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Delivering Effective Suicide Postvention in Australian School Communities

headspace National is pleased to present the attached report on *Delivering Effective Suicide Postvention in Australian School Communities*.

This report is a culmination of the work we have done in suicide postvention in school communities across Australia. Between 2011–2017, the Australian Government funded the **headspace** School Support Program and this report shares our key learnings and recommendations from this time.

We are pleased that this important work continues to evolve under the recently announced Be You initiative, led by Beyond Blue. This initiative confirms the Australian Government's commitment to supporting all Australian schools to be prepared to respond to and recover from the suicide of a student or school community member.

As a delivery partner with Beyond Blue, **headspace** brings its learnings, resources and expertise in suicide postvention to this new initiative. Be You consultants based at **headspace** will continue to provide support to secondary schools who have experienced a death by suicide. They will also support primary and secondary schools across Australia to engage with the Be You initiative's whole school approach to promoting mental health for children and young people.

headspace is committed to working with all our partners in supporting the further development of knowledge and practices which enable schools to address suicide and suicide ideation and to support young people and their families through such experiences.

It is our sincere hope this report continues to inform school-based postvention practices at national, state and territory levels.

For further information about this report please contact:

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Yours sincerely

Jason Trethowan
Chief Executive Officer

Encl.

Delivering effective suicide postvention in Australian school communities

A report on headspace School Support's practice, learnings and recommendations for action.

headspace
School Support

Delivering effective suicide postvention in Australian school communities was written by Gabriel Baldwin, Helen Butler and Maggie Hannaway with **headspace** School Support.

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Foreword

I am pleased to present *Delivering effective suicide postvention in Australian school communities*.

This publication has been compiled by **headspace** School Support, a world-first suicide postvention service funded by the Australian Government Department of Health. **headspace** School Support is part of a suite of programs developed by the **headspace** National Youth Mental Health Foundation to provide mental health support to young people aged 12–25 years throughout Australia.

The death of a student by suicide is a traumatic and complex event that can have wide-reaching impacts on students, families, teachers and the broader school community. Sadly, in 2015 suicide was the leading cause of death of children between 5 and 17 years of age. As part of a whole school approach to suicide prevention, **headspace** School Support offers immediate and ongoing clinical and educational support to schools to reduce the impact of suicide in school communities. This support encompasses a range of flexible, integrated and targeted services to assist schools to prepare for, respond to and recover from a death by suicide. Effective postvention can contribute to the prevention of further deaths among those exposed to suicide.

Since its inception in 2011, **headspace** School Support has amassed considerable experience and knowledge in this field. To contribute to the further development of effective postvention services in Australian school communities and to respond to the increasing international interest in the **headspace** School Support model of postvention, this publication provides a comprehensive account of the practice and learnings of the School Support service. **headspace** believes that this work has the potential to be useful to key stakeholders in the field of suicide prevention and postvention, including policymakers and those working to support schools to respond to and recover from a suicide.

I encourage all those who are engaged in the design and delivery of suicide postvention in school communities to draw on this significant body of practice and evidence in their work.

Jason Trethowan

CEO **headspace**
National Youth Mental Health Foundation

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Common abbreviations

ABS ..... Australian Bureau of Statistics
CAMHS ..... Child and Adolescent Mental Health Services
CYMHS ..... Child and Youth Mental Health Services
hSS ..... **headspace** School Support
MHE ..... Mental Health in Education
NSPS ..... National Suicide Prevention Strategy
NYSPS ..... National Youth Suicide Prevention Strategy
STORM ..... *Skills-based Training on Risk Management*

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Definitions

Attempted suicide

Self-inflicted harm where death does not occur but the intention of the person was to die (1).

Exposure

In the context of suicide, exposure refers to any individual who knows or identifies with someone who has been suicidal or has died by suicide. This can encompass the following groups of people, along a 'continuum' of exposure:

- those ***bereaved*** by the suicide of a significant other. This includes anyone who experiences a 'grief response' to the suicide
- those ***affected*** by the suicide of another. This refers to anyone who experiences 'significant psychological distress' as a result of the suicide
- those who are ***exposed*** to the suicide of another. This can include those who lose an acquaintance in their school, workplace or other social circle (e.g., social media). It also encompasses those who did not know the deceased personally, but knew about the death through reports of others or media reports (e.g., the suicide of a celebrity) and those who personally witnessed the death of a stranger (2).

Postvention

An intervention conducted after a suicide, to reduce associated trauma and restore wellbeing (3, 4). It is often suggested that postvention 'acts as prevention for the future' (5) because those affected by a suicide may be vulnerable to suicide behaviour. Postvention includes procedures to alleviate the distress, depression and prolonged grief and trauma experienced by those most affected by the suicide, reduce the risk of subsequent suicides and promote the healthy recovery of the affected community.

In a school context, postvention strategies are designed to provide bereavement support and advocacy for those affected by the suicide and prevent further suicide events, including contagion suicides. It helps people to heal, continue to function in their community and importantly, it helps to reduce the risk of further suicides by other young people.

Postvention planning (Preparedness)

The planning, implementation and review of strategies and processes to ensure that, should a suicide occur, relevant staff, resources and services are capable of coping with the effects. This may include preparation of processes and structures, staff training and development, or the establishment of partnerships with local service providers to manage the wellbeing of the school community.

Secondary consultation

The provision of clinical advice to school wellbeing staff about how to support a vulnerable student at their school. This student may have been identified as being at medium to high risk of suicide, or may have an unknown level of risk. During secondary consultation, hSS clinical staff may offer their opinion about the impact of a suicide on a student and make suggestions for referral and support, where required. This process helps to develop a plan for the student, while also increasing the capacity of school wellbeing staff to respond to and support vulnerable students.

Secondary consultation is typically short-term focused, and school wellbeing staff are encouraged to utilise the internal support structures available to them as much as possible. Secondary consultation can be provided via the telephone or face to face.

Self harm

Any behaviour that involves deliberate injury to oneself. Self harm may be an attempt at suicide although it is not necessarily so. It is usually a response to distress. Self harm is not a mental illness, it is a behaviour or symptom.

Suicidal behaviour

Acts such as suicide and attempted suicide. This also includes suicide-related communications such as verbal or nonverbal statements expressing suicidal intent.

Suicidal ideation/thoughts

The presence of any thoughts, plans, images, imaginings or preoccupations a young person may have about ending their own life. Suicidal thoughts can range from a vague thought about 'not wanting to be around' to very specific thoughts and plans to die by suicide. These thoughts may or may not lead to a suicide attempt.

Suicide

Death determined by a coroner as a result of self-inflicted harm where the intention was to die (1).

Suicide contagion

The phenomenon whereby exposure to, or knowledge of, suicide or a suicidal act within a school, community or geographical area increases risk of suicide for other people in a school community – particularly young people who perceive themselves to be closely connected to the deceased (6-9). International research has found that exposure to a recent schoolmate's suicide is associated with ongoing suicidal ideation and attempts in peers, independent of other factors including mental health issues (10, 11). Young people are more vulnerable to suicide contagion than older people (10, 12, 13), and contagion is thought to be a key factor in 60% of all youth suicides (14).

Suicide contagion can lead to a suicide cluster, where a number of connected suicides occur following an initial death. Suicide clusters are common among young people (15), as well as Indigenous communities (16, 17). Youth suicides are more than twice as likely to occur as part of a cluster than adult suicides (18), and between 1 and 5% of all youth suicides are part of a cluster (19).

For a summary of the hSS experience of suicide contagion, see Appendix A.

Key terminology

The following terms are used throughout in this report:

School refers to a secondary school, unless otherwise specified.

Suicide Postvention Plan refers to a plan developed by a school to respond to the suicide of a student.

Emergency Response Team refers to the group of individuals who will implement a Suicide Postvention Plan.

School wellbeing team refers to those members of the school community who are employed with the aim of supporting the physical and emotional wellbeing of students within the school.

Throughout the report the words 'suicide' and 'death' are used interchangeably.

Background

Prevalence of youth suicide

Suicide[1] is the leading cause of death for young people in Australia. Data released by the Australian Bureau of Statistics (ABS) in September 2016 identifies suicide as the leading cause of death for children between 5 and 17 years of age (20), with many more young people considering or attempting suicide (21)[2].

Consequences of youth suicide

The impact of youth suicide is immediate and traumatic for those affected by it – for the friends or family of the individual especially, but also for the broader community (22)[3]. People bereaved by suicide frequently experience slower recovery than those bereaved by other types of death (23), and tend to struggle with the meaning of the death, guilt, blame – from self and others – for not preventing the death, feelings of rejection (24), isolation and abandonment, anger towards the deceased (25) and complicated grief (26). The extent to which the bereaved cope with these factors is strongly influenced by the immediate and ongoing response to the death and the support available.

This is particularly important in a school context, where the risk of subsequent student deaths after a suicide escalates – a phenomenon known as **suicide contagion**. Contagion is a key issue for young people in school settings (27, 28). Adolescent peers of people who have **attempted suicide** or people who have died by suicide have reported significantly more suicide-related behaviour than those students who have not been exposed to the suicidal act of a peer (11).

Need for school-based suicide interventions

It can be difficult for schools to know how to respond effectively to a suicide and minimise the emotional and operational impact of the death on the school community. In these circumstances, schools need clear, practical and reliable guidance and support to respond to the death, prevent subsequent deaths and aid in the recovery of the school community. **Postvention**, an intervention conducted after a suicide, is specifically designed to meet these needs. In a school setting, postvention aims to prevent further suicides in an affected school community by reducing the impact of the initial suicide on the community.

Establishment of headspace School Support

In 2012, **headspace** School Support (hSS) became the first service in the world to offer a postvention service to schools affected by suicide. Funded by the Australian Government Department of Health, hSS offers immediate and ongoing services to schools to reduce the impact of suicide on school communities to ultimately reduce the rates of suicide among Australian secondary school students.

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[1] All bold terms are defined in the Definitions section of this report.

[2] As many suicide attempts and thoughts go unreported, it is difficult to estimate the extent that young people think about or attempt suicide. In the second Australian Child and Adolescent Survey of Mental Health and Wellbeing, 7.5% of 12–17 year olds reported having seriously considered attempting suicide in the previous 12 months and 2.4% had made an attempt. This equates to approximately 41 000 Australian adolescents.

[3] On average, three other school communities are also affected by a suicide in a school community.

The hSS service was developed in three distinct stages:

- **Stage 1: Scoping the hSS service (July 2011 – December 2011):** This six-month scoping stage comprised a systematic review of the literature relating to suicide prevention and postvention in school settings (29), and national consultation with stakeholders from both the suicide prevention and education sectors. Together, these activities informed the development of the initial hSS Service Model.
- **Stage 2: Soft launch of hSS (January 2012 – October 2012):** This development stage comprised a soft launch of the service, including the hSS website. The service operated solely from **headspace** National Office in Melbourne. Clinically trained staff supported secondary school staff across the country via a dedicated telephone line and email account. In addition, a database was developed to record service activity. In July 2012, hSS began employing clinical staff in locations across Australia.
- **Stage 3: Formal launch of hSS (October 2012):** hSS formally launched on 25 October 2012. At this stage, clinical staff were employed in most Australian states and territories. The hSS Service Model was further developed between November 2012 and April 2013 in line with key learnings about the type of support desired and required by schools.

For further detail about each phase of service development, see Appendix B.

hSS forms part of **headspace**, Australia's National Youth Mental Health Foundation, which also provides mental health support to young people aged 12–25 years throughout Australia via:

- a network of over 100 **headspace** centres
- **eheadspace** (a national online and telephone support service)
- the **headspace** Digital Work and Study Service (an online and telephone service for young people aged 15–24 years who need support with their work or study issues)
- the **headspace** Digital Industry Mentoring Service (an online and telephone service that connects young people aged 17–24 years with an industry mentor).

As of 31 December 2016, hSS had offered assistance to 2678 primary and secondary schools to prepare for, respond to and recover from a suicide. This assistance spans the complete spectrum of postvention support, specifically:

- **postvention planning**: working with schools to develop strategies and processes to enable effective and timely suicide response and recovery
- **response**: responding to the immediate and short-term needs of the school community in the initial stages of the recovery process
- **recovery**: responding to the longer-term recovery needs of a school community[4].

At the time of publication, the hSS model of postvention service delivery is in the process of being incorporated into a national end-to-end Mental Health in Education (MHE) program funded by the Australian Government Department of Health.

[4] For further information about the services hSS offers to schools, see Section 1, What does hSS offer to schools?

Building the evidence base for suicide postvention in schools

Suicide postvention is still an emerging field of practice, and evidence for school-based interventions is limited (30, 31). One reason for this is the difficulty in establishing a control group of school-based suicide postvention programs, due to methodological and ethical considerations (32, 33). By studying the lived experience of schools and hSS workers, hSS has amassed considerable practice-based evidence in the field of postvention in Australian schools.

As a service innovation, it is essential that hSS is rigorously evaluated. To ensure a consistently high standard of service delivery, hSS has commissioned the following evaluation and evidence-gathering projects.

