration he was going through.”(48-years old husband, SV 1)

“Our senior pastor called and advised me that something had happened that his own lecturer who helped him to gain employment, the wife got burnt on a bed but neither the bed nor things in the room got burnt.”(16- Years sister, SV 2)

“Some came to share with me their testimonies and what has happened.” (53-years, SV 3)

“A similar thing happened in Kumasi. A woman had three children and was pregnant the whole house got burnt and the man was not around” (28-years old sister, SV 4).

Relocation as Coping Strategy Used by Families of Suicide Victims

The second coping strategy used by families of suicide victims was relocation(sub-theme 2). Some of the participants objectively handled matters by relocating to another place to avoid flashbacks and the re-ignition of painful memories anytime they came to the scene of the event; they said:

“So, the best solution is to vacate your existing house if you have the funds to do so. I realized that every day I woke up in this house flashbacks from the past flooded my mind. It’s very disturbing; different locations around the house remind me of my late wife and the times we shared together here. Can you imagine entering the kitchen and, in your mind’s, eye seeing your wife preparing your favorite meal and you chatting with her about how your day at work went; such memories keep playing back as I move through the house. Also, if the house belongs to you, you can rent it and get yourself a new place to help keep the old memories at bay (48-years old husband, SV 1)

“If it is your house, you can rent it and get somewhere else.” (53- Years old brother, SV 3)

Social Bonds as Coping Strategy Used by Families of Suicide Victims

Again, some of the participants reported that the formation of social bonds(sub-theme 3) and discussing issues among themselves, i.e., some of the unpleasant things they have been through and advising each other really helped. Some of them had very strong friendships and such friends would go through thick and thin with them; some of these friends had even become like blood brothers and sisters and they came in handy with all the support the grieving family needed; this was gathered from the participants:

“Some will get closer to you and encourage you. After it happened, some got closer to me; I was quite surprised at the way they were there for me at my lowest points after the traumatizing event. It was as if they were running some sort of shift system as they kept coming and going, with each sharing a word of encouragement with me. It really helped my recovery. It is said that a friend in need is a friend indeed, and this problem really made me see my true friends and the bonds have become stronger” (48- years old husband, SV1)

“After it happened some friends got close to me.” (16-yearsold sister, SV2).

Psyching Oneself and Acknowledging that Tragedy May Come to Anyone as a Coping Strategy Used by Families of Suicide Victims

Most of the participants also believed that they were psychologically overwhelmed because of the death of the loved one and therefore psyched themselves (sub-theme 4) up mentally as a coping mechanism to address any unhealthy situation they found themselves in. A person’s mental posture or psychological build-up determines their physical activities, so when a grieving person tells him/herself that ‘I am not going to get drowned by this tragedy’, they then need very little or no external help to get through this misfortune as this participant said:

“So, if you are not strong it can bring negative effects on you. One has to tell himself that I am a man, and it is men who swallow bitter pills, as we say here in Ghana. I have to strengthen myself in my mind otherwise I can easily go mad, I tell you it is not easy at all. It is one thing to see it happen to somebody and you try to comfort them but when it happens to you, no amount of outside comfort can help; you have to encourage yourself” (48-years old husband, SV 1).

Another remarked:

“It is not easy to see your family member die in such a horrible manner, but I tell myself no matter what I do, what has happened has happened, so I just have to be strong and move on”. (16-years old sister, SV 2)

Other participants recapped that one of the ways by which they handled the tragic death of a loved one through suicide was by acknowledging that tragedy may come to anyone. That gave them peace of mind and made them able to handle the situation at hand. They refused to see themselves as special people but rather ranked themselves among common men, therefore they accepted that what has just happened to them is what happens to every common man so there was no need to panic since they were not the first family to experience this pain and neither will they be the last to encounter such a problem, this really helped them to cope well under the pressure. They stated that:

“Notice that what happened to your brother can happen to anyone. I have come to realize that no one is immune to tragedy and that, as the Akan proverb goes “when you see your neighbour’s chin on fire, you better prepare yourself by getting a bowl of water ready for yourself, since you don’t know when yours will also catch fire. I used to hear of such things in the news, but I never thought it could happen to me. Now a loved one can pass away, what happened has already happened and it can encourage you. I realize now that I am not the first person to experience this kind of tragedy, I know God can give me another chance and this shows that I have a father.” (48-years old husband, SV 1)

“We are not the first to go through something like this, so we know this too shall pass.” (53-years old brother, SV 3)

Word of God, Prayer and Reliance upon God as Coping Strategy Used by Families of Suicide Victims

Sub-theme 5 finally showed that when participants have utilized all the aforementioned coping mechanisms to no avail, they usually turn to God for spiritual empowerment in order to overcome the effects of this tragic event. Many respondents revealed the various means through which they derived spiritual strength from God. Some got involved with the reading of the Bible which contains several motivational messages that helped lift a person’s faith and

trust in God for a better future. Others also became seriously involved in prayers to God with friends and family; they poured out their heart felt pain before their heavenly father believing that as he has heard them so will he answer them. The last group of participants just left their future and plans in the hands of God believing that he understood whatever happened and will let it work together for their future well-being. They will quote popular scriptures like Romans chapter 8 verse number 28. The quotations below buttress the beliefs of the respondents respectively:

“Your Bible reading will make you strong. I can tell you that without the teachings of the Bible, I would not have known what to do. It gets to a point you realize that you just don't want to talk to anyone, you take your Bible and open it at random and you see God begin to talk to you personally through His word.” (16-years old sister, SV 2).

“If not for the word of God, we would not have known what to do, we have really been encouraged and guided in these trying time by the Bible, I can tell you for a fact.” (28-years old sister, SV 4)

Your prayer... will make you strong” “...it is time to help your brother in prayer for God to strengthen him. Your prayer will also help. There were certain things and certain questions I could not ask anyone, but through prayers, I was able to directly pour my heart to God in prayer. I can tell you that the relief that ensues prayer to God is phenomenal and it helped me a lot in the recovery process” (28-years old sister, SV 4).

“Prayer also helped us because at certain times you need to speak with your heavenly father directly, because human beings cannot understand you.” (28-years old sister, SV 4).

This participant in conclusion underscored that,

“It got to a time, and I realized it is only God who gives hope...” “I had no hope, and it is only our father I rely on” “So far it is only He that has protected myself and the children up to date.” “In fact, you can also end your life when you go through such a situation if you don't have Christ.” (53- Years old brother, SV 3)

“We trust and rely on God alone who understands everything whether good or bad. (16-years old sister, SV 2)

4.8 Conclusion

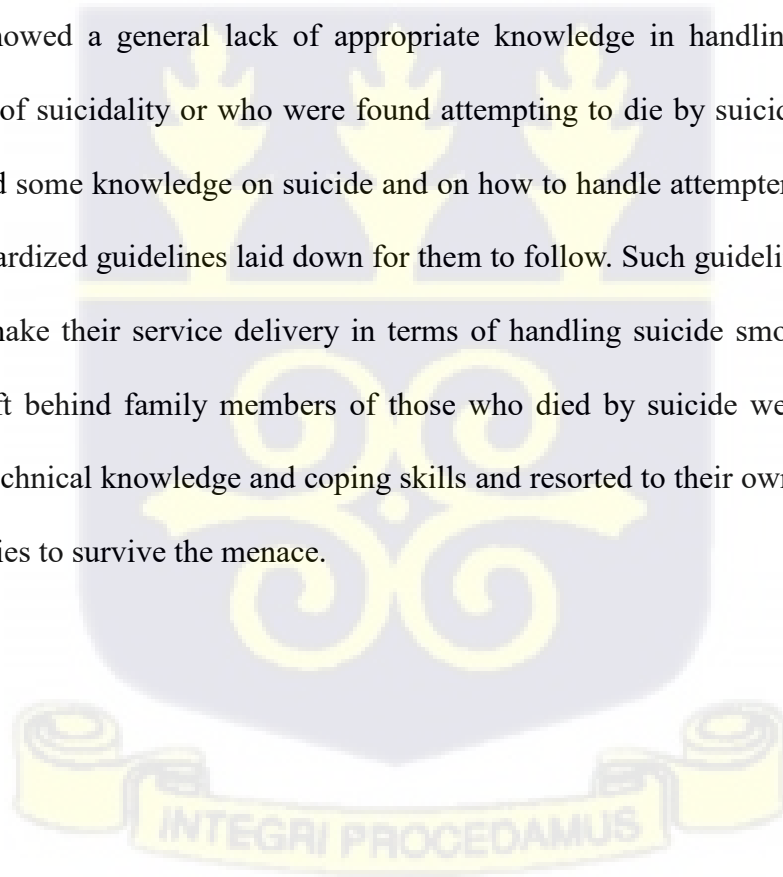
These findings have so far shown that suicide is a complex phenomenon, which does not have an easy way to point out a single factor as a cause. What we are seeing rather is that it stems from an interplay of factors, because some childhood experiences make some people develop psychiatric issues in later life; false accusations can be a relationship issue that stems from financial challenges which can also bring shame and disgrace; the combination of factors could be endless and complex but then it is usually attributed to the final trigger that led the person to engage in the act.

Beyond the attempt the results showed that suicide attempts do not only affect the victim but also the family; some of the general effects of the attempt on the family were anger, shock, and in some instances the attempt generated concern and solidarity within the extended family. The members of the communities in which the suicide attempters lived also expressed their views on how they handled such suicide related cases within their communities, they mentioned methods like neutralizing the poison, inducing vomiting with the use of palm oil and crude oil, stoppage of bleeding, cutting down of noose for those who tried to hang themselves, employing the services of skilled swimmers and calling of the police in the event of completed suicides.

When a suicide attempter is found and brought to a health facility, it is the duty of psychiatric nurses to receive such patients and to employ available nursing skills and strategies to help the victim recover both within the health facility and out in the community. The strategies used by CPNs in the management of individuals and families of attempted and completed suicide cases included assessment of patients, counselling and psychotherapy, medication, engaging the person in an area of their interest, separation of the patient/victim from stressors, removal of harmful items, physical monitoring and referral of patients to higher health facilities. Finally for the families who lost a member to suicide, there was the need to know

how they coped with the loss; the study indicated the following as coping strategies used by families of suicide victims; these are experience sharing and encouragement, relocation, social bonds, psyching of one's self, acknowledging that tragedy may come to anyone, study of the word of God, prayer and reliance upon God.

Glancing through the results of this study, one major common denominator that seems to emerge for all the groups involved was a lack of appropriate knowledge of some kind about the complex phenomenon of suicide; there seemed to be a lack of appropriate knowledge concerning what was happening to them and the necessary help to seek. Among the suicide attempter's family, ignorance and illiteracy about suicide and how to detect it in a family member or as to how to handle the attempter was lacking, similarly the members of the community showed a general lack of appropriate knowledge in handling members who showed signs of suicidality or who were found attempting to die by suicide. CPN's on the other hand had some knowledge on suicide and on how to handle attempters, however there were no standardized guidelines laid down for them to follow. Such guidelines could help to further help make their service delivery in terms of handling suicide smoother and better. Finally the left behind family members of those who died by suicide were also woefully bankrupt on technical knowledge and coping skills and resorted to their own self determined coping strategies to survive the menace.



CHAPTER FIVE

DISCUSSION

5.1 Introduction

The study employed qualitative methods to explore community psychiatric services and suicide resilience in selected communities in the Greater Accra region of Ghana. Orlando's theory of the deliberative nursing process and the community resilience framework were utilized as a guide for the research. The findings of this study discussed in this segment, include exploring the experiences of individuals who have attempted suicide in relation to precipitating factors, describing the responses of suicide attempters families in relation to the general effects of the attempt on the family, examining the views of community members that almost lost or lost a member to suicide in relation to how they handled such cases, assessing the strategies used by community psychiatric nurses in the management of individuals and families of both attempted and completed suicide cases.

5.2 The Experiences of Individuals Who Have Attempted Suicide

The socio ecological model of health shows that the individual's unique experience and background are a major contributory factor to their health and total wellness, and this is reemphasized in this study because the precipitating factors to suicide identified were childhood experiences, psychiatric issues, mistrust, shame or disgrace, parental pressure, emotional breakdown, domestic violence, infidelity and difficult life pursuit. The above triggers to suicide attempt are all referred to as vulnerabilities in the community resilience framework that was utilized for these studies. These susceptibilities if not handled properly will lead to a weakening of community resilience to suicide.

The results also showed that some adolescent and youthful suicide attempts did not just occur out of the blue, rather it was observed that some of these attempters had experiences dating way back to their childhood: a prospective study (Orri et al., 2022; Thompson, Kingree, &

Lamis, 2019) confirmed this. Child and adolescent suicide attempts, suicidal behavior, and adverse childhood experiences also throws more light on this (Lensch et al., 2021; Satinsky et al., 2021). The known prospective study of child suicidal behavior in sub-Saharan Africa aims among things to determine whether cumulative exposure to adverse childhood experiences are a contributory factor to suicidal behavior that is child and adolescent suicide attempts, suicidal behavior, and adverse childhood experiences in South Africa: a prospective study (Cluver et al., 2015) confirmed this. Some of these had left indelible mental scars of feeling neglected by parents, or experiencing a form of segregation at home where parents gave preferential treatment to some of the children (McCoy & Keen, 2022). Using a generalized structural equation model, Perez et al sought to determine the effects of adverse childhood experiences on suicide ideation in adulthood (Perez et al., 2016). Those given less attention and privilege grow up feeling unwanted and unloved. These feelings get compounded as they reach adolescence and struggle with issues of low self-esteem and self-worth. Any further shaking of their already fragile self-image leads to them crumbling and taking desperate decisions like attempting suicide because they feel no one really wants them around so it will be better they leave this world. A US nationally representative sample in South Africa was carried out to determine associations of adverse childhood experiences and suicidal behaviors in adulthood, and it throws more light on the findings of this study (Thompson, Kingree, & Lamis, 2019).

Psychiatric issues came up as one of the precipitating factors for some participants' suicide attempt which happens to be in consonance with (Oexle et al., 2018; Orri et al., 2020). They are usually present in various forms which include Anxiety disorders, Behavioural and emotional disorders in children, Bipolar affective disorder, Depression, Dissociation and dissociative disorders, Eating disorders, Obsessive compulsive disorder, Paranoia, Post-traumatic stress disorder, Psychosis and Schizophrenia (Shanthi, 2020). Related literature

revealed that people living with these disorders have 2 to 5 times higher rates of suicidal propensities (Taylor et al., 2021).

In this current study participants were pushed to the verge of taking their own lives as they were commanded by strange voices in their head. These participants were experiencing auditory hallucination which happens to be one of the effects of some psychiatric disorders (Dellazizzo et al., 2022; Okuneye et al., 2020; Slotema et al., 2018). Other studies also discovered that certain medical diagnoses could trigger psychological stress which may in turn lead to suicidal ideation; a typical example is suicidal ideation among depressed people living with HIV/AIDS (Shittu et al., 2014).

Accusation came up as a contributing factor to some suicide attempts. The study found out that a single act of accusation levelled against an innocent person could lead them to attempt suicide to prove their innocence, since those they felt trusted them had lost that trust in them. A more serious scenario is when the accusation is repeatedly levelled against the same person when the person in question knows he or she is innocent, this sometimes leads to desperate measures that include suicide ideation and attempts. Related literature show that some of the accused undertake the suicide attempt as a form of revenge to cause those aspersing them to experience the pain that they felt when they were wrongfully accused. This phenomenon was termed Samsonic suicide or a suicide of revenge; which may be committed to punish someone else (Deshpande, 2020; Mwangi & Armbruster, 2022; Oravec & Mrovlje, 2018; Owusu, 2023; Parker, 2021; Women, 2021). In Burkina Faso for example it was found out by a study that some elderly Mossi women were accused of witchcraft, this among other things led to them being isolated from the rest of the society for fear of harm to others; some of these women later attempted suicide because they felt they had been wrongfully accused and treated unfairly (Barbier, 2020)

In order to avoid shame and disgrace, some attempters saw suicide as a better option. From the results it was clear that living with shame and seeing the public discuss a person's problems took a heavy toll on some of the participants; they would rather die than stand public ridicule. This shame may stem from some unfavourable life events like a man's impotence, a woman's barrenness, joblessness, conviction for a crime like rape et cetera. The shameful aspect is the low self-esteem that comes with such events; however, the disgraceful component is when others remind them of these past events or discuss it with other people as a way of discrediting them. Similar literature in Ghana have shown that the consequences of shame, embarrassment, and or disgrace, as explained by some men were the reasons why they attempted suicide (Akotia et al., 2019). Additional studies in Ghana reported that suicidal behavior could result from the shame associated with painful, incurable, disgraceful, and scary diseases (Knizek, Akotia, & Hjelmeland, 2011; Osafo et al., 2012). In Africa and elsewhere in the world, research detected that sometimes police officers who have engaged in some moral evil which attracts dishonor and shame to one's family, resort to suicide attempts in a bid to escape the shame and disgrace that come with their action (Agyemang & Parimah, 2022).

