


# **Mental health care providers talk about suicide prevention among people with substance use disorders in South Africa**

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## **Declaration**

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## Abstract

**Introduction.** Substance use is a well-established and potentially modifiable risk factor for suicidal behaviour. As a result, the World Health Organization has suggested that suicide prevention efforts should target people with substance use disorders (PWSUDs). Most suicide prevention strategies are largely framed within the biomedical paradigm and suggest somewhat generic approaches to suicide prevention. As such, they lack specificity for high-risk populations (such as PWSUDs) and for the different contexts in which they are implemented. Few studies have focused on the experiences of mental health care providers (MHCPs) who provide care for suicidal PWSUDs; the clinical, health care, and contextual factors they perceive to hinder suicide prevention; and their specific ideas for preventing suicide in PWSUDs. In my study, I sought to investigate MHCPs' experiences of preventing suicide in PWSUDs in South Africa (SA); their perceptions of the factors impacting on suicide prevention in this context; and their context- and population-specific suggestions for preventing suicide in PWSUDs.

**Methods.** I conducted in-depth, semi-structured interviews with 18 mental health care providers (psychiatrists, psychologists, counsellors, and social workers) working in Cape Town, SA, who had experience providing care for suicidal PWSUDs. I used thematic analysis to analyse the data inductively with Atlas.ti software.

**Findings.** I identified three superordinate themes: (1) experiences of preventing suicide; (2) perceptions of barriers to suicide prevention; and (3) ideas for suicide prevention. Participants described feeling hopeless, helpless, impotent, and guilty, and said they needed to debrief from their work. They perceived their experiences to be related to difficulties they encountered treating substance use disorders and assessing and managing suicide risk, and their perceptions that treating substance use might increase suicide risk. Structural issues in service provision (such as inadequate resources, insufficient training, and fragmented service

provision) and broad contextual issues (such as poverty and inequality, the breakdown of family, and stigma) were perceived as barriers to suicide prevention. Participants thought that PWSUDs were not receiving the psychiatric, psychological, and social care that they needed. Participants suggested a number of evidence-based strategies to prevent suicide, but also made novel, context- and population-specific suggestions for suicide prevention, including: improving training of health care providers to manage suicide risk; optimising the use of existing health care resources; establishing a tiered model of mental health care provision; providing integrated health care; and focusing on early prevention.

**Conclusion.** These findings suggest that the ways MHCPs think about suicide and make sense of their experiences impact on their perceived abilities to prevent suicide. Additionally, these findings indicate that structural, social, and economic issues pose barriers to suicide prevention. Participants highlighted specific strategies that take account of socio-cultural contexts that may be effective in preventing suicide among PWSUDs in SA. These findings challenge individual, biomedical risk-factor models of suicide prevention and highlight the need to consider a broad range of social, cultural, economic, political, and health care factors when planning suicide prevention interventions. Tailoring suicide prevention interventions to the specific needs of high-risk groups and to specific contexts may be important to prevent suicide.

## Opsomming

**Inleiding.** Middelgebruik is 'n gevestigde en potensieel veranderlike risikofaktor vir selfmoordgedrag. As gevolg daarvan, het die Wêreldgesondheidsorganisasie voorgestel dat selfmoordvoorkomingspogings gerig moet word op mense met middelgebruiksteurnisse (MMMSe). Selfmoordvoorkomingstrategieë word grootliks binne die biomediese paradigma beplan en stel ietwat generiese benaderings tot selfmoordvoorkoming voor. As sodanig ontbreek hierdie strategieë spesifisiteit vir hoë-risikobevolgings (soos MMMSe) en vir die verskillende kontekste waarin hulle geïmplementeer word. Daar is min studies wat fokus op die ervarings van geestesgesondheidsorg-verskaffers wat versorging aan MMMSe met selfmoordneigings verskaf; hul waarnemings rondom die kliniese, gesondheidsorg, en kontekstuele faktore wat selfmoordvoorkomingspogings verhinder; en hul spesifieke idees vir die voorkoming van selfmoord in MMMSe. In my studie het ek gepoog om GGVs se ervarings van selfmoordvoorkoming in MMMSe in Suid-Afrika (SA) te ondersoek; hul persepsies van die faktore wat selfmoordvoorkoming in hierdie konteks beïnvloed; en hul konteks- en bevolkingsspesifieke voorstelle vir die voorkoming van selfmoord in MMMSe.

**Metodes.** Ek het in-diepte, semi-gestruktureerde onderhoude gevoer met 18 geestesgesondheidsorg-verskaffers (psigiaters, sielkundiges, beraders, en maatskaplike werkers) wat werk in Kaapstad, SA, en ervaring in die versorging van MMMSe met selfmoordneigings gehad het. Ek het tematiese analise gebruik om die data induktief te analiseer met Atlas.ti sagteware.

**Bevindings:** Ek het drie oorheersende temas geïdentifiseer: (1) ervarings rondom die voorkoming van selfmoord; (2) persepsies van hindernisse tot selfmoordvoorkoming; en (3) idees vir selfmoordvoorkoming. Deelnemers het beskryf dat hul hopeloos, hulpeloos, magteloos en skuldig gevoel het, en gesê dat hulle 'n behoefte aan ontlading van hul werk het. Hul persepsie was dat hul ervarings verband hou met probleme wat hulle ondervind met die

behandeling van middelgebruiksteurnisse en die assessering en bestuur van selfmoordrisiko, en hul persepsies dat die behandeling van middelgebruik selfmoordrisiko kan verhoog. Strukturele kwessies in diensverskaffing (soos onvoldoende hulpbronne, onvoldoende opleiding, en gefragmenteerde diensverskaffing) en kontekstuele kwessies (soos armoede en ongelukheid, die ineenstorting van families, en stigma) was beskou as struikelblokke vir selfmoordvoorkoming. Deelnemers het gedink dat MMMSe nie die geestesgesondheidsorg ontvang wat hulle nodig het nie. Deelnemers het 'n aantal bewysgebaseerde strategieë voorgestel om selfmoord te voorkom, maar het ook konteks- en bevolkingspesifieke voorstelle vir selfmoordvoorkoming gemaak. Hierdie voorstelle sluit in: verbetering van opleiding van gesondheidsorgverskaffers om selfmoordrisiko te bestuur; optimalisering van die gebruik van bestaande gesondheidsorgbronne; oprigting van 'n multi-vlak model van geestesgesondheidsorg-voorsiening; verskaffing van geïntegreerde gesondheidsorg; en 'n fokus op vroeë voorkoming.

**Gevoltrekking.** Hierdie bevindings dui daarop dat die maniere waarop geestesgesondheidsorg-verskaffers oor selfmoord dink en sin maak van hul ervarings, 'n impak op hul waargenome vermoëns het om selfmoord te voorkom. Daarbenewens dui hierdie bevindings aan dat strukturele, sosiale, en ekonomiese probleme hindernisse tot selfmoordvoorkoming veroorsaak. Deelnemers het spesifieke strategieë uitgelig wat rekening hou met sosio-kulturele kontekste wat effektief kan wees om selfmoord onder MMMSe in SA te voorkom. Hierdie bevindings daag individuele, biomediese risikofaktormodelle van selfmoordvoorkoming uit en beklemtoon die behoefte om 'n wye verskeidenheid sosiale, kulturele, ekonomiese, politieke, en gesondheidsorgfaktore te oorweeg wanneer selfmoordvoorkomings-intervensies beplan word. Om selfmoordvoorkomings-intervensies aan te pas by die spesifieke behoeftes van hoë-risikogroepe en spesifieke kontekste, kan belangrik wees om selfmoord te voorkom.

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## **Chapter 1**

### **Introduction**

#### **Introduction**

Suicide is a major public health concern around the world. Over 800,000 people die by suicide each year, with an estimated 75% of these deaths occurring in low- and middle-income countries (LMICs) (World Health Organization [WHO], 2014a). In South Africa (SA), suicide is considered a public health concern (Bantjes & Kagee, 2013; Schlebusch, 2012). Substance use is a well-established risk factor for both fatal and nonfatal suicidal behaviour (Borges & Loera, 2010; Breet, Goldstone, & Bantjes, 2017; Kennedy et al., 2015; Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006), making targeted suicide prevention efforts an important part of providing care for suicidal people with substance use disorders (PWSUDs). There appears to be a lack of research that focuses on suicidal behaviour and its prevention from the perspectives of the people who are tasked with treating substance use and preventing suicidal behaviour on a daily basis (Mangnall & Yurkovich, 2008). Mental health care providers (MHCPs) such as psychiatrists, psychologists, social workers, and counsellors are tasked with providing mental health care services for PWSUDs and have first-hand experience of preventing suicide in this population (Feldman & Freedenthal, 2006; Kleespies, Penk, & Forsyth, 1993; Ruskin, Sakinofsky, Bagby, Dickens, & Sousa, 2004). Investigating MHCPs' experiences of preventing suicide in PWSUDs, their perceptions of the factors that impact suicide prevention, and their ideas for suicide prevention may provide important insights into suicide prevention and mental health care service delivery in SA. The aim of my study was to investigate these topics.

Understanding the role of substance use and substance use disorders (SUDs) in suicidal behaviour is important if we hope to provide targeted interventions to high-risk

groups. Various theories exist concerning the possible role that substance use may play in suicidal behaviour. Biological theorists hypothesise that acute substance use generates a vulnerability (or diathesis) to suicidal behaviour by increasing disinhibition, impulsiveness, impaired judgment, and pain tolerance (Norström & Rossow, 2016; Pompili et al., 2010). Stressful life events (e.g., relationship loss or a depressive episode) then precipitate suicidal behaviour when combined with substance use of varying severity (Borges, Walters, & Kessler, 2000; Norström & Rossow, 2016; Pompili et al., 2010). This is known as the diathesis-stress model of suicide (van Heeringen, 2012; see also O'Connor & Nock, 2014). Substance use and SUDs are directly associated with social isolation (Chou, Liang, & Sareen, 2011), and the sociological theory of suicide postulates that suicide can result from social isolation or social disintegration (Durkheim, 1897/1952). The interpersonal theory suggests that thwarted belongingness, perceived burdensomeness, and the ability to engage in suicidal behaviour must be present before a person attempts suicide (Joiner, 2005; Van Orden et al., 2010). Social-ecological theories add a contextual dimension to these models, suggesting that the risk for suicide depends on cultural, social, environmental, and economic factors in addition to individual vulnerabilities (Neeleman, 2002). Finally, the integrated motivational-volitional model brings all these components together to conceptualise suicide as the outcome of a complex array of proximal and distal risk factors, thereby combining diathesis-stress perspectives with interpersonal and social-ecological components (O'Connor, 2011).

In sum, SUDs can have physical sequelae such as increased pain tolerance and decreased motor control; cognitive consequences like disinhibition, impulsiveness, and impaired judgment; emotional consequences like depressed mood; and social consequences like increased isolation and disconnection from significant others. These then combine in different ways to precipitate suicidal behaviour. Despite these hypotheses and models, the precise role of substance use and SUDs in suicidal behaviour is still poorly understood

(Vijakumar, Kumar, & Vijakumar, 2011). PWSUDs are a high-risk group for suicide, and given the clear links between SUDs and suicidal behaviour, investigating suicide prevention in this population of health care users appears particularly important.

In this chapter, I define key terminology for my research and highlight the difficulties of finding neutral and accurate terminology in the fields of suicidology and substance use. Thereafter, I explain the rationale and motivation for my research, followed by the research questions for my study. I conclude the chapter with an outline of my thesis.

### **Key Terminology**

Classifying suicidal behaviour using standardised terminology is important for the purposes of research, public health, epidemiology, clinical work, law- and policy-making, and communication between these different sectors and the people working within them (Silverman, 2011). However, issues of nomenclature and classification pervade the literature on suicide and self-harm (see De Leo, Burgis, Bertolote, Kerkhof, & Bille-Brahe, 2006; Silverman, 2006, 2011; Silverman, Berman, Sanddal, O'Carroll, & Joiner, 2007a, 2007b).

Defining what makes a death suicidal depends on (a) intent and (b) the locus of origin of the death (De Leo et al., 2006; Silverman, 2006; Silverman et al., 2007b), but these are often difficult to determine. Intent can only be subjectively measured and is often marked by significant ambivalence and contradiction, as a person may have multiple intentions for their behaviour (De Leo et al., 2006). Furthermore, intent refers only to the desired outcome of behaviour and gives no indication of the motivation for the behaviour (Hjelmeland & Ostamo, 1997). In a case of suicide, where the death was clearly deliberately self-caused, there may still be no way to know whether the person intended to die or not (i.e., intent cannot be inferred), or what the motivation was for the behaviour. Auto-asphyxiation, self-inflicted wounds, and even self-poisoning could have multiple motivations and multiple

intended outcomes, and if they lead to death, may still appear to be caused by someone other than the deceased. As such, determining the locus of origin of a death may also be troublesome.

As suicide attempts and other forms of suicidal behaviour may have multiple factors influencing both the motivation for the behaviour and the intent for its outcome, suicide attempts have been difficult to classify accurately (Andriessen, 2006; Silverman, 2011). It is therefore important to keep in mind that intent and motivation for a behaviour are separate but related concepts, and that determining intent is an important way to separate suicide attempts from other (nonsuicidal) self-injurious behaviour. Nonsuicidal self-injurious behaviour is as complicated to define and classify as suicidal behaviour (see De Leo et al., 2006; Silverman, 2006, 2011; Silverman et al., 2007a). This study focuses specifically on suicidal behaviour, thus nonsuicidal self-injurious behaviour will not be discussed further.

In addition to these noted difficulties surrounding the nomenclature and classification of suicidal behaviour from an epidemiological standpoint, the terms used to refer to suicidal behaviour are also complicated by their cultural and social meanings. For example, more women attempt suicide than men, but more men die from suicide (WHO, 2014a). Feminist scholars have critiqued the use of the term suicide "attempt", as it implies that the person who engaged in the behaviour is less competent than the person who dies. In other words, it implies that women are less competent than men (Lester, 1994). Similarly, speaking of "committing" suicide has links to the legal terminology of committing a crime, therefore semantically criminalising (and stigmatising) the deceased. Finally, using terms like "parasuicide," "superficial" injury, "failed suicide," "suicide gesture" and "completed suicide" are problematic as they imply certain negative connotations and value judgments, and can therefore be derogatory and pejorative (De Leo et al., 2006; Silverman, 2006). Deciding

upon a nomenclature that is free of ideological, philosophical, religious, cultural, political, theoretical, and sociological bias has remained a challenge in suicidology (Silverman, 2011).

The terminology surrounding substance use has also been critiqued for being unclear, pejorative, and stigmatising (Broyles et al., 2014; O'Brien, Volkow, & Li, 2006). Using terms like "drug abuser" or "addict" carry negative social stigmas, and terms like substance "use" or "misuse" lack clarity regarding the severity of the use or the impairment resulting from it. This has led to the issue that much of the literature on substance use and SUDs is vague and nonspecific regarding the terminology used (Breet et al., 2017). This makes it difficult to know whether "substance use" use refers to pathological use or not. In an effort to further standardise the terminology surrounding substance use, the American Psychiatric Association (APA) replaced the terms substance "abuse" and "dependence" with "substance use disorder" in 2013, specified according to severity (APA, 2013).

Reaching consensus on nomenclature and classification of suicidal behaviour and substance use is important not only from the perspective of respecting human dignity, but also to ensure that there is a common language being used amongst those researching, preventing, and treating suicidal behaviour (De Leo et al., 2006; Silverman, 2011). In the context of these difficulties surrounding the nomenclature and classification of suicidal behaviour and substance use, some key terms and concepts must be defined for this study, despite their limitations. Below I define key terms, and I attempt to use terminology that is not ambiguous or pejorative, that is person-first (Broyles et al., 2014), and that is as widely agreed-upon in the literature as possible. The terms defined below are used deliberately throughout the rest of the thesis, and are not used interchangeably.

**Substance use** refers to the use of any substance that has the potential to cause some form of intoxication and has the potential to cause functional impairment to the user. For this study, "substance use" refers to the use of alcohol, illicit drugs, and legal (prescription or over

the counter) drugs that are used for recreational (nonmedical) purposes. This includes harmful or risky use and use that is severe enough to meet diagnostic criteria for a substance use disorder.

**Substance use disorders (SUDs)**, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (APA, 2013), are mental disorders characterised by a pattern of physiological, behavioural, and cognitive symptoms that cause impairment to the substance user, who continues using the substance(s) despite this impairment. Hallmark impairments are in control and social functioning (e.g., not being able to fulfil occupational/social commitments), while risky/hazardous substance use and pharmacological criteria (e.g., drug tolerance and withdrawal upon cessation of use) must be present for a SUD diagnosis to be made (APA, 2013). SUDs are specified according to severity, and can be mild, moderate, or severe (APA, 2013).

**People with substance use disorders (PWSUDs)** are people who have been diagnosed with a SUD, who may or may not be receiving treatment for that SUD.

**Suicidal behaviour** refers to the collection of thoughts, feelings, intended and actual behaviours experienced or engaged in by a person, where the person had a nonzero intent to die (Posner, Brodsky, Yershova, Buchanan, & Mann, 2014). This includes suicidal ideation, suicide attempt, and suicide.

**Suicidal ideation** is defined as thoughts of ending one's own life, and can be differentiated according to whether a person only has a wish/desire to die without taking any steps to carry out a suicide (passive ideation) or whether they have a suicide plan or the intent/desire to make an actual suicide attempt (active ideation) (Beck, Kovacs, & Weissman, 1979).

**Suicide attempt** refers to self-inflicted, potentially injurious behaviour that has a nonfatal outcome, for which there is evidence (either implicit or explicit) that the person had

a nonzero intent to die as a result of the behaviour (APA, 2013; Crosby, Ortega, & Melanson, 2011; Silverman et al., 2007b). A suicide attempt may or may not result in injuries (De Leo et al., 2006).

***Suicide*** refers to the act of deliberately killing oneself (WHO, 2014a).

**Suicidology** is the scientific study of suicide (Shneidman, 1981).

**Mental health care provider (MHCP)** refers to an individual who provides mental health care services and is paid for providing such services. In this study, this refers to psychiatrists, clinical psychologists, registered counsellors, lay counsellors, and social workers.

### **Rationale and Motivation for the Present Study: Think Local, Act Local**

The majority of research on substance use and suicidal behaviour has focused on risk factors, correlates, and predictors (for example, see Fliege, Lee, Grimm, & Klapp, 2009; Nock, Borges, Bromet, Alonso, et al., 2008; Sher, 2016). Hjelmeland and Knizek (2010) state that suicidology in particular has focused on three coarsely classified areas: (1) epidemiological research; (2) biological and neurobiological research; and (3) studies of interventions such as randomised controlled trials. These types of studies, favouring quantitative methodologies, have been useful to elucidate what the risk factors for suicidal behaviour are, but they have done little to tell us how or why these risk factors, such as substance use and SUDs, are involved in suicidal behaviour, and what implications this might have for suicide prevention (Nock, 2012).

A major issue in the field of suicide prevention research is that suicide rates worldwide have not decreased appreciably in the past few decades, and may even have increased in nations with the highest historical suicide rates (Värnik, 2012). This may mean that well-designed intervention efforts do not work as effectively as intended (e.g.,

Harrington et al., 1998). This could be due to the fact that research has focused predominantly on risk rather than protective factors, and because interventions are conceptualised as treatments rather than prevention efforts (Brent, 2011).

Both the WHO and the United States National Institute of Mental Health promote the idea of thinking globally and acting locally (see Insel, 2011) in an effort to encourage people to make changes to the lives of those around them rather than those far afield. One notable problem with this philosophy is that global solutions may not apply to all local contexts. In the field of global mental health, some have argued that transporting reductionist, Western concepts of psychiatric illness to non-Western contexts ignores local knowledge systems and culturally determined expressions of mental illness (Fernando, 2011; Summerfield, 2013). Additional arguments have been made to suggest that global mental health medicalises everyday distress, that Western psychiatric ideologies are biologically deterministic (Mills & Fernando, 2014; Summerfield, 2013), and that the social, economic, political, and structural determinants of mental health are largely disregarded (Ingleby, 2014; Mills, 2014).

In the field of suicidology, there is a similar tension between viewing suicide as a homogenous universal phenomenon (that can be studied systematically and prevented effectively) and viewing suicide as highly context-dependent. Each act of suicidal behaviour is informed and shaped by the context in which it takes place. To conceptualise suicide as a problem that is the same the world over and can therefore be solved with global solutions may be overly optimistic and ignorant of the vast differences across sociocultural contexts. Recent research in the African context has highlighted that the meanings of suicide are specific to culture and context, and that suicide prevention efforts must take such diversities and local understandings into account (see Hjelmeland, Osafo, Akotia, & Knizek, 2014; Knizek, Kinyanda, Owens, & Hjelmeland, 2011; Mugisha, Hjelmeland, Kinyanda, & Knizek, 2013; Osafo, Hjelmeland, Akotia, & Knizek, 2011a, 2011b).



De Leo (2002) has argued that the "Think globally, act locally" (p. 29) philosophy in global health should be replaced by a "Think locally and act locally" (p. 29) approach in suicidology. We cannot merely transport global solutions to highly variable and specific local contexts. Rather, it is within unique cultural milieus that meaning and understanding should be sought, so that appropriate and specific solutions and preventive measures can be created (Colucci, 2006). Global approaches to suicide prevention are important, but adapting these solutions to the particular needs of high-risk groups in different contexts is essential to ensure their effectiveness.

In line with these arguments, there has been a recent shift in the field of suicidology to include a more critical approach to research on suicide. This movement, termed "critical suicidology," is centred on two premises that oppose mainstream approaches to suicide: first, that research on suicide has historically focused too narrowly on individual pathology, has failed to account for the person in context, and is overly reductive; and second, that an individualist biomedical paradigm is dominant in the literature, and its associated positivist methodologies have not allowed investigation of aspects of suicide that do not fit within these conventions (Marsh, 2010, 2016; White, Marsh, Kral, & Morris, 2016a, 2016b). One problem with mainstream approaches is that solutions to suicidal behaviour are developed to target individuals and fail to account for the specific social, political, economic, and cultural contexts implicated in suicidal behaviour (Marsh, 2016; White, 2017). These critical suicidologists call for "more expansive, dynamic, and creative conceptual paradigms, which will enable a broader set of responses" (White, 2017, p. 2) and assert that we need to employ more qualitative methods so that we may better understand and explore the context and meaning of suicidal behaviour (see Hjelmeland, 2011, 2012; Hjelmeland & Knizek, 2010, 2011; Marsh, 2016; White, 2015, 2017; White et al., 2016b).

Critical suicidologists argue that it is only through investigation of the local contexts of suicidal behaviour by using exploratory rather than explanatory methods, will the field of suicidology and suicide prevention research move forward (see Hjelmeland, 2011; Hjelmeland & Knizek, 2010, 2011; Kral, 2012; Marsh, 2016; White, 2015; White et al., 2016a). Marsh (2016) has asserted that we need to question and challenge reified "truths" (p. 15) in suicidology, such as that suicide is individual and suicide is pathological, linking to broader critiques of the psycho-centric view of distress implicit in mental health discourses (Rimke & Brock, 2012). White (2015) has argued that the cultural and political antecedents of suicidal behaviour need to be considered when assessing how to prevent suicide, while White et al. (2016b) argue similarly for an acknowledgment of the historical and socioeconomic contexts of suicide when designing prevention efforts. By challenging the dominant, biomedical, risk-factor approaches to suicide prevention, these researchers hope that we will be able to understand suicidal behaviour more comprehensively and prevent it more effectively.

In SA, rates of SUDs have been described as high (Herman et al., 2009; Shilubane et al., 2013), and little is known about how substance use and SUDs contribute to suicidal behaviour (Bantjes & Kagee, 2013). Additionally, there is a lack of research describing the psychosocial context of suicidal behaviour in LMICs, particularly in SA (Joe, Stein, Seedat, Herman, & Williams, 2008). Researchers have suggested that the needs of PWSUDs receiving care in treatment facilities need to be more closely examined in order to improve service provision for these patients (Myers & Fakier, 2009). The fact that PWSUDs constitute a large and well-delineated group that is at high risk of suicide (Breet et al., 2017), suggests that they should be a population targeted for specific suicide prevention interventions, and that their specific needs may differentiate them from others who experience or engage in suicidal behaviour. This makes it important to better understand the

context in which suicidal behaviour occurs in PWSUDs, the contextual factors that might hinder suicide prevention in this population of health care users, and what this might mean for suicide prevention in the future.

There have been no studies to date assessing how MHCPs experience providing services for suicidal PWSUDs and what implications this might have for suicide prevention in SA. Psychiatrists, psychologists, counsellors, and social workers are just some of the people who come into contact with PWSUDs who experience or engage in suicidal behaviour, yet their training is vastly different and each brings a different perspective to the issue. Understanding these varied service providers' lived experiences of providing mental health care services and preventing suicide in PWSUDs in SA may help provide specific insights into: (a) the experiences of MHCPs who prevent suicide in PWSUDs; (b) what MHCPs think impacts on suicide prevention in PWSUDs in SA; (c) what may be required to prevent suicide in PWSUDs; and (d) the particular social, economic, and cultural contexts that need to be considered when planning suicide prevention interventions for PWSUDs in SA.

In this research, I seek to investigate the experiences of MHCPs who provide mental health care services to and prevent suicide in PWSUDs to address some of the aforementioned gaps in the literature. Uncovering the perceived factors that impact MHCPs' experiences and influence the organisation of health care may help us identify strategies that can be targeted towards preventing suicide in PWSUDs in SA. These may include useful insights into possible public health interventions aimed at reducing suicidal behaviour among PWSUDs in SA. Findings from this research will add to our understanding of the experiences of MHCPs who provide services for suicidal PWSUDs in SA and will help inform future research in this area.

## Research Questions

In this study, I seek to investigate MHCPs' experiences of preventing suicide in PWSUDs in SA. The specific research questions are:

1. What experiences do MHCPs have when preventing suicide in PWSUDs in SA?
2. What specific factors do MHCPs perceive to contribute to their experiences preventing suicide in PWSUDs in SA?
3. What can we learn about the health care and contextual factors that impact on suicide prevention in PWSUDs seeking care in SA, from the experiences of MHCPs?
4. What can be said about the context of suicide prevention in SA, based on the factors MHCPs perceive to contribute to their experiences?
5. What do MHCPs think is required for preventing suicide in PWSUDs?
6. What sense can be made of MHCPs' ideas for suicide prevention in the context of health care provision in SA?

## Overview of the Thesis

This thesis is divided into eight chapters. In Chapter 2, I review the literature focusing on suicidal behaviour and its prevention, substance use and SUDs, health care provision in SA, and qualitative research in suicidology that focuses on the experiences and perspectives of health care providers. This includes both global and local literature on these topics, with a particular focus on the SA health care system and treatment provision for PWSUDs. In Chapter 3, I discuss the research paradigm for this study and why a research paradigm is an important theoretical point of departure in research on suicide. In Chapter 4, I detail the methods employed in the present research, explaining how the data were

inductively analysed and the strategies I employed to enhance rigour and trustworthiness in this qualitative research.

In Chapters 5, 6, and 7, I report the findings and discussion of my study. In each chapter, I focus on a subset of the findings and discuss each subset of the findings in the context of relevant literature. The reason I have organised the findings in this way is that each of these chapters represents a superordinate theme, and organising the thesis in this way improves the readability of the work. In Chapter 5, I discuss MHCPs' experiences of preventing suicide in PWSUDs and the factors they perceive to contribute to these experiences. In Chapter 6, I discuss MHCPs' perceptions of the health care and contextual barriers to preventing suicide in PWSUDs and what this says about the context of suicide prevention in SA. In Chapter 7, I discuss these participants' ideas for suicide prevention in PWSUDs and what these ideas might mean in the context of health care provision in SA.

By discussing each subset of the findings directly, it is easier to see how the research questions have been answered and the flow of ideas is more logical and delineated. Discussing each superordinate theme separately has three added advantages. First, it allows me to examine the consistencies and inconsistencies between the subsets of the findings, allowing greater insight into where MHCPs draw links between their experiences, perceptions of factors influencing suicide prevention, and ideas for suicide prevention, and where they do not make such explicit links. Second, it allows me to discuss each superordinate theme directly in the context of literature relevant to that superordinate theme. This may mean that some findings appear to be discussed more than once (albeit in different ways), but allows the reader to read the chapters as a narrative. Third, it shows the cross-cutting nature of the themes, and it shows how the findings are interrelated and interconnected. Additionally, each of these chapters has been prepared for publication. The findings presented in Chapter 6 have already been published (Goldstone & Bantjes, 2017a),

and the content of Chapters 5 and 7 have been prepared for publication and are currently under review (Goldstone & Bantjes, 2017b, 2017c).

Finally, in Chapter 8, I examine the findings and discussion as a gestalt, highlighting consistencies and inconsistencies across the data. I outline the limitations of this study, the implications of these findings for service delivery in SA, and possible future directions. I conclude with some final reflections on the data and what it means to be an ethical researcher in the field of suicidology.

## **Chapter 2**

### **Literature Review**

#### **Introduction**

In this chapter, I provide a broad overview of relevant literature pertaining to suicidal behaviour and its prevention, substance use, the SA health care system, and qualitative research on the experiences of health care providers who are tasked with preventing suicide. I begin the chapter with an overview of the epidemiology of suicidal behaviour both worldwide and in SA, providing some detail on the comorbidity between substance use and suicide. Thereafter, I outline the epidemiology of substance use in SA and the context of health care provision in SA, focusing on treatment provision for PWSUDs. I then review the literature on suicide prevention around the world and examine suicide prevention in SA in the context of the National Mental Health Policy and Strategic Plan 2013–2020 (henceforth, MH Policy and Plan; Department of Health [DOH], 2013). Finally, I provide an overview of qualitative research in suicidology, paying close attention to the experiences of MHCPs who are tasked with preventing suicide and their perceptions of suicidal behaviour.

#### **Epidemiology of Suicidal Behaviour**

**Global epidemiology of suicidal behaviour.** Suicidal behaviour is a serious public health concern worldwide that stretches across gender, ethnicity, and socio-economic status (Amitai & Apter, 2012; Choi, DiNitto, & Marti, 2015). The 2014 WHO report "Preventing suicide: A global imperative" provides evidence that suicide is an important global cause of death and disability, and that suicide rates are likely underestimated (WHO, 2014a). An epidemiological study covering 17 countries showed that the average prevalence of suicidal ideation, plans, and attempts was 9.2%, 3.1%, and 2.7%, respectively (Nock, Borges, Bromet,

Alonso, et al., 2008). Suicide rates vary around the globe, ranging from 35.3 per 100,000 in Sri Lanka to a reported 0.0 per 100,000 in Antigua and Barbuda (WHO, 2015). The WHO (2014a) reports that the average rate of suicide globally is 11.4 per 100,000. Seventy-five and a half percent of all suicides occur in LMICs, with 39.1% of global suicides taking place in LMICs in South-East Asia and 7.6% in LMICs in Africa. LMIC populations seem to be at the highest risk for suicides worldwide, as they represent only 35.4% of the world's population, yet 41.4% of global suicides take place in these regions (WHO, 2014a).

Problems such as poor vital registration data, underreporting, and misclassification of causes of death have made accurate recording of suicide deaths challenging (WHO, 2014a). Countries have different laws, policies, and medicolegal systems for classifying and recording deaths. Coupled with the global stigma that surrounds suicide, as well as the illegality of suicide in some countries (e.g., North Korea and Singapore), accurate records of suicide are difficult to obtain, making it difficult to monitor the true rates of suicides in different countries and to plan prevention efforts accordingly (WHO, 2014a).

Patterns of suicide vary not only by region, but also by sex, age, and method. There is a clear difference in the incidence of male (15.0 per 100,000) and female suicides (8.0 per 100,000), with a global ratio of 1.88:1. This ratio ranges from 0.5 to 12.5, indicating large variability in the gendered nature of global patterns of suicide. These variations are likely due to differences in gender power relations around the world, accepted gendered patterns of stress and/or conflict management, availability of methods, availability of alcohol and other drugs, mental health care provision and availability, and social norms dictating the acceptability of seeking mental health care (WHO, 2014a).

**Risk factors for suicidal behaviour.** Risk factors for suicidal behaviour are many and varied. Psychiatric risk factors have received the most attention in the literature, but other, non-psychiatric risk factors appear to be as important. Personality/individual



differences, cognitive factors, health conditions, and social, cultural, and economic factors all present risks for suicide (Windfuhr & Kapur, 2011). These risk factors differ in their associations with various forms of suicidal behaviour, and are discussed below.

***Psychiatric risk factors.*** A systematic review and meta-analysis of the past 50 years of research on suicide shows that prior psychiatric hospitalization, a previous suicide attempt, and prior suicidal ideation are the three best predictors of suicide (Franklin et al., 2017). However, the review showed that the three best predictors of suicidal ideation were prior suicidal ideation, hopelessness, and depression, while the three best predictors of suicide attempt were prior nonsuicidal self-injury, prior suicide attempt, and positive screening for prior suicidal behaviour. This shows that suicidal behaviour may exist on a continuum, with different risk factors being important at different points on that continuum (see the integrated motivational-volitional model for a possible explanation of this; O'Connor, 2011).

An earlier systematic review of psychological autopsy studies showed that as many as 90% of suicide cases may have a psychiatric disorder (Cavanagh, Carson, Sharpe, & Lawrie, 2003), while other studies show that between 33% and 98% of people who engage in nonfatal suicidal behaviour have a psychiatric diagnosis (Ferreira de Castro, Cunha, Pimenta, & Costa, 1998; Haw, Hawton, Houston, & Townsend, 2001). The principal psychiatric disorders associated with suicidal behaviour are mood disorders, personality disorders, SUDs, and psychotic disorders (Ferreira de Castro et al., 1998; Franklin et al., 2017; Hawton, Comabella, Haw, & Saunders, 2013; Hawton, Sutton, Haw, Sinclair, & Deeks, 2005).

A study of psychiatric out-patients (many of whom had attempted suicide) found that 14% of patients were using non-prescription drugs and 25% were using alcohol at the time in their psychiatric illness when they felt the most despair (Eagles, Carson, Begg, & Naji, 2003). Additionally, 29% of patients found that alcohol was helpful when they were feeling at their lowest. While many, but not all patients were suicidal, this indicates the close ties between

substance use, psychiatric illness, and feelings of despair/suicidality, even in psychiatric populations without a SUD. Substance use may serve the function of blunting unwanted emotions or as a coping strategy when times get tough and when life feels unbearable (the so-called self-medication hypothesis; Khantzian, 1997).

However, while those who die by suicide are highly likely to have a mental disorder, the general psychiatric population is highly unlikely to die by suicide. For example, fewer than 5% of people who receive in-patient treatment for an affective disorder die by suicide (Bostwick & Pankratz, 2000). Quantitative psychological autopsy methods assign diagnoses post-mortem by interviewing people close to the deceased or relying on other secondary sources. This method is plagued with issues (see Pouliot & De Leo, 2006) and has received criticism for being unreliable and invalid (Hjelmeland, Dieserud, Dyregrov, Knizek, & Leenaars, 2012). As such, the purported high comorbidity between psychiatric conditions and suicidal behaviour should be interpreted with caution.

A long history of literature has shown that alcohol and drug use or dependence are risk factors for both fatal and nonfatal suicidal behaviour (Borges & Loera, 2010; Breet et al., 2017; Cherpitel, Borges, & Wilcox, 2004; Gart & Kelly, 2015; Kennedy et al., 2015; Nock et al., 2006). For example, substance use is an independent risk factor for suicidal ideation (Pages, Russo, Roy-Byrne, Ries, & Cowley, 1997), which is itself a risk factor for suicide (Kessler, Borges, & Walters, 1999). Manning et al. (2015) have shown in a study of PWSUDs that more than 20% had thoughts of suicide (passive ideation) and more than 10% had an actual suicide plan (active ideation).

A meta-analysis by Wilcox, Conner, and Caine (2004) reports that PWSUDs who seek treatment are approximately 9.8 times more likely to die by suicide than the general population. A systematic review suggests that alcohol use is implicated in approximately 10% to 69% of fatal and approximately 10% to 73% of nonfatal suicidal behaviours

(Cherpitel et al., 2004), while the WHO Global Status Report on Alcohol and Health 2014 (WHO, 2014b) states that the alcohol-attributable fraction for suicide and associated disease burden may be as high as 20%.

Estimates from the Institute of Health Metrics and Evaluation indicate that a significant portion of the suicide disability-adjusted life years attributable to mental and substance use disorders come from amphetamine dependence (2.4%), opioid dependence (1.9%), and cocaine dependence (0.9%) (Ferrari et al., 2014). The role of other drugs (such as cannabis) in suicide is currently a matter of debate (Hall, 2015). Typically though, rates of drug use implicated in suicidal behaviour have not been reported adequately.

A recent epidemiological study suggests that substance use serves as a risk factor for repeated incidents of suicidal behaviour (Gonzalez, 2012). There is also evidence to show that individuals who are intoxicated at the time of presenting for treatment following an incident of suicidal behaviour are less likely to be admitted to hospital or to be seen by a psychiatrist because of problems with the stigma associated with substance use (Li, 2007; Ries, Yuodelis-Flores, Comtois, Roy-Byrne, & Russo, 2008).

Although SUDs serve as risk factors for suicidal behaviour, not all PWSUDs experience or engage in suicidal behaviour (Yuodelis-Flores & Reis, 2015). Available research suggests that certain factors such as: (a) substance use proximity (i.e., current or past use); (b) severity of SUD (Pompili et al., 2010); and (c) comorbid psychiatric diagnosis (i.e., whether substance-induced or independent from substance use) constitute significant risk factors for suicidal behaviour among PWSUDs (Conner & Ilgen, 2011). In addition, certain personal characteristics such as impulsivity/aggression, interpersonal stress, or negative affect pose as risk factors for suicidal behaviour among PWSUDs (Conner & Ilgen, 2011).

A recent systematic review was conducted of the studies assessing the associations between various types of substance use and various dimensions of suicidal behaviour in

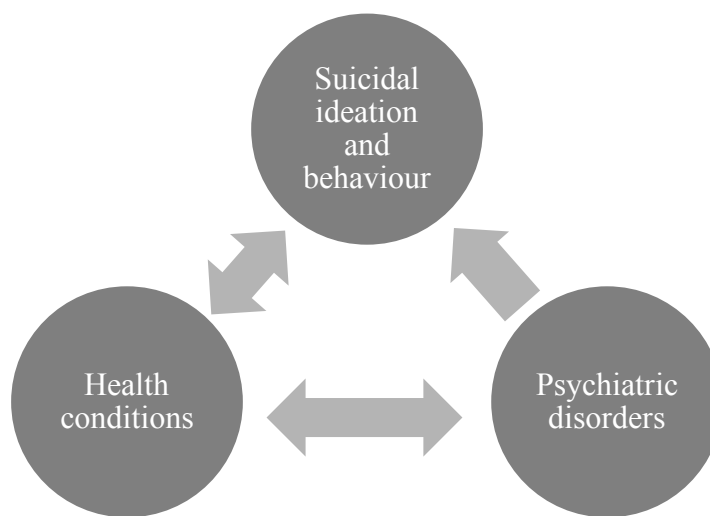
LMICs (Breet et al., 2017). The review included 108 studies and showed clear associations between all types of substance use (including use, misuse, and SUDs) and all dimensions of suicidal behaviour (including ideation, attempt, and death). This provides evidence that substance use and SUDs are clear risk factors for suicidal behaviour, especially in LMICs.

***Personality and individual risk factors.*** There are many personality and individual risk factors for suicidal behaviour. These include hopelessness, impulsivity, perfectionism, and neuroticism. Each shows an association with suicidal behaviour, although mixed results beset the literature investigating these risk factors (O'Connor & Nock, 2014). Hopelessness is associated with suicidal ideation more than suicide (Beck, Steer, Kovacs, & Garrison, 1985; Brezo, Paris, & Turecki, 2006), while impulsivity, perfectionism, and neuroticism are associated with both suicidal ideation and attempts (Batterham & Christensen, 2012; Nock, Borges, Bromet, Cha, et al., 2008; O'Connor, 2007),

***Cognitive risk factors.*** The cognitive risk factors associated with suicide are many and varied, and include cognitive rigidity (Marzuk, Hartwell, Leon, & Portera, 2005), rumination (Morrison & O'Connor, 2008), autobiographical memory biases (Pollock & Williams, 2001), perceived burdensomeness (Hatcher & Stubbersfield, 2013), agitation (Fawcett, Busch, Jacobs, Kravitz, & Fogg, 1997; Ribeiro et al., 2015), attentional biases (Cha, Najmi, Park, Finn, & Nock, 2010), pessimism for the future (MacLeod, Pankhania, Lee, & Mitchell, 1997), and defeat and entrapment (Taylor, Gooding, Wood, & Tarrier, 2011).

***Health conditions as risk factors.*** Health conditions, such as chronic pain conditions (Ratcliffe, Enns, Belik, & Sareen, 2008), tuberculosis (Peltzer & Louw, 2013), HIV/AIDS (Badiee et al., 2012; Catalan et al., 2011; Freeman, Nkomo, Kafaar, & Kelly, 2007), and pregnancy (Onah, Field, Bantjes, & Honikman, 2017) are risk factors for suicide. Psychiatric disorders such as depression and anxiety are significantly more prevalent among those with

health problems, particularly chronic health problems, than among the general population (Katon, Lin, & Kroenke, 2007; Moussavi et al., 2007). This worsens health outcomes and increases the risk for suicidal behaviour (Katon et al., 2007; Moussavi et al., 2007) (see Figure 2.1). A particularly high-risk group in SA is pregnant mothers living in low socio-economic contexts, with recent research showing a one-month prevalence of suicidal behaviour of 18% (Onah et al., 2017).



*Figure 2.1.* Inter-relationships between suicidal behaviour, psychiatric disorders, and health conditions.

***Social, cultural, and economic risk factors.*** Social, cultural, and economic factors have varying degrees of influence on risk for suicidal behaviour. A family history of suicide increases suicide risk independent of any mental disorder (Qin, Agerbo, & Mortensen, 2002), while exposure to suicidal behaviour predicts later suicidal behaviour (Nanayakkara, Misch, Chang, & Henry, 2013). Social isolation and the absence of social support are also clearly associated with suicidal behaviour (Fässberg et al., 2012; Haw & Hawton, 2011; Pompili et al., 2014). Kral (2012) shows how imposing Western cultural narratives and practices onto non-Western cultures changes cultural practices and relationships, and argues that high

suicide rates in Inuit youth in Canada are related to these changes. Divorce rates correlate strongly with suicide rates (Inoue, 2009a, 2009b) and the dissolution of an intimate relationship is an important risk factor for suicidal behaviour (Ide, Wyder, Kolves, & De Leo, 2010). Non-heterosexual individuals face two to four times the risk of making a suicide attempt compared to heterosexual individuals (Centers for Disease Control and Prevention, 2012; King et al., 2008). Regarding the gender differences in suicidal behaviour mentioned above, some scholars have argued that these differences may be attributable to the performative and demonstrative aspects of masculinities and femininities (Payne, Swami, & Stanistreet, 2008).

There is robust evidence suggesting a strong link between suicidal behaviour and poverty, with unemployment as one of the factors most consistently associated with suicidal behaviour (Iemmi et al., 2016). High rates of poverty and comorbidity between poverty and suicide in SA (see Table 2.1) mean that the general population is at increased risk of suicide regardless of whether they have a psychiatric or general health condition as well.

Table 2.1.

*Poverty and Suicide in SA*

Indicator	Percent
Suicide cases that are unemployed <sup>a</sup>	56.9%
Current expanded national unemployment rate <sup>b</sup>	36.6%
Population living below national poverty line <sup>c</sup>	45.5%

<sup>a</sup>Stark et al. (2010). <sup>b</sup>Statistics SA (2017a). <sup>c</sup>Statistics SA (2014).

**Epidemiology of suicidal behaviour in SA.** In SA, suicide is a major public health problem (Schlebusch, 2005, 2012). Bantjes and Kagee (2013) summarised the research on suicide epidemiology in SA up to 2011. Suicide was about four times more prevalent among men compared to women, while the average suicide rate from the years 2002–2008 was 13.25 per 100,000. Matzopoulos et al. (2015) report more recent data on unnatural (external)

causes of death in SA. SA has an average suicide rate of 13.4 per 100,000, and suicide is the third leading cause of non-natural death in the country. Suicide is highest in the age group 15–29 years old (accounting for 40.98% of all suicides) and second highest in those aged 30–44 (accounting for 33.36% of all suicides). The current ratio of male to female suicides is 4.6:1. Suicide is highest in the white SA population, followed by Asian, coloured, and finally black South Africans, consistent with previous research on the racial profile of suicides in SA (Flisher & Parry, 1994).

Other nationally representative data estimate a 2.9% lifetime prevalence of suicide attempts and a 9.1% lifetime prevalence of suicidal ideation in the SA population (Joe et al., 2008), comparable to global estimates (see Nock, Borges, Bromet, Alonso, et al., 2008). In a 2013 study, 19% of students in grades 8–11 in government schools in SA reported suicidal ideation in the past six months and 21.8% reported at least one suicide attempt in the past six months (Shilubane et al., 2013). Suicide is also particularly high in prisons. In 2015, there were 61 recorded suicide deaths in all SA prisons (Department of Correctional Services, 2016). At a current prison population of around 161,984 (World Prison Brief, 2016), the prison suicide rate is 37.7 per 100,000, almost three times the national suicide rate, yet these numbers are likely to be underestimated due to a lack of post-mortem examinations (Du Plessis, 2010).

For every suicide, it is estimated that there are between 12 and 30 suicide attempts, with these rates being highest in youths (American Foundation for Suicide Prevention, 2017; National Center for Injury Prevention and Control, 2015; Schlebusch, 2012). Given the current size of the SA population (56.52 million people; Statistics SA, 2017b), there are likely to be around 7,574 suicides in SA in 2017, with 20.8 suicides per day and between 10 and 26 attempts per hour. At this rate, somewhere between 87,000 and 228,000 suicide attempts will be made in SA in 2017.

Suicide rates in SA appear to vary dramatically by region. For example, rates of suicide in six urban cities in SA were found to be 13.4 per 100,000 (Burrows & Laflamme, 2006), while rates in the Transkei (a rural, poverty-burdened region of the Eastern Cape) were a staggering 38.6 per 100,000 (Meel & Leenaars, 2005). This may indicate the importance of socioeconomic circumstances in determining why suicide rates vary by region, as rural regions of SA have poor mental health care service provision and poor crisis-management services (Petersen & Lund, 2011).

The most common methods for suicide in SA are hanging (accounting for 46% of all suicides), poisoning (17%), and death by firearm (13.5%) (Medical Research Council [MRC], 2010). Hanging is consistently the most common method of suicide across age groups (MRC, 2010). However, Bantjes and Kagee (2013) have noted that the available data provide an incomplete picture of suicide in SA, as the data were collated from a number of sources that were not comprehensive in their assessment of suicide in SA. This makes it difficult to draw conclusions about why there are differences in suicide rates according to different variables (e.g., age, gender), as it may be because of demographic differences (i.e., distribution of the population by age) or because there are real risks for suicide associated with different demographic factors.

Suicide is not only a health problem, but an economic one. In industrialised nations (Canada, Ireland, Scotland, New Zealand, United States), the annual cost of suicide is in the region of \$84–\$489 (USD) per capita, from lost productivity and medicolegal expenses (Shepard, Gurewich, Lwin, Reed, & Silverman, 2016). Extrapolating to the SA context (no such figures exist for SA), the cost to the SA economy from suicide deaths in 2017 is likely to be at least R61.7 billion (at an exchange rate of 1 USD = 13 ZAR). These data highlight the importance of suicide as a public health concern, especially because suicides are preventable.



## **Epidemiology of Substance Use in SA**

The latest population-wide statistics on alcohol use are provided by Statistics SA (2016). Amongst SA women, only 25.7% have ever had an alcoholic drink and 18.4% have drunk in the past year. Over a quarter of those who drank in the past year showed patterns of risky drinking, and one eighth showed signs of disordered/problematic alcohol use.

Disordered/problematic alcohol use was highest in women aged 20–24. Amongst SA men, 61.3% have ever had an alcoholic drink and 53.8% have drunk in the past year. Over half of those who drank in the past year showed patterns of risky drinking, and one third showed signs of disordered/problematic alcohol use. As can be seen, more than twice as many men drink as women, and problematic alcohol use is more prevalent amongst males.

Disordered/problematic alcohol use was highest in men aged 25–34, with 21.5% of men in this age group showing signs of alcoholism. Harmful alcohol use is associated with low education level and being from the Coloured population group in both sexes; low socioeconomic status and being in the 20–54 year age group in men; and urban residence and higher income in women (Peltzer, Davids, & Njuho, 2011).

Herman et al. (2009) found that 13.3% of the population report a lifetime diagnosis of a SUD; higher than in most European countries (see Kessler et al., 2007). Rates of comorbidity between SUDs and psychiatric disorders are in excess of 20% (Saban et al., 2014), and nationally representative data show that that high rates of alcohol use (37%), marijuana use (10%) and tobacco use (25%) significantly predict suicidal behaviour among SA youths (Shilubane et al., 2013). Additionally, van der Westhuizen, Wyatt, Williams, Stein, and Sorsdahl (2014) have shown that 43% of patients who present to emergency departments with intentional and unintentional injuries meet diagnostic criteria for a SUD, highlighting the importance of understanding the associations between SUDs and suicidal behaviour.

Substance use in SA differs by region, with the primary substances of misuse in the Western Cape being methamphetamine and cannabis (29%), followed by alcohol (21%) and heroin (13%) (Dada et al., 2017). In contrast, cannabis and alcohol are the predominant substances of misuse in Gauteng (36% and 22%, respectively) the Eastern Cape (24% and 39%, respectively) and KwaZulu Natal (24% and 37%, respectively) (Dada et al., 2017). Van Heerden et al. (2009) report nationally representative data suggesting that alcohol is the most used substance in the SA population (38.7%), followed by tobacco (30%), extra-medical drugs<sup>1</sup> (19.3%), cannabis (8.4%), and other drugs (2%). In their study, males were eight to nine times more likely to use substances than females, except when it came to extra-medical drugs. Drug use was more prevalent in urban areas, and younger participants (aged 18–29) began using alcohol and other drugs at a much younger age than older participants (aged 50+). This may indicate a shift in popular culture over recent decades, with drug use (especially "harder" drug use) becoming more acceptable or accessible earlier on in life. This puts SA youths at an increased risk of using substances earlier on, which may lead to more problematic substance use later in life. Indeed, national studies have shown that 56.4% of SA youths (aged 15–24) have consumed alcohol (Statistics SA, 2016), and 12.7% of school learners have engaged in illegal drug use (Reddy et al., 2010).

SA youths show similar substance use patterns to their older counterparts, with more males than females engaging in harmful drinking and drug use (Meghdadpour, Curtis, Pettifor, & MacPhail, 2012). Meghdadpour et al. also found that, for males, social cohesion, peer support, increased education, and attendance at faith services seems to be protective against alcohol and drug use, while peer pressure, unemployment, and perceived

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<sup>1</sup>Extra-medical drug use refers to the use of alcohol, tobacco, and illegal drugs, as well as prescription over-the-counter drugs for the purpose of getting "high" or for reasons other than what the drugs are prescribed or dispensed for (Van Heerden et al., 2009).

vulnerability to HIV increased the risk of drug and alcohol use. For females, perceived vulnerability to HIV and ever having spoken to friends about HIV were associated with increased drug and alcohol use, whereas strong familial ties and faith service attendance were associated with decreased alcohol and drug use.

## **Health and Mental Health Care Provision In SA**

**Health care provision.** Health care provision in SA has been shaped by the country's political history. In the apartheid era, the tri-cameral arrangement of the government led to health service provision being separated by race (white, coloured, and Indian), with health care provision for black populations being provided by homeland administrations (Van Rensburg, 2012). This led to inequalities in the availability of resources and resultant differences in health outcomes for people belonging to different race groups. Other issues identified between the period of 1960–1994 were fragmentation of services, constraints in the provision of psychiatric services, shortages in staff, poor public education about health, and increased focus on the private sector (Van Rensburg, 2012). The National Health Plan of 1986 sought to rectify many of these issues and established the current tiered model of health care provision (described below), but continued to encourage privatisation of health care (Department of National Health and Population Development, 1986).

After the democratic election in 1994, many apartheid-informed health policies were abolished, but the race and social class inequities in access to and utilisation of health care remained. New health care policies were aimed towards unifying fragmented services, reducing disparities and inequities, and improving access to resources (DOH, 1996, 1997). Access to health care was viewed as a human right, and the state was tasked with providing health care for all citizens. Intersectoral collaboration between different government departments was outlined as important to improve health outcomes, and the focus of health

policies was to attend specifically to the needs of the most vulnerable groups (Van Rensburg & Engelbrecht, 2012).

Currently, health care in SA is provided by two parallel systems (public and private health care). Public health care is provided in a tiered system, is government-funded, and is available to all SA citizens (DOH, 2012). Private health care is funded by medical aid schemes and out-of-pocket payments. There are 83 medical aid schemes in SA, yet these only service around 8.8 million beneficiaries, or around 16% of the SA population of 56.52 million people (Council for Medical Schemes, 2016). This means that the majority of the SA population relies on public health care, and research shows that the public health system services more than 80% of the SA population (Benatar, 2013). The health system is inundated and plagued with stark inequalities (see Table 2.2), and faces multiple challenges such as a high burden of disease and a lack of staff, resources, and infrastructure (Chopra et al., 2009; Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; Econex, 2015).

Table 2.2.

*Inequalities Between Public and Private Health Care*

Measure	Sector	
	Public	Private
Percent of population served <sup>a,b</sup>	84%	16%
Percent of national health care expenditure <sup>c</sup>	48%	52%
Calculated ratio of expenditure per capita in public vs private sector	1	5.3
Number of general practitioners per 100,000 beneficiaries <sup>d</sup>	25.1	92.5
Number of specialists per 100,000 beneficiaries <sup>d</sup>	5.6	86.5

<sup>a</sup>Benatar (2013). <sup>b</sup>Council for Medical Schemes (2016). <sup>c</sup>Organisation for Economic Co-operation and Development (2014). <sup>d</sup>Econex (2015).

**Mental health care provision.** Many advances have been made in public mental health care in SA over the past 20 years. The Mental Health Care Act No. 17 of 2002 marked a turning point in SA's mental health care legislation, as it was the first Act to promote

respect for the human rights of patients with mental health issues, and was aligned with the WHO recommendations to have mental health care integrated into primary health care (PHC) (DOH, 2002). In 2013, the release of the MH Policy and Plan (DOH, 2013) indicated a shift towards provision of person-centred mental health care that is integrated into PHC. However, the aforementioned issues in the health system have obstructed such integration at a PHC level (Marais & Petersen, 2015). Finally, the recent release of the White Paper on national health insurance provides hope that health and mental health care will become more accessible and equitable in SA, as it addresses one of the major fragmentations in the SA health care system: the split between private and public health care (DOH, 2017).

**Treatment for SUDs in SA.** Treatment programs for SUDs in SA may be the most sophisticated on the continent (Myers, Harker, Fakier, Kader, & Mazok, 2008; Pasche & Myers, 2012), but demand for these services far exceeds supply (Myers, Louw, & Fakier, 2008). Barriers such as cost of treatment, access to transport, not knowing where to access services, burdensome travel distances, and more pressing financial priorities combine to prohibit PWSUDs from accessing care (Myers, Kline, Doherty, Carney, & Wechsberg, 2014; Myers, Louw, & Pasche, 2010; Pasche & Myers, 2012). Burnhams, Dada, and Myers (2012) have shown that PWSUDs who experience the aforementioned barriers may be able to access care through social services offices, providing an alternative entry point for accessing health care services. Other historical barriers included the lack of a strategic governmental plan for SUD service delivery, which led to PWSUDs believing that treatment resources do not exist, which in turn led to these patients not seeking treatment (Myers, Louw, et al., 2008). A National Drug Master Plan (Department of Social Development [DSD], 2013a) has since been drawn up, but it is unclear whether these issues have been addressed.

Service provision for PWSUDs is divided between the DOH and the DSD. The DOH is responsible for treating the acute medical needs of SUD and suicide patients, while the

DSD is responsible for psychosocial services, prevention efforts, and community rehabilitation (Myers, Louw, et al., 2008). This organisational structure reflects more global trends to deal with SUDs and other mental health issues separately (for example, in the WHO). Given the high comorbidity between SUDs and other psychiatric disorders (Kandel, Huang, & Davies, 2001; Stein et al., 2008; Zimmerman, Sheeran, Cheliminski, & Young, 2004), it is unclear why these issues are separated or what impact this has on service provision and suicide prevention.

Historically, there has been no national regulating legislation to oversee the training, qualifications, and competencies of substance use prevention service providers (Puljević & Learmonth, 2013), and no minimum norms or standards to serve as guides for substance use prevention interventions (Burnhams, Myers, & Parry, 2009). Minimum norms and standards for in-patient and out-patient SUD treatment centres have recently been promulgated by the DSD, but they continue to lack specificity regarding what sorts of treatment should be offered or how employees at these centres should be trained (DSD, 2013b, 2013c). Combined with under-resourced, underfunded, understaffed treatment facilities, the splitting of service provision and lack of specific training requirements compounds the problem of providing effective care to PWSUDs who may be suicidal (Myers, Louw, et al., 2008).

Affordable state-sponsored SUD treatment facilities have long waiting lists (Myers, Harker, et al., 2008) and private centres with high standards of care are unaffordable for the majority of the population (Pasche & Myers, 2012). Many SA organisations are under-resourced and are forced to offer once-off interventions rather than prevention programmes and long-term/on-going/supported care (Burnhams et al., 2009). Furthermore, only a handful of treatment facilities offer ancillary psychological and psychiatric services, which are desperately needed for PWSUDs who experience or engage in suicidal behaviour (Myers & Fakier, 2009). These psychological and psychiatric services are least likely to be provided at

state-owned or private non-profit facilities (Myers & Fakier, 2009), yet these facilities service the majority of PWSUDs in SA (Myers, Louw, et al., 2008). What is especially concerning is that these services are least likely to be offered to SUD out-patients in particular, who make up the majority of the SUD patient population (Myers & Fakier, 2009). Given the evidence that PWSUDs with comorbid psychiatric difficulties have greater functional impairment, are challenged with more chronic and severe problems, and have poorer treatment outcomes than those who only have a SUD (e.g., Grella & Stein 2006; Johnson et al., 1995; McKay et al., 2002; Padgett, Henwood, Abrams, & Davis, 2008), it is concerning that these facilities are not providing these services.

Some recent research has shown promise for the use of brief interventions for substance use in SA. Sorsdahl et al. (2015) found that a brief blended motivational interviewing and problem solving therapy intervention administered in emergency departments was effective at reducing scores on the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST). However, the same study also found that readiness to change was an important predictor of substance use involvement at three-month follow-up, suggesting that motivational enhancement should be an important part of substance use interventions (Myers, van der Westhuizen, Naledi, Stein, & Sorsdahl, 2016). Similar reductions in ASSIST scores were found by Mertens, Ward, Bresick, Broder, and Weisner (2014) when nurse practitioners delivered a single-session brief motivational interviewing intervention. However, these results were only significant for at-risk alcohol users and the intervention did not lead to reductions in rates of risky substance use at three-month follow-up, suggesting that brief interventions need to consist of more than a single session. Finally, a systematic review has shown that early interventions also hold some promise for reducing harmful substance use in adolescents (Carney & Myers, 2012).

## Suicide Prevention

**Suicide prevention in the global context.** There is a large body of literature describing suicide prevention strategies. The WHO has published a set of broad recommendations on suicide prevention, which suggest generic strategies at three levels (see Table 2.3 for a summary). Various governments have also proposed national strategies for suicide prevention, combining broad directions and some more specific suggestions for suicide prevention (see Table 2.4 for examples). Additionally, professional organisations have proposed standard treatment and clinical practice guidelines, which provide more specific direction to clinicians on the assessment and management of suicidal behaviour (see Table 2.5 for examples of these and the principles they advocate; see also Bernert, Hom, & Roberts, 2014, for a systematic review of such guidelines). There are also more specific, evidence-based interventions, which describe very specific strategies for preventing suicide in high-risk individuals (see Table 2.6 for examples).

There are a number of systematic reviews that summarise the evidence base for specific suicide prevention interventions; see for example Mann et al. (2005), van der Feltz-Cornelis et al. (2011), and Zalsman et al. (2016). These interventions include restricting access to means for suicide, improving access to mental health care services, improving the abilities of health care providers (especially general practitioners) to screen for and manage depression and suicide risk, and training community gatekeepers to recognise suicide warning signs and link at-risk individuals with mental health services. One limitation with these various interventions is that they are typically implemented as isolated interventions and therefore attend to only a single risk factor for suicide. To address this, the national



Table 2.3.

*Summary of Suicide Prevention Strategies Proposed by the WHO*

Level of approach	Description
Universal	Target the general population and focus on health promotion, through strategies such as: reducing access to means; improving access to mental health care; and reducing harmful substance use.
Selective	Target vulnerable groups through strategies such as training gatekeepers to identify warning signs and establishing services such as helplines.
Indicated	Target specific high-risk individuals, like PWSUDs, by improving their access to mental health care, improving identification and management of suicidal behaviour, offering community support, and increasing training and education for health care workers working with these patients.

*Note.* Summarised from "Preventing suicide: A global imperative," by WHO, 2014a, retrieved from [http://www.who.int/mental\\_health/suicide-prevention/world\\_report\\_2014/en/](http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/).

Table 2.4.

*Examples of National Suicide Prevention Strategies*

Country	Guiding Principles	Action Areas
United States <sup>a</sup>	<p>Healthy public dialogue about suicide should be fostered.</p> <p>The needs of vulnerable groups must be prioritised.</p> <p>Interventions should be applied in a context-specific manner.</p> <p>Interventions should be coordinated and integrated.</p> <p>Changes in policies, systems and environments to prevent suicide should be promoted.</p>	<p>Build healthy and empowered individuals, families, and communities, by integrating suicide prevention interventions across sectors and settings, changing negative attitudes and behaviour, increasing knowledge of protective and wellness-related factors, and promoting responsible media reporting of suicide.</p> <p>Provide clinical and community preventive services, including implementing effective programmes to promote wellness and prevent suicide, reducing access to means, and training service providers to prevent suicide.</p> <p>Provide treatment and support services, by making suicide prevention a core component of health services, implementing effective suicide risk management protocols, and providing care and support to suicidal individuals.</p> <p>Strengthen research on suicide prevention.</p>
Australia <sup>b</sup>	<p>Suicide prevention activities will do no harm.</p> <p>There will be community ownership and responsibility for action to prevent suicide.</p> <p>Service delivery will be client-centred.</p> <p>The responsibility for suicide prevention lies with individuals, professional groups and services across the community.</p> <p>Interventions should be provided in a coordinated and integrated way according to the needs of the individual and community.</p>	<p>Improve the evidence base and understanding of suicide prevention.</p> <p>Build individual resilience and the capacity for self-help.</p> <p>Improve community strength, resilience and capacity in suicide prevention.</p> <p>Take a coordinated approach to suicide prevention.</p> <p>Provide targeted suicide prevention activities.</p> <p>Implement standards and quality in suicide prevention.</p>

Suicide prevention activities will occur across eight overlapping domains of care and support.

Safety nets should be provided to support people moving between treatment options and back into the community.

Japan<sup>c</sup>

Comprehensive approaches take social factors into account.

Efforts should be made to have individual citizens play a leading role in suicide prevention.

Measures should be combined effectively to deal with each stage and each target group.

Inclusive support must be strengthened for everyday life by coordinating all those concerned.

Policies must be based on actual conditions of suicide.

Policies are tested and evaluated from a mid- and long-term perspective.

Suicide prevention measures are promoted based on the actual conditions of each targeted group.

Efforts between government, non-governmental organisations (NGOs), local authorities, businesses, related organizations, and the general public must be coordinated to have maximum effects on suicide prevention.

Clarify the actual conditions of suicide.

Encourage citizens to be aware of and monitor potential suicide victims.

Train personnel who play a central role in early response.

Promote mental health.

Ensure that appropriate psychiatric care is received.

Prevent suicide through social measures.

Promote measures to deal with suicide-related information on the internet.

Prevent repeat suicide attempts.

Improve support for the bereaved.

Strengthen coordination with NGOs.

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<sup>a</sup>United States Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention (2012). <sup>b</sup>Australian Government Department of Health and Ageing (2008). <sup>c</sup>Japanese Ministry of Health, Labour and Welfare (2015).

Table 2.5.

*Examples of Suicide Prevention Clinical Practice Guidelines and the Strategies They Advocate*

Professional Body/Government Department	Underlying Principles	Strategies for Suicide Prevention
National Institute for Health and Clinical Excellence <sup>a</sup>	<p>Treat patients with compassion, respect and dignity.</p> <p>Adopt a non-judgemental approach to the patient.</p> <p>Ensure that patients are consulted in the treatment process.</p> <p>Ensure health care providers are adequately trained to manage risk of suicidal behaviour.</p> <p>Health care providers work cooperatively while caring for suicidal individuals.</p>	<p>Acute-care interventions, including treatment of self-inflicted injuries, acute care management, and risk assessment.</p> <p>Treatment of underlying psychopathology.</p> <p>Referral to specialised services.</p> <p>Activation of psychosocial support.</p> <p>Designing long-term care and risk management plans.</p>
APA <sup>b</sup>	<p>Thorough psychiatric evaluation is imperative for managing suicide risk.</p> <p>Respect for cultural differences.</p> <p>Health care providers work cooperatively while caring for suicidal individuals.</p>	<p>Psychiatric evaluation, including assessment of suicide risk.</p> <p>Establish a psychiatric management plan, including treatment of psychopathology with pharmacological and psychotherapeutic means.</p> <p>Risk management.</p> <p>Psychoeducation for family of the suicidal individual.</p> <p>Strengthen research on suicide prevention.</p>
Spanish Ministry Of Health, Social Services And Equality <sup>c</sup>	<p>Suicidal behaviour should be addressed from a broad perspective.</p> <p>Comprehensive assessment of suicidal individuals should involve health professionals from different levels of care.</p> <p>The development of a strong therapeutic alliance between patient and professional should be promoted.</p>	<p>Acute medical treatment of suicidal behaviour-related injuries.</p> <p>Comprehensive psychiatric assessment, including assessment of suicide risk and associated risk factors.</p> <p>Refer high-risk patients to specialised services.</p> <p>Treat suicidal behaviour and psychopathology with</p>

Establishing support in the patient environment is a pharmacological and psychotherapeutic means.  
fundamental part of the therapeutic process.

Patient is consulted at all stages of treatment.

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<sup>a</sup>National Institute for Health and Clinical Excellence (2004, 2011, 2013). <sup>b</sup>Jacobs et al. (2003). <sup>c</sup>Working Group of the Clinical Practice Guideline for the Prevention and Treatment of Suicidal Behaviour (2012).

Table 2.6.

*Specific, Evidence-Based Suicide Prevention Protocols and Their Key Features*

Protocol	Underlying Principles	Key Treatment Features	Examples of Studies Showing Evidence for Effectiveness
Collaborative Assessment and Management of Suicidality (CAMS) <sup>a</sup>	<p>Empathy for the suicidal individual.</p> <p>Collaboration between clinician and patient regarding suicide assessment and risk management plan.</p> <p>Honesty and forthrightness with the patient.</p> <p>Maintaining clinical documentation that reflects excellent practice helps decrease liability.</p> <p>Flexibility and adaptability across theoretical orientation, discipline, and clinical setting are central.</p>	<p>Establish a strong clinical alliance and increase patient motivation.</p> <p>Comprehensively assess suicidal risk.</p> <p>Develop and maintain a problem-focused treatment plan that is suicide-specific.</p> <p>Sit next-to, rather than across from, the suicidal individual when working out a risk management plan.</p> <p>Use the Suicide Status Form to guide assessments, treatment planning, tracking of ongoing risk, and clinical outcomes.</p> <p>Focus only on suicide prevention, not on treatment of comorbid conditions.</p>	<p>Comtois et al. (2011)</p> <p>Andreasson et al. (2016)</p> <p>Ellis, Rufino, and Allen (2017)</p> <p>Ellis, Rufino, Allen, Fowler, and Jobes (2015)</p>
The Safe Alternatives for Teens & Youths (SAFETY) Program <sup>b</sup>	<p>Rooted in a social-ecological cognitive-behavioural model.</p> <p>Treatment is guided by a cognitive-behavioural fit analysis (CBFA) that specifies key risk and protective processes hypothesized to impact the likelihood of repeat suicide attempts for each youth.</p> <p>Focus specifically on preventing suicidal</p>	<p>CBFA of suicidal behavior; including explaining how suicidal behaviour "fits" within multiple systems (families, peers, school, community) through an ecological analysis, identifying risk and protective factors to be targeted through treatment plan.</p> <p>Enhance protective familial support and monitoring in the home.</p>	<p>Asarnow et al. (2015)</p>

	behaviour in adolescent suicide attempters. Emphasise enhancing protective supports within social systems (family, peers, community). Family focus aims to increase parent motivation and decrease family treatment barriers.	Ensure a safe environment by restricting access to potentially lethal methods. Develop and practice SAFETY plan, to change maladaptive thought patterns. Collaborate with youth and family to develop the treatment plan and targets. Implement treatment plan, to strengthen emotion regulation and distress tolerance.	
Cognitive-based therapy for suicide prevention <sup>c</sup>	Specified session structure. Time-limited therapy. Interventions are cognitive or behavioural in nature, and are chosen dependent on cognitive case formulation. Patient and clinician work collaboratively. Clinician delivers all interventions in the context of a warm, non-judgmental, empathetic, collaborative therapeutic setting.	Identify and evaluate automatic thoughts and beliefs. Modify fundamental dysfunctional thoughts and beliefs, through cognitive reappraisal and restructuring, modifying core beliefs, identifying reasons for living, developing coping cards, reducing impulsivity. Implement behavioural strategies (such as increasing pleasurable activities, improving social support, sensory self-soothing) to modify mood and manage overwhelming emotions that do not involve self-harm. Develop and implement a suicide safety plan.	Brown et al. (2005) Stanley et al. (2009) Tarrier, Taylor, and Gooding (2008)

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<sup>a</sup>Jobes (2016). <sup>b</sup>Asarnow, Berk, Hughes, and Anderson (2015). <sup>c</sup>Stanley et al. (2009) and Wenzel, Brown, and Beck (2009).

suicide prevention strategies mentioned in Table 2.4 have been designed as integrated, multi-level social ecological approaches to suicide prevention. It is possible that by designing multi-level strategies (employing universal, selective, and indicated interventions at once), greater reductions in suicide will be realised than by implementing isolated interventions. At least one such multi-level strategy has shown effectiveness at reducing suicide rates (Hegerl et al., 2010). For these interventions to be effective, intersectoral collaboration and integrated health care are required.

The implementation of a national suicide prevention plan appears to lead to consistent reductions in suicide rates in countries like the United Kingdom (Office for National Statistics, 2017), although national suicide prevention strategies around the globe appear to have varying effectiveness at lowering the suicide rates for different population groups (Matsubayashi & Ueda, 2011). Research shows that clinicians' abilities to predict suicide based on the assessment of risk factors is no better than chance (Franklin et al., 2017). Despite this, current approaches to suicide prevention are typically premised on individual risk-factor models, with interventions usually being aimed at identifying at-risk individuals, putting them in contact with MHCPs, and attenuating risk factors (Mann et al., 2005). Additionally, most suicide prevention interventions suggest approaches that are useful for high-risk groups in general but lack specificity for particular high-risk groups (e.g., PWSUDs). Particularly in settings where resources are limited, there may be contextual factors that make these approaches unsuitable. Research in other LMICs has indicated that there are specific contextual (social, economic, and cultural) and personal variables that need to be accounted for when preventing suicide in PWSUDs (Armstrong et al., 2014). As such, biomedical risk factor approaches to suicide prevention may be unsuitable for high-risk groups, yet specific guidelines for particular at-risk populations (such as PWSUDs) and for particular low-resource contexts have not been developed.



In the global south, multiple barriers impede access to mental health care, such as stigma, refusal of care (Nguyen et al., 2010), and lack of recognition that a person with a mental disorder requires psychiatric care (Tuan, Dalman, Thiem, Nghi, & Allebeck, 2009). At least one study has shown that a lack of resources, training, and time are perceived as barriers to suicide prevention in low-resource settings (Medina, Kullgren, & Dahlblom, 2014). Another study has shown that infrastructural and familial factors were associated with suicide attempts in PWSUDs, while more established risk factors such as depression and anxiety were not (Armstrong et al., 2014). This highlights the importance of understanding the context of suicide, how different high-risk populations may experience specific risk factors, and how contextual factors within the health care system may hinder suicide prevention. It is unclear at present what contextual factors may act as barriers to suicide prevention in the specific context of providing care to PWSUDs in SA.

**Suicide prevention and policy in SA.** In SA, a lack of intersectoral collaboration and integrated care have been noted as barriers to the provision of mental health care in general (Brooke-Sumner, Lund, & Petersen, 2016). Research shows that the nature of suicides and their correlates and predictors vary by region in SA (Burrows & Laflamme, 2006; Meel & Leenaars, 2005), and patients who have attempted suicide in SA may not be receiving the psychological and psychosocial support that they require in emergency psychiatric units (Bantjes et al., 2016). This is supported by other SA studies showing that psychiatric patients in general do not receive the psychosocial care that they need (Joska & Flisher, 2007) and that doctors and nurses in PHC facilities often feel insufficiently trained to deal with psychiatric emergencies (Petersen et al., 2009; Temmingh & Oosthuizen, 2008; Van Deventer, Couper, Wright, Tumbo, & Kyeyune, 2008).

In SA, some progress has been made in the past 20 years to prioritise the mental health needs of the population and improve mental health services in the country. Despite the

agenda for research on suicide and its prevention suggested by Bantjes and Kagee (2013) and the possible suicide prevention strategies and plans suggested by Burrows and Schlebusch (2008) and Schlebusch (2012), no progress has yet been made to plan or implement coordinated, targeted suicide prevention interventions in SA.

The backbone of current mental health policy in SA is the MH Policy and Plan (DOH, 2013; commentary on other mental health legislation can be found elsewhere: Ramlall, 2012; Schneider et al., 2016). The MH Policy and Plan outlines clear commitments to integrating mental health care into general health services, with a focus on PHC. Suicide is mentioned three times in the document. First, it is subsumed under the intention to develop a national public education programme on mental health, part of which is to inform the population of the availability of suicide prevention helplines. Second, it is stated that suicide prevention should be the responsibility of district mental health teams, but that it should be embedded in PHC so that risk factors for suicide can be identified in all health service provision. Third, it is noted that a national suicide prevention programme should be developed.

Based on the MH Policy and Plan, it appears that the necessary intention has been set to address suicide as a public health problem and to incorporate interventions at a PHC level. However, omissions of the details of how this is to be done preclude us from knowing how these objectives will be achieved. It is unclear whether a public education campaign has yet been run, and it is not stipulated who should be responsible for or fund suicide prevention helplines (most current national suicide prevention helplines, e.g., Lifeline, SADAG, Befrienders, are still run on a volunteer basis by NGOs). Additionally, a national suicide prevention programme has not yet been developed, and there is no indication as to whether this programme will aim to reduce suicidal behaviour across all population groups or whether it will focus on implementing targeted interventions for high-risk groups like PWSUDs.

The intention to integrate suicide prevention into PHC is imperative. Research in high-income countries has shown that suicidal patients are more likely to come into contact with general health services than mental health services in the year preceding their death, and that the majority of those who die by suicide come into contact with a PHC provider in the month preceding their death (De Leo, Draper, Snowdon, & Kølves, 2013; Luoma, Martin, & Pearson, 2002). This highlights the need to train PHC providers to screen for suicidal behaviour and to intervene where necessary. Given the current rate of 2.6 clinical psychologists per 100,000 of the SA population but only 0.47 clinical psychologists and 0.03 psychiatrists per 100,000 employed in public rural PHC facilities (De Kock & Pillay, 2017a, 2017b), having specialist mental health teams oversee mental health care in each district may be a good way to utilise limited resources. The MH Policy and Plan offers little clarity on how the district specialist mental health teams will oversee the training of PHC practitioners in suicide prevention, how appropriate services might be provided, who will be responsible for suicide prevention interventions, and how these will be most effectively integrated into PHC.

### **Qualitative Research in Suicidology**

As noted in Chapter 1, critical suicidologists have focused on promoting non-positivist methods of inquiry into suicidal behaviour. Their critiques of mainstream suicidology include pointing out that quantitative research continues to focus on investigating already well-established risk factors for suicidal behaviour (Hjelmeland, 2016; Hjelmeland & Knizek, 2016; White et al., 2016b), despite the fact that dominant, biomedical risk-factor models cannot help us predict suicide any better than by chance (Franklin et al., 2017). White (2016) highlights that risk factors are not static entities and do not help us understand the phenomenon of suicide, or how social arrangements and factors combine with

demographic and psychiatric risk factors to produce vulnerability to suicidal behaviour. Qualitative research, which can help explore lived experience and the contextual and cultural determinants thereof, is needed to understand suicide and its prevention more comprehensively.

A number of qualitative studies have been conducted in the field of suicidology. Hjelmeland and Knizek (2016) have summarised some of the literature on qualitative psychological autopsy studies. These studies differ from their quantitative counterparts in that they investigate suicide from the perspectives of many of the bereaved and they focus on uncovering the meaning of suicide and what might have led to it, rather than on assigning a psychiatric diagnosis (cf. Cavanagh et al., 2003). These reviewed studies highlight that psychiatric symptoms appear to play an insignificant role in suicide from the perspective of the bereaved, with factors such as self-esteem, experienced meaninglessness, existential struggles for control, psychosocial stressors, particular culturally-relevant gender roles, and context-dependent life experiences playing a more prominent role (see the studies by Kizza, Knizek, Kinyanda, & Hjelmeland, 2012a, 2012b; Kjølseth, Ekeberg, & Steihaug, 2009, 2010a, 2010b; Rasmussen, Dyregrov, Haavind, Leenaars, & Dieserud, 2015; Rasmussen, Haavind, Dieserud, & Dyregrov, 2014).

White (2016) conducted a review of the qualitative literature in suicidology pertaining to suicide ideation, suicide attempts, and suicide prevention. The studies reviewed fell into three broad categories: (1) lived experiences of suicidal behaviour; (2) conceptualisations of suicidal behaviour and suicide prevention; and (3) practices and perceptions of care and treatment for people who have experienced or engaged in suicidal behaviour. Studies assessing lived experiences of suicidal behaviour have investigated what it was like to attempt suicide (e.g., Rosen, 1975), why people choose different methods (e.g., Biddle et al., 2010; Biddle et al., 2012), emotions surrounding suicidal ideation and attempts (e.g., Bostick

& Everall, 2006, 2007), social and familial factors perceived to contribute to suicidal behaviour (e.g., Nolle, Gulbas, Kuhlberg, & Zayas, 2012; Zayas, Gulbas, Fedoravicius, & Cabassa, 2010), and the paradoxes present in suicidal behaviour (e.g., Holm & Severinsson, 2011; Vatne & Naden, 2012).

Conceptualisations of suicidal behaviour and suicide prevention have been investigated from the perspectives of health care providers and suicidal individuals themselves. Suicidal behaviour is variously considered to be related to social exclusion and stigmatisation (Kidd, 2004), struggles around sexual identity and gender (Roen, Scourfield, & McDermott, 2008), culturally-specific gender roles (Hjelmeland et al., 2014; Knizek et al., 2011; Mugisha et al., 2013; Osafo et al., 2011a, 2011b), and disruptions in family life or romantic relationships (Kral, 2013).

Practices and perceptions of care and treatment have also been investigated from a wide variety of perspectives. These include attitudes and beliefs surrounding suicidal behaviour and experiences of providing or receiving care. Suicidal individuals tend to experience care as positive and helpful, provided that health care providers are caring, kind, and empathic, and practice a humanistic approach in their work (Cardell & Pitula, 1999; Cutcliff, Stephenson, Jackson, & Smith, 2006; Jordan et al., 2012). When health care providers do not embody these characteristics, suicidal individuals report experiencing care as upsetting and negative (Cardell & Pitula, 1999). Aspects of care experienced as most meaningful include flexibility in the treatment programme, offering informal types of support, and connecting with the health care provider (Cutcliff et al., 2006; Jordan et al., 2012). The attitudes, beliefs, and experiences of health care providers are discussed in greater detail below.

**Health care providers' attitudes and beliefs about suicidal behaviour.** A systematic review has shown that medical professionals hold largely negative attitudes

towards people who harm themselves and that doctors hold worse attitudes than nurses (Saunders, Hawton, Fortune, & Farrell, 2012). Compared to medical professionals, MHCPs had more favourable attitudes towards people who harm themselves (Saunders et al., 2012). Multiple studies have found that doctors and nurses endorse ideas that people who are suicidal have a mental illness (notably depression), that people should have the right to take their own lives, and that suicide is an impulsive act (Anderson & Standen, 2007; Domino, Lin, & Chang, 1995; Domino & Perrone, 1993; Domino & Shen, 1997). When patients have made multiple suicide attempts, MHCPs hold more negative attitudes towards them, chiefly because these patients continued to try and take their lives despite the efforts MHCPs were making to help them (Bailey, 1994; Sun, 2004). Of note is that medical professionals' attitudes are more negative towards PWSUDs than towards those who harm themselves (Saunders et al., 2012). This highlights how suicidal PWSUDs are particularly vulnerable to being treated poorly by medical staff. More professional education and experience with suicidal patients leads to more positive attitudes towards these patients (McLaughlin, 1994; Samuelsson, Sunbring, Winell, & Åsberg, 1997; Sun, Long, & Boore, 2007).

Health care providers acknowledge that their attitudes towards suicidal patients affect service provision by either facilitating or preventing adequate care (Hawton, Marsack, & Fagg, 1981; Sun et al., 2007). Negative or hostile attitudes towards suicidal patients are likely to decrease MHCPs' interest in helping these patients (Samuelsson et al., 1997). Negative attitudes (e.g., rejection, judgment) towards suicidal patients tend to reinforce patients' feelings of hopelessness and worthlessness, while positive attitudes can be protective by helping patients feel loved and cared for (Aish, Ramberg, & Wasserman, 2002). In one study, MHCPs recognised that they need to help suicidal patients identify the precipitants of their suicidal thoughts (Long & Reid, 1996). Attitudes towards suicidal patients are likely to influence MHCPs' experiences of suicide and suicide prevention.

**Health care providers' experiences of patient suicidal behaviour.** While no research has investigated the experiences of MHCPs in providing care for suicidal PWSUDs specifically, there is literature documenting medical and mental health care providers' experiences of providing care to suicidal patients in general. In SA, one study investigated the experiences of nurses who provided care for medical patients who had died by suicide by jumping out of third-story hospital windows (Matandela & Matlakala, 2016). The nurses felt blamed, guilty, inadequate, and helpless for not being able to help the patients. They also thought they were undertrained and unprepared for such events. In other regions, health care providers experience a range of responses to patient suicides that may negatively impact on their mental health, including stress, guilt, self-blame, anger, shame, sadness, depression, self-doubt, a sense of responsibility, isolation, and helplessness (Castelli Dransart, Gutjahr, Gulfi, Kaufmann Didisheim, & Séguin, 2014; Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989; Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988; Gaffney et al., 2009; Jacobson, Ting, Sanders, & Harrington, 2004; Ting, Sanders, Jacobson, & Power, 2006). These experiences were found to negatively impact on MHCPs' effectiveness as service providers, with many becoming concerned about their competence as professionals as well as possible legal implications of patient suicidal behaviour (Chemtob et al., 1988; Dewar, Eagles, Klein, Gray, & Alexander, 2000).

One study investigated psychiatric nurses' experiences of providing care for patients who harm themselves, and found that they experienced significant burdens in their work providing care for these patients (Wilstrand, Lindgren, Gilje, & Olofsson, 2007). Wilstrand et al. identified the importance of releasing health care providers from these emotional burdens for the sake of their mental health and for the quality of patient care that they were able to provide. A close relationship with the suicidal patient, especially with patients who die by suicide, is more likely to result in a patient's suicidal behaviour having a greater

negative impact on the MHCP (Gulfi, Heeb, Castelli Dransart, & Gutjahr, 2015). This often results in MHCPs needing to seek professional help themselves to help work through the loss of a patient by suicide. In some instances, clinicians' responses to patient suicidal behaviour are so severe that they come close to meeting clinical criteria for mental health conditions such as post-traumatic stress disorder (Castelli Dransart et al., 2014; Takahashi et al., 2011). However, research has also found that MHCPs who have support from colleagues feel much less affected by the adverse effects of a patient's suicidal behaviour, and those who have received specific training in self-care are able to cope better with the demands of their jobs (Gulfi et al., 2015; Mache, Bernburg, Baresi, & Groneberg, 2016).

### **Moving Research on Suicide Prevention Forward**

Our inability to predict suicide (Franklin et al., 2017) is obviously problematic, as it leaves clinicians unable to know who is at highest risk for suicide, making it difficult to know how to prevent suicide in high-risk groups. Some critical suicidologists argue that people who have tried to kill themselves are the "real experts" on suicidal phenomena (Hjelmeland, 2012, p. 18), and are therefore best positioned to help improve our knowledge of how to prevent suicide. However, this is problematic, as asking a patient about their experiences with a mental health issue may not have much relevance for prevention or treatment (Bantjes & Swartz, 2017). MHCPs have professional knowledge of preventing suicide in PWSUDs (gained during their training) as well as lived experiences of providing services. This positions them ideally to reflect on suicide prevention, which could have valuable implications for suicide prevention in clinical practice.

To-date, global research on suicide has focused largely on epidemiology, risk factors, and testing various methods for suicide prevention. This has been important to describe the current state of suicide and its associated risk factors, and has helped discover some effective



suicide prevention interventions. In SA, we have some knowledge of risk factors for suicide, but very little evidence for effective suicide prevention interventions. Much of the available qualitative research in suicidology has focused on describing MHCPs' attitudes and professional and emotional responses to patient suicidal behaviour. This has provided insight into the challenges faced by MHCPs, and has shown us that MHCPs' negative responses to suicidal behaviour impact on their abilities to provide services. However, no research has focused on the factors that MHCPs perceive to contribute to their experiences and the implications this has for clinical practice. The emotional responses of MHCPs are likely to have a bearing on how they conceptualise suicide, how they understand their responses to suicidal patients, and the ways that they provide treatment (Mackay & Barrowclough, 2005). Exploring MHCPs' real-world suicide prevention experiences and how they understand these experiences may help provide a more nuanced understanding of health care provision and suicide prevention in high-risk groups such as PWSUDs. Additionally, investigating MHCPs' experiences preventing suicide in a high-risk population in SA might help provide directions for targeted, context-appropriate suicide prevention interventions.

## **Conclusion**

In this chapter, I outlined the epidemiology of suicidal behaviour around the globe and in SA, and I discussed the epidemiology of substance use in SA. This, along with describing health care provision in SA and the particular niche of treatment provision for PWSUDs, has helped set the context for the present study. A summary of the literature on suicide prevention was provided and the current state of suicide prevention in SA was examined in the context of the MH Policy and Plan. Finally, I discussed qualitative research in suicidology with a particular focus on the attitudes, beliefs, and experiences of MHCPs.

## **Chapter 3**

### **Research Paradigm and Theoretical Points of Departure**

#### **Introduction**

In this chapter, I discuss the research paradigm for my research and why research paradigms are important theoretical points of departure in critical suicidology. To preface this chapter, I restate my research questions:

1. What experiences do MHCPs have when preventing suicide in PWSUDs in SA?
2. What specific factors do MHCPs perceive to contribute to their experiences preventing suicide in PWSUDs in SA?
3. What can we learn about the health care and contextual factors that impact on suicide prevention in PWSUDs seeking care in SA, from the experiences of MHCPs?
4. What can be said about the context of suicide prevention in SA, based on the factors MHCPs perceive to contribute to their experiences?
5. What do MHCPs think is required for preventing suicide in PWSUDs?
6. What sense can be made of MHCPs' ideas for suicide prevention in the context of health care provision in SA?

To answer these research questions, I situate my research within the research paradigm of postpositivism. Below, I outline what research paradigms are and explain each axiom of the postpositivist research paradigm adopted in this research. I do this to highlight the assumptions I make about knowledge, reality, what is knowable, and how it can be known in this research. This is especially important given the qualitative research design that I utilise and the inductive approach I take to data analysis (see Chapter 4). I conclude with a

discussion of the importance of considering research paradigms as theoretical points of departure within the field of critical suicidology.

## **Research Paradigms**

All researchers, whether they know it or not, subscribe to a particular worldview and way of understanding reality when thinking about and designing research studies. This worldview, or research paradigm, is a basic set of philosophical beliefs that defines the nature of reality, an individual's place in that reality, and the relationships between the varying elements and parts of that reality (Guba & Lincoln, 1994). It is a metaphysical approach that represents a collection of constructed ideas and assumptions about the world whose truthfulness can never ultimately be established (Denzin & Lincoln, 2005). The research question usually determines which research paradigm should be chosen, and the chosen research paradigm informs every subsequent aspect of the research process, from the ways the data are collected, understood, deconstructed and reconstructed, to the ways in which the researcher locates themselves within the research (Leavy, 2014).

Guba and Lincoln (2005) state that research paradigms have an axiomatic nature, and that the axioms are defined in terms of ontology, epistemology, and methodology. Postpositivism combines a critical realist ontology with a modified dualist/objectivist epistemology, and may use a variety of qualitative methodologies (Guba & Lincoln, 2005). Postpositivist approaches to research acknowledge that reality exists independent of human perception, but that a critical approach should be taken to the nature of that reality and its constituent components (Guba & Lincoln, 1994). This allows the researcher to recognise that physical reality is overlaid with a multiplicity of social and interactional realities, and that the relationships between these realities can be questioned and explored. Below I explain each axiom of postpositivism and how I have understood it in my research.

**Ontology.** Ontology refers to the dimension of a research paradigm concerned with understanding the nature and structure of reality and social entities (Bryman, 2012; Leavy, 2014). The ontological question is: What is the nature and form of reality and what can be known about it? (Guba & Lincoln, 1994). Ontological considerations concern whether reality is appraised as something external to those who exist and act within it, or whether it is shaped and defined by those social actors (Bryman, 2012).

From the critical realist ontological perspective in postpositivism, the world can be defined as a stratified open system (Bhaskar, 2008). It is stratified because each structure/system has constituent parts that have properties unique and separate from, perhaps even antithetical to, that structure/system. When the parts of a structure/system come together, their emergent properties generate that structure/system and its new, unique properties. The world is an open system because each system is influenced by and influences other systems, where unobservable causal laws interact to generate changes in observable events (Bhaskar, 2008). Each agent in a system is acted on by and acts on that system, such that social realities can be defined by "linking structure and agency, with structures conditioning rather than determining agents' behaviour" (Cruickshank, 2012, p. 73). Research grounded in such an approach allows a critical investigation of a system, leading to generation of a scientific perspective of how a system functions, finally leading to knowledge that can be used to suggest policy and structural reforms if/where necessary (Archer, 1995).

Adopting a critical realist ontology in my research means that I assume that MHCPs provide mental health care services in a variety of systems. The largest system I define for this study is SA. SA can be thought of as a context that, for a range of historical reasons (the most prominent being apartheid), is characterised by income inequality, political unrest, a dearth of health care resources (Coovadia et al., 2009), and a diversity of cultures, languages, and people. Within that system is the SA health care system, within which is the SA mental

health care system, consisting of myriad buildings, structures, people, patients, policies, legal frameworks, economic constraints, and protocols that govern and condition the behaviour and happenings within that system. Each MHCP works in an institution or setting that forms a smaller system within the larger mental health care system. In turn, each institution or setting has its own buildings, structures, policies, and protocols that constitute it and govern what happens within it, which may be different from other institutions and settings. Institutions, settings, and MHCPs interact, giving rise to the open organisation of the system of reality. Each MHCP is a part of the system of the institution where they work, the larger mental health care system, the country of SA, and any number of other affiliated bodies, such as the Health Professions Council of SA (HPCSA). In other words, MHCPs are some of the emergent properties of each of these systems, but they have their own characteristics, experiences, and perceptions that may not necessarily reflect those of the systems they inhabit and constitute. Recognising that MHCPs are parts of these systems and by-products of those systems, but are not necessarily the systems themselves, allows a critical approach to be taken to their realities and the systems that they constitute.

**Epistemology.** Epistemology refers to the theory and nature of knowledge about the world (Bryman, 2012). It concerns the relationship between the researcher and the researched, and the epistemological question would be: How can I know the world? (Denzin & Lincoln, 2005). Epistemological considerations concern whether one takes a positivist or interpretivist approach to reality, or whether one falls somewhere in between (Bryman, 2012). The qualitative research process is an embodied, co-constructed activity between researcher and participant (Hesse-Biber & Leavy, 2011). The researcher is the research instrument, as involved in the process of meaning-making as the participant, intertwined in the construction and interpretation of reality. Research participants are considered to be the

experts in the research process, integral to the co-creation of meaning and essential to the understanding of phenomena (Gergen, 2001; Leavy, 2014).

As noted above, postpositivism encompasses a modified dualist/objectivist epistemology, where researchers reject the assumption that there is a completely objective external reality, but maintain that objectivity serves as a "regulatory ideal" (Guba & Lincoln, 1994, p. 110). In other words, reality exists somewhat independently of people but cannot be studied objectively. Reality is subject to interpretation, and qualitative postpositivist research is therefore always considered to be broadly interpretivist, even though it contains elements of a positivist epistemology (Denzin & Lincoln, 2005). Reality and knowledge are affected and influenced by those who study, analyse, and interpret it. Reality can be discovered and investigated, and theories can be generated, but they must always be falsifiable (Leavy, 2014).

Investigating the world using a modified dualist/objectivist epistemology in this research entails recognising that there is an observable, physical, external reality within which experiences occur and perceptions are formed. When providing mental health care services to PWSUDs, MHCPs do and say certain things, and those things have real, observable consequences in the world. However, how reality is appraised by MHCPs is dependent on their interpretations of reality rather than on some single "truth" of reality. Investigating these interpreted realities allows us to uncover what MHCPs experience when preventing suicide in PWSUDs, their perceptions of the factors that contribute to these experiences, and what they think is important for preventing suicide in PWSUDs. Moreover, it allows us to explore MHCPs' experiences and perceptions of the systems they inhabit and their roles in these systems, linking to the critical realist ontology discussed above.

**Methodology.** Methodology refers to how the researcher can go about discovering what can be known about any particular reality, and delineates the steps, processes and tasks

that a researcher must engage in to successfully conduct research on a particular topic. The methodological question is: How can the researcher find out whatever they believe can be known? (Guba & Lincoln, 1994). Within the postpositivist paradigm, a variety of research methods may be used, and qualitative methods may be particularly appropriate (Guba & Lincoln, 1994). In qualitative research, the methodology should be hermeneutical (focused on interpretation and meaning), dialogical (concerning dialogue) and dialectical (allowing different and potentially contradictory meanings to arise through the logical discussion of ideas and opinions) (Guba & Lincoln, 1994). Only through interactions between the investigator and the respondent(s) can the meanings of phenomena be elucidated. Knowledge must be therefore be revealed through dialogical interactions that allow the interpretation of social phenomena. The interchange between researcher and participant provides a context for phenomena to come alive and for insight to be illuminated.

An important methodological strength of postpositivism is the emphasis on investigation of a topic/an issue from multiple viewpoints in order to gain a more complex and well-rounded understanding of the topic, and to provide opportunities for hypotheses to be falsified rather than verified (Guba & Lincoln, 1994). This allows an opportunity to uncover and map different aspects of a phenomenon, rather than to validate a diverse data set (McEvoy & Richards, 2003). In my research, this entailed interviewing MHCPs from a range of professions (psychiatry, psychology, counselling, and social work) in order to uncover a multiplicity of experiences, interpretations, and perceived realities related to suicide prevention in PWSUDs. The methods for this study are discussed in detail in Chapter 4.

### **Theoretical Points of Departure in Critical Suicidology: Some Considerations**

I locate my research broadly within the field of critical suicidology. As noted in Chapter 1, critical suicidologists argue that: (a) suicide is context-dependent; (b) qualitative research will help uncover the specific meanings inherent in the context-dependent act of suicide; (c) the truths about suicide can best be discovered through qualitative enquiry; and (d) only by uncovering the contexts of suicide can we hope to transcend the limitations of current approaches to suicide prevention (see Hjelmeland, 2011; Hjelmeland & Knizek, 2010, 2011; Kral, 2012; Marsh, 2016; White, 2015; White et al., 2016b). Indeed, the critical turn in suicidology has been important to help challenge dominant, de-contextualised, deterministic views of suicide and suicide prevention, and has opened up avenues for critical research on suicide prevention (Bantjes & Swartz, 2017; White, 2015; White et al., 2016b). Investigating the political, cultural, historical, and socioeconomic antecedents and contexts of suicide is important to inform effective suicide prevention interventions (White, 2015; White et al., 2016b).

Critical suicidologists make at least three related, implicit, a priori assumptions: first, that suicide should, in fact, be prevented; second, that current risk-factor approaches to suicide prevention are not working; and third, that employing qualitative methods without a consideration of the research paradigm within which those methods are situated is sufficient to generate useful/meaningful knowledge about suicide prevention. In this section, I will trouble these assumptions. I first outline that the assumption that suicide should be prevented stems from a moralistic view of suicide, and that this may be problematic. I then motivate for why considering research paradigms ahead of choosing an appropriate research method is crucial in research on suicide and its prevention in order to generate knowledge that is useful.

The assumption that suicide should be prevented stems from a moralistic view of suicide as something that is wrong, as a problem to be solved, as something that health care



providers have a responsibility to address (see Donnelly, 1990). However, the cultural and contextual meanings of suicide have shifted across time and place (see Fitzpatrick, 2014). Counter-arguments to this moralistic view might include: (a) whether we are actually removing personal autonomy and agency by preventing a person's suicidal behaviour, thereby acting not in their best interests but against their freedom of choice; (b) whether the right to life also means the right to death; and (c) whether there are conditions under which allowing or even facilitating suicide is more humane and respectful than preserving life (e.g., in a case of incurable terminal illness where the person constantly experiences unbearable pain). Discussion of the various ethical, religious, and philosophical issues concerning suicide can be found in Battin (1995). All I wish to do here is highlight that it is important to recognise that doing research on suicide prevention often implies an a priori assumption that suicide should be prevented, that this assumption is contended in the literature, and that assuming that suicide should be prevented has implications for the paradigms that can be used to research suicide and its prevention.

Indeed, the assumption that I make in this research is that suicide should be prevented. By outlining my a priori assumption that suicide should be prevented, I am acknowledging further assumptions that: (a) saving other people's lives is important; (b) as a researcher in the field of suicidology, I have a responsibility to help prevent suicide; (c) suicide is real and is not primarily socially constructed; (d) suicide can, in fact, be prevented; and (e) there are probably actionable steps that can be taken to prevent suicide, although what these are and how appropriate these are in different contexts may need to be discovered. These assumptions already reveal that I require a research paradigm that combines components of both positivist and interpretivist research paradigms. As such, in designing this research project, I needed to consider how the assumptions I make about the nature and

structure of reality, how I can come to know that reality, and how I can investigate that reality are informed by my assumptions about suicide and its prevention.

Bringing this all together, my assumption that suicide can and should be prevented means that I require a research paradigm that allows me to investigate how reality is experienced, perceived, and influenced by those who constitute it, and how those perceptions and experiences shape and are shaped by the actual observable structures of reality. For these reasons and those noted above, the chosen paradigm for this research is postpositivism. By approaching research in this way, I am able to show how the paradigmatic assumptions I make have influenced my choice of research methods and the broad framework that I use to understand and interpret the data.

Other researchers in the field of critical suicidology appear not to make such explicit links between their a priori assumptions about suicide and its prevention, how this influences and is influenced by the research paradigm they adopt, and how this determines appropriate research methodologies. In their proposals to conduct more qualitative research, critical suicidologists imply that this research should be conducted within interpretivist paradigms (including phenomenology, hermeneutics, and social constructionism), where the focus of the research is on discovering the social and cultural meanings of suicide. The lack of explicit paradigmatic considerations is potentially problematic, as implicitly interpretivist approaches to suicide research run the risk of viewing suicide as so context-specific and culturally-determined that we cannot say whether any approach to preventing suicide would be helpful or effective. From this purely interpretivist research paradigm, if asked what would prevent suicide, one could only answer, "Well, it depends." In the SA context, Bantjes and Swartz (2017) have noted the difficulties of making truth claims about the importance of culture in suicide prevention and the danger of reifying culture and context as undeniable determinants

of suicide. This reification may stem from a lack of consideration of the research paradigm within which researchers conceptualise suicide and its prevention.

In critical suicidology, as perhaps in other critical disciplines, research paradigms can be considered the foremost theoretical points of departure. Consideration of theories of knowledge and reality should precede consideration of theories of behaviour and how best to investigate reality. As a paradigmatic point of departure, postpositivism allows something of a middle ground between objective positivist paradigms and subjective interpretivist paradigms. Suicide must be prevented in the world "out there," with an acknowledgement of the objective existence of the structures of reality. Postpositivist approaches to qualitative research allow us to accept the existence of those structures, but to challenge, question, and critique them. By conceptualising qualitative research on suicide and its prevention within a postpositivist paradigm, researchers can acknowledge the context-dependence of suicide and its prevention (the interpretivist side of postpositivism), but can also remain aware of the established risk factors for suicide, the effective interventions likely to help prevent suicide in most contexts, and the necessity to move beyond thinking about suicide to implementing interventions to prevent it (the positivist side of postpositivism).

It is likely that by adopting a research paradigm combining positivist and interpretivist elements, context-dependent knowledge that is specific to time and place but that is relevant to and grounded within external reality will be generated and will be most useful for informing suicide prevention interventions. In the context of needing suicide prevention interventions that are more population-specific and context-appropriate, doing qualitative research within the postpositivist paradigm may be the way forward in critical suicidology.

## **Conclusion**

In this chapter, I have explained what a research paradigm is, what its axioms are, and why postpositivism is an appropriate research paradigm within which to answer my research questions. Thereafter, I explained the importance of considering a research paradigm as a theoretical point of departure in the context of critical suicidology. It is important to reiterate that a research paradigm is not a theoretical framework. It is a worldview and an approach to research. As such, I do not attempt to analyse the data as it pertains to a postpositivist research paradigm. Rather, by explicating the research paradigm, I allow the reader to understand how I have conceptualised and understood knowledge, research, methods, and the social world in my research.

## **Chapter 4**

### **Methods**

#### **Introduction**

Bryman and Burgess (1994) have noted that qualitative researchers are often vague about the exact methods of analysis used, given that it is somewhat difficult to explain exactly how a particular theme was arrived at after successive readings of lengthy interview transcripts. Additionally, Mays and Pope (2000) highlight that "clear exposition of methods of data collection and analysis" (p. 51) is critical if any qualitative research is to be considered of high quality. The methods of data collection invariably influence the research participants in some form or another. Asking particular questions, following up certain points, and honing in on specific issues are all ways that the methods of data collection and the researcher themselves (as the tool for data collection) influences the types of responses elicited from the participants. These should be detailed as far as possible so that the reader is able to understand exactly how the research progressed from conceptualisation through to the final written product (Mays & Pope, 2000).

Below, I provide a detailed description of the research design, how I designed the interview schedule, and how I collected and analysed the data. Thereafter, I discuss the ethical considerations of my research. To conclude, I note the measures I took to ensure trustworthiness and rigour in my research and I reflect on my positionality in my research.

#### **Research Design**

I have used a qualitative research design in my research. Qualitative research is an engaged approach to research that prioritises increasing our understanding of social reality by generating knowledge about peoples' lived experiences (Leavy, 2014). While quantitative

methods are useful for testing hypotheses and theoretical relationships, they may be too limited and reductionist for exploring and studying the social world and do little to further our understanding of social phenomena (Martin & Stenner, 2004). Qualitative research is well suited for the exploration of personal phenomena, such as MHCPs' experiences of suicide prevention, and may be the only way to truly understand how people perceive and interpret their realities.

Qualitative research can generate vast amounts of detailed data (Pope, Ziebland, & Mays, 2000) and benefits from an iterative approach to data collection and analysis. This entails a process of continuous engagement with the data and research questions, allowing the researcher to modify, adapt, and reformulate the interview questions as the series of interviews proceeds, to ensure that all aspects of the investigated phenomena are covered. It can be thought of as a continuous process of thinking with the data (Jackson & Mazzei, 2012) rather than about the data. Continuously engaging with the data and the research process allows the meanings in the data to unfold.

There is often a misnomer that qualitative research is not as rigorous or systematic as quantitative research, and that the findings are subjective, anecdotal, and overly descriptive without delving into the meaning behind the findings. And of course, this can be true, but only for poor quality qualitative research. High quality qualitative research can be as rigorous and systematic as any quantitative research when it is able to "document its claim to reflect some of the truth of a phenomenon by reference to systematically gathered data" (Fielding, 2001, p. 160). In my research, I have taken such an approach to data collection and analysis, in order to do justice to the experiences, perceptions, and ideas of the participants.

## **Approaching the Literature**

Some qualitative researchers (e.g., Charmaz, 2006) recommend that a reading of the literature pertaining to a research project should be postponed as far as possible until after the data have been collected. This serves two purposes: (1) it allows the researcher to approach the research topic, data collection, and data analysis "fresh," with less chance that the literature they have read will interfere with and shape the research process, and (2) it allows the researcher to find the most relevant literature for the data, rather than extracting the most relevant data for the literature, as may happen in an attempt to prove that one's research is important and is supported by other literature.

I suspended a deeper reading of the literature on suicidal behaviour, substance use, and health care provision until I had completed a large portion of the data collection. Initially, I only read the literature that helped provide a rationale for why this research is important and why it needed to be done; in other words, the literature showing that substance use is a risk factor for suicidal behaviour and that suicide and its prevention are relatively poorly understood phenomena in SA. As I began collecting my data and started to see the stories that were emerging from the interviews with MHCPs, I began to realise the value in having not extensively read all the literature on these issues, as it would have most likely shaped the way I conceptualised these issues and the ways in which I analysed the data. My relative inexperience in this field helped ensure that I was able to examine the data as inductively as possible, without trying to fit it to some body of literature and without my ideas of what themes were important being heavily influenced by literature I had read.

## **Sampling and Recruitment of Participants**

I used purposive and snowball sampling to recruit a diverse range of MHCPs who had experience working with suicidal PWSUDs. Purposive sampling entails selecting

participants because they are able to provide detailed descriptions of the phenomena under study and because the research question is likely to be significant to them (Smith & Osborn, 2008). Purposive sampling enables the researcher to carefully choose a sample that is acutely relevant to the research question and that consists of participants who can provide a comprehensive array of opinions and experiences on the topic of inquiry. Interviewing participants with a deep understanding of the topic, who indicate that they are willing to share openly and honestly about their experiences, is important in qualitative research (Creswell, 2013). Snowball sampling entails asking participants to identify other potential participants who are able to contribute to the research based on similar expertise (Ritchie & Lewis, 2010). Snowball sampling is useful when it is difficult to know as the researcher who would be able to offer expert opinion on the topic of interest.

My supervisor and a colleague who ran an out-patient SUD treatment clinic at a tertiary hospital in Cape Town (Groote Schuur Hospital) had each worked in the mental health field in SA for over a decade. Both were intimately acquainted with public and private mental care settings in SA and were able to suggest a limited number of possible participants who worked in mental health care, had experience working with suicidal PWSUDs, and would be able to provide insight on the research questions for my research. This formed the purposive phase of the sampling procedure. Once I had contacted and interviewed participants suggested by my supervisor and his colleague, I asked these participants whether they could suggest any colleagues of their own who they thought would be able to contribute in a meaningful way to my research. This formed the snowball phase of the sampling procedure. I informed participants that participation in my study was voluntary and I asked all participants to provide written informed consent (see Appendix A). Three potential participants did not respond to invitations to participate, 18 consented, and none refused to



participate (more detail is provided below in the section "Data Collection" on why 18 participants were interviewed).

I applied the principle of maximum variation sampling to ensure that I gathered as wide and diverse a range of opinions and perspectives on the topic of investigation as possible (Creswell, 2013; Patton, 2015). The sample included psychiatrists, clinical psychologists, registered and lay counsellors, and social workers. Collecting data from a diverse sample of MHCPs who worked in a range of different settings was important for critical multiplism or methodological triangulation (Guba & Lincoln, 1994). This enabled a wide range of opinions and insights to be obtained from MHCPs with different types of training, exposure to different health care environments, and different types of experiences providing care to suicidal PWSUDs.

### **Description of Participants**

Participants are described in Table 4.1. Most participants (11) were female and most (12) were registered with the HPCSA (either as psychiatrists, clinical psychologists, or registered counsellors). Between all participants, there was an average of 9.6 years worked with PWSUDs and a collective 173.3 years of experience working with PWSUDs.

Participants had worked in a variety of roles in a variety of settings, including: as treatment providers in out-patient SUD treatment facilities, in-patient SUD treatment facilities, psychiatric hospitals, emergency psychiatric units in tertiary hospitals, consultation-liaison settings in general hospitals, private practice, NGOs, the SA Police Force, prisons, schools, and community health clinics; lecturers and researchers at universities; and advisors to the SA government on policies related to substance use.

Table 4.1.

*Participants' Characteristics*

Pseudonym	Sex	Type of MHCP	Number of years	
			worked with PWSUDs	Settings worked in
Kagiso	M	Psychiatrist	10	Emergency psychiatry Out-patient psychiatry Consultation-liaison psychiatry
Berkeley	M	Psychiatrist	6	Emergency psychiatry Out-patient psychiatry in general hospital Out-patient SUD treatment facility (public) Psychiatric hospital out-patient unit
JC	M	Psychiatrist	6	Psychiatric hospitals Community health clinics Public hospitals Private practice
Izelle	F	Psychiatrist	20	Emergency psychiatry Psychiatric hospitals Community health clinics
Sophie	F	Clinical psychologist	6	NGO Public hospital Psychiatric hospital
Charlie	M	Clinical psychologist	10	Psychiatric hospital In-patient SUD treatment facility (private) Out-patient SUD treatment facility (private) Private practice
Tatum	F	Clinical psychologist	3	Out-patient SUD treatment facility (public) Psychiatric hospitals
Francesca	F	Clinical psychologist	31	Out-patient SUD treatment facility (public) Private practice

Mo	M	Social worker	19	Out-patient SUD treatment facility (public) NGO Private practice
Jeanri	F	Social worker	7	Out-patient SUD treatment facility (public) NGO NGO
Courtney	F	Social worker	5	Out-patient SUD treatment facility (public) SA Police Force
Soraya	F	Social worker	14	Out-patient SUD treatment facility (public) NGO
Insaaf	F	Registered counsellor	6	Out-patient SUD treatment facility (public) Public hospital out-patient clinic NGO
Frank	M	Registered counsellor	5 months	School Community groups Community health clinic
Babalwa	F	Registered counsellor	4	Out-patient SUD treatment facility (public) In-patient SUD treatment facility (public) NGO Private practice
Josephine	F	Registered counsellor	19	NGO Prison
Shaun	M	Lay counsellor	6	Out-patient SUD treatment facilities (public) Psychiatric hospital University Government (consultant)
Michelle	F	Lay counsellor	11 months	Out-patient SUD treatment facility

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## Data Collection

**The interview schedule.** I chose semi-structured interviews for this study because they are well suited for the exploration of participants' experiences, perceptions, and ideas, and allow for deeper exploration and clarification of an issue than a structured interview (Willig, 2013). In a semi-structured interview, the interview flows as a conversation and allows interesting aspects of the topic to be explored in the moment. Semi-structured interviews also had the added advantages that they helped organise the interviews and ensured that data were collected on all the topics and sub-topics of interest (Willig, 2013).

To design the interview schedule, I noted down each research question, and underneath it, I drafted some preliminary questions, such as: "Tell me about your experiences providing care to people with substance use disorders?"; "Tell me about your experiences providing care to people with substance use disorders who have been suicidal?"; "What do you think would support you in your work providing care to suicidal people with substance use disorders?" After the first two interviews, my supervisor and I discussed the interviews and the questions. Based on this discussion, we refined the questions to focus more on (a) the positive experiences of MHCPs, (b) the negative experiences of MHCPs, and (c) their ideas for suicide prevention. After three more interviews, we discussed the interview questions once more, as I had begun to form an idea of what the common threads were in the data. Again, we refined the interview questions so that we were finally asking about (a) the experiences of MHCPs in preventing suicide in PWSUDs, (b) the barriers that MHCPs perceived in their work preventing suicide, and (c) their ideas for suicide prevention. The final interview schedule can be found in Appendix B.

**Collecting the data.** I collected qualitative data using semi-structured, face-to-face interviews. I interviewed new participants until data saturation occurred. Data saturation refers to reaching a point in data collection where no new/novel information can be gleaned

from conducting further interviews (Morse, 1995). Theoretically, the data collection process can continue *ad infinitum*, as one never knows whether the next case may produce data that contradicts previous interviews. However, a middle ground can be found where the researcher is able to present a comprehensive understanding of the phenomenon under study that is coherent and integrated, without sacrificing the nuances in the participants' accounts (Elliott, Fischer, & Rennie, 1999). I collected and analysed the data concurrently, in an iterative fashion, as far as the practical limits of interview transcription would allow. This allowed me to determine when a point of sufficient data saturation had been reached, at which point I stopped collecting data (see "Searching for themes" below for further details).

I arranged for each interview to take place at a time and place of the participant's choosing, and most interviews lasted approximately one hour (ranging from 38 min to 1 hr 43 min). I conducted all interviews in English, although I informed participants that they were welcome to speak Afrikaans if they so chose. I digitally audio-recorded and transcribed all interviews, and collected the data between 02 September and 30 November 2016.

I collected all data under the supervision of Dr Jason Bantjes (registered with the HPCSA as a counselling psychologist). I conducted the interviews in a way that was sensitive and empathetic. If a participant looked uncomfortable, I asked them whether the question I was asking them made them uncomfortable and whether they wanted to stop the interview. No participants indicated that any of the questions I asked were too emotionally challenging for them to answer (see "Ethical Considerations" below for more details).

## **Data Analysis**

I used thematic analysis (Braun & Clarke, 2006) to analyse the data inductively. Thematic analysis is a technique of organising and describing qualitative data in rich detail (Braun & Clarke, 2006). It is a rigorous method of data analysis that allows explication of

each step of the analysis process, such that there can be little to no doubt about what the researcher did to arrive at the research findings after having collected the data. It allows the researcher freedom in defining what a theme is and what is important in the data, and it allows the researcher to convey the stories and messages in the data untainted by other research or theory (Braun & Clarke, 2006). Once the data have been analysed and themes have been identified, the researcher can return to the literature, and can find the literature that suits the data most appropriately for the research questions. In this way, the qualitative researcher has completed a truly inductive research cycle, from defining research questions a priori, to deciding on the research paradigm most appropriate to investigate the research questions, to collecting data in ways that are consistent with the research questions and paradigm, to analysing the data inductively, and finally to interpretation of the data in the context of literature most relevant to the data.

Thematic analysis proceeds through six phases, namely: (1) familiarising oneself with the data; (2) generating initial codes; (3) searching for themes; (4) reviewing themes; (5) defining and naming themes; and (6) producing the report (Braun & Clark, 2006). Table 4.2 indicates Braun and Clarke's summary of each phase of thematic analysis. Codes are considered the smallest meaning units in the data and represent elements of the raw data that appear interesting or appear to be relevant to the research questions (Boyatzis, 1998; Braun & Clarke, 2006). Themes are meaningful aspects of the data that are related to the research questions and are in some way patterned across the data set (Braun & Clarke, 2006). A theme need not be present in all data units (i.e., interviews) but should reflect something important that is present in a number of the data. Additionally, the importance of a theme is determined by what it illuminates about the research questions rather than its frequency or prevalence in the data set (Braun & Clarke, 2006).

Table 4.2.

*Phases of Thematic Analysis*

Phase	Description of the process
1. Familiarising yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

*Note.* Adapted from "Using Thematic Analysis in Psychology" by V. Braun and V. Clarke, 2006, *Qualitative Research in Psychology*, 3, p. 87. Copyright 2006 Edward Arnold (Publishers) Ltd.

I coded and organised themes using the software program ATLAS.ti for Mac<sup>2</sup>.

Thematic analysis was an appropriate data analysis method for my research as the research questions are not theory-bound, and neither is the method of analysis (Braun & Clarke, 2006). I analysed the data inductively, allowing the data to drive the findings, rather than searching for themes to fit within a particular pre-existing theory/body of literature. Below, I outline how I analysed the data during each phase of thematic analysis.

**Familiarising yourself with the data.** The first phase of data analysis entailed listening to the audio recordings, transcribing the recordings, and reading through the transcribed data. I listened to each audio recording for the first time as I transcribed it. Once

<sup>2</sup>Version 1.0.50, Copyright © 2013-2016 ATLAS.ti Scientific Software Development GmbH.

I got to the end of the audio recording, I listened to it again to check that the transcription was 100% accurate. Thereafter, I read through each interview once before commencing with coding, to familiarise myself further with my transcripts. At this stage, I was already forming ideas on what the prevalent themes in the data were. However, I was careful to put these aside mentally while coding (see "Bracketing" below.). I wrote memos to note down my initial reflections and thoughts on the data. Memos are a written record of each element of the data collection and analysis process, including reminders to return to certain sections or look up specific literature, and notes to compare what one participant was saying to another (Willig, 2013). I used memos to help track my thoughts on possible themes, my own reflections on the data, and the progression of my ideas as I read through the transcripts.

**Generating initial codes.** I coded the first nine interviews using open, line-by-line coding, a strategy that aligns historically with the methods of grounded theory (see Charmaz, 2006; Corbin & Strauss, 2015; Glaser & Strauss, 1967). While the method of data analysis employed here is thematic analysis, line-by-line coding is a rigorous approach to data analysis that allows any possible code to be identified in the initial round of coding, and can also be a part of thematic analysis (Braun & Clarke, 2006). Generating codes inductively entailed scrutinizing the transcribed text to identify what the meaning behind the participant's communication might be, and then assigning a code to each section of text (be it a word, phrase, or paragraph). At this point I had generated around 3,500 different codes.

I then read through the data I had collected up to that point once without coding further, to immerse myself in the data and to get a broader picture of what themes might be present across the data. This helped me identify similarities and differences in participants' stories, and allowed me to gain a greater perspective on the topics I had investigated. This also helped me begin to weave together the narratives of different participants. I used memos extensively during this time to note down (a) my thoughts on links between what one



participant was saying and what another was saying, (b) possible broad themes that I was seeing in the data, and (c) personal reflections on the data, its meanings, and its relevance for service provision and the organisation of health care in SA.

**Searching for themes.** The next phase of analysis entailed a detailed reading of the codes already generated to link them to other, similar codes. I did this by creating code groups on Atlas.ti. I went through this process slowly and methodically as I wanted to ensure that I thought carefully about each code, what it and the related quotes meant, and where they fitted into the broader picture. As a result, I ended up with 28 code groups.

Next, I drew up an outline of how the code groups were related to one another and what each code group represented in the data. I did this after having had a break from the data, so that the ideas had time to percolate and collect themselves in my mind. I wrote the skeleton/outline of the findings *de novo*, returning periodically to the code groups to see what they were and to help organise the findings in the most coherent and sensible way. I also made use of the memos I had written to help guide my thoughts and to remind myself of the relationships between code groups I had noted previously. This led to an outline of five possible major themes: (1) experiences of MHCPs; (2) understanding health care provision; (3) fragmentations/problems in the healthcare system; (4) needs; and (5) ideas for suicide prevention.

At this point, nine interviews had been conducted and coded using line-by-line coding, those codes had been organised into groups of codes, and those groups of codes formed the basis of the themes. I then recommenced collecting and analysing the data. As I continued collecting the data, I analysed the transcripts and compared them to the previous transcripts and themes already identified. This technique of examining the data and checking them against each other is known as constant comparison. Constant comparison entails analysing each discrete data item (for example, a paragraph or quote) against other data items

to establish different categories (Pope et al., 2000). I realised by the sixteenth interview that I was not seeing any more new themes (in other words, I was reaching a point of data saturation). I conducted two more interviews before cessation of data collection.

As a final part of this step in the analysis, I read through interviews 10–18, and made detailed memos on them. During this process, I focused on looking for common themes that had emerged in the first nine interviews (derived from the code groups), as well as noting any novel themes and ideas that emerged in the new transcripts. This ensured that I kept an open mind so that I could identify new themes, and so that I was not fitting the un-analysed data to the themes that I had already tentatively generated. I then coded interviews 10–18 using the 28 code groups and assigned new codes where appropriate.

**Reviewing themes.** To review the themes, I compared the memos that I had written on all of the interviews with the themes that I had generated from the first nine interviews. Some new themes had emerged in interviews 10–18, which were added to the theme list. I then read through the interview transcripts and memos and cross-checked them against the themes, codes, and quotes to ensure that the themes were a fair and accurate representation of the underlying data. By the end of the data analysis, I had identified 19 themes in the data. The 19 themes were sorted into three superordinate themes, which became the outline of the three separate findings and discussion chapters of this thesis.

**Defining and naming themes.** I defined and named the themes in an iterative fashion, and changed the names of the themes slightly as I analysed the interviews and drafted the findings. I identified the three superordinate themes as: (1) experiences preventing suicide; (2) perceptions of barriers to suicide prevention; and (3) ideas for suicide prevention. Within the superordinate theme "Perceptions of barriers to suicide prevention," I grouped themes under subordinate themes. I did not do this in the other two superordinate themes as it did not seem appropriate. Table 4.3 provides an overview of the themes

identified in the data. I named each theme according to the data that it represented, and I derived some theme names directly from quotations.

Table 4.3.

*Themes Identified in These Data*

Superordinate theme	Subordinate theme	Theme
Experiences of preventing suicide	(None)	Hopelessness, helplessness, impotence, and guilt
		Managing emotional experiences
		Suicide risk assessment and management are problematic
		Perceptions of substance use
		Treating SUDs might increase suicide risk
Perceptions of barriers to suicide prevention	Structural issues in service provision	A lack of resources
	Contextual issues extending beyond health care	Insufficiencies in training
		Fragmentations in the organisation of care
		Poverty and inequality
		The breakdown of family
Ideas for suicide prevention	(None)	Stigma
		Providing support
		Instillation of hope
		Conditions of good care
		Providing effective treatment
		Integrated and comprehensive care
		Resource requirements and utilisation
		Early prevention
		Reducing stigma

**Producing the report.** While writing up the findings, I searched through the quotes linked to each theme to find the quotes most illustrative of the theme. These are included in the findings chapters. Data from all 18 interviews are included in the findings, to ensure that there was no bias towards or against any participants.

## **Ethical Considerations**

I obtained ethics approval for this study from Stellenbosch University Health Research Ethics Committee (N16/02/026; see Appendix C) and the University of Cape Town Human Research Ethics Committee (352/2016; see Appendix D). This study posed no risk to the physical health of participants. I explained the research questions and methods of the study to potential participants prior to participation. I emphasised that participation was voluntary and that the participant could stop the interview if they became uncomfortable. Each participant provided written informed consent prior to participation, to ensure that they understood the research and any risks involved with participation. Given that this research involved topics of a personal and possibly sensitive nature, I assured participants that they did not have to answer any questions they felt uncomfortable with, and could terminate the interview at any time should they become uncomfortable.

Participant anonymity is particularly important in research on potentially sensitive topics. It is therefore crucial to ensure that participants feel safe and protected in the research endeavour, such that they may provide as full and rich an account of their experiences as possible. To anonymise the data, I gave all participants the opportunity to choose a pseudonym to protect their identities, and I assigned them pseudonyms if they elected not to choose one. Only one participant (Shaun) explicitly stated that he did not want a pseudonym to be used. To protect the privacy of the participants, I entered the collected and anonymised data into a password-protected database. Only my supervisor and I had access to the database, and any hard-copy data (e.g., interview schedules) were kept in a fire-proof safe in the Department of Psychology at Stellenbosch University.

There is a risk in qualitative research that investigates potentially painful/difficult phenomena that it may cause participants psychological harm by re-traumatising them (Cutcliffe & Ramcharan, 2002). This concern may be perceived to be especially valid for

research on suicidal phenomena, as the topics are sensitive and there is a concern that talking about these phenomena might cause emotional distress to participants (Deeley & Love, 2010). However, research has shown that this concern is unfounded and it is unlikely that participation in research on suicidal behaviour will increase participant distress (Crawford et al., 2011; Crocker, Clare, & Evans, 2006; Muehlenkamp, Walsh, & McDade, 2010; Rivlin, Marzano, Hawton, & Fazel, 2012). Rather, participation in research gives participants an opportunity to relay their experiences and to contribute to research (Biddle et al., 2013) and may give them a sense of relief or a greater sense of happiness after the interview (Rivlin et al., 2012).

While the risk of disturbing participants in this research was low, given that participants were only talking about their experiences of providing services, it was nonetheless important to ensure that I had not elicited any negative emotions. After I conducted each interview, I asked each participant what it had been like for them to talk about their experiences and to reflect on preventing suicide in PWSUDs. I did this to provide an opportunity for participants to debrief in case they felt they needed to. I had been trained in person-centred counselling, which prepared me to debrief participants. Many told me that they had found it refreshing to be able to talk about their experiences and that the interview had given them a grasp on how important and central suicide prevention was in their work with PWSUDs. Many said that they felt relieved to be able to tell their story for a change, as they were usually the ones who had to sit patiently and listen.

An important priority for all health-related research is beneficence: that the research should ideally benefit the participant. It was my hope that this research would have some sort of direct benefit for the participants in some way, and would perhaps be able to indirectly affect the lives of PWSUDs who feel suicidal. I was happy to learn that participants had found the interview experience to be positive. Hopefully, through publication of the findings,

this research will be able to have a positive impact in some way on other MHCPs who provide services for PWSUDs.

### **Trustworthiness and the Importance of Quality in Qualitative Research**

Guba (1981) and Guba and Lincoln (1981) recognised the problems of trying to equate quantitative methodological rigour with qualitative methodological relevance and scientific excellence. As a way to outline the comparable elements of both forms of research, they defined four major criteria that relate to the trustworthiness of a research project: (1) truth value; (2) applicability; (3) consistency; and (4) neutrality. Each of these criteria has comparable quantitative and qualitative concepts, and I employed a number of methods to meet each of these criteria in my research (discussed below).

**Credibility and truth value.** How can we know the "truth" of the findings of a research inquiry with a particular set of participants in a particular context? In quantitative research, this question is answered by demonstrating internal validity, or an acceptable level of agreement between the data of the project and the phenomena (reality) those data purport to represent (i.e., isomorphism or verisimilitude between the data and the phenomena; Guba, 1981). In qualitative research, the comparable concept is credibility. Credibility refers to the amount of agreement between the data and the perceived reality of the respondents (Guba, 1981; Guba & Lincoln, 1981; Shenton, 2004). A robust way to test credibility is to go back to the interviewees after having made interpretations of the data and written up the findings, and ask them whether they feel the research report is representative of their experiences (i.e., is it credible and plausible?). This is known as respondent validation and is a way of reducing error in the interpretations of the data rather than ensuring that the data are perfectly representative of the wider population's experiences and opinions (Mays & Pope, 2000). A more immediate way to check the credibility of findings is to ensure that the researcher asks

clarifying questions during the interview process to ensure that they understand the data as the participant intended them. This is known as on the spot member checking (Mays & Pope, 2000). To ensure credibility in this research, I tested my understanding of what participants said using on the spot member checking. I asked clarifying questions to ensure that my interpretation of what participants were saying matched theirs, and noted where my interpretations had differed from those of my participants.

**Transferability and applicability.** How can we know whether the findings of one research study will be applicable to other studies, in other contexts, or with other participants? In quantitative research, the requirement that the findings be generalisable (or have external validity) ensures that the research is conducted in such a way that any chronological or contextual variations of the research study have an insignificant impact on the results and are thus irrelevant (in an ideal world, of course) (Guba, 1981). However, the world changes constantly, and generalisations cannot hold true forever, a point that Cronbach (1975) made over 40 years ago. This points to the strength of qualitative methodologies, which veer away from making claims about the generalisability of research findings and toward a recognition of the intimate intertwining between a particular context and point in time and a particular research enquiry. Qualitative research favours transferability over generalisability (Guba, 1981). There is a good chance that some inherent similarity between two contexts or groups of respondents will mean that investigation of the same phenomena in the other context/group will yield similar findings. If two contexts fit a similar mould, one could formulate tentative hypotheses that findings uncovered in context A have a good chance of being found in context B (i.e., the research is transferable). However, it will be up to new researchers to test this transferability, and it is only the responsibility of the initial researcher(s) to provide enough data that transferability may be assessed (Bradley, 1993).

To enhance transferability and attenuate problems caused by situation uniqueness, Guba (1981) suggests that purposive sampling be utilised and a thick description of phenomena and participants be produced (see also Geertz, 1973). Purposive sampling ensures that a wide scope of detailed phenomena is covered and explored, resulting in a saturated understanding of the topic. Pursuing a thick description of the sample and phenomena ensures that other researchers know enough about the research to be able to examine the fit of the findings to similar contexts (Geertz, 1973). By using purposive sampling, providing a thick description of the findings, giving a description of the participants, providing sufficient data in the findings, and discussing the findings in relation to the contexts to which they refer, I enhance the ability of readers to assess the transferability of the findings of my research to similar contexts with which they are familiar.

**Dependability and consistency.** How can we know whether the same findings from a study will be found if that study were conducted multiple times with the same or similar participants in the same or a similar context? Stability of findings over time is encapsulated by the concept of reliability in quantitative research. Reliability is more a precondition for validity than an essential requirement in its own right (Guba, 1981), and any variance in a quantitative research instrument can be ascribed to error. In qualitative research, consistency is about dependability (Guba, 1981). Consistency in qualitative research is more challenging to maintain than in quantitative research, as the research instrument (the researcher) is themselves dynamic and malleable, continually changing as they grow and adapt to the environmental constraints around them. Rather than concerning oneself with the ability of the research instrument to perform in the exact same manner time in and time out, qualitative research seeks dependability: that the researcher will change, adapt, and grow; that the method of collecting data will evolve rather than remain exactly the same as the research process unfolds (Guba & Lincoln, 2005). Dependability is about "trackable variance" (Guba,



1981, p. 81) that can be accounted for by various sources, such as error, as well as shifts in reality or increases in the efficiency and proficiency of the research instrument (the researcher). By meticulously documenting the research process, particularly data collection and analysis, the dependability of the research is maximised (Guba, 1981). This can be likened to an audit trail (consisting of, for example, memos of field notes, researcher's reflections, and actual interview transcripts) that can be checked and scrutinised in a "dependability audit" by an external agent who ensures that due diligence was carried out and that the research process was of an acceptable quality.

Using extensive memos to record the coding process, my thoughts on possible themes, reflections on the data, and the progression of my ideas as I collected and analysed the data helped me track the variance in the research process. This ensured that I was able to identify when and for what reasons changes in reality, in the data, or in my interpretations of the data had occurred. My supervisor checked the codes and themes against the interview transcripts and supervised the data collection and analysis closely. These procedures, records, and checks helped ensure the dependability of my research.

**Confirmability and neutrality.** How can one know that the findings of a study are free of investigator characteristics such as personal agendas and motivations, bias, perspectives, and interests, and are a function only of the research context and the research participants? Objectivity is the first synonym that might spring to mind, and it is indeed objectivity that quantitative researchers seek by doing things such as employing standardised tests, removing themselves from any aspect of the research process that might influence the findings (particularly data collection), and making the research process transparent. The burden of demonstrating neutrality in qualitative research is shifted onto the data rather than the researcher, as the researcher need not evince neutrality of themselves (which would be impossible, given the supposition that the researcher is the research instrument) but only need

show the confirmability of the data (Guba, 1981). By being able to show that the data were collected in a certain way, using a particular research protocol, and by noting the limitations of the data collection process, the data can be confirmed as collected in a scientifically sound way without making any claims about objectivity (Guba, 1981; Shenton, 2004). A confirmability audit can be conducted at the end of the research process to ensure that for every interpretation there is corresponding and relevant data, and a useful way to do this is to include sufficient quotes in the findings (Guba, 1981).

In this chapter, I have provided a detailed description of the methods used to collect and analyse the data, and I include verbatim quotes in the findings and discussion chapters to support the themes and interpretations of the data. In the final chapter of the thesis, I note the limitations of this research. This, along with having my supervisor check the codes and themes against the interview transcripts, helped ensure the confirmability of the findings. Additionally, bracketing and reflexivity are two important ways to ensure confirmability in qualitative research, and warrant discussion below.

***Bracketing.*** An important technique to help ensure confirmability is bracketing. Bracketing means recognising and setting aside one's own knowledge, preconceptions, biases, opinions, and a priori assumptions about the research topic with the intent of being open minded and maximally receptive to participant experiences (Gearing, 2004; van Manen, 1990). This enables the researcher to focus sharply on the structure and essence of the phenomena under study while being aware of the ways that their prior knowledge, biases, and experiences are influencing the research process (Gearing, 2004). Bracketing is a technique traditionally associated with phenomenological enquiry (Gearing, 2004), but can be usefully applied in most forms of qualitative research. The concept of bracketing is congruent with the inductive approach to qualitative research of suspending what one thinks, knows, and thinks one knows, in favour of letting the meanings of the phenomena under study emerge

through the data. This allows the data to assume the foremost role in the research, making the researcher's own ideas secondary to the data. Below, I outline my specific biases in order to enhance the confirmability of my research.

At the outset of this research, I was a young researcher with no clinical experience and very little personal experience with or exposure to both substance use and suicidal behaviour. Regarding substance use and SUDs, I recognised the comorbidities with psychiatric disorders and was vaguely aware of the role that social and relational problems play in substance use and SUDs. This allowed me to empathise with the difficulties of having a SUD. On the other hand, I thought that if a person has enough internal strength and support, they can resolve a SUD. I was highly sensitive to suicide, as it was always something that I had considered to be quite frightening to think about. I felt empathy with those who experience or engage in suicidal behaviour, but tended to distance myself from discussions about suicide, as I thought that I had little authority to comment on something I knew little about. Finally, I had no experience with the health or mental health care systems in SA at the beginning of this project. I perceived the public health care system to be overrun with problems and was sceptical of how easy it was to receive adequate care, while I thought the private health care system was well-run and expensive, despite my lack of experience with these systems. These formed the biases that I had when embarking on this research.

At the outset of data collection, I bracketed as best possible my biases, assumptions, and prejudices about suicide, substance use, and treatment provision in SA, in order to allow the data collection to flow as organically as possible. This became harder as time went by and I collected more data, as the data that I had collected in the first few interviews started to shape my opinions on my research. Bracketing my initial biases and assumptions was also important in my inductive approach to data analysis, but again became more difficult as my opinions began to be shaped by the data.

***Reflexivity and positionality.*** Reflexivity is a fundamental part of confirmability, and refers to a constant process of reflecting upon the research process and one's positionality within that research process as the researcher (Willig, 2013). The researcher is central to the qualitative research process, as they shape and influence the research process because of their existence as a person (personal reflexivity) and as a researcher (epistemological reflexivity) (Willig, 2013). Reflecting on the researcher's position in the research is an integral part of the research process, and serves the dual purpose of: (1) allowing the researcher to provide transparency on how their personal and professional characteristics and biases may have influenced the research; and (2) providing the opportunity for the researcher to think about how their reactions to the data and research context allowed particular understandings and insights to be illuminated (Willig, 2013). The goal is not to remove oneself from the research process, but rather to recognise how one's own biases, interests, preconceptions, perceptions, and life experiences shape the research process and the nature of the data obtained. Below, I reflect on aspects relating to personal and epistemological reflexivity. Aspects of personal reflexivity are covered in the section "About me," while epistemological reflexivity is discussed in the section "Demand characteristics and identity performance." A general reflective note on the data is provided in the section "Levels of interpretation." Finally, I only became aware of some aspects of reflexivity and positionality, and how they affected me during the data analysis, after the write-up of the findings. As such, they are discussed further in Chapter 8, where they can be seen and understood in relation to the research findings.

*About me.* When I embarked on this research, I was a 22-year-old white male who had just completed a Bachelor of Science Honours degree in Psychology. It is possible that these characteristics influenced the research process. Participants may have perceived me to represent stereotypical male qualities (e.g., toughness and restricted emotional capacity; see

Bantjes, Kagee, & Meissner, 2017; Morrell, 1998), given dominant perceptions of hegemonic masculinity and a historically patriarchal culture in SA society (Bantjes et al., 2017). While I do not consider myself to embody many stereotypically male characteristics and I attempted to approach participants with warmth and empathy, participants may have perceived me to be otherwise. Being a white male, it is possible that participants who identify with different racial classifications related to me in a particular way, based on the racial divides and tensions caused by apartheid in SA. Having just finished my Honours degree, I had little research experience. During the first few interviews, this affected my ability to keep the interview focused on the research questions, although this improved as I conducted more interviews.

*Demand characteristics and identity performance.* Demand characteristics refer to participants being aware of what the researcher is investigating, or what the researcher might anticipate finding, and the influences this may have on participant responses and expected behaviour (McCambridge, de Bruin, & Witton, 2012). Asking MHCPs about their experiences preventing suicide in PWSUDs, their perceptions of the factors that affect suicide prevention, and their ideas for suicide prevention may have created a number of demand characteristics. First, asking such questions may have created an expectation that they know something about these topics, by virtue of the fact that they agreed to participate in the study. Second, this may have positioned them as the experts in the research process. Third, it may have created an expectation that they should perform their identities as MHCPs, which may have meant that they felt a need to advocate for their profession or for their clients/patients, or that they needed to show some mastery of knowledge about suicide and its prevention.

I also experienced demand characteristics and a need to perform my identity as a researcher. I experienced an expectation from the participants to know more about research and about suicide than them, positioning me as the expert in their eyes when, to me, they

were the experts on the topics I was investigating. Additionally, I experienced a responsibility to know what to do if a participant became distressed or if they became defensive in the interview.

As a co-constructed reality between the participant and me, each interview represented an artificial world where the participant was required to reflect on and relate an enormously complex collection of experiences, insights, perspectives, and opinions in a single interview. The positioning of the participant as the expert and my position as a young researcher created a paradoxical expectation about who possessed more knowledge, and may have created a complicated (possibly unconscious) power dynamic between the participants and me. As a younger person, participants may have expected me to have less knowledge and less understanding of suicide prevention than them, but as the researcher, they may have expected that I would have more knowledge and expertise than them, even in comparison to those with decades of experience providing services for PWSUDs. This appeared to play out in some participants performing their identities as MHCPs by formulating their answers in ways that made them appear to be competent treatment providers. With others, this played out in them becoming uncomfortable when I asked probing questions, probably resulting from a perceived expectation of themselves to have the "correct" answers.

Asking questions about what participants did to prevent suicide and what they thought was important for suicide prevention seemed to generate discomfort for them, as if I was conducting an audit. After the first few interviews, I made it explicit that I was merely interested in their opinions and experiences, and that there were no right answers to my questions. This appeared to put participants at greater ease.

Finally, as the interviewer, it was my responsibility to ensure that participants were not unduly upset by the questions I asked them, yet I had to ask some probing and personal questions. This created a dynamic where participants were asked to be vulnerable by

providing personal answers, when usually they are the ones asking others to be vulnerable (as they are MHCPs and conduct some form of counselling/psychotherapy with their clients/patients). Some participants responded to these questions by giving academic rather than personal answers, perhaps to defend against this vulnerability. For others it was easier to be vulnerable and offer more personal viewpoints, but they were very clear that their identities could not be revealed as it might compromise their careers or appearances as MHCPs in some other way. These reflections highlight how positionality in research creates particular dynamics between the researcher and the research participants, how this may create a need for the researcher and the participants to perform certain aspects of their identities, and how this may affect what data are able to be collected.

*Levels of interpretation.* The data I present in my research have undergone at least three levels of interpretation, quite separate from the thematic analysis I conducted. Bryman (2012) has suggested that data go through two levels of interpretation: the researcher's interpretation of participants' interpretations; and then an interpretation of those interpretations in the context of relevant literature. However, there is another level of interpretation. The very first is participants' filtering and selection of particular thoughts, emotions, and memories in their accounts of their experiences. These are the participants' interpretations of their realities. The second is how I understood and appraised those accounts: the researcher's interpretation of the participants' interpretations. Finally, there is the way that I discuss and interpret these interpretations in the context of broader literature (Bryman, 2012). Acknowledging that the experiences, thoughts, memories, emotions, and ideas relayed by these participants are potentially distorted and shaped by their and my interpretations is important for the purpose of reflexivity in this research.

## **Conclusion**

In this chapter, I have described the methods I employed to conduct my research. Thematic analysis was an effective method of data analysis and allowed me to generate a detailed research report. Few ethical issues arose during the study. By providing a comprehensive account of measures taken to ensure trustworthiness and rigour in my research, I was able to identify how I affected the research process and the possible roles that my personal characteristics and biases, as well as those of the participants, may have played in my research. In the next three chapters, I present the findings and discussion of this study.



## Chapter 5

### Findings and Discussion, Part 1: Experiences of Preventing Suicide

#### Introduction

In this chapter, I present the findings and discussion for the first of the three superordinate themes: experiences of preventing suicide. I grouped five themes under this superordinate theme: (1) hopelessness, helplessness, impotence, and guilt; (2) managing emotional experiences; (3) suicide risk assessment and management are problematic; (4) perceptions that substance use is difficult to treat; and (5) treating SUDs might increase suicide risk. Participants reported feeling hopeless, helpless, impotent, and guilty in their work preventing suicide in PWSUDs. They described how they managed the emotions evoked by doing this work, including debriefing from their emotional experiences and finding ways to explain their experiences. Participants' emotional responses to their work preventing suicide seemed to be a function of their perceptions that: (a) assessing and managing suicide risk is difficult; (b) SUDs can be difficult to treat; and (c) treating SUDs might increase suicide risk.

#### Findings

**Hopelessness, helplessness, impotence, and guilt.** Underlying the narratives of all participants was a sense of deep hopelessness and helplessness. MHCPs said they felt tired and worn out from the emotional nature of their work. Participants thought that "there is that responsibility for the preservation of life," and felt especially responsible for the death of a patient by suicide. Their feelings of hopelessness were tied into their experiences of powerlessness and impotence. Participants were uncertain about whether they were always able to help suicidal clients, especially because of the challenges involved in recovery from

SUDs.

As a counsellor you are a support person, right? You are someone they possibly are actually opening up to for the first time maybe in their lives... and the difficulty in it being, you know someone who's suicidal is, no matter what you say, no matter what you process, there isn't a guarantee that that person's going to maybe walk out of this space feeling like "okay there's a little bit of hope."... So... as a person, as a human being, what makes it difficult is, I know for example that I'm actually powerless to whatever the client feels.

Participants spoke about "the guilt we feel about patients dying," doubting their skill and usefulness as treatment providers, and needing to decompress from the heavy toll that their work sometimes took on them. Francesca said that it was "very scary when people are suicidal," reflecting the anxiety participants experienced when trying to prevent suicide. Many felt that their jobs as MHCPs were very draining, especially when it came to suicidal behaviour, where participants believed they had to work extra hard to help their patients.

This job in itself is taxing, because it's almost like you have to think for this person, to a certain point, to get into their mind, to sift through their thoughts, to sift through their behaviour and looking for, the goodness. Sifting through all the bad, and looking for the goodness.

Participants said that they sometimes felt depressed and burned out, which affected the quality of their work. They were unable to "pay full attention to somebody's body language, or what they're not saying," leading them to feel like they became "automatic" and that their only goal was to "get through this day." Mo stated that his work with suicidal clients often "leaves me with a bit of sadness... and a lot of disappointment to think that 'you don't see the value of life.'"

Despite the hopelessness and helplessness experienced by these participants, those who worked in a team noted that it was a huge benefit as they were able to debrief after a patient attempted suicide or were able to receive the support and supervision they required

from their colleagues. Those who worked alone, particularly in private practice, noted that working in a "silo" meant that they were not able to receive the support they thought they needed.

**Managing emotional experiences.** Participants spoke about various strategies they used to manage their emotional experiences. Many said that they thought there was a time limit to how long they could work with suicidal PWSUDs before they could not manage any more. Despite their "reflexive wanting to cure everyone and fix everything," many resigned themselves to the belief that suicide may be unpreventable in some PWSUDs. Berkeley noted that MHCPs often say that suicide is unpreventable to serve as a "defense" against feelings of hopelessness, helplessness, impotence, and guilt. The heaviness of their work led participants to think that that helping suicidal PWSUDs was a monumental challenge, and that their patients were difficult to deal with. JC explained a need to accept his limitations as a MHCP to help him guard against feeling excessive worry and powerlessness:

Ultimately, at the end of the day, one thing that I have realised and accepted for myself is that there's only so much that I can do in my office, in my job, in my work. I wish I had a crystal ball that I could prophesise the future, and say whether this person is or isn't going to kill themselves. So I've accepted within myself, all doctors lose patients, including psychiatrists. I think we lose patients less often, so it hurts more, you know it affects you more, but there are some things that I cannot change, and for some people there has been so much trauma in their life that suicide and suicidal thinking, suicidal behaviour, it's almost a force of nature that cannot be changed.

The heavy emotional load that participants carried in their work meant that they had to "cut away from that a bit, to kind of maintain your own sanity." When MHCPs had an experience that re-sensitised them to the tragedy of suicide, they needed to find ways to debrief.

It's tough you know, you take some of that stuff home with you, you debrief in whatever way: you debrief with your wife, with your dogs, with going for a walk, with your own therapist... simply because of the type of stuff that we hear and, and the really, really harrowing horrible things we hear, and it's nice to have someone to offload that onto, you know, and to not judge you, or to reassure you, or very often to help you understand what it was in that patient that made you feel so upset.

**Suicide risk assessment and management are problematic.** Participants perceived their emotional experiences to be a partial result of the imprecision and inadequacies of suicide risk assessment and management. Participants explained that "risk assessment is such an imprecise thing in and of itself, and you combine substance use, it makes it even more imprecise." It became especially difficult to gather sufficient information to assess and manage risk because "the suicidality is normally not when they're here, but when they out[side the premises]." Despite having mechanisms in place to try and manage suicide risk such as suicide safety plans and anti-suicide contracts, it was "foolish to think that any stupid anti-suicide contract that I had a client sign, would actually make any real difference at the end of the day." A particular concern was what patients might do while intoxicated, as participants felt that their patients' substance use made their behaviour impulsive and unpredictable.

We are useless in predicting risk. But you can to some extent do some sort of risk assessment. But while intoxication, intoxicated, you cannot manage, or it's very difficult to manage that risk... you cannot predict what someone will do while they're under the influence of tik for instance. You can, while they sober, predict their behaviour, but not the influ—but also with self-harm and suicide. It is very difficult to predict that.

Not being able to predict suicide was deeply concerning for participants. Some remarked that they were least worried about those patients who they knew were feeling

suicidal, as at least they were then able to intervene. Patients who concealed their suicidality caused participants the greatest amount of worry and stress, as JC explained that "it leaves you feeling sometimes very disabled, in terms of being able to help those people."

Participants with years or even decades' experience explained that "it's easier when you've been in this field for a long time to start hearing the same thing, from the mouths of many different people." They thought that it was easy to become complacent about suicidality because they heard it so often, which they said sometimes blunted their abilities to identify when a suicide threat was serious.

Many participants noted that suicide is a particularly delicate subject to approach with patients, which made it difficult to know how to manage. Needing to create a "safe space" in the therapeutic environment was obstructed by a perceived oversensitivity to suicide risk, with Tatum noting that "as therapists, we tend to be overly cautious" which meant that emergency admissions for suicidality "can be unhelpful, and it keeps interrupting the therapeutic process." Dealing with suicide necessitated a "need to be so delicate with it because... it's a make or break situation in that if you scratch too deep and they not comfortable, they not gonna return [to treatment]."

**Perceptions that substance use is difficult to treat.** Participants' perceptions of substance use being difficult to treat contributed powerfully to their experiences of trying to prevent suicide, as it made suicidal behaviour both understandable and difficult to prevent. Suicide was perceived as a solution to the problems faced by PWSUDs, as substance use was believed to lead to the unravelling of patients' lives and the deterioration of their relationships.

[It is] probably just hopelessness, helplessness, and the vicious cycle: trying to come clean, going back, stealing, getting arrested, coming clean. It's like, they go through that process a lot, and I suppose they can't any more, and then feel like they just need to take their life.

Substance use itself was perceived to be "a difficult process to work with... because the... success rate in treatment is so low." High rates of relapse were perceived to lead to chronic suicidality, making it especially difficult to adequately address suicidal behaviour or prevent it without addressing other mental health and social issues in patients' lives. PWSUDs were often experienced as manipulative and "pretty dishonest," which contributed to the difficulties of preventing suicide. For some participants, this was experienced as frustrating, as they felt that suicidal behaviour interfered with the "recovery" process. Dealing with suicidal behaviour was perceived to be a lengthy process that uncovered emotions that PWSUDs had been trying to ignore or forget about. However, participants found it challenging to prevent suicide when their interventions had to be delivered in a finite number of contact sessions. Babalwa articulated this, saying "we work within six weeks, so six weeks is a *very* short time to be able to unpack as many things as possible, so that I find is a bit of a tricky situation."

Participants said that when suicidal behaviour and substance use co-exist, "it's a colossal issue." Participants found it difficult to know whether SUDs caused suicidal behaviour or vice versa, or whether there was a more complex pathway to suicidal behaviour that involved the presence of mental disorders, social issues, poverty and inequality, or the breakdown in people's relationships. One participant noted that "at the end it's not the substance abuse [causing the suicidal behaviour], it's more all their feelings around all the different things that we speak about that then comes up." This made it difficult to know whether to treat the SUD or suicidal behaviour first, or whether there was some other factor (potentially beyond the scope of practice of MHCPs) causing both problems.

**Treating SUDs might increase suicide risk.** While participants noticed that PWSUDs often had fleeting suicidal thoughts before entering treatment for their SUD, most participants recounted experiences of PWSUDs becoming suicidal during the treatment

process. They said suicidal behaviour could emerge rapidly and intensely at any point in the treatment process. Many thought that it was quite understandable or even normal to become suicidal as one tries to address one's SUD, as "an abnormal response would be: 'I'd like this to continue forever.'"

I think feeling suicidal, feeling quite depressed, is a normal part for most—for a lot of people in recovery. If you don't feel it immediately, maybe later in the process. I think for many people recovery is a good thing, but it's also like going through a grieving process, because now there is the substance—"the substance has helped me through life for twenty years, it's been my only constant and now I'm leaving it behind." Never mind leaving just the substance behind, there's usually many damages and losses. So that person has to work through those feelings, and depression is just one of those stages, and feeling suicidal will many times go hand in hand with depression.... [Substance use is] their coping mechanism, and up to a certain point they can actually kind of like fake it until something crashes somewhere. Now leave that coping mechanism behind, "Of course I'm going to feel suicidal, what else is—who, who—where do I go?"

Due to the perceived link between treating SUDs and patients becoming suicidal, participants expressed ambivalent and contradictory opinions about whether or not treating someone's substance use is harmful or helpful for preventing suicide, at least in the short term. Many MHCPs were constantly worried about their patients overdosing either as a method of suicide, or as a result of having lost their tolerance to large quantities of substances from the SUD treatment process. Many thought treating SUDs would reduce suicidal behaviour, but realised that taking away someone's substance use would be taking away what was often thought to be the one thing helping PWSUDs cope. In effect, substance use acted as a protective factor against suicide in PWSUDs.

[S]ubstance use can almost save the person from, from harming or killing themselves because it's kind of, in a way, keeps them going... I mean there are

cases where people say, "If I hadn't been using, I probably would have killed myself... that just took the edge off."

## **Discussion**

The subset of findings presented in this chapter draw attention to MHCPs' experiences of preventing suicide in PWSUDs as well as what they perceived to contribute to these experiences. The emotional responses of participants made them feel drained, numbed to suicidality, and unable to accurately identify when a suicide risk was serious or not. Participants ended up thinking that they were unable to prevent suicide, and explained their experiences to be related directly to their patients' substance use and the imprecision of suicide risk assessment.

The hopelessness, helplessness, impotence, guilt, anxiety, and depression reported by these participants appears to be commonly experienced by health care providers dealing with suicidal patients (Chemtob et al., 1988; Chemtob et al., 1989; Gaffney et al., 2009; Jacobson et al., 2004; Matandela & Matlakala, 2016; Ting et al., 2006). It is concerning that MHCPs continue to have these experiences, especially because these experiences can lead to burnout. Burnout can be a serious problem, affecting the health (West, Tan, & Shanafelt, 2012), mental health (Shanafelt et al., 2011), professionalism (Dyrbye et al., 2010; West & Shanafelt, 2007), productivity (Dewa, Loong, Bonato, Thanh, & Jacobs, 2014), motivation (Shanafelt et al., 2016), and effectiveness of health care providers (Fahrenkopf et al., 2008; West, Tan, Habermann, Sloan, & Shanafelt, 2009). Previous research has shown that negative emotional experiences interfere with health care providers' abilities to perform their jobs properly (Wilstrand et al., 2007). Empowering and supporting MHCPs when they feel hopeless and helpless is critically important to ensure that they believe in their abilities to prevent suicide, remain able to do their work, and do not end up suffering from burnout.



In this research, participants with greater support noted that this was important in buffering them against feeling hopeless and helpless. This has also been identified in resourced settings and therefore appears particularly important for MHCPs providing care for suicidal patients in environments with different resource availabilities (Wurst et al., 2010). Improving workplace support, implementing self-care programmes for MHCPs, and ensuring that MHCPs have resources at their disposal (including colleagues) that can help them deal with patient suicidality may be ways to protect MHCPs against negative emotional experiences and burnout (Gulfi et al., 2015; Mache et al., 2016).

Unlike in previous studies (Bailey, 1994; Saunders et al., 2012; Sun, 2004), participants did not exhibit negative attitudes towards their patients, despite finding their work emotionally evocative and potentially burdensome. Recognising their limitations as MHCPs and the need to care for themselves helped participants guard against feeling excessive negative emotions and may have prevented these participants from developing negative attitudes towards their patients. In fact, participants appeared to be able to empathise with their patients to the extent that they identified with their patients' perceived experiences of hopelessness and helplessness.

While empathy might be thought to represent an important part of being a MHCP, it is potentially problematic that participants empathised to the point of identifying with their patients' emotions. Perceiving suicide as acceptable and normalising suicide is strongly associated with later suicidal behaviour (Joe, Romer, & Jamieson, 2007), and only when suicide is perceived as acceptable are depression and hopelessness positively linked to suicidal ideation (Gibb, Andover, & Beach, 2006). Participants highlighted that their patients often feel depressed and hopeless, but this does not mean that these experiences should make patients suicidal. In their efforts to be kind and empathetic, participants may have unwittingly allowed their patients to see their suicidal thoughts as an acceptable response to

their feelings and experiences. It is important that MHCPs are able to recognise that empathising to the point that they develop permissive views of suicide is likely to decrease their effectiveness in preventing suicide.

Participants attributed many of their difficulties preventing suicide to undiagnosed and untreated mental illness, impulsive behaviour, and mood fluctuations associated with substance use in their patients. These perceived links between suicidal behaviour and psychological variables are consistent with research and reflect that these participants still subscribe to biomedical risk-factor models of suicide (Aldao, Nolen-Hoeksema, & Schweizer, 2010; Fox, Axelrod, Paliwal, Sleeper, & Sinha, 2007; Franklin et al., 2017; Rimkeviciene, O’Gorman, & De Leo, 2015, 2016). An implicit assumption of these models is that knowing risk factors will help predict (and by implication prevent) suicide. However, risk-factor models provide a limited understanding of suicidal behaviour and cannot help clinicians predict suicide deaths any better than by chance (Franklin et al., 2017).

Participants believed that they needed to precisely assess suicide risk to be able to prevent suicide, and thus conflated predicting suicide with preventing suicide. However, preventing suicide effectively may not be contingent upon precise risk assessment. Multiple interventions have shown favourable results in reducing suicide rates in a number of settings (Mann et al., 2005; Rutz, Wålinder, Knorrning, Rihmer, & Pihlgren, 1997; Zalsman et al., 2016). Most do not depend on risk assessment, and those that do only require assessment of whether risk is present or not, rather than precise assessment of risk severity. This may mean that participants either do not have the training they need to feel competent in preventing suicide, or that the way they think about suicide risk assessment contributes to them thinking they are unable to prevent suicide, and consequently leaves them feeling impotent.

It appears important to educate MHCPs about evidence-based brief interventions for suicidal behaviour, so that they understand that suicide can be prevented and that they are not

powerless and impotent to intervene. One such brief intervention, CAMS, adopts a person-centred approach to suicide prevention and shows better reductions in suicidal behaviour than care as usual or enhanced care as usual over follow-up periods up to 12 months (Comtois et al., 2011; Nielsen, Alberdi, & Rosenbaum, 2011). Training MHCPs to assess suicide risk and intervene can be inexpensive and time-efficient, and can help MHCPs feel confident in their abilities to prevent suicide (Fenwick, Vassilas, Carter, & Haque, 2004). Additionally, it seems that MHCPs may require further training in evidence-based approaches to treat SUDs, comorbid mental illnesses, and associated psychosocial problems. A recent systematic review of randomised controlled trials on treatments for common mental disorders in SA shows that there is a paucity of evidence for the treatment of depression, anxiety, and SUDs in the local context (Kaminer, Owen, & Schwartz, 2017). However, two randomised controlled trials showed that brief interventions based on motivational interviewing led to score reductions on the ASSIST and may lead to decreased substance use at three month follow-up, provided the intervention consists of more than a single session (see Mertens et al., 2014; Myers et al., 2016; Sorsdahl et al., 2015). Providing such brief interventions and augmenting existing mental health services with life skills training, family counselling, and vocational training may be important for suicide prevention. This could entail a multidimensional approach to both training of MHCPs and treatment of SUDs, by expanding existing packages of care to include more sessions from MHCPs and to include inputs from allied professions. Treating SUDs and associated psychosocial and health problems more effectively may help MHCPs feel less hopeless and helpless in their work preventing suicide in PWSUDs.

Perhaps one of the more paradoxical findings in this subset of the data was that MHCPs perceived SUDs to be a potential protective factor against suicidal behaviour. While explanations of suicidal behaviour based on risk factors were evident, many MHCPs noted

that most of the suicidal behaviour they saw emerged in the course of treatment and was related to circumstances surrounding or resulting from substance use, rather than the use itself. Uncovering broken relationships and feelings of depression and hopelessness by removing a person's substance use were thought to be what made PWSUDs suicidal. A possible reason is that the antecedents of SUDs (e.g., mental illness, social isolation, poverty and inequality) might be what make PWSUDs suicidal, rather than the SUD itself. Indeed, broad socioeconomic factors are perceived as barriers to suicide prevention in PWSUDs in SA (see Chapter 6). This may explain why participants perceived suicide prevention to be so difficult, as their roles as MHCPs were only to intervene with their patients' SUDs and possible comorbid mental health problems. These issues were compounded by the limited time available to provide mental health care services.

Taken together, these findings suggest that we may need to reconsider the implications of current approaches to suicide prevention. The data presented in this chapter suggest that treatments for SUDs may need to be provided in a more integrated manner to include psychosocial as well as biomedical interventions (see also Voros, Osvath, & Fekete, 2009). This could include skills training for PWSUDs to alleviate non-psychiatric comorbid problems, such as unemployment. This can also help ensure that the life stressors of PWSUDs are being attended to in addition to PWSUDs learning more appropriate emotion- and stress-management strategies than substance use.

## **Conclusion**

In this chapter, I have presented and discussed the subset of findings dealing with MHCPs' experiences of providing care for suicidal PWSUDs and their perceptions of factors that contribute to these experiences. MHCPs may need to be supported to protect them against the potentially overwhelming emotions evoked by patient suicidal behaviour. The

findings in this chapter indicate that conceptualising suicidal behaviour as a normal part of the phenomena of SUDs may be problematic and may contribute to MHCPs' ideas that suicide is difficult to prevent. Educating MHCPs to believe that they are able to prevent suicide despite the limitations of available risk factor models appears important to help them experience fewer negative responses to patients' suicidal behaviour. It is also important to take into account the factors that may have caused the SUD in the first place, as they might well be what is causing a patient's suicidal behaviour. It may be important in this regard to provide further training to MHCPs in evidence-based interventions for suicide prevention, common mental disorders, and the problems typically associated with SUDs (such as poor problem solving and interpersonal conflicts). Finally, MHCPs may need to be supported in their work by agencies responsible for community, social, and family work. By targeting the specific factors that make PWSUDs suicidal, we can help prevent suicide more effectively and help MHCPs experience their work as less burdensome.

## Chapter 6

### Findings and Discussion, Part 2: Perceptions of Barriers to Suicide Prevention

#### Introduction

In this chapter, I report and discuss the findings pertaining to the second of the three superordinate themes: MHCPs' perceptions of the barriers to suicide prevention in PWSUDs in SA. I identified two subordinate themes under this superordinate theme: (1) structural issues in service provision; and (2) contextual issues extending beyond health care. I grouped three themes within the subordinate theme "structural issues in service provision": (1) a lack of resources; (2) insufficiencies in training; and (3) fragmentations in the organisation of care. These structural issues led participants to think that many suicidal PWSUDs do not receive the psychiatric, psychological, and social care that they need. I grouped three themes within the subordinate theme "contextual issues extending beyond health care": (1) poverty and inequality; (2) the breakdown of family; and (3) stigma. These broad contextual issues were perceived to make it difficult to effectively prevent suicide in PWSUDs. Together, these factors acted as barriers to suicide prevention and contributed to participants' feelings of hopelessness and powerlessness in their work preventing suicide in PWSUDs (described in Chapter 5).

#### Findings

##### **Structural issues in service provision.**

*A lack of resources.* Participants said suicide prevention was hampered by a widespread lack of resources in an overburdened system. Insufficient emergency psychiatric services and the thin spread of specialised MHCPs across health facilities meant that "service provision is inundated and clogged up by seriously ill patients," who were then prioritised

ahead of those with problems that were perceived as less serious. This led many to think that mental health, especially substance use and suicidal behaviour, is relegated to the bottom of the government's list of health care priorities. The lack of resources, especially the lack of specialised services for suicidal behaviour and SUDs, often prevented patients from receiving the care that they needed, with Shaun expressing that "we had four suicides in one year... [and] I believe they were all let down by the system as a whole."

Many participants said they were frustrated because they were unable to implement best practices due to severe time and funding constraints. Participants working in NGOs financially supported by the government thought that the lack of available funding was responsible for needing to follow a "standardised treatment plan" in order to meet "targets." This was perceived to limit the quality and duration of care that MHCPs were able to provide, with Tatum expressing that "sometimes it's more important just to focus on the relationship with the client... because I think at the end of the day, most of our clients already know most of what we're going to tell them." Having limited time to provide services meant that participants often had to refer patients who needed services to other overburdened facilities. Frank explicitly expressed his own distrust in the system, stating that "[the health care system is] very bleak, I fear for if I feel suicidal one day. I don't trust the system because I don't know how well the system is functioning." Similarly, Sophie expressed that the lack of an integrated treatment approach and the lack of social services made her job as a psychologist more difficult:

Just in terms of social things like living, where can people live, where can they stay? Also simple things, like assisting people with getting ID documents, assisting people with places where they can wash, there's all sorts of things, and I think that's really neglected, I mean, again someone with a substance use disorder, where do they go?

***Insufficiencies in training.*** Participants with only four years of training (counsellors and social workers) explained how their university education had not prepared them to adequately screen for, identify, and manage suicidal behaviour. Many noted that they thought they needed continuous postgraduate training to "keep on top of new literature" and best practices in order to prevent suicide and treat comorbid mental illnesses effectively.

The insufficiencies in training were perceived to be more severe for health personnel who were not MHCPs. Emergency services and staff at day hospitals are usually the first people to come into contact with suicidal PWSUDs, but participants thought that they often mismanaged these patients. This made participants hesitant about referring suicidal PWSUDs to health facilities that were supposed to provide services for suicidal PWSUDs. Despite some of their own perceived gaps in training, they said that they were doing their best to prevent suicide but thought that it was made more difficult when medical personnel did not take suicide risks seriously.

***Fragmentations in the organisation of care.*** Multiple participants used the phrase "falling through the cracks" to describe how suicidal PWSUDs often did not receive the mental health care that they required, which was thought to result from the way that health care in SA is organised. Participants said that the tiered system of health care provision and standard process of referral from specialist SUD treatment facilities, to primary health care facilities, to secondary or tertiary facilities caused major delays before suicidal PWSUDs were able to receive admission for suicidal behaviour. Participants related experiences of referring high-risk suicidal patients to a hospital for admission, and then having patients be turned away. Discharge of patients who were imminent suicide risks from health care facilities led participants to feel despondent about suicide prevention, relating to the unhelpful emotional responses that participants experienced when preventing suicide (see Chapter 5).



Part of the fragmentation in health care provision was thought to result from the split between public and private health facilities. One participant highlighted the blatant inequality between private and public health care settings, stating that "if you don't have a medical aid, and you've got a substance use problem in this country, you are in a very, very difficult situation." The lack of SUD treatment facilities in the public sector meant that patients must "wait like two or three months to see the substance use doctors." Conversely, in the private sector patients have to pay high fees to MHCPs. Even for those who can afford private care, many are limited by their medical aid policies and the restrictions placed on what types of care are covered. Participants said that both scenarios made patients feel unwelcome and uncared for, giving PWSUDs the perception that the health care system (public or private) does not have their best interests at heart. This led participants to conclude that PWSUDs are left feeling "complete and utter frustration with [not feeling like your problems are important] and an inability to actually access good quality care, acutely, and also afterwards as an out-patient [that leads to PWSUDs becoming suicidal]."

Participants working at substance use rehabilitation centres often distinguished SUDs from mental health issues, saying that mental health issues must be resolved and a person must be nonsuicidal before they could address the person's SUD. Conversely, psychiatric/medical staff thought that a person's SUD should be addressed before the mental health issues could be treated. Conceptualising SUDs and mental health as separate issues reflected the "very weird split" between the DOH and DSD. This splitting in service provision meant that "substance use is the portfolio of the Department of Social Development [but] the Department of Social Development doesn't provide the health services that are needed." Participants thought this reflected "no real coherence [as] everyone's just sort of doing their own thing, and there's just this sort of turn over, but it's not really addressing the underlying problem, or the cause." Poor follow-up systems and a lack of communication

between MHCPs made it "very difficult" for participants as they did not know what was happening to patients who were suicidal and had been discharged from health or SUD treatment facilities or referred to others. Many said that this made it difficult to know whether they were preventing suicides at all.

### **Contextual issues extending beyond health care.**

***Poverty and inequality.*** Some participants outlined how the vast inequality and poverty in SA are economic and social after-effects of apartheid and are clearly evident in the lives of PWSUDs. This tied in to high levels of trauma and violence that participants said PWSUDs experience, and participants theorised that this played an undeniable role in the substance use and suicidal behaviour of their clients and patients. Josephine told of one client who had ended up in prison:

The reason why she ended up in prison was because she had tried to take her own life and her child's life. And she'd done that twice.... Each time she was completely drunk, but when I examined her life... there was a lot of rape, a lot of physical abuse from very young and also a lack of complete hope that things would change for her child. So I said to her, "But why would you take the child's life?" You know? And she said, "Because I could see her life going the same way as mine and I was afraid for her, and I couldn't leave her, because then she would be without anybody, and so I thought I'd take both of our lives."

Many participants perceived SUDs to be "a symptom, of what's happening in our communities" and "a social disease that actually results in medical changes in the brain" as a result of "unemployment, disenfranchisement, lack of representation of local government, gangsterism, domestic violence, disintegrated social fabric, [and] substance abuse in families." Participants empathised with their clients and thought it was understandable that someone would feel suicidal if they experienced the problems listed above. Participants believed that for many PWSUDs, there is no meaningful alternative to substance use. As a

result, participants thought that removing their "coping mechanism" has detrimental effects on their psychological wellbeing and often causes suicidal behaviour.

The poverty that suicidal PWSUDs experienced became a significant factor in the therapeutic environment when participants tried to help patients restructure their lives. Participants told of needing to go above and beyond their responsibilities or scope of practice as MHCPs to help their patients. Providing patients with "bus fare," "helping a lot of them with drawing up CVs," or walking them to a hospital "wasn't my job" but became part of preventing suicide, because patients were so poor or poorly educated that they could not do these things themselves. Poverty not only created the conditions under which people felt suicidal, but was also a major barrier to addressing their suicidal behaviour.

***The breakdown of family.*** As with poverty and inequality, participants said that the "breakdown... in family in the society that we live in" reflected a much broader societal issue that served as a barrier to suicide prevention in PWSUDs. Participants said that family often played a central role in the lives of PWSUDs, either in directly causing the person's substance use, or in contributing to the continuation of the person's use and their suicidal behaviour. Having poor role models and parents who used substances was thought to be a major factor causing some patients' substance use and suicidal behaviour. In other cases, many PWSUDs "are highly displaced people who have been kicked out by their families... either the drug use was an excuse, or they were excluded prior to their drug use becoming a big problem." Participants said that even when a PWSUD exists within a family system, they are often deeply rejected and receive no support, love, and care from that system. As a result, treating someone for suicidal behaviour and then sending them back into the very environment that made them suicidal was thought to be unlikely to be an effective way to manage suicidal behaviour, and is a poignant reflection that suicide, like substance use, is a community and social problem and not an individual one.

**Stigma.** Stigma against suicidal PWSUDs was thought to be a major barrier to suicide prevention, for two reasons. First, suicide is "still so stigmatised, that it's very difficult for people to access the help that they really need without being vilified and stigmatised." This "help" referred to both formal mental health services and informal support from family and friends. PWSUDs were treated "almost like they're not a human, like they're not a person, they're just a drug addict." The continued presence of stigma and dehumanisation was believed to result in PWSUDs identifying with the stigma and stigmatising themselves, meaning that "[not] all substance users present for treatment." Stigma was perceived to be such a powerful barrier to suicide prevention in PWSUDs that Insaaf said, "I don't know what can be done with the suicide thing besides the stigma. Because just going for help in general is like almost seen as, 'You weak,' or, 'You mad,' or, 'You crazy.'"

Second, stigma prevented suicidal PWSUDs from speaking about their suicidal behaviour even when they were receiving help. The stigma that came from medical professionals was especially condemning and was believed to traumatise patients deeply, with Berkeley noting that "people think if [PWSUDs] do hurt themselves or they're suicidal it's kind of like... 'Well it's, they better off dead,' this is what our colleagues [think], these are the kind of things you hear." This was another factor that made participants very reluctant to refer suicidal PWSUDs to health facilities. When PWSUDs concealed their suicidality, it was "much more scary than the one that's... actually telling you 'I'm gonna go get my father's gun and I'm gonna shoot myself,'" as participants could then "respond to the emergency," while "when things are hidden, that's really scary."

Stigma was understood to be a result of many things. The lack of knowledge amongst the general population about how to deal with suicidal behaviour and the fear that many feel about discussing suicidal behaviour was thought to give rise to stigma. Similarly, the belief

that mental illnesses (including SUDs) and suicidal behaviour "do not exist" or are a moral failing in the person was also thought to be a reason that suicidal behaviour and SUDs were stigmatised. JC attributed the rejection of suicidal PWSUDs and the shame and embarrassment that surrounds suicide and SUDs to the conservative mindset of many South Africans:

South Africa, it's a very conservative country... and a lot of that is probably because of the influence of you know religion, conservative upbringing, this idea that if you commit suicide, you're gonna go to hell [or] bring shame upon the family [or] the life insurance policy may not pay out [or] "if my child commits suicide, it means that I'm a bad parent."... So society stigmatises a condition because it doesn't understand the condition.

Participants said that the rejection that PWSUDs experienced from their families and communities led to deep feelings of shame and embarrassment about their substance use and suicidal behaviour, which in turn made their substance use and suicidal behaviour worse. A cycle developed of substance use leading to shame, embarrassment and suicidal behaviour, with rejection and lack of support compounding these feelings, leading to further substance use, shame, embarrassment and suicidal behaviour, and so on.

## **Discussion**

Participants highlighted that a lack of training makes preventing suicide in PWSUDs difficult, especially because they perceived the SA health care system to be under-resourced and overburdened. This is indeed the case in SA (Coovadia et al., 2009) as well as other LMICs (Murthy, 2011; WHO, 2014a), and these issues have been identified as barriers to providing adequate care for suicidal patients and PWSUDs in SA (Bantjes et al., 2016). Additionally, inadequate training and experience in suicide prevention diminishes the competencies of health care providers to respond appropriately to suicidal patients

(Neimeyer, Fortner, & Melby, 2001). To reduce the burden on health systems, task-shifting is often utilised or proposed as a cost-effective method of transferring the care of patients to MHCPs with comparatively less training (such as counsellors and social workers) (Petersen, Lund, Bhana, Flisher, & the Mental Health and Poverty Research Programme Consortium, 2012; Spedding et al., 2015). However, the experiences and perceptions of these participants question the usefulness of task-shifting when MHCPs are not prepared to manage suicidal patients. While more services are needed, current legislation governing who can provide services for PWSUDs in SA does not clearly articulate the minimum skills and competencies required by service providers (see DSD, 2013a, 2013b, 2013c). There is no indication that training to manage suicide crises is mandatory. Further training of MHCPs in targeted suicide prevention strategies may be required to strengthen current task-shifting models of care. Training medical personnel to be more empathic with suicidal individuals and to accurately assess suicide risk may also be an important way to ensure that fewer patients are turned away when seeking care.

Many of the fragmentations and socioeconomic issues identified by the participants in this study are historical artefacts from apartheid-era SA. While significant steps have been taken to rectify these issues, the segregation between public and private health care continues to underserve patients and undermine suicide prevention in PWSUDs. With a current unemployment rate of 36.6% and almost half the population living below the national poverty line (Statistics SA, 2017a), it is clear that population-wide poverty and inequality that resulted from apartheid policies have still not been addressed. Poverty and inequality are established risk factors for suicidal behaviour (Iemmi et al., 2016) and substance use (Kalichman et al., 2006), and the combination of poverty and substance use is a strong predictor of first-time suicide attempts (Thompson, Alonzo, Hu, & Hasin, 2017). With one SA study showing that 56.9% of individuals who died by suicide over a five-year period were

unemployed (Stark et al., 2010), it is evident that poverty and inequality are relevant risk factors for suicide in SA. Taken together, this shows that contextual factors may be as important as individual risk factors for suicide prevention in PWSUDs in SA.

Participants in this study say that they cannot take sole responsibility for suicide prevention because they believe there are social, economic, and cultural factors that give rise to the circumstances under which people develop SUDs and under which PWSUDs become suicidal. The split between the DSD and DOH was believed to add to these issues by creating diffusion of responsibility regarding who should provide care for these patients. This highlights the apparent difficulty of being a health care provider tasked with preventing suicide when there are much broader factors at play influencing suicide prevention. This brings into question the scope of the role of the health care provider. On one hand, health care providers have a medical and legal responsibility to prevent suicide, but on the other, they cannot be expected to be solely responsible for suicide prevention given the perceived social, economic, and cultural barriers to suicide prevention. It may be important in this regard to open up healthier and more collaborative conversations about suicide between MHCPs and other stakeholders involved in preventing suicide.

As such, more integration and intersectoral collaboration between different health care services, policy makers, and government departments appears to be required so that the responsibility for suicide prevention can be shared and these perceived barriers can be addressed. Such integrated approaches have been proposed in both the National Drug Master Plan 2013–2017 (DSD, 2013a) and the MH Policy and Plan (DOH, 2013), although evidence for this integration is absent. Research has identified a lack of communication between sectors, problems delineating roles, and perceptions of not being supported by other sectors as some of the reasons for this lack of integration and intersectoral collaboration (Brooke-Sumner et al., 2016). Suggestions for improving intersectoral collaboration have been

recognised more generally for mental health in SA (Brooke-Sumner et al., 2016) but suggestions specific to suicide prevention are currently lacking.

Preventing suicide requires a careful understanding of a very complex phenomenon, and we lack precise models to predict suicide based solely on individual risk factors (Franklin et al., 2017). By focusing only on mental illness, or SUDs, or social disintegration, we miss how these factors interact with one another and we miss broader factors related to health care seeking and suicide prevention. For example, stigma is a known barrier to mental health care seeking (Corrigan, Druss, & Perlick, 2014; Reynders, Kerkhof, Molenberghs, & Van Audenhove, 2014), and was identified in this study as an important barrier to suicide prevention. Additionally, the organisation of care within the SA health system was also identified as a major barrier to suicide prevention. While it may be a uniquely South African phenomenon that services are so segregated, arising from the divisions between (a) public and private health care and (b) the DOH and DSD, it is apparent that the structural and organisational components of health care systems need to be considered in addition to individual risk factors when designing suicide prevention interventions.

Research shows that social, economic, and cultural issues are significantly linked to suicidal behaviour (Iemmi et al., 2016; Sun & Zhang, 2016). For example, in PWSUDs in India, social and economic issues (housing insecurity and poor family relationships) were associated with suicide attempts while mental health problems (depression and anxiety) were not (Armstrong et al., 2014). Along with the findings of this research, this shows that PWSUDs appear to experience specific social and economic risk factors for suicide that may not apply to other high-risk groups (Armstrong et al., 2014). This provides good reason to challenge and transform individual risk-factor models of suicide prevention in PWSUDs and move towards more comprehensive, context-specific models of understanding suicide and its prevention (Armstrong et al., 2014; Jacob, 2008; White et al., 2016b).



## Conclusion

The structural and contextual barriers to suicide prevention in SA identified and discussed in this chapter draw attention to the possible limitations of suicide prevention interventions premised on individual risk-factor models. Contextual issues may need to be targeted and addressed as part of integrated, multi-level suicide prevention strategies, particularly for high-risk populations like PWSUDs. In resource-limited settings, training MHCPs adequately in targeted, evidence-based suicide prevention interventions may be important for the success of task-shifting models of health care provision. Additionally, training medical personnel with more effective skills to accurately assess suicide risk and express more empathy with suicidal patients may help improve service provision and suicide prevention efforts. The current fragmented organisation and provision of services points to a need for more integrated services and intersectoral collaboration. This is not unique to suicide prevention as it may be required to improve mental health care provision more generally. Finally, addressing fragmentation of services, improving intersectoral collaboration, and implementing multi-level suicide prevention strategies may help distribute the responsibility for suicide prevention between various stakeholders, including government departments, MHCPs, families, and communities, so that MHCPs feel supported and more able to prevent suicide.

## Chapter 7

### Findings and Discussion, Part 3: Ideas for Suicide Prevention

#### Introduction

In this chapter, I report and discuss the findings of the third and final superordinate theme: ideas for suicide prevention. I grouped eight themes under this superordinate theme: (1) providing support; (2) instillation of hope; (3) conditions of good care; (4) providing effective treatment; (5) integrated and comprehensive care; (6) resource requirements and utilisation; (7) early prevention; and (8) reducing stigma. Participants suggested a number of strategies to prevent suicide, such as providing support for PWSUDs and giving them hope, and they described what they considered to be conditions of good care. They also made context- and population-specific suggestions for suicide prevention in PWSUDs in SA, including: providing effective treatment for mental disorders, improving training of health care providers to manage suicide risk and treat mental disorders, providing integrated health care, establishing a tiered model of mental health care provision, augmenting resources and optimising the use of existing health care resources, focusing on early prevention, and reducing stigma.

#### Findings

**Providing support.** MHCPs said that providing support (from MHCPs, family, friends, and other suicidal individuals) should be a critical component of suicide prevention. Participants suggested improving community cohesion and said that family and friends were important sources of support. JC noted that PWSUDs need "aftercare and support," while others said that providing support would make patients feel less alone and more prepared to deal with a suicide crisis themselves. A "suicide support group" similar to

Narcotics/Alcoholics Anonymous was suggested as a place where people who felt suicidal, or who had experienced or engaged in suicidal behaviour in the past, could go and offer support to one another.

**Instillation of hope.** MHCPs said that they "also have to provide hope" and empower PWSUDs. Mo stated, "there is always value in a person, but they don't always see it." Tatum noted the importance of helping PWSUDs find a "sense of purpose" by helping create "future goals." Providing hope was said to protect PWSUDs against suicidal behaviour and help motivate them to address their substance use. Some suggested that providing PWSUDs with employment opportunities and homes would be a way to provide them with hope. Part of providing hope was believing in the autonomy and capacity of PWSUDs to heal themselves and make positive changes in their lives.

**Conditions of good care.** Participants affirmed the importance of building a "trusting relationship" by communicating "compassion" and "kindness." Focusing on a "Rogerian approach" by maintaining "unconditional positive regard and acceptance" was proposed as a strategy for suicide prevention. Frank said that when a patient is suicidal, they "would need just, at that stage to be listened to completely and putting every other therapeutic goal, just, away, and just being there with that client at that stage. I think that in itself... will be effective." Authenticity meant being "empathic and to be real, to be real in the relationship." Establishing "rapport" and maintaining "a focus on the relationship" was paramount to suicide prevention, especially because it provided "a different experience to what they get in a community." Containment meant being somebody who could "understand... set boundaries, [and] think through what's going on."

**Providing effective treatment.** Participants said that effective treatment of SUDs will significantly decrease suicidality. As "treating the addiction... will definitely help reduce the suicide risk," participants suggested a "step-down" approach where people move from

intensive in-patient treatment to out-patient facilities. Participants advocated for a "harm reduction" approach to treatment of SUDs in order to prevent suicide. They also suggested that "access to an immediate response of some sort" was critical when PWSUDs were in a suicidal crisis. Participants highlighted a need for minimum norms and standards for the treatment of SUDs. They said there was a need for MHCPs to be trained in evidence-based approaches to both the treatment of SUDs and suicidal behaviour. They said that this needs to be based on a model that allows patients to manage "triggers in their environment" that make them want to use substances or make them feel suicidal.

Participants noted how important it is to accurately assess and treat comorbid mental health conditions, especially depression, in order to prevent suicide. One participant said, "you can't treat the one without the other." When PWSUDs are suicidal, Tatum affirmed the importance of doing "a systematic inquiry" to "exclude major depressive disorder or an anxiety disorder," and of providing effective treatment for these conditions where necessary to prevent suicide.

All participants noted a need for better training for all health care providers in suicide prevention. They said MHCPs need to be equipped to conduct thorough risk assessments and manage the bounds of confidentiality when working with suicidal patients, and that they need to receive training in "motivational interviewing." Participants said there is a need to include more suicide-specific training in the curricula of trainee MHCPs to "prepare them in dealing with suicidal patients. Identification, features and that. I think we can do a lot more work in training with that."

Participants said that in order to provide effective interventions, there should be minimum norms and standards for the training and accreditation of MHCPs who work with PWSUDs. They also suggested that treatment facilities be better monitored to ensure that they are registered with the correct government department. Charlie stated, "There should be

some kind of minimum requirements to say if you want to work in this area, you know, you need to have at least a diploma in addictions or something like that, a postgraduate diploma."

**Integrated and comprehensive care.** Participants noted a need for more integrated service provision and intersectoral collaboration, where different health care providers, MHCPs, community/non-governmental organisations, and government departments work in harmony to prevent suicide, treat mental health problems, and address problematic substance use. The specific suggestions participants made regarding the reorganisation of care to achieve integrated and comprehensive care are summarised in Table 7.1. Izelle said that MHCPs need to intervene beyond addiction as "you treat the addiction, but it remains hopeless... if you can't help the patient rebuild their life." Frank noted that "the resource that we lack the most is connectivity and integration... systems integration."

Table 7.1.

*Suggestions for Reorganisation of Care*

Level of care	Suggestion
Health care system	Departments of "Health and Social Development... working together" "Communication" between sectors Integration of health and mental health services
Organisation	"Multi-disciplinary team" consisting of "a psychiatrist, a psychologist, occupational therapist, social worker, psychiatric nurse, a medical doctor"
Individual	"Follow-up" of patients "Unpack... predisposing things that might have happened, or other things that [PWSUDs] might sit with, and challenges"

Using multi-disciplinary teams to provide "integrated treatment" for SUDs and mental health conditions was also said to be integral to suicide prevention. Participants noted that this allows "input from different experts who focus on different things" meaning that PWSUDs could "work through those different elements that are contributing to suicidality." This care was needed "post-acute in the sort of recovery phase" as well as during in-patient

treatment. Providing integrated care was related to the kinds of resources that participants thought PWSUDs need.

I think just more, a more coherent system, where there's sort of interlinked services, between health, between social services, where it's all much more interlinked, but I think also linked up again with things like self-development, job creation opportunities, housing opportunities, so that it becomes more community orientated, and again I'm not negating the medical, because I do think that the medical is very important, and again, often with substance use there are comorbid physical conditions, and I think those can't be ignored either. So I really think sort-of, one needs a coherent approach, where the physical, the medical's looked at, medication's looked at, psychiatric, as well as psychological, relationships, social stuff, ideally.

**Resource requirements and utilisation.** When it came to providing integrated and comprehensive care to prevent suicide, participants expressed plainly that "we just need more resources to be able to do these things." Resources included financial support, infrastructure, health services, and personnel (see Table 7.2). More resources would allow more specialised service provision for patients with SUDs and/or suicidal behaviour. "Good quality acute care" is needed to help "effectively manage the risk and help that person get to a position where they more able to engage, and develop coping skills and strategies around that." Some said that they wished they had resources such as a "suicide safety room" to deal with a suicide crisis "on site." Having more resources was suggested as a way to relinquish some of the burden on existing MHCPs, allowing them to make "a bit more of a mind shift" and give "a bit more time" and thought to suicidal patients.

While participants said that more resources are undoubtedly needed, they also said that there are existing resources that are perhaps not being used optimally. Participants said that they need to optimise referral pathways, "redistribute resources more cleverly," and "think creatively around" resource allocation to prevent suicide. Participants suggested that

Table 7.2.

*Resources Required to Prevent Suicide*

Type of resource	Resources needed
Financial	"Government" funds
Infrastructural	Attractive buildings Accessible services "Suicide safety room" (seclusion room that is suicide-proof, preferably with constant observation, for use until the person could be transported to a hospital)
Health services	"Community services" "Clinics to deal specifically with addiction" "Outpatient programmes in the communities" "Rehab centres" "Halfway houses" "More beds" Medical and psychiatric care
Human resources (personnel)	"A lot more social workers" "A lot more occupational therapists" "A lot more nursing staff" "We need more therapists—just don't have enough psychologists"

"task-shifting" and "supervision" be utilised as an effective and cost-effective way to decrease the burden on more highly-trained MHCPs (such as psychologists and psychiatrists). Referring to hospitals and SUD rehabilitation facilities, Insaaf suggested that "if they can't afford clinical psychologists, they can employ registered counsellors."

I think there's an opportunity to train, you know, kind of, a tiered system... people that are coming out with an undergraduate degree who could then go off and do an extra year internship or a placement like you know, kind of somewhere, get—and in that placement do some kind of counselling diploma, they get registered as a counsellor. I mean the structure's there. [The idea is that] they get trained in suicidality, they get trained in substance abuse, they get trained in a whole lot of different areas. But the rules of their registration are that they have to be in supervision.

**Early prevention.** Participants mentioned the importance of good child care practices, primary school education, and interventions such as the "good behaviour game" to

act as a prophylaxis against adversity. Having loving parents and strong communities were mentioned as important ways to prevent later substance use and suicidal behaviour, as Sophie said that "if every child had a caregiver who truly, who truly cared for him or her, that in itself—I think society would change radically." Teaching "coping skills," stress tolerance, general "life skills," interpersonal skills, and "communication skills" to youths was highlighted as important to help promote mental health, prevent suicidal behaviour, and "change the trajectory of these kids."

Creating awareness in communities around how to deal with suicide, how to identify the signs of suicide, what resources are available, and to improve people's understanding of SUDs and suicidal behaviour were suggested to improve help-seeking behaviours. Public education initiatives and pamphlets in doctors' waiting rooms were suggested in addition to psychoeducation in schools. "Social media" was suggested as a platform to disseminate information about mental health, substance use, suicidal behaviour, and help-seeking, through creating government-funded websites that can be accessed "free of charge."

**Reducing stigma.** Many MHCPs said that a critical part of preventing suicide was to demystify and destigmatise substance use and suicidal behaviour. Participants said that "we've gotta have this rational conversation around drugs" and "we need to talk more about suicide" in order "to get rid of the stigma." Participants said that this is likely to improve treatment adherence, acceptance of the fact that one needs help, support from loved ones, and help-seeking behaviour. Participants suggested that stigma be reduced in medical staff, MHCPs, and the general public. As such, stigma-reduction initiatives could be a part of public education campaigns and training of MHCPs, and were suggested as imperative to the success of preventing suicide in PWSUDs.



## Discussion

Many of the suicide prevention strategies advocated by the participants in this chapter are evidence-based and congruent with best practice literature. These include providing thorough assessments and effective treatments for SUDs and comorbid mental disorders, adopting integrated and multi-level approaches to suicide prevention, offering screening and follow-up for suicidal behaviour, strengthening family and social support, increasing access to services, containing the suicide risk and making patients feel safe, and improving early prevention and education (Mann et al., 2005; van der Feltz-Cornelis et al., 2011; Zalsman et al., 2016). Some suggestions, such as improving public awareness of mental illness and suicidal behaviour, appear not to be robustly associated with any reductions in suicidal behaviour, improvements in health care seeking, or with increased antidepressant use (Dumesnil & Verger, 2009; Mann et al., 2005). However, these interventions may have more positive results when part of a multi-level strategy to prevent suicide (Isaac et al., 2009). Additionally, many of the ideas for suicide prevention reported in this chapter address the barriers that MHCPs perceive to suicide prevention in PWSUDs (see Chapter 6).

Participants' suggestions indicate that they endorse the general principles of established suicide prevention strategies and have some knowledge of evidence-based approaches. However, these participants also made a number of specific suggestions for preventing suicide in PWSUDs. No national suicide prevention guideline (see Table 2.4), clinical practice guideline (see Table 2.5), or evidence-based suicide prevention strategy (see Table 2.6) is specifically targeted towards the particular needs of various high-risk populations. The specific suggestions made by these participants (discussed below) may help with designing suicide prevention strategies tailored to the specific needs of PWSUDs.

Through their suggestions for the use of specific therapeutic techniques, reduction of stigma among health care providers towards PWSUDs who are suicidal, improving attitudes

towards SUDs and suicidal behaviour, adopting harm-reduction approaches to the treatment of SUDs, and increasing the integration of health care provision, participants advocated for person-centred approaches to suicide prevention. Providing person-centred health care has been prioritised by the WHO in recent years (WHO, 2017). Person-centred approaches to suicide prevention focus on the formation of a positive therapeutic alliance and show far better reductions in suicidal behaviour than care as usual or enhanced care as usual over follow-up periods up to 12 months (Comtois et al., 2011; Gysin-Maillart, Schwab, Soravia, Megert, & Michel, 2016; Gysin-Maillart, Soravia, Gemperli, & Michel, 2017; Nielsen et al., 2011). However, person-centred health care may be difficult to implement in the current mental health climate in SA. A lack of health care personnel and funding, poor integration of mental health into general health services, and overburdened health care systems are current problems in health care provision in SA (Brooke-Sumner et al., 2016; Myers & Fakier, 2009; see also Chapter 6) and impede the implementation of integrated, person-centred care (Ramlall, 2012). Preventing suicide in PWSUDs in SA is experienced as emotionally provocative, draining, and burdensome, which puts MHCPs at risk of burnout (see Chapter 5). This may make it more difficult to provide care with empathy, compassion, patience, and understanding. It appears important in the SA context to address structural barriers to suicide prevention (identified in Chapter 6) in order to create the requisite environment for optimal, person-centred care and suicide prevention.

Education and training of health care providers (particularly those working in SUD treatment centres) in basic medical and psychiatric assessment, treatment of mental health conditions, and screening for suicide risk was suggested as imperative for suicide prevention. These suggestions address the insufficiencies in training noted as barriers to suicide prevention in Chapter 6. Closing the evidence-practice gap in the delivery of mental health services has been recognised as a priority for health services and workforce planning globally

(Furber et al., 2015). A need for training in evidence-based interventions for SUDs and other common mental disorders is apparent in SA (Myers & Fakier, 2009; Myers, et al., 2010; see also Chapter 6), although a recent systematic review has shown that the evidence base for the treatment of SUDs and comorbid mental health conditions is weak (Kaminer et al., 2017). Additionally, there appears to be ambivalence amongst those who train mental health care providers about the relevance of evidence-based psychological interventions in SA (Kagee & Lund, 2012). In spite of these potential challenges, training MHCPs in effective, evidence-based strategies to prevent suicide (such as CAMS) and treat mental health problems is critical.

Interestingly, participants in this study spoke of a perceived lack of legislation and minimum norms and standards to oversee the training, qualifications, and competencies of those who provide treatment to PWSUDs in SA, and suggested that this be addressed. Minimum norms and standards for SUD treatment facilities in SA exist (DSD, 2013b, 2013c), and it is unclear why some participants are unaware of their existence. However, these regulations appear not to specify the exact training required by employees of SUD treatment facilities and appear not to necessitate that a MHCP registered with the HPCSA be a part of the treatment team. These were noted as barriers to suicide prevention in Chapter 6. Indeed, not all treatment centres in SA are registered with the DSD and not all treatment centres employ adequately qualified staff (DSD, 2016). Core competencies are specified in the policies outlining minimum norms and standards for these treatment centres, but do not include the ability to treat comorbid mental health conditions or, critically, to prevent suicide. In effect, the minimum norms and standards appear not to be meeting the needs of PWSUDs, and may need revisions to include more specific recommendations. Some of the problems associated with these norms and standards have been noted by other scholars (Burnhams et al., 2009; Puljević & Learmonth, 2014).

It is unsurprising that these participants suggest that more resources, multi-disciplinary teams, and greater intersectoral collaboration are needed in order to prevent suicide effectively. The SA health system continues to face financial and infrastructural resource constraints and a lack of intersectoral collaboration (Brooke-Sumner et al., 2016; Burns, 2011; Coovadia et al., 2009; see also Chapter 6). However, these participants highlight some important and simple ways to make more effective use of existing resources, to advance progress towards a more comprehensive, multi-disciplinary approach to suicide prevention. Notable is the recommendation to utilise task-shifting and implement a tiered model of service delivery. Registered counsellors, who have four years of professional training in psychology and counselling, are an underutilised cadre of mental health care providers, with the majority of graduates not practicing in the field of mental health due to a lack of job opportunities (Abel, 2007). Employing more registered counsellors in SUD treatment settings may provide opportunities for this tiered system to be realised. Additionally, there may be room to employ strategies such as tele-mental health services, where a highly trained MHCP (e.g., psychologist/psychiatrist) provides remote services via an internet-based platform to under-resourced centres. These models use existing resources highly efficiently, can be used to support task-shifting models of care, and are as effective as in-person consultations (Hailey, Roine, & Ohinmaa, 2008; Hilty et al., 2013). Tele-mental health services can be used to strengthen models implementing collaborative care and task shifting, and may be highly applicable in low-resource environments. For this tiered model to be effective, however, the issue discussed above of ensuring that these MHCPs have the competence to provide evidence-based interventions for suicide prevention would need to be addressed, and a tiered system of mental health care would need to be further developed and implemented.

Many of the suggestions discussed thus far suggest improving access to health care resources and strengthening mental health care provision in various ways. As such, these suggestions are situated within dominant, biomedical, treatment-focused approaches to suicide prevention. The overly narrow focus of these approaches and their other limitations have been noted in Chapters 1 and 2. Participants' suggestions to focus on strategies such as early intervention and prevention programmes to promote healthy development may be the key to address the shortcomings of such biomedical approaches. Importantly, their suggestions to promote good parenting and foster adaptive psychological functioning in children offer a departure from traditional early intervention strategies for suicide prevention, which still focus on raising awareness about suicidal behaviour and improving access to health services (Robinson et al., 2013).

Addressing the contextual factors influencing suicide may be particularly important in the context of substance use in LMICs. Researchers have argued for the need to consider the structural determinants of suicide in PWSUDs in other LMICs, and have suggested a number of important strategies to help prevent suicide in PWSUDs (Armstrong & Samson, 2016). Raising awareness of the high risk of suicide in PWSUDs; developing culturally appropriate suicide prevention guidelines; upskilling health care workers to screen for and manage suicide risk; addressing the psychosocial drivers of suicidal behaviour by tending to housing, vocational, and family crises; and moving towards a social model of recovery are just some of these suggestions (Armstrong & Samson, 2016). These suggestions support the findings of this study. Such comprehensive, socially-focused approaches to suicide prevention in PWSUDs have yet to be trialled and tested. Awareness of the need to extend suicide prevention efforts to address more distal risk factors and enhance distal protective and resilience factors may be important for suicide prevention in PWSUDs as well as other high-risk groups.

## Conclusion

The findings presented and discussed in this chapter indicate that MHCPs propose a person-centred, multisectoral, integrated approach to suicide prevention among PWSUDs in SA. Many of the suggestions they make focus on addressing potentially modifiable individual risk factors (e.g., treating SUDs and comorbid mental illness, and decreasing social isolation), while other suggestions (e.g., providing integrated care, reducing stigma, and using resources more effectively) are more eco-systemic and focused on social, economic, and contextual factors. Additionally, many of these suggestions address the barriers perceived to suicide prevention in PWSUDs in SA (see Chapter 6). Despite many of the participants' suggestions being reflective of dominant, biomedical approaches to suicide prevention, they made many context-specific suggestions for suicide prevention that help add specificity to the general principles proposed in many suicide prevention strategies (see Chapter 2). These specific suggestions include ideas about the types of training they need and the particular ways that intervention efforts could be implemented. Additionally, they suggest concrete ways to prevent suicide specifically in PWSUDs. This may help provide direction for suicide prevention interventions tailored to the specific needs of different high-risk groups. As such, this research adds valuable, context- and population-specific suggestions for suicide prevention in PWSUDs, and highlights key elements of what MHCPs propose for suicide prevention in PWSUDs in SA.

## **Chapter 8**

### **Conclusion**

In this research, I sought to investigate MHCPs' experiences of preventing suicide in PWSUDs in SA, focusing on their perceptions of the factors impacting on suicide prevention and their ideas for how to prevent suicide in this high-risk population. The findings of my study showed that MHCPs have a range of potentially unhelpful emotional responses to their work preventing suicide and utilise a number of strategies to manage these experiences. These participants perceived their experiences to be related to their perceptions of treating SUDs, the difficulties of assessing and managing suicide risk, and how treating SUDs might increase suicide risk. They identified a number of factors that impacted on suicide prevention, and these factors were perceived as barriers to suicide prevention. These included structural issues in service provision (a lack of resources, insufficiencies in training, and fragmentations in the organisation of care) and contextual issues extending beyond health care (poverty and inequality, the breakdown of family, and stigma). Participants made a number of concrete and potentially useful suggestions for preventing suicide as health care providers (providing support, instilling hope, providing person-centred care, making use of evidence-based treatments for SUDs and comorbid mental illnesses) and offered ideas for how broader issues could be addressed to help prevent suicide (providing integrated and comprehensive care, improving resource utilisation, focusing on early prevention, and reducing stigma).

The findings highlight the complexities implicit in suicide prevention and show that MHCPs need to be supported in their work preventing suicide. The findings also show that MHCPs may need to be trained to see suicidal behaviour as something that can be manageable and can be prevented. Supporting MHCPs in their work may require increased

intersectoral collaboration and inputs from various stakeholders outside of health care environments. The structural and contextual barriers to suicide prevention identified by these MHCPs highlight a need to move beyond biomedical risk-factor models of preventing suicide and a need to pay greater attention to the contextual factors implicated in suicide prevention. Providing integrated, multi-level suicide prevention interventions that target high-risk groups like PWSUDs appears important in this regard. These interventions may need to be designed with person-centred care in mind, and need to ensure that MHCPs are adequately trained to prevent suicide and treat mental illnesses. These findings suggest that balancing the attenuation of risk factors with addressing broader contextual factors may be critical to advance research and practice in suicide prevention. Context- and population-specific suicide prevention interventions are clearly needed.

In the rest of this chapter, I reflect broadly on the findings and discussions as a gestalt, highlighting consistencies and inconsistencies across the subsets of the findings. I then outline the limitations of my study along with some implications and possible future directions. To conclude, I offer some post-hoc reflections, focusing on the ethics of this research within the context of health care provision in SA.

### **The Gestalt: Consistencies and Inconsistencies**

There are some clear links between the experiences of these participants, their perceptions of barriers to suicide prevention, and their ideas for suicide prevention. Participants clearly experienced their training in suicide prevention to be problematic (Chapter 5), highlighted that insufficient training in suicide prevention and evidence-based treatment of mental illness impeded their abilities to prevent suicidal behaviour (Chapter 6), and suggested that MHCPs receive more comprehensive training in management of suicide risk and treatment of mental illness (Chapter 7). As noted in Chapter 7, these insufficiencies



in training may be related to the lack of clarity provided in the documents governing minimum norms and standards for SUD treatment facilities. Most MHCPs who work in these facilities are counsellors and social workers, yet these documents do not require that they be trained in evidence-based suicide prevention interventions. Participants also said that a lack of resources makes it difficult for them to do their jobs properly (Chapters 5 and 6) and that more resources are undoubtedly needed (Chapter 7). They provided some useful and innovative suggestions for utilisation of existing resources (Chapter 7). They also highlighted fragmentations in the organisation of care for PWSUDs (Chapter 6) and said that more integrated care and intersectoral collaboration are needed to help prevent suicide (Chapter 7). Finally, they noted that broad sociocultural issues pose barriers to suicide prevention (Chapter 6) and need to be addressed through early prevention efforts, public education campaigns, and possible social reform to help prevent suicide in PWSUDs (Chapter 7). It is evident that there are logical consistencies between the experiences of MHCPs (Chapter 5), their perceptions of the barriers to suicide prevention (Chapter 6), and their ideas for suicide prevention (Chapter 7).

However, there were also some inconsistencies between MHCPs' experiences, their perceptions of the factors impacting on suicide prevention, and their ideas for suicide prevention. MHCPs reported experiences of hopelessness, helplessness, impotence, and guilt when working with suicidal PWSUDs (Chapter 5), but did not explicitly suggest that they needed more support themselves in order to do their work with fewer emotional consequences and to prevent suicide more effectively. They did note that they need to debrief from their experiences (Chapter 5), but conveyed this as a consequence of their work rather than as a routine part of them caring for their own needs. They were careful to suggest that PWSUDs need support and hope (Chapter 7), but did not say that they need this themselves. This may indicate that MHCPs felt so defeated in their work that they did not

consider to ask for support for themselves. Alternatively, this may highlight a blind-spot for MHCPs: a lack of recognition that self-care is important to do one's job as a MHCP.

While participants mentioned some ideas for suicide prevention that included interventions conceptualised outside the biomedical risk-factor paradigm of psychiatric and psychological treatment, most of their suggestions fell within this paradigm (Chapter 7). This may illuminate just how pervasive and powerful the biomedical model is in the field of suicidology and in the practice of mental health care. This shows a possible limitation in the ways that MHCPs think about suicide and its prevention, despite the fact that they are able to recognise contextual issues that extend beyond health care and pose barriers to suicide prevention (Chapter 6). For example, it seems clear that poverty and inequality are major problems that influence substance use and suicidal behaviour and impede suicide prevention (Chapter 6), yet no participants suggested that poverty and inequality be addressed to prevent suicide.

Similarly, participants mentioned how the split between public and private health care caused major inequalities in health care provision (Chapter 6), but none mentioned the need to address this. The recent proposal by the SA government to implement a national health insurance system is a first step towards addressing this issue (DOH, 2017), but participants did not seem to engage with this as a potential possibility for improving suicide prevention. It is hard to understand the reasons for this, but one possibility might be that participants have trouble suggesting that the political determinants of health care provision need to be addressed as part of the solution to the contextual problems they are able to identify.

One might anticipate that participants would make a more direct link between their perceptions of the barriers to suicide prevention and their ideas for suicide prevention, but this link was tenuous and inconsistent. It may be difficult to suggest that social, political, and economic reform are important for suicide prevention, as suicide is traditionally seen as a

health problem. However, the findings show that expanding our view of what is required to prevent suicide beyond the biomedical paradigm may be an important part of preventing suicide in PWSUDs in SA. The findings also indicate that there may be a need to disrupt MHCPs' tendencies to fall back on biomedical models when conceptualising how to address mental health issues.

### **Limitations**

This study has a number of limitations. First, I conducted this study in the greater Cape Town area in the Western Cape, SA, which has some of the highest rates of mental health problems in the country (Herman et al., 2009). However, the Western Cape is also considered to be one of the better resourced regions in the country when it comes to mental health resources (Naledi, 2017). As such, these participants may have provided services for a population with particularly severe SUDs, may also see more psychiatric comorbidity and social issues than in other regions of the country, but may be comparatively better resourced than MHCPs working in other regions of SA. This means that these findings may not be applicable in other regions of SA or to other LMICs.

Second, the focus on the perspectives of MHCPs does not allow us to know what the opinions of suicidal PWSUDs are, or whether they perceive the same issues to be important in preventing their own suicidal behaviour. There is clearly a need for future research to generate this understanding.

Third, there is always the possibility that, despite efforts made to ensure that the data became saturated and that I identified all the themes relevant to the research questions, doing another interview may have uncovered contradictory data (Brocki & Wearden, 2006). As such, these data cannot be considered to be an undeniably complete representation of the experiences and perspectives of MHCPs.

Fourth, while this group of participants was well represented by different types of MHCPs, the sample size was relatively small and cannot be said to be representative of all MHCPs. Similarly, non-probabilistic sampling methods were utilised, which may have introduced bias into the data.

Fifth, as mentioned in detail in the section "Demand characteristics and identity performance" in Chapter 4, I (as the research instrument) undoubtedly had an effect on data collection and analysis. It may be that participants responded in particular ways to the questions I asked because of my characteristics as a person or as a researcher, or because of the demand characteristics of the context in which data were collected and the way the research was framed. This may have occurred despite the careful measures I took to provide a space where participants felt that they could talk openly and honestly with me about their experiences, despite how they thought it might make them appear.

Sixth, given the iterative nature of the data collection and analysis process (see Chapter 4), the foci of the interviews and the topics of inquiry necessarily shifted and became more specific as the research progressed. This meant that I focused on particular aspects relating to the research questions and potentially lost other aspects as a result. It was therefore not possible to investigate all potential aspects of the phenomena under study. This meant that, in effect, I edited out certain aspects of participants' stories during the data collection, analysis, and write-up to develop a clear narrative arc across the findings. This sacrifice of some aspects of participants' stories for other, potentially more interesting or significant points is inevitable in qualitative research, but is a particular reflection of the dynamic nature of qualitative research and the importance of being able to adapt to the data and to the flow of the research process. Sacrificing certain elements of participants' experiences in both the interviews and in the data analysis was necessary to keep the study focused on the research questions.

Finally, limitations of space necessitated omission of some longer quotes in the findings. This may detract from the perceived confirmability of the findings.

### **Implications and Future Directions**

This study provides a useful first step in (a) describing the lived experiences of MHCPs tasked with the responsibility of providing care for suicidal PWSUDs in SA, (b) identifying the barriers to suicide prevention perceived by these MHCPs, and (c) suggesting how suicide prevention interventions can be tailored to the specific needs of PWSUDs in SA. This has helped answer the research questions posed in Chapter 1. MHCPs clearly need to be more supported in their work preventing suicide, and need better training in the assessment and management of suicide risk as well as evidence-based treatments for SUDs and comorbid mental illnesses. Structural issues in the provision of care may need to be addressed to help prevent suicidal behaviour in PWSUDs in SA, although the extent to which this may help prevent suicidal behaviour remains to be seen. Participants indicated that more resources are needed for mental health care in SA, and that basic tenets of good, person-centred medical and psychological care may go a long way to help prevent suicide in PWSUDs. It is interesting to note that many of these principles are congruent with basic tenets of good practice in mental health care provision and are not necessarily suicide-specific.

Addressing broad factors like poverty and inequality, the breakdown of family, maladaptive childhood functioning, and stigma may be far more challenging than providing solutions such as the provision of person-centred mental health care. These issues highlight how health is affected by the social, economic, cultural, and political fabric of society, and this has implications for who should be responsible for problems like suicide. Perhaps it is important to increasingly focus our attention on the social and economic factors related to suicide, and address those in a comprehensive prevention model, rather than trying to address

and prevent suicidal behaviour at the level of acute treatment provision. Similar strategies have been advocated by authors such as Armstrong et al. (2014) and Armstrong and Samson (2016). An approach of proactive prevention (by enhancing resilience factors and preventing subsequent problems) rather than reactive prevention (addressing problems like suicidal behaviour only once they are apparent) may be important in this regard, as has been described by the United States Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention (2012).

This research offers a number of possible future directions. First, investigating the lived experiences of PWSUDs who have engaged in or experienced suicidal behaviour may provide important insights not illuminated in my study. Second, these findings could be used to inform future policy decisions regarding suicide prevention in PWSUDs. Third, similar studies could be conducted in other high-risk populations in SA (e.g., prisoners) to determine the specific factors that need to be accounted for to prevent suicide in those high-risk groups. Fourth, future research on this topic could investigate the perspectives of multiple other stakeholders (such as policy experts and representatives from the DOH and DSD) and could be designed as part of a coordinated effort to improve suicide prevention in high-risk populations in SA. Finally, research could be done to investigate whether implementing these participants' suggestions for suicide prevention leads to reductions in suicidal behaviour. This might include, for example, a randomised controlled trial investigating the effects that training MHCPs in specific suicide prevention interventions has on rates of suicidal behaviour in their patients.

### **Post-Hoc Reflections**

In the final section of my thesis, I reflect on my responses to the data, changes in my perspective, and ethical considerations that became apparent at the end of the research

process. These reflections can be considered as a continuation of the section "Reflexivity and positionality" in Chapter 4, but are most appropriately presented here as they only became apparent to me as I reflected on the thesis during the final stages of the write-up.

**Responses to the data and changes in my perspective.** The interviews took me on a journey that I had not completely expected. As I learned more about the problems faced by MHCPs and PWSUDs, the difficulties of providing services to chronically relapsing or chronically suicidal patients, the challenges of working in a seemingly broken health system, and the emotional heaviness of managing and preventing suicide, I began to experience the emotions of my participants. I felt despondent, depressed, and powerless about preventing suicide in PWSUDs, and could not help but acknowledge the hopelessness that seemed so inherent in the stories of my participants. I had to manage my own feelings when conducting the interviews, in order to not try and solve the problems I was hearing about or to try and counsel the MHCPs who were telling me how difficult their jobs could be at times. I ended up thinking that perhaps the participants were right: perhaps suicide was unpreventable after all.

However, through many hours of conversation and supervision with my supervisor, I was able to talk through not only the data, but also my experiences of the data collection and analysis process. I was able to understand and come to terms with the data and the problems of identifying with the emotions of my participants. Receiving supervision on the difficulties of working as a researcher in the field of suicidology and working in what can be a difficult line of mental health care provision helped me understand my data in the context of health care provision in SA. This helped shape my thinking on the findings presented in Chapters 5 and 6 especially, dealing with the experiences of MHCPs and the barriers they perceived to suicide prevention.

Many of my perspectives, opinions, and biases shifted throughout the course of this research. I embarked upon this research with a keen interest in clinical psychology but with little knowledge about suicidal behaviour, substance use, or mental health care provision in SA. It was challenging to get up to speed with the literature on suicidal behaviour and substance use, and it opened my eyes to the nature and depth of pain, hopelessness, and despair (in Edwin Shneidman's words, "psychache"; Shneidman, 1993, p. 145) that can colour the life experiences of suicidal PWSUDs, and the effects this can have on those who provide care for them. As the research progressed, I gained respect for those who feel or have felt suicidal, or who have engaged in suicidal behaviour. I experienced similar emotions of respect and empathy when reading and hearing about substance use, and the multiple and varied problems that it can cause for people. I became acutely aware of conversations about suicide and SUDs going on around me and of the implicit biases and assumptions that other people exhibited regarding substance use and suicidal behaviour.

Learning about providing mental health care, about suicidal behaviour, and about substance use gave me a much deeper understanding of these phenomena and has shifted the way I think and feel about these issues. In the later stages of data analysis, I worked as a researcher in the emergency psychiatric unit at Groote Schuur Hospital. This contextualised many of the research findings for me and helped provide perspective on the data and the SA health care system. It also shaped my thinking around SUDs and suicidal behaviour as serious problems with social, economic, political, and cultural determinants. By the end of the thesis, I came to see suicide prevention as a difficult task, involving multiple challenges that are shaped by factors related to health care, mental health, social and economic instability, and SA's political history.

**On the ethics of being a researcher in the field of suicidology.** In Chapter 3, I explained why I considered postpositivism an appropriate research paradigm for my study,



and in Chapter 4, I detailed my personal reflections on the research process. Here, I offer final reflections on my research in the context of health care in SA, paying attention to what it means to be an ethical researcher.

To recap, by adopting a critical realist ontology in this research, I was able to view reality as a stratified open system, where MHCPs are social actors who both constitute and influence the systems in which they operate. Adopting a modified dualist/objectivist epistemology allowed me to acknowledge that MHCPs' experiences, perceptions, and behaviour have observable consequences in external reality. Looking back on the findings of this thesis, readers can see that MHCPs interpreted their realities and the systems that they operate within a number of ways, including the ways they make sense of their emotional experiences, the ways they conceptualise the factors influencing suicide prevention as barriers to suicide prevention, and the paradigms they draw on when suggesting how to prevent suicide in PWSUDs in SA.

What we don't see explicitly in the findings, however, is that the ways these MHCPs perceive and interpret their realities have direct effects on how they do their jobs and how they occupy their roles as social and institutional actors in the mental health care system. The experiences and perceptions of MHCPs shape and inform the ways they behave in and respond to the systems in which they operate, which in turn shifts and alters those systems. This may cause the systems to change, or may perpetuate existing structures in those systems in particular ways. The effects of these behaviours and perceptions were only implicitly investigated in this research, yet they have implications for improving suicide prevention in PWSUDs. It may not only be academically important and interesting to understand the experiences and perceptions of these MHCPs, but it may also be important ethically and from advocacy perspectives. We cannot hope to change systems if we do not understand how the

social actors within them constitute and influence those systems. This brings me to some final ethical considerations I became aware of at the very end of my study.

Ethics in research is usually considered as something substantive: approval to be obtained from a relevant ethics body and consent to be obtained from research participants (Frank, 2004). Bantjes and Swartz (in press) highlight that traditional approaches to ethics, particularly in the health sciences, are predicated on the assumption that the researcher and the research participants are entirely separate, with the researcher having a responsibility to protect the participants (through ensuring privacy, anonymity, and non-maleficence). This canonical form of ethics is limited, especially when it comes to research on health and factors related to life and death (Frank, 2004). Research, especially when conducted within health systems, is deeply affected and determined by the contexts in which it takes place, meaning that researchers might occupy advocacy roles in addition to their roles as scholars and clinicians. Indeed, some scholars have argued that social science researchers have a moral responsibility to act as agents of social change (Chari & Donner, 2010).

Frank (2004) notes that, in health care research particularly, ethics-as-substance should be replaced by ethics-as-process. The process of being ethical necessitates developing a set of guiding principles for behaviour throughout the research process, which can help researchers navigate unforeseen ethical considerations. These may arise based on the findings of the research, and by definition can not be accounted for through the simple acts of obtaining ethical clearance from a health care body and informed consent from participants. Bantjes and Swartz (in press) highlight just how unforeseeable and unnavigable these ethical considerations might be when conducting research that reveals something about the organisation of health care systems.

While reflecting on the data and what they may mean in the broader context of health care provision in SA, I realised the findings may read as depressing and critical of the

difficult work that MHCPs do every day. Why might it be that MHCPs report predominantly problematic emotional experiences? Is it the "truth" of these participants' lives that their work is so challenging, that the fragmentations in the health care system are so debilitating, and that some of their ideas for suicide prevention may be outdated and couched within supposedly problematic biomedical paradigms? Or is it just one truth of many? What about the way I discussed the findings? Might that not have an impact on how they are perceived by readers, including these very MHCPs? Might this not, in turn, influence the ways MHCPs act within the various systems that they constitute, shifting and altering those systems? Or has the mere fact that these MHCPs participated in my study influenced their behaviour to shift and alter those systems already?

Of course, answers to these questions are many and varied. As highlighted in the limitations above, these findings can only be seen to represent one truth of many, as I had to focus on particular aspects of participants' experiences while sacrificing others. Additionally, I adopted a critical approach to the findings, highlighting inconsistencies and looking for ways to trouble the data (see Jackson & Mazzei, 2012). I did this to ensure that, as a social researcher, I was thinking carefully about not only presenting these findings, but understanding how they might make a significant contribution to the knowledge base. Moreover, as stated in Chapters 3 and 4, it was my wish that this research would be able to contribute in some meaningful way to the field of suicide prevention; for example, by helping influence policy or by helping advance our knowledge about preventing suicide.

Previous researchers have noted the difficulties of doing qualitative research on topics where the findings indicate that social change is needed, but where the researcher is in no position to enact or influence such a change (see Armstrong, 2012; Keikelame, 2017). I experienced similar frustrations in this study. Preventing suicide in PWSUDs seems like it should be a top priority for the provision of care for these patients, yet this appears not to be

prioritised in the training of MHCPs or in the policy documents guiding their training or registration (see DOH, 2013; DSD, 2013a, 2013b, 2013c). Additionally, broad social and economic problems, along with infrastructural problems in the provision of health care appear to require imminent redress if we hope to prevent suicidal behaviour in high-risk populations. These are not issues that I can address directly as a researcher, yet they arise as priorities from this work.

Within my assumed dual role as researcher/advocate, I became aware of an important ethical consideration that had been present throughout this study but only became visible at its conclusion. As an advocate for social change, I had a responsibility to focus on the problems in my participants' stories, to ensure that I uncovered what might need to be attended to, to critically assess what could be done better, in the hope of providing evidence in case some form of change was indicated. But as a researcher considering ethics-as-process, I had to consider the impact that my writing and interpretations could have on my participants. I formed relationships with my participants (who themselves have relationships with their clients and patients), and had a responsibility to question how the publication of these findings might affect those relationships in the real world. Additionally, I had to consider how these findings might affect the motivation and willingness of MHCPs who treat PWSUDs to continue doing their work, should they read the findings. It is not particularly inspiring to read that your work makes your colleagues feel hopeless and helpless, and that you may be working within a fragmented health care system. This made me question the role I should occupy when the research I am conducting uncovers problems that I am powerless to address. Do I act as a researcher with a social advocacy agenda, publish the findings, and hope that it does not affect my participants adversely? Do I act as an ethical researcher who prioritises his participants' wellbeing, and find some other, less public way to disseminate the findings? Is there a middle ground? Whose wellbeing and rights matter most: my

participants' or suicidal PWSUDs'? Similar issues and concerns have been raised by Fitzpatrick and Kerridge (2013), yet consensus on what may be the best way forward is unclear.

In the end, I am left wondering about where the responsibility for any researcher-advocate lies, as I straddle the divide between acting as an ethical scholar who provides useful knowledge to help inform suicide prevention interventions, and acting as an ethical human to protect the wellbeing of my participants. Just as my thesis has answered some questions, it has raised others. In all, I hope that reflecting on these issues helps uncover the difficulties encompassed in health research of this nature, and I hope that, through publication of the findings, this thesis helps contribute something meaningful to the field of suicide prevention.

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## Appendices

### Appendix A: Informed Consent Form

#### PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

**TITLE:** *An exploratory investigation of suicidal behaviour and substance use among patients seeking care in clinics in Cape Town: Implications for suicide prevention and service delivery*

**REFERENCE NUMBER:** N16/02/026 (Stellenbosch University) and 352/2016 (University of Cape Town)

**PRINCIPAL INVESTIGATORS:** Dr Jason Bantjes<sup>1</sup> and Dr Lisa Dannatt<sup>2</sup>

**CO-INVESTIGATORS:** Elsie Breet<sup>1</sup> and Daniel Goldstone<sup>1</sup>

**ADDRESS:**

<sup>1</sup>Department of Psychology; Stellenbosch University; Private Bag X1; Matieland; 7602; South Africa

<sup>2</sup>Department of Psychiatry and Mental Health, Groote Schuur Hospital, University of Cape Town

**CONTACT NUMBERS:**

Dr Jason Bantjes: 083 234 5554

Dr Lisa Dannatt: 021 404 2151

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff or doctor any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part. If any new, relevant information becomes important during the course of the study, you have the right to be notified of this.

This study has been approved by the **Health Research Ethics Committee at Stellenbosch University** (021 938 9677) and the **University of Cape Town Human Research Ethics**

**Committee** (021 650 3002). You may contact these committees if you have any questions or concerns regarding your rights or the welfare of the research participants. Furthermore, the study will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

**What is this research study all about?**

*We are trying to find out what can we learn from mental health care providers about their experiences providing care for people with substance use disorders who have experienced or engaged in suicidal behaviour. We are interested in how mental health care providers make sense of their experiences, as well as what factors they perceive to impact on these experiences. We would like to know what mental health care providers perceive to be the therapeutic/treatment needs of these patients, the current status of service provision, and areas where services may need to be improved for these patients. Finally, we are interested in mental health care providers' ideas for suicide prevention in people with substance use disorders.*

**Why have you been invited to participate?**

*You are being asked to take part in the study because you are a mental health care provider who offers psychosocial services (either psychiatric service provision, counselling, or social work) to substance use disorder patients with and without a history of suicidal behaviour.*

**What will your responsibilities be?**

*If you agree to take part in this study you will be interviewed and asked to tell us what your experiences have been of providing care to people with a diagnosis of substance use disorder and a history of suicidal behaviour. You will be asked to reflect on your experiences providing care for these patients and what needs you perceive these patients to have. You will also be asked about what you think impacts on your experiences preventing suicide and how you think suicide could best be prevented in this population.*

**Where will the interview take place?**

*The interview will be conducted at a time and place of your choosing.*

**How long will the interview take?**

*The interview will take approximately 60 minutes.*

**Will you benefit from taking part in this research?**

*There is no direct benefit for taking part in this study, although information provided may help to improve service provision for people with substance use disorders who have a history of suicidal behaviour. We hope that the findings from this study can be used to help inform suicide prevention interventions for among people with substance use disorders.*

**Are there any risks involved in your taking part in this research?**

*There are no perceived risks in your taking part in this research. Your name will be removed from your data and replaced with a pseudonym of your choosing when the data are analysed so that confidentiality is maintained and so that you remain anonymous.*

**If you do not agree to take part, what alternatives do you have?**

*Participation is voluntary and there will be no disadvantages if you choose not to participate.*

**What will happen in the unlikely event of some form injury occurring as a direct result of your taking part in this research study?**

*There is no danger of physical injury by participating in this study. You may however become emotionally upset as a result of answering the questions. If you do become upset or uncomfortable you may withdraw from the interview at any time, and you can discuss your thoughts and feelings with the interviewer if you feel that you need to receive psychological support.*

**What will happen if I do become emotionally upset as a result of the interview?**

*In the event that you are emotionally upset as a result of participating in this interview, you can discuss your thoughts and feelings with the interviewer if you feel that you need to receive psychological support.*

**Is there anything else that you should know or do?**

- You can contact Dr Jason Bantjes (at 083 234 5554 ) or Dr Lisa Dannatt (at 021 404 2151) if you have any further queries or encounter any problems.

- You can contact the Stellenbosch University Health Research Ethics Committee at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed.
- You will receive a copy of this information and consent form for your own records.

### Declaration by participant

By signing below, I ..... agree to take part in a research study entitled, *An exploratory investigation of self-injurious behaviour and substance use among patients seeking care in outpatient clinics in Cape Town: Implications for suicide prevention and service delivery.*

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ..... on (*date*) ..... 2016

.....  
**Signature of participant**

.....  
**Signature of witness**

**Declaration by investigator**

I (*name*) ..... declare that:

- I explained the information in this document to .....
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*)

Signed at (*place*) ..... on (*date*) ..... 2016.

.....  
**Signature of investigator**

.....  
**Signature of witness**



## Appendix B: Semi-Structured Interview Schedule

1. Can you tell me about your experiences of providing care for people with substance use disorders?

Potential probes:

- 1.1. In what context did this take place? (context)
- 1.2. What was the duration of care? (duration)
- 1.3. What resources did you need and have/not have available? (resources)
- 1.4. What type of training have you received in mental healthcare provision?  
(training)
- 1.5. What is your perceived ability to detect suicide risk and intervene effectively?
- 1.6. What do you think of the effectiveness of the treatments you provide? (perceived faith in treatment / effectiveness of treatment)
- 1.7. Can you tell me about any perceived barriers to care?

2. Can you tell me what you think impacts on your experiences preventing suicide amongst people with substance use disorders?

Potential probes:

- 2.1 Based on your experience, can you tell me what you think about suicide in PWSUDs based on your experience?
- 2.2. Do these patients/clients differ from other suicidal patients/clients, and if so, how?
- 2.3. Any difficulties providing care?
- 2.4. Any suggestions for improved care?
- 2.5. Any suggestions for prevention of suicide?
- 2.6. What is your perception of the extent of the problem?
- 2.7. What factors do you think impact on your experiences providing care for PWSUDs?
- 2.8. In your mind, what is the state of the current care and support available for PWSUDs who engage in suicidal behaviours?
- 2.9. What type of psychosocial support needs do you think PWSUDs who engage in suicidal behaviours have?

- 2.10. What psychiatric services do you think are critical for PWSUDs who engage in suicidal behaviour? Does this differentiate them from other patients with a history of suicidal behaviour?
3. What do you feel would support you in your work or enable you to provide better care for substance users with a history of suicidal behaviour? What do you think is required to prevent suicide in people with substance use disorders?
- Potential probes:
- 3.1. Is there any sort of information that you need but don't have?
  - 3.2. Is there training that you need or want?
  - 3.3. Any resources needed?
  - 3.4. What are your suggestions for future research in this area?

## Appendix C: Ethics Approval: Stellenbosch University



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY  
jou kennisvennoot • your knowledge partner

### Approval Notice Response to Modifications- (New Application)

30-May-2016  
Bantjes, Jason JR

**Ethics Reference #: N16/02/026**

**Title:** An exploratory investigation of the relationship between self-injurious behaviour and substance use: Implications for suicide prevention and service delivery in South Africa

Dear Dr. Jason Bantjes,

The **Response to Modifications - (New Application)** received on **22-Apr-2016**, was reviewed by members of **Health Research Ethics Committee 2** via Expedited review procedures on **30-May-2016** and was approved.

Please note the following information about your approved research protocol:

Protocol Approval Period: **30-May-2016 -29-May-2017**

Please remember to use your **protocol number** (**N16/02/026**) on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

#### **After Ethical Review:**

Please note a template of the progress report is obtainable on [www.sun.ac.za/rds](http://www.sun.ac.za/rds) and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.

Translation of the consent document to the language applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372

Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

#### **Provincial and City of Cape Town Approval**

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health ([healthres@pgwc.gov.za](mailto:healthres@pgwc.gov.za) Tel: +27 21 483 9907) and Dr Helene Visser at City Health ([Helene.Visser@capetown.gov.za](mailto:Helene.Visser@capetown.gov.za) Tel:

+27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.

For standard HREC forms and documents please visit: [www.sun.ac.za/rds](http://www.sun.ac.za/rds)

If you have any questions or need further assistance, please contact the HREC office at .

**Included Documents:**

Application form.doc

CV - Elsie Breet.pdf

Protocol.docx

20160509 MOD Declaration Lisa Dannatt

Investigator Declaration - Elsie Breet.pdf

Investigator Declaration - Daniel Goldstone.pdf

20160509 MOD Cover letter

CV - Daniel Goldstone.pdf

Investigator Declaration - Jason Bantjes.pdf

CV - Jason Bantjes.pdf

Checklist.doc

20160509 MOD Protocol

Protocol Synopsis.docx

20160509 MOD CV - Lisa Dannatt

Sincerely,

Francis Masiye

HREC Coordinator

Health Research Ethics Committee 2

## Investigator Responsibilities

### Protection of Human Research Participants

Some of the responsibilities investigators have when conducting research involving human participants are listed below:

1. Conducting the Research. You are responsible for making sure that the research is conducted according to the HREC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research.
2. Participant Enrolment. You may not recruit or enrol participants prior to the HREC approval date or after the expiration date of HREC approval. All recruitment materials for any form of media must be approved by the HREC prior to their use. If you need to recruit more participants than was noted in your HREC approval letter, you must submit an amendment requesting an increase in the number of participants.
3. Informed Consent. You are responsible for obtaining and documenting effective informed consent using **only** the HREC-approved consent documents, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least fifteen (15) years.
4. Continuing Review. The HREC must review and approve all HREC-approved research protocols at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period**. Prior to the date on which the HREC approval of the research expires, **it is your responsibility to submit the continuing review report in a timely fashion to ensure a lapse in HREC approval does not occur**. If HREC approval of your research lapses, you must stop new participant enrolment, and contact the HREC office immediately.
5. Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, number of participants, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the HREC for review using the current Amendment Form. You **may not initiate** any amendments or changes to your research without first obtaining written HREC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the HREC should be immediately informed of this necessity.
6. Adverse or Unanticipated Events. Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research-related injuries, occurring at this institution or at other performance sites must be reported to the HREC within **five (5) days** of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the HREC's requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch University Health Research Ethics Committee Standard Operating Procedures [www.sun025.sun.ac.za/portal/page/portal/Health\\_Sciences/English/Centres%20and%20Institutions/Research\\_Development\\_Support/Ethics/Application\\_package](http://www.sun025.sun.ac.za/portal/page/portal/Health_Sciences/English/Centres%20and%20Institutions/Research_Development_Support/Ethics/Application_package) All reportable events should be submitted to the HREC using the Serious Adverse Event Report Form.
7. Research Record Keeping. You must keep the following research-related records, at a minimum, in a secure location for a minimum of fifteen years: the HREC approved research protocol and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the HREC
8. Reports to the MCC and Sponsor. When you submit the required annual report to the MCC or you submit required reports to your sponsor, you must provide a copy of that report to the HREC. You may submit the report at the time of continuing HREC review.
9. Provision of Emergency Medical Care. When a physician provides emergency medical care to a participant without prior HREC review and approval, to the extent permitted by law, such activities will not be recognised as research nor will the data obtained by any such activities should it be used in support of research.
10. Final reports. When you have completed (no further participant enrolment, interactions, interventions or data analysis) or stopped work on your research, you must submit a Final Report to the HREC.
11. On-Site Evaluations, MCC Inspections, or Audits. If you are notified that your research will be reviewed or audited by the MCC, the sponsor, any other external agency or any internal group, you must inform the HREC immediately of the impending audit/evaluation.

## Appendix D: Ethics Approval: University of Cape Town



**UNIVERSITY OF CAPE TOWN**  
**Faculty of Health Sciences**  
**Human Research Ethics Committee**



Room E53-46 Old Main Building  
 Groote Schuur Hospital  
 Observatory 7925  
 Telephone [021] 406 6492  
 Email: [sumayah.ariel@uct.ac.za](mailto:sumayah.ariel@uct.ac.za)  
 Website: [www.health.uct.ac.za/fhs/research/humanethics/forms](http://www.health.uct.ac.za/fhs/research/humanethics/forms)

08 September 2016

**HREC REF: 352/2016**

**Dr L Dannatt**  
 Department of Psychiatry & Mental Health  
 J-Block-GSH

Dear Dr Dannatt

**PROJECT TITLE: AN EXPLORATORY INVESTIGATION OF SELF-INJURIOUS BEHAVIOUR AND SUBSTANCE USE AMONG PATIENTS SEEKING CARE IN OUTPATIENT CLINICS IN CAPE TOWN: IMPLICATIONS FOR SUICIDE PREVENTION AND SERVICE DELIVERY (MSc-candidate-D Goldstone & PhD-candidate-E Breet)**

Thank you for your response letter, addressing the issues raised by the Human Research Ethics Committee (HREC).

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

**Approval is granted for one year until the 30 September 2017.**

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

(Forms can be found on our website: [www.health.uct.ac.za/fhs/research/humanethics/forms](http://www.health.uct.ac.za/fhs/research/humanethics/forms))

**Please quote the HREC REF in all your correspondence.**

***We acknowledge that the following students, D Goldstone & E Breet will also be involved in this study.***

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval before the research may occur.

Yours sincerely

pp T. Bures

**PROFESSOR M BLOCKMAN**  
**CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE**

Federal Wide Assurance Number: FWA00001637.

HREC 352/2016

Institutional Review Board (IRB) number: IRB00001938

This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP), South African Good Clinical Practice Guidelines (DoH 2006), based on the Association of the British Pharmaceutical Industry Guidelines (ABPI), and Declaration of Helsinki (2013) guidelines.

The Human Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.