Responding to Suicide in Secondary Schools: A Delphi Study 2015

In 2013, an independent research team led by Orygen, The National Centre of Excellence in Youth Mental Health, conducted an expert consensus (Delphi) study to develop guidelines that would assist secondary schools to develop a plan to respond to a student suicide. From 2014 to 2015, multiple rounds of consultation with national and international experts who had worked with schools following a suicide were conducted until consensus was achieved. A postvention guidelines document was developed from 548 endorsed actions, which overwhelmingly affirmed existing hSS practice and resources for working with schools (34).

hSS Evaluation 2014

In 2014, an evaluation was completed by the **headspace** Research and Quality Improvement team to explore the implementation, and the emerging impacts and outcomes, of hSS. The evaluation employed a mixed methods approach to ensure the reliability and richness of the data and consisted of hSS activity data, two online surveys, interviews and case studies. For further details of the evaluation and its findings, see Appendix C.

hSS Awareness and Satisfaction Evaluation 2015

The **headspace** Research and Quality Improvement team undertook further evaluation in 2015, which was based on the surveys that formed the *hSS Evaluation 2014* described above. The two online surveys were repeated; one involved school wellbeing staff and explored the need for and awareness of hSS, and the second involved school representatives who had used hSS and explored satisfaction with and early impacts and outcomes of hSS (35).

Findings from these projects will be referenced throughout this report to describe hSS in practice.

In addition to the formal evaluation and evidence-gathering described above, hSS relies on the following types of practice-based evidence to continuously improve its operations:

- hSS suicide and service activity data from all states and territories, collected via the **headspace** Application Platform Interface (HAPI), an innovative suite of electronic data collection tools used across the **headspace** centre network. Data are analysed using Tableau business intelligence software. All staff enter data into HAPI and entries are regularly audited by the hSS National Clinical Advisors[5]. For further information about data collected via HAPI, see Section 2, Component 10: Data collection, evaluation and dissemination
- feedback from hSS State and Territory Coordinators. hSS State and Territory Coordinators are actively involved in the continuous review and improvement of hSS services. Feedback from Coordinators is provided to the national hSS team via weekly telephone meetings and quarterly face-to-face meetings
- responses from immediate feedback groups, e.g., personal written communications – referenced as 'Personal communication, [Title (State), Year]

[5] Further information about the workforce structure of hSS is provided in Appendix F.

- regular consultation with stakeholders across education, health and community sectors informs the continuous improvement of the hSS program and in turn the capacity of schools and systems to prepare for, respond to and recover from the suicide of a student.

Evidence gathered from these forums is fed into the hSS quarterly progress reports to the Australian Government Department of Health. Although these reports are not publicly available, relevant data and information extracted from these reports has been made available in the body of this report.

The immediate and organic format of the evidence described above has enabled hSS to expand its knowledge of postvention in areas outside the boundaries of formal research in the field to date. This has enabled hSS to play a critical role in shaping best practice in postvention planning, response and recovery and in driving continuous and contemporaneous improvement in the field.

This practice-based evidence has now been organised into the 10 core components of effective postvention practice outlined in Section 2 of this report. As the steps taken to achieve each component may differ widely within each school community, the components are flexibly described to ensure their relevance and applicability to the range of school environments.

About this report

This report has been designed as a resource for policymakers, schools and service providers to guide decisions around the effective delivery of suicide postvention in schools using the hSS Service Model. Over recent years increasing interest has been shown in this service model internationally.

There is considerable evidence that suicide postvention in schools is critical to reduce the lasting impact of a suicide. This includes preventing subsequent deaths, shortening recovery periods and restoring overall wellbeing to affected school communities. But effective postvention is multifaceted and complex and can be challenging to achieve. Although many think that postvention work is limited to the days immediately following an event, postvention work is intricate and ongoing and difficult to represent in a simple way. This report aims to showcase the many layers of activity that encompass this work.

To offer evidence-based, practical guidance about suicide postvention in schools, this report draws on extensive research, practice and qualitative and quantitative evaluations of hSS from July 2011. It presents service delivery data, lived-experience case studies and feedback from school communities and stakeholders in education, health and community sectors to operationalise available evidence and provide recommendations for effective suicide postvention in Australian schools.

Note: Although this report is focused on postvention in secondary schools, hSS acknowledges the increasing interest in suicide postvention at either end of the education spectrum (i.e., primary and tertiary settings). For this reason, hSS has widened the scope of its recommendations to encompass postvention across the education spectrum.

Section 1: The situation and responses to date

Suicide and young people – what do we know?

The situation in 2011 (Pre-hSS)

In 2011, growing concerns were being raised in Australia about high suicide rates among secondary-school-aged young people, and the impacts of these. 'Causes of death' data released by the Australian Bureau of Statistics (ABS) in 2011 indicated that in 2008, suicide was the leading cause of death for young people aged 15–24. (This publication did not include detailed information about suicides for young people aged under 15 years, given that the number of reported suicides in this age group was likely to be underestimated.) The publication also indicated that suicide comprised a much higher proportion of total deaths in younger age groups compared with older age groups. This was particularly the case for young men, as suicide accounted for 24% of all male deaths in this age group (36).

The need for a school-based postvention program was strengthened at this time by international research confirming that contagion is of particular concern among young people, especially in school settings. This research indicated that between 1 and 5% of all youth suicides are part of a cluster (19), and **suicidal behaviour** in school students is a key predictor of similar behaviour in peers and friends (27, 28). Research suggesting that up to 90% of young people who die by suicide or make a suicide attempt have at least one mental health problem at the time (37) reinforced the need for this service to combine both clinical and educational support to schools.

The situation in 2016 (6 years since the establishment of hSS)

The demand for a nationwide suicide postvention service for young people has become even more apparent in light of ABS statistics released in 2016 – relating to suicide data in 2015 – confirming that the rate of youth suicide is at a 10-year high (20). Two of the most concerning trends revealed by this data are:

- 1 child (aged 5–17) dies from suicide on average every 4 days
- 8 children/young people (aged 5–24) die from suicide each week – an increase of 32% since 2006.

When compared to older age groups, the number of suicides among young people is relatively few. Nevertheless, suicide accounts for a sizeable proportion of deaths in this age group. In 2015, suicide accounted for 30.5% of deaths of Australians aged between 15 and 19 years — 28.6% of male deaths and 33.9% of female deaths in this age group (20).

Suicide has also been identified as a significant concern for young people: in a national survey of almost 19 000 young people aged 15–19 years, one in five reported that suicide was a concern for them (35). Increasing rates of suicide are particularly evident among young women aged 15–24 years: an increase of 62% between 2006 and 2015 was reported by the ABS (20).

In 2016, hSS received notification of 223 deaths and 252 attempted suicides and responded to 4–5 deaths per week. hSS suicide data differs from suicide data collected by the Australian Bureau of Statistics for two reasons:

1. hSS collects information about student deaths that have not necessarily been confirmed as suicides by a coroner
2. hSS only collects information about a student suicide with the consent of the student's next of kin.

hSS suicide notifications are received from a number of sources, including departments or associations, school staff members, **headspace** centres, StandBy[6], local Child and Adolescent Mental Health Services (CAMHS) and Child and Youth Mental Health Services (CYMHS), coroners and police.

[6] StandBy is a national suicide postvention program that provides a coordinated response of support and assistance for people who have been exposed to or bereaved through suicide.

Research has continued to emerge emphasising the need for renewed and integrated suicide prevention, intervention and postvention activities in secondary schools. Of particular importance is research confirming that young people who had lost a friend to suicide share levels of increased stress, depression, prolonged grief symptoms and reduced coping skills consistent with similar studies of other suicide-bereaved populations described in the literature (38). This situation supports the enhancement of assistance offered to young people bereaved by the suicide of a friend.

Why is suicide postvention in schools a priority?

Schools are a key platform for the provision of mental health services that engage children, young people and families along the continuum of intervention for health and wellbeing. Not only are schools well-accustomed to supporting students' learning and developmental needs, schools also help students to develop resilience, social and emotional health, and confidence in seeking services and treatment. For these reasons, schools have long been regarded as suitable environments for implementing suicide prevention initiatives for vulnerable young people (29). Over recent decades, schools have also become recognised as important sites for postvention (29, 39, 40), which involves responding to the mental and physical health and wellbeing of students and staff, both immediately following a suicide and in the longer term.

This shift is primarily in response to international research indicating that young people are particularly susceptible to suicide contagion (10, 12, 13, 18), and that schools are a common setting for youth suicide clusters (41). This has reinforced the need for effective and quality-assured postvention services in schools. The shift has also been supported by research highlighting that student services' supports are a popular and easily accessed source of help for young people (42). This is particularly important given the reluctance of young people to seek help from services, especially young people who are experiencing risk factors (43). Schools are well placed to identify students experiencing such issues, take early intervention measures and refer more complex cases to appropriate local service providers. In addition to addressing the immediate safety needs of the young person, schools are also in a prime position to understand what ongoing support students may need – emotionally, socially, psychologically and academically.

Postvention in a school setting also serves the best interests of young people by enhancing their traditional support networks and ensuring that disruptions to routines are minimised. As well as potentially reducing the risk of subsequent suicide deaths or attempts, effective postvention in schools responds to complex grief, disengagement from school, risky behaviours and disruption to relationships triggered by a suicide (5, 38, 44). This is particularly significant in light of research suggesting that the key determinant of whether someone is affected by a suicide is their 'perceived closeness' to the deceased (7). This expanded definition of who is most likely to be affected by a suicide highlights the importance of schools identifying and supporting vulnerable members of the community following a suicide.

In recent decades, Australian education systems and schools (both primary and secondary) have become increasingly comfortable with their role in promotion and prevention. This has driven the development of policy and school improvement frameworks premised upon the fact that student health and wellbeing is a precondition to engagement and performance in learning. In other words, mentally healthy students have a greater ability to engage in learning and school activities; they have a greater sense of belonging and connectedness and are more likely to succeed (45).

Nevertheless, even with the most comprehensive prevention and promotion strategies, Australian schools will continue to be confronted by serious and complex youth health issues, including **self harm** and suicide. As school staff have often reported feeling under-resourced to respond appropriately to youth suicide and suicide behaviours (35, 46, 47), it is essential that dedicated postvention services assist schools to respond effectively. hSS fulfils this role by building the capacity of school staff to respond to students' needs as they deal with the trauma that follows a suicide.

National responses to youth suicide

The prevention of youth suicide has been a national priority in Australia since the mid-1990s due to the prevalence of, and negative consequences associated with, suicide-related behaviours in young people. This has resulted in the following efforts to reduce youth suicide in Australia.

National Youth Suicide Prevention Strategy 1995–1999

In response to growing international, government and community concerns about youth suicide in the 1980s and 1990s, Australia became one of the first countries in the world to develop a national strategic approach to youth suicide prevention, specifically, the National Youth Suicide Prevention Strategy 1995–1999 (NYSPS) (48). The NYSPS was administered and coordinated through the Mental Health Branch of the then Australian Government Department of Health and Aged Care. Rather than creating new services and programs the strategy aimed to build the capacity of existing services and programs to provide more effective responses to suicide. The NYSPS placed a strong emphasis on early intervention programs that aimed to address risk factors for youth suicide.

National Suicide Prevention Strategy 2000

In 2000, the National Suicide Prevention Strategy (NSPS) replaced the NYSPS. The NSPS expanded the focus on suicide prevention activities across the whole lifespan but maintained a specific focus on at-risk groups, including young people (49). One component of the NSPS is the Living Is for Everyone (LIFE) Framework, which provides an overarching policy framework for national action to prevent suicide and promote mental health and resilience across the Australian population (50).

National Action Plan on Mental Health 2006–2011

In 2006, the Council of Australian Governments (COAG) agreed to a National Action Plan on Mental Health 2006–2011. This plan committed the Australian Government to increase funding for the NSPS to enable the expansion of suicide prevention programs. In 2007, a new LIFE Framework was also released along with a suite of practical resources to assist the wider community in suicide prevention (50). In 2011, the LIFE Framework was adopted in all jurisdictions as Australia's overarching suicide prevention framework.

The hidden toll: Suicide in Australia (2010)

In 2010, the Senate Community Affairs References Committee called for an evidence-based, whole-of-community and whole-of-government response to target those at particular risk of suicide in *The hidden toll: Suicide in Australia* (51). This report recommended targeting high-risk groups, including young people, via a national suicide prevention and awareness campaign. The Australian Government's response to this report committed additional funding to services promoting good mental health and building resilience in young people, to prevent suicide later in life (52).

Before it's too late: Report on early intervention responses aimed at preventing youth suicide (2011)

In 2011, a parliamentary inquiry into youth suicide by the House of Representatives Standing Committee on Health and Ageing – ***Before it's too late: Report on early intervention responses aimed at preventing youth suicide*** – also called for a stronger and more strategic focus on the prevention of youth suicide across Australia that is coordinated, collaborative and inclusive (53). This report made a number of key recommendations to reduce youth suicide through better data monitoring, collaboration, research and evaluation to inform best practice interventions and build mental health literacy and gatekeeper training[7] for people with critical roles in a young person's life.

