



Suicide prevention education within youth work higher education: Negotiating presence and procedure

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Résumé de l'article

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SUICIDE PREVENTION EDUCATION WITHIN YOUTH WORK HIGHER EDUCATION: NEGOTIATING PRESENCE AND PROCEDURE

Patti Ranahan

Abstract: Child and youth care practitioners are likely to encounter issues of suicidality. Practitioners play an important role in the well-being of youth; thus, mental health literacy, and suicide prevention education in particular, should be an integral part of child and youth care pedagogy and curricular practices in higher education programs. With the aim of explicating a social process of learning and applying mental health literacy, this grounded theory study examined how a curriculum specifically designed for child and youth care practitioners is subsequently applied in suicide or mental health interventions. Thirteen students enrolled in youth work courses at a large university in Eastern Canada participated in the 18-month study in 2015 and 2016. Informed by critical and social literacy theories, conceptualizations of mental health literacy, and experiential pedagogy within higher education, analysis of the data identified a process of becoming and being in youth work comprising two subcategories: struggling to become a youth worker, and being a youth worker. Conditions, such as particular pedagogical strategies and specific content, served to shape and influence the process and, consequently, participants' movement therein. The inclusion of a suicide intervention learning activity was a condition that influenced participants' learning processes, yet also reflected a struggle with the dialectical position of presence and procedure. Recommendations and insights are discussed with the aim of enhancing pedagogical approaches to suicide intervention within child and youth care higher education programs.

Keywords: child and youth care, youth work, suicide prevention, mental health literacy, higher education

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*“Experiential understandings adds flesh and life to the bones
so often polished smooth and white by analytical thought.”*

(Jickling, 2009, p. 168)

Child and youth care¹ practitioners are likely to encounter issues of suicidality as part of their relational practice with young people, their families, and their communities (Ranahan, 2010). Suicide is a leading cause of death for young people worldwide (World Health Organization, 2019). Previous research findings suggest that child and youth care practitioners may resort to rote problem-solving responses when faced with youth contemplating ending their lives (Cartmill et al., 2009). Indeed, suicide intervention can be experienced as stressful and challenging, especially for early-career youth workers (Ranahan & Pellissier, 2015). Child and youth care practitioners play an important role in the well-being of youth; thus, mental health literacy, and suicide prevention education in particular, should be an integral part of child and youth care pedagogy in higher education programs.

In this qualitative grounded theory study, I examined how a mental health literacy curriculum, specifically designed for child and youth care practitioners, was implemented in the classroom context and subsequently applied in interventions with young people impacted by suicidality or mental health concerns. The study involved three groups of youth work students ($N = 13$) enrolled in preservice graduate and undergraduate programs between September 2015 and December 2016. In this paper I focus specifically on the inclusion of a suicide intervention learning activity as a condition that was influential on participants’ learning processes. To situate the discussion, I begin with a brief overview of suicide intervention education within higher education settings. Next, I discuss key features of critical and social literacy theories, conceptualizations of mental health literacy, and experiential education in child and youth care higher education settings, which served as sensitizing concepts. Following this, I outline the research method and present the research findings. I conclude with insights on and recommendations toward enhancing suicide intervention teaching and learning within child and youth care higher education programs.

Suicide Prevention Education

As a topic with limited traction in higher education professional programs, often included based on faculty interest or by guest lecture, teaching and learning about suicide and suicide intervention can be challenging to implement and locate. There is a dearth of research examining the uptake of structured suicide prevention education within child and youth care higher education programs, or how the topic of suicide is addressed with students in informal ways. A previous literature review looked to allied helping professional programs, such as social work or nursing, as a method of identifying a level of engagement with the topic of suicide within higher education (Ranahan, 2013). This literature review concluded that the need remains for overt

¹ The terms “child and youth care” and “youth work” are used interchangeably throughout this article.

inclusion of suicide content within child and youth care programs and future examination of how pedagogical approaches are linked to subsequent practical actions in suicide prevention. Given the absence of research specific to child and youth care, locating the presence of, and approach to, suicide prevention education within higher education holds relevance.

While some research points to the ongoing absence of suicide prevention education within higher education course content within the helping professional disciplines (see, e.g., Wachter Morris & Barrio Minton, 2012), some recent consideration of suicide prevention education within social work programs has occurred. Different pedagogical and curricular approaches have been used, including implementing brief standardized programs in gatekeeper training such as Question, Persuade, Refer (QPR; Quinnett, 2007), or offering a course on suicide as part of an academic program. Social work students who completed QPR identified an increase in confidence and knowledge, and reported using acquired skills (e.g., asking directly about suicide) during field placements after completing training (Sharpe et al., 2014). Beyond the implementation of brief gatekeeper training programs, Almeida and colleagues (2017) designed a comprehensive full-semester course on suicide that took up topics such as the epidemiology of suicide, risk factors, public health approaches, and conducting risk assessments. In post-test assessments, a correlation was identified between increased suicide-related knowledge and social work students feeling confident and prepared to intervene.

While increased knowledge and confidence may be immediate outcomes of suicide prevention education, research findings also illustrate the complexities of applying these outcomes in local contexts in a practical way. A consideration of contexts moves beyond an individualized focus on suicide as located within persons to include the social, political, organizational, and cultural contexts, including structural inequalities and broader social dimensions of health and well-being (see White, 2017 for discussion). To illustrate, McConnellogue and Storey (2017) identified the systemic challenges teachers experienced that undermined their self-efficacy. Inadequate referral pathways to mental health care, lack of interprofessional communication, and parents' dismissiveness were barriers experienced by teachers as they tried to apply suicide intervention skills within a school setting. The authors suggested that existing standardized gatekeeper training programs are designed as "universal" approaches and not tailored to specific contexts, potentially impeding responses to young people who are suicidal (p. 180). Complexities of context in applying intervention skills acquired through suicide prevention training were noted by Evans and Price (2013) as well: organizational policies impeded practitioners' responses and, over time, practitioners' confidence waned.

Given the apparent misguided sole focus in suicide prevention education on participants' knowledge and confidence outcomes, pedagogical approaches and content must appreciate the importance of context, moving context from the background to the foreground, as Hawe and colleagues (2009) suggested. Proposed strategies offered by Ranahan and White (2016) may

enhance current suicide prevention pedagogical approaches by inviting a greater appreciation for the complexities of contexts:

(1) recognizing literacies in mental health are contextually located in the youth–youth worker interaction; (2) integrating culturally responsive features that invite diverse meanings of suicidality and its origins; (3) repositioning expert educators as co-learners through a relational pedagogical approach; and (4) enhancing youth workers’ awareness, reflexivity, and presence through teaching and experiencing mindfulness exercises in the classroom. (pp. 187–188)

Critically, investigations are needed into how these and other such strategies are employed within child and youth care higher education, how specific pedagogical approaches may enhance practitioners’ responses and, more importantly, whether young people experience suicide intervention in new, relational ways that work to instil hope and promote life. This study begins to address this need.

Sensitizing Concepts

Sensitizing concepts are concepts that provide an initial focus on and sensitivity to the topic at hand (Blumer, 1954; Charmaz, 2006; Holloway, 1997), and “identify theoretically relevant phenomena” when analyzing the data (Kelle, 2007, p. 207). Critical and social literacy theories, conceptualizations of mental health literacy, and experiential pedagogy within higher education provided a focus for exploring how emerging youth work practitioners learned and subsequently applied mental health literacies in practice.

Critical and Social Literacy Theories

Critical and social literacy theorists have moved beyond the notion of literacy as a fixed set of skills and acquired knowledge located within individuals whereby they are deemed either literate or illiterate. Menezes de Souza (2007) described literacy as “a socio-culturally situated practice involving the ongoing negotiation of meaning in continuously contested sites of meaning construction” (p. 4). As a situated and socially constructed practice, Freire and Macedo (1987) suggested analysis of literacy must occur “within the context of a theory of power relations and an understanding of social and cultural reproduction and production” (p. 142). Critical literacy theory emphasizes a process of empowerment that redefines teachers as collaborators instead of transmitters of knowledge (Gee, 2007; McDaniel, 2004). Knowledge, then, is co-created as a “relational act” (Giroux, 1987, p. 15) requiring self-awareness and critical examination of one’s sociocultural location (Shannon, 1995). Developing awareness includes exploring how language constructs meaning (Street, 1995). For example, questioning current mental health language (e.g., health, disorder, illness, treatment) can lead to new terms (e.g., wellness, community, culture, confidence, control), and alternate meanings may be communicated (Stewart et al., 2008).

With respect to pedagogy, critical literacy theorists suggest teaching and learning are focused on transforming thinking, not technical skills (McDaniel, 2004). Through critical reflection, assumptions are examined and new opportunities for social action to address inequities, promote justice, and challenge the status quo emerge (Shor, 1999). Further, social literacy theorists pluralize literacy, suggesting that multiple literacies are required to negotiate variable and diverse contexts (Gee, 2007; Ivanič, 2009). This feature shifts pedagogical approaches away from teaching a universal skill set or list of competencies toward “the complexity of meaning making” by persons embedded in particular contexts influenced by power relations, identities, or cultural practices (Street, 2009, p. 26). Critical and social literacy theories enhance understanding of how mental health literacy is relationally and contextually produced and influenced by the processes of empowerment, self-awareness and critical reflection, transformation, and social action (Ranahan, 2015).

Mental Health Literacy

Originally proposed by Jorm and colleagues (1997), mental health literacy encompasses knowledge and beliefs about mental disorders, risk factors and causes, prognosis, available treatments, and attitudes toward help-seeking (p. 182). The Canadian Alliance on Mental Illness and Mental Health (2007) extended this definition, emphasizing “the recognition, management and prevention of mental health problems” (p. 7). Current conceptualizations maintain an individualized emphasis on knowledge, beliefs, and attitudes; yet some have turned toward acknowledging the complexities of applying such literacy in context. For example, Kutcher and colleagues (2016) moved away from a sole focus on individuals’ literacy and suggested that mental health literacy be “context specific” and “integrated into existing social and organizational structures” (p. 155). Mental health literacy is a relevant concept for the field of child and youth care given our close proximity to young people who may be considering suicide, or suffering from other mental health concerns (Ranahan, 2010). Further, child and youth care practice has evolved to make interprofessional collaboration and participation on multidisciplinary teams increasingly commonplace (Gharabaghi & Charles, 2019). “Professional ‘ownership’ of mental health care competencies” no longer holds true, as practice shifts toward integrating mental health care into general health services (Kutcher et al., 2009, p. 315).

Experiential Education

While there are divisions and tensions among educators in child and youth care as to what should be prominent in education (for current debates see Mann-Feder et al., 2017), experiential learning via students’ active participation guided by professors as facilitators and mentors remains a common feature of child and youth care higher education programs (Emslie, 2009a). As Hillman (2018) aptly noted in his reflection after a child and youth care preconference Educators’ Day, “Long gone are the days of education as strictly knowledge acquisition” (p. 62). The classroom itself is viewed as a “therapeutic milieu” where pedagogical approaches are used to promote critical reflection and self-awareness (Browne et al., 2016, p. 143). The emphasis is placed on becoming and being a youth worker and the development of students’ professional

identity towards this end, rather than on demonstrating preestablished competencies (Emslie, 2009a; Ross, 2014). Indeed, Ross (2014) suggested that the child and youth care teaching and learning environment is created for students to “learn what it means to ‘be’ a youth worker and not just learn about youth work” (p. 958). Nurturing students’ movement into the profession is a dynamic and interactional process. Conditions for effective child and youth care education include “a safe and structured learning environment, embodied participatory learning activities and attention to self-awareness, and a commitment by students to an emergent learning process as it occurs over time” (Ranahan et al., 2012, p. 13). As such, teaching in schools of child and youth care requires instructors to demonstrate congruence with the relational and strength-based principles of the profession (Ward, 2013).

As a former student embedded within child and youth care programs at Malaspina University-College (now Vancouver Island University) and the University of Victoria, and as an educator with over 12 years of teaching in child and youth care programs, I entered the present study sensitized to experiential pedagogy and curricular practices. Further, critical and social literacy theories provided the foundation of my doctoral work and subsequent engagement over the past several years in mental health literacy research. Woven together, these concepts provided “points of departure” for the development of a mental health literacy curriculum for child and youth care, and for subsequently examining its implementation and application to practice during the grounded theory study (Charmaz, 2006, p. 17).

Method

In this section, I describe the development of a mental health literacy curriculum for child and youth care students, the use of grounded theory method, participant recruitment and data collection methods, and the analytical process.

Curriculum Development

A comprehensive explanation of the mental health literacy curriculum and the specific suicide intervention experiential learning activity employed in the study is provided elsewhere (see Mann-Feder et al., in press; Ranahan & Alsaieq, 2018). In sum, beginning in 2012, in partnership with child and adolescent psychiatrist, Stan Kutcher (Dalhousie University), I developed a mental health literacy curriculum to address a perceived gap in mental health education within child and youth care higher education. Notably, some schools of child and youth care have included required course work in mental health for some time. Yet the uptake of mental health content, and more specifically, of pedagogical approaches of teaching and learning about mental health within child and youth care programs, has been studied relatively little. Thus we aimed in the development of the curriculum to provide a foundational point for examining dominant content knowledge (e.g., presentations of mental health issues) with the complexities of context (e.g., power relations in interprofessional collaborations, Indigenous perspectives on

wellness, professional identity development). Suicide intervention is incorporated into the curriculum in both content (prevalence of suicidality, cultural continuity, components of intervention conversations) and experiential learning (group and dyad simulation exercises, critical reflection activities). For example, as described in Mann-Feder et al. (in press), students have an opportunity to engage in a tag-team role play with the whole class. This tag-team role play is used as a chance for the instructor to coach and mentor students through a simulated suicide intervention. At the outset, one student volunteers to act as a young person contemplating suicide, and their classmates are positioned as youth workers engaging in an intervention. Individually, each “youth worker” converses with the youth, while having the option to ask for guidance from classmates observing the conversation, or “tag” another student into the role-play to continue where they left off. Following this group simulation exercise, students engage in a dyad simulation outside of class in which one student portrays a youth thinking of suicide, and the other student is situated as a youth worker. This dyad simulation is video-recorded and the student provides a written critique on their experience of supporting the youth as a youth worker (see Mann-Feder et al., in press).

A key pedagogical aim in facilitating learning about suicide intervention is developing students’ appreciation for and comfort with uncertainty. As Ross (2014) suggested, youth work pedagogy should facilitate the development of “intangible skill[s] of how to appraise and respond to complex problems of practice” (p. 959). Given that suicide is a “wild problem” (White, 2012, p. 42), certainty should be resisted and complexity welcomed. Congruent with Ranahan and White’s (2016) recommendations, learning exercises incorporated into the curriculum were designed to enhance reflexivity through mindfulness exercises, oral and written reflections, the suicide intervention simulation group and dyad exercises, and generating creative products (visual body maps, explorations of beliefs and myths about mental health, etc.).

Grounded Theory Methodology

Grounded theory is both method and methodology: the procedural rules provided initially by Glaser and Strauss (1967), the founders of the approach, outlined a systematic way — a method — of accomplishing a research project, as well as a methodology with an underlying philosophy of how knowledge is constructed (i.e., pragmatism, symbolic interactionism). Interpreting actions is central to symbolic interaction (Blumer, 1969), and pragmatism is focused on action as the central unit of analysis (Star, 2007). Thus the method is highly suitable for investigating “individual processes, interpersonal relations and the reciprocal effects between individuals and larger social processes” (Charmaz, 1995, pp. 28–29). The aim, then, of grounded theory is to explicate a social process, a phenomenon, including identifying the various conditions that influence how the process unfolds, and the consequences that arise (Corbin & Strauss, 1990). Key features of grounded theory method include “(a) simultaneous collection and analysis of data, (b) a two-step data coding process, (c) comparative methods, (d) memo writing aimed at the construction of conceptual analyses, (e) sampling to refine the researcher’s emerging theoretical ideas, and (f) integration of the theoretical framework” (Charmaz, 2000, pp. 510–511). Grounded

theory method was highly suitable for the present study given that the objective of the study was to explicate the process of learning and applying mental health literacy in variable youth work practice contexts.

Participants and Data Collection

Recruitment commenced after ethical approval from Concordia University's Human Research Ethics Committee was received in July 2015. Between September 2015 and December 2016, 13 volunteers ($N = 13$, of 47 eligible) were recruited to participate during the 18-month study. The participants were involved in graduate and undergraduate higher education programs and engaged in youth work internships. Twelve identified as female, and one as male; all were between 24 and 48 years of age.

Participants were divided into three groups, two of which ($n = 10$) comprised graduate students enrolled in a 12-month youth work program who were registered in a course entitled *Mental Health and Addictions: Youth Work Perspectives, Policies and Practices*, which was offered during the Winter terms in the 2015–2016 and 2016–2017 academic years. Suicide intervention was a topic included in the content and learning activities of this graduate course. Inclusion criteria additionally required graduate students to be enrolled in an internship course structured as a capstone course in the summer term. Depending on student preference and need, the graduate internship course spanned between 320 and 420 hours. The remaining group was comprised of undergraduate students ($n = 3$) enrolled in a baccalaureate program in Human Relations, and taking a 360-hour internship course entitled *Internship in Youth and Family Work*. In addition to regular seminar meetings and completion of internship hours, students were offered a series of three 3-hour workshops on mental health topics (youth work and mental health care, depression and anxiety, and suicide intervention) derived from the curriculum. Participation in the workshops was completely voluntary and not associated with course grade. As I was the instructor of the courses and workshops, participants who volunteered for the study remained confidential and anonymous until after grades were posted at the end of each term. Research assistants thus facilitated the recruitment, consent process, and initial data collection for each group of students.

Data were comprised of individual audio-recorded interviews, participants' written reflections and creative artifacts, and the researchers' observations and reflexive memos. Over 60 pieces of data were collected during the 18-month study. For example, individual interviews were conducted with graduate student participants on two occasions: first, prior to engagement in the *Mental Health and Addictions: Youth Work Perspectives, Policies and Practices* course; and second, within 3 months of completing the course. Creative artifacts generated during the workshops with the undergraduate participants were gathered immediately following each workshop.

Data Analysis

Data analysis ran concurrent to data collection in order to pursue questions that emerged, adapting to new situations, events, and participants (Charmaz, 2005; Morse, 2009). Analysis began with line-by-line coding of transcripts, texts, and artifacts, followed by focused coding using the track changes feature in Microsoft Word. Through the constant comparison method, a codebook was developed that grouped and collapsed codes into delineated categories (Corbin & Strauss, 2008). Comparisons were made to delineate similarities and differences, while pinpointing influencing conditions (Charmaz, 2005; Corbin & Strauss, 2008). As noted previously, in the present paper I offer an in-depth look at the suicide intervention content and requisite learning activities as a central condition that influenced students' learning.

Results

Treating mental health literacy enhancement and application as a social process, and not merely knowledge acquisition, provided an opportunity to examine contextual elements at play in the learning process. Analysis of the data identified two subcategories in the learning process: struggling to become a youth worker, and being a youth worker (Ranahan, 2018; Ranahan & Alasaiq, 2018). Struggling to become a youth worker involved a process of self-examination (interrogating self), moving between valuing and devaluing youth work as a profession, and making peace with not knowing. Features of being a youth worker included attunement, collaboration, reflexivity, and embracing societal challenges. Conditions, such as specific curricular practices and specific content, served to shape and influence the becoming and being process and, consequently, participants' movement therein. The inclusion of a suicide intervention learning activity was a condition identified by several participants as significantly influencing their learning process; however, they struggled with the dialectical positioning of presence and procedure. Presence can be defined as relational and physical proximity in moment-by-moment youth worker–youth interactions (Ranahan, 2017), whereas procedure refers to following predetermined or standardized responses to a young person who has expressed thoughts of suicide (Ranahan, 2016). This struggle was amplified for some participants once they were engaged in child and youth care practice contexts, where suicidality is frequently negotiated in terms of risk and responsibility and adherence to organizational protocols. In the following section, I utilize participants' quotes to illustrate the suicide intervention activity as an influencing condition, and depict the struggle of presence and procedure. Gender-neutral pseudonyms and pronouns are used to maintain participants' confidentiality.

Suicide Intervention Learning Activity as Influencing Condition

Structure is important in shaping social processes (Dey, 1999). The suicide intervention learning activity was an integral component of the mental health literacy curriculum and one of the structural elements that fostered the unfolding of the process of becoming and being a youth worker. Chalmers (2014) identified that “structures and processes are interwoven, essentially embedded within and constitutive of each other” (p. 93). Structure came in the form of

substantial time dedicated towards facilitating large group discussions, engaging in group and dyad simulations, individual readings, and individual written reflections on suicide and suicide intervention in the context of child and youth care relationships. Several students remarked on the importance of the suicide intervention learning activity. For example, Jordan stated, “The suicide intervention video exercise was probably the most significant experience for me in this class.” Morgan identified, “What stood out to me the most was the suicide intervention.” Hayden noted, “The assignment on the topic of suicide was very enlightening.” Further, Taylor indicated an absence of the topic of suicide and suicide intervention in their prior course work: “Surprisingly, I realized that not once have I had the opportunity to address this prevalent social issue [suicide] during my [previous] psychology bachelor.” With content and learning activities focusing on suicide prevention quite limited in higher education, and practitioners often left to gain “downstream” knowledge once actively working in the field (Oordt et al., 2009, p. 22), participants regarded this suicide intervention learning experience as important to enhancing mental health literacy.

Presence

In child and youth care literature, presence is often defined as “being there” (Krueger, 1994), attuned to the youth–youth worker interaction, where self meets self (Fewster, 2002). Krueger (2007) suggested that practitioners attempt to hold the relational space with a particular confidence that conveys to the young person commitment and persistence. They can do this, in part,

by [communicating] the underlying message: we can move forward together, you and I. I am confident based on my experience and knowledge of your needs that we can make it. You are safe, because I am here and will go with you. I will try to know myself if you will try to know yourself. (para. 20)

Seemingly accustomed to the *banking* model of acquiring knowledge (Freire, 1970/2005), student participants struggled with the ability to feel confident and certain during the suicide intervention learning activity. The banking model of education suggests that, once educated (i.e., content knowledge has been delivered/deposited), a student is competent and holds the knowledge required. Yet, in regard to suicidality, certainty was not gained and confidence was not found even after participants engaged in simulations or child and youth care practice in their internships. Hayden noted, “I had a hard time just asking them, like, ‘Are you suicidal?’ ” Taylor noted uncertainty and a lack of confidence: “I very much lack confidence because I feel like it’s so new, I just don’t want to do something wrong.”

As participants engaged experientially in suicide intervention simulations and in practice contexts, several reported difficulties in staying present in these interactions. During the video-recorded simulation completed as part of the graduate course, Taylor stated they were “speechless at one time” and “stumbling on my words because I didn’t know what to say”. The

suicide intervention simulation also left one participant, Raleigh, acutely aware of a “knowledge gap” and feeling less comfortable:

I found it difficult to do this intervention and I would have like more coaching. I feel I have only touched the surface of suicide intervention and I feel even less comfortable than before because I am aware that this is a gap I have. For a long time, I thought I wanted to do crisis intervention [work]. But doing the video made me realize how much being put on the spot in such a dramatic context may not suit me.

This uncertainty was also evident for another participant when working in their internship setting a few months after the course completed. Morgan described feeling “unsure of what I was doing” when speaking with a youth in a residential centre who disclosed suicide ideation. After navigating the interaction with the youth, Morgan attempted to convey their concerns to fellow staff members. Unfortunately, these concerns were dismissed, leaving Morgan feeling discouraged: “Yeah, it’s pretty tough especially when you feel like you’re kind of powerless, ’cause I’m not exactly in a position to make certain decisions or calls.”

Other participants spoke of this unmet expectation of confidence and certainty as a need for more knowledge:

- I feel like I still have a lot to learn in this area, like suicide intervention. (Taylor)
- I realized that I need more knowledge on suicide intervention ... because I was still left like unsure of what I was doing. (Morgan)

Knowledge about suicide was assumed to be quantifiable: youth work students believed that banking more knowledge would ultimately provide certainty in navigating suicide interventions.

Other participants reflected on the need to stay present with the young person, notwithstanding feeling discomfort. Morgan identified a need to be responsive to what unfolds in the moment: “It is a dance, so sometimes it’s going very well and sometimes you kind of stop and you need to re-evaluate what’s going on and adapt to the person and what they’re going through.” Sidney identified the importance of listening, trying to understand the youth’s experience while staying engaged and aware of one’s motivations:

One of the basic components involves listening. When we’re confronted with someone who is thinking about suicide, so often we want to jump in, save them, and tell them all the reasons why their life is worth living. But we need to take a step back.

Staying attuned to the moment-by-moment interaction, managing discomfort, adapting to what unfolds, and listening to try to understand the young person’s experience were mechanisms

identified by child and youth care students that supported their ability to remain present during suicide interventions.

Procedure

Suicide intervention is often thought of as separate from other engagements with young people — as a structured process with a specific protocol or list of questions designed to assess the level of risk for suicide, which is linked to action (Ranahan, 2016). This procedural response often stands in contrast to the attuned and responsive presence participants aspire to hold, which was integral to their prior course work in child and youth care. This contrast is evident in the first interview with Tobin in which they shared a story of responding to a young person who expressed thoughts of suicide while residing at a shelter:

And I said, ‘Your two choices, unfortunately, two choices are either you go to the hospital and then you come back, or you leave the center because we can’t keep you here.’ And oh my god, I fought with all the other workers because I didn’t want him to leave. Because what would that mean if he left? This is the only place that he has connection! Like, this is the only place he was able to stabilize himself and he has severe social anxiety.

Tobin’s encounter depicts the struggle of following a procedure (referring the youth to the hospital) and still being relationally responsive (attuned to the youth’s needs). Tobin explained further that should the youth not go to the hospital, they would be discharged from the facility, as suicide was not the “responsibility” of the organization.

Employing a protocol may be a way of mitigating the practitioners’ discomfort with suicide and uncertainty. Linden explained:

Many people have been impacted by suicide in some way in their lives, and this experience is not often acknowledged. Instead we tend to distance ourselves from the personal impact of it and discuss it in a very clinical way.

In the context of suicide intervention, presence and procedure seemingly unfold as conflicting and divergent approaches, emerging as a dialectical space requiring reconciliation. Kingsley described this dialectical space and the struggle to remain responsive in their reflective paper:

I experienced a struggle between adhering to protocol while remaining flexible. To be sure, it matters that youth workers carry out their duties according to protocol, but it is likewise prudent that they do so while remaining inquisitive about the client.

Holding presence and procedure simultaneously was also described by Clarke: “Competent intervention is not merely a matter of ticking off boxes, and practitioners should be ever vigilant for signs that their approach is falling short of its mark.” There is no reconciliation of these

apparent opposing forces identified by Kingsley and Clarke. Rather, both suggested that it is essential to maintain a judicious awareness of when one is favouring procedure over responsiveness.

Learning to hold this dialectical space was fostered, in part, in two ways: first, engaging in a tag role-play during class; and, second, positioning mental health content in connection with child and youth care principles as defined by Ranahan and colleagues (2015). These principles include collaborative relationships, a developmental perspective, a rights-based approach, an ecosystemic perspective, and reflexivity and ethics. In reference to the tag role-play, Morgan suggested this learning experience was beneficial in appreciating the diversity of responses: “Through the in-class exercise of role playing a suicide intervention, this allowed me to learn from my peers and see how each approach is different. This made me realize there is no ‘one size fits all’ approach.”

In addition, as the mental health content was integrated with principles of youth work throughout the curriculum, it held an emphasis on strengths as opposed to pathology (Ranahan et al., 2015). During the course, participants’ responses and responsiveness to young people shifted to seeing them as persons, not disorders. Tobin explained: “Seeing it from a youth work perspective that was a little different ... it’s reminding myself that I have to remember that I’m working with an individual despite their mental health.” This quote from Tobin is illustrative of the larger process of becoming and being a youth worker, in which integration into the child and youth care profession is transformative (Ranahan, 2018; Ranahan & Alsaieq, 2018). Young people and issues they face are reconfigured as students begin to integrate child and youth care perspectives, such as an emphasis on strengths and collaborative relationships (Ranahan et al., 2015). In the next section, I discuss how this negotiation of presence and procedure identified by participants in the present study holds implications for suicide prevention education and pedagogical strategies in child and youth care higher education.

Discussion and Implications

White (2012) posited that youth suicide is “an unstable, historically contingent, and unruly problem [which] cannot be solved, nor contained through an exclusive reliance on pre-determined, universal or standardized interventions” (p. 42). As such, learning experiences in child and youth care higher education that parallel the complexities encountered in practice and safe learning spaces are needed for students to question, take risks, share beliefs, express vulnerabilities, and accept others’ feedback and perspectives (Samaras et al., 2014). Moments of fear and anxiety can be viewed as opportunities for learning that can lead to personal transformation (Walinga & Harris, 2016). Suicide prevention education thus requires addressing notions of confidence and desires for certainty, while encouraging the development of multiple literacies in mental health.

Confidence and Certainty

Certainty and confidence create feelings of security and predictability, and yet complex social problems, such as suicide prevention, are inherently messy. Students' experiences of not knowing and uncertainty can create anxiety, and the potential to rely on technical, detached responses. The attributes of feeling prepared, confident, and knowledgeable are often assessed in suicide prevention education research with a heavy reliance on self-report; these assessments show the effects of education varying widely (Pistone et al., 2019). Some participants in the present study deemed the content knowledge afforded during the course insufficient, and identified a need to know more. Exactly what amount of knowledge is needed, and on what topics, are questions that remain unanswered. Suicide prevention education can vary from 1.5-hour professional development workshops to comprehensive courses offered within graduate programs. Yet no single curriculum, learning activity, or classroom can fully prepare child and youth care practitioners for the complexities of being with children, youth, families, and communities in diverse contexts (Fewster, 2004). As Pistone et al. (2019) suggested, "Although education has been statistically shown to increase knowledge and attitudes, the practical relevance of this increase is largely unknown at present. A gain in knowledge is only relevant if it leads to an actual change in behaviour" (p. 410).

In his analysis of youth work students' reflective journals completed while engaged in internships, Emslie (2009b) notably identified a common theme of feeling overwhelmed when working with complex issues. Emslie noted, "Responding to young people who had self harmed and who spoke about suicide was particularly difficult" (p. 68). As such, a critical feature of suicide prevention education would be preparing students for uncertainty, and its resulting discomfort (Ranahan, 2020). This repositions our knowledge about suicide prevention as incomplete and tenuous at best, and contradicts the message that suicide is a preventable death. As White (2017) explained:

Within mainstream suicidology, suicide has come to be understood as a static, individual, and recognizable phenomenon that is strongly associated with psychopathology and individual risk factors. As a knowable entity with relatively stable properties — the thinking goes — suicide can be explained, documented, and ultimately controlled. (p. 472)

While applying the descriptor *complex* in reference to suicide intervention may be met with nods of approval and recognition among inexperienced and experienced practitioners alike, child and youth care students are positioned, and position themselves, as open repositories expecting to be filled up by the knowledge needed to negotiate this complexity with ease. Morgan's "need to know more" and Taylor's "I still have a lot to learn" illustrate this taken-for-granted assumption that suicide is a "knowable entity" (White, 2017, p. 472).

To add to this complexity, students are likely to have prior experiences and knowledge of suicide through personal experience, family history, peer engagements, or media exposure. For

example, 85% of students in Scott's (2015) study identified that they personally knew someone who had died by suicide. Experiential learning can be challenging as learning activities can serve as a context for revisiting prior painful experiences, while also instigating feelings of confusion, conflict, and discomfort (Chen, 2014). During my undergraduate course work in child and youth care, the instructor, Gerry Fewster, often repeated the mantra "Do not ask others to do what you are not willing to do yourself". With this mantra in mind, educators and students alike should embrace challenging topics within child and youth care education and the difficulties such topics impart in the classroom context. Prior to engaging in suicide prevention learning activities, educators can scaffold experiences that prepare students to be more comfortable with the activities. For example, identifying suicide as a topic within the course description, including a structured assignment on suicide intervention in the course outline, and positioning suicide prevention learning activities at the mid- to end-point of the course can provide the necessary framework for students to participate fully in the experience. Further, deferring the topic to an outside expert or guest speaker may serve to convey the message that suicide intervention is not the responsibility or role of child and youth care practitioners. Educators have opportunities to position suicide prevention as part of practice, as part of our ongoing conversations with young people, and as part of how we work on interprofessional teams in caring for children, youth, and their families.

"Inside-Out" and "Bottom-Up" Mental Health Literacies

Approaches to mental health literacy enhancement often solely focus on the transmission of dominant knowledge, emphasizing psychopathology and the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013). Indeed, course descriptions for mental health courses in child and youth care continue to privilege an illness ideology (see Appendix). While knowledge of mental disorders, treatments, and resources available may support interprofessional collaborations in guiding children, youth, and their families through pathways to mental health care (Ranahan, 2018), findings from the present study are illustrative of other literacies that require concurrent attention.

Literacies include how lived, relational, and situational knowledges are produced and communicated, and "valuing knowledges that emerge from the inside-out and the bottom-up" (Licona & Russell, 2013, p. 2). Further, the adult learner is "developmentally distinct", whereby "learning is optimized when their experience is recognized and utilized in the learning process" (Chen, 2014, p. 407). As noted, students are likely to have experience, and thus knowledge, at the outset that can be recognized and built upon.

Critically examining how organizational protocols may inhibit responsiveness to a young person's needs, or querying whether the values underpinning such protocols are congruent with child and youth care principles, are indicative of critical literacy praxis. As Lankshear and McLaren (1993) suggested, this involves facilitating learning experiences that help students "understand the nature and implications of the ideology on parade: and in doing so engage

students in reflection upon their *own* ideological investments” (p. 9). In the present study, Linden aptly summarized the transformation that occurs when students are encouraged to examine the implications and investments underpinning their assumptions in their written reflection after attending the workshop series:

Bringing in discussions and principles related to youth work also allows a unique space for those working in the field to apply questions to their own experience, and uncover buried assumptions, discomfort, knowledge and personal connections. Unlike typical discussions of mental health, when we are actively engaged through discussion and activities using multiple intelligences we bring in our own emotional knowledge. One example of this is when I realized through discussing an issue of mental health how uncomfortable I was talking about it due to the words that came out of my mouth. Having spaces that help us process information and share experiences helps us practice speaking in a way that is more congruent with our values, through safe trial and error, as well as exploration of discomforts.

Linden’s learning experience is congruent with White and Morris’ (2019) recent suggestions of how a narrative therapeutic approach embedded in suicide prevention education supports participants’ movement towards relational responses and a collaborative way of working in which care is humanized. Several present features of child and youth care higher education support pedagogical strategies that evoke “inside-out” and “bottom-up” literacies required in suicide prevention education. For example, an emphasis on self-care and critical reflection can broaden students’ perspectives and improve decision-making (Emslie, 2009a; Kostouros et al., 2019), and mindfulness teaching supports students’ openness, curiosity, and creativity (Ventrella, 2017).

Conclusion

As a key component of the mental health literacy curriculum under investigation in this study, learning activities on suicide and suicide intervention served as conditions that influenced the paths student participants followed in becoming and being youth workers. Participants identified a struggle as they attempted to apply learning within simulated and real-world practice contexts, often citing the need for more knowledge as the pathway to increased confidence. This struggle was amplified by students’ discomfort and apparent desire for certainty while attempting to hold attuned relational engagement and satisfy protocols simultaneously. Thus participants were positioned in a dialectical space, experiencing tensions between maintaining presence and procedure. Implications for pedagogy include resisting pressure for certainty and for simplifying complex issues, building upon existing features found in child and youth care higher education (e.g., reflexivity, self-awareness, mindfulness, collaborative relationships), while embracing suicide and suicide intervention as critical topics integral to students’ future practice.

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Appendix

Example Course Descriptions

AHSC 540 Mental Health and Addictions: Youth Work Perspectives, Policies and Practices

This course explores the precursors, presentations, nature, and impacts of mental health concerns and addictions for youth, their families, and within communities. Students have the opportunity to develop, and apply within the classroom, knowledge and skills related to addictions and mental illness prevention, assessment and intervention, and mental health promotion. Topics include an introduction to adolescent psychopathology; diagnosis, assessment, and current policy and practices in relation to the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM); the uses of standardized testing to evaluate adaptation; psychopharmacology; suicide; evidence-based and alternative treatment interventions (e.g., psychoeducational approaches; dialectical behaviour therapy); ethical and legislative considerations; and the roles/responsibilities of youth workers in the inter-professional and community care of adolescents with mental health and/or addictions concerns. (Concordia University, 2019, pp. 58–59)

CYC 470 Child and Youth Care Practice in Mental Health Settings

An examination of the prevalence of patterns of atypical behaviours in childhood and adolescence and research on neurobiological correlates and socio-cultural contextual factors often associated with these patterns. Students gain understanding of key concepts, classification systems, assessment methods, and objectives guiding the delivery of child and youth mental health services, the use of psychopharmacology and other approaches. The interface between mental health services and professional practice in child and youth care is explored. (University of Victoria, 2020, CYC470)

Biography

Patti Ranahan is an Associate Professor in the Department of Applied Human Sciences at Concordia University. She is a skilled community-engaged researcher, educator, and practitioner with expertise in child and youth care, suicide prevention, mental health literacy, counselling and parent–youth relations, which is based on over 25 years of direct practice and leadership experience promoting child, youth, family, and community well-being.