Article:
Brossard, Baptiste Pascal Marylin and Garrec, Ivan (2026) Suicide Prevention Under Austerity: The Local Shaping of Referral Practices in French Primary Care. Sociology of Health and Illness. 2241807. ISSN: 1467-9566

https://doi.org/10.1111/1467-9566.70223

Suicide Prevention Under Austerity:

The Local Shaping of Referral Practices in French Primary Care

(Accepted, file sent to production)

Baptiste Brossard, University of York, baptiste.brossard@york.ac.uk (orcid: 0000-0002-9539-9290)

Ivan Garrec, Centre Européen de Sociologie et de Science Politique, ivan.garrec@ehess.fr (orcid: 0009-0001-9120-8354)

Acknowledgements: The authors wish to thank Karl Atkins, Chris Redd, Sarah Nettleton as well as the reviewers of *Sociology of Health and Illness* for their insightful comments on previous versions of this manuscript.

Abstract: This article examines how French general practitioners (GPs) navigate suicide-related referrals within a healthcare system strained by austerity. Drawing on repeated interviews with 29 GPs and a mind-mapping methodology, it shows that referral practices are shaped less by formal clinical pathways than by local resource configurations and the workarounds practitioners develop in response to them. The analysis highlights three interrelated dynamics. First, GPs rely on a sense of technical mastery—an embodied, experience-based judgement of what they can manage—which is continually stretched as they assume responsibilities once assigned to specialists. Second, they operate with expectations inherited from a previously better-resourced institutional network, generating tensions between normative ideals of care and limited referral possibilities. Third, in this context local social capital becomes an essential resource: personal relationships, informal networks, and accumulated local knowledge decisively structure how practitioners deal with patients deemed suicidal. Situating these dynamics within the concept of suicidescape, the article advances a locally anchored sociology of suicide prevention.

Keywords: suicide; sociology of suicide; austerity; general practice; social capital

Introduction

> ‘Ultimately, we can detect [suicide risk], yes, we can see it. But then we don’t really know what to do about it.’ (Dr Martin)
>
> ‘The few patients who answer yes, we say to ourselves, “Shit, what do I do now?”’ (Dr Arnaud)
>
> ‘The problem is, well, we generally spot people alright, I think we identify them pretty well. But we can’t actually take care of them.’ (Dr Favre)

These interview excerpts illustrate a recurrent challenge for general practitioners (GPs): once suicidal risk has been identified, what course of action should they pursue? What steps should they follow, in what order, and with whom? In principle, the answer appears straightforward: GPs are expected to refer patients to the most appropriate mental health service according to their assessment of risk. In practice, however, the saturation of available services—exacerbated by high demand and austerity measures, here in France, though similar policies affect most healthcare systems in the Global North (Annandale 2014, pp. 154–73; Gabe et al. 2020; Nettleton 2020, pp. 203–32)—renders this line of action no longer feasible within a timeframe that accommodates tangible suicide risk. How GPs operate under these constrained conditions is the central concern of this article.

This concern echoes the pivotal role primary care plays in suicide prevention. Numerous studies indicate that many individuals who die by suicide have consulted a general practitioner within the year preceding their death (Mughal et al. 2023; Stene-Larsen and Reneflot 2019). General practice, as part of primary care, thus constitutes a critical site for suicide prevention (Mughal et al. 2021) and the management of suicide attempts (Younes et al. 2020). Yet much of the existing literature has concentrated on refining screening tools to single out ‘at-risk’ patients (Dueweke and Bridges 2018; Thangada and Kasoju 2024). Where referral processes are discussed, the focus tends to rest on improving communication with patients (Saini et al. 2010, 2024), while the structural conditions shaping referrals remain underexplored, even though research increasingly shows that staffing shortages, limited consultation time, and fragmented relations between primary and secondary care undermine suicide prevention (Elzinga et al. 2020; Marshall et al. 2025; Muñoz-Sánchez et al. 2018; Rex et al. 2022).

In this context, the sociology of health helps broaden the analytical frame. Critical suicide studies have challenged individualistic models of suicide and prevention, advocating approaches that attend to the socially constructed meanings of suicide, as well as its relational and political dimensions (Chandler et al. 2022; Drongiti and Brossard 2024; Mueller and Abrutin 2024; Zhang et al. 2024). Applied to general practice, this perspective redirects attention from the individual competence of GPs to the social configurations that shape suicidal trajectories. These configurations span a wide spectrum of institutions—from law enforcement to community services (Bendelow et al. 2019)—as well as the formal and informal relationships through which social support is articulated. Thereby, they endow suicidal pathways with context-dependent social and institutional forms that are both structured by and structuring the cultural meanings of suicidality.

Drawing on repeated interviews with 29 GPs in France and a mind-mapping methodology, this article examines one fragment of this process: how practitioners navigate referral decisions for patients they perceive to be at risk of suicide, within local contexts marked by constrained and uneven mental health provision. We show that referral practices engage a *sense of technical mastery*, continually stretched by scarce mental health services; that they are rooted in *professional hysteresis*, that is, expectations inherited from a formerly better-resourced institutional network; and that, under these conditions, *local social capital* becomes a decisive factor. Together, these dynamics point to the need for a locally anchored sociology of suicide prevention.

Suicidescapes and the local turn in suicide research

Suicide prevention has recently emerged as a growing area of interest within sociology. A wave of critical research has shown that suicide prevention is a field underpinned by political and ethical principles (Button and Marsh 2019; Fitzpatrick 2021; Oaten et al. 2022), in which structural determinants are frequently reduced to individual attributes (Marzetti et al. 2025). Challenging such individualist models, this scholarship has highlighted the significance of community in suicide prevention (Mueller and Abrutyn 2024), as well as the effects and meanings shaping suicidal trajectories (Chandler and Wright 2023). Kirmayer's (2022, p. 3) call to move beyond 'crude generalisations about

suicide based on psychological theories developed mainly in Western contexts' towards 'fine-grained analyses of the experience of diverse populations' prompts attention to the local contexts of suicide prevention, pushing the sociological gaze past the national frameworks that have dominated since Durkheim's seminal work on the topic ([1897] 2002).

This 'local turn' has underscored how material resources, institutional infrastructures, and shared meanings shape both the incidence and interpretation of suicidality. It includes ethnographic studies conducted in specific communities, such as the London Alevi-Kurdish population (Cetin 2016) and Anhui Province, China (Pearson and Liu 2002). Mueller and Abrutyn's (2024) study of suicide clusters in a US neighbourhood demonstrates how local pressures, including those related to academic standards, intersect with community life, translating Durkheimian intuitions about social cohesion into empirical insight. Overall, these works illustrate the value of a locally grounded sociology of suicide, linking the production of distress to local issues of identity and culture.

Building on this emergent 'local turn', we examine suicide prevention as a set of interdependent activities distributed across institutions, determined by the particular arrangement of those institutions in a given locality. The concept of *suicidescape*, put forward by Chandler et al. (2024), offers a productive framework in this regard, capturing the spatial, emotional, and socio-political forces that influence how suicidality is locally experienced, interpreted, and acted upon. Suicidescapes encompass the social configurations in which visibility, meaning, and institutional response emerge from the interaction of place, organisational networks, and culture. They draw attention to the meanings ascribed to places as either protective (e.g. community centres) or risky (e.g. bridges, cliffs). Our study aims to extend this framework by integrating the configurations of healthcare services and professionals that render suicidality locally visible and actionable or, conversely, invisible and neglected.

Austerity, locality, and the French healthcare system

This local turn is not only a theoretical stance; it gains particular salience under conditions of austerity, where shrinking resources amplify disparities between regions and emphasise the significance of territorial specificities. In France, from the 1980s onwards,

the healthcare system entered a period of intensified budgetary restraint, in stark contrast to its post-war expansion (Soual 2017). While the association between causes of suicide and austerity has been established (Mills 2018), we extend this concern to consider what such political shift entails for suicide prevention.

The French healthcare system follows a nationalised social insurance model, with compulsory health insurance reimbursing medical expenses (Annandale 2014, p. 160). Since 1945, this *sécurité sociale* ('social security') framework has combined public facilities with partially-covered 'private' services (Da Silva 2022). As in many countries across Europe, GPs constitute the cornerstone of the French healthcare system. Although patients may access specialised care without GP referral, GPs nonetheless function in practice as the primary point of contact for most patients (Younes et al. 2020). Hospital doctors and those employed in public institutions are often salaried, but most GPs work in the so-called *libéral* sector, operating under a fee-for-service model, with consultations partially covered by social security. A standard consultation costs approximately €30, with up to 65% reimbursed. GP training consists of six years of medical study, followed by a four-year residency with multiple internships across different specialities; psychiatry is not a mandatory speciality in this curriculum. Access is regulated by a quota, which was tightened in the 1980s and 1990s (DREES 2001), with repercussions today on the number of trained GPs in exercise. This helps explain why the number of GPs declined by 9% from 2010 to 2020 (CNOM 2022), despite a growing, ageing population.

Mental healthcare exhibits a similar public–private ambivalence. Its territorialised structure derives from the reorganisation of psychiatric care in the 1960s, characteristic of the broader 'deinstitutionalisation' of Western psychiatry (Henckes 2018), which shifted resources from long-term hospitalisation to outpatient and community-based care (Eyraud and Velpry, 2014). The entire French territory is divided into 'psychiatric sectors', each serving approximately 80,000 inhabitants over a variable geographical area, and including at least one outpatient facility, the *Centre Médico-Psychologique* (CMP), designed as the hub of local mental healthcare (Velpry 2008). There, patients receive free follow-up from psychiatrists, psychologists and nurses and may be referred to specialised services when needed. However, most CMPs today are saturated and unable to accept new patients.

Private psychiatrists, on the other hand, operate in independent practices or private clinics. Fees vary by 'conventional sector': sector 1 charges €50–100 per session, reimbursed at about 70% by social security; sector 2 permits additional fees, potentially reimbursed by private health insurance; and sector 3 sets prices freely, with minimal reimbursement. Although patients may consult psychiatrists directly, GP referral ensures higher reimbursement. Despite France's relatively high psychiatrist-to-population ratio (24 per 100,000; Dattani et al. 2024), territorial inequalities mean that many GPs struggle to find available psychiatrists. Private psychologists are more numerous but costly—€50–100 per session—and not reimbursed by social security. Introduced in recent years, the "*Mon soutien psy*" scheme now covers 12 sessions, but limited professional participation has led to long waiting times and scepticism about the programme (Delespierre et al. 2024). Furthermore, increasing demand for mental health care has reinforced a mismatch between perceived needs and available services (Consoli et al. 2025). Finally, the charity sector and peer-support programmes are confined to rare, local initiatives.

This means that GPs, already in short supply, struggle to direct patients to mental health services, especially when time is critical, as in suicidal risk. In such circumstances, they cannot rely on standard clinical guidelines only; they must cultivate situated knowledge of local service availability and waiting times which vary markedly across localities.

Methodology

Our approach combined semi-structured, repeated interviews with a mind-mapping technique designed to elicit GPs' representations of the local institutional networks in which patients identified as suicidal circulate.

Participants

Recruitment initially relied on professional newsletters and social media. However, faced with limited responses, we employed snowball sampling through professional acquaintances, primarily psychiatrists who referred former classmates or colleagues. Recruiting GPs proved challenging, as they are often overburdened, frequently approached for studies, and may perceive suicide as a particularly sensitive subject, both because the loss of patients raises questions of professional responsibility and because

suicide rates within the medical profession are high. We recruited 29 participants (15 men and 14 women) and conducted 50 interviews in total. Participants ranged from interns to retired practitioners, with an average of 12 years of experience (from 0 to 57). They also represented diverse settings, from rural areas to large metropolitan centres, and from solo practices to multidisciplinary health centres. Three were salaried public practitioners, while all the others worked in private practice. This diversity is outlined in Figure 1.

Data collection and analysis

Data were collected in two stages. First, we conducted semi-structured interviews with participants, focusing on suicidality assessment, referral practices, and perceptions of available services, as well as collecting demographic and basic practice-related information. We encouraged interviewees to recount concrete cases, with emphasis on the practical challenges associated with different levels of estimated suicidal risk. This approach enabled us to compare general statements with specific examples.

Following each interview, inspired by mind mapping methods (Wheeldon and Faubert, 2009), we drew a map depicting referral options suggested to suicidal patients, based on their social and clinical characteristics. We noted all the institutions and actors mentioned during the interview (e.g. emergency services, local psychiatrists, CMPs, etc.) and drew arrows to represent the types of patients referred to these services, including information on waiting times and economic barriers. We grouped these resources according to whether they belonged to the public healthcare sector, the private healthcare sector, the fields of work or education. This helped us better understand the institutional context in which each participant practiced medicine and the meaning-making processes through which they connected to other services.

Then, we conducted follow-up interviews in which participants were invited to comment on the map, correcting inaccuracies and adding relevant details. In most cases, the modifications were minor, concerning omitted organisations (often specialised community centres) or clarification of institutional pathways. Moreover, the second interview provided an opportunity to specify points raised during the first interview and to document recent changes in the local configuration of services.

Each of the two researchers was responsible for a subset of participants, managing both interviews and maps to foster rapport and continuity. All maps were, however, reviewed jointly. Interviews were audio-recorded, transcribed verbatim. The maps were subsequently finalised, thus serving both as elicitation devices during follow-up interviews (prompting further discussion about available referral options) and as analytical tools enabling comparison of local networks and referral practices. They offered a visual synthesis of data relating to the overall saturation of CMPs, the complexity of care pathways for patients assessed as suicidal (especially with 'moderate' risk), and limited connections with school and occupational health services. Figures 1 and 2 present examples of such maps.

[Insert Figure 2 and Figure 3]

Throughout data collection, we coded interviews using reflexive thematic analysis (Braun and Clarke 2022). After familiarisation reading, for each interview, one researcher identified emerging themes (within broader categories such as 'institutional networks', 'clinical reasoning', or 'suicide scripts'), while the other reviewed and refined the analysis. These rounds of coding enabled the iterative generation of hypotheses and the development of theoretical leads, progressively elaborated and revisited. Thus, we combined inductive and deductive reasoning, in an abductive mode of analysis (Tavory and Timmermans 2022). An overall preliminary finding was that GPs reported having little difficulty detecting suicidal risk, but considerable difficulty in referring affected patients to specialised care, as mentioned in the introduction. We progressively encouraged participants to elaborate on this aspect and, collecting accounts of saturated services and improvised referral solutions, we came to analyse our data in relation to broader institutional and political contexts underpinning the described situations, here drawing on situational analysis (Clarke et al., 2016). Our attention consequently shifted towards the effects of austerity on medical practice. This process led to the findings presented in the following sections.

Ethics and funding

All participants provided written informed consent. Names were pseudonymised, and identifying details were altered to preserve confidentiality. The study received ethical approval from the University of York Faculty of Social Sciences Ethics Committee

(approval no. 90 23 24 / 2024). Although suicide is a sensitive topic, the research was assessed as low risk, as participants routinely encounter it in their professional practice. The project was funded by the Observatoire National du Suicide (France). The authors declare no conflicts of interest.

Should they stay, or should they go? The sense of technical mastery

What happens when a patient expresses suicidal intentions during a medical consultation? This question marks the starting point of our analysis, for the GP is immediately confronted with a fundamental decision: whether to manage suicidality alone or refer the patient elsewhere.

The first option involves scheduling another appointment within a period ranging from 48 hours to one month, depending on the perceived level of urgency. The key challenge here is time: mental health consultations are considerably longer than ordinary visits. 'I don't have an hour to spend,' Dr Bernard summarised. 'Otherwise, I'd have to send people with cancer away, and that's just not possible.' As the extract suggests, even for GPs who consider that mental health deserves attention, it represents a more uncertain form of care—something of a bet—compared to the management of physical illnesses (such as prescription renewal or symptom monitoring). To accommodate patients deemed suicidal, some practitioners keep a few timeslots unlisted on the national online booking platform Doctolib, or work during lunch break. The organisation of the health centre in which they work, including schedule flexibility and relationships with administrative staff, conditions these possibilities and, by extension, structures locally embedded referral decisions. Time constraints also explain why some GPs occasionally schedule consultations to administer the Hamilton Depression Rating Scale, despite being sceptical of its clinical value, as this test is the only mental health scale that unlocks an hour-long appointment reimbursed by social security. The second option is to seek external help, though this requires determining what kind of help is available. This decision relies on three factors: the perceived degree of urgency, the availability of referral options, and, as we will see, what we term a sense of technical mastery.

Assessing urgency usually involves determining whether the patient has developed a suicide plan (place, method, and possible timing) while weighing 'protective factors' such

as family responsibilities that may deter self-harm. Yet even when the risk is judged significant, the feasibility of referral ultimately depends on the availability of local services. Dr Abadie explained this tension:

> When someone is at risk of suicide, but this risk is contained by the fact that they have not planned anything and have a protective factor, I'm not necessarily going to get them hospitalised. But I will make sure to see them again and that they have the necessary medication, personal support, and psychotherapy in place, even if it means doing a little bit of everything and referring them to a psychiatrist if necessary. But in our area, it's difficult to find one. Appointments are three to four months away.

Faced with the scarcity of mental health resources, GPs delineate the problems they feel competent to manage in order to triage which patients absolutely must be referred to other services. Some, like Dr Perrin, distinguish between neurosis and psychosis: 'I don't follow any patients with psychosis… These are patients who really need to see a psychiatrist.' Most, such as Dr Marsault, differentiate between 'mild to moderate' depression, which tends to be manageable within their practice, and 'complex' cases requiring specialist input. For many, these distinctions follow pharmacological boundaries: disorders treatable with selective serotonin reuptake inhibitors (SSRIs) fall within general practice, whereas those requiring neuroleptics are seen as 'purely psychiatric' cases lying outside their professional remit.

Although the division of labour between services is formally clear, in practice the definition of what can be handled rests on a *sense of technical mastery*: an embodied, situationally informed feeling of competence grounded in experience with specific diagnostic categories and therapeutic tools. Using 'sense of' here underscores the intuitive nature of this judgement, a 'sense of the game' (Bourdieu 1990), as it operates within medical practice (Nettleton et al. 2008). This is well described by Dr Jornet:

> I can't tell you how I make one decision over the other. I don't really know why I go one way sometimes… I don't know why, at a given moment… well, I sort of do, but there are lots of things: the context, family support around the patient, who and what I can lean on to put things together…

The reiteration of this sense of technical mastery—how 'comfortable' practitioners feel managing mental health issues—leads some GPs to acquire local reputations: as Dr Perrin illustrates, in his health centre, 'we all have our specialities. Mine is psychology'. Others expressed marked discomfort with mental health care, particularly around suicide. Dr Mallat, who 'almost never prescribe[s] antidepressants', explained, 'I don't think I'm as effective at treating suicidal patients as psychiatrists are.' Similarly, Dr Henry mentioned feeling uneasy treating suicidal adolescents, due to the lack of local child psychiatrists available to assist with prescription. This points to a *dynamic of cumulative disadvantage*: resource scarcity in a given domain tends to stretch GPs' sense of technical mastery, whereas greater availability of specialist support does not, thereby reinforcing local disparities.

Each practitioner tries to draw boundaries that limit the scope of their practice. But these boundaries are constantly transgressed. Structural constraints compel GPs to extend their sense of technical mastery to accommodate situations that would ordinarily fall outside their attributions. For instance, according to Dr Bossard, practitioners are 'well versed in SSRI', they can 'handle' conditions ranging from depression to anxiety disorders. However, 'where it gets tricky is with people who are starting to develop psychological disorders that are beyond our expertise'. In the absence of options, he added, 'sometimes, we have to renew treatments without having any mastery over them'. In short, while referral decisions arise from the interplay between assessed risk, the perceived configuration of local services, and the practitioner's sense of technical mastery, the latter is continually stretched to compensate for service saturation.

Referrals: theory and practice

This section examines what happens once the decision has been made to refer a patient elsewhere, largely on the basis of assessed risk. In this regard, GPs' clinical reasoning broadly follows similar lines: suicide risk is often considered hidden, direct questioning is seen as essential to establish intent and assess risk, notably by determining whether patients have a specific 'plan' (method and timeframe), as well as identifying protective factors. Referral practices are structured around three main areas: high-risk situations, low to moderate risk, and specific populations.

High risk: meanings and uses of 'emergency'

Emergency departments (EDs) constitute a major referral option for GPs (Younes et al. 2020). In theory, this pathway is reserved for the most acute situations, when a patient presents an imminent plan to end their life. Yet not only is this 'high-risk' threshold interpreted unevenly, but some GPs are reluctant to expose patients to the emergency environment, particularly outside psychiatric emergency opening hours. 'I avoid the ED at all costs,' Dr Mayer told us. 'It's extremely harsh, and it's almost a bit stigmatising to have to wait three, four, even five hours there just for a chance to see a psychiatrist, sitting around with drunk people.' Others are more inclined to send patients to emergency services, especially when informed by patients, colleagues, or personal contacts that the local department has a decent reputation.

However, EDs are often used for situations that are not, strictly speaking, emergencies. For example, when patients are perceived as needing regular psychiatric follow-up, and long waiting times render this option unworkable, then the ED becomes the only alternative for GPs. Similarly, some practitioners use EDs strategically to trigger hospital admission: 'There's no point wasting time trying to get hold of the hospital', Dr Favre explained, 'We just have to send them to the ED.' In most localities, indeed, dense interconnections exist between psychiatric emergency units, general emergency departments, and psychiatric hospitals. As Dr Caron summarised, 'if I consider that it's really bad, I try to refer either to a colleague psychiatrist, or eventually I hospitalise: I send them to the ED, saying it's not going well at all.' In other words, referral to the ED has become a strategy for securing patient access to care, even when the situation does not qualify as an emergency. Many EDs become gatekeeping services.

Once patients reach the ED, another challenge arises: emergency staff may not share the GP's assessment and decide that follow-up is unnecessary. For Dr Marsault, 'they don't really take our assessment into account. They do their own assessment, which is fair enough, but our concerns—us, who actually know the patient!—aren't considered at all.' This tension exemplifies what Hughes (1951) termed the 'social drama of work', namely the discrepancy between how occupational groups define gravity: 'It's never serious enough for psychiatrists to keep these patients,' Dr Pons noted ; 'The crisis according to them is never a crisis according to us.' These issues, coupled with long waiting times,

lead some practitioners to reduce referrals to the ED. In just two years of practice, Dr Garcia had thus shifted from systematically sending high-risk patients there to seeking alternative solutions whenever possible.

Perceptions of risk therefore fluctuate throughout GPs' careers in relation to surrounding services and their evolving sense of technical mastery, resulting in varying uses of ED referrals: in some cases 'inflationary,' where the ED is treated as a gatekeeping service; in others 'deflationary', where the ED becomes a last resort.

Moderate risk: navigating public and private options

For patients assessed as presenting a *moderate* risk of suicide (generally defined as the absence of a near-term plan to end one's life), three main referral options have been reported. The first is Centres Médico-Psychologiques (CMPs), free outpatient mental health centres. Once the cornerstone of French public psychiatry, CMPs have become severely saturated in most localities, with waiting times ranging from several months to over a year. The second option is private psychologists, who are relatively numerous, but whose consultations are rarely reimbursed by social security. The third is private psychiatrists, whose consultations are partially covered but who are in short supply in most regions. In this resource-constrained landscape, GPs develop locally adapted strategies.

While some practitioners avoid CMPs altogether, others continue to refer patients there. As Dr Bernard explained, 'knowing full well the kind of wait times there are', referring patients to psychiatrists would be even less effective: 'There's no point, we just don't have any.' A few GPs persist in what they characterise as 'lobbying': engaging in repeated phone calls, drawing on personal connections, or activating professional networks to secure an appointment for patients they consider to be particularly in need. 'It takes several follow-up calls,' Dr Garcia sighted. 'The first time I call, there's a nurse telling me, "Oh yes, yes, I'll make a note of that, we'll call you back tomorrow," and the next day, nobody calls back, so we have to chase them, and so on.'

Private psychologists and psychiatrists represent alternative routes but remain out of reach for many. Psychiatrists are often unavailable, and psychologists' fees are prohibitive for patients with modest means. This situation exacerbates social inequalities.

Dr Caron highlighted the difference between those who 'have the means to pay for a psychologist who isn't covered by social security, have time for things like sophrology, meditation, and the possibility of taking long breaks from work', and others for whom such options are unattainable. To try to help the latter, GPs increasingly find themselves testing their sense of technical mastery. From Dr Richard, who stated that 'we manage more and more psychiatric problems', to Dr Bossard, who lamented the growing number of antidepressant treatments he now initiates without fully appropriate expertise, practitioners appear to be quietly drawn into taking on tasks once reserved for specialists. For these reasons, patients assessed as being at moderate risk may be the most challenging, as they extend GPs' responsibilities beyond their initial remit.

Specialised services at the margins

A range of other services can support follow-up care for patients at risk of suicide, but their availability varies considerably by locality. With few exceptions, these services are not nationally implemented and tend to be concentrated in urban centres such as Paris, Lyon, or Toulouse, contributing to significant urban–rural inequalities.

Participants mentioned a range of specialised centres dedicated to addiction, domestic violence, eating disorders, or youth. These services often require patients to travel significant distances, but when available, they provide valuable alternatives to general mental healthcare, particularly if they offer open-door access. In some areas, addiction treatment centres enjoy a strong reputation and are preferred over general psychological services. Yet access to such facilities depends on whether a patient's situation aligns with their focus, leading some GPs to strategically reframe suicidality as secondary to another issue, as Dr Marsault explained:

> You always needed another argument. It couldn't just be about psychological issues. If people only have psychological issues, we're in a bit of a mess. If it is psychology and violence, we have a solution. Psychology and early childhood, a solution. Psychology-addiction, psychology-trauma, and exile. But psychological issues on their own are complicated. It's complicated. And otherwise, it's a desert. If you don't have money, it's a desert.

Community organisations are sometimes present locally but usually target specific populations, such as trans people or migrants. They may play an important role both in reducing the stigma faced by these groups in mainstream healthcare and in providing alternative access points through flexible contact methods. Dr Caron, for example, mentioned a trans association that could be contacted by email or telephone and felt less intimidating for some patients. However, most GPs did not spontaneously mention such options, in many cases because they do not exist locally.

Connections with occupational health services also vary considerably. Some GPs described occasional exchanges with occupational physicians, either receiving patients referred from workplaces or sending patients when depression appeared linked to working conditions, though most reported having no contact at all. These differences reflect local professional ties and reputations. Communication appears even more limited with school medicine. Most GPs noted that recent staff shortages have reduced opportunities for collaboration, even where youth suicide rates are concerning. Dr Caron compared school health services to 'the Gobi Desert'. Contact often depends on the individual commitment of overworked school nurses or physicians, and some GPs, such as Dr Dubois, observed that the decline of school medicine has shifted responsibilities onto general practice: 'School doctors have stopped doing some of their many duties, and apparently those have now become our job.'

Finally, national helplines are rarely used. The recently implemented 24/7 suicide prevention hotline (3114), despite providing valuable support in other sectors (Notredame et al. 2025), is only marginally mobilised by the GPs, at least at the time of the interviews.

Professional hysteresis and the localisation of suicide prevention

> 'The problem is that the healthcare system is overloaded and not as efficient as we'd like. Seeing a professional isn't as easy as it used to be. Not that I feel like I ever really knew that time, but, well, that's what people say.'

This comment by Dr Henry encapsulates two key dynamics. Since major budget cuts were introduced in the 2000s, this young practitioner—born in the early 1990s and with only two years of professional experience—has never personally known the healthcare

system before austerity. Yet he still expects access to a readily available, free network of specialised professionals (mainly psychiatrists and psychologists). This discrepancy reflects the generational structure of professional socialisation: medical education and mentorship are delivered by practitioners who trained during what is sometimes remembered as a golden age of French public service, when universal access and hospital-based coordination defined the healthcare system (though this system had its limitations, particularly its strong reliance on hospitalisation).

In Bourdieu's terms (1990), this represents a hysteresis effect: a lag between an individual's dispositions and the social field in which they now operate, where the field has evolved faster than these dispositions can adapt. In this case, we observe a situation of professional hysteresis, where a professional group continues to act upon expectations formed in an earlier configuration. This disjuncture frequently appears in our data, for example, in Dr Caron's remark: 'In an ideal world, anyone even slightly suicidal should be kept in for 24–48 hours under observation.' Such statements testify to the persistence of past professional models that guide how GPs imagine what should be possible, even as the structures that once enabled such expectations have eroded and have not been replaced by substantial alternatives.

Our most experienced participants have witnessed these transformations firsthand. Dr Bernard, with 57 years of practice, recalled the gradual recognition of psychologists in the 1990s; the shift towards relatively more holistic approaches among GPs, contrasting with the heavy biomedical focus of the 1980s and 1990s, when physicians prescribed medication that 'could have killed an elephant'; and the defunding of public services, which has rendered psychiatrists largely unavailable, particularly in rural areas. In his region, one psychiatrist serves a population of 500,000. Dr Weber, with 29 years of experience, offered a similar account:

> In 2002, 2003, and 2004, the system completely shut down. We learned to stop using [the hospital system] almost entirely, especially in psychiatry. We no longer expected anything from psychiatry. We referred our patients, and they came back the same evening… In the 2000s, we learned to do without the hospital.

Professional hysteresis profoundly conditions referral practices and, by extension, suicide prevention. It renders suicide prevention an increasingly local issue, for several reasons. First, GPs can no longer rely on services that were once organised at the national level, such as psychiatric hospitals or CMPs, to which they have been trained to refer patients. This is not because their training has failed to adapt, but because austerity measures have chiefly consisted of 'doing more with less' and not been accompanied by organisational alternatives. Trained in (partially inapplicable) national guidelines, physicians encounter the constraints and local variations of everyday practice from the outset of their internships. Already significant in French mental healthcare (Coldefy and Curtis 2010), territorial inequalities have thus become decisive. Second, austerity policies have intensified the territorialisation of healthcare. Contemporary medical practice is increasingly structured around *Communautés Professionnelles Territoriales de Santé* (Territorial Professional Health Communities), which are intended to develop locally tailored and supposedly more effective networks for both prevention and treatment; in practice, however, this model seems to shift responsibility for resource shortages onto local actors. Finally, despite its aim of expanding access to psychological care in the aftermath of the COVID pandemic, the "Mon soutien psy" scheme has had a limited impact: few professionals participate, waiting times remain long, and most GPs continue to refer patients to trusted psychologists outside the reimbursement framework (Delespierre et al. 2024).

In sum, under conditions of sustained austerity, health services are undergoing a de facto institutional reorganisation which varies across localities, while GPs continually reassess their referral options and professional boundaries. Dr Roux provided an illustration of this reorganisation: in her region, a new specialised facility was created to screen young people in distress, and eventually direct them to the CMP; however, as the CMP became saturated and unable to welcome patients, it began sending its own patients to this new facility for treatment, thereby reversing the roles of screening and care services. Professional hysteresis, beyond professional socialisation, may thus be further sustained by organisational settings characterised by local particularisms and perceived dysfunction.

The rising value of local social capital

In this context, GPs' ability to secure timely and appropriate care for their patients increasingly depends on tips acquired on the job and familiarity with local resources. As a result, local social capital has become a pivotal feature of referral practices and, therefore, of suicide prevention.

Bourdieu (1986, p. 21) defines social capital as 'the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalised relationships of mutual acquaintance and recognition', providing each member with 'the backing of the collectively owned capital' and functioning as a form of 'credential'. For GPs, such capital derives primarily from socialisation within medical networks—through training, professional exchanges, or family ties when these exist—as well as from more personal connections. By local social capital, we mean the subset of these resources grounded in one's embeddedness within a specific locality: contacts made through residence, daily interactions, neighbourhood acquaintances, and the overlapping professional and personal relationships that come from being there, occupying a sustained position within a locality, or 'being around for a while'.

While GPs might be expected to base referral decisions on technical expertise, the saturation of health services compels them to draw on local social capital to find available practitioners. This resource is crucial when prescribing medications beyond one's sense of technical mastery. Having a psychiatrist in one's network provides both reassurance and informal supervision, as in the case of Dr Caron, whose sister-in-law is a psychiatrist: 'A big shout-out to [her] because I really send a lot of messages about choosing medications.' Others rely on peer groups, where difficult cases may be discussed more or less formally. GPs derive technical competence from these ties, a process reinforced by the uneven composition of general practice training, where psychiatric internships are optional.

Local social capital is also mobilised by GPs to navigate the shifting institutional landscape of their locality. Practitioners cultivate informal contacts to determine where their patients can realistically be sent. Patients themselves are a source of information. For example, Dr Mallat discovered that contacting EDs directly was 'the only option for

urgently seeing a psychiatrist in this area' through a patient who was a psychiatric nurse there. In group practices and health centres, local social capital can be collectivised, shared through conversations with colleagues. 'We used to have a contact list of specialists we could refer to—cardiologist, psychiatrist, whatever', Dr Bruni explained, but the only psychiatrist available in his area had such a poor reputation among patients that he stopped using this contact. Practising in a health centre or independently (as permitted in France) largely shapes physicians' local social capital.

GPs who have stayed in the same locality for many years logically benefit from greater local social capital, which confers certain advantages. Dr Pinchon, for instance, 'always works with the same' psychologist, whom he met 15 years ago. 'She's 200 metres from here,' he added, 'so I have a card, I give it [to patients], and she knows that when it's me, I send patients to her.' This increases patients' chances of obtaining timely appointments. In contrast, young doctors starting practice in an unfamiliar locality find themselves disadvantaged. When asked about the mental health services she collaborates with, Dr Muller, who has one year of experience and works in solo practice—therefore unable to benefit from colleagues' networks—abruptly replied, 'None.' Pressed to elaborate, she described the difficulty of navigating the local healthcare network without prior contacts:

> I spent five or ten minutes just trying to find the number for the psychiatric emergency service, because it's really not clear, nothing's set up properly. Normally, we're assigned one CMP per area. . . You have to call a CMP, give them the address, and they say, 'Oh no, that's not us, it's the other CMP.' So it's a bit of a hassle. And CMPs are pretty much at their limit anyway. For mental health care in general, there's the government's Mon soutien psy program with approved psychologists. So often I refer patients there. But again, I get the feeling there's a long waiting list, and it takes ages to get an appointment with a participating psychologist. So, in the end, most of the time, it's something we handle ourselves at the practice.

These difficulties have led some practitioners to develop instrumental strategies. Dr Weber shared his 'grim tactic' for finding psychiatrists:

> We had this psychiatrist from the public hospital who'd left the public system and started a private practice in town, and within three months, we'd fill up his schedule with all our most serious patients, and after those three months, he'd say, 'I'm not taking any new ones.' Fine, okay! So basically, and this is pretty cynical, we'd end up waiting for public hospital psychiatrists to burn out, and when they eventually left and opened a private practice, we'd think, 'Great, here's a fresh appointment book we can start filling with our patients.' And since I had good connections with the public hospital, partly through the university, I could find out which psychiatrists were leaving.

Dr Jouanneau is one of the few who successfully send patients to his CMP, but this access reflects years of (local) trust-building: regular communication with CMP staff and the assurance that he refers only when necessary: 'We know each other well enough that when we call one another, we help each other out for the sake of the patient.' Tellingly, several practitioners used the lexicon of friendship to describe professional ties, indicating that personal relationships may circumvent the constraints of an overburdened system. Dr Pons noted that without personal connections, securing an appointment with a psychiatrist is almost impossible:

> The last referral I managed was thanks to a birthday party of a friend who's a doctor. There was a psychiatrist there, and we talked. . . she told me she's in sector 2 and all that—but I did manage to refer one patient to her. I told the patient, 'Call her and say it's from me.' I also left a message, and in the end, he was able to get follow-up care.

Discussion: austerity-driven suicidescapes

The concept of *suicidescape* (Chandler et al. 2024) captures how political and economic conditions—here marked by austerity policies—shape the practices through which suicidality is interpreted and managed within a given locality. It further draws attention to the spatial and affective configurations through which certain forms of suicidality (and not others) become visible, recognised, and acted upon. Among the key dimensions discussed by Chandler et al. are: spatial contexts; situated knowledge and affects; and the situated activities through which suicidality comes to be unequally understood. Our

findings empirically articulate these dimensions in the context of general practice through the case of referrals. In this section, we build on these three dimensions by highlighting: the constructed significance of the local scale; the local enactments of medical knowledge; and social inequalities.

First, austerity heightens the importance of the local scale. Suicidescapes are local not only as a theoretical proposition, or because the local level matters in its own right, but also because specific sociopolitical processes confer particular meanings and practical relevance to this level. Our analysis shows that austerity and the subsequent restructuring of mental health provision profoundly influence how suicide prevention practices vary across localities. General practitioners occupy a pivotal position in this local landscape: a combination of policy expectations and patient demand increasingly brings mental health concerns into their routine consultations; however, the institutional framework within which GPs were trained presupposed the availability of a nationally organised network of services, such as CMPs, to which they could redirect patients. The erosion and uneven distribution of these services mean that such guidelines can no longer be followed. In this context, referrals depend on the relationships that practitioners develop with their local networks. In this sense, suicidescapes are not simply territorially situated: *they are local-ised*, in that they are *produced as local* through a range of sociopolitical processes.

Second, these processes have implications for the forms of *knowledge mobilised to account for suicidality, including their affective, embodied dimension*. GPs, even when they claim to adopt a holistic approach, primarily rely on medical and psychiatric frameworks. Although earlier research has shown how the neoliberal bureaucratisation of medicine has resulted in the disembodiment of professional knowledge (Nettleton, Burrows and Watt 2008), the opposite appears to occur in the specific case of mental health and suicide: a reliance on embodied judgement, emotion, and intuition. As GPs 'stretch' their sense of technical mastery, they accentuate the embodied and interpretive dimensions of their work: what they "feel" they can handle, and which patients they "worry" about. Because suicide risk cannot be objectified through simple indicators, unlike some somatic diseases, practitioners must interpret what patients express; in this respect, the clinical management of suicidality resembles domains such as pain medicine, where practitioners decipher subjective experiences to translate them into medical decisions (Baszanger 1998). This interpretive labour intensifies the emotional dimensions

of general practice, as GPs navigate concern for patient safety in a context where institutional support is perceived as both insufficient and locally specific.

Third, suicidescapes determine *which suicidal pathways become visible and acted upon, thereby generating inequalities among patients.* These effects are complex and, at times, contradictory. Wealthier patients are advantaged in navigating the healthcare system, as they have access to a broader range of options. Urban patients may also be relatively privileged in this respect—although this raises the question of whether the medical visibilisation of suicidal intentions should be systematically understood as privilege. On the other hand, austerity and the resulting local variability increase *randomness* in suicidal trajectories. As referral pathways depend less on formalised institutional arrangements and more on the networks that practitioners have built over time, the orientation of patients increasingly hinges on locally embedded relationships. Access to care, and crucially, the medical acknowledgement of suicidal intent, is not only premised on patients' resources, but also on whether, 'by chance', they consult a GP with long-established connections. Individuals assessed as being at moderate risk (who, as shown, pose specific challenges) may be particularly vulnerable to such contingencies.

Overall, our observations reflect a context in which austerity affects the functioning of most health services and preventive approaches to mental health are developing—albeit unevenly understood among professionals (Saïas et al., 2015)—placing GPs at the forefront of the interpretation of psychological distress. However, this position is less the result of a coordinated policy than of a convergence of institutional transformations. As a consequence, effects such as blurred professional jurisdictions and complexified treatment pathways increasingly operate at the local scale, producing particular suicidescapes marked by the salience of the local, the role of professional emotions, and reconfigured inequalities among patients.

Conclusion

This article has sought to develop conceptual tools for analysing a pivotal sequence in suicide prevention—how GPs refer patients they assess as at risk of suicide—in a context where austerity produces uneven local configurations, shaping both the meanings and practices of suicide prevention. First, referral decisions are largely determined by the

interplay between practitioners' knowledge of locally available services and their sense of technical mastery, which is continually stretched as they assume an expanding share of mental health work. Second, these practices are conditioned by professional hysteresis: GPs operate with dispositions adapted to a better-resourced healthcare system, they experience a mismatch between their dispositions and the organisational, economic, and other structural features of the medical field. Third, under these conditions, local social capital becomes a crucial resource, enabling practitioners, albeit unevenly, to navigate saturated networks of care. GPs therefore rely on compromises and workarounds to support their patients, rather than follow what they themselves understand as clinical best practice.

Although one possible conclusion of this study would be that coordination skills and network-building should be strengthened (Long et al. 2022), we instead advocate a more 'systemic' approach: competencies are embedded within local configurations of care that give medical practices meaning and render referrals variably possible. The aspects of medical practice highlighted in this article—GPs' sense of competence in engaging with mental health care, the professional ideals that orient their decisions, and the contingent value of social capital—interact within specific resource environments to produce what comes to count as suicide prevention, that is, the identification, interpretation, and (herein medical) management of suicidality. Taken together, these dynamics constitute a fully-fledged dimension of the suicidescape (Chandler et al. 2024): they contribute to how policies, infrastructures, affects, institutional logics, and everyday discursive practices combine to locally generate, constrain, and channel the chains of circumstances through which suicidality becomes eventually visible and potentially actionable.

References

Annandale, E. (2014) *The sociology of health and medicine: A critical introduction.* Cambridge: Polity.

Baszanger, I. (1998) *Inventing pain medicine: From the laboratory to the clinic*. Rutgers: Rutgers University Press.

Bendelow, G., Warrington, C. A., Jones, A.-M. & Markham, S. (2019) 'Police detentions of "mentally disordered persons": A multi-method investigation of Section 136 use in Sussex', *Medicine, Science and the Law,* 59(2), pp. 95–103.

Braun, V. and Clarke, V. (2022) *Thematic Analysis: A Practical Guide.* London: Sage.

Bourdieu, P. (1986) 'The Forms of Capital', in Richardson, J. (ed.) *Handbook of Theory and Research for the Sociology of Education*, Westport, CT: Greenwood, pp. 15–29.

Bourdieu, P. (1990) *The logic of practice.* Stanford, CA: Stanford University Press.

Button, M. E. & Marsh, I. (eds) (2019) *Suicide and social justice.* London: Routledge.

Cetin, U. (2016) 'Durkheim, ethnography and suicide: Researching young male suicide in the transnational London Alevi-Kurdish community', *Ethnography,* 17(2), pp. 250–277.

Chandler, A. & Wright, S. (2023) 'Suicide as slow death: Towards a haunted sociology of suicide', *The Sociological Review,* 72(5), pp. 1038–1056.

Chandler, A., Cover, R. & Fitzpatrick, S. J. (2022) 'Critical suicide studies, between methodology and ethics: Introduction', *Health,* 26(1), pp. 3–9.

Chandler, A., Huque, S., Helman, R., Anderson, J. & Yue, E. (2025) 'Embodiment and space in understandings of suicide and self-harm', in *Routledge Handbook on Spaces of Mental Health and Wellbeing.* London: Routledge.

Clarke, A. E., Washburn, R. & Friese, C. (2016) *Situational analysis in practice.* London: Routledge.

Coldefy, M. & Curtis, S. E. (2010) 'The geography of institutional psychiatric care in France 1800–2000', *Social Science & Medicine,* 71(12), pp. 2117–2129.

Conseil National de l'Ordre des Médecins (2022) *Atlas de la démographie médicale en France – Situation au 1er janvier 2021.* Paris: CNOM. [Online].

Consoli, A., Crozier, S., Gzil, F., Bacquet, L. & Delfraissy, J.-F. (2025) 'Crise de la psychiatrie en France', *Les Tribunes de la santé,* 83(1), pp. 105–112.

Da Silva, N. (2022) *La bataille de la Sécu: Une histoire du système de santé.* Paris: Éditions La Fabrique.

Dattani, S., Lucas Rodés-Guirao, H. & Roser, M. (2023) 'Mental Health'. Data adapted from WHO Mental Health Atlas 2020 via UNICEF. [Online].

Delespierre, A., Peretti-Watel, P. & Verger, P. (2024) 'Limites et angles morts d'un dispositif de santé publique: le cas des "chèques psy" étudiants durant la crise sanitaire du Covid-19', *Agora débats/jeunesses,* 97(2), pp. 132–148.

DREES – Ministère de la Santé (2001) *Les médecins hospitaliers depuis le milieu des années 80.* Études & Résultats n°145. Paris: DREES. [Online].

Drongiti, A. & Brossard, B. (2024) 'Sociologie du suicide: approches contemporaines', *Déviance et Société,* 48(1), pp. 7–20.

Dueweke, A. R. & Bridges, A. J. (2018) 'Suicide interventions in primary care', *Families, Systems, & Health,* 36(3), pp. 289–302.

Durkheim, E. (1897) *Le Suicide.*

Elzinga, E., de Kruif, A. J., de Beurs, D. P., Beekman, A. T., Franx, G. & Gilissen, R. (2020) 'Engaging primary care professionals in suicide prevention: A qualitative study', *PLoS One,* 15(11), p. e0242540.

Eyraud, B. & Velpry, L. (2014) 'De la critique de l'asile à la gestion de l'offre en santé mentale: une désinstitutionnalisation à la française de la psychiatrie?', *Revue française d'administration publique,* 149(1), pp. 207–222.

Fitzpatrick, S. J. (2021) 'The moral and political economy of suicide prevention', *Journal of Sociology,* 58(1), pp. 113–129.

Gabe, J., Cardano, M. & Genova, A. (eds) (2020) *Health and illness in the neoliberal era in Europe.* Bingley: Emerald Publishing Limited.

Henckes, N. (2011) ‘Reforming psychiatric institutions in the mid-twentieth century’, *History of Psychiatry,* 22(2), pp. 164–181.

Hughes, E. C. (1951) ‘Work and the self’, in Rohrer, J. H. & Sherif, M. (eds) *Social Psychology at the Crossroads.* New York: Harper & Brothers, pp. 313–323.

Kirmayer, L. J. (2022) ‘Suicide in cultural context: An ecosocial approach’, *Transcultural Psychiatry,* 59(1), pp. 3–12.

Long, J. C., Ruane, C., Ellis, L. A. et al. (2022) ‘Networks to strengthen community social capital for suicide prevention in regional Australia: the LifeSpan suicide prevention initiative’, *International Journal of Mental Health Systems,* 16(1), p. 10.

Marshall, J., Oliver, P., Hulin, J., Huddy, V. & Mitchell, C. (2025) ‘General practitioners’ perspectives regarding suicide prevention: a systematic scoping review’, *BJGP Open.* [Online first].

Marzetti, H., Chandler, A., Oaten, A. & Jordan, A. (2025) ‘The cruel optimism of suicide prevention: Thinking beyond the mental health model’, *Sociology.* [Online first].

McDowell, A., Lineberry, T. W. & Bostwick, J. M. (2011) ‘Practical suicide-risk management for the busy primary care physician’, *Mayo Clinic Proceedings,* 86(8), pp. 792–800.

Mills, C. (2018) ‘“Dead people don’t claim”: A psychopolitical autopsy of UK austerity suicides’, *Critical Social Policy,* 38(2), pp. 302–322.

Mueller, A. S. & Abrutyn, S. (2024) *Life under pressure: The social roots of youth suicide and what to do about them.* Oxford: Oxford University Press.

Mughal, F. et al. (2021) ‘Suicide prevention in primary care’, *Crisis,* 42(4), pp. 241–246.

Mughal, F. et al. (2023) ‘Recent GP consultation before death by suicide in middle-aged males’, *British Journal of General Practice,* 73(732), e478–e485.

Muñoz-Sánchez, J.-L., Sánchez-Gómez, M. C., Martín-Cilleros, M. V. et al. (2018) ‘Addressing suicide risk according to different healthcare professionals in Spain: A qualitative study’, *International Journal of Environmental Research and Public Health,* 15(10), p. 2117.

Nettleton, S. (2020) *The sociology of health and illness.* 2nd ed. Cambridge: Polity.

Nettleton, S., Burrows, R. & Watt, I. (2008) 'Regulating medical bodies? The consequences of the "modernisation" of the NHS and the disembodiment of clinical knowledge', *Sociology of Health & Illness,* 30(3), pp. 333–348.

Notredame, C. E., Wathelet, M., Morgiève, M., Grandgenevre, P., Debien, C., Mannoni, C., Pauwels, N., Ducrocq, F., Leaune, E., Binder, P. & Berrouiguet, S. (2025) 'The 3114: A new professional helpline to swing the French suicide prevention in a new paradigm', *European Psychiatry,* 68(1), p. e43.

Oaten, A., Jordan, A., Chandler, A. & Marzetti, H. (2022) 'Suicide prevention as biopolitical surveillance: A critical analysis of UK suicide prevention policies', *Critical Social Policy,* 43(4), pp. 654–675.

Pearson, V. & Liu, M. (2002) 'Ling's death: An ethnography of a Chinese woman's suicide', *Suicide and Life-Threatening Behavior,* 32(4), pp. 347–358.

Rex, M., Brezicka, T., Carlström, E., Waern, M. & Ali, L. (2022) 'Coexisting service-related factors preceding suicide: A network analysis', *BMJ Open,* 12(4), p. e050953.

Saïas, T., Véron, T., Delawarde, C., & Briffault, X. (2025) 'Prevention in mental health: Social representations from French professionals', *Health Sociology Review,* 23(2), pp. 159-164.

Saini, P., Hunt, A., Blaney, P. & Murray, A. (2024) 'Recognising and responding to suicide-risk factors in primary care: a scoping review', *Journal of Prevention,* 45(5), pp. 727–750.

Saini, P., Windfuhr, K., Pearson, A. et al. (2010) 'Suicide prevention in primary care: General practitioners' views on service availability', *BMC Research Notes,* 3, p. 246.

Soual, H. (2017) 'Les dépenses de santé depuis 1950', *Etudes et Résultats,* 1017, pp. 1–6.

Stene-Larsen, K. & Reneflot, A. (2019) ‘Contact with primary and mental health care prior to suicide: A systematic review of the literature from 2000 to 2017’, *Scandinavian Journal of Public Health,* 47(1), pp. 9–17.

Tavory, I. & Timmermans, S. (2022) *Abductive analysis.* Chicago, IL: University of Chicago Press.

Thangada, M. S. & Kasoju, R. (2024) ‘A systematic review of suicide risk management strategies in primary care settings’, *Frontiers in Psychiatry,* 15, p. 1440738.

Velpry, L. (2008) *Le quotidien de la psychiatrie.* Paris: Armand Colin.

Wheeldon, J., & Faubert, J. (2009). Framing Experience: Concept Maps, Mind Maps, and Data Collection in Qualitative Research. *International Journal of Qualitative Methods*, *8*(3), 68-83.

Younes, N., Rivière, M., Urbain, F., Pons, R., Hanslik, T., Rossignol, L., Chan Chee, C., Blanchon, T. (2020) ‘Management in primary care at the time of a suicide attempt and its impact on care post-suicide attempt’, *BMC Family Practice,* 21(1), p. 55.

Zhang, J., Uscola, C., Abrutyn, S. & Mueller, A. S. (2024) ‘Phenomenology, cultural meaning, and the curious case of suicide’, *Philosophy of the Social Sciences.* [Online first].

Figure 1: Participants

Pseudonym	Age	Sex	Professional status	Years of experience	Patient population	Geographical characteristics	Number of interviews
Gabriel Mayer	43	M	Private practice	5	1,100	Medium-sized town, working-class area with migrant population	2
Amélie Caron	34	F	Public practice	4	1,000	Socio-economically mixed suburb of Paris	2
Alain Bernard	75	M	Public practice	57	2,000	Semi-rural "medical desert"	2
Ludivine Dubois	35	F	Private practice	8	1,300	City centre, few elderly patients	2
Solène Martin	35	F	Private practice	7	700	Central urban area, mainly young and working-class patients	2
Camille Arnaud	30	M	Locum in private practice	2	NA	(1) Urban centre, young affluent adults; (2) semi-rural office, older and more diverse population	2
Bastien Favre	30	M	Private practice	1	1,500	Mixed area near social housing, with suburban and affluent patients	2
Gustave Weber	59	M	Private practice and lecturer in general medicine	29	1,200	Initially rural, later urban (community medicine with HIV, migrant, and LGBT populations)	2
Julien Perrin	45	M	Private practice	18	1,350	Paris suburb, increasingly affluent	2
Cieran Henry	34	M	Private practice	2	500	Medium-sized provincial town	1
Didier Pichon	62	M	Private practice	35	2,800	Predominantly working-class area	1
Cécile Marsault	40	F	Public practice	13	Unknown	Northern suburb of Paris, socio-economically mixed	1
Pauline Pons	40	F	Private practice and university lecturer	14	1,500	Semi-urban area in southwestern France	2
Cédric Abadie	45	M	Private and hospital physician; volunteer in medical association	16	1,700	Rural (hospital and office), urban (association)	2
Chloé Muller	28	F	Locum in private practice	1	NA	Suburb of a large city in western France	2
Antoine Mallat	39	M	Private practice	7	3,100	Paris suburb combining social housing and rural surroundings	2
Justine Richard	34	F	Private practice	4	850	Semi-rural area in southwestern France	2
Romain Perard	47	M	Private practice	14	1,300	Rural area near a large city in eastern France	1
Lucas Bruni	27	M	General practice intern	0	NA	Paris region	1
Lucile Jornet	36	F	Private practice and lecturer in general medicine	10	1,600	Medium-sized city in eastern France	2
Jeanne Becker	31	F	Private practice	3	350	Northern suburb of Paris	1
Maxime Bossard	36	M	Private practice and emergency medical dispatcher	8	300	Large city in western France	2
Floriane Roux	47	F	Private practice	20	1,300	Rural area in central France	2
Maxens Garcia	32	M	Private and hospital physician	3	Unknown	Medium-sized town in southwestern France	1
François Jouaneau	53	M	Private practice and university professor	23	1,500	Semi-rural town in western France	2
Amandine Viera	37	F	Private practice	10	1,500	Urban area near a large city in eastern France	2
Claire Merceron	30	F	Private practice	2	200	Urban area in Western France	2
Julie Lemoine	34	F	Private practice	3	700	Paris region	2
Audrey Lagrange	31	F	Private practice	4	500 (part-time)	Rural area, Western France	1

Figure 2 - Dr Marsault, 13 years of experience, northern suburb of Paris, socio-economically mixed

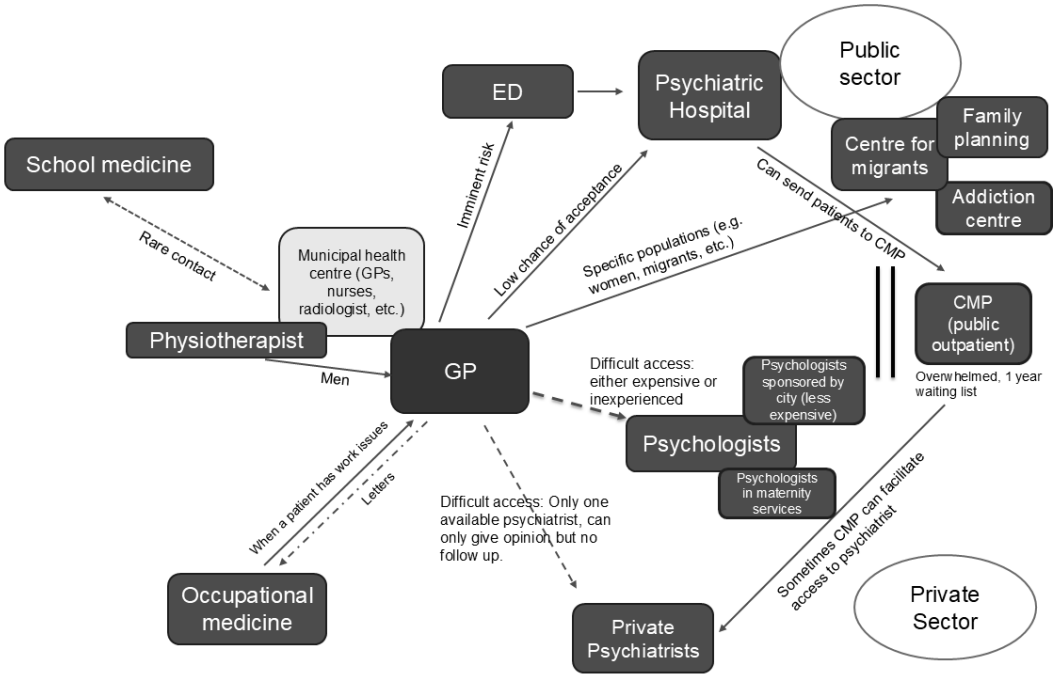

Figure 3 - Dr Mayer, 5 years of experience, Medium-sized town in the centre of France, working-class area with migrant population