National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013

To complement the National Suicide Prevention Strategy 2000, Australia's first National Aboriginal and Torres Strait Islander Suicide Prevention Strategy was developed by the then Australian Government Department of Health and Ageing in 2013. The National Aboriginal and Torres Strait Islander Suicide Prevention Strategy calls for community-focused, holistic and integrated approaches to suicide prevention, with an emphasis on investment in 'upstream' prevention efforts to build community, family and individual resilience and restore social and emotional wellbeing (55).

National Review of Mental Health Programmes and Services 2015

In the 2015 National Review of Mental Health Programmes and Services, the National Mental Health Commission recommended that the Australian Government work with state and territory governments, people with lived experience and other key stakeholders to develop a reinvigorated National Suicide Prevention Framework. To effectively reduce suicide rates, the Commission advocated for systemic, multi-level and multi-sectoral prevention models in particular communities in collaboration with key stakeholders in those communities (56).

National Suicide Prevention Strategy 2015

In response to the National Review of Mental Health Programmes and Services, in 2015 the Australian Government announced a renewed approach to suicide prevention through the establishment of a new National Suicide Prevention Strategy (57). This strategy involves:

- a systems-based regional approach to suicide prevention led by Primary Health Networks (PHNs) in partnership with Local Hospital Networks, states and territories, and other local organisations with funding available through a flexible funding pool
- national leadership and support activity, including whole-of-population activity and crisis support services
- refocused efforts to prevent suicide in Aboriginal and Torres Strait Islander communities, taking into account the recommendations of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy
- joint commitment by the Australian Government and states and territories, including in the context of the Fifth National Mental Health Plan (forthcoming), to prevent suicide and ensure that people who have self harmed or attempted suicide are given effective follow-up support.

headspace School Support

In its response to ***Before it's too late: Report on early intervention responses aimed at preventing youth suicide***, the Australian Government highlighted its efforts to expand youth-focused mental health and wellbeing initiatives. This included the commitment of $31.3 million over five years, commencing 1 July 2011, to the **headspace** Youth Mental Health Foundation to establish a nationwide network of 'outreach teams to schools'. These teams were to provide direct support to secondary schools and surrounding communities impacted by suicide or concerned about vulnerable students. Direct support would involve working with schools to minimise the distress caused to students and staff, and coordinating appropriate services and resources (54).

[7] For further information on gatekeeper training, see Section 2, Component 6: Early identification and management of vulnerable students (Gatekeeper training).

1

What does hSS offer to schools?

hSS is a national postvention service for all secondary schools across Australia. It has developed a range of flexible, integrated and targeted postvention services to assist government, independent and Catholic secondary schools to manage the impact of suicide on students, staff, families and the community, and reduce the risk of suicide contagion.

The hSS Service Model, illustrated in Figure 1, offers the complete spectrum of suicide postvention support. This includes:

- **postvention planning**: working with schools to develop strategies and processes to enable effective and timely suicide response and recovery
- **response**: responding to the immediate and short-term needs of the school community in the initial stages of the recovery process
- **recovery**: responding to the longer-term recovery needs of a school community. A breakdown of each stage of response and recovery is provided below.

For the purposes of comprehension these three phases of postvention are presented as distinct and chronological components throughout this report. In practice, the order in which hSS provides **postvention planning**, response and recovery services is entirely dependent on the unique requirements of the school community. This can result in the delivery of overlapping phases of postvention support simultaneously, as demonstrated in Figure 1.

Figure 1. hSS Service Model

All of these services are undertaken only with the permission of the school's governing body/principal. The coordination and planning of all response and recovery activities is completed in partnership with the school principal, leadership and wellbeing staff, and relevant education departments.

Note: Schools are expected to undertake immediate risk management processes, follow emergency management protocols and contact the relevant department or school authority. hSS can assist schools to perform these tasks, if required.

The hSS Service Model has continued to evolve over time in response to both formal research and evaluation and practice-based evidence, in particular, the lived experience of hSS State and Territory Coordinators delivering postvention services throughout Australia. For further information on the development of the hSS service, and the hSS Service Model, see Appendix B.

Stages of response and recovery

The phases of response and recovery are typically divided into the following stages:

- immediate response
- first 24–48 hours
- first week
- first month
- longer term (including anniversaries, birthdays and other significant events).

Within each of these stages, hSS tailors a range of services to the needs of individual schools, based on an assessment of their presenting problem(s), physical location, size, existing support structures and policies and their links to local services. These services may include:

- improving the capacity of school staff to manage issues related to suicide – through the provision of information, advice, education and training and policy development. (For a summary of hSS resources, see Appendix D)
- working directly with schools and the wider community to coordinate immediate, short and long-term response and recovery activities
- building and strengthening the relationships between schools and local mental health services to facilitate effective support for students. (For two response and recovery case studies, see Appendix E.)

These front-line services are delivered either in person, via telephone and/or email, by multidisciplinary state and territory-based hSS staff[8]. In situations where multiple suicides or attempts have occurred in a region, response and recovery activities may involve a number of schools, to contain contagion. To ensure hSS services are accessible to regional and remote schools, the location of hSS staff aligns with the location of schools at a state/territory and a metropolitan/regional level.

[8] Further information about the workforce structure of hSS is provided in Appendix F.

hSS staff are now located in every state and territory, and all service regional and remote schools. Across 2015 and 2016, 53% of the schools that hSS worked with were categorised as either inner regional (24%), outer regional (16%) or remote or very remote (13%). For a map of services delivered across 2015 and 2016, see Figure 2.

Rather than replacing support that already exists – such as **headspace** centres, education departments, suicide support services, general practitioners and local mental health services – hSS aims to enhance the skills of those involved in the response, help schools to better utilise local services where available, and to directly assist with the front-line response, where local services are limited. By learning from the lived experience of hundreds of service users as well as front-line staff, hSS is able to expertly assist schools to respond to and recover from the rare and traumatic event of a student death. The significant increase in the number of hSS services delivered between 2015 and 2016 (as shown in Figure 3) attests to the critical role that hSS has retained in suicide postvention in Australian secondary schools.

For further information on the development of the hSS service, see Appendix B.

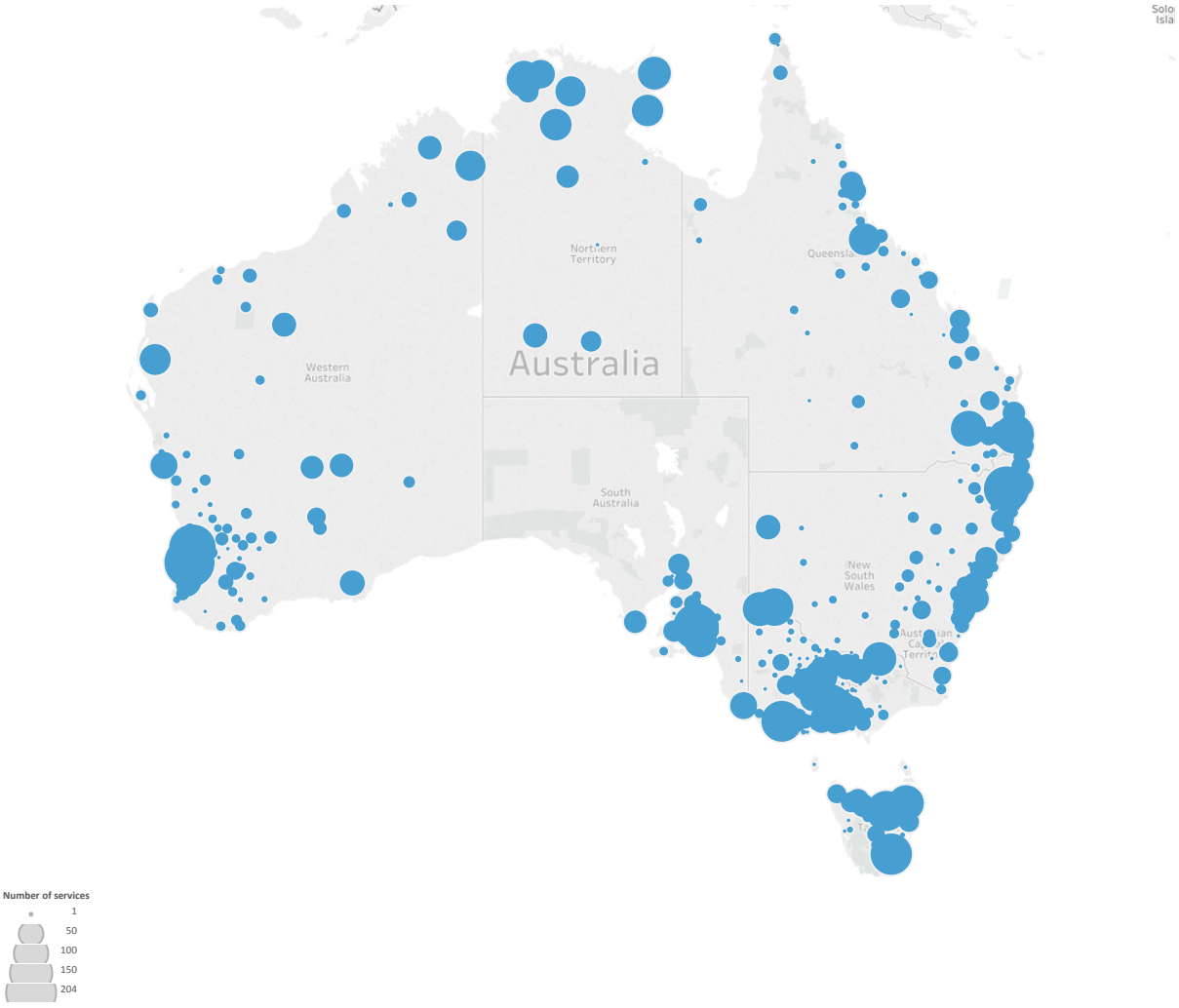


Figure 2. Map of hSS services delivered across 2015 and 2016

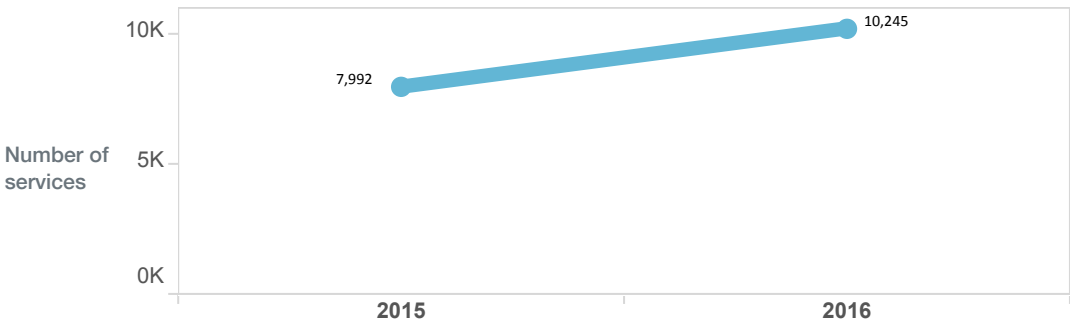


Figure 3. Graph showing increase in number of services delivered between 2015 and 2016

hSS workforce structure

National hSS team

The national hSS team is located in Melbourne at **headspace** National Office. It is responsible for the development and strategic direction of hSS throughout Australia. The national team oversees all services offered by the program, ensuring the delivery of suicide postvention services to secondary schools nationally. It is also responsible for liaising with, and reporting to, the Australian Government Department of Health.

The core functions of the national team include:

- supporting state/territory teams to implement the national hSS Work Plan
- continuous development of the service, including the provision and implementation of standards, policies and practices
- backup support to state/territory hSS teams through the direct provision of services to secondary schools
- resource development, production and provision
- development and provision of education and training to ensure the consistency and quality of services across the national workforce
- development and integration of an evaluation strategy that guides data collection, facilitates reporting and informs the ongoing development of the service
- ongoing development of the suicide postvention evidence base to inform the provision of effective support services to secondary schools
- driving and contributing to strategic reform in the field of youth suicide, particularly through the development of relationships with peak bodies and education and health systems and sectors
- building partnerships with relevant national education and health, government and non-government bodies (e.g., Principals Australia Institute, Hunter Institute of Mental Health, Black Dog Institute) to facilitate the ongoing development of postvention services in Australia.

State/Territory hSS teams

The state and territory-based hSS teams provide front-line suicide postvention support to government, independent and Catholic secondary schools.

The core functions of the state/territory teams include:

- establishment and maintenance of relationships with relevant state and territory education and health government and non-government bodies. This includes working collaboratively with **headspace** centres to ensure the continuity and consistency of service provision to schools
- acting as the hSS point of contact for secondary schools in their state/territory
- provision of postvention services to secondary schools
- longer-term monitoring and support for schools that have utilised hSS services
- promotion of hSS through the provision of information and resources
- regular reporting to the hSS national team
- participation in national evaluation activities, including data collection and reporting.

