

Suicidality in people with long-term health conditions: a qualitative exploration

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Abstract

Background

Suicide is a major public health issue globally. People with a long-term health condition are twice as likely to experience suicidal ideation and behaviours. This study aims to understand how people with long-term health conditions experience suicidality, and what support would benefit them. This understanding is important to help prevent future suicide attempts in this population.

Methods

This qualitative study explored the experiences of individuals living with long-term physical or mental health conditions who had previously attempted suicide or experienced persistent suicidal thoughts. Semi structured interviews were conducted with fifteen participants: 11 individuals with lived experience and four carers. Interviews explored health journeys, emotional wellbeing, experiences of support, and factors that contributed to suicidality. Reflective thematic analysis was used to analyse the data.

Results

Five themes were produced showing how the impact of their health condition led to their suicidality. The themes are “What’s the point?” describing the emotional and physical toll of living with a chronic health condition, “Am I on my own here?” capturing experiences of isolation, alongside inconsistent, but occasionally, exceptional support from the healthcare providers, “The system is not working for me” addressing system failures in the healthcare system, “See me” reflecting the need for recognition and respect as individuals, and “New Purpose. New Normal” describing adaptations to life changes and finding meaning in life post-diagnosis.

Conclusion

The findings show a need to improve how healthcare systems address patients’ wellbeing to reduce suicidality in patients. If initial and follow-up appointments included a quality of life or wellbeing assessment, mental health issues could be recognised and addressed sooner before thoughts of suicide develop into action. Further research could help to improve policy and how wellbeing issues are approached in practice. This could reduce poor wellbeing and the development of suicidal ideation and action. Further research into healthcare professionals’ experiences would increase the knowledge base in this area. Expanding the current research further to include more men, more people from ethnic minority groups and those with other health conditions is essential.

Background

Suicide and long-term conditions

Suicide is a major public health concern. Globally, more than 720,000 people died by suicide in 2021 with suicide being the third leading cause of death in people aged 15–29 in 2021 (World Health Organisation (WHO), 2025). In the UK, suicide was the leading cause of death for both males and females aged 20–34 between 2001 and 2018 and continues to be the leading cause of death for men under 50 (ONS, 2020). Due to this, suicide prevention continues to be an ongoing priority. This is highlighted by the World Health Organisation’s Live Life approach to suicide prevention of ‘early identify, assess, manage and follow up anyone who is affected by suicidal behaviours’ (WHO, 2021).

There are several factors which influence a person's decision to take or attempt to take their own lives. One major risk factor is living with a long-term health condition (WHO, 2025). Quantitative research consistently shows that people with long-term conditions experience higher rates of suicidal ideation and suicide than the general population. People with a long-term health condition are twice as likely to experience suicidal ideation and behaviours (Lutz, 2019; Nafilyan et al., 2022). This is more profound in conditions characterised by chronic pain and degenerative conditions, such as Parkinsons Disease, where the risk is up to 6 times higher than the general population (Nafilyan, et al., 2022). Depression is commonly comorbid with the health condition, and this further elevates risk. Most studies focus on risk estimation rather than understanding lived experience and how individuals with a long-term health condition and suicidal ideation could be better supported.

Physical health, mental health and theories of suicide

There is a close and bi-directional relationship between physical and mental health (Ohrnberger et al., 2017, Gandhi, 2024). People with long-term conditions are more likely to experience depression, anxiety and social isolation while individuals with severe mental illness experience co-morbidities with physical health conditions and lower life expectancy (Ohrnberger et al., 2017). There are several factors associated with long-term health conditions leading to poor emotional health, impacting psychological and social wellbeing, affecting quality of life and potentially leading to suicidal ideation. These include social isolation, reduced mobility, chronic pain, emotional distress, side effects from medication, stigma and discrimination (National Institute of Mental Health, 2021).

While suicide is often assumed to be closely linked to mental illness, many individuals who die by suicide are not known to mental health services. Contemporary psychological models agree suicidality is a complex issue arising from psychological pain, created through various life experiences (O'Connor, 2011, Klonsky & May 2015). Several established theories, such as the Interpersonal-psychological Theory of Suicidal Behaviour (Joiner, 2005) and O'Connor's (2011) Integrated Motivational-Volitional Model of Suicidal Behaviour highlight the role of pain, perceived burdensomeness, thwarted belongingness and hopelessness in the transition from suicidal ideation to action. These feelings link closely to those experienced by people with a long-term health condition (Klonsky et al., 2021)) Despite this, there are a paucity of studies applying suicide theories to people living with long-term health conditions.

Ability to cope, long-term conditions and suicidality

Emotional wellbeing, ability to cope and perceived quality of life are important factors in determining whether a person develops suicidal ideation. There is no single agreed definition for emotional wellbeing, but it is generally understood as how people feel and function on a personal and social level, and how they evaluate their lives as a whole (Michaelson, et al. 2012). Wellbeing is influenced by physical and mental health and, in turn, influences the experience and outcomes of different health conditions. For people with long-term conditions, emotional wellbeing can be affected a variety of issues including chronic pain, loss of mobility, and the development of depression and anxiety (Akif, et al., 2024)

Another factor to consider is that a person's ability to cope with living with a long-term health condition will be influenced by their perception of their quality of life (Park et al., 2022). A person's perception of their quality of life will affect their emotional wellbeing. The interconnection between emotional wellbeing, ability to cope and quality of life are profound with each influencing the other, either positively or negatively (Park, et al., 2022, Sirgy, 2021). If a person's emotional wellbeing deteriorates, they may develop anxiety, depression and possibly suicidality Hawton et al. (2013).

Long-term conditions, health psychology and suicide research

There is limited research on long-term health conditions and suicidality. Existing research suggests that deterioration of physical health, loss of independence, worsening symptoms and feeling a burden to family and friends can contribute to suicidal thoughts. However, there remains a lack of in-depth exploration of how individuals' health experience progress over

time, how negative experiences in the healthcare system, and what supports adaption and change to get through the adversity.

Health psychology offers a useful framework for understanding how biological, psychological and social factors interact across the illness journey. Models such as the Common-Sense Model of Self-Regulation (Leventhal, et al., 2016) emphasise how illness perceptions, beliefs about control, and resilience influence coping and wellbeing. Although the Common-Sense Model has been used to explain behaviours for both physical and mental health, it has not previously been used to understand suicidality. The model highlighted the importance of health management, and how early identification of poor mental health and a holistic approach to health interventions that address wellbeing alongside symptom management for better health outcomes. The elements of this model could explain key issues relating to long-term health conditions and suicidality.

There are very few studies which have spoken directly with people who have a long-term health condition who have attempted to take their life or have experienced persistent suicidal thoughts. Without asking those who have experienced these life events, we are not able to truly understand what happened within their lives to bring them to the place where they felt suicide was the feasible option. This study adds to the limited research data. By developing a deeper understanding, support can be adapted for those with long-term health conditions to help to meet their needs and not make their experiences more difficult. From this we may be able to support people better and reduce the number of people who experience suicidal ideation or attempt to take their life because of their health issues.

Methods

Design

A qualitative design was chosen for this research as it would allow for an in-depth exploration of people's experiences in managing their long-term health condition and the effects on their emotional health and wellbeing. The research took an interpretivist, inductive approach to analysing the data (Braun and Clarke, 2013).

Semi-structured interviews were used so participants had the opportunity to discuss their experiences in detail (Braun and Clarke, 2013) and gave the researcher an opportunity to explore points raised by participants (Megaldi and Berler, 2020). This technique was particularly useful in this study as there were participants with different conditions and experiences, giving flexibility flow to the conversation which would have been lost with rigid questions.

Patient and Public Involvement

Patient and Public Involvement (PPI) informed the development of the interview schedule. Three individuals with lived experience contributed to refining the questions to ensure they were appropriate, sensitive, and emotional safe. The group's input helped shape the sequencing of questions, including the addition of an opening question about life prior to their illness to establish context and reduce distress.

Participants and recruitment

Fifteen participants were recruited between March and May 2025. This included eleven individuals with lived experience of long-term health conditions and suicidality, and four carers. Of the eleven people with lived experience, five had previously attempted to take their life and seven had experienced persistent suicidal thoughts. Of the four carers interviewed, three had supported family member following a suicide attempt, and one following persistent suicidal thinking. One carer had also experienced their own suicidal ideation.

Participants ranged in age from 27 to 68 years (mean age 46), with eleven women and four men. Twelve were White British, one was White British and Black African, one was Black British Caribbean, and one was Asian British – Indian. Participants

had a wide range of physical and mental health conditions, including chronic pain conditions, neurological disorders, diabetes, eating disorders and psychosis.

The initial inclusion criteria were people with a long-term health condition who have previously attempted suicide because of their, or a carer of an individual with the forementioned lived experience. Participants needed to be 18 years or over, live in the UK and speak English. Participants self-determined eligibility for their health condition and suicidal behaviour. Following difficulties in recruiting individuals who had attempted suicide, the inclusion criteria were expanded to include persistent suicidal ideation.

The first phase of recruitment was conducted through physical health condition charities, a local suicide prevention network and social media using Facebook and LinkedIn. For the second phase of recruitment mental health charities were also approached to share the research advertisement with their members and through their social media channels.

Data Collection

Semi structured interviews were conducted either face to face or online via Microsoft Teams, depending on the participant's preference. Six interviews were in person at a local council office, and nine were online. Interviews lasted between 56 and 129 minutes, with the mean time being just under 85 minutes. The data collected generated over 1,359 minutes of data, equivalent to just under 23 hours of recordings. Interviews explored participants' health journeys, emotional wellbeing, experiences with healthcare systems, suicidality, and sources of support. The interview schedule was informed by previous literature on long-term health conditions, suicidality and previously mentioned PPI input (see Supplementary Material A). All interviews were audio recorded, transcribed verbatim, and anonymised.

Ethics

The University of West England Research Ethics Committee granted full ethics approval on 15 August 2024. Following recruitment challenges, an ethics amendment was submitted in February 2025 to widen the pool of participants. This amendment was approved on 27 March 2025. Safeguarding procedures were a key ethical consideration, to ensure participants did not feel worse emotionally from sharing their story. Prior to interview, the researcher conducted an initial telephone or video call with the participants to inform them of the aims of the research, the interview process, confidentiality and discuss safeguarding and the person's support system following the interview.

Data Analysis

Reflective thematic analysis was used to interpret the data following Braun and Clarke's six-phase approach; familiarising with the data, creating codes, generating initial themes, developing and reviewing these themes, refining, defining and naming the themes, and lastly writing up the narrative reinforced with data extracts (Braun and Clarke, 2022). This method allowed the researcher to have an active role in the interpretation of the data and acknowledge her presence and interaction with the participants (Braun and Clarke, 2019).

Following the initial sematic code development, where the researcher created codes based on a more descriptive analysis of the data, the researcher re-visited the data. By re-visiting phase one of Braun and Clarke's model, the researcher was able to gain a deeper understanding of the data and create latent codes which identified veiled meanings and underlying assumptions within the data (Byrne, 2021). From these codes, the researcher identified connections and developed initial themes. The researcher re-visited the data to further develop the themes. Seven themes were initially created. After further analysis and in conversation with the second and third authors, two themes were merged, and one theme was removed as it did not address the research question. Finally, five themes were agreed upon. Final analysis was shared with participants to sense check the themes.

Availability of Data and Materials

The thesis addressing this research can be found at the University of West England repository at An exploration of the experiences of people living with a long-term health condition and its effect on their emotional wellbeing that led to a suicide attempt or persistent suicidal thoughts

Reflexivity

This research was driven by the first author's extensive experiences of working in suicide prevention in a local authority. There were several people with long-term health conditions in the coroner's records with a suicide verdict. As a person with a long-term health condition, the first author was aware that people do not routinely receive emotional support when managing their condition. The research was shaped by their personal experiences of living with a condition, its effects on daily life and wanting to understand and make a difference for those who were not coping well with their condition. The second and third authors were health psychologist with an interest in supporting this important area of research and a qualitative health researcher with little knowledge on this topic area but qualitative research expertise.

Results

Through the thematic analysis process five themes were created from the data. The themes are: 'What's the point?', 'Am I on my own here?', 'The system is not working for me', 'See me' and 'New Purpose. New Normal'. All the themes together encapsulate a more complete view of the participants' experiences that led to suicidality.

What is the point?

This theme relates to individuals' experiences of living with a long-term condition and their difficulty in managing this, causing frustration and exhaustion. The never-ending personal struggles with their physical and emotional health made some participants feel there was no way out of their current situation, making suicide a plausible option.

Amanda lived with depression and fibromyalgia, and without hope for a more positive, pain free future, suicide was seen as a reasonable option.

'My pain level was off the charts like putting clothes on was, like putting barbed wire on. ... And my mental health was really struggling... I just reached a point of. What is the fucking point? I can't fix this. Nothing I do seems to make it better. Nothing...' (Amanda, 36)

Ashley had several conditions causing chronic pain. Ashley hoped future medical interventions could improve her situation, but if not, she would consider suicide as an option.

'...now it is the thoughts, very... much are, I cannot physically live in this pain. And so, if someone doesn't give me an out or a solution soon. I fear that I would end up in a place of, well, I can't live like this forever. And especially with how much worse...it gets as times been going on.' (Ashley, 29)

Participants experienced several physical symptoms, many with chronic pain, which affected their quality of life. The physical challenges caused a detrimental effect on their emotional wellbeing, creating feelings of entrapment, hopelessness and suicidal ideation. Chronic pain had the most profound effect on daily life, and suicidal ideation.

Am I on my own here?

This theme captures how participants often felt alone when requesting treatment through the healthcare system; recognising frustrations within the system but also acknowledging positive experiences and support.

Courtney felt the healthcare professionals were unaware of the condition, Type 1 diabetes and disordered eating, and did not pick up on her disordered eating behaviours.

'But they just weren't grasping that the relationship with diabetes was why I kept losing weight...Because I could eat, but it was not having any... carbohydrates.... No one ever... picked up on it.' (Courtney, 27)

Jasmine (30) explained about the complexity of her condition, and she had been misdiagnosed because the healthcare professionals did not know enough about it. Ehlers Danlos Syndromes *'... still counts as a rare condition, even though it's technically not. It's just under researched.'* She explained there are several types of the Syndromes, and they had mixed her condition up with other Ehlers Danlos Syndromes.

Conversations with participants emphasised their experiences made them feel undervalued, misunderstood and abandoned. This created feelings of isolation, depression and suicidality.

The other side to this theme were the 'shining lights', individuals who had gone above and beyond to support the people they were caring for. Jessica spoke about her admiration and respect for her GP as she felt 'held' by her GP giving her the confidence to share her suicidal feelings which saved her life after a recent suicide attempt.

From a carer's perspective, Lisa spoke warmly about the advice one healthcare worker gave her, which she regularly shares with other carers.

'... And she just said to me, "Do you know what, Lisa ? Have hope that your daughter will get better. I see people get better." And do you know what? I've never forgotten her words, because I needed to hear that at the time.' (Lisa, 54)

For carers, they felt particularly isolated as advocates, did not feel they were being heard or respected, alongside issues navigating the system. Carers spoke about the negative impact their caring role had on their own emotional health. Kelly highlighted the huge effect caring for three family members had on her own emotional health, the difficulty in coping and the increased her stress levels leading to suicidal feelings.

'... I could just run my car into a wall and that'll be the end of it, wouldn't it? And I wouldn't have to worry about it anymore.' (Kelly, 55)

The system is not working for me

Participants felt the healthcare system did not provide individualised holistic care because it was not set up to support people this way. Several participants felt that the treatment they received had a detrimental effect on either their physical or mental health outcomes. Poor communication and a lack of knowledge were key problems experienced.

Along with several other participants, Lawrence emphasised how his treatment by one healthcare professional had a profoundly negative impact. Following this, it took Lawrence a long time to ask for other support,

'The psychiatrist... saying that... was not valid suicide attempt because ... she didn't believe... it wasn't determined enough. ... what [do] you... think... I felt when I heard that?' (Lawrence, 66)

Some participants felt the inflexibility in the system had made their health worse. Heather spoke about the issues with receiving a mental health diagnosis that led to only one avenue of treatment, and was not right for her daughter's complex needs.

'You can't regulate your emotions about something that hasn't been dealt with. I'm sorry, but you can't...and... then on the other hand, they're saying...until she's emotionally stable, we can't really start trauma more work. [laughs]' (Heather, 50)

Participants from ethnic minority backgrounds also discussed the importance of being supported by a healthcare workforce that reflected their experiences and culture. One participant said it would have been welcomed to have someone "that looked like me" and understood her identity, culture and values.

All the issues experienced with the healthcare system added to the frustration and difficulties experienced by participants and contributed to their thoughts of suicide.

See me

Participants felt they were often only seen through the lens of their condition or judged because of it, both in the healthcare system and in wider society.

Participants spoke of the lack of understanding they experienced from the community they lived in and the wider negative perception in society about people with long-term conditions and disabilities, particularly in relation to working, benefits and cheating the system. As Linda explains this is particularly difficult when the health condition is not outwardly visible, and people are less sympathetic.

'You get stress overload, and you have to keep explaining that to people and they don't get it either. I mean, because it's not obvious, you know, cause you look reasonably normal, I guess.' (Linda, 68)

Michael was an active member of his local community, but he still felt he was viewed negatively by some people because of his health condition and not being able to work.

'...there's this awful kind of stigma. Where certain groups will be targeted and... scapegoated.' (Michael, 57)

The need to be seen was also linked to individualised care. Participants wanted consistent support workers who knew their circumstances and needs, regular contact points, and professionals who would not require them to repeat their story. Sejal said healthcare professionals needed to take time to get to know the individual sitting in front of them:

New Purpose. New Normal.

Developing a long-term health condition created many life changes and impeded participants' expectations for their future lives. Participants were forced into changes in work, education, home life, relationships and hobbies. Their planned direction in life had been altered forever, and some parts of their lives they could not get back. These life changes affected emotional health in a negative way and either led to a suicide attempt or suicidal ideation. Having a new purpose or new direction helped to replace thoughts of suicide with thoughts of hope for the future.

Every participant spoke about how their educational path or work life had been affected by their health condition. One participant lost the job she loved and had planned as a career for life, while also managing pain and uncertainty about the future.

'...my brain was whirring... I'm in pain all of the time. I can't do the job that I love. There aren't any ways to accommodate me, to be able to do the job that I love... Fuck, what do I do?' (Amanda, 36)

This loss of future and identity contributed to a suicide attempt because she could see no way of improving her current situation and could not see a new future for herself.

Carers also experienced changed work and family life. Several had reduced hours, changed jobs or left paid employment to become full-time carers. They described the effect on the rest of the family, including siblings, and guilt about the wider impact. Carers tried to protect family members, advocate within services and manage daily life, often without clear guidance or support.

Participants also described learning to live with their condition. For some, diagnosis brought knowledge and access to treatment; for others it brought grief and finality. Jasmine described feelings of grief following diagnosis and when symptoms worsened.

'It's been better knowing, but I think there was like a period of like grief where or maybe a couple of periods of, like, grief with it, especially when it's gotten worse.' (Jasmine, 30)

Some participants regretted missing out on life experiences such as motherhood, relationships or careers. Others wondered if they had received earlier or different support, they might have had better outcomes in their illness and emotional wellbeing.

Several participants described activities that supported recovery and helped them find a new normal and feel valued and connected. These included exercise, healthy eating, assistance dogs, hobbies, advocacy, volunteering, peer support and being an expert by experience. One participant emphasised having a toolkit and putting cues into life to prevent deterioration.

'...I think you can put cues... into your life to prevent these... from happening. But you have to be aware... you've got to filter your own techniques out and see what work[s]...I feel that you've got to do it yourself.' (Luis, 30)

Some participants had found a new normal, while others were still on that journey. Recovery was not linear; participants still faced triggers and challenges and used therapy, self-help tools or support when needed. For those with degenerative conditions, finding a new normal was harder because the goal posts kept moving. Nonetheless, participants continued working towards a place where they could cope and reduce suicidal thoughts.

Discussion

This study explored the lived experiences of people with long-term health conditions and suicidality. The results show that physical issues, emotional distress, judgement by society and inadequacies in healthcare built up over time, leading to suicidality. The five themes captured the toll of chronic or deteriorating illness, isolation and exceptional support, system failures, the need for recognition and respect, and finding meaning post-diagnosis.

Emotional health when living with a long-term condition

Emotional health was affected throughout participants' journeys: from initial recognition of illness to diagnosis, to learning to live differently. Pain management was a key issue and, for some, the main cause of suicidal ideation (Racine (2018)). Chronic pain affected quality of life, reduced daily functioning, removed positive coping mechanisms and increased hopelessness. The findings align with suicide theories which consider pain, hopelessness, entrapment, perceived burdensomeness, thwarted belongingness and acquired capability as relevant to the development of suicidality (Ribeiro and Joiner, 2009).

Participants' accounts demonstrate that quality of life is central. They discussed perceptions of health, social position, roles, expectations and what they valued. Quality of life assessments, such as the World Health Organization Quality of Life assessment (WHOQOL) (1995) could help identify people with long-term conditions, including carers, who are struggling emotionally and need earlier support before distress develops into suicidal thoughts.

The findings also show the importance of illness perceptions and self-perceived health. How participants viewed their own opportunities to improve, or not, influenced emotional wellbeing and coping. People with degenerative conditions described being overwhelmed or resigned because their health would not improve. Although not used to explain suicidality before, the Common-Sense Model of Self-Regulation (Leventhal et al. 2016) could explain how participants adjusted thoughts, feelings and behaviours over time as they understood and managed their health conditions. It may also help explain how people re-adjusted beliefs about life after suicidal ideation or an attempt, finding new activities and purpose that fitted their current perception of health.

Holistic care and a disconnect with healthcare

All the participants spoke about the importance of being seen as an individual and not just a patient or a health condition. Many also felt unheard by healthcare professionals, and some had their care stilted because of arbitrary barriers within the system. A systematic review of holistic patient care over the last 5 years has shown that although literature agrees that

person-centred care is the goal, there are numerous barriers to achieving this in practice (Urfiles, 2026). A whole person assessment focusing on all aspects of the person's life would be best way to action holistic care. However, practical application relating to feasibility, quality, staff training and available time remain issues in implementing these types of assessments (Thomas, et al., 2023). This research highlights the importance of holistic care and the implementation of assessments that support the whole person to improve health outcomes and recovery. Asking about quality of life, caring responsibilities and thoughts of suicide could help professionals notice when a person is moving from coping to feeling trapped.

Conversely, positive experiences with exceptional professionals were powerful because they conveyed care, time, hope, continuity and recognition. These experiences show how holistic care can and does work within the system, However, despite these experiences being highly valued, they were rare. If the health system treated participants in a holistic way, it would improve their ability to cope, reducing feelings of isolation and suicide.

Participants described the UK National Health Service as a system that could be inflexible, fragmented and difficult to navigate. For people already managing a chronic condition, navigating a fragmented system became an additional burden (Smyth, et al, 2025). The Burden of Treatment Theory addresses the experiences and burden for those with long-term conditions managing their healthcare and its effects on their wellbeing (Chikumbu, et al., 2022). There are close links here with the participants who felt the system did not routinely support their emotional wellbeing outside the treatment they received for their condition. Rather than just referring people with long-term conditions to specialist mental health services, prevention and support should be embedded across long-term condition pathways.

The findings also indicate that small relational acts matter. Being listened to, believed, remembered and treated as an individual changed how participants felt about their care. For commissioners and service leads, this means designing pathways where emotional wellbeing, carer need and suicide prevention are visible, measured and acted on throughout long-term condition care, not only at crisis points.

Life does not exist in a vacuum.

Participants used wider societal issues to make sense of their journeys towards suicide. Stigma, disability, unemployment, benefits, social judgement, equality and assisted dying were not peripheral to emotional wellbeing; they formed part of the environment in which participants lived with long-term conditions. Participants felt marginalised when they were seen as a burden or judged as less useful because they were unable to work. These feelings support concepts from the Interpersonal Theory of Suicide (Joiner, 2005) particularly perceived burdensomeness and thwarted belongingness.

The distinction between assisted dying and suicide was raised by participants in relation to degenerative conditions, particularly Parkinsons. Participants discussed death, future deterioration, advanced care planning and whether people should be able to decide when the time is right. Allowing for individuals to consider their future and have conversations where some people with degenerative conditions can have safe, sensitive and proactive opportunities to talk about death, suicide, assisted dying and future care planning is important (Sillitti, et al., 2025). Avoiding these conversations can increase isolation, but in countries where assisted dying is not an option, it could leave some people open to suicidality, as they do not feel they have other options. Professionals may need training and guidance to discuss these topics in a way that is legally, ethically and clinically appropriate, regardless of the legislation in that country.

Strengths and limitations

This study provides valuable insights into the experiences of people with long-term health conditions and suicidality. A strength was that most participants had lived experience of suicide attempts or persistent suicidal thoughts, allowing first-hand accounts of why they became suicidal and what could have helped. The qualitative method allowed nuance, depth and complexity that would not have been captured through retrospective survey data alone.

