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Mental Health Support Workers and Suicide Prevention

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Abstract

Individuals who have a mental health diagnosis have increased risk for suicidal behaviours. Previous research has focused on understanding the attitudes and suicide risk assessment skills of professionals who provide mental health care to those with mental health problems, but comparatively little research has focused on non-professional frontline mental health support workers (MHSWs). It is important to understand how MHSW conceptualise their work within this role in relation to suicide prevention and how they regard their capacity to carry out suicide prevention tasks. Two studies were conducted to examine these issues. Understanding the factors that contribute to MHSWs confidence in caring for those at risk may contribute to suicide prevention. In Study One seven experienced MHSWs were interviewed and the resulting transcripts subjected to thematic analysis. This analysis identified six themes: (i) Dealing with Suicide is Something We Do and We Play a Key Role, (ii) We Feel Very Responsible, (iii) Our Role in Suicide Prevention: Dismissed and Underutilised, (iv) Dealing with Suicide has a Large Emotional Effect, (v) Our Amorphous and Undervalued Role, and (vi) We Need Increased Support, Training, and Talk. In Study Two an online survey was conducted with 91 MHSWs. Statistical analysis of the online survey indicated basic suicide intervention training, suicide literacy, and general self-efficacy were significantly related to self-reported confidence in dealing with client suicidality. The combined findings suggest that MHSWs could play a significant part in suicide prevention; work that is experienced as emotionally demanding, particularly in the absence of adequate training and support. Their participation in suicide prevention demands better recognition of their role in mental health care generally, and enhanced training and supervision in suicide prevention is needed. Gatekeeper training for all MHSW is suggested to promote better communication between staff groups that work in mental health care, MHSW role clarity and legitimacy, and skills in identifying suicide risk and managing client suicidal behaviour.

Keywords: Suicide, Support Workers, Mental Health Support Workers, Frontline Mental Health Staff, Paraprofessionals, Lay Health Worker, Gatekeeper, Suicide Training, Suicide Prevention.

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CHAPTER ONE: INTRODUCTION

There are just under 5000 support workers in New Zealand (S. Malhotra, personal communication, July 27, 2018) working for both government and non-government organisations (NGO's). A large proportion of these frontline staff members work within the mental health (MH) sector and take on roles supporting vulnerable people. They are variously referred to as 'mental health support workers', 'mental health community support workers', 'peer support workers', 'MH frontline staff', or 'mental health community service providers'. What unifies this role is that they are considered non-clinical 'paraprofessionals'. Henceforth in this thesis they will be referred to as mental health support workers (MHSWs). MHSWs represent the predominant group of workers within our mental health system. At present, there is no requirement for training prior to entering the role, yet MHSWs generally work with individuals diagnosed with severe mental health disorder.

There is a strong relationship between having a mental health diagnosis and suicide ideation, plans, attempts, and completion (Beautrais, Collings, Ehrhardt, & Henare, 2005; Nock et al., 2008). Clinicians such as psychiatrists, nurses, and psychologists play a significant role in suicide prevention. However, these trained professionals may not be the first 'port of call' for clients receiving mental health services when there is a risk of suicide. Decreased access to MH professionals is seen to be problematic in the current climate of an overrun and under-resourced mental health system (Chow & Mulder, 2017; New Zealand Government, 2018). Thus it is likely that MHSWs represent an important resource or potential lifeline for those contemplating suicide. If this is the case, it is not only logical but necessary that this group of workers is better understood with regards to their potential to prevent clients' suicide. Yet there is a paucity of research nationally and internationally with this group of workers, both in respect of their general role and with specific regard to their potential role in suicide prevention.

Suicide is an emotive and distressing topic, enmeshed with personal and shared social meaning and cost. It is also acknowledged that when face-to-face with a person who is overwhelmed, desperate, and contemplating suicide, asking them directly about this topic can be extremely challenging and can often result in daunting anxiety for the helper. Yet literature suggests that asking about suicide can provide relief for those contemplating suicide and connect

them with resources to help (Department of Communities, The State of Queensland, 2010; Evans & Farberow, 1988; Tatarelli, Pompili, & Lester, 2005). In light of suicide conversations being a challenge for many, preparation or training for such a circumstances is likely to be beneficial. It is expected that professional mental health care providers such as psychologists, nurses, social workers, and psychiatrists are trained for such a difficult task. However, this is not always the case for MHSWs, and any inadequacy of necessary training represents cause for disquiet; particularly in view of New Zealand's high suicide rate.

Supporting clients at risk of suicide with minimal guidance or training is difficult. This is confirmed through my own past experience as a fulltime MHSW faced directly with such challenges. During my time in this role I was surprised by the absence of mandatory suicide intervention training. Given the elevated risk of suicide for those with mental health difficulties, client suicidal behaviours and thoughts were a regular source of concern. Yet, instead of skill-development targeting suicide prevention, there appeared to be a stronger emphasis placed on training for other aspects of health and safety, such as fire and infection control. Although health and safety training are useful and necessary, this apparent priority in training highlighted a disparity that was inconsistent with the known risks of suicide amongst this population. I became increasingly concerned about this and became motivated to research the actual and potential role MHSWs may have in suicide prevention.

In this thesis I sought to understand the experiences of MHSWs in working with clients who become suicidal. I also explore the factors that may inhibit and encourage MHSWs to feel confident in enacting suicide preventative behaviours. A convergent mixed method design was used consisting of interviews with a small sample of MHSWs, which were then subjected to qualitative analysis, and a larger group online survey of MHSWs which was subjected to statistical analysis. The purpose of using mixed methods was to gain an enriched, thorough, and triangulated set of findings informed by contextual and experiential data, as well as quantifiable observations that show patterns and relationships. The main aims of this research are reflected in seven initial research questions:

1. How do MHSWs experience interactions with clients who have suicidal behaviours?
2. What do they perceive of their role in suicide prevention, if any?
3. What does this experience mean to them (personally or professionally)?

4. What do MHSWs consider could be improved within their role regarding interacting with suicidal clients?
5. What training is offered to MHSW related to suicide prevention?
6. What factors (including training, self-efficacy, beliefs, attitudes, religion, knowledge, and skills) influence the likelihood that MHSW will feel confident in talking to suicidal clients about suicide, and do so adequately?
7. How might these factors be worked with to encourage MHSW in suicide prevention for their clients in consideration of the numerous societal, organisational, and personal contexts surrounding this workforce?

The thesis begins with a broad literature review introducing the topics of suicide (including risk factors, and the association of suicide with mental health), MH care in New Zealand (including deinstitutionalisation, the emergence of the private MH sector, and the historical development of the MHSW role), as well as an overview of MHSWs' current role and general training. Then the likelihood and possible effects of exposure to suicidal behaviours for MHSWs is covered, as well as the efficacy of gatekeeper training as a method for suicide management and prevention. An overview of the mixed methods approach in this thesis is presented.

The remainder of the thesis is structured according to the two studies. The first of these is a qualitative study involving semi-structured interviews with seven MHSWs which were analysed using Thematic Analysis (Braun & Clarke, 2006). The second is a quantitative study with 91 MHSWs who completed an online questionnaire concerned with stigma and attitudes towards suicide, generalized self-efficacy, religiosity, suicide knowledge and beliefs, confidence and other factors. In a final chapter the overall outcomes of this research is presented.

Overview of Suicide and Suicide Prevention

Suicide Rates in New Zealand - Prevalence and Burden

New Zealand's overall suicide rate is around the median in comparison with other Organization for Economic Cooperation and Development (OECD) countries, at an age-standardised rate of 11.3 per 100,000 population in 2013 (OECD, 2018). In regards to youth suicide rates however, the suicide rate is one of the highest in the OECD. Of additional concern is that the suicide rate in New Zealand appears to be increasing: In the past year alone, suicide

has increased in New Zealand from 12.64 deaths per 100,000 people to 13.67 deaths per 100,000, representing the highest rates since 2007 when provisional statistical recording began (Ministry of Justice, 2018). As of August 2018 the New Zealand total suicide rate was 668 deaths per year; a count that has been rising continuously over the last four years. As of June 2018, provisional statistics reported by the Coronial Services of New Zealand described males aged 20-24 as having the highest rate of suicide amongst OECD countries: a rate of 29.50 deaths per 100,000 population. Men are 2.5 times more likely to die by suicide than women, although women are more than twice as likely as men to be hospitalised for self-harm or suicide attempts (Ministry of Health, 2016). Recent data from a New Zealand sample indicates women are more likely to exhibit chronic non-suicidal self-harming behaviours than men (Fitzgerald & Curtis, 2017), which has been considered a precursor to suicide (Joiner, 2005).

New Zealand is relatively unique in comparison to other countries in showing a trend towards higher rates of youth suicide (between ages 15 to 24) than in other age groups (UNICEF Office of Research, 2017). There is a global trend for suicide rates to increase with age (Bertolote & Fleischmann, 2002) which is not reflected in New Zealand. In 2013, youth suicide (15 to 19 years) contributed to 45% of the suicide deaths in New Zealand. In this same year the rate of suicide for adults aged between 25 to 44 years was 15.8 per 100,000, while older adults over 65 years had a rate of suicide at 9.3 per 100,000.

The rate of suicide amongst Māori is particularly high. Yet this has not always been the case. The rate of suicide for Māori youth sits at a high 39.1 per 100,000. Non-Māori youth suicide rates are comparatively lower at 12.6 per 100,000 (Ministry of Health, 2016). A trend for indigenous groups to have a higher rate of suicide is reflected internationally (Pollock, Naicker, Loro, Mulay, & Colman, 2018) and may indicate the intergenerational effect of historical trauma and colonization on indigenous people and the breaking down of cultural structures through these processes (Hunter & Harvey, 2002). It is worth noting however that the rates of suicide for elder Māori (over 65 years) and non-Māori are significantly reversed compared to youth. The 2012 statistics reported only one Māori suicide per 100,000 compared to 53 European suicides per 100,000 for those over 65 years. This begs the question as to what differences exist between the older Māori community and Māori youth relating to resiliency and decreased suicide risk.

When examining comparative global suicide rates it must be considered that data collection of suicides appears more rigorous in New Zealand than many other countries where an estimated 20% to 100% of suicides go underreported (Bertolote & Fleischmann, 2002). Nevertheless, concern about unrecorded suicides in New Zealand also exists; for example, with regard to the possibility of undetermined fatal car crashes (Routley, Staines, Brennan, Haworth, & Ozanne-Smith, 2003). In cases where intent is not established, suicide may be recorded as accidental or with undetermined cause (Garland & Zigler, 1993). Hence, reported suicide rates may not be entirely reflective of the full magnitude of suicides in New Zealand, as elsewhere.

Not only does the prevalence of suicide in New Zealand contribute to significant social costs, including that felt by bereaved families, friends and communities of victims of suicide, but it also carries a significant economic cost – not least from the loss of potential productivity of a life cut short. In 1998 the economic cost of suicide was calculated as \$11.8 billion US dollars (dollars relative to 1998) through the loss of productivity due to premature death by suicide in the United States.

Given the high rates of suicide in New Zealand, and the related costs which are of personal, community, and national significance, research into new or enhanced prevention strategies is considered a relevant and pertinent endeavour.

Risk Factors

Suicide is an extremely complex and multifactorial phenomenon (Beautrais et al., 2005). Psychological, philosophical, social, economic, cultural, legal, and biological factors contribute towards a more comprehensive understanding of suicide. Risk factors include those that increase risk of suicide, and conversely, protective factors serve to buffer against suicide risk (Beautrais, 2000). The following risk factors, which do not represent an exhaustive list, are largely based on the first World Health Organisation's (WHO) report in 2014 on preventing suicide. A more thorough review of some of these factors and issues can be found in Goldsmith (2002) and Beautrais et al. (2005); the latter for greater relevance to the New Zealand context.

In the following sections an overview of risk factors is presented. Psychopathology will be discussed more substantively in a later section. Risk factors are described within five broad and often interrelating categories: individual, relationship, community, societal (World Health Organization, 2014), and cultural (Colucci & Lester, 2013).

Individual factors. One of the strongest individual risk factors identified by WHO is having attempted suicide in the past (Kessler, Borges, & Walters, 1999; Ribeiro et al., 2016; Suominen et al., 2004) or having a history of suicidal thoughts, threats, self-harm, and suicide plans (Briere & Gil, 1998; Disley, 1996). Unemployment, financial losses, and the effects that these have on a person's home and living security is seen to be associated with increased risk of suicide (World Health Organization, 2014). Feelings of hopelessness (May & Klonsky, 2016; Shaffer et al., 1996) and corresponding thoughts (e.g., "things will never get any better") existing alongside either a prior suicide attempt or a mental disorder (commonly depression) is particularly associated with increased risk of suicide (World Health Organization, 2014). Furthermore, chronic pain and sleep disturbance, usually associated with an illness that perpetuates pain (either physical or neurological), can increase the risk of suicide two to threefold for individuals suffering with such symptoms (Bernert, Kim, Iwata, & Perlis, 2015; Calati, Bakhiyi, Artero, Ilgen, & Courtet, 2015; World Health Organization, 2014). Loneliness and social isolation are also considered risk factors for death by suicide (Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015), which has been included as an individual risk factor that, like many other factors, overlap with social and systemically influenced issues.

An important distinction has been made between 'ideators' (those who have suicidal thoughts), and those who go on to attempt suicide. Risk factors may be different between these two groups, although for some, there is considered a *transition* from one group to the other (Nock, Kessler, & Franklin, 2016; Weissman et al., 1999). Being single, having less high school education, having anxiety, drug use, or alcohol disorders and having a history of sexual abuse, are significantly associated with those who contemplate suicide and go on to attempt - as opposed to those who ideate but do not go on to attempt (Ferrari et al., 2014). Further, impulsivity has been associated with suicide attempts rather than ideation (Swann et al., 2005). May and Klonsky (2016) in their meta-analysis found that hopelessness was equally prevalent for both ideation and those who go on to attempt suicide.

Genetic vulnerabilities are thought to increase risk of suicide in so far as they contribute to a person's vulnerability to developing a mental or physical disorder that results in chronic pain or suffering (World Health Organization, 2014). One recent meta-analysis, explored biological and genetic related identified risk factors for suicide. The factors explored in this meta-analysis included genes, blood related factors, serotonin and dopamine levels, nutrients

and hormone changes, among others (Chang et al., 2016). Within this analysis, Chang and colleagues found weak data to support all but two factors which might be considered biologically related risk factors for suicide. Those factors supported were cytokines and low levels of fish oil nutrient. There was, however, no evidence of protective effects of either of these two factors.

Additionally, use of antidepressants has been implicated in suicide. This type of medication is considered to target neurochemical imbalances within individuals. A meta-analysis of 372 double-blind randomised placebo controlled trials found an increased risk of suicide for those taking antidepressants who were aged under 25 years old. No effect was found for those between 25 and 64 years, and only adults over 64 years experienced reduced suicidality with antidepressant use (Stone et al., 2009). Hence antidepressant use and the neurobiological and psychological mechanisms likely acting on suicidality should be considered as complex, and age related (Colucci & Lester, 2013).

Relational factors. The loss of a relationship or presence of a relationship that is unhealthy are considered risk factors for suicide. Isolation and lack of social support can contribute to feelings of disconnection from people and networks, precipitating loneliness and despair which are also seen as risk factors (World Health Organization, 2014). Relationships that are conflicting can contribute to feelings of grief and situational psychological stress. Violence (in the form of physical or emotional) within or outside of an intimate partner relationships is also associated with increased risk of suicide (Clark, Robinson, Fleming, Ameratunga, & Denny, 2011); Maru et al., 2018; Wolford-Clevenger & Smith, 2017).

Simply knowing someone who has suicided can produce emotional, practical, economic, and social consequences. For example, feelings of grief, shame, guilt, and anger may result from the disruption of a lost family member. This type of disruption can be brought about through changes in roles in the support system and changes accompanied by the absence of a loved one lost to suicide. People who have lost a family member to suicide may experience increased stigmatisation from within the community. These issues can impede further help seeking behaviours and offers of support from and towards individuals affected. Hence, having known someone, either in the family or community, who has suicided increases suicide risk (Bearman & Moody, 2004; Chan et al., 2018).

Community factors. Community level risk factors for suicide can include such events as natural disaster, war, and conflict. Stresses of acculturation and dislocation, in particular for indigenous people, refugees, and other vulnerable groups is considered a contextual and population level risk factor (Beautrais, 2000). Further, discrimination, stigmatisation, rejection, oppression or violent behaviour towards peoples and groups (e.g., people who are incarcerated, bullied, refugees, asylum-seekers or migrants, and those who identify as lesbian, gay, bisexual, transgender or intersex) are seen to have higher risk of suicide due to experiences of stressful life events (Fergusson, Woodward, & Horwood, 2000). Linked to discrimination, the effects of cultural traumatisation or abuses including emotional, physical or sexual abuse, bullying, severe humiliation, neglect, violence, maltreatment, or other adverse childhood factors can have a cumulative effect that may act to increase of risk of suicide (World Health Organization, 2014).

Societal factors. Barriers to health care impede people from gaining appropriate services that may otherwise help to reduce various risk factors (Barnes, Ikeda, & Kresnow, 2001; Czyz, Horwitz, Eisenberg, Kramer, & King, 2013). One Australian study found that less than a third of individuals with suicide ideation, plans, and/or attempts received help from mental health services (van Spijker et al., 2015) indicating that many who are suffering do not access professional support. Stigma towards help-seeking can be a factor in preventing access to appropriate care, and may hinder people from reaching out to other support networks (Gary, 2005). The availability and access to particular means of suicide (e.g., firearms, railway tracks, poisons, alcohol and drugs) is seen to influence the choice of suicide method as well as the rate at which suicide occurs (Milner, Witt, Maheen, & LaMontagne, 2017; Skegg, Firth, Gray, & Cox, 2010). The accessibility of some particular means of suicide may differ depending on geographical, national and cultural regions (Cantor & Baume, 1998). For example, age and eligibility to own firearms between countries differ significantly (World Health Organization, 2014).

Lastly, inappropriate media reporting of suicide is considered a risk factor (Beautrais, 2000). Reporting descriptions of method used, pictures of methods, and reports of celebrity suicides that may inadvertently glorify, sensationalize, or normalize suicides, are considered inappropriate (Beautrais et al., 2005). Vulnerable groups may be subject to a contagion effect of

suicides, sometimes described as “copycat” suicides, as a result of inappropriate media and social media reporting or pro-suicide internet sites.

Cultural factors. As mentioned, there are four main categories employed by the WHO to organise related risk factors for suicide. These four levels (individual, relational, community and societal) can interrelate differently across and within different cultural settings (Colucci & Lester, 2012). For example, in India, humiliation, shame, economic hardship, examination failure and family disputes were described by Bhatia, Khan, Mediratta, and Sharma (1987) as being major high risk factors for suicide in that country. These risk factors are less prominent in other cultures such as USA where mental illness along with alcoholism, personal loss, and age are seen to be the major risk factors (Goldsmith, 2002). Amongst Māori, a recent study by Clark, Robinson, Fleming, Ameratunga and Denny (2011) found that depression symptoms, lack of close friends or family, having anxiety symptoms, being exposed to domestic violence, and being uncomfortable in New Zealand European social surroundings were all major risk factors for suicide attempts in that population.

Suicide Behaviours: Ideation, Plans, Attempts and Fatal Suicide

Suicide ideation, plans, and attempts are considerably more common than fatal suicides. For every one suicide it is estimated that there are between 20 (World Health Organization, 2014) and 400 (Cutler, Glaeser, & Norberg, 2001) suicide attempts within the general community. (This broad discrepancy may be due to cultural differences across the different countries surveyed with respect to methods used for defining and measuring suicide behaviour). Furthermore, thoughts of suicide are found to be more prevalent than specific plans, which were more prevalent than suicide attempts (Bertolote et al., 2005). Not all those who attempt suicide have suicidal ideation, though most do (Andrews & Lewinsohn, 1992). With regards to lifetime suicide ideation, this has been estimated to exist in 2.1% to 18.5% of the general public (Weissman et al., 1999). This estimate is from data of nine countries which included New Zealand.

In New Zealand, calculation of the rate of attempted suicide is based solely on hospitalisation of those who had intentionally self-harmed. In this respect the rate is likely under-represented due to not all hospitals collecting such data, and not all self-harm attempts resulting in hospitalisation. In the years 2004 to 2013 this rate has increased by 4.6%, with a rate of 176.7 per 100,000 population being admitted for intentional self-harm (Ministry of Health, 2016).

Notably, females are particularly more likely to self-harm (especially between the ages of 15 to 19 years) (Ministry of Health, 2016) compared to the suicide rate in New Zealand described earlier of 13.67 per 100,000. The statistics above suggests that the prevalence of suicidal thoughts and planning are far greater than those who actually go on to attempt or complete suicide.

People may present to MH services due to concerning suicide behaviours. Yet while consideration of risk factors at these various levels (described above) is important, acknowledgement of the presence of risk factors does not necessarily translate meaningfully into clinical relevance at the individual level (Franklin et al., 2017). Warning signs are distinct from risk factors in that they indicate imminent suicidal risk (Rudd et al., 2006), and they are a key aspect to care for those who are vulnerable to suicide from the presence of risk factors as described above. Warning signs are likely to vary per individual, but some suicide warning signs are considered generally significant, for example the act of giving away possessions. Suicidal ideation, plans and attempts may also be considered warning signs to fatal suicide.

The Relationship between Mental Health Diagnosis and Suicide

It is broadly considered that having a mental health diagnosis is one of the major risk factors for suicide (Barraclough, Bunch, Nelson, & Sainsbury, 1974; Beautrais et al., 2005; Mortensen, Agerbo, Erikson, Qin, & Westergaard-Nielsen, 2000; Shaffer et al., 1996; Tan, Chen, Xia, & Hu, 2018). Mood and substance use disorders are considered to be *proximal* risk factors (Conner, Bridge, Davidson, Pilcher, & Brent, 2017). Predominantly in Western cultures, diagnoses of bipolar disorder, alcohol and substance use disorders, schizophrenia, and depressive disorders, have been acknowledged as most frequently associated with suicide (Beautrais et al., 2005; World Health Organization, 2001). The overall risk of suicide for these disorders are said to range between 8%, 7%, 5% and 4% respectively (World Health Organization, 2014). Disorders such as Borderline Personality Disorder and Antisocial Personality Disorders are also associated with suicide (Bolton, Pagura, Enns, Grant, & Sareen, 2010; Goldsmith, 2002). Having a co-morbid mental disorder diagnosis (a commonality among those with personality disorders) increases suicide risk further (Bolton et al., 2010).

There are several qualifications to the claimed ‘strong association’ between mental disorders and suicide. While many studies describe a significant correlation between mental health disorders

and suicide, some of the studies have sample sizes in the thousands, where “it is difficult not to detect a statistically significant effect” (Franklin et al., 2017, p. 4). Further, for some diagnoses seen to be associated with suicide attempts, such as Borderline Personality Disorder, suicidality is included within its diagnostic criteria – hence strong correlations would be expected (May, Klonsky, & Klein, 2012). Lastly, significant correlations between mental health disorders and suicide is not sufficient on its own to conclude a mental health diagnosis is a ‘risk factor’; especially in the absence of longitudinal studies which may be able to show a mental health diagnosis has preceded suicide behaviours (Kraemer et al., 1997).

Therefore, the status of mental health disorders as a major risk factor for suicide is under debate. One report concluded that the majority of findings regarding risk and protective factors for suicide in the last 50 years (prior to 2017) were weak and inaccurate (Franklin et al., 2017). Yet others have asserted that a majority of those who died by suicide suffered a mental illness or mental health disorder and some state explicitly, or imply, a causal relationship. For example, Beautrais et al. (2005) state in their review contracted by the New Zealand Ministry of Health that mental disorders “play the strongest role in the aetiology of suicidal behaviours” accounting for 90% who suicide (p.21). Their reference to *aetiology* suggests a specific claim of a *causal* effect. Others researchers have made similar claims with regard to the ‘90% statistic’ (Cavanagh, Carson, Sharpe, & Lawrie, 2003; Isacsson & Rich, 2003). However, many of the studies that claim a causal link (in particular from major depression) are largely based on the disputed methodology of psychological autopsy (PA) (Cavanagh et al., 2003; Franklin et al., 2017; Hjelmeland, Dieserud, Dyregrov, Knizek, & Leenaars, 2012; Pouliot & De Leo, 2006; Pridmore, 2015; Shahtahmasebi, 2013). PA describes the process of reviewing certain documentation of the deceased (including personal diaries, letters, police reports, official records, etc) as well as conducting interviews with people who knew the person. This information is brought together with clinical opinions to assess a deceased person’s state of mind prior to death (Cavanagh, Carson, Sharpe, & Lawrie, 2003; Hjelmeland, Dieserud, Dyregrov, Knizek, & Leenaars, 2012; Pouliot & De Leo, 2006). Inconsistencies in findings across controlled studies, challenges in matching controls, and undertrained interviewers enabling bias and errors, are some of the criticism against PA (Pouliot & De Leo, 2006). Noteworthy is the criticism that addresses how implausible it is that psychiatric diagnoses can be made through PA without adequate

information; for example, many questions necessary for diagnosis are impossible to answer via proxies (Hjelmeland et al., 2012).

More robust longitudinal studies report that increased severity of depression symptoms are minimally or negligibly useful in predicting suicide (Franklin et al., 2017; May et al., 2012). Moreover, studies from Africa, India, and China have found mental disorders were present in less than half of those who attempted suicide, citing 11%, 23%, and 48% risk of suicide attributable to mental disorders respectively (Mars, Burrows, Hjelmeland, & Gunnell, 2014; Venkoba Rao et al., 1989; Zhang, Xiao, & Zhou, 2010).

As discussed above, there are a broad range of factors that increase the risk of suicide. These may be the same factors that cause mental disorder. They may also occur separately to, or independently of, the existence of mental disorder. Or events which increase the risk of suicide may be more likely to occur when mental disorder is present. Hence the relationship between mental disorder and suicide is complex; any claim that mental health disorders necessarily *cause* suicide is disputed. In this context it is noted that about 95% or more who are diagnosed with depression do not kill themselves (Blair-West, Mellsop, & Eyeson-Annan, 1997). Hence, while mental disorder may be highly correlated with suicide, it should not be considered a cause of suicide (Isacsson & Rich, 2003). However, what is not in contention is that a population categorised as having a mental health diagnosis has a higher prevalence of suicide and of suicidal behaviours than the general population (Sara, 2015).

It appears that broad acceptance of claims that most, if not all, people who suicide are mentally ill has led to an over-simplification of explanations of suicide. With regards to research there are concerns that the “90% statistic” has led to a narrowing of focus within the field resulting in confirmation bias; a redirecting of funding towards mental health services (Shahtahmasebi, 2013); a monopolisation of suicidology by psychiatric or biomedical illness models (Colucci & Lester, 2013); limited diversity of research findings based on homogenous risk factors (Franklin et al., 2017); and inadequacy of functional causal explanations (Hjelmeland & Knizek, 2017). Restated, such a narrowing of focus may neglect investigation of the complexities surrounding suicide, resulting in a reductionist and a “biologification” of suicide (Colucci & Lester, 2013) which has in practice dismissed or reduced research of possible third/confounding variables acting on both mental health *and* suicide. Lastly, it may be considered that the causal assumptions about

mental disorder and suicide may, at a societal level, pose consequences of inflating pre-existing stigmatisation of those with a mental health diagnosis.

Additionally, conceptualising suicide as a *symptom* of a mental health diagnosis serves to distance the idea that suicide exists as a risk of death for all, irrespective of a mental health diagnosis. Following this line of inquiry from a social psychological perspective, one plausible reason for considering mental health disorder to be the predominant cause of suicide may be explained by the Defensive Attribution Bias (Zuckerman, 1979). Defensive Attribution is defined as a psychological mechanism used to defend against the belief that a person (or group) may be equally as vulnerable to becoming a victim (e.g., victims of rape, homelessness, or illness) by placing more responsibility on the victimised person (or group) than is justifiable (Walster, 1966). In other words, people tend to blame victims rather than the social conditions in order to distance themselves from the reality of limited control for their own fate. Mental disorder has long been associated with the effects of defensive attribution, such that people suggest those with mental illness are more personally at fault than those considered ‘normal’ (Sadava, Angus, & Forsyth, 1980). It could be hypothesised, therefore, that casting suicide as predominantly an outcome of mental disorder serves as a defensive attribution functioning to relinquish the responsibility society hold for the social determinants of suicide, as well as the acknowledged unpredictability of its occurrence. Importantly for New Zealand, the high rates of child abuse and domestic violence cannot be overlooked as contributing factors to our suicide rates as a nation (Beydoun, Williams, Beydoun, Eid, & Zonderman, 2017; Longden, Sampson, & Read, 2016; Mullen, Martin, Anderson, Romans, & Herbison, 1993; Read & Bentall, 2012; Spataro, Mullen, Burgess, Wells, & Moss, 2004; Springer, Sheridan, Kuo, & Carnes, 2007), along with homelessness, socioeconomic status, and other factors.

The New Zealand Suicide Prevention Strategy 2006–2016 recognised the multifactorial nature of suicide within communities by explicitly acknowledging the need to resource (financially and legislatively) housing, education, and income support to reduce suicide risks factors for New Zealanders. This prevention strategy has since lapsed, together with the Action Plan (Ministry of Health, 2013). A new government strategy is under development as of 2017, the draft of which outlines the recognition of NGOs to fill “gaps” within services with regards to suicide prevention (Ministry of Health, 2017). Such “gaps” appear not to be new, at least for mental health services in New Zealand. One study from 2012 reported mental health services in

New Zealand are typically under pressure, with attention being diverted from clinical needs consideration increasingly towards risk assessment and management (Saunders, Hawton, Fortune, & Farrell, 2012).

In summary, while there is an association between mental health problems and suicide, a causal link cannot be assumed: that is, the same risk factors that lead to mental health problems are those which also lead to increased risk of suicide. Hence, regardless of whether or not there is a causal relationship, those in mental health care are considered at greater risk of suicidal behaviours than the general population.

Suicide amongst those in Mental Health Care

The prevalence of suicide within mental health services is of particular interest to the studies within this thesis. Rates of suicide in those who are engaged in MH settings shed light on the possible degree to which community MHSWs may be dealing with suicide.

Limited studies assess the prevalence of suicide behaviour among those who present to mental health centres. One New Zealand study by Fortune, Seymour and Lambie (2005) found that despite presenting to child and adolescent mental health services with other primary MH referral reasons, suicide and self-harm were common among clients within this setting. Also in New Zealand, of those who die by suicide, 40% were found to have had access with mental health services in the year before they died (Ministry of Health, 2016). International findings show 20-36% of suicide attempters make contact with GP's or psychiatrists leading up to their attempt (Eagles, Klein, Gray, Dewar, & Alexander, 2001). MHSWs largely receive client referrals from community mental health settings like this. Hence, such research supports anecdotal evidence of the commonality of suicide behaviours among the population of clients that MHSWs are supported by in New Zealand.

Mental Health Care in New Zealand

The following section is a brief review of historical and present factors that have contributed to the development of the role of MHSW, particularly in New Zealand.

Deinstitutionalisation. From the 1950's to 1970's there began a major shift in mental health care in New Zealand from institutionalisation/hospital care to community based treatment (Brunton, 2003). The process of removing people physically and psychologically from the

effects of institution-based care was a slow one and was not immediately matched by provision of adequate community-based care (Brunton, 2003). Perhaps as an indication of this, during the initial political reforms that accompanied deinstitutionalisation, the overall suicide rate in New Zealand increased, peaking at 16.7 suicides per 100,000 in 1996-1998. Prior to this and during the 1950's, after the great depression and the World War 2, New Zealand's suicide rate was less than 10 in 100,000.

By the 1980's deinstitutionalisation was being cast as a social experiment gone wrong (Barber, 2015; Brunton, 2005). The transfer of services from institution to community left the sector fragmented and underfunded. Underdeveloped ad-hoc community resources containing under-skilled workers and ineffective planning had eventuated, and arguably, became the norm. Public attitudes towards mental health reflected stigma and negativity towards those with MH diagnoses. This had not been apparent previously perhaps as result of people with significant mental disorder being removed from the community.

Out of the discontent came a reorganisation of a new health system in the 1990's. New Zealand government introduced multiple initiatives to reform the MH care system, including restructure of mental health provision, increased funding and workforce drives, introduction of service provision guidelines, and public awareness campaigns (Barber, 2015; Wells, Oakley Browne et al., 2006). Most of these initiatives have been influenced by MH reforms internationally. The rise of the private sector and Non-Government Organisations (NGOs) accompanied these reforms (Barber, 2015).

Rise of the private sector/NGO participation in community care. In 1993 the government introduced a major reorganisation of the health system. Public hospitals were no longer the preferred or sole providers of healthcare, opening up opportunities for private healthcare providers and the NGO sector. The introduction of the Disability Commissioners Act 1994 and the Code of Consumers Rights legislations were considered key turning points, redirecting power towards the consumers of mental health services. Consumers began to see a shift towards the rights to informed consent, respect, and culturally appropriate treatment. Important inquiries led by Judge Ken Mason pushed development, funding, resourcing, and training of the community sector. Such efforts supported the development of The Blueprint for Mental Health Services in New Zealand (Mental Health Commission, 1998).

The provision of mental health care by NGO's demanded "the business" of efficient administration and management of health services to meet investment targets for stakeholders. Managerial models of healthcare administration often came into friction with competing therapeutic models of care. There were however, benefits of this overall reform. Consumer voices and rights were respected during the development of outcome measures for services, as well as a strengthening of recovery focused models within these services (Barber, 2015).

Rise in the development of a budding profession: support workers. Alongside these changes was the accompanying establishment of the National Mental Health Workforce Development Co-ordinating Committee in 1998 (Mental Health Commission, 1998). This committee aimed to facilitate growth and initiate competency standards for all mental health workers in New Zealand. A report titled *A Competency Framework for the Mental Health Workforce* (1999) outlined the need for a flexible workforces at varying levels and defined competencies to meet the demand of a growing sector and the mental health community care needs.

In response to the reorganisation over these last three decades came a rise in the development of a rather new population of workers in New Zealand that reflected global change. These workers are commonly referred to internationally as 'Community Health Workers' (Witmer, Seifer, Finocchio, Leslie, & O'Neil, 1995) or 'Lay Health Workers'. Many of these paraprofessional workers have a primary role to increase client compliance to treatment programmes and assist in wider services of preventative and primary care initiatives (Witmer et al., 1995). The core elements of the effectiveness of the support worker role lies in their social skills of interconnection and rapport building with clients. They function as role models and advocate to "improve the health and overall wellbeing of disenfranchised, medically underserved communities" (Arvey & Fernandez, 2012, p.1636). Although there is no formal definition for these workers, their key role is to "empower community members to identify their own needs and implement their own solutions" as well as linking consumers to appropriate services (Witmer et al., 1995a, p.1055).

As at 2015 there was an estimated 42,400 'Healthcare Assistants' throughout New Zealand (Ministry of Business, Innovation and Employment, 2015). In New Zealand, part of this larger group of paraprofessionals are referred to as 'Support Workers' (MHSWAG, 2003). The support worker role, more generally, is as diverse and broad ranging as the environments within which

they are employed (MHSWAG, 2003). Support worker positions can span formal establishments like public hospitals through to community centres, religious community centres, NGOs, District Health Boards (DHB's), outreach programmes working in client's homes, residential facilities, and workplaces (Arvey & Fernandez, 2012; MHSWAG, 2003). They exist both as volunteer workers or paid workers (Witmer et al., 1995). 'Support workers' or 'community health workers' have multiple important practises and legitimate social roles within communities and health systems (Arvey & Fernandez, 2012), and broader society (Witmer et al., 1995).

A portion of community support workers work specifically in mental health settings with mental health consumers. As previously described, these frontline workers are often called Mental Health Support Workers (MHSWs) or MH Community Support Workers or CSWs. MHSWs are not professional practitioners, as compared with nurses, social workers, psychiatrists, psychologists, or counsellors – all of whom are aligned with a professional registered body. They have been described as “non-clinicians who work with people with mental illness” (Mental Health Commission, 1998, p.111).

In New Zealand, MHSWs are predominantly employed by NGOs, although a small proportion are employed by DHB/government agencies. They are expected to carry out a supportive relationship with people who have been or are experiencing mental health challenges. They support individuals in their care to develop and implement individual lifestyle or support plans. MHSWs work in a collaborative manner alongside consumers/tangata whai ora (and sometimes with their whanau, family, and friends) to support them in their recovery. MHSWs work within a framework for practice informed by Te Tiriti o Waitangi (the Treaty of Waitangi), ethical standards, health standards, service specifications, and legislation.

Competencies of MHSWs. In highlighting the development of the MHSW role, together with the entailed role diversity and expectations of this job, it becomes clear that MHSWs represent a unique population in MH care, particularly in regard to training and competencies. MHSWs are unique because they are not required to have any formal training (including in specific suicide prevention). Governing committees and agencies, through the National Mental Health Workforce Development Co-ordinating Committee, take responsibility for defining competency requirements expected for all levels of the MH workforce in New Zealand. They have set a framework of three levels of competencies - Basic, Advanced and Specialist - effectively creating a hierarchy of MH staff from professional groups to support workers

(National Mental Health Workforce Development Co-ordinating Committee., 1999). While MHSWs are not required to have formal training, basic competence levels “are expected to be held by mental health workers who may have no formal qualifications at entry but who have gained experience and expertise while working in the mental health sector, and are supported by formal education and training programmes” (National Mental Health Workforce Development Co-ordinating Committee., 1999, p.9).

This group of workers, because they are not required to have training, attract a diverse range of people to the role. This is considered positive in that workers are more likely to relate to and represent the diversity of the client group they serve. Yet it is also possible MHSW are equally challenged by the same inequalities observed in client groups (e.g., financial strain, discrimination, marginalisation, etc). Internationally, people within carer roles are often themselves from marginalised ethnicities, migrant groups, have lower socio-economic status, are women, and are thereby vulnerable to being exploited (Mayseless, 2015; Robinson, 2011). Similar issues may also apply to support workers in New Zealand.

A unique role. MHSWs hold a unique role (Hennessy, 2015) and have a significant position in respect of communications with clients (Arvey & Fernandez, 2012). It has been argued that for community health workers of all types (including MHSWs) their work, “should be based in, and should be reflective of, the community served” (Witmer et al., 1995, p. 1056). Anecdotally, in New Zealand there appears to be a large number of MHSWs with a university degree or who are completing university qualifications. This information appears not to be formally captured or reported on (Platform Trust and Te Pou o te Whakaaro Nui, 2017). Also anecdotally, there appears not to be an explicit policy of employing for diversity or representation in New Zealand’s mental health sector.

Internationally the requirements of the support worker are that they should be flexible and able to manage and communicate effectively within all key relationships with clients, community and clinicians (Hoeft, Fortney, Patel, & Unützer, 2018; Witmer et al., 1995). Therefore, they are able to translate not only the system itself, but also the language within the (health) system, into the languages and values specific to clients and communities they serve (Arvey & Fernandez, 2012; Witmer et al., 1995). These skills are seen to be related to their immersion or familiarity with the targeted community (Hodgins, Gnich, Ross, Sherriff, & Worlledge-Andrew, 2016). These workers are able to cut through power differentials associated

with professionalism, education, income level, status, and cultural barriers which exist through occupational stratification in many systems and societies. Their role serves to facilitate a continuum of care from natural supports to para-professionals to clinical/professional care (Eng, Parker, & Harlan, 1997).

Given the value placed on their ‘non-expert’ status, there has been debate surrounding their training, and in particular the risk of institutionalisation of community health workers that may result from formal training (Arvey & Fernandez, 2012). Arvey and Fernandez summarise this debate: “how might making experts out of community health workers who are supposed to be ‘like’ the community members with whom they work, change the dynamic of community health worker’s program delivery and interpersonal communications with clients?” (p. 1636).

This question appears relevant to New Zealand MHSWs with regards to how, and if, MHSWs are trained in suicide specific prevention skills. How might encouraging specific suicide training affect the alliance between MHSWs as community members and their clients? The MHSW role is a precious commodity in an ever increasing expert-based world. It represents valued connection with clients (South, Kinsella, & Meah, 2012). Yet, a lack of training within the role may strain connections between support worker and clinicians if support workers are not perceived by clinicians as competent.

It appears that the MHSWs’ role is hindered by a lack of recognition, proper understanding, and utilisation by specialists in health care setting (Goh, 2018; Hennessy, 2015; Pace, 2010). A lack of role legitimacy is exemplified in their lack of a uniform body and/or code of ethics (Sotelo, 2015), as well as a lack of standard definition of their role (Swider, 2002). These issues have been highlighted in New Zealand (Goh, 2018; MHSWAG, 2003; Pace, 2010; Public Service Association - Te Pūkenga Here Tikanga Mahi and the Service and Food Workers Union Nga Ringa Tota, 2009).

Job conditions and staff turnover. There is a high staff turnover rate in New Zealand and around the world for MHSWs (Blankertz & Robinson, 1997; Public Service Association - Te Pūkenga Here Tikanga Mahi and the Service and Food Workers Union Nga Ringa Tota, 2009). Hence, it is important to consider factors related to the role which may bring this about (Nkonki, Cliff, & Sanders, 2011).

Internationally, burnout and stress are seen as the main contributing factors to high turnover rates for MHSWs (Blankertz & Robinson, 1997). Parsons, Dixon, Brandt and Wade

(2004) identified that the main factor in New Zealand for leaving the MHSW role was the desire for better pay. Difficulties experienced with clients and the stress and demands of such roles were also highlighted as reasons to quit. Inadequate staffing levels and shift work were also implicated. Support workers are said to have higher emotional exhaustion and burnout scores than average. When workers are under such pressure and are not reimbursed for their role, the ability for them to function effectively is likely jeopardised.

Challenges in Caring for Suicidal Clients

According to the New Zealand Guidelines Group (NZGG) and Ministry of Health (2003), MH care professionals (psychologists, psychiatrists, etc.) are expected to be trained in assessing, monitoring, and providing psychological support for suicide risk. However, under the care of trained professionals, clients may experience inadequate care due to services being under-resourced and staff shortages. Nirui and Chenoweth (1999) conducted a small qualitative study on the inadequacies often experienced by suicide victims from the perspectives of their close relatives. They reported seven of the eight suicide victims (living in Sydney) who had contact with either community mental health centres, NGO's, and/or government health centres expressed inadequate treatment and lack of follow-up services. The main conclusions of this study were that where people have restricted access to appropriate social support systems (including follow-ups and healthcare) suicide risk persists. Similarly, one meta-analysis of 31 studies (both qualitative and quantitative) found common themes of poor communication between patients and staff and a perceived lack of staff knowledge of clients after presentation to services for self-harming (Taylor, Hawton, Fortune, & Kapur, 2009).

In addition, the ability to detect warning signs of suicidal behaviours is in itself a very difficult practice (Eagles et al., 2001). Behavioural warning signs have been described to include poor treatment compliance (Piacentini et al., 1995; Rotheram-Borus et al., 1996), aggression, anxiety and depressive emotions, and the person distancing themselves from the client-helper relationship (Nirui & Chenoweth, 1999). Sometimes people who become suicidal find it hard to verbalise their suicidal thoughts. In relation to ongoing therapy, therapists are encouraged to rely on interpreting aspects of the transference and counter-transference processes (Richards, 2000). These issues can provoke feelings of helplessness in therapists and, through the counter-transference process, the therapist can feel that the client is “attacking” the therapeutic

relationship such that the relationship is often terminated (Richards, 2000). This action can have the effect of confirming a sense of isolation for the client, which may be inadvertently interpreted as reinforced reasons for dying.

Warning signs are important considerations for those treating clients who become suicidal. However, the process described above highlights the potential challenges that exist for professionals in monitoring and treating those with suicidal tendencies. If these challenges exist for trained MH professionals, they are even more likely to pose a challenge for those under- or un-trained carers, such as MHSWs. Nirui and Chenoweth (1999) noted that the challenges which exist in providing care to individuals who become suicidal are potentially most salient for those with less experience.

There is little research that comments on MHSWs abilities to identify warning signs. Given some MHSWs have little training, their response to clients who become suicidal may more likely approximate the responses of a friend rather than of a mental health care staff member. Owens et al. (2011) described how family, friends and colleagues are exposed to a number of relational, emotional, and cognitive dynamics that block their ability to be aware of and interpret suicidal signs. Family, friends and colleagues play a significant role in the social wellbeing of people, and therefore are considered as protective of suicide (Babiss & Gangwisch, 2009; Compton, Thompson, & Kaslow, 2005; Kleiman & Liu, 2013; Rubenstein, Heeren, Housman, Rubin, & Stechler, 1989). However, it is considered that their being proximal to the suicidal person contributes to difficulties in recognising warning signs and taking appropriate actions with a suicidal family members (Owens et al., 2011). Owens' and colleagues' findings help to explain this phenomena and are outlined as follows:

- a) The signs of distress from the suicidal person were often difficult to communicate. For example, the suicidal person was often described as being withdrawn or private by nature or personality.
- b) Sometimes in an attempt to distract the family or prevent intervention, the suicidal person would express not only signs of suicidal ideation but also 'countersigns' – verbal or non-verbal (e.g., they stated they were 'OK', or appeared to go out with their friends often).
- c) Often due to the busyness of people's lives or other things attracting their attention, family show difficulty in interpreting and heeding distress signals.

- d) Lastly, there were three barriers to family taking action: (i) promoting silence by not saying anything for fear of being seen as fussing, being a hypocrite or nervousness about discussing feelings; (ii) finding it hard to break the trust between themselves and the suicidal member by telling someone else inside their network (particularly if they have specifically asked them not to); and (iii) not knowing when, where, or how to seek help outside their networks. Non-help seeking coping styles or previous bad experiences with the health system may contributed to inaction by family members (Owens et al., 2011).

As highlighted above, family, friends, colleagues, and professionals alike are faced with certain challenges in responding to people who are suicidal. These challenges appear to be somewhat unique to the type of role/relationship helpers have with the person who is suicidal (Fisher, Fitzgerald, & Tuffin, 2017). Unlike family and friends, MHSWs are in a paraprofessional position, and it is therefore conceivable that they might serve to more objectively and effectively recognise and respond to suicidal crisis. However, it is likely that for this to occur for MHSWs (under the rubric of supervised task-sharing) training is required for such specialised tasks (Hoeft, Fortney, Patel, & Unützer, 2018; World Health Organization, 2007). Nirui and Chenoweth's (1999) recommendations included to "educate general medical practitioners and *other healthcare staff* working in a variety of settings about identifying the risk factors associated with suicide". Hence, the quality of education and training of MHSWs in suicide prevention is important.

Training of Mental Health Support Workers

Formal training for a MHSW in New Zealand is known as the National Certificate in Mental Health (Mental Health Support Work -Level 4) (New Zealand Qualifications Authority, 2011). This national certificate framework is based upon a "recovery approach" to mental disorder, and includes standards relating to Te Tiriti o Waitangi (the Treaty of Waitangi), ethics, health and safety, service specifications, and legislation. The National Certificate was introduced in 1998 – the same year as the Mental Health Support Worker Advisory Group was established (MHSWAG, 2003). MHSWAG has a regulatory role to ensure that the competencies required, training given, competencies gained, and experiential demands of the role are balanced and mutually reflective of each other.

The New Zealand Qualifications Authority (NZQA) are assigned to manage the Level Four Mental Health Support Work training. The National Certificate is described as follows:

The National Certificate in Mental Health (Mental Health Support Work) (Level 4) [Ref: 0431] is designed to be a minimum qualification for people who wish to enter mental health support work, or who already work as paid or unpaid mental health support workers under supervision. This national certificate acknowledges the skills of those already in the workplace who work safely with consumers/tangata whai ora, and requires those who wish to enter the mental health support workforce to demonstrate competence through theoretical learning and practical experience with consumers/tangata whai ora.” (New Zealand Qualifications Authority, 2011, p. 1)

An evaluation of the National Certificate in Mental Health (MHSWAG, 2003) identified some significant gaps within the training. The gaps identified included a lack of uniformity between the different teaching schools (polytechnic schools and private teaching organisations), failure to represent the diversity of roles and therefore needs of the MHSWs, a deficiency in training for cultural competence (especially with Māori and Pacific clients and their families), inadequate teaching of documentation skills to reflect the realities of the job, and inadequate cover of the role of client advocacy.

Since this report there have been significant changes within the unit standards comprising the National Certificate (New Zealand Qualifications Authority, 2011). Thirteen of the 22 unit standards evaluated in 2003 were eliminated and replaced by nine new unit standards. The units include knowledge of consumer perspectives, supporting those on drugs and alcohol, preparing for family involvement, relationships with Pacific people, client rights, relationship skills, documenting incident reports, and networking (New Zealand Qualifications Authority, 2011). Specific unit standards reflecting first aid and resuscitation have been abolished from the certificate, presumably due to NGO’s generally sourcing this training separately for all staff. Since 2011 Careerforce (the industry training organisation for New Zealand’s health, wellbeing, and community sector) has developed a NZQA Level 3 Certificate for support work, a NZQA Level 4 apprenticeship for support work, and a NZQA Level 5 diploma for advanced support work. Each qualification takes between 12 and 18 months, with levels four and five requiring concurrent practical work.

Of relevance to suicide prevention training for MHSWs is the competency specifications of the National Mental Health Workforce Development Co-ordinating Committee. This committee set out basic competences for “every mental health worker”, which include the requirement to *assess* health needs (“Performance Criteria 4.3 - Assess risk of harm to self and others”); and to provide appropriate *interventions* (Performance Criteria 5.5 “Recognise and respond to changes in the consumer, self and the environment”). Further, the requirements for attending to physical health needs are specified under Competency 5 (“Provide appropriate intervention for consumers”) (National Mental Health Workforce Development Co-ordinating Committee, 1999, p. 62-63). For example, the performance criteria 5.8 specifies workers to “Administer cardiopulmonary resuscitation”, yet there are no specific acknowledgements for suicide intervention; for example, for “first-aid” suicide assessment and intervention skills. Notably, physical first-aid training is highly regulated and funded within the mental health sector.

Despite the availability of the National Certificate for MHSWs, this training is not a requirement for the role. Hence, it is likely that many MHSW may not have received training. Furthermore, for those who do receive general training for this role, specific training related to suicide prevention may well be lacking as this is not specifically referenced within the national qualification for MHSWs

Impacts of Exposure to Suicidal Behaviours on Staff.

Research in the United States reports up to half of psychiatrists, psychologists, and social workers experience their clients attempting or completing suicide, and one-third of professionals experience clients dying by suicide (Jacobson, Ting, Sanders, & Harrington, 2004). As outlined earlier, frontline staff in the mental health sector are also highly likely to be exposed to suicidality (threats, behaviours, ideations, plans and attempts exhibited by their clients). Exposure to suicidal behaviours carries the risk of personal impacts. Research into these impacts have not focussed on MHSWs but inferences are made from research regarding professionals.

One study researching ‘Compassion Fatigue’ found that of MH case managers in their sample, 18% experience symptoms of Post-Traumatic Stress Disorder (Figley, 2002). Symptoms such as avoidant behaviours, hypervigilance, intrusive thoughts, and feelings of guilt and fear have been found in professionals working with suicidality. Such experiences pose a high risk

factor for secondary trauma and compassion fatigue culminating in high turnover from staff (Kinzel & Nanson, 2000). For those who are insufficiently trained to deal with such confronting and difficult behaviours, burnout may be especially prevalent.

One qualitative study conducted with social workers explored common experiences among those who had contact with client suicide. Twelve major themes were identified from the reactions of social workers after their client had suicided. These were: denial and disbelief (being shocked and feeling like the suicide came out of nowhere); grief, feeling traumatised and bringing up personal loss; anger - both towards the client and the agency; self-blame and guilt; feelings of failure and incompetence (questioning their competence as a therapist); responsibility (feeling like you “bear the weight” especially if one doesn’t feel part of a team); isolation (lack of support, and being discouraged from talking about it for fear of prosecution); avoidant behaviour (clinicians not wanting to take on clients who were suicidal, instead referring them on to other professionals); intrusive feelings of anxiety and fear spilling over to their personal and professional mental health; changes in professional behaviour (changing in practice with more focus on suicidality and changes in professional environment – instigating policy changes for suicide and postvention, as well as more team work and support); justification (absolving oneself of blame and not being ‘blindsided’ by the suicide); and finally, acceptance (“I was relieved for him. Being out of his pain, realising there was nothing more you could have done”) (Ting, Sanders, Jacobson, & Power, 2006). The conclusions of this study were that although grief is a normal human reaction to death, for those in a professional role experiencing client suicide is considered to pose a different and complex range of emotional and cognitive reactions. Such reactions have the potential to influence mental health professionals’ collegiality (through changes in professional behaviour) and their sense of competence in their role. This study recommended that organisations adopt training programmes to raise awareness of the effects of suicide on mental health professionals where the risk of client suicide is high.

Other research has shown that the level of suicide education (knowledge and skills) related to dealing with suicidal clients, along with working in an interdisciplinary environment, increased professionals’ confidence with suicidal clients (Sethi & Shipra, 2006; Smith, Silva, Covington, & Joiner Jr, 2014). The quality of supervision (over quantity) was also found as important to promoting resiliency for social workers (Ting, Jacobson, & Sanders, 2008). The belief that one is making a difference in their professional capacity, as well as self-care and other

individual and contextual factors, have also been found to relate to resilience (McCann et al., 2013).

Gatekeeper Training

Specific suicide intervention and prevention training, termed “gatekeeper training”, has been found to improve trainees’ knowledge, skills, confidence and attitudes around suicide (Beautrais et al., 2005; Isaac et al., 2009). Gatekeepers are described as those who are in a position of frequent contact with people and families who may be in distress or at risk of suicide, and to whom people may turn to for help (Quinnett, 2007; Snyder, 1971).

Gatekeeper training, a predominant method of suicide intervention outlined in the USA National Strategy for Suicide Intervention (Goldsmith, 2002), has become increasingly popular as a major preventative strategy for suicide. Beautrais et al. (2007) describes gatekeeper training as one of the “most promising interventions likely to be effective in reducing suicidal behaviours” (p. 75). The effectiveness of the gatekeeper model is premised on the fact that those considering suicide tend to talk to friends, family and known community members over mental health professionals (Corrigan, 2004; Everall, Bostik, & Paulson, 2006; Michelmore & Hindley, 2012; Turley, 2018). Hesitation in help seeking is described to be due to stigma (Corrigan, 2004), isolation and alienation (Michelmore & Hindley, 2012), a failure in natural community acknowledgement of warning signs (Snyder, 1971), as well as the perception suicidal individuals have of helpers, and whether they are seen to be trustworthy and capable of helping (Pisani et al., 2012).

Gatekeeper training is clearly relevant for MHSWs. For MHSWs, general barriers such as stigma, reluctance to intervene, and a lack of self-efficacy in engaging in suicide preventative behaviours (Burnette, Ramchand, & Ayer, 2015), together with systemic and organisational barriers (e.g., time pressures), can reduce suicide intervention behaviours (Moore, Cigularov, Chen, Martinez, & Hindman, 2011) and may need to be considered within training. It is important that the boundaries of a paraprofessional role in suicide prevention should be defined because their role is not necessarily to provide a full risk assessment (Durlak & Roth, 1983; Hoeft et al., 2018; Sibeko, 2018; Turley, 2018). The role of a gatekeeper is to recognise signs of distress and provide immediate help to persuade the person away from suicide, and hold the knowledge and ability to refer the suicidal person to appropriate resources and for further help

(Quinnnett, 2007). The efficacy of suicide gatekeeper training in developing appropriate beliefs, knowledge, attitudes, self-efficacy, and motivation for intervening to promote suicide prevention is well documented (Beautrais et al., 2007; Burnette et al., 2015; Coppens et al., 2014; Cross, Matthieu, Cerel, & Knox, 2007; Isaac et al., 2009; Lipson, 2014; Turley, 2018; Wyman et al., 2008).

While there are many suicide gatekeeper trainings available globally (Turley, 2018), there are two major evidence based gatekeeper training modalities available in New Zealand. These are QPR (Question, Persuade and Refer), and ASIST (Applied Suicide Intervention Skills Training) (Oliver, 2015). Further, there is a very recent initiative, led by LeVa in partnership with the Ministry of Health, called LifeKeepers (Le Va, 2018), although there is as yet no research evidence of its effectiveness. To date the only evidence-based gatekeeper training is for the standardised QPR and ASIST programmes. Both of these programmes are supported by the Ministry of Health with funding and dissemination specifically into communities deemed more at risk. A brief overview of each programme is presented here, though for more information Oliver (2015) provides a thorough description.

Question Persuade Refer (QPR). QPR was created in 1995 by Paul Quinnnett in California and now claims to have trained 300,000 people (Quinnnett, 2007). The training takes between 1-2 hours and is accessible by face-to-face with trainers or interactively through online resources. Lancaster et al. (2014) found the online training programme of QPR to be equivalent in its initial impact to face-to-face programmes, but a general decline was seen in measures of knowledge, self-efficacy, and behavioural intentions to engage in suicide prevention at 6 month follow-up for the online format. In another USA study involving a randomised control trial with social workers, QPR online training led to an increase in knowledge, efficacy and skills of those who participated in the training compared with the nonparticipating control group (Jacobson, Osteen, Sharpe, & Pastoor, 2012). These findings have been replicated in other studies with a range of different populations such as college students, social work students, and hospice staff (Coleman & Del Quest, 2014; Institute of Public Research, 2010; Jacobson et al., 2012; Matthieu & Swensen, 2014; Mitchell, Kader, Darrow, Haggerty, & Keating, 2013). However, in a randomised control trial, Wyman et al. (2008) reported that QPR had no significant impact on gatekeeper behaviours for participants in the trial group of secondary school staff.

In New Zealand QPR is delivered under the name of QPR New Zealand, a subsidiary of Walker Psychology and Consulting Ltd, who are exclusively licensed by the QPR Institute to deliver and manage the training courses for New Zealand. QPR New Zealand offers a multi-tiered approach to training for different levels of qualifications (for family, counsellors, psychologists, etc.) which can be tailored to the organisation's particular needs. QPR New Zealand also offers an online course which covers the following areas (see www.qpr.org.nz).

- Understand the background, rationale and guidelines for use of the QPR Suicide Screening Method.
- Identify information on suicide risk reduction practices and critical information on unrecognized suicide risk.
- Discuss the epidemiology of suicide and describe the relationship between mental illness and suicide.
- State recognised risk factors for suicide.
- Use the QPR Suicide Screening process, including asking the "Suicide Question," supporting the suicidal person's decision to get help, assisting the suicidal person in accessing additional resources.

Half day or full day face-to-face workshops can be arranged to meet requirements of the organisation as an alternative to the online format.

Applied Skills in Suicide Training (ASIST). ASIST is a two day workshop developed in 1983 in Canada specifically for frontline caregivers/gatekeepers within varying disciplines and occupations. They have now trained over 1,000,000 people through these workshops (LivingWorks Education, 2014). The workshops utilise adult learning principles including interactive group work (around 30 participants) and splitting off into smaller groups that helps to orchestrate a feeling of safety around the topic, balanced with challenging participants to broaden skills practice (Rodgers, 2013). The following outlines the five sequential stages of workshop content of the two consecutive training days (see <https://www.livingworks.net/programs/asist/>):

- **Preparing:** Sets the tone, norms, and expectations of the learning experience.
- **Connecting:** Sensitises participants to their own attitudes towards suicide. Creates an understanding of the impact that attitudes can have on the intervention process.

- **Understanding:** Overviews the intervention needs of a person at risk. It focuses on providing participants with the knowledge and skills to recognize risk and develop safe plans to reduce the risk of suicide.
- **Assisting:** Presents a model for effective suicide intervention. Participants develop their skills through observation and supervised simulation experiences in large and small groups.
- **Networking:** Generates information about resources in the local community. Promotes a commitment by participants to transform local resources into helping networks.

ASIST is likely the most highly evaluated and validated suicide prevention training programmes available (LivingWorks Education, 2013; LivingWorks Education, 2014; Rodgers, 2010; Rodgers, 2013; Sareen et al., 2013). In one of the most robust studies to have been conducted recently, Gould, Cross, Pisani, Munfakh and Kleinman (2013) conducted a national randomised control trial at 17 Lifeline Centres (crisis phone line) over one year. This study reported that callers who were answered by ASIST trained counsellors, compared to non-ASIST trained counsellors, were significantly more likely to be less depressed, less suicidal, less overwhelmed, and more hopeful by the end of the call. New improved versions of the ASIST workshop have been developed from recommendations of this study (Rodgers, 2013).

A randomised control trial conducted by Sareen et al. (2013) concluded that there was a lack of efficacy for ASIST compared to the control group. Sample size in these groups however, may have not been sufficient to detect small effect sizes. Furthermore, the participants in the control group had more adult members and had more participants with a higher level of educational attainment. These factors may have contributed to the lack of a positive finding.

Since 2005, Lifeline Aotearoa has been registered to deliver ASIST programmes in New Zealand. LivingWorks also has collaborations and registered trainers in Canada, Australia, Scotland, Norway, United States, Ireland, Guam, Hong Kong, Russia, and Singapore. In New Zealand, ASIST has also been accredited for inclusion in registration programmes by the Midwifery Council of New Zealand and the Addictions Practitioners' Association Aotearoa-New Zealand.

LifeKeeper - a New Zealand initiative. LifeKeeper (National Suicide Prevention Training) is a new gatekeeper programme which has been developed in New Zealand by LeVa.

Its design and delivery were advanced by collaborations with three strategic partners (including Walker Psychology who hold the license to deliver QPR training), as well as collaborations with an expert advisory group, key national prevention organisations (including the Mental Health Foundation), DHBs, individual academics, people with lived experience of suicide, cultural consultants, and other suicide prevention leaders. LifeKeepers is described as “clinically safe” and “culturally responsive”. It launched in September 2017. Amongst the many groups it is suggested to be useful for, support workers is first on the list. Importantly, this initiative is funded by the Ministry of Health. It offers free e-learning or one day workshops for all those not otherwise provided training but who interact with people at risk of suicide. This ambitious and promising national resource may transpire to be highly relevant and useful for MHSWs (Le Va, 2018).

Comparison of programmes. The two evidence based programmes (QPR and ASIST) have been compared and appear to be equivalent on measures of knowledge gained (Coleman & Del Quest, 2014; Institute of Public Research, 2010). However, in respect of suicide prevention behaviour enactment, one evaluation from the Connecticut Youth Suicide Prevention Initiative found that ASIST trained participants reported completing more actual behaviours at a 6 month follow-up than QPR trainees. For example, ASIST trainees were almost twice more likely than QPR trainees to be involved in referring a young person to a Mobile Crisis Response Team. This study was not a controlled comparison as QPR trainees were mental health professionals at university campuses and ASIST trainees were Hotline managers (Institute of Public Research, 2010). Hence, due to the nature of their roles, one group may have had more opportunity to act compared to the other. A more recent study found that ASIST trainees showed a larger increase in asking at-risk youths about suicide at follow up compared with QPR trainee’s working with the same population (Coleman & Del Quest, 2014).

As well as encouraging actual behaviour, it appears that ASIST training also improves attitudes of helping, whereas some studies of QPR have found no changes in attitudes (Jacobson et al., 2012; LivingWorks Education, 2014; Rodgers, 2010). It may be that attitude changes seen in ASIST trainees mediate increased actual behaviours to prevent suicide. The advantages apparent in the ASIST programme over QPR may arise from the interactive and interpersonal nature of workshops in the ASIST training protocols.

Overall, both of these programmes are described as being successful in enhancing trainees' knowledge and skills (Smith et al., 2014) compared to pre-training measures, and in arguably breaking down suicide stigma within the wider community. Both training QPR and ASIST are run and utilised in New Zealand, yet both have been found to be lacking in cultural relevance and therefore may be limited with regard to its application across cultures (Oliver, 2015). This point is especially important given the Ministry has signalled priority to fund training in specific communities such as Māori and Pasifika. While QPR was regarded as appropriate for a broader audience (whanau/family, community members, and MH workers alike), ASIST was perceived by some within DHBs as better suited for people who work in the mental health sector (Oliver, 2015). NGOs regard the ASIST programme as an expensive option, even with government subsidy. Lastly, frustration exists for some gatekeeper trainees in New Zealand surrounding the major gap within the MH services to support, and professionally assess, those at risk of suicide. It has been recognised as potentially risky to provide first aid suicide intervention to people in need if there is a lack of immediate follow-up services are available (Oliver, 2015).

Suicide is preventable. These suicide prevention gatekeeper training programmes appear to hold the potential to empower and equip communities with the skills that are required to avert death and should be considered equally as important and necessary to be learnt as CPR (Quinnett, 2007). This appears particularly important within mental health organisations where there is a heightened risk of suicide and a lack of resources, monitoring, and training on suicide intervention specially. Towards the end of her report, Oliver and colleagues clarify priority targets for moving forward with gatekeeper training in New Zealand. This section contained an open question for future focus: "Which roles amongst mental health practitioners might benefit from suicide first aid training?" (Oliver, 2015, p.78). It is hoped that the outcomes of this thesis will go some way towards contributing to the answer.

Summary of Literature Review

Mental health service users have high rates of suicidal behaviours compared to the general population. Accordingly MHSWs will encounter suicidal behaviours in their care work. Training is not mandatory for MHSWs in New Zealand, including training in suicide prevention.

Although their clients are typically under the care of a MH professional who holds overall responsibility for the client (New Zealand Guidelines Group (NZGG) and Ministry of Health, 2003), there are barriers to clients accessing professionals, as well as concerns about the clinical oversight of MHSWs to provide suicide prevention (Nancarrow, Shuttleworth, Tongue, & Brown, 2005; Pace, 2010). Accordingly, there is a need to enhance aspects of multi-layered suicide prevention approaches within our MH system; especially given the ongoing high rates of suicide in this country. In order to enhance a multi-layered prevention approach to suicide and to broaden the reach of assistance to marginalised groups, effective utilisation and recognition of MHSWs in this capacity is needed. MHSWs likely represents an underutilised resource for suicide intervention and prevention. Little is known and understood about this role in New Zealand and internationally, with respect to suicide prevention. It seems likely that specific suicide prevention training within this workforce is lacking. Gatekeeper training has been recognised globally and within New Zealand as a promising efficacious and evidenced-based intervention to support suicide prevention behaviours.

Overall, it is necessary to gain a deeper level of understanding of MHSWs experiences, identities, roles, suicide preventative practices, attitudes, and relevant relationships surrounding MHSWs, to contribute towards general knowledge of this workforce.

Research Overview

Previous research has focused on understanding the attitudes and risk assessment skills of professionals who provide mental health care; comparatively little research has focused on non-professional MH support staff. Understanding the factors that contribute to frontline MHSWs' confidence in caring for those at risk will contribute to suicide prevention endeavours.

Accordingly this research has two overall aims: To understand the experience of MHSWs in dealing with client suicidality, and to investigate factors that influence MHSWs' preparedness in working with client suicidality. There may be supportive and inhibitive factors in addition to training needs that might affect the confidence of staff to prevent suicide, such as staff attitudes towards suicide, confidence and self-efficacy, culture, religion, organisational and societal factors such as stigma. Thus the contribution of these factors will also be considered in the research. Given the paucity of research with frontline mental health staff, like MHSWs, and not least the

lack of research that explores the relevance of their personal responses to suicide, a particular aim of this thesis will be to give this unheard community of helpers a voice. Findings are likely to have relevance for the MHSW population in New Zealand and internationally.

The research seeks to answer the following questions:

1. How do MHSWs experience interacting with clients who become suicidal?
2. What do they perceive of their role, if any, in suicide prevention?
3. What does this experience mean to them, personally or professionally?
4. What do support workers consider could be improved upon within their role regarding interacting with suicidal clients to prevent suicides?
5. What training is offered to MHSWs in NZ related to suicide intervention?
6. What factors (including training, self-efficacy, beliefs, attitudes, religion, knowledge, and skills) influence the likelihood that MHSWs will feel confident in identifying warning signs and talking to clients about suicide?
7. How might the above factors be employed together to encourage MHSWs in suicide intervention for clients (potentially at individual and systemic levels)?

Methodological Framework

This thesis employed a mixed-method approach. There has recently been a call for increased qualitative methods in suicide research in this area alongside quantitative methods (Hjelmeland & Knizek, 2011). Over a decade ago Shneidman (1998) suggested that: “Our best route to understanding suicide is not through the study of the structure of the brain, or the study of social statistics, or the study of mental diseases, but directly through the study of human emotions” (p.24).

A concurrent mixed method was deemed appropriate for this research given the research aims above, and in consideration of the complex social and systemic world of which MHSWs are embedded. As a clinician assessing the mental health of clients, triangulation has been a basic rule of thumb when gathering information to better conceptualise clients’ difficulties. Accordingly, the research questions above will be addressed by utilising two methods, qualitative and quantitative, which will be presented respectively in two parts.

The first study is a qualitative study reporting on findings from seven participants. It is concerned with identifying the unique experiences of this workforce dealing with client suicidality. The second study presents quantitative findings from 91 MHSWs who undertook an online survey. The online survey focused on measuring stigma and attitudes towards suicide, self-efficacy, religiosity, suicide knowledge and beliefs, and largely the effects these factors may have on confidence to deal with client suicidality. In bringing these two streams together it is intended that the breadth and scope of the overall finding will complement one another with a focus on increasing understanding, rather than the use of one method informing the development of another (Hanson, Creswell, Clark, Petska, & Creswell, 2005). Accordingly, a final overarching chapter functions to combine the conclusions of these two studies to form a more comprehensive understanding of MHSWs and their role in suicide prevention, with a focus on developing suggestions for future directions.

CHAPTER TWO: A QUALITATIVE STUDY

Experiences of mental health support workers in dealing with client suicidality

Suicide behaviours are common in those with a mental health diagnosis (Beautrais et al., 2005; Lund, Nadorff, & Seader, 2016; Mortensen et al., 2000; Nock et al., 2008; Tan et al., 2018) and therefore suicide prevention is a significant focus in mental health (MH) care. Mental Health Support Workers (MHSWs) make up the largest proportion of workers in the mental health sector (Te Pou o te Whakaaro Nui, 2015; Te Pou o te Whakaaro Nui & New Zealand Disability Support Network, 2016) and spend significant face-to-face hours with MH clients; arguably more so than professionally trained MH specialists. As a result of these factors, it is likely MHSWs are often exposed to client suicide behaviours. Research suggests that those considering suicide are more likely to disclose ideation to people they know over MH specialists (such as clinicians) (Corrigan, 2004; Everall et al., 2006; Michelmore & Hindley, 2012; Turley, 2018). Lapsley, Nikora, and Black (2002) found that, as well as MHSWs being easy to talk to, MH consumers also saw support workers as trustworthy and that the relationship felt equal, supportive, helpful, and respectful. It is therefore possible that MHSWs are in positions whereby clients may choose to disclose suicidal thoughts to them. MHSWs are not required to have any formal training - though many complete general mental health qualifications as supplementary to learning on the job - and in particular, there is no requirements for specific training in suicide prevention.

There is a paucity of research, internationally and in New Zealand, on the role of MHSWs (Durlak, 1979; Hennessy, 2015; Lund et al., 2017). However, a number of challenges facing MHSWs have been identified. MHSWs lack role clarity and there are difficulties with recruitment and retention (Kemp & Henderson, 2012; MHSWAG, 2003; Public Service Association - Te Pūkenga Here Tikanga Mahi and the Service and Food Workers Union Nga Ringa Tota, 2009; Swider, 2002; Te Pou o te Whakaaro Nui and Platform Trust, 2018). Furthermore, there is minimal research into the role of MHSWs with respect to suicide prevention. To my knowledge there is no research in New Zealand specifically addressing suicide prevention within the MHSW role.

Suicide is a topic that often evokes highly emotive responses. Working in a therapeutic or recovery context, one is likely to be confronted with people who suffer negative affect, feelings of worthlessness, social isolation, and a sense of their life is not meaningful (Shneidman, 1977). Responding to these experiences in clients can be challenging for professionals (Saunders et al., 2012), and this may be particularly so for those in helper roles who are less trained to deal with

suicidal behaviour (Lund et al., 2017; Lund, Schultz, Nadorff, Galbraith, & Thomas, 2017; Lund et al., 2018; Nirui & Chenoweth, 1999). Uncertainty about how to respond to suicidal behaviour in clients may spill over into workers' personal life (Ting et al., 2006). Asking about suicide can be helpful to clients and opens an opportunity for provision of help, but asking someone about their suicidal ideation induces a state of daunting anxiety for many (Department of Communities, The State of Queensland, 2010; G. Evans & Farberow, 1988; Tatarelli et al., 2005). Specific suicide training has been found to decrease stigma and increase knowledge and confidence in these skills (Beautrais et al., 2007; Oliver, 2015; Rodgers, 2013).

The degree to which employers support MHSWs role in suicide prevention in New Zealand is not known, although more generally, support workers have been under-utilised within health systems (Dohan & Schrag, 2005; Skills for Health Working Paper 2, 2016). In studies conducted elsewhere it has been shown that organisations (e.g. in Justice, Welfare, mental health, education, emergency, and community organisation, in charity and statutory service settings) can play a role in facilitating MHSWs suicide intervention-related behaviours through suicide-specific training, and by providing positive support, discussion, and acknowledgment of their role in suicide intervention (Evans & Price, 2013; Moore et al., 2011).

The purpose of this study was to investigate the MHSWs' role in supporting clients who become suicidal, their experiences in doing so, and the support they experience within their employment structure. Describing the role they enact with client suicidality, and the challenges they face, will inform future direction for this predominant frontline mental health workforce. The specific areas of investigation included; how MHSWs relate to suicidal clients, a consideration of the nature and meaning of these experiences for them both personally and professionally, how MHSWs conceive of their role in suicide prevention, and what they perceive to be the factors that impinge on, or enable them, in this activity.

Method

This study utilised a qualitative method. Qualitative methods can be open to and capture a broad range of data. Suicide research has been dominated by quantitative research methods which has to some extent limited findings (Colucci & Lester, 2012). A call for qualitative and in-depth research has been stated in recent times in order to expand the understanding of this

phenomenon (Hjelmeland, 2011a; Hjelmeland, & Knizek, 2011). Qualitative methods are useful in expanding literature where there may otherwise be limited research on a given area.

Qualitative research may be employed to ascertain the personal and social perspectives and worldviews of those being researched. A qualitative method allows for the voices of participants to be heard (Ahearn, 2000); especially important for those who are under-represented or in low positions of power. Furthermore, a qualitative approach is adaptable and able to allow for more cultural sensitivity.

It is important to recognise that qualitative analyses are being interpreted or understood through the perspective of the researcher. The data can be shaped by the interactions of researcher and participant. However, the use of semi-structured interviews help guide the researcher's questions, ensuring that relevant research on the topic is covered while also actively making space for the participants' unique account of their stories and experiences.

In this study thematic analysis as described by Braun and Clark (2006) was employed. Thematic analysis has many advantages for use in psychological research. Namely, its theoretical flexibility in identifying, describing, and interpreting data, and it is a simple and straightforward method to use. Thematic analysis, in essence, identifies patterns or themes in the data that are analysed and interpreted (Braun & Clarke, 2006). A detailed description of the thematic analysis method used within this study is set out in the section below on data analysis.

Participants

Participants in this study were MHSWs working in one of the major mental health, addictions and disability NGOs in New Zealand. Participants were recruited via posters placed in the premises of the organisations, and via emails sent through the NGO network (see Appendix A). Participants were required to be 18 years or older and currently employed within a MHSW role. Participants were informed questions would be in relation to working with suicidal clients, but also more broadly about their experience of their role and job, and about their attitude in general relating to coping with suicide.

The initial goals were to interview at least 10 participants. Nineteen people initially indicated interest in participation. However only seven were eventually interviewed, with the reasons for others not being interviewed including that they lived too far away in New Zealand to feasibly interview face-to-face.

All interviewees were woman. They were aged between 22 and 51 and were from a variety of ethnic backgrounds including Māori, Cook Island Māori, Pakeha/New Zealand European, Fijian, and Pilipino. To protect the confidentiality and anonymity of the participants, the information about this sample has been purposefully limited to the above description.

Interview Process

Face-to-face interviews were conducted with seven participants who lived in Auckland. Due to funding pressures face-to-face interviews with people from elsewhere were unable to be complete. Four face-to-face interviews were conducted at a University of Auckland office with the remainder conducted in an office of the participants' place of work in a private room.

At commencement of the interviews, participants were informed again of the purpose of the study and given the opportunity to ask any questions they had about the research. Participants were given time to read through a copy of the Participant Information Sheet (see Appendix B) and Consent Form (see Appendix C) and were reminded that they were able to withdraw, pause, or pass on any particular questions any time throughout the interview. The Consent Form was signed and then answered some basic demographic questions before the interview proceeded further.

It was explained to all participants they would be asked questions that would guide the interview, but that there would also be flexibility as to the order, dependent upon how the interview proceeded. Participants were told it would hopefully feel more like a conversation rather than a question and answer session.

During the interview if participants became upset, time was given for them to collect their thoughts in a non-pressured way. None of the participants chose to end the interview. After the formal interview had finished and the recorder was turned off and participants were asked to comment of how the experience was for them and if there was anything else they would have liked to talk about. Only a few had further comments or stories and these were recorded in a notebook also used to record any observational data and reflections on the interviews.

The shortest interview went for 30 minutes and the longest interview went for 89 minutes. The average length of an interview was 62 minutes.

No follow up contact with the participants was deemed necessary. It was assumed that given their position as MHSWs - representing their chosen career where issues of suicidality are

likely to arise - that they had strengths in dealing psychologically with these issues, and probably had already reflected on their own ability to work with suicidal clients.

The semi-structured interview schedule was used in all interviews and covered broad topics that were deemed relevant to the MHSWs role in suicide prevention. These included their experiences with clients who become suicidal, as well as experiences within the MHSW role generally, effect of dealing with client suicidality, and how attitudes and thoughts on suicide aetiology, intervention, prevention, and culture/religious/and societal factors might impact the way they work. The interview schedule (shown in the Appendix E) was predominantly shaped by the literature review; although it was also partly based on reflections on my own experiences of working as a MHSWs. A few additional questions were added to subsequent interviews based on responses in the early interviews (see Appendix F).

Data Analysis

Interview recordings were transcribed verbatim by a transcriber (who had previously signed a confidentiality form) or by myself, the author. Thematic analysis was the method of data analysis. Braun and Clarke (2006) offer a step-by-step guideline for conducting robust thematic analysis, which was followed. At the first step audio recordings were transcribed. For those interviews not transcribed by the author, all audios were listened to by myself and the transcripts checked; a process which contributed towards familiarisation and immersion in the data. In the next step Nvivo software was used to develop codes. These codes were later organised into themes. Careful attention was paid to accounts that deviated from dominant narratives to make sure they were not dismissed or overlooked. Pieces of data were coded to form a thematic map, where some themes were merged and others discarded. A process of re-reading the transcripts in consideration of the themes was employed to reflexively identify appropriateness of themes within the wider data set. Themes were reworked and refined with regards to overlap and hierarchy of codes. Journaling and memos of this process was kept throughout. This included documenting discussions with my supervisor and the process of revision and refinement that proceeded from these discussions.

Trustworthiness and credibility of data analysis was gained through these systematic processes and by working collaboratively with my supervisor. This process was seen as

particularly important given my previous experience as a MHSW, to ensure themes were logical, reflected the data, and to limit the impact of confirmation bias (Morrow, 2005).

Subjectivity and Reflexivity. The process of deciding on methods, collecting data, identifying themes and interpreting data can all be influenced by personal, philosophical, and knowledge factors relevant to the researcher. Reflecting on these factors and how these may impact the data analysis is an important, if not essential, characteristic of conducting a robust research project.

This research has personal significance to me in that the motivation to explore this field came from my own experience as a fulltime MHSWs prior to post-graduate studies. Through this work history I gained connections with the NGO that provided a participant pool for research. It was also through my own experiences of being a MHSW that I realised there may be a disconnect between the training available to support workers, and the actual experience of the role working with individuals with complex needs. Having been a MHSW previously helped me to build rapport easily with the participants which assisted them being able to talk candidly about their experiences.

Like many, I have known someone who has completed suicide and know people who have contemplated suicide. I have not personally contemplated suicide. I have spent many years as a telephone counsellor speaking to people with varying degrees of suicidality and I spent time as a MHSW with clients who were suicidal. These experiences helped to colour my understanding of what it is like to be a MHSWs. However, I soon realised my own experience as a MHSW was different from those interviewed. I was conscious through the process of data analysis to double check that the themes I had interpreted had not been overly influenced by my own experiences. My supervisor assisted me in this endeavour.

By the time of completing the data analysis it had been over four years since I was a MHSW. During this period I had been training as a clinical psychologist. Fostering an open-minded and curious interest in this field from the perspective of a psychologist enabled a separation such that I was mindful of not over-identifying with the particular narratives of the MHSWs interviewed.

With regards to the relational dynamic with participants, it is important to recognise that as a clinical psychologist and researcher I may have been perceived as an authority figure on topics discussed. Further, there were a number of people from different ethnic and cultural

groups. Coming from the dominant culture I reflected upon on my relative power position in these interactions. I remained aware of these dynamics during communications and endeavoured to achieve and maintain a warm and empathetic relational style during interviews.

Lastly, I have remained aware of my great desire to give voice and prominence to MHSWs, their role within the mental health system, and for the role they can play in suicide prevention.

Ethical considerations

The University of Auckland Human Participants Ethics Committee granted approval for this study. Details of ethical approval was included on all relevant documentation necessary for participation in the study, such as the Information Sheet and Consent Forms. Confidentiality was maintained in the write-up and in storage of the data. As with most qualitative research, quotes were used verbatim. However, any contextual information that provided clues to the identity of individuals or their employers were removed. Participants were assigned a number to further maintain confidentiality.

It was made explicit within the Participant Information Sheet and Consent Form that there would be no sharing of information with the organisation about individual participant responses. Only recommendations based on the overall findings will be provided to the organisation, at the end of the project.

Safety and risk

Suicide is an emotionally laden topic. Given the high rate of suicide, it was considered that participants may have experiences of someone they knew who had suicided. Further, dealing with suicide within their work could also be very difficult and potentially a traumatising experience for those who are helping or are witness to self-injurious behaviours. It was therefore expected that discussion of their experiences of client suicidality might bring up difficult memories - both within professional and personal capacities - and that participants may experience some level of psychological distress.

In managing psychological distress for participants, a number of measures were considered. Firstly, participants were provided an outline of the focus of the interview to reiterate and warn the potential for difficult conversations. I monitored their emotional reactions during

interviews carefully. I was able to rely on experience and skills in identifying and managing distress gained from training as part of a Doctorate in Clinical Psychology. If a participant appeared to be in distress or disclosed distress I had planned to offer support, validated that it was a difficult topic, provided a change of topic in the discussion, and suggested to end the interview or take a break. If my concerns had remained for the participant after the interview I planned to encourage them to seek support, offer for them to speak to my supervisors (both qualified clinical psychologists), or provide details to other psychological services. No referrals were required for any participants. As already reported, there was a debrief at the end of each interview with the participants once the recorder was turned off, which enabled an assessment of levels of distress. In all interviews the levels of distress for remained contained.

Cultural considerations. As a means of ensuring a culturally safe experience for Māori participants, consultation was sought early on from Dr Matthew John Shepherd (Ngāti Tama), an experienced researcher who also is a clinical psychologist and senior lecturer at the University of Auckland. Māori principles influenced the interview process. For example, *manaakitanga* aimed to be upheld in providing tea and biscuits at interviews to ensure people felt comfortable and welcome, and *whakawhanaungatanga* influenced ways in which the researcher sought to build rapport prior to the interviews commencing.

Findings

Six themes and various subthemes were identified. Braun and Clarke (2006) make a distinction between the extent to which themes are identified as either semantic (surface level) or latent (deeper level). The approach in this study to identify themes focused in large part on what is practically relevant for answering the research questions. Given this, themes - such as the first theme: "Dealing with Suicide is Something We Do and We Play a Key Role" - may be considered as being at the semantic/surface level. This first theme describes the extent to which MHSWs are occupied by client suicidality within their role. Other themes may be considered to be at a deeper/interpretive level.

Theme two, "We Feel Very Responsible" describes how MHSWs feel a burden of responsibility where client suicidality is concerned and how this impacts their functioning within their daily work. The third theme, "Our Role in Suicide Prevention: Dismissed and

Underutilised", speaks to the systemic deficiencies of inter-professional communication with MHSWs. It identifies the sense of powerlessness participants felt as a result of their low status within a hierarchical health system and how they felt their perspective of client suicidality went largely unheard. The fourth theme, "Dealing with Suicide has a Large Emotional Effect" describes the emotional work or 'labour' required to support clients in distress, and to a similar extent the emotional toll required for working with suicidal clients. Theme five, "Our Amorphous and Undervalued Role", describes participants' underlying perception of their role and experience of relational dynamics with clients as ill-defined and confusing. Lastly, theme six, "We Need Increased Support, Training and Talk", relates to MHSWs' call for more open conversations about suicide, suicide related training, and better remuneration. This theme acknowledges the anxiety and uncertainty that exists for MHSWs when dealing with suicide behaviours while suggesting possible avenues for improvement. It also reflects hope: that confidence and coping skills, both practically and emotionally, can be built to align with the experienced realities of this role.

Table 1: Qualitative Themes and Subthemes

Themes	Subthemes
1. Dealing with Suicide is Something We Do and We Play a Key Role	Looking and seeing warning signs. Dilemmas and judgment calls - asking, confidentiality, and reporting. Pass the parcel of risk and responsibility. Enacting strategies to help.
2. We Feel Very Responsible	We are all they've got. Fear of being blamed.
3. Our Role in Suicide Prevention: Dismissed and Underutilised	Lack of information exchange and going in blind. Feeling underutilised and at the bottom of the cliff.
4. Dealing with Suicide has a Large Emotional Effect	Difficult to switch on and off. Personal experience: benefits and burdens. Emotion management and coping.
5. Our Amorphous and Undervalued Role	The role is confusing and ill-defined. One thing was clear: the relationships is key (but lacks clear boundaries). Bottom of the food chain - a low status role.
6. We Need Increased Support, Training, and Talk	Resourcing and support. A need for training.

Theme 1: Dealing with Suicide is Something We Do and We Play a Key Role

Supporting clients who become suicidal was described as something MHSWs do, are occupied with, and are regularly confronted by. The different aspects of their role in relation to suicide are represented in several subthemes: how MHSWs pick up on warning signs; the challenge or dilemmas around having conversations about suicide; the implications of 'passing on risk' with respect to their sense of responsibility felt; and intervention strategies MHSWs used to directly address their clients' suicidal state and decrease suicidal risk.

All participants spoke of how the context of their work and the ubiquitous nature of suicide risk contributes towards demands to be occupied by suicidality within their role.

I worked in residential and pretty much every single client that we had come through our house had a history of either suicide attempts or suicidal ideations or that sort of thing... So I have experienced a lot of it. (P2)

Some participants also described vivid and intense experiences of witnessing self-harming or suicidal behaviour first-hand.

I ran and got the first aid kit. And she was just sitting there. To her it was nothing when I saw her do that ... But yeah when she did that and I just saw the blood coming out and that. I was a bit shaken up that day. This is just something we have to deal with. (P5)

As exemplified above, there were a number of factors which contribute to the omnipresence of suicide for MHSWs. Firstly, because of the increased time they spend with clients they have increased opportunities to observe these behaviours. Secondly, they are in a unique position to observe clients in various settings; for example, their homes, schools, and communities, within which problems may emerge to trigger suicidality.

Because we are the people that probably have the most direct one-on-one interaction with people in their own natural environment if that makes sense. So if we are meeting with someone in their environment we are the ones that are most likely to see, okay this person is acting like this and that probably is a sign things aren't going so well or it could be going towards something and that's where I think we come in, especially with the suicide stuff. Like we are there to be people to watch out for these things and to be aware of what somebody might do that might indicate they might be wanting to commit suicide or thinking about it. (P2)

Data here suggests MHSWs gain a unique perspective into their client's lives and are positioned to attend to suicide behaviours. Accordingly, five subthemes were identified. These subthemes explain the ways in which participants are engaged with client suicidality.

Looking and seeing warning signs. The first subtheme describes the process of watching for and identifying warning signs. Some participants were concerned over their perception that warning signs often went disregarded: "some people saw it as a bit of an attention seeking act and that to me was quite concerning" (P2). Generally the participants regarded looking for warning signs as a substantial and legitimate aspect of their role.

I think that is a huge part of our role is learning early warning signs and having those plans in place and sort of being, I guess, the person on the front line seeing the person and then communicating that back to their clinical team or whoever else is involved. (P2)

Participants recognised that watching for warning signs was important and that unrecognised signs can be dangerous for clients.

She just hinted. And it wasn't until later I realised, hell that's what she was saying.

So then I had to go back and explain to her why I needed to tell someone. (P7)

An attitude of being open to conversations about suicide with clients and being willing just to listen was a stance adopted by many participants.

Quite often I mean I think I would listen more, I would say something like has something happened that makes you want to feel that way, happened recently?

And then they'll talk about it. I don't tell them what to do or anything. I'll just ask and let them talk. So it's mostly about asking. (P7)

Overall it seemed that in noticing warning signs and evaluating them as serious may have required a type of mental or emotional preparation the enabled conversations to occur with clients about their feelings of suffering.

Dilemmas and judgment calls - asking, confidentiality, and reporting. Once a warning sign is recognised, participants are in a position where they have to make a series of decisions and ultimately make a call about whether to pass information on and, if so, to who. Firstly, they have to decide whether to make further enquiry. Secondly, they have to figure out how to deal with the consequences of the conversation. Thirdly, they have to decide who to pass

the information to. The first step in 'making the call' involved asking clients directly about suicide. These decisions and action were described by most participants as something that provoked challenging emotions, the personal impact of which is described in later themes. A couple of participants described a fear that by asking directly about suicide they may inadvertently 'trigger' a client to suicide.

Worried that it might trigger into actually doing something, or give them ideas, yeah those are the main ones. Or even just not knowing how to deal with it if the answer's 'yes'. Not 'deal with it' but you know what I mean -what to do, what to say. So incompetency. Or being afraid. (P1)

All participants stated that asking a client about suicide was a difficult task for a number of reasons, for example one participant stated "It's uncomfortable because it's unnatural talking about it and it makes me uncomfortable" (P3). Hence participants used different methods to overcome their discomfort in asking directly about suicide. One described approaching the task in an "off-the-cuff" manner, as opposed to another who rehearsed the question beforehand. Many adopted an approach that reflected simply "not being afraid, not shying away from the topic." (P1) One participant described the way she approached clients who become suicidal was by just being blunt about it: "It's something that I have to be really blunt with." (P3)

Adequate rapport was considered to be essential in order to ask about suicidal risk in a way that was safe and supportive. In other words, the better the relationship, the easier it was to ask about suicide.

I have been quite fortunate that once you develop your relationship rapport with a person that I am not afraid of asking those key questions anymore and being quite direct in a safe and supported kind of a way. (P6)

However, as well as the personal emotional impact of asking 'the question', there was concern about how asking the question may impact their relationship with the client. This was described as being a pivotal moment between client and MHSWs whereby there exists a consequential risk to their relationship. The action of asking about suicide required participants to consider and negotiate the client's boundaries with respect to differing views of what was considered personal and intimate. Some described the potential to misjudge, and then have to manage the discomfort for the client. Ultimately, participants saw asking the question

as a potential risk of losing the relational rapport and trust built, something that was highly revered. Hence, these deliberations represented an ethical dilemma by some accounts.

It's the same as asking a person, are you having unprotected sex. You know, you're getting really personal and intimate and you're asking them to tell you something that is huge risk in a relationship. (P7)

A further issue complicating this decision was participants' concern about breaking confidentiality. Participants recognised that maintaining confidentiality with their clients was important and that breaking confidentiality could potentially cause a rupture within the relationship or bring tensions to it.

Where does your responsibility end as far as when is the point that you've got to tell someone, hey this person was really down, they were talking about this, is that an early warning sign? And the difference between that and keeping confidentiality and trying to continue to build their trust, because it is important to build trust with somebody but also where is the line of okay actually they could be in danger. (P2)

If after asking directly about suicide it was identified that the client was indeed at risk, the second step participants identified was deciding what to do next, even within these conversations with clients. A couple of participants highlighted that one of the concerns that arose for them was contemplating whether they were expected by their employers to handle the situation by themselves or not.

I've felt alright I guess, well not alright, but I ought to manage it, you know what I mean? Knowing what, what to, where to take it, what to do. I guess in some ways it can be a bit of a challenge. (P1)

Most participants acknowledged their obligation to pass on information about suicidality and thereby breaking confidentiality; yet they also contemplated the relational damage that such an obligation entailed. One MHSW described the sense of betrayal her client felt towards her having broken confidentiality.

The person who said she was having (suicidal) thoughts and she didn't want me to tell her mum and I didn't hear from her for a couple of weeks after that and I was really worried that she was pissed off with me and angry and didn't want to talk to me anymore because that has happened with adults. (P7)

For the most part it seemed participants were asking themselves important and relevant questions with regards to ethical considerations. However, they appeared to lack guidance and support in negotiating these ethical dilemmas.

Passing the parcel of risk and responsibility. Most participants discussed the idea of 'passing on risk'. They seemed confident that passing on the risk was what they should be doing. Essentially, participants likened this action to that of passing on a parcel; the consequences of which reduced their emotions of concern, liability and fear.

If we did go somewhere and they did something that put themselves at risk I don't want that on my shoulders ... If anything does happen I'm handing on the responsibility. So I'd rather hand it on than carry it. (P7)

Nonetheless the feelings of responsibility weren't necessarily relinquished or reduced by this action of passing on the risk. Some participants felt an ongoing heavy burden of care. They felt a duty to deal with the client in front of them, whether or not they had the trust or support of clinical professionals to 'hold' the risk.

Like if you've got someone who is right on the point of wanting to kill themselves and you call the clinical team and they've got five other people who are in the same situation it's very difficult because you've really got to deal with it yourself and not everybody has the experience to be able to do that. (P2)

Whether the parcel of risk was passed or not, some participants felt they were left with remnants of what they had unwrapped.

Every time I have an appointment with a young person I always ask them, have you seen so and so? Have you seen the clinical team? And if they haven't I get worried. (P3)

Hence, the idea of passing on risk concerns to relinquish a sense of responsibility was, for most, incomplete. In reality participants attempts to 'pass on' risk did not mean they had offloaded.

Enacting strategies to help. Participants spoke about the strategies they employed with their clients to directly address their suicidal state and decrease suicidal risk.

Being prepared to listen. Most participants spoke about the importance of being prepared to listen to the hard things. They recognised that having these discussions about a client's suicidal thoughts is a hard topic to talk about. By simply listening and practicing good empathetic active

listening skills, they felt they were doing something helpful for their clients. Some participants spoke about the importance on being present and grounded within these conversation and being engaged with them, as opposed to assessing symptoms in a detached 'tick off the list' way: "Yeah, being prepared to listen, yeah being prepared to sit in there through some really dark stuff ." (P3)

Identifying individual reasons to die. A few participants spoke about recognizing the idiosyncratic reasons their clients wanted to die. They recognised that understanding these reasons might guide them in the direction of targeted prevention responses.

It is different things that actually bring it up, like for example one of the girls who committed suicide that was around hallucinations. (P1)

Finding relevant reasons to live. Some participants spoke about finding reasons for their clients to live as their main strategy to prevent clients from suicide; believing MHSWs could "hold the candle of hope" (P6) for their clients by reminding them of reasons to live. A myriad of reasons to live were given ranging from reminding clients of ice cream, to re-establishing a sense of worth by highlighting key attachment relationships and ties to significant others. One powerful message from these participants was that the reason, whatever it is, had to 'hook' them. In other words, the 'hope' MHSWs carry and offer in the form of a reason to live, needs to be personalised and meaningful to clients to hold weight.

I suppose for me I do go back to my default position of shared similar experience and just give them hope. Yeah, maybe family, whanau, if they have children, goals that they are working towards, anything, anything that hooks them. If it's just the fact that you wake up tomorrow and have an ice cream so be it, you know, anything. (P6)

Some participants derived their approach to helping clients to find reasons to live from having themselves been through similar situations and feelings.

Convincing clients to wait. Underneath the idea of convincing clients to wait or delay their plans to suicide, lay an acknowledgement of the sometimes fickle nature of suicidal ideations. A few spoke about simply convincing clients to wait, without supporting their decision or implying permission. Some would describe this conversation as more of a negotiation where a deal would be struck between client and MHSW. Others plainly asked clients to wait until the morning.

Yeah, and I know it sounds morbid, but saying to people okay can you give me, you know, can you wait a week, wait two weeks, wait overnight... Instantly something can change and they can feel completely different about it. They could have a really positive experience with somebody, you know and instantly feel like they don't want to do it anymore. (P2)

Either way, there was a recognition that client's mind could often be changeable and sometimes all that was required was a bit of time.

Reassure, refocus on goals. A few participants utilised the predominant work they do with clients to distract and bolster them by refocussing clients away from suicide and towards their goals: “Tell myself to calm down as well as calming them down and going through the steps, reminding them of their goals.” (P4)

Lifting the moment by changing the environment. Most participants described changing the negative into positive as something they did to lift the mood - perhaps both their own and their clients'. When clients became suicidal, these participants would take their clients outside their normal environment, often to one that was more calming and lifted the client's mood in those moments, sufficiently to find further strategies or supports.

A lot of the time it's trying to make an environment, for me trying to make an environment more liveable, like doing something that they enjoy doing, finding something that would make them feel better, and for some people it's like eating their favourite food or going out for a drive or going and doing an activity they really want to do and it's hard because it's really just putting a band aide over it, their problem is still there. (P2)

Such strategies, although helpful, were nevertheless considered short term solutions.

Summary. Participants described dealing with suicide behaviours as part of the work. They deal with suicide within their role, in the practical and relational sense. This includes watching for warning signs, deliberating on what action to take, managing discomfort with asking directly about suicide, making decisions about the seriousness of the signs, considering confidentiality and ethical dilemmas, passing their concerns to others, and intervening to decrease their clients' suicidal risk. Limitations existed in the degree to which they felt they could help their clients, yet experience gained contributed to nuanced and skilled ways of responding to client suicide risk.

Theme 2: We Feel Very Responsible

When they described their role, the frontline nature of it and the realities they experience in supporting people who become suicidal, participants communicated a strong sense of responsibility for their clients.

We are all they've got. The idea of "we are all they've got" arose for many. It represented a sense, derived from the perception that many clients lacked natural supports and resources which resulted in clients relying upon them, particularly in times of suicidal risk.

He used to self-harm quite often. He didn't have many family connections, so that was a huge thing. His family, his mother didn't really care that much about him. She was in the area but she never visited him in the whole time I worked there ... He had no natural supports of his own, so all he had was our team and the clinical team. (P2)

This sense of responsibility was displayed both generally: "a hundred percent. It kind of feels they really, really need us." (P5), and in times of crisis: "I feel very responsible, especially if this person is telling me yeah I want to kill myself" (P7). A sense of responsibility appeared compounded by a sense of isolation whereby some participants thought they were "the only one here holding the line" (P3). It appears there was also a sense of isolation from clinical/professional staff (discussed in later themes) which increased their sense of responsibility when they were unable to rely on or access clinicians. This sense of 'we're all they've got' was borne out of contextual factors related to the job.

I think our responsibility is quite a lot. We have that one on one time with them. You've got other professionals, the clinicians and all that stuff that see them, GPs or whoever. They don't see them as much as we do. I see all my clients once a week, you know. They only see their clients every three months ... I think it's a lot of responsibility we hold. We have more information than probably what ... I think we have so much responsibility. (P5)

Nearly all participants mentioned isolation and lack of natural social supports as main factors that contribute to suicide: "I think the main one that I have seen is definitely lack of natural supports." (P2) Where participants observed obvious gaps in a client's natural support system they expressed a desire to fill this gap by meeting the client's social needs. Participants worried about becoming a proxy for natural social roles, such as friends or

family. Yet it seemed many participants found themselves challenged, uncertain, pressured, frustrated, and guilty in recognising their experience of their relationship with clients as 'proxies' or social replacements.

She was one of my first clients and I became very attached and also she didn't have very good support around her. I took the role as kind of like an older sister, which I shouldn't have and I know. But it's kind of hard when you get into these relationships with young people. They are going through real sensitive stuff and sometimes they can't speak to other people. So that was definitely a hard one to approach. (P3)

The development of proxy 'friendships', or other relational comparisons, was for many challenging and confusing (as elaborated on in later themes). Yet, they were also seen as necessary for developing trust. Trust, one participant described, was fundamentally important to the working relationship especially in dealing with suicidality. Nevertheless, this trusting and connected relationship generally facilitated participants' strong sense of responsibility for clients. Such felt responsibility led a number of participants to act in certain ways to reduce their anxiety and concern about clients in times of suicide crisis, especially where they perceived they were all clients had. Such behaviours included giving out private phone numbers, taking client calls out of hours, or staying late at work.

At the end of the task there is, who can you call on, who can you contact, you know. I would struggle to not give them my number to contact me as well, you know. Just because when someone's in a crises that's intense and if that person feels alone already and is just talking to me, how confident can I feel that this person is going to call that other number or call their parents. (P3)

Staying late or leaving late from a shift to be there for a client when they are particularly vulnerable, maintaining contact outside of work hours, or meeting up with the client despite ending the relationship with the service, was discussed by one participant. She explained these decisions as being an urge that was hard to disregard due to a sense of pressure (or obligation) within the relationship.

You feel a lot of pressure to stay and to be there for them and to keep in contact with them, especially if you leave a job you feel like I should still go and talk to them because that was all they had. (P2)

Many participants acknowledged such actions as inappropriate and constituted crossed boundaries. They recognised it was important to find others to help when clients were suicidal and their work day had finished.

You've just got to really rely on the fact that somebody will come and help you. It's sort of about reaching out to the people who have more ability. (P2)

Overall, participants described their sense of responsibility being in part, underpinned by the close relationships they developed with clients, as well as a perceived sense of isolation for clients and themselves. Although some encouraged the idea that reaching out for help was necessary, others perceived inconsistent availability of clinical oversight.

Fear of being blamed. As an extension of feeling responsible, there was a level of fear participants expressed about being potentially blamed if suicidal acts are carried out by clients under their care or within their work setting. One participant spoke about feeling threatened by the clinical team and being blamed for a client's death by suicide.

Um, and I guess kind of just when you don't notice a sign and you kind of like get questioned by the clinical team, threatened by the clinical team. (P1)

A participant spoke about being in a situation where a client had completed suicide in one of the residential facilities she was working in. A person from within the organisation was flown up from another branch to interview all the staff working within the service to enquire about what had happened in the lead-up to the suicide. The participant said she felt interrogated and blamed in this process, and the fact that there was never any report fed back to the staff on the conclusions of the findings from their interviews felt wrong to the participant.

Summary. Most participants felt they enacted a pivotal social role for their clients to such an extent that they often perceived themselves to be all the clients had; a limited yet needed social resource. The close relationships with clients and the clients' social isolation increased their concerns for them. This sense of isolation was reflected in the participants own feelings of being isolated from other clinicians. These factors culminated to increase participants' sense of responsibility for clients when they were in crisis. Further, most participants found the responsibility as burdensome. Consequently, care for their clients risked becoming 'unboundaried', leaking into their personal lives wherein they found themselves worrying about and supporting clients outside of work hours. Some also feared being blamed or found accountable for client's suicidal behaviours.

Theme 3: Our Role in Suicide Prevention: Dismissed and Underutilised

This theme suggests that the type of work MHSWs do is often undervalued or minimised. The first subtheme reflects the lack of communication about suicide risk that MHSWs feel exists between them and MH professionals as a result of the undervaluing of their role. The second subtheme describes MHSWs sense of feeling underutilised and powerlessness to effect change or realise their perceived potential.

Lack of information exchange and going in blind. Participants described a lack of information about their clients' risk as well as a general lack of information exchange between MHSWs and clinicians. They felt there was a lack of interest or appreciation from clinicians about information MHSWs may have to offer with regards to their clients' wellbeing and progress. As a result of the lack of information exchange, some participants felt they were going in blind; simply learning about the client and their level of risk 'as they went along'.

Sometimes you kind of feel like we are just floating around and going along with what the other nurses or other staff are doing. (P4)

Participants had diverse experiences of support and information provision. Some clinical staff were viewed by participants as open, supportive, and positive, whereas others were experienced as closed, unsupportive, and even intimidating (something that will be further described in the last theme relating to training, support, and supervision). Participants found the lack of information, which could otherwise facilitate a better understanding of their clients, as challenging.

I feel it's also because as a support worker it's not clinical work. It's not therapeutic in that sense that I don't get told all of the information. So I am also trying to find it out as I go along. Like I'm shedding some light on new things, which makes it hard, especially if I don't have someone like a clinical team I can be open with. (P3)

In general participants regarded information provision about a client's risk as inadequate and this represented a concern for them. 'Working blind' was associated with uncertainty.

I think the biggest problem is that I don't know everything, so the person who is self-harming I don't know what she's doing or how or how bad it is or anything like that. And the person who went to respite over the weekend because she does

have a plan, I don't know what the plan is, I don't know that it is relevant. But I feel like I am kind of working blind. (P7)

Some participants believed successful outcomes with clients could be overlooked by managerial or clinical staff. Small wins that were celebrated by both client and support worker were often disregarded or minimised by other staff. Few participants spoke about clinicians giving positive feedback to MHSWs. Many of the achievements that MHSWs had gained a sense of pride around were felt to be given little recognition and their contribution towards client outcomes were under-acknowledged.

Key workers value us. I think parents do if the relationship is good and we get to explain to them what we do and how we do it. I think relationship is really crucial in making sure parents know what has changed. This person wouldn't walk into a shop and buy something themselves two months ago and now they will. And we see that as progress but other people might not. They tend to overlook it. (P7)

Lastly, a couple of participants attributed being treated disparagingly by clinical staff as a reflection of the fact that MHSWs are not associated with a professional or registered body.

Feeling underutilised and at the bottom of the cliff. The analogy of an ambulance at the bottom of the cliff was used by more than one participant in describing how they felt their role was regarded in responding to suicide. It aptly described both being responsible for clients in crisis as their last hope, but also the sense of being helpless or powerless to provide more help in client's lives.

Working with these kids as well in this job I've noticed that I'm at the bottom of the cliff waiting for, you know, that top down approach, I'm at the bottom waiting for it to happen rather than how do we change it up there. (P3)

On the other hand, one participant utilised this same analogy to highlight the potential she saw for MHSWs to act as a 'fence' rather than an ambulance. Her idea was that by speaking openly about suicide and using personalised experiences to build empathic responses and relationships with clients, this would contribute towards reducing stigma about suicide and change the negative social taboo towards suicide through discourse.

Rather than being the ambulance at the bottom of the cliff I would rather tackle those sensitive subjects in an appropriate head-on way, be honest about things and

I guess I've got lived experience coming into that from myself and my whanau as well. (P6)

A few of the participants spoke about feeling like they were capable of doing more within their job. They recognised they may not have the competencies and therapeutic skills needed at present but believed they were, at some level, being underutilised within their role. Some referenced the amount of driving or cleaning they are asked to do: practical tasks which they did not consider a legitimate part of their role. Others described feeling like their undergraduate degrees went unrecognised and under-remunerated.

It's frustrating because often I am treated like I don't know what I am talking about or I'm not using my skills and I often feel as professionally to grow I need to be utilised a little bit more. (P3)

These comments demonstrated that participants were passionate about their role and in particular about helping and being useful to their clients' recovery. Alongside this passion it seemed their relational skills, which contributed to their understanding of clients, was also under-valued.

Summary. Participants experienced a lack of recognition and often felt they weren't respected by those higher up within the health system. At a practical level, their experience of their role being viewed as low status was perceived to impact the flow of information between them and clinical staff about clients. This was seen as particularly problematic when information related to a client's suicide risk. Given that suicide was already a challenging aspect of their work with clients, 'going in blind' increased uncertainty about management of their clients. Additionally, they felt their achievements with clients often went unrecognised by both management and clinicians. The experience of being disregarded and left in the dark appeared to contribute to a sense of failure, hopelessness, and powerlessness for participants in helping their clients in crisis. They generally saw their role as a last resort for clients and felt that there were constraints on them being more proactive. However, there were exceptions where participants experienced positive, collaborative interactions with clinicians, inspiring hope.

Theme 4: Dealing with Suicide has a Large Emotional Effect

Terrifying, scared, worry, panic, intense, draining, tiring, pressure, sad, upset, empowered, great, and worthy, were all emotions participants described feeling in response to their experiences working with clients who had suicidal thoughts and behaviours.

She was in a daze, just staring out into space and quite anxious, like scared of herself and that's quite terrifying to see a young person scared of themselves. (P3)

The most common comment made by participants about both the emotional and physical content of the work was that it was exhausting and draining.

It's draining, definitely draining. I can't say anything else. It's so tiring. (P3)

This was a consequence of the work which had a very real effect for participants.

Difficult to switch on and off. Relationships generally continue to exist 'in mind', even in the absence of physical contact with the other. However, the expectation or implicit rule for MHSWs within their professional capacities, was that they should be able to “switch off”. Many found switching off difficult to do.

Seeing her in isolation and struggling with her own feelings and emotions was really hard to just switch off and go home and just kind of pretend that it wasn't happening but then switch on again when I saw her Monday. It was kind of strange. I struggle with that part in my role. (P3)

Furthermore, many participants spoke about the issue of 'taking (emotional) work home'; reflecting difficulties being able to distance themselves in mind and emotion from the topics and issues associated with work and clients. Switching off from work required active effort, and having the ability to do this was regarded as something that had to be learnt over time.

Sometimes at the end of the week it can be really draining and I never take it home with me. I have just learnt not to. Once I leave here that's it. Work stays at work.

When I go home that is me and my family. (P5)

Experiences with clients' suicidality can be traumatic for some MHSWs, and this work may result in the development of secondary or vicarious trauma. A couple of participants spoke about blocking or numbing emotions and thoughts in order to deal with the emotional toll. In a busy day MHSWs may be required to continue working with multiple clients despite their

own distress. Blocking was one strategy used by some participants for managing their own emotional responses to suicide in order to remain emotionally available for clients.

When she did that I kind of realised that it happens pretty fast, if someone like for example if one of my clients talked about it, they could do it just like that. I don't know why I forgot about that. I tend to block certain things and just not think about that. (P5)

Another participant spoke about having to remind herself about the significance of suicide. She spoke about becoming emotionally numb to suicide and its effects as a result of having been exposed to it regularly for a long time.

Yeah it's kind of weird, I mean I guess I have more of a numb relationship with suicide because I was at a mental health phone-line for three years and it was an everyday thing and I got used to talking about it. And I have to keep reminding myself that this is a huge issue for a lot of people but it's not so much for me. (P7)

This same participant did not find it challenging to switch off and discontinue thinking about work when she was at home. Importantly, she found it helpful to distance herself from worries towards suicidality by engaging with philosophical or spiritual rationale that recognised the limitations to her personal responsibility for these people. She reminded herself that other options exist for clients to pursue help, options she had guided them towards.

However, this ability to block had also been criticised by others as 'insensitive'.

(Switching off)... it's not too hard ... I've got a friend who is always having a crisis, always having a crisis and I've been accused of being insensitive. But if I know that there is another chain in the support that they can refer to, if there is something in place it doesn't have to be me all the time ... But my foundation is probably a spiritual one so I tell myself that everyone is living their own life for a reason and the things that happen to that person happen for a reason. (P7)

Ultimately, being able to disconnect from the burden of responsibility may require trust in the client themselves, in other support workers' competence, and in recognising alternative support options available. Recognition that a plan involving other forms of support may have been created for these times of crisis was suggested as a way to mitigate the perception of responsibility.

I just go okay there's something going on with them but I know that they have a support plan in place, they know what to do if they need help. It's the weekend. I'll just leave it, you know because if they have a plan in place but I know something is going on, it's the weekend, it's my time, because crisis doesn't stop. If I wasn't around someone else would be dealing with it anyway. (P7)

The quote above exemplifies active engineering of her emotions by a process of rationalising to detach from feeling concerned for clients; in order to comply with the expectations of “switching off”. Switching off was perhaps seen by participants as an expedient approach.

Personal experience: benefits and burdens. Almost all of the participants spoke about having a close friend or family member who had either attempted or completed suicide. A few participants spoke about having experiences of wanting to end their own lives at some point. In general, those who had personal experiences (the majority) described these experiences as both useful and troublesome with respect to how these experiences influenced responses to client suicidality.

Benefits. Participants’ personal experiences of suicide deepened and broadened their conceptualisation of suicide. In describing their personal connections to suicide within their own lives they came to realise certain insights, for example, about the stigma surrounding suicide. These insights were seen as relevant and useful to their work with clients in anticipating barriers, such as cultural attitudes towards suicide and mental health challenges presented to clients within different communities.

It appeared these experiences had been a significant source of motivation for some participants in choosing this line of work. For many, personal experiences were considered a major source of understanding and empathy that helped to foster connection with clients:

I guess for me it's kind of easier to deal with situations like this than what it is to deal with clients with schizophrenia. Just because ... I've had that kind of experience. So I kind of can have a bit more, understanding and empathy, and stuff like that. (P1)

For those with personal experience of feeling suicidal, their experiences were generally something that assisted them meaningfully in their work with clients. Their experiences

helped in recognising common thoughts and feelings present for suicidal clients, in developing empathy for clients, and motivated participants in work in this field.

I struggled as a teenager and had thoughts of suicide growing up. So I know what it feels like to be alone, to feel lonely and so yeah trying to be another person that someone can reach out to. That's big for me. (P3)

Some participants recognised that in order to 'use' personal experiences to connect and help clients, whereby they were able to draw meaningfully and positively from such experiences, required a personal journey of healing, facilitated by therapeutic work.

I've put a lot of effort and energy into bettering myself as a person personally so I'm in a good space. Years ago I wasn't but yeah now I'm really empowered so it's not an issue for me anymore. It was in the past definitely. But that is because I hadn't sorted out my own issues. But now fortunately I've been able to move through that. And I suppose that gives me a good starting point for sitting alongside someone and some of the circumstances because I am the postcard picture of moving through something like that. (P6)

Participants felt that when they could utilise their personal experiences of suicide as useful in helping clients, this represented a transformative experience for themselves; being able to turn past negative experiences into a vehicle for connection, hope, and meaning making.

Burdens. There was, however, a flipside of personal experiences with suicidality, in that it could trigger personal experience in a way that was detrimental to their own well-being. All but one participant spoke about the how working with clients who are suicidal could activate their own memories of being suicidal or dealing with close family members who were suicidal. Self-management of flashbacks from potentially traumatic experiences was necessary.

I get flashbacks of my friend. It's weird. Every time I go into the situation ... like right now I am really conscious of what has happened in my past. (P3)

Some participants had experienced trauma through exposure to client suicidal behaviour. One participant commented on the recurrent triggering nature of suicide exposure within this line of work, where previous traumatic or challenging experiences from past client suicides became reignited.

I suppose in some ways it can trigger what, what happened with the other two clients that passed away, um through suicide. (P1)

If early warning signs are not noticed and acted upon, this may increase the likelihood that MHSWs are exposed to vivid attempts. If attempts are experienced as spontaneous and scary this may increase the likelihood of traumatisation and work stress.

We were just opposite each other having a good conversation, talking about her son. I saw something in her hand but I just didn't ... I thought it was paper or something and then I just saw her hand go there and then like that. I just looked and I saw the blood and I was like oh gosh.... (P5)

Overall, managing emotions based on memories of past experiences of suicide exposure was described as a very challenging aspect of their role. It added heavily to feeling emotionally drained by the job. Among close colleagues, discussing personal experiences and struggles to maintain their own emotional equilibrium was said to be important.

I have had close connections with some of my colleagues and we have spoken about it. Going through depression and how it's hard to be in a situation like this helping another but also rewarding at the same time. (P3)

Having personal memories triggered was an aspect of the work did not appear to be discussed within the organisation.

Emotion management and coping. Supporting and working closely alongside people who have particularly challenging emotional and mental health difficulties requires workers to be equally competent at managing their own emotional reactions when helping to regulate those of the client's. The ways participants managed the challenges of emotional work involved the application of skills learned in their private spheres; that is, it did not rely on workplace training.

A couple of the participants spoke about the way in which they worked to interpret their own emotional responses in order to become more attuned to their clients' emotions. They described their own emotional responses in reaction to their clients as being on a spectrum, from angry to understanding. These interpretations were useful insights into the attuned care they gave their clients.

The quote below demonstrates the intricate and skilled emotional work of one MHSW, in this instance, to balance the concern for her client and the importance of her self-management in conducting the conversation.

Try and focus on this person my energy and take things slow, almost as if I am trying to pick out any uncomfortable unsettledness from the other person ...I don't

want to sound like I'm listing things off, even though I am. Asking are you going to kill yourself, have you got a plan? I've got that list in my head but trying to make it a little bit more natural. And I'm trying to do it as I speak now. I am really trying to ground myself. Because I feel if I don't do that this person is going to think oh you don't really care. (P3)

Many of the participants spoke about the need to 'keep under wraps' or manage their emotions especially in regard to anxiety around asking about suicide. They also described managing emotions when anticipating clients becoming suicidal, or through feelings triggered about their own personal experiences with suicide. In these situations, participants spoke about how difficult it was to manage their own, often big emotions while around clients, in order to prevent this arousal from influencing their focus and support for their clients.

Trying not to let my emotion take over to me supporting them, but then deep inside I do feel sorry for them and if I am responsible for them as well I get a bit panic in a way. (P4)

While underlying emotional reactions were hidden from the clients, it seemed they were also left to be managed later on at home and through support from family and partners. Other coping strategies were employed and recognised as important considerations for functioning well emotionally within their role.

Basically just trying to enjoy life at home and also just using my other coping skills with those negative emotions I might have and basically getting social support from my family and my partner. (P4)

Debriefing at work with people who were in an authoritative and competent position to accurately address those concerns for staff was seen as a helpful way to process the cognitive and emotional toll that comes with being exposed to client suicides when they occur.

Yeah, we had a clinician there, a specialist clinician, one of those specialists that came in and just we had like a debrief, so sit down and talk to us and told us that hey these things happen, it's not your fault what she did, it's not your fault so don't take it in and think that it was your fault. (P5)

Self-care and the importance of it was brought up by a few of the participants. It was discussed by participants in respect to the challenges that arose from the emotional, practical, and relational aspects of the MHSW role.

The most important thing I wanted to be asked was how the support worker themselves is taken care of and self-care is important but also how the organisation looks after. Because the reason why we get into this line of work is because we care about people, we care about taking care of people and we understand mental health as something big and massive for people. But we also have our own pasts coming into it and I think being able to take care of one self's wellbeing is really important and often not talked about. (P3)

Some participants spoke about the support they received from colleagues and co-workers regarding concern for their own emotional safety, and that this support was appreciated. Others complained that self-care is overlooked as an element of their training or within the organisational culture. Where self-care was perceived as absent, this was related to the high staff turnover. Some participants pursued self-care themselves. Many spoke about having a good support system within their personal lives and engaging in activities which they recognised as being 'self-care'.

Summary. Unsurprisingly, dealing with client's suicidality had a large emotional impact for participants. Utilising and relying upon their own emotions and personal experience, assisted most in their ability to deal with their clients' risk. Most participants who commented on their personal experience of suicide felt these experiences enhanced greater connection with clients, helped them understand what clients might be going through, and provided an example of hope. This practise appeared to be underpinned by a range of nuanced relational skills which involved attuned client-focussed care, as well as the dual management of their client's and their own emotional responses. However, managing their own responses to triggered traumatic memories was difficult for most participants. Past suicide experiences and memories, either personal or work related, were often re-triggered. 'Emotional management' reflected a demanding process that traversed private and professional spheres. There was an implicit expectation that MHSWs should 'switch off' at the end of the day which some participants found hard to do. To avoid taking emotional stress home, some participants described 'blocking' or 'burying' negative experiences. Participants were largely left to manage on their own without

support of their organisation. Positive coping strategies they developed for themselves included debriefing with others and attending to self-care processes.

Theme 5: Our Amorphous and Undervalued Role

The majority of participants spoke about their role generally as confusing and ill-defined. The first subtheme described how participants found it somewhat challenging to communicate or articulate clearly what their role entailed in its general scope, and similarly their role in preventing suicide. Many spoke about feeling like they did a 'bit of everything'.

It's really weird because my role is real ... I've got a contract which outlines my role but at the same time it's real grey. It's not black and white. I don't do this and I don't do this and do, do that. It's kind of like oh I can do a little bit of everything.
(P3)

The second subtheme describes an element of their role that was not confusing. One thing that was clear for participants was that their relationship with clients was key, and in this sense the client/MHSW relationship was the most easily defined and acknowledged aspect of their role. However, this apparent paramountcy of the relationship with clients was not free of ambiguity.

In the last subtheme, 'bottom of the food chain', participants describe their status with other professionals as being undervalued in general. It highlights 'gender inequality' where the requirements of the role attract people with specific skills in caring and compassion, typically woman.

The role is confusing and ill-defined. Many of the participants found it difficult to articulate their role, particularly in delineating differences between their work and other mental health professions, such as nurses and therapists. One participant settled on words such as "social support", "calming down" (sometimes other professionals as well as clients) and attending to the emotional states of those around them, particularly giving "emotional support" to clients. Within the broader system of professionals, participants positioned themselves as needing to defend their role and advocate for its importance.

An unclear understanding of the core nature of the role can produce a sense of uncertainty or unease. The participant below spoke about her experience of panic linked to a lack of understanding of the role in suicide prevention.

... at first I was a bit panicking and didn't know what to do as a support worker and then once I've kind of just learnt on the job as to what my role is and what I can do then I kind of felt more confident and that panic just disappeared. (P4)

Because the role in general was difficult to describe, some participants spoke about the challenge of communicating their role to family members of clients, who participants experienced as not fully understanding what they did.

I'm not sure that parents understand so well. A lot of parents just see us as relief for them. But then if it helps in some way then that's okay. Our role is to teach skills really and skill development and so we have to keep reminding parents that that's what we do. (P7)

It is often the case that MHSWs work alongside mental health key-workers or clinicians, especially when they were based in a community settings. Often the referral for a MHSW was made by the client's clinician and so there was an expectation that clinicians know what the role of a MHSW is. However, some participants found themselves having to restate their role to referring clinicians.

Quite a lot of us work for the same clinician. I just found it annoying that she said that we were respite. It's like no, we're not respite. (P5)

The question as to whether their role was considered therapeutic or not arose for many participants. Some had been told their role was not supposed to be therapeutic. For others however, they believed (either fervently or speculatively) that what they did with clients was therapeutic. However, for many this remained ambiguous, as reflected in the following extract.

With my role I am not supposed to be therapeutic ... (yet) because we do gradual exposure and sometimes I'll get stuff off the clinicians to practice with, sensory modulation and getting a sensory kit and so it's kind of therapeutic. (P3)

While some participants spoke about this 'role ambiguity' as causing uncertainty, one participant framed the amorphous nature of the role positively as "dynamic and evolving" (P6). However, participants generally attempted to define their role by likening it to numerous other community roles. They saw themselves as constantly floated between these varied roles and responsibilities.

We reconnect whanau, we pick up kids in the community, we deal with issues from child poverty to food security to behaviours. (P6)

For some participants at least, resentment surrounded this reality. For the participant below, it was her opinion that the work they do is equal to the role of caregivers, teachers, and social workers combined. Comparing these roles, this participant described the main difference between MHSWs and those listed, as being paperwork/formal training.

They've just got the paperwork. It's all about paperwork. We do a social worker role, caregiver role, teaching role, facilitator. Our role encompasses everything plus. (P6)

One thing was clear: the relationship is key (but lacks clear boundaries). Whether or not participants struggled to define their role, believed it was therapeutic, not therapeutic, confusing, or evolving, many participants were explicit and clear of the value of connection within "key relationship(s) with people who are vulnerable" (P7). Having positive relationships with clients was described as a pivotal and defining aspect of their role.

Positive relationships definitely are important and I think that's where my role comes in. New experiences that give hope. (P3)

A couple of participants spoke about situations where clients preferred to communicate or maintain contact with MHSWs over clinicians. They considered factors that may explain this choice, such as differing philosophical approaches, or MHSWs social standing within the health system which may strengthen relationships with clients. One participant thought this choice reflected the casual 'friendlier' approach of support workers. Participants acknowledged their role in-between clients and clinicians to be "the other person to link it in" (P3), especially when clients don't want to talk to their clinicians.

I think it's different in the way that I've had especially younger clients where they are scared of the psychiatrist for example ... And with us they feel I think they are a bit more comfortable with the support workers ... I think we just have a bit more friendlier and casual approach to the clients than the nurses and the other health professionals. (P4)

This experience further added confusion as to whether their role and relationship with clients was therapeutic or not.

With regards to managing suicide with clients, building a consistent and predictable relationship with clients was seen by most participants as enabling of safe and supportive conversations about suicide to occur. There was a perception that having a strong relationship meant that clients trusted MHSWs with their thoughts and plans of suicide. Also, the relationship was said to support MHSWs knowing the most suitable way of interacting with individual clients: understanding clients' unique set of problems, coping skills, and strengths during their darkest time.

I mean we have a key relationship with people who are vulnerable and how we manage the relationship depends on how much information we get told (by the client), how we support them, that kind of thing. So I think meeting people where they're at is crucial to the relationship and I am prepared to do that and that is not really responsibility, it's how I work. (P7)

Further, participants suggested that continuity within the relationship, across time and contexts, leads to a balanced view of their clients and stability.

I feel like consistency is key when it's working with young people, whether they are thinking of killing themselves or not, often these kids have the chaos in their lives so having that one person that is going to stay for at least two years, that is ideal. (P3)

Those participants who had worked in both a residential settings and mobile community settings described differences between the two working environments and the effect these environments had on their relationships with clients. Most participants spoke about the residential service being more difficult in terms of building and maintaining relationships. They described the practical tasks expected of them within the residential setting as promoting role confusion and causing ethical and philosophical tensions.

Just because the model of recovery (in residential service) is a different model to what we seem to be working with the youth (mobile community service) ... It's more just a lodge type of living, supported living, kind of model ... you become a housekeeper-cleaner. We are not employed to do those kinds of things but that's what you do. (P6)

The potential for such role confusion appears to have an impact on boundary crossing which was identified (in residential settings mainly) as a blurring of home/work-life settings.

Because we did shift work as well, that was another thing that actually causes a lot of problem because you spend time there with them during the day and the evening, overnight. You spend all aspects of your life with them at some point, so that is a challenge as well because essentially you don't want to cross the boundaries but you do have to learn to live your life in the house with them at different times of the day and doing different activities and stuff like that. That also put a lot of pressure on people I think and me. (P2)

This sense of 'living with' clients, was described as challenging and put pressure on the client/MHSW relationship. As practical tasks became more prioritised, relationship boundaries became more diffuse. The act of trying to maintain one's professional capacity alongside respecting client's autonomy and living space caused further uncertainty.

It appears the working environment at residential settings could also facilitate deeper connectedness and knowledge of the client; resulting in something that felt like a friendship in many accounts. One participant described making a conscious effort to build relationships with clients that felt natural despite knowing it was not: "I try and make it organic, even though it's not an organic relationship, as much as I can, to try and develop that trust" (P3). However, participants worried that the relational parameters in these settings would often stretch or morph into more familiar or natural social capital for the clients' sake; that is, reflecting social relationship proxies. A few participants mentioned terms like "babysitter", "sister", or "parental", to illustrate how the relationship dynamics felt with clients. A sense of friendship (felt at the least from clients) was often seen as inevitable.

She was one of my first clients and I became very attached and also she didn't have very good support around her. I took the role as kind of like an older sister, which I shouldn't have and I know. But it's kind of hard when you get into these relationships ... They are going through real sensitive stuff and sometimes they can't speak to other people. (P3)

For some participants though, there seemed also to be an understanding, or a questioning as to whether fulfilling this core social need (i.e., connectedness) was more beneficial or detrimental for clients in the long term.

Like I say the friendship thing, you are not supposed to be friends with them. If they've not got friends, who is going to be friends with them, you know. That is

really concerning because you want them to have friends. You want them to feel like a connection to something but it's not supposed to be that they have a connection to you, but sometimes they will form a connection to you. (P2)

Many participants found themselves challenged, uncertain, pressured, frustrated, and guilty in recognising that their relationships with clients could become 'proxies' or social replacements. The environments in which these relationships took place was seen as contributing towards a morphing of these relationship dynamics.

Bottom of the food chain - a low status role. Describing one's job as within the food chain is essentially commenting on the fundamental organisational structure or hierarchy that exists within systems of employment and status. Being at the bottom of the food chain represents the position that is considered the least important. Economically, this means the position that receives the least pay. Socially, this means the position that receives the least respect. Many participants spoke about feeling like they were economically and socially denigrated within the mental health system and society: "Support workers are like care workers, so yeah bottom of the food chain" (P3). However, a few participants spoke about sometimes feeling like they were respected by other clinical teams at various professional levels. Despite these exceptions, generally participants felt they were either disrespected or unappreciated by clinical staff: "Some (are) really awesome. Some just use you" (P6). One person, in particular, spoke about her experience at multidisciplinary clinical team meetings and feeling like they were regarded as the "scum" of the meeting compared to other professionals within the mental health system.

You do get a few good clinical team members that really do appreciate the job that you do but we're often looked at as the scum of the meeting, when at times your input is required and then key pivotal times it's just glossed over. (P6)

Participants felt their role was undervalued in part because of the fact that they are underpaid. Lack of recognition and under-acknowledgement of emotional work and the large emotional toll, both contribute towards a disheartening narrative for many participants.

I actually have just been in a pay review meeting and we get paid on par with people who work in supermarkets or who work in a bar and that sort of thing and I don't think that's fair because we do take on a lot of responsibility for the people that we work with and we are working with people and taking on a lot of sort of risk ourselves. If someone wants to hurt themselves, if someone wants to commit

suicide, the effect that could have on us as well. You work in the supermarket you don't have that kind of feeling. You work in a bar you don't have that kind of feeling. Whereas we have to take that on board constantly and also the amount of work we do, the trainings we do, the effort we put in, we do a lot of that and I often don't think we get recognised for it. We could definitely be a lot more recognised. (P2)

One participant raised the issue that being paid so poorly for this type of job was related to gender inequality “With the pay equity thing because it's a woman issue... we are just undervalued and underpaid” (P6). She described feeling the reality of a glass ceiling and that society was capitalising on these roles being predominantly done by women: "Men don't go into this job because they don't want to get as less pay so they are capitalising on our multi-skilled natures" (P6), which appeared to triangulate experiences of feeling at the bottom of multiple social food chains. With regards to suicide, this sense of low status was manifested by an experience of her male superior minimising and invalidating her concerns for a client's suicidal behaviours.

Summary. Participants found it difficult to explain their role. Hence, the amorphous nature of their role was borne out of a common experience of it as confusing and ill-defined. There was some uncertainty surrounding how their position differed to other professional groups (e.g., social workers), or if their role was considered therapeutic. Yet amid the uncertain and ill-defined aspects of their role, one thing was sure: participants saw the relationship with clients as key to the role. Though upon deeper reflection, these relationships in themselves lacked clarity. The practical and environmental aspects of the role (e.g. with regard to mobile and residential settings) appeared to augment participants’ experience of relational dynamics with clients. Participants felt they became ‘used’ as substitutes for otherwise more natural social relationships; reflecting relationships 'proxies'. In general, participants felt that their role was undervalued, by clinicians, and poorly remunerated. For one participant these issues served as a reminder of perceived gender inequality within their position.

Theme 6: We Need Increased Support, Training, and Talk

This theme contains two subthemes relating firstly to the types of support currently received and the support actually required in order to properly continue doing their work in

responding to client suicidality. Secondly the subtheme reflects the clear request for training and outlines various aspects of dealing with client suicidality that could be improved by suicide specific training, for more ethical care of clients and MHSWs alike.

Resourcing and support. Some participants spoke about not being properly resourced to manage client suicide risk, referring to inadequate information provision about a client's suicide risk, lack of training generally, and lack of processes such as safety plans.

When I first came to our service there were no safety plans and I thought what the fuck. So we got those implemented but even now they don't really meet the needs of the 'client demographic'. (P6)

Overall, participants gave both positive and negative accounts of support. Positive accounts included managers and colleagues being available to talk or listen in an open and supportive way. This sometimes took the form of debriefs after a challenging client contact sessions. Impromptu debriefs were considered as very supportive and helpful. It was noted that participants described deriving the most of their support from their team members.

My team, fully supported by my team and my boss as well. If shit hits the fan I call my boss and the good thing about that is X will call one of my team members and say are you going to be at the office when X gets back and then I get to the office and I have a debrief, talk about what is going on for me, what happened and it's like a sounding board. It's really good that support. So immediately I get support. (P3)

One participant described feeling that her organisation was overly focused on maintaining funding over caring for people and attributed this 'business' or corporate model of MH administration as responsible for high staff turnover rates.

There's so much stress on maintaining the service to maintain funding that we forget about the people running the service, which we are often forgotten about.

There is so much finger-pointing that we forget about the people doing the work and having to take care of them and that's why there is high turnover. (P3)

This participant found the organisational culture within her place of work to be blaming and one that disregarded their responsibility for quality client care and workers health.

A need for training. One of the important considerations regarding caring for clients at risk of suicide was reported to be the participants' level of competence in dealing with such

situations. Many participants perceived a lack of general and specific training or experience required for the role. They expressed that if you don't know what you're doing (i.e., have necessary skills or knowledge required to be adequately supportive and beneficial to clients' mental wellbeing) you may be yourself a risk factor for the clients who are in vulnerable situations or states.

I think people in this job should be probably trained a bit more, like there should be more requirements to do this. As an example, when I started doing it I had no experience and no qualification, but I was still allowed to do it and I was still allowed to work with vulnerable people which I think is ... I mean I am grateful obviously because I got the job and I got to do that, but I think in hindsight people who don't have experience and don't know what they're doing, you know, that is a huge risk factor. (P2)

For those that had completed specific suicide training outside of the organisational 'core trainings', they reported this source of learning being where they got most of their knowledge and guidance regarding how to work with clients who disclose suicidality.

Yeah I think it's mainly from ASIST. That course gave me a really good like you say a check list of what to do with this person, how I can support this person. I've also just finished a Diploma in Psychotherapy and we did a little bit of suicide intervention with the readings through that and so it's quite interesting looking at that and trying to use that for young people who don't quite have the vocabulary to express themselves. (P3)

One participant spoke about feeling as if she had learnt very little specifically about suicide during her time working as a MHSW. Her sense was that the organisation did very little to directly address the relevance of suicide intervention knowledge and skills within her role.

I think if they were more supportive around that then I think I would know more about suicide. Like, since I've come to this organisation I haven't learnt anything about suicidal, like how to deal with clients who are attempting to hurt or harm themselves ... had those brief little talks but not actual trainings. Yeah, it's pretty new to me. (P5)

Apart from formal training, participants recognised their predominant source of knowledge for dealing with suicidality came from feedback from managers or clinical staff, indicating that a mode of formal supervision might be helpful.

... like just from feedback for instance we've had, and feedback on how to deal with the situation, talking to my manager, talking to my manager's manager, having feedback from clinical teams about what was right to do and what wasn't right to do. (P2)

When asked about confidence in dealing with client suicidality, participants were very clear: they thought training would help them feel more confident and better equipped to respond well to suicidal behaviours. Aside from the generic MH support work training gained, the need for suicide specific training was a strong message from almost all participants.

I know for me and my colleague it was really helpful for them ... you have like trainings on client rights and everything else, but having a training on like how to deal with this sort of stuff like ASIST it would actually be quite beneficial. (P 1)

Upon asking participants what they thought might help them become more confident in managing clients who become suicidal, a number of suggestions were given. Some concerned content: self-care, self-awareness, risk, inter-organisational processes, understanding more about why people feel suicidal, and general frontline and support work expectations. Requested processes for learning included role-play/practice of techniques or skills to use.

Other suggestions were for more support from their organisation; for example, on policies, procedures, debriefing time, forums, refreshers, self-care, co-worker support, and having more open conversations about suicide talk. These were topics/skills participants thought would help them function well within their role, to develop competence in dealing with suicide with clients, and more generally within their role. One participant stated that she thought a clear and established checklist would assist in the management of risk and responsibility.

I kind of see it as a streamline process. Because we are not a clinical service we have to hand it on and that's how I decide whether to act or not, whereas I know colleagues at times have tried to deal with things themselves and I think it is easy to streamline if you know the right questions to ask. So just maybe having a

criteria, like has a recent event in this person's life occurred that makes them more vulnerable to risk? Who else knows that they may be at risk? Has this happened before? I guess a check list really. (P7)

In discussing suicide issues, many participants spoke about the struggle they had when they 'bought into' their clients intentions to suicide and how difficult it was to hold a different, life affirming perspective at times. Although they did describe this as a training need per se, this concern suggested the need to help MHSWs to manage over-identifying with the clients' hopelessness.

I always feel a bit of fear and sadness. Kind of sad, it sounds quite morbid thinking like that. There's a little bit of hope as well. I don't know. I think I'm just saying that. I would like to think that there's hope. (P3)

While almost all of the participants spoke about wanting specific training on suicide management, some spoke about the added need of learning about self-care. One participant who had previously completed the ASIST course spoke about how while this training facilitated her to deliver safer and more professional care to clients, it also had the added benefit of keeping herself safe from the emotional burden of this kind of work; particularly as she had previously struggled with her own personal experiences of suicidality. What she described as beneficial from this course was an understanding of the boundaries that exist around her capacity to deliver suicide intervention in an ethical way within her scope; that is, brief suicide intervention rather than therapy.

I mean I'm comfortable with getting the ASIST check list and making sure that this person is safe. I suppose where I'm coming from is my own struggle with suicide in my life and I think the pain that I went through is really, was really hard so I don't know how I would deal with that again. I think that's it, reliving that and I suppose with my role I am not supposed to be therapeutic so I just go through the ASIST stuff. It has kept me quite safe from that sort of experience. (P3)

Among the participants who spoke about wanting to attend a specific suicide training course of some sort, there was also a point of frustration around the perceived organisational factors of time, funding, or opportunity that prohibited them from attending such training.

I have been banging on at these guys for years about getting some component of suicide training into the core training of the work we do ... And I've been fobbed off numerous times. Told that it's coming. (P6)

One prominent request that many participants spoke about regarding factors that would help them feel more confident and/or supported in working with suicide was feeling like they could have a safe and open space to converse with their colleagues, managers/supervisors, and even in the community about the effects of suicide and how to support people who are suicidal. Participants who commented on this noted that there was a general lack of discussions about suicide within their place of work, despite suicidality being an issue for many clients. Feeling comfortable and supported to be open about suicide was something they thought would be helpful.

Summary. Training was perceived as a neglected issue within participants' organisations, but suicide prevention training in particular was definitely something they wanted more of. Participants spoke about how helpful and meaningful it was to have supportive colleagues, managers, and clinical team members to debrief with after a suicide related interaction with clients to allay their sense of uncertainty, to gain guidance, or to manage risk and responsibility. Nevertheless, this support was not consistently available for them. Participants cared about self-care. They saw it as a needed component for alleviating the emotional stress resulting from working with suicidality. Most participants seemed to consider training as necessary to achieve increased knowledge and confidence. Participants thought training would also contribute to self-care processes, safe client care, and progressing open conversations about suicide at a more social and systems level to enhance suicide prevention more generally.

Discussion

Seven MHSWs were interviewed about the MHSW role in a general capacity and particularly with regards to their experiences dealing with client suicidality. Six themes were identified from interviews which include: (1) Dealing with Suicide is Something We Do and We Play a Key Role; (2) We Feel Very Responsible; (3) Our Role in Suicide Prevention: Dismissed and Underutilised; (4) Dealing with Suicide has a Large Emotional Effect; (5) Our Amorphous and Undervalued Role; and (6) We Need Increased Support, Training, and Talk.

Throughout the interviews it became clear that suicide was a big concern for participants and that the risk of suicide was experienced as omnipresent. Participants described both being exposed to suicide-related behaviours, and dealing with it in various ways. They understood the function of their role as including this social and life sustaining aspect of care.

Suicide not only occupied a large part of their role but dealing with it had a large emotional impact. Participants managed negative emotional states not only for their clients, but also for themselves. Having had limited training and supervision in suicide prevention, participants spoke about relying on personal experiences of suicide from their own lives. They also spoke about the use of their own experiences as assisting in the core component of their role - developing a trusting relationship with clients - which they saw as contributing to their ability to manage client suicide risk. Moreover, where suicide was concerned they experienced worry and felt a large degree of responsibility for their clients. The emotional demands of the work left participants regularly feeling exhausted. They described having to numb their emotions towards suicide in general, and use strategies to forget their client-focused concerns in order to switch off at the end of the day. The ability to switch off was an implicit expectation, yet difficult to achieve. Many participants spoke about feeling worry for clients which extended beyond their work time, and blurred boundaries between the home and work life spheres.

Participants described practices of utilising their own private and challenging emotions and memories as necessary to facilitate trust and connection with clients. Yet they did not always feel in control of personal emotions and memories of suicide that could become triggered by this work. As such there was a personal cost for many, such as having to self-manage negative emotions and flashback to their personal suicide experiences, or those of previous clients. Nevertheless, participants also regarded their previous experience of suicide as having potential to help them with their clients. Their experiences helped them relate to clients, connect with clients, understand client's struggles better, and build hope for clients. All these relational aspects were considered positive by participants, and in some ways transformed their perceptions of their own experiences meaningfully.

One of the issues that appeared to exacerbate these emotional impacts were the ways in which participants felt their efforts with clients were under-acknowledged by others within the MH systems within which they worked. They felt positive outcomes with clients were not recognised and they weren't respected for the job they did. In general, participants felt they were

the ‘bottom of the food chain’. Participants gained this sense from a lack of remuneration, and some also linked their position’s low status to gender inequality. The lack of respect for their role was substantiated, in part, through a lack of information fed from clinical teams about client suicide risk. Hence they often felt unequipped, incompetent, and that they were ‘going in blind’ with clients. Where there were instances of good collaboration and dual-communication with clinical teams, participants felt respected, informed, and positive about their role in preventing suicide. However, participants largely felt their role was often not preventative in nature but enacted a ‘bottom of the cliff’ approach. Their skills, they felt, were underutilised and they believed their role held more potential with regard to suicide prevention.

As well as an overworked, understaffed MH system, one of the possible explanations for the barriers in communication experienced between MHSWs and clinical teams may be related to confusion generally about the MHSW role. Participants themselves struggled to articulate their role clearly and felt it was ill-defined and amorphous in nature. They likened it to many other care support roles, but were also clear that they were not just carers. They regarded their work as coming together with clients to achieve goals. Their role included both practical duties but also working supportively with clients through building relationships with them. They observed their clients as often having limited social and support networks, and as a result they felt like they replaced or substituted otherwise natural social roles for clients. The significant contact hours with clients in different environments contributed to their sense that they were all their clients had. This experience challenged some participants ethically and emotionally, particularly in relation to blurring of boundaries in their worker-client relationship. Their understanding of suicide - that this was related to social factors of loneliness and isolation - added to their sense of responsibility for clients. When it came to managing suicide risk, their own isolation arising from lack of training, support, and information provision from professionals contributed to their burden of responsibility and lack of confidence. They called strongly for suicide-specific training. They perceived training as having the potential to make a positive impact in their ability to recognise warning signs in a more skilled manner, to develop much needed personal self-care strategies, and to begin to develop what they saw as necessary conversations around suicide to support and validate the work they do.

The skills involved in caring for someone who is at risk of suicide are multifaceted, and the relational dynamics are complex (Fisher et al., 2017). Previous research has suggested that

recognising warning signs is not an easy task (Centre for Suicide Prevention, 2010; Owens et al., 2011). Furthermore, decisions surrounding whether and how to ask directly about suicide, responding appropriately, and informing appropriate networks of support, can also be difficult. In particular, difficulties arose for participants from fear of jeopardising the trust of the person suffering by breaking confidentiality. Although they thought breaking confidentiality was the right thing to do, this did not discount their concern about the potential harm to the trust they had built with their clients; a dilemma previously acknowledged in other informal types of support roles (Fisher et al., 2017). Owens' and colleagues' research reflected similarly that one of the reasons family members did not act on warning signs was, among other things, because of their fear of breaking trust with a suicidal relative. Hence despite their paraprofessional role, MHSW may also become encumbered by relational concerns surrounding these difficult decisions. The particular focus MHSWs have on holding the relationship as key likely compounds the dilemma of breaking confidentiality.

Previous research has indicated the numerous personal barriers that need to be overcome in order to do this work (Saunders et al., 2012). For example, the Centre for Suicide Prevention (2010) proposed that people are hesitant to ask about suicide because of fear of being suggestive of, or normalising, suicide. Furthermore, uncertainty and incompetence in responding appropriately to suicide has been found to be related to a lack of training and knowledge. For example, training has been shown to improve people's skill and confidence to work with suicidal individuals (Coppens et al., 2014; Jahn, Quinnett, & Ries, 2016; Lund et al., 2017; Scheerder, Reynders, Andriessen, & Van Audenhove, 2010). People need the capacity to manage and suppress their own fear and anxiety related to asking directly and openly about suicide (Lawrence & Ureda, 1990). Findings from this study show participants put effort into managing their own emotional responses while also focusing on managing the client's emotions. Research on general community health workers that describe the "pre-eminent social skills" used in this role, indicates that MHSWs require complex relational skills (South, White, Branney, & Kinsella, 2013). Knowledge and support can increase people's capacity and confidence in carrying out this difficult emotional work.

Participants spoke of the personal cost of working with client suicidal behaviours. Recent literature on vicarious trauma highlights that there are impacts from exposure to suicidal behaviours among various professional groups (Dageid, Akintola, & Sæberg, 2016; Finlayson &

Graetz Simmonds, 2018; Mirick, Bridger, McCauley, & Berkowitz, 2016; Ting et al., 2006). Findings in the current study suggest MHSWs are not an exception. Secondary trauma, vicarious trauma, compassion fatigue, and empathetic distress can contribute towards burnout (Blankertz & Robinson, 1997; Smith & Rose, 2011). Findings in the present study indicate that because of a lack of specific suicide training reported by participants, and their reliance on personal experiences, the impacts of suicide exposure may be far greater for this workforce than for more highly trained professions. Specifically, responses to suicide exposure for participants in this study paralleled those found in Ting, Sanders, Jacobson, and Power's (2006) research of Lay Health Workers. These included reported feelings of shock, traumatisation, sadness, a lack of support resulting in responsibility and isolation, intrusions (triggered negative memories, flashbacks, anxiety, and panic), a 'spilling over' of concern into their personal lives, and feeling a sense of being blamed. For this reason, training, advice on self-care and regular debriefing opportunities were strongly requested from participants.

A lack of clarity in the function and structure of the MHSW role was evident in the participants' accounts in this study. The unstructured nature of the environments that participants worked in (both community and residential) and the unstructured way they interacted with clients facilitated a unique relationship. The challenge of defining this role has been reported for many years internationally (Love, Gardner, & Legion, 1997; South et al., 2012; Witmer et al., 1995). Participants in this study described their role as amorphous and ill-defined. Participants reported confusion as to whether their role was considered as therapeutic or not. Nevertheless participants were clear that their relationship with clients within this role was key. Relationship-building as a priority has also been reflected internationally with similar populations of workers in different health fields (South et al., 2012).

Participants had the benefit of interacting with clients in many different environments and facets of their lives, from which they developed a more contextualised perspective of clients. Yet while this role expanded opportunities for broader social understandings of clients, and of possible contributing factors to suicide behaviours, it resulted in a difficulty in identifying relationship parameters. Participants likened client relations to familial and natural/personal social relationships. Perhaps as a result of these circumstances, some clients occasionally preferred to communicate with the MHSW over clinicians. MHSWs have a capacity to communicate between and bridge social and professional divides. Previous literature has

described this type of role as ‘cultural mediators’ across different fields, based on their building of trusting relationships (Love et al., 1997; South et al., 2012; Witmer et al., 1995) that reduce barriers to accessing health care (Arvey & Fernandez, 2012; Hodgins et al., 2016) by instigating a ‘continuum of care’ for clients (Dageid et al., 2016). Overall, findings support the view that MHSWs’ fluid role facilitates unique important relationships (Hennessy, 2015). Furthermore, they hold a perspective on clients that clinicians could utilise to build richer formulations through which to understand clients.

Other research suggests that those employed in support roles, including lay health workers, often function with minimal co-ordination or support from wider health services (Blankertz & Robinson, 1997; Cataldo, Kielmann, Kielmann, Mburu, & Musheke, 2015; South et al., 2013; South et al., 2012; Walt, 2005), despite the role requiring complex inter-relationships between professionals, community, and care recipients (South et al., 2012). Insufficient remuneration (Cataldo et al., 2015; Dageid et al., 2016), poor supervision, inadequate training, and a lack of resources were often cited for the conditions surrounding attrition in this group of workers (Abbatt, 1990; Cataldo et al., 2015; Hoeft et al., 2018; Nkonki et al., 2011). Nkonki and colleagues also suggested that experiences of lay workers themselves is often overlooked by researchers in favour of prioritising outcomes of intervention delivered by lay workers professionals. This study adds to this literature by showing that New Zealand MHSWs have similar experience of their role. Participants felt they were underpaid, undervalued, lacking in recognition and had a low status within the health system, being at the ‘bottom of the food chain’. Some participants described denigrating interactions with professionals and poor communication with clinicians, including withholding of information relevant to suicide risk.

Support workers internationally have been described as comprising predominantly poorer woman, often with low education and from marginalised communities (Dageid et al., 2016; Love et al., 1997; Swartz & Colvin, 2015). Between 70% and 81% of the workforce in this sector in New Zealand are woman (Te Pou o te Whakaaro Nui, 2017; Te Pou o te Whakaaro Nui & New Zealand Disability Support Network, 2016). Issues of gender inequality were raised by one participant as a problem faced by this workforce, prompting consideration on how inequalities uphold certain power structures within health and broader social systems. For example, there is a historical and continuing pay disparity and status accorded to those occupational groups that are

populated by women. Low pay, high stress, limited training, and minimal recognition were common issues in all the participants' accounts.

Participants' positive experiences of communication with clinicians, instances of responsive support by colleagues, and management and provision of training within their role shone a light onto possible avenues for stepped improvements. In considering the reports of underutilisation of this workforce, and regard for the relational and emotional skills present among MHSWs, improvements in resourcing this workforce appears an obvious need. Specific suicide related training was requested by participants, and the benefits from such training for client care is a likely outcome.

Limitations of this Research

Prominent among the limitations of this study was the lower than anticipated number of participants. However, despite the low participant number, the interviews provided a rich tapestry of experiences and data. Consistency of themes emerged as well as points of difference. Despite initial concerns that those who choose to participate may have been particularly critical of their situation, results suggested a balanced regard of their participation in the MH system.

A further consideration is whether self-selection may have contributed towards overrepresentation of those with particularly difficult experiences of suicidal exposure. To this end, it is unknown to what extent the findings are reflective of the broader MHSW population.

Conclusion

Overall the findings call attention to the various conditions that contribute to this role's endemic challenges, especially where suicide is concerned. The findings suggest that this workforce is largely undertrained, underpaid, low in status, and ill-defined. It reveals that MHSWs feel their work goes unrecognised; work which includes often intense emotional labour amplified when managing clients' suicide risk. These findings reveal how the emotional demands, when experienced within a clinically isolated mental health system, leads to a large burden of responsibility accompanied by personal psychological costs for MHSWs. However, participants also gave accounts of how they facilitated effective relationships with clients and managed the demands of their role, including strategies for managing suicide risk.

CHAPTER THREE: A QUANTITATIVE STUDY

Factors that contribute to mental health support workers' confidence in dealing with suicidal behaviour

Mental Health Support Workers (MHSW) are exposed to client suicidal behaviours in the course of their work. Within these circumstances they are ethically and morally obliged to attend to and support their clients in distress; as suggested in the Competency Framework for the mental health workforce and the Code of Health and Disability Services Consumers' Rights (Health and Disability Commission, 1996; National Mental Health Workforce Development Coordinating Committee, 1999). Yet their confidence in suicide prevention may be limited by a lack of suicide prevention training, and the emotional impact suicidality can have on MH caregivers (Lund et al., 2018; Saunders et al., 2012). Lund and colleagues completed a study in USA involving Vocational Rehabilitation Counsellors who worked with people deemed at risk of suicide. They found that these workers perceived themselves as not competent and unprepared to carry out suicide assessment and intervention skills (Lund et al., 2017). Smith et al. (2014) in another study undertaken in USA compared a range of health professionals' knowledge and skills around suicide prevention. They found para-professionals and 'support staff' had significantly lower confidence in suicide prevention skills than other professional mental health workers.

In order to enhance the ability of MHSWS to provide appropriate and adequate suicide prevention it is important to understand the factors which serve to enhance confidence and enactment of suicide prevention behaviours. Training is likely to be one such factor. Specific suicide intervention and prevention training (often termed 'gatekeeper' training) has been found to increase trainees' knowledge, skills, confidence and attitudes around suicide (Isaac et al., 2009). Other factors that have been identified as having an impact on acting and intervening in a helpful, informed and appropriate way with people who become suicidal include attitudes to suicide, knowledge, general self-efficacy and religious beliefs.

Attitudes regarding suicide may inhibit or facilitate adequate responding to people with suicide behaviours (Angermeyer, Matschinger, & Riedel-Heller, 1999; Chan, Chien, & Tso, 2009; LivingWorks Education, 2014; Zdravec, Grad, & Socan, 2006). Attitudes include whether or not a person regards suicide as a rational choice. Werth and Holdwick (2000) found the majority of MH professionals who responded to a survey reported acceptance of rational suicide and physician-assisted suicide: about one fifth of respondents found this unacceptable. Also relevant are stigmatising attitudes towards those with suicide behaviours; stigmatisation has been recognised as detrimental for those at risk of suicide (World Health Organization, 2012).

Stigmatising attitudes have been investigated within helper populations (Bagley & Ramsay, 1989). For example, based on an emergency medical setting in India, Seithi and Shipra (2006) distinguished seven attitudes toward suicide: expressing avoidance; rejection of those who make suicide attempts; dismissing the need for professional help or need to vent after dealing with suicidal clients; hostility and perceiving the suicidal person as a coward; justifying avoidance of a suicidal patient due to anxiety and fear; regarding suicide as unlawful and manipulative; and feeling inadequate to deal with the suicidal person. Such attitudes towards suicide in helpers may have practical and clinically relevant implication to appropriate care delivery - such as avoidance – and may decrease the effectiveness of the therapeutic relationship (Carlén & Bengtsson, 2007; Cutcliffe, Stevenson, Jackson, & Smith, 2006) wherein assistance may otherwise be gained.

The attitudes of people in positions of care towards suicidal individuals are impacted by cultural, social, educational, gender, age, professional groups, and dominant health models. For example, nurses' attitudes in the UK were seen to be more accepting of open discussion of suicide than nurses in Turkey who endorsed hiding of suicidal behaviours and punishment after death (Giacchero Vedana et al., 2017). In relation to different professional groups, a study in Brazil found little variance in attitudes towards suicide behaviour between non-clinical staff (such as security staff) and clinical staff (e.g., nursing attendants) (Berlim, Perizzolo, Lejderman, Fleck, & Joiner, 2007), but others have found that attitudes can vary significantly between, and within, professional 'helper' groups with less discriminatory attitudes observed from those working within the MH field (Suokas, Suominen, & Lönnqvist, 2008). A study in Ghana found that general nurses working in an emergency ward (non-mental health specialist) held moralistic attitudes toward suicide in which they saw suicide as punishable and believed those who attempt suicide should be blamed, whereas psychologists tended towards a 'mental health' view of suicide which was seen to contribute to 'caring' responses and more empathetic attitudes overall (Osafo, Knizek, Akotia, & Hjelmeland, 2012).

Differences in suicide knowledge between professional groups has also been observed. Knowledge includes such aspects as common aetiology of suicidal behaviour, warning signs, risk factors, treatment and prevention strategies, as well as common myths about suicidal behaviours. For example, child and adolescent mental health services staff were seen to be significantly more

knowledgeable and felt more effective with regards to suicide responding than accident and emergency staff and school teachers (Timson, Priest, & Clark-Carter, 2012).

Research has also identified that general self-efficacy may be an important component in suicide preventative behaviours of people supporting those at risk of suicide. Albert Bandura described self-efficacy as a belief in one's ability to succeed, and self-efficacy can be mediated by observational learning and social experiences (Bandura, 1997). For example, self-efficacy has been found to be associated with young people's confidence to talk to a suicidal friend about suicide, to recognise warning signs, to have knowledge that talking about suicide is helpful and appropriate, and to have the capability to overcome fears about talking to their friend (Lawrence & Ureda, 1990). Although knowledge of suicidality and suicide intervention is important, knowledge alone may not be sufficient for people to utilise the necessary practices required to assist in suicide intervention. (Cross et al., 2007). Self-efficacy may contribute to applying knowledge in practice.

A link between religion and suicide has been found whereby the strength of religious beliefs is a protective factor, if not against suicidal ideation, at least for suicide attempts (Kamal & Loewenthal, 2002; Lawrence, Oquendo, & Stanley, 2016). Holding religious views may serve those who are suicidal as a reason not to complete suicide (Eagles, Carson, Begg, & Naji, 2003). Additionally, religious beliefs may promote help-seeking among those with suicidal ideation. However, the effect that religion may have on helpers or carers is less clear. Some support for a relationship between suicide responding by helpers or carers and their religious beliefs is given in a study with nurses in Ghana (Knizek, Akotia, & Hjelmeland, 2010). It has been found that despite being bound by professional standards and expectations, nurses felt compelled to impart moralistic arguments based on religious beliefs (about who is responsible for life, and how suicide is wrong) in an attempt to persuade patients not to suicide, which may be contrary to what would be considered a preferred empathic response (Osafo et al., 2012). Similarly, in a study with nurses in Taiwan, those who did not report having a religion had more positive empathetic attitudes towards suicidal patients (Sun, Long, & Boore, 2007).

Exposure to specific training in managing suicidal behaviour has been shown to shape attitudes positively (Berlim et al., 2007; Brunero, Smith, Bates, & Fairbrother, 2008; World Health Organization, 2012). Knowledge about suicide preventions has also been shown to be influenced by education and training, which in turn has been associated with increased

confidence, comfort and competence in managing vulnerable clients (Brunero, Jeon, & Foster, 2012; Jahn et al., 2016; Scheerder et al., 2010; Shannonhouse, Lin, Shaw, & Porter, 2017; Smith, Silva, Covington, & Joiner Jr, 2014). These effects have been shown for professionals as well as lay public and volunteer groups (Terpstra et al., 2018). For example, mass media campaigns targeted towards the general community have been shown to increase knowledge of suicide warning signs and greater confidence to intervene with those at risk of suicide (Acosta & Ramchand, 2014). Further, gatekeeper training programmes for ‘first aid’ suicide specific intervention has been shown to specifically increase knowledge in multiple professional groups (Isaac et al., 2009), along with improvements in confidence (Isaac et al., 2009; Jacobson et al., 2012). Finally, suicide specific training has been shown to influence self-efficacy (Cross et al., 2007), particularly through workshop trainings which used experiential learning techniques such as role play (LivingWorks Education, 2013).

Most health professionals and workers within the mental health field could be assumed to have some level of general mental health training. Given this, questions arise as to whether increased knowledge from suicide specific training would benefit professional care givers any more than the knowledge they may otherwise have gained through more general training. One study found that specific training for general medical practitioners led to increases in knowledge, changes in attitudes and increased confidence (Coppens et al., 2017). Similarly another study showed similar gains from specific suicide related training amongst nurses (Bolster, Holliday, Oneal, & Shaw, 2015). These findings support the need for suicide specific training for knowledge and confidence in dealing with suicide.

Research Aims

This study aimed to investigate the role different factors had in determining confidence levels of MHSWs in identifying warning signs and asking about suicidality for clients they perceive may be at risk of suicide. The factors that were examined in relation to confidence levels included general education, gender, basic suicide (intervention) training, past experience of suicide intervention, general self-efficacy, beliefs, attitudes, and knowledge relating to suicide.

Several research questions and associated hypotheses were generated to develop understanding of MHSWS and their confidence in working with client suicidality. These questions encompass:

1. What are the demographics for this population of workers within the mental health field (MHSWS) in terms of gender, age, ethnic group, job title, general education, and specific education to mental health and suicide?

2. What is the relationship between basic suicide training (independent variable) and confidence in dealing with client suicidality (dependent variable)?

Hypothesis: Basic suicide training is related to increased confidence (in dealing with client suicidality).

3. What is the relationship between religiosity and stigma?

Hypothesis: There is a correlation between these variables such that higher religiosity is related to higher stigma towards suicidal individuals.

4. What is the relationship between stigma towards suicidal individuals, as measured by the stigma subscale within the Stigma of Suicide Scale – Short Form (SOSS-SF), and confidence in dealing with client suicidality?

Hypothesis: There is a correlation between these variables such that those who rated lower on stigma towards suicide are more likely to have higher confidence in dealing with suicide.

5. What is the relationship between suicide literacy as measured by an adapted version of the Literacy of Suicide Scale (LOSS) and confidence in dealing with client suicidality?

Hypothesis: There is a correlation between these variables such that those who had greater suicide literacy would be related to increased confidence in dealing with client suicidality.

6. What is the relationship between general self-efficacy as measured by the Generalised Self-Efficacy Scale, and confidence in dealing with client suicidality?

Hypothesis: There is a correlation between these variables such that those who had greater general self-efficacy would be related to increased confidence in dealing with client suicidality.

7. Does someone's general education (as measured by highest level of general education) effect how confident MHSWS feel in dealing with client suicidality?

Hypothesis: That level of general education would not related to confidence in dealing with client suicidality.

8. Does training impact whether MHSWS reported past experience delivering a suicide intervention?

Hypothesis: That those who have specific suicide training are more likely to have past experience of delivering suicide intervention.

Method

Participants

Survey data were collected from MHSWs post-merger of two major national providers (NGOs) of community mental health, addictions and disability support services. At the time of the merger the organisation provided support services which spanned Auckland, Northland, Waikato, Tauranga, Rotorua, Eastern Bay of Plenty and Gisborne, Wellington and the South Island. After the merger there were 672 support workers employed in generic support worker and peer support roles. An email was sent 493 of these workers requesting participation in an online survey about mental health support workers (MHSWs) and suicide. As a result of the recent merger it appears the email list may not have been updated sufficiently resulting in the exclusion of 179 employees. A total of 110 people responded to the survey request, of whom 109 consented to participation. Of the 109 participants who went on to either partially or fully complete the survey, 91 completed the questions comprising the main dependent variable. The sample therefore comprised of $N = 91$ respondents, corresponding to a response rate of approximately 18%.

Participants in this study consisted of non-health practitioners (which excluded nurses, social workers, psychologists, psychiatrists, doctors, or the like). The majority of participants in this sample were female, aged under 50 years and identified their ethnicity as NZ/European (see Table 2 for a complete summary of demographic information gathered).

Survey Contents

The survey (see Appendix H) consisted of several parts including demographic questions, standardised questionnaires and two Likert scale questions to measure the dependent variables.

The introduction of the survey included a Participant Information Sheet, and consent to participate in the survey was gathered. The survey began by gathering general non-identifiable

demographic information about each participant (including age, gender, ethnicity, level of education, job title, and clientele age). Participants were asked about what general training they had gained for the role, and about specific suicide training (including the name of specific suicide training if completed, format, length, main learning, and value rating of training). Awareness of suicide risk for clients was asked about. Participants were also asked about personal experiences with suicidal individuals (e.g., client, family, friend etc.) and behaviour (regarding both suicide attempts and deaths) answered by multiple choice where more than one answer was permitted. Respondents were also asked if they had experienced giving suicide intervention in the past with any person deemed suicidal.

Participants were offered a chance to enter into a \$50 raffle for completing the online questionnaire. 'Qualtrics' served as the platform through which participants could access and complete the questionnaire via an emailed web link.

Participation was anonymous. The average completion time for the questionnaire was 28 minutes.

Dependent variable. The dependent variable in this study was the confidence levels of MHSWs in enacting suicide preventative behaviours. Two questions were included with each answered on a 5 point Likert scale: "How confident would you rate yourself in identifying suicidal warning signs in your clients?" and "How confident would you rate yourself in asking directly if a client was suicidal". Answers for both questions ranged from 1 (Very Confident) to 5 (Not confident at all). The two answers were then merged by taking the mean of each answer to provide a single confidence score, labelled as 'Combined Confidence' (in dealing with client suicidality).

The reason for combining these two questions into one variable are threefold. Firstly, combining these questions produced a more inclusive representation of dealing with suicidality encompassing not just identifying suicide risk, as has been utilised in other studies (Coppens et al., 2014), but also the action of asking about suicide risk. Both of these tasks are required for suicide prevention within a gatekeeper model. Secondly, combining these questions created a variable with wider variability of answers within this continuous scale and a more normal distribution of data points. Thirdly, the two scales were in fact related based on correlational findings (refer to results for details).

Preliminary analyses confirmed that no significantly different results would have emerged if the two confidence questions were treated as separate dependent variables (Appendix N).

A second dependent variable was included to investigate hypothesis eight, specifically, to measure past experience delivering a suicide intervention. This variable asked if participants had given brief suicide intervention before, or helped a person who they thought was at risk of suicide. This question was answered dichotomously: i.e. yes or no.

Independent variables. Independent variables consisted of factors which related to MHSWs experiences, attitudes, and knowledge. Specifically, these variables were: basic suicide training, religiosity, suicide literacy, self-efficacy, gender, educational attainment, and stigma. Four of these factors were measured by standardised questionnaires and are described below.

Measures

The survey included four standardised questionnaires assessing religious commitment, suicide stigma, suicide literacy, and generalized self-efficacy. All scales have previously been reported as having excellent psychometric properties. Together the scales have been normed on populations consisting of postgraduate and undergraduate medical student (Chan, Batterham, Christensen, & Galletly, 2014), general university students (Chan, Batterham, Christensen, & Galletly, 2014; Schwarzer & Jerusalem, 1995), adult populations, high school students, migrants (Schwarzer & Jerusalem, 1995), and the RCI was normed on various ethnicities and religious groups (Worthington Jr, Wade, Hight, Ripley, McCullough, Berry, Schmitt, Berry, Bursley, & O'connor, 2003). Previous reliability analyses of each of these scales is reported in Table 4 with a comparison with alphas obtained in the current study.

Religious Commitment Inventory. The short Religious Commitment Inventory (RCI-10) (E. L. Worthington Jr et al., 2003; E. Worthington Jr et al., 2012) consisted of 10 items using a 5 point Likert scale. The scale is scored by simply adding up the total points. Previous scores obtained from a United States sample of adults has been suggested to be used as a comparison where the normative mean for this general sample was 26 with a standard deviation of 12 (E. Worthington Jr et al., 2012). A score of 38 or higher would be considered highly religious.

Stigma of Suicide Scale. The Stigma of Suicide Scale – Short form (SOSS-SF) (Batterham, Calear, & Christensen, 2013c) was included to measure participants' attitudes

towards suicide. In this study the SOSS-SF was used as opposed to the long form version (SOSS) which contains 58 items. The SOSS-SF consisted of 15 items using a 5 point Likert scale which loaded onto three distinct subscales: Isolation, Glorification, and Stigma. The scale was scored by summing the items in each subscale and calculating the mean to produce three scores; one for each of the three subscales. Hence the mean scores ranged from 1 to 5, with higher scores indicating higher *stigma*, greater attribution to *isolation*/depression, and greater normalization/*glorification*.

Literacy of Suicide Scale. The original Literacy of Suicide Scale (LOSS) (Batterham et al., 2013c) was adapted to fit with an Aotearoa/New Zealand context. Its final form consisted of 29 items - statements about suicide facts and myths for which participants choose to answer either “true”, “false”, or “I don’t know”. Any missing data was recoded as “I don’t know”. The scale included four subscales labeled: Causes/Nature, Signs, Risk Factors, and Treatment/Prevention. The adapted LOSS (for the New Zealand context) measured participants’ knowledge of suicide-related facts and information. (More information on the amendments of this scale can be found requested of the author). Total scores were the sum of correct answers. Similarly, subscale scores were the sum of correct answers within that subscale. Higher scores suggest higher suicide related knowledge.

Generalized Self-Efficacy Scale. Finally, a Generalized Self-Efficacy Scale (GSE) (Schwarzer & Jerusalem, 1995) was included and consisted of 10 items using a 4 point Likert scale. Total scores are calculated by summing items; producing scores ranging between 10 and 40. Higher total scores indicated greater generalized self-efficacy where the general mean for items has been reported by developers to be 2.9 for use as comparison (Schwarzer & Jerusalem, 1995).

Planned Data Analysis

Quantitative data collected through the online questionnaire were analysed using IBM SPSS Statistics version 23 and R version 3.3.1 (Team, 2018).

Scale internal consistency/reliability analysis. A Cronbach Alpha was used to estimate the internal consistency of a set of items within a psychometric test. By assessing the average covariance between items and the variance of the total score within a psychometric test Cronbach’s α can estimate the extent to which a questionnaire item is measuring the same

construct. If the absolute value of the Cronbach's alpha falls above .7 this is usually an acceptable level for research purposes, although Cronbach's alpha should be around .8 to .9 (Allen & Bennett, 2012; Loewenthal, 2001). Cronbach Alpha were used to ascertain the internal consistency of the four scales used in the survey assessing religious commitment, suicide stigma, suicide literacy and generalized self-efficacy.

The original version of the Literacy of Suicide Scale had been validated using Item Response Theory (IRT) and the Cronbach's alpha had also been referenced as adequate. However, given the number of changes in the scale used within this research to match an Aotearoa/New Zealand context, care was taken to check each item within the adapted scale for discrimination and difficulty and the Cronbach's Alpha was calculated for the now 29 items within it. Item response analysis was used to ascertain item difficulty and item discrimination. Item difficulty was calculated for each item by taking the number of respondents who answered the item correctly, divided this by the total number of respondents, and multiplied by 100 for a percentage. Qualifications for items being 'difficult' or 'easy' are reported in Table 9. The discrimination index was calculated by first ordering the respondents by total correct scores, and then finding the upper 27% and the lower 27% of responses to form two groups (an 'Upper/high' group and a 'Lower' group) (Kelley, 1939). Next, for each item the number of respondents in the high group who answered the item correctly is divided by the number of respondents in the high group. This provides a calculated Ph . This process is repeated for the lower group giving a Pl . Lastly, Ph is subtracted from Pl to obtain the discrimination index. Calculations for item difficulty and discrimination indices were based on guidelines from Popham (2006) on educational measurement.

Hypothesis testing. Hypothesis testing was carried out for all procedures. For all testing involving correlations, the assumptions of normality, linearity, and homoscedasticity were assessed prior to calculating r . This involved a visual inspection of the normal Q-Q and detrended Q-Q plots for each variable to confirm that there were no major concerns about treating these variables as normally distributed. Most were found to be supported and where there were departures to normality these were acknowledged within the results section. However, any departures found were not too extreme to cause a loss of confidence in the results due to the robustness of the simple linear regression. Further, visually inspecting a scatterplot of residuals

versus fitted values confirmed that the relationships between all variables were linear and not heteroscedastic.

A *t*-test for independence was used to compare the average confidence ratings reported by participants who had attended basic suicide intervention training and those who had not. A follow up Mann-Whitney *U* test was also conducted due to identification of some violations of normality assumptions. However, overall the *t*-test is considered to be robust against small to moderate violations of the normality assumptions, provided the sample size is greater than 40.

A bivariate Pearson's product-moment correlation coefficient (*r*) was calculated to assess the size and direction of the linear relationship between religiosity scores and stigma scores; and between confidence scores and stigma scores, literacy of suicide scores, and self-efficacy scores, individually. Note, all correlations coefficients (*r*) were measured against Cohen's (1988) conventions for sized effect where around .1, .3, and .5 can be considered small, medium and large, respectively (Cohen, 1988). A Kendall's tau-b analysis was also used to support the investigation of religiosity and stigma scores. Kendall's tau-b is considered to provide better estimates of the true population correlation than the Spearman's rho and was therefore used over the Spearman's rho as the non-parametric measure of association between variables (Allen & Bennett, 2012).

A simple linear regression was calculated to predict confidence based on suicide literacy, and confidence based on self-efficacy, in turn. Further, a *t*-test for independence was used to compare total and subscale scores between those with and without basic suicide training.

A one-way between groups analysis of variance (ANOVA) was used to investigate the impact that MHSWs' level of education had on their confidence scores. Original questionnaire answer categories were recoded into new variables that excluded those education groups where there was only one data point entry (excluding "primary" and "apprenticeship").

Lastly, A Pearson's chi-square test of contingencies was used to evaluate whether basic suicide intervention training was related to whether or not participants' had reported past experience of suicide intervention (as the dependent variable).

Methods for multiple regression. All Possible Regressions (APR) was used to determine which variables would be in the final multiple regression model.

All possible regressions for variable selection. There are various ways of deciding which variables should be included in a multiple regression model. One way is backwards selection

where non-significant variables are removed one-by-one starting with the least significant variable until all variables are significant at the .05 level. There are concerns with this method however and p -values should not be trusted from such models (standard errors too small, p -values too small) (Miller, 2002). When the data structure is simple (one observation per person) and least squares estimation can be used, all possible regressions (APR) is a good solution for variable selection. It computes all possible models using all possible combinations of variables and compares them using some fit statistic (in this case, Mallows C_p).

The leaps function in the leaps package in R version 3.3.1 was used to perform the all possible regressions (Thomas Lumley based on Fortran code by Alan Miller, 2017). Leaps performs an exhaustive search for the best subsets of variables for predicting the outcome in linear regression, using an efficient branch-and-bound algorithm. For the procedure to run, any rows with a missing value for any of the variables (that we were using) needed to be removed from the data. For each model size (model size = the number of variables in the model), the procedure runs models for all combinations for variables. For example, for a model size of one (only one variable in the models), 9 models are fit (a model for each predictor variable). For a model size of two (two variables in the models), 36 models are fit (all possible combinations of two variables from the 9 variables considered for inclusion). For each model size, the procedure records the best model as assessed by mallows C_p . We then have 9 “best” models (one for each model size) and look at the mallows C_p to see which of the 9 models is the best (has the smallest mallows C_p). This is the model that was chosen (in combination with examining the change in R -squared). A model with the variables in this “best” model was then fit in SPSS to get the model coefficients, standard errors, etc. (Miller, 2002).

R -squared was used to estimate the proportion of variance in Confidence (in dealing with client suicidality) that can be accounted for by suicide literacy, basic suicide training, and self-efficacy, in a standard multiple regression analysis (MRA). The final MRA was presented hierarchically by showing the change in R -squared that occurred as each variable was added to the model. Scatterplots of standardised residuals against standardised predicted values were created to test assumptions of normality, linearity and homoscedasticity of residuals. Mahalanobis was also examined to consider the assumption of multivariate normality.

Results

Sample Demographics

Table 2 displays confidence score mean and standard deviations for each demographic variable. Table 2 also shows the greatest number of respondents were under 50 years of age and the majority were females. Respondents represented a diversity of ethnicities from New Zealand/European, Māori, Pacific, Asian and others with majority reporting to be NZ/European. The respondents worked with varying ages of clients from five through to 64 years of age. The greatest proportion worked with people aged 15-24 years.

With regards to educational attainment, just under half of the respondents reported having a Bachelor's degree of some type (a degree in psychology being the most common). The second largest proportion of respondents had a NCEA level (School Certificate, Sixth Form Certificate or Bursary). Out of the sample, 72.9% of people responded as having at least some nationally recognised training for the mental health role. Prior to becoming a MHSWs, 12.5% of the respondents said that they had not done any training prior to the role and that they were learning on the job.

Table 2: Demographic Characteristics of Sample ($N = 91$)

Variables		n (%)	Confidence Score Mean	Confidence Score (SD)
Gender	Female	74 (81%)	2.095	(0.738)
	Male	16 (18%)	2.125	(0.532)
	Transgender	1 (1%)		
Age Group	18-24	9 (10%)	2.389	(0.546)
	25-30	15 (16%)	2.300	(0.591)
	31-40	16 (18%)	2.281	(0.604)
	41-50	18 (20%)	2.083	(0.844)
	50+	33 (36%)	1.818	(0.705)
Ethnicity	NZ/European	53 (58%)	2.009	(0.668)
	NZ/Maori	13 (14%)	1.885	(0.650)
	Pacific Peoples	9 (10%)	2.278	(0.506)
	Asian	7 (8%)	2.857	(0.748)
	Other Ethnicity	8 (9%)	2.125	(0.916)
	Middle Eastern/Latin American/ African	1 (1%)		
Education	Secondary only	10 (11%)	2.100	(0.966)
	NCEA Level (School Cert, bursary)	28 (31%)	2.089	(0.694)
	Bachelors	43 (47%)	2.128	(0.673)
	Master's Degree	7 (8%)	2.000	(0.816)
	Primary	1 (1%)		
	Apprenticeship	1 (1%)		
General Mental Health Training	None, I am currently learning or have previously learnt on the job	11 (12%)	2.136	(0.674)
	In-house Training Only	8 (9%)	2.063	(0.863)
	National MH Certificate in Support Work	29 (32%)	2.155	(0.708)
	University Degree in related field	19 (21%)	2.342	(0.727)
	In-house & National Certificate	11 (12%)	1.773	(0.646)
	In-house & University Degree	6 (7%)	1.917	(0.736)
	National Certificate & Related University Degree	2 (2%)	1.750	(1.060)
	In-house & National Certificate & Related University Degree	5 (5%)	1.700	(0.273)
Basic Suicide Training	Yes	56 (62%)	1.795	(0.578)
	No	35 (38%)	2.557	(0.650)

 SD = Standard deviation

Specific training in suicide prevention. Of the participants 62.5% stated that they had completed basic training specific to suicide prevention and 37.5% said they had not received any training.

A large number of people who had completed suicide specific training elaborated on the names of these trainings and what they involved. See Table 3 below for a breakdown of specific suicide trainings reported of those respondents who nominated what their specific training had been. (Note: although 60 respondents stated they had completed any basic or other suicide intervention training, only 43 respondents went on to report the name or type of training as this was optional).

Table 3: Suicide Training Undertaken by Respondents (n = 43)

Training type	N (%)
ASIST (Applied Suicide Intervention Skills Training)	8 (19%)
QPR (Question Persuade Refer)	6 (14%)
In-house suicide prevention	5 (12%)
LeVa	2 (5%)
Mental Health & Addiction Level 4 NZQA	2 (5%)
ABACUS Suicide Prevention Workshop	1 (2%)
Blueprint Training	1 (2%)
Counselling Training	1 (2%)
DHB (District Health Board)	1 (2%)
Lifeline In-house Training	1 (2%)
Motivational Interviewing	1 (2%)
Pacific Suicide Intervention	1 (2%)
University	1 (2%)
Victim Support	1 (2%)
Youthline In-house Training	1 (2%)
Unknown Name	10 (23%)
Total	43

Suicide risk awareness. Just under half of the respondents either had a client who had died by suicide, or knew of a client in their service that died by suicide. Almost half of the respondents had a client who had attempted suicide. Furthermore, there were a large proportion of respondents who had a friend, partner or family member die by suicide.

Almost half the respondents stated that they were aware of at least one of their clients who had a degree of suicide risk. Of respondents, 43% claimed to have many clients with either past or present risk of suicide. A small number (6%) stated that all of their clients had suicide risk (past and present) and 2% stated that they did not have any clients that they were aware of who had suicide risk (past or present).

The majority of the respondents (83.5%) reported that they had been in a position where they had to either ask a person about suicide, had given brief suicide intervention, or helped a person who they believed was at risk of suicide.

Reliability Analysis of Variables (Cronbach Alpha's) of Scales Used.

All Cronbach values were above .7 and relatively consistent with previously reported Cronbach's alphas for the respective scales. The measures therefore can be considered internally consistent. Table 4 displays the Cronbach Alphas for this sample as well as those reported in previous studies as a comparison (Batterham, Calear, & Christensen, 2013a; Chan, Batterham, Christensen, & Galletly, 2014; Luszczynska, Gutiérrez - Doña, & Schwarzer, 2005; Worthington Jr, Wade, Hight, Ripley, McCullough, Berry, Schmitt, Berry, Bursley, & O'Connor, 2003).

Table 4: Summary Cronbach Alpha's for Scales used.

Continuous Variables	# of items in scale	Cronbach Alpha in present sample	Previously reported Cronbach Alphas and (item number)
Religious Commitment Inventory	10	.98	.95 (Worthington Jr et al., 2003)
Self-Efficacy	10	.85	.79 to .88 (Luszczynska et al., 2005)
Overall Stigma of Suicide Scale- Short Form	15	.83	.78 (16) (Batterham, Calear, & Christensen, 2013b)
Stigma Subscale	7	.95	.89 (8) (Batterham et al., 2013a)
Isolation/Depression Subscale	4	.94	.78 (Batterham et al., 2013a)
Normalisation/Glorification Subscale	4	.87	.82 (Batterham et al., 2013a)
Adapted Literacy of Suicide Scale	29	.89	.71 (27) (Chan et al., 2014)

The Cronbach alpha for the adapted version of the Literacy of Suicide Scale used in the current study was found to be .89. This result is a positive finding given changes made to the original questionnaire. However, given a number of items in this questionnaire were changed to fit a New Zealand context, further individual item analysis was completed by assessing item difficulty and item discrimination power reported below.

Adapted Literacy of Suicide Scale: Item response analysis. Of the original 27 items, six of these were changed to varying degrees (See Table 6) where *Italicised* items reflect those items that were amended slightly from the original questionnaire, ***Italicised and bold*** items reflect those items that underwent major changes from the original questionnaire, and **Bolded** Items only reflect those items that additional items added for the purpose of reflecting myth identified to exist in New Zealand. For a full breakdown of the item changes, rational, and research to support the answers for each item please refer to the appendix. You can see from Table 6 below that out of the six altered items and the two additional items, only one of the eight changed items (Item 28) has been rated as having poor discrimination i.e. to discern between those who have higher literacy and those who have lower literacy on this topic. This item was also seen to be easy in terms of difficulty. Hence in the future it should be discarded or improved. However not all items rated easy should be discarded or improved. For example, only one other of the changed items was also rated as being easy (Item 1) yet it had reasonably good discrimination power and therefore would not be of a concern necessarily. Overall it is difficult to judge these two changed items given that majority of the items which were rated easy or having poor discrimination ability were of the original questionnaire. However, most items in the scale (75.0% and 62%) were seen to have moderate difficulty and reasonably good to very good discrimination ability respectively, and was therefore considered an acceptable measure. Though for future research this questionnaire may be improved upon to with four questions in particular having poor discrimination and these current results may be ties to the contextual and cultural differences.

Table 5 defines the indices by which individual item difficulty and discrimination could be established and assessed to assist in interpretation of Table 6. Typically scale items would show varying degrees of difficulty, and for example, easy items are usually associated with poor discrimination. However this is not always the case. Nevertheless, it is ideal if all items are able

to discriminate well i.e. items with poor discrimination ability should be revised or discarded especially for testing purposes.

Table 5: Item Difficulty and Discrimination Index

Difficulty Index	Difficulty Evaluation	# in each category	% in each category	Discrimination Index	Discrimination Evaluation	# in each category	% in each category
< .20	Difficult	0	0.0%	<.19	Poor (P)	4	13.8%
.20 to .80	Moderate	22	75.9%	.20 to .29	Marginal (M)	7	24.1%
> .80	Easy	7	24.1%	.30 to .39	Reasonably Good (RG)	11	37.9%
				>.40	Very Good (VG)	7	24.1%

Item Difficulty and Item discrimination Indices were taken from Popham (2006)

Table 6 shows on the individual items within the adapted version of the LOSS, including those items changed or amended. It also refers to the subtheme associated with each item, how many people answered each item correct and reports on item difficult and discrimination power.

Table 6: Adapted Literacy of Suicide Scale (LOSS) Item Response Analysis Results: Items in the Adapted LOSS, with correct answers, percentages of correctly answered responses, and discrimination index (n=85)

Adapted LOSS Item ^{ab}	Theme ^c	n correct	% correct	Difficulty of Question	Discrimination (Ph - PL) ^d	Item Evaluation
1. If you talk to a consumer about suicide, you may inadvertently give them permission to seriously consider it or put the idea in their head (F)	C/N	70	82.4%	Easy	0.35	RG
2. Those who attempt suicide do so only to manipulate others and attract attention to themselves (F)	C/N	78	91.8%	Easy	0.13	P
3. Very few people have thoughts about suicide (F)	C/N	73	85.9%	Easy	0.22	M
4. Suicide is hereditary (F)	C/N	58	68.2%	Moderate	0.43	VG
5. A suicidal person will always be suicidal and entertain thoughts of suicide (F)	C/N	66	77.6%	Moderate	0.52	VG
6. Talking about suicide always increases the risk of suicide (F)	C/N	79	92.9%	Easy	0.22	M
7. Motives and causes of suicide are readily and easily established (F)	C/N	58	68.2%	Moderate	0.39	RG
8. Media coverage of suicide will inevitably encourage other people to attempt suicide (F)	C/N	56	65.9%	Moderate	0.35	RG

9. Most people who attempt suicide fail to kill themselves (T)	C/N	22	25.9%	Moderate	0.26	M
10. A person who suicides is mentally ill (F)	C/N	49	57.6%	Moderate	0.22	M
11. Most people who suicide are psychotic (F)	RF	77	90.6%	Easy	0.22	M
12. People with relationship problems or financial problems have a higher risk of suicide (T)	RF	55	64.7%	Moderate	0.22	M
13. A person who has made a past suicide attempt is more likely to attempt suicide again than someone who has never attempted (T)	RF	45	52.9%	Moderate	0.13	P
14. Men are more likely to suicide than women (T)	RF	48	56.5%	Moderate	0.35	RG
15. <i>Maori have a higher risk of suicide than non-Maori (T)</i>	RF	44	51.8%	Moderate	0.61	VG
16. There is a strong relationship between alcoholism and suicide (T)	RF	42	49.4%	Moderate	0.48	VG
17. <i>Most people who suicide in New Zealand are older than 65 (F)</i>	RF	51	60.0%	Moderate	0.30	RG
18. Not all people who attempt suicide plan their attempt in advance (T)	S	58	68.2%	Moderate	0.70	VG
19. <i>People who talk about killing themselves rarely complete suicide (F)</i>	S	39	45.9%	Moderate	0.43	VG
20. People who want to attempt suicide can change their mind quickly (T)	S	34	40.0%	Moderate	0.30	RG
21. Most people who suicide don't make future plans (F)	S	44	51.8%	Moderate	0.39	RG
22. Suicide rarely happens without warning (T)	S	29	34.1%	Moderate	0.35	RG
23. A time of high suicide risk in depression is at the time when the person begins to improve (T)	S	24	28.2%	Moderate	0.35	RG
24. Nothing can be done to stop people from making the attempt once they have made up their minds to kill themselves (F)	T/P	67	78.8%	Moderate	0.30	RG
25. Only experts can help people who want to suicide (F)	T/P	79	92.9%	Easy	0.13	P
26. Every death is preventable (F)	T/P	34	40.0%	Moderate	0.22	M
27. Seeing a psychiatrist or psychologist can help prevent someone from suicide (T)	T/P	57	67.1%	Moderate	0.43	VG
28. <i>If a person discloses privately to you that they are suicidal or planning to kill themselves then you should respect their decision and keep it confidential (F)</i>	T/P	80	94.1%	Easy	0.09	P
29. Suicide is currently an offence in New Zealand and equal to committing a crime (F)	T/P	34	40.0%	Moderate	0.39	RG

^a (T) and (F) denote 'True' and 'False' as the correct answer to the corresponding question.

^b *Italicised* items = Amended from original question, ***Italicised and bold*** items = Major change from original item, and **Bolded** Items only = Additional Items.

^c Items under this column are represented as follows: T/P: treatment/prevention; C/N: causes/nature; RF: risk factors; S: signs.

^d (Ph - Pl) = Percentage of respondents who correctly answered the item in the Higher 27% group minus the percentage of respondents who correctly answered the item in the Lower 27%.

Examination of Correlations between Variables for Collinearity. Table 7 shows the intercorrelations between variables and to check for collinearity.

Table 7: Correlation Matrix – Examination of Collinearity

	Total Stigma	Stigma Sub Stigma	Stigma Sub Isco	Stigma Sub Glori	Suicide Literacy	Self- Efficacy	Suicide Training	Religiosity	Combined Confidence
Total	1								
Stigma									
Stigma Sub_Stigma	.463**	1							
Stigma Sub_Isco	.727**	.119	1						
Stigma Sub_Glori	.573**	-.235*	.216*	1					
Suicide Literacy	-.187	-.098	.005	-.124	1				
Self- Efficacy	.271*	.071	.380**	.095	.085	1			
Suicide Training	.103	.298**	.093	-.241*	-.221*	-.077	1		
Religiosity	.067	.455**	-.081	-.189	-.178	.047	.271*	1	
Combined Confidence	-.031	.149	-.181	-.147	-.497**	-.347**	.526**	.185	1

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Descriptive Statistics

Independent Variables. With regards to religiosity in this sample, Religious Commitment Inventory scores ranged from total scores of nine to 49 with the mean score of this

group of MHSWs being 19.76 ($SD=12.21$) and a median of 14. By comparison with the normative sample (of adults in the United States) with a mean total of 26 and standard deviation of 12, this current group is overall less religious.

With respect to stigma, mean scores ranged from 1 to 5 ($n=88$), as measured by the SOSS-SF. MHSWs in the current study were more likely to hold attitudes that supported descriptions of suicidal individuals as being isolated or depressed, with a mean of 3.9 ($SD .91$). This was followed by attitudes that supported the glorification or normalisation of those who suicide, with a mean of 2.38 ($SD .94$). This sample were less likely to hold attitudes which stigmatise individuals who suicide, with a mean of 1.57 ($SD .87$).

Suicide literacy was measured by the Adapted LOSS, where total scores in this sample ranged from 7 to 25, with a mean total score of 18.2 ($SD=3.91$). Table 8 illustrates the totals scores within each subscale of the Adapted LOSS. Participants tended to have more difficulty with items related to signs or indicators of suicide, and less difficulty with items related to causes of suicide.

Table 8: Literacy of Suicide Scale Total Scores Frequencies ($n=85$, missing=6)

Frequencies	Adapted LOSS Subscales (# of Items)				
	Total (29)	Risk Factors (10)	Signs (7)	Causes/ Nature (6)	Treatment/ Prevention (6)
Mean (SD)	18.23 (3.91)	4.26 (1.52)	2.68 (1.32)	7.16 (1.86)	4.13 (1.21)
Median	18	5	3	7	4
Minimum	7	1	0	1	1
Maximum	25	7	5	10	6

Lastly, total self-efficacy scores for this sample ranged from 23 to 40. MHSWS in the current survey (Table 9) had a mean total score of 32.19 ($SD 3.82$)

Table 9 describes the descriptive statistics for the independent variables.

Table 9: Summary Statistics for Continuous Variables

Continuous Variables	Mean (<i>SD</i>)	Minimum	Median	Maximum	Valid Data <i>n</i>	Number and Percent of Missing Data
Combined Confidence	2.08 (0.71)	1	2	4	91	0 (0.0%)
Adapted Literacy of Suicide Scale (LOSS)	18.24 (3.91)	7	18	25	85	6 (6.6%)
Self-Efficacy	32.19 (3.81)	23	32	40	85	6 (6.6%)
Stigma Subscale	1.57 (0.87)	1	1	4.71	88	3 (3.2%)
Isolation Subscale	3.97 (0.91)	1	4	5	89	2 (2.2%)
Glorification Subscale	2.38 (0.92)	1	2.5	4.25	88	3 (3.2%)
Religious Commitment Inventory (Religiosity)	19.76 (12.21)	9	14	49	87	4 (4.4%)

Descriptive statistics of dependent variable – confidence in suicide intervention

questions. Majority of respondents were confident overall in dealing with client suicidality ($M = 2.08$, $SD = 0.709$). Table 10 displays the descriptive statistics for the two confidence questions that make up the combined confidence score, separately. With respect to confidence in identifying client warning signs, half (50%) reported being confident. However with respect to asking about suicide, the largest proportion of respondents (40%) reported being very confident. This indicates that respondents were more confident asking about suicide than identifying warning signs, as illustrated in Table 10.

Preliminary test for combined confidence. A bivariate Pearson's product-moment correlation coefficient (r) was calculated to assess the relationship between the two confidence questions (in identifying client suicidality and asking about client suicidality).

The bivariate correlation carried out between the two confidence variables was positive and strong, $r(87) = .553$, $p < .001$, providing evidence for the combining of these two variables into one combined dependent variable of confidence scores. For $n = 3$ participants, the combined confidence score was based on the answer of only one of the questions. In these cases their mean combined confidence score was based on one question or was equal to that confidence rating, and this decision was premised on the recognition of the strong correlation between the two variables.

Table 10: Descriptive Statistics of Confidence in Dealing with Client Suicidality (N=91)

Variables	Ratings	%	<i>n</i>	Minimum	Maximum	Mean (<i>SD</i>)
Confidence in identifying client suicidality	Very Confident	9.1%	8			
	Confident	50%	44			
	Neutral	36%	32			
	Not very confident	4.6%	4			
	Not confident at all	0.0	0			
	Total (missing)		88 (3)	1	4	2.36 (.714)
Confidence in asking about client suicidality	Very Confident	40.0%	36			
	Confident	36.7%	33			
	Neutral	20.0%	18			
	Not very confident	3.3%	3			
	Not confident at all	0.0%	0			
	Total (missing)		90 (1)	1	4	1.87 (.851)
Combined Confidence in dealing with client suicidality (Mean of both questions)			91	1.0	4.0	2.08 (.709)

Note. Standard deviations (*SD*) appear in parentheses beside means.

Findings from Independent Variable Hypothesis Testing

Basic suicide training. It was hypothesised that those who had completed training would have a higher confidence rating. An independent samples *t*-test was used to compare the average confidence ratings reported by participants who had reported attending basic suicide intervention training ($n = 56$) to those who reported not attending basic suicide intervention training ($n = 35$). The Shapiro-Wilk statistic was significant for the trained group but not for the untrained group. For the trained group, further inspection of the skew and kurtosis statistics (via calculating the *z*-scores) indicated the data in both groups were only mildly non-normal. Hence, the *t*-test was carried out. Levene's test was also non-significant, thus equal variances can be assumed. The result from the *t*-test was statistically significant, with the trained group ($M = 1.80$, $SD = .58$) reporting confidence ratings some -.76 points lower on the scale from 1 to 5 (indicating the trained group had greater confidence), 95% CI [-1.02, -.50], than the untrained group ($M = 2.56$, $SD = .65$), $t(89) = -5.83$, $p < .001$, two-tailed, Cohen's $d = 1.26$.

To confirm the results of the t -test, a Mann-Whitney U test was also conducted. The Mann-Whitney U test indicated that the confidence levels of the participants having had training in basic suicide intervention ($Mean Rank = 36.46, n = 56$) were significantly higher than those participants who did not report having had basic suicide training ($Mean Rank = 61.26, n = 35$), $U = 446.00, z = -4.783$ (corrected for ties), $p < .001$, two-tailed. This effect can be described as “large” ($r = -0.501$) where $r (= -4.783/\sqrt{91})$ is used as effect size indices by converting z into r as recommended by Clark-Carter (2009) and measured against Cohen’s (1988) conventions for sized effect, and is illustrated in Figure 1.

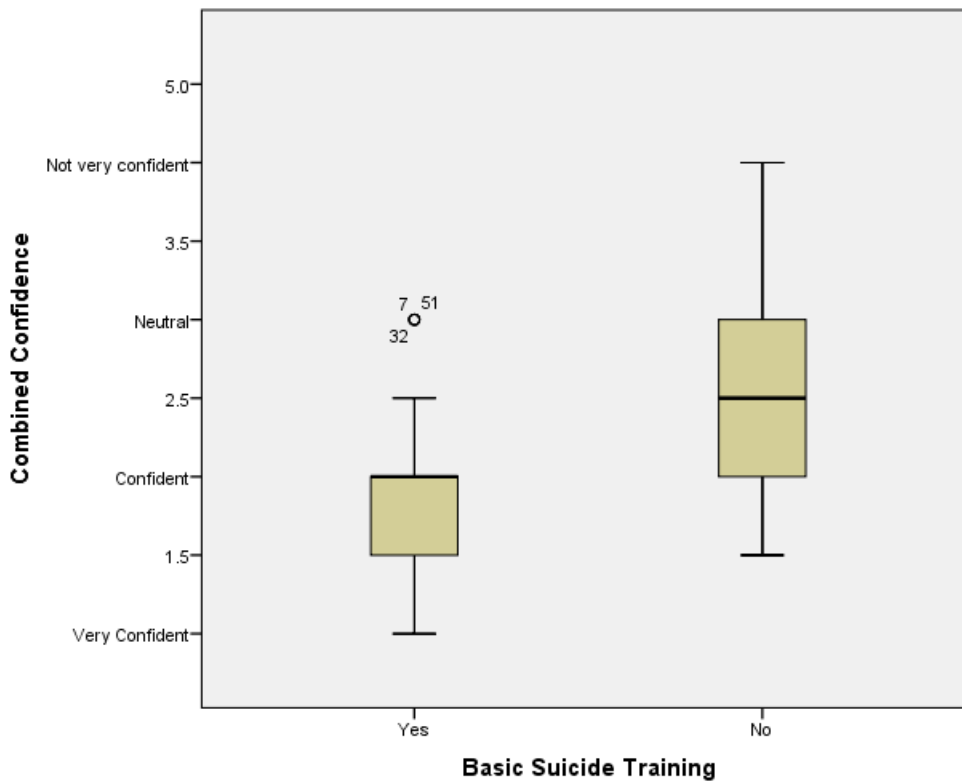


Figure 1: The distribution of combined confidence scores of those trained ($n = 56$) and not trained ($n = 35$) in basic suicide intervention.

Religiosity. It was hypothesised that religiosity or religious commitment scores are related to stigma scores. The bivariate correlation between these two variables was positive and medium to strong, $r(84) = .448, p < .001$.

There was some concern with the assumptions of normality given significant results in the Test of Normality/Shapiro-Wilk. A visual inspection of the normal Q-Q and detranched Q-Q

plots for the residuals from the regression of religiosity on stigma showed some departure from normality. However, Pearson's correlation and linear regression are robust to departures from normality, hence both a bivariate Pearson's product-moment correlation, and a Kendall's tau-b was carried out.

Kendall's tau-b indicated that the correlation between religiosity and stigma was medium and positive $\tau = .31$, $p < .001$, two-tailed, $n = 86$.

Stigma. It was hypothesised that those who rated lower on the stigma scale were more likely to have higher confidence ratings. The bivariate correlation between confidence scores and stigma subscale scores was positive, weak, and statistically non-significant, $r(85) = .149$, *ns*, 95% CI [-.060 to .341], bootstrap 1000. Thus this hypothesis was not confirmed; decreased stigma towards suicide was not seen to be associated with increased confidence in dealing with client suicidality.

Suicide literacy. It was hypothesised that higher literacy of suicide would be related to increased confidence. The bivariate correlation between confidence and Adapted LOSS was negative, large (Cohen, 1988), and significant, $r(83) = -.497$, $p < .001$. Thus the hypothesis was confirmed. This test indicated that increased confidence in dealing with client suicidality was associated with increased suicide literacy.

A simple linear regression indicated a moderate negative association ($F(1, 83) = 27.288$, $p < .001$), with an R^2 of .247 (24.7% of the variability in participants' confidence scores can be predicted by variability in their suicide literacy scores). Participants' confidence scores were associated with a decrease (more confidence) of .08 points on the Likert scale for each correct answer in the suicide literacy scale ($SE = .016$, 95% bias-connected bootstrap from 2000 samples CI [-.114 to -.051], $t = -5.224$, $p < .001$).

Table 11 illustrates the average adapted LOSS scores of participants within subscales as well as the overall total scores. It also reports if the differences between total and subscale scores differ significantly for those with and without basic suicide training using a *t*-test for independence. There was a statistically significant difference between total scores on the adapted LOSS between those without basic suicide training ($M = 58.62$, $SD = 12.0$) and those with basic suicide training ($M = 65.45$, $SD = 14.9$, $t(83) = 2.19$, $p = .032$). Additionally, out of the four subscales that comprise the scale, only one: Causes/Nature, was found to be statistically different

between groups where those with basic suicide training had significantly higher scores on this subscale than those without.

Table 11: Adapted Literacy of Suicide Scale (LOSS) - Mean % correct

Theme	# of Items	All survey respondents (n=85)	With Basic Suicide Training (n=53)	Without Basic Suicide Training (n=32)	<i>t</i> -test	
					<i>t</i>	<i>p</i>
Total Scores	29	62.88 (13.5)	65.45 (12.0)	58.62 (14.9)	2.197*	
Risk factors (RF)	7	60.84 (21.7)	62.00 (22.9)	58.90 (19.8)	0.651	0.516
Signs (SS)	6	44.71 (22.0)	47.20 (22.3)	40.63 (21.1)	1.353	0.180
Causes/nature (CN)	10	71.65 (18.6)	77.17 (12.3)	62.50 (23.4)	3.280	0.002*
Treatment/prevention (TP)	6	68.82 (20.2)	68.24 (19.6)	69.79 (21.4)	-0.334	0.739

* = $p \leq .05$

Self-efficacy. The hypothesis was that those with greater self-efficacy would have more confidence in dealing with client suicidality. The bivariate correlation between confidence scores and self-efficacy scores was negative, significant, and the strength of the relationship was medium, $r(84) = -.347$, 95% CI [-.528 to -.125], $p < .001$. Thus the hypothesis was confirmed.

There was evidence of non-normality with mild skew and a spike in the distribution and an 's' shape on the Q-Q/P-P plot, but linear regression is robust to departures from normality.

Given the significant result, a linear regression was conducted to quantify the result and to test assumptions. Linear regression indicated a moderate positive association ($F(1, 82) = 11.20$, $p < .001$), with an R^2 of .120 (12.0% of the variability in participants' confidence scores can be predicted by variability in their self-efficacy scores). Participant's confidence scores were associated with a decrease (more confidence) of -.063 points on the Likert scale for each increased point on the self-efficacy scale ($SE = .019$, 95% CI [-.100 to -.026], $t = -3.347$, $p < .001$). This test indicated that increased confidence in dealing with client suicidality was associated with increased self-efficacy.

Bootstrapping was completed with the variables to check if the linear regression was robust enough against the departures of normality. These results (95% bias-connected bootstrap from 5000 samples CI [-.098 to -.028]), were found as evidence that the linear regression is robust against the departures.

Education. The hypothesis was that years or level of general education would not be related to confidence in dealing with client suicidality. Inspection of the skewness, kurtosis and Shapiro-Wilk statistics indicated that the assumption of normality was supported. Levene's statistic was non-significant, $F(3, 84) = .950, p = .420$, and thus the assumption of homogeneity of variance was not violated.

The ANOVA was not statistically significant, indicating that confidence dealing with client suicidality was not associated with level of general educational attainment, $F(3, 84) = .067, ns, \eta^2 = .011$. Hence, the hypothesis was confirmed.

Past experience of suicide intervention and basic suicide training. The majority of the respondents (83.5%) reported that they had been in a position where they had to either ask a person about suicide, had given brief suicide intervention, or helped a person who they believed was at risk of suicide. It was hypothesised that those who have had training are more likely to have asked about suicide or intervened in the past. This hypothesis was not confirmed.

A Pearson's chi-square test of contingencies (with $\alpha = .05$) was used to evaluate whether previous experience of a MHSWs having asked or intervened with a person who they perceived to be at risk of suicide is related to whether or not the MHSW had completed basic training in suicide intervention. The chi-square test was approaching significance, $\chi^2(1, N = 91) = 3.52, p < .061$, and the association between history of asking about or intervening and suicide training was quite small, $\phi = .19$ ($\phi = \text{Phi}$ and Cramer's V used as effect size indices for chi-square test of contingencies). Table 12 shows that, of those who had basic suicide training, 89.3% had previously intervened and, of those who had not had basic suicide training, 74.3% had previously intervened. However, as stated above, these differences were not statistically significant.

Table 12: Basic Suicide Training and Previous Intervention

			Previous Intervention		Total
			Yes	no	
Basic Suicide Training	Yes	Count	50	6	56
		% of group	89.3%	10.7%	
	No	Count	26	9	35
		% of group	74.3%	25.7%	
	Total	Count	76	15	91
		% of Total	83.5%	16.5%	100%

Findings of Regression Analysis

Summary of univariate results. Due to the complexity of the dataset it is important to examine each predictor/independent variable in separate models. Hence, prior to conducting the multiple regression analysis, consideration was given to those variable where a significant effect was found. For example if the p value of the predictor/independent variable is extremely high, then it is very unlikely that it will also be significant in the multiple regression model. Table 13 summarises the results from the simple linear regressions to observe which variables were not significant and therefore which variable should be excluded from the multiple regression.

Table 13: Linear Regression Table

Univariate Results						
Predictor/Variable/ Independent V		Std	95% C.I.		p Value	
		β	Error	Lower	Upper	
Basic Suicide Training		-.763	.129	-1.016	-.509	.001**
Religiosity		.111	.061	-.009	.231	.070
Literacy		-.083	.016	-.114	-.051	.001**
Self-Efficacy		-.063	.019	-.100	-.026	.001**
Gender		-.030	.193	-.409	.348	.875
Education (reference Secondary)	NCEA	-.011	.262	-.524	.503	.967
	Bachelors	.018	.250	-.461	.517	.911
	Masters	-.100	.350	-.787	.587	.775
Stigma Subscales	Stigma	.117	.084	-.051	.285	.168 (n=87)
	Isolation	-.141	.082	-.305	.023	.091 (n= 88)
	Glorification	-.107	.078	-.262	.048	.175 (n= 88)

** = $p \leq .001$.

Multiple regression analysis (MRA) results. Prior to interpretation of the results of the MRA, several assumptions were evaluated using the residuals from the final model. Inspection of the normal probability plot of standardised residuals as well as the scatterplot of standardised residuals against standardised predicted values indicated that the assumptions of normality, linearity and homoscedasticity of residuals were met. Mahalanobis distance did not exceed the

critical χ^2 for $df = 4$ (at $\alpha = .001$) of 18.46 for any cases in the data file, indicating that multivariate outliers were not of concern. Relatively high tolerances for both predictors in the regression model indicated that multicollinearity would not interfere with our ability to interpret the outcome of the MRA.

In considering the output for APR and the Indices of Model Fit, the lowest number of the Mallows' C_p criterion for each sub-model suggested the best three variables: Training, Suicide Literacy and Self Efficacy. The second lowest number of Mallows' C_p criterion suggested using the Isolation Subscale of the Stigma of Suicide Scale- Short Form (SOSS-SF) as a fourth variable, however introducing this fourth variable would not make a major predictive change to fit the model (it would have only increased R^2 by .01) and it also had a larger p value than the other variables. Hence, after considering these results, the results of the APR, the change in R-squared, and theory, only Basic Suicide Training, Literacy and Self-Efficacy were included in the final multiple regression model.

The standard MRA confirmed that in combination, Suicide Literacy, Basic Suicide Training, and Self Efficacy accounted for a significant 44.2% of the variability in confidence (in identifying warning signs and asking about suicidality with suicidal clients) $R^2 = .442$, adjusted $R^2 = .421$, $F(3, 80) = 21.104$, $p < .001$. By Cohen's (Allen & Bennett, 2012; Cohen, 1988) conventions, the combined effect is calculated using the R^2 based on this formula:

$$f^2 = \frac{R^2}{1 - R^2}$$

This formula produced a f^2 of .79 which by Cohen's conventions can be considered "large" effect size. Unstandardised (β) for each predictor in the regression model, are reported in Table 14.

Table 14: Regression Coefficients (Unstandardized) for the Multiple Regression Model of Confidence.

Variable	β	Std. Error	t	p Value	95.0% Confidence Interval for β		Change in R^2
					Lower Bound	Upper Bound	
Intercept	5.108	.543	9.401	<.001	4.027	6.190	
Basic Suicide Training	-.591	.123	-4.806	<.001	-.836	-.346	.259
Adapted LOSS	-.055	.015	-3.542	<.001	-.085	-.024	.100
Self-Efficacy	-.052	.015	-3.428	.001	-.083	-.022	.082

Total R -square = 0.442, Adjusted R -square = 0.421, N = 84 (25 observations deleted due to missingness), residual standard error = 0.531 on 80 df .

The extent to which each predictor contributed individually to the regression model was investigated by examining the change in R -squared. After adjusting for Literacy (of Suicide, or the Adapted LOSS) and Self-Efficacy, Basic Suicide Training was found to be associated with a decrease of 0.59 points on the confidence scale.

After adjusting for Basic Suicide Training and Self-Efficacy, a one point increase in the suicide literacy scores was associated with a decrease of .06 points on the confidence scale. After adjusting for Basic Suicide Training and Adapted LOSS scores, a one point increase in Self-Efficacy was associated with a decrease of .05 points on the confidence scale.

In summary, basic training, followed by greater literacy and greater self-efficacy contributed to most of the variation in confidence scores. Hence, increased confidence was associated with having basic suicide training, more suicide literacy, and higher generalised self-efficacy.

Discussion

This study investigated the influence various factors had in determining the confidence levels of MHSWs in dealing with client suicidality. A sample of 91 MHSWs responded to an online survey. Personal and professional exposure to suicidality was common. Almost a quarter knew of a client who had died by suicide, and almost half were aware of suicide risk for at least one of their clients. Most respondents (84%) reported having given suicide intervention in the

past to someone who was suicidal (either a client or non-client), and half reported having a client attempt suicide. This indicates that MHSWs are likely providing suicide intervention within the community; that is, not only for clients but also within their private sphere. Lund et al. (2018) found their sample of rehabilitation counsellors reported also assisting with suicide intervention outside of work; for example, in volunteer capacities and assisting friends and family in crisis. Of all respondents in this study, 62.5% had received some suicide intervention training. This percentage is slightly lower than in another study by Lund and colleagues (2017) where two thirds of rehabilitation support staff reported receiving training related to suicide.

Overall this group reported having confidence in dealing with client suicidality. Similar findings with regards to self-reported confidence level in managing suicide were found by Schmidt (2016) in a counsellors, social workers and psychologist in the United States.

Out of the seven hypotheses tested, the majority were supported. Those that were supported included a (strong) relationship between basic suicide intervention training and confidence level, a relationship between religiosity and stigma (with a medium positive correlation), a relationship between suicide literacy and confidence (with a large negative correlation), and a relationship between generalised self-efficacy and confidence interpreting and intervening with suicidal clients (with a medium negative correlation). Those hypotheses not supported included the relationship between stigma and confidence, and the difference between attendance of basic suicide intervention training and past experience in suicide intervention.

To examine the comparative influence training and other factors had on confidence levels, a multiple regression analyses was constructed. Basic suicide training, suicide literacy, and self-efficacy together accounted for a 44.2% of the variability in combined confidence scores. This was considered a large combined effect. Basic suicide training accounting for the highest amount of variance in confidence (25.9%), followed by suicide literacy (10.0%) and a general measure of self-efficacy (8.2%). This finding is consistent with other research that found staff who are unskilled, unknowledgeable, and feel isolated are more likely to feel anxious and uncomfortable in dealing with suicidal clients (Sethi & Shipra, 2006). Two of the factors which accounted for the highest variance in confidence in this study - suicide specific training and suicide literacy - can be influenced by mental health service employers, whereas generalised self-efficacy may be less subject to direct intervention.

These findings highlight the strong impact suicide specific training has on confidence for MHSWs in suicide intervention. This study supports research with professional mental health care-giver groups where specific suicide training has been an effective intervention for increasing subjective competence, confidence, and/or comfort in suicide intervention (Jahn et al., 2016; Scheerder et al., 2010; Shannonhouse et al., 2017; Smith et al., 2014). A similar impact of training has been found for lay public and volunteers (Terpstra et al., 2018). Yet, to the author's knowledge, this is the first study that investigates this positive effect of training on MHSWs.

Some reasons that confidence may be associated with basic suicide training include simply having the knowledge that one has been trained for such a difficult task, having developed specific skills, increased understanding and knowledge, and/or having benefitted from practical experience gained through role-play or simulation of intervention techniques.

To reinforce the importance of suicide specific training, this study found general educational attainment level did not influence confidence. This finding is consistent with other research which attributes confidence in suicide preventative behaviours to tailored and specific suicide training programmes (rather than general education level) (Coppens et al., 2014; Fenwick, Vassilas, Carter, & Haque, Jun 2004; Scheerder et al., 2010). Having a degree in psychology or other fields is not sufficient to gain confidence in suicide intervention behaviours for MHSWs, as for any other mental health care provider. Furthermore, this finding indicates that confidence in suicide preventative behaviours in this role can be gained irrespective of the educational background of staff.

One surprising finding in this study with regards to basic suicide training was that those who had received basic suicide intervention training were no more likely to have previously asked or intervened with a person perceived at risk of suicide than those without training. It had been hypothesised that those with training would have been more likely to have intervened in the past. Reasons for this outcome may be due to the fact that most people (84%) had asked or intervened with a person (not necessarily a client) who was deemed suicidal in the past, leaving a small proportion of those who had neither suicide specific training nor past experience. Unfortunately the small sample size may not have allowed sufficient statistical power for this hypothesis to be adequately tested. Further the binary answer of "yes" and "no" may not have been sufficiently sensitive. A measure which quantified asking (i.e., "how often?") may have

achieved a different result. Another reason could be that if training was only recently completed, those with training may not have gained opportunity to intervene post-training.

Suicide literacy was another important factor found in this study to be related to confidence in dealing with suicide for respondents. The current study found a significant relationship between total suicide literacy and confidence scores such that higher literacy scores were associated with increased confidence in dealing with suicide. This is consistent with previous research (Coppens et al., 2014; Smith et al., 2014; Walter, Gouze, & Lim, 2006). However, when subscale scores were analysed within the adapted LOSS only the Causes/Nature subscales scores - which described literacy of the nature and general causes of suicide - for those with suicide training was seen to be significantly higher than those without. Furthermore, for all respondents the subscale of Signs (literacy of suicide warning signs) had the lowest mean percent correct scores. These findings may go some way to explaining the lower confidence scores for identifying warning signs in clients compared to confidence in asking directly about suicide.

Taken together, these findings that training may have less impact on identifying suicidal behaviours has implications for training efforts. This finding is consistent with a similar study which found subjective confidence scores specifically in identifying warning signs were unchanged when measured pre- to post-training (Terpstra et al., 2018). An obvious implication is that training should be more targeted towards identifying signs. It may also be the case that identifying warning signs may be better learned from work-based ongoing practice supervision.

The relationship between higher generalised self-efficacy and confidence scores supports previous research which identifies increased confidence in suicide intervention is related to self-efficacy (Lawrence & Ureda, 1990).

Previous research has identified a relationship between suicide attitudes and religiosity (Lawrence et al., 2016) and accordingly it was hypothesised that such a relationship would exist for carers or workers dealing with people at risk of suicide. In this study, a positive association was found between religiosity and stigma for this group, such that the more participants who reported commitment to religious practices the more likely to also report stigmatising attitudes towards suicide, thus supporting the hypothesis. These results are consistent with similar research that explored religiosity and suicide acceptability, which found that endorsement of religious beliefs and commitment were associated with lower rates of suicide acceptability across different religious and ethnic groups ((Foo, Alwi, Ismail, Ibrahim, & Osman, 2014); Jahangir,

Rehman, & Jan, 1998; Kamal & Loewenthal, 2002; Neeleman, Halpern, Leon, & Lewis, 1997).

It should be noted that religiousness is a social factor that is vulnerable to change by the same contextual impacts that also shape suicide attitudes (i.e., both religiosity and suicide attitudes may be impacted by values, belief systems, and worldviews (Cleary & Brannick, 2007)).

Notably, religiosity has the potential to shape one's beliefs about the meaning of life, which is likely to implicate opinions on suicide as an action to dissolve one's life. Overall, this group appeared to be less religious than American samples (Worthington Jr et al., 2003). Low religious commitment may therefore be associated with this group's lower levels of stigmatising attitudes towards suicide.

If people who are in a position to care for those at risk of suicide hold stigmatising attitudes and beliefs towards suicide, that this may be detrimental to those at risk (Bagley & Ramsay, 1989) insofar as such attitudes could provide a barrier to help-seeking, therapeutic relationships, care (Carlén & Bengtsson, 2007; Cutcliffe et al., 2006), and could possibly contribute to shame inducing responses towards those who are suicidal (Osafo et al., 2012). Given the possible detrimental effects of stigmatising attitudes towards suicide, it is noteworthy that this may be one of the first quantitative studies to show how greater religiosity in caring positions is related to more stigmatising attitudes towards suicide. Hence, although religiosity is seen as protective when held by those at risk of suicide (Kamal & Loewenthal, 2002; Eagles et al., 2003; Lawrence et al., 2016), religiosity may conversely be detrimental with regards to suicide prevention with carers/MHSWs.

No significant relationship was found between the degree of stigma towards suicide held by MHSWs and confidence scores. That is, people's confidence in dealing with clients who become suicidal is not associated with negative attitudes. Generally this group was more likely to hold attitudes towards suicide that endorsed a view that people who are suicidal are isolated and depressed, as opposed to holding attitudes that stigmatise people who are suicidal. Although it was hypothesised that less stigma towards suicide might promote less avoidance of suicide related tasks and hence contribute towards people feeling more confident in dealing with those who become suicidal, this hypothesis was not supported by the results.

Limitations of this Research

This was a self-selected sample which may not have been representative of the general population of MHSWs. For example, people who elected to take part in this study may have been those with personal experience of suicide. Additionally, those who did not feel confident with suicide may have been less likely to complete the survey. It is also possible that respondents may have talked up their confidence. One of the major limitations of this type of research is that self-reported confidence levels does not necessarily reflect behaviour. Hence a causal relationship cannot be drawn between confidence in suicidal interventions, and ultimately suicide preventative behaviour enactment with clients.

Respondents of this survey may also have differed from the general population of MHSWs in other ways. The respondents varied in age from 18 to over 50, and were from a broad range of ethnicities, though they were predominantly European, female, aged under 50, and university educated. Most had received basic suicide training. It is difficult to form robust comparisons of this sample with the broader population of MHSWs. However, as illustrated in Appendix O, this sample only slightly over-represents woman, only slightly under-represents males, appears to represent the population's age fairly accurately, and included a mix of ethnicities comparable to the general population of MHSWs. Gender, age, and ethnicity statistics in this sample were consistent with those reported across mental health, addictions, and disability sectors between NGO's, DHB, and workforce population data (Te Pou o te Whakaaro Nui, 2015; Te Pou o te Whakaaro Nui, 2017; Te Pou o te Whakaaro Nui & NZDSN (New Zealand Disability Support Network), 2016). The survey aimed to capture a large geographical region through dissemination to multiple NGO sites around the country. However, due to the anonymity of participation in the survey such geographical diversity could not be confirmed, therefore it is hard to make generalised statements on this data. Further, suicide being both a challenging topic and an emotionally difficult part of service delivery within this role may have accounted for a lower than anticipated response rate (18%, $N=91$) where a bigger sample size would have been preferred.

Another limitation of this study was that the four scales used in the study have not been normed on a New Zealand population. Hence, a revised/adapted version of the Literacy of Suicide scale that had been adapted to fit New Zealand suicide statistics had not been validated in a New Zealand context. While the Generalised Self-efficacy scale and the Religious

Commitment Scale were developed in USA, the Literacy of Suicide scale and the Stigma of suicide scale were developed closer to New Zealand in Australia.

As indicated above, it is recognised that asking the question of ‘how often’ instead of asking ‘whether or not’ participants had intervened in suicide intervention in the past may have assisted in comparing the pattern of suicide preventative behaviour and its association with training. Further questioning into participants’ prior experience of suicide intervention behaviours, for example intervention with clients versus others, may have yielded more understanding of the role that experience plays in confidence. This is considered something that might be important for future research.

CHAPTER FOUR: GENERAL DISCUSSION

Previous research has shown that the highly emotive and difficult nature of suicide can produce barriers to effective intervention, including with those staff who care for people with mental health disorders (Eagles et al., 2001; Nirui & Chenoweth, 1999; Richards, 2000; Saunders et al., 2012; Taylor et al., 2009). The role MHSWs play in mental health prevention, and the barriers they face in providing care, has received little attention in research to date. In this thesis MHSWs were the subject of investigation using a mixed methodology that included a quantitative analysis of responses to an online questionnaire which was completed by 91 MHSWs; and a qualitative study from interviews with seven experienced MHSWs. The results from both streams of data are discussed together in this final chapter.

From the interviews with MHSWs it was found they considered their contribution to supporting clients with suicidal behaviours was under-recognised by others in the MH system. In respect of their position within the MH workforce they perceived their role as generally invalidated. Confidence is considered key to enacting suicide prevention skills. The quantitative study found that basic suicide training was the single largest predictor of increasing MHSW confidence, followed by suicide literacy and generalised self-efficacy. Overall, participants identified a lack of training and suicide-related support and supervision, as well as restricted resourcing which exacerbates challenges and personal costs to MHSWs. The findings of this research reflect the complexities and corresponding difficulties associated within the MHSW role, and highlights factors which may improve suicide prevention and intervention, including better staff training and support.

An Undervalued Role

From the deinstitutionalisation process in New Zealand emerged the MHSW role as a way to support clients to live independently within communities. Currently MHSWs comprise one of the single largest workforces within the mental health system. Furthermore, MHSWs have more client contact than any other staff group, which contributes to their unique and valuable relationship with clients (Hennessy, 2015). However, despite the value that MHSWs themselves

place on their contribution to client care through their relationship with clients, they perceived the MHSW role as undervalued. This is consistent with other New Zealand based findings of the MHSW role (Hennessy, 2015; Pace, 2010).

MHSWs have the lowest remuneration rates in the mental health sector and they receive little training (Cowan, 2008). As may be expected, these two points were regarded by MHSWs in the qualitative study as exemplifying why they felt undervalued and their perceived role as having low status. Participants believed they have important relationships with clients as a result of their engagement in the varied social contexts of clients' worlds and the amount of time MHSWs spend with clients in comparison with other mental health professionals. Enhancing social networks, from client's point of view, has been seen to be particularly supportive with regards to suicide prevention (Eagles et al., 2003). Many participants in the qualitative study felt as if they acted to fulfil otherwise natural social roles for clients. They developed a unique socially contextualised understandings of their clients. Yet participants believed this unique perspective of clients was rarely recognised by professional staff.

Most participants interviewed in the qualitative study described their relationship with clients as key to their role. However, they expressed uncertainty as to whether their role was considered therapeutic, or as contributing to the recovery of wellbeing for the clients in their care. Pace (2009) has argued for the recognition of the therapeutic nature of MHSWs' relationship with clients. The lack of recognition of the therapeutic contribution of this work may arise from the status assigned to the MHSW role as fundamentally being one of 'care'. MHSWs have typically been referred to as carers (Pace, 2010) and their role has been derived from roles generally referred to as 'caregivers' (Cowan, 2008). Care work is typically given little value in society, despite it being a core element of a functional civil community (Robinson, 2011). Internationally, care roles have been devalued or commodified as 'soft labour' (Mayseless, 2015). Care roles are predominantly held by women and are seen to reflect the devaluation and commodification of relational and emotional labour in society (Robinson, 2011). Robinson (2011) has estimated that globally two thirds of carer roles are filled by women – the majority of whom are either under-remunerated or un-remunerated. The majority of participants in this research, across both studies, were women. Mayseless (2015) has argued that women are often positioned in society as natural candidates for caring roles because of having 'caring natures' which are 'innate' virtues of their gender, but that this patriarchal discourse diminishes the fact

that these socialised skills have been earned through practice and dedication. A result of such skills being regarded as ‘natural’ is that women are not afforded recognition for having such skills in terms of the status afforded to these work roles and associated monetary compensation (Mayseless, 2015). It could be argued in the context of the present study that the potentially complex, sophisticated emotional and relational work and skills that have been learned and applied by MHSWs are similarly under-recognised. In the qualitative study, participants described the emotional and relational skills deployed to assist them to attune to clients’ distress and suicide risk. It is also possible that because these skills may be taken for granted, the recognition of the need for providing specific training may be lacking.

Many people in such care roles are from marginalised races, or migrants and refugees (Andrews, Felton, Wewers, & Heath, 2004; Goh, 2018), and by virtue of this, are considered of lower socio-economic status (Robinson, 2011). This is seen to be the case globally where transnational systems exploit those who are less educated and minimally trained and who perhaps struggle to find jobs elsewhere (Robinson, 2011). In this research, a large proportion of participants were women from diverse ethnic backgrounds, in respect of both the survey respondents and interview participants. A key difference in the present research was that participants involved in this study often held tertiary qualifications. Given this underpaid role is made up of predominantly women with tertiary qualifications, such findings point to obstacles of inequalities which maintain a gender bias in this workforce.

MHSWs Play a Role in Suicide Prevention that could be Utilised More Effectively

It was evident from both studies that MHSWs were commonly exposed to suicide behaviours and that they were involved with suicide prevention. One in two MHSWs in the quantitative study had at least one client who attempted or completed suicide. Alongside being frequently exposed to a range of suicide behaviours, interview participants strongly felt that watching for warning signs and providing interventions for suicide was a part of their role. More than three quarters of survey respondents had provided help or brief suicide intervention. The risk of suicide was regarded as ever-present and was felt to be ubiquitous within this role.

As noted above, MHSWs are in a prime position to perceive warning signs for clients and to provide suicide intervention as they spend significant time with clients in a variety of contexts. Yet interview participants stated that suicide is not often talked about within their organisation.

Their perspective on suicide emphasises social isolation as making a significant contribution to suicidal behaviours. This view appears to be consistent with the perspective of suicide researchers who maintain that ‘context is key’; a perspective that is in contrast to the dominant biological and psychiatric frameworks in suicide research (Colucci & Lester, 2013; Hjelmeland, 2011). In this respect, MHSWs’ perspectives and attitudes on suicide are likely to be more aligned to clients than they are to clinicians (Hodgins et al., 2016). MHSWs’ perspective may offer new avenues of consideration to clinical professionals to broaden their often silo’ed health perspectives (Colucci & Lester, 2013). Suicide researchers are calling for increased interdisciplinary collaboration for this reason, after recognising how the practice of such collaboration can become side-lined (Colucci & Lester, 2013; De Leo, 2002a; De Leo, 2002b; Hjelmeland, 2011).

A risk that arose from the close contact with clients - in the absence of collaboration with professional staff, training, and supervision - were difficulties in maintaining appropriate relational boundaries. Maintaining boundaries for the safety of people in support roles and individuals at risk has been identified as a necessary skill (Fisher et al., 2017). Cowan (2008) has raised concerns about MHSWs’ lack of recognition of the importance of boundaries within their role. This idea was reflected in the qualitative study of this thesis where some participants came to see their role as proxies for otherwise natural social resources, and their reports of the burden and emotional toll that this entailed.

Suicide Prevention in the MHSW Role Requires Emotional Tasks which have a High Emotional Toll

Findings from the qualitative study show that constructing relationships was considered a positive aspect of facilitating client’s development, and this was unpinned by a strong connection between MHSWs and their clients. This has been described as emotionally demanding work in the sense that building empathy often involves utilising private experiences, which may come at significant personal costs (Hochschild, 1983). This labour relies on the recognition of feelings, vulnerabilities, and needs of the client, and interpreting these to assist attuned and responsive care. The emotional demands are split between the practice of *utilising* personal experiences in order to empathise with clients and *managing* one’s own personal emotional responses in order to contain the client’s emotions. Interview participants described having to manage the process of

masking their own emotional responses in order to manage clients' distress. Participants also reported the burden arising from *deliberating* on risk and the relational consequences of breaking confidentiality. For example, MHSWs had to find a way to 'switch off' after a shift as a way of coping with traumatic instances of suicide behaviours. Such coping strategies have been highlighted as being potentially detrimental to workers (Hochschild, 1983). Given their lack of explicit suicide prevention training, reliance on personal experience of suicide was necessary to informing how to connect with, prioritise, and respond effectively to clients' suicidal expressions. Yet these practices often left them less able to take care of themselves in the absence of training and supervision in such work. Such emotional costs of caring have previously been associated with helper roles, particularly for women (Fisher et al., 2017; Smith & Rose, 2011).

Potential repercussions from under-acknowledgment of the emotional toll within the MHSW role and a lack of strategies to cope carries the risk of MHSWs reliving personal painful emotional experiences of suicide in their own lives. Some struggled with having traumatic memories of past client suicide attempts brought to the forefront. For some, the cost of being exposed to client suicidality was akin to re-traumatisation and/or burnout. Burnout in the MHSWs' work has been cited as of noteworthy concern (Blankertz & Robinson, 1997; Kinzel & Nanson, 2000).

Training is Associated with Confidence and MHSWs Want More Training and Support

Interview participants described instigating conversation about suicide or responding to potential warning signs as difficult and worried about breaking the trust within this relationship. They suggested that those who were more confident to have suicide related conversations were more likely to gain information on client suicide risk and use this information to protect client safety. Across both studies it appeared that many respondents were confident in their ability to respond to warning signs by asking about suicidal ideation, but there was less confidence in their ability to identify warning signs.

One of the aims of this research was to describe factors that have an impact on confidence in suicide preventative behaviours for MHSW. Based on this research, systemic changes are considered necessary for the ethical and effective practice of suicide prevention. Other researchers have identified a general need for increased education, professional development and supervision for MHSWs and paraprofessionals (Mackenzie, 2006; Pace, 2010;

Sutcliffe, 2007), as well as greater interdisciplinary collaboration (Hennessy, 2015; Nancarrow et al., 2005). Findings from the present research also supports the need for greater availability of training, supervision and inter-MH staff collaboration.

Participants in the current research perceived there was little opportunity to attend specific training on suicide prevention, that there was a lack of standardised procedures for assessment of suicide risk and inconsistent clinical supervision specific to suicide prevention. Alongside these organisational factors were personal factors which may impact on suicide intervention confidence, and which are less likely to be impacted by organisation decisions. Specifically, generalised self-efficacy significantly predicted confidence in suicide prevention behaviours.

The quantitative study showed that specific suicide intervention training was most likely to predict suicide intervention confidence and accounted for the highest amount of variance in confidence scores. Hence specific suicide training is supported as being the most important factor in enhancing the confidence of MHSWs enacting suicide preventative behaviours with clients. Various studies have shown evidence of the effectiveness of brief suicide related training (Beautrais et al., 2005; Beautrais et al., 2007; Goldsmith, 2002; Isaac et al., 2009). The findings from the present study support the specific effect of suicide prevention training on staff confidence (Cross et al., 2007). Collectively, the two studies found that basic suicide prevention training was desired by MHSWs and was perceived as possibly having broader positive consequences in the area of confidence, self-care, and support within this role.

Suicide literacy was the second largest predictor of confidence in suicide intervention within this role. While suicide literacy is likely to be impacted by training events, it is also likely to be increased through suicide-related discussion and clinical supervision that increases knowledge and reduces misconceptions. One of the benefits of suicide training and clinical supervision is that they may deepen MHSWs' understanding by enhancing language with which to communicate about suicide risk.

Nancarrow et al. (2005) reported that supervision for MHSWs has been variable in its provision, and has included provision of mentors, team supervision, and both formal and informal line management supervision. Health professionals who were charged with delivering supervision to paraprofessionals in one study considered this task burdensome (Mackenzie, 2006). Yet supervision has been shown to play a useful role in the development of related skills

and functions to empower MHSWs and to development 'professional identity', as well as increasing the safety and wellbeing of MHSWs (Pace, 2010; Sutcliffe, 2007). Mackenzie et al. (2006) found health professionals perceived support staff at risk of over-identification with client difficulties. Recognition of clinical responsibility in relation to risk concerns and responses to these, issues of maintaining boundaries with clients, and ethics of practice may also be addressed in training and supervision (Nancarrow et al., 2005; Pace, 2010).

Views about suicide may be derived or influenced by religious beliefs, as has been shown in previous research (Foo et al., 2014; Osafo et al., 2012; Sun et al., 2007). This study evidenced how higher religious commitment was associated with more stigmatising attitudes concerning those who are suicidal. MHSWs come from varied backgrounds, ethnicities, and cultures whereby their religious beliefs are also likely to be variable. It may be that people's values of supporting others may come to conflict with their religious beliefs about suicide. These findings suggest that basic suicide training should integrate discussions which include religious views in order to ameliorate stigmatising attitudes and behaviours towards suicidal individuals.

Unlike the trends seen in global literature for carer roles, and perhaps surprisingly given their low pay, the majority (55.5%) of participants in the quantitative study held either a Bachelors or Masters Degrees. However, the multiple regression analysis found that general education did not account significantly for differences in suicide intervention confidence. Hence, it is specific training in suicide prevention that appears to be critical rather than general education. Organisations therefore, cannot assume that hiring those with higher levels of education will translate necessarily to suicide literacy. These findings also support the strong interest the interview participants expressed towards being trained specifically in suicide intervention. The benefits of specific suicide preventative training have been identified for other groups including nurses and a variety of professionally trained staff (Chan, Chien, & Tso, 2009; Fenwick et al., 2004).

Implications for Improvement

Training and MHSWs as Suicide Gatekeepers. Interview participants identified that MHSW roles require a high level of emotional labour, and there appeared to be irregular and insufficient training on the self-care aspects of this role. This finding is consistent with other work conducted in New Zealand which outlines a need for greater availability and consistency of

training for MHSWs (Goh, 2018; Pace, 2009; Pace, 2010). An implicit benefit of training would be recognition of the MHSWs' position within MH service provision and their contribution to suicide prevention. By training MHSWs as suicide gatekeepers there are likely to be specific benefits in relation to suicide prevention (Beautrais et al., 2005; Beautrais et al., 2007; Goldsmith, 2002; Isaac et al., 2009), including MHSWs' confidence and ability to communicate with other MH staff using shared language, knowledge, and understanding - thereby increasing a sense of role legitimacy. Training may enhance interdisciplinary communication and support more generally, and as such decrease MHSWs' sense of isolation in their responsibility for clients at risk.

Inter-MH staff collaboration. Collaborative inter-professional relationships should be fostered and strengthened where they already exist through systemic and procedural changes. This may require increased communication with MHSWs, especially where suicide prevention is concerned. It may be the case that professionals benefit from education on the MHSWs role and how a multi-disciplinary relationship can be mutually advantageous.

Self-care. Findings call for increased provision for learning self-care through increased access to supervision, training and general recognition of this need. Structured training may not be sufficient on its own, although suicide prevention training could incorporate consideration of self-care practices.

Role recognition. Lastly, broader systemic changes are required at a social and governmental level to address the lack of status assigned to this role. Recognition of the MHSW role more generally should be granted through appropriate pay, role definition and training. This is considered particularly important for addressing the possible gender bias that exists within the sector and consideration for the value society places on care work more broadly.

Future Research

Within the MH sector and broader social and political system in New Zealand, MHSW have little political power given their perceived lower status compared to other professional standings. Hence their voices are often overlooked. Therefore, any future research that is able to add meaningfully to enhance general understanding and consideration for this workforce is highly desirable. To assist in this, future research should aim for larger sample sizes than was

achieved in the present research, particularly with a view to ensuring greater representation of the MHSW population.

Future research could include an intervention study of a specifically designed training course for MHSWs tailored to suicide prevention tasks within this role. Development of an intervention could aim to equip MHSW with the resources and skills needed to address the practical reality and emotional challenges of supporting clients at risk of suicide. Consideration might be given to their unique needs identified within this thesis. Training may include provision for how staff could access ongoing support and address the issue of self-care.

An evaluation of training is important for those organisations that adopt the new gatekeeper training developed in New Zealand termed, ‘Life Keeper’ (LeVa, 2018).

A further potential research project is an examination of MH professionals’ perceptions of MHSWs’ role in suicide prevention with clients. Such research could yield greater understanding of these relationships within the MH sector, and serve to identify barriers to inter-group communication and how these could be overcome with respect to suicide intervention.

Concluding Comments

This thesis set out to contribute towards suicide prevention by exploring how suicide intervention tasks were conceptualised and practiced within the MHSW role. Motivation for this research arose out of my personal experience in this role before I trained as a clinical psychologist, from which I gained an awareness of suicide prevention tasks being undertaken within this role and my observation of inadequate training provisions. Accordingly, this research amalgamated two main topics - suicide prevention and the paraprofessional MH workforce. Broader contributions of this thesis entailed an outline of the factors that impact suicide and suicide intervention, as well as the historical and recent contexts that map the development of the MHSW role. By taking a mixed method approach, the findings gave accounts of the contributions to confidence suicide intervention training, suicide literacy, and self-efficacy. Findings from interviews with the MHSWs indicated complexities of role ambiguity and legitimacy, burden of responsibility, as well as the emotional effect of exposure to suicide behaviours that were accentuated by inadequate training compared to role demands.

Positive instances of suicide prevention were revealed in this research, and of worthy note is that most MHSWs did feel confident to intervene with client suicidal behaviour. Positive

reflections of helping clients through dark times brought self-worth and personal satisfaction to their role. Enriching educational experiences with generous MH professionals provided both satisfaction and hope for improved interdisciplinary communication. Experiences of training were valued and contributed to the desire for increased access to training.

In itself, participation in this research seemed to reflect a sense of hope and recognition that things could be improved in preventing suicide. Interview participants in particular were able to show their commitment to care and a passionate concern for client wellbeing. Participants desired dignity, recognition, and validation of their role and the unique relationships they built with clients. Such desires were captured succinctly by one participant's plea for others to "understand the *value* of the mahi we do" (P6). In response to this plea, it is hoped this thesis has made a contribution that meaningfully enriches understandings of how MHSWs strive to prevent clients from suicide, by valuing what they offer as well as highlighting the potential for advancing support, training, and research in this field.

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APPENDICES

Appendix A: Recruitment Email

First Email for Recruitment:

SUICIDE & SUPPORT WORKERS IN AOTEAROA/NEW ZEALAND

Are you a Mental Health Support Worker?

Would you like to take part in an Online Questionnaire?

Participation is voluntary and anonymous.

Complete the Questionnaire any time, any place, online at:

Questionnaire Link -

https://jfe.qualtrics.com/form/SV_e8vU4IQPFKpoc1n

Should you choose to complete the questionnaire it will take about 20 minutes

Be in the draw to win 1 of 4 \$50 vouchers.

Please see research poster attached.

**This is an independent study (by Ursula Bach- Doctoral Student at University of
Auckland) supported by Emerge Aotearoa.**

For more information about the study visit:

www.suicidesupportwork.wix.com/participate

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS
COMMITTEE ON 04 DECEMBER 2014 FOR (3) YEARS, REFERENCE NUMBER
013410

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Ursula Bach
Clinical Psychology Doctoral Student,
The University of Auckland.
ubac001@aucklanduni.ac.nz

Second Email for Recruitment

To the frontline staff and Community Support Workers at Emerge Aotearoa.

In June of this year I send out a request for support workers/CSW's to participate in my research on Mental Health Support Workers and Suicide.

I am extremely grateful to those who participated and am happy to say that 84 completed the online surveys. I am working towards having brief report to feedback on this data in January. The survey is still open and I am aiming to get 200 responses. If you haven't yet completed the survey and would like to, it would take roughly 20 minutes of your time. Please see the link below.

Survey Link -

https://jfe.qualtrics.com/form/SV_e8vU4IQPFKpoc1n

I am also recruiting support workers who are interested in meeting with me for a one-on-one interview. I will be asking questions about your experience as a support worker and around working with client with suicide risk. Please contact me via email if you would like to have a chat or know more about the study: ubac001@aucklanduni.ac.nz

[mailto:ubac001@aucklanduni.ac.nz?subject=Research participant](mailto:ubac001@aucklanduni.ac.nz?subject=Research%20participant)

This is an independent study (by Ursula Bach- Doctoral Student at University of Auckland) supported by Emerge Aotearoa. For more information about the study visit: www.suicidesupportwork.wix.com/participate

Ursula Bach
Clinical Psychology Doctoral Student,
The University of Auckland.
ubac001@aucklanduni.ac.nz

Appendix B: Study One – Participant Information Sheet

PARTICIPANT INFORMATION SHEET

- Interview



Project Title: **Suicide and Support Workers in Aotearoa/New Zealand: Exploring factors that influence frontline mental health staff talking and intervening with suicidal clients.**

Department of Psychology
10 Symonds Street, rm 660
Private Bag 92019
Auckland

Name of Researcher: **Ursula Bach**

Dear Potential Participant,

Thank you for completing the online questionnaire. Your time and participation in that first phase of the research is really appreciated. You are now invited to participate in the second phase of the study, which seeks to explore further attitudes and beliefs of mental health frontline staff around suicide. Through an interview I am able to grasp richer information to assist in understanding how frontline staff currently deals with suicidal clients. I am genuinely curious to hear your views about how you deal with suicidal clients and how you feel suicide in general is managed in your field of work.

Purpose: The aim of this project is to understand how different factors (e.g., training, self-efficacy, beliefs, attitudes, and knowledge) influence mental health workers' confidence in asking and talking about suicide with clients.

Who can participate? I am asking individuals who work in New Zealand, and who are currently considered frontline mental health staff (e.g. mental health support workers, mental health community workers, mental health volunteers, or Youth Workers etc) but are not considered registered health professionals (e.g. nurses, psychologists, psychiatrists, or social workers) - to participate in a one-to-one interview with the researcher, about these factors and personal experiences.

What will participation involve? Participation in this second stage of the research will involve a one-to-one interview with the researcher. This will take between 30 minutes to an hour of your time, and the meeting can take place in your home or the University of Auckland premises in a private room. Interviews will be audio recorded and transcribed for analysis. The researcher will analyse transcripts from multiple participants to identify common themes. Confidentiality will be maintained and respected throughout this process. Any contextual information that provides clues to identity will be removed via a coding or de-identification process. Published transcripts will not be connected with your name and the researcher will try to amend any identifying information contained within published transcripts/quotes used. The interview will be guided by a series of 12 questions about your attitudes towards suicide. Your recording will be confidential and kept on an external hard-drive, in a locked cabinet on the University premises. A transcriber (other than the researcher - Ursula) may be hired to transcribe the content of the interview for use as data for the research, but this transcriber will sign a confidentiality agreement which will restrict them from disclosing any of the content of the recording. Recordings and transcripts will be held in secure storage on university premises for a period of 6 years after publication. After 6 years post publication all data will be shredded and/or permanently deleted. Participants can withdraw or edit their information up to one month after participating in an interview.

Are there any risks to participating? Due to the sensitive topic area of the study, associated risks with participating in the interview may include bringing up unpleasant feeling or thoughts, particularly if you have been significantly affected by suicide in the past. Please note following completion of the interview a list of resources will be made available to all participants. Please also note that interviews and the

content within the interviews are confidential and will not be made available to your employee or employing organisation

What are the benefits to participating? I hope that sharing the results of this study will benefit the community. Understanding attitudes, needs, and strengths of Mental Health Frontline Staff will hopefully guide organisations and the mental health sector towards better training, practice, and policy for suicide intervention and hopefully less suicides. Findings from this research may be published online and in academic journal articles and conferences. If you wish to have a summary of findings, please contact the researcher (Ursula Bach: ubac001@auckland.ac.nz) or visit the website (www.suicidesupportworkers.wix.com/participate) and enter the password “participants4findings”.

If you wish to participate please email ubac001@aucklanduni.ac.nz or visit the website (www.suicidesupportworkers.wix.com/participate) where you can access information about the study. Thank you for your time and help in making this study possible. If you have questions or would like to discuss participation, please contact me (Ursula Bach) at the email address below:

Ursula Bach
 Doctorate in Clinical Psychology
 Department of Psychology
 The University of Auckland
 Private Bag 92019, Auckland
 (09) 373 –7599 ext 88517
ubac001@aucklanduni.ac.nz

Professor William Gordon Hayward
 Head of Psychology Department
 University of Auckland
 +64 (0) 9 923 8516
w.hayward@auckland.ac.nz

For any queries regarding ethical concerns you may contact the Chair of the University of Auckland Human Participants Ethics Committee, The University of Auckland, Office of the Vice Chancellor, Private Bag 92019, Auckland 1142. Telephone 373-7599 extn. 83711

**APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE
 For 3 years. Reference Number 013410**

School of Psychology
Human Sciences Building
Floor 6, 10 Symonds Street
Telephone 64 9 373 7599
Facsimile 64 9 373 7450
Private Bag 92019
Auckland, New Zealand
The University of Auckland
Private Bag 92019
Auckland, New Zealand

CONSENT FORM for INTERVIEW

Project Title: Suicide and Support Workers in Aotearoa/New Zealand: Exploring factors that influence frontline mental health staff talking and intervening with suicidal clients.

Name of Researcher: Ursula Bach

Supervisors: Professor Fred Seymour and Dr Gwenda Willis

I have read the Participant Information Sheet, understood the nature of the research and why I have been invited to participate. I have had the opportunity to ask questions and had them answered to my satisfaction. I understand that participation in this study is voluntary.

- I agree to take part in this research, involving my participation in an interview. The interview will take approximately 30 minutes to one hour.
- I can withdraw from the interview at any time without giving a reason, and withdraw any information I have provided up to one month after the interview.
- I understand that the interview will be audio recorded.
- I acknowledge that I may choose to have the recorder turned off at any time.
- You are able to contact the researcher following the interview if you wish to edit any content of your interview up to one month following the interview date.
- Findings will be published as part of the researcher's Doctorate in Clinical Psychology thesis and may be published in international or domestic journals and presented at conferences. I understand that parts of what I say may be quoted in research publications and presentations, but that these quotations will be anonymous with any identifying contextual information removed. Any contextual information that provides clues to identity will be removed via a coding or de-identification process.
- I understand that the audio file record of the interview may be transcribed by a third party, who has signed a confidentiality agreement.
- I understand that electronic and hardcopy data will be kept for a period of 6 years after publication, at which time the data will be permanently deleted and destroyed.
- I would / would not like to receive a copy of findings. *[Please indicate one]*
- I understand that I am welcome to contact the researcher for an update on the research.
- I understand that this form will be kept, securely and separately from data, recordings or transcripts, for a period of 6 years after publication, at which time the data will be deleted and destroyed.

Name _____
Contact details (not required) _____
Signature _____ Date _____

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE
For 3 years. Reference Number 013410

Appendix D: Study One - Demographics

Please answer the following:

What is your age? _____

Sex: male ☐ female ☐ transgender ☐

What is your race/ethnicity? _____

What is your highest education level? _____

If university level, or apprenticeship, what area of study was this in?

What is your current job title in the mental health field? _____

What age are majority of your clients in your current mental health role? (Circle one or more)

Under 5yrs, 5-14yrs, 15-24yrs, 25-44yrs, 45-64yrs, 65yrs and over, All ages.

Are you aware of any suicidal risk either present or in the past of any of your clients?

Yes ☐ No ☐

What level of training have you done for this role in mental health?

None/ In-house training (please specify e.g. medication training etc.)/ National Certificate in Mental Health (Mental Health Support Work) NZQA (Level 4)/ Other? Please Specify:

Have you completed any training in basic (or other) suicide intervention? Yes ☐ No ☐

If yes, what was the name of (or how would you describe) the training?

What format was it presented in? Web based ☐ Workshop ☐ Lecture ☐

Literature/reading material ☐ Seminar ☐ Training sessions ☐

How long was the training for? Number of days ☐ or hours ☐

What was the main thing you took away from the training?

How would you rate the value of this training?

1

2

3

4

5

Highly Valuable

Valuable

Somewhat

Valuable

Not very

valuable

Not valuable at

all

How confident would you rate yourself in identifying suicidal warning signs in your clients?

1	2	3	4	5
Very Confident	confident	Somewhat confident	Not very confident	Not confident at all.

How confident would you rate yourself in asking directly if a client was suicidal?

1	2	3	4	5
Very Confident	confident	Somewhat confident	Not very confident	Not confident at all.

Have you ever asked and given brief suicide intervention before or helped a person who you thought was at risk of suicide? Yes ☐ No ☐

Please check all that apply for the following section:

Have you known anyone:

Who has committed suicide? Yes ☐ No ☐

Who has attempted suicide? Yes ☐ No ☐

Who has had multiple suicide attempts? Yes ☐ No ☐

Please check all that apply for the following section:

What was your relationship(s) with the person(s) who **died** by suicide?

Immediate Family ☐ Extended Family ☐ Significant other ☐ Child ☐ Friend ☐ Acquaintance ☐
Client ☐

What is your relationship(s) with the person(s) who have **attempted** suicide?

Immediate Family ☐ Extended Family ☐ Significant other ☐ Child ☐ Friend ☐ Acquaintance ☐
Client ☐

Appendix E: Study One - Original Semi-structured Interview Questions

1. What is your overall attitude towards suicide in general?
2. There are a number of reasons why people don't ask others directly if they are contemplating suicide. What do you think some of the reasons for yourself might be?
3. How do you feel about suicidal clients, and how do you react with a suicidal client? (Probe: Do they perceive the person as needing care or are they blameful of the suicidal person?)
4. How supported do you feel by your organisation (don't need to disclose your organisations name) regarding dealing with suicide?
5. What do you think could help you feel more confident asking clients about suicide and providing 'first aid' suicide intervention?
6. What do you think the cause of suicide is?
7. What kind of treatment is most appropriate for a suicidal person?
8. Why shouldn't people suicide?
9. Should suicide be a crime? (and why?)
10. Should suicide be prevented?
11. In your view, what is the best way to prevent suicide?
12. How do you feel your culture or religion impact on your attitude towards suicide?

Appendix F: Study One - Developed Semi-structured Interview Questions

1. What prompted you to want to participate?
2. How long have you been working as a support worker?
 - a. Have you had clients who have been suicidal either in their history or while you have been working with them?
3. What has your experience been in working with clients who have become suicidal as a support worker?
 - a. Would you say there has been any one particular experience that has been more significant for you than others? Tell me about that...
4. How supported do/did you feel by your organisation (pre/during/post) this experience dealing with suicide, (you don't need to mention who your organisation is).
5. What is it like for you to sit face to face with a person who is talking about suicide or is suicidal?
 - a. What are your reactions when you realise you may have to intervene?)
6. How have you felt in those situations?
 - a. Where do you feel you've gained your understanding from?
- b. What to do and say to clients who are suicidal?
7. How do you feel dealing with suicide with clients affects you emotionally?
8. What do you see is the role of the support worker and particularly when clients become suicidal/attempt suicide or display suicidal behaviours?
 - a. How responsible do you feel for their care?
 - b. How do you feel the amount of responsibility varies between you and that of other professionals you're working, with regards to these clients?
 - c. How do you feel about this responsibility? (and what you get paid)?
 - d. How clearly do you feel your role is understood or respected by yourself and other professions, e.g. the clinical team?
9. I'm interested in the attitudes that support workers hold about suicide in generally and also what they think and feel about the clients they work with who become suicidal or attempt suicide. Most people have a range of responses. What do you think some of these might be?
 - a. So for you, when I say the word suicide, what thoughts or feelings come about for you?
10. What do you think would be the cause of suicide?
11. What kind of help you think is most appropriate for someone that's suicidal?
12. What would you say to a person who is suicidal and high risk? Or what would be some of the reasons you might give to a person to convince them not too?

13. Are there any reasons why might not ask a client directly about suicide, what do you think these might be?
 - a. On a scale of one to ten how confident would you be to judge that?
 - b. What do you think could help you feel more confident in asking clients about suicide and providing brief suicide intervention?
14. In your opinion, should suicide be a crime?
15. What is the best way to prevent suicide?
16. And how do you feel your culture, religion or society has impacted your attitudes about suicide?

Post Interview Additional Questions

17. Was there anything that you expected me to ask about that I haven't asked?
18. Is there anything else that you wanted to talk to me about in terms of your experiences as a support worker that you think might be important?
19. Was there anything I asked that was perhaps unexpected?
20. Are you feeling ok about what we have talked about? It's quite a heavy topic...

Appendix G: Study Two – Participant Information Sheet and Consent

PARTICIPANT INFORMATION SHEET

- Questionnaire



Te Whare Wānanga o Tāmaki Makaurau

Department of

Psychology

10 Symonds

Street, rm 660

Private Bag

Project Title: **Suicide and Support Workers in Aotearoa/New Zealand: Exploring factors that influence frontline mental health staff talking and intervening with suicidal clients.**

Dear Potential Participant,

My name is Ursula Bach. I am a doctoral student of the University Of Auckland Department Of Psychology conducting research on mental health support workers and their attitudes, skills, and beliefs around suicide and suicide intervention.

Thank you for your interest in this research!

Purpose: The aim of this project is to understand how different factors (e.g., training, self-efficacy, beliefs, attitudes, and knowledge) influence mental health workers' confidence in asking and talking about suicide with clients.

Who can participate? I am asking individuals who work in New Zealand, and who are currently considered frontline mental health staff (e.g. mental health support workers, mental health community workers, mental health volunteers, or Youth Workers etc) but are not considered registered health professionals (e.g. nurses, psychologists, psychiatrists, or social workers) – to participate in an online questionnaire. After completing the online questionnaire, participants can then choose to participate in a one-to-one interview with the researcher, about these factors and personal experiences.

What will participation involve? Participation will involve completion of an anonymous online questionnaire. The questionnaire should take less than 30 minutes to complete. The questions being asked will help to answer the research question. I will also ask for some demographic information (e.g., age, ethnicity, gender, education level etc). You are under no obligation to participate. Your participation is **voluntary** and you may withdraw at any time. If you do not want to continue, you can simply leave this website. If you do not click on the "DONE" button at the end of the survey, your answers and participation will not be recorded. You also may choose to skip any questions that you do not wish to answer. All your responses to the questionnaire will be anonymous. To compensate for time spent you can choose to go into a draw to win one of four \$50 vouchers by leaving a contact phone number and name at the end of the questionnaire. These details will not be paired with your answers.

All information collected via the online questionnaire will remain **anonymous**. That is, your identifying information will not be associated with published results or known to the researcher, or the organisation you work for. If you heard about this study via your organisation, this study will **not** impact your employment. This study is **independent** to your place of work and run by the University of Auckland. Survey Monkey is the questionnaire platform used and has a privacy and security policy which is available to view on the website (www.suicidesupportworkers.wix.com/participate).

All information in the study will be held in secure storage on University premises for a period of 6 years after publication. After 6 years post publication all data will be shredded and/or deleted. Participants cannot withdraw their information once it has been submitted online. The data we collect via online survey will not be linked to your identity in any way. I will NOT know your IP address when you respond to the Internet survey. The survey will not ask for any information that could lead to revealing your identity. Only the researcher will see individual survey responses, which will be stored electronically in a password protected folder.

Are there any risks to participating? Due to the sensitive topic area of the study, associated risks with completing the questionnaire may include bringing up unpleasant feeling or thoughts, particularly if you have been significantly affected by suicide in the past. Please note following completion of the questionnaire, links to resources will be made available to all participants.

What are the benefits to participating? I hope that sharing the results of this survey will benefit the community. Understanding attitudes, needs, and strengths of Mental Health Frontline Staff will hopefully guide organisations and the mental health sector towards better training, practice, and policy for suicide intervention and hopefully less suicides. Findings from this research may be published online and in academic journal articles and conferences. If you wish to have a summary of findings, please contact the researcher (Ursula Bach: ubac001@auckland.ac.nz) or visit the website (www.suicidesupportworkers.wix.com/participate) and enter the password “participants4findings”.

Thank you for considering participating in this study. If you would like to proceed, please click the “Next” button below, which indicates you have read and understood the information on this screen. The survey questions will appear on the following screen.

If you have any ethical concerns about this research, please contact: The Chair, The University of Auckland Human Participants Ethics Committee, the University of Auckland, Private Bag 92019, Auckland. Tel: +64 9 3737599 (ext 87830)

- ☐ Yes, I am at least 18 years of age and a frontline mental health worker as described above, and I have read and agree with the above statement.
- ☐ No, I do not wish to participate

I Agree

Ursula Bach
 Doctorate in Clinical Psychology
 Department of Psychology
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**APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE
 For 3 years. Reference Number O13410**

Appendix H: Study Two – Demographic and Survey Questions

Please tick an option below

Answer – Tick one

Yes, I am at least 18 years of age and a frontline mental health worker as described above, and I have read and agree with the above statement.

No, I do not wish to participate

How old are you?

Answer – Tick one

18 - 24yrs

25 - 30yrs

31 - 40yrs

41 - 50yrs

Over 50

What is your gender?

Answer - Tick one

Male

Female

Transgender

What is your ethnicity?

Answer – Multiple answers aloud

NZ/European

NZ/Māori

Pacific Peoples

Asian

Middle Eastern/Latin American/African

Other Ethnicity (enter option)

What is your highest education level? E.g. NCEA level, University degree, etc

Answer - Tick one

Primary School

Secondary/high school

NCEA level (school certificate, 6th form certificate, bursary)? (Enter Option)

Bachelors Degree

Masters Degree

Doctorate or higher

Apprenticeship

If university degree, or apprenticeship, what area of study was this in? Enter Answer

What is your current job title within the mental health field? Enter Answer

What age are majority of your clients in your current mental health role?

Answer – Multiple answers aloud

Under 5yrs

5-14yrs

15-24yrs

25-44yrs
 45-64yrs
 65yrs and over

Are you aware of any suicide risk either in the past or in the present of any of your clients?

Answer - Tick one

No

Yes - all

Yes - at least one

Yes - many

Have you done any level of nationally recognised training for this role in mental health?

Answer - Tick one

Yes

No

Did you complete any training prior to becoming a frontline mental health worker that was related to the mental health field?

Answer - Tick one

None, I am currently learning or have previously learnt on the job

I have completed 'in-house' training given by my organisation. Please specify as best as possible any training that was related to the mental health field (excluding fire safety training and first aid training for example)

I completed a National Certificate in Mental Health (e.g. Mental Health Support Work, NCEA Level 4), or other (specify if possible):

I completed a university level degree in a related field. Please specify what field or degree:

Follow up Questions:

I have completed 'in-house' training given by my organisation. Please specify...

Enter Answer

I completed a National Certificate in Mental Health. Please specify...

Enter Answer

I completed a university level degree in a related field. Please specify...

Enter Answer

Have you completed any training in basic (or other) suicide intervention?

Answer – Tick one

Yes

No

If yes, what was the name of (or how would you describe) the specific suicide training? Enter Answer

What format was the training presented in?

Answer – Multiple answers aloud

Web based

Workshop

Lecture

Literature/reading material

 Seminar

 Training sessions

 Other (Enter option)

How long was the training for?

 Answer – Enter answers – optional

 Number of days? (enter)

 or hours? (enter)

What was the main thing you took away from the training? Enter Answers
How would you rate the value of this training?

 Answer – Tick one

 Highly Valuable

 Valuable

 Neutral

 Not very Valuable

 Not valuable at all

How confident would you rate yourself in identifying suicidal warning signs in your clients?

 Answer – Tick one

 Very Confident

 Confident

 Neutral

 Not very confident

 Not confident at all

How confident would you rate yourself in asking directly if a client was suicidal?

 Answer – Tick one

 Very Confident

 Confident

 Neutral

 Not very confident

 Not confident at all

Have you ever asked a person and given brief suicide intervention before, or helped a person who you thought was at risk of suicide?

 Answer – Tick One

 Yes

 No

Have you known anyone who has committed suicide?

 Answer – Tick One

 Yes

 No

Have you known anyone who has attempted suicide?

 Answer – Tick One

 Yes

 No

Have you known anyone who has had multiple suicide attempts?

Answer – Tick One

Yes

No

What was your relationship(s) with the person(s) who died by suicide?

Answer – Multiple Answers aloud

Immediate Family

Extended Family

Significant other

Child

Friend

Acquaintance

Your Client

A client under your team or organisation

What is your relationship(s) with the person(s) who have attempted suicide?

Answer - Multiple Answers aloud

Immediate Family

Extended Family

Significant other

Child

Friend

Acquaintance

Your Client

A client under your team or organisation

Questions proceeded by:**Religiosity Scale:** Religious Commitment Inventory- 10 (Worthington et al., 2003)**Stigma of Suicide Scale** **Stigma of Suicide Scale:** Shortened (Batterham, Calear, Christensen 2012)**Adapted Literacy of Suicide Scale:** based on original LOSS by (Calear, Batterham, Christensen 2012)**Generalized Self-Efficacy Scale:** (Schwarzer & Jerusalem, 1995).

Appendix I: Study Two – End of Questionnaire Resources and Recruitment**Thank you for Participating in the Questionnaire!**

By entering a contact phone number below I agree to go into the draw to win one of four \$50 vouchers. I am aware my phone number will not be connected with my questionnaire responses, and that it will only be used for the purpose of contacting me to let me know I have won a \$50 gift voucher if this is the case.

Name: _____

Contact Phone(s): _____

Would you like to participate in the second stage of the research for this project involving a one-to-one interview with the researcher? (Restricted to Auckland) Email Ursula Bach on ubac001@aucklanduni.ac.nz

Below are some contact details of helplines and the researcher should you feel the need to contact them...

Lifeline Aotearoa: Free 24 hour telephone counselling

Within Auckland: 09 5222 999

Outside Auckland: 0800 543 354

Suicide Helpline

0508 TAUTOKO (82 88 65)

If you think you, or someone you know, may be thinking about suicide, or you have been affected by the death or injury of someone to suicide.

Call 0508 TAUTOKO (82 88 65) for support – Available 24 hours, 7 days.

Locate community service providers in your area

Find out where to access community help services that can help with issues relating to parenting, special needs, family support, family violence, custody and access, child behaviour, life skills, counselling, addiction, sexual abuse, grief and loss etc.

Call the Ministry of Social Development 211 Information line: 0800 211 211.

Researchers Details:

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University of Auckland

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St Johns / Auckland 1072

New Zealand

Dr Gwenda Willis

Senior Lecturer in Psychology

Registered Clinical Psychologist

+64 (0) 9 923 4395

g.willis@auckland.ac.nz

Appendix J: Study Two – Religious Commitment Inventory- 10 (Worthington et al., 2003)

Instructions: Read each of the following statements. Use the scale to the right,
CIRCLE the response that best describes how true each statement is for you.

	Not at all True of me 1	Somewhat True of me 2	Moderately True of me 3	Mostly True of me 4	Totally True of me 5
1. I often read books and magazines about my faith	1	2	3	4	5
2. I make financial contributions to my religious organization	1	2	3	4	5
3. I spend time trying to grow in understanding of my faith	1	2	3	4	5
4. Religion is especially important to me because it answers many questions about the meaning of life.	1	2	3	4	5
5. My religious beliefs lie behind my whole approach to life.	1	2	3	4	5
6. I enjoy spending time with others of my religious affiliation.	1	2	3	4	5
7. Religious beliefs influence all my dealings in life.	1	2	3	4	5
8. It is important to me to spend periods of time in private religious thought and reflection.	1	2	3	4	5
9. I enjoy working in the activities of my religious affiliation.	1	2	3	4	5
10. I keep well informed about my local religious group and have some influence in its decisions.	1	2	3	4	5

Appendix K: Study Two – Stigma of Suicide Scale - Shortened (Batterham, Callear, Christensen 2012)

Using the scale below, please rate how much you agree with the descriptions of people who take their own lives (suicide). In general, people who suicide are . . .

	<i>strongly disagree</i>	<i>disagree</i>	<i>neutral</i>	<i>agree</i>	<i>strongly agree</i>
	1	2	3	4	5
brave	1	2	3	4	5
cowardly	1	2	3	4	5
dedicated	1	2	3	4	5
disconnected	1	2	3	4	5
an embarrassment	1	2	3	4	5
immoral	1	2	3	4	5
irresponsible	1	2	3	4	5
isolated	1	2	3	4	5
lonely	1	2	3	4	5
lost	1	2	3	4	5
noble	1	2	3	4	5
pathetic	1	2	3	4	5
shallow	1	2	3	4	5
strong	1	2	3	4	5
stupid	1	2	3	4	5
vengeful	1	2	3	4	5

Appendix L: Study Two – Adapted Literacy of Suicide Scale
– based on original LOSS by (Calear, Batterham, Christensen 2012)

This questionnaire consists of 14 statements. Please read each item carefully and circle the number that best reflects your agreement or disagreement with the statement.

Please remember to circle only one number for each statement.

Tick One				<i>T= True, F=False, ?=I don't know</i>
T	F	?	1	If you talk to a consumer about suicide, you may inadvertently give them permission to seriously consider it or put the idea in their head
T	F	?	2	Those who attempt suicide do so only to manipulate others and attract attention to themselves
T	F	?	3	Very few people have thoughts about suicide
T	F	?	4	Suicide is hereditary
T	F	?	5	A suicidal person will always be suicidal and entertain thoughts of suicide
T	F	?	6	Talking about suicide always increases the risk of suicide
T	F	?	7	Motives and causes of suicide are readily and easily established
T	F	?	8	Media coverage of suicide will inevitably encourage other people to attempt suicide
T	F	?	9	Most people who attempt suicide fail to kill themselves
T	F	?	10	A person who suicides is mentally ill
T	F	?	11	Most people who suicide are psychotic
T	F	?	12	People with relationship problems or financial problems have a higher risk of suicide
T	F	?	13	A person who has made a past suicide attempt is more likely to attempt suicide again than someone who has never attempted
T	F	?	14	Men are more likely to suicide than women
T	F	?	15	Maori have a higher risk of suicide than non-Maori
T	F	?	16	There is a strong relationship between alcoholism and suicide
T	F	?	17	Most people who suicide in New Zealand are older than 65
T	F	?	18	Not all people who attempt suicide plan their attempt in advance
T	F	?	19	People who talk about killing themselves rarely complete suicide
T	F	?	20	People who want to attempt suicide can change their mind quickly
T	F	?	21	Most people who suicide don't make future plans
T	F	?	22	Suicide rarely happens without warning
T	F	?	23	A time of high suicide risk in depression is at the time when the person begins to improve
T	F	?	24	Nothing can be done to stop people from making the attempt once they have made up their minds to kill themselves
T	F	?	25	Only experts can help people who want to suicide
T	F	?	26	Every death is preventable
T	F	?	27	Seeing a psychiatrist or psychologist can help prevent someone from suicide
T	F	?	28	If a person discloses privately to you that they are suicidal or planning to kill themselves then you should respect their decision and keep it confidential
T	F	?	29	Suicide is currently an offence in New Zealand and equal to committing a crime

Appendix M: Study Two – Generalized Self-Efficacy Scale (Schwarzer & Jerusalem, 1995).

1.	I can always manage to solve difficult problems if I try hard enough.	1 Not at all true	2 Hardly true	3 Moderately true	4 Exactly true
2.	If someone opposes me, I can find the means and ways to get what I want.	1 Not at all true	2 Hardly true	3 Moderately true	4 Exactly true
3.	It is easy for me to stick to my aims and accomplish my goals.	1 Not at all true	2 Hardly true	3 Moderately true	4 Exactly true
4.	I am confident that I could deal efficiently with unexpected events.	1 Not at all true	2 Hardly true	3 Moderately true	4 Exactly true
5.	Thanks to my resourcefulness, I know how to handle unforeseen situations.	1 Not at all true	2 Hardly true	3 Moderately true	4 Exactly true
6.	I can solve most problems if I invest the necessary effort.	1 Not at all true	2 Hardly true	3 Moderately true	4 Exactly true
7.	I can remain calm when facing difficulties because I can rely on my coping abilities.	1 Not at all true	2 Hardly true	3 Moderately true	4 Exactly true
8.	When I am confronted with a problem, I can usually find several solutions.	1 Not at all true	2 Hardly true	3 Moderately true	4 Exactly true
9.	If I am in trouble, I can usually think of a solution.	1 Not at all true	2 Hardly true	3 Moderately true	4 Exactly true
10.	I can usually handle whatever comes my way.	1 Not at all true	2 Hardly true	3 Moderately true	4 Exactly true

Appendix N: Study Two – Statistics with Separate Confidence Variables

Results of tests with confidence as separate variables (including Question 21 and 22). The following set of results displayed are in respect to tests performed on Question 21, in table's 15, X and X.

Table 15: Correlation Results for Question 21 (confidence in identifying warning signs) with Independent Variables

Independent Variable	Correlation Coefficient	95% CI	P value
Religiosity	$r(81) = .113$	$[-.092, .305]^a$	.310
Stigma Subscale	$r(88) = .085$	$[-.104, .259]^a$	.445
Glorification Subscale	$r(84) = -.174$	$[-.413, .063]$	.113
Isolation Subscale	$r(85) = -.149$	$[-.329, .060]$	.182
Adapted LOSS	$r(82) = -.447$	$[-.605, -.255]$	>.001
Self-Efficacy	$r(81) = -.226$	$[-.417, -.011]^b$	.042

^a Bootstrap 5,000, ^b Bootstrap 10,000

Table 16: Simple Linear Regression for Question 21 with Independent Variables

Independent Variable	β	SE	t	P value	R ²
Adapted LOSS	-.074	.017	-4.469	<.001	.200
Self-Efficacy	-.042	.020	-2.065	.042	.051

Table 17: T-test Results for Question 21 Comparing Between Those With and Without Basic Suicide Training

Independent Variable	d	95% CI	Test Statistic	P value
Basic Suicide Training	-0.725	$[-.455, .994,]$	$t(86) = 5.346$	>.001

Table 18: One way ANOVA for Question 21 Comparing Between General Education Groups

Independent Variable	Test Statistic	P value
Education	$F(3;81) = .285$	.836

Table 19: Multiple Regression for Question 21 with Independent Variables that were Significant from Table 16, 17 and 18

Variable	β	Std. Error	t	p Value	95.0% Confidence Interval for β	
					Lower Bound	Upper Bound
Basic Suicide Training	-.582	.137	-4.253	<.001	-.855	-.310
Adapted LOSS	-.050	.017	-2.876	.005	-.084	-.015
Self-Efficacy	-.035	.017	-2.029	.046	-.069	-.001

Total R-square = 0.342, Adjusted R-square = 0.317, $n = 80$, residual standard error = 0.585.

The following set of results displayed are in respect to tests performed on Question 22, in table's 21, 22 and 23.

Table 20: Correlation Results for Question 22 (confidence in asking about suicide) with Independent Variables

Independent Variable	Correlation Coefficient	95% CI	P value
Religiosity	$r(83) = .173$	$[-.044, .389]^a$	.113
Stigma Subscale	$r(86) = .159$	$[-.098, .394]^a$	.144
Glorification Subscale	$r(86) = -.096$	$[-.357, .151]$	.380
Isolation Subscale	$r(87) = -.129$	$[-.335, .107]$	.234
Adapted LOSS	$r(85) = -.452$	$[-.608, -.264]$	>.001
Self-Efficacy	$r(83) = -.326$	$[-.518, -.116]^b$	.003

^a Bootstrap 5,000, ^b Bootstrap 10,000

Table 21: Simple Linear Regression for Question 22 with Independent Variables

Independent Variable	β	SE	t	P value	R ²
Adapted LOSS	-.089	.019	-4.594	<.001	.205
Self-Efficacy	-.070	.023	-3.099	.003	.106

Table 22: T-test results for Question 22 Comparing Between Those With and Without Basic Suicide Training

Independent Variable	d	95% CI	Test Statistic	P value
Basic Suicide Training	-0.732	$[-.399, 1.066]$	$t(88) = 4.368$	>.001

Table 23: One way ANOVA for Question 22 Comparing Between Education Groups

Independent Variable	Test Statistic	P value
Education	$F(3;83) = .305$	.822

Table 24: Multiple regression for Question 22 with Independent Variables that were Significant from Table 21, 22 and 23

Variable	β	Std. Error	t	p Value	95.0% Confidence Interval for β	
					Lower Bound	Upper Bound
Basic Suicide Training	-.548	.160	-3.432	.001	-.866	-.230
Adapted LOSS	-.062	.020	-3.047	.003	-.102	-.021
Self-Efficacy	-.060	.020	-3.047	.003	-.100	-.021

Total R-square = 0.334, Adjusted R-square = 0.309, $n = 82$, residual standard error = .689

Appendix O: General Population Data for New Zealand's Support Workforce

Table 25: NZ Proportion of Ethnic Diversity in Mental Health, Addictions, and Disability Workforce

Support Staff Ethnicity	Within this study	Mental Health and Addiction Sector		Mental Health Sector		Disability Sector
Ethnicity	%(#) <i>n</i> = 99	Non-clinical FTE positions ¹	Care and support staff in DHB ²	Staff in NGO ¹	Staff in DHB ¹	Support Workers ³
NZ/European	55.56%(55)	-	-	-	-	-
NZ/Māori	16.16%(16)	24%	29%	27%	12.4%	18%
Pacific Peoples	9.09%(9)	7%	-	7.6%	2.8%	11%
Asian	8.08%(8)	6%	-	8.0%	3.7%	9%

¹ (Te Pou o te Whakaaro Nui, 2015), ² (Te Pou o te Whakaaro Nui, 2017), ³ (Te Pou o te Whakaaro Nui & NZDSN (New Zealand Disability Support Network), 2016)

Table 26: NZ Health Support Workforce Proportion of Age

Age	Within this study	Care and support staff in DHB ²	Support workers in the Disability sector ³
Over 50 years	35%	57%	-
Over 55 years	-	-	36%

² (Te Pou o te Whakaaro Nui, 2017; Te Pou o te Whakaaro Nui & NZDSN (New Zealand Disability Support Network), 2016)

Table 27: NZ Proportion of Gender in Mental Health, Addictions, and Disability Workforce

Gender	Within this study	Mental Health and Addiction Workforce Care and support staff in DHB ²	Support workers in the Disability sector ³	All employees in Mental Health and Addiction sector ²
Male	18%	-	25%	-
Female	81%	53%	75%	70%

² (Te Pou o te Whakaaro Nui, 2017; Te Pou o te Whakaaro Nui & NZDSN (New Zealand Disability Support Network), 2016)

NB. For care and support staff within the Mental Health and Addiction Workforce in DHB's it was reported their average years of service years was nine, and 20% had been employed for under 2 years. The turnover rate for this group was 10% (the lowest of all professional levels within the DHB). Nevertheless, the overall employee turnover in the sector overall was reported to be 12% and 11% within the DHB's (Te Pou o te Whakaaro Nui, 2017).

Appendix P: Consent form for Organisation



CONSENT FORM for ORGANISATION

Project Title: Suicide and Support Workers in Aotearoa/New Zealand:
Exploring factors that influence frontline mental health staff talking and
intervening with suicidal clients.

Name of Researcher: Ursula Bach

Supervisors: Professor Fred Seymour and Dr Gwenda Willis

School of Psychology
Human Sciences Building
Floor 6, 10 Symonds Street
Telephone 64 9 373 7599
Facsimile 64 9 373 7450
Private Bag 92019
Auckland, New Zealand
The University of Auckland
Private Bag 92019
Auckland, New Zealand

I have read the Participant Information Sheet, understood the nature of the research and why this organisation has been invited to assist in providing permission to access employees as participants. I have had the opportunity to ask questions and had them answered to my satisfaction. I understand that as the Chief Executive Officer of this Non-Government Organisation granting permission to access employees is voluntary.

- I agree to give permission for the researcher to access the employees of this company via email and poster display.
- I understand what is required of the employees in participating in the study and the resources available to them for participating in the online questionnaire and the interview.
- Findings will be published as part of the researcher's Doctorate in Clinical Psychology thesis and may be published in an international or domestic journal and presented at conferences. I understand that the identity of the organisation which I work for will not be identified in any published studies by the researcher where the organisation's name is paired with specific results, or any findings that reflect negatively on the organisation.
- I accept that the name of the organisation may be denoted in a list of participating organisation for publication.
- I understand that the online questionnaire is anonymous and information gathered from employees via this method will not be known or paired with any particular organisation.
- I understand that employees may choose to be involved in an interview with the researcher at a time convenient to the employee. The interview will take place either at the participant's home or at the University of Auckland premises.
- I agree / do not agree - to supply the researcher with information and documentation regarding the core training or qualifications required or dispensed for the role of a Mental Health Support Worker Staff for my organisation. This information may be analysed by the researcher to compare with other Non-Government Organisations in a confidential manner. Copy right and acknowledgements of these programs will be respected in possible publishing of finding relating to comparisons of training methods/programs. *[Please indicate one]*
- I understand that as an organisation we will not have access to any raw data from the study.
- I would / would not like to receive a copy of findings. *[Please indicate one]*
- I understand that I am welcome to contact the researcher for an update on the research at any time.
- I understand that this form will be kept securely and separately from data, recordings or transcripts, for a period of 6 years after publication, at which time will be deleted and destroyed.
- I understand and can assure that the participation or non-participation in this research of any employee within this organisation will not impact on their employment.

Name of Organisation

Address of Organisation: -

Designation (if not Chief Executive Officer):

Name:

Contact details (email and Phone):

Signature

Date

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE
For 3 years. Reference Number O13410

Appendix Q: Participant Information Sheet for Organisations

PARTICIPANT INFORMATION SHEET – For Organisations



Te Whare Wānanga o Tāmaki Makaurau

Department of Psychology
10 Symonds Street, rm 660
Private Bag 92019
Auckland

Project Title: Suicide and Support Workers in Aotearoa/New Zealand: Exploring factors that influence frontline mental health staff talking and intervening with suicidal clients

Name of Researcher: **Ursula Bach**

Dear Potential Interested Organisation,

My name is Ursula Bach. I am a doctoral student of the University Of Auckland Department Of Psychology conducting research on Mental Health Support Workers and their attitudes, skills, and beliefs around suicide and suicide intervention.

Your organisation and your employees are invited to participate in a study regarding attitudes around asking and talking about suicide. Some mental health support workers or mental health volunteers have a varied type and amount of training. Some training may or may not involve learning ways to ask and deal with suicidal clients. Training may not be the only factor that effects whether or not staff feel comfortable asking and talking to clients about suicide. Other factors may be: beliefs, skills, attitudes, personal self-efficacy, the organisation we work in, and the society we live in.

Purpose: The aim of this project is to understand how these factors, for mental health workers, influence confidence in asking and talking about suicide with people and what factors in particular promote effective suicide monitoring and interventions for mental health clients.

Who can participate? I am asking individuals who work in New Zealand, and who are currently considered frontline mental health staff (e.g. mental health support workers, mental health community workers, mental health volunteers, or Youth Workers etc) but are not considered health professionals (e.g. nurses, psychologists, psychiatrists, or social workers) - to participate in an online questionnaire. After completing the online questionnaire participants will be asked if they would like to also participate in a one-to-one interview with the researcher to gather richer data on attitudes of suicide within this field of work.

What will participation involve? The online questionnaire can be accessed via the internet and completed at any time between January 2015 and June 2015. The questionnaire should take less than 30 minutes. The questions being asked will help to answer the research question. I will also ask for some demographic information (e.g., age, ethnicity, gender, education level etc).

Participants are under no obligation to participate. Participation by your employees is **voluntary** and they are made aware of this and that they can withdraw at any time. To compensate for time spent, participants can choose to go into a draw to win one of four \$50 vouchers by leaving a contact phone number, which will not be paired with their details and only used if they win the draw. All information collected via the online questionnaire will remain **anonymous**. That is, identifying information will not be associated with published results or known to the researcher, or the organisation they work for. Survey Monkey is the questionnaire

platform used and has a privacy and security policy which is available to view on the website above also. Participants are made aware that involvement in this study will **not** affect their employment and that the study is independent to their place of work and run by the University of Auckland.

Anonymous research data will be held in secure storage on university premises for a period of 6 years after publication. After such time all data will be shredded or deleted. Participants cannot withdraw their information once it has been submitted online, but can withdraw or edit their information up to one month after participating in an interview.

If they decide to participate in a one-to-one interview, this will take between 30 minutes to an hour of their time, and the meeting will be taken place either in their home or at the University of Auckland premises.

Interviews will be audio recorded and transcribed for analysis. The researcher will analyse transcripts from multiple participants to identify common themes. Interviews will be recorded for thematic analysis only by those who agree to being recorded. This recording will be the property of the researcher who will analysis the themes of your discussion. Confidentiality of participant's identity will be maintained and respected throughout this process. Participant's identities who participate in the interview will not be made available to the organisation by the researcher.

The interview will be guided by a series of 12 questions about attitudes towards suicide. Recordings will be confidential and kept on an external hard-drive, in a locked cabinet on the University of Auckland premises. A transcriber (other than the researcher - Ursula) may be hired to transcribe the content of the interview for use as data for the research, but this transcriber will sign a confidentiality agreement which will restrict them from disclosing any of the content of the recording. Recordings and transcripts will be deleted 6 years after publication. During which time any information and data will be held in security at the University of Auckland.

As part of the initial consultation process of the study, the researcher would like to access information and documentation regarding the core training or qualifications required or dispensed for the role of a Mental Health Support Worker Staff for your organisation. This information may be analysed by the researcher to compare with other Non-Government Organisations in a confidential manner. This information will give the researcher awareness of what kind of training is currently disseminated to or required from Mental Health Support Workers currently within the sector and how much this differs between organisations. This may be in the form of contracted training programs, internet based training programs, individual internalised programs etc. Copy right and acknowledgements of these programs will be respected in possible publishing of finding relating to comparisons of training methods/programs.

Are there any risks to participating? Due to the sensitive topic area of the study, associated risks with participating in the interview may include bringing up unpleasant feeling or thoughts, particularly if staff have been significantly affected by suicide in the past. Please note following completion of the interview a list of resources will be made available to all participants.

What are the benefits to participating? I hope that sharing the results of this study will benefit the community. Understanding attitudes, needs, and strengths of Mental Health Frontline Staff will hopefully guide organisations and the mental health sector towards better training, practice, and policy for suicide intervention and hopefully less suicides.

As an organisation that is willing to assist in the study, it is estimated that employees of that organisation will appreciate being given the opportunity to be heard in this way. Promoting participation in this study by granting access to employees may reflect well onto the organisation by employees. The researcher will be available to present the finding or to collate a report of recommendation which reflect on the overall findings to the organisation if it is requested. Findings from this research may be published

online and in academic journal articles and conferences. If you wish to have a summary of findings, please contact the researcher (Ursula Bach: ubac001@auckland.ac.nz).

Confidentiality: Only the researcher will see individual survey responses, which will be stored electronically in a password protected folder. Those who participate in an interview will have their confidentiality maintained throughout this process. Please be assured that whether or not employees choose to participate in the study, that this will not impact of their employment within your organisation.

If you wish to participate in the study by allowing access to employees please contact the researcher (Ursula Bach) with any questions you may have, and fill out the Consent Form available on the website (www.suicidesupportworkers.wix.com/participate) or given to you by the researcher. Thank you for your time and help in making this study possible. If you have questions or would like to discuss participation, please contact me at the email address below:

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For any queries regarding ethical concerns you may contact the Chair of the University of Auckland Human Participants Ethics Committee, The University of Auckland, Office of the Vice Chancellor, Private Bag 92019, Auckland 1142. Telephone 373-7599 extn. 83711

**APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE
 For 3 years. Reference Number O13410**