Within each state/territory team, the State/Territory Coordinator is primarily responsible for the strategic direction of the team, the Clinical Consultants are responsible for the delivery of services to schools and liaison with locally based services, and the Education Consultants are focused on postvention planning.

An organisational chart illustrating the structure of the hSS workforce is provided in Appendix F.

Section 2: The 10 core components of effective postvention practice

Effective postvention is much more than an immediate response to a suicide – it is also an ongoing process of planning to respond to and recover from suicide within a whole school, whole community approach.

To effectively deliver this spectrum of postvention planning, response and recovery support, hSS draws on 10 integrated and overlapping key components, at a national, state/territory and/or local level:

1. cross-sectoral partnerships across education and health services
2. strong working relationships between schools, the community and local service providers
3. a whole school, whole community and whole sector approach to mental health
4. ongoing postvention planning
5. a timely, tailored and clinically sound response, valuing in-person support
6. early identification and management of vulnerable students
7. responsiveness to population groups that are overrepresented in suicide and self harm statistics
8. school staff wellbeing and support
9. long-term recovery support
10. data collection, evaluation and dissemination

The evidence base for the 10 core components

The 10 components of effective postvention practice are informed by and contribute to the hSS postvention evidence base, which draws on research, program evaluation, internal and external stakeholder consultation and hSS service delivery learnings since 2011.

For a taxonomy of evidence relied upon in the development of this report, including a summary of the formal research and evaluation measures used to instruct hSS service delivery, see Background, Building the evidence base for suicide postvention in schools.

Structure and order of the 10 core components

Each of the 10 components is presented in the following structure:

1. **Rationale** – reasons why the component is important
2. **Process** – how hSS is operationalising the component at a national, state/territory and local level. It must be noted that the steps taken to achieve each of these components by hSS may differ dramatically within each school community. This is because an effective postvention service must respond to the complex combination of factors involved in an individual suicide and the unique characteristics of a particular school environment
3. **The component in practice** – examples from practice and evaluation that demonstrate what hSS has achieved and learnt from the work it has undertaken.

To emulate best practice in suicide postvention the components are ordered in a linear structure, beginning with postvention planning and then transitioning to the response and recovery phases in the event of a suicide. hSS acknowledges the limitations of depicting this dynamic and highly tailored service structure in a linear fashion, and the overlapping and adaptable nature of each of these components.

1. Cross-sectoral partnerships across education and health services

Rationale

The far-reaching impact of a suicide requires a range of supports across education, health and community services and organisations, during both the immediate response and the longer-term stages of recovery.

It is well recognised that there can be differences in how health issues are understood, approached and discussed in education and health sectors. Bridging these differences is especially important in the challenging and distressing circumstances of a suicide to:

- provide coordinated and comprehensive support for schools with minimal service duplication
- maximise the quality of care provided to those affected by suicide
- build and sustain the capacity of schools to deliver suicide postvention.

At a national level, the Australian Government's Fourth National Mental Health Plan 2009–2014 (58) and the National Review of Mental Health Programmes and Services 2015 (56) also recognise that mental health is a whole-of-government responsibility and encourage cross-sectoral collaboration.

Process

To achieve strong cross-sectoral collaboration, hSS builds partnerships with education and health organisations at a range of levels.

Local

hSS staff, including Clinical and Education Consultants[9], work closely with health and education professionals to share understanding and expertise when developing and delivering resources and services at a school level or within regional clusters of schools. The partners involved in these processes are determined by local needs and the availability of services, but can include school leaders, school counsellors/wellbeing staff, local Child and Adolescent Mental Health Services (CAMHS) and Child and Youth Mental Health Services (CYMHS), **headspace** centres and regional health and education staff.

Mechanisms for hSS staff to develop these cross-sectoral relationships include:

- attendance at community linkage meetings
- provision of information to schools about existing services and how to refer
- provision of information to services about demands on local schools and the types of wellbeing services that can be provided to them.

State/Territory

hSS seeks to meet regularly with relevant policymakers and service providers in government, Catholic and independent school sectors to ensure that hSS practice is aligned with existing state and territory-wide policies, programs and services. Initially, agreements were signed in most states and territories to guide these partnerships[10]. hSS has also established formal notification protocols with these organisations to ensure hSS is notified about student suicides, and vice versa.

hSS has also implemented a series of roundtables for key stakeholders in 7 out of 8 Australian states and territories to develop strong, effective and sustainable partnerships; address any service duplications and gaps; and ensure coordinated service delivery to schools. Stakeholders at these roundtables included representatives from state/territory and local mental health networks, departments of health and education, coroners' courts, lead agencies involved in suicide response and Primary Health Networks (PHNs). Unlike hSS, few of these stakeholders regarded suicide postvention as their core work.

hSS also works with a range of stakeholders (including coroners, bereavement services, local government and emergency services) to identify patterns of suicidal behaviour and strategies for responding effectively when a suicide occurs. For further information about a data linkage study that hSS undertook with a state coronial court, see Component 10: Data collection, evaluation and dissemination.

National

hSS forges productive working relationships and consultative processes, including hosting national meetings, with national education and health bodies, and other organisations whose work is related to mental health and/or suicide in schools to integrate planned support from education departments and mental health services, including:

- Primary Health Networks
- StandBy
- MindMatters
- *beyondblue*
- the Principals Australia Institute
- the Australian Secondary Principals' Association
- the Hunter Institute of Mental Health
- Response Ability
- *Mindframe*
- the Black Dog Institute
- ReachOut Teachers' Network
- Good Grief.

hSS also undertakes research, evaluation and consultation with key organisations to inform the service improvement, stakeholder engagement and capacity building of both schools and systems in suicide postvention.

[9] An organisational chart outlining the workforce structure of hSS is provided in Appendix F.

[10] For further information, see Appendix B (Stage 3: Formal launch of hSS).

The component in practice

Cross-sectoral collaboration has placed hSS in a unique position to contribute to and drive policy and strategic reform addressing youth suicide at a local, state/territory and national level. The hSS-instigated roundtables have also been praised for providing fresh opportunities for cross-sectoral collaboration across the country.

'Congratulations on today's event – it was a great success bringing together so many key, but varied contributors to such critical work. It certainly will be a springboard to further collaboration.' – Personal communication, Senior Leader, State Education Department 2015

This regular liaison also allows hSS to be part of the ongoing development of the body of postvention knowledge and services at all levels and jurisdictions. These opportunities further legitimise the service and increase the likelihood of schools utilising hSS. The contribution of hSS to the operationalisation of Tasmania's first Youth Suicide Prevention Plan 2016–2020 (59) and the development of the 'Youth Suicide Postvention' section of the Respectful Schools, Respectful Behaviour framework (60)[11] are notable examples.

To this end, hSS has also initiated collaborative meetings between hospitals, the Child and Adolescent Mental Health Service (CAMHS) and the Department of Education in Tasmania to develop a state-wide communication protocol when young people who attempt suicide present to an emergency department. This protocol will allow for Department of Education schools to be notified by hospital staff of young people who present to the hospital after an attempted suicide (with the consent of a parent or guardian). By improving communication between the hospital systems, CAMHS and schools and prompting the early identification of vulnerable students, including students exposed to a suicide attempt, this initiative will ensure that assertive aftercare support is provided to the young person and their school peers.

The role of hSS in facilitating greater communication between stakeholders is also evident at a national level – hSS program data shows that 86% of suicide notifications received by hSS in 2015 and 2016 came directly from schools, school systems and **headspace** centres.

The *hSS Evaluation 2014* also demonstrated the strength of the reciprocal relationships hSS has cultivated with key stakeholders in the health and education sectors, and the hSS impact on policy and strategic direction in these sectors[12]. In many states and territories, education departments are now seeking hSS advice on direction and policy and commissioning hSS to upskill their workforces. Government resources have also been developed that draw on and acknowledge hSS resources.

These developments are indicative of the success of hSS in establishing itself within the existing service landscape in Australia and the importance of continuing to enhance cross-sectoral partnerships. Given this service landscape is a dynamic, agile and evolving space, this remains an area of constant focus for hSS, to ensure these partnerships are continually nurtured and that hSS is responsive to new and ongoing challenges inherent in the delivery of a world-first service.

2. Strong working relationships between schools, the community and local service providers

Rationale

When strong relationships between schools and local health services are established, schools have a broad network of supports and expertise they can draw upon to ensure the wellbeing of their students. As previously noted, schools are well placed to identify young people who are vulnerable to suicide. But while much progress has been made in establishing pathways for appropriate referral of vulnerable students there is often still a gap between the rhetoric and reality of school–community–agency relationships. There are many reasons for this:

- lack of awareness and/or training
- lack of confidence and trust in reciprocal organisational capacities
- the time required to build relationships
- the breakdown of existing relationships.

Further, even where schools are aware of and engage in referral processes, it is clear that young people are often reluctant to seek help from strangers. This is of concern, given the evidence that prevention of adverse health outcomes, particularly suicide, is much more successful where help is sought from professional sources (61).

Schools that can easily refer students to local services and maintain open lines of communication with them are better-equipped to streamline the care of vulnerable students who are in need of additional support. This creates a stronger and more supportive school environment for young people after a school suicide (38, 62).

Process

To cultivate strong working relationships between schools, the community and local service providers, hSS does the following:

- where strong relationships do not exist between schools and local services, hSS encourages both parties to explore how they operate, what they offer in terms of health and wellbeing services and ultimately, how they can cooperate in the delivery of health and wellbeing services

[11] The Respectful Schools, Respectful Behaviour framework sits within the broader Respectful Schools and Workplaces framework developed by the Tasmanian Department of Education. This framework outlines the strategies the department is implementing to contribute to safe and inclusive learning and working environments in Tasmania.

[12] For a summary of the *hSS Evaluation 2014*, see Appendix C.

- when postvention planning with schools, hSS examines what can be put in place to integrate local service providers into a school's response to a suicide. For example, hSS may advocate for a school to invite a mental health professional to be part of the Emergency Response Team for an appropriate period after a suicide to manage the short-term recovery phase. Schools may also develop clear referral processes for vulnerable students to access additional services after a suicide or hold case management meetings with local health services present
- when schools are in close proximity to one another, hSS facilitates connections between these schools to share resources and response actions, maximise professional learning opportunities and foster collaboration between school wellbeing teams. In the event of a suicide, this may involve schools developing a shared language about how the death is communicated and recognising a shared duty of care for students that are transitioning between schools. To further streamline the response, an impacted school may offer to host a joint information session and invite other impacted schools to attend.

The component in practice

By acknowledging the strengths and expertise of all agents delivering suicide postvention, and being responsive to the gaps in skills and/or knowledge and how to best address these, hSS has mobilised schools, communities and service providers to respond to a suicide in a cohesive and sustainable manner. The world-first nature of the hSS Service Model, with its combination of clinical and educational support, also places hSS in a unique position to identify local referral pathways and protocols and identify gaps in the skills and capacity of local professionals to deliver care and coordinate training and workforce development. The reciprocal nature of the relationships hSS has developed with local schools, communities and service providers has also resulted in hSS receiving as well as providing linkages to schools, communities and services.

In a Victorian town, for example, hSS worked closely with the local **headspace** centre, to respond to the needs of the school and wider community following a suicide. This arrangement involved hSS coordinating the school response while the **headspace** centre led the community response, in collaboration with the local health and mental health services. Where possible and appropriate, centre staff also attended the school response, supported schools identified as being in need and hosted and participated in hSS training sessions. hSS and local **headspace** centre staff were well-positioned to guide the local response to a suicide and continue to strengthen their relationship with the community via an active membership in a local suicide postvention working group.

In communities that do not have an accessible **headspace** centre, hSS has worked to ensure local service providers have been meaningfully engaged by schools to provide immediate support to affected students; identify other vulnerable young people; screen vulnerable students; provide information sessions for parents, staff and students; take referrals from families and staff; help plan for significant events (e.g., funerals and anniversaries) and liaise with hospital personnel and the media where necessary. As a result, schools have also begun promoting local mental health services to students and families. This collaborative relationship has created robust referral pathways to ensure timely access to local services, with local services prioritising the care of students from schools that have been affected by a suicide. It has also created opportunities for the development of resources, training and shared service delivery as a normal course of a school's work. For information about how hSS has facilitated this process in the regional South Australian town of Strathalbyn, see Component 3: A whole school, whole community and whole sector approach to mental health.

Results from the *hSS Evaluation 2014* also suggest that hSS is contributing to the creation of strong working relationships between schools and local service providers. Young people reported that they were becoming aware of and linked in with other **headspace** services (namely **headspace** centres and **eheadspace**) via hSS, indicating that hSS is well placed to seamlessly facilitate young people accessing mental health support. In the shifting landscape of service provision to schools, this integrative role is an essential element of postvention in Australian secondary schools, and one that requires continual maintenance.