Parental pressure, the study found, was another potential cause of suicide ideation and attempt. In the typical African family setting, parental pressure was determined as a causative factor in some suicides (Adewuya & Oladipo, 2020; Ajibola & Agunbiade, 2022). In our African setting marriage does not involve just a man and a woman but it also involves their parents and the extended family (Bassey & Bubu, 2019; Emelone, 2023; Knijn & Patel, 2018). Disapproval from one of the parents can jeopardize the upcoming marriage (Cohen & Strong, 2020; Cross et al., 2018; Opong, 2023). Parents usually give many reasons for refusing their daughter or son's marriage into a particular family (Mohlabane, Gumede, & Mokomane, 2019). Families usually conduct background investigations of the potential spouse before

finally agreeing for the marriage to proceed (Adzovie & Dabone, 2021; Opoku-Adjei, 2018). If during the investigation, some negative things are discovered, the family may advise their son or daughter to call off the marriage (Obeng-Hinneh, 2022). Some of the things that could hinder the upcoming marriage include hereditary ailments like mental illness (Buertey, 2022b; Gyamfi, Hegadoren, & Park, 2018). Other reason could be discovering a family trait of theft, barrenness, pride, irresponsibility, promiscuity and domestic violence et cetera (Amongin et al., 2021). Parents may counsel the potential wife or husband against proceeding with the marriage; however in many cases by the time a man or woman introduces their potential spouse to the family, they would have already become emotionally attached to each other, and as the adage goes “love is blind”, any attempt by the family to separate them at this point will be met with vehement resistance (Estévez et al., 2018). When such parental pressure mounts, various acts, including suicide attempts can be undertaken by the partner in question to drive home the fact that they will either be allowed to marry or take their own lives, because to them, they cannot imagine living without their partner (Zortea, Gray, & O’Connor, 2021). Parental pressure does not end after marriage, in some cases parents continue to dictate to the husband in many ways. When this happens the wife may become mentally distressed and this could fuel depression and subsequent suicidal behavior (Wrath & Adams, 2019). Some families go as far as bringing in a new wife for the man if they deem it necessary, especially in scenarios where the original wife delays in having children due to certain uncontrollable circumstance (Gouni et al., 2022; Ikeke, 2021). A study conducted on “Rapid increase of infidelity among married women in Nigeria-causes and effects: Implication for counselling.” This particular study in Nigeria supported the facts above when it investigated the rapid increase of infidelity among married women in Nigeria that had led to depression and suicide ideation in some of these women; the research found that, early marriage; imposition of marriage partners; sexual incompatibility; childlessness; uncaring attitude of a partner;

hopelessness; revenge; lack of preparation for marriage; and parental disapproval; were primary causes. In instances where young ladies are forced into marriages against their wish, by their parents, for various reasons it could turn sour when the girl in question realizes she has no affection for the man in question or that the age gap is way too big for her to be comfortable in the union. As a sign of rebellion, some of these girls would prefer attempting to take their lives than being in these unwanted unions. (Okere & Ubani, 2020). In Bangladesh for example, some harmful practices prevail despite legal knowledge; it was found that sometimes the bride commits suicide because she feels trapped and the only people that could help release her from this trap were the same people pushing her in (Akter et al., 2022).

The study's findings revealed the precipitating factors that led individuals to attempt suicide were relationship issues. Even though many factors triggered suicide attempts, relationship issues turned out to be one of the major ones, this was in line with a study conducted in Kenya, among high school students aged 14-22, that showed that relationship problems was the second most severe precipitant to suicide (Mugambi, Munene, & Mogute, 2020). Matters bordering on different encounters between the opposite sexes, accounted for many suicide attempts (Eisenwort et al., 2014). Though a relationship with the opposite sex was traditionally thought to generate positive emotions like love, happiness, peace of mind and satisfaction, the results of this study buttressed the fact that certain negative occurrences within relationships could turn the relationship sour (Bloch, Haase, & Levenson, 2014). These relationship issues included emotional breakdowns, wasted resources, domestic violence, and infidelity.

Some study participants disclosed that the actions of their spouse left them in shock and tears, while others said that what they experienced was worse than depression (Pincus, 2023; Schober, 2012). Some participants started abusing alcohol as a result of the emotional breakdown experienced, yet still others felt shattered, some rejected and feeling that no one

understood them. Personal relationship breakdown, which eventually leads to emotional breakdowns or depression can ultimately trigger suicide ideation as was found in a study conducted among University students in western Nigeria; some of these students did not breakdown emotionally only because of their own relationship problems, but rather relationship issues involving parents at home (Ajibola & Agunbiade, 2022) All these emotions led many of the participants to feel like taking their lives because it was not worth living.

After investing so much in a relationship, it is expected that the partner at the receiving end show some gratitude and love as a normal response for all the sacrifices made, it is however sad to say the least that many spouses upon whom so much love and resource has been bestowed, coldly repays with evil (Fraser & Fraser, 2023); this makes the giving partner feel so messed up and see no point in continuing to live since most of their life's work has been poured into this relationship. From the study a participant stated that his wife's current attitude towards him makes him feel like he has wasted his resources and life's earnings. A study by (Kafka et al., 2022) confirmed that intimate partner issues like this contributed to suicide among men, and it might occur absent of some other precipitating factors or emotional states that are conventionally linked to suicide.

The study revealed that domestic violence was also a trigger for some of the suicide attempters. It was discovered through the study that men were not the only ones who maltreated their partners, as was traditionally thought, but some women also abused their partners; also known as domestic violence against men (DVAM), and this led some of them to attempt suicide (Adebayo, 2014; Aragbuwa, 2021; Deshpande, 2019; Obarisiagbon & Omage, 2019). Domestic violence (DV) or Intimate Partner Violence (IPV) finds expression in various forms which include physical violence, sexual violence, stalking and psychological aggression (CDC, USA). Some female participants stated that in spite of being supportive of their partners they turned to abuse them physically, however from the results of the study,

IPV was not a female preserve because it showed that some men also experienced it in another form. Some men posited their wives verbally abused them and this had a strong psychological effect on them, and it made them lose their self-image. A study in Nigeria reiterated this fact that DV or IPV can even trigger suicide attempts not only in females but in males as well (Adebayo, 2014).

Infidelity was also one of the relationship issues that the study results revealed. The activities of one partner usually led to paranoia on the part of the other; this suspicion is usually not baseless; it is usually as a result of some past events (Haseli et al., 2019; Urooj & Anjum, 2015). In the first place if the suspect was not behaving this way from the very onset of the relationship, but has suddenly started to put up strange behavior, it will definitely raise some doubt (Fincham & May, 2017; Scheeren, Apellániz, & Wagner, 2018). From the study results it was made clear that some wives would prematurely end a telephone chat immediately the husband comes around; and this wife would not give any proper reason for this abrupt end to the call, meanwhile earlier on in the relationship, the lady would not mind having the man around when she was on a call, any vigilant husband would immediately notice a change in the wife's attitude and subsequently question her and denial would lead to further mistrust, other literature has shown that infidelity and Romantic Jealousy (RJ) have frequently been cited as triggers for IPV in South Africa and has found that suspected female infidelity could also lead to femicide, which refers to the killing of a woman or girl, in particular by a man and on account of her gender, and the subsequent suicide of the perpetrator (Pichon et al., 2020). What will further aggravate matters would be when it is clear that the person at the other end of the call is of the opposite sex; this can trigger suicide ideation because the husband feels he is not man enough, in terms of sexual prowess, and the big question would be what will make my wife enjoy chatting continuously with another man rather than myself; what does he have that I don't have? In Africa in particular, manhood is a big deal, and many

men would rather die than lose their manhood (Ben-Daniels & Glover-Meni, 2020). This fact is clear in the following study from Ghana titled “Better dead than dishonored”, which shows that sometimes some men resort to suicide to conceal their loss of manhood and its ensuing dishonor; this same literature found that in other cases at the arbitration hearing, the wife admitted her infidelity but cited the impotence of her husband as the cause, in some of these cases the man envisaging the mockery from society that will follow this revelation from the wife, will prefer to end it all than stand public ridicule; these men usually enter depression and alcoholism which are two precursors for suicide (Adinkrah, 2012).

Academic demands from parents seemed to be a source of stress for some students. Considering the hefty sums spent on a child’s education, academic excellence is seen as the only reward that parents get for all their financial toils. However, due to several personal and external factors, some students may fall well below the expected levels of academic performance, and this immediately triggers an unpleasant response from parents who then mount pressure on these students to revamp their performance (Maajida Aafreen, Vishnu Priya, & Gayathri, 2018). If the factors inhibiting academic excellence persist after fruitless efforts, the students see suicide as an escape route that will help them avoid upcoming criticism from parents. A study of some students in South Africa showed that academic demands were a source of stress among first year rural based university students and this activated suicide ideation in some of them due to their fears of failing academically and disappointing their families who see these students as a beacon of hope and honour for the family. These psychological responsibilities weigh so much on these students that for some of them, suicide seemed like a good escape which can help them drop this responsibility (Pillay & Ngcobo, 2010). Other literature have shown that this problem is not unique to a particular geographic zone because an overview of the causes of suicide and preventive strategies in Kenyan universities made it clear that demands in terms of academics, adaptation

to the college environment, school fees as well as relationship demands and students' moods increased the risk of student suicide (Kabugi, 2019).

Adverse life situations sometimes push people to take desperate decisions (Chen & Lucock, 2022). When a sudden negative change in a person's fortunes occur, it can silently eat up the person and sometimes cause them to attempt suicide because they don't see any way out of the mess (Tse, Tang, & Wong, 2014). A qualitative study in Ghana bordering on how economic, financial, or relational stressors faced by the men led to novel and excessive alcohol or drug use which also steered them to suicide ideation and attempt, agrees with this fact in the current study, that some negative life events could actually make a person become suicidal (Andoh-Arthur et al., 2020). Other literature also reveals how epidemics generate a chain reaction that can also lead to suicide ideation and attempt. A pandemic like COVID-19, which in its wake caused a global economic downturn, led to male suicidal behaviors with triggers such as joblessness, unemployment, failure at work, relationship strains, and depression (Khan, Ratele, & Arendse, 2020).

Financial challenges, the study found, pushed some men to attempt suicide. Failure of business, loss of employment and bankruptcy all fell under financial challenges (Coope et al., 2015). Financial challenges affects both male and female but due to the traditional African societal setup, where the value of a man is sometimes primarily linked to his substance, a man generally feels like he has lost his manhood when he encounters any of the above financial challenges. Related literature showed that while suicide is not a leading cause of death in South Africa, it is a serious public health issue triggered sometimes by unemployment, financial problems and problems at work (Netshiombo & Mashamba, 2012). It even gets aggravated if his immediate family (wife and children), especially the wife begins to castigate the man due to his inability to provide for the house as is required of every traditional African man, especially where the man refused to listen to counsel against modern vices like

gambling. A study in East Africa confirms this; many men here lose large sums of money to gambling every year and this results in the failure of these men to meet their family's financial needs. Some eventually turn to the taking of loans to supplement but the ensuing pressure that come from their creditors gradually lead some of these men to feel like ending it all to avoid excessive pressure on their mind. This can lead many a man into making desperate decisions including suicide ideation and attempt, because he feels he is better off dead than to live a broke life. This is particularly the case where the man had previously enjoyed wealth with his family before the financial crises struck (Kaggwa, Mamun, et al., 2022).

5.3 The general response of family members to the suicide attempt

The second objective describes the general response of the suicide attempter's family to the suicide attempt which according to the socio ecological model of health contributed to the individual's wellbeing. It was discovered that the suicide attempt had three major effects on the family which included, anger, shock, concern and solidarity. As shown also in the community resilience model (CRM), the suicide attempter's family expressed their vulnerabilities through their response to the suicide attempt of the family member, and the CPN had to utilize the asset of public education as represented in the CRM to help properly handle the event.

Some attempter's family received the news of the suicide attempt with anger. They could not believe that the attempters could really do what they did, considering how much the family had invested in them. Where the attempter had parents, these parents felt angry because they saw the suicide attempt as a very selfish act (Buus et al., 2014; Sheehan et al., 2016), that is to say, the attempter did not consider the fact that he/she was not an island, and that every act has an effect on everyone in the family; this really made some parents angry. This is in similitude with a phenomenological study of the experiences of bereaved families by suicide

in South Korea which showed that families bereaved by suicide had a sense of anger, among other emotions (Lee, 2022).

Some families were also in total shock after discovering their family member had attempted suicide. This was because many of the family members never expected this particular family member to do what he or she did, this was consistent with the study by (Buus et al., 2014). Some did not understand what could possibly drive their relative to attempt suicide. The questions and the emotional flood could drown one's soul. Existing literature, consistent with this study found that families experienced a state of shock and paralysis during the initial days and weeks following a family member's suicide attempt (Creuzé et al., 2022).

Study participants revealed that when their family member attempted suicide and they were at their lowest moments, it had an effect of bringing the extended family and friends around to express solidarity and concern. They came around to see what had occurred, how and why it happened and to comfort the family whilst counselling the attempter. Beyond physical concern and solidarity, studies elsewhere in the USA also show that for grieving black boys, online worlds offer unusual space for emotional freedom, social support, and solidarity. The advent of social media is a good example of such digital solidarity. Through modern phone applications like Whatsapp, Facebook, Twitter, Instagram, Tiktok and many others, the world truly becomes a global village. Various groupings on these apps become like virtual families that offer solidarity and support for each other in moments of grief (Gross, 2023).

5.4 How Community Members Handled Attempted and Completed Suicide Cases

Through this study, community members played an integral role in an individual's life as is also evident in the socio ecological model of health promotion. These community members expressed that when an event like a suicide attempt takes place and the victim is found, the community responds in various ways and the response was made according to the mode of suicide attempt; neutralizing the poison, induce vomiting with the use of palm oil and crude

oil, Stoppage of bleeding, cutting down of noose, skilled swimmers, calling of the police. However, most of these had inherent vulnerabilities which needed to be tackled through the CPNs utilization of their asset of public health education. To better equip the community members in terms of suicide resilience.

In a scenario where someone attempts suicide by ingesting some poisonous substance, community members resorted to making the victim drink some red palm oil. This they claimed made the victim vomit and, in the process, get rid of the toxic substance from their digestive system in order to save their lives (Nalivaiko, Rudd, & So 2014). The second effect of administering the red palm oil, they claimed was to neutralize the poison (Twumasi, Nsiah, & Osei, 2014). Another substance that the community members said helped expel ingested toxic substances was 'crude oil', as they called, otherwise known as automobile oil. They stated that, placing a few drops of this oil in the mouth of the victim and allowing them to swallow it will also induce vomiting of whatever toxic substance ingested. In other literature however different means are used to get rid of the ingested toxic substance other than the use of palm oil and crude oil. Research has shown that Ipecac syrup is also very effective; *Carapichea ipecacuanha* is a plant native to South and Central American rainforests. Its root contains two powerful alkaloids, emetine and cephaeline, which have emetic and expectorant properties. These roots are used to make ipecac syrup, which is used in both human and veterinary medicine. The most important use of ipecac syrup is vomiting induction, after the ingestion of toxic compounds or after a drug overdose (Smajlović & Dučić, 2021).

When a suicide attempter is found to have used a sharp object to slit the throat, wrist or any other part of the body in an attempt to end their lives, community members who are first responders in such cases said they usually looked for means to stop blood flow as first to help save the life of the victim (Yadav, Raheel, Kumar, Sharma, & Kanwar, 2016). Then subsequently rush the victim to the nearest health institution for treatment. Other literature

also suggest several methods employed to stop bleeding before the patient is rushed to the health facility for further treatment or surgery, a case in point involving pulmonary embolism as a cause of suicide attempt by stabbing in the chest bleeding was stopped by packing and compression (Nożewski et al., 2022).

If a community member is found to have attempted suicide by hanging, other community members look for the nearest sharp object to cut down the noose holding the person up. If the victim is found in time, this process helps to save the life. In India suicidal hanging by saree, rope and dupata is one of the most common methods of suicide attempt (Liju, 2020; Meena et al., 2020; Mishra et al., 2018). A study to determine the clinical profile and neurological outcome of the patients of suicidal hanging showed that partial hanging is more common than complete hanging; that is to say that many of the people who attempted suicide were found in time and rescued, it showed that of the 70 attempters who were studied, 65 of them had the noose cut down to save their lives and 5 of them were discovered too late and therefore lost their lives. Several patients had an erstwhile history of suicidal attempts, so it is obligatory to go through psychiatric assessment and counselling before getting cleared from the hospital (Liju, 2020).

