

# Information about youth suicide

## A DEFINITION...

***Suicide is a conscious act to end one's life***

A *conscious act* means that the act undertaken is done on purpose to end the person's life. It is important to note that a conscious decision is not the same as a rational decision. At the time the act is undertaken, the person is not necessarily in a rational state of mind. The young person may be experiencing a depressive illness or some form of psychosis, or be affected by rage, stress, alcohol or other substances. Research into youth suicide suggests that young people are not necessarily fully aware of the finality of death.

The goal of suicidal behaviour by a young person may be more to stop emotional pain rather than to deliberately end a life.

## Trends in youth suicide in Australia

Since 1968, the rate of suicide in Australian youth aged between 15 and 19 has more than doubled. The rate in 1968 was 5.6 persons per 100 000, and in 1998 this had risen to 11.5 persons per 100 000. In 1998, suicide was the second leading cause of death, behind motor vehicle accidents, for both males and females within this age group.\*

\* Australian Bureau of Statistics.

## Suicide deaths in the 15 to 19 years age group

1998 data on suicide deaths for the 15 to 19 years age group reveals the following trends:

- **MALES**  
116 suicide deaths  
a rate of 17.2 per 100 000 persons  
(78 hanging, 10 guns, 4 jumping, 9 gassing, 4 poisoning, 1 drowning, 1 cutting, 9 other)
- **FEMALES**  
35 deaths  
a rate of 5.5 per 100 000 persons  
(23 hanging, 4 poisoning, 1 drowning, 2 guns, 2 jumping, 3 other)
- **PERSONS**  
151 deaths, a rate of 11.5 per 100 000 persons.

## Attempted suicide

Evidence would suggest that there are between 40 to 50 suicide attempts for every completed suicide in the 15 to 19 years age group in Australia, and that suicide attempts are the most prevalent in this age group. There is difficulty, however, in getting accurate data about attempts, as many incidences, particularly those involving males, may be passed off as injuries or accidents.

Distinguishing suicide attempts from deliberate self-harm can be difficult. Young people do not always have a clear perception of the potential lethality of a particular method, so deliberate self-harm without suicidal intent may result

in death, while attempts to die may result in minimal injury. Self-harm is more common than attempted suicide and is an indicator of increased risk for a suicide attempt.

In the 1996-97 financial year, 296 girls and 68 boys aged between 10 and 14 years harmed themselves seriously enough to be admitted to hospital. In the age group 15 to 19 years, 1 528 young women and 673 young men were admitted to hospital for deliberate self-harm.

Of these 2 565 attempts, over 2 260 used drug overdose, with the second most common method of attempt being self-cutting. The vast majority of these young people were kept alive. On the other hand, of those who seriously injured themselves using guns, hanging or car exhaust during the period, only 38 were saved.

A comparison of completed suicides with attempted suicides demonstrates the high relative lethality of particular means such as hanging, guns and car exhaust. Lack of knowledge of the more lethal means of suicide appears to be protecting many vulnerable young people from death, and this protection should be maintained.

## Suicidal thoughts

The Western Australian Child Health Survey (1995) found that over 15 per cent of adolescent students reported having had suicidal thoughts in the six months prior to the survey. The proportion of older adolescents who had suicidal thoughts (22 per cent) was almost twice that for younger students

\* Similar data has been collected in other Australian studies

(12 per cent).<sup>\*</sup> Approximately 30 per cent of students reporting suicidal thoughts had also deliberately tried to harm or kill themselves.

Students who had experienced suicidal thoughts and engaged in deliberate self-harm were also more likely to use alcohol and cannabis than those who had never had suicidal thoughts.

Suicidal thoughts were reported in similar proportions by those students with academic competence at or above their age level and those with below age level academic competence. There was little difference in the proportion of students with suicidal thoughts at Government, Catholic and other non-government schools. However, suicidal thoughts were more prevalent at those schools having a higher rate of student behaviour problems.

Parents and teachers were often not aware of a student's mental health problems, suicidal ideation, or self-harming behaviour. Most adolescent self-harm and suicidal ideation is kept private, even from friends and family.

## Gender differences

As previously discussed, young men and young women are most likely to attempt suicide by an overdose or cutting, and are less likely to die by this method. Those who die are more likely to have used guns, hanging or car exhaust, and these methods are much more likely to be used by males.

**School-based suicide prevention is fundamentally about good mental health promotion.**

## Urban-rural differences in youth suicide

Young men and young women are more likely to die from suicide if living in a rural or remote community that is not a major population centre. Young people living in towns of less than 4 000 people may be most at risk.

## Links with depression and mental health problems

Psychiatric illness, particularly depression, is implicated in 60 to 90 per cent of youth suicides. Depression affects between one and three per cent of young people at any one time. It is more common in older adolescents and females. The first episode of depression usually occurs in mid to late adolescence. Up to 24 per cent of adolescents will have had an episode of depression by the age of eighteen. At least 50 per cent of adolescents who suffer an episode of depression will experience a recurrence of depression. They are more at risk to both attempt or complete suicide.

Depression frequently occurs in combination with anxiety disorders, substance-related disorders, conduct disorders, eating disorders, and attention deficit / hyperactivity disorder.

Depression is common. Deep unhappiness, disordered mood, disordered sleep, feelings of hopelessness or helplessness, and thoughts of suicide

are signs of illness, not a natural stage of adolescence. Although most young people receive no treatment for depression, in reality young people with depression can benefit from treatment and should be encouraged to seek professional help.

In addition to those suffering depression, around 40 per cent of young people in any six month period suffer prolonged periods of sadness or unhappiness which may affect their ability to cope. This lowered mood may be a risk factor for long-term social problems and for depression.

Young people with concerns about their sexuality may be at greater risk of experiencing depression and suicidal behaviours.

## Unemployment, social disadvantage and suicide

The research literature reveals a correlation between increased rates of suicide, chronic physical illness, unemployment, dependency, poverty, homelessness and being in police custody.

In general, male rates for death by suicide correspond with periods of economic downturn, with high male rates occurring in 1912, 1930, 1962-67 and again in 1987. The influences are not as clear for females. The rate of youth unemployment has increased relative to overall unemployment rates. The male youth suicide rate has also increased relative to overall male suicide rates.

## Aboriginal and Torres Strait Islander young people

There are many indications of serious problems with suicide and other forms of self-harming behaviour among the young people of many Aboriginal and Torres Strait Islander communities.

The Australian Institute of Health and Welfare (1994) reported that, based on a sample of 67 identified cases, the suicide rate of Aboriginal and Torres Strait Islander youth was 1.4 times that of non-Indigenous young people.

The limited evidence available suggests that youth suicide rates vary greatly from one community to another within the Aboriginal and Torres Strait Islander population.

Urban and remote communities can experience significantly different levels and forms of stress. While urban communities theoretically have better access to health care services, racist attitudes among service providers have been identified as a barrier to health care for Aboriginal people and Torres Strait Islander people in general.

There is a need to acknowledge the importance of variations in history, culture and current circumstance among Aboriginal and Torres Strait Islander communities when dealing with this issue.

## Alcohol and other drugs

Alcohol and other drugs are frequently associated with suicidal behaviour. Alcohol is immediately involved in 20 to

50 per cent of suicide deaths in Australia. Similarly, the ingesting of drugs has also been implicated as a precipitating factor in suicidal actions. Particular prescribed and over-the-counter medications have also been associated with deaths from suicide.

## Adverse childhood experiences

There is a clear association between a history of sexual abuse and an increased likelihood of attempted suicide and repeated attempts. Seventy-five per cent of young people who self-report sexual abuse in a schools-based survey, also self-report suicidal behaviour.

## Contributing and risk factors

The reasons why a person chooses suicide are complex. The factors are sometimes described as risk factors and contributing factors.

Risk factors are situations or events that may directly heighten the young person's vulnerability to suicide. The risk is greater when more than one factor is present. These factors can also lead to other self-destructive behaviours such as alcohol and drug use, and unsafe sex, as well as behavioural problems in the classroom. In addition, other factors may contribute by impacting on a young person's ability to cope.

Precipitating factors are those events or issues which trigger suicide. For example, personal loss or the breakdown of a romantic attachment are common precipitating factors for suicide.

<b>YOUTH SUICIDE</b>		<b>RISK FACTORS</b>	
<b>Psychiatric difficulties</b>	Depression Anxiety Substance abuse Eating disorders Conduct problems Psychosis Past or present suicidal ideation Threats or attempts of suicide		
<b>Difficulties with social adjustment</b>	Academic failure Social isolation Legal problems Interpersonal conflict		
<b>Family or environment</b>	Interpersonal crisis Abuse or neglect Family breakdown Family history of psychiatric disorder or suicide Cultural conflict Unemployment or financial problems Exposure to suicide		
<b>Physical health</b>	Change in health status (such as diagnosis of STD or HIV, pregnancy, onset of a chronic illness such as diabetes)		

<b>YOUTH SUICIDE CONTRIBUTING FACTORS</b>			
<b>Unresolved grief / loss of significant person</b>	Suppression of emotions Unrealistic expectations from self and others Feeling of hopelessness, sense of no future Care-eliciting and attention-seeking behaviour derived from a feeling of not being heard or feeling unloved and unaccepted Lack of resolution of psychological crisis Negative sense of self-regard Peer pressure or bullying Fear of rejection or prediction of punishment Abuse, violence or break-up of relationships		
<b>Sexual identity issues</b>	Coming to terms with sexual preference		
<b>Loss / confusion of cultural identity</b>	Injustice – desire for revenge Dropping out or failure in education system		
<b>Media / publicity</b>	Compelling media images may increase the capacity for imitation suicide, normalise or glamorise suicide as an option		

## Definitions of terms used in the suicide prevention literature

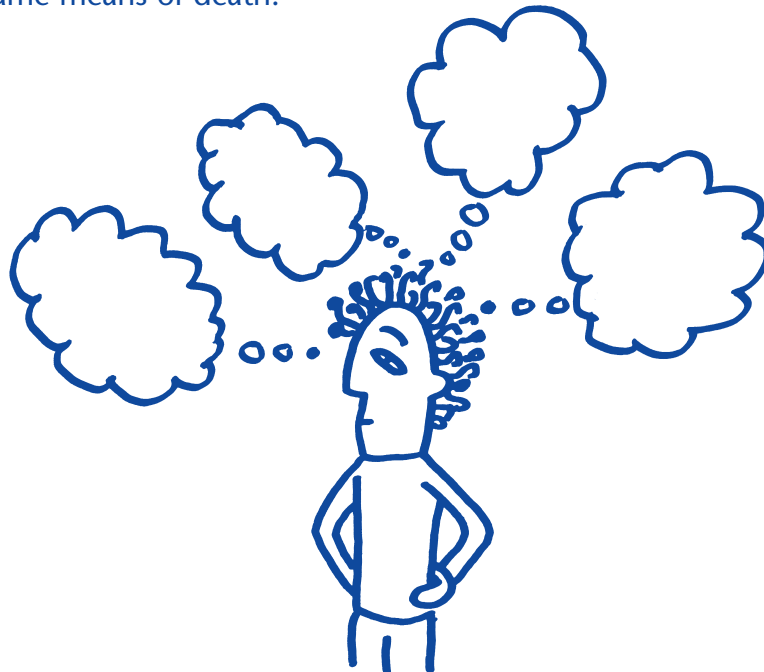
**Suicide contagion** describes the phenomenon by which one suicide precipitates the occurrence of a subsequent suicide in another person. In this situation there is a relationship (however loose) between the first person who suicides and the people who subsequently suicide. While not specific to young people, contagion does seem to occur more in the youth population than in the adult population.

**Suicide imitation**, also known as 'copycat' suicide, is where one suicide becomes a compelling model for other suicides. In suicide imitation there does not need to be a relationship with the first suicide: the main connection is choosing the same means of death.

**Suicide cluster** is a specific form of suicide contagion. In a cluster, there is an excessive number (more than the average rate) of suicides in close time and / or geographic proximity. Those who suicide may not know each other, but are aware of the suicides through media publicity or common knowledge.

**Suicide pact** occurs when there is a pre-death agreement to suicide among those involved. Pacts commonly involve two or three people usually with romantic or strong friendship links.

**School-based suicide prevention is fundamentally about good mental health promotion.**



# Mental health promotion and school policy

School-based suicide prevention is fundamentally related to good mental health promotion. Any school-based suicide prevention program will have activities and programs that work to create a safe and supportive environment for everybody, as well as to assist and support the individual young person in distress.

It is recommended that schools address suicide prevention within broader health, welfare and critical incident policies. All suicide prevention activities must be in accordance with the school's state policy and practice guidelines. (See *SchoolMatters* for advice about a whole school approach to mental health promotion. The *MindMatters* curriculum units provide useful models for those schools wishing to address issues of bullying, grief and loss, mental illness and enhancing resilience.)

## The Health Promoting Schools framework

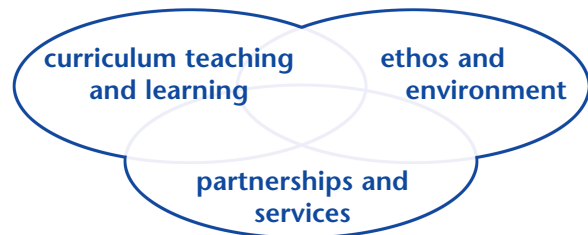
The Health Promoting Schools framework is an ideal context in which to locate a policy incorporating suicide prevention. This model allows a school to take a holistic approach to suicide prevention. A Health Promoting School addresses the underlying suicide risk factors and builds resilience without placing an over-emphasis on suicide.

The Health Promoting Schools framework entails a whole school approach to

mental health promotion in addressing the three arenas of:

- **Curriculum** – both the formal and informal curriculum: what is taught and how it is taught
- **Ethos / environment** – policies and practices which support the creation of a safe and supportive school environment
- **Partnerships** – the involvement of the family, the wider community, and health and welfare services in efforts to promote health and wellbeing.

### The Health Promoting Schools framework



The Health Promoting Schools framework invites a proactive, rather than a reactive, approach, and is fundamentally life affirming. It recognises that schools must address the broader environment in which young people are learning, and examine the linkage between curriculum and welfare services in a school. It takes cognisance of the relationship between welfare and disciplinary policies. It acknowledges the need for schools to develop and maintain ongoing partnerships with parents, carers, community groups and health services.

A Health Promoting School provides a safe learning environment by actively pursuing programs aimed at reducing

bullying, racism, sexism and homophobia in the school, and by the promotion of mutual respect and dignity (see page 26).

## School policy and guidelines

Schools that develop policies are in a much better position to develop a comprehensive suicide prevention program in their school and to effectively respond to a critical incident. A policy also provides greater legal protection for a school if it is shown to be based on credible and current knowledge and good practice in youth suicide prevention. A policy also provides a process to evaluate external agencies offering suicide prevention activities in a school.

## Development or review of a policy addressing suicide prevention

A brief and accessible school policy can be developed or reviewed in consultation with staff, student bodies and parent groups. It is likely to be grouped with or linked to critical incident policy, drug prevention policy, welfare policy and discipline policy.

Refer to *SchoolMatters* for material on developing a school policy addressing critical incident management. See next page for material addressing the suicide prevention component of a critical incident policy.

### *Community Matters*

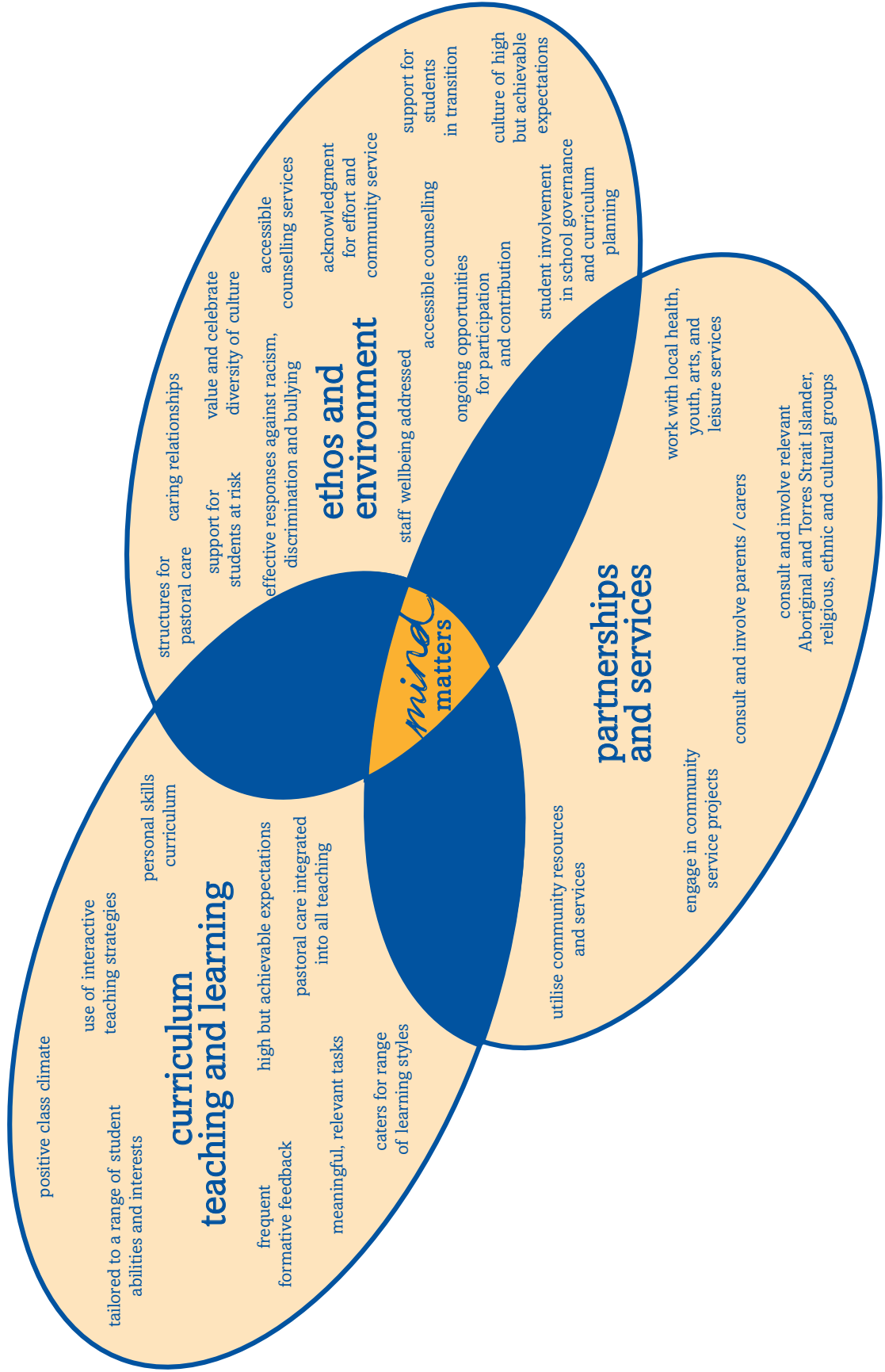
Chapter 5 ('Working together – community does matter') suggests ways that schools can work in partnership with their communities.



## **A school policy addressing suicide prevention is likely to include:**

- Goals and objectives addressing the provision and maintenance of:*
  - a safe and supportive environment (considering physical, social and emotional safety)
  - safe and appropriate curriculum content
  - welfare service delivery.
- Procedures for critical incident and postvention management plans including:*
  - clear and concise procedures that outline the minimum standards of practice
  - outline of the process of referral within the school.
- Professional development, including:*
  - plans to ensure all staff will receive introductory level training or awareness raising about youth suicide
  - descriptions of how interested parents, health services and community members will be involved
  - identification of welfare staff and key teaching staff for involvement in advanced training, in areas such as risk assessment and critical incident response.
- Support for students, describing:*
  - provision of counselling and welfare support
  - Pastoral Care, Health or Personal Development education which all students are entitled to receive
  - special support to be put in place in a critical incident
  - identification procedures for special needs of students at risk.
- Staff support and debriefing, outlining:*
  - provision of ongoing support or debriefing for staff following a critical incident.
- Parental involvement, describing:*
  - the preferred way to involve, consult with, support, or respond to parent concerns.
- Referral contacts, identifying:*
  - the relationship the school has with external specialist services
  - details of how referrals should be made from the school, including follow-up
  - protocols established in terms of referral to these services and the ongoing role of the school
  - a regularly updated register of contact details.

# A whole school approach to Mental Health Promotion



# Critical incident management

The death of a student or staff member can have a major and long-term impact on a school community. The degree to which the death impacts on the school is greatly influenced by how a school chooses to respond. It is essential that a school has a critical incident management plan that can be immediately implemented. In the event that the death is a result of suicide, the school has to respond to the grief within its community. It may have to deal with a great deal of self-questioning, and in addition must also be alert to the possibility of suicide contagion. Those previously identified as vulnerable to suicide and self-harm may be particularly vulnerable at this time, whether or not they were closely associated with the person who died. Most schools will address suicide postvention within their existing critical incident management plan.

## Develop a critical incident management plan

A critical incident management plan gives the school control over the response, avoids much confusion and stress amongst staff, and ensures that the best possible help is available to the school in a timely manner (see *SchoolMatters* for advice on development of a critical incident management plan). There are many generic principles that underpin any response regardless of the

type of incident. The section on death by suicide should address specific issues such as:

- discussing the suicide with pupils
- prevention of suicide contagion
- identification of students and staff at risk
- discussion of suicide with the media
- informing and working with parents
- school involvement in memorial services or activities.

The plan needs to be able to be implemented immediately should a death occur, and is best developed through consultation. The plan must be made known and accessible to all staff.

Critical incident response, including postvention plans, need to be developed in advance of an incident.

Schools that respond 'on the run' are much less effective in their response and may initiate activities that can have either short-term or long-term negative consequences. Schools need to be aware of any policies and critical incident services that are available to schools from their State or Territory Education Department. As part of this process it is advised that schools allocate responsibility for critical incident response to a team.

**School-based suicide prevention is fundamentally about good mental health promotion.**

## Form a critical incident response team

- Select a leader from senior staff with authority to ensure procedures are implemented and resources allocated.
- Identify key welfare and student management staff for membership.
- Ensure the leader and the team have training in critical incident management, and are familiar with guidelines and legal requirements.

## Main responsibilities of the critical incident response team

- Develop or review a critical incident plan in consultation with staff, students and the community.
- Coordinate delivery of introductory level training to all staff.
- Oversee the implementation of the response plan in the event of a critical incident.
- Coordinate and communicate with support services external to the school.
- Manage support and professional counselling for students and school staff.
- Conduct ongoing review of the critical incident plan.

## Identify external support agencies or individuals

In the event of a suicide, mental health or youth health services should be advised and invited to provide counselling, assessment and follow-up. Those whose services or offers of help will be accepted by the school should be defined in advance in the critical incident plan.

In developing or reviewing the school's critical incident plan, the team should:

- clarify the roles and areas of responsibility of service providers
- ensure all support personnel (chaplain, nurse) have an understanding of suicide postvention
- identify representatives of Aboriginal and Torres Strait Islander communities and, ethnic and religious groups, to provide advice
- establish ongoing communication and consultation with service providers and community or cultural groups.

## Postvention

### What is postvention?

Postvention is the term used to describe strategies implemented to respond to a suicide death, and is an important part of a school's suicide prevention plan and critical incident management plan.

The postvention plan is designed to assist the school to respond to the grief

within its community, and to prevent the possibility of further suicides or suicide attempts. A postvention response may also be needed following a suicide attempt.

### **Aims of postvention**

A postvention strategy aims to facilitate the expression of feelings about the suicide and to avoid romanticising the death.

Strategies used to achieve these aims include:

- identifying troubled or potentially suicidal students and providing appropriate support
- helping students and staff to understand why suicide occurs
- providing accurate information and opportunities to discuss the suicide
- conducting psycho-educational activities with classes to help students understand their emotions and grief responses
- facilitating appropriate participation in expressions of condolence, like letter writing or attendance at the funeral
- avoid romanticising the death, by actions such as making shrines or flying the flag at half-mast
- highlighting that suicide is a choice, but there are many better choices.

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### **The provision of support and professional counselling to those affected is a significant component of the postvention activity.**

A well prepared postvention plan will ensure that the school can:

- offer immediate opportunities for support and counselling
- be responsive to needs of both students and staff
- work in partnership with appropriate Aboriginal and Torres Strait Islander communities, and ethnic or religious groups about their needs, practices or belief systems
- provide longer-term support for those most affected
- provide one-to-one support where needed, as well as group work.

### **Those most affected by the suicide will require additional support.**

The postvention plan should assist in the identification of those most affected, including vulnerable students who may not have been closely connected to the person who has died.

Those most affected may include:

- close friends
- siblings and cousins
- girlfriend or boyfriend
- those with whom there has been a recent or unresolved falling out
- key staff
- vulnerable students and staff.

**A postvention plan aims to prevent the possibility of suicide contagion.**

Strategies to assist in the prevention of suicide contagion include:

- being vigilant in observing and identifying those who may be at risk
- understanding that those most affected are not always the obvious ones
- taking particular care with those who become very withdrawn and quiet or who are experiencing emotional distress in their own lives
- monitoring all activities
- ensuring that extra support structures and referral procedures are in place
- communicating with parents about grief reactions, warning signs and available support
- avoiding romanticising the death
- monitoring for distress at time of anniversary
- avoiding memorials such as tree-planting or plaques.

**The ultimate aim of a postvention plan is facilitating a healthy resolution of issues and returning to normal.**

To achieve this the school should set out to:

- provide ongoing safe and secure structures at school, such as presence of staff, and regular classes (even if in the short-term, lessons focus on facilitation or psycho-educational curriculum)

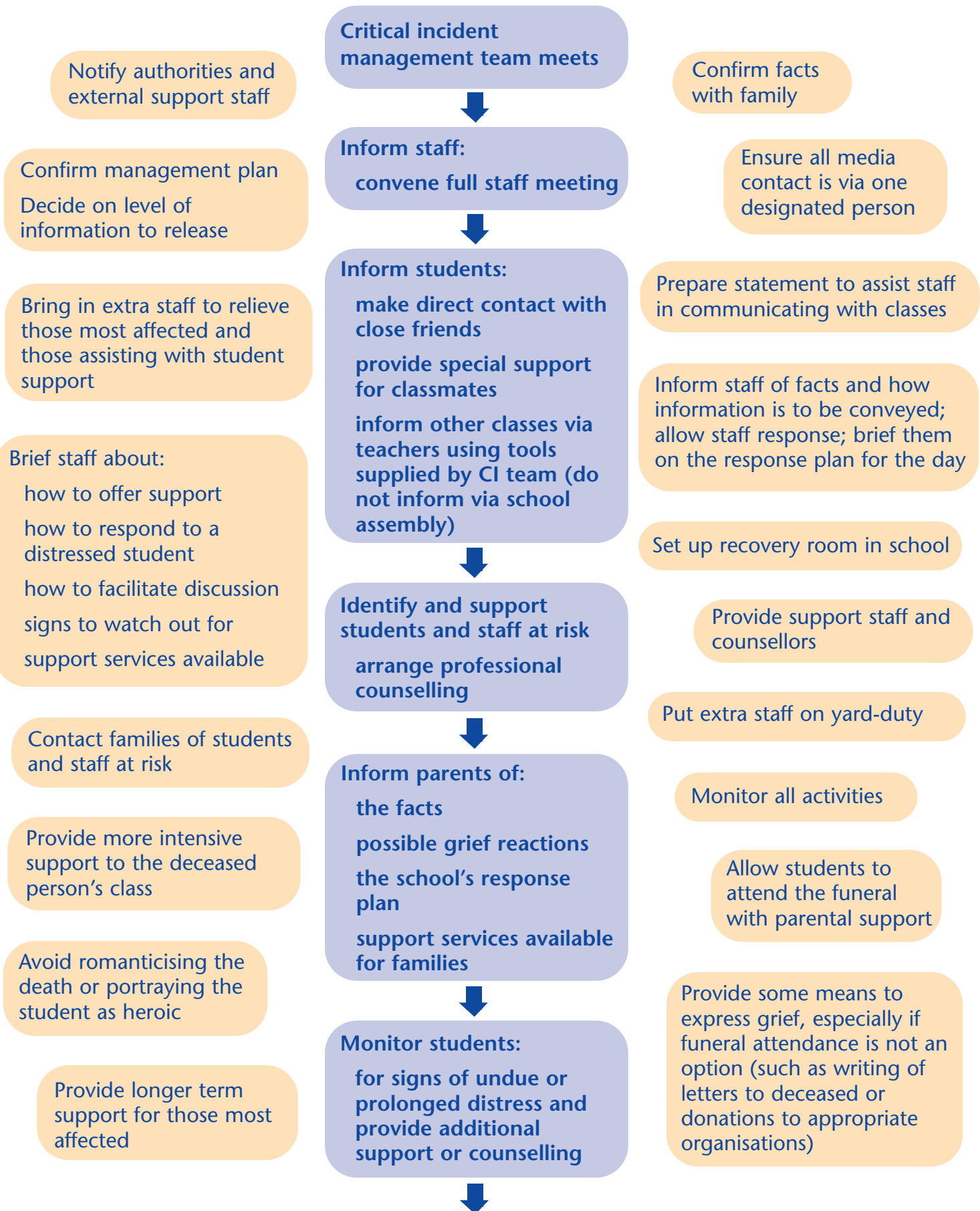
- debrief the critical incident management team
- review the school’s management of the critical incident and revise the postvention plan if necessary.

## Develop a postvention guide

Use the following postvention guide to assist in the development of the school’s postvention plan. In addition, schools should refer to the guidelines for handling critical incidents and emergencies provided by their state or territory education system.



# SUICIDE POSTVENTION GUIDE



**Restore school to regular routine as soon as practicable while continuing to inform and support staff, students and parents**

# Addressing suicide issues in the curriculum

## All teachers should be aware of the following

- Any disclosure, incident or thoughts of self-harm, even those presented in the abstract, require serious attention and should be passed on via the designated school pathway. All students and staff should understand that when someone's life or safety may be at risk, a secret should not be kept.
- If a student makes a disclosure, they should be informed that, under duty of care, a teacher is obliged to pass on information to appropriate personnel in the designated manner, or to accompany or assist the young person to pass on this information to those who need to know.
- Privacy should be respected, even though confidentiality can not be promised. When information is to be passed on, tell the student and inform or involve them in passing on the information to the appropriate people.
- All students should know who and how they can ask for help for themselves, a peer or a family member.
- The classroom teacher does not provide treatment or counselling but offers an ongoing pastoral relationship.
- Attention in class to the issue of suicide, while potentially interesting for many students, can be distressing for those with suicidal ideation and may make the option more viable for these vulnerable students. It should be noted that these students may not have told anyone about their distress.
- Due to the suggestibility factor in relation to suicide, teachers are advised not to undertake specific 'suicide awareness' units. A suicide awareness unit can be described as a series of one or more lessons focussing on suicide. Teachers are also advised not to prescribe suicide as the central topic or sole focus for research projects, class debate, creative writing, poetry study, scriptwriting or playmaking.

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# Advice about specific situations is provided below

## **What if a teacher is considering teaching about suicide as part of the Health or Personal Development curriculum?**

- It is best to refer to suicide within the context of a broader curriculum of problem-solving and emotional wellbeing, for example, in the context of discussing coping or help-seeking, dealing with grief or teaching about mental illness.
- Teachers need to be aware that vulnerable students can respond badly to discussion of this issue. In the context of an ongoing Health or Personal Development class, reference to, or discussion of, suicide should be kept to a minimum.

Teachers should endeavour to:

- promote positive attitudes, coping strategies and healthy options
- promote help-seeking behaviour. Inform students about types of support services available, and how to access these
- explain to students that suicide attempts often occur in association with depression, and that depression is treatable
- avoid increasing knowledge about methods of suicide and their lethality
- ensure that when using or exploring examples, they *do not* portray suicide as romantic, heroic, tragic or inevitable. It should be emphasised

that there are better options than suicide

- avoid alienating individuals or groups. Do not shame, blame or trivialise the painful realities of some people's lives
- acknowledge that some students can find this topic distressing, and invite students to speak with them (or another trusted adult) outside the regular class time if they are concerned about themselves or about someone else, or feel the need to take the issue further for some reason
- notify welfare staff about any worrying statements or behaviours
- inform welfare staff if class discussion of suicide has been held
- identify and note students opting out of class.

## **What if the issue of suicide comes up in the context of another study (such as a novel or film study)?**

- Question portrayals of suicide as romantic, tragic or heroic. Expose the myth if the novel / film portrays the suicide in this way.
- Explore the positive attitudes, coping strategies or help-seeking behaviour that would have been available in the circumstances where a suicide has been described.
- Avoid stigmatising or alienating individuals or groups. Do not shame, blame or trivialise the painful realities of some people's lives.
- Promote optimism, for example, things to live for or hope for in the future. Better options are always available. Most people recover from or deal with depression and other mental

illnesses once they get support and treatment.

- Avoid literature that provides information about suicide means and methods.
- Inform students about types of support services available should similar issues arise for individuals in the school community. Provide information about how to access these.
- Conclude class with reminders about availability of support should students ever need to seek help.
- Inform welfare staff that a class will be or has been held, which focussed on suicide.
- Notify welfare staff immediately about any worrying statement or behaviours of any student.

### **What if a student selects this as the focus of a research study?**

- Recommend the student frames the research in such a way as to deal with suicide as one aspect in a study of related issues, such as youth, depression, mental health, resilience in young people or problem-solving skills.
- Suggest parameters of the study, for example, factual or technical aspects (such as the rise in suicide rates), government policy, support programs, or suggestions about how to help a friend in distress.
- Follow-up the student during their research phase to check for emotional impact.

- Read assignments carefully to check for coded calls for help.
- Pass on any concerns to a designated staff member.
- Preview student's work prior to presentation in front of the class.
- Screen performances by students prior to public presentation.
- Use discussion to challenge messages endorsing suicide as an inevitable or acceptable option.
- Engage in prereading on the issue, particularly suicide myths. Be prepared to challenge misinformation.
- Monitor any signs of distress in the presenter or other students. Follow-up after class, and refer if necessary.
- Engage relevant local services in support of the student.

### **What if the topic of suicide arises spontaneously during class discussion?**

- Clarify the area of interest and concern. Clarify how this has arisen. Is this an interest or concern of an individual, small group or the whole class?
- Do not become involved in providing opinion or advice in this area beyond your specific training and comfort level.
- Do assess whether the student(s) who raised the issue are upset or concerned about a particular student or situation.
- If the class wishes to pursue the issue but it does not appear that anyone is at immediate risk, agree to arrange a

presenter who can plan a responsible approach to handling the student's interest or concern. For example:

*'This is not my particular area, but if you think it needs to be discussed I am happy to facilitate an informed discussion. I will discuss it with the counsellor (or principal or year coordinator if this is more appropriate), and see if we can arrange a guest presenter who can deal with the matter properly.'*

- If students are presenting as upset or very concerned, stay engaged with the concerned student(s) but avoid getting involved in an immediate general discussion. Perhaps the following words could be used:

*'This is obviously an important issue. Let's meet at recess (or lunch break or after school) when we can sit down and talk properly about it.'*

The following principles should then be applied.

- Ensure all concerned students are identified and included in any follow-up sessions.
- Don't handle it alone. Involve a student counsellor, year adviser, principal or other school-based or external person who is experienced in dealing with sensitive situations.
- Make it clear that confidentiality must always be broken if a life is in danger.

### **What if a visiting health presenter or theatre group offers a specific suicide awareness program for students?**

- The school should reject programs that focus on suicide awareness for students.
- As far as possible, ensure that visiting performers or educators will not present material that deals with suicide and, in particular, which highlights means or methods, or unduly focuses on suicide as a solution or inevitable or glamorous option. Such a program may possibly raise more issues than it solves, and vulnerable students may become distressed.
- If this arises, ensure that follow-up sessions are provided by school staff, which include reference to support available and help-seeking options. Ensure that the same principles are adhered to as those used for the class teacher in their practice.
- Ensure that welfare and pastoral staff are informed.