3. A whole school, whole community and whole sector approach to mental health

Rationale

Suicide postvention in schools is more effective when it forms part of a multidimensional, consistent and comprehensive whole school, whole community and whole sector approach to mental health. This universal approach understands that:

- mental health is fundamental to learning and healthy development (34)
- individual and collective mental health is influenced by all members of a school community as well as education sector policies, programs and practices and the broader community.

For a young person, this approach to mental health can improve their engagement and performance in learning and school activities and give them a greater sense of belonging and connectedness within the school community.

At a school/community/sector level, this approach to mental health also:

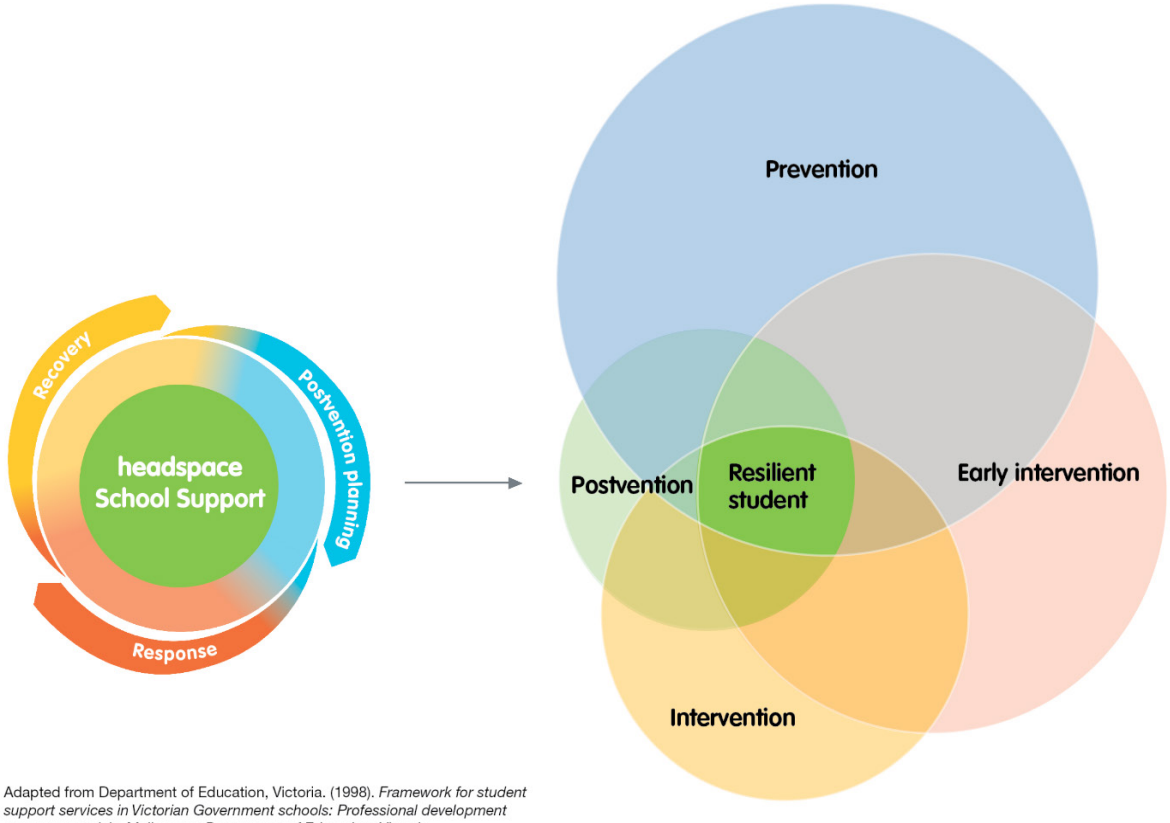
- avoids service duplication
- respects existing practices, procedures and protocols
- ensures schools are aware of the evidence-based, youth-friendly mental health services that are available to them
- integrates service delivery into existing whole school mental health frameworks and curriculum learning
- allows for effective pathways between health services, the education sector and related organisations.

What is a whole school approach to mental health?

A whole school approach to mental health relies on the whole school community to create a healthy environment for living, learning and working. At a school level, this may involve school staff, parents and students facilitating health promotion activities, which are supported by an overarching government and/or local education authority policy. For further information on the concept of a whole school approach to mental health, see Appendix G.

Process

hSS fosters a whole school, whole community and whole sector approach to mental health by building the capacity of schools to foster resilient students as they move through the stages of prevention, early intervention, intervention and postvention, as shown in Figure 4 (96). This involves a number of awareness-raising, promotion and prevention strategies, throughout the cycle of postvention planning, response and recovery[13].



Adapted from Department of Education, Victoria. (1998). *Framework for student support services in Victorian Government schools: Professional development support materials*. Melbourne: Department of Education, Victoria

Figure 4. Postvention within a whole school approach

[13] For further detail on each of these stages of postvention, refer to Components 4, 5 and 9.

This level of integration is achieved by:

- collaborating with national youth mental health programs and initiatives, such as MindMatters[14], to ensure that postvention work aligns with that of broader mental health objectives of these organisations
- partnering with national, state/territory and local organisations to develop and deliver customised postvention guidelines, resources and professional education programs to schools that are focused on youth mental health and suicide prevention and postvention
- working closely with state and territory education departments to align hSS services with their own services and programs
- collaborating with the **headspace** Youth National Reference Group (hYNRG) and Local Youth Reference Groups (LYRGs) on the development of hSS services and resources.

This continual focus on activities that enhance student resilience ensures that every response undertaken by hSS feeds back into the school's ongoing mental health approach.

The component in practice

By helping schools to embed suicide postvention within a whole school, whole community and whole sector approach to mental health, hSS has assisted schools to better navigate through the challenging phases of response and recovery following a death by suicide (62).

Following a number of suicide deaths in a region of South Australia hSS initiated a suicide pre/postvention project to provide a holistic and sustainable model of support and response to the region. With funds provided by the South Australian Department of Premier and Cabinet, hSS provided free training and support to secondary schools in the region on how to help young people build coping skills, resilience and emotional literacy and how to identify and support young people at risk of suicide (i.e., gatekeeper training)[15]. Schools were also given the opportunity to receive training from MindMatters on how to build a whole school approach to mental health. This project was supported by both local and state-based agencies – including the local Council, the Suicide Prevention Network, the South Australia Department for Education and Child Development, the Association of Independent Schools of South Australia, the Principals Australia Institute and Uniting Communities. By improving communication and referral pathways between schools and service providers, the project helped to foster a consistent and joined-up approach to mental health, resilience and grief and loss in the region.

These partnerships between schools, support agencies and the community are particularly important given that young people often transition between schools and have connections and relationships external to their current school. The project also demonstrated the important role that local government can play within a whole school, whole community and whole sector approach to suicide postvention.

hSS has also received positive feedback from a series of parent and carer information sessions in a rural New South Wales community that had been experiencing increasingly high rates of youth suicide. These sessions – which introduced parents and carers to **headspace** and hSS, common mental health problems, self harm and suicide, young people and grief, and support services – formed part of a series of whole school, whole community postvention strategies undertaken by hSS in the region in 2017. These sessions received an overall satisfaction score of 4.7 out of 5 (based on 52 responses) and all participants indicated that they would recommend the sessions to other parents and carers.

'Wish more parents could attend – community-wide education could dispel guilt/myths.'

– Qualitative comment, Parent and Carer Session Evaluation 2017

'Definitely learned more viable ways of talking to my teen…'

– Qualitative comment, Parent and Carer Session Evaluation 2017

'A welcoming, informative event, much needed.'

– Qualitative comment, Parent and Carer Session Evaluation 2017

[14] MindMatters is a national mental health initiative that assists secondary schools to plan and implement a whole school approach to mental health promotion.

[15] For further information on gatekeeper training, see Component 6: Early identification and management of vulnerable students.

At a national level, hSS works closely with the national mental health initiatives MindMatters (secondary education) and KidsMatter (primary and early childhood education), which assist schools to plan and implement a whole school approach to mental health promotion – including mental illness prevention and early intervention. hSS has also worked with Good Grief, a nationwide bereavement program for young people and adults who have experienced loss, to develop an additional suicide postvention component to their grief training program. This component has included a specific focus on the *Seasons for Healing* program for Aboriginal and Torres Strait Islander communities. A warm referral pathway has been established between hSS and Good Grief to ensure school staff referred to the program by hSS receive a high level of support from Good Grief when they attend training.

Linking mental health strategies at a school, community and sector level has become an important foundation for hSS service delivery; as new technologies facilitate increasingly global school communities, hSS efforts to create a whole school, whole community and whole sector approach to mental health at a local level can now engender positive impacts on an international scale. These developments also highlight the need for a national cross-sectoral postvention body to quickly mobilise positive strategies across the range of digital channels.

Seasons for Healing is a culturally appropriate small group grief and loss education program for Aboriginal and Torres Strait Islander adults who are managing experiences of change, loss and grief. The program has been developed by Good Grief in partnership with Aboriginal Family Support Services (SA) with funding provided by the Aboriginal and Torres Strait Islander Healing Foundation (63).

Targeted Facebook messaging initiative

To reach vulnerable people living in towns or regions that are overrepresented in suicide and or self harm statistics, hSS entered into an Australian-first partnership with Facebook to deliver targeted messaging to these communities via their Facebook news feeds. Communities selected for this program met a number of the following criteria:

- low-level of help seeking
- lack of access to traditional services
- rural and/or remote location
- high levels of distress and risk due to suicide, suicide attempts, self harm and self injury.

Over the course of a number of weeks or months, Facebook users in these communities received an advertisement each day, sponsored by Facebook, encouraging them to seek support if they were experiencing mental health difficulties. Each post included an engaging graphic and a question such as 'Are you going through a tough time or struggling with difficult thoughts?' along with links to a **headspace** centre in their area, the **headspace** website and/or **eheadspace**.

During the first iteration of the program from November 2016 to March 2017, hSS used Facebook-sponsored advertisements to target 11 communities across New South Wales, Western Australia, Queensland and Victoria. These advertisements were rotated over the Christmas and New Year period to reach young people at a time when they were most at risk of disconnection, as a result of difficulties leaving school and/or finding an employment opportunity or education pathway. Given the number of businesses and services that shut down over this holiday period, especially in rural and/or remote locations, these advertisements also reminded young people of the availability of **headspace** services during these times. In communities that lacked a physical **headspace** centre, advertisements linked young people with **eheadspace** for online and telephone support.

The success of this program in areas of hSS involvement has been clearly demonstrated in a rural town that had been experiencing increasingly high rates of suicide by young people. At the time that the **headspace** advertisements went live in November 2016, hSS had led, facilitated and/or supported a number of community postvention strategies, in collaboration with local services and schools. Advertisements targeted to this community over a holiday period reached over 19 000 people and received 135 reactions and 90 shares. A number of Facebook users also commented on the need for a physical centre in the area. The strength of this campaign, in combination with a number of other **headspace** initiatives in the region, culminated in intensive successful campaigning by the community to open a centre in the region.

hSS found that across the targeted communities, the advertisement click-through rate was also high for adults wanting to find out more information about **headspace** services. This high level of engagement with the advertisements demonstrates the effectiveness of the campaign in removing the stigma around help seeking in communities with typically low rates of engagement with mental health services.

Given the early success of this program, at the time of publication, hSS is in discussions to expand the initiative in other states and territories across multiple social media platforms, and establish ongoing program evaluation mechanisms.

Responding to dangerous suicide content in the media

hSS took a leading role in assisting schools and parents to respond to Netflix series *13 Reasons Why*, which graphically depicts a young woman who suicides after outlining 13 'reasons' for her death. The series, which was watched by many children and young people and widely discussed on social media, divided opinion in Australia. While some people argued that the series enabled useful conversations about suicide and young people's issues – including bullying, sexual assault and harassment and relationships – **headspace** received many calls from parents and schools concerned about the potentially harmful messages and imagery in the series. Following the show's release in March 2017, hSS National Manager and other **headspace** staff participated in approximately 50 interviews about the series and its messages across a range of television, internet, print and radio news media channels. In these forums, hSS shared concerns expressed by parents and schools about the potential risk the series posed to the wellbeing of young people – particularly the show's graphic depiction of the suicide method and means and its negative portrayal of help seeking.

Acknowledging that it was difficult to prevent young people from watching such a readily accessible show, hSS encouraged parents and teachers to talk with their children/students about their responses if they had watched the series. To facilitate such conversations, hSS prepared a fact sheet that listed its main concerns and provided suggestions for parents and teachers to discuss more helpful messages and strategies with young people. This fact sheet was distributed to hSS educational stakeholders in every state and territory and was gratefully received. It also had an impact overseas; for example, in America it was circulated by Stanford University's Centre for Youth Mental Health and Wellbeing. In collaboration with **eheadspace**, hSS ran an online group chat session for parents to provide further information and field questions. This was well received, with a number of participants thanking **headspace** for providing this opportunity. The transcript can be read at bit.ly/ehschat110517. In light of efforts such as these, Netflix have now provided more support material for viewers online. hSS is continuing to voice its concerns around the portrayal of mental health issues in the media and to collaborate with other national mental health organisations, in particular *Mindframe*, the Australian Government's national media initiative, to respond to dangerous content in the media.

