Factors influencing professional help-seeking for suicidality: systematic review

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FOR SUICIDE

Abstract

Background

Evidence suggests that the majority of people with suicidality do not seek help. Little systematic evaluation of factors influencing professional help-seeking has been done.

Aims

To systematically evaluate the factors that influence professional help-seeking for suicidality.

Methods

Published quantitative and qualitative studies in Medline and PsycInfo databases were reviewed following PRISMA.

Results

Fifty-five relevant studies were identified. Fifteen studies examined professional help-seeking intentions for perceived suicidal ideation, among people with or without suicidality. Twenty-one studies examined professional help-seeking behaviour among people with suicidality, and 19 studies examined suicidal decedents' health services use. Several potential important barriers were identified including high self-reliance, lack of perceived need for treatment, stigmatising attitudes towards suicide, towards mental health issues, and towards seeking professional treatment. Presence of suicidality and mental health issues was found to generally decrease help-seeking intentions for perceived suicidal ideation while facilitating actual service use. Social support and informal support from family and friends also played an important role in professional help-seeking.

Conclusions

Further quantitative and qualitative studies examining the potential important factors in broader community samples, especially in developing countries, are needed.

Keywords: help-seeking, suicide, service utilization

Introduction

Suicide is a global public health issue that causes around 800,000 deaths every year (World Health Organization, 2014). Many suicides could be prevented if individuals with suicidal thoughts or behaviour sought help from appropriate health services that met their needs (Trueland, 2014). However, a significant proportion of individuals with suicidal thoughts or behaviour do not seek help (Bruffaerts et al., 2011; Luoma, Martin, & Pearson, 2002; Pitman & Osborn, 2011). Two published reviews examined the factors that influence help-seeking for suicidal behaviour and self-harm, but focusing exclusively on adolescents (aged from 11 to 19) and young adults (aged up to 26) (Michelmores & Hindley, 2012; Rowe et al., 2014). Several factors such as stigmatization, fear of confidentiality being breached, and high self-reliance have been highlighted as barriers to help-seeking. However, it is not clear if the factors identified among young people are applicable to all age groups. Exploring a wider age cohort is important as low rates of help-seeking for suicidal ideation and behaviours (suicidality) are not specific to young people, but are also evident in older adults (Lee, Lin, Liu, & Lin, 2008).

Previous reviews exploring help-seeking factors for suicidality have also examined the factors that influence both professional and non-professional help-seeking sources. The current review focuses specifically on professional help-seeking to refine the findings, as professionally trained health workers are more likely to provide evidence-based treatments and accurate information than family or friends, who may find it difficult to recognize potentially unhealthy thinking states that may lead to suicide (Owens, Lambert, Donovan, & Lloyd, 2005). In line with the World Health Organization, the current review defines professional help-seeking as use of professional supports such as health services, formal social institutions or professional care providers, either in the public or private sector (Gary, 2007). In consideration of the benefits and low rates of professional help-seeking for suicidality internationally, a

review to summarise the current findings may help inform researchers and health professionals of the knowledge gaps and barriers to professional help-seeking, and help develop high quality suicide prevention campaigns.

This review aims to explore the existing literature of factors that influence professional help-seeking along the progression of suicide, from suicidal ideation to suicidal behaviour and death by suicide. For this purpose, this review contains three distinct research foci: (1) professional help-seeking intentions for perceived suicidal ideation, among people with or without suicidality, (2) professional help-seeking behaviour among people with suicidality, and (3) suicidal decedents' health services use. To our knowledge, this is the first review to summarize the factors influencing professional help-seeking for suicidality across these multiple study designs.

Methods

Search strategy

Relevant studies in English were identified using Medline and PsycInfo, accessed through the Ovid interface. Databases were searched between January 1, 1995 and December 31, 2015. Search terms used were: suicid* AND ('seek*' OR 'service use' OR 'service util*' OR 'getting' OR 'care util*') AND ('help*' OR 'treat*' OR 'service*' OR 'care*') within abstract or title. References from identified studies were also reviewed for completeness.

Selection of studies

A total of 3183 research papers were identified through the search strategy. Of these, 1912 abstracts were screened, after removing non-human studies, duplicate abstracts, and non-English articles. The first author (JH) examined all titles and abstracts, and 109 articles were retained based on the following inclusion criteria: (1) published in a peer-reviewed journal; (2) not an editorial or a review; (3) examination of the factors that influence professional help-seeking intentions for suicidality, or examination of the factors that influence professional help-

seeking behaviour among individuals with suicidality or suicide decedents. Studies containing both professional and non-professional help-seeking sources such as family, friends, and intimate partners were included, but only the results from professional help-seeking sources were coded.

The full text of the 109 articles was obtained and double-coded by the first author and one of the co-authors independently (either PJB, ALC or RR). Disagreements between reviewers were resolved through discussion with a third coder. This process resulted in 54 additional research papers being excluded, and 55 total studies being included in the review. Figure 1 depicts the PRISMA flow diagram for inclusion.

Data extraction

All papers were coded using a pro-forma coding sheet to identify a range of study characteristics. Factors that influence professional help-seeking were coded based on a narrative synthesis instead of a meta-analysis due to the diverse nature of the study designs and outcomes included in this review. Factors were marked as adjusted if potential confounding variables were accounted for in statistical analysis. Otherwise, factors were marked as unadjusted. To evaluate the quality of the included studies, the assessments of quantitative studies (Glasziou, Irwig, Bain, & Colditz, 2001) and qualitative studies (Mills, Jadad, Ross, & Wilson, 2005) were used. Studies that used both quantitative and qualitative methods were coded with respect to the relevant assessments. The first author and one of the co-authors independently (either PJB, ALC or RR) coded all the studies. Any disagreement was resolved by discussion. The results are presented in Table 1. The majority of the included studies were of sound quality.

Results

Study characteristics

Fifty-five publications met the inclusion criteria for the review. Studies were classified based on three distinct research foci; specifically 15 (27%) studies examined professional help-seeking intentions for perceived suicidal ideation, among people with or without suicidality (Type I), 21 (38%) examined professional help-seeking behaviour among people with suicidality (Type II), and 19 (35%) studies examined suicidal decedents' health services use (Type III).

The sample size ranged from 107 to 1896 participants (Median = 302) in the Type I studies, from 15 to 5100 (Median = 543) in the Type II studies, and from 49 to 19426 (Median = 370) in the Type III studies. The proportion of females ranged from 0% to 78% (Median = 65%) in the Type I studies, from 0% to 87% (Median = 63%) in the Type II studies, and from 3% to 40% (Median = 25%) in the Type III studies. The characteristics of the included studies are presented in Table 1. Only the factors influencing professional help-seeking were coded and analysed. Table 2 illustrates the summary of the factors being reported five times or more across three types of studies.

