Original Article

Perceptions of Suicide Prevention Measures among Japanese Junior High School Teachers

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Background: Student suicide rates have been increasing in Japan since 2009, rising sharply in 2022. Schools are crucial sites for intervention in youth suicide; however, little is known about how teachers approach the risk of student suicide.

Objective: This study aimed to understand junior high school teachers' perceptions of suicide, how they detect signs of suicide in their students, and their resistance to and difficulty in implementing suicide prevention measures. Further, the study also sought to uncover how to support collaboration between junior high school teachers and nursing professionals.

Method: We conducted semi-structured interviews with ten in-service middle school teachers across Japan. Data were analyzed using a qualitative inductive procedure to extract codes, which were then organized into categories and subcategories.

Results: Eight men and two women with a mean age of 44.0 ± 6.6 years participated in the interviews. The analysis revealed 107 codes related to existing suicide prevention measures, organized into four categories (early detection and preventive measures for students at risk, creating an environment conducive to reporting distress, strengthening the cooperation of counseling and support, and improving skills and abilities for suicide prevention); 68 codes related to suicide risk were organized into six categories (behaviors and actions that could lead to suicide, school refusal and bullying should be monitored, unstable family life, poor relationship-building skills, death of someone close, and trivial and unknown omens); and 86 codes related to teachers' resistance and barriers to suicide prevention measures were organized into four categories (anxiety about dealing with suicide, difficulty with dealing with diverse issues, lack of awareness regarding suicide prevention, and lack of a support system).

Conclusion: The findings suggest that it may be helpful to introduce school consultation opportunities for nurses to reduce teachers' resistance to suicide prevention education; further, using the nursing profession's knowledge in mental health and other counseling services to support teachers may be effective.

Keywords: suicide prevention, students, teachers, nursing professionals, Japan

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I. Introduction

The suicide rate in Japan was high for several decades, exceeding 30,000 in 1997-1998, before beginning to decline in 2009. While the historical decline in Japan's suicide rate suggested a drop to below 20,000 in 2019, it notably began to increase again in 2020[1]. Meanwhile, the suicide rate (number of suicides per 100,000 people) among young people aged 10-19 years steadily declined until 2008, but by 2020, had risen by 100 from the previous year to 499, with a particularly marked increase among female high school students. In 2022, it reached a record high of 514 (17 elementary, 143 junior high, and 354 high school students)[2]. Although the suicide rate across all ages decreased by approximately 33% between 2006, when the Basic Law on Suicide Prevention was enacted, and 2022, when the government took comprehensive measures to prevent suicide, the student suicide rate increased by approximately 70% during this period, showing that trends in student and adult suicide

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differ in Japan.

A study examining suicide attempts among junior high school students using hospital records found that although over half of the attempts were directly caused by school-related problems, 80% of these students were experiencing family problems[3]. This indicates that suicide prevention measures must be devised by considering multiple disciplines. In a study on multidisciplinary cooperation in schools, Ozaki et al.[4] recommended the promotion of a "school team" comprising professionals from different fields, with duties divided to prevent excessive workload; notably, the report describes a vicious cycle, wherein teachers feel burdened due to the lack of a spare time before they realize the benefits of collaborating.

Studies have also been conducted on collaboration between teachers or school nurses and school counselors (SC), school social workers (SSW) [5][6], SC and teachers[7], and SC and medical institutions[8], as well as other professionals. However, studies on collaboration between nurses (including public health nurses), SC, and SSW are lacking[9]. To our knowledge, few peer-reviewed studies have been done on collaborations with nursing professionals to support school health in Japan. As a nursing professional at a medical institution attended by the students and their families, we presume that collaboration is taking place with the students and their families, but the same is not mentioned in the practice report. We believe that collaborations between medical and educational professions hold great potential for preventing student suicide (e.g., such collaborations could focus on the importance and preciousness of life, how to access support, the elements of mental health and mental health disorders, and appropriate responses to declines in mental health).

Undoubtedly, some teachers would prefer to avoid the issues of suicide and death[10]. Prior research indicates that the national implementation rate of suicide prevention education is only 1.8%, partly due to resistance to using suicide-related terminology[11]. Other reasons for the low rate of suicide prevention education include: "small number of teachers with knowledge and experience," "difficulty of considering consideration to children who have experienced bereavement," "lack of curricula and teaching plans," and "difficulty in arriving at a common understanding among teachers regarding teaching"[12]. Further, such interventions may also be inhibited by the fact that many parents and community members react negatively to the mere mention of suicide[13]. Teachers' concerns in implementing suicide prevention education were related to the "image" of the content, their understanding of the "need" for such education, their "sense of efficacy" in implementing it appropriately, and their "sense of anxiety" about its negative effects[14]. Previously, we surveyed junior high school students to investigate the relationship between pro-suicide states, and lifestyle habits and behaviors believed to be factors of suicide[15]. Notably, we found that teachers had difficulty understanding our research on suicide and strongly resisted asking students about suicide, worrying that it would put the idea into their minds and expressing uncertainty over what they would do if the survey revealed problems. The Basic Law on Suicide Prevention, revised in April 2016, mandated that schools engage in suicide prevention education, and the Comprehensive Suicide Prevention Program Outline, approved by the Cabinet in July 2017, further obligated efforts to implement "suicide prevention education in cooperation with universities, vocational schools, etc." Based on the above, it is necessary to confirm the thoughts of teachers around suicide prevention measures in education to determine how best to engage them in such efforts.

II. Objective

The purpose of this study was to understand the perceptions of junior high school teachers about suicide, how they detect signs of suicide risk in their students, and their resistance to and difficulty in implementing suicide prevention measures. Further, the study also sought to uncover measures to support collaboration between junior high school teachers and nursing professionals[1].

III. Methods

1. Study Participants

The target participants included all in-service teachers (including teachers, school nurses, principals, and vice principals) at junior high schools across Japan. Part-time lecturers, former teachers, and others who were in-service but not working full-time were excluded.

1 Nursing professionals are defined as nurses, public health nurses, and midwives specializing in the field of school health.

2. Data collection method

A research company (Neo Marketing Co., Ltd.[2]) was engaged to recruit participants for the study. Eligibility was confirmed using a web-based questionnaire comprising items that asked participants whether they used Zoom and a webcam; their sex, age, job title (and position); years of teaching experience; the grade level in which they have homeroom experience; and their desired date for an interview. Based on the results of the survey, we prioritized participants as follows (in order of highest priority to lowest): 1) were available to interview with the researcher on the designated date and time, 2) were willing to be interviewed on Zoom with the web camera turned on, and 3) had experience as a homeroom teacher. The researcher selected the participants. Subsequently, the research firm collected the participants' consent and tested the Zoom connection. Each participant was interviewed only once. Data were collected through individual semi-structured interviews on Zoom using an interview guide. One author conducted all the interviews. Interviews were recorded using a voice recorder and the Zoom record function with the consent of the participants. Recorded data were deleted immediately following the preparation of verbatim transcripts. After the interview, participants were given a shopping card as honorarium by the research company.

The interviews aimed to discern the participants' perceptions of suicide; experience in perceiving signs of suicide; and their concerns, difficulties, and reasons for any resistance regarding student suicide prevention measures. Data were collected from March to April of 2023.

3. Statistical Analysis

Data were analyzed from three perspectives: suicide prevention measures implemented in junior high schools, ways of perceiving suicide risk, and resistance and difficulties in implementing suicide prevention measures, with reference to Yatsu's[16] qualitative description procedure.

(1) Creation of codes: After making a verbatim transcript of each study participant and reading it carefully, we extracted it as a single sentence for each analytical viewpoint. Then, the extracted one-sentence was made into a concise one-sentence so that the semantic content could be understood. The concise one-sentence sentences were then classified, organized, and integrated into a code.

(2) Extraction of subcategories and categories: Subcategories were created by focusing on the similarities in the semantic content of the individual codes, organized in the previous step, of all study participants. In addition, categories were extracted by raising the abstraction level along the similarities and differences of the subcategories.

The entire analysis was conducted by two researchers with expertise in qualitative research. Interview data were repeatedly and closely read, and findings presented and discussed in conferences to ensure their validity. In addition, the analysis phase was supervised by a certified nurse educator and expert in qualitative research, to further ensure the validity of the results.

4. Ethical considerations

When contacting potential participants, the principal investigator explained the purpose of the research, the expected benefits and disadvantages for the participants, and methods to minimize the latter, both orally and in writing. We explained that participation was voluntary, that the participants would not face any negative consequences if they did not consent, and that they could withdraw their consent at any point. Further, we advised them that their data would be used only for this study and not for any other purpose, and that their identity would be protected in any ensuing publication. Personal information was processed in symbolic form, and the personal computer used in the study was set up with a PIN code to prevent others from logging in. The study was approved by the Ethics Committee of the Division of Epidemiology and General Research on Human Subjects in Life Sciences and Medicine at the Kumamoto University (Ethics No. 2677).

IV. Results

1. Summary of Study Participants

A summary of the participants' details is presented in **Table 1**. There were ten participants (eight men and two women) with a mean age of 44.0 ± 6.6 years. The participants' mean teaching experience was 16.0 ± 9.0

2 This company has built one of the largest panel networks in the country and is able to conduct surveys on subjects who meet specific criteria.

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Table 1 Participant demographics

Participants	Sex	Age	Years of teaching experience	Grade level in which they have had homeroom experience
A	Male	40-49	15	All
B	Female	30-39	2	1st and 3rd grade
C	Male	50-59	34	All
D	Male	40-49	14	All
E	Male	40-49	13	All
F	Male	50-59	30	All
G	Male	30-39	7	All
H	Male	40-49	15	All
I	Male	30-39	14	All
J	Female	30-39	16	All

years. All participants had homeroom teaching experience prior to the interview. The average interview time was 46 minutes (35-60 minutes).

2. Junior High School Teachers' Perceptions of Suicide

The analysis extracted 107 codes from the verbatim transcripts related to suicide prevention measures implemented in the participant's middle schools, which we classified into four categories: "early detection and preventive measures for students at risk," "creating an environment conducive to reporting distress," "strengthening cooperation for counseling and support," and "improving skills and abilities for suicide prevention" (**Table 2**).

Regarding perceptions of suicide risk, 68 codes were extracted from the verbatim transcripts and classified into six categories: "behaviors and actions that could lead to suicide," "school refusal and bullying should be monitored," "unstable family life," "poor relationship-building skills," "death of someone close," and "trivial and unknown omens" (**Table 3**).

In terms of resistance to and difficulties experienced regarding suicide prevention measures, 86 codes were extracted and classified into four categories: "anxiety about dealing with suicide," "difficulty with dealing with diverse issues," "lack of awareness regarding suicide prevention," and "lack of a support system." (**Table 4**).

The categories and subcategories, along with a few key codes exemplifying them, are listed in **Table 2-4**. Each theme is described below.

(1) Suicide prevention measures implemented at the participant's junior high school

The category of "early detection and preventive measures for students at risk" that promote coping comprised five subcategories associated with prevention. "Understanding bullying" was described as identifying cyberbullying through an easy-to-fill tablet questionnaire thrice annually. "Identifying at-risk students" included sharing information on at-risk students and keeping an eye on students who write things such as "I want to die" or "I don't think my life has meaning." "Sensing differences from the usual" involved noticing any unusual behavior and talking to students. "Observing a sense of crisis on a daily basis" included checking in with students about their experiences with bullying such that anti-bullying interventions could be implemented, if necessary. "Conveying the importance of life" included education about life throughout the three years of junior high school, including suicide prevention and the value of life in terms of morality.

Meanwhile, the category, "creating an environment conducive to reporting distress" comprised five subcategories. "Assistance in building friendships" included school counselors' efforts to help students make friends. "Creating a comfortable, safe, and welcoming place for students" included making the counseling office a safe place in the school. "Aiming for a relationship where students can express their true feelings" involved talking to students showing signs of being at risk during

Table 2 Suicide prevention measures implemented at the participant's junior high school

Categories	Subcategories	Example codes*	N**
Early detection and preventive measures for students at risk	Identifying at-risk students	Keeping an eye on students who write things such as "I want to die" or "I don't think my life has meaning"	18
	Conveying the importance of life	Education about life throughout the three years of junior high school, including suicide prevention	10
	Understanding bullying	Identifying cyberbullying through an easy-to-complete tablet questionnaire that is administered thrice annually	8
	Sensing differences from the usual	Noticing any unusual behavior and talking to students	6
	Observing a sense of crisis on a daily basis	Checking in with students about their experiences with bullying such that anti-bullying interventions could be implemented if necessary	5
Creating an environment conducive to reporting distress	Aiming for a relationship wherein students can express their true feelings	Talking to students showing signs of being at risk through extended interviews	9
	Making any adjustments necessary to facilitate consultations with students	Asking students to complete a questionnaire about their lives at school and subsequently addressing any issues highlighted by the questionnaire with the teacher of their choice	7
	Assistance in building friendships	School counselors' efforts to help students make friends	5
	Creating a comfortable, safe, and welcoming place for students	Making the counseling office a safe place in the school	4
	Disseminating consultation services	Informing young carer students of outside sources of advice	3
Strengthening the coordination of counseling and support	Connecting with a school counselor	Individual counseling and referral to a counsellor	9
	Cooperating with external organizations	Connecting with counselors and experts	6
	Sharing concerns about students with their parents	Asking parents to share their concerns in individual interviews	5
	Connecting with a school nurse	Students are most likely to rely on the school nurse for support	5
Improving skills and abilities for suicide prevention	Sharpening responses	Acquiring skills, such as self-assessment and assertion, with the assistance of an outside counselor who could engage in role-play	4
	Receiving training in suicide prevention	Counseling and supervisory training is provided	3

* Only one typical code is listed.
** Indicates the number of codes.

more extended interviews. "Making any adjustments necessary to facilitate consultations with students" included asking students to complete a questionnaire about their lives at school and subsequently addressing any issues highlighted by the questionnaire with the teacher of their choice. "Disseminating consultation services" included informing young carer students of outside sources of advice.

Further, the category, "strengthening coordination of counseling and support" was extracted from four

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Table 3 Perceptions of Suicide Risk

Categories	Subcategories	Example codes*	N**
Behaviors and actions that could lead to suicide	Self-injurious behavior	Repeated wrist cutting, and going up to the roof of the school	6
	Expressions related to death	The need to urgently engage with students who write things with frequent use of words such as "death" or "kill"	2
	A history of psychiatric visits	At-risk students attending psychiatry consultations	1
School refusal and bullying should be monitored	Refusal to attend school	Students who are not attending school and students who situate themselves as at risk for suicide	4
	Bullying	Suicide is derived from bullying	3
Unstable family life	Poor parent–child relationship	Students with poor relationships with their parents are in danger	3
	Delinquency	Students who run away from home are at risk	3
	Suspected neglect	Watching students with stained shirts and store-bought rather than homemade lunches every day for further signs of neglect	2
Poor relationship-building skills	A lack of friends	Students who are alone and have no one to talk to, have strong thoughts about suicide	6
	A lack of belonging	Students who cannot go to class and who are in the counseling office are at high risk of wrist cutting and jumping	6
	Poor ability to connect with others	Students who do not have the ability to connect with other people are in danger	2
Death of someone close	Death of a family member	Students who are absent from school or acting out at home after their parents pass away are at high risk for suicide	2
	Death of another middle school student by suicide	When a middle school student commits suicide in the county, it affects students at other schools	2
Trivial and unknown omens	Children at high risk of suicide do not show signs	Concern about overlooking the suicide risk of students who are not considered a problem and students who do not write anything in response to the survey but may still face problems	7
	The signs of suicide are hard to see in school life alone	Even if you are having a lot of trouble in your school life, you cannot tell by the look on your face at school	7
	Children at high risk of suicide may look and act somewhat differently than usual	Knowing the daily routine and recognizing that minor differences in their daily routine may be signs they are at risk	6
	We do not know the signs of suicide	A lack of knowledge about middle school suicides	4
	Suicide occurs suddenly	The impression that several things were bothering the student; and that the student had crossed their boiling point, suddenly turning to suicidal behavior	2

* Only one typical code is listed.
** Indicates the number of codes.

Table 4 Resistance or barriers to suicide prevention measures

Categories	Subcategories	Example codes*	N**
Anxiety about dealing with suicide	Feeling that the word "suicide" incites suicide	The word "suicide" should not be used in case it provokes the action and morality tells people that suicide is not okay and that life is important	5
	Difficulty with students who have experienced suicide close to home	Dealing with students who are troubled by news reports of suicides or when they experience suicides close to home	3
	Concern about overlooking at-risk students	I am afraid that even if you are meticulously, you may miss a risk	3
	Anxiety regarding a lack of knowledge about the psychology of suicide	Difficulty in recognizing signs without studying psychology	3
	Difficulty with students who engage in risky behavior	Unable to grasp the factors contributing to the dangerous behavior of running away from home and climbing on school rooftops	2
Difficulty with dealing with diverse issues	Difficulty with building relationships	Students often have difficulty asking adults for help and hide their true feelings	7
	Difficulty with dealing with developmental concerns	The problems of developmental disabilities are difficult to solve for the children themselves, and it is quite difficult for the adults around them to give advice	4
	Poor skills at teaching sex education	Teachers are the worst at the sex education part of the program, and it is taboo	3
	Inability to deal with academic and career concerns	Junior high school students are struggling with the content of their career paths, but they find the teachers annoying and do not write much about their true feelings	2
	No quick fixes for LGBTQ concerns	Some LGBTQ students are struggling with their high school uniforms and their career paths, and there is no immediate solution	2
	Difficulty dealing with suspected neglect	Some teachers are unable to deal with students suspected of neglect	2
	Difficulty with skin-to-skin contact	The masks worn during the COVID-19 pandemic made it difficult to read students facial expressions and to talk to them casually	2
	Difficulty dealing with shut-ins	It is difficult to deal with students who are shut-ins or on welfare and cannot get by in school	1
Lack of awareness regarding suicide prevention	Low sense of risk for suicide	Suicide prevention is not an urgent issue	6
	Young teachers are inexperienced and have poor teaching skills	Young teachers lack competence and awareness	3
	Some teachers are not adequately prepared to deal with the situation	Some teachers are not good at providing student guidance and educational counseling to children	3
	The moral education approach is not effective	Even if you tell students about the importance of life in a moral class, students cannot think about it concretely and it is not effective	2

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	The distribution of a mental health counseling number does not make sense	The mental health counseling number is not for students who are really struggling	2
Lack of a support system	Exhaustion due to increased teacher workload	It is not good that the teachers in charge of educational guidance are fixed and not distributed	7
	Lack of school nurses and school counselors	School consultation appointments are booked	6
	Lack of coordination with external parties	Failure to involve outside professionals	5
	Insufficient training sessions to improve knowledge and skills	Limited training on how to deal with students at risk of suicide	4
	Lack of parental support	Parents with risk factors are less likely to attend suicide prevention-related workshops	3
	Difficulty sharing information within the school	Middle schools have to teach across grade levels, making it difficult to share information	2
	Failure to create a safe place for students	Wondering what to do to create a safe place for children	2
	Difficulty in utilizing surveys	Significant difficulties in applying a Q-U test	2

* Only one typical code is listed.
** Indicates the number of codes.

subcategories. "Sharing concerns about students with their parents" involved asking parents to share their concerns in individual interviews. "Cooperating with external organizations" involved connecting with counselors and experts. "Connecting with a school nurse" revealed that students are most likely to rely on school nurses for support. "Connecting with a school counselor" included individual counseling and referral to a counselor.

Finally, the category, "improving skills and abilities for suicide prevention" that promote coping involved two subcategories. "Receiving training in suicide prevention" included counseling and supervisory training. However, only two study participants stated that they were making efforts to complete training on suicide prevention, both inside and outside the school. "Sharpening responses" included acquiring skills, such as self-assessment and assertion, with the assistance of an outside counselor who could engage in role-play.

(2) Perceptions of Suicide Risk

The category, "behaviors and actions that could lead to suicide" comprised three subcategories. "Self-injurious behavior" was based on codes such as repeated wrist cutting and going up to the roof of the school. "Expressions related to death" included the need to urgently engage with students who write things with frequent use of words such as "death" or "kill." "A history of psychiatric visits" was based on codes such as at-risk students attending psychiatry consultations. These findings offer insights into the student characteristics that educators relate to suicide risk.

The category "school refusal and bullying should be monitored" comprised two subcategories. "Refusal to attend school" was based on codes such as students who are not attending school and students who situate themselves as at risk for suicide. "Bullying" was based on codes such as suicide is derived from bullying.

The "unstable family life" category emerged from three subcategories. "Poor parent-child relationship" derived from codes such as students with poor relationships with their parents are in danger. "Suspected neglect" involved watching students with stained shirts and store-bought rather than homemade lunches every day for further signs of neglect. "Delinquency" included codes such as students who run away from home are at risk. These findings reveal that teachers kept a close watch and observed the daily lives of their students, especially in relation to their family lives.

The category of "poor relationship-building skills" was based on three subcategories. Specifically, "a lack of friends" described students who are alone and have

no one to talk to, who may have strong thoughts about suicide. “A lack of belonging” was derived from codes such as students who cannot go to class and who are in the counseling office are at high risk of wrist cutting and jumping. “Poor ability to connect with others” described the notion that students who do not have the ability to connect with other people are in danger.

Further, the “death of someone close” category emerged from two subcategories. “Death of a family member” described the belief that students who are absent from school or acting out at home after their parents pass away are at high risk for suicide. “Death of another middle school student by suicide” comprised codes such as when a middle school student commits suicide in the county, it affects students at other schools.

The last category in this theme, “trivial and unknown omens,” was based on five subcategories. “Children at high risk of suicide do not show signs” subcategory captured codes including concern about overlooking the suicide risk of students who are not considered a problem and students who do not write anything in response to the survey may still face problems. Meanwhile, the subcategory of “children at high risk of suicide may look and act somewhat differently than usual” included knowing the student’s daily routine and recognizing that minor differences in their daily routine may be signs they are at risk. Additionally, the subcategory, “we do not know the signs of suicide” included codes such as a lack of knowledge about middle school suicides. “The signs of suicide are hard to see in school life alone” included even if you are having a lot of trouble in your school life, you cannot tell by the look on your face at school. “Suicide occurs suddenly” included the impression that several things were bothering the student; and that the student had crossed their boiling point, suddenly turning to suicidal behavior. These findings underscore that teachers must always carefully evaluate each student and consider risk aversion; moreover, they highlight the difficulty of dealing with a lack of visible symptoms of suicide risk.

(3) Resistance or barriers to suicide prevention measures

The category “anxiety about dealing with suicide” encompassed five subcategories. The “feeling that the word ‘suicide’ incites suicide” included codes such as the word ‘suicide’ should not be used in case it provokes the action and morality tells people that suicide is not okay, and that life is important. Additionally, “difficulty with students who engage in risky behavior” involved the code unable to grasp the factors contributing to the dangerous behavior of running away from home and climbing on school rooftops. “Difficulty with students who have experienced suicide close to home” included dealing with students who are troubled by news reports of suicides or when they experience suicides close to home. The “concern about overlooking at-risk students” involved the code I am afraid that even if you are meticulously, you may miss a risk. Further, “anxiety regarding a lack of knowledge about the psychology of suicide” included codes such as difficulty in recognizing signs without studying psychology. These findings reveal that teachers who engaged in suicide prevention measures remained worried about using particular terms and the difficulties in handling such measures.

The category of “difficulty with dealing with diverse issues” comprised eight subcategories such as a “difficulty with building relationships,” “difficulty with dealing with developmental concerns,” “poor skills at teaching sex education,” “inability to deal with academic and career concerns,” “no quick fixes for LGBTQ concerns,” “difficulty dealing with suspected neglect,” “difficulty with skin-to-skin contact,” and “difficulty dealing with shut-ins.” The “inability to deal with academic and career concerns” included codes such as junior high school students are struggling with the content of their career paths, but they find the teachers annoying and do not write much about their true feelings. “Poor skills at teaching sex education” included codes such as teachers are the worst at the sex education part of the program and it is taboo. “Difficulty with building relationships” subcategory included codes such as students often have difficulty asking adults for help and hide their true feelings.

Meanwhile, the “lack of awareness regarding suicide prevention” category represented five subcategories such as a “low sense of risk for suicide,” “young teachers are inexperienced and have poor teaching skills,” “some teachers are not adequately prepared to deal with the situation,” “the moral education approach is not effective,” and “the distribution of a mental health counseling number does not make sense.” The findings in this category showed that responses to suicide prevention measures varied from teacher to teacher and that a climate conducive to suicide prevention had not taken root in some schools. For example, the subcategory of “low sense of risk for suicide” reflected codes such as suicide prevention is not an urgent issue. Meanwhile, “young teachers are inexperienced and have poor teaching skills” contained the code young teachers lack competence and awareness.

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The category of "lack of a support system" was derived from eight subcategories such as a "exhaustion due to increased teacher workload," "lack of school nurses and school counselors," "lack of coordination with external parties," "insufficient training sessions to improve knowledge and skills," "lack of parental support," "difficulty sharing information within the school," "failure to create a safe space for students," and "difficulty in utilizing surveys." The "lack of school nurses and school counselors" included codes such as school counselor's consultation appointments are booked and "exhaustion due to increased teacher workload" included it is not good that the teachers in charge of educational guidance are fixed and not distributed. "Difficulty in utilizing surveys" also involved significant difficulties in applying a Q-U test. These results reveal that the diversity of student problems and the lack of adequate staffing and coordination across schools have prevented the creation of support systems.

V. Discussion

Based on our interviews with ten junior high school teachers, we uncovered insights into their perceptions of existing suicide prevention measures, suicide risks, and the issues they faced with existing measures.

1. Suicide Prevention Efforts and Teachers' Perceptions of Suicide

Our study showed that moral education and lectures on the preciousness of life rather than death were the main measures taken to prevent suicide in junior high schools. In addition, information was shared through regular questionnaires and individual interviews, and efforts were made for "early detection and preventive measures for students at risk". Further, the teachers reported working to "create an environment conducive to reporting distress" and "strengthen cooperation in counseling and support". This was reflected in the Comprehensive National Suicide Prevention Plan approved by the Cabinet in October 2022, which called for "further promotion and strengthening of measures to prevent suicide among children and young people," in addition to past efforts to promote education on the importance and preciousness of life, how to raise an alarm, and proper understanding and appropriate responses to mental illness[17]. The responses to the questions regarding student perspectives were captured by the participants' responses. The suicide risk categories that we uncovered of "refusal to attend school and bullying should be monitored", "unstable family life," and "poor relationship-building skills" should be contextualized in relation to reports on refusal to attend school and bullying during the coronavirus disease pandemic of 2019 (COVID-19), which revealed that such issues were difficult for school organizations to resolve independently[18], interpersonal problems at school increase suicidal ideation[19], and discordant parent child relationships increase the motivation for suicide[20].

Further, relationship-building problems are characteristic of this age group and seen across all schools. Meanwhile, numerous studies have shown that students are often unable to discuss their problems with others, especially if they have a disorder[21-23], emphasizing the difficulty in designing suicide prevention interventions for this age group. These factors may explain why some teachers experience resistance and barriers to suicide prevention measures due to their limitations. Moreover, they indicate the need for collaboration among professionals specializing in developmental crises and mental health. In light of the recent involvement of teachers[24] in suicide prevention measures, some key issues have been identified, such as teachers' insufficient and inaccurate knowledge of suicide prevention[25], limited expertise in this subject[26], and relatively poor ability to transmit suicide prevention knowledge to younger teachers[27]. Middle schools and local communities must work together to address these limitations plaguing in-school measures.

2. Support to Reduce Resistance and Difficulties with Suicide Prevention Among Teachers

The participants of this study were teachers who were interested in suicide prevention measures for junior high school students. The findings revealed that some of these teachers experience a sense of difficulty while actively working to prevent student suicide, whereas others understand the need for such measures but are reluctant to adopt them because of their resistance to the idea of suicide. According to Kubota's survey of teachers and staff[28], more than 95% acknowledged the need for suicide prevention in schools, including suicide prevention education for students, whereas more than 80% were concerned about directly discussing suicide with children, and approximately 80% were concerned about talking to students who self-harm (with approximately 90% of the teachers and staff members anxious about the response of students who self-harm or are at high risk of self-harming). Similar to Kubota's results, the teachers

in the current study frequently mentioned "anxiety about dealing with suicide." This is attributable to the lack of suicide prevention education, such as the "lack of awareness regarding suicide prevention" and "lack of a support system," as well as the fatigue caused by the increased workload of teachers on account of the diversity of student problems.

The lack of a teacher support system also fueled resistance among the target group. Iwai[29], based on the strong aversion among teachers to the topics of "death" and "suicide" in education, recommends reforming the teacher training curricula to include suicide prevention as an independent topic and providing teachers with the opportunity to improve themselves. Besides engaging in self-improvement, collaborating with various professionals will reduce teachers' burden. One of the key points of the Comprehensive National Suicide Prevention Plan[17] is the "establishment of a system wherein schools and community supporters can work together as a team to deal with the suicide crisis of children." Furthermore, the nursing profession can effectively collaborate with local stakeholders and other professionals to prevent student suicide.

Additionally, although various efforts have been made to promote education in schools that emphasize the importance and preciousness of life, how to raise an alarm, proper understanding of mental illness, and appropriate responses, teachers struggled with resistance and barriers to suicide prevention measures. We believe that this is the area where collaboration between schools and healthcare professionals is important[30]. In particular, it is necessary for teachers to consciously check whether students are able to recognize signs that they may be experiencing a mental health crisis and know how to seek help (e.g., are aware of local aid agencies and contact points). Aid workers' responses are also important[31], and this survey revealed that the foundation for receiving distress reports from teachers and others is weak. "Difficulty with dealing with diverse issues in students," reflected in subcategories such as "no quick fixes for LGBTQ concerns" and "difficulty with dealing with developmental concerns" were also burdensome for teachers. This has led to a decline in teachers' mental health[32], and considering the impact of mental health literacy on students[33], reducing the burden on teachers is urgently required to prevent school dysfunction.

Despite strengthening the counseling and support system on campus with school nurses and counselors, teachers still faced difficulties dealing with student problems, supporting Ozaki et al.'s report[34]. We believe that it is inadequate to respond only by improving the knowledge and skills of teachers and that the intervention of specialists is required to understand the characteristics of students and the best ways to support them[14)30]. On the other hand, in a survey of teachers' perceptions of multidisciplinary collaboration[35], the following inhibitory factors were reported: "promoting collaboration among teachers and other school staff is more important," "not wanting to be evaluated and not being able to rely on others," and "difficulty in building collegiality due to differences in values and directions." As factors for promotion, it was indicated that professionals should display a positive attitude toward the involvement and working together with teachers. They should also know the job description of the partner with whom they are collaborating, thus making it clear that they can collaborate as nursing professionals. There was a need to appeal to them as a non-threatening presence. We believe it would be useful to create school consultation[36] opportunities to support teachers in reducing their resistance and difficulty in suicide prevention education and to utilize the knowledge of the nursing profession in mental health and other counseling services to support teachers. Nursing professionals can collaborate in following areas: (1) mental health support for teachers; (2) training sessions for students and teachers (education on the importance and preciousness of life, how to raise SOS, proper understanding of mental illness and appropriate responses); and (3) school consultation (joint case review meetings, and analysis of characteristics and trends from survey results). By collaborating with the nursing profession, the burden on the classroom teacher will be reduced, roles will be clarified, and work can be re-distributed to take advantage of each professional's expertise. Crucially, classroom teachers should be aware that not only the teachers but also the specialists are a team, and contribute to rebuilding collaboration rather than face challenges alone.

VI. Limitations of the Study

Based on our experience of facing considerable opposition from teachers regarding research on suicide prevention among middle school students, this study aimed to focus on middle school teachers to clarify their perspectives, therefore excluding elementary school teachers this time. The participants did not have uniform teaching experience, but considering that school organizations have teachers with various years of experience, the structure was designed to accommodate

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the opinions of less experienced teachers as well. The participants in this study had never dealt with suicides in the junior high schools where they worked. An undeniable difference exists in the tone of statements regarding suicide prevention measures depending on the presence or absence of students whose behavior suggests suicide risk. Since only one school nurse teacher was recruited, the survey was conducted with teachers other than school nurses. In the future, we hope to conduct a survey on how school nurses can best collaborate with other nursing professionals.

VII. Conclusion

We interviewed ten junior high school teachers about their perceptions of suicide and their resistance to and difficulties with suicide prevention measures. We aimed to uncover insights useful for fostering collaboration between teachers and nursing professionals to reduce student suicide.

In total, 107 codes emerged for suicide prevention measures implemented at the subject's junior high schools, and four categories were extracted: "early detection and preventive measures for students at risk," "creating an environment conducive to reporting distress," "strengthening coordination of counseling and support," and "improving skills and abilities for suicide prevention." Meanwhile, 68 codes were found for perceptions of suicide risk, and six categories were extracted: "behaviors and actions that could lead to suicide," "School refusal and bullying should be monitored," "unstable family life," "poor relationship-building skills," "death of someone close," and "trivial and unknown omens." Lastly, 86 codes were found for resistance and barriers to suicide prevention measures. Four categories were extracted: "anxiety about dealing with suicide," "difficulty with dealing with diverse issues," "lack of awareness regarding suicide prevention," and "lack of a support system."

The findings suggest that it is necessary to create school consultation opportunities to reduce teachers' resistance to and difficulties with suicide prevention education; further, it may also be effective to utilize the knowledge of the nursing profession in mental health and other counseling services to support teachers.

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IX. Conflict of Interest

The authors declare no conflicts of interest associated with this manuscript.

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