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THE CHALLENGES OF SCHOOL-BASED YOUTH SUICIDE PREVENTION: EXPERIENCES AND PERCEPTIONS OF MENTAL HEALTH PROFESSIONALS IN SOUTH AFRICAN SCHOOLS

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Abstract

Youth suicidal behaviour poses a significant public health concern. Mental health care professionals working in schools have an important role to play in youth suicide prevention initiatives, although little is known of the experiences of this group of professionals in the developing world. The aim of this study was to explore the experiences of mental health professionals working in South African schools and document their insights, attitudes and beliefs regarding youth suicidal behaviour. In-depth semi-structured interviews were conducted with seven school-based mental health care professionals and data were analysed using Thematic Analysis. Participants reported that they relied on a reactive strategy by responding to youths who were in crisis. They were challenged by a lack of support from faculty staff, lack of access to resources, and heavy caseloads. Findings highlight the need for a proactive and collaborative approach to suicide prevention among mental health care professionals, teachers and parents in South African schools and improved training and supervision.

Keywords

school-based suicide prevention; youth suicide; mental health care professionals; challenges to suicide prevention

INTRODUCTION

Suicide is the third leading cause of death globally (WHO, 2012) with the incidence of youth suicide in Western countries estimated to be as high as 9.9 per 100 000 (Center for Disease Control and Prevention, 2013; Krug, Mercy, Dahlberg and Zwi, 2002). High rates of youth suicide have serious public health implications for suicide prevention and postvention initiatives (Bertolote, Fleischmann, De Leo, Bolhari, Botega, and de Silva, 2004 ; O'Connor, Platt and Gordon, 2011) and highlight the importance of school-based suicide prevention strategies. A number of authors note that school-based mental health workers have an important role to play in youth suicide prevention and postvention due to their proximity to the at-risk population (Debski, Spadafore, Jacob, Poole, and Hixson, 2007; Fineran, 2012;

Miller, Eckert and Mazza, 2009). It is therefore important to document the experiences of school-based mental health care workers and investigate how they understand youth suicidal behaviour, how they assess and manage suicide risk, how they conceptualise their role in school-based suicide prevention and postvention initiatives and the challenges they face in carrying out their duties. In this paper we describe a study undertaken to investigate the experiences and perceptions of a group of social workers, psychologists and registered counsellors working in South African schools. We wanted to document their insights and the challenges they face with respect to youth suicide prevention.

The South African context

In SA, the incidence of youth suicidal behaviour is largely underreported, especially in rural areas (Burrows and Schlebusch, 2008). A review of National Injury Mortality Surveillance System (NIMSS) data over an eight year period indicated that suicide fatalities are highest amongst the 15–29 year-old group and suicide deaths in those younger than 21 constitute approximately 8% of all suicides in SA (Bantjes and Kagee, 2013). Rates of suicidal behaviour, psychological distress and risk taking among the country's youth are reported to be very high (Herman et al., 2009; Reddy, Panday, Swart, Jinabhai, Amosun, and James, 2002; Reddy, James, Sewpaul, Koopman, Funani, and Sifunda, 2010) with poor access to child and adolescent psychiatric and psycho-social services (Kleintjes, Lund and Flisher, 2010). Given that 40% of the country's population is of school-going age (Statistics South Africa, 2011), schools would seem to be an appropriate site for psychological interventions in SA. Nonetheless, many schools in SA lack mental health care workers (Schlebusch, 2004).

Defining suicidal behaviour, suicide prevention and postvention

“Suicide” is defined by the World Health Organization as the act of intentionally killing oneself (WHO, 2012). “Suicidal behaviour” refers to a range of self-injurious acts and cognitions motivated by an intention to kill oneself (Silverman, 2011; Steele and Doey, 2007). Findings suggest that non-fatal suicidal behaviour is strongly associated with the incidence of completed suicide and is regarded as a significant risk factor for completed suicide (Hawton and James, 2005; Hawton, Bergen, Kapur, Cooper, Steeg, Ness, and Waters, 2012; Kapur, Cooper, King-Hele, Webb, Lawlor, and Rodway, 2006; Owens, Horrocks and House, 2002; Suominen, Isometsä, Suokas, Haukka, Achte, and Lönnqvist, 2004). It is, therefore, important to focus on all forms of suicidal behaviour in order to prevent deaths by suicide.

The term “suicide prevention” refers to activities aimed at inhibiting acts of suicide (Hadlaczky, Wasserman, Hoven, Mandell, and Wasserman, 2011). “Postvention” refers to strategies employed following an act of suicide in a bid to lower the probability of contagion (King, 2001).

LITERATURE REVIEW

The incidence of youth suicide varies worldwide. In Western countries such as the USA, suicide claims 1.5 per 100 000 lives in the 10–14 year-old group (CDC, 2010). Suicide rates

among the 15–19 year-old group in Russia and the UK are 23.5 per 100 000 and 4.2 per 100 000 respectively (WHO, 2004). In addition, youth suicide rates in Australia are 8.9 per 100 000 and in Japan the rate is 6.4 per 100 000 (WHO, 2004). Findings suggest that families, peers and teachers are adversely affected by youth suicide (Christianson and Everall, 2009; King, 2001; Feigelman and Gorman, 2008; Sakinofsky, 2007).

Kalafat (2003) highlights the need for comprehensive, evidence-based suicide prevention programmes in schools. Although many schools in the USA subscribed to standardised prevention programmes, marked variations in how these programmes are implemented and upheld compromise their integrity and efficacy (Kalafat, 2003). Fineran (2012) has highlighted the role of the School Counsellor in the successful implementation of postvention programmes and emphasized the need for greater collaboration among school administration, teaching staff and school-based mental health professionals in implementing proactive suicide protocols. Capuzzi (2002) noted that school counsellors were an integral part of school-based suicide prevention and crisis management efforts. Evidence suggests that school counsellors are at times reluctant to engage in suicide prevention efforts because they feel devalued and unacknowledged for their expertise (Christianson and Everall, 2009). Some school counsellors are, however, motivated to intervene as they believe they have the skills to prevent youth suicides (Christianson and Everall, 2009).

School-based suicide prevention strategies are hampered by a number of factors, including the fact that suicidal ideation impedes help-seeking behaviour among young people (Deane, Wilson and Ciarrochi, 2001) and the tendency for youths to communicate suicide intent to their peers rather than seek professional help (Kalafat, 2003). Implicitly, these findings suggest that at-risk youths may be hard to detect in the school system and that school based mental health care workers may have a responsibility to actively seek out undetected at-risk youths. Zenere and Lazarus (2009) argued that raising awareness by training school-based mental health care workers in identifying and assessing at-risk learners was imperative to a suicide prevention programme.

Although there are some international studies exploring the experiences and beliefs of school-based mental health professionals regarding youth suicide, studies conducted in SA are scant. Furthermore the studies conducted in this area have tended to focus on teacher-counsellors rather than social workers and psychologists. A study conducted by Öncü, Soykan, Özgür han and Sayil (2008) in Turkey, reported that school guidance teachers (n=57) believed youth suicide is predominantly caused by interpersonal problems and that suicides can be prevented. In another study conducted in the USA, only 9% of health teachers said they believed they could adequately identify at-risk youths and approximately 42% said they believed they could offer support to at-risk youths (King, Price, Telljohann, and Wahl, 1999). King et al. (1999) reported that health teachers believe it is important to identify at risk youths although they regarded their lack of knowledge as an impediment to suicide-prevention. Studies in the USA found that school counsellors were reluctant to identify at risk youths through screening because they believed that suicide screening was intrusive, laborious and encouraged suicidal behaviour (Eckert, Miller, DuPaul, and Riley-Tillman, 2003). Capuzzi (2002) cautioned that the actions of school counsellors is sometimes shaped by misinformation and myths about suicide. Common myths include the

belief that talking to youths about suicide may increase its incidence (Leenaars and Wenckstern, 1999; Kalafat, 2003), that suicide is caused by social and familial stressors rather than mental illness (Moskos, Achilles and Gray, 2004), and that little can be done to prevent suicide once an individual decides to complete suicide (King et al., 1999).

The risk factor model is a common approach to conceptualising suicide (Sanchez, 2001). Within this model suicide is understood to be the consequence of a number of specific risk factors such as the lack of a significant interpersonal relationship, the presence of psychopathology, a history of suicidal behaviour and chronic medical problems (Sanchez, 2001). The risk factor model also acknowledges that protective factors such as active employment, presence of a support system and effective problem-solving act as ameliorative factors against suicide (Sanchez, 2001). The risk factor model provides a comprehensive and logical framework for assessing suicide as it organises historical, psychosocial, clinical, personal and environmental risk factors, as well as highlighting ameliorating factors during the assessment and treatment of suicidal patients (Bantjes and van Ommen, 2008). The risk factor model also provides a framework for suicide prevention programmes in schools by highlighting what factors need to be addressed to reduce suicidal behaviour (Kalafat, 2003). Within the risk factor model, school-based mental health professionals have a role to play in suicide prevention by working to reduce risk factors and promote protective factors among learners. Risk factors for youth suicidal behaviour have been well documented and are summarized in table 1 below.

The risk factor model of suicide has limitations. Stark, Riordan and O'Connor (2011) argue that a more rigorous conceptual model, such as the "Cry of Pain" model, is required when planning suicide prevention programmes so as to take cultural and social factors into account. Similarly, Colucci (2006) argues that effective suicide prevention necessitates a culturally-sensitive approach as an individual's cultural background impacts the way people understand and engage in suicidal behaviour. Alternatives to the risk factor approach to suicide assessment have been proposed by scholars such as Rudd (2014) and Jobes and Drozd (2004).

The accurate assessment of suicide risk is a complex process since suicidal behaviour is a multifaceted construct (Schlebusch, 2012). The complexity of assessing suicide risk is further compounded by the fact that suicide risk fluctuates from moment to moment, making any assessment of risk only accurate for a brief period of time (Bantjes and Van Ommen, 2008). Because assessing suicide risk is complex, some scholars have noted the need for clinicians to employ psychometric instruments in the assessment process. In a review of suicide risk assessment tools, Brown (2001) noted the usefulness of the Beck Depression Inventory (BDI) and the Beck Hopelessness Scale (BHS) in determining suicide risk.

To date, few studies have explored the challenges faced by school-based mental health professionals as they have mainly focussed on the efficacy of school-based suicide prevention programmes (Walsh, Hooven and Kronick, 2013) and the legal and ethical implications of school counsellors' role in suicide prevention (Capuzzi, 2002). Research conducted in developed countries has documented school counsellors' preparedness to intervene with youths at risk of suicide and their perceived confidence to intervene

effectively to prevent suicides (Christianson and Everall, 2000; King and Smith, 2000). Little is, however, known about the challenges school-based mental health professionals working in developing countries face when attempting to fulfil their roles. Hamilton (2008) notes how compassion fatigue, burnout and deficits in training impede school-based mental health professionals in developed countries from effectively preventing youth suicides. Moyer and Sullivan (2008) have highlighted the tensions school counsellors in the USA face with respect to managing confidentiality, abiding by multiple ethical codes and having to respond to the needs of a large population of clients. Similar challenges faced by school counsellors in SA schools hamper their ability to deliver mental health care services and prevent suicides (Pillay, 2011; Petersen, 2004). Pillay (2011) notes how the roles performed by school counsellors in SA are often confused as they are expected to fulfil a wide variety of tasks daily and carry heavy caseloads. School counsellors in SA also face challenges to build collaborative networks (Pillay, 2011). The difficulties of preventing youth suicides are compounded for school counsellors by the lack of a national suicide prevention strategy in SA, inadequate knowledge of local risk factors, insufficient understanding of the socio-cultural context in which suicide occurs in the country and inadequate adolescent psychiatric referral pathways.

METHODS

Our aim was to explore the experiences and perceptions of mental health care workers regarding suicidal behaviour in SA schools and highlight the challenges they faced in prevention efforts. We employed a qualitative research design and collected data via in-depth, semi-structured telephonic interviews. The use of telephonic interviews in qualitative research has been found to be valid, rendering equal amounts and quality of data as face-to-face interviews (Sturges and Hanrahan, 2004).

The study focused on mental health care workers (i.e. psychologists, counsellors and social workers) employed in SA schools. As few schools in SA employ mental health care professionals, the participants were identified using purposeful sampling. Mental health care workers from 14 large schools were identified and invited to participate; these schools were purposefully approached because they are known to have mental health care professionals employed in the role of school counsellors. Purposeful sampling was deemed to be apt for this study since it enabled us to identify appropriate participants in a bid to gather the data needed to answer the research question (Marshall, 1996) and allowed for the retrieval of deep, rich, phenomenological data. Seven participants (see characteristics in table 2) were recruited for the study. The sample was not intended to act as a representative population nor were we intending to make claims about the generalizability of our findings; instead we wanted to simply explore the perceptions and experiences of the participants in order to lay the foundation for future work in this area of youth suicide prevention.

Interviews, lasting between 40 minutes and an hour, were conducted in which participants were asked to share their: experience of working with suicidal youths; awareness of aetiology of suicidal behaviour; perception of warning signs; assessment and management procedures; attitudes towards suicidal youths; perception of the role of postvention in schools; and perceptions of barriers to suicide prevention in schools.

Interviews were audio-recorded, transcribed verbatim and analysed using the Thematic Analysis (TA) method outlined by Braun and Clarke (2006). The following six step process was employed in the data analysis in order to ensure rigour: (1) Transcripts were read and reread to allow for immersion in the data set; (2) After immersion, the raw text was grouped into meaning units and coded; (3) The coded units were then assessed to identify similar units and grouped into themes and sub-themes; (4) The list of themes and sub-themes were reviewed to ensure that the coded units fitted logically into the theme categories, and a thematic map was created to ensure that themes and sub-themes were refined; (5) The themes were then reviewed to ensure that each theme was unique, after which they were named; and finally, (6) The research findings were presented in the form of a coherent narrative.

Ethical considerations

Ethical approval was obtained from the relevant ethics committee and the education department. Informed consent was obtained and data collected during the interviews were cleared of any identifying information to ensure confidentiality and protect the privacy of the participants. The data were stored on a secure computer that was only accessible to the researchers.

FINDINGS

Six participants reported personal experience of suicide in their social and family contexts, yet only one reported a completed suicide in a school setting. Five participants reported encountering youth suicidal behaviour on a monthly basis in the course of their work, one participant reported two incidents in the last decade and the other participant reported encountering suicidal behaviour approximately once every two weeks.

When asked about their attitudes towards suicidal youths in schools, all participants expressed concern and empathy towards them. One participant said, “I feel a huge amount of compassion”, and another, “I feel desperate for them”. Jim expressed that his attitude towards suicidal people has changed over the years:

In my earlier days I might have seen it as a sign of like weakness or whatever, so those sort of attitudes you have when you were younger. But for me it’s just somebody who is needing some help and some support.

(Jim)

Five participants said they believed that suicide could not be prevented. This belief is evident in Patrick’s assertion:

I don’t think that suicide can be prevented. I think we can obviously put systems in place and do the best that we can but I think there’s always a risk factor.

Some participant said they believed youth suicides could be prevented if there was more open communication regarding suicide and less stigma associated with acknowledging suicidal thoughts. Richard, for example, said:

I think if people could speak more openly, if people had someone to turn to, if there were communication structures or open lines of communication in certain situations, yes, I think suicide could be prevented.

Perceived causes of youth suicidal behaviour

Participants expressed a belief that youth suicide was a complex phenomenon driven by a multitude of factors. Patrick, for example, said:

I think it's a very complex issue...in terms of why they complete it [suicide], I suppose it would vary from depression, some kind of mental illness, family stresses - a whole range of things really.

Participants articulated a belief that mental illness is a primary cause of youth suicidal behaviour. This perception is evident in Jane's words:

I think that the people that really are in such a depressed state and they are so desperate and often I think it's associated to just sort of a depression episode or a mood disorder.

Participants also noted that perceived burdensomeness was implicated together with mental illness in precipitating youth suicides. As Samantha noted:

I think those are people who are suffering from chronic, clinical depression or a mood disorder and see that they're a burden to other people.

Most participants stated that suicide was the result of longstanding suffering and a profound sense of worthlessness, hopelessness and loneliness. Richard, said for example:

They [suicidal youth] believe that there's no one, absolutely no one. Everything is going wrong for them and they don't see a way out and they believe that there's no one who loves them and they believe that no one can actually assist them.... I think they sometimes feel that the world would be a better place without them around.

Similarly, Jane said:

They just don't see any hope for the future in positive things that can happen. They can't actually see how they're ever going to get out of the depression.

Four participants stated that they believed youths that attempted suicide were at the end of their wits, overwhelmed and saw it as a solution or a way out. Their perception is that suicidal behaviour is sometimes a goal-directed attempt to solve a problem. Johan, for example, said:

I think the individual usually sees it as a solution. So, they want a solution to something.

Similarly, some participants saw suicidal behaviour as a means for youths to draw attention to themselves or to punish others.

I think sometimes suicide is also a way of punishing other people.

(Patrick)

All participants agreed that suicidal behaviour was often used as a communication tool to express needs and distress.

How else does an adolescent communicate except by acting out? So by that they are drawing attention to themselves. You have to ask yourself the question. What are they not getting that they have to do this? What are they trying to tell us?

(Samantha)

Perceived warning signs

Most participants reported “warning signs” which they believe signal that a youth is at imminent risk of suicide. When participants were asked how they identified at-risk youths, they agreed that one of the most significant indicators is “changes in behaviour”. Samantha said:

I think one has to look at consistent changes in behaviour, withdrawal, perhaps using alcohol and drugs that they normally wouldn't.

Additionally, most participants agreed that the presence of suicidal ideation or plan, a history of self-harm or suicide attempts, feelings of hopelessness and a sense of foreshortened future were indicators that someone was at risk of suicide. As Patrick stated:

I would say the main warning signs obviously, if they tell somebody, so that would be, telling someone about their suicidal ideation, previous attempts and obviously if they had a plan.

Jane echoed this perception saying:

I would be looking for whether they see any hope for the future, sort of what if anything that they're looking forward to in their future.

Six participants regarded prior suicidal behaviour as a risk factor. Jim, for example, said:

Somebody who's made multiple life threatening attempts, those are high risk.

All participants believed mental illness was strongly associated with suicidal behaviour, but only one participant saw physical illness as a potential risk factor for suicide. Jane said, “I think it's their medical state at the time”.

Assessment and management of at-risk youths

Participants described how they assessed and managed youths at risk of suicide. Most participants acknowledged the need for a detailed and thorough assessment of suicide risk but said that this was time consuming and difficult since they did not always have all the information they needed to make an accurate assessment. The majority asserted that they used the “mental status exam” and did a thorough “history taking”, reflecting their predominant psychiatric understanding of suicidal behaviour as a symptom of psychopathology. Two participants reported that they gathered “collateral” information from teachers, peers and parents if they suspected risk. Equally, two participants relayed that they found certain psychometric instruments useful. As Patrick stated:

Obviously the interview and the assessment would be very important, but I would also use a measure. The Beck Depression Inventory would be the one that I would use.

Four participants reported that they assess suicide risk in youths by directly asking them if they had a plan, a means to complete suicide, or if they intended to harm themselves. As Amy put it:

One needs to first of all kind of talk to them about it, what is their intent, you know. Find out what exactly are they saying here.

Participants said that they used on-going monitoring as a means to manage and assess risk and showed cognisance of the fact that suicide risk fluctuates. Patrick described how he was currently managing a boy at risk of suicide by saying:

He (the at-risk boy) basically says to me that he thinks about it but he would never do it. So I definitely check in with him around ideation and also a plan.... I still need to check up with him about that [ideation] regularly to make sure that it hasn't shifted to an actual plan.

Participants acknowledged the importance of asking directly about suicidal ideation and assessing intention by gathering as much detail as possible. Jane, for example, said:

I would ask them about their thoughts of suicide and if they're thinking about it and then I would ask them to give me details around it. I would look at the sort of possibility of it really happening. So like, there's a girl whose father is a doctor and she says well there's Morphine tablets in the house. I would know if she's thinking of taking them.

Participants spoke about the importance of working within a collaborative team, being able to make referrals and involve others in the management of at risk youths. They all said they would refer an at-risk youth to a psychiatrist or another colleague to obtain a second-opinion. Samantha said, "Certainly, I wouldn't do it [treatment] in isolation. I think if someone is suicidal, there needs to be somebody else". Participants seemed to see their role as mainly supportive within the school context. Richard said, "I would not feel comfortable in taking that on 100%, however, I would still support that individual."

All participants reported that they would always "inform the parents" if they suspected a youth to be suicidal and acknowledged that there were limits to confidentiality when dealing with suicidal behaviour. As Jane stated:

If there was any sign of them thinking about suicide or talking about it or planning it, I would definitely call in a parent or somebody who's looking after them.

Three participants reported that they would have a youth admitted to a hospital if there was suicidal intent. As Jane said, "In some cases they need to be admitted", and Samantha said, "The family gets called in and they are admitted straight away".

Perceived barriers to school-based suicide prevention

Participants expressed concern that there were limits to how much they could do to prevent suicides and they all articulated perceived challenges to school-based suicide prevention. Jane reported that in her experience at-risk youths seldom seek help, which presented a challenge in identifying those in need of intervention. Related to this is participants' perception of the challenge of stigma; they said that they believed many youth at risk of suicide were reluctant to self-identify or disclose their suicidal ideation or intent for fear of being labelled as mentally ill. In this context, participants expressed a perception that some at risk youths go undetected and fail to communicate their suicidal intent. Jane, for example, stated:

I believe that the people that really are the most at risk for having a successful suicide, they don't come to the counsellor at school and they don't tell their parents and they don't get help.

Many participants highlighted the importance of school-wide collaboration in suicide prevention by noting that at-risk youths were often identified by teachers, parents and learners. As Jane stated:

Another thing that happens often here is that girls come to me and they say, "We're really worried about our friend. She's got very thin or she's not socializing with us anymore, there's problems with friendships and we're worried" and then I'll call her in.

Although many participants agreed that they relied on teachers and parents to report anomalies in learner behaviour, some felt that teachers and parents hampered the process. Richard, for example said:

Some teachers are very good and then some teachers, I don't know, maybe they sometimes feel that it would be seen as, they must deal with everything in the class and they don't need to refer it out. They are teachers who perhaps have been here a long time and maybe don't get the value in psychology and the counsellors and they often don't approach us.

Some participants said they also felt that lack of parent support was a challenge for them. They spoke about how some parents withhold important information (such as a child having a mood disorder or conflict at home) thus preventing the school from providing additional support or monitoring. Similarly participants said that they found some parents to be unsupportive and unwilling to acknowledge that their children needed psychological support.

Participants also said that they were hampered in the performance of their role in suicide prevention by their own lack of knowledge and insufficient time to rigorously assess suicide risk because of heavy caseloads and having to perform many other school-related duties. In the context of discussing these challenges, Patrick described how insufficient time impeded risk assessments and caused blind-spots:

I would say blind spots, maybe during assessments, maybe that you've misread the situation or you haven't gone through it rigorously enough.

Samantha echoed this perception by describing how heavy caseloads, lack of experience and poor access to resources posed challenges to suicide prevention:

I think the case load, especially for social workers, the volume. Not all social workers are clinically trained. Experience, obviously but I think a higher case load, the pressure of work. Unfortunately people miss stuff. Also a lack of access to resources.

Two participants said that they found suicide prevention work difficult with adolescents because they associated this developmental period with increased impulsivity and reluctance to ask for help. Amy, for example, said:

I think children tend to be more open about that kind of thing [suicidality], certainly that has been my experience, whereas with adolescents it's a far more complex situation.

Similarly, Patrick said, "Certainly amongst boys or young men it can be that they have a suicidal impulse and then they act on it. So it's sort of impulsivity".

In addition, one participant emphasized how young men may adopt hegemonic masculine gender roles to mask their fears and vulnerabilities, making it harder to identify them:

Sometimes guys aren't great with expressing where they're at. So whether it's depression without suicide or more serious depression with suicidal thoughts, I think the guys will often mask their feelings behind behaviours, which can be misinterpreted as just being bad or naughty.

(Jim)

In spite of the challenges they face, all participants agreed that they had an ethical and moral responsibility to prevent youth suicide. Amy asserted this perception by saying:

I think we do definitely have a responsibility to do our best at this stage to prevent children from taking their lives.

Suggestions for school-based suicide prevention

Many participants shared insights and suggestions for suicide prevention in schools. Some participants highlighted the need for practical training in risk assessment and management. As Patrick asserted:

(We) need to know some practical steps on how to manage it - a patient who is expressing suicidal ideation and how to work with that.

Some participants asked for information on how gender roles influence suicidal behaviour. Richard said "I suppose also the gender, the gender dynamics of it [suicidal behaviour]" and Jim said, "... (we need help) recognising the symptoms in men and boys and helping effect treatments in terms of men and boys and I think that would be linked to a whole big picture of depression and emotions". Implicitly participants acknowledged the importance of understanding socio-cultural influences in suicide prevention. Similarly, participants acknowledged the need to take cognisance of developmental processes and understand how children communicate psychological distress. Samantha expressed this perception by saying:

They (school-based mental health professionals) have to understand how children and adolescents communicate how they're feeling or don't or how they will act out and then to look at the clinical signs and symptoms.

Patrick noted the need to include information regarding no-harm and no-suicide contracts in training and stated, "I think we need to know about suicide contracts".

Some participants agreed that suicide prevention could be better operationalized with the buy-in of parents and by training school staff. As Richard noted, "Some parents are very good to, you know, some parents will keep us in the loop", and Jane said, "It is definitely our responsibility to inform all the people that are with that person day to day and educate them around preventing it".

Additionally, Jim suggested that a forum may be useful whereby youths raise awareness by sharing experiences. He said, "...building some empathy around somebody's life that, maybe people who have been seriously depressed, sharing their stories with people so that you try and build up something of a picture".

Only one participant highlighted the need for intervention following acts of suicidal behaviour. As Samantha noted, "That's what we have to do, that once the immediate crisis is over, is to help them develop tools to cope when they are feeling like that again and mostly it works".

One participant also noted the use of a supervisor in his prevention strategy. Most participants agreed that workshops, web pages and access to relevant research would assist them in their prevention endeavours. As Patrick said he would find it helpful to attend, "... occasional workshops where we get to compare ideas and learn from best practice".

DISCUSSION

Participants reported coming into frequent contact with suicidal youth and they all believe school based mental health professionals have a role to play in youth suicide prevention. However they also identified a number of challenges which they believe impede their ability to effectively prevent youth suicides, namely insufficient training, burnout, lack of resources, poor support from parents, heavy caseloads and stigma. While many of the challenges reported by these participants were congruent with the literature from other countries (Christianson and Everall, 2009; Hamilton, 2008; King and Smith, 2000) some of the challenges seem to be unique to SA and a function of contextual factors. These context-specific challenges are congruent with findings from other SA studies which show that lack of resources and large caseloads impede the work of mental health care professionals in the country (Kleintjes, Lund and Flisher, 2010; Pillay, 2011; Schlebusch, 2004). The findings suggest that school-based mental health care workers need to be supported and assisted to overcome the challenges they face in order to optimise their potential role in youth suicide prevention.

Participants did not report that breaking confidentiality was a challenge when managing youths at risk of suicide, which is in line with findings from the USA (Moyer and Sullivan,

2008). They also said they have a moral and ethical responsibility to prevent suicides but they did not speak about the ethical challenges implicit in doing this nor did they show awareness of their legal responsibilities when discussing how they assess and manage youths at risk of suicide. This seems to suggest that mental health care workers in SA schools may not be adequately informed about the ethical complexities of youth suicide prevention and their legal responsibilities in this area.

All participants were able to identify the most common risk factors associated with youth suicide; namely, mental illness, prior suicide attempts and behaviour changes. Their perception of common risk factors for youth suicide are congruent with the findings reported in the literature. It is significant that participants reported a reliance on the risk-factor model to identify at risk youth but they failed to recognise the limitations of this approach and were not able to identify alternative models of suicide risk assessment. This seems to suggest that school based mental health care professionals in SA might benefit from additional training and education to introduce them to more contemporary evidence-based ways of conceptualising suicide risk assessments, such as the CAMS approach described by Jobes and Drozd,(2004) or the core competencies approach articulated by Rudd (2014).

It is also significant that the participants in this study reported that they were not proactively engaged in identifying at-risk youths and that they relied on a reactive strategy by responding to youths who were already in crisis. These findings draw attention to the lack of proactive approaches to suicide prevention in SA schools and seem to suggest that school based mental health care professionals are forced (due to resource constraints and heavy caseloads) to adopt a reactive approach to suicide prevention by simply responding to youth who self-identify as at risk or who are identified by peers and teachers. More attention needs to be paid to how proactive approaches to suicide prevention could be used in local schools.

All participants provided suggestions to optimise youth suicide prevention in schools. They suggested that school based mental health professionals should be supported in their role through the provision of additional training, access to supervision and support networks which would enable them to share knowledge and expertise with one another. The participants believe that teachers need to be adequately trained to identify at risk youth but also to recognize their own limitations as teachers so that they referred at risk youth to mental health care professionals rather than trying to manage the youth themselves. Furthermore the experience of the participants in this study highlights the need for clear referral pathways for at risk youth and the importance of collaboration among school-based mental health care professionals, teachers and parents in suicide prevention efforts.

CONCLUSION

The study explored the experiences and perceptions about youth suicide of a group of mental health care professionals working in SA schools. The small sample size and the purposeful sampling of participants from well-resourced schools are significant limitations to the study and prevent us from drawing generalizable conclusions from the findings. Nonetheless, findings suggest that school-based mental health care professionals in SA have an important role to play in youth suicide prevention but that they are hampered by a number of

challenges. These findings highlight the need for more extensive work in this area to establish how wide spread these experiences and perceptions are among other mental health care workers in SA schools and to document what is happening with respect to youth suicide prevention in the country's poorly resourced schools. Future research into youth suicide prevention in SA schools may also seek to explore the knowledge held by teachers regarding youth suicide as well as the practices they employ when faced with youths displaying suicidal behaviours. The findings suggest that there is an urgent need for work to be undertaken in SA schools to build the capacity of school-based mental health care workers to prevent suicide and to support them in performing their roles.

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Table 1

Common risk factors for youth suicidal behaviour

Risk Factor	Author
Prior suicide attempts and/or behaviour	Hawton and Fagg (1988)
Psychiatric illness	Stenager and Qin (2008)
Personality disorders and Schizophrenia	Kawashima et al. (2012)
Childhood abuse and familial stressors	Dube et al. (2001)
Aggressive and impulsive traits	McGirr et al. (2007)
Socio-economic factors	Page et al. (2014)
Self-harm	Bergen et al. (2011)
Substance use	Kelly et al. (2002)
Exposure to peer suicide	Swanson and Coleman (2013)

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Table 2

Summary of participant information

Participant*	Category of registration	Years of experience
Amy	Professional counsellor	Approx. 5
Samantha	Social Worker	Approx. 10
Patrick	Clinical Psychologist	15
Jim	School Counsellor	20
Johan	Registered Counsellor	Approx. 10
Jane	School Counsellor	Approx. 5
Richard	School Counsellor	20

* Participant names have been changed to ensure anonymity.