4. Ongoing postvention planning

Rationale

Ongoing postvention planning is the vital first step in building the capacity of schools to respond to and recover from a suicide (62), and the greatest predictor of an effective response and recovery process.

Due to the unique circumstances of each school community, postvention planning must constantly adapt to changing staff and circumstances to remain effective and proactive. With regular and consistent input from both the school and hSS, ongoing postvention planning can:

- improve the capacity and confidence of staff to manage the emergency response calmly and effectively (62)[16]
- increase the likelihood of a clinically sound response and recovery process (62)
- facilitate planned and coordinated support from education departments and mental health services.

Process

hSS provides regular postvention planning workshops and education sessions to:

- educate school staff about mental health, suicide and its impact on school communities, postvention, hSS services (in the context of state and territory protocols) and the role of school staff and other agencies in suicide response and recovery. This framework helps schools understand the need for postvention planning
- help schools to assess their needs and identify gaps in staff skills and/or knowledge of suicide prevention and how to best address these
- assist with the establishment of an Emergency Response Team to coordinate the response
- provide schools with planning tools to develop and implement a customised and coordinated team-based Suicide Postvention Plan, aligned with system protocols and emergency management guidelines. Planning tools include various templates and documents to complete – including templates for informing students and parents about a suicide. hSS engages with education departments to ensure that they encourage schools to utilise hSS for this purpose
- assist schools to review their Suicide Postvention Plan annually.

[16] The identification of appropriate roles and responsibilities for a school Emergency Response Team and other professionals was also found to be particularly important in the Delphi study. For further information on the research and evaluation activities undertaken by hSS, see Background, Building the evidence base for suicide postvention in schools.

The Emergency Response Plan

The Emergency Response Plan should include provisions for:

- communicating with the bereaved family. This includes confirming the death and the language to use to describe the death with the family
- contacting all school staff as soon as possible following the suicide, including non-teaching staff and staff on leave
- determining the extent of **exposure** to the death in the school community. This will also assist in identifying levels of contagion and areas of potential vulnerability
- communicating developmentally appropriate information about the death to students, without disclosing the means or other aspects of the death
- allocating space for any support rooms, individual counselling or external mental health professionals required
- assessing and responding to staff wellbeing needs
- relieving team members who are unable to fulfil their roles (e.g., due to illness or absence etc.)
- reporting the suicide to relevant authorities
- managing media and social media
- communicating to parents about exposure and further risk, and how to support their young people
- streamlining risk assessments for weeks after the death
- handling the death of a recently graduated student
- providing support to students in the holidays if a death by suicide occurs outside the school year.

The team-based nature of this plan ensures that responsibility for the response and the decision-making process does not sit with just one individual.

Impact of social media following a suicide

Following a suicide, students are likely to turn to social media for a variety of purposes. These include sending news out about a death (both accurate and rumoured), posting online messages (both appropriate and inappropriate), calling for impromptu gatherings, supporting each another and creating virtual memorials.

Messages posted on social media platforms can have a large impact because they can quickly reach a high number of people. This can cause anxiety for parents and school staff. In the emotionally charged atmosphere that follows a suicide, schools may be inclined to try to control this kind of student interaction. Although this is almost impossible, given that most communication takes place outside of school hours and away from the school itself, schools can utilise social media to promote suicide prevention and mental health and distribute other important information to students and the broader school community.

The component in practice

Across 2015 and 2016, representatives from 255 schools and organisations took part in hSS postvention planning sessions (e.g., workshops and/or meetings). Findings from hSS evaluations have consistently indicated that the hSS postvention planning service has improved the capacity of schools to manage the emergency response, both strategically and psychologically, and ensured schools receive planned and coordinated support from education departments and mental health services.

In the *hSS Awareness and Satisfaction Evaluation 2015*, satisfaction survey data (total number of respondents surveyed was 359) showed that overall school staff and other school representatives (e.g., private health worker involved with a school) who had accessed hSS resources and/or received support from hSS were better equipped to respond to and prepare for suicide. Increased knowledge was reported by the majority of respondents in the following areas: services that can assist in dealing with suicide (83.8%), how to respond to and manage a suicide (81.0%), suicide generally (75.5%) and the signs and symptoms that someone at risk of suicide may exhibit (71.3%) (35). Increased skills and capacity were reported by the majority of respondents regarding the following areas: referring students in need of help to appropriate services (80.1%), dealing with future suicides should they occur (78.6%), responding to students at risk of suicide and related behaviour (76.1%), responding to student distress (76.1%), supporting students at risk (74.9%) and identifying students at risk of suicide and related behaviour (70.6%) (35).

The vast majority of respondents who received postvention planning assistance from hSS reported that this had increased their knowledge about how their school should manage a suicide (90.4%), assisted them in realising that there were steps that their school should take to be better prepared for a suicide (89.9%) and indicated that they had developed or commenced work on a Suicide Postvention Plan (69.2%) (35). This is significant given recent research indicating that plans of this kind are an important part of a school's suicide response (64).

'The presenter of the workshop was articulate and spoke in accessible language. She also was able to adjust the information to how my particular community could best be served by the information.'

– Qualitative comment, hSS Awareness and Satisfaction Evaluation 2015

'The presenters that came to the College were very helpful and supportive of all the questions asked… a worthwhile cause in assisting schools… informed of all institutions who can be contacted for numerous occurrences… excellent resources individually tailored for the College.'

– Qualitative comment, hSS Awareness and Satisfaction Evaluation 2015

'The training and assistance with the Suicide Postvention Plan was invaluable. We feel better equipped to respond if this occurs as we have an increasing number of students engaging in self harm and with suicidal ideation and attempts. There has been an increase in staff reporting warning signs and referrals to other agencies as a result of the increased awareness raised.'

– Qualitative comment, hSS Awareness and Satisfaction Evaluation 2015

In partnership with the New South Wales Department of Education, the Association of Independent Schools and Catholic dioceses, hSS delivered postvention planning workshops to regional schools (the Collaborative Postvention Planning Project). This project included:

1. postvention planning workshops for school principals and directors. These workshops gave participants an overview of hSS services and the concepts of exposure, suicide contagion and postvention. Participants also worked through a postvention case scenario and were provided with relevant fact sheets and Department of Education guidelines
2. postvention planning workshops for members of critical management teams (such as principals, deputy principals, school counsellors and head teacher welfare roles). This training gave participants key postvention planning evidence and information along with a breakdown of immediate and longer-term postvention planning considerations. Participants were then provided with dedicated planning time and information from key services.

These workshops were highly rated in participant evaluations, with the majority of participants indicating that their satisfaction with the session was 'excellent' and that each component of the workshop was 'very useful' to the development of their tailored postvention plans.

'I gained huge amounts and valuable reflection on practice.'

– Qualitative comment, Collaborative Postvention Planning Project Evaluation 2017

'The case scenario was excellent with different complexities'.

– Qualitative comment, Collaborative Postvention Planning Project Evaluation 2017

'Reinforced that we have the basic structures in place to be able to build towards developing a robust plan and strategy.'

– Qualitative comment, Collaborative Postvention Planning Project Evaluation 2017

'Top shelf – every word was gold. Keeps us safer in our own mental health.'

– Qualitative comment, Suicide Postvention Planning Workshop Evaluation 2017

'Very thorough and presented well. Engaging and adequate time provided to discuss with school team.'

– Qualitative comment, Suicide Postvention Planning Workshop Evaluation 2017

'Great day, we are quite well prepared at [school], only as a result of the work you do.'

– Qualitative comment, Suicide Postvention Planning Workshop Evaluation 2017

In Queensland, hSS is working with an association of independent schools to develop a customised postvention response plan specific to each school. This process involves:

- undertaking postvention planning and capacity assessments in schools
- collaborating with the association to administer preparedness planning to secondary schools under its auspice, ensuring that priority is given to schools that have previously experienced a suicide death
- promoting and supporting cross-sectoral engagement between schools under the auspice of the association, Catholic Education, the Queensland Department of Education and Training and Independent Schools Queensland
- assisting schools to build and strengthen their relationship with all areas of **headspace** – including hSS, **headspace** National Office, **headspace** centres within their region and **eheadspace**

- improving the knowledge, skills and confidence of central/area office staff who may be called upon to support schools in the region impacted by a suicide/serious attempted suicide
- helping secondary schools to operationalise the Catholic Education, Archdiocese of Brisbane Postvention Guidelines within schools under the auspice of the association.

At a national level, hSS has also released practical guidelines, specifically, the *Suicide Postvention Toolkit – A Guide for Secondary Schools* (65), to assist secondary schools to develop a plan to respond to a student suicide or to respond to a suicide in the absence of a predetermined plan[17]. This is a practical resource with a step-by-step checklist and instructions on how to effectively respond to and recover from a suicide. Each section of the toolkit outlines the actions to take, and considerations to make, during the following response and recovery stages:

- **immediate response** – this includes ensuring the immediate safety of students and school staff and following up the facts and circumstances of the suicide
- **first 24–48 hours** – this includes informing relevant representatives at the education department (or equivalent body) and convening the Emergency Response Team to provide for the support of vulnerable students and inform the school community of the death
- **first week** – this includes restoring the school to its regular routine, planning the school's involvement in the funeral and monitoring student and staff wellbeing
- **first month** – this includes planning for peak risk periods (e.g., award nights and graduations), conducting a critical incident review and providing information sessions for parents and the wider community
- **longer term** – this includes implementing recommendations from the critical incident review, planning for peak risk periods (e.g., anniversaries, birthdays and other significant events) and ensuring that the Suicide Postvention Plan is included in the school's staff induction process.

The toolkit also contains information regarding memorials, media, social media and supporting staff, and provides sample documents and scripts for staff to use when notifying students and parents of the suicide. The toolkit can be applied to schools in the majority of developed English-speaking countries. The use of the toolkit as a framework has also been shown to be useful in responding to suicide in remote and Indigenous communities. It can also be used by the wider postvention community to inform already existing postvention resources (e.g., for sporting and community groups) and to develop new postvention resources at both a school and a state and territory level. (For a summary of all hSS resources, see Appendix D.)

The work of hSS since its inception has increasingly demonstrated the critical benefit of postvention planning in enabling effective responses when a death by suicide occurs. For this reason, postvention planning remains one of the largest growth areas in hSS service delivery.

5. A timely, tailored and clinically sound response, valuing in-person support

Rationale

To minimise the risk of negative mental health outcomes and suicide contagion following a suicide, schools must respond in a timely, tailored and clinically sound manner (62). As a student suicide triggers many immediate, complex and traumatic responses, it is essential that the response is immediate, clinically sound and includes face-to-face support, where possible. Further, as every suicide and school context is unique, the response to a suicide must be tailored to the circumstances, needs, policies and resources of the particular school community. It must also align with relevant policy and practice frameworks and protocols of the school's education system.

A timely, tailored and clinically sound response that values in-person support can:

- reduce the impact of grief and trauma on the school community, including the risk of depression and anxiety (38)
- reduce the risk of suicide contagion
- minimise interruption to the learning environment
- enable the school community to begin a process of healing and in turn reduce the time taken to return to typical school routines
- minimise the risk of reduced productivity, absenteeism, diminished staff morale and damaged community reputation.

Each of these factors is necessary to minimise recovery time and foster resiliency in a school community.

Process

To help schools appropriately respond to the immediate and short-term needs of their school community, hSS staff offer a range of services, which can be delivered either in person or via telephone and/or email, as necessary. These services include:

- contacting the impacted school/s immediately after receiving notification of a suicide and providing readily available advice, information and resources
- working respectfully and collaboratively with state and territory critical incident response teams
- conducting a needs assessment to collect detailed information about the context of the suicide, the school's response to date, the strengths of the school

[17] This toolkit is heavily informed by the work of the South Australian Department for Education and Child Development, Catholic Education South Australia and the Association of Independent Schools of South Australia, who jointly developed suicide postvention guidelines. The work of the American Foundation for Suicide Prevention and the Suicide Prevention Resource Centre have also been influential in the creation of this resource.

and community, and required and desired areas of support

- offering clinical supports and services, within 12–24 hours after a suicide notification
- helping schools to coordinate the immediate response, within 48 hours after a suicide notification. This includes offering advice on how to inform the community of the suicide and how to provide for the support needs of students and staff
- providing expert information, advice and support to schools to address their specific concerns, questions or requests in relation to the suicide and to accommodate the differing needs of students, staff and the broader community. This may involve offering clinical advice to school wellbeing staff about how to support particular students that may be vulnerable to suicide (i.e., **secondary consultation**) and assisting the school to conduct a critical incident review in the weeks following a suicide, as the school transitions from the response phase to the recovery phase
- supporting schools to coordinate their short-term response to a suicide, that is tailored to the needs of the school community and integrated with their resources and policies. This may involve planning and/or facilitating an initial information session – for parents, staff and other community members – to provide information about the school's response, how the suicide may impact on other young people and how parents/staff can support their young people. hSS may also help schools make use of local supports and provide details of the funeral or other memorials
- helping schools to return to regular routines and activities.

