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Multidisciplinary Approach to Suicide Prevention of Adolescents in Slovakia and Kyrgyzstan

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ABSTRACT

The prevalence of suicides among young people continues to be a top health challenge worldwide. It affects individuals, families, and communities. The causes encompass both mental health issues and psychosocial stressors, which are exacerbated by a number of determinants such as financial constraints, poor family relationships, peer bullying and victimization, and any forms of abuse. Suicide prevention calls for strategies at every level of society. This approach should include a range of preventive strategies and activities to identify and intervene early, build young people's life skills and provide access to appropriate services and support. As a holistic strategy, a multidisciplinary team is known for taking a thorough approach to prevent many youth issues, including suicide, bringing together different stakeholders, and is based on their current contexts and resources. The teams include specialists such as educators, primary health professionals, social workers, police, children's organizations, and other stakeholders which work best in ensuring that individuals at risk of suicide receive the holistic care and support they need. However, there is a lack of long-term policy, practical tools, and evidence-based research that can guide social service providers working together in assessing adolescent suicidal ideation, putting general prevention into place, and reducing potential risks. This study aimed to analyze the system of work of the multidisciplinary teams in the prevention of adolescent suicide in educational settings in Slovakia and Kyrgyzstan. The study utilized a qualitative research method – a semi-structured interview of 10 various specialists from Slovakia and Kyrgyzstan. Despite different levels of development and practical implementation of multidisciplinary team concepts in both countries, the results revealed a generally positive image of the collaborative effort of various professionals in the prevention area. The teams in schools aim to create a protective environment with family and community support for young people contributing substantially in mitigating many issues of adolescents during their fragile period of upbringing. It is concluded in the study that prevention efforts require coordination among multiple social institutions with good governance and unified strategy. However, it has been noted that there is still potential for development, particularly in terms of better cooperation among specialists, recognition of the problem of youth suicide on the national level, and institutionalizing procedures to increase the status and education level of multidisciplinary teams. This research is innovative in its originality and adds a valuable and up-to-date point in suggesting a more comprehensive system for work of the multidisciplinary teams in both countries which potentially may contribute to suicide reduction among adolescents.

Key words: adolescent suicide, prevention, multidisciplinary team.

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INTRODUCTION

BACKGROUND

Globally, adolescent suicide is one of the leading causes of death among young populations. World Health Organization recognizes suicide as a human disaster, and it is a top priority of concern for many developed countries (WHO, 2014). In recent years (2017-2019), the suicide rate among young people worldwide was highest in Guyana (40.37). Lesotho (30.49) in southern Africa and Micronesia (30.03) are also not far behind. Estonia (12.05), Lithuania (11.71), and Finland (10.41) are the highest in adolescent suicide in Europe with rates of over 10 deaths per 100k, which is around 2.5 times higher than the EU average (WHO, 2021). Slovakia remains the medium with a rate of 4.02 (WHO, 2021). Meanwhile, among the Central Asian countries, Kyrgyzstan is in third place (10.04) after Uzbekistan (15.38) and Kazakhstan (15.35) (WHO, 2021). This is despite Kyrgyzstan is three times smaller than Kazakhstan and six times smaller than Uzbekistan in terms of the general population.

Adolescence is a period of development marked by changes in one's biology, psychology, and social environment. As a means of achieving greater independence, it frequently involves taking risks, testing limits, and pushing them. Success in navigating adolescence has an impact on the transition into young adulthood when new jobs and family obligations take priority (Shaffer & Kipp, 2014). Psychologists and social service providers all over the world claim that young suicides are characterized by subjectivity - a long chain of events is usually triggered by some cases in personal life that have escalated with time or situation. According to numerous studies, the following are risk factors for suicide in adolescence and young adulthood: mental illness, previous suicide attempts, hopelessness, poor relationship with parents/caregivers, parental divorce, child abuse, school issues, peer suicide, poor problem-solving skills, easy access to lethal means, conduct disorder in youth, strained parent-child relationships, and peer victimization are just a few of the risk factors that can contribute to suicidal behavior (WHO, 2014; WHO, 2021; Bilsen, 2018; Wasserman, 2016).

In many countries, suicide prevention is practiced not only under the domain of clinical workers but also by social service providers who regulate suicide prevention programs organized by each country individually. World Health Organization (2014) invites all European countries to employ a multi-sectoral approach which addresses suicide in a comprehensive manner, as well as brings together different stakeholders, and is based on their current resources and contexts.

The issue cannot be solved just from one side and it is significantly important to integrate different approaches in mitigating the problem of adolescent suicide. The literature review spots the necessity of the presence of social service providers, especially in educational settings (Singer & Slovak, 2011). It mainly implies that social institutions such as schools, primary health services, social work, usually implement their activities “in the field” directly with clients and, thus, have access to them, their

surrounding and available services. As a proof, according to Renaud et al. (2009), children who committed suicide either had no contact with the care system at all or received subpar treatment that was not coordinated across various caregivers and service providers. Therefore, the Multidisciplinary Team approach is known to help fulfill the needs of young people not only in crisis but also on the prevention level by ensuring young people receive the best support from social service providers.

PROBLEM STATEMENT

Unfortunately, suicide prevention is still too often a low priority for many governments and policy-makers, especially in developing countries. It is noted that suicide prevention needs to be prioritized on global public health and public policy agendas and awareness of suicide as a public health concern must be raised by using a multidimensional approach that recognizes social, psychological, and cultural impacts (WHO, 2014). Moreover, a national suicide prevention strategy is important because it indicates a government's clear commitment to prioritizing and tackling suicide while providing leadership and guidance on key evidence-based suicide prevention interventions.

Schools are a perfect place to spot and address juvenile suicide risk, but there is not much research on school-based suicide prevention programs because of difficulties with implementation and evaluation (Singer et al., 2011). However, the scarce evidence which is provided in the literature review demonstrates the high need for a more profound research and evaluation of different programs and roles of each specialist in the Team.

Nevertheless, there are known to be some effective practices of different collaborative approaches to suicide prevention of adolescents with the involvement of social service providers such as social workers, social pedagogues/school counselors, psychologists/psychiatrists, police, and other community members (Wasserman, 2016; UNICEF, 2018; Upanne, 2001; Widgorowitz & Hassem, 2019; Stone & Crosby, 2014; WHO 2014).

Slovakia has vividly progressed in advancing multidisciplinary teams into prevention interventions through School Support Teams (Krnáčová et al., 2020; Miller et al., 2020). Yet, minor amount has been identified in research about the efficacy of provided interventions in Slovakia due to the new approach. In developing countries like Kyrgyzstan, the problem remains under-prioritized as the country still lacks qualified specialists; there is no holistic system of prevention either at local (including educational) or governmental levels; and social policies do not respond to the needs, but instead react post-factum (UNICEF, 2020). Therefore, due to a lack of unified and systemization of support on government and local levels, practitioners in Kyrgyzstan jointly point to the significant need to work multidisciplinary to fasten the service provision to children and youth at risk or/and at a

crisis of risk and, as a result, contribute to suicide prevention in children and young people (Molchanova et al., 2022; UNICEF, 2020).

OBJECTIVES OF THE STUDY

The **General Objective** of this study is to analyze and discuss the similarities and differences in the system of work of the multidisciplinary team in the prevention of adolescent suicide in educational settings in Slovakia and Kyrgyzstan.

The **Specific Objectives** include:

1. To analyze to what extent multidisciplinary teams contribute to preventing adolescent suicide in Slovakia and Kyrgyzstan.
2. To research professional settings in the prevention of suicidal behavioral risks of adolescents in Slovakia and Kyrgyzstan;
3. To assess preventive activities focusing on the general prevention of adolescent suicide by multidisciplinary teams in Slovakia and Kyrgyzstan.
4. To discuss the suggestions for improvement from various specialists about preventive programs by multidisciplinary teams in Slovakia and Kyrgyzstan.

RESEARCH QUESTIONS

In order to stay focused on the objectives, the study addresses the following research questions. The **General Research Question** is to explore the perspectives of various specialists on the work of multidisciplinary teams in suicide prevention among adolescents in Slovakia and Kyrgyzstan as well as to discuss the practical implications of multidisciplinary teams and different approaches and models in prevention of adolescent suicide in these countries.

More **Supporting Research Questions** include the following areas:

1. To what extent can the multidisciplinary approach contribute to the prevention of adolescence suicide in Slovakia and Kyrgyzstan?
2. What are the roles of social institutions in preventing suicide among adolescents in Slovakia and Kyrgyzstan?
3. What are the suicide preventive activities implemented by the multidisciplinary teams in Slovakia and Kyrgyzstan?
4. What can be suggested to improve the work of multidisciplinary teams working with adolescent suicide in Slovakia and Kyrgyzstan?

The object of the study includes studying multidisciplinary teams' collaborative efforts in suicide prevention of adolescents in Slovakia and Kyrgyzstan.

SIGNIFICANCE OF THE STUDY

Understanding the system of support for suicidal adolescents on the prevention level as well as the roles and functions of specialists in multidisciplinary teams is a key to achieving global health and social goals (WHO, 2021; De Beurs et al., 2013; Grant & Lusk, 2015). The US has produced most of the literature on youth suicide and this is hardly shocking because the US has a thriving social assistance system for young people who are at danger and in crisis. Also, there is a robust prevention system at many levels with the involvement of different specialists in multidisciplinary collaboration. However, there is a huge deficiency of evidence-based studies in other countries which would give a clearer picture of the situation with the support for youth in suicidal crisis.

It appears that the work of multidisciplinary teams especially in education settings is relatively new in Slovakia and there is a deficiency of evidence-based proof of results. Therefore, this study assists in finding out the perspectives of a team's work in prevention including prevention of suicidality among youth in educational settings. In Kyrgyzstan, this area is very underdeveloped and requires foundational research in the area of support and prevention. Despite the practical implications and efforts of indifferent specialists who work in place, the work still lacks structuration and operationalization of collaborative work as those are somewhat chaotic, reactive, and post-factum. Therefore, this research will strive to study the successful models of multidisciplinary teams in the world, mainly including Slovakia, and suggest strategies to formalize and institutionalize the procedures for the prevention and support of children in crisis and/or at risk of crisis in Kyrgyzstan.

Furthermore, the study is especially significant as it strives to analyze the importance of the involvement of social service providers, especially social workers and social pedagogues, in the multidisciplinary team to help understand the common precipitating factors of suicide in adolescence both from social and environmental perspectives, develop a cohesive and smooth model of prevention, find the best and integrated solutions for the child, suggest improvements for policy-making, and provide more clearance of roles and functions of different social institutions.

STRUCTURE OF THE STUDY

Overall, this study has six (4) chapters. Each chapter has been designed to follow the general objective of the study. The Introduction and Problem Area of the study presents the study's background, its context, and the research problem. The study's objectives, research questions, and significance are also all covered in the Introduction. The Literature Review is included in the first chapter. Here, prior research that is relevant to the study's goal has been evaluated and discussed in books, journals, reports, and websites. The Theoretical Framework is presented in the second chapter, which goes over how various theories, models, and systems give the current study perspective and direction. The study's

Methodology is covered in chapter three. The methodology includes a comprehensive discussion of the study design, sample size, sampling techniques, study procedure, data collection and management, ethical issues, and imitations of the study. The Findings and Analyses are covered in the fourth chapter. The thematically analysed data are explained with interview transcripts and explored in relation to previous studies in the Findings and Analysis chapter. The key conclusions of this study as well as the ramifications of the findings to recommend are presented in Conclusions and Recommendations. The Appendices present Interview Guide Template, Informed Consent Example and Non-plagiarism declaration.

CHAPTER 1: LITERATURE REVIEW

This chapter strives to clarify the topic of the multidisciplinary team approach in suicide prevention of adolescent suicide with examples of practices and experiences from world-evidence practical implications including Slovakia and Kyrgyzstan. It also explains the importance of considering the adolescent age as a very fragile period, presents the most influential models of general prevention of suicidal behavior up to date in the field, and demonstrates the importance of the roles of each specialist in prevention.

1.1. THE THEORETICAL AND METHODOLOGICAL BASIS OF THE RESEARCHED ISSUES

1.1.1. Suicide as a social pathology behavior

World Health Organization views suicide as a serious public health problem and a global phenomenon that occurs in all regions of the world. Notably, suicide is a tragedy affecting families, communities, and entire countries and has long-lasting negative effects on people throughout their lifespan (WHO, 2021).

Although there are several definitions of the word 'suicide' in pieces of literature, it is imperative to trace the origin of the word. The word "suicide" was derived from the Latin word – 'sui' meaning "of oneself" and also 'cide' or 'cidium' which also means "a killing" and in general terms, it connotes an intentional, self-inflicted death. Maris (2002) defines suicide as "*a multidimensional concomitant of psychiatric diagnoses, especially mood disorders, and is complex in both its causation and in the treatment of those at risk*" (Maris, 2002).

Unlike the typical definitions, Lester (2009) compared suicide with the criminal act to oneself of voluntary (in passion or in the heat of the moment) and involuntary (criminally negligent homicide) manslaughter. This legal perspective involves the dimensions of intent, premeditation, and provocation as a part of self-destructive deaths which is also suggested to be included in the classification scheme of suicide definition (Lester, 2009).

Studies have shown that mental illness is a cause of suicide as seen in Bertolote and Fleischmann (2002) where they reported that about 90% of adult people who died by suicide suffered from mental illnesses such as depression and substance abuse. Schnyder et al. (1999) also corroborated that most suicide attempters experience feelings of anxiety and panic prior to their suicidal act, and that a higher percentage reportedly lose control over themselves, thus indicating a state of emotional crisis. Conversely, due to the multifactorial causes of suicide, it is expedient to mention that intervention and prevention measures should be multi-faceted because it is necessary to take into consideration the social, physical, and environmental factors (Bertolote & Fleischmann, 2002).

Consequently, Philip and McCullough (1967) emphasized the importance of social factors in classifying persons who kill themselves. In their research, they showed that persons admitted to a hospital following a suicidal attempt manifested the variables of social pathology to a high degree; meaning that it is important to assess the patients' personal relationships and social background (Philip & McCulloch, 1967). Essentially, 'social pathology' is known as a condition or phenomenon in society, which might often lead to a flood of social, economic, and psychological problems that can undermine overall well-being.

Emile Durkheim (1858-1917), known as the founder of modern sociology, developed a new perspective where the concept of suicide was viewed not just from a psychological concept but also from sociological standpoint, a social fact - a so-called "sui generis". Emile Durkheim (1897) defined suicide as social phenomenon that "*is applied to all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result*". Although this definition has continued to raise several concerns from sociologists and psychologists, the focus of this definition by Durkheim (1897) is to reveal that suicide is a social action which has both internal and external influence (Durkheim, 1897 cited in Jones, 1986).

1.1.2. Epidemiology of suicide and suicidal behavior among adolescents

The definition of youth in terms of strict age ranges is known as rather arguable and varies by country and over a certain period of time. Still, many scientists substantiate that adolescence is the most vulnerable period. Due to consistent escalating risk factors and stressors which can be aggravated by different social situations and events such as natural disasters, political and economic instability, pandemic, young people are constantly manifesting their right to continue living in such devastating conditions (Bilsen, 2018; Greydanus & Calles, 2007). Unfortunately, for some, the decision to die comes first as an idea, then as an attempt, and later it may turn into a complete suicide act.

Suicide is the second leading cause of death for young people age 15-24 year-olds (WHO, 2019). It is well established that suicide touches all ages, race and ethnicity, gender, geography and affects both high- and low-income families. Yet, rates of suicide and suicidal behaviors are two times higher among young males than females, while females have higher rates of suicidal ideation and attempted suicide (Uddin et al, 2019; Hink et al., 2022). In the US rates of attempted and completed suicide are highest among young Native Americans, Hispanic and African Americans (Hink et al., 2022). The Center for Disease Control and Prevention[1] reports that the leading mechanisms of suicide among US adolescents aged 10-19 are suffocation and firearm injury. Additional mechanisms include drug

[1] Suicide for ages 10-14, United States 2020, Both Sexes, All Races. Retrieved from https://wisqars.cdc.gov/data/lcd/drill-down?causeLabel=Suicide&agegrp=10-14

poisoning and falls, and less than 1% each include cut and pierce, burns, drowning, and non-drug poisoning.

While it is already proved in many research that the main reason for suicide is a mental health disorder, it may not be always necessarily true for adolescent suicide (Wasserman, 2019; Bilsen, 2018). Many researchers distinguish adolescence as the most vulnerable period. In most cases young people have committed suicide because of family or economic reasons and that the adolescents have never displayed any signs of psychological issue or diseases before (Bilsen, 2018). Along with psychological disorders, world researchers highlight other reasons such as financial limitations, poor family relationships, peer bullying and victimization, physical, psychological and sexual abuse (Leeb et al., 2011; Bilsen, 2018).

Therefore, reducing suicidality can be obviated by eliminating risks and developing preventive strategies.

1.1.3. Prevention of suicidal behavior

Prevention, as an act of stopping or hindering something from happening, is proffered as one of the most effective ways in reducing the rates of suicides. According to Goldston (1986) prevention is 'revolutionary' in its goal of early detection of disorder, as well as a practice of 'maximum participation' and 'maximum open sharing' of information (Goldson, 1986). Align with that, Wasserman (2019) finds it very important to include prevention in all levels of interaction - societal, community, interpersonal, and individual with the strong intention to guide and assist countries in strengthening their suicide prevention efforts (Wasserman, 2019).

According to the World Health Organization's framework, a person may make up to 20 attempts before actually committing suicide, hence prevention is thought to be one of the most effective approaches to fight suicide (WHO, 2014). Young people go about making decisions in a somewhat different way. Teenage suicide attempters may have a greater history of prior suicide attempts than adult suicide attempters, which explains both the method and the reason. Adolescents utilize more non-lethal techniques, such as poisoning by over-the counter medications (WHO, 2014; Wasserman, 2019).

Lee et al. (2019) consider that interpersonal issues are less likely to be the driving force behind adolescent suicide attempts than financial or health-related issues. Because adolescent suicide attempts are generally less severe and fatal than adult suicide attempts, it is even more pertinent and essential to start prevention initiatives for young age groups.

"*Suicides are preventable*" – this sentence was repeatedly said by Dr. Margaret Chan, a Director-General of the World Health Organization (2006-2017) while presenting a critical publication of

World Health Organization in 2014 "Preventing suicide: A global imperative", the main goal of which is to increase the awareness of the public health significance of suicide and to make suicide prevention a high priority on the global public health agenda. It also aims to support countries to develop or strengthen comprehensive suicide prevention strategies in a multi-sectoral approach (WHO, 2014). Danuta Wasserman (2019), the Founding Head of the National Centre for Suicide Research from Sweden, emphasizes the importance of preventive measures because "*suicide does not occur at random, but rather is considered an ongoing process; from suicidal thoughts to suicide attempts and in some cases a completed suicide*" (Wasserman, 2019).

The World Health Organization (2014; 2019) states that typical national strategies may include a variety of prevention measures, including training for health professionals, educators, police, and other stakeholders in the health and education sectors. These measures also include surveillance, means restriction, media guidelines, stigma reduction, and public awareness raising. These programs typically also involve postvention and crisis intervention services for both adults and children (WHO, 2014; WHO, 2019). Non-specialized health and social professionals can be employed to enhance the assessment and management of suicidal behaviors in children and adolescnets in order to provide effective practical assistance.

Since it has been identified that prevention is necessary for diminishing suicidal behavior, it is highly recommended to include prevention strategies in all forms of interventions with suicidal youth.

1.1.4. Multidisciplinary team and its role in the work with suicidal clients

The multidisciplinary approach is widely used in a health system where mental health professionals work as a part of a team to promote high-quality care and best practice in delivering mental health services (Knapp et al., 2007). Since the concept of health incorporates a complex and holistic system where all spheres such as biological, psychological, physical, socioeconomic, cultural, and environmental factors function as interconnected and interacting determinants of one another, it is noted that health and social issues are characteristically broad and complex and are most appropriate examined from a multidisciplinary perspective (Carpenter et al., 2003).

With increasing specialisation in healthcare and expansion of knowledge about mental health and health conditions in general having a forum of different groups that reflect various areas of specialization is increasingly necessary. The benefits of a multidisciplinary team include improved clients' health outcomes, which leads to strengthened quality of life, as well as reduction of costs and utilization of medical services (Kutash et al., 2014).

Grant and Lusk (2015) consider that a multidisciplinary approach allows professionals and clients to come together with sound procedures and solutions with an adequate number of interventions. It is

based on the connection and coordination of experts from one or more institutions and the client's active involvement. They say, that the experience of success from multidisciplinary collaboration strengthens the team and simultaneously allows it to solve more challenging tasks (Grant & Lusk, 2015).

For general prevention of suicide among young people, it is especially essential to implement a collaborative team approach because it targets the general population of adolescents who might be at risk for developing suicidal ideation at the initial stage when influenced by different social stressors. Leeb et al. (2011) strongly emphasize the connection of suicide with other forms of violence. For example, it is reported that young people who have experienced violence, including child abuse, bullying, or sexual violence tend to have a higher suicide risk (Leeb et al., 2011). Consequently, when the multidisciplinary team is comprised of different professionals involved in the matter, the interests of a child are especially considered. Together with Kutash et al. (2014) they also point out that the success of a case is more likely to be complete if there is a strong connection with a child's family, school personnel, community leaders, social workers, psychologists, as well as a provision of adequate support and an easy access to health care (Leeb et al., 2011; Kutash et al., 2014).

Meanwhile, the forms of multidisciplinary teams can vary according to the goals and competences of the specialists; however, the essence of the multidisciplinary team remains the same which is to provide the best care to the client in need. For suicide prevention, the team serves as one of the mechanisms to enhance resiliency and help reduce suicidal thoughts and behaviours.

1.1.5. The place of a social worker in suicide prevention

Social workers play a critical role in identifying risk factors and warning signs of adolescent suicide (Singer & Slovak, 2019). Although many suicidal adolescents do not self-report, they often display warning signs to their peers, parents, or trusted school personnel (Wasserman, 2019). In many countries, social workers are trained to recognize these warning signs and risk factors, which may include mental health conditions such as depression, social isolation, and substance abuse (Bilsen, 2018). By identifying these factors early on, social workers can help prevent suicide attempts and provide the necessary support to adolescents in crisis.

Social workers also play a vital role in developing prevention strategies and treatment plans for adolescents at risk of suicide. The study by Singer et al. (2011) highlights the crucial role of a social worker as a specialist who works with adolescents and their family to develop a safety plan, connect them with appropriate mental health services, and provide ongoing support and counseling. Research has shown that community outreach social workers can directly provide services to youth with suicidal thoughts or attempts, resulting in better outcomes (Daniel & Goldston, 2009). As the result, through

their expertise and training, social workers can help adolescents develop coping skills and resilience, which can serve as protective factors against suicide.

Collaboration with other professionals and community resources is another crucial role for social workers in adolescent suicide prevention. This may include working with schools, healthcare providers, and government agencies to develop comprehensive suicide prevention programs that address the unique needs of adolescents (Andrews et al., 2022). Additionally, social workers can collaborate with community organizations to increase awareness about suicide prevention and provide support to at-risk adolescents. By working together, social workers can help create a support network for adolescents who are struggling with suicidal thoughts or behaviors.

1.2. DEFINING ADOLESCENCE IN THE CONTEXT OF SUICIDAL BEHAVIOUR

1.2.1. Psychological and social specifics of adolescence age

As a rule, suicide most often occurs during the crisis periods of a person's life. Researchers attribute adolescence to such periods, which is associated with psychological, physiological and social characteristics of personality development during this critical period.

World Health Organization defines ‘adolescents' as individuals in the 10-19 age group. While 'young people' covers the age range 10-24 years (WHO, 2020). Today, about 1.2 billion adolescents comprise 16% of the world’s population. However, United Nations[2] declares an interesting fact, that the proportion of adolescents in the global population peaked around 1980 and is now on the decline almost everywhere.

Anthony Lake, an executive director of UNICEF said in his foreword to “The State of the World’s Children 2011”: “*Adolescence is not only a time of vulnerability; it is also an age of opportunity*” (UNICEF, 2011, p. 42). Indeed, adolescence is traditionally considered the most difficult age period. The main content of adolescence is its transition from childhood to adulthood. All aspects of development undergo a qualitative restructuring; new psychological formations arise and are formed. This transformation process determines all the basic personality traits of adolescent children, and, consequently, the specifics of working with them.

Anna Freud (1895-1982) was the first person, who promoted the idea of adolescence as a period of ‘internal disharmony’ (Gullotta & Adams, 2007). Undeniably, adolescents are known to go through all sorts of changes which are emphasized by the fact that they are not children anymore but not yet adults. Their emotional and physical health is precarious; and therefore, various conditions and situations trigger their behavior. Averin (1998) defines normal "healthy" behavior in adolescents as

[2] United Nations. Who are the youth?. Retrieved from https://www.un.org/en/global-issues/youth

the active interaction of the adolescent with society, with surrounding people, adequate to the needs in life and their ability to harmonize socialization in society (Averin, 1998).

1.2.2. Risks and signs of suicidal behaviour of adolescents

American Academy of Child and Adolescent Psychiatry (2021) report that while young people experience a whole different spectrum of feelings, their suicide attempts are very often associated with "*feelings of stress, self-doubt, pressure to succeed, financial uncertainty, disappointment, and loss*". For some of those adolescents, suicide may appear to be a solution to their problems.

There is a widespread myth that if someone talks about suicide, one will not harm oneself. Many child psychiatrists firmly believe that even a demonstrative attempt, when a person really only intends to scare, can be potentially hazardous. They also emphasize the importance to be vigilant about what a child says. Children who think about suicide may make suicidal statements or comments very openly. American Academy of Child and Adolescent Psychiatry (2021) give examples of those statements such as "*I wish I was dead*" or "*I won't be a problem for you much longer*". Scholars define suicidal ideation as '*a desire to end one's own life*' (Cha et al., 2017). It typically ranges from relatively passive ideation (e.g. wanting to be dead) to active ideation (e.g. wanting to kill oneself or thinking of a specific method on how to do it). A Suicide attempt is considered to be the next step after suicidal ideation, it is defined as '*an action intended to deliberately end one's own life*' (Cha et al., 2017).

According to the Centre for Disease Control and Prevention (2020), thoughts about suicide and suicide attempts are often correlated with the symptoms of depression. However, additionally to depression, other risk factors may include family history of suicide attempts, exposure to any kind of violence, impulsivity, aggressive or disruptive behaviour, access to firearms, peer bullying, internal feelings of hopelessness or helplessness, and acute loss or rejection (CDC, 2020).

The results of the Global School-based Student Health Survey (GSHS) among adolescents of age 13-17 from 2003 to 2017 from 90 countries reveal pretty much the same picture. It shows that the majority of adolescents of both sexes with slight discrepancies have common reasons for a suicidal attempt which is associated with being bullied or/and having no close friends (Campisi et al., 2020).

In addition, the COVID-19 pandemic, as one of the modern risk factors, considerably worsened physical health and influenced the mental well-being of people including youngsters (Wasserman et al., 2020). CDC (2021) stated that at the beginning of the COVID-19 pandemic emergency room visits for suspected suicide attempts began to increase among adolescents in the United States, and this aimed a reported overall decline in the suicide rate (CDC, 2021; WHO, 2021). As the world responds to the COVID-19 challenges, youngsters are among those who experience a spectrum of effects from the pandemic in many aspects of their lives. Wasserman and her colleagues (2020) inform that there

are particular reasons why children should be protected in the times of pandemics. Directly the virus may lead to the loss of a parent support due to death, illness or separation, which at the same time may lead to high risk of violence and neglect in the family. Surely, it can also be a result of the limited economic situation of caregivers. In addition, the pandemic destroys the habitual routine and family foundations that have been a norm. All these stressors amplify the unfavorable environment for a child to grow and develop properly (Wasserman et al., 2020; WHO, 2021).

However, it is said that it is possible to detect suicidal behavior of young people, since almost all adolescents, before deciding to take an extreme step, send a desperate signal, informing "*Stop me!*". Usually this horrible solution matures from several days to months or even years. But often the surrounding symptoms are not well-noticed. Bilsen (2018) identifies that suicidal behavior has a number of essential features, which are extremely important to distinguish between members of the adolescent's environment to try to prevent suicidal attempts in time. He also suggests that the first sign of a suicidal behavior is a loss of the ability to experience positive emotions. Some people stop taking care of themselves, they look neglected by appearance and lost in their thoughts. The circle of contacts and anything that brings joy and interest to them is narrowing down. Some demanding actions are perceived as simply a blackmail which require no actions bur rather disregard.

Other warning signs of suicide, according to the American Academy of Child and Adolescent Psychiatry (2021), can be changes in eating or sleeping patterns, frequent sadness, withdrawal from friends, family, and normal social activities, frequent complaints about physical symptoms often linked to emotions, a decline in the standard of academic work, and preoccupation with death and dying.

So, any statement that may indicate the desire to commit suicide should be treated with utmost care and attention. It is better to be mistaken a hundred times than to underestimate a child’s intention and let one die.

1.2.3. Protective factors to help prevent suicidal behavior of adolescents

Borowsky et al. (2001), in their study to identify risk and protective factors for suicide attempts adolescents, declared that the presence of protective factors reduces the risk of suicide attempt among at-risk and not at-risk adolescents (Borowsky et al., 2001). Moreover, they said the risk might be reduced by as much as 70%–85% when at least one or more of these are present.

A protective factor[3] is a characteristic that helps reduce the likelihood of attempting or completing suicide. By protective factors, we may mean skills, strengths, or resources that help deal with stressful

[3] Suicide Prevention Program. Western Michigan University. Retrieved from https://wmich.edu/suicideprevention/basics/protective

events more effectively. The factors are known for enhancing resilience and helping to counterbalance risk factors, and those can be considered to be either personal or environmental (Wasserman et al., 2021).

The researchers also identify social connectedness as one of the foremost and influential protective factors among a variety of other protective factors, such as hope for the future and optimism, strong beliefs about the meaning and value of life, cultural, religious, and spiritual beliefs, healthy lifestyles, sobriety, problem-solving skills, safe environment, positive peer relationships, positive adult relationships, resiliency, etc. (SAMHSA, 2020; Whitlock et al., 2014). Interpersonal and community connectedness includes perceived caring, support, and quality of communication, and is described as a major protective factor against suicide. Indeed, lack of connection with family and school is consistently reported as negatively associated with suicidal thoughts and behavior among children and adolescents. Connectedness constructs practical and intuitive appeal to the fact that it decreases the influence on suicidal ideation and behavior of adolescents (Whitlock et al., 2014).

Positive self-esteem also acts as a protective factor, especially when the interaction with perceived social support is considered. Josh Watson (2019), a trained expert in Family Systems Therapy in the US, gives an interesting perspective of how a healthy and formed personal identity helps a teenager to develop a confident and stable sense of self as one of the key tasks of being an adolescent. Watson (2019) specifies that some young people can learn to develop and discover their identity in a healthy and age-appropriate way. However, for others, the time of identity formation results in participation in risky behaviors that could potentially have a negative effect on their lives (Watson, 2019). Therefore, it is tremendously important for an adolescent to develop a strong sense of self, personality, connection to others, and individuality. Watson (2019) says, that "*a positive teen self-identity is vital because it shapes a teen's perception of belonging not just for their teen years but for most of their adult life. In addition, a positive self-identity is correlated with higher self-esteem. Positive reinforcements of effort, good choices, and perseverance from parents can help adolescents develop a strong sense of self*."

Youth have a better chance to recover, process, get help, and develop into healthy adults by reducing risk factors and boosting protective variables.

1.2.4. Methods and approaches in the work with the suicidal adolescents

World Health Organization (2020) states that suicide rates worldwide increased 30% between 2000–2018, and declined in 2019 and 2020. The Center for Disease Control and Prevention (CDC) emphasizes that suicide is a leading cause of death in some countries like the United States with 45,979 deaths in 2020 (CDC, 2020). This is about one death every eleven minutes. The CDC also reports that

the number of people who think about or attempt suicide is even higher. According to CDC statistics in 2020, an estimated 12.2 million American adults seriously thought about suicide, 3.2 million planned a suicide attempt, and 1.2 million attempted suicide. This implies an essential message that huge effort should be focused on preventive measures.

The foundation of the joint collaboration as one of the best approaches in the work with suicide clients is very well articulated in the National Strategy for Suicide Prevention (National Strategy or NSSP) which was designed in 2001 in the US to be a catalyst for social change with the power to transform attitudes, policies, and services in suicide prevention (US Public Health Service, 2001).

However, the rudiments of the program can be traced back to 1966 when the Center for Studies of Suicide Prevention was established at the National Institute of Mental Health. Later, the American Association of Suicidology and then the American Foundation for Suicide Prevention were established with such activities as increasing the scientific understanding of suicide as a base for practical prevention activities. In 1983, the focus was brought to an increasing number of youth suicide rates by the Centers for Disease Control and Prevention (CDC). During the Hearing on Youth Suicide Prevention Act of 1985, the first attempt of reinforcing the role of the interdisciplinary approach was voiced: "*In 1984 Four Winds, an inpatient psychiatric hospital, established the Committee on Sudden Adolescent Death – an interdisciplinary group of therapists and schools."* (Hearings of Youth Suicide Prevention Act of 1985).

In response to this, the Secretary of Health and Human Services established the Secretary's Task Force on Youth Suicide to review risk factors for youth suicide and promising interventions in this field. These reviews and the Task Force's prevention recommendations were published in 1989 by Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA, 1989 cited in Institute of Medicine, 2002).

Basically, NSSP is '*a plan for suicide prevention: goals, objectives, and activities; the public health approach as applied to suicide prevention; the international experience building suicide prevention strategies'* (US Public Health Service, 2001). Based on current research on suicidal behavior and suicide prevention, the document outlines goals and objectives that are then followed by preventative activities. The public health approach stands out as a logical and well-organized way to launch prevention efforts and guarantee their efficacy. Unlike the clinical approach which explores the history and health conditions that could lead to suicide in a single individual, the public health approach focuses on identifying patterns of suicide and suicidal behavior throughout a group or population (US Public Health Service, 2001).

Since then, at least 20 years have passed and according to the average statistics of the American Foundation for Suicide Prevention, the suicide rates in the US in 2020 (13.48 per 100k) dropped slightly compared to the pick of stats in 2018 (14.23 per 100k). Generally, in 2020, the suicide rates

were higher among adults ages 25 to 34 years (18.35 per 100k) and 75 to 84 years (18.43 per 100k), with the rate highest among adults ages 85 years or older (20.86 per 100k). Younger groups had consistently lower suicide rates than middle-aged and older adults. In 2020, adolescents and young adults aged 15 to 24 had a suicide rate of 14.24 which is still relatively high compared to other countries (American Foundation for Suicide Prevention, 2020).

The efforts on reducing youth suicide in the US were begun being to be outlined in the Report of the Secretary's Task Force on Youth Suicide (cited in Institute of Medicine, 2002) back in 1989 with specific directions of recommendations on the importance of collaboration of multidisciplinary parties which is necessary since the risk factors for suicide are linked with many other areas. It stressed out that suicide prevention should be integrated into broader health promotion programs and health care delivery services to prevent other self-destructive behaviors, including alcohol and substance abuse, adolescent pregnancy, and interpersonal violence (ADAMHA, 1989 cited in Institute of Medicine, 2002).

The World Health Organization developed a so-called multisectoral approach over the subsequent two decades that integrates nongovernmental and community organizations, works across government sectors, and promotes knowledge sharing, the sharing of methodologies, resources, and lessons learned, as well as the sharing of data and research on suicide (WHO, 2021). It says: "*Suicide prevention cannot be addressed by the health sector alone as risk factors associated with suicide and its prevention cut across many areas. For suicide prevention to be effective, a multisectoral approach is critical*." (WHO, 2021, Part A, p.13). It suggests that having a group of people who represent various specializations is more required due to the growing development in health and social care and the increased understanding of health conditions. Multidisciplinary team models have several benefits, including increased consumer health outcomes and functioning, enhanced quality of life, decreased costs, and utilization of medical services, in addition to the chance for professionals to exercise collaborative cooperation and professional advancement.

1.2.5. Evidence-based approach to decreasing suicidal behaviour in children and adolescents

According to the Systematic Review of suicide preventive strategies, the following are considered the most impactful and effective evidence-based suicide prevention methods - physician education, restriction of access to lethal means of suicide, pharmacological and psychological treatment, and school-based prevention programs (Zalsman et al., 2016; Wasserman 2019). The knowledge of epidemiology and risk factors is fundamental to successful prevention and treatment. This may include programs on medication treatment, psychosocial treatment, different tools of assessment for evaluation suicide risks, as well as school-based programs, gatekeeper training, and suicidal awareness campaign.

According to the United States Youth Risk Behaviour Survey (2019), the prevalence of suicidal thoughts and behaviours among high school students varies from 19% of those who seriously considered attempting suicide, 16 % of those who made a suicide plan, 9% attempted suicide and 3% made a suicide attempt that had to be treated by a medical. Therefore, prevention plays a massive role in interventions with suicidal youth.

When discussing the topic of suicide, many people focus on the clinical approach to the psychosocial treatment of suicide. Indeed, suicidal ideation, self-harm, and suicide attempts are linked to a variety of detrimental effects, including co-occurring mental disorders, subpar educational and professional outcomes, and early mortality from unrelated causes. The use of mental health services, the diagnosis of a mental disorder, and adult suicide are all more likely in those who had attempted suicide as adolescents (SAMHSA, 2020).

The treatment course for children with depression and other mental illnesses usually includes psychotherapy and medication, which, unfortunately, may negatively affect the adolescent brain as it differs from the adult brain (SAMHSA, 2020). Conversely, psychosocial treatment includes the **Cognitive-Behavioral Approach** (CBT) which is considered to be a prevailing treatment approach for suicidal and depressed people and is successfully used both for treatment and prevention of suicidal behavior (Dirks 2017). Whilst researchers argue whether CBT is as effective for adolescents due to the fact that suicidal adolescent often needs a full range of interventions such as psychotherapy, medication, family therapy, engagement of peers, and spiritual counselling, CBT continues to be one of the most researched treatment models for suicidality reduce of adolescents and children (Dirks, 2017).

In the cognitive-behavioral approach, SAMHSA suggests one more evidence-based program that demonstrates high results in reducing suicidal ideation, self-harm and suicide attempts. **Safe Alternatives for Teens and Youth (SAFETY)** is a 12-week family-oriented treatment designed to build skills, increase safety, and reduce risk of suicide attempts. This program enhances protective factors and reduces risk factors within individual youth, family, and other social systems. The itinerary focuses on a youth who works with one therapist while parents simultaneously work with a different therapist. Then youth and family come together to practice skills identified as essential to prevent repeat suicide attempts. The uniqueness of this program is that it can be conducted in outpatient setting and/or the client's home (Asarnov et al., 2017).

Robinson et al. (2013) identify that programs for universal suicide prevention typically occur under the umbrella of curriculum-based education initiatives, which attempted to give interventions to the entire student body through the academic program.

In school settings, the following prevention program is known to work best - **the Signs of Suicide (SOS)**[4] Middle School and High School Prevention Programs in the US. SOS is an empirically supported program for preventing adolescent suicide that has improved students' understanding of suicide risk and adaptive attitudes about it. SOS teaches students how to recognize the warning signs of depression and suicide in themselves and their peers while also providing resources to assist educators, parents, and communities in identifying at-risk students and taking the necessary action. Moreover, according to the assessment of SAMHSA (2020), SOS showed a reduction in self-reported suicide attempts by 40%.

Also, besides clinical workers, trained school personnel and practical social workers use universal **screening assessment** for suicide risk which is a standardized tool and an essential component of a comprehensive suicide prevention program. Screening helps providers identify individuals who may be at risk and implement appropriate care and safety plans. The screening tools vary from its complexity and practicality. In schools, personnel use simple screening tools: surveys, observations, and monitoring. However, there are known validated screening tools such as the Ask Suicide-Screening Questions (ASQ)[5], the Columbia Suicide Severity Rating Scale (C-SSRS)[6], and the Patient Health Questionnaire-9 Modified for Adolescents (PHQ-A)[7] which are well used in medical and other settings for youth.

In addition, school-based programs also bring much-needed evidences in how the interventions with suicidal youth can be implemented. One such example would be the national "**Saving and Empowering Young Lives in Europe (SEYLE)**" program funded by the 7th Framework of the European Union, where professionals and researchers conducted research on evaluating risk behavior prevention interventions among 11,110 school students aged 14 to 16 from 11 European countries from 2009 to 2011. The main objectives of this longitude research were to collect data on the health and wellbeing of adolescents in Europe, to improve adolescents' mental health by reducing risk-taking and suicidal behavior, to assess the success of various preventive programs, and to suggest efficient culturally appropriate models for promoting adolescent mental health in various European nations. The longitudinal study revealed a significant need for ongoing monitoring and the application of preventative, scientifically-based intervention techniques for the targeted adolescents (Wasserman 2016).

[4] Suicide Prevention for Students. MindWise Innovations. Retrieved from https://www.mindwise.org/sos-signs-of-suicide/

[5] Zero Suicide. Retrieved from https://zerosuicide.edc.org/resources/resource-database/ask-suicide-screening-questions-asq-toolkit

[6] Columbia-Suicide Severity Rating Scale Scoring and Data Analysis Guide. Retrieved from https://cssrs.columbia.edu/wp-content/uploads/ScoringandDataAnalysisGuide-for-Clinical-Trials-1.pdf

[7] PHQ-9 modified for Adolescents (PHQ-A) Questionnaire. Retrieved from https://www.childrenshospital.org/sites/default/files/2022-03/PHQ%20Form.pdf

The uniqueness of this program was that the SEYLE generated an extensive database containing information about socio-demographics, risk factors, lifestyles, and the status of mental health of adolescents in Europe. And even though, the primary setting was at school, it still serves as evidence-based proof of the importance of implementing preventive interventions at any level of the Ecological system including community, interpersonal, and individual environments.

In Central Asia, Kazakhstan took the highest rank in adolescent suicide among all neighbouring countries (21.7) in 2016 according to the World Health Organization. These concerning findings were supported by a baseline research done in 2012, which found high rates of attempted suicides among school students (1.5% in the two weeks prior) and a significant percentage (26.5% of those sampled) classified "at risk." According to UNICEF (2014), linked mental health issues like anxiety and depression were also quite common. **The Adolescent Mental Health and Suicide Prevention program (AMHSP)** was tested in Kazakhstan's pilot districts from 2015 to 2017 as a solution to this issue, with the assistance of UNICEF Kazakhstan. The program included several directions, such as identification of adolescents at risk for suicide and mental health problems; gatekeeper[8] training for school staff; awareness-raising intervention for adolescents; capacity building of mental health workers and primary health workers; and assessment of the impact of adolescent suicide prevention program (UNICEF, 2018). The final evaluation of the intervention demonstrated the success of the AMSHP pilot program. According to WHO stats the suicidal rate reduced to 15.35 in 2019. The outcome data show that suicidal ideation, stress and anxiety significantly reduced in students for both males and females on 36.1%, 56.1% and 80.6% respectfully. Students generally reported the following positive and unintended effects: improved sociability/peer relationships; improved academic performance; improved coping with aggression; decreases in bullying; overall self-development; support for groups not targeted by the pilot; support from parents; use of pilot evidence for planning; a catalyst for changes in other areas of social development; improved status of school psychologists; development of strong leadership skills (UNICEF, 2018). Moreover, among many other lessons learned, AMSHP revealed that involving more comprehensive health and education providers, beyond psychiatric staff, worked well not only to broaden access to care rapidly but also built an effective team approach in managing adolescents at risk. This collaborative approach increased the delivery of care, for instance, by bringing school psychologists and gatekeepers together during training and developing methods to collaborate during treatment and follow-up. Such multidisciplinary teams employed what is known as a "dynamic follow-up scheme," which entails inspecting and keeping track of teenagers who have been recognized as at-risk while assigning each team member a set amount of

[8] The World Health Organization defines ‘gate-keeper’ as ‘a health care provider at the first contact level who has responsibilities for the provision of primary care as well as for the coordination of specialized care and referral’.

activities to complete. This made it easier to create unified preventative programs and deal with high-risk adolescents in a more thorough manner (UNICEF, 2018).

Although some approaches share common theoretical roots, and most address similar targets and mechanisms, these practice-friendly interventions show us that prevention and treatment are necessary in all their forms and agendas to reduce suicidal and/or self-harm behavior in adolescents with or without prior histories of these behaviors.

1.2.6. Situation with adolescent suicide in Kyrgyzstan and Slovakia

In Kyrgyzstan, the proportion of young people is relatively high, as adolescents cover almost one-fifth of the whole population. According to Kyrgyz Republic National Statistics at the beginning of 2022, more than 2 million children under the age of 18 lived in the Kyrgyz Republic, of which more than half (51%) were boys. Compared to the beginning of 2021, the number of children increased by 43 thousand, or 1.7%. Of the total number of children at the beginning of this year, 43% are children under the age of 7 (1 million 108 thousand people); 44% are at the age of 7-14 years (1 million 119 thousand people), and 13% are adolescents aged 15-17 (328 thousand people). The overwhelming majority of Kyrgyzstani children (65,6%) live in rural areas with limited access to health, education, social services, and recreational activities. At the end of 2021, there were more than 15 thousand socially unprotected, dysfunctional, difficult families in Kyrgyzstan, in which about 309 thousand children lived (National Statistical Committee of the Kyrgyz Republic, 2021).

These numbers tell us an important message! The socioeconomic conditions in which young people grow up can importantly affect choices and opportunities in adolescence and adulthood. Deprived living conditions or neighborhoods, for example, may be seen by young people as shameful or degrading, may reduce their opportunities for productive learning and social interaction, or may increase their exposure to substance abuse, disease, injury, and suicide (World Health Organization, 2019). Researchers from Kyrgyzstan specify that since the suicide rate is significantly high among children from the vulnerable environment, they might be more often inclined to risky behaviors. This may mean that these 309k children of different ages need special attention and care from the community and most importantly from the government (UNICEF, 2016).

The report of UNICEF (2020) represents data on the suicide rate in Kyrgyzstan from 2008 to 2018. According to statistical information from the Ministry of Internal Affairs of the Kyrgyz Republic, the accumulative number of all completed cases of suicide for this period is 1,080 cases among adolescents from 10 to 18 years old (UNICEF, 2020). According to the report, the peak of suicide among teenagers was in 2013, when 125 children took their own lives. After that, the statistics began to decline to 95 cases in 2016, while 58 children died in 2017. Then there was an increase in 2018 with 88 children who committed suicide (UNICEF, 2020). According to the National Statistics of the Kyrgyz Republic,

the number of suicidal young people declined to 48 people in 2019 (National Statistics Committee of the Kyrgyz Republic, 2019). In addition, the study found that for 42% of respondents, interpersonal issues (with friends or family) were the main motivators for trying to commit suicide. These attempts have profound psychological and emotional consequences, making it necessary to provide quick psychiatric care. The survey also revealed that half of the adolescents aged 12 to 18 who attempted suicide had parents who were immigrants at the time of the attempt (UNICEF, 2020).

The recent COVID-19 pandemic became an unexpected disaster for many people causing a direct impact on their health. History shows various scenarios when pandemics have also exacerbated people's anxiety levels, fear, and loneliness leading to depression, suicidal thoughts, and even the act of committing suicide itself. In Kyrgyzstan quarantine due to COVID-19 increased the number of adolescent suicides dramatically: within the first three weeks of isolation 13 teenagers committed suicide (Podolskaya, 2020). The year-end statistics of 2020 indicated 98 cases of adolescent suicide, roughly twice that of last year's 48 cases (KR National Statistics, 2021; Kudayarov, 2021).

Regarding Slovakia, the country ranks relatively low in adolescent suicide rates among EU countries. In 2019 there were 4.93 suicides by young people aged 15-19 per 100,000 citizens (EuroStat, 2019), while the sum number of suicides per 100k people is 12.1 (World Population Review, 2019). From the statistical data for the years 2008 to 2017 made in the article of Prof. PhD. Ingrid Emmerová (2018), it is stated that for complete acts of suicide the unknown reasons dominate. On the other hand, for suicide attempts, interpersonal conflicts in the family and at school are the most common motives in the age category of 15-19. Emmerova (2018) says that most suicide attempts are an expression of fear and an attempt to escape any forms of threat such as punishment. The impetus for adolescent suicide tends to be a sense of disappointment and despair when for the first time in their lives they face a more significant problem or failure. Therefore, at this age there are frequent suicidal attempts that can be interpreted as an emotionally charged way of calling for help (Emmerová, 2018).

1.3. THE PLACE OF A MULTIDISCIPLINARY TEAM IN PREVENTION OF ADOLESCENT SUICIDE

1.3.1.Multidisciplinary team in the prevention of suicidal behaviour in adolescence

It has been widely observed that multidisciplinary practice is the best approach to addressing societies' varied health and social care needs. While this argument has been mirrored in many national government policies and guidelines of regulatory bodies of health and mental sectors, the positive impact, still rarely used, is also visible in non-clinical social aspects.

For suicidal behaviour treatment, the approach may vary due to different purposes and models. For example, one emerging multidisciplinary team model is known as a **Peer-based Model** where

adult family members of children with emotional and behavioural disorders fulfil a role of a family support specialist and works together with a case manager, a mental health clinician, other specialists to provide a holistic outreach, information, advocacy and emotional support to the families (Kutash et al., 2014). Since they already have experience in their roles, such family support specialists are in a special position to interact with other parents whose children are being treated in the mental health system. This helps build trust, disseminate hope and facilitate collaboration with other service providers.

When discussing non-clinical community based initiatives in prevention of suicidal thoughts and behaviours, it is important to mention different **School-based Programs** which has proved to be effective in improving knowledge about suicidal behaviour of adolescents and attitudinal change towards approaches in dealing with suicidal youth (Gijzen et al., 2022). The school-based team includes school-based and external personnel who have formal roles to play as a problem-solving unit in assessing risky behaviour of the youth and environmental condition, if necessary, connecting to further clinical or non-clinical treatment, as well as providing general education about suicidal ideation and behaviour and training on bystander interventions. The meta-analysis has proved to show promise within a three-month post-test assessment and potentially also have effects on suicide prevention that are sustained over time. Moreover, the studies show that such programs that focus on increasing social and emotional skills positively affect adolescents' mental health in a sustainable manner, especially when they are done with active family members involvement (Gijzen et al., 2022).

Multidisciplinary collaboration has grown dramatically over the past few decades and has begun to play a significant role in matching services to the specific needs of children and young people. However, social service workers still find it challenging to work across disciplines, particularly those who work with young people (Rumping et al., 2017).

1.3.2. Multidisciplinary team actors

As earlier discussed, a multidisciplinary team setting is more used and diverse in mental health care system (Carpenter et al., 2003), and the traces of history goes back to 1989 when US Department of Health recommended the establishment of multidisciplinary teams as "*different approaches to treatment and the participation of people from a number of professional disciplines are required to cater adequately for the needs of the mentally ill*" (Physiopedia, visited 2022). However, the appearance of "psychiatric teams" appeared in the 1950s when psychiatrists and psychiatric nurses, psychologists, social workers and occupational therapists formed such teams to arrange comprehensive treatment and care for the mentally ill people (Martin, 1987). In the mental health sector, the multidisciplinary team typically comprised of a group of people each of whom possesses

particular skills and expertise. This might include a consultant psychiatrist, a registrar and housemen, clinical psychologists, social workers, occupational therapists, speech therapists, physiotherapists, dietician and hospital chaplain, as well as nurses. Some team members might meet daily or weekly to discuss patient treatment and progress (Martin, 1987).

Today's multidisciplinary team may vary due to its change in social policies, society's needs, innovations, and the constant development in professional background of specialists. The roles of each team member may also be fulfilled with different additional duties and responsibilities. The roles of social workers are considered to be key in any team setting. However, the study of Carpenter et al. (2003) shows that the social workers identified no less strongly with the teams than did their health service colleagues. The researchers explain that social workers spoke about their frustrations occasioned by the lack of understanding of their role by other professions (Carpenter et al., 2003).

In universal prevention, government and social institutions, community members and organizations may play significant roles in any type of interventions with young people at-risk, including suicidal adolescents.

Communities can accomplish engagement projects which can help communities tackle issues with mental health in general and prevent suicide in particular. For example, in *The Community Engagement Toolkit* (2018) on preventing suicide, the authors offer the following activities such as social media campaigns; traditional media campaigns (e.g. on television); community city hall meetings; workshops or webinars; banners, posters, advertisements; street plays, drama or theatre; training sessions, etc. (WHO, 2018). Such approaches are often relatively cost-effective and are, therefore, particularly encouraged to be used by low- and middle-income countries where stigma and taboo often limit access to quality care for suicidal cases. In many countries as a part of a media campaign, every year, the Lifeline and other mental health organizations and individuals raise awareness of suicide prevention during the month of September - National Suicide Prevention Month[9]. During all of the month, mental health advocates, prevention organizations, survivors, allies, and community members unite to promote suicide prevention awareness.

The **government's** ability is expended to law and policy making in the area of family and children protection, as well as issuing decrees and national programs on Prevention of Suicide in respective countries. Thus, in 53 countries out of 158, around 20 countries of which are from the European region, where suicide prevention strategy is recognized as their health priority, the governments have launched internal suicide prevention programs to decrease the number of suicides, raising community awareness and breaking down the taboo to make progress in preventing suicide (WHO, 2014).

[9] Promote National Suicide Prevention Month. Retrieved from https://suicidepreventionlifeline.org/promote-national-suicide-prevention-month/

Social institutions (organizations) are usually seen as front-liners when dealing with suicidal youth and, therefore, their education and involvement level is very significant. Wigdorowitz and Hassem (2019) offer multi-facet approach in order to effectively meet the needs of a child or adolescent with suicidal thoughts and behaviors.

In school-based prevention programs *school counsellors/social pedagogues* work as gate-keepers to identify behavioural, social, and emotional signs of suicide risk among students. This helps to ensure that they put in place preventive methods. Moreover, the school counsellors work in tandem with legal guardians and appropriate authority to report suspected suicide risk and develop safety plans in order to protect students from unforeseeable harm (ASCA, 2016; CDC, 2015).

Teachers at school setting is a bit of a controversial role as it implies many responsibilities to carry on. However, the findings of the study (Nadeem et al., 2011) demonstrated how important teachers are in identifying students who have suicidal risk. Well-defined crisis policies and procedures, communication of these processes, staff collaboration, and the availability of on-campus mental health resources all seemed to encourage teacher engagement in the suicide prevention program. The necessity for direct teacher training on suicide risk factors, crisis management, and classroom management was noted by the participants. Moreover, the study emphasizes that in-school instruction on mental health resources and procedures, regular updates to this instruction, and increased visibility of mental health workers are some further tactics for enhancing suicide prevention efforts (Nadeem et al., 2011). Such frontline services of general practitioners in the field (teachers, school doctors, voluntary health workers) are not recognized as primary identifiers of at-risk children.

Child psychologists/clinical psychiatrist/educational psychologists as well as *behavioural teachers* often work in isolation or as part of a multidisciplinary team. When working in a multidisciplinary team, professionals from this area may move to a more specialist teams where they work with outsource professionals to follow-up the issue to the next level of intervention (Wigdorowitz & Hassem, 2019).

Police on prevention/juvenile inspectors are those who particularly work together with other specialists in the areas of suicide-related awareness and education, suicide research, suicide prevention programming and training, and collaboration between the juvenile justice and social and health systems (NAASP, 2013). Stone and Crosby (2014) underlined that police have a crucial role to play in the team in understanding how to recognize and respond to young people who are at risk mainly because police officers are frequently the first responders to individuals in crisis. According to the study of Arensman et al. (2016), one-fifth of suicide cases had a documented interaction with police in the three months prior to the death, demonstrating that police officers frequently interact with persons who commit suicide

Social workers frequently work in settings other than social work, including those related to health, education, mental health, and courts. This emphasizes the significance of social workers' roles and responsibilities to adopt a multidisciplinary approach in dealing with a variety of issues, including young people's suicidal behavior. The findings of Singer and Slovak's study (2011) showed a large amount of school social workers contact with suicidal teenagers: 88 percent of school social workers had such interactions with youths in the previous two years, and rates for school social workers working in high schools were close to 100 percent. Moreover, most social workers were in charge of conducting suicide assessments, felt very competent recognizing suicide risk factors and making the proper referrals, were very aware about school suicide policy, and were highly prepared to work with suicidal adolescents.

Having these actors work together is a massive effort but their mutual and professional collaboration definitely contributes significantly to decrease of suicidality rate among young people.

1.3.3. Social work in the prevention of suicidal ideation and behaviour of adolescents

Due to social workers' dual focus on the individual and their environment, social work considerably differs from other occupations. According to the Systems Theory[10], a person is always interacting with their environment, and various aspects that function as a system have an impact on how they behave. The external influences that affect a person's position and viewpoint can be dealt with by social workers. They also provide chances for assessment and intervention, assist clients and communities in successfully adjusting to their reality, and, if required, alter that reality (Mccave & Rishel, 2010).

Supporting youth and children is usually seen as the main duty of most social workers. The countries that have ratified the Convention of Children's Rights (UN Human Rights, 1989) and support their programs with additional staff, budget implications, and policy changes, significantly drop in crime statistics against children. For instance, in response to a high-profile child death enquiry in the UK, the government ordered a report to consider how to implement recommendations aimed at radical improvements to every area of social work practice. As one of the outcomes from the report, it made key suggestions to improve social work education, practice and management. It emphasized that "*the job social workers do is critical to the nation. They play an essential role in protecting children and young people from harm and in supporting people of every age. The work they do can be difficult and very demanding, requiring careful professional judgements that can make all the difference to those they serve*" (Hromková, 2020).

[10] Encyclopedia of Child Behavior and Development. Retrieved from https://link.springer.com/referenceworkentry/10.1007/978-0-387-79061-9_941

It is essential to understand that for suicide prevention the social workers are unlikely to provide pharmacological advice or effect to build appropriate infrastructure for protection or restrict access to lethal means which are known to be the most effective for risk reduction of suicide (WHO, 2014). On the contrary, social workers are known to be good at harm-minimization by practicing regular home visits, surveillance, education, problem-solving therapy, and media outreach (WHO, 2014; WHO, 2021).

A social worker's role in suicide interventions has grown more crucial over time. The literature review demonstrates the value of school social workers' presence in educational settings as well as the necessity of their skill upgrades in order to better address concerns with youth suicidal behavior in particular (Kelly et al., 2015). In the schools of the United States, an exploratory study on school social workers' experiences with youth suicidal behavior found that these school social workers were able to intervene with at least one student who made suicide threats (88%), attempted suicide (50%), was hospitalized for suicide risk (64%), or actually died by suicide (10%) (Singer & Slovak, 2011).

Scott and Guo (2012) identified a number of school-based interventions which were mainly focused on issues such as raising awareness of suicide, encouraging behavioral change and coping strategies, and were usually delivered by school staff or social workers. Despite good intentions, out of ten suicide prevention programs, only two programs that focused on behavioral change and coping strategies in the general school population demonstrated lowered suicidal tendencies, improved ego identity and improved coping ability. The authors explained it that methodological limitations meant that the results from these studies were difficult to compare and the soundness of conclusions based on such studies may be questioned. However, they believe, that the importance of the program cannot be underestimated but require more impact research (Scott & Guo, 2012).

This may also be connected with the ability of social workers to constantly develop their skills necessary to assess the resources and the risk factors which may exist in the child's family, neighborhood surrounding, and the larger social environment (Ragesh et al., 2017). In this instance, the emphasis of intervening activity is shifted from the individual level to the context of meso and macro levels. These intervention tactics may in fact involve approaches to enacting change at various levels, including the classroom or school, the peer group, the community, or the population at large.

1.3.4. Multidisciplinary teams in dealing with adolescent suicide in Slovakia and Kyrgyzstan

Since suicide is considered to be the consequence of multiple psychological and social stressors which influence adolescents' well-being mostly, the prevention programs should first-hand focus on protection from such triggers such as bullying at schools, discrimination and stigmatization, any forms of violence and abuse in the family and in schools, as well as romantic failures, peer relationships, and

family attachments. However, the number one social stressor served the exposure to violence and abuse toward children both in the family and in educational settings (Lee, 2019; Hink, et al., 2022; WHO, 2021).

Many countries ratified the Convention on the Rights of the Child[11] adopted by General Assembly Resolution 44/25 in 1989. **The Slovak Republic** observes the compliances with the rights of the children and ensures the protection and well-being of children in accordance with International Convention since 1993[12]. In 2000, Slovakia created the Committee for the Rights of the Child, which is composed of representatives of state administration central authorities, non-governmental organizations, and local government, all dealing with children's rights in legal proceedings. Slovakia has been steadily devoted to progress regarding the Convention with measures in social, economic, educational, and legal areas of children's rights.

The principle of the consideration of the best interest of the child was reflected in the Family Law, in the Law on Social and Legal Protection of Children and Social Guardianship, the Code of Civil Procedure, as well as the Civil Code. According to Act no. 305/2005 Coll. on the Social Legal Protection of Children and Youth[13] and on the amendment of certain laws, everyone is obliged to draw the attention of the body of social legal protection of children and social guardianship to the violation of the rights of the child. This applies, for instance, to the recommendation, assurance, or provision of social counseling, psychological support, expert methods for working on conflict resolution in family circumstances, and adapting to a new scenario. If required, they might also choose to impose certain educational methods. The local government is crucial in preventing family crisis situations, as well as in limiting and removing their detrimental effects (Ministry, 2022).

Many non-governmental initiatives in partnership with the Ministry implement grass-root projects on supporting disadvantaged and at-risk youth (Children's Fund of the Slovak Republic - Detský fond Slovenskej republiky[14]), on raising awareness on healthy lifestyles and on factors affecting the health and well-being of young people (Countrywide Integrated Non-communicable Disease Intervention Programme - CINDI[15]). Moreover, any child who needs help or wants to help someone can call the Child Safety Line[16]. It is free, anonymous, and professionally guaranteed. Its main goal is the provision of immediate contact with a child or young person in need of communication or specific help in a

[11] Convention on the Rights of the Child. Retrieved from https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child
[12] United Nations Human Rights Treaty Bodies. Retrieved from https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?CountryID=158&Lang=EN
[13] International Labour Organization. Retrieved from https://www.ilo.org/dyn/natlex/natlex4.detail?p_isn=84794&p_lang=en
[14] Defence for Children International. Retrieved from https://defenceforchildren.org/slovakia/
[15] European Commission. YouthWiki. Retrieved from https://national-policies.eacea.ec.europa.eu/youthwiki/chapters/slovakia/74-healthy-lifestyles-and-healthy-nutrition#
[16] Linka Detskej Istoty. Retrieved from http://www.ldi.sk/

crisis or stressful situation. Adults - parents, relatives, teachers, health professionals, and everyone who identifies any threat to the child's safety can also turn to the Child Safety Line.

In addition, recognizing the importance of the educational setting support system in prevention of any forms of violence and negligence against children, as well as exposure to risky behaviors of young people, **Slovakia** observes the following acts (Act No. 245/2008 Coll. on Teaching and Education[17], and Act No. 325/2008 Coll. on School Facilities for Educational Counselling and Prevention[18]) which define the conditions for providing professional help to school students and their parents. The help is provided primarily by psychologists, social and specialized pedagogues, who are most often the employees of school facilities for school counselling and prevention ("counselling facilities") or direct employees of schools. The Act on Teaching and Education distinguishes three types of student help: psychological, special-pedagogical, and social assistance. Matulaynova (2013) defines 'social assistance' in this sense as "*observation and evaluation of children's behavior by methods, techniques, and procedures corresponding to the latest findings of social pedagogy and the current state of practice; social counselling; socio-therapy; using the diagnostic methods of social pedagogy*." (Matulayova, 2013). The structure of counselling facility – Specialized Counselling and Prevention Center (SCPP) has been changed a few times and still brings with many ambiguities and question marks due to the personnel and financial under-dimensions of the advisory system[19]. Yet, Vasiľová and Lovašová (2018) consider that having social workers at school setting would contribute a lot to the development of their expertise in the social environment, whose task is the prevention and intervention in the area of socio-pathological phenomena and providing professional help to young clients in solving their social problems.

Furthermore, from very recent updates, Slovakia established the **School Support Team**. This is a relatively new program (NP POP II) launched with the help of the Ministry of Education and have been implemented by the Methodological and Pedagogical Center from September 2020. The program assists the professional and pedagogical staff of the school, who actively participate in creating an inclusive school culture and work not only with school students, but also with teachers, parents, their community, and other professionals in the education sector and beyond. Through multidisciplinary cooperation, they effectively support school children and maximize their chances of success in a safe and productive environment (Krnáčová et al., 2020). It is noted that the standards are well-prescribed

[17] Slov-Lex Legal and Information Portal. Retrieved from https://www.slov-lex.sk/pravne-predpisy/SK/ZZ/2008/245/20210901.html

[18] Slov-Lex Legal and Information Portal. Retrieved from https://www.slov-lex.sk/pravne-predpisy/SK/ZZ/2008/325/20080901

[19] Inklucentrum. Od 1. 1. 2023 platí vyhláška o poradenských zariadeniach. Retrieved from https://inklucentrum.sk/od-1-1-2023-plati-vyhlaska-o-poradenskych-zariadeniach/

and ready to use[20]. Since the initiative is very fresh, the application has not been implemented fully; therefore, we cannot tell about what impact it brings to preventing risky behaviors including suicide attempts and acts.

As for **Kyrgyzstan**, the situation has been progressing slowly due to deprioritization of the issue of adolescent suicide in comparison with other social issues. Besides, rather general mechanisms and strategies for supporting children and youth in difficult family situations, crime inclination behaviors, and other issues, are overviewed in such documents as the Convention on the rights of the child[21], the Code of on children of the Kyrgyz Republic[22], and other interdisciplinary acts, laws and order. However, it is accurate to claim that Kyrgyzstan has made conscious efforts to acknowledge the issue of suicide in the country and to implement some measures that present institutional implementation mechanisms and an all-inclusive strategy to combat suicide and suicide attempts. Yet, the implementation leaves much to be desired.

One of such mechanisms was the Order No. 120 "On the prevention of suicides, offences and crimes among children and youth", issued on March 22, 2016. The Order also approved an Interministerial Action Plan to prevent suicides, offenses, and crimes among children and youth in the Kyrgyz Republic for 2016-2018[23] which expired due to unknown reasons. The Ministry of labor and social development (now the Ministry of labor, social protection and migration) of the Kyrgyz Republic, as a central authority in charge of child protection, was appointed to monitor and execute the order which gave some notable observations in revealing the availability and existence of clinical guidelines and protocols to provide psychological support to the children in need (Molchanova et al., 2022). However, the practice of implementation of clinical protocols need to be evaluated. It is known that two departments at the National Center for Mental Health (NCMH) in the Kyrgyz Republic accept patients with common mental disorders. Those patients with suicidal tendencies are referred to acute psychosis wards, regardless of the diagnosis they may have received. It is quite clear that a stay in hospital for a patient with a panic disorder is unlikely to help, just as it is unlikely to help a patient with a generalized anxiety disorder. Moreover, with a caseload of 15–30 people per clinician, there is essentially no time for psychotherapeutic work (Molchanova et al., 2022).

The report of UNICEF (2020) mapped the following service providers in suicide prevention at primary level which should be represented by school psychologists, social pedagogues and social workers, and who are responsible for the identification of those in need of psychosocial support

[20] Project Standards about Muldisciplinary Teams in Slovakia. Retrieved from https://vudpap.sk/en/x/projekty/standardy/tvorba-standardov/odborne-postupy-a-skusenosti-mdp/skusenosti-mdp/

[21] The Kyrgyz Republic joined the Convention by a resolution Jogorku Kenesh of the Kyrgyz Republic dated January 12, 1994 No. 1402-XII. Retrieved from http://cbd.minjust.gov.kg/act/view/ru-ru/17444?cl=ru-ru

[22] The Code on children of the Kyrgyz Republic dated July 10, 2012 No. 100. Retrieved from http://cbd.minjust.gov.kg/act/view/ru-ru/203700?cl=ru-rum

[23] Retrieved from http://cbd.minjust.gov.kg/act/view/ru-ru/215103/10?mode=tekst

(UNICEF, 2020). Methodological tools in providing psychosocial support to children, as well as a clinical protocol to help children victims of violence, include algorithms to assist and redirect cases to the appropriate services. For instance, a psychologist may report child abuse to the direct supervisor (the Chief Psychologist of the Republican Health Center, Head of Multidisciplinary Team), who then notifies the police and the Child Support Center (support for victims of violence) by phone and completes a special registration card with information about the child. The Child Support Center is responsible for managing the case's referral and follow-up. In addition, if the organization helping children harmed by violence has few resources, its psychologists can refer a child for additional psychiatric treatment (UNICEF, 2020).

It is offered for a social pedagogue, a school psychologist, or a social worker to use the same scheme if they come across a case where a child is in need of assistance. However, it is important to note that this assistance scheme is relevant for urban areas and regional centers rather than in rural areas, where the approach is different due to the lack of appropriate services and specialists (UNICEF, 2020). Moreover, in the country there are no social workers specifically specialized on children and youth issues. The recent initiative in the new version of the Child Code[24] to allocate a budget for such specialists is still under the consideration on the government level and execution of such a decree is taking too much time while children and youth are dying due to lack of needed support and recognition. Since independence, despite the fact that Kyrgyzstan has received all the documents for the protection of the child, there has not been a service in Kyrgyzstan to support families and children in difficult situations (Makymbai kyzy, 2022).

[24] The old Code was developed in July 2012. The new Code was amended in 2017, passed Parliament's 1st and 2nd readings in 2021-2022. As of now it is still awaiting for the President's final approval.

CHAPTER 2: THEORETICAL FRAMEWORK

Theories in social work are known to seek to describe what is occurring in the field, explain certain behavior or phenomena, predict specific events, and offer guidelines for therapeutic and social interventions (Gray & Webb, 2013). This study considers one main theory – Bronfenbrenner's ecological system theory. Along with this theoretical framework, this chapter discusses the theoretical concept of 'suicide as a social pathology behavior' with the help of Emile Durkheim's study as well as The Interpersonal-Psychological Theory of Suicidal Behavior and Psychosocial Theory to support young people in the critical period of time. The other theoretical aspects include the System of Prevention and the Model of a Multidisciplinary Team to overview the importance of interventions in suicide prevention of adolescents.

2.1. Bronfenbrenner's Ecological Systems Theory

Suicide is often seen as "*an internal problem tied to mental illness or psychological constructs – with context often left out or considered only as an afterthought*" (Gunn, 2020). However, it is important to explore suicide with a greater focus on context. Ecological Systems Theory was created by Urie Bronfenbrenner to define the influence of the surroundings on human development (Bronfenbrenner, 1979). The developmental model of **Bronfenbrenner's Ecological Systems Theory** is described as a model where at the center of the model there is the individual, or self-system, influenced by personal, dispositional, and genetic factors (Bronfenbrenner, 1979). The System itself has four layers – microsystem, mesosystem, ecosystem, and macrosystem.

Microsystem refers to relations between the child and the immediate environment such as family, school, and peer group. The next one is the **mesosystem** and its connections among the child's immediate settings such as the relations between home and school. The **ecosystem** refers to social settings that affect but do not contain the child and this might be connections between home and the parent's workplace or neighborhood. And the last one is the **macrosystem** which refers to the overshadowing ideology of the culture such as the national regime, belief system, knowledge, infrastructure, lifestyles, and hazards. These nested systems all exist within a chronosystem which refers organically to the changes in persons and environments over a certain period of time.

Suicidal behaviors and the dynamic relationships between different individual and environmental factors are understood to be addressed by this approach. Young individuals move through a series of life transitions, all of which demand environmental support and coping skills, so social support factors (family, school, community, organizations, etc.) should be subsumed under the ecological model that helps to access factors relevant to the issues of suicide prevention.

The recent study of John F. Gunn (2020) attempts to show the different levels of influence potentially working on Black children to increase their risk for death by suicide. Suicide is probably likely correlated with feelings of burdensomeness, lack of belonging, and distress on an individual level. These, however, are personal factors that have an impact on other domains and are also affected by them. Gunn (2020) stresses out that the immediate environment (familial support, peer group), the community (poverty, discrimination), the culture (systematic racism, white supremacy), as well as the connections and interactions across these domains, all have an impact on these individual-level characteristics (Gunn, 2020).

Ecological models like this bring much-needed attention to contextual factors shaping suicidal behaviors. However, since contextual models deal with issues of change and diversity within specific contexts while staying away from explanations rooted in psychopathology, they still generally cannot answer why certain individuals growing up in similar contexts think about, attempt, or die by suicide, while others do not. But what we know for sure from previous discourses is that suicidal behaviors result from intricate connections between individuals' traits, their experiences in life, and the larger sociocultural environment in which they live.

2.2. Suicide by E.Durkheim's Study

Studies have shown that due to the multifactorial causes of suicide, it is expedient to mention that intervention and prevention measures should be multi-faceted because it is necessary to take into consideration the social, physical, and environmental factors (Bertolote & Fleischmann, 2002).

The father of contemporary sociology, Emile Durkheim (1858–1917), created a fresh perspective on suicide that took into account sociological as well as psychological considerations. In his book "Suicide", Durkheim (1897) identifies three main types of suicide, depending on the causes of suicide, which in turn depend on the state of the social environment. According to Durkheim, these are - altruistic, selfish, and anomical suicide. **Altruistic suicide** is characterized by the fact that a person who commits this kind of suicide does not belong to himself in the full sense of the word. Among the altruistic suicides are suicides based on a sense of duty, religious fanaticism, death for an idea, a heroic death on the battlefield, etc. **Selfish suicide** is a type of suicide caused by the fact that a person closes in on himself and breaks away from society, as opposed to the previous, altruistic type. If the risk of committing suicide is higher, the weaker the interpersonal ties around the person and the weaker the social cohesion in society. Among selfish suicide examples, religion is known as one of the attributes, but also can be affected by the person's marital status, the political situation in the country, etc. either a social group or society as a whole. Durkheim (1897) defines **anomic suicide** as a result of disorientation in society. In general, social anomie is a state of society without norms, that is when old

norms have been lost, and new ones have not yet been formed. Naturally, society has a strong impact on the individual. Accordingly, when society is in a state of instability when there are no clearly formed values, it is extremely difficult for a person to adapt and find his place. In this regard, there is a sharp increase in the number of suicides during economic crisis.

At that time, Durkheim's theory was revolutionary. Despite the fact that it has been more than a century since the book was first published, it has lost none of its relevance or significance. Even today, strong family ties can prevent suicide, and in many nations, rising divorce rates are correlated with rising suicide rates. Similar to this, there is still a strong link between suicide rates and economic variables, particularly the unemployment rate and social inequality. Moreover, despite increased secularization, religion continues to have a substantial deterrent impact on suicide (Kołodziej-Sarzyńska et al., 2019).

2.3. Supporting Theories on the Development of Suicidal Behavior in Adolescents

Modern explanations remain very much structured around Durkheim's seminal insights. Suicidologists specifically look into the interactions between social (such as cultural norms) and extra-social (such as personal psychology and environmental factors) components in order to understand the reasons of suicidal conduct (Kołodziej-Sarzyńska, et al., 2019).

Meanwhile, this is well explained in the **Interpersonal-Psychological Theory of Suicidal Behavior** which was first mentioned by Thomas Joiner (2005). According to Joiner's opinion, a person will not commit suicide unless they have the desire and the means to do so. Here the author emphasizes two main words – "desire" and "capability". The first one is supported by two psychological states simultaneously having in mind of which an individual develops a desire for death. These two psychological states are perceived burdensomeness (I am a burden) and a sense of low belonging or social alienation (I am alone). While it is rather common to think about suicide, few go on to make an attempt[25], and even fewer die by suicide. This is explained by the fact that the instinctual inclination toward life and a strong drive for self-preservation is strongly ingrained, which means it is difficult for an individual to act on the suicidal desire. However, the capability to overcome the deep-rooted desire to live is aided by frequent instances of suicidal experience. Joiner (2005) reasons that it is through repeated exposure to experiences that reduce an individual's fear of death and pain sensitivity, or the cognitive rehearsal of such experiences, can the hold on life be undermined and the capability for lethal self-harm strengthened. Having all in combination may result in lethal or near-lethal suicidal attempts (Joiner, 2005).

[25] A suicide attempt is when someone harms themselves with any intent to end their life, but they do not die as a result of their actions. Retrieved from https://www.cdc.gov/suicide/.

While Joiner (2005) captured the undefined age group of individuals, this perspective is well defined in the **Psychosocial Theory**, where Erik Erikson (1959) identifies adolescence is the stage of life when a young person develops a sense of self, a set of principles that will guide important decisions as they approach maturity. According to Erikson, as people develop and evolve throughout the course of their lives, they pass through a number of phases. Everyone has a developmental conflict at each stage, which must be overcome in order to properly develop the stage's main virtue. Erikson was concerned with how connections and social interaction impact growth and development (Erikson, 1959).

The Theory generally describes the Stage of Adolescence (12-18 y.o.) from "crisis of identity" and "roles confusion" dimensions where identity is specified "as a fundamental organizing principle which develops constantly throughout the lifespan". This involves experiences, relationships, beliefs, and values. Whereas, roles are constructed from exploring and testing out different 'hats' aka identities, and confusion in roles may result in over-identity or loss of identity (Ragelienė, 2016).

Also, the Theory presents various factors that contribute to whether a person forms a strong identity which are friends, family, schoolmates, other social groups, societal trends. In this regard, the Theory provides a stepping-stone for movement toward proper growth that social service providers and other professionals can apply to distinguish individual difficulties, including suicidal ideation and risky behaviours, and provide the appropriate support and services for tackling these challenges.

2.4. System of Prevention

In the health and social sectors, there are traditionally known to be three levels of prevention – primary, secondary, and tertiary (Goldston, 1986). Primary prevention is focused on reducing risk factors and promoting protective factors, secondary prevention is aimed at addressing the short-term effects of suicide, and tertiary prevention is long-term to address the after-effects of suicide (Horowitz et al., 2020).

However, confusion regarding these definitions led the Institute of Medicine (IOM) Committee on Prevention of Mental Disorders in 1994 to recommend that the definition of prevention be limited to interventions that occur prior to the initial onset of a clinically diagnosable disorder (Mrazek & Haggerty, 1994). As such the **Model of the Spectrum of Interventions for Mental Health Problems and Mental Disorders** (Mrazek & Haggerty, 1994) focuses on disorder prevention strategies, which are broken down into eight domains for each of the three categories of interventions for mental health problems: Prevention, Treatment, and Continuing Care. Universal (general) prevention programs target the general population without focusing on subpopulations that might be at risk for the development of the disorder of interest; selective prevention programs are aimed at populations that

have been identified as at-risk for the development of the disorder of interest (usually through some biological, psychosocial, or environmental risk factor); and indicated prevention programs that target individuals who already display low levels of symptoms of the disorder of interest (Mrazek & Haggerty, 1994).

The study on suicide prevention among young people by Mendoza and Rosenberg (2010) notes that preventing suicide among young people should be the duty of all agencies that deal with child development and welfare. The complexity of the causes of suicide is also mentioned, which necessitates a long-term, strategic, and open program of investment in numerous service interventions, service coordination, and ongoing research to develop evidence-based strategies for effectively and practically preventing the loss of life. A variety of state government departments and authorities, medical and social professionals, the private sector, and non-governmental organizations are currently offering information, services, and support to stop or lower the risk of young people taking their own lives within each category of suicide prevention strategies (Mendoza & Rosenberg, 2010).

Since it is identified that prevention is necessary for diminishing suicidal behavior, it is highly recommended to include prevention strategies in all forms of interventions with youth at risk of all kinds, including those with suicidal behaviors.

2.5. Multidisciplinary Team Model

Professionals from various industries must collaborate in order to meet the requirements of individuals, their families, and their communities. Working in isolation leads to ineffective collaboration, resource waste, and occasionally harm to others. Taberna et al. (2020) define one of the ways of strengthening such cooperation is known as '**a multidisciplinary team'**, which brings together the relevant professionals and practitioners who are seen as an effective means to encourage better coordination of their work and provide each participant with the opportunity to collaboratively care for beneficiaries with the help of teamwork.

Multidisciplinary teams first came into being in the healthcare industry, where experts from many fields collaborate to treat patients (Martin, 1987; Carpenter et al., 2003). However, other spheres quickly embraced this concept, forming new teams out of people with different professional backgrounds, completing tasks from unique perspectives, and coming up with innovative answers to problems. Carpenter et al. (2003) consider that a multidisciplinary approach allows professionals and clients to come together with useful procedures and solutions with an adequate number of interventions. It is based on the connection and coordination of experts from one or more institutions and the active involvement of the client. They say that the experience of success from multidisciplinary collaboration strengthens the team and at the same time allows it to solve more challenging tasks

(Carpenter et al., 2003). De Beurs et al (2013) make a vivid correlation of how much it is important and necessary that the team is trained and competent enough in the assessment and treatment of suicidal behavior.

However, what is noticed to be lacking in this Model is that despite extensive practices and literature reviews about the actors of teams in suicide general (primary) prevention, the theoretical framework still experiences a deficiency in demonstrating this Model as one of the methods in the prevention of suicide in the primary level. Moreover, the contribution level and significance of the roles of each team's participants in prevention are not well-defined yet.

CHAPTER 3: RESEARCH METHODOLOGY

3.1.DESCRIPTION OF THE STUDY AREA

This study is intended to analyze the work of multidisciplinary teams in suicide prevention in Slovakia and Kyrgyzstan, including practical implications of strategies and mechanisms used by professionals from the multidisciplinary team in various settings but mainly from the educational sphere.

3.2.STUDY DESIGN

This study is comprised of qualitative data coalesced from the **semi-structured interview**. Interviews are known to be best used for research that focuses on the participants' knowledge, experience, values and attitudes (Bryman, 2012). Unlike a structured interview, the semi-structured interview provides flexibility in its process to understand the issues and events; therefore, this method is recognized as a perfect tool to build on the information beyond those questions which are in the interview guide (Bryman, 2012).

The interview questions were structured around four main research questions of the study including probing questions to proceed for further information in the context (*See Table 1*). The complete Interview Guide can be found in Appendix 1.

Table 1: Construction of the Interview Guide Questions

#	Research questions	Interview questions	Probes (not limited to this list)
1	To what extent can the multidisciplinary approach contribute to the prevention of adolescent suicide in Slovakia and Kyrgyzstan?	1. What is a multidisciplinary team, in your opinion?	General understanding of a multidisciplinary team's essence, social and educational settings, level of contribution to suicide prevention
		2. In your opinion, how does/can it help to prevent suicide in your country?	General approaches, in the domain of support to children and adolescents, personal experience
2	What are the roles of social institutions in the prevention of suicide among adolescents in Slovakia and Kyrgyzstan?	3. From your experience, who is usually involved in the prevention of suicide among adolescents in your country? What are the roles of each professional? What activities do they usually implement?	Cultural and country specifics, personal and professional experience in working with different specialists, successful practices and challenges
		4. What kind of institutions are involved in suicide prevention in your country? What are their main functions?	Level of involvement of social institutions, understanding their roles and functions in practice, correlation with legitimate procedures, in professional setting and general

			prevention program(s) at school.
3	What are the suicide preventive activities implemented by the multidisciplinary teams in Slovakia and Kyrgyzstan?	5. What does your job as a … entail?	Professional and personal perceptions, best practices, challenges.
		6. As a …., when you witness suicidal behavior in an adolescent, what is the algorithm of preventive measures do you undertake (or suggest to undertake) in order to support an adolescent? Who is usually involved? Who else needs to be involved?	Applied tools and techniques, methods which work, challenges, constructing the system of support inside of team.
		7. If you personally don't feel comfortable working with adolescents with suicidal thoughts, who are other professionals do you refer for help?	Copying strategies, referral in the educational and other settings.
4	What can be suggested to improve the work of multidisciplinary teams working with adolescent suicide in Slovakia and Kyrgyzstan?	8. What suicide prevention strategies are made by the government of your country?	Availability of national campaigns, prevention programs and strategies, any other initiatives on reducing adolescent suicide in different levels.
		9. From your professional experience, what do you recommend to improve the work of the multidisciplinary team(s) working with adolescent suicide in your country?	Implementation on national and local levels, personal perspectives and opinions on strengthening the work of multidisciplinary teams.

3.3. SAMPLE SIZE

The interview participants of five (5) specialists from Slovakia and five (5) specialists from Kyrgyzstan (n = 10) were sampled by **purposive sampling method** and invited via a personal network of professionals from Slovakia and Kyrgyzstan. Purposive sampling is essential for the selection of units (people or organizations) in a strategic way to yield helpful information with a direct reference to the Research Questions (Bryman, 2012). Based on the theoretical study, the multidisciplinary teams were comprised of various specialists including social service workers, school social pedagogues, children psychologists, juvenile inspectors/police, NGO activists. Bryman (2012) mentions that "if saturation is the criterion for sample size, specifying minima or maxima for sample sizes is pointless". Considering this, the number of sampling (n=10) ensures as broad a variation as possible in terms of the dimension of interest and provides a cohesive number to achieve data saturation, theoretical saturation and informational diversity (Bryman, 2012).

The semi-structured interview guide consisted of 17 questions which were divided by Introductory Statement, Demographic Characteristics (questions on education, profession, roles, age, sex, geography), and Core Questions (questions evaluating the level of involvement in dealing with adolescence suicide (general prevention), collaborative approach, practical implications of country's policies, defining roles of each specialist in this field, possible solutions and limitations, etc.). Additional questions that arose as part of the process were added when needed.

Inclusion criteria included:

- Professionals (social workers, social pedagogues, child psychologists, NGO activists, police officers/juvenile inspectors);
- All genders;
- Those who provide any support to children and youth with risky behavior and potential suicidal ideation;
- Experience in working with youth of any kind.

Generally, the interview considered professional characteristics and personal involvement in the research topic, as well as professional experience and education level specifics of participants.

3.4. SAMPLING TECHNIQUE

The interview participants were invited via the personal network of professionals from Kyrgyzstan and the practicum site in Slovakia. Before the interviews, the Researcher had an opportunity to job shadow some of the team members' daily routines in order to better understand the situation regarding the researched topic and build rapport with the informants. This approach helped the Researcher to ensure the appropriateness of the chosen sample and cross-check with the studied literature. As a result, the sample of both teams' composition included professionals from different fields of expertise from both countries allowing them to represent a great variety of views that respond to the study's research questions. The team in each country comprised specialists such as:

1. **A social worker** is a specialist in the field of welfare service or social work, who provides services publicly or privately which are intended to aid disadvantaged, distressed, or vulnerable persons or groups. For the interview in Slovakia and Kyrgyzstan, it was possible to invite social workers from the municipal service departments and children's organizations respectively who work with children and youth exposed to any forms of risk and their detection and prevention.
2. **A child (school) psychologist** is a professional who specializes in understanding the processes of childhood development from infancy to adolescence. In the sample from Kyrgyzstan and Slovakia, child psychologists worked in public practice (school and center for psychological support) in the areas of prevention, provision of support, as well as referral of cases.

3. **A social (school) pedagogue** provides care, support, and education to children and young persons with different backgrounds or capabilities. Practical specialists from school settings were invited for the interview in Kyrgyzstan and Slovakia. In Kyrgyzstan, this specialist is an additional role to a standard teacher's scope of work, while in Slovakia there is a separate position that provides support in the detection and general prevention of any risky behaviors of children and youth.
4. **A police/juvenile inspector** is a leading specialist working under the division of city/regional departments of police with the direct or additional purpose to protect children's rights and interests. In Kyrgyzstan, the juvenile inspector is a separate position strictly involved in the prevention of neglect and delinquency of minors, as well as providing them with the necessary educational impact. In Slovakia, this function is formed under the city police and is limited to prevention activities.
5. **A representative of a children's organization** is usually a professional who works on different children and youth issues. In Kyrgyzstan and Slovakia, it was possible to invite participants from locally-based children's organizations who were actively involved in activities for children's protection and prevention of risky behaviors of any kind.

3.5. STUDY PROCEDURE

This study included the views of different specialists working in the area of suicide prevention in various settings, however, predominantly in educational settings.

The interview participants from Kyrgyzstan were approached individually from the Researcher's professional networking. Preliminary meetings were arranged by phone and social media means, where the Researcher introduced the research goal and explained the details, including ethical considerations. Those who indicated interest, met the inclusion criteria, and consented to signing the Informed Consent form were invited to the interview. Three (3) interviews were done in person with a recorder, and the other two (2) interviews were completed via zoom link.

The interviews in Slovakia were carried out during and after the practicum implementation where the Researcher was placed allowing to observe daily activities and duties of the informants. Three (3) interviews were audio recorded and field notes were taken during the interviews. Two (2) interviews were received via written forms and followed up with additional questions and clarifications in person, as well as job shadowing the work process.

All interviews were audio recorded and field notes were taken during the interviews. The audio recordings were transcribed verbatim in a Microsoft Word document and accuracy was ensured by thorough re-listening and examination of transcribed sheets.

3.6. DATA MANAGEMENT

The model to analyze qualitative data in this study is a thematic analysis which is considered one of the most commonly used methods of identifying, analysing and reporting patterns (themes) with data (Bryman, 2012). A thematic analysis of this research was to help identify patterns of themes in the interview data. The Researcher highlighted statements and phrases from the interviews that were significant to the study. The Researcher went back and forth among transcripts until consistent and distinct codes existed. The quotes related to each themes were brought together and looked into for relationships within and across data sources. This helped the Researcher to arrange and refine categories of participants' ideas until they were solidified. Codes were then arranged into subthemes, and they were brought into main discussions. ATLAS.ti was used to organize data.

3.7. ETHICAL CONSIDERATIONS

It is imperative to consider ethical issues in the qualitative research design. The topic of suicide is taboo in many conservative countries. In addition, social service provisions in this domain are highly controlled and in-shaded. Therefore, the Researcher's main goal was to consider principles of ethical considerations to fulfill the main objective of the study. This study was guided by the ethical principles described by Bryman (2012). The Researcher considered four (4) areas of ethics, including harm to participants, informed consent, invasion of privacy, and deception (Bryman, 2012).

First, the sample size and qualification were preliminary agreed upon with the Master Thesis's Supervisor. Also, all necessary documents were prepared and coordinated with the Supervisor. Prior to the interview, the Researcher conducted introductory meetings to clarify the qualifications for the study's purpose. The chosen participants were informed about the study's objectives and their rights. The participants were also informed about their voluntary participation and their rights to withdraw from the study at any time without any consequence.

Later, the Informed Consent forms were signed by all participants after the purpose of the study had been explained to them. Almost all consent forms were received face-to-face which helped ensure transparency and confidentiality in the process.

In addition, participants' data were kept confidential and no names were used. The participants were assured of the confidentiality of their responses, and their anonymity was maintained throughout the study. With the permission of the participants, all interviews were recorded to avoid misinterpretation and cross-checking of the information.

It was decided to hold interviews with professionals individually so they could speak freely about their personal experiences in working in multidisciplinary teams, challenges, and recommendations

without any biases. Moreover, the participants chose the time, date, and location of the interview to allow them to feel relaxed and comfortable.

It is essential to mention that the Researcher established a trustworthy rapport with all the participants by job shadowing, participating in the events together, and involving personal and professional networks to attract informants.

3.8. LIMITATIONS OF THE STUDY

Although this study has managed to fulfil the primary goal of the research, it still has encountered some challenges during the process. The main challenge was a language barrier with professionals from Slovakia. The Researcher had to invite translators for those who agreed to participate vis-à-vis. However, two (2) informants filled the interview guide online with a thorough follow-up and job shadowing from the Researcher's side. Still conducting the interviews, especially semi-structured interviews, in Slovak and translating them into English may have affected the meanings of terms, mood readings, and time efficacy. In Kyrgyzstan, the Researcher encountered difficulty in finding a social worker, a social pedagogue, a school psychologist, and a juvenile inspector. This may be explained from the point of view of the Researcher, that in a conservative culture like Kyrgyzstan's when someone works in a government position, the person is less likely to be willing to participate in any kind of research due to dealing with the bureaucracy to obtain permission and a general fear of saying politically unpalatable truths about such sensitive topics as suicide. The Researcher had to involve her professional network and personal meetings to find appropriate persons for the interview.

CHAPTER 4: FINDINGS AND ANALYSIS

4.1.INTRODUCTION

This chapter presents the findings from the interviews and analysis conducted in this study. The analysis of the interview findings was conducted using a qualitative approach, which included coding and thematic analysis of the data. The demographic information of participants is presented to ensure the uniqueness of the answers according to each specialist's roles and responsibilities (*see Table 2*).

Table 2. Information about the participants of the interview

#	Country	Position	Place of work	Education	Years of experience	Coding for the research
1	Kyrgyzstan	Social pedagogue	Public school	University degree (5 years of higher education) in pedagogy, professional training for social pedagogues from the district department of education	9 y.	KG social pedagogue
2		Social worker	Support center for children and family	Bachelor's degree in social work	1,5 y.	KG social worker
3		Psychologist at school	Public school	University degree (5 years of higher education) in psychology, professional trainings	8 y.	KG psychologist
4		Juvenile inspector	Juvenile inspection	Bachelor's degree in jurisprudence	10 y.	KG juvenile inspector
5		Director of social organization	Support center for children and family	University degree (5 years of higher education) in pedagogy, professional trainings on psychology, social work, and pedagogy.	4 y.	KG director of children's organization
6	Slovakia	Social pedagogue	Public school	Master's degree in social pedagogue	4 y.	SV social pedagogue
7		Social worker	Day center for children and families	Master's degree in social work, course - lecturer of informal education, coaching in work with youth, intervention and prevention of bullying	10 y.	SV social worker
8		Psychologist	Center of pedagogical and psychological counseling and prevention	Doctor's degree in psychology	20 y.	SV psychologist
9		Police officer on prevention	City police	Master's degree in jurisprudence	17 y.	SV policeman
10		Director of social organization	Day center for children and families	Doctor's degree in social work, professional course in special education (etopedist and socio-therapist)	10 y.	SV director of children's organization

The gathered data were analyzed using thematic analysis. The study was formed around four (4) main themes which were derived from the Research Questions. Also, eight (8) sub-themes came out from the interview questions, and twenty-five (25) emerging themes were formed from one hundred sixteen (116) codes and group of codes alongside the specialists' statements that reflect each of these emerging themes (*see Table 3*).

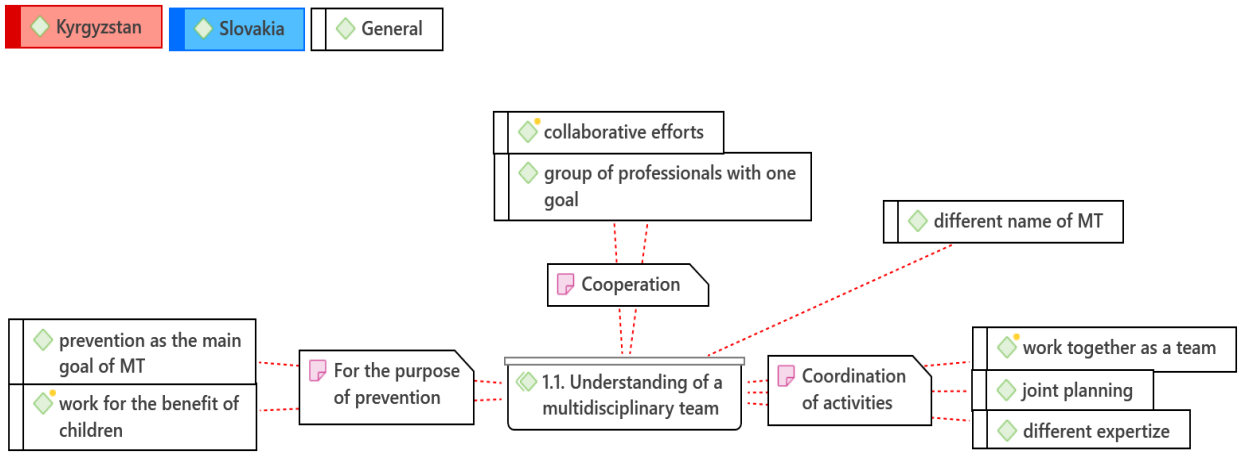
Table 3. Themes

Main themes	Subthemes	Emerging themes
1. The contribution of the multidisciplinary approach to the prevention of adolescent suicide	1.1. Understanding of a multidisciplinary team	Cooperation
		Coordination of activities
		For the purpose of prevention
	1.2. Views on the level of contribution	Environment
		Team capacity
		Problem indication
		Challenges with partnership
2. The roles of social institutions in the prevention of adolescent suicide	2.1. Experience with participating institutions	Primary contact
		Secondary contact
		Follow-up
	2.2. Areas of concentration (importance of roles)	School
		External
4. The activities on suicide prevention by the multidisciplinary teams	3.1. Using preventive measures	Screening
		Individual
		Group
		Outsource assistance
	3.2. System of support	Relationship building
		School involvement
		Other approaches
		Challenges on local level
4. Suggestions to improve the work of multidisciplinary teams in the prevention of adolescent suicide	4.1. Publicly known preventive strategies	In a school setting
		Aided by state and social organizations
		Deficiency of strategies
	4.2. Suggestions for improvement	An local level
		At government level

The chapter is structured in this chronology according to the Main Themes and Subthemes: the contribution of the multidisciplinary approach to the prevention of adolescent suicide; the roles of social institutions in the prevention of adolescent suicide; the activities on suicide prevention by the multidisciplinary teams; and suggestions to improve the work of multidisciplinary teams in the prevention of adolescent suicide. Each of the Subthemes are presented with the Figures derived from the ATLAS.ti to visualize the grouping of codes. Moreover, the code-coloring has been applied to illustrate the differences in opinions between Slovakian and Kyrgyzstanian specialists, as well as their common points of view which are highlighted in white. It is significant to note that the results from this study have been presented holistically in order to accurately reflect the actual and complete descriptions of each professional's experiences with help for preventing adolescent suicide. In this regard, the findings present a various perspectives involved in each circumstance and, in general, shed light on the overall image. Each Main Theme is concluded with the Discussion Part, which gives an analysis in correlation with the literature studies, theoretical framework, as well as the researcher's conclusions and observations.

4.2.THEME 1: THE CONTRIBUTION OF THE MULTIDISCIPLINARY APPROACH TO THE PREVENTION OF ADOLESCENT SUICIDE

4.2.1. Understanding of a multidisciplinary team



Participants described a multidisciplinary team mainly from three different perspectives. These included *cooperation, coordination of activities,* and *for the purpose of prevention.*

It was discovered that all interview participants had a good understanding of the multidisciplinary team's purpose and its basic functions. The majority of interviewees linked the word 'joint' with the essence of the multidisciplinary team.

> "*… in our practice, it's a team of people who work together with different expertise*" (SV psychologist)

Also, it was emphasized that it is important to coordinate activities for a right solution for the client.

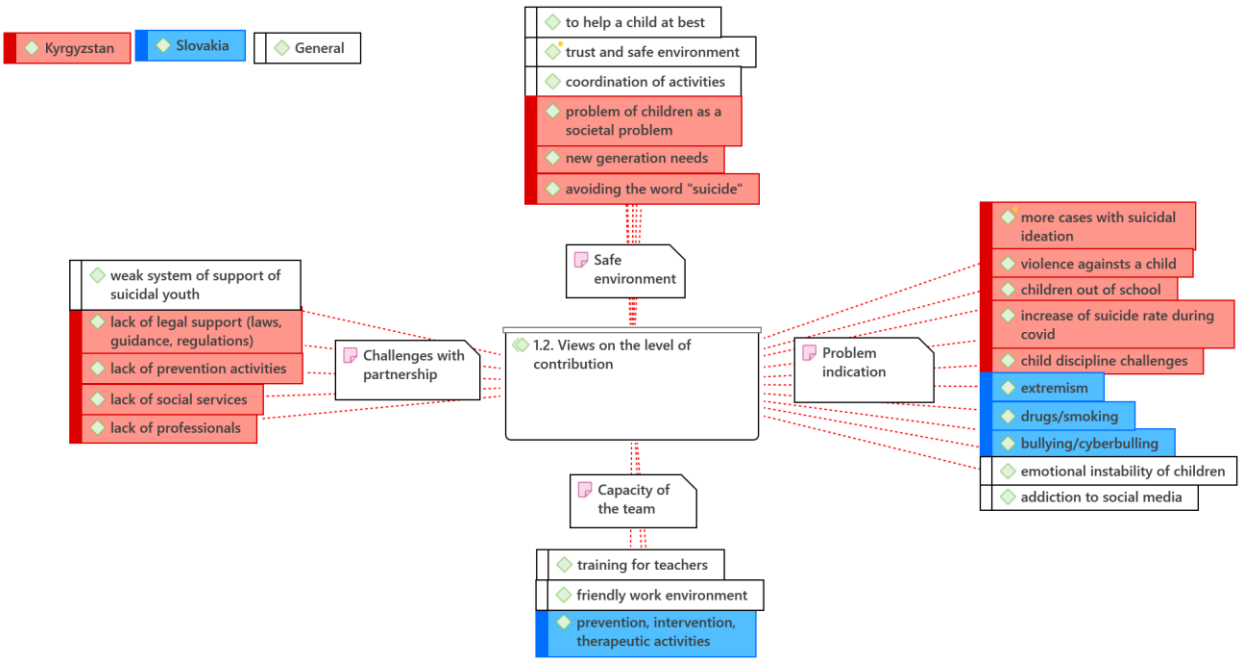
> *"… who communicate, exchange information, propose solutions, procedures in order to help the client …"* (SV social worker)
> *"If it all comes together, it really helps on all sides of the support, and the child starts to feel more needed"* (KG social worke)

Almost all participants highlighted that the multidisciplinary team better works on the prevention levels and as a primary point of contact.

> "*The multidisciplinary team can also work on prevention of the emergence of problems or against the deepening of problems for clients and vulnerable groups*" (SV social worker)
> *"The main goal of the multidisciplinary team should be prevention"* (KG director of children's organization)

As an additional opinion, many informants connected the phrase "multidisciplinary team" with other terms such as "concilium," "supportive team," "inclusive team," "mobile team", and "inter-resourceful conference," which have roughly the same meaning and a structure similar to that of the multidisciplinary team concept.

4.2.2. Views on the level of contribution



Participants viewed the level of contribution of the multidisciplinary team from a few angles –*safe environment, capacity of the team, challenges with partnership,* and *problem indication.*

Almost all participants responded that the creation of trust and a safe environment for children plays a key role in the work of the multidisciplinary team. Participants from Kyrgyzstan specifically featured a few problems such as the needs of new generation and the necessity to avoid the word "suicide" due to cultural context.

> *"We must be very careful to approach this topic because we must always understand that the forbidden fruit is sweet. When we start talking about suicide, we may touch people who have never had it. And a child may go for it. And it may seem to be our fault."* (KG juvenile inspector)
> *"Well, I try not to talk about suicide too much. I try to avoid the word "suicide". I try to substitute it. For example, was there a desire to go away, to leave life? was there and is there such a thing that you do not want to live? or just close your eyes and not to wake up?"* (KG psychologist)

The high importance of the team's competence was emphasized as a part of the professional contribution to the team's successful work. Participants from Slovakia especially highlighted the significance of various activities which the Team's members do.

> "*It is very important that people in the first contact are informed and educated about warning signs in children and know how to notice their tightness, sadness, depression, self-harm and respond to them adequately*" (SV social worker)

During the interview, many participants indicated the emergence of different problems of adolescents, their work experience in service provision, and observations on potential risk factors. While participants from Kyrgyzstan underlined the emergence of more suicidal cases, including an increase in suicidal ideation of younger children, as well as the high level of violence against children,

the participants from Slovakia brought up such issues as extremism, using drugs/smoking, and bullying/cyberbullying. Both countries agreed upon children's emotional instability and overuse of social media.

> "*I think, we need to pay attention to young people who are on social media all the time and talk about with specialists how to solve the issues. Because it's really a problem.*" (SV policeman)

The participants highlighted the challenges with the partnership on different levels emphasizing how weak the system of support for children at risk of suicide. In addition, Kyrgyzstan's specialists clearly voiced the lack of prevention activities at all levels, as well as the lack of legal and social support.

4.2.3. Discussion of Theme 1

In this theme, professionals from organizations in Slovakia and Kyrgyzstan expressed ideas and perceptions regarding the work of a multidisciplinary team that was quite comparable.

Participants generally defined a multidisciplinary team as a cohesive organization that works jointly and cooperatively to address a problem (*see Figure 1*). This is in line with the definition of the idea offered by Carpenter et al. (2003), who believe that a multidisciplinary approach enables professionals and clients to collaborate to develop meaningful procedures and solutions with adequate interventions. It is based on the connection and coordination of experts from one or more institutions and the client's active involvement. Further stressed is the fact that the team becomes more potent due to multidisciplinary teamwork, which also enables it to tackle more difficult tasks (Carpenter et al., 2003).

Figure 1: Word cloud on the understanding of Multidisciplinary Team essence (from ATLAS.ti).

The opinions of interview participants also supported the notion that teamwork is quite helpful in identifying and resolving a wide range of adolescent concerns, from ideation to augmentation of actual suicide instances. The participants frequently brought up the problems of bullying, drug and alcohol misuse, excessive social media use, and parent-child relationships throughout the interviews. The key risk factors, according to numerous international researchers, also include feelings of hopelessness or helplessness, acute loss or rejection, exposure to violence, impulsivity, aggressive or disruptive behavior, access to firearms, and family histories of suicide attempts (Wasserman et al., 2021; CDC, 2020; WHO, 2021).

It was also highlighted that the team's goal to serve in the frontline brings up a validated notion to the essence of the Multidisciplinary Team. Wigdorowitz and Hassem (2019) brings another model which describes the Multidisciplinary Team as a cohesive structure consisting of different tiers such as general practitioners (school and health workers) on the first level of intervention, child/school psychologists and psychiatrists on the second level, social workers on the third level. The authors say that although such a multidisciplinary approach may also lead to successful outcomes, a multi-tiered approach is necessary and beneficial when dealing with complex cases (Wigdorowitz & Hassem, 2019). Even though it might not necessarily correlate with the model of the teams in this particular study, this provides a broader picture of team's diversity and potentiality.

One of the team's goals was reflected in the purpose of prevention. The studies of Zalsman et al. (2016) and Wasserman (2019) highlight that among such prevention activities as physician education, restriction of access to lethal means of suicide, pharmacological and psychological treatment, school-based programs are also one of the most critical and influential evidence-based suicide prevention methods. This notion makes this empirical research very relevant and actual which helps to justify why suicide prevention should start from the school environment and whether multidisciplinary teams in educational settings contribute to the prevention of suicide.

Schools are the greatest setting for identifying and addressing juvenile suicide risk, according to Singer et al. (2019). More waking hours are spent by youth at school or in activities related to school than anywhere else, including home. Schools are a special setting where adults can observe and engage with children across a range of functions. Professionals working in schools have a distinctive view on what is typical throughout short and long periods.

Therefore, it was noted numerous times in the interviews that for the general prevention of suicide among young people, it is especially essential to implement a collaborative team approach because it targets the general population of adolescents who might be at risk for the development of suicidal ideation at the initial stage influenced by different social stressors. For example, Leeb et al. (2011) strongly emphasize the connection of suicide with other forms of violence. In their study, it is reported that youth who have been exposed to violence, such as child abuse, bullying, or sexual violence, are

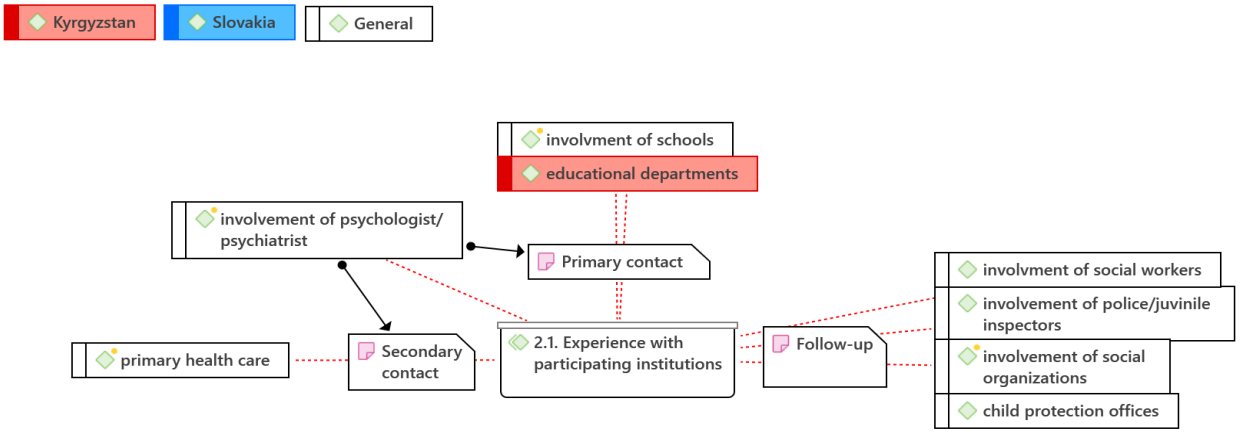
more likely to commit suicide (Leeb et al., 2011). Consequently, when the multidisciplinary team is composed of different professionals involved in the matter, the interests of the child is especially considered. Together with Kutash et al. (2014) the authors also point out that the success of a case is more likely to be complete if there is a strong connection with a child's family, school personnel, community leaders, social workers, psychologists, as well as a provision of adequate support and an easy access to health care (Leeb et al., 2011; Kutash et al., 2014).

Many interview participants confirmed that the work of Multidisciplinary Teams is successful when all components work as a united organism. Each interviewed specialist viewed their contribution to the team's mission depending on their own roles, knowledge level, experience, and cultural specifics. Apparently, the last intake plays a bigger role in traditional societies like Kyrgyzstan. It was observed that according to the opinions of interviewees from Kyrgyzstan, suicide is considered a taboo or forbidden topic, so this terminology is preferred to be avoided or mascaraed positively. In relation to this, Wasserman (2019) considers that it might hinder the implementation of preventive methods and potentially slow down the recognition of the problem by the government on the national level.

Generally, it is essential to gain a deeper awareness of suicidal communication and all specialists' joint work, the various ways it can be conveyed, and the impact that various responses can have on all spheres of society. This would help identify suicidal thoughts and behaviors more quickly, allowing for the deployment of suicide prevention strategies to reduce suicide.

4.3. THEME 2: THE ROLES OF SOCIAL INSTITUTIONS IN THE PREVENTION OF ADOLESCENT SUICIDE

4.3.1. Experience with participating institutions



Participants described their experience with different organizations which participate in the prevention of adolescent suicide from the following perspectives – *primary contact (schools), secondary contact (social and medical support), and follow-up (other organizations).*

The majority of interviewees affirmed the high involvement of a school as a central focal point in preventing adolescent suicide. The interviewees from Kyrgyzstan specifically emphasized the

involvement of educational departments and the necessity of coordinating any prevention activities with them even though it is sometimes very bureaucratic and formal.

> *"We directly work with the school to help identify kids who have some kind of social, psychological, or legal problems."* (KG social worker)
> "*In our school, we have our supporting team that consists of our social pedagogue, school psychologist, career counselor and coordinator for prevention, assistants of principals and special pedagogue*" (SV social pedagogue)

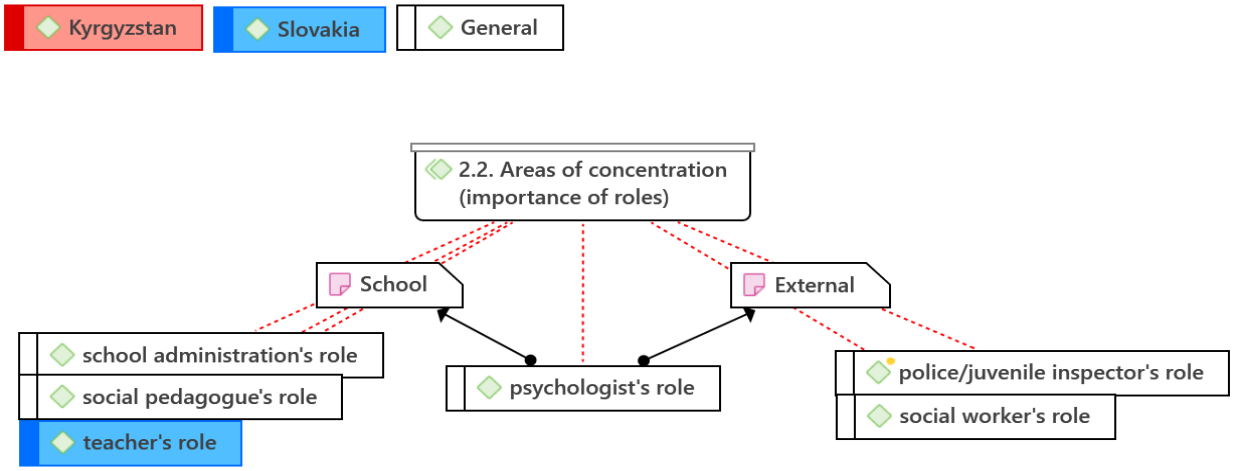
When there is a question about suicide prevention measures, interview participants highlighted the significance of the involvement of primary health care providers such as doctors, school/community nurses, child therapists, due to the peculiarity and sensitivity of the issue. Interestingly enough, psychological and/or psychiatric support was introduced at both levels – primary and secondary levels of points for more than half of the respondents. In most of the replies, the psychological/psychiatric role was strongly highlighted in terms of professional expertise and necessary reference in case of any suicidal cases or/and any augmentation of issues. In Slovakia, this specialist has a more structured position within the counselling facility of SCPP – a specialized center for counselling and prevention where the center's specialists work together with school personnel to assess difficulties in academic performance, assess risky behavior, and provide psychological support if needed.

> *"There are also psychologists. We work with them if there is a bigger problem… I think professionals, like psychiatrists and psychologists, should be more involved"* (SV policeman)

The social service organizations, including police, public organizations, social work, child protection offices are closely related to identifying problems in young people's families, evaluating teenagers' environments, and coordinating the efforts of all concerned specialists.

> *"We work with the child's natural environment, especially with the parents if possible, and we exchange information with other experts who work with the child - teachers, special pedagogue, psychologist, social worker, child psychiatrist. …. work with the department of social and legal protection of children to ensure the protection and monitoring of the child's family environment"* (SV director of children's organization)

4.3.2. Areas of concentration (importance of roles)



The areas of concentration are divided according to the level of importance of the roles followed by two main functions – *school functions* and *external functions.*

The school's role prevailed in most of the interviews as one of the significant areas of support in both prevention and later interventions. Respondents from both countries highlighted the huge role of social pedagogues and school administration in general prevention at the school level. It is interesting to note that Slovakian specialists emphasized the teacher's role a few times as the main role in dealing with prevention. It was explained that teachers and social pedagogues are separate positions at schools in Slovakia, while in Kyrgyzstan this role is very confused with the role of an ordinary teacher or a classroom teacher.

> *"Social pedagogue at school conducts individual work with such children, so they have to identify the children's problems at first"* (KG director of children's organization)

However, the roles of specialists outside of the school arena such as police, social workers, etc. were also brought up in specific cases when the client needed special support and when other specialists had already implemented their primary support functions.

> "*Policemen are involved when something happens really quickly, like if a child is standing on the edge or not, he trying already committing suicide. Or if the child is missing from school, and if there are some reasons that are leading to suicidal behavior, … if there's a suspicion of some suicidal attempt or something, social workers may come to the child's house and examine the situation. For example, if there is a child that is abused"* (SV social pedagogue)

Again, the role of psychologists was mentioned in both categories, as they are institutionalized in schools in Slovakia and urban schools in Kyrgyzstan, and less frequently provide separate expertise in most rural schools in Kyrgyzstan.

4.3.3. Discussion of Theme 2

In this theme, interview participants identified particularly important social institutions in Slovakia and Kyrgyzstan where the specialists work and have experience to collaborate to prevent adolescent suicide.

According to the literature review and empirical research, such teams usually are comprised of a few social institutions such as social pedagogue, social worker, school/child psychologist, police, children's center. In addition, other social elements were identified during the interviews. Those are school administration and other teachers, psychiatrists, medical facilities, child protection office, and family (parents, caregivers). Some institutions are strongly presented in one country, some are less. For example, as it was found from the research the system of support is more structured in Slovakia through the School Support Team, whilst in Kyrgyzstan those teams are more informal and connected more by personal networking connections. However, all of them are inclined to create a circle of

support and assurance of implementation of prevention activities in place following the regulation of local and national prevention strategies (*see Figure 2*).

Figure 2: Model of Multidisciplinary Team generated from the interview findings (adopted from Grant & Lusk, 2015)

It was revealed during the study that among those mentioned social institutions, the prevailed majority were the schools. The participants highlighted the work of school personnel as front-liners in identifying, assessing, and proceeding actions toward preventive interventions. This finding leads to a similar conclusion where Robinson et al. (2013) contemplate that universal suicide-prevention programs generally fall into the category of curriculum-based education programs, which aim to deliver interventions to whole school populations via the school curriculum. The school-based team typically consists of school and outside personnel with formal roles as a problem-solving unit in assessing risky behavior of the youth and environmental condition, connecting to additional clinical or non-clinical treatment as needed, as well as providing general education about suicidal ideation and behavior and training on bystander interventions. Gijzen et al. (2022) have proved to show promise within three months of post-test assessment and potentially also have effects on suicide prevention that are sustained over time. Furthermore, research indicates that initiatives that emphasize enhancing social and emotional abilities have a long-lasting positive impact on adolescents' mental health, particularly when they engage family members (Gijzen et al., 2022).

Today's multidisciplinary team may vary due to its change in social policies, society's needs, innovations, and the constant development in the professional background of specialists. The roles of each team member may also be fulfilled with different additional duties and responsibilities. For example, according to the interview results in a school setting the role of a teacher is identified as a highly involved team member who must be included in all levels of prevention. Moreover, a nationwide survey of school teachers has found that on the school level, teachers are

generally knowledgeable about warning signs and risk factors for suicide as they believe it is their role to detect students at risk for suicide (Nadeem et al., 2011).

In this regard, the interviewees from Slovakia supported the effective operation of the School Support Team, which was recently established as a structure to support the professional and pedagogical staff of the school. These staff members actively contribute to the development of an inclusive school culture and collaborate not only with students but also with teachers, parents, the local community, other professionals in the field of education, and professionals outside of the educational setting. According to Krnáčová et al. (2020), multidisciplinary collaboration enables staff to provide appropriate support for schoolchildren and increase their chances of success in a secure setting.

The participants believe it is reasonable to refer a case to a professional with more experience in cases of difficulty. Besides psychologists, both school-based and outsourced, these specialists are most frequently classified as psychiatrists, clinical psychologists, and medical personnel. This was not unexpected, since the work of multidisciplinary teams was primarily formed in the health sectors. The appearance of so-called "psychiatric teams" appeared in the 1950s when psychiatrists and psychiatric nurses, psychologists, social workers and occupational therapists formed such teams to arrange comprehensive treatment and care for mentally ill people (Martin, 1987).

It is pleasant to see the mention of the role of a social worker in each country's responses in spite of the experience where social workers are not employed in the schools. The study of Carpenter et al. (2003) reveals, however, that social workers' identification with the teams was no weaker than that of their other counterparts. Although the function of social workers in this study was less frequently emphasized than that of the educational staff, the social work institution still made a significant contribution. This current study has revealed, that the interviewed school personnel refer to social workers if there is a need to follow up with the cases (e.g. through therapeutic groups in Slovakia and work with the community in Kyrgyzstan). This helps establish a grounded practice for support which is needed from different professionals. However, there is still a gap and confusion in understanding the roles of social workers since the majority of the work is predominantly done by school personnel and, therefore, the capacity of social workers is not fully used. At the same time, Slovakian and Kyrgyztanian experience with social workers in the education setting might differ from the US practice where the social workers are allocated at schools. According to the exploratory study on school social workers' experiences with youth suicidal behavior in schools of the United States, those school social workers were able to intervene with, at least one student who threatened suicide (88%), attempted suicide (50%), was hospitalized for suicide risk (64%), or died by suicide (10%) (Singer & Slovak, 2011).

Other structures such as social organizations and police were highlighted in a number of interview responses as seemingly equal. Arensman et al. (2016) appeal that the creation of a locally coordinated,

systematic service delivery response network is crucial to guarantee that young people who are at risk of suicide receive prompt assessments, good care, effective follow-up, and thorough monitoring. Many communities have chosen to create proactive rules and policies that define the roles and duties of each service delivery organization. In Kyrgyzstan, the Department for the Support of Families and Children[26] is a structural governmental subdivision which is a specialized body for the rights and protection of children. They were mentioned to be involved when there was a need for a supervisory function. The Children Support Center was often mentioned as an organization that provides consistent support on all levels of interventions in reducing suicides among teenagers. In Slovakia, those functions were implemented by the Day Center for Children and Family and other non-governmental organizations. Police are also more frequently included in the work of the team in Kyrgyzstan under the Regulations on Commissions on juvenile affairs[27], one of the functions of which is to work closely with social protection services and schools to control crime level as well as to prevent any risky behaviors among young people. Those observations were significant for the Researcher as they revealed the different levels of involvement of team members in these two countries. It is yet unclear whether the frequency of involvement of police or/and social organizations in the team might depend on how strong the support system in the school (e.g. Slovakian School Support Team) or because of requirements of the national regulations (e.g. Regulations on Commissions on juvenile affairs in Kyrgyzstan).

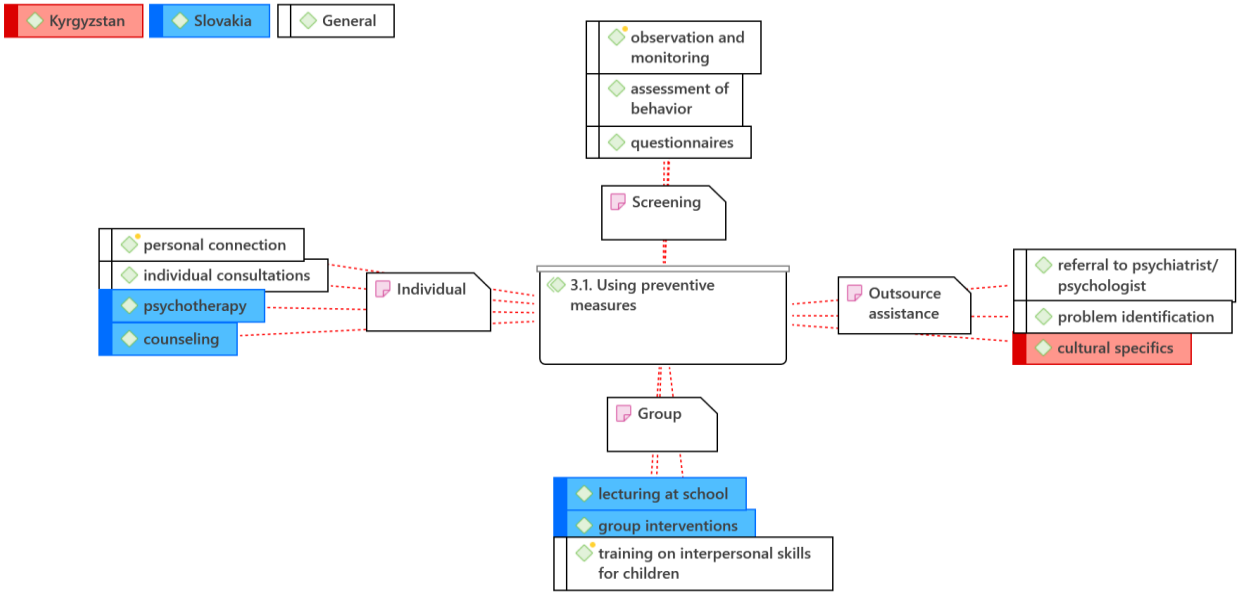
At this stage of understanding, it is believed that social institutions and their level of education and experience play a critical role in suicide prevention for adolescents. They can provide support and resources to help young people cope with the stressors in their lives, such as family problems, bullying, and mental health issues. Schools, social services, and community organizations can provide a safe and supportive environment for adolescents to talk about their feelings and get help when needed. Additionally, these institutions can provide education and awareness about suicide prevention and mental health, which can help young people recognize the warning signs of suicide and seek help before it is too late. Finally, social institutions can provide access to mental health services and resources, such as counseling and support groups, which can help adolescents manage their mental health and reduce the risk of suicide. By working together, social institutions can help to reduce the number of suicides in the society.

[26] The Department of Support for Families and Children, approved by the public administration of the Kyrgyz Republic, dated June 10, 2008 No. 285. Retrieved from http://cbd.minjust.gov.kg/act/view/ru-ru/59198/20?cl=ru-ru

[27] Government Decree on commissions on juvenile affairs. Approved by the Government of the Kyrgyz Republic, dated November 3, 2000 N 646. Retrieved from http://cbd.minjust.gov.kg/act/view/ru-ru/7746?cl=ru-ru

4.4. THEME 3: THE ACTIVITIES ON SUICIDE PREVENTION BY THE MULTIDISCIPLINARY TEAMS

4.4.1. Using preventive measures



Participants described various preventive measures which help them in suicide prevention among adolescents. They are grouped in the following aspects – *individual, group, screening, and outsource assisting.*

The majority of participants highlighted individual consultations as one of the most used and effective measures in preventing any risky behaviors, as well as building a strong rapport with children who are potentially inclined to suicide. Professionals from Slovakia especially highlighted such methods as counseling and psychotherapy.

> *"I prefer to work face-to-face with the child in my office, without notes and in a very friendly atmosphere"* (KG social pedagogue)

Specialists from both countries use screening methods and they found them tremendously useful, especially in the early detection of the problems.

On the group level, the professionals from both countries highlighted the usefulness of training for children on interpersonal skills, including communication, self-esteem, etc. Lecturing at school and therapeutic group interventions were mentioned numerous times by the Slovakian professionals.

> *"As a social worker, sometimes I am involved in preventive and intervention activities at schools (in school groups), discussions and activities to prevent the emergence of addictions and help children in groups to solve their relationship and class problems. Such activities help a lot in building a healthy relationship"* (SV social worker)

A number of the interviewees mentioned referral to another specialist in the team or externally in case of necessity for additional assistance. Among the list of such specialists, there was a child psychiatrist/psychologist.

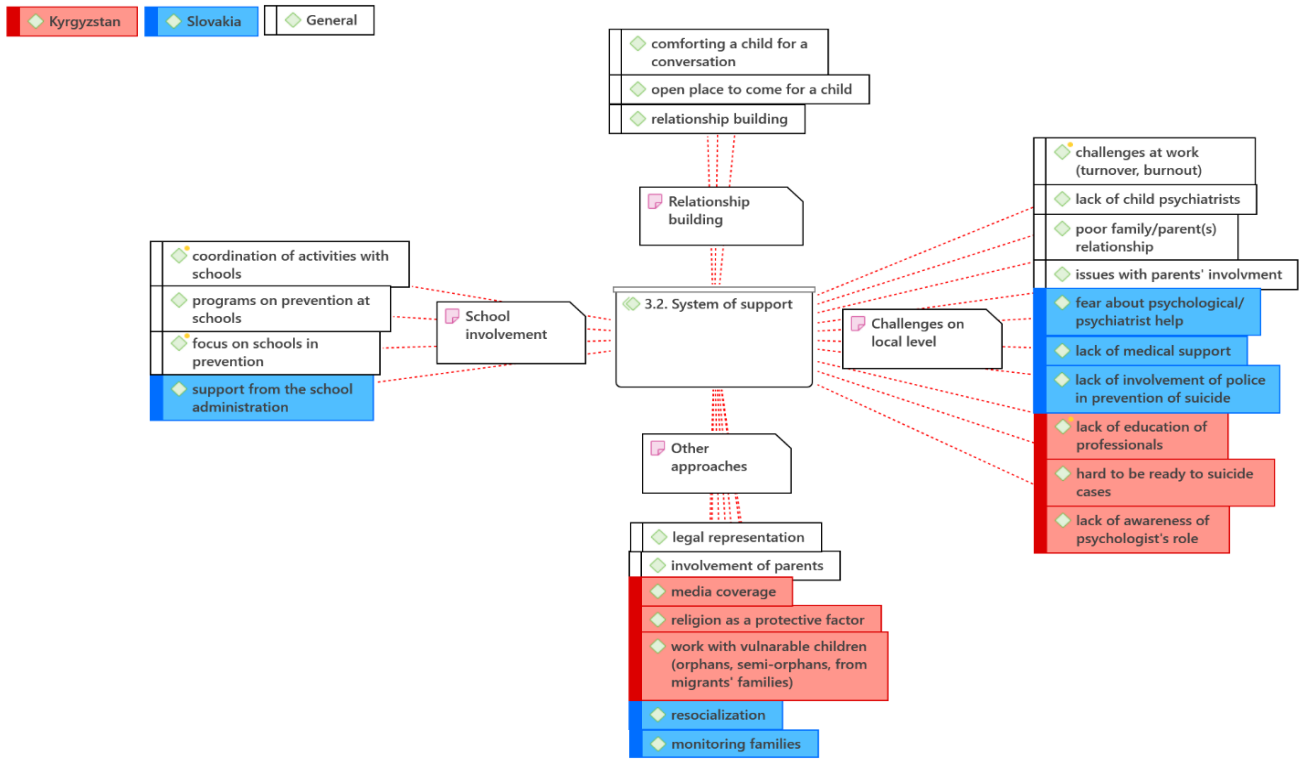
"The person who can help identify this further is a child psychologist. If you can find out through the psychologist what the child is really hiding, maybe there's a more serious reason for the suicide that requires legal intervention" (KG social worker)

Very often specialists are the ones who contribute to the "*primary detection of the problem at its origin*" (SV social worker). This helps to have the problem responded on time, offer support, help at the beginning of the problem and, as a result, prevent a tragedy.

The high importance of noting cultural specifics and using positive quotations instead of "suicide" was emphasized by numerous Kyrgyzstani specialists. This is explained by tabooing and stereotyping the term of suicide in a traditional community.

"We tell children to appreciate their lives, live healthy, positively, in peace with their families. We don't want them even to think about leaving this world by their own choice. Therefore, we don't use the word "suicide. Even though, this may seem not to make the problem less" (KG social pedagogue)

4.4.2. System of support



In this theme, participants highlighted the following groups – *relationship building, school involvement, challenges on local level* and *other approaches.*

It was revealed that all participants considered relationship building is number one in the prevention of any kinds of issues, including suicide prevention.

"Relationship is the number one. Every child should have at least one person in their life that they can go to and talk to" (SV psychologist)

The majority of interview participants consider that the school creates a supportive environment for preventive and interventive activities. Moreover, the participants indicated the existence of any

programs on prevention at schools. Slovakian participants indicated the importance of support from the school administration to build a cohesive support environment for school personnel.

> *"On any of our preventive activities, we have to consult with the school administration first. They explain the situation and we come to the class activity prepared"* (SV director of children's organization)

Other approaches were highly focused on parents' involvement as well as legal representation. The professionals from Slovakia brought up resocialization as one of the ways to help with activating the internal abilities of children who demonstrated risky behaviors to overcome the physical, psychological and social consequences of their actions. It connects closely with monitoring the families to help intervene from a different angle when needed.

At the same time, the professionals from Kyrgyzstan featured media coverage to effectively promote services of local organizations as well as post information about different social initiatives. Religion was brought up as a protective factor when trying to convince adolescents about reconsidering risky behavior during conversations with them. Also high importance was placed on close work with children from vulnerable groups such as orphans, semi-orphans, and migrants' families.

While discussing the system of support, all interview participants equally highlighted the challenges that they meet on the local level. These are problems at work (turnover and burnout of local staff), lack of child psychiatrists, poor family relationships, and issues with the involvement of parents.

> *"Parents are very important because children should come first to their parents when they have got a problem. And they should help to solve it. But the children don't find support in their parents"* (SV policeman)

Some interview participants from Slovakia mentioned that both children and parents experienced fear when there was a need for psychiatric assistance as this would bring unnecessary stigmatization around the diagnosis of mental illness. At the same time, they mentioned a lack of support from medical staff and police support as there are not enough specialists and they are overloaded with their primary responsibilities. On the contrary, some interview participants from Kyrgyzstan touched on the issue of a lack of educated professionals in the area of prevention as well as a deficiency of awareness of what psychologists' role is.

4.4.3. Discussion of Theme 3

In this theme, the interview participants described their own experience in implementing their roles in the teams presenting preventive measures they use as well as the creation of the system of support for adolescents in crisis or at-risk of crises.

Many specialists concur that prevention activities for diminishing suicide behavior at a school level can be framed around three main pillars – education, collaboration, and monitoring – in order to ensure that young people are provided with the necessary resources and support to prevent suicide (*see Figure 2*). Education is essential in order to raise awareness and understanding of suicide and its causes, as well as to provide students with the skills and knowledge to recognize when someone may be at risk. Collaboration is also important in order to ensure that all stakeholders in multidisciplinary teams – including social services, school students, teachers, administrators, community members and parents – are working together to create a supportive environment and to ensure that resources are available to those in need. And lastly, monitoring is necessary in order to track and measure the effectiveness of prevention activities, as well as to identify any potential areas of improvement. All these essential elements should work in coherence to ensure the success of the teams' work.

The interview participants described their experience in implementing their roles through preventive measures as both challenging and rewarding. They discussed the importance of creating a system of support for adolescents in difficult situations, and how they worked to ensure that the measures they implemented were useful and appropriate for the situation. This also led to the importance of providing resources and support to the adolescents and their families, as well as the need to create a safe and supportive environment for them. Additionally, it was highlighted how significant it is to collaborate and communicate between the team members to ensure that the measures they implemented are adequate and appropriate.

These findings tie nicely with the previous studies where, according to the United States Youth Risk Behaviour Survey (2019), the prevalence of suicidal thoughts and behaviours among high school students varies from 19% of those who seriously considered attempting suicide, 16 % of those who made a suicide plan, 9% attempted suicide and 3% made a suicide attempt that had to be treated by a medical worker. Therefore, prevention plays a huge role in interventions with suicidal youth. Still most existing suicide prevention programs in schools are considered universal and target the entire student population. This occurs primarily through the training of school personnel and students to be "gatekeepers." These trainings teach risk factors, warning signs, and help-seeking behaviors, should students be concerned about themselves or a peer (SAMHSA, 2020).

To implement the prevention activities, it is crucial to use appropriate tools and methods. In this theme, most of the mentioned screening tools were very basic, ranging from observations to simple questionnaires. In the practice of health and social service providers, there are known the following universal screening assessment for suicide risk, which is a standardized tool and an essential component of a comprehensive suicide prevention program. It is known that screening helps providers identify individuals who may be at risk and implement appropriate care and safety plans. According to research, school-based screening detects more at-risk individuals than professional screening does,

and some programs have had positive results in lowering suicide attempt rates (Stone & Crosby, 2014). There validated screening tools such as the Ask Suicide-Screening Questions (ASQ), the Columbia Suicide Severity Rating Scale (C-SSRS), and the Patient Health Questionnaire-9 Modified for Teens (PHQ-A) are well used in medical and other settings for youth and are usually conducted by licensed specialists, however, the adopted versions can be accommodated to the educational setting requirements.

Regarding group intervention activities, the participants emphasized the effectiveness of those methods in educational settings. This is also an opinion expressed by Singer & Erbacher (2019) where it is highlighted that universal suicide prevention programs for students can integrate awareness exercises, curriculum, and/or skill development focusing on healthy coping and other proven protective factors for suicide, such as improving problem-solving skills and fostering connectivity. For the successful implementation of those interventions, the interview participants noted that it is extremely important to build a strong system of support which includes relationship building with young people, as well as school involvement and other outsource assistance, among which parents take a leading place. This corresponds to the Interpersonal Theory of Suicide, where Joiner (2005) emphasizes the significance of interpersonal connections, social support, and environmental factors in mitigating the risks of suicidal ideation (Rodríguez-Otero et al., 2022). In addition, the literature study revealed that the success of a case is more likely to be complete if there is a strong connection with a child's family, school personnel, community leaders, social workers, psychologists, as well as a provision of adequate support and easy access to health care (Leeb et al., 2011; Kutash et al., 2014). Some of those concerns have been voiced as the main obstacles in the responses of the participants. Such close interactions with social institutions and the nature of the sensitivity of this topic may not get by without certain challenges. Numerous responses have brought up the issue with poor parent-child attachment. Bilsen (2018) highlights poor family relationships as one of the reasons for suicidal behavior. The findings are supported by the Bronfenbrenner's (1979) Ecological Model which describes relations between the child and the immediate environment such as family, school and peer group to be vital in formation of a child's personality and behavior. The social ecological model which encompasses multiple levels of focus from the individual, relationship, community, and societal, brings a useful framework for viewing and understanding suicide risk and protective factors.

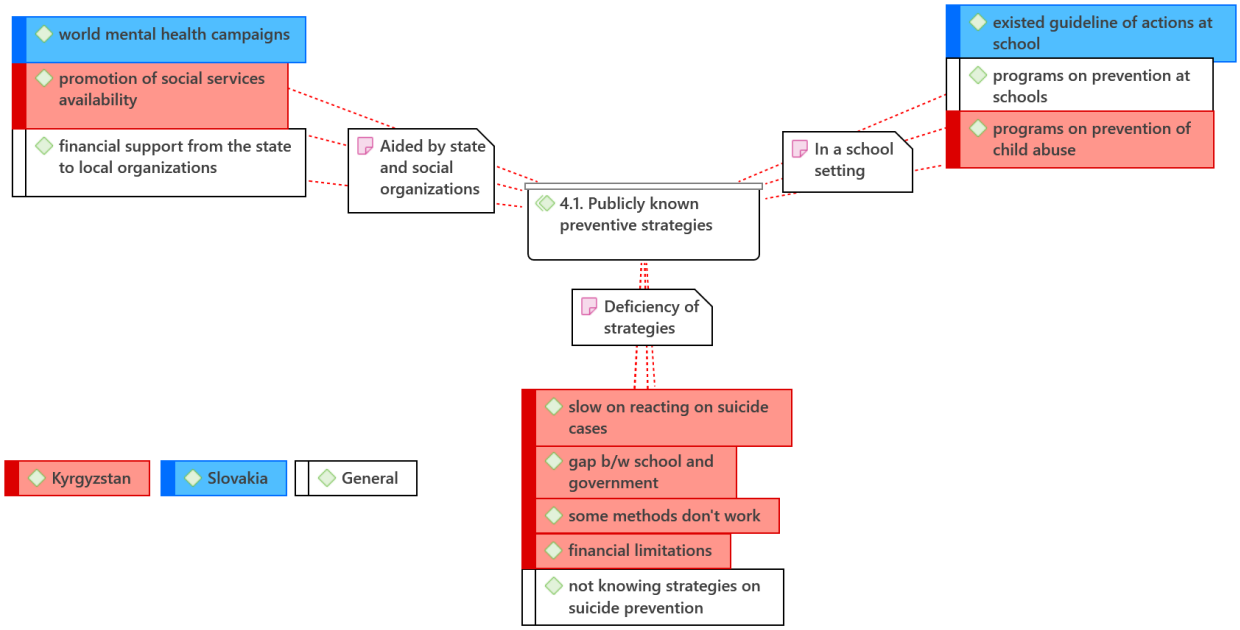
Again, it was interesting to observe different opinions from specialists from two countries. Due to different countries' priorities and levels of development, some answers especially stood out. For example, it was repeatedly noted that knowing and considering the cultural characteristics in dealing with suicidal cases is very important. In Kyrgyzstan, the specialists attached great importance to referring to religion as a way to create a "fear" in making something terrible and a preference for not using the word "suicide" to avoid temptations. Such findings corresponded to Durkheim's theory by

showing that membership in the Catholic Church exerted a protective effect against suicide (Durkheim, 1897 cited in Jones, 1986). The social integration paradigm of Durkheim, which he saw as the connecting factor between numerous particular empirical variables including the familial, religious, and governmental institutions, has been a widely held stance on suicide. The family and religious organizations occupied a significant portion of Durkheim's well-known analysis (Kołodziej-Sarzyńska et al., 2019).

In summary, the interview participants have demonstrated an outstanding commitment to the success of their teams and the implementation of preventive measures. They have also shown a great deal of creativity in creating support system tailored to their team's needs. It is obvious that the interviewees have a thorough awareness of the value of taking preventative actions and building a system of support for each person in their own way. Moreover, the success of the collaboration cannot be vivid without consistent monitoring of the progress and evaluation of actions. In spite of some obstacles and challenges at the workplace, their dedication and passion for their work is commendable and should serve as an example to others.

4.5. THEME 4: SUGGESTIONS TO IMPROVE THE WORK OF MULTIDISCIPLINARY TEAMS IN THE PREVENTION OF ADOLESCENT SUICIDE

4.5.1. Publicly known preventive strategies



According to the interview participants, the responses were grouped the following way - *in a school setting, aided by state and social organizations* and *deficiency of strategies.*

Almost all the informants considered that prevention should start happening primarily at school and both countries mapped various activities on the prevention that are organized in the educational setting. Moreover, in Slovakia, the schools follow the state guidelines of actions on the prevention of

different risky behaviors and how the school personnel should to react to those cases. In Kyrgyzstan, the participants highlighted the existence of programs on prevention of child abuse at schools.

> *"There is a manual for schools on prevention. The topic on suicides together with mental health is one of them. The schools are obliged to cover these topics. Sometimes it can be handled by a teacher of different subjects, but sometimes it can be a psychologist, sometimes they call policemen."* (SV psychologist)

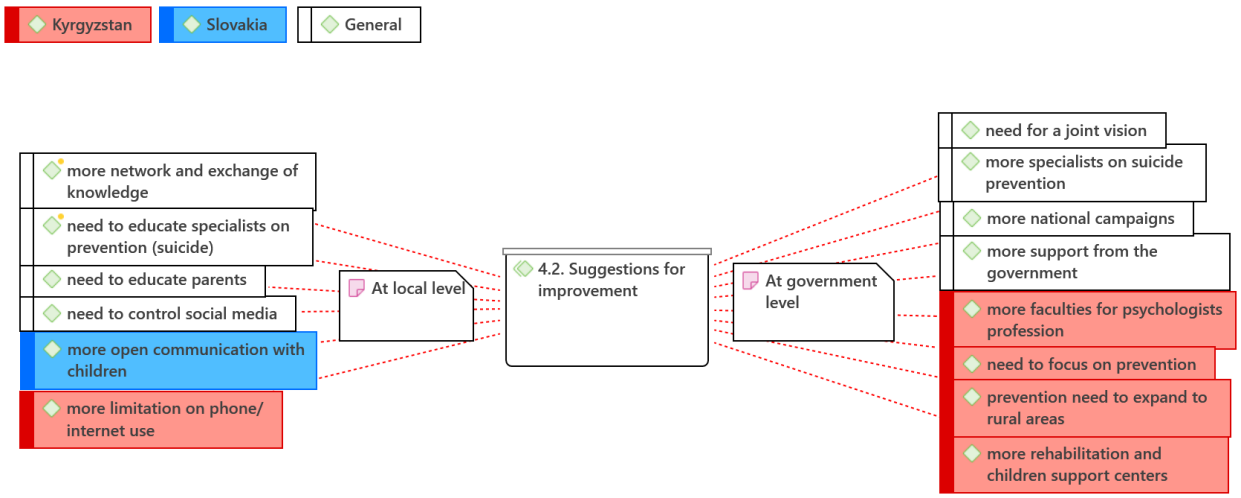
Besides schools, the interviewees noted the involvement of various social organizations and their valuable contribution to the prevention of suicide. Both countries indicated some financial support from the state to conduct prevention activities. The involvement of children's NGOs and centers was marked as a considerable contribution of co-financing, joint projects (e.g. mental health campaigns in Slovakia), and mutual support in promoting services (in Kyrgyzstan).

> *"There is some funding for professional workplaces working with children and youth, supports organizations and campaigns and programs to improve the mental health of children and youth" (*SV social worker)

Roughly half of the respondents reported that there is a vivid deficiency of activities on suicide prevention due to different reasons. For example, specialists from Kyrgyzstan indicated the problem of financial limitations for doing activities, a gap between the school sector and governmental support, as well as complaints about slow reaction of different specialists to the issue.

> *"Suicide prevention [in Kyrgyzstan] is not legislated. It's not enshrined that way, at least. I agree that we should name things by their proper names. But our mentality, however, doesn't allow it yet. That's why there is a lack of support provided"* (KG juvenile inspector)

4.5.2. Suggestions on improvement



Interview participants provided suggestions for improvement through two perspectives – *at the local level and at the government level.*

At the local level, almost all participants agreed that there is a high need for the provision of education and guidance to specialists on prevention methods, as well as parents on how to build

trusting relationships with their children at home, and teachers on how to communicate and support adolescents in a school environment. Some professionals highlighted the need to control young people's social media to better respond to primary signs of suicidality. Specialists from Kyrgyzstan especially suggested limiting phone and internet usage by adolescents.

> *"First of all, teachers, social workers must be equipped with information about up-to-date life situations. They must know what the reasons can be, what to pay attention to, how a child behaves, and whether there is any prone to suicidality. The specialists should be analytical!"* (KG social pedagogue)

The majority of the informants also agreed that there is a vital necessity to collaborate with each other and share joint vision and planning of national events. Moreover, government support in this regard should be even more explicit and consistent in the prevention of suicide among adolescents.

> *"Better connection, more communication and exchange of information between experts and especially more experts in first contact with children at schools, at facilities, on the street and training-education of already working teachers, youth workers about this issue."* (SV social worker)

At the government level, almost all participants indicated the necessity to have a joint vision and strategy to ensure cohesion of the actions, the regulation of which needs to be managed by the governmental structure. Other areas were also stressed as equally important such as a precondition of having more specialists working on prevention, more national campaigns to voice the issue of suicide in society, as well as support from the government on implementation of those activities on the local level.

> *"There has to be some kind of vision and strategy. I see that it has to be like this. But then again, there has to be a person who does this practically. It's just that when it's all assembled, it has a bigger picture of a sustainable mechanism."* (KG psychologist)

Specialists from Kyrgyzstan offered specific suggestions, emphasizing the necessity of developing additional university departments for psychology so that graduates will have incentives to work in schools and centers and receive fair wages. Also it was emphasized that more preventative efforts must be made, and they must also be extended to rural areas where there is a glaring lack of any prevention efforts. Only regional levels have Children's Support Centers, thus the Kyrgyz specialists recommended expanding this crucial service to additional regions.

4.5.3. Discussion of Theme 4

Participants in this Theme introduced their knowledge about different general preventive strategies as well as sharing their suggestions for improvement in this domain.

It has been widely observed that interview participants put a special emphasis on the implementation of different activities on the locally-based level, noting a necessity for better networking and sharing of knowledge among all of a team's members. While this argument has been mirrored in recent national government policies and guidelines of regulatory bodies of the Government of Slovakia (School Acts), the work of Support Teams (NP POP II[28]) at school serves as a pilot project and has just started in 2020. It is demonstrated in the interviews that the school personnel find it already very beneficial and impactful to have clear guidance and instructions regarding the actions towards preventive activities. Therefore, this initiative is suggested to be extended and expanded in the area of first contact with children at schools, and other facilities to better respond to the issue of adolescent suicide together with teachers, social workers, and other specialists.

In Kyrgyzstan, the situation is a bit different. Since the model of a Multidisciplinary Team works according to different internal documents of each service institution, the activities' cohesion is noticed to be not structured and formalized. Therefore, some participants indicated that either some of these methods do not work in place or they do not know that there are any activities held. In addition, it is crucial to remember that this assistance scheme only applies to urban areas and regional hubs; in rural areas, a different strategy must be used due to a lack of adequate resources, including human resources and the expertise of professionals (UNICEF, 2020).

Moreover, the interview notes correlate with the current situation of adopting the new Children's Code in Kyrgyzstan which includes protecting children and supporting families in difficult situations. The new draft version of the Code suggests a mechanism where different specialists including a social worker on children's protection would play a key role in detecting, monitoring and dealing with children in difficult situations (Makymbai kyzy, 2022). Unfortunately, the new version of the Children's Code is still under consideration of the government due to budget limitations and Kyrgyzstan still lacks social workers specialized on the issues of children and youth. As it has been noted by interview participants from Kyrgyzstan, this regrettably affects the work of social service providers in the field, which might cause a slow reaction to dealing on both prevention levels and when suicidal attempts or/and acts occur.

To improve the situation, the interview participants made some helpful suggestions which were stratified by two main areas of implementation – at the local and government levels. Although it is important to note, that those suggestions reflect the personal opinions and views of the interview participants only, these suggestions attract much interest and relevancy to the work of the multidisciplinary team in the prevention of adolescent suicide in Slovakia and Kyrgyzstan. This may also be explained from the prospective of the Ecological System Theory, where an individual is a

[28] National Project POP II. Retrieved from https://mpc-edu.sk/sk/project/pop2

product of a complex system, and the behavior is influenced by a variety of environmental factors that work together as a system. These factors include family, friends, social settings (school), religious structure, and economic class which can all influence how an individual acts and thinks (Bronfenbrenner, 1979; Bronfenbrenner, 1994; Gunn, 2020). This theoretical framework emphasizes the relational, societal, and communal aspects of the factors that contribute to an adolescent's vulnerability, highlighting these components as crucial to the creation of prevention strategies.

Despite seeming limitations and obstacles in implementing preventive strategies, it was observed that each specialist showed commitment to implementing the activities on the prevention of adolescent suicide on their level of control and obligation. Their suggestions for improvement are a great starting point for further exploration and action. It is vital to continue to work together to create a more supportive and understanding environment for adolescents, and to ensure that they have access to the resources they need. Educating specialists, building networks and exchanging ideas, and creating national campaigns that promote positive mental health and well-being is also necessary. By joining forces and creating a joint vision, it is possible to create a real difference in the lives of young people and help to reduce the rate of adolescent suicide.

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

Suicide is a significant public health problem that affects individuals, families, and communities worldwide. It is a complex issue that requires a comprehensive and multidisciplinary approach for prevention. This approach should include a range of strategies and activities to identify and intervene early, build young people's life skills and provide access to appropriate services and support. A multidisciplinary team approach to general suicide prevention should early-on involve collaboration among various specialists to ensure that individuals at risk of suicide receive the holistic care and support they need.

This qualitative study analyzed the system of the multidisciplinary team in preventing adolescent suicide in educational settings in Slovakia and Kyrgyzstan, as well as discussed the similarities and differences between these two countries. The following research questions were pursued in this study: to what extent do multidisciplinary teams contribute to the prevention of adolescent suicide in Slovakia and Kyrgyzstan; what are professional settings in the prevention of suicidal behavioral risks of adolescents in Slovakia and Kyrgyzstan; what are preventive activities focusing on the general prevention of adolescent suicide implemented by multidisciplinary teams in Slovakia and Kyrgyzstan; and what are the suggestions of various specialists on the improvement of the work of multidisciplinary teams in Slovakia and Kyrgyzstan. This study also aimed to reveal some gaps in practical implementation, successful practices, and constructing relevant and up-to-date knowledge around the concept of the multidisciplinary team in suicide prevention of young people.

Based on the outcomes of this study, it can be concluded that multidisciplinary team collaboration plays one of the key roles in tackling young people's issues, including in the area of suicide reduction. As it was revealed during the empirical research, Slovakia and Kyrgyzstan have different levels of practical implementation of multidisciplinary team concepts. The perspectives of various specialists interviewed in this study were framed around their personal experience, level of involvement, and knowledge. Therefore, the caution is issued that the conclusions should not be generalized to reflect the experiences of all specialists in multidisciplinary teams in Slovakia and Kyrgyzstan.

This study has found that already existing structures of multidisciplinary teams in both countries, more formally in Slovakia and less formally in Kyrgyzstan, aim to alleviate different young people's problems in society, such as violence at school, poor academic performance, poor family relationships, excessive use of social media, inner experiences, etc. As can be seen from the study, creating a protective environment with family and community support for young people strongly contributes to mitigating many issues of adolescents during their fragile period of upbringing. It is concluded that the prevention efforts require coordination among multiple social institutions with good governance

and leadership. Such form of collaboration enables knowledge-sharing, exchanges of methodology and lessons learned, sharing of suicide-related data and research, and coordinating messaging about suicide. However, it is still difficult to explain such results within the context of just suicide prevention activities as there are a lot of antecedents of suicide which require more critical observations and research.

The importance of the multidisciplinary team approach to the prevention of adolescent suicide can help address underlining etiologies of suicidal behavior of adolescents. By bringing together a variety of professionals from different disciplines, the multidisciplinary team is able to provide a comprehensive and integrated approach to understanding and addressing the issues that may lead to suicidal behavior. Within its competencies, resources and regulations, the team has all potential to identify and address the individual, family, and community factors to reduce the risk of suicidality among adolescents.

The school setting seems best able to adopt a holistic strategy and multidisciplinary approach to suicide prevention not only to lower the suicide risk factors but also to raise the possibility that children at risk would feel safe in and attached to a school, which, in turn, strengthens important protective elements against suicide risk. Specialists such as school personnel, social workers, child psychologists, police and children's organizations' representatives agree that prevention activities for reducing suicidal ideation and behavior at the school level work best when they are framed around three main pillars – education, collaboration, and monitoring. This is important to provide a holistic approach, ensure coherence of activities, and grow as professionals. Additionally, it is fundamental to consider the opinions of other social institutions and structures such as family, public health care, child protection offices which bring a valued vision for preventive activities.

There are still significant limitations and challenges in both countries, though, that must be overcome and tackled from a long-term, strategic perspective. Unfortunately, due to budget constraints in Kyrgyzstan, the likelihood of children's rights being violated increases significantly in the absence of social workers who specialize in defending children's and youth's interests. Slovakia might tackle issues more quickly and effectively if parents/caregivers are more involved in prevention as well as social workers are employed in educational settings.

The work of multidisciplinary teams on adolescent suicide prevention can be definitely improved locally and nationally. As stated by interview participants, on the local level, teams should be better integrated into existing mental health and social services and should be provided with adequate resources and training. Teams should also be better connected within a school setting and to other community organizations to ensure that adolescents can access appropriate resources and support from different angles. On the national level, more research should be conducted to better understand the risk factors for adolescent suicide and to develop effective prevention strategies.

This research is innovative in its originality and adds a valuable point in analyzing the system of work of the multidisciplinary teams in both countries and their contribution to suicide prevention among adolescents. As demonstrated with the example of School Support Teams in Slovakia, they are in a well-structured setting for implementing prevention efforts focused on raising awareness, identifying youth at risk through screening and observation, and providing referrals and intervention activities. Kyrgyzstan's example is less structured but no less effective in spite of some limitations and lack of clarity of roles and responsibilities. Moreover, for a country with seemingly limited resources such as Kyrgyzstan, this type of collaboration may provide a starting point to work opportunistically with what is already available and within the cultural context.

The best results come from proactive efforts integrated with multiple professionals and their joint vision and initiatives.

IMPLICATIONS AND RECOMMENDATIONS

Based on the findings of this study, the following recommendations have been made and proposed on the level of policy and practice in Slovakia and Kyrgyzstan, as well as implications for social work practice and future research and perspectives.

Policy and practice

For Slovakia:

1. To reinforce the system of School Support Teams by expanding financial and methodological support by the Ministry of Education and other stakeholders.
2. To institutionalize the role and functional duties of a School Social Worker in the educational setting to better monitor, assess and intervene early-on in suicide prevention.
3. To improve the level of involvement of parents/caregivers as a family support system to safeguard monitoring and collaboration with specialists.
4. To invite police for active participation in the team to ensure prevention measures from a legal perspective and to build rapport with young people for outreach support.
5. To increase acknowledgement of the problem of adolescent suicide and start formulating a coordinated strategy for nation-wide suicide prevention efforts.

For Kyrgyzstan:

1. To strengthen the work of multidisciplinary teams by formalizing the procedures and standards on the national level.
2. To institutionalize the procedures and policies to support the role of a Social Worker, specifically working on the protection of children's and youth's interests.

3. To institutionalize the position of a School Psychologist in all schools (not only in the two main cities) across the country to help ensure a specialist's early-on and professional involvement in dealing with difficult cases, including suicidal ideation among adolescents.
4. To encourage culturally appropriate discussions about youth suicide and its risk factors to expand the availability of information regarding all areas of preventing adolescent suicide to the general public and professionals.
5. To reinforce the establishment of the integrated data collection system to better identify at-risk groups, individuals, and situations.
6. To improve the system of early identification, assessment, intervention, and referral of young people at risk of suicidal behaviors for professional care when needed.

Social work practice

As it was found from literature review and empirical study, among other team specialists, social workers were found to be in a unique position to identify and intervene with at-risk youth either in educational settings or/and community outreach, and provide support to those who had been affected by suicide. This hardship was undertaken in spite of some issues with the lack of clarity of social workers' role and the low prioritization of their work functions. Social work practices can be even further strengthened by including individual and family counseling, connecting clients with appropriate resources, and providing crisis intervention. Additionally, social workers have the potential to provide education and training to school personnel, community members, and other professionals on suicide prevention and intervention. In this regard, having social workers in multidisciplinary teams with certain skills and experience in working with children and youth is mentioned to be essential in the prevention of adolescent suicide. It is vitally significant that the teams work collaboratively to develop and implement suicide prevention strategies together with school personnel, mental health professionals, police, and other community members who can provide support and resources to at-risk youth. Even though this study primarily invited opinions from different specialists in the teams, the social work organization was mentioned quite frequently with the notion of the important contribution to the joint work in suicide prevention. This may explain why social work practice should be continued to be included in the work of multidisciplinary teams when dealing with different issues of young people.

Future research and perspectives

Even though this study has contributed significantly to constructing the literature and empirical base of adolescent suicide issues, future studies should continue to investigate the following areas of research:

1. **The existence and effectiveness of training program for gatekeepers**: Future research should explore what training program exists to prepare gatekeepers (teachers, social service providers, police, health workers, parents, etc.) and their effectiveness to better identify youth with suicidal behaviors and any other at-risk behavior in Slovakia and Kyrgyzstan.
2. **The impact of social work services on suicide prevention**: Future research should explore different approach of social services in preventing suicide among adolescents in Slovakia and Kyrgyzstan. This could include examining the impact of social work on suicide rates, as well as exploring the effectiveness of social services and interventions on decreasing the rate of suicide among adolescents.
3. **The role of family and community in suicide prevention**: Future research should investigate the role of family and community in suicide prevention among adolescents in Slovakia and Kyrgyzstan by examining the impact of family and community support on diminishing suicide rates. This may also include exploring the effectiveness of different types of interventions where family and community members are involved.
4. **The impact of cultural and religious beliefs on suicide prevention:** Future research may focus on how different cultural and religious beliefs shape attitudes towards suicide, how they influence the way people respond to suicidal behavior, and how they can be used to create effective suicide prevention strategies. Additionally, research could explore how cultural and religious beliefs can be used to create more inclusive and effective suicide prevention programs, especially to help adolescents in conservative societies like Kyrgyzstan and examine how cultural and religious beliefs can be used to reduce stigma and increase help-seeking behavior among those at risk of suicide.
5. **The influence of media and technology on suicide prevention:** This is relatively new domain of research which hasn't been investigated enough. Therefore, future research may contribute to understanding on how media and technology can be used to support suicide prevention efforts, such as through the development of online support networks, the use of social media to spread awareness and provide resources, and the use of technology to monitor and intervene in cases of suicidal ideation among young people. This may also include exploration of the potential risks associated with the use of media and technology in suicide prevention, such as the potential for cyberbullying or the spread of misinformation.

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APPENDICES

Appendix A - Interview Guide Template

Introductory Statement:

Dear colleague, let me express deep gratitude for agreeing to participate in my research which is a part of my Master Thesis topic "MULTIDISCIPLINARY APPROACH TO SUICIDE PREVENTION OF ADOLESCENTS" within Erasmus Mundus Joint Master Program ESWOCHY. This interview is intended to find out your level of involvement in dealing with prevention of adolescence suicide, practical implications of country's policies, defining roles of each specialist in this field and your collaborative experience with other professionals, possible solutions and limitations. The participants for this research were selected by purposive sampling with the help of professional network in Slovakia and Kyrgyzstan. The participation in this interview is voluntary and confidential. You may ask any questions during and after the interview. You will be asked to sign the Informed Consent Form before the interview. You also have the right to withdraw yourself from the interview if you wish. The results of the analysis will be shared on the universities platforms, on research websites and will be provided to you upon your request.

Socio-demographic Information (not for recording):

Country: _____

Profession: _____

Education: _____

Place of work: _____

Years of experience: _____

Core Questions for the Interview (for recording):

1. ***What is a multidisciplinary team in your opinion?***
   Probes:
   a. *Please, share your personal understanding.*
   b. *In your opinion, what does it mean in relation to social and educational settings?*
   c. *What is/should be the level of contribution of the team in the prevention of adolescent suicide?*

2. ***In your opinion, how does/can it help to prevent suicide in your country?***
   Probes:
   a. *What are the general approaches in prevention can you name?*
   b. *How it can help in the work with children and adolescents?*
   c. *Can you share any personal experience?*

3. ***From your experience, who is usually involved in the prevention of suicide among adolescents in your country? What are the roles of each professional? What activities do they usually implement?***
   Probes:
   a. *What cultural specifics in the work of prevention do you notice?*
   b. *What is your personal experience in collaborating with different specialists?*

c. *Are/were there any successes and challenges?*

4. ***What does your job as a ….. entail?***

Probes:

a. *What are functions on paper and how do those functions work in reality?*
b. *Tell about your personal challenges? Welcome to share any stories.*
c. *What are the issues in the professional sphere?*

5. ***What kind of institutions are involved in suicide prevention in your country? What are their main functions?***

Probes:

a. *What is the level of involvement of these social institutions in a work of a multidisciplinary team? Who is more or less involved, in your opinion?*
b. *How do you see the involvement of other institution to be also included?*
c. *How well do they understand their roles and functions in practice?*
d. *How do their functions correlate with the regalements or protocols or prevention programs? Any obstacles in this regard?*

6. ***As a …… when you witness suicidal behavior in an adolescent, what is the algorithm of preventive measures do you undertake (or suggest to undertake) in order to support an adolescent? Who is usually involved? Who else needs to be involved, in your opinion?***

Probes:

a. *What tools and techniques do you personally find helpful in your work with young people? Are they your personal inventions?*
b. *What best practices can you share with me that are definitely worth sharing?*
c. *From your experience, how does the system of support should work best inside of the team?*

7. ***If you personally don't feel comfortable working with adolescents with suicidal thoughts, who are other professionals do you refer for help?***

Probes:

a. *Please, share any personal coping strategies in case of challenges.*
b. *Please, describe how the referral helps/ed build the system of support.*

8. ***What suicide prevention strategies are made by the government of your country?***

Probes:

a. *What do you know about national campaigns in suicide prevention in your country?*
b. *What national programs and strategies are in place in your country? How beneficial are they, in your opinion?*
c. *Tell me more if you know of any initiation of laws and decrees in relation to reducing adolescent suicide in your country? How do they contribute to the prevention of adolescent suicide?*

9. ***From your professional experience, what do you recommend to improve the work of the multidisciplinary team(s) working with adolescent suicide in your country?***

Probes:

a. *What implementation challenges in the work of multidisciplinary teams have you noted in your work? Differences on local and national levels?*
b. *What are your personal perspectives regarding the issue of adolescent suicide and its prevention in your country?*
c. *What do you suggest to strengthen the work of a multidisciplinary team in suicide prevention?*

10. Is there anything you would like to tell me about which I haven't thought to ask you?

Probes:

a. Please share any of your personal stories if there are any worth sharing.
b. Anything else, that has not been covered by these questions yet?

Thank you for your time!

Appendix B - Informed Consent Example

Dear Participant,

My name is Leila Salimova, a Master's Degree student of the Erasmus Mundus Joint Master Program "Social Work with Children and Youth (ESWOCHY)". This study is aimed at exploring the place of the multidisciplinary team in the prevention of adolescent suicide in Kyrgyzstan and Slovakia. I appreciate your participation; however, your participation is voluntary. Please note that information obtained will be treated with confidentiality and you have the right to withdraw at any time during your participation without any consequences. Kindly give honest responses as any wrong information may affect the validity of the results obtained for this research. Only the Researcher will have access to this information. Thank you for taking part!

Statement of study participant giving informed consent:

Now that the study has been well explained to me and I fully understand the content of the study, I hereby agree to participate in the study.

Date ..……/……/……. Signature…….…….

Appendix C - Non-plagiarism declaration

Submitted to the Erasmus Mundus Master's Programme in Social Work with Children and Youth:

- Has not been submitted to any other Institute/University/College
- Contains proper references and citations for other scholarly work
- Contains proper citation and references from my own prior scholarly work
- Has listed all citations in a list of references.

I am aware that violation of this code of conduct is regarded as an attempt to plagiarize and will result in a failing grade in the programme.

Date: May 30th, 2023

Signature: Leila Salimova

Name: LEILA SALIMOVA