Professional help-seeking intentions for perceived suicidal ideation, among people with or without suicidality

Fifteen studies examined professional help-seeking intentions for perceived suicidal ideation (Table 1). Thirteen (87%) were conducted in Australasia, one in Japan, and one in US. Twelve studies (80%) were among student population. All the studies used self-reported measurements. Eleven studies (73%) used the General Help-Seeking Questionnaire (GHSQ) (Wilson, Deane, Ciarrochi, & Rickwood, 2005) to measure help-seeking intentions. Another four studies used similar questions asking participants' willingness to seek help for perceived suicide ideation. It is noticeable that definition of professional help varies across studies, from

psychologist only, to mental health professionals, or to a broader range of professionals including family doctor, physician, phone helpline, religious/spiritual leader, and social workers.

Older age was associated with lower help-seeking intentions among elderly Japanese adults (Sakamoto, Tanaka, Neichi, & Ono, 2004), while younger Australians had lower help-seeking intentions (Calear, Batterham, & Christensen, 2014). In a study of 527 New Zealand prisoners with a wider age range from 16 to 72 years, older age was positively associated with greater intentions to seek psychological help in prison (Skogstad, Deane, & Spicer, 2006). Male was usually found to have lower help-seeking intentions than females (Calear et al., 2014; Ciarrochi & Deane, 2001).

Severity of mental health issues including depression (Calear et al., 2014; Wilson & Deane, 2010) and psychological stress (Wilson, Deane, Marshall, & Dalley, 2010) was negatively associated with professional help-seeking intentions, while the effect of anxiety symptoms was in the opposite direction – facilitate help-seeking intentions (Calear et al., 2014). Seven studies (47%) supported the existence of help-negation effect of suicidal ideation on help-seeking intentions (Calear et al., 2014; Carlton & Deane, 2000; Deane, Wilson, & Ciarrochi, 2001; Wilson & Deane, 2010; Wilson, Deane, & Ciarrochi, 2005; Wilson et al., 2010; Yakunina, Rogers, Wachler, & Werth, 2010).

Increased stigma toward suicidal people measured by the Stigma of Suicide Scale (SOSS) (Batterham, Calear, & Christensen, 2013) was significantly associated with lower help-seeking intentions towards mental health professionals among Australian adults in the community (Calear et al., 2014); however, the effect of stigma was not significant in a study of 321 US university students measured by a difference scale (the Stigma of Suicide Scale, SSS) (Yakunina et al., 2010), nor in a study of Australian university students (measured by SOSS) (Chan, Batterham, Christensen, & Galletly, 2014). In addition, stigma toward mental illness was addressed as an important barrier to help-seeking in a qualitative study among eight New

Zealand university students (Curtis, 2010).

Positive attitudes towards psychological help measured by the Attitudes Towards Seeking Professional Psychological Help Scale (Fischer & Farina, 1995) were found to facilitate help-seeking intentions (Carlton & Deane, 2000; Deane & Todd, 1996; Skogstad et al., 2006; Yakunina et al., 2010), while high self-stigma measured by the Self-Stigma of Seeking Help Scale (SSOSH) (Vogel, Wade, & Haake, 2006) and perceived stigma of seeking help measured by the Stigma Scale for Receiving Psychological Help (SSRPH) (Komiya, Good, & Sherrod, 2000) were significantly associated with low help-seeking intentions (Yakunina et al., 2010). Prior treatment was reported as a facilitator to help-seeking intentions (Carlton & Deane, 2000; Ciarrochi & Deane, 2001). Skogstad et al. (2006) suggested, however, that the characteristics of prior treatment influenced whether it had a positive, negative or null relationship with help-seeking.

Although willingness to seek help from non-professionals such as partner and family is associated with higher intentions to seek help from professionals (Wilson, Rickwood, Bushnell, Caputi, & Thomas, 2011), a quantitative study conducted by Yakunina et al. (2010) among US college students suggests that social support only facilitate help-seeking from non-professional sources, but not from professional sources.

Self-reliance was found to be another barrier of help-seeking intentions for suicidal thoughts among New Zealand university students (Curtis, 2010). A quantitative study among Australian university students found a significant but weak negative relationship between autonomy and formal help-seeking intentions (Wilson et al., 2011). Another potential barriers of help-seeking intentions include hopelessness (Ciarrochi & Deane, 2001), and difficulty in identifying and describing emotions (Ciarrochi, Wilson, Deane, & Rickwood, 2003; Ciarrochi & Deane, 2001).

Professional help-seeking behaviour among people with suicidality

Twenty-one studies examined professional help-seeking behaviour among people with

suicidality (Table 1). Sixteen (76%) were conducted in US or Canada, three (14%) in Australia, and two (10%) in Europe. Only eight studies (38%) clarified the purpose of service use was relevant to suicidality. Others did not give information whether people had disclosed their suicidality to professionals or not. Only one study (5%) used actual service use record, while the majority (95%) of the findings were based on self-reported service use.

Older age was generally associated with higher self-reported service use among people with suicidality (Ahmedani et al., 2012; De Leo, Cerin, Spathonis, & Burgis, 2005; Encrenaz et al., 2012). Females were more likely to talk about suicidal ideation to health professionals (Encrenaz et al., 2012) and use health services (Ahmedani et al., 2012; De Leo et al., 2005; Routhier, Leduc, Lesage, & Benigeri, 2012; Wong, Brownson, Rutkowski, Nguyen, & Becker, 2014) than males. Ethnic minority including Latino (Ahmedani et al., 2012; Downs & Eisenberg, 2012; Freedenthal, 2007; Meyer, Teylan, & Schwartz, 2015; Wu, Katic, Liu, Fan, & Fuller, 2010), Black (Ahmedani et al., 2012; Freedenthal, 2007; Meyer et al., 2015; Wu et al., 2010), and Asian (Ahmedani et al., 2012; Downs & Eisenberg, 2012; Wong et al., 2014) had less help-seeking behaviour compared to Caucasian.

Presence of mental health issues such as depression (Ahmedani et al., 2012; Arria et al., 2011; Encrenaz et al., 2012; Husky et al., 2012; Vasiliadis, Gagne, Jozwiak, & Preville, 2013; Wu et al., 2010), anxiety (Ahmedani et al., 2012; Arria et al., 2011; Encrenaz et al., 2012; Wu et al., 2010), and substance use (Encrenaz et al., 2012; Freedenthal, 2007; Routhier et al., 2012) were associated with greater help-seeking behaviour among people with suicidality. In addition, severe suicidal intent (De Leo et al., 2005; Wong et al., 2014), history of suicidal ideation (Husky et al., 2012; McKibben et al., 2014; Pagura, Fotti, Katz, Sareen, & Tea, 2009), suicidal plans (Encrenaz et al., 2012; Husky et al., 2012), and suicidal attempts (Ballard et al., 2014; De Leo et al., 2005; Encrenaz et al., 2012; Freedenthal, 2007; McKibben et al., 2014; Milner & De Leo, 2010; Pagura et al., 2009) also facilitated help-seeking behaviour.

Four qualitative studies highlighted the negative influence of stigma toward mental health

issues or suicide on help-seeking behaviour (Czyz, Horwitz, Eisenberg, Kramer, & King, 2013; De Leo et al., 2005; Freedenthal & Stiffman, 2007; Strike, Rhodes, Bergmans, & Links, 2006). In addition, stigmatising attitudes towards mental health services also impeded people's help-seeking behaviour (Czyz et al., 2013; De Leo et al., 2005; Downs & Eisenberg, 2012). Two quantitative studies reported prior treatment as a facilitator to help-seeking behaviour (Arria et al., 2011; Milner & De Leo, 2010), although other studies suggest specific setting of treatments such as hospital emergency department (Routhier et al., 2012), level of satisfaction with prior treatment (Czyz et al., 2013; Strike et al., 2006), and whether the relationship between clients and medical helpers is consistent (Osvath, Michel, & Fekete, 2003) could also influence the role of prior treatment on help-seeking.

Family and friends' influence on help-seeking behaviour was complicated. On one hand, disclosure of suicidal intentions to people surrounding (De Leo et al., 2005; Encrenaz et al., 2012; Wong et al., 2014) and being referred to professionals by family and friends (De Leo et al., 2005; Wong et al., 2014) are associated with higher likelihood of service use. On the other hand, findings also suggest that warm and trusting relationships may impede therapy or medication as it could decrease the subjective perception of distress (Downs & Eisenberg, 2012) and need for professional help (Czyz et al., 2013).

In addition, no perceived need for treatment was reported as the most frequently perceived reason for not seeking professional help among US students. There are 66% (Czyz et al., 2013), and 29% (Freedenthal & Stiffman, 2007) of the students citing this reason as the primary motivation for not seeking help. Furthermore, another US study suggested that perceived need for help significantly facilitated treatment use among students with serious previous suicidal thoughts (Downs & Eisenberg, 2012).

Self-reliance was reported to be a barrier for help-seeking behaviour in two US qualitative studies (Czyz et al., 2013; Freedenthal & Stiffman, 2007). Religion was also found to influence youth suicide attempters' mental health service use in a qualitative study of Canadians,

although it is still not clear whether it facilitates or impedes health service use (Bullock, Nadeau, & Renaud, 2012). Pragmatic barriers including lack of time, long waitlist, financial difficulties, lack of transportation or practicing GPs (Ahmedani et al., 2012; Czyz et al., 2013; Freedenthal, 2007; Osvath et al., 2003) were also identified.

Suicidal decedents' health services use

Nineteen studies examined professional help-seeking behaviour among people with suicidality (Table 1). Four studies (21%) were conducted in Canada, four (21%) in UK, two (11%) in US, two (11%) in Australia, two (11%) in Hong Kong, two (11%) in Taiwan, one (5%) in Sweden, one (5%) in Korea, and one (5%) in Singapore. Six studies (31%) were based on surveys or interviews among decedents' family, friends, carers or community members. All the studies did not clarify whether decedents had disclosed their suicidal intentions to professionals during service use.

Females were generally reported to have greater service use than males (Chang et al., 2012; Cho et al., 2013; Hamdi, Price, Qassem, Amin, & Jones, 2008; Law, Wong, & Yip, 2010; Lee et al., 2008; O'Neill, Corry, Murphy, Brady, & Bunting, 2014; Rhodes et al., 2013; Vasiliadis, Ngamini-Ngui, & Lesage, 2015; Vassilas & Morgan, 1997). Being single (Basham et al., 2011), employed (Hamdi et al., 2008; Law et al., 2010; Loh, Tai, Ng, Chia, & Chia, 2012), having low income (Law et al., 2010), problem gambling (Seguin et al., 2010), and being in rural area (Vasiliadis et al., 2015) were associated with less service use before suicide.

Previous diagnosis of mental disorders (Hamdi et al., 2008; Law et al., 2010; Law, Wong, & Yip, 2015; Vasiliadis et al., 2015), anxiety (De Leo, Draper, Snowden, & Kolves, 2013), mood disorders (De Leo et al., 2013), or problematic alcohol use (Sveticic, Milner, & De Leo, 2012) was significantly related to increased contact with health services among suicidal decedents. Family history of suicide facilitated mental health service use among young suicide decedents in Singapore (Loh et al., 2012). Low level of suicide intent (Law et al., 2010), and history of suicidal attempts (Hamdi et al., 2008; Kisely, Campbell, Cartwright, Bowes, &

Jackson, 2011; Loh et al., 2012; Sveticic et al., 2012) also increased help-seeking behaviour among suicidal decedents. Previous contact with a primary care services and GP was found to facilitate mental health service use among suicidal decedents in a UK study (Hamdi et al., 2008).

In addition, shame and stigma surrounding mental health issues (Moskos, Olson, Halbern, & Gray, 2007; Tornblom, Werbart, & Rydelius, 2015) were described as barriers to seek professional help by the informants in qualitative studies.

In another qualitative study, 36% of suicidal decedents had been persuaded to seek medical help by a close friend or relative (Owens et al., 2005), suggesting that members of the family and immediate social network may play a key role in determining whether or not suicidal individuals would seek help from a medical practitioner. Furthermore, suicidal decedents who did not seek help were depicted as self-reliant and resourceful characters who expected to be able to solve their own problems by informants (Owens et al., 2005).

Discussion

To our knowledge, this is the first systematic review delineating the factors that influence professional help-seeking for suicidality across three stages: population's help-intentions for perceived suicidal ideation, people with suicidality's help-seeking behaviour, and suicidal decedents' service use. Several potentially important barriers were identified. To sum up, To sum up, low perceived need for treatment, high self-reliance, and stigmatising attitudes towards suicide and mental health issues were identified as barriers to professional help-seeking, although much of the evidence were from the studies using qualitative design. Presence of suicidality and other mental health issues such as depression and psychological stress generally reduced help-seeking intentions for perceived suicidal ideation, while facilitating help-seeking behaviour among people with suicidality or suicidal decedents. The influence of social support on professional help-seeking was complicated. People with good social support seemed to favour informal sources, which might reduce professional help-seeking. However, there was also evidence that referrals to professionals by family or friends facilitated service use among individuals with suicidal thoughts and behaviour. Other factors such as treatment history, exposure to suicide, and knowledge of suicide were found to influence help-seeking intentions and behaviour, however, evidence was scant or diverse to draw robust conclusions. The findings on demographic factors were somewhat inconsistent, suggesting local factors such as culture, ethnicity, and religion may need to be taken into consideration.

Suicidality and mental health issues

Suicidality and a number of mental health related factors were significantly associated with professional help-seeking. Higher levels of suicidal ideation, depression and psychological stress were associated with lower help-seeking intentions for perceived suicidal ideation, while history of suicidality and mental health issues tended to facilitate help-seeking behaviour among people with suicidality and suicidal decedents. The underlying basis has not

been identified. One possible explanation is people with history of suicidality and mental health issues may have to receive physical or mental health treatments in medical settings regardless of whether they were willing to seek care or not.

Attitudes and knowledge of suicide and mental health issues

Stigmatising attitude and limited knowledge of suicide and mental health issues were identified as barriers to seek professional help, although much of the research was qualitative in nature. This may reflect the limited number of validated scales that are available to measure suicide attitudes and knowledge (Batterham et al., 2013). Further investigation of these relationships in quantitative studies is warranted, and in particular there is a need for research to distinguish between attitudes and knowledge, and to differentiate between self-stigma, and personal and perceived stigma.

Attitudes towards professional treatments, perceived need for treatment, and treatment history

Attitudes towards health professional treatments were associated with both help-seeking intentions and behaviour across three subgroups of studies. Positive attitudes towards professionals facilitated professional help-seeking. Meanwhile, lack of perceived need for treatment was the most frequently self-reported barrier to professional help-seeking among people with suicidality. However, the relationship between treatment history and help-seeking was not consistent in all studies. The quality and satisfaction level of previous treatment may therefore need to be taken into consideration when studying the effects of previous treatment on help-seeking. All of these results suggest the important role of professional treatment during help-seeking process.

Self-reliance and social support

Self-reliance was a frequently reported barrier for both help-seeking intentions for perceived suicidal ideation and actual help-seeking behaviour for suicidality. Extreme views on the value of self-reliance may contribute to self-stigma, whereby people's negative attitudes

about help-seeking combined with self-reliance prevent them from disclosing their symptoms or engaging in professional treatment even in the face of dangerous mental health symptoms (Labouliere, Kleinman, & Gould, 2015). However, only one quantitative study suggested a significant but weak negative effect of self-reliance on predicting intentions to seek help from a mental health service among a student sample (Wilson et al., 2011). All other studies reporting on self-reliance are qualitative.

The influence of social support on professional help-seeking was complicated. Seeking support from informal sources and having better social support facilitated professional help-seeking for suicidality, while people with good social support could rely on their social network instead of professional services (Downs & Eisenberg, 2012). It is also of note that encouragement from others was suggested to be an important motivation for seeking professional help. Eighty percent of people with suicidality used health service because others thought it was important for them to (De Leo et al., 2005), while 36% of suicidal decedents had been persuaded to seek medical help by a close friend or relative (Owens et al., 2005).

Limitations

There are some potential limitations of this review. First, different types of research, such as quantitative and qualitative studies, were included in the current review in order to report a greater coverage of findings. Although the majority of the included studies were of sound quality, the variability of the findings may relate to the inclusion of a variety of research designs in the review. Second, only results from published English studies were coded in this review, which may limit the generalizability of the findings. Third, many studies included in this review were based on students or selected samples such as prisoners and soldiers. Further investigation in broader community samples, particularly on perceived help-seeking intentions for suicidal ideation, may allow for greater generalisation of the findings. Four, as noted throughout, some of the factors identified in the review were tested in relatively few studies, and most of the included studies were conducted in industrialized countries. As culture may

have a considerable influence on help-seeking, further studies among developing countries and comparative studies are needed.

Implications

This review highlighted several potential important barriers across all types of studies. They include high self-reliance, lack of perceived need for treatment, stigmatising attitudes towards suicide, towards mental health problems, and towards seeking professional treatment, which warrant additional high-quality studies using quantitative and qualitative methods, especially in developing countries. The positive influence of suicidality and mental health issues on help-seeking behaviour but not on intentions suggests people with suicidal thoughts or behaviour may be passively engaged with health services, where stigmatising attitudes and unpleasant previous treatment experience could discourage subsequent help-seeking behaviour. Efforts to make mental health services more approachable, less coercive, and less stigmatising are strongly encouraged. In addition, this finding also suggests that enabling factors might be lacking among those without history of suicidality or mental health issues. Future suicide prevention initiatives may need to target a broader community, connecting with individuals who have never used mental health services. The complicated influence of social support on professional help-seeking also requests further investigation, especially the gatekeeper effects of family and friends. It is also noticeable that most of the studies among people with suicidality and suicidal decedents failed to examine whether participants had disclosed their suicidality to professionals or not. Future studies are therefore recommended to better delineate the purposes of help-seeking.

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Competing interests

The authors declare no competing interests.

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Figure1

Figure 1. PRISMA flow diagram

Table 1. Factors influencing professional help seeking for suicidality

Author (published year) country	Participants and settings	Sample size	Age	% female	Study design	Help-seeking outcomes	Help-seeking sources	Reasons to seek professional help	Barriers to seek professional help	Quality critique
Professional help-seeking intentions for perceived suicidal ideation among people with or without suicidality										
Calear et al. (2014) Australia	Community members	534	18+	57.8%	Cross-sectional quantitative study	Professional help-seeking intentions (GHSQ)	Psychiatrist/psychologist, GP	Perceived suicidal thoughts	Younger age, male, low anxiety, high depression, severe suicidal ideation, high stigma (all sig, A)	4/5
Chan et al. (2014) Australia	University students	194	19 - 42 M=25	53.8%	Cross-sectional quantitative study	Professional help-seeking intentions (GHSQ)	Formal help including GP, PHL, and MHP	Perceived suicidal thoughts	Null	4/5
Wilson et al. (2011) Australia	University students	641	18 - 25 M=19.4 SD= 1.8	74.4%	Cross-sectional quantitative study	Professional help-seeking intentions vignette (GHSQ-V)	Mental health services including MHP, GP, and PHL	Perceived suicidal thoughts	Less willing to seek help from family, need for autonomy (all sig, A)	4/5
Curtis et al.(2010) New Zealand	University students	1896	15 - 25	64.8%	Quantitative and qualitative mixed study	Question regarding help-seeking intentions	MHP	Perceived suicidal thoughts	Stigma, perceived need for self-reliance (Q)	3/5 3/8 (Q)
Wilson et al. (2010) Australia	University students	302	M=19.8 SD=1.6	77.5%	Cross-sectional quantitative study	Professional help-seeking intentions (GHSQ)	Professional care including MHP, GP, and PHL.	Perceived suicidal thoughts	Severe suicidal ideation (sig, A), high depression, hopelessness (sig, UA)	4/5
Wilson et al. (2010) Australia	High school students	590	13 - 18 M=15.6 SD=0.7	56.7%	Cross-sectional quantitative study	Professional help-seeking intentions (GHSQ)	GP	Perceived suicidal thoughts	Severe suicidal ideation, high psychological distress, low desire for help, high perceived barrier to engage in treatment (all sig, A)	4/5
Yakunina et al. (2010) US	University students	321	18 - 56 M=20.0 SD=5.3	66.6%	Cross-sectional quantitative study	Professional help-seeking intentions (GHSQ)	Professional sources including physician, psychiatrist, psychologist, college counselling centre, counsellor, social worker,	Perceived suicidal thoughts	Severe suicidal ideation, high self and social stigma towards seeking help, negative attitudes towards seeking professional psychological help (all sig, A)	4/5

Author (published year) country	Participants and settings	Sample size	Age	% female	Study design	Help-seeking outcomes	Help-seeking sources	Reasons to seek professional help	Barriers to seek professional help	Quality critique
Skogstad et al. (2006) New Zealand	Prisoners	527	16 - 72 M= 30.4	0.0%	Cross-sectional quantitative study	Professional help-seeking intentions (TPB)	Psychologist	Perceived suicidal thoughts and feelings	Younger age, subjective norm (social pressure), negative attitudes towards seeking help, low perceived behavioural control, contact with a psychologist in prison (all sig, A) Severe suicidal ideation (sig, A)	4/5
Wilson et al. (2005) Australia	High school students	269	12 - 18 M=15.9 SD=1.3	64.0%	Cross-sectional quantitative study	Professional help-seeking intentions (GHSQ)	MHP	Perceived suicidal thoughts		4/5
Sakamoto et al.(2004) Japan	Community members	230	65+ M=73.5 SD=6.4	64.3%	Cross-sectional quantitative study	Help seeking intentions (case vignette)	GP and public nurses	Case vignette describing suicidal ideation	Older age, not participation in mental health workshop (all sig, A)	4/5
Ciarrochi et al. (2003) Australia	High school students	217	M=14.4 SD=1.2	67.3%	Cross-sectional quantitative study	Professional help-seeking intentions (GHSQ)	GP, MHP including school counsellor, counsellor, psychologist, and psychiatrist	Perceived suicidal thoughts	Poorly skilled at identifying and describing emotions (sig, A)	2/5
Ciarrochi et al. (2001) Australia	University students	300	M=20.6 SD=5.0	77.0%	Cross-sectional quantitative study	Professional help-seeking intentions (GHSQ)	Professional help seeking including health professional, GP, and PHL	Perceived suicidal thoughts	Male, poorly skilled at managing self-relevant emotions, no past help seeking experience, and high hopelessness (all sig, A) Severe suicidal ideation (sig, UA)	3/5
Deane et al. (2001) Australia	University students	302	M=20.6 SD=5.0	76.8%	Cross-sectional quantitative study	Professional help-seeking intentions (GHSQ)	MHP, GP	Perceived suicidal thoughts		3/5
Carlton et al.(2000) New Zealand	High school students	150	14 - 18 M=15.6 SD=1.2	51.0%	Cross-sectional quantitative study	Professional help-seeking intentions (GHSQ)	Psychologist, counsellor	Perceived suicidal thoughts	Severe suicidal ideation, no prior help, negative attitudes towards seeking professional	4/5

Author (published year) country	Participants and settings	Sample size	Age	% female	Study design	Help-seeking outcomes	Help-seeking sources	Reasons to seek professional help	Barriers to seek professional help	Quality critique
Deane et al. (1996) New Zealand	University students	107	19 - 72 M=40.0 SD=11.4	65.0%	Cross-sectional quantitative study	Question regarding help-seeking intentions	Professional psychological help	Perceived suicidal thoughts	Negative attitudes towards seeking professional psychological help (sig, UA)	3/5
Professional help-seeking behaviour among people with suicidality										
Meyer et al. (2015) US	LGB community	388	18 - 58 M=32.6 SD=9.3	NG	Cross-sectional quantitative study	Self-reported service use	Mental health and other medical professionals	Mental health problems	Ethnic minority (sig, UA)	3/5
Ballard et al. (2014) US	Community members	1422	27 - 31	58.0%	Cross-sectional quantitative study	Self-reported service use	Primary care, hospitalization, emergency department	Medical care	No presence of suicidal attempts (sig, A)	4/5
McKibben et al. (2014) US	Army soldiers	5100	NG	13.0%	Cross-sectional quantitative study	Self-reported service use	Psychologist, psychiatrist, clinical social worker, or other mental health counsellor	Mental health issues or substance use	No presence of suicidal ideation or attempts (sig, A)	3/5
Wong et al. (2014) US	University students	1045	M=23.8	65.0%	Cross-sectional quantitative study	Self-reported service use	Psychologist, social worker, counsellor	Suicide ideation	Male, low suicidal intent, no communicated intent, no referrals to professionals, ethnic minority (all sig, A)	4/5
Czyz et al. (2013) US	University students	157	M=20.0, SD=3.1	67.5%	Longitudinal cohort study	Self-reported service use	Mental health services (therapy or medication)	Suicidal ideation, suicidal attempt, depression, or alcohol abuse	No perceived need for treatment, have no time, self-management, support from family and friends, pragmatic barriers such as financial concerns and waiting period, high stigma, negative previous experience, mistrust of professionals (Q)	6/8(Q)

Author (published year) country	Participants and settings	Sample size	Age	% female	Study design	Help-seeking outcomes	Help-seeking sources	Reasons to seek professional help	Barriers to seek professional help	Quality critique
Vasiliadis et al. (2013) Canada	Community members	211	65+	75.0%	Longitudinal cohort study	Self-reported service use	Health services	Mental health problems	No presence of depression (sig, UA)	5/5
Ahmedani et al. (2012) US	Community members	3179	18+	43.1% (Suicidal ideation) 30.4% (Suicidal attempts)	Cross-sectional quantitative study	Self-reported service use	Specialty psychiatric treatment	Mental health problems, alcohol and drug use	Younger age, male, no presence of depression, no presence of drug or tobacco use, no presence of psychological stress, ethnic minority, no health insurance, in a good health condition (all sig, A)	5/5
Bullock et al. (2012) Canada	Outpatients	15	14 - 18 M=15.2 SD=1.4	87.0%	Qualitative psychological autopsy study	Self-reported service use	Mental health services	Suicidal attempts	Religion matters, need to be further identified (Q)	4/8(Q)
Downs et al.(2012) US	University students	543	18+	58.5%	Cross-sectional quantitative study	Self-reported service use	Counselling/therapy, prescription medication use	Mental health problems	Higher personal or low perceived stigma toward mental health service use, more social support, ethnic minority, no contact with service users, low perceived need for help, low belief in effectiveness of treatment (all sig, A)	4/5
Encrenaz et al. (2012) France	Community members	4019	18 - 100	64.4%	Cross-sectional quantitative study	Self-reported service use	Health professional	Suicidal ideation	Younger age, male, no history of suicidal plans, no history of suicidal attempts, not talking to friend/relative, no presence of panic disorder, no presence of major depressive episode, of generalised anxiety, or of other substance use disorder (all sig, A)	4/5

Author (published year) country	Participants and settings	Sample size	Age	% female	Study design	Help-seeking outcomes	Help-seeking sources	Reasons to seek professional help	Barriers to seek professional help	Quality critique
Husky et al. (2012) US	Community members	558	13 - 18	51.0%	Cross-sectional quantitative study	Self-reported service use	Outpatient, inpatient, and specialized mental health care	Mental health problems	No presence of depression, no presence of eating disorder, no presence of suicidal ideation, no presence of suicidal plans (all sig, A)	5/5
Routhier et al.(2012) Canada	Inpatients and outpatients	525	M=42.9 SD=17.3	54.0%	Retrospective study on administrative data and patient records	Actual service use	GP, emergency, local community health centre, outpatient and inpatient care	Mental health problems	Male, no presence of substance use, hospital emergency department contact, no health contact in three months post attempt (all sig, A)	4/4
Arria et al. (2011) US	University students	158	21 - 24	64.6%	Cross-sectional quantitative study	Self-reported service use	Counsellors, campus- or community-based health or counselling centres, hospitals or other facilities, law enforcement officials, support groups, rehabilitation clinics, or PHL	Mental health problems	Older age at first episode of psychological distress, less life episodes of psychological distress (depression and anxiety), no previous treatment (all sig, UA)	5/5
Milner et al.(2010) Australia	Community members	399	18 - 83	62.7%	Cross-sectional quantitative study	Self-reported service use	GP, hospital, mental health professional, PHL	Suicidal attempts	No presence of mental illness, no communicated intent for suicide, no lifetime suicidal attempts, no historical mental treatment, not using drugs as a suicidal method (all sig, A)	3/5

Author (published year) country	Participants and settings	Sample size	Age	% female	Study design	Help-seeking outcomes	Help-seeking sources	Reasons to seek professional help	Barriers to seek professional help	Quality critique
Wu et al.(2010) Australia	Community members	877	12 - 17	70.0%	Cross-sectional quantitative study	Self-reported service use	Inpatient and outpatient, school based service	Mental health problems	No presence of depression, no presence of disruptive behaviour problems (all sig, UA) low family income, good perceived health, ethnic minority, no presence of anxiety, no participation in extracurricular activities (all sig, A)	4/5
Pagura et al.(2009) Canada	Community members	1464	15+	NG	Cross-sectional quantitative study	Self-reported service use	Psychiatrist, physician, psychologist, nurse, social worker, religious advisor	Emotions, mental health problems, use of alcohol or drugs.	No presence of suicidal ideation, no presence of suicidal attempts, limited knowledge of how or where to get help, problems with things like transportation, children, or scheduling (all sig, A)	4/5
Freedenthal et al. (2007) US	Community members	101	15 - 21, M=17.7 SD=1.6	72.3%	Qualitative interview	Self-reported service use	Medical or mental health professionals including an emergency room doctor, psychiatrist, social worker, psychiatric hospital, or other psychiatric person or place	Suicidal ideation and attempts	No perceived need for help, high stigma and embarrassment, having other support, high self-reliance, feeling hopeless or alone, fear of consequences, high cost, no service available (Q)	6/8(Q)

Author (published year) country	Participants and settings	Sample size	Age	% female	Study design	Help-seeking outcomes	Help-seeking sources	Reasons to seek professional help	Barriers to seek professional help	Quality critique
Freedenthal et al. (2007) US	Community members	2226	12 - 17 M=14.7 SD=1.6	64.3%	Cross-sectional quantitative study	Self-reported service use	Mental health professionals including inpatient hospital, residential treatment, partial hospital, mental health clinic, private therapist, psychologist, social worker or counsellor	Problems related to behaviour, emotions, or use of alcohol or illicit drug use	Ethnic minority, being in rural and small city, no insurance, no presence of substance use, no presence of psychiatric symptoms, no presence of conduct disorders, no presence of suicidal attempts (all sig. A)	3/5
Strike et al. (2006) Canada	Outpatients	15	20+	0.0%	Qualitative interview	Self-reported service use	Mental health services including emergency department, crisis team, assessment, GP, psychiatrist, alcohol and drug treatment centres, and social workers	Mental health and substance use problems	Negative prior experiences of mental treatment, high stigma, low literacy (Q)	6/8(Q)
De Leo et al.(2005) Australia	Community members	1311	18+	53.0%	Quantitative and qualitative mixed study	Self-reported service use	GP, counsellor, PHL, psychiatrist, hospital	Suicidal plans, suicidal attempts	Male, younger age, no presence of psychiatric symptoms, no recurrent suicidal ideation, no communicated suicidal intent, no presence of suicidal attempts, no presence of violent attempt method (all sig. A) no referrals to professionals, low perceived need for treatment, high stigma, do not want to trouble others, low literacy, cost (Q)	3/5 2/7(Q)
Osvath et al. (2003)	Outpatients and	167	M=36.5	59.9%	Qualitative	Self-reported	GP and other	Physical and	Low number of	1/8(Q)

Author (published year) country	Participants and settings	Sample size	Age	% female	Study design	Help-seeking outcomes	Help-seeking sources	Reasons to seek professional help	Barriers to seek professional help	Quality critique
Hungary, Switzerland	inpatients				interview	service use	healthcare professionals	psychological symptoms, suicidal ideation	practicing GPs , inconsistent relationship with a medical helper or system (Q)	
Suicidal decedents' health services use										
Law et al. (2015) Hong Kong	Decedents' carers/family/friends	115	M=38.4 SD=11.4	33.0%	Retrospective psychological autopsy study	Self-reported service use	Physical health, psychosocial, and psychiatric services	Health problems, mental health problems	No presence of psychiatric diagnosis (sig, UA)	4/4
Törnblom et al. (2015) Sweden	Decedents' carers/family/friends	52	14 - 25	36.5%	Qualitative study, Case control	Help-seeking decision	Psychiatric contact	Not specified	Shamefulness, powerlessness (Q)	6/8(Q)
Vasiliadis et al. (2015) Canada	Decedents	8851	11+	21.4%	Retrospective study on patient records	Actual service use	Health services including outpatient, emergency visit, hospitalisation	Not specified	Younger age, male, being in rural area, no presence of psychiatric disorders and general medical condition (sig, UA)	4/4
O'Neil et al. (2014) UK	Decedents	1667	10 - 70+	23.0%	Retrospective study on administrative data	Actual service use	GP, outpatient mental health treatments, psychiatric inpatient care	Not specified	Male (sig, UA)	4/4
De Leo et al. (2013) Australia	Decedents' carers/family/friends	261	35+	NG	Psychological autopsy case-control study on administrative data	Self-reported service use	GP, psychiatrist	Not specified	No presence of mood disorder or anxiety disorder (sig, UA)	4/4
Cho et al. (2013) Korea	Decedents	11523	10+	31.4%	Retrospective study on administrative data	Actual service use	Hospital care or admission	Psychiatric disorders, musculoskeletal, cardiovascular, respiratory, or gastrointestinal disease, injury	Younger age, male (sig, A)	4/4
Rhodes et al. (2013) Canada	Decedents	724	10 - 25	26.5%	Retrospective study on patient	Actual service use	Outpatient, emergency	Mental health and other problems	Male (sig, UA)	4/4

Author (published year) country	Participants and settings	Sample size	Age	% female	Study design	Help-seeking outcomes	Help-seeking sources	Reasons to seek professional help	Barriers to seek professional help	Quality critique
Chang et al. (2012) Taiwan	Decedents	862	12 - 24	35.5%	record and administrative data Retrospective study on administrative data	Actual service use	Psychiatric inpatient and outpatient facilities, GP, non-psychiatric hospital specialists	Mental health problems	Male (sig, UA)	5/5
Loh et al. (2012) Singapore	Decedents	188	10 - 24	NG	Retrospective study on administrative data	Actual service use	psychiatrist, primary care physician	Mental health problems	Being employed, no family history of suicide (all sig, UA) no previous suicidal attempts, no presence of psychological stressors (sig, A)	3/4
Sveticic et al. (2012) Australia	Decedents	7126	NG	20.9%	Retrospective study on administrative data	Actual service use	GP, outpatient, inpatient, other source of help	Mental health problems	No communicated suicidal intent, no history of suicidal attempts, no problematic use of alcohol (sig, A)	3/4
Basham et al. (2011) US	Decedents in veteran	968	18+	2.9%	Retrospective study on administrative data	Actual service use	Ambulatory care visit (including phone), inpatient stay, veteran care (any health care)	Not specified	Single or divorced, not enrolled at veteran (sig, UA)	4/4
Kisely et al. (2011) Canada	Decedents	101	M=44.7 SD=13.3	16.8%	Retrospective study on administrative data and patient records	Actual service use	Health professionals	Mental or physical health problems	No history of suicidal attempts (sig, UA)	4/4
Law et al. (2010) Hong Kong	Decedents' carers/family/friends	119	M=39.8 SD=11.0	39.5%	Retrospective psychological autopsy study	Self-reported service use	Psychiatrist	Not specified	Older age, male, being full/partially/self-employed at the time of death, low income, no presence of psychotic disorders, severe suicide	4/4

Author (published year) country	Participants and settings	Sample size	Age	% female	Study design	Help-seeking outcomes	Help-seeking sources	Reasons to seek professional help	Barriers to seek professional help	Quality critique
Seguin et al. (2010) Canada	Decedents	122	M=44.2	5.6%	Retrospective study on patient records	Actual service use	GPs, nurses, social workers, youth centre, school professionals, police, psychiatrists, psychologists, hospital emergency departments, PHL, clergy	Not specified	intent, unmanageable debts, having a higher level of social problem-solving ability (sig, UA) Problem gambling (sig, UA)	4/5
Hamdi et al. (2008) UK	Decedents	479	15 - 93	25.0%	Retrospective study on patient record, administrative data	Actual service use	Primary health care service and mental health service	Not specified	Male, being employed, not living alone, no contact with primary care services (all sig, UA) no presence of mental disorders, no presence of suicidal attempts, no communication of suicidal intent (all sig, A)	3/4
Lee et al. (2008) Taiwan	Decedents	19426	15+ M=49.5 SD=18.1	32.3%	Retrospective study on administrative data	Actual service use	Mental health and non-mental health professionals	Mental health problems	Older age, male (all sig, A)	4/4
Moskos et al. (2007) US	Decedents' carers/family/friends	49	13 - 21	16.30%	Qualitative study on psychological autopsy data	Barriers to mental health treatment	Any	Mental health problems	Bad experience with mental health providers, reluctant to admit having mental health problems (Q)	3/8(Q)
Owens et al. (2005) UK	Decedents' carers/family/friends	66	18+	31.80%	Qualitative study on psychological	Help-seeking decision	GP	Not specified	High help resistance, low awareness of the severity by surrounding	6/8(Q)

Author (published year) country	Participants and settings	Sample size	Age	% female	Study design	Help-seeking outcomes	Help-seeking sources	Reasons to seek professional help	Barriers to seek professional help	Quality critique
					autopsy data				people (Q)	
Vassilas et al. (1997) UK	Decedents	144	17 - 85 M=43.0 SD=18.0	22.90%	Retrospective study on patient records and administrative data	Actual service use	potential helping agencies (health and social services and ACAD)	Not specified	Younger age, male (all sig, UA)	2/4

Quality critique: the summary score of the quality assessment reported over the total number of applicable criteria;

Suicidality: a term concludes suicidal ideation, suicidal plans and suicidal attempts;

M, mean; SD, standard deviation;

Sig, significant; A, adjusted for confounding variables; UA, not adjusted for confounding variables; Q, qualitative study; NG, not given;

F/F, family/friend; GP, general practitioner; MHP, mental health professionals; PHL, phone help line.

Table 2. Summary of the factors influencing professional help seeking

Research Focus	Type I n=15 n (%)			Type II n=21 n (%)			Type III n=19 n (%)		
	Significant in quantitative studies	Not significant in quantitative studies	Qualitative studies	Significant in quantitative studies	Not significant in quantitative studies	Qualitative studies	Significant in quantitative studies	Not significant in quantitative studies	Qualitative studies
Age	3 (20%)	1 (7%)		4 (19%)	4 (19%)		5 (26%)	7 (37%)	
Sex	2 (13%)	7 (47%)		5 (24%)	5 (24%)		9 (47%)	4 (21%)	
Relationship status		2 (13%)		1 (5%)	2 (10%)		1 (5%)	4 (21%)	
Education		2 (13%)			3 (14%)			2 (11%)	
Employment		1 (7%)			2 (10%)		3 (16%)	1 (5%)	
Income				1 (5%)	2 (10%)		1 (5%)	1 (5%)	
Locality		1 (7%)		1 (5%)	2 (10%)		1 (5%)	1 (5%)	
Ethnic minority		2 (13%)		6 (29%)	4 (19%)				
Depression	2 (13%)	1 (7%)		6 (29%)	1 (5%)		1 (5%)		
Anxiety	1 (7%)	1 (7%)		3 (14%)			1 (5%)		
Substance use				4 (19%)	3 (14%)		1 (5%)		
Suicidal ideation	7 (47%)	1 (7%)		5 (24%)	1 (5%)		1 (5%)		
Suicidal attempts		1 (7%)		7 (33%)	2 (10%)		4 (21%)	1 (5%)	
Literacy of suicide, mental health, or health system		2 (13%)		1 (5%)		2 (10%)			
Stigma toward suicide or mental health issues	1 (7%)	2 (13%)	1 (7%)			4 (19%)			2 (11%)
Attitudes towards seeking professional treatment	4 (27%)			1 (5%)		2 (10%)			1 (5%)
Perceived need for treatment	1 (7%)			1 (5%)		2 (10%)			
Previous treatment	3 (20%)	1 (7%)		3 (14%)	1 (5%)	3 (14%)	1 (5%)		
Self-reliance	1 (7%)		1 (7%)			2 (10%)			1 (5%)
Social support		1 (7%)		2 (10%)	1 (5%)	2 (10%)			1 (5%)

Note. The factors being reported five times or more were included in this table. Type I, professional help-seeking intentions for perceived suicidal ideation, among people with or without suicidality, Type II, professional help-seeking behaviour among people with suicidality, Type III, suicidal decedents' health services use.

Appendix 1a. Quality assessment of the quantitative studies

Study	Study participants well defined (time, place, personal characteristics)?	Selection random or consecutive?	Participant rate >80% or if participant rate is low, comparison respondents/nonrespondents described?	Standardized, validated questionnaire or clear description of what outcomes were measured?	Did the article report ethical review?
Professional help-seeking intentions for perceived suicidal ideation among people with or without suicidality					
Calear et al. (2014)	Yes	Yes	No	Yes	Yes
Chan et al. (2014)	Yes	Yes	No	Yes	Yes
Wilson et al. (2011)	Yes	Yes	Cannot tell	Yes	Yes
Curtis et al.(2010)	Yes	Yes	No	No	Yes
Wilson et al. (2010)	Yes	Yes	Cannot tell	Yes	Yes
Wilson et al. (2010)	Yes	Yes	Cannot tell	Yes	Yes
Yakunina et al. (2010)	Yes	Yes	Cannot tell	Yes	Yes
Skogstad et al. (2006)	Yes	Yes	No	Yes	Yes
Wilson et al. (2005)	Yes	Yes	No	Yes	Yes
Sakamoto et al.(2004)	Yes	Yes	Yes	Yes	No
Ciarrochi et al. (2003)	No	Yes	No	Yes	No
Ciarrochi et al. (2001)	Yes	Yes	Cannot tell	Yes	No
Deane et al. (2001)	No	Yes	Cannot tell	Yes	Yes
Carlton et al.(2000)	Yes	Yes	No	Yes	Yes
Deane et al. (1996)	Yes	Yes	Cannot tell	Yes	No
Professional help-seeking behaviour among people with suicidality					
Meyer et al. (2015)	Yes	Yes	Cannot tell	Yes	No
Ballard et al. (2014)	Yes	Yes	Cannot tell	Yes	Yes
McKibben et al. (2014)	Yes	Yes	No	No	Yes
Wong et al. (2014)	Yes	Yes	No	Yes	Yes
Vasiliadis et al. (2013)	Yes	Yes	Yes	Yes	Yes
Ahmedani et al. (2012)	Yes	Yes	Yes	Yes	Yes
Downs et al.(2012)	Yes	Yes	No	Yes	Yes

Encrenaz et al. (2012)	Yes	Yes	Cannot tell	Yes	Yes
Husky et al. (2012)	Yes	Yes	Yes	Yes	Yes
Routhier et al. (2012)	Yes	Yes	Not applicable	Yes	Yes
Arria et al. (2011)	Yes	Yes	Yes	Yes	Yes
Milner et al. (2010)	Yes	Yes	No	Yes	No
Wu et al. (2010)	Yes	Yes	No	Yes	Yes
Pagura et al.(2009)	Yes	Yes	No	Yes	Yes
Freedenthal et al. (2007)	Yes	Yes	No	Yes	No
De Leo et al. (2005)	Yes	Yes	No	Yes	No
Suicidal decedents' health services use					
Law et al. (2015)	Yes	Yes	Not applicable	Yes	Yes
Vasiliadis et al. (2015)	Yes	Yes	Not applicable	Yes	Yes
O'Neil et al. (2014)	Yes	Yes	Not applicable	Yes	Yes
De Leo et al. (2013)	Yes	Yes	Not applicable	Yes	Yes
Cho et al. (2013)	Yes	Yes	Not applicable	Yes	Yes
Rhodes et al. (2013)	Yes	Yes	Not applicable	Yes	Yes
Chang et al. (2012)	Yes	Yes	Yes	Yes	Yes
Loh et al. (2012)	Yes	Yes	Not applicable	Yes	No
Sveticic et al. (2012)	Yes	Yes	Not applicable	Yes	No
Basham et al. (2011)	Yes	Yes	Not applicable	Yes	Yes
Kisely et al. (2011)	Yes	Yes	Not applicable	Yes	Yes
Law et al. (2010)	Yes	Yes	Not applicable	Yes	Yes
Seguin et al. (2010)	Yes	Yes	Yes	Yes	No
Hamdi et al. (2008)	Yes	Yes	Not applicable	Yes	No
Lee et al. (2008)	Yes	Yes	Not applicable	Yes	Yes
Vassilas et al. (1997)	Yes	Yes	Not applicable	No	No

Appendix 1b. Quality assessment of the qualitative studies

Study	Were the data transcribed verbatim (i.e., were audiotapes, videotapes, or field notes used)?	If interviews were conducted, were the questions predefined?	If focus groups were used, was the facilitator trained?	Was saturation mentioned?	Was there a description of how the research themes were identified?	Were the research findings analyzed by more than one assessor?	Were participant answers reviewed for clarification (i.e., member check)?	Were sequences from the original data presented (i.e., quotes)?	Did the study report ethical review?
Professional help-seeking intentions for perceived suicidal ideation among people with or without suicidality									
Curtis et al. (2010)	Cannot tell	Yes	Not applicable	No	No	Cannot tell	Cannot tell	Yes	Yes
Professional help-seeking behaviour among people with suicidality									
Czyz et al. (2013)	Yes	Yes	Not applicable	Cannot tell	Yes	Yes	No	Yes	Yes
Bullock et al. (2012)	Yes	Cannot tell	Not applicable	Cannot tell	Yes	No	Cannot tell	Yes	Yes
Freedenthal et al. (2007)	Yes	Yes	Not applicable	No	Yes	Yes	No	Yes	Yes
Strike et al. (2006)	Yes	Yes	Not applicable	No	Yes	Yes	No	Yes	Yes
De Leo et al. (2005)	Yes	Yes	Not applicable	No	Not applicable	No	No	No	No
Osvath et al. (2003)	Cannot tell	Yes	Not applicable	No	No	No	No	No	No
Suicidal decedents' health services use									
Törnblom et al. (2015)	No	Yes	Not applicable	Yes	Yes	Yes	No	Yes	Yes
Moskos et al. (2007)	Cannot tell	Yes	Not applicable	No	No	No	No	Yes	Yes
Owens et al. (2005)	Yes	Yes	Not applicable	Yes	No	Yes	No	Yes	Yes

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