For two case studies describing the hSS response process, see Appendix E.

The component in practice

Across 2015 and 2016, hSS provided 606 schools and organisations with response assistance and provided 191 schools with needs assessments. Survey responses from the *hSS Awareness and Satisfaction Evaluation 2015* showed that of school staff who had used hSS following a suicide, the vast majority indicated that hSS had helped them/their school to manage the response (92%) and helped them/their school to feel supported following the suicide (92%). From the total pool of survey respondents (N=359), 92.4% indicated that they would recommend hSS to other staff/schools and 82.3% reported that if a suicide occurred in the future, they would 'definitely' contact hSS for assistance (35).

'The overall support, advice, and guidance from headspace was invaluable. The school was contacted promptly by headspace who arranged a meeting with our Wellbeing Team. There was a clear focus on the care of not only our students but also staff, parents and the school community. Appropriate resources were provided for the school which detailed information useful for dealing thoroughly with such a terrible event. headspace representatives also made themselves available for a staff care session, as well as information sessions for both students and parents.'

– Qualitative comment, hSS Awareness and Satisfaction Evaluation 2015

'My observation of the headspace School Support provision of service through the experience of multiple suicides, (having experienced the school coping with loss through suicide before headspace School Support service was available, then several with your support and all with different flavours of complexity), is that support has been at the exact level the school required (checking in continually to assess the schools needs and understanding), readily available with a fast response time, and offered in a range of ways to meet need from phone secondary consults, wellbeing team meetings at the school, critical response team meetings, training such as STORM [Skills-based Training on Risk Management]**, and even community information evening events to target whole school community needs. I would recommend the service to any school.'**

– Qualitative comment, hSS Awareness and Satisfaction Evaluation 2015

> **'In regard to the recent suicide, the support of headspace was invaluable. They gave us a solid plan to focus on when we were all feeling lost. The fact that they were able to come on that first day back to school after the suicide was incredible. We were so appreciative of their ongoing support for that first week while we tried to support students and staff but also get back to school normality and routine which we also needed. headspace left the door open for us to have ongoing contact if needed and I would feel very comfortable calling on them should we need more guidance and also to request some training. They were so professional and calm. I just hope we never have to experience such a loss at our school again. We could not thank you enough for your support.'**
>
> – Qualitative comment, hSS Awareness and Satisfaction Evaluation 2015

> **'The service could not have been more thorough, relevant, available and appropriate. They provided expertise and guidance in a nurturing and calm manner and I am not sure our response would have been so systematic and thorough without them.'**
>
> – Qualitative comment, hSS Awareness and Satisfaction Evaluation 2015

In response to the death of a student in Queensland, hSS staff arrived at the student's school within an hour of receiving notification of the suicide to provide secondary consultations to school counsellors. hSS staff also worked with leadership and wellbeing staff to identify vulnerable young people, liaised with local mental health providers to coordinate support for vulnerable students and supported the school to notify parents of the death. Following this, hSS provided a parent information session and training to staff on understanding suicide and responding to **suicidal ideation**.

In the Australian Capital Territory, hSS was able to quickly equip a high school with no systematic postvention plan in place with a clear process to respond to the death of a student. In this instance, hSS worked face-to-face with the school to ensure students and staff could effectively respond to the immediate impact of the death onsite. This involved designating areas where students could talk with counsellors and/or arrange to be collected by their parents if they chose, and arranging for the school's Employee Assistance Program to be available to staff onsite. Reflections from school staff following the incident confirmed the importance of having a logical and clinically sound process in place to manage the immediate impact of the death and ensure that every student who required support had a mechanism to access this.

The practical guidance immediately available to school staff via the hSS suite of postvention resources has been a vital resource for schools responding to a suicide in the absence of a predetermined plan:

> **'Having not previously engaged with your service I was pleasantly astounded by your level of support. The templates and the pack as well as the advice given and the care were exemplary and the feedback from staff and parents has been very positive to say the least. It's not often in this job you get the question, "how can we help?" and "what do you need?".'**
>
> – Personal communication, Executive school staff member (Victoria), 2016

School satisfaction with the hSS suite of resources on suicide and suicide-related topics was also found to be high in the *hSS Evaluation 2014*, with nearly all respondents indicating that they found the resources relevant (97%), helpful (97%) and well written (97%). Free text comments provided by respondents were generally positive and included the following:

> **'We used the [postvention toolkit] following a recent death by suicide. Clear directives and draft scripts were essential to the smooth management and progress of the follow up process.'**
>
> – Qualitative comment, hSS Evaluation 2014

> **'The information is very practical and easily readable for those with limited knowledge of assisting young people in crisis. I commend headspace for the work they have done in this area.'**
>
> – Qualitative comment, hSS Evaluation 2014

Psychoeducation was an important element of the hSS response to the suicide of a young person in a Tasmanian town. As there had been a high level of exposure to the deceased by the school community, hSS staff provided education at community meetings with service providers, and at parent and school staff sessions, about suicide contagion, the importance of not glamorising or stigmatising the death and not drawing simplistic conclusions about the cause of the suicide. Secondary consultation was also provided to the school to assist in the identification of vulnerable students, and referrals to **eheadspace** were provided to students in the absence of a local **headspace** centre.

From all sources of feedback, it is clear that the routine availability of personalised, clinically sound in-person support during the immediate and short-term response has been paramount to a school's ability to recover from a suicide.

6. Early identification and management of vulnerable students

Rationale

One of a school's main responsibilities after a suicide is to ensure their process for identifying, supporting, referring and monitoring vulnerable students is well understood and effective. It is imperative that schools identify vulnerable students following a suicide so that they can be appropriately supported and monitored. hSS has found that schools are often well equipped to identify students who are immediately or already considered vulnerable to suicide (e.g., students with a history of suicide attempts; students who are/have been accessing mental health services for depression, suicidal ideation and/or self harm; and students struggling with grief or trauma related to other events, including family breakdown or emotional, physical or sexual abuse). Importantly, without expert guidance on the wider population who may be at higher risk following a suicide, schools may not identify lesser-known groups of vulnerable students that require additional supports.

Vulnerable students who may not be identified include students who are connected to the deceased in the following ways:

- **geographically:** students who witnessed the death, were exposed to it or had contact with the student shortly before they died. Contact via social media and mass media is also important here
- **psychologically:** students who relate to the person who died through cultural connections, shared experiences (e.g., classmates, victims of bullying) or perceive themselves to be similar to the young person who died in some way (e.g., both were fans of the same celebrity)
- **socially:** students who had a relationship (positive or negative) with the person who died – including family, friends, social circles or romantic partners. Social proximity is determined by the perception that a bereaved person has of their relationship to the deceased, rather than their actual relationship. Such perception of closeness has been found to significantly influence the level of risk (7, 66).

To mitigate the risk of suicide contagion, school staff need to have the skills and confidence to have supportive conversations with students and to refer students to an appropriate mental health professional when required.

Process

Within schools, hSS assists staff to quickly identify and manage vulnerable students by:

- providing information, education and training to help schools understand suicide contagion and other young people who might be at an increased risk of suicide
- providing schools with strategies to identify other young people who may be profoundly affected by a suicide, for example, mobilising staff, student and parent networks to notify the school of any young people they are worried about
- working with education systems to develop early intervention strategies – e.g., the *SAFEMinds* program (described overleaf)
- mobilising **headspace** centres to be alert for vulnerable young people in their area following a suicide – e.g., by checking their records to identify young people who may have missed appointments and who may be at risk of suicide
- delivering *Skills-based Training on Risk Management (STORM)* – i.e., gatekeeper training – to school staff
- arranging individual risk assessments for students identified as being vulnerable or in need of mental health assistance in collaboration with local mental health services. If a needs assessment has identified that there are no services and/or school wellbeing staff with the skills or capacity to conduct a risk assessment, hSS clinical staff arrange to conduct the required risk assessment
- encouraging staff to discuss any students they are concerned about with wellbeing or mental health staff. This may result in a student being referred to the school wellbeing team for initial support or monitoring and/or an external mental health service as appropriate
- helping schools to develop safety and support plans for all identified vulnerable students, in collaboration with mental health professionals
- building the capacity of schools to maintain appropriate documentation of all actions taken in response to vulnerable students.

Gatekeeper training

Gatekeeper training has been a key component of many Australian suicide prevention strategies (50) and it is a key part of the integrated approach to suicide prevention that will be trialled in Australia (67). It teaches adults who regularly interact with young people to recognise young people who are at risk of suicide, and intervene appropriately to ensure they are referred for assessment and treatment, where necessary. A gatekeeper essentially provides a link – or opens the gate – between a young person and a mental health professional, and provides front-line support to the young person as they seek and access mental health assistance.

Research conducted in 2015 supports the effectiveness of gatekeeper training when it comprises a core component of large-scale, community-based, multimodal suicide prevention strategies. While the specific contribution that gatekeeper training made within these comprehensive suicide prevention strategies could not be confirmed, these multimodal interventions revealed significant reductions in suicide mortality and suicide attempts among young people in the two years after implementation, compared to those in control conditions (68).

While more research is warranted into the effects of specific suicide prevention training on school staff, gatekeeper training has been shown to be effective in increasing the skills, knowledge and confidence of gatekeepers to provide support vulnerable students and facilitate access to treatment (69, 70). A study describing a randomised controlled trial of a specific suicide prevention training program on high school staff found increases in self-reported knowledge, appraisals of self-efficacy and service access following participation in the training program (47, 71). Another study examining the effects of a specifically designed training program on the management of deliberate self harm in schools also reported similar improvements in confidence, perceptions of skill and knowledge of deliberate self harm (72).

Although less is known about the effect of gatekeeper training on behavioural action (e.g., referrals) and population-level outcomes (e.g., help-seeking behaviours and actual suicide rates in the target population), a study conducted by Kataoka et al (2007) has linked gatekeeper training to high numbers of referrals to specialist services and treatment of vulnerable students. In this study, the majority of students identified by the program were referred to school or community mental health services and more than half had subsequently received these services within five months of the crisis intervention (73).

hSS is licensed to facilitate the evidence-based gatekeeper training program *STORM (Skills-based Training on Risk Management)* (70) to build the capacity of school staff to identify vulnerable students, in line with their assessed needs. *STORM* is a program for school-based leaders covering suicide risk assessment, safety planning and postvention. This training package began as a research project at the University of Manchester in the United Kingdom in 1997 (74). *STORM* uses the gold-standard, evidence-based adult learning methods of rehearsal, filmed role-rehearsal, self-reflection and feedback. The package had undergone rigorous testing into its efficacy, feasibility and sustainability with positive results but this testing was done with front-line health professionals and in prison settings – it had not been tested among secondary school staff.

In partnership with the University of Manchester, hSS conducted a pilot of *STORM* to explore its feasibility, efficacy and acceptability in the Australian secondary school setting with a view to making it widely available via hSS in the future if the pilot indicated positive results. The pilot had a rigorous evaluation component in the *hSS Evaluation 2014*[18]. Key findings from this evaluation suggest that:

- the training can increase the confidence and skills of school staff in working with students at risk of suicide and related behaviour, and the confidence and skills of school staff in working with students with mental health issues
- school representatives who attend *STORM* are likely to use the skills gained through the training in their school.

SAFEMinds

hSS supported a dedicated **headspace** team to develop *SAFEMinds: Schools And Families Enhancing Minds.* It is an evidence-based package of online and face-to-face resources developed to assist Victorian primary and secondary school communities to actively intervene with early stages of mental health issues, particularly mild mood disorders (anxiety and depression) and self harm. Launched in 2014 with funds provided by the Victorian Government, the program is an example of how hSS has been able to leverage national funding to build the capacity of a state-based education system to effectively identify children and young people with early signs of mental health issues, offer school-based brief interventions and refer appropriately when needed. The key components of *SAFEMinds* are:

- *SAFEMinds: Online* – immersive video training and tools targeted to the whole school community. These resources aim to develop knowledge and understanding about the many different forms of emotional distress children and young people may experience
- *SAFEMinds: In Practice* – face-to-face workshops targeted to school-based decision-makers with responsibility for student wellbeing. These workshops support participants to lead the implementation of *SAFEMinds* in their schools
- *SAFEMinds: At Home* – a range of resources to help parents and carers support their child's positive mental health and to enhance connections between parents and carers, schools and local mental health services. Resources include targeted videos and tip sheets and parent information forums held in various locations across Victoria, which are attended by a panel of local mental health agencies, who provide information and answer questions from families about the services they provide.

SAFEMinds is underpinned by the NIP It In the Bud! early intervention approach (75). Resources for planning referrals assist in the development of clear, effective referral pathways between schools, families and community youth and mental health services. This is an important foundation for linking suicide prevention, risk assessment and postvention strategies within a whole school, whole community approach. To ensure sustainability of the program, a Train the Trainer model has been implemented, which delivers ongoing training via cross-sectoral regional teams of health and education professionals.

Resources for planning referrals assist in the development of clear, effective referral pathways between schools, families and community youth and mental health services. This is an important foundation for suicide prevention, risk assessment and postvention within a whole school, whole community approach. To ensure sustainability of the program, a *Train the Trainer* model has been implemented, which delivers ongoing training via cross-sectoral regional teams of health and education professionals. At the time of publication, evaluations of the program are in progress in Victoria. **headspace** is also exploring further adaptation

[18] For a summary of the *hSS Evaluation 2014*, see Appendix C.

and implementation of the program in response to interest from other states and territories.

The component in practice

hSS efforts to mobilise **headspace** centres to be alert for vulnerable young people in their area following a suicide have been crucial to the early identification and management of vulnerable students. For example, after receiving notification of a student suicide by the South Australia Department for Education and Child Development (DECD), hSS staff notified relevant **headspace** centres to ensure that vulnerable students attending these centres could be identified and supported. This enabled the identification of a vulnerable young person at the same school as the deceased who had missed an appointment the previous week. The centre immediately followed up the young person and the school counsellor, resulting in the young person being seen by school staff and then assessed by a social worker from DECD.

hSS has also worked to facilitate a continuous cycle of prevention and early intervention in Australian secondary schools by ensuring the effective implementation of programs such as *STORM* and *SAFEMinds* at a state and territory level. Given that the identification and management of vulnerable students is a core responsibility for school's following a suicide, and a key component of effective postvention in schools, this remains a fundamental element of the hSS Service Model.

Gatekeeper training (STORM)

In Queensland, hSS has partnered with the Queensland Department of Education and Training to train every secondary guidance officer in the department in *STORM*, thereby ensuring that Queensland secondary school staff are better able to identify vulnerable students and undertake safety planning and postvention check-ins. Similarly in Tasmania, hSS has trained almost all Department of Education social workers and psychologists to respond to student suicide attempts. This initiative has enhanced the early identification of vulnerable students and the aftercare they receive to help support their return to school. It has also improved the follow-up process for students exposed to a suicide attempt.

The growing rate of participants in *STORM* training in recent years also attests to the high levels of support for the *STORM* approach in Australia: between June 2013 and December 2016, a total of 202 gatekeeper training sessions were attended by 1807 attendees nationwide – a breakdown of the number of sessions and attendees for this period is presented by state in Figure 5).

	Jun 16–Dec 16		Jun 15–Jun 16		Jun 14–Jun 15		Jun 13–Jun 14	
State	**Sessions**	**Attendees**	**Sessions**	**Attendees**	**Sessions**	**Attendees**	**Sessions**	**Attendees**
VIC	12	123	19	190	26	229	42	375
TAS	0	0	3	28	2	14	10	66
NSW	7	75	5	53	5	38	4	34
QLD	25	237	1	8	2	18	10	90
WA	0	0	2	14	6	47	1	8
NT	1	7	2	14	1	7	2	19
SA	2	19	4	24	4	29	0	0
ACT	2	24	0	0	2	17	0	0
Totals	**49**	**485**	**36**	**331**	**48**	**399**	**69**	**592**

Figure 5. ***Skills-based Training on Risk Management (STORM)*** *delivered by state from June 2013 to December 2016*

In 2016 alone, 251 schools around Australia were represented in these training sessions, which were highly rated by an overwhelming number of participants. Of the 485 school staff who received training in 2016:

- 99.7% reported that they found the training worthwhile and would recommend it to others
- 84% responded that the modules as 'very relevant' for work/practice
- 81% rated facilitator knowledge/skills as 'excellent'
- 75% rated all training modules as 'excellent'.

Participants at these sessions reported that:

- the program empowered attendees to carry out risk assessment and management:

'[The trainers] had a wealth of knowledge and [were] also able to involve participants in the experience … I now feel empowered and confident to deal with all necessary procedures and situations.'

– Qualitative comment, STORM Evaluation 2016

- the trainers effectively handled sensitive content in a safe learning environment:

'A warm and supportive atmosphere – I think everyone felt "safe" contributing to the discussion on difficult topics.'

– Qualitative comment, STORM Evaluation 2016

- the customisation of individual training sessions to particular school settings made the training highly relevant:

'It was great to do this training in a group specifically working in alternative school settings. Great to be able to problem solve specific issues directly related to working in such environments.'

– Qualitative comment, STORM Evaluation 2016

Survey responses from school staff that have undertaken hSS *STORM* training also strongly attest to their heightened ability to proactively recognise the signs and symptoms of someone at risk of suicide and respond appropriately:

'A brilliant evidenced-based approach. One of the best training sessions I (as a Psych) have undertaken in 15 years. Have put strategies learned into action and results have been so positive. Has enhanced the way I can tackle the issue of self harm and suicide "front on", which has revealed the issue is more prevalent than I thought and I have better skills to then work with individuals to hopefully ensure they do not take action.'

– Qualitative comment, hSS Awareness and Satisfaction Evaluation 2015

'I did the STORM training and found that to be exceptionally informative and helpful … it led to the formation of the school's Crisis Response Team and the implementation of a structured response program.'

– Qualitative comment, hSS Awareness and Satisfaction Evaluation 2015

Participants also reported on the importance hSS placed on staff wellbeing during the training:

'Thank you for your kindness and understanding and your concern for our wellbeing during the training.'

– Qualitative comment, STORM Evaluation 2016

SAFEMinds

The *SAFEMinds* program has been equally well received. In recognition of the successful delivery of the initiative in 2014, the program was awarded the 'Mental Health Educator Excellence Award' at the 2014 Victorian Public Healthcare Awards and an international 'Best in Class (Healthcare) Award' at the Interactive Media Awards in 2014. To ensure program sustainability and local ownership, a Train the Trainer model was developed to support further training of *SAFEMinds* champions in schools. These champions continue to oversee the implementation of the program in schools. In 2015, Regional Training Teams were established and almost 200 trainers, including education professionals and mental health professionals, received training across Victoria. These teams plan and deliver *SAFEMinds: In Practice* Champion Training to schools as required. Evaluations of the initial program development and implementation of the *SAFEMinds* program have had an overwhelmingly positive response rate from participants, with between 90 and 100% of participants reporting that they found the training useful and would recommend it to others (76). These outcomes demonstrate the value of combining national and state government funding to spur significant and sustainable mental health initiatives at a state and territory level.

7. Responsiveness to population groups that are overrepresented in suicide and self harm statistics

Rationale

Effective postvention practice must explicitly address the needs of young people from population groups that are overrepresented in self harm and suicide statistics, specifically:

- Aboriginal and Torres Strait Islander populations (20, 77-79)
- Culturally and Linguistically Diverse populations. **Note:** Statistics regarding suicide in Culturally and Linguistically Diverse communities are not routinely collected. Often these statistics relate only to specific population groups and should be interpreted with caution (80)
- sexuality and gender diverse populations (78, 79, 81).

Wherever possible, this involves working with young people from each of these population groups to identify their needs in ways that are safe, culturally appropriate and supported.

Process

hSS responds to the needs of population groups that are overrepresented in self harm and suicide statistics by:

- maintaining an awareness of the population dynamics of each school/community that hSS services, and their unique needs
- collecting data about the characteristics of suicides and attempted suicides, specifically, whether a young person is a member of a population group that is overrepresented in self harm and suicide statistics
- providing suicide postvention training and support in communities with a high proportion of Aboriginal and Torres Strait Islander peoples, people from Culturally and Linguistically Diverse backgrounds and/or sexuality and gender diverse people
- translating hSS resources into six languages other than English, including Vietnamese, traditional and simplified Chinese, Italian, Greek and Arabic
- consulting and working collaboratively with key community members (e.g., Elders and other respected persons in the community) to ensure that hSS services and resources are culturally relevant and safe
- retaining a diverse workforce, including qualified and skilled staff who are Aboriginal and Torres Strait Islander, from a Culturally and Linguistically Diverse background and sexuality and gender diverse
- requiring all hSS staff to complete a two-day workshop in cultural competency.

Postvention planning and response considerations in Aboriginal and Torres Strait Islander communities

To support postvention planning and response work in Aboriginal and Torres Strait Islander communities, hSS undertakes the following tasks:

- consulting with an Aboriginal and Torres Strait Islander working party (the Cultural Yarns Group) to continually identify opportunities to enhance service delivery
- appointing an Aboriginal and Torres Strait Islander Project Worker to tailor hSS resources to Aboriginal and Torres Strait Islander audiences, strategically engage Aboriginal and Torres Strait Islander stakeholders and support all hSS staff in their cultural development
- advocating for appropriate representation from the relevant community group – for example, an Indigenous Education Assistant – who can also act as link between the school and the community in the event of a response and guide the school through community lore and grief processes such as sorry time. **Note:** Sorry time will often exclude services and agencies and at times schools so it is important in the postvention planning phase for schools to consider who could be available as supports that would be accepted by the community
- encouraging schools to build networks with local Aboriginal and Torres Strait Islander services
- recognising local and customary lore and healing within the community, and encouraging schools to engage in this as a therapeutic support for their Aboriginal and/or Torres Strait Islander students, rather than solely relying upon 'western' clinical approaches
- facilitating separate professional development sessions with teaching staff and community members who are teacher's aides at the school. Mental health literacy can often vary between groups and having separate sessions allows for community members to have a dialogue that is specific to them
- adapting presentations to meet the needs within the community, for example, facilitating yarning circles rather than PowerPoint presentations
- identifying the language and/or symbols for suicide in the community and incorporating this into training to create consistency in communication
- adapting postvention planning resources to recognise the community-led nature of a response
- connecting with local land councils and shires to seek permission to enter the community and share what support is being offered to the school. This allows for transparency and limits duplication of service, as well as creating trust.

The component in practice

To help schools respond to homophobic and transphobic behaviour and create more inclusive school policies and practices, hSS has also linked schools with vulnerable transgender students to providers of sexuality and gender diverse training and support services. For example, following the attempted suicide of a student with gender identity issues, hSS recommended that school staff participate in gender identity training with Safe Schools Coalition Australia. School staff reported that the training was informative and increased their awareness of gender pronouns. The relevant hSS team has also built relationships with sexuality and gender diverse support services in the state to improve the process for notifying hSS about sexuality and gender diverse young people who have attempted suicide.

The customisation of hSS services and resources to meet the needs of Aboriginal and Torres Strait Islander communities has been similarly effective. To support the Aboriginal community following the death of a young Aboriginal male in one state, hSS provided secondary consultations to the Aboriginal service that was supporting affected students, as well as to the school wellbeing team. One of these consultations resulted in the identification of a young male at risk of suicide and his referral to an appropriate external mental health service. hSS also advocated for the education department to allow a local Aboriginal youth worker to have access to the school to support Aboriginal students who had been impacted by the death and organised gatekeeper training to be delivered

to Aboriginal education workers[19]. This training was highly rated by participants, as evidenced by the feedback received from their Manager below.

> **'I am hearing glowing anecdotal reports of the training. Participants felt that it was extremely worthwhile and beneficial. Thanks for making the effort to make yourselves known to us and to follow through.'**
>
> – Personal communication, Manager, Community Service, 2016

At a national level, hSS has developed resources that address the specific needs of Aboriginal and Torres Strait Islander populations, in collaboration with external consultants with expertise in Aboriginal and Torres Strait Islander mental health education. In the development of these resources, hSS is able to draw on the vast collection of resources produced by the **headspace** National Youth Mental Health Foundation. The **headspace** commitment to engage with young people from relevant population groups in the development of these resources has been critical to ensure the relevance of these resources to target audiences. (For a summary of these resources, see Appendix D.)

As the following example shows, consultation with key community members is a vital precursor to the provision of these resources to an Aboriginal and Torres Strait Islander community, to ensure that the information is tailored to the unique circumstances of the relevant Indigenous country and community. Following a student suicide in a remote northern Australian school, hSS arranged with the school's Community Engagement Coordinator to meet with relevant members of the community to discuss the suicide resources that would be provided as part of the response. As a number of people in the community had been affected by suicide, the group advised that the use of the term 'suicide' in these resources would re-traumatise affected members of community. Instead, the group suggested that hSS resources incorporate more gentle language to describe a person who has suicided – i.e., 'someone who has passed away because of self harm' in the first instance and then 'someone who has passed away' thereafter. This enabled hSS to minimise the risk of distributing culturally inappropriate materials to this population group.

This level of sensitivity to the school's community and context is also evident in the training hSS undertakes:

> **'Ours is a remote Aboriginal school and the mainstream responses don't necessarily work here. headspace listened and supported us to come up with positive ways to support our teaching and admin. staff through these terrible times. We revisit these during staff meetings and "alert" staff to be on the lookout for certain behaviours or changes in personalities as described by headspace.'**
>
> – Qualitative comment, hSS Awareness and Satