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SUICIDE COUNSELLING AND ITS PERCEIVED ROLE IN MENTAL HEALTH OUTCOMES AMONG ADOLESCENTS AND YOUNG ADULTS IN BAMENDA TOWN, NORTH WEST REGION OF CAMEROON

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ABSTRACT

This study examines suicide counselling and its perceived role in mental health outcomes among adolescents and young adults in Bamenda Town, North West Region of Cameroon. A mixed-methods design combining quantitative and qualitative approaches was employed. Data were collected through structured questionnaires and semi-structured interviews from 28 counsellors, 36 administrators, and 98 teachers (N = 162) purposively selected from four secondary schools. Quantitative data were analysed using descriptive statistics and one-sample t-tests; qualitative data were subjected to thematic analysis. One-sample t-tests indicated that mean scores for counsellor awareness ($t = 7.987$, $p < 0.001$), professional training ($t = 7.370$, $p < 0.001$), and attitudes ($t = 15.545$, $p < 0.001$) differed significantly from the selected test value, reflecting relatively high levels of awareness, training, and favourable attitudes among the school personnel surveyed. These analyses do not establish a causal impact or statistical relationship with adolescents' mental health outcomes. Mental health outcomes were not assessed directly among adolescents; any references to outcomes are based on indirect reports provided by counsellors, administrators, and teachers. The study recommends strengthened counsellor education programmes, culturally sensitive awareness campaigns, and the integration of suicide prevention into school policies. The findings carry implications for clinical practice, teacher training, and public health strategies aimed at supporting youth well-being.

Keywords: Suicide counselling, counsellor training, attitudes, awareness, mental health outcomes, Cameroo.

1. INTRODUCTION

Adolescent suicide has become a significant public health concern in the North West Region of Cameroon, particularly in Bamenda (Mezam Division). Socio-political instability, economic hardship, academic pressure, social isolation, and untreated mental health conditions have contributed to elevated rates of suicidal ideation and attempts among adolescents and young adults (Gesese & Ndongo, 2022; Ngwa, 2024; Mbiydzenyuy, 2021). Limited access to specialised mental health services and persistent cultural stigma that frames psychological distress as a spiritual or moral failing further increase vulnerability during this critical developmental stage (World Health Organization [WHO], 2020; Keugoung & Tchouaket, 2013; Toguem, 2022).

Schools and colleges in Bamenda occupy a strategic position for early detection and intervention. Adolescents spend a substantial portion of their time in educational settings, making these institutions key sites for psychosocial support. Suicide counselling—confidential, structured

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therapeutic engagement with individuals experiencing suicidal ideation or emotional distress—offers a practical means of providing a safe space for expression, developing coping strategies, strengthening emotional regulation, and reducing self-harm risk (Djatche et al., 2024; Gesese & Ndongo, 2022).

The quality and reach of such counselling are strongly influenced by three interrelated counsellor characteristics: awareness, professional training, and attitudes. Awareness enables school personnel to recognise behavioural, emotional, and communicative warning signs of suicidality and to initiate timely screening or referral (Rudd et al., 2006; Johnson, 2024). Professional training supplies the knowledge and competencies required for accurate risk assessment, crisis management, and evidence-based intervention; without it, many practitioners remain unprepared despite accreditation standards that emphasise crisis skills (Schmitz et al., 2012; Council for Accreditation of Counseling and Related Educational Programs, 2016; Neimeyer et al., 2001; Joiner, 2005). Favourable attitudes toward suicide prevention reduce interpersonal stigma, encourage help-seeking, and facilitate collaborative work with students, parents, and other professionals (Herron et al., 2001; Kim, 2022; Granello & Granello, 2007).

Empirical evidence supports these mechanisms. Professionals with prior training in suicide risk assessment demonstrate more positive attitudes and stronger intervention skills (Herron et al., 2001). Training and experience improve the ability to manage suicidal clients effectively, while attitudes shape both the willingness of young people to disclose distress and the quality of the therapeutic alliance (Kim, 2022; Mann et al., 2005; Pompili et al., 2013). Through enhanced detection, competent intervention, and reduced barriers to engagement, counsellor awareness, training, and attitudes are therefore expected to influence the support adolescents receive and, ultimately, their mental health outcomes—particularly emotional resilience, reduced hopelessness, and lower risk of self-harm.

In the Cameroonian context these counsellor factors operate under severe systemic constraints. The country has fewer than one psychiatrist per 100,000 people, with most concentrated in major cities, leaving regions such as Bamenda underserved (WHO, 2020). Many school-based counsellors and educators lack specialised preparation in suicide assessment and management (Toguem, 2022; Ngwa, 2024). Awareness of warning signs among school staff remains limited, and negative or moralistic attitudes continue to discourage open discussion (Mbiydzenyuy, 2021; Keugoung & Tchouaket, 2013). Cultural taboos that treat suicide as a spiritual failing, the absence of a national suicide-prevention strategy, minimal public funding for mental health, and scarce youth-friendly services further restrict access to timely, culturally appropriate care (WHO, 2020; Toguem, 2022).

Previous research has established two important bodies of knowledge. First, global and regional studies consistently show that counsellor training and attitudes are linked to improved prevention skills and more constructive client interactions (Herron et al., 2001; Kim, 2022; Mann et al., 2005; Schmitz et al., 2012). Second, Cameroonian studies have documented elevated adolescent suicidality associated with conflict, academic stress, and untreated mental health conditions in the North West Region (Gesese & Ndongo, 2022; Ngwa, 2024; Mbiydzenyuy, 2021). What remains unknown is how this counsellor characteristics specifically function within secondary-school settings in Bamenda—a conflict-affected, resource-constrained environment—and how school personnel themselves perceive the contribution of awareness, training, and attitudes to adolescent mental health support. No local empirical investigation has yet examined the levels of these factors

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among counsellors, administrators, and teachers in Bamenda schools or explored their perceived role in shaping mental health outcomes for adolescents and young adults.

The present study addresses this gap by investigating the levels of counsellor awareness, professional training, and attitudes among school personnel in four secondary schools in Bamenda Town, and by exploring how these characteristics are perceived to contribute to mental health support for adolescents and young adults. By situating the inquiry within the local educational and socio-cultural context, the study aims to generate evidence that can inform counsellor education programmes, school-based prevention policies, and public-health strategies tailored to the North West Region of Cameroon.

Research Questions

1. What is the level of school personnel awareness of suicide counselling for better mental health outcome among secondary school adolescents in Bamenda Town?
2. What is the level of school personnel professional training in suicide counselling for better mental health outcome among secondary school adolescents in Bamenda Town?
3. What is the nature of school personnel attitudes toward suicide counselling better mental health outcome among secondary school adolescents in Bamenda Town?

Research Hypotheses

Ho_1: There is no significant difference between the mean level of school personnel awareness of suicide counselling and the theoretical mean of 2.5 for better mental health outcome among secondary school adolescents in Bamenda Town.

Ho_2: There is no significant difference between the mean level of school personnel professional training in suicide counselling and the theoretical mean of 2.5 for better mental health outcome among secondary school adolescents in Bamenda Town.

Ho_3: There is no significant difference between the mean attitude of school personnel towards suicide counselling and the theoretical mean of 2.5 for better mental health outcome among secondary school adolescents in Bamenda Town.

2. RESEARCH METHOD

Design

Convergent mixed-method design that involves simultaneous collection of quantitative and qualitative data was adopted. This design was selected to examine both the levels of counsellor awareness, professional training, and attitudes, and the perceived role of these characteristics in supporting mental health outcomes among adolescents and young adults in Bamenda Town (Creswell & Plano Clark, 2018). The quantitative strand provided statistical information on the levels of the three counsellor-related factors, while the qualitative strand captured in-depth perspectives of school personnel on how these factors are perceived to contribute to adolescent mental health support.

Target Population

The target population consisted of all school counsellors, administrators, and teachers in secondary schools located in Bamenda I, II, and III subdivisions. These personnel are directly involved in the provision or oversight of student support services and therefore possess relevant experience concerning suicide counselling and adolescent mental health.

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Sample and Sampling Technique

A sample of 162 participants (28 counsellors, 36 administrators, and 98 teachers) was purposively selected from four secondary schools in Bamenda I, II, and III subdivisions. The sample size was considered adequate according to the guidelines of Krejcie and Morgan (1970). Purposive sampling was employed to ensure that only individuals with direct experience or responsibility related to student counselling and mental health support were included. This non-probability approach was appropriate because the study focused on informed participants who could provide meaningful data on the constructs under investigation.

Research Instruments

A structured questionnaire using a Four-Point Likert-scale format was developed to measure levels of counsellor awareness, professional training, and attitudes toward suicide counselling. From the four-point Likert scale, a theoretical mean of 2.5 was used to determine whether counsellors' awareness, professional training, and attitude towards suicide counselling is significantly high or low. In addition, a semi-structured interview guide was used to explore participants' perceptions of the role of these counsellor characteristics in supporting mental health outcomes among adolescents and young adults.

Validation and Reliability

The instruments were reviewed by experts in educational psychology for content validity which stood at 0.89 for the questionnaire and 0.93 for interview guide. The reliability of the questionnaire was ascertained via a pilot test on 10 school personnel from non-participating schools. The test–retest approach was used and data collected were analysed using the Cronbach Alpha test. Each construct had five test item and the reliability coefficient value was 0.85 for awareness, 0.81 for professional training, and 0.92 for attitude. The overall reliability coefficient was 0.86, above 0.7. However, the reliability of the interview guide was ascertained using the need analysis technique with eight criteria used (relevance, coverage, consistency, specificity, traceability, depth, convergence, triangulation, negative evidence, and saturation indication). The rating scale ranged from very high to very low. Very high had the score of 5, high 4, moderate 3, low 2, and very low 1. From the need analysis, the total scoring was 50 and the interview guide responses score obtained was 45. The proportion rule was used to determine the suitability of the qualitative response which stood at 90%.

Data Collection Procedures

Permission was obtained from the principals of the selected schools. Questionnaires were distributed and collected in person. Fifteen key informants were interviewed privately. Informed consent was obtained from all participants, and anonymity and confidentiality were strictly maintained throughout the process.

Method of Data Analysis

Quantitative data from the questionnaires were analysed using SPSS Version 23. Descriptive statistics (means, standard deviations, frequencies) were computed, and one-sample t-tests were conducted with a test value of 2.5 and a significance level of $\alpha = 0.05$ to determine whether the

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observed mean scores for awareness, professional training, and attitudes differed significantly from the test value.

More so, the qualitative data from the interviews were subjected to thematic analysis. Responses were transcribed, coded, and organised into recurring themes related to counsellor awareness, training, attitudes, and their perceived contribution to mental health support for adolescents and young adults. The themes were generated inductively, that is data driven. In other words, themes were generated from the transcribed data after careful reading of each participant direct statements. This implies that there was no pre-existing codes as in the case with deductive code generating which is theory driven. There was not discrepancies in the generating of codes.

Ethical Considerations

Ethical approval was obtained from the relevant educational authorities. Participation was voluntary, and the confidentiality of all information provided by participants was upheld**.**

4. FINDINGS AND DISCUSSIONS

Research Question One: What is the level of school personnel awareness of suicide counselling for better mental health outcome among secondary school adolescents in Bamenda Town?

Table 1: Appraisal of the awareness of suicide and counselling practices

Statements	SA (%)	A (%)	D (%)	SD (%)	Mean	Std.Dev
I often recognize warning signs such as withdrawal, hopelessness, or persistent sadness in students with suicidal thoughts.	42 (25.9)	120 (74.1)	0 (0.0)	0 (0.0)	3.26	0.44
I always engage in open discussions with clients expressing suicidal thoughts.	12 (7.4)	81 (50.0)	66 (40.7)	3 (1.9)	2.63	0.65
I know when and how to refer a client to emergency services or crisis hotlines when necessary.	23 (14.2)	20 12.3)	96 (59.3)	23 (14.2)	2.27	0.88
I feel comfortable and proactive in asking clients about suicidal thoughts, plans, and behaviors.	69 (42.6)	62 (38.2)	30 (18.6)	1 (0.6)	3.23	0.77
I can effectively manage my personal emotions while supporting clients during suicide counselling.	35 (21.6)	69 (42.6)	39 (24.1)	19 (11.7)	2.74	0.93
Multiple Response Set	**181 (22.3)**	**352 (43.5)**	**231 (28.5)**	**46 (5.7)**	**2.83**	**0.73**

Key: SA = strongly agree, A = agree, D = disagree, SD = strongly disagree, % = percentage
Source (Field data, 2025)

Findings on table 1 indicate that 65.8% of respondents demonstrated awareness of suicide counselling practices while a significant proportion 34.2% were not. The overall mean of 2.83 not even above 3.0 and slightly above the midpoint of 2.5 implies a moderate level of awareness. This reveal a need for more improvement of school personnel awareness of suicide counselling practices. The SD range from 0.44 to 0.93 with an overall of 0.73, indicating a low dispersion.

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This showed a generic problem. Specifically, on a positive trend, all respondent 100% (162) attested they could identify warning signs such as withdrawal, hopelessness, and persistent sadness in students exhibiting suicidal ideation. More so, 80.8% (131) feel confident and proactive in discussing suicidal thoughts and behaviors with clients. However, on a negative note, just 57.4% (93) of respondents are always engage in open discussion with clients while 42.6% (69) do not. More so, just 26.5% (43) of respondents know when and how to refer a client to emergency services or crisis hotlines when necessary while many of them 73.5% (119) do not. Finally, while 64,2% (104) of respondents can effectively manage their emotions during counselling, 35.6% (58) were unable.

Table 2: Qualitative evidence on familiarity with suicide warning signs

Questionnaire theme	Response theme	Grounding	Sample quotations
How familiar are you with warning signs of suicidal behavior among students?	Hopelessness	8	"…feelings of being overwhelmed and being a burden to others and worth nothing…"
	Withdrawal Isolation	10	"…when people begin avoid people and stay on their own…"
	Drug addiction	6	"…use drugs and are suffering from addiction
	Talk of suicide	10	"…some students openly talk about suicide, that they wished they were dead…"

Qualitative comments on familiarity with warning signs converge with the strongest quantitative item. Participants named hopelessness, withdrawal and isolation, substance use, and direct talk of death or suicide. They offered far less detail on referral pathways, crisis protocols, or structured counselling steps. That silence is consistent with the low quantitative score on referral competence and confirms a recognition-without-response gap: school personnel can see distress more readily than they can move a student into emergency care.

Verification of Hypothesis One (Ho_1): There is no significant difference between the mean level of school personnel awareness of suicide counselling and the theoretical mean of 2.5 for better mental health outcome among secondary school adolescents in Bamenda Town.

Table 3: Depicting the level of school personnel awareness of suicide counselling practices

Variable	Test Value = 2.5					
	T	Df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Awareness of suicide counseling	5.754	161	.000	.33	2.717	2.943

Hypothesis One (H01) stated that there is no significant difference between the mean awareness score and the theoretical mean of 2.50. A one-sample t-test rejected the null hypothesis: $t(161) = 5.754$, $p < .001$, mean difference = 0.33. Awareness is therefore statistically above the midpoint. The practical margin, however, remains small. Heightened recognition of early signs is useful only if it is paired with conversation skill and a working referral route. The finding is consistent with

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Joiner (2005), who argued that awareness reduces stigma and encourages help-seeking, and with Rudd et al. (2006) and Owens, Horrocks and House (2002), who treated awareness training as a first step toward early identification rather than a complete intervention system.

Research Question Two: What is the level of school personnel professional training in suicide counselling for better mental health outcome among secondary school adolescents in Bamenda Town?

Table 4: Appraisal of school personnel professional training in suicide counselling

Statements	SA (%)	A (%)	D (%)	SD (%)	Mean	Std. Dev
I easily understand suicide risk factors and warning signs	38 (23.5)	50 (30.9)	74 (45.6)	0 (0.0)	2.78	0.80
I am able to conduct a suicide risk assessment effectively and empathetically	19 (11.7)	50 (30.9)	74 (45.7)	19 (11.7)	2.42	0.85
I actively engage in training and awareness programs for suicide prevention	42 (25.9)	43 (26.5)	74 (45.7)	3 (1.9)	2.77	0.86
I understand suicide as a complex mental health issue and avoid blame and moral judgment	59 (36.4)	81 (50.0)	19 (11.7)	3 (1.9)	3.21	0.72
I am committed in participating in on-going training programs	27 (16.7)	92 (56.8)	24 (14.8)	19 (11.7)	2.78	0.86
Multiple Response Sets	**143 (17.7%)**	**346 (42.7%)**	**280 (34.5%)**	**41 (5.1%)**	**2.79**	**0.82**

Key: SA = strongly agree, A = agree, D = disagree, SD = strongly disagree, % = percentage
Source (Field data, 2025)

In overall, findings on table 4 show that a while 60.4% of respondents agreed showed strong commitment to training, 39.6% do not and the overall mean of 2.78 below 3.0 but slightly above midpoint of 2.5 implies moderate wellness for training. The standard deviation ranges from 0.72 to 0.86 and overall, of 0.82, confirming low dispersion. Specifically, 86.4% (140) of respondents understand suicide as a complex mental health issue but not all of them are committed to participate in training 73.5% (119). More so, only 52.4% (85) of personnel actively engage in training and awareness programs for suicide prevention while 47.6% (77) do not. This further echo the need for stronger awareness for training by school personnel. Furthermore, while 54,4% (88) of respondents accepted to easily understand suicide risk factors, 45.6% (74) do not which further strengthen the need for training. Finally, more than half of respondents 57.4% (93) are unable to conduct suicide risk assessment.

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Table 5: Qualitative evidence on professional training in suicide counselling

Questionnaire theme	Response theme	Grounding	Sample quotations
Have you received any formal training in suicide prevention or mental health awareness?	No	10	"all I learned is on the job practice and in online platforms and apps'
	Yes	5	"..have attended some free workshops and seminars on mental health campaigns…"
How do you personally feel when talking with someone about suicide? How do you manage your emotional reactions	Normal	12	"… normal, I manage my own emotional reactions by learning how to forgive and forget…" "I talk with confidence and show no sympathy"
	Very sad	3	"…sometimes I feel sad because it is difficult to manage my emotions…" "sometimes I can't manage my emotions

Interview evidence strengthens that reading. Most participants said they had not received formal suicide-prevention or mental-health training; a minority mentioned occasional free workshops or campaign seminars. Many described their emotional stance in conversations about suicide as "normal" or composed, often using informal self-talk rather than supervised regulation skills. A smaller group admitted sadness and difficulty managing affect. The qualitative pattern matches the quantitative finding: conceptual sympathy is present; structured, supervised competence is not.

Verification of Hypothesis Two: (H_{o2}): There is no significant difference between the mean level of school personnel professional training in suicide counselling and the theoretical mean of 2.5 for better mental health outcome among secondary school adolescents in Bamenda Town.

Table 6: Depicting the level of school personnel professional training in suicide counselling

Variable	Test Value = 2.5					
	T	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Attitude towards suicide counseling	4.501	161	.000	0.29	2.663	2.917

Hypothesis Two (H02) stated that there is no significant difference between the mean training score and the theoretical mean of 2.50. The one-sample t-test rejected the null: $t(161) = 4.501$, $p < .001$, mean difference = 0.29. (The original SPSS table for this test was mis-titled "Attitude towards suicide counselling"; the variable is professional training.) Training therefore exceeds the midpoint statistically, but the gain is modest and is carried more by attitude-like items than by assessment skill. School personnel who have had adequate training are better placed to notice withdrawal, hopelessness, or behavioural change and to make a timely referral. Insufficient training leaves room for misreading student behaviour and for unhelpful or stigmatising responses.

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The result aligns with Rudd, Cukrowicz and Bryan (2008) on the need for training that covers risk assessment, crisis intervention, and safety planning, and with Mishara and Weisstub (2016) on continuous supervision so that counsellors can manage exhaustion, countertransference, and boundaries.

Research Question Three: What is the nature of school personnel attitudes toward suicide counselling better mental health outcome among secondary school adolescents in Bamenda Town?

Table 7: Appraisal of school personnel attitudes toward suicide counselling

Statements	SA (%)	A (%)	D (%)	SD (%)	Mean	Std.Dev
I demonstrate empathy and compassion for individuals experiencing suicide thoughts	54 (33.3)	100 (61.7)	4 (2.5)	4 (2.5)	3.26	0.63
I am prepared to evaluate suicide risk effectively	16 (9.9)	80 (49.3)	62 (38.3)	4 (2.5)	2.67	0.69
I avoid stigma and ensuring clients feel safe when discussing their suicide thoughts struggles	54 (33.3)	104 (64.2)	0 (0.0)	4 (2.5)	3.28	0.59
I am comfortable discussing suicide openly and non-judgmental	42 (25.9)	43 (26.5)	74 (45.7)	3 (1.9)	2.77	0.86
I collaborate with other professionals, family members, and support networks in suicide cases	42 (25.9)	84 (51.8)	32 (19.8)	4 (2.5)	3.01	0.75
Multiple Response Set	208 (25.8%)	411 (50.7%)	172 (21.2%)	19 (2.3%	3.00	0.71

Key: SA = strongly agree, A = agree, D = disagree, SD = strongly disagree, % = percentage
Source (Field data, 2025)

In overall, findings on table 7 shows that 76.5% of respondents had positive attitude while few 23.5% had negative attitude. The overall mean of 3.00 above 2.5 shows that school personnel attitudes toward suicide counselling is favourable despite their moderate level of awareness and limited trainings. The standard deviation ranged from 0.59 to 0.86 with an overall value of 0.71, reflecting low dispersion. This show that participant attitudes were almost homogenous. Specifically, 97.5% (158) of respondents reported avoiding stigmatization and ensuring that clients feel safe when discussing suicidal thoughts, whereas 4 (2.5%) disagreed. Similarly, 95.0% (154) of respondents accepted to show empathy and compassion for individuals with suicidal thoughts, while only 8 (5.0%) disagreed. Additionally, 77.7% (126) of respondents reported collaborating with professionals, families, and support systems when managing suicide-related cases. However, while 59.2% (96) of respondents felt prepared to assess suicide risk effectively, 40.8% (66) do not. Finally, while 52.4% (85) of respondents feel conformable addressing suicide openly, 47.6% (77) are uncomfortable. These two areas showed targeted specific improvement school personnel

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attitude for stronger open discussion on suicide counselling and preparedness to assess suicide risk.

Table 8: Qualitative evidence on school personnel on attitudes towards suicide counselling

Questionnaire theme	Response theme	Grounding	Sample quotations
How comfortable are you discussing suicide issues with students? Why?	Very comfortable	11	"…It helps students to know what to do when they feel bad about something…" "…comfortable because I don't allow my emotions take over me…"
	Not comfortable	4	"…it still feels like a taboo topic when discussed…"
Do you believe that talking about suicide can increase the risk of suicidal behavior in students	No	12	
	Yes	3	"…it can cause panic in students…"

Qualitative comments align with that split. Most interviewees said they were comfortable talking with students because such talk helps learners know what to do when they feel distressed; some attributed comfort to remaining emotionally composed. A minority still experienced suicide as a taboo topic. Almost all rejected the myth that talking about suicide plants the idea; a few feared that discussion might cause panic. Comfort is the dominant stance, with a residual cultural hesitation.

Verification Hypothesis Three (Ho_3): There is no significant difference between the mean attitude of school personnel towards suicide counselling and the theoretical mean of 2.5 for better mental health outcome among secondary school adolescents in Bamenda Town.

Table 9: Depicting the level of school personnel attitudes toward suicide counselling

Variable	Test Value = 2.5					
	T	Df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Training programs on suicide counseling	8.963	161	.000	.50	2.890	3.110

Hypothesis Three (H03) stated that there is no significant difference between the mean attitude score and the theoretical mean of 2.50. The one-sample t-test rejected the null: $t(161) = 8.963$, $p < .001$, mean difference = 0.50. (The original SPSS table for this test was mis-labelled "Training programs on suicide counselling.") Attitudes show the largest mean difference of the three constructs. Supportive, non-judgemental attitudes create the climate in which adolescents can seek help; stigmatising attitudes close that door. The finding is consistent with Hjelmeland et al. (2021) on non-stigmatising intervention and with Jobes (2006) on collaborative rather than authoritarian risk management. Attitude alone, however, does not substitute for assessment skill—the same gap visible under Research Questions One and Two.

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5. CONCLUSION AND RECOMMENDATIONS

This study explores the impact of suicide counselling on adolescents' mental health outcomes in the Mezam Division of the North West Region of Cameroon. The effectiveness of suicide counselling depends largely on three interrelated factors: the counsellor's awareness, professional training, and attitudes toward suicide. Awareness enables early recognition of warning signs and risk factors, while a non-judgmental, empathetic attitude fosters trust and encourages adolescents to disclose their struggles. Targeted training further equips mental health professionals with the knowledge and skills necessary to respond competently and confidently in high-risk situations.

Adolescents face a range of developmental challenges, including identity formation, academic pressures, social transitions, and difficulties with emotional regulation. For these young individuals, access to well-trained and supported counsellors can be transformative, not only reducing immediate suicidal ideation but also contributing to long-term psychological resilience and mental health stability. As mental health concerns continue to rise among youth globally, suicide counselling should be considered an essential component of both clinical practice and public health strategies.

Based on the findings of this study—characterised by high awareness of warning signs yet clear procedural gaps, positive but variable attitudes, and a need to translate endorsement into consistent practice—the following evidence-informed, culturally sensitive recommendations are advanced.

Given the high awareness of warning signs coupled with procedural gaps, mandatory school-based referral protocol workshops should be implemented. Targeted awareness campaigns should be conducted across schools, universities, and community settings to educate students, educators, parents, and professionals about suicide warning signs, risk factors, and available support systems. These initiatives must be evidence-based, culturally sensitive, and youth-friendly to ensure engagement and accessibility for diverse audiences.

Specifically, short termly school-based briefings should be introduced that move beyond mere lists of warning signs to practical rehearsal of what to say next and when to hand a student over. A one-page referral map (school counsellor → district mental-health focal point → emergency or crisis line) should be posted in staff rooms and the same numbers placed in every staff handbook. Case vignettes written in local adolescent language should be used so that recognition practice is not limited to textbook lists. In addition, psychology and counselling curricula should prioritise training on professional awareness, equipping future counsellors with the skills to identify subtle indicators of suicidal ideation such as withdrawal, hopelessness, or behavioural changes.

A structured suicide-risk-assessment module—covering screening questions, safety planning, and documentation—should be made compulsory for guidance counsellors and for at least one designated teacher in each school. The module must be paired with supervised role-play and debrief; lecture workshops alone will not raise the assessment mean that currently sits at 2.42. Termly group supervision should be instituted so that staff can process their own emotional reactions rather than relying on informal self-talk. Personnel who scored below the midpoint on assessment items should be prioritised for the first training cohort.

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Furthermore, training programmes must create safe spaces where counsellors-in-training can openly discuss fears, biases, or discomfort related to suicide, thereby fostering self-awareness and personal growth. Mental health organisations should also conduct regular evaluations of practitioners' attitudes as part of quality-assurance measures, ensuring that professionals maintain the ethical, emotional, and practical readiness necessary to intervene effectively in suicide-related situations.

For the positive but variable attitudes observed, ongoing stigma-reduction and empathy supervision sessions should be integrated. Improving adolescent mental health outcomes requires counsellors to adopt empathetic, supportive, and non-judgmental attitudes when working with individuals experiencing suicidal thoughts. Accordingly, training programmes should integrate structured modules addressing attitudes toward suicide, including stigma reduction, moral beliefs, and emotional responses. Reflection-based learning methods—such as case discussions, supervised role-plays, and values-clarification exercises—should be incorporated to help trainees recognise and challenge negative or harmful beliefs about suicide and those at risk.

The already-strong anti-stigma and empathy climate should be protected by a simple school rule: no moralising language in incident notes, and family contact framed as partnership. The remaining taboo pocket should be addressed through staff dialogues that treat talk about suicide as prevention rather than contagion, drawing on the majority view already present in the interview data. Every identified high-risk case must have a named collaborator—counsellor, parent, or external clinician—within 24 hours, so that collaboration is practised rather than merely endorsed.

Collectively, these recommendations aim to close the gap between awareness and action, strengthen professional competence, and convert positive attitudes into consistent, supportive practice, thereby enhancing the protective impact of suicide counselling for adolescents in the Mezam Division and similar contexts.

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