There were some limitations. The sample included diverse health conditions but only one participant per condition, limiting condition-specific conclusions. Most participants were from a single county in Southeast England, with others from other parts of England. The study would have benefited from more men and more people from ethnic minority groups which could address understanding of health inequality. Opportunity sampling may also have attracted people with unresolved healthcare concerns, although participants described both positive and negative experiences.

Clinical implications

The findings suggest that patients and carers may benefit from integration of quality-of-life surveys into routine long-term condition care pathways. Piloting survey options would allow services to understand which tools are best for patients and feasible for staff. These tools such as World Health Organization (WHO) Quality of Life assessment (WHOQOL) (1995), WHO Self-Reporting Questionnaire (SRQ-20) (Beusenbergh and Orley, 1994) or Health-related quality of life instrument (HRQOL) could help healthcare professionals understand wellbeing needs and implement support or intervention when required. This would provide early intervention to support wellbeing and reduce the development of poor emotional wellbeing and suicidality.

Healthcare professionals across the system may benefit from more training in mental health and suicide prevention, with mandatory refresher training embedded in continuing professional development. The training could be led by psychologists working within the system allowing their skills and experience in healthcare, as well as psychology, to tailoring the training to other healthcare professionals' needs. This could increase confidence in talking about suicide, asking the right questions, recognising signs of suicidal ideation and knowing where to signpost. Training such as ASIST (Substance Abuse and Mental Health Services Administration 2023) could also reduce stigma by making conversations about emotional wellbeing and suicide more routine. These findings reinforce the value of early, routine and compassionate conversations about wellbeing within long-term condition care.

The WHO provides guidance on the importance of person-centred care in healthcare delivery (WHO, 2026). The UK NHS has policies supporting person-centred care, however participants did not feel this was their routine experience. The findings highlight the need to investigate challenges implementing this policy. Owen et al., (2022) discussed the need for policy makers to have a better understanding of the needs of people with long-term conditions and their carers to improve policy on person-centred care. Understanding the whole person, including culture, values, identity and ethnicity, and taking emotional health into account, would support suicide prevention.

The study also highlights the important role of unpaid carers and the value of improving relationships between carers and healthcare services. Effective communication, a collaborative approach, structured communication protocols and inclusion in care planning meetings would benefit the whole system. This could reduce poor emotional health in both carers and patients.

Future research

Further research is also needed with healthcare professionals working with people with long-term conditions across physical and mental health disciplines, to understand their knowledge and experiences of supporting wellbeing outside routine condition-specific care. This will help reduce barriers to implementation of wellbeing support.

Future research should also focus on carers of people with long-term conditions and carers of those with suicidality, examining intersectionality and where relationships between healthcare systems and carers are most likely to break down. Testing Leventhal's Common-Sense Model (Leventhal, et al., 2016) in relation to suicidality could help explain how people with long-term health conditions develop suicidality and how repeat suicide attempt behaviours may occur. Current suicide theories should also be tested in relation to long-term health conditions to understand specific risk factors and support mechanisms.

Conclusions

This research provides deeper insight into people's experiences of having a long-term health condition, how this led to suicidality and how people continued their lives afterwards. Participants spoke about the varied impact of their health condition on aspects of their life, and their life trajectory. They also spoke to ineffective support from healthcare systems. Each of these elements built up over time and took some participants to a place where they did not want to live any longer. Despite this, participants highlighted things that do support (e.g. family, peers and exceptional healthcare professionals) and new activities that gave new meaning. This study should inform further research into wellbeing assessment, professional training, carer support and holistic, co-produced practice.

Declarations

Ethics Approval and consent to participate

The University of West England Research Ethics Committee granted full ethics approval on 15 August 2024. An ethics amendment was submitted in February 2025. This amendment was approved on 27 March 2025. Approval - UWE REC REF No: CHSS.24.04.178. Written informed consent was obtained from all participants prior to participation. The research was conducted in accordance with the University of the West of England's Code of Practice for Research, which aligns with the Concordat to Support Research Integrity and Declaration of Helsinki.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

Funding

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Authors' contributions

Shelley Taylor conceptualised the study, led project administration, methodology development, collected and interpreted data, and wrote the original manuscript draft. Maddie Tremblett and Pippa Tollow provided supervision, contributed to interpretation of findings, and critically reviewed and edited the manuscript. All authors approved the final manuscript.

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