In the case of drowning, there are two approaches community members employ. First of all, if the victim is seen in time, good swimmers are employed to attempt to save the suicide victim (Armstrong, & Erskine 2018). The second scenario is when the rescue attempt fails; the only option remaining will be to call the police to the scene to investigate and then carry the body away. Similar international studies have also shown that swimmers are usually engaged in an attempt to rescue drowning persons, but the big difference is that, whereas in Ghana swimmers are sought for in the event of drowning, other nations have a permanent outfit known as beach lifeguards, with expert swimmers whose job is to patrol water bodies

so as to prevent drowning and rescue suicide victims who attempt to drown (Vansteenkiste, Lenoir, & Bourgois, 2021).

The police as part of their duties to protect the citizenry of a country, are usually called upon in the events of threats of suicide and also for suicides in progress as this study has shown, it is also the case in other parts of the world as existing literature has shown; 911 emergency calls for the services of the police for suicides in progress and threats of suicide are always made (Lersch, 2020).

5.5 The strategies used by CPNs in the management of individuals and families of both attempted and completed suicide cases.

The fourth objective of the study assessed the strategies used by Community Psychiatric Nurses in the management of individuals and families of both attempted and completed suicide cases. The application of Orlando's theory of the deliberative nursing process was most appropriate here because it was identified that there was not one specific way of managing individuals and families of both attempted and completed suicide cases. The theory guided CPNs on the interaction between the nurse and patient, perception validation, and the use of the nursing process to produce positive outcomes or patient improvement; Orlando's theory consents to nurses creating effective nursing care plan that can similarly be improved if any difficulties arise with the patient some of which are outlined and explained below.

Assessment of suicide attempters upon the arrival at the health facility, by CPNs was shown in this study as one key factor that helped in appropriate treatment of various cases. It was necessary to engage the attempter in a conversation to determine certain salient indicators. CPNs do this by employing the MSE (Mental State Examination) technique (Renn, & John, 2019). This technique enables CPNs determine the best way to handle the patient. Through this interrogation patients who have suicidal ideation but have not yet progressed to attempt it are put through the test which would reveal if they would actually attempt it if all factors

were conducive or not. The result of the test serves as a good guide for the nurses in the handling of patients who have already attempted suicide, to reveal if they might or might not attempt it again; thus, enabling them to tailor treatment appropriately. In cases where patients would not speak or cannot speak, CPNs would have no other option but to obtain the necessary information from the relatives who brought the victim to the health facility. Research akin to this current one has shown that one's suicide attempt (SA) may contribute to the development of post-traumatic stress disorder (PTSD). This study intended to typify the phenomenology, rate, and associated features of PTSD following one's SA; it was discovered through its results that a substantial proportion of SA survivors may experience SA-related PTSD, and therefore SA-related PTSD may be a viable assessment and intervention target to improve the quality of life and to reduce future suicide risk among SA survivors (Stanley et al., 2019) .

Counselling and psychotherapy were one of the ways utilized by CPNs to manage suicide attempters. The knowledge acquired by these CPNs through training affords them the opportunity to properly engage these attempters without being judgmental (Robinson, Cox, Bailey, Hetrick, Rodrigues, Fisher, & Herrman, 2016); the ensuing rapport that is established allows the victims to open up and speak about what pushed them into the attempt. Related literature indicated the development of a randomized controlled trial of cognitive therapy for acutely suicidal patients with early psychosis as a suicide prevention strategy in first episode psychosis (Power et al., 2003). Elsewhere in Canada, mental health professionals with knowledge in counselling psychology support specific suicide prevention programs with strategies including developmental group psychotherapy, family communication .They utilized these strategies in the midst of ideological and cultural differences critically reflecting on youth suicide prevention in indigenous communities in Canada (White, 2007). Mental health nursing services have greatly been influenced by counselling and psychotherapy. it brings about therapeutic relationship (Winship, & Hardy 2014).

Medication was utilized in certain cases of suicide attempt, especially with depression-based suicide patients. With this type of suicide attempt the patient usually has an underlying psychiatric disorder like depression or psychosis that usually triggers suicide ideation (Fredriksen, Schoeyen, Johannessen, Walby, Davidson, & Schaufel, 2017). Other psychiatric conditions like schizophrenia that gave rise to auditory hallucinations sometimes made attempters hear voices commanding them to take their lives (Woods, Jones, Alderson-Day, Callard, & Fernyhough 2015). The depressed ones usually felt hopeless and exhausted with life; they usually felt it was better to be out of this world than to be here and suffer mentally; their sufferings are usually in their minds and limits their functionality. The study found that for attempters who experienced hallucination, CPNs administered anti-psychotics to help them get relief; but for depressed attempters, anti-depressants were the panacea to their predicament. Allied inquiry confirms that both psychotropic medication and anti-depressants are helpful in the recovery process of suicide attempters (Hom et al., 2021).

Some suicide attempters lose interest in living and in life's activities (National Academies of Sciences, Engineering, and Medicine 2020), as made evident from the results of this study. In order to help these patients bounce back to normalcy, nurses realized that there was a need to fish out activities and things that excited these patients (Stone, Holland, Bartholow, Crosby, Davis, & Wilkins, 2017). Consciously encouraging and involving patients in activities that used to excite them could help pull them out of their shells. Deliberately spelling out to these attempters, reasons why life is worth living, in spite of all they have been through, rather than dying. This will help them find good reason to move on with life despite past experiences. Other writings from researchers who sought to gain an understanding of the experience of recovery from anonymous online postings in recovery support forums, found that hope and feelings of self-satisfaction exist as a positive experience of recovery and they also deduced that there are clear benefits to online recovery communities and that healthcare providers have

an important role to play as allies in the recovery experience by helping victims regain interest in things they were previously interested in (Caleb, 2013; Dyregrov, Plyhn, & Dieserud, 2012).

Separation from stressors; when the person, scenario, environment or situation that triggered the suicide attempt is removed, it usually aids in recovery for suicide attempters (Athey, Overholser, Bagge, Dieter, Vallender, & Stockmeier, 2018), as found out from the results of the study. When a spouse is removed from the presence of an abusive partner (Gordon, 2022), the new environment without the abuse helps ease the pain that triggered the suicide attempt (World Health Organization 2014). In many instances recovery is a slow road to travel on and there is the need to be exposed to things that will facilitate healing. More literature agrees with the findings of this study when it posited that, the healing and recovery route embodies a sensitive course-plotting manoeuvre (Stone, Holland, Bartholow, Crosby, Davis, & Wilkins, 2017). Each stage might follow the previous stage; however, it is not a linear course, and patients might move in reverse and frontwards through the segments depending on the nursing interventions they receive together with their drive to heal. It is important for nurses to use innovative communication skills to assist them to co-travel therapeutically with patients (Chi et al., 2014).

Many suicide attempters would most likely repeat the act if they were not handled properly and this was also found to be true from the results obtained from this research. Even at the health facility where suicide patients are receiving rehabilitation, care must be taken to get rid of all potentially harmful items and substances to avert the reoccurrence of an attempt. Patients must be distributed in appropriately designed and furnished spaces during the rehabilitation period; it would be deadly to have a ceiling fan and a twine sponge in the room of someone who recently attempted suicide by hanging; this could be catastrophic (Veisani, Delpisheh, Sayehmiri, Moradi, & Hassanzadeh, 2017). In other relevant studies this fact is

reemphasized; assessment and admission took place at specialized wards as a precaution, belongings were searched to remove all potentially dangerous things (Samuelsson et al., 2000).

CPNs who participated in this study, in their line of duty to help suicide attempters who have recently been brought to the health facility for treatment, recognize that physically monitoring these attempters went a long way to help stabilize patients (Porrás-Segovia, Díaz-Olivan, Barrigón, Moreno, Artes-Rodríguez, Pérez-Rodríguez, & Baca-García, 2022). Few days after the attempt, these victims are most likely to re-attempt to complete what they started, it was realized therefore from this study that when nurses kept a close eye on the patients they could easily pick up any signs that implied there was a likelihood for something negative to occur and for them to act in time to forestall it (Morrissey, & Higgins, 2019). Similar studies to determine predictors of re-attempt in a group of suicide attempters concluded that since a previous suicide attempt is the main prognosticator of imminent suicidal behaviour, clinical management, including physical monitoring, of suicide attempters is vital for reducing mortality (Brodsky, Spruch-Feiner, & Stanley, 2018).

Referral, due to the nature of some suicide attempts, some CPNs resorted to referrals in order to avert calamity or aggravation of already fragile situations (Davidson, Accardi, Sanchez, Zisook, & Hoffman, 2020). When a patient attempts suicide and is rushed to the health facility, they are sometimes brought directly to the CPNs, however, where the patient is bleeding profusely due to a deep cut on a part of the body the CPNs would usually refer the patient to the appropriate department for emergency treatment to stop the blood flow and then they take over from there (Betz, Arias, Miller, Barber, Espinola, Sullivan, & Boudreaux, 2015). Sometimes the patient may have to see a psychologist or be referred to one of the three main psychiatric hospitals because their issue would usually require higher knowledge and expertise, the nurses don't hesitate to refer such cases to higher facilities that can appropriately

handle the situation. Similar studies on the prevalence and determinants of suicidal ideation and suicide attempt in people with human immunodeficiency virus in Africa, show that early screening, treatment, and referral of suicidal patients are necessary for HIV clinics, in order to reduce ideation and suicide attempts among patients (Metekiya et al., 2022).

5.6 The Coping Strategies Used by Families of Suicide Victims

Participants described several ways of coping when asked how they dealt with apparent unpleasant feelings and experiences of the death of a loved one to suicide. This included experience sharing and encouragement, relocation, social bonds, psyching yourself, acknowledging that tragedy may come to anyone, word of God, Prayer, and reliance upon God. As All these represents assets (health education) as mentioned in the community resilience model together with the CPNs that help survivors' families cope well.

The study discovered that the encouragement received by surviving family members of suicide victims from other members of the society, served to help them cope with the tragedy of the loss of a family member (Ross, Kõlves, Kunde, & De Leo, 2019). Some family friends also related similar personal experiences or close third party stories to show that if these examples were able to sail through the period of grief, this grieving family too could also do same, thus buttressing the saying that 'sorrow shared is halved sorrow and joy shared is double joy', a qualitative study in the UK exploring experiences of support from primary care and professed needs of parents grieving because of the suicide of a child, proposed that if general practices initiated contact, it could encourage those who needed support to access it, who might not otherwise have done so. Parents said it was important that people working in general practice have a consciousness of suicide bereavement and understanding of their needs, including knowledge of where to direct people for further support (Williams et al., 2018).

Every time the surviving family come around the premises of the tragic event, they get flashbacks and renewed sorrow, in order to avoid this, some survivor family members relocate

to other places in a bid to help erase the pain from their minds (Hagaman, Sivilli, Blanton, Ellis, Lopes Cardozo, & Shetty, 2016). This was however the case if the family had the means to relocate. Financial constraints will not allow every bereaved family to relocate but will be forced to endure the pain of memories every time they come around the scene or location (Kasahara-Kiritani, Ikeda, Yamamoto-Mitani, & Kamibeppu, 2017). Similarly, a study in Israel about the experience of homeroom teachers coping with the death of a student in their class, had the teachers claim that the experience affected their personal lives and indicated that memories of it continued to surface long afterwards. Some found it difficult to function and even chose to leave the school and profession. Thus showing that in some instances, relocation really aids in the healing process (Levkovich & Duvshan, 2021).

This served to provide emotional warmth for the bereaved family. As different people around visit and share fellowship with the surviving family it produces a sense of belonging and helps ameliorate the effects of the tragedy on the family (Cerel, McIntosh, Neimeyer, Maple, & Marshall, 2014). When a person stands alone in the face of adversity, it tends to weigh them down disproportionately (Young, Iglewicz, Glorioso, Lanouette, Seay, Ilapakurti, & Zisook, 2022); but if there are friends or loved ones around, the social interactions help to reduce the burden of grief. Where there are no immediate family members, well-meaning neighbors do fill in well and their social bonding with the bereaved usually brings great relief in this period of crises (Klass, Silverman, & Nickman, 2014). A longitudinal qualitative analysis over two years on experiences of parental suicide-bereavement, had results that highlighted the importance of supporting parents in their reconstruction of social ties (Entilli et al., 2021). Morris et al also posited that a virtual celebration of life with family and friends to muse over happy memories, drawing from cognitive behavioural therapy (CBT) strategies is very helpful. The bereaved is gently encouraged to live again. The results showed that this provided social connections and normalization of grieving (Morris, Moment, & Thomas, 2020).

The news of a loved one losing their life through suicide is so traumatic that inner strength is needed to be able to bear such situations (Feigelman, & Cerel, 2020). It was found out in this study that a person needed to brace him/herself psychologically to be able to sail through a heavy misfortune like losing a loved one to suicide; without this a person can break down mentally trying to make sense of the whole occurrence (Doka, 2014). So many questions go through one's mind, for example, 'what exactly will make this person do this?'; 'did I do anything wrong?'. the questions may be unending in the mind and these could even trigger some psychiatric issues; to forestall this, a lot of mental strength is required, it is one thing to be spoken to by friends or loved ones, but until the one who has loved the loved one takes that personal decision that they would not allow what has happened to destroy their mind, the effect of most outside counsel will be minimal. A qualitative study in Poland carried similar information, where COVID-19 patients and family admitted their psychological wellbeing was improved by some care givers who used humor to ameliorate their psyche (Marcinowicz et al., 2022).

It was determined from this study that acknowledging that tragedy can befall anyone, was also effective as a coping mechanism that helps people overcome and survive the loss of a family member to suicide (Simon et al., 2013). Questions like 'why me?', 'this can't happen to me' etc., denote absolute shock that can throw surviving family members into jeopardy, because they had done nothing to deserve what just occurred. However, when family members acknowledge that tragedy may befall any person and that what has happened was not unique to them and that they may not have necessarily done anything wrong for this to happen, it helps them take it easy. The Lancet Commission on the Value of Death asserted that without death every birth would be a tragedy (Sallnow et al., 2022).

Some respondents through this study confirmed that the teachings of the Bible coupled with prayer really helped them sail through the stormy season in their lives when they lost a loved

one to suicide (Bourke, 2014). The teachings of the Bible primarily produce hope in a person; it is the primary means by which God speaks to man; verses like Romans 8:28, encourage readers to know that all things will work together for their good. Readers are therefore strengthened when they read such scriptures. Prayer on the other hand is the means by which a person talks to God (Bonhoeffer, 2021). Survivor families engage in prayers to talk to their father God. Visualizing God as a caring father who is able to help us with our burdens, the family is able to offload some of the pressure on their mind and this helps them cope (Lawrence, Oquendo, & Stanley, 2016). In the Philippines, studies have established that some Filipino catholic youth use religious coping strategies to deal with anxiety disorder, suicide, and substance abuse. It is how [the Filipino] people have made it a culture to utilize the Gospel coupled with prayer to overcome serious adversity (Del Castillo & Alino, 2020).

From the research findings, when all avenues for coping fail, most people now see no option but to return to their father God for assistance (Del Castillo & Alino, 2020). God therefore becomes the final resort when all avenues to cope with the issue at hand fail. Further studies align with this coping mechanism. It examined how religiosity and spirituality may function as developmental assets promoting pathways to safety and positive development for young black men transitioning to adulthood in Baltimore, USA (Rohmi et al., 2023).

5.7 Limitations of the study

The participants were selected from only five districts in the Greater Accra Region and not from all the districts in the country presupposes that the views expressed might not represent that of the general populace in Ghana; however, that limitation is offset by the fact that the Greater Accra region, the capital of Ghana, is a cosmopolitan area having representation from all the regions of Ghana. Due to shame, disgrace and stigma associated with suicide, some suicide attempters, attempters' family and suicide victims' families were not willing to

participate in the study. It is possible that those who did not take part in the study could have provided further insight that the people who participated did not provide.

5.8 Strengths of the study

The effect of this study will promote resilience to suicide to the individual, families, communities, and the nation in that the SEM of health shows that the individual's unique experience and background are a major contributory factor to their health and total wellness and this is reemphasized in this study.

SEM of health contributed to the individual's wellbeing. It was discovered that the suicide attempt had three major effects on the family which included, anger, shock, concern and solidarity. As shown also in the CRM, the suicide attempter's family expressed their vulnerabilities through their response to the suicide attempt of the family member and the CPN had to utilize the asset of public education as represented in the CRM to help properly handle the event.

Community members played an integral role in an individual's life as is also evident in the SEM of health promotion. These community members expressed that when an event like a suicide attempt takes place and the victim is found, the community responds in various ways and the response was made according to the mode of suicide attempt; neutralizing the poison, induce vomiting with the use of palm oil and crude oil, Stoppage of bleeding, skilled swimmers, calling of the police. However, most of these had inherent vulnerabilities which needed to be tackled through the CPNs utilization of their asset of public health education. To better equip the community members in terms of suicide resilience.

The application of Orlando's theory of the deliberative nursing process for the fourth objective of the study; was most appropriate because it was identified that there was not one specific way of managing individuals and families of both attempted and completed suicide cases. The theory guided CPNs on the interaction between the nurse and patient, perception validation,

and the use of the nursing process to produce positive outcomes or patient improvement; Orlando's theory consents to nurses creating effective nursing care plan that can similarly be improved if any difficulties arise with the patient.



CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

This chapter presents the summary of the key findings and conclusions drawn from the study in accordance with the objectives. The contribution of the research to knowledge, recommendations for practice and future research that emerged from the study have been outlined to enable policy makers make informed decisions. The areas for future research have been clearly stated in this chapter.

6.2 Summary of Findings

This study was carried out using qualitative methods to explore community psychiatric services and suicide resilience in selected communities in the Greater Accra Region of Ghana. The study was carried out with 89 participants aged 16 years to 69 years. Five (5) districts were selected from the Greater Accra region depending on the suicide ascendancy of the five indigenous ethnic groups in the region. The study employed the phenomenological approach to qualitative probing. The purposive sampling technique was employed to recruit 18 CPNs, 11 people who had attempted suicide, 9 suicide attempters' family, four (4) family members of succeeded cases for an in-depth interview and five focus group discussion making up of 46 community members from the five selected districts of the Greater Accra region of Ghana. This was to bring out information on the persistent occurrence of suicide cases in the five districts and its various communities. The main findings of the study include:

1. Individuals who had attempted suicide to do so, these factors included childhood experiences, psychiatric issues, mistrust, shame or disgrace, parental pressure, emotional breakdown, wasted resources, domestic violence, infidelity and difficult life pursuit (academic demands and financial challenges).

2. The study established that the opinions of suicide attempters' families in relation to the general effects of the attempt on the family was anger, shock, concern and solidarity.
3. The study brought out neutralizing the poison, Inducing vomiting with the use of palm oil and crude oil, stoppage of bleeding, cutting down of noose, employing the services of skilled swimmers and calling of the police to be the ways by which community members that almost lost/lost a member to suicide handled such cases.
4. The study reported that there is no specific guideline or policy in handling suicide cases but then, some of the strategies used by CPNs in the management of individuals and families of attempted and completed suicide cases were assessment, counselling and psychotherapy, medication, engaging the person/client in the area of interest, separating the person from the stressors, removing harmful items, physical monitoring and then referral of cases that were beyond them to other health facilities.
5. The study emphasized that the coping strategies used by families of suicide victims were through experience sharing and encouragement, relocating, social bonds, psyching of oneself, acknowledging that tragedy may come to anyone, Word of God, prayer and reliance upon God.
6. The study gathered and confirmed from the Mental Health Authority that the fact remains; there is no clear guideline or policy in handling suicidal patients but then they all fall on whatever they have. It could be from WHO or through experience but in actual fact there is no clear guideline adopted or adapted for service delivery; everyone manages what they are familiar with. So in case a particular country handles it in a certain way and it seems to yield results, then they fall on it and do same. But it was also discovered that despite all that they usually fall on WHO protocols. The

national coordinator also said that “So currently as a country we manage to establish a help line for anyone who has suicidal ideation. When you observe someone with suicidal tendencies and you want to call for help, currently the help line is not active 24/7 because it is managed by national service personnel. They run it during the daytime from 8 am-5pm which is not ideal. The futuristic plan is to have a 24-hour line to attend to emergency calls; a call comes in and after assessing the client, depending on where the person is calling from or geographical location you refer the caller to the appropriate avenue to get the needed help. So, there is no structured guideline, they are just trying something for now. When an emergency call comes in, they refer. It is a toll-free number, 0800678678.

In our communities, suicidal tendencies are trivialized, as found by this study so community psychiatric services would need to be improved. Also, as a nation, we have no national suicide prevention protocol, although there are pockets of strategies like the mental status examination and risk assessment; we therefore need to come together to be able adopt a protocol. We have done a lot, but we need to put them together. We have come to a point where we need to decriminalize suicide. We need to put things together so that as a nation we come up with a sustainable and practical suicide prevention protocol for the nation, this will help guide national policies in the right direction.

6.3 Conclusions

Most attempted suicide cases are precipitated by factors that are encountered as a part of daily living. Although one person undertook the action of attempting to end their life, the person was not an isolated island, and that every individual is linked directly or indirectly to a long chain of other individuals; therefore, any action, taken by this individual will definitely have

some effect on others linked to them. The study showed that when a person attempts suicide, it has major consequences on their family, both nuclear and extended.

Moving on from individual family units, community members also played a part in handling the menace of suicide attempts in the community. Most African communities are organized like an extended family, with every family looking out for other families; when a member of the community is therefore found to have attempted suicide, even in the absence of the person's nuclear family, other community members utilize various means to attend to the person before seeking further medical attention. The mode of response is determined by the means by which the person attempted the suicide. Methods like neutralizing the poison and inducing vomiting with the use of palm oil or crude oil are used in Ghana when a victim attempts suicide by ingesting toxic substances; stoppage of bleeding is undertaken when a person attempts suicide by means of a sharp object; in the event of suicide attempted by hanging, first responders usually will usually cut down the noose and attempt to rescue the victim; finally community members sometimes employ the services of skilled swimmers to help save the lives of people who attempt by drowning but in the event failure and the eventual death of the victim ,the police are usually called to investigate to clear all suspicion of foul play and then to help deposit the body in a morgue.

This study again scrutinized the mediums through which CPNs managed suicide attempt victims and found that there was no specific strategy/guideline or policy used by CPNs in the management of individuals and families of attempted and completed suicide cases in handling suicide cases but then they rely on assessment, counselling and psychotherapy, medication, engaging the person/client in the area of interest, separating the person from the stressors, removing harmful items, physical monitoring and then referring cases that were beyond them to other health facilities.

The families of suicide victims had to use certain coping strategies to overcome the pain and anger in order to reduce the effects it had on them, and these were: experience sharing and encouragement, relocation, social bonds, psyching themselves, acknowledging that tragedy may come to anyone, the word of God, prayer and reliance upon God.

The above conclusions are supported and based on participants' expressions. It is therefore imperative that the foregoing information be utilized by all heads of departments and districts hospitals to help them put measures in place and adopt new strategies in order to help CPNs deliver better services to strengthen community resilience to suicide and to help reduce suicide cases in persons with/without mental illness. Furthermore, CPNs will need more support from the mental health authority, community members as well as the media to enable them to intensify their public health education programmes which, from the findings of this study will become the principal tool of strengthening community resilience to suicide.

6.4 Contributions of the Study to Knowledge

This study utilized the Socio Ecological Model (SEM) and the Community Resilience Framework for community development practitioners, building equity and adaptive capacity as a guide. The socio-ecological model shows that persons are affected by a varied and diverse collection of social influences and nested environmental interfaces. The SEM remains as one that is in constant evolution because it takes cognisance of the fact that factors that regulate psychological well-being can intersect at numerous points. The community resilience framework portrays community assets to include the human capital. It also acknowledges that the level of built infrastructure in given communities affect the quality of life of inhabitants; furthermore, natural resources alone do not by themselves ensure citizenry are living well but rather it is the proper harnessing and utility of these resources that will ensure better living standards, again the framework reiterates sufficient financial reserves as another factor that contributes to community resilience; then social and cultural development was as well noted

as an essential component. Finally political leadership is given the mandate to pull all these resources together to better the lives of the people in the community and the nation as a whole and thereby promoting resilience to suicide.

This study, however, contributes to knowledge by revealing that other factors exist in addition to the ones highlighted by the original conceptual framework that are necessary if the objective of promoting community resilience to suicide must be realized.

1. Without a national suicide prevention strategy, backed by appropriate policies and funding, the drive towards community resilience to suicide will be a mirage. It has previously been realized that issues concerning suicide have not received enough attention nationally.
2. General guidelines for community psychiatric nurses in handling suicide attempters is lacking, thus causing some CPNs to resort to using their own strategies to handle something as delicate as suicide.
3. The public are generally illiterate on issues involving suicide, massive public education by CPNs on how to detect suicide ideation, signs and symptoms of suicidality and how to handle those who attempt suicide before seeking institutional medical attention; this public education must be done through all forms of media. It was realized that the more knowledgeable the people in the community were about suicide, the more empowered and resilient they ultimately became, because, issues bordering on suicide were stigmatized and treated as a taboo by many communities; this attitude limited help seeking and ultimately led more people to attempt and sometimes complete suicides.

6.5 Recommendations

This segment looks at recommendations of the study; it comprises of recommendations for practice, future research and for policy makers.

6.5.1 Recommendations for practice

1. The study revealed that various factors ranging from childhood experiences to difficult life pursuit among others precipitated individuals who had attempted suicide to do so, it is therefore necessary that measures are put in place to mitigate this, by CPNs health education on parents deliberately making the home environment conducive for the growing child and to also shield them from any traumatic event. For adults there is the need for integrated social support services by the government so as to prevent people who are financially challenged in becoming overly desperate in going to the extent of attempting suicide.
2. Families need to be encouraged to respond appropriately to members who attempt suicide so as to aid in total recovery, because if family members approach attempters wrongly and make them feel more depressed there is the high possibility of a reattempt and even completion of suicide. CPNs should therefore run family members through the appropriate way to relate to these attempters so as to help them become more resilient to suicide ideation.
3. The people in the various communities need updating on modern methods of handling suicide attempt victims, by CPNs as some of the methods have become outmode. While other methods meant to save suicide attempters actually lead to further loss of lives of rescuers especially in drowning cases.
4. Specific guidelines by Mental Health Authority and other vital stakeholders like the Ministry of Health need to be provided for CPNs to serve as a prototype for the management of suicide attempters and suicidal patients. These guidelines will streamline the service of these caregivers so as to help them deliver high quality standard protocols to patients and the community as a whole, which will contribute to promoting community resilience to suicide

5. Family members of completed suicide victims need CPNs to take them through additional coping skills, aside the ones they already know so as to prevent them from being negatively affected by the event. Research has shown that many family members are prone to suicide contagion, the phenomenon by which exposure to one suicide death can trigger suicidal behavior in others. The services of the CPNs are therefore crucial in order to forestall this phenomenon from occurring and thus making the members of the family and community at large more resilient to suicide.

6.5.2 Recommendations for Future Research

1. Organization of programs on suicide for various community leaders such as Pastors, Imams, Assembly members, MPs et cetera in the dissemination of knowledge on suicide and suicide prevention will help take quality information down to the grassroots and ensure further decentralization of the suicide resilience information propagation.
2. Future research on how community religious leaders will be train on how to integrate suicide prevention into their teaching so as to make their congregation enlightened on signs and symptoms and help seeking.
3. Suicide prevention education should be integrated in our school curriculum.

6.5.3 Recommendation for Policy makers

1. The Mental Health Authority should develop a policy that would help minimize if not totally curb suicide attempts by involving the media in the education of the general public. Policies should be put in place to ensure that the allowances for visiting and tracing clients in their various homes are paid promptly so that they can trace and visit clients frequently to prevent relapses and suicide attempts and thereby reducing the work load of CPNs as well.

2. Key stakeholders, including NGOs, significant institutions and groups in the society could financially be of assistance in the care and rehabilitation of the mentally ill in the community.
3. The Article 846 of the Mental Health Act 2012 should be reviewed to include the use of other community-based health providers who are outside the biomedical system through integrated, complementary and alternative medicine use.
4. Majority of suicide attempters and completed suicide family members established that victims resorted to the use of rat poison or 'Nkura aduro', it is therefore necessary that policy makers design a regulation that will guide the sale of such toxic substances to the general public.



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APPENDICES

APPENDIX II: CONSENT FORM

STUDY TITLE:

**COMMUNITY PSYCHIATRIC SERVICES AND SUICIDE RESILIENCE IN
SELECTED COMMUNITIES IN THE GREATER ACCRA, REGION OF GHANA.**

PARTICIPANTS' STATEMENT

I acknowledge that I have read or have had the purpose and contents of the Participants' Information Sheet read and satisfactorily explained to me in a language I understand (English, Twi). I have had the opportunity to ask questions; and any question I have asked has been answered to my satisfaction. I fully understand the contents and any potential implications as well as my right to change my mind (i.e. withdraw from the research) even after I have signed this form without in any way it affecting my further medical care.

I voluntarily agree to be part of this research.

Name or Initials of Participant.....

Participants' SignatureOR Thumb Print.....

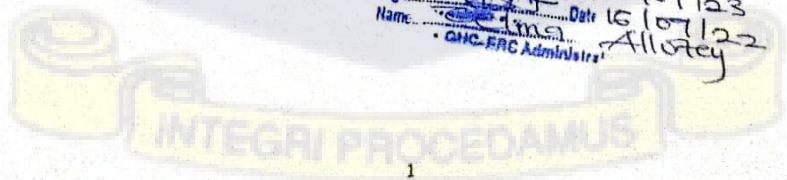
I also agree for the interview to be audio recorded. YES [] NO []

Name or Initials of Participant..... ID Code

Participants' SignatureOR Thumb Print.....

Date:.....

This is to Certify that this Study's Inform Consent Form Has Been Approved by GHS
Period 12/07/22 to 12/07/23
Sign: [Signature] Date 15/07/22
Name: [Signature] Attorney
GHC-ERC Administrator



APPENDIX A: CONSENT FORM FOR DATA COLLECTION

INTERPRETERS' STATEMENT

I interpreted the purpose and contents of the Participants' Information Sheet to the afore named participant to the best of my ability in the (Twi) language to his/her proper understanding.

All questions, appropriate clarifications sought by the participant and answers were also duly interpreted to his/her satisfaction.

Name of Interpreter.....

Signature of Interpreter..... Date:.....

Contact Details

STATEMENT OF WITNESS

I was present when the purpose and contents of the Participant Information Sheet was read and explained satisfactorily to the participant in the language he/she understood (Twi).

I confirm that he/she was given the opportunity to ask questions/seek clarifications and same were duly answered to his/her satisfaction before voluntarily agreeing to be part of the research.

Name:.....

Signature..... OR Thumb Print

Date:.....

INVESTIGATOR STATEMENT AND SIGNATURE

I certify that the participant has been given ample time to read and learn about the study. All questions and clarifications raised by the participant have been addressed.

Researcher's name.....

Signature

Date.....

This is to Certify that this Study's Inform Consent Form Has Been Approved by GHS - ERC for the Period 15/01/22 to 12/01/23
Sign..... Date: 16/01/22
Name.....
* GHS-ERC Administrator

APPENDIX 1: PARTICIPANT INFORMATION SHEET

INFORMATION SHEET FOR COMMUNITY PSYCHIATRIC NURSES

Title of study: Community Psychiatric Services and suicide resilience in selected communities in the Greater Accra, Region of Ghana.

Introduction

My name is Abigail Ansere Buerthey, I am a PhD student at the School of Public Health, University of Ghana, Legon. I would like to request your participation in my study on Community Psychiatric Services and suicide resilience in selected communities in the Greater Accra, Region of Ghana.

This information leaflet is to let you fully understand what this study is about to help you make an informed decision to take part.

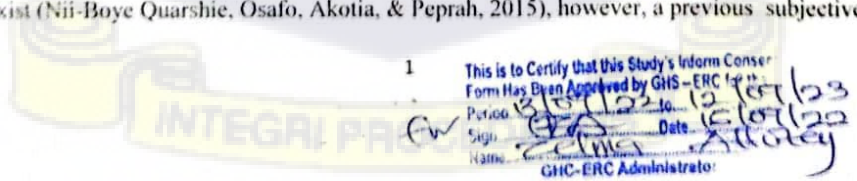
Address: School of Public Health, College of Health Sciences, University of Ghana, Legon, P.O. Box LG 13, Legon.

Tel: 0244646955; Email: abuerthey@ug.edu.gh

Background and purpose

Suicide is the act of deliberately taking one's own life (WHO, 2014). Studies have revealed that majority of suicidal behaviour in Lower and Middle Income Countries (LMICs) are triggered by social, economic and cultural factors (Bantjes et al., 2016). Many African countries are also experiencing a rise in suicide rates and these trends are not easy to explain (Mars, Burrows, Hjelmeland, & Gunnell, 2014).

In Ghana, the scenario is similar to the general African situation; very little official records of data exist (Nii-Boye Quarshie, Osafo, Akotia, & Peprah, 2015), however, a previous subjective



and journalistic account shows that about 1556 people (approximately five people daily) take their lives annually in Ghana (Oti, 2014). Victims of the suicides were mostly male (85.92%), with age ranging 10-86 years (Abdulai, 2020). Commonly identified suicide methods included self-hanging (67.94%), firearms (18.32%), and self-poisoning (8.93%) (Abdulai, 2020). Online news portals report an upsurge of suicides in Ghana in the last 3 years; 2017 saw the highest news coverage of 30 (21%) cases (Abdulai, 2020)s. Matrimonial or relationships and domestic difficulties commonly served as the reasons for the suicides; Also mental disorders, and monetary problems were also named as instant triggers of the suicides by close relatives of the victims (Abdulai, 2020). These do not only have positive effects but also some adverse effects. Therefore, strengthening community resilience could prevent or reduce suicidal behaviours.

What is the nature of this study?

This research explore, investigate, examine and identify how community resilience against suicide can be strengthened. I will like to know the experiences you have gone through as a Community Psychiatric Nurse. This will help me understand your experiences in managing suicide, the challenges you faced and how you cope with these challenges. This involves using interview guide at the community mental health units of the Ga South Municipal Hospital, Ningo Prampram, Ga East, Ledzokuku and Weija/ Mallam. Duration of this research is expected to last for about seven months.

What do I have to do in this study?

If you agree to take part in the study, you will be asked to sign an informed consent form. This will serve as proof of your consent to take part in the study and permission for me to use the information provided. As a safety precaution, you will be required to follow COVID-19 protocols during my interactions with you. Before the interview, you will be given a nose mask to wear and sanitizer to sanitize your hands before and after you sign the consent forms. If you agree, the interview will be recorded with a voice recorder and the conversation will be typed. If you don't agree, then I will take notes instead. Both of us will maintain social distance of at least

2

This is to Certify that this Study's Inform Consent Form Has Been Approved by GHS-ERC for the
Period 13/09/22 to 12/09/23
Sign: *[Signature]* Date: 12/09/22
Name: *[Signature]* Attorney
GHC-ERC Administrator

6 feet during the interview. I will ask questions about your age, religion, marital, educational and employment status, to know a little about yourself. After that, I will ask questions about your experiences with suicide and resilience in the community. This interview will last for about an hour. In the course of the interview, you may ask me to pause for a while or to discontinue with the interview if you feel uncomfortable. If you have the urge to cough during our interaction, you are advised to do so with your elbow covering your nose and mouth.

What are the conditions that qualify me for the study?

You have to be an individual who have attempted suicide, family member of the attempter, stakeholder, community member and a Community Psychiatric Nurse who is a Ghanaian and resides in either Ga South, Weija/Mallam, Ledzokuku, Ningo Prampram and Ga East.

What are the risks of taking part in the study?

You may feel sad or upset during the interview. If this happens, you will be referred to an experienced counsellor who will discuss your concerns with you and reassure you about the difficulty you face. However, you reserve the right to withdraw from the study anytime and it will not affect your treatment and relationship with the community mental health nurses. Secondly, due to the COVID-19 pandemic, you may be exposed to the virus. You are however assured of strict COVID-19 protocols to ensure your safety.

What are the benefits of participating in this study?

You may not benefit directly from this study, however, indirectly your participation will in this study provide information that will bring out recommendations that will support community psychiatric nurses work, individuals, opinion leaders, stake holders and community members in handling and developing resilience against suicide.

What rights do you have as a participant in this study?

Participation in this study is left to your discretion and is entirely voluntary. You have the right to withdraw from the study at any time without any consequences to you. You also have the right to prevent me from using the information recorded even after the interview. Your personal information and identity will remain anonymous in this study and will not be shared with

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Name: [Signature] GHS-ERC Administrative

anyone. However, codes will be used instead of your name when referring to the information you shared with me.

Is there reimbursement for taking part in the study?

You will receive no payment to take part and you will not be paid for taking part. However, you will be provided a token to take care of your cost of transportation to and from the health facility or venue for the interview.

How will confidentiality be maintained?

All information obtained from you will be kept confidential without mention being made of your name or any identifying information about you. A code will be allocated for information provided by each participant and which cannot be linked to your name. Pseudonyms will be used instead of your name when references are being made to the information you provided.

Conflict of interest

There are no conflicts of interest in this study. Data generated from the study will be owned by the researcher. The data will be kept for two years if published and six years if not published, after this period it will be destroyed.

Outcome and feedback

At the end of the study the results will be published in a scientific journal. Information that identifies you as a participant in the study will not be in the journal. Summary of the results will be provided to you as feedback after analysis of data collected.

Who can I call for enquires?

A copy of the information sheet and consent form will be given to you after it has been signed or thumb-printed to take home. Should you have a concern about the study you can contact me (Abigail Ansere Buerthey) on telephone number +233 244646955 or Email: abuerthey@ug.edu.gh

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Name.....Abigail Buerthey.....
GHC-ERC Administrator

INTEGRI PROCEDANDUS

For further clarification on ethical issues you can contact GHS ERC administrator Nana Abena Apatu, on telephone number 050 353 9896 or email: ethics.research@ghsmaail.org, on rights of participation.

Thank you for taking time to go through this information sheet.

Abigail Ansere Buerthey

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Sign: [Signature] Date: 15/09/22
Name: Abigail Buerthey
GHS-ERC Administrator



APPENDIX I: PARTICIPANT INFORMATION SHEET

INFORMATION SHEET FOR COMMUNITY MEMBERS

Title of study: Community Psychiatric Services and suicide resilience in selected communities in the Greater Accra, Region of Ghana.

Introduction

My name is Abigail Ansere Buerterey, I am a PhD student at the School of Public Health, University of Ghana, Legon. I would like to request your participation in my study on Community Psychiatric Services and suicide resilience in selected communities in the Greater Accra, Region of Ghana.

This information leaflet is to let you fully understand what this study is about to help you make an informed decision to take part. Each participant will be required to sign a consent form.

Address: School of Public Health, College of Health Sciences, University of Ghana, Legon, P.O. Box LG 13, Legon.

Tel: 0244646955; Email: abuerterey@ug.edu.gh

Background and purpose

Suicide is the act of deliberately taking one's own life (WHO, 2014). Studies have revealed that majority of suicidal behaviour in Lower and Middle Income Countries (LMICs) are triggered by social, economic and cultural factors (Bantjes et al., 2016). Many African countries are also experiencing a rise in suicide rates and these trends are not easy to explain (Mars, Burrows, Hjelmeland, & Gunnell, 2014).

In Ghana, the scenario is similar to the general African situation; very little official records of data exist (Nii-Boye Quarshie, Osafo, Akotia, & Peprah, 2015), however, a previous subjective

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Name: [Signature] GHS-ERC Administrator

INTEGRITY PROJECT

and journalistic account shows that about 1556 people (approximately five people daily) take their lives annually in Ghana (Oti, 2014). Victims of the suicides were mostly male (85.92%), with age ranging 10-86 years (Abdulai, 2020). Commonly identified suicide methods included self-hanging (67.94%), firearms (18.32%), and self-poisoning (8.93%) (Abdulai, 2020). Online news portals report an upsurge of suicides in Ghana in the last 3 years; 2017 saw the highest news coverage of 30 (21%) cases (Abdulai, 2020)s. Matrimonial or relationships and domestic difficulties commonly served as the reasons for the suicides; Also mental disorders, and monetary problems were also named as instant triggers of the suicides by close relatives of the victims (Abdulai, 2020). These do not only have positive effects but also some adverse effects. Therefore, strengthening community resilience could prevent or reduce suicidal behaviours.

What is the nature of this study?

This research explore, investigate, examine and identify how community resilience against suicide can be strengthened I will like to know the experiences you have gone through as a community member. This will help me understand your experiences about suicide, the challenges you faced and how you cope with these challenges. This involves using interview guide with community members who resides within Ga South, Ningo Prampram, Ga East, Ledzokuku and Weija/ Mallam. Duration of this research is expected to last for about seven months.

What do I have to do in this study?

If you agree to take part in the study, you will be asked to sign an informed consent form. This will serve as proof of your consent to take part in the study and permission for me to use the information provided. As a safety precaution, you will be required to follow COVID-19 protocols during my interactions with you. Before the interview, you will be given a nose mask to wear and sanitizer to sanitize your hands before and after you sign the consent forms. If you agree, the interview will be recorded with a voice recorder and the conversation will be typed. If you don't agree, then I will take notes instead. Both of us will maintain social distance of at least

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GHS-ERC Administrator

For further clarification on ethical issues you can contact GHS ERC administrator Nana Abena Apatu, on telephone number 050 353 9896 or email: ethics.research@ghsmail.org, on rights of participation.

Thank you for taking time to go through this information sheet.

Abigail Ansere Buerthey

This is to Certify that this Study's Inform Consent Form Has Been Approved by GHS-ERC
Period 3/5/22 to 2/09/23
Sign [Signature] Date 15/09/22
Name Zelma Alotey
GHC-ERC Administrator:



to wear and sanitizer to sanitize your hands before and after you sign the consent forms. If you agree, the interview will be recorded with a voice recorder and the conversation will be typed. If you don't agree, then I will take notes instead. Both of us will maintain social distance of at least 6 feet during the interview. I will ask questions about your age, religion, marital, educational and employment status, to know a little about yourself. After that, I will ask questions about your experiences with suicide and resilience in the community. This interview will last for about an hour. In the course of the interview, you may ask me to pause for a while or to discontinue with the interview if you feel uncomfortable. If you have the urge to cough during our interaction, you are advised do so with your elbow covering your nose and mouth.

What are the conditions that qualify me for the study?

You have to be an individual who have attempted suicide, who is a Ghanaian and resides in either Ga South, Weija Mallam, Ledzokuku, Ningo Prampram and Ga East.

What are the risks of taking part in the study?

You may feel sad or upset during the interview. If this happens, you will be referred to an experienced counsellor who will discuss your concerns with you and reassure you about the difficulty you face. However, you reserve the right to withdraw from the study anytime and it will not affect your treatment and relationship with the community mental health nurses. Secondly, due to the COVID-19 pandemic, you may be exposed to the virus. You are however assured of strict COVID-19 protocols to ensure your safety.

What are the benefits of participating in this study?

You may not benefit directly from this study, however, indirectly your participation will in this study will provide information that will bring out recommendations that will support community psychiatric nurses, individuals, opinion leaders, stake holders and community members in handling and developing resilience against suicide.

What rights do you have as a participant in this study?

Participation in this study is left to your discretion and is entirely voluntary. You have the right to withdraw from the study at any time without any consequences to you. You also have the

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for Sign: [Signature] Date: 12/09/22
Name: [Signature] - GHS-ERC Administrator

right to prevent me from using the information recorded even after the interview. Your personal information and identity will remain anonymous in this study and will not be shared with anyone. However, codes will be used instead of your name when referring to the information you shared with me.

Is there reimbursement for taking part in the study?

You will receive no payment to take part and you will not be paid for taking part. However, you will be provided a token to take care of your cost of transportation to and from the health facility or venue for the interview.

How will confidentiality be maintained?

All information obtained from you will be kept confidential without mention being made of your name or any identifying information about you. A code will be allocated for information provided by each participant and which cannot be linked to your name. Pseudonyms will be used instead of your name when references are being made to the information you provided.

Conflict of interest

There are no conflicts of interest in this study. Data generated from the study will be owned by the researcher. The data will be kept for two years if published and six years if not published, after this period it will be destroyed.

Outcome and feedback

At the end of the study the results will be published in a scientific journal. Information that identifies you as a participant in the study will not be in the journal. Summary of the results will be provided to you as feedback after analysis of data collected.

Who can I call for enquires?

A copy of the information sheet and consent form will be given to you after it has been signed or thumb-printed to take home. Should you have a concern about the study you can contact me (Abigail Ansere Buertery) on telephone number +233 244646955 or Email: abuertery@ug.edu.gh

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Sign: [Signature] Date: 15/01/22
Name: Abigail Buertery
GHC-ERC Administrator

In Ghana, the scenario is similar to the general African situation; very little official records of data exist (Nii-Boye Quarshie, Osafo, Akotia, & Peprah, 2015), however, a previous subjective and journalistic account shows that about 1556 people (approximately five people daily) take their lives annually in Ghana (Oti, 2014). Victims of the suicides were mostly male (85.92%), with age ranging 10-86 years (Abdulai, 2020). Commonly identified suicide methods included self-hanging (67.94%), firearms (18.32%), and self-poisoning (8.93%) (Abdulai, 2020). Online news portals report an upsurge of suicides in Ghana in the last 3 years; 2017 saw the highest news coverage of 30 (21%) cases (Abdulai, 2020)s. Matrimonial or relationships and domestic difficulties commonly served as the reasons for the suicides; Also mental disorders, and monetary problems were also named as instant triggers of the suicides by close relatives of the victims (Abdulai, 2020). These do not only have positive effects but also some adverse effects. Therefore, strengthening community resilience could prevent or reduce suicidal behaviours.

What is the nature of this study?

This research explore, investigate, examine and identify how community resilience against suicide can be strengthened I will like to know the experiences you have gone through as a family member. This will help me understand your experiences about suicide, the challenges you faced, the precipitating factors and how you were able to cope with these challenges. This involves using interview guide. It will involve persons who resides in Ga South, Ningo Prampram, Ga East, Ledzokuku and Weija/ Mallam. Duration of this research is expected to last for about seven months.

What do I have to do in this study?

If you agree to take part in the study, you will be asked to sign an informed consent form. This will serve as proof of your consent to take part in the study and permission for me to use the information provided. As a safety precaution, you will be required to follow COVID-19 protocols during my interactions with you. Before the interview, you will be given a nose mask

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In Ghana, the scenario is similar to the general African situation; very little official records of data exist (Nii-Boye Quarshie, Osafo, Akotia, & Peprah, 2015), however, a previous subjective and journalistic account shows that about 1556 people (approximately five people daily) take their lives annually in Ghana (Oti, 2014). Victims of the suicides were mostly male (85.92%), with age ranging 10-86 years (Abdulai, 2020). Commonly identified suicide methods included self-hanging (67.94%), firearms (18.32%), and self-poisoning (8.93%) (Abdulai, 2020). Online news portals report an upsurge of suicides in Ghana in the last 3 years; 2017 saw the highest news coverage of 30 (21%) cases (Abdulai, 2020)s. Matrimonial or relationships and domestic difficulties commonly served as the reasons for the suicides; Also mental disorders, and monetary problems were also named as instant triggers of the suicides by close relatives of the victims (Abdulai, 2020). These do not only have positive effects but also some adverse effects. Therefore, strengthening community resilience could prevent or reduce suicidal behaviours.

What is the nature of this study?

This research explore, investigate, examine and identify how community resilience against suicide can be strengthened I will like to know the experiences you have gone through as a family member. This will help me understand your experiences about suicide, the challenges you faced, the precipitating factors and how you were able to cope with these challenges. This involves using interview guide. It will involve persons who resides in Ga South, Ningo Prampram, Ga East, Ledzokuku and Weija/ Mallam. Duration of this research is expected to last for about seven months.

What do I have to do in this study?

If you agree to take part in the study, you will be asked to sign an informed consent form. This will serve as proof of your consent to take part in the study and permission for me to use the information provided. As a safety precaution, you will be required to follow COVID-19 protocols during my interactions with you. Before the interview, you will be given a nose mask

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Name... [Signature] M.A. Akotey
GHC-ERC Administrator

APPENDIX I: PARTICIPANT INFORMATION SHEET

INFORMATION SHEET FOR SUICIDE ATTEMPTERS' FAMILIES

Title of study: Community Psychiatric Services and suicide resilience in selected communities in the Greater Accra, Region of Ghana.

Introduction

My name is Abigail Ansere Buerterey, I am a PhD student at the School of Public Health, University of Ghana, Legon. I would like to request your participation in my study on Community Psychiatric Services and suicide resilience in selected communities in the Greater Accra, Region of Ghana.

This information leaflet is to let you fully understand what this study is about to help you make an informed decision to take part.

Address: School of Public Health, College of Health Sciences, University of Ghana, Legon, P.O. Box LG 13, Legon.

Tel: 0244646955; Email: abuerterey@ug.edu.gh

Background and purpose

Suicide is the act of deliberately taking one's own life (WHO, 2014). Studies have revealed that majority of suicidal behaviour in Lower and Middle Income Countries (LMICs) are triggered by social, economic and cultural factors (Bantjes et al., 2016). Many African countries are also experiencing a rise in suicide rates and these trends are not easy to explain (Mars, Burrows, Hjelmeland, & Gunnell, 2014).

For further clarification on ethical issues you can contact GHS ERC administrator Nana Abena Apatu, on telephone number 050 353 9896 or email: ethics.research@ghsmaail.org, on rights of participation.

Thank you for taking time to go through this information sheet.

Abigail Ansere Buerthey

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Period 13/09/22 to 12/09/23
for
Sign: [Signature] Date: 16/09/22
Name: Zelma Attorney
GHS-ERC Administrator



right to prevent me from using the information recorded even after the interview. Your personal information and identity will remain anonymous in this study and will not be shared with anyone. However, codes will be used instead of your name when referring to the information you shared with me.

Is there reimbursement for taking part in the study?

You will receive no payment to take part and you will not be paid for taking part. However, you will be provided a token to take care of your cost of transportation to and from the health facility or venue for the interview.

How will confidentiality be maintained?

All information obtained from you will be kept confidential without mention being made of your name or any identifying information about you. A code will be allocated for information provided by each participant and which cannot be linked to your name. Pseudonyms will be used instead of your name when references are being made to the information you provided.

Conflict of interest

There are no conflicts of interest in this study. Data generated from the study will be owned by the researcher. The data will be kept for two years if published and six years if not published, after this period it will be destroyed.

Outcome and feedback

At the end of the study the results will be published in a scientific journal. Information that identifies you as a participant in the study will not be in the journal. Summary of the results will be provided to you as feedback after analysis of data collected.

Who can I call for enquires?

A copy of the information sheet and consent form will be given to you after it has been signed or thumb-printed to take home. Should you have a concern about the study you can contact me (Abigail Ansere Buerthey) on telephone number +233 244646955 or Email: abuertey@ug.edu.gh

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Period 13/09/22 to 12/09/23
Sign. [Signature] Date 16/09/22
Name: Selma Abietey
GHC-ERC Administrator

to wear and sanitizer to sanitize your hands before and after you sign the consent forms. If you agree, the interview will be recorded with a voice recorder and the conversation will be typed. If you don't agree, then I will take notes instead. Both of us will maintain social distance of at least 6 feet during the interview. I will ask questions about your age, religion, marital, educational and employment status, to know a little about yourself. After that, I will ask questions about your experiences with suicide and resilience in the community. This interview will last for about an hour. In the course of the interview, you may ask me to pause for a while or to discontinue with the interview if you feel uncomfortable. If you have the urge to cough during our interaction, you are advised do so with your elbow covering your nose and mouth.

What are the conditions that qualify me for the study?

You have to be an individual who have attempted suicide, who is a Ghanaian and resides in either Ga South, Weija/Mallam, Ledzokuku, Ningo Prampram and Ga East.

What are the risks of taking part in the study?

You may feel sad or upset during the interview. If this happens, you will be referred to an experienced counsellor who will discuss your concerns with you and reassure you about the difficulty you face. However, you reserve the right to withdraw from the study anytime and it will not affect your treatment and relationship with the community mental health nurses. Secondly, due to the COVID-19 pandemic, you may be exposed to the virus. You are however assured of strict COVID-19 protocols to ensure your safety.

What are the benefits of participating in this study?

You may not benefit directly from this study, however, indirectly your participation will in this study will provide information that will bring out recommendations that will support community psychiatric nurses, individuals, opinion leaders, stake holders and community members in handling and developing resilience against suicide.

What rights do you have as a participant in this study?

Participation in this study is left to your discretion and is entirely voluntary. You have the right to withdraw from the study at any time without any consequences to you. You also have the

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Name: [Signature] Allogbey
GHC-ERC Administrator

In Ghana, the scenario is similar to the general African situation; very little official records of data exist (Nii-Boye Quarshie, Osafo, Akotia, & Peprah, 2015), however, a previous subjective and journalistic account shows that about 1556 people (approximately five people daily) take their lives annually in Ghana (Oti, 2014). Victims of the suicides were mostly male (85.92%), with age ranging 10-86 years (Abdulai, 2020). Commonly identified suicide methods included self-hanging (67.94%), firearms (18.32%), and self-poisoning (8.93%) (Abdulai, 2020). Online news portals report an upsurge of suicides in Ghana in the last 3 years; 2017 saw the highest news coverage of 30 (21%) cases (Abdulai, 2020)s. Matrimonial or relationships and domestic difficulties commonly served as the reasons for the suicides; Also mental disorders, and monetary problems were also named as instant triggers of the suicides by close relatives of the victims (Abdulai, 2020). These do not only have positive effects but also some adverse effects. Therefore, strengthening community resilience could prevent or reduce suicidal behaviours.

What is the nature of this study?

This research explore, investigate, examine and identify how community resilience against suicide can be strengthened I will like to know the experiences you have gone through as an individual. This will help me understand your experiences about suicide, the challenges you faced, the precipitating factors and how you were able to cope with these challenges. This involves using interview guide. It will involve persons who resides in Ga South, Ningo Prampram, Ga East, Ledzokuku and Weija/ Mallam. Duration of this research is expected to last for about seven months.

What do I have to do in this study?

If you agree to take part in the study, you will be asked to sign an informed consent form. This will serve as proof of your consent to take part in the study and permission for me to use the information provided. As a safety precaution, you will be required to follow COVID-19 protocols during my interactions with you. Before the interview, you will be given a nose mask

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This is to Certify that this Study's Inform Consent Form Has Been Approved by GHS-ERC
Period 12/09/22 to 02/09/23
Sign [Signature] Date 16/09/22
Name [Signature] Attorney
GHC-ERC Administrator

APPENDIX I: PARTICIPANT INFORMATION SHEET

INFORMATION SHEET FOR SUICIDE ATTEMPTERS'

Title of study: Community Psychiatric Services and suicide resilience in selected communities in the Greater Accra, Region of Ghana.

Introduction

My name is Abigail Ansere Buerterey, I am a PhD student at the School of Public Health, University of Ghana, Legon. I would like to request your participation in my study on Community Psychiatric Services and suicide resilience in selected communities in the Greater Accra, Region of Ghana.

This information leaflet is to let you fully understand what this study is about to help you make an informed decision to take part.

Address: School of Public Health, College of Health Sciences, University of Ghana, Legon, P.O. Box LG 13, Legon.

Tel: 0244646955;

Email: abuerterey@ug.edu.gh

Background and purpose

Suicide is the act of deliberately taking one's own life (WHO, 2014). Studies have revealed that majority of suicidal behaviour in Lower and Middle Income Countries (LMICs) are triggered by social, economic and cultural factors (Bantjes et al., 2016). Many African countries are also experiencing a rise in suicide rates and these trends are not easy to explain (Mars, Burrows, Hjelmeland, & Gunnell, 2014).

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Sign: [Signature] Date: 15/09/22
Name: E. Alotey
GHC-ERC Administrator

Outcome and feedback

At the end of the study the results will be published in a scientific journal. Information that identifies you as a participant in the study will not be in the journal. Summary of the results will be provided to you as feedback after analysis of data collected.

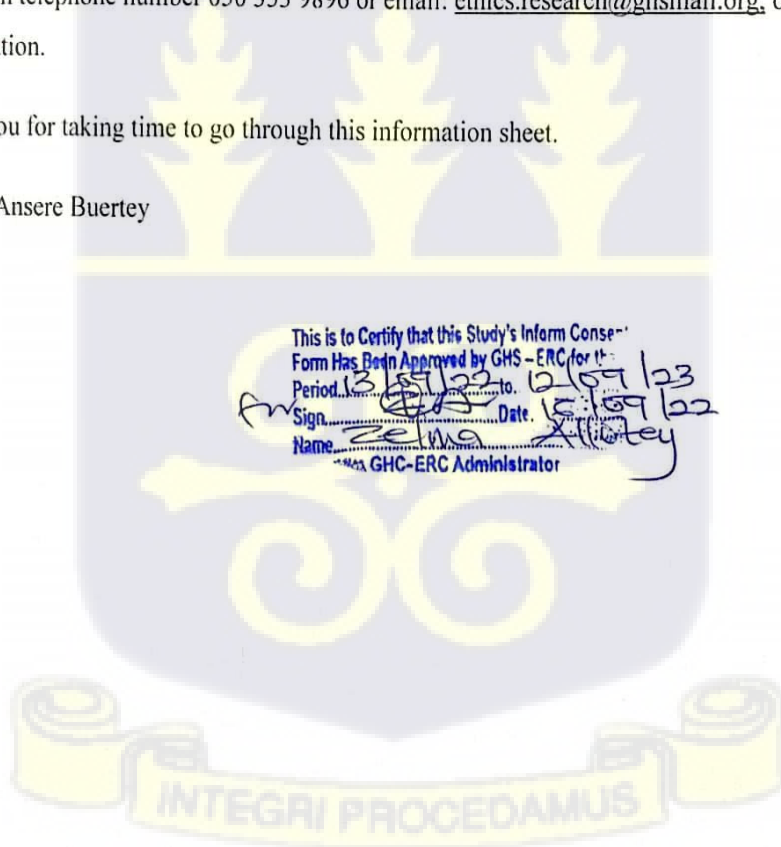
Who can I call for enquires?

A copy of the information sheet and consent form will be given to you after it has been signed or thumb-printed to take home. Should you have a concern about the study you can contact me (Abigail Ansere Buertery) on telephone number +233 244646955 or Email: abuertery@ug.edu.gh

For further clarification on ethical issues you can contact GHS ERC administrator Nana Abena Apatu, on telephone number 050 353 9896 or email: ethics.research@ghsmaail.org, on rights of participation.

Thank you for taking time to go through this information sheet.

Abigail Ansere Buertery



psychiatric nurses, individuals, opinion leaders, stake holders and community members in handling and developing resilience against suicide.

What rights do you have as a participant in this study?

Participation in this study is left to your discretion and is entirely voluntary. You have the right to withdraw from the study at any time without any consequences to you. You also have the right to prevent me from using the information recorded even after the interview. Your personal information and identity will remain anonymous in this study and will not be shared with anyone. However, codes will be used instead of your name when referring to the information you shared with me.

Is there reimbursement for taking part in the study?

You will receive no payment to take part and you will not be paid for taking part. However, you will be provided a token to take care of your cost of transportation to and from the health facility or venue for the interview.

How will confidentiality be maintained?

All information obtained from you will be kept confidential without mention being made of your name or any identifying information about you. A code will be allocated for information provided by each participant and which cannot be linked to your name. Pseudonyms will be used instead of your name when references are being made to the information you provided.

Conflict of interest

There are no conflicts of interest in this study. Data generated from the study will be owned by the researcher. The data will be kept for two years if published and six years if not published, after this period it will be destroyed.

This is to Certify that this Study's Inform Consent Form Has Been Approved by GHS - ERC
Period 13/09/22 to 12/09/23
Sign. [Signature] Date 16/09/22
Name Zelma Ailley
GHC-ERC Administrative

psychiatric nurses, individuals, opinion leaders, stake holders and community members in handling and developing resilience against suicide.

What rights do you have as a participant in this study?

Participation in this study is left to your discretion and is entirely voluntary. You have the right to withdraw from the study at any time without any consequences to you. You also have the right to prevent me from using the information recorded even after the interview. Your personal information and identity will remain anonymous in this study and will not be shared with anyone. However, codes will be used instead of your name when referring to the information you shared with me.

Is there reimbursement for taking part in the study?

You will receive no payment to take part and you will not be paid for taking part. However, you will be provided a token to take care of your cost of transportation to and from the health facility or venue for the interview.

How will confidentiality be maintained?

All information obtained from you will be kept confidential without mention being made of your name or any identifying information about you. A code will be allocated for information provided by each participant and which cannot be linked to your name. Pseudonyms will be used instead of your name when references are being made to the information you provided.

Conflict of interest

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This is to Certify that this Study's Inform Consent Form Has Been Approved by GHS-ERC
Period: 13/09/22 to 12/09/23
Sign: *[Signature]* Date: 16/09/22
Name: Zetna A. Aboye
GHC-ERC Administrator

What do I have to do in this study?

If you agree to take part in the study, you will be asked to sign an informed consent form. This will serve as proof of your consent to take part in the study and permission for me to use the information provided. As a safety precaution, you will be required to follow COVID-19 protocols during my interactions with you. Before the interview, you will be given a nose mask to wear and sanitizer to sanitize your hands before and after you sign the consent forms. If you agree, the interview will be recorded with a voice recorder and the conversation will be typed. If you don't agree, then I will take notes instead. Both of us will maintain social distance of at least 6 feet during the interview. I will ask questions about your age, religion, marital, educational and employment status, to know a little about yourself. After that, I will ask questions about your experiences with suicide and resilience in the community. This interview will last for about an hour. In the course of the interview, you may ask me to pause for a while or to discontinue with the interview if you feel uncomfortable. If you have the urge to cough during our interaction, you are advised do so with your elbow covering your nose and mouth.

What are the conditions that qualify me for the study?

You have to be an individual who have attempted suicide, who is a Ghanaian and resides in either Ga South, Weija/Mallam, Ledzokuku, Ningo Prampram and Ga East.

What are the risks of taking part in the study?

You may feel sad or upset during the interview. If this happens, you will be referred to an experienced counsellor who will discuss your concerns with you and reassure you about the difficulty you face. However, you reserve the right to withdraw from the study anytime and it will not affect your treatment and relationship with the community mental health nurses. Secondly, due to the COVID-19 pandemic, you may be exposed to the virus. You are however assured of strict COVID-19 protocols to ensure your safety.

What are the benefits of participating in this study?

You may not benefit directly from this study, however, indirectly your participation will in this study will provide information that will bring out recommendations that will support community

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Period 12/09/22 to 12/09/23
Sign: [Signature] Date: 15/09/22
Name: Zenna Allyay
GHC-ERC Administrator

experiencing a rise in suicide rates and these trends are not easy to explain (Mars, Burrows, Hjelmeland, & Gunnell, 2014).

In Ghana, the scenario is similar to the general African situation; very little official records of data exist (Nii-Boye Quarshie, Osafo, Akotia, & Peprah, 2015), however, a previous subjective and journalistic account shows that about 1556 people (approximately five people daily) take their lives annually in Ghana (Oti, 2014). Victims of the suicides were mostly male (85.92%), with age ranging 10-86 years (Abdulai, 2020). Commonly identified suicide methods included self-hanging (67.94%), firearms (18.32%), and self-poisoning (8.93%) (Abdulai, 2020). Online news portals report an upsurge of suicides in Ghana in the last 3 years; 2017 saw the highest news coverage of 30 (21%) cases (Abdulai, 2020)s. Matrimonial or relationships and domestic difficulties commonly served as the reasons for the suicides; Also mental disorders, and monetary problems were also named as instant triggers of the suicides by close relatives of the victims (Abdulai, 2020). These do not only have positive effects but also some adverse effects. Therefore, strengthening community resilience could prevent or reduce suicidal behaviours.

What is the nature of this study?

This research explore, investigate, examine and identify how community resilience against suicide can be strengthened I will like to know the experiences you have gone through as a family member of suicide victim. This will help me understand your experiences about suicide, the challenges you faced, the precipitating factors and how you were able to cope with these challenges. This involves using interview guide. It will involve persons who resides in Ga South, Ningo Prampram, Ga East, Ledzokuku and Weija/ Mallam. Duration of this research is expected to last for about seven months.

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Period 12/09/22 to 12/09/23
Sign: [Signature] Date: 15/09/22
Name: [Signature] A. Hotey
GHC-ERC Administrator

APPENDIX I: PARTICIPANT INFORMATION SHEET

INFORMATION SHEET FOR FAMILIES OF SUICIDE VICTIMS Title of study:
Community Psychiatric Services and suicide resilience in selected communities in the
Greater Accra, Region of Ghana.

Introduction

My name is Abigail Ansere Buerterey, I am a PhD student at the School of Public Health, University of Ghana, Legon. I would like to request your participation in my study on Community Psychiatric Services and suicide resilience in selected communities in the Greater Accra, Region of Ghana.

This information leaflet is to let you fully understand what this study is about to help you make an informed decision to take part.

Address: School of Public Health, College of Health Sciences, University of Ghana, Legon, P.O. Box LG 13, Legon.

Tel: 0244646955;

Email: abuerterey@ug.edu.gh

Background and purpose

Suicide is the act of deliberately taking one's own life (WHO, 2014). Studies have revealed that majority of suicidal behaviour in Lower and Middle Income Countries (LMICs) are triggered by social, economic and cultural factors (Bantjes et al., 2016). Many African countries are also

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Period: 13/07/22 to 12/09/23
Sign: *[Signature]* Date: 16/07/22
Name: *[Signature]* Attorney
GHS-ERC Administrator

For further clarification on ethical issues you can contact GHS ERC administrator Nana Abena Apatu, on telephone number 050 353 9896 or email: ethics.research@ghsmaail.org, on rights of participation.

Thank you for taking time to go through this information sheet.

Abigail Ansere Buerthey

This is to Certify that this Study's Inform Consent Form Has Been Approved by GHS - ERC for the Period 2/15/22 to 12/31/23
Sign: [Signature] Date: 12/17/22
Name: Abigail Buerthey
GHS-ERC Administrator



anyone. However, codes will be used instead of your name when referring to the information you shared with me.

Is there reimbursement for taking part in the study?

You will receive no payment to take part and you will not be paid for taking part. However, you will be provided a token to take care of your cost of transportation to and from the health facility or venue for the interview.

How will confidentiality be maintained?

All information obtained from you will be kept confidential without mention being made of your name or any identifying information about you. A code will be allocated for information provided by each participant and which cannot be linked to your name. Pseudonyms will be used instead of your name when references are being made to the information you provided.

Conflict of interest

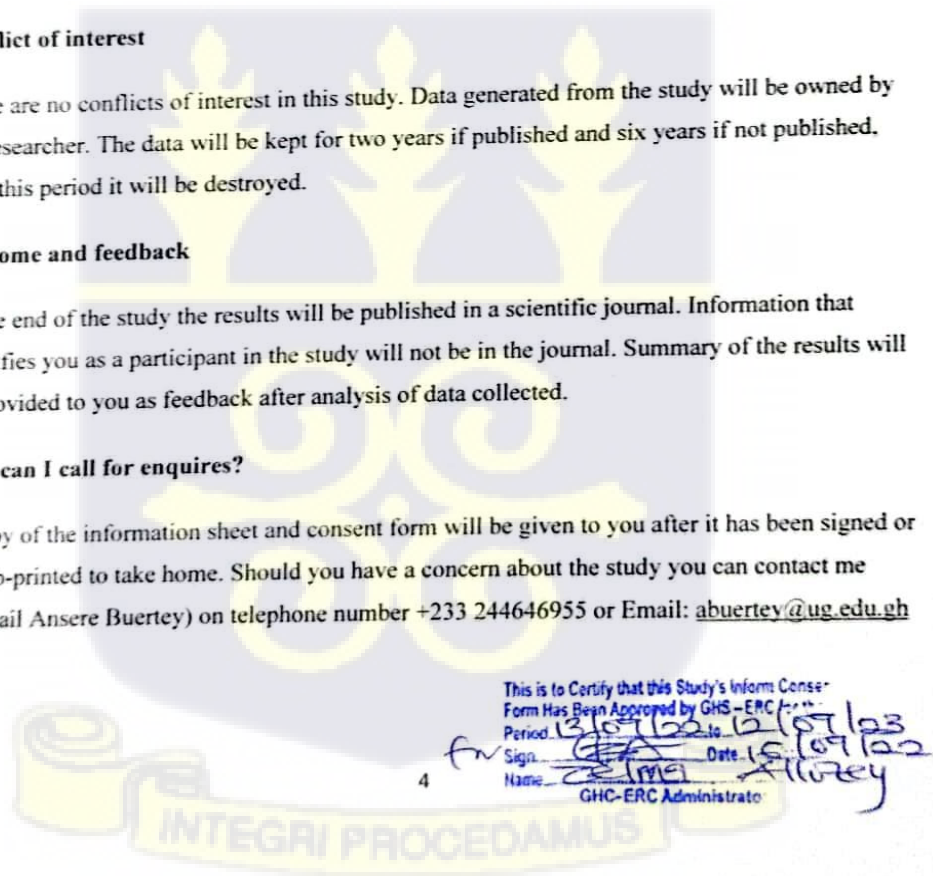
There are no conflicts of interest in this study. Data generated from the study will be owned by the researcher. The data will be kept for two years if published and six years if not published, after this period it will be destroyed.

Outcome and feedback

At the end of the study the results will be published in a scientific journal. Information that identifies you as a participant in the study will not be in the journal. Summary of the results will be provided to you as feedback after analysis of data collected.

Who can I call for enquires?

A copy of the information sheet and consent form will be given to you after it has been signed or thumb-printed to take home. Should you have a concern about the study you can contact me (Abigail Ansere Buertery) on telephone number +233 244646955 or Email: abuertery@ug.edu.gh



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Period: 12/07/22 to 12/07/23
Sign: *[Signature]* Date: 12/07/22
Name: *[Signature]*
GHC-ERC Administrator

6 feet during the interview. I will ask questions about your age, religion, marital, educational and employment status, to know a little about yourself. After that, I will ask questions about your experiences with suicide and resilience in the community. This interview will last for about an hour. In the course of the interview, you may ask me to pause for a while or to discontinue with the interview if you feel uncomfortable. If you have the urge to cough during our interaction, you are advised do so with your elbow covering your nose and mouth.

What are the conditions that qualify me for the study?

You have to be an individual who is a Ghanaian and resides in either Ga South, Weija/Mallam, Ledzokuku, Ningo Prampram and Ga East.

What are the risks of taking part in the study?

You may feel sad or upset during the interview. If this happens, you will be referred to an experienced counsellor who will discuss your concerns with you and reassure you about the difficulty you face. However, you reserve the right to withdraw from the study anytime and it will not affect your treatment and relationship with the community mental health nurses. Secondly, due to the COVID-19 pandemic, you may be exposed to the virus. You are however assured of strict COVID-19 protocols to ensure your safety.

What are the benefits of participating in this study?

You may not benefit directly from this study, however, indirectly your participation will in this study will provide information that will bring out recommendations that will support community psychiatric nurses, individuals, opinion leaders, stake holders and community members in handling and developing resilience against suicide.

What rights do you have as a participant in this study?

Participation in this study is left to your discretion and is entirely voluntary. You have the right to withdraw from the study at any time without any consequences to you. You also have the right to prevent me from using the information recorded even after the interview. Your personal information and identity will remain anonymous in this study and will not be shared with

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Form Has Been Approved by GHS-ERC for the
Period 12/10/22 to 12/10/23
Sign: *[Signature]* Date: 15/11/22
Name: *[Signature]*
GHC-ERC Administrator

and journalistic account shows that about 1556 people (approximately five people daily) take their lives annually in Ghana (Oti, 2014). Victims of the suicides were mostly male (85.92%), with age ranging 10-86 years (Abdulai, 2020). Commonly identified suicide methods included self-hanging (67.94%), firearms (18.32%), and self-poisoning (8.93%) (Abdulai, 2020). Online news portals report an upsurge of suicides in Ghana in the last 3 years; 2017 saw the highest news coverage of 30 (21%) cases (Abdulai, 2020)s. Matrimonial or relationships and domestic difficulties commonly served as the reasons for the suicides; Also mental disorders, and monetary problems were also named as instant triggers of the suicides by close relatives of the victims (Abdulai, 2020). These do not only have positive effects but also some adverse effects. Therefore, strengthening community resilience could prevent or reduce suicidal behaviours.

What is the nature of this study?

This research explore, investigate, examine and identify how community resilience against suicide can be strengthened I will like to know the experiences you have gone through as a community member. This will help me understand your experiences about suicide, the challenges you faced and how you cope with these challenges. This involves using interview guide with community members who resides within Ga South, Ningo Prampram, Ga East, Ledzokuku and Weija/ Mallam. Duration of this research is expected to last for about seven months.

What do I have to do in this study?

If you agree to take part in the study, you will be asked to sign an informed consent form. This will serve as proof of your consent to take part in the study and permission for me to use the information provided. As a safety precaution, you will be required to follow COVID-19 protocols during my interactions with you. Before the interview, you will be given a nose mask to wear and sanitizer to sanitize your hands before and after you sign the consent forms. If you agree, the interview will be recorded with a voice recorder and the conversation will be typed. If you don't agree, then I will take notes instead. Both of us will maintain social distance of at least

2

This is to Certify that this Study's Inform Consent Form Has Been Approved by GHS-ERC
Period... 13/09/22 to 12/09/23
Sign... [Signature] Date... 15/09/22
Name... [Signature] Allotey
GHC-ERC Administrative

APPENDIX 1: PARTICIPANT INFORMATION SHEET

INFORMATION SHEET FOR COMMUNITY MEMBERS

Title of study: Community Psychiatric Services and suicide resilience in selected communities in the Greater Accra, Region of Ghana.

Introduction

My name is Abigail Ansere Buerterey, I am a PhD student at the School of Public Health, University of Ghana, Legon. I would like to request your participation in my study on Community Psychiatric Services and suicide resilience in selected communities in the Greater Accra, Region of Ghana.

This information leaflet is to let you fully understand what this study is about to help you make an informed decision to take part. Each participant will be required to sign a consent form.

Address: School of Public Health, College of Health Sciences, University of Ghana, Legon, P.O. Box LG 13, Legon.

Tel: 0244646955;

Email: abuerterey@ug.edu.gh

Background and purpose

Suicide is the act of deliberately taking one's own life (WHO, 2014). Studies have revealed that majority of suicidal behaviour in Lower and Middle Income Countries (LMICs) are triggered by social, economic and cultural factors (Bantjes et al., 2016). Many African countries are also experiencing a rise in suicide rates and these trends are not easy to explain (Mars, Burrows, Hjelmeland, & Gunnell, 2014).

In Ghana, the scenario is similar to the general African situation; very little official records of data exist (Nii-Boye Quarshie, Osafo, Akotia, & Peparah, 2015), however, a previous subjective

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fws Sign: [Signature] Date: 15/07/22
Name: Abigail Buerterey
GHC-ERC Administrative

APPENDIX I: PARTICIPANT INFORMATION SHEET

INFORMATION SHEET FOR COMMUNITY MEMBERS

Title of study: Community Psychiatric Services and suicide resilience in selected communities in the Greater Accra, Region of Ghana.

Introduction

My name is Abigail Ansere Buerterey, I am a PhD student at the School of Public Health, University of Ghana, Legon. I would like to request your participation in my study on Community Psychiatric Services and suicide resilience in selected communities in the Greater Accra, Region of Ghana.

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Tel: 0244646955; Email: abuertey@ug.edu.gh

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Sign: [Signature] Date: 15/01/22
Name: [Signature] Allegrey
GHC-ERC Administrator

For further clarification on ethical issues you can contact GHS ERC administrator Nana Abena Apatu, on telephone number 050 353 9896 or email: ethics.research@ghsmaail.org, on rights of participation.

Thank you for taking time to go through this information sheet.

Abigail Ansere Buerthey

This is to Certify that this Study's Inform Consent Form Has Been Approved by GHS-ERC for the Period 15/09/22 to 12/09/23
Sign: [Signature] Date: 15/09/22
Name: Abigail Buerthey
GHS-ERC Administrator



anyone. However, codes will be used instead of your name when referring to the information you shared with me.

Is there reimbursement for taking part in the study?

You will receive no payment to take part and you will not be paid for taking part. However, you will be provided a token to take care of your cost of transportation to and from the health facility or venue for the interview.

How will confidentiality be maintained?

All information obtained from you will be kept confidential without mention being made of your name or any identifying information about you. A code will be allocated for information provided by each participant and which cannot be linked to your name. Pseudonyms will be used instead of your name when references are being made to the information you provided.

Conflict of interest

There are no conflicts of interest in this study. Data generated from the study will be owned by the researcher. The data will be kept for two years if published and six years if not published, after this period it will be destroyed.

Outcome and feedback

At the end of the study the results will be published in a scientific journal. Information that identifies you as a participant in the study will not be in the journal. Summary of the results will be provided to you as feedback after analysis of data collected.

Who can I call for enquires?

A copy of the information sheet and consent form will be given to you after it has been signed or thumb-printed to take home. Should you have a concern about the study you can contact me (Abigail Ansere Buertey) on telephone number +233 244646955 or Email: abuertey@ug.edu.gh

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Form Has Been Approved by GHS-ERC
Period: 15/09/22 to 12/09/23
4 for Sign: [Signature] Date: 15/09/22
Name: Zelma Attoey
GHC-ERC Administrator

6 feet during the interview. I will ask questions about your age, religion, marital, educational and employment status, to know a little about yourself. After that, I will ask questions about your experiences with suicide and resilience in the community. This interview will last for about an hour. In the course of the interview, you may ask me to pause for a while or to discontinue with the interview if you feel uncomfortable. If you have the urge to cough during our interaction, you are advised do so with your elbow covering your nose and mouth.

What are the conditions that qualify me for the study?

You have to be an individual who have attempted suicide, family member of the attempter, stakeholder, community member and a Community Psychiatric Nurse who is a Ghanaian and resides in either Ga South, Weija/Mallam, Ledzokuku, Ningo Prampram and Ga East.

What are the risks of taking part in the study?

You may feel sad or upset during the interview. If this happens, you will be referred to an experienced counsellor who will discuss your concerns with you and reassure you about the difficulty you face. However, you reserve the right to withdraw from the study anytime and it will not affect your treatment and relationship with the community mental health nurses. Secondly, due to the COVID-19 pandemic, you may be exposed to the virus. You are however assured of strict COVID-19 protocols to ensure your safety.

What are the benefits of participating in this study?

You may not benefit directly from this study, however, indirectly your participation will in this study provide information that will bring out recommendations that will support community psychiatric nurses work, individuals, opinion leaders, stake holders and community members in handling and developing resilience against suicide.

What rights do you have as a participant in this study?

Participation in this study is left to your discretion and is entirely voluntary. You have the right to withdraw from the study at any time without any consequences to you. You also have the right to prevent me from using the information recorded even after the interview. Your personal information and identity will remain anonymous in this study and will not be shared with

3

This is to Certify that this Study's Inform Consent Form Has Been Approved by GHS - ERC
Period: 21/09/22 to 15/09/23
Date: 15/09/22
Signature: [Signature]
Name: [Signature]
*GHC-ERC Administrator

6 feet during the interview. I will ask questions about your age, religion, marital, educational and employment status, to know a little about yourself. After that, I will ask questions about your experiences with suicide and resilience in the community. This interview will last for about an hour. In the course of the interview, you may ask me to pause for a while or to discontinue with the interview if you feel uncomfortable. If you have the urge to cough during our interaction, you are advised do so with your elbow covering your nose and mouth.

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You have to be an individual who have attempted suicide, family member of the attempter, stakeholder, community member and a Community Psychiatric Nurse who is a Ghanaian and resides in either Ga South, Weija/Mallam, Ledzokuku, Ningo Prampram and Ga East.

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You may feel sad or upset during the interview. If this happens, you will be referred to an experienced counsellor who will discuss your concerns with you and reassure you about the difficulty you face. However, you reserve the right to withdraw from the study anytime and it will not affect your treatment and relationship with the community mental health nurses. Secondly, due to the COVID-19 pandemic, you may be exposed to the virus. You are however assured of strict COVID-19 protocols to ensure your safety.

What are the benefits of participating in this study?

You may not benefit directly from this study, however, indirectly your participation will in this study provide information that will bring out recommendations that will support community psychiatric nurses work, individuals, opinion leaders, stake holders and community members in handling and developing resilience against suicide.

What rights do you have as a participant in this study?

Participation in this study is left to your discretion and is entirely voluntary. You have the right to withdraw from the study at any time without any consequences to you. You also have the right to prevent me from using the information recorded even after the interview. Your personal information and identity will remain anonymous in this study and will not be shared with

3

This is to Certify that this Study's Inform Consent Form Has Been Approved by GHS - ERC No. 11
Period 15/09/22 to 15/09/23
Date 15/09/22
Signature [Signature]
Name [Signature]
GHC-ERC Administrator

Study title: Community Psychiatric Nursing services and suicide resilience in selected communities in the greater Accra region of Ghana.

PARTICIPANTS' STATEMENT

I acknowledge that I have read or have had the purpose and contents of the Participants' Information Sheet read and satisfactorily explained to me in a language I understand (English, Twi, Ga, Ewe) etc. I have had the opportunity to ask questions; and any question I have asked has been answered to my satisfaction. I fully understand the contents and any potential implications as well as my right to change my mind (i.e. withdraw from the research) even after I have signed this form without in any way it affecting my further medical care.

I voluntarily agree to be part of this research.

Name or Initials of Participant.....

Participants' SignatureOR Thumb Print.....

I also agree for the interview to be audio recorded. YES [] NO []

Name or Initials of Participant..... ID Code

Participants' SignatureOR Thumb Print.....

Date:.....

INTERPRETERS' STATEMENT

I interpreted the purpose and contents of the Participants' Information Sheet to the afore named participant to the best of my ability in the (Twi, Ga, Ewe etc) language to his/her proper understanding.

All questions, appropriate clarifications sought by the participant and answers were also duly interpreted to his/her satisfaction.

Name of Interpreter.....

Signature of Interpreter..... Date:.....

Contact Details

STATEMENT OF WITNESS

I was present when the purpose and contents of the Participant Information Sheet was read and explained satisfactorily to the participant in the language he/she understood (Twi, Ga, Ewe).

I confirm that he/she was given the opportunity to ask questions/seek clarifications and same were duly answered to his/her satisfaction before voluntarily agreeing to be part of the research.

Name:.....

Signature..... OR Thumb Print

Date:.....

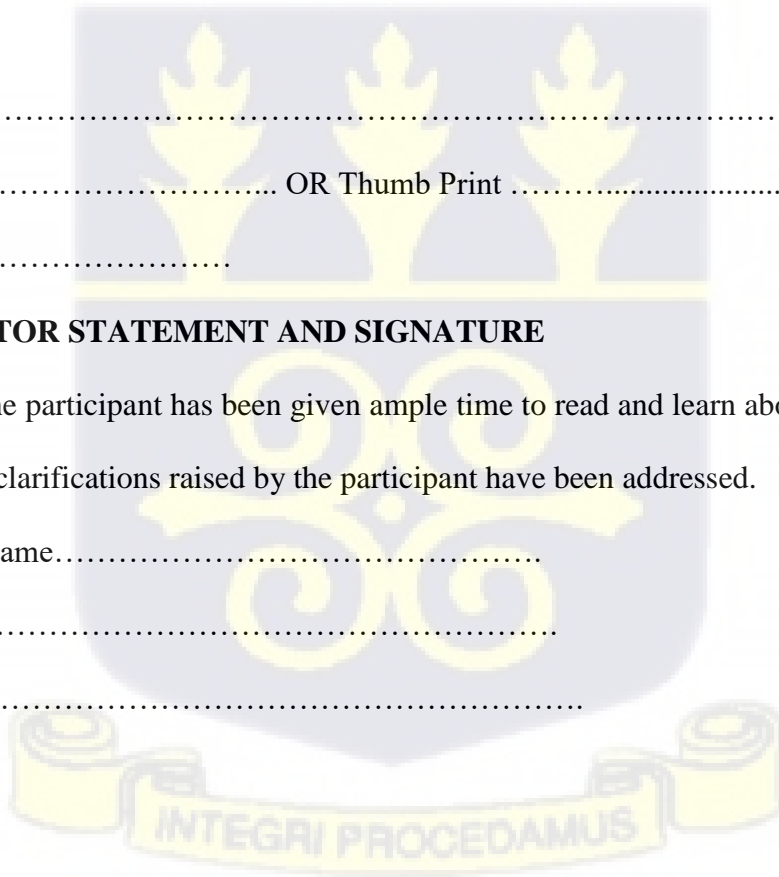
INVESTIGATOR STATEMENT AND SIGNATURE

I certify that the participant has been given ample time to read and learn about the study. All questions and clarifications raised by the participant have been addressed.

Researcher's name.....

Signature

Date.....



APPENDIX B: IN-DEPTH INTERVIEW GUIDE FOR INDIVIDUALS WHO HAVE ATTEMPTED SUICIDE IN RELATION TO PRECIPITATING FACTORS

Demographic

1. Age (years).....
1. Sex.....
2. Place of residence.....
3. Marital Status.....
4. No of children.....
5. Level of education.....
6. Religion.....
7. Occupation.....

Views on suicide

1. Please tell me how the suicide thoughts begun?
2. Did you discuss this thought with anyone? (probe; if yes who)
3. Has anyone discussed suicide with you before?
4. Have you wished you were dead or wished you could go to sleep and not wake up?
Have you actually had any thoughts about killing yourself?
5. Please tell me if you have discussed suicide with someone before?
6. What made you discuss leaving this world with the person?
7. Did the person support your idea of leaving this world or not?
8. What reasons did the person give to support/ not to support your answer to your question on suicide?
9. Looking back now do you think it was the best choice?

10. How did you progress to attempt the suicide after you had tried all avenues to help you out of the crises to no avail? Did you collect pills; obtain a gun; give away valuables; write a will or suicide note; hold a gun but changed your mind; cut yourself; try to hang yourself **(or what other means did you employ)?**
11. What happened to save you from completing the attempt?
12. Do you have any regrets?
13. Are you still exposed to the precipitating factors?
14. How are you coping in the light of these realities?
15. What do you think can be done by your immediate family to help you completely recover?
16. How have community psychiatry services and nurses helped you on the road to recovery?
17. Have you heard about someone attempting suicide in your community before
(Probe)
18. What are your future expectations for yourself?
19. What other thing would you like to tell me about the current situation of suicidal cases?

Thank you.

2. IN-DEPTH INTERVIEW GUIDE FOR SUICIDE ATTEMPTERS' FAMILIES IN RELATION TO THE GENERAL EFFECTS OF THE ATTEMPT ON THE FAMILY

Demographic

1. Age (years).....
2. Sex.....
3. Place of residence.....

4. Marital Status.....
5. Number of children
6. Level of education.....
7. Religion.....
8. Occupation.....

Views on suicide

1. How is the attempter related to you?
2. How long have you known the attempter?
3. How was the attempter's lifestyle like originally?
4. Did you notice any changes in the life of the attempter just before the attempt?
5. What was your response to the person when you noticed the change in behaviour?
6. How successful was your response?
7. On the actual day of the event what occurred?
8. How come the person failed to complete the suicide/succeed?
9. What did you do after you discovered the person had attempted?
10. What were the immediate effects on you as an individual?
11. What were the effects on the immediate and extended family?
12. What was the effect on the community in general?
13. How did people relate to you after finding out what occurred?
14. How did people's attitude affect you (positively/negatively)?
15. How did CPN services help you in the period of the crises
16. What suggestions do you have for the CPNs to help improve service delivery and community resilience to suicide?
17. What future expectations do you have for yourself and persons with suicidal ideation?

18. In your view what is the one key thing within the community that you think can work best to prevent suicides

Thank you.

3. FOCUS GROUP DISCUSSION FOR COMMUNITY MEMBERS THAT ALMOST LOST/LOST A MEMBER TO SUICIDE IN RELATION TO HOW THEY HANDLED SUCH CASES

Demographic

1. Age (years).....
2. Sex.....
3. Place of residence.....
4. Marital Status.....
5. Number of children.....
6. Level of education.....
7. Religion.....
8. Occupation.....

Views on suicide

1. How do you understand suicide?
2. How often do you hear about suicide cases in your community (from which medium)
3. How is suicide managed or addressed in your community?
4. In your view, what are the key things in the community that help in preventing suicide (probe....describe or explain how these things do help prevent suicide)
5. How do you perceive the psychiatric services in your community?

6. Describe how these services work to prevent or address suicidal issues
7. How will you assist CPNs at various community levels to prevent suicide?
8. Is there a clear guideline or policy in handling suicidal patients in your community?
9. What are your future expectations for yourself and persons with suicidal ideation
10. In your view what is the one key thing within the community that you think can work best to prevent suicides
11. Any recommendations?
12. How has suicide affected the community?
13. What other thing would you like to tell me about the current situation of suicidal cases in your community?

4. IN-DEPTH INTERVIEW GUIDE FOR FAMILIES OF SUICIDE VICTIMS ON THE COPING STRATEGIES USED

Demographic

1. Age (years).....
2. Sex.....
3. Place of residence.....
4. Marital Status.....
5. Number of children.....
6. Level of education.....
7. Religion.....
8. Occupation.....

Views on suicide

1. How was the victim related to you?
2. How long have you known the victim?
3. How was the victim's lifestyle like originally?
4. Did you notice any changes in the life of the victim just before the event?
5. What was your response to the person when you noticed the change in behaviour?
6. On the actual day of the event what occurred?
7. What did you do after you discovered the person had attempted/completed the suicide?
8. What were the immediate effects on you as an individual?
9. What were the effects on the immediate and extended family?
10. What was the effect on the community in general?
11. How did people relate to you after finding out what occurred?
12. How did the attitude of people affect you (positively/negatively)?
13. How have you been coping after the loss of your loved one?
14. How did CPN services help you in the period of the crises?
15. What suggestions do you have for the CPNs to help improve service delivery and community resilience to suicide?
16. What future expectations do you have for yourself and persons with suicidal ideation?
17. In your view what is the key thing within the community that can work best to prevent suicides?
18. Any recommendations?

19. What other thing would you like to tell me about the current situation of suicidal cases?

SEMI-STRUCTURED KEY INFORMANT INTERVIEW GUIDE FOR COMMUNITY PSYCHIATRIC NURSES

Demographic Data

1. Age (years).....
2. Sex.....
3. Place of residence.....
4. How do you get to work and how long does it take?
5. Marital Status.....
6. Level of education.....
7. Religion.....
8. Name of employer.....
9. How long have you been an RMN?
10. How long have you been a CPN?
11. Place of Work.....
12. How Long have you been working.....

Section B: Experience with suicidal behaviours

1. What is your experience working in the district hospital and community?
2. What are your experiences meeting with suicidal patients?
3. Please tell me how you related with a suicidal patient?
4. How was the experience like with the patient who has attempted suicide or taken his/her life?

5. Describe any other experiences with regard to that?

Section C: Experience With Managing Suicidal Behaviours

1. In what ways have your efforts in caring for persons who attempted suicide yielded results?
2. Please tell me about how you manage suicidal patients
3. What systems do CPNs employ for the detection of suicidal ideation and attempt in the communities?
4. What factors determine how resilient a community is?
5. How do you determine readiness towards handling various types of suicidal issues?
6. What ways can vital stakeholders assist in ensuring that research findings are implemented?
7. How will essential stakeholders assist you at various community levels in the integration of the outcomes of the study?
8. Is there a clear guideline or policy in handling suicidal patients? Yes, or No?
If yes, kindly give me the details.
9. What are your future expectations for yourself and persons with suicidal ideation?
10. What are your views on suicidal behaviours in the community and how they are managed?
11. Any recommendations?
12. What other thing would you like to tell me about the current situation in handling suicidal cases?

Thank you.



**SEMI-STRUCTURED IN-DEPTH INTERVIEW GUIDE FOR OPINION LEADERS
AND STAKEHOLDERS**

Demographic

1. Age (years).....
2. Sex.....
3. Place of residence.....
4. How do you get to work and how long does it take?
- 5 Marital Status.....
6. Level of education.....
7. Religion.....
8. Occupation.....

Views on suicide

14. How do you understand suicide?
15. How do you understand suicide behaviour?
16. How often do you hear about suicide cases in your community (from which medium)
17. How is suicide managed or addressed in your community?
18. In your view, what are the key things in the community that help in preventing suicide (probe.... describe or explain how these things do help prevent suicide)
19. How do you perceive the psychiatric services in your community?
20. Describe how these services work to prevent or address suicidal issues.
21. How will you assist CPNs at various community levels to prevent suicide?
22. Is there a clear guideline or policy in handling suicidal patients in your community?

23. What are your future expectations for yourself and persons with suicidal ideation?
24. In your view what is the one key thing within the community that you think can work best to prevent suicides
25. Have you wished you were dead or wished you could go to sleep and not wake up?
26. Have you actually had any thoughts about killing yourself?
27. Have you thought about how you might do this?
28. Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?
29. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?
30. Always ask question 6: In the past three months, have you done anything, started to do anything, or prepared to do anything to end your life?
31. Have you collected pills; obtained a gun; given away valuables; written a will or suicide note; held a gun but changed your mind; cut yourself; tried to hang yourself
am currently pursuing such opportunities to make this tool as well as awareness about suicide widely available with the ultimate goal of saving young lives.
32. Any recommendations?
33. What other thing would you like to tell me about the current situation of suicidal cases?

THEMES AND SUB THEMES

Themes	Sub themes
1. Precipitating factors to suicide	<ul style="list-style-type: none"> a. Childhood experiences b. Psychiatric issues c. Childhood experiences d. Mistrust e. Shame and disgrace f. Parental pressure g. Emotional breakdown h. Wasted resources i. Domestic violence j. Infidelity k. Difficult life pursuit (Financial challenges and academic demands)
2. effects of the attempt on the family	<ul style="list-style-type: none"> a. Anger b. Shock c. Concern and solidarity
3. How community members handle suicide cases.	<ul style="list-style-type: none"> a. Neutralizing the poison, Induce vomiting with the use of palm oil and crude oil, b. Stoppage of bleeding, c. Cutting down of noose, d. Skilled swimmers e. Calling of the police.

<p>4. Strategies used by CPNs in the management of individuals and families of completed suicide cases b</p>	<ul style="list-style-type: none"> a. Assessment b. Counselling and psychotherapy c. Medication d. Engage the person in the area of interest e. Separation from stressors f. Removal of harmful items g. Physical monitoring h. Referral
<p>5.coping strategies used by families of suicide victims</p>	<ul style="list-style-type: none"> a.Experience Sharing and Encouragement b. Relocation c. Social bonds d. Psyche Yourself e. Acknowledging That Tragedy May Come to Anyone f. Word of God g. Prayer h. Reliance upon God





UNIVERSITY OF GHANA
DEPARTMENT OF SOCIAL AND BEHAVIOURAL SCIENCES
SCHOOL OF PUBLIC HEALTH

Ref No.:

8th June, 2022

The Chairman
Ghana Health Service
Ethics Review Committee
P.O. Box MB 190
Accra-Ghana

Dear Sir/Madam,

REQUEST FOR ETHICAL REVIEW
MS. ABIGAIL ANSERE BUERTEY

I write as a primary academic supervisor to support the application for the ethical clearance of Ms. Abigail Ansere Buerthey, a PhD Student in the Department of Social and Behavioural Sciences, School of Public Health, University of Ghana, Legon.

Ms. Abigail Ansere Buerthey is undertaking a study on “**Community Psychiatric Services and Suicide Resilience in Selected Communities in the Greater Accra Region of Ghana**”.

I would be grateful if the committee reviews her proposal for possible approval to enable her undertake the study.

Thank you.

Yours faithfully,

Dr. Emmanuel Asampong
Primary Academic Supervisor

COLLEGE OF HEALTH SCIENCES
P.O. Box LG 13, Legon, Accra, Ghana.

• Telephone: +233 (0)30 396 6406, Ext 7590/1 • Email: sphdsobs@ug.edu.gh • Website: <https://www.ug.edu.gh/sbs/>



UNIVERSITY OF GHANA
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Ref No.:.....

8th June, 2022

The Chairman
Ghana Health Service
Ethics Review Committee
P.O. Box MB 190
Accra-Ghana

Dear Sir/Madam,

REQUEST FOR ETHICAL REVIEW
MS. ABIGAIL ANSERE BUERTEY

Ms. Abigail Ansere Buerthey is a PhD student in the Department of Social and Behavioural Sciences, School of Public Health, University of Ghana, Legon.

I write as the Head of Department to support her application for the ethical review of her proposal titled "**Community Psychiatric Services and Suicide Resilience in Selected Communities in the Greater Accra Region of Ghana**".

I would be grateful if the committee reviews the research proposal for possible approval to enable the student start her data collection.

Thank you.

Yours faithfully,

Professor Phyllis Dako-Gyeke
Head of Department

COLLEGE OF HEALTH SCIENCES
P.O. Box LG 13, Legon, Accra, Ghana.

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GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.



Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Digital Address: GA-050-3303
Mob: +233-50-3539896
Tel: +233-302-681109
Email: ethics.research@ghsmail.org
13th September, 2022

My Ref. GHS/RDD/ERC/Admin/App | 22 | 393
Your Ref. No.

Abigail Ansere Buerterey
University of Ghana
School of Public Health
P.O. Box LG 13
Legon - Accra
Ghana

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	GHS-ERC: 013/07/22
Study Title	Community Psychiatric Services and Suicide Resilience in Selected Communities in the Greater Accra Region of Ghana
Approval Date	13 th September, 2022
Expiry Date	12 th September, 2023
GHS-ERC Decision	Approved

This approval requires the following from the Principal Investigator

- Submission of a yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

You are kindly advised to adhere to the national guidelines or protocols on the prevention of COVID -19

Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....

Mr. Kofi Wellington
(GHS ERC Vice Chairperson)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra