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Minding Mental Health: Clinicians' Engagement with Youth Suicide Prevention

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Abstract: Suicidal ideation and deaths among children and adolescents have seen an unprecedented rise over the last ten years, recently further exacerbated by the COVID-19 pandemic. This research explores mental health professionals' approaches to delivering suicide prevention treatment services. Using insights from Giddens' structuration theory, the study examines licensed mental health professionals' (1) reflections on suicide prevention trainings for those in their profession, (2) appraisals of available treatment options, and (3) assessments of postvention services provided to professionals who encounter a client suicide. Additional attention was given to the structural impacts of the COVID-19 pandemic on intervention services. Data were collected through qualitative interviews with youth mental health clinicians in the state of Texas. Results underscore the interplay between structural influences and practitioner innovations in the delivery of these essential services to a vulnerable population. This study underscores the agency of mental health professionals in navigating the demands of a difficult profession.

Keywords: suicidality; children; adolescents; youth; coronavirus; mental illness; mental health; youth risk; structuration

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1. Introduction

The prevalence of suicide and adverse mental health conditions has rapidly increased over the last few years, only to be exacerbated by pandemic conditions. Suicide is the second leading cause of death for youth between the ages of 10 and 19 years old in the United States. Since 2007, youth 15–19 years of age have experienced an increase of 76% in suicide deaths, with an annual increase of 10% since 2014 (Curtin and Heron 2019). The crisis of mental health issues, including completed and attempted suicides, has left generations in the United States scarred. Investigating the pressures faced by frontline mental health practitioners, such as the training and practice of treating suicidal individuals during pandemic restrictions, is integral to developing key strategies for professional development. Currently, fallout from the 2019 novel coronavirus (COVID-19) pandemic has contributed to a rise in suicidal behaviors and adverse mental health conditions among children and adolescents (Leeb et al. 2020; Longobardi et al. 2020; Marchini et al. 2020; Nearchou et al. 2020; Singh et al. 2020). However, there has been limited sociological insight as to professional motivations, areas of professional pressure, and structural adaptations.

Factors that influence suicidal tendencies and mental health problems, such as social isolation, stress and anxiety, economic hardship, and discrimination, have been notably relevant in the current pandemic climate (Guessoum et al. 2020; Martinelli et al. 2020; Marques de Miranda et al. 2020; Thakur and Jain 2020; Szlyk et al. 2020; Wigg et al. 2020; Cowie and Myers 2021). Prior to and during the pandemic, youth who displayed suicidal behaviors or attempts were generally referred to local emergency departments for risk assessment and were then encouraged to attend individual or group psychotherapy (Szlyk et al. 2020). In May 2020, emergency visits for suspected suicide attempts began to

increase among adolescents aged 12–17 years; during 21 February–20 March 2021, suspected suicide attempt emergency visits were 50.6% higher among girls and 3.7% higher among boys aged 12–17 years than during the same period in 2019 (Yard et al. 2021). These data reflect increased pandemic-related stress on youth and the unintended consequences of implementing widespread in-person restrictions at the start of the pandemic. Training in suicide risk management and intervention would be beneficial in both long- and short-term practices and encouraged implementation of a mandated training during educational and professional development (Jacobson et al. 2012; Rothes et al. 2014; Binkley and Leibert 2015; Schwab-Reese et al. 2018; Almaliah-Rauscher et al. 2020).

As telehealth can be used alone or in conjunction with in-person practices, this service has proved to be similarly effective as in-person suicide prevention services in the short term (Golberstein et al. 2020; Martinelli et al. 2020). Practitioners caution that minorities, youth in low-income families, and those in under-served and low-income neighborhoods are especially at risk of developing long-term mental health issues in relation to pandemic stressors while also going without treatment (Fegert et al. 2020; Singh et al. 2020; Wigg et al. 2020). At the beginning of the COVID-19 pandemic, the U.S. Department of Health and Human Services allowed for a limited waiver to loosen Health Insurance Portability and Accountability Act (HIPAA) rules. Tools that had not been HIPAA compliant (i.e., Facetime) are now available to practitioners for evaluation and treatment.

This study identifies how, in the face of elevated pandemic risks, mental health clinicians have engaged in innovative suicide intervention practices for youth (ages 3–18) they serve, many of whom may engage in self-harm (i.e., excessive alcohol or drug consumption, creating burns, skin cutting) which may lead to or stem from thoughts of anger, shame, guilt, anxiety, or hopelessness or worthlessness (NAMI 2021). This investigation uses insights from Anthony Giddens (1984) structuration theory to examine mental health professionals' four dimensions of intervention practice. Theoretical concepts of structuration include the application of professionals as agents and their agency (innovation capacity), the duality of structure, unintended consequences, and routine as a primary form of daily activity (Giddens 1984). Other elements refer to the importance in context of interactions and social identities in relation to the associated obligations and sanctions of a given role (i.e., licensed practicing counselor [LPC], psychiatrist, psychologist). The COVID-19 pandemic has given a rare opportunity to study a widespread, rapid upheaval in the extent of clinicians' agency, the duality of structure regarding new therapeutic deliveries balanced with formal education experiences, and changes in the contexts of professional mental health-related experiences.

2. Materials and Methods

Qualitative semi-structured interviews were used to conduct this study. The interviews spanned multiple mental health practices across the state of Texas that served child and adolescent client groups and specialized in suicide pre-, post-, and intervention techniques. This study procured reflections on clinicians' standpoints (perspectives) on treating suicidal individuals, strategies (motivations and actions) in treatment, and stories (narratively recounted experiences) based on memorable treatment encounters.

2.1. Sampling Design and Data Collection

This research was conducted through analysis of qualitative semi-structured interviews with mental health practitioners (Appendix A). The interview sample size consisted of 22 mental health professionals who either obtained full licensing or were in pre-licensing stages for a series of mental health licensure titles at the time of the interview. Interviews were conducted over the course of five months (June through October 2021) after contacting 312 separate private individual practices, nonprofit facilities, practitioner network agencies, and group practices. Recruitment followed by interviews took place upon the approval of the Institutional Review Board (IRB) of The University of Texas at San Antonio. Participant confidentiality is protected within the limits of the law according to the regulations put

in place by the Institutional Review Board. A phone call and email script were utilized when contacting youth-related mental health practices in Texas for potential participants. As part of the interview preparation, the participant was asked to complete a pre-interview survey to collect demographic data (i.e., race and ethnicity, age, gender) and qualifying information (i.e., licensing title, mental health specialization). During each semi-structured interview, the participant was asked a series of questions following an interview guide. This approach left room for naturally developing questions and responses, thereby encouraging another layer of depth to the insight given from the participant. (The recruitment script and pre-interview survey both ensure that participants met all criteria for inclusion in the study sample.)

The data collected were composed of primarily English-speaking (or multilingual) mental health professionals aged twenty and older. Practitioners (with licensure titles of psychologist, psychiatrist, therapist, or counselor) were recruited throughout Texas with participants ranging from north-central to southern Texas locations. Interviews took place over the course of a five-month period (June through October 2021). A videoconferencing platform (Zoom) and telephone calls were utilized in place of in-person meetings due to COVID-19 health and safety recommendations and to maximize participant reach. All interviews were conducted in a secure environment (i.e., empty apart from the researcher, closed doors and windows) and were recorded using a password-encrypted audio-recording app on a password-encrypted mobile device.

The participant was emailed an informational sheet through which the principal investigator (first author) outlined that the interview would be audio-recorded but ensured that no mention of the individual's identity would be involved, with the audio-recording destroyed upon transcription completion. The interviews were transcribed using a qualitative transcription software (Descript) and stored on a password-encrypted laptop only accessible to the researchers located in a secure location.

2.2. Data Management and Analysis

Data obtained were fully transcribed using transcription software and were coded for interview transcription analysis. Interview transcripts were analyzed with the use of software suitable for coding and comparing interview data for thematic elements. Interviews were analyzed for key themes (i.e., perspectives and strategies) according to chronological stages of professionalization, as well as experiential narratives (i.e., stories).

All data were organized around sensitizing concepts related to the stages of mental health professional experiences (Blumer 1969; Bowen 2006; Bowen 2019). Analysis relied on the structuration concepts of duality of structure, agency, power, and context for understanding the stages of professionalization related to professional education (presence of suicide-specific training), client treatment options, and continuous professional development. The researcher anticipated that participants would share stories of past or recent experiences regarding suicidal clients and the impact that COVID-19 has had on professional settings, clientele changes, and practitioner-client interactions. The data exhibited robust internal validity, where there was significant alignment between interviewees' stated perspectives, motivations, etc., and their description of academic and professional suicide prevention-related experiences. The narratives articulated by the study participants appeared to be credible, as they often featured specific examples and thought-provoking reflections. Additionally, saturation was achieved, which encompasses the documentation of consistent responses with respect to evident stages of professionalization. Care was taken not to discount distinct experiences (e.g., outlier themes and narratives).

Interview data were organized according to the findings that were consistently observed across cases in relation to the sensitizing concepts. At the same time, attention was given to unique themes that shed important light on the investigated topic. Multiple reviews of the data were conducted to ensure clarity of connections between collected data and theoretical concepts. A final series of examinations of the data were also completed using an emergent themes technique. At this point, sensitizing concepts were set aside,

and themes embedded in the data were ascertained inductively. Relevant to this study's topic, quotes from interviews are included because they allow the connection of the current mental health professionalization stages to be incorporated into the analysis. Demographic information is included (see Table 1) describing participants' age, race and ethnicity, and gender to provide a deeper understanding of the persons included in the sample. Qualification data for this study are also included in Table 1, describing participants' licensure titles, amount of experience under each current license, practice specialization, age group specialization, and number of hours worked during a regular work week. The data collected were utilized to comprehend clinicians' motivations, strategies, and experiences rather than to generalize regarding the profession. These data therefore have robust internal validity in as much as they reflect clinicians' perspectives in their own words.

Table 1. Demographics and study qualifications of mental health professionals.

* Work Week Hours	* Age Group Specialization	* Area(s) of Specialization	* Experience Under Current License(s)	* Licensure Titles	* Children	Marital Status	* Age	Race	Gender	Participant Pseudonym
40+	3–99	Youth	9 yrs	LPC; CRC	2	Divorced	42	Hispanic or Latinx	Female	Caroline
40	5+	Clinical Mental Health	5 yrs	LPC	3	Divorced	43	Hispanic or Latinx	Male	Jason
45–50	17–3	Child/Adolescent Trauma; Grief	1 yr	LPC-A; NCC	0	Never Married	27	Non-Hispanic White	Female	Justine
37.5	Adolescents; Adults	Adolescents; Mindfulness; Family	7 yrs	LPC; LMFT	0	N/A	31	Non-Hispanic White	Female	Kaitlin
45–50	0–25; Parents	Trauma; Pediatric Transgender Populations; Youth, Families; Child Welfare	(LPC) 5 yrs; (LPA) 9 yrs	LPC; LPA	0	Married	36	Non-Hispanic White	Female	Arlene
40	Adolescents; Adults	Family; Couple, Individual	12 yrs	LPC	1	Married	43	Hispanic or Latinx	Female	Desiree
40	6+	Depression, Anxiety, Trauma; Individual Counseling	7 mths	LPC-A	0	Never Married	28	Hispanic or Latinx	Female	Zoey
20	Late Adolescents; Adults	Couple; Addiction; Trauma	LPC 3 yrs; LCDC 15 yrs	LPC; LCDC	2	Married	40	Non-Hispanic White	Female	Cora
40	17–3	N/A	2 yrs	LPC; NCC	0	Married	30	Non-Hispanic White	Female	Kamila
5–10 Clinical; 10–15 Supervising; 15–20 Administrative	6+	Anxiety; Depression; Parenting/Behavioral Issues	6 yrs	LPC; NCC	2	Married	43	Non-Hispanic White	Female	Juliet
40	5+	Generalist	4 yrs	LCSW	0	Never Married	31	Non-Hispanic White	Female	Sera
30	7+; 40+	Pastoral Counseling; Addiction; Relationships	14 yrs	Grace Life Fellowship Pastoral Counselor	2	Married	59	Non-Hispanic White	Male	Roger
40+	13+; Families with Children 5+	Relationships; Trauma; Anxiety	12 yrs	LPC	1	Married	56	Non-Hispanic White	Female	Josie
55	3–100	Eclectic	10 yrs	LPC	2	Divorced	61	Non-Hispanic White	Female	Kloe

Table 1. *Cont.*

* Work Week Hours	* Age Group Specialization	* Area(s) of Specialization	* Experience Under Current License(s)	* Licensure Titles	* Children	Marital Status	* Age	Race	Gender	Participant Pseudonym
Varies; 20	Adults; Some Adolescents	Trauma	5 yrs	Ministry License; Pastoral Medical License; Prior Psychiatry	0	Never Married	61	Non-Hispanic White	Female	Audrey
40	18–3	Play Therapy	1 yr	LPC (Registered Play Therapist)	0	Never Married	28	Non-Hispanic White	Female	Sadie
40	3–75	Psychiatry	20 yrs	Psychiatrist	2	Married	44	Asian American	Male	Quinn
40	All Ages	Adult/Adolescent Mental Health	11 yrs	PMHNP	2	Married	38	Non-Hispanic White	Female	Clara
35	3+	Children and Adolescents	2 yrs	Psychologist	0	Never Married	29	Non-Hispanic White	Female	Nora
40	Adolescents; Adults	Clinical Psycho	5 yrs	Psychologist	0	Never Married	36	Non-Hispanic White; Hispanic or Latinx	Male	Rafael
40	All Ages	Generalist	1 yr	Pre-Licensed Psychologist	0	Married	30	Non-Hispanic White; Hispanic or Latinx	Female	Stella
35	14+	Depression, Anxiety, Mood Disorders, and Chemical Dependency	3 yrs	LPC; NCC; LCDC	1	Never Married	28	African American or Black	Female	Jessica

Note: Study qualification and demographic columns with (*) were included in the pre-interview survey as open-ended response items. Average age of mental health practitioners (in this study) is 40. Experience Under Current License(s): yrs = years, yr = year, mths = months. Age Group Specialization: Age+ = age and older; Adults = 18 and older; Adolescents = 11–17; Late Adolescents = 16–18. Average amount of experience under current license(s) is 12 years. Average number of hours worked per week is 38.

3. Results

This section reports findings from the interviews with 22 mental health practitioners.[1] The results are best understood when placed in a chronological order as experienced by practitioners. The presentation of results is structured around three stages of professionalization (professional preparation, professional practice, and ongoing professional development). In what follows, results are described according to various tensions or exigencies (pressure points) that mental health professionals experience, especially in relation to the pre-pandemic versus pandemic conditions. The concepts of the duality of structure, agency, power, and context are applied to elucidate the perspectives of the interviewed clinicians.

3.1. Professional Preparation: Becoming a Practitioner

3.1.1. Educational Background

Education offers the general replication of a structure; it also lays the potential groundwork for suicide prevention and intervention training and professional practices under pressure. The agency—or innovative engagement with structure—of professionals enables education and training to be effectively reshaped to fit the flexible nature of mental health and individual characteristics. With few exceptions, mental health professional programs generally do not require suicide-specific trainings or certifications, but they may be offered after professional certification is achieved. While the training practicum offers hands-on experience prior to applying for a license, it is unable to cover a wide scope of possible client encounters and appropriate responses or protocols. Therefore, efficiently navigating the pressures of a high-intensity workplace, client needs, and client loads often proves difficult. The educational programs offer foundational knowledge so that through the agency of the individual, the structural expectations of care may be maintained.

It is with this knowledge that Kaitlin expresses the dual reality of mental health care education. According to Giddens (1984), structure can provide a platform for social action and professional structures are a collaborative achievement. Such is the case with the profession of mental health care. Clinical practices are informed by education and training, but often with hints of autonomy and innovation that are responsive to the specific characteristics of individuals and their particular situations.

> *There were some professors that were very candid about their own experiences in the field. And I think that was the most beneficial and the most helpful, there were some professors that were definitely more focused on the literature than the real-life application. And so, it was definitely a mixed bag. I think where I have learned the most is by doing. Just because you can read as many books as you can, and it tells you, oh, I can get this kind of patient or this kind of client, this is what you need to do. What if they don't want to do that? And still having to navigate that and realize that they're real people, they're not just robots, a case study.* (Kaitlin)

Rarely were practitioners required to participate in any suicide-specific education. Certain programs included a child and adolescent life course development class, while others openly encouraged a wide variety of trainings. Other programs allowed a trauma and grief certification to cover all aspects of death and dying. The discrepancies between programs may allow for professionals to enter the workforce feeling ill-prepared to treat suicidal clients or unwilling to treat them at all. It is of the practitioners' own agency and within their power to seek outside suicide-related knowledge and apply it to their current field, as with Desiree.

> *So, I haven't been required to participate in any suicide prevention trainings, but that's a real important part of the work that we do. So, we are required to get 24 CPU's over the course of two years before license renewal. And early on I actually did a training that comes in a book for social workers. I did it just because it was interesting. And it was very impactful in the sense that it delineated risk factors, protective factors and that stuck with*

me. And the other part of that . . . so the practical piece came in when I had to do my first assessment with a client who was a teenager. I was working with a teen at a shelter for kids who expressed wanting to die, wanting to just, they just wanted to die. And before I met with this teenager, I met with my supervisor and she said, you've already trained for this. What you need to do is just go through the whole assessment with his child. And we had a psychosocial assessment . . . And so, when we came to the end of the assessment, and we talked about how he was feeling. Really, he didn't want to die. It was a statement that he had made about his situation. Like my situation just seems so hopeless, I don't know if I want to be alive . . . But he didn't have a plan. He had never thought about it before, he didn't have a family member that had died as a result of suicide. There was no concern that he would actually follow through because we had safety protocols in place for him. But that was the part about it, the practical piece of what we do. (Desiree)

A general theme throughout several interviews was a distinct lack of suicide-related education prior to licensing. Often, a clinician's suicide-awareness training and credentialing are required only by the agency at which one was employed or not at all. It is expected that with experience in a clinical or therapeutic setting, the practitioner will gain the needed tools to successfully treat a suicidal youth client. The trainings that are offered vary just as widely as licensure programs. However, a consensus on educational development was to broaden the focus of applying the knowledge learned. How does one address a situation effectively that their training could have covered, but did not?

3.1.2. Primary Client Factors

Some practitioners expressed a tentative approach to accepting suicidal clients and, as with many others, will include questions about suicidality on the patient intake form. Stemming from education, a professional lacking the necessary suicide-related training and skills may negatively respond to the pressures that surround working with a suicidal client. The expectation of "saving" or "healing" the client is a common public ideal pressed upon mental health professionals, which is neither realistic nor conducive to successful treatment. In order to minimize the amounts of clients accepted that need higher levels of care than are offered at some practices, forms will include questions regarding having a current or past formal mental health diagnosis, the presence of any medication, and details regarding the types of medication being taken. Several therapists extend their intake form to include analysis of family and other social contexts. Jessica examines the presence of a range of traumatic experiences and family dynamics to gain a more thorough understanding of the youth's mental state.

So, I look at how the family is structured, who is in the household, who they spend their time with. How's school been for them? So, I really look at that family dynamic. Did they consider it a support to them? Do they feel like they have any support within the family dynamic? Do they have siblings? How the relationship with their siblings is, and then talking about any abuse, whether sexual, physical, emotional, mental, or neglect, or if they witnessed domestic violence. Also, I look at any substance abuse. And with adolescents now, the chemical dependency has increased so much because parents will get their children diagnosed and then put on medications, and then not realize that these teens then become biologically dependent upon these medications. And so, if they can't get that specific thing, then they'll go on and get another thing... If they have high suicidality, if they attempted suicide before. If they just have frequent thoughts, aggression or anger, outburst, and history. If they've been violent in the past. Have they made threats towards others? (Jessica)

Many practices utilize specific screening questionnaires for mental illnesses and suicidal tendencies, such as the Columbia Scale or the Patient Health Questionnaire. Zoey describes the implementation of such a screener.

As far as prevention, a lot of what we do is to screen them with what we call the Patient Health Questionnaire. So, it's a PHQ-9 screening for depression related symptoms. It

asks specific questions about motivation, depressed mood. How are you feeling? How are you sleeping? How are you eating? And then the last question is, "Over the last two weeks, have you thought about being better off dead or harming yourself in some way?" And so that's a question we really look at closely. Depending on how they score, they will assess further, as far as do you have plan, do you have intent? Do you have the means? And then we go through a process depending on that. (Zoey)

Practitioners often assist a diverse population of clients and, while the psychiatrists and psychologists often referred clients to other mental health professionals, many LPCs who were employed by nonprofit organizations did not have that autonomous ability. However, there is a limit at every facility, and waitlists are often utilized and were mentioned in several interviews with professionals. In the first session with clients, professionals may assess whether a weekly individual session is going to have successful outcomes with the client, or if they need a higher level of care than the professional can provide.

3.2. Professional Practice: Applying Practitioner Knowledge

3.2.1. Suicide-Specific Treatments

There is a myriad of suicide prevention screenings, techniques, and suicide-intervention treatments. The participants of this study referred to a variety of methods, including Cognitive Behavioral Treatment, Play Therapy, and Family Therapy. However, the activities involved with suicide prevention most often included means reduction and safety contracts.

Means reduction is probably the number one like most important thing, especially if somebody is high risk. So, having a spouse or family member lock up all medications in the house in a safe, having somebody remove the gun from the house, or at least put a trigger lock on the gun and then they give the key to somebody who doesn't live in the house. If it's somebody who lives alone, they'll call law enforcement to come in and safely store a weapon. All the local law enforcement agencies will do that for you. You just gotta ask. So, removing access to means for someone who's at a high risk for suicide is the number one most important thing you can do to prevent them from hurting themself. And then you work on the other stuff like sobriety and counseling and ambivalence and so on, but you can't do that stuff if they've got a loaded gun in the house. (Clara)

Professionals often utilize their flexibility in treatment practices to understand clients' mental states. Gathering information related to a client's suicidality, such as the presence of passive thoughts, which usually minimally requires psychoeducation to teach the client what causes harmful or suicidal thoughts and keeping track of their worsening or lessening in frequency and intensity. Juliet clarifies the need to validate the client and acknowledge the suicidal thoughts or behaviors to move past them and implement healing.

And I think a lot of times, even just not necessarily normalizing it, but making it clear that it's common to have these kinds of thoughts, and it's not necessarily cause for feeling like you're going crazy or something. But figuring out why is this happening and what can we do about it? (Juliet)

No-harm contracts, also called safety contracts, are a point of contention in the mental health field. It is interesting that no-harm contracts are continuously utilized, as they are essentially encouraging the suicidal individual to "pinky promise", as one interviewee noted, not to harm or kill themselves without securing other means of prevention (such as with means reduction, establishing emergency-safe contacts, discussing in-patient services or hospitalization). A no-harm contract differs somewhat from a safety plan. A safety plan often involves securing the harmful means in a locked space (i.e., padlocked drug or gun cabinet), establishing contacts for when the person is feeling vulnerable to suicidal behaviors, calling the professional for crisis aid, or hospitalization. No-harm contracts are often enacted for individuals who do not currently have an active suicide plan but have attempted in the past or currently are considering death by suicide. Kloe elaborates on contracting for safety, which, in her case, is a safety plan and not a no-harm contract.

We contract for safety, you know, making sure that they're doing good self-care. I'm very much in favor of more homeopathic and holistic methods when possible. And I have a certified homeopath that I do refer to cause I like to explore that before we go the pharmaceutical and psychiatric route. However, if someone has schizophrenia or schizoaffective, something with more of a serious mental illness or family history of, you know, mental illness and depression and previous suicide history, then of course my go-to would be referring them to a psychiatrist that I know. I'm certified in CBT, so we also apply some of those techniques. (Kloe)

While the applied therapies differ among professionals, Cognitive Behavioral Therapy (CBT), Talk Therapy, Play Therapy, and Family Therapy are most commonly utilized by practitioners in this study. Professionals spoke regarding the most effective therapies (Play and Family) second to CBT, where it seems so much a part of the mental health profession that the clinicians did not feel the need to discuss it further than a brief mention. The mix and match approach so many professionals utilized to meet their clients' individualized needs takes a creative assertiveness—essentially, clinician agency—to adapt therapeutic approaches that were given to them within relatively rigid parameters.

Play therapy encourages individuals of all ages, but especially children and adolescents, to experience an emotional release or emotional processing that may not be available in their environments. Sadie elaborates on the uses of play therapy and the need for flexibility in therapeutic training and treatment implementation for differing age groups.

I am a play therapist, so I would say that's my number one. I advocate for that the most, but I see teenagers as well. So, I am trained in sand tray therapy. I do a lot of expressive types of things, even with middle-schoolers; so, like we'll play a game or something that's more expressive. I wouldn't say that I'm just a talk, CBT person though. But I see 17-, 18-year-olds, so I'm not going to necessarily play with them. I feel like the older teenagers will definitely benefit more from CBT and talk (therapy). I would say like 14 or even 13 maybe and under or even middle school age, I'll do more sand tray. (Sadie)

Family therapy, as Quinn and several other practitioners elaborated, encourages a more widespread and long-term solution-based focus. Including the parents or other family members in the youth's therapy enables learned coping skills and practices to be reinforced outside of scheduled appointments.

Family therapy is usually the most effective. Because therapy in the office is maybe maximum once a week or when I do it twice a week, but with good family dynamics there are other people that are working with that person more often, they can be aware of different things, they can understand things. (Quinn)

3.2.2. Treatment Options Process

Practitioners expressed the need to make treatment collaborative, which introduces an additional pressure point: flexibility. The treatment process is different for each client. As the professional examines the intake evaluation, and assesses the client for a diagnosis, the clinician will collaborate with the client following specific questions. What are the client's treatment goals? What skills does the client aim to develop? In what areas does the client desire to improve during their time in treatment? Cora expressed regularly checking in with the client related to the treatment process and how that is essential in building rapport, while also ensuring effective practices are in place and can evolve successfully.

We very much start by talking about what those thoughts sound like in their head and what's happening to trigger those thoughts. And I think that the tool that I use most often would be a no harm contract where me and the client really talk about what the plan is and what to do instead. And also, daily check-in. I had a client once that was severely suicidal, but I was also going on vacation the next day. Within our clinic, we're able to bring in one of our advocates and she was able to sit in on that assessment with me, and he agreed to answer her call by ten o'clock every morning. He would check in the

evenings via text. And he knew that if he didn't do that, we would make a wellness check call. (Cora)

Identifying suicidal individuals is intricate in that not one person expresses suicidal intent or behavior the same way. It takes adaptability in treatment practice, focused attention to verbal language, body language, dress, and if utilizing telehealth, the individual's background, to establish the presence of suicidal tendencies. Setting straightforward, honest communication with the client is paramount to understanding the level of past, current, and possible future suicidal risk the client may be confronting. Cora exemplifies the practitioner's need to modify perspectives on interpreting potential high-suicide risk language.

I'm thinking of two different clients. One, highly emotional in the initial setting. In the initial session had been contemplating suicide, basically his whole life. It was more of an underlying thought, but that popped up really big. I'm not wording that very well. But we get bigger in different areas. So, it's just a constant thought, right? And that is the one we were able to because he was used to dealing with it and he had some of his own techniques for coping with it. He just needed a little assistance and that's the one we did the check-ins with. Whereas another client who had less experience with having these types of thoughts, this was very new for her. We needed to override it. CBT works. We also included a family member in her work as well. And so is having a family member . . . And when you're bringing in a family member, you have to really be prepared to educate them and prepare them for the things that they might hear or see. (Cora)

3.2.3. Cultural and Ethnic Awareness

As with the ability to maintain adaptability in treatment modalities, having a sense of general appreciation and flexibility for individual characteristics related to religion/spirituality or ethnic identity is crucial in the development of client-professional relationships and successful treatment implementation. Clients who share the same racial or ethnic or gender identity are encouraged to speak about their own perspective on what those identities meant to them, how they embodied them, and how they were related to their mental health experiences. Utilizing familiar cultural terms given to the practitioner by the client fosters an understanding of the cultural implications of mental health more wholly. For example, a Mexican immigrant with limited English proficiency may not understand schizophrenia in its scientific term but may use "evil eye" or "cursed by the evil eye" to interpret and characterize mental health issues in their family. In addition to being actively aware of the potential cultural and racial differences between the clinician and the client, the professional also often aims to consider how the client may react to a clinician of a different racial or ethnic background than their own, considering any past possible trauma. Stella expands on this perspective, elaborating on a point of consideration on which several participants spoke.

It's more something we talk about, whether they've brought it up or I've noticed something, and we explore that together, or our racial impact on that person or the climate of society right now and how that's impacting that individual in every which way. So, I think definitely discussing that, but also, I think as clinicians it can be challenging, too. Maybe this is just my perception, but we're taught what healthy looks like. And I don't think that healthy looks the same across people within the same racial ethnic group, but let alone across racial, ethnic groups. Taking things culturally into consideration that may be typical for a very Eurocentric society, by which we tend to live in the U.S., but that may not be typical for that person's culture. And I have some patients who are immigrants, and so especially taking that into consideration of anything that they're experiencing here or what would have been different where they grew up. (Stella)

3.3. Ongoing Professional Development: Navigating Practitioner Postvention

3.3.1. Proficiency in Support

Only a few practitioners expressed experiencing a client's death by suicide, and the support they received from their then-current team was encouraging. Secondhand trauma can still be formidable through the shock of the death occurring, listening to the emotional struggles of other practitioners, or witnessing the practice for which they work offer little to no reprieve for the affected professionals. To accomplish professional expectations, which are aimed towards assisting individuals through mental health crises or illnesses not curing them (though expectations are often placed on the latter), professionals' emotional states (i.e., grief, frustration, anger, confusion, worry) are set aside so as to more wholly concentrate on the client's successful wellness journey. Desiree gives detailed examples of the stressors experienced with suicidal clients who have the intent but do not complete suicides.

> *[In my previous workplace] there were at least two incidences where I was - I just felt like I was in over my head with this client and I needed someone to come help me. And so, in those two instances, my director was available to come in and to help me direct this session in a way that was the most helpful to the client. So, I had a client who was suicidal. She had her plan; she knew what she was going to do. The only thing holding her back was, who was going to take care of her puppy? And so, we couldn't guarantee that she could go home and stay safe. We had to get this client to the hospital. And that's where at that point it was still, at that time we were called interns. I was a young intern. And then it was like, I have no idea what to do with this client because I can't just plan to not want to go to the hospital. And so, between myself and the director, found a place where she could take her puppy and when we found a place for her to get her dog, then she was willing to go to the hospital. So that took probably about an hour and a half to two hours to sort out and to get her the service that she needed. At that time, we had cab services and the cab service took her to the hospital. And the follow-up was that her emergency contact later contacted me to let me know, yes, she made it to the hospital, she's fine. So, that's how we ended that. And what was the most helpful in that situation was to have somebody come in and direct the rest of the session because I was stuck. I didn't know what to do. And then there was a debriefing after that, "Let's talk about what you did and how you did it and how you felt in the middle of all of it, and what you learned from that, and what can you do or how can you handle a situation like this in the future?" That was huge. And so, I don't know about the mental health community as a whole, but for our agency, because of my own experience with that, I like to make sure that the people that I supervise know how to get ahold of me, and if anything happens, I'm here and I can come in and help, too.* (Desiree)

All practitioners expressed a high level of unawareness regarding community support for practitioner postvention. A client's death is usually not discussed with other professionals to avoid sharing feelings of shame or guilt. Professionals are often encouraged to seek support on their own time with their own funds if they are encouraged to seek support at all. However, several practitioners relied heavily on supervisors during internship practicums or supervisors in smaller practices, which allowed the practitioner the ability to speak about their grief and process the situation. Others shared that they have established a family or practitioner support network for themselves in times of client deaths by suicide, which allows them time to themselves but also communicates a willingness to listen. Jessica shares experiences based on witnessed client death handlings at her past practice.

> *At another hospital I was working at, a patient, and it was a frequent flyer.*[2] *Very severe psychosis and depression. She had been committed several times, like at a state hospital. And because she was a frequent flyer, she was in the PICU, the psychiatric intensive care unit. And they just let her sit in the lobby because she had come in so many times and she was just telling them I need to get back there. I need to get back there. And this was a situation that I'd heard about once I was gone from the hospital, but they just kept telling*

her like, okay, we got you, you're going to get back in a minute, but because she was such a frequent flyer, it was we'll get to her when we get to her because we know ... She ended up leaving and committing suicide that night. And again, I hadn't been working at the hospital at that time I had moved actually to Houston, but from the therapist who told me about the situation. I was a court liaison, so I was the person who would get her paperwork processed. So, I knew her name very well. She had been committed several times. I don't believe that they offered them anything for that. I don't think that they offered the PICU therapists any services because I think they just know that EAP[3] *is there for them. EAP is there, but that's at your request.* (Jessica)

Noting that having a voluntary system is helpful, offering no other briefing session or accommodations to preserve the mental wellbeing of the practitioner is concerning but common, especially in large hospital settings. Private individual or group practices seem more willing to express concern for their practitioners, with whom they know and experience daily interactions.

3.3.2. Professional Development Recommendations

If practitioners could make any changes they wanted to their field, what changes would they pursue? It is not often that professionals in a high-intensity field are offered the opportunity to share their expectations and desires for improvement across their professions. In a demanding, often overworked area such as mental health care, the practitioners' voices are often silenced by a variety of social and structural factors, including fear of judgment or buried grief if a client is lost to suicide, an exhaustive amount of client cases and paperwork, and the insistent demand of clinical and administrative leaders expecting more out of the professional without offering a system of support. However, the presence of support often depends on the practice environment. As Giddens (1984) emphasized, structure is not a tangible object, but a force transmitted through individual (often routine) social actions. The mental health field offers, in its relative infancy, the ability to reshape the structure of practice through the agency and power of the professionals and surrounding community organizations. Justine offers a unique perspective on understanding the clients and the treatments often utilized with youth.

The mindfulness, mind-body work that I've done, like the training has been so impactful for me and helped me so much in my ability to be present with really difficult conversations that I think I would really love to see that more broadly offered, and chances not just to learn it academically, but to learn it like personally, to have your own experience of doing the work that we ask our clients to do. Because I think that's one of the biggest things that's helped me is like doing my own work and yeah, I would love more of that to be offered. I've had also a lot of training in collaborative work, collaborative practices. And that's helped also with flexibility, asking better questions. (Justine)

All interviewed professionals agreed that creating a support system of counselors is highly desirable, though it does face certain stigmas from within the field. Counselors that have the same training and education enable the professional to ask questions and have meaningful discussions regarding considerations and concerns related to suicidal clients. Zoey and other professionals expressed a significant need for suicide-specific trainings and certifications to be made more widely available to pre-professionals. Although trainings may be offered, not requiring them encourages professionals uninterested in working with suicidal individuals to forgo even the most foundational knowledge of suicide prevention.

I'm thinking back to you, the question that you asked me about if there was anything required when I was in going through my schooling through my master's program, I would say just a little bit more emphasis on that, because I think even now, we have interns who come in and they don't really know much about crisis interventions specifically for youth. (Zoey)

The ability to network is often limited for those who utilize primarily telehealth or go into an individual private practice. Establishing a formal or semi-formal flexible network

outside of luncheons and continuing education courses would be instrumental to both the short-term wellbeing and long-term efficacy in treatment practices of professionals.

The mental health field is unquestionably a helping profession. The expectations of health care workers require remarkable ability and fortitude. While mental health professionals embark on a journey that so few readily embrace, it is imperative to understand that their education, their experiences, and their professional and personal abilities make them no less susceptible to trauma and burnout than those outside of this professional field. As such, professionals need community support and time for reflection and personal care, an integral aspect of mental wellbeing encouraged in clients but overlooked in clinicians. Stella describes this needed adaptation in the workplace and educational settings.

> *I think we get a lot of training on how to help our patients and all of that, which is very important. I hesitate to say most important because of this caveat of . . . I think there is this under emphasis of therapists taking care of themselves, especially when we have a high caseload of suicidal patients. A thing like that is really heavy and it can really weigh on any individual whether they were trained or not. I think what struck me is that . . . I don't know what to say about whether there's support after a patient, like support for therapists after a patient has committed suicide. Like, we have all these groups and individual therapies and treatment centers and stuff for our patients, but where are those groups when it comes to us and things that we might need to process and it's, I think that there's a significant . . . I don't think it's a denial, but this significant under emphasis on the importance of our own mental health, especially in a challenging time like this, where most of us in our personal lives are already strained because of COVID and because of everything else going on, and then to add the clinical aspect of that and the heaviness of clinical work always, but especially at a time like this. So, I wish that programs would really over emphasize because programs can be like, make sure you take care of yourself. You do self-care, which is yeah, that's great, but it's still important to model that, too. Like I had a professor, "I'm taking next week off for a mental health day and I want all of you to do the same." There's this showing by doing, not just telling. Not commanding, "Take care of yourself, but I don't take any days off and I work when I'm sick because I can't afford not to work." I wish that programs had more of that, like where the people in power would model what it's like to be a good user of mental health as someone working in the mental health field.* (Stella)

4. Discussion

Exploring the multidimensional aspects of mental health practitioners' experiences with suicidal youth can yield scholarly dividends but, more importantly, can provide real-world benefits for society's most vulnerable individuals. Practitioners often face barriers in their systems of education, training, practice, and everyday social interactions that may impede their ability to treat individuals or seek help for themselves (Scheerder et al. 2010; Kolar et al. 2017; Roush et al. 2018; De Lyra et al. 2021; Jorgensen et al. 2021). The COVID-19 pandemic has contributed to the advancement of mental health treatment delivery while also widening the gap between lower-income and minority group mental health care accessibility. The pandemic has also exacerbated strain on the mental health of clients and practitioners alike (Phelps and Sperry 2020; Stark et al. 2020; Wigg et al. 2020; Adegboye et al. 2021; De Witte et al. 2021; Karacic et al. 2021). Prior to this research, there have not been in-depth accounts of the motivations and experiences of mental health professionals using insights from structuration theory.

By accounting for state-mandated licensing regulations and varying professional roles and levels, thus analyzing the knowledge related to working with suicidal youth, this study expands on a growing area of mental and physical health research (Longobardi et al. 2020; Marchini et al. 2020; Nearchou et al. 2020; Karacic et al. 2021). Continued exploration into the demands and experiences of mental health professionals is crucial in comprehensively understanding social interactions related to suicide. Our analysis of interview data was

informed by key themes of structuration theory, which included such concepts as duality of structure (rules and resources), agency, power, and context.

Several professionals spoke in favor of an unwritten rule amongst professionals: flexibility. While their education is valuable, it generally fails to provide a clear image of all possible cases and clients they will encounter, as is to be expected. Additionally, understanding that professionals in this field are susceptible to burnout or secondhand trauma is integral in establishing necessary limitations on clinicians' own flexibility. These limitations act as safeguards in stressful situations or instances where the professional may feel overworked, as with the modifications to treatment installed in response to the COVID-19 pandemic.

The prevalence of feeling overburdened and facing chronic stress is especially concerning as many expressed their schedule often consists of 50% client treatment and 50% paperwork, with little time for self-care practices. Several participants further expressed a lack of autonomy regarding input on client assignments as they are often the ones most qualified (or most willing) to work with suicidal youth, especially when employed by non-profit organizations. This situation greatly increases the amount of stress they encounter, as they do not have the opportunity to work with lower-risk clients often enough for those cases to act as buffers between high-risk client cases.

Professionals also take it upon themselves to do as much beneficial work with their clients as possible, endeavoring to avoid client hospitalization. These efforts may include long workday hours or after-hours (round-the-clock) communication and availability. Interacting with youth clients outside of official appointments has risen in accordance with widened telehealth adaptations in lieu of the coronavirus pandemic according to the interview data. The adaptability of practitioners and the knowledge of increased stressors and increased flexibility regarding modes of interactions (i.e., Zoom or texting versus primarily in-person) have seen more successful encounters with youth clients, fewer no-shows (clients maintain their appointments), and more positive reinforcement of skills learned during official appointments since the start of the pandemic.

Many comments were made regarding the less effective experience of hospitalization on deterring youth from suicide in the short- and long-term. The short-term effectiveness was noted as acting as an immediate safeguard against suicide completions. However, the conflicting perspectives on hospitalization effectiveness may shed some light on the differentiating levels at which certain licensed professionals interact with various clients and hospital needs (i.e., psychiatrists versus LPCs). Additionally, maintaining proper telehealth protocols has extended stressors and enforced the need for autonomy among professionals. There is a certain unpredictability with this therapeutic modality (i.e., clients logging off unexpectedly, not being in a quiet room to be undisturbed), which does not enable the professional to rely on others for assistance or to ensure the wellbeing of their clients.

Several areas for improvement in the education and professional practices were examined through the practitioners' lenses. There is a distinct lack of professional support systems should a professional encounter a client suicide. As discussed by Karacic et al. (2021), the responsibility for addressing and navigating burnout (resulting from chronic, overbearing stress) has shifted to rest solely on the shoulders of the organization. Many interviewees addressed implementing their own self-care practices without the aid or guidance of their agencies, and the reluctance of their agencies to address potential burnout, case overloads, or client deaths. The lack of organizational involvement is in direct contrast to the mission of healthcare politics, which aims to collaborate with all mental and physical health agencies in understanding and addressing burnout syndrome in preventive and remedial measures (Karacic et al. 2021). Rather, interviewees stated they are often encouraged to seek assistance on their own time with their own funds. Scheduled time off or in-facility assistance was only granted by three participants' practices. There were common situations shared that display a need for greater professional development. Pressing questions remain. How should professionals navigate interacting and speaking with family members of a youth client? How do those interactions change with a family member who has their own

mental health issue? What are possible circumstances in the youth's home? Additionally, there is a need to teach networking skills and emphasize suicide-specific trainings in professionals' educations.

There are a few limitations to this study. First, noting the time constraints and limited amount of mental health professionals in the state of Texas, there was an unequal amount of licensed professional counselors in comparison to psychiatrists, psychologists, psychiatric nurse practitioners, and licensed clinical social workers. It would be beneficial to the field to compare varying state education and licensure requirements for the differing mental health professional titles. Second, this study has limited sample diversity. Although the screening questionnaire detailed participant demographics, there was no active recruitment for specific sociocultural characteristics of professionals. The thematic focus of this study required attention primarily on licensure and previous or current experiences with treating suicidal youth. However, this study's interview guide allowed an examination of practitioner perspectives and interactions related to racial and ethnic diversity.

Future research should include a comparison of suicidal youth and adult treatment experiences of mental health clinicians. Children, adolescents, and adults at various life stages undergo varying mental health challenges in line with social contexts. As the effects of the COVID-19 pandemic become increasingly understood in both long-term and short-term aspects, further analysis of pandemic restrictions, early pandemic confusion, and fears would also be advantageous in examining the effects of such experiences by mental health practitioner interactions with clients and personal wellbeing. Recent research has shown that youth mental health needs fluctuated over the course of 2020. However, it would be beneficial to understand the extent of pandemic influence on practitioner telehealth use, treatment options, and willingness to interact at the in-person level with clients. It would be further beneficial to gain insight into practitioner mental health impacts related to the coronavirus pandemic and how their coping and treatment practices for themselves as clients interacted with their clinical treatment of clients. Until then, there is much to learn from the voices of clinicians articulated in this study. They are trained to listen carefully to their clients. Researchers would be wise to listen to clinicians' reflections and recommendations.

5. Conclusions

There is much to gain from exploring the perspectives of frontline mental health care workers. This study advanced the empirical knowledge on mental health clinicians' educational and professional experiences with detailed insight into the structure and practice of youth suicide prevention. Additionally, this study utilized theoretical concepts of structuration to examine the mental health care system related to youth treatment and the structural adaptations influenced by the COVID-19 pandemic. We have much to learn from the innovative practices and experiential accounts of mental health clinicians who are committed to delivering effective treatment to suicidal youth.

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Appendix A. Interview Guide

(1) To begin, tell me how you first became involved with the mental health field.
   (a) What motivated you to become a practicing clinician?
   (b) What concerns, if any, did you have about becoming a clinician?

(2) Describe what kind of schooling was required for you prior to becoming a licensed practitioner.
   (a) In what ways was your schooling sufficient or insufficient in preparing you for working with suicidal youth?
   (b) How long did it take to complete your schooling (undergraduate, graduate program) and obtain your license?

(3) Could you describe for me what suicide-specific trainings, certifications, and continuing education in which you were required to participate? Were any related to interactions with youth?
   (a) What did you find most helpful about these training sessions?
   (b) In what ways could they have been improved?

(4) What are the primary factors (i.e., actively suicidal, age, insurance) you consider prior to taking on a client? How have you seen your considerations change during the pandemic?
   (a) How often do you refer clients to another mental health professional? Could you describe how this has changed since the start of the pandemic?

(5) Thinking more generally about approaches and therapeutic techniques that you have used, Can you elaborate on the suicide prevention techniques available that you most often recommend with your clients? What types of therapy do you utilize?
   (a) Can you tell me of an experience where that approach or technique worked especially effectively, or did not work as you had expected?
   (b) Which of the available options have you seen be most effective?

(6) Reflecting on the different therapeutic pathways, how do intervention techniques differ from prevention?
   (a) How often do you utilize prevention, intervention, and postvention techniques?
   (b) How did you acquire these approaches and techniques?

(7) Could you elaborate on the process of choosing a treatment option for your clients?
   (a) How would you describe the adaptations in therapeutic delivery and interactions you've had to make because of COVID-19-related restrictions?
   (b) Could you tell me about a time when you had to adapt your delivery? How about when you needed to adapt or alter your initial treatment option?

(8) Cultural competency has become prevalent across various health fields. How do you consider ethnic diversity in your treatment delivery?

(9) In recent years, there has been an expansion of religious and spiritual awareness in therapeutic treatments. How do you consider the religion and spirituality of a client in your treatments?
   (a) How does your own religious or spiritual background affect your treatment modality?
   (b) (If employed by a religious organization or non-profit: How does the ideology of the organization you work with influence your treatment?)

(10) Most health insurance plans in the U.S. are required to cover mental health disorder services. What are your thoughts on accepting clients who can only afford mental health services through insurance?
(11) For clients you take on, how do (ethical) concerns change or remain constant while giving therapeutic treatments?
    (a) How have you seen these concerns shift in the face of the pandemic?
    (b) Could you describe how you interact with a potential client who says they are considering suicide or self-harming?
(12) The prevalence of stigma and fear of repercussions may prevent a client from sharing suicidal ideation or behaviors. Could you describe how you might adapt your interactions with a client who does not convey suicidal tendencies at the beginning of sessions but later relays those struggles?
(13) What are a few *ethical and* legal concerns, if any, that you have about treating youth exhibiting suicidal behaviors?
    (a) Earlier you mentioned how method delivery and interactions have changed because of COVID. What are some legal concerns with these options?
    (b) How does your professional training address any legal concerns that you may encounter?
(14) What are some protocols you are instructed to follow when encountering a suicidal youth client? How do the protocols differ from suicidal adults?
    (a) Could you describe a situation when you have had to push the boundaries of protocol?
(15) How would you describe the mental health community's proficiency in offering postvention treatment options for professionals who experience a client suicide?
    (a) What are available postvention options for professionals?
    (b) Can you recall a time when you've had to reach out for assistance or offer assistance to a fellow clinician?
(16) Thinking back on what you've shared with me today, what changes would you make, if any, if you could change professional development in your field?
    (a) How do you think the changes that the pandemic influenced will alter the future of mental health treatment and delivery?

Notes

1. One interview was not relied upon heavily due to limited data collected as a result of time constraints.
2. Frequent flyer is a mental health care term for an individual who has been admitted into psychiatry wards twice a month across approximately six months.
3. EAP, the Employee Assistance Program, is a voluntary, work-based program that offers free and confidential assessments, short-term counseling, referrals, and follow-up services to employees who have personal or work-related problems (OPM 2021).

References

Adegboye, Dolapo, Ffion Williams, Stephan Collishaw, Katherine Shelton, Kate Langley, Christopher Hobson, Daniel Burley, and Stephanie van Goozen. 2021. Understanding Why the COVID-19 Pandemic-Related Lockdown Increases Mental Health Difficulties in Vulnerable Young Children. *JCPP Advances* 9: e12005. [CrossRef]

Almaliah-Rauscher, Sharon, Noa Ettinger, Yossi Lev-Belz, and Yari Gvion. 2020. 'Will You Treat Me? I'm Suicidal!' The Effect of Patient Gender, Suicidal Severity, and Therapist Characteristics on the Therapist's Likelihood to Treat a Hypothetical Suicidal Patient. *Clinical Psychology and Psychotherapy* 27: 278–87. [CrossRef]

Binkley, Erin E., and Todd W. Leibert. 2015. Prepracticum Counseling Students' Perceived Preparedness for Suicide Response. *Counselor Education and Supervision* 54: 98–108. [CrossRef]

Blumer, Herbert. 1969. *Symbolic Interactionism*. Englewood Cliffs: Prentice-Hall.

Bowen, Glenn A. 2006. Grounded Theory and Sensitizing Concepts. *International Journal of Qualitative Methods* 5: 12–23. [CrossRef]

Bowen, Glenn A. 2019. Sensitizing Concepts and Other Entries. In *SAGE Research Methods Foundations*. Thousand Oaks: SAGE Publications. [CrossRef]

Cowie, Helen, and Carrie-Anne Myers. 2021. The impact of the COVID-19 pandemic on the mental health and well-being of children and young people. *Children and Society* 35: 62–74. [CrossRef]

Curtin, Sally C., and Melonie Heron. 2019. Death Rates Due to Suicide and Homicide among Persons Aged 10–24: United States, 2000–2017. *National Center for Health Statistics Data Brief* 352: 1–8.

De Lyra, Renan Lopes, Sarah K. McKenzie, Susanna Every-Palmer, and Gabrielle Jenkin. 2021. Occupational exposure to suicide: A review of research on the experiences of mental health professionals and first responders. *PLoS ONE* 16: e0251038. [CrossRef]

De Witte, Nele A. J., Per Carlbring, Anne Etzelmueller, Tine Nordgreen, Maria Karekla, Lise Haddouk, Ang'elique Belmont, Svein Øverland, Rudy Abi-Habib, Sylvie Bernaerts, and et al. 2021. Online Consultations in Mental Healthcare during the COVID-19 Outbreak: An International Survey Study on Professionals' Motivations and Perceived Barriers. *Internet Interventions* 25: 100405. [CrossRef]

Fegert, Jörg M., Benedetto Vitiello, Paul L. Plener, and Vera Clemens. 2020. Challenges and Burden of the Coronavirus 2019 (COVID-19) Pandemic for Child and Adolescent Mental Health: A Narrative Review to Highlight Clinical and Research Needs in the Acute Phase and the Long Return to Normality. *Child and Adolescent Psychiatry and Mental Health* 14: 20. [CrossRef]

Giddens, Anthony. 1984. *The Constitution of Society*. Cambridge: Polity Press.

Golberstein, Ezra, Hefei Wen, and Benjamin F. Miller. 2020. Coronavirus Disease 2019 (COVID-19) and Mental Health for Children and Adolescents. *JAMA Pediatrics* 174: 819–20. [CrossRef]

Guessoum, Sélim Benjamin, Jonathan Lachal, Rahmeth Radjack, Emilie Carretier, Sevan Minassian, Laelia Benoit, and Marie Rose Moro. 2020. Adolescent Psychiatric Disorders during the COVID-19 Pandemic and Lockdown. *Psychiatry Research* 291: 113264. [CrossRef]

Jacobson, Jodi Michelle, Philip Osteen, Andrea Jones, and Alan Berman. 2012. Evaluation of the Recognizing and Responding to Suicide Risk Training. *Suicide and Life-Threatening Behavior* 42: 471–85. [CrossRef]

Jorgensen, Maribeth F., Sara Bender, and Ashley McCutchen. 2021. "I'm haunted by it:" Experiences of licensed counselors who had a client die by suicide. *Journal of Counselor Leadership and Advocacy* 8: 100–15. [CrossRef]

Longobardi, Claudio, Rosalba Morese, and Matteo Angelo Fabris. 2020. COVID-19 Emergency: Social Distancing and Social Exclusion as Risks for Suicide Ideation and Attempts in Adolescents. *Frontiers in Psychology* 11: 10–12. [CrossRef]

Karacic, Jasna, Harold J. Bursztajn, and Marianna Arvanitakis. 2021. Who Cares What the Doctor Feels: The Responsibility of Health Politics for Burnout in the Pandemic. *Healthcare* 9: 1550. [CrossRef]

Kolar, Christina, Kathryn von Treuer, and Carly Koh. 2017. Resilience in Early-Career Psychologists: Investigating Challenges, Strategies, Facilitators, and the Training Pathway. *Australian Psychologist* 52: 198–208. [CrossRef]

Leeb, Rebecca T., Rebecca H. Bitsko, Lakshmi Radhakrishnan, Pedro Martinez, Rashid Njai, and Kristin M. Holland. 2020. Mental Health–Related Emergency Department Visits among Children Aged <18 Years During the COVID-19 Pandemic—United States, January 1–October 17, 2020. *The Morbidity and Mortality Weekly Report* 69: 1675–80. [CrossRef]

Marchini, Simone, Elena Zaurino, Jason Bouziotis, Natascia Brondino, Véronique Delvenne, and Marie Delhaye. 2020. Study of Resilience and Loneliness in Youth (18–25 years old) during the COVID-19 Pandemic Lockdown Measures. *Journal of Community Psychology* 49: 468–80. [CrossRef]

Marques de Miranda, Debora, Bruno da Silva Athanasio, Ana Cecília Sena Oliveira, and Ana Cristina Simoes-e-Silva. 2020. How is COVID-19 Pandemic Impacting Mental Health of Children and Adolescents? *International Journal of Disaster Risk Reduction* 51: 101845. [CrossRef]

Martinelli, Katherine, Yakira Cohen, Harry Kimball, and Hannah Sheldon-Dean. 2020. *2020 Children's Mental Health Report: Telehealth in an Increasingly Virtual World*. New York: Child Mind Institute.

NAMI. 2021. Self-Harm. National Alliance on Mental Illness. Available online: https://www.nami.org/About-Mental-Illness/Common-with-Mental-Illness/Self-harm.0 (accessed on 5 April 2021).

Nearchou, Finiki, Clodagh Flinn, Rachel Niland, Sheena Siva Subramaniam, and Eilis Hennessy. 2020. Exploring the Impact of COVID-19 on Mental Health Outcomes in Children and Adolescents: A Systematic Review. *Children and Youth Services Review* 17: 8479. [CrossRef]

OPM.gov. 2021. *Frequently Asked Questions: What Is an Employee Assistance Program (EAP)?* Washington: U.S. Office of Personnel Management. Available online: https://www.opm.gov/faqs/QA.aspx?fid=4313c618-a96e-4c8e-b078-1f76912a10d9&pid=2c2b1e5b-6ff1-4940-b478-34039a1e1174 (accessed on 14 October 2021).

Phelps, Chavez, and Linda L. Sperry. 2020. Children and the COVID-19 Pandemic. *Psychological Trauma: Theory, Research, Practice, and Policy* 12: S73–S75. [CrossRef]

Rothes, Ines Areal, Margarida Rangel Henriques, Joana Barreiros Leal, and Marina Serra Lemos. 2014. Facing a Patient Who Seeks Help after a Suicide Attempt: The Difficulties of Health Professionals. *Crisis* 35: 110–22. [CrossRef]

Roush, Jared F., Sarah L. Brown, Danielle R. Jahn, Sean M. Mitchell, Nathanael J. Taylor, Paul Quinnett, and Richard Ries. 2018. Mental Health Professionals' Suicide Risk assessment and Management Practices: The Impact of Fear of Suicide-Related Outcomes and Comfort Working with Suicidal Individuals. *Crisis* 39: 55–64. [CrossRef]

Scheerder, Gert, Alexandre Reynders, Karl Andriessen, and Chantal Van Audenhove. 2010. Suicide Intervention Skills and Related Factors in Community and Health Professionals. *Suicide and Life-Threatening Behavior* 40: 115–24. [CrossRef]

Schwab-Reese, Laura M., Vladka Kovar, Sarah Brummett, and Carol Runyan. 2018. Should Suicide Prevention Training be Required for Mental Health Practitioners? A Colorado, United States Case Study. *Journal of Public Health Policy* 39: 424–45. [CrossRef]

Singh, Shweta, Deblina Roy, Krittika Sinha, Sheeba Parveen, Ginni Sharma, and Gunjan Joshi. 2020. Impact of COVID-19 and Lockdown on Mental Health of Children and Adolescents: A Narrative Review with Recommendations. *Psychiatry Research* 293: 113429. [CrossRef]

Stark, Abigail M., Allison E. White, and Nancy S. Rotter. 2020. Shifting from Survival to Supporting Resilience in Children and Families in the COVID-19 Pandemic: Lessons for Informing U.S. Mental Health Priorities. *Psychological Trauma: Theory, Research, Practice, and Policy* 12: S133–S135. [CrossRef]

Szlyk, Hannah S., Michele Berk, Ana Ortin Poralta, and Regina Miranda. 2020. COVID-19 Takes Adolescent Suicide Prevention to Less Charted Territory. *Journal of Adolescent Health* 67: 161–63. [CrossRef]

Thakur, Vikram, and Anu Jain. 2020. COVID-2019 Suicides: A Global Psychological Pandemic. *Brain, Behavior, and Immunity* 88: 952–53. [CrossRef]

Wigg, Cristina Maria Duarte, Isabella Maria Felix de Almeida Coutinho, Isabelle Cristine da Silva, and Larissa Bezerra Lopes. 2020. The Mental Health of Children and Adolescents during the COVID-19 Pandemic: A Narrative Review. *Research, Society, and Development* 9: e704997687. [CrossRef]

Yard, Ellen, Lakshmi Radhakrishnan, Michael F. Ballesteros, Michael Sheppard, Abigail Gates, Zachary Stein, Kathleen Hartnett, Aaron Kite-Powell, Loren Rodgers, Jennifer Adjemian, and et al. 2021. *Emergency Department Visits for Suspected Suicide Attempts among Persons Aged 12–25 Years before and during the COVID-19 Pandemic—United States, January 2019–May 2021*; Atlanta: Centers for Disease Control and Prevention. Available online: https://www.cdc.gov/mmwr/volumes/70/wr/mm7024e1.htm?s_cid=mm7024e1_w (accessed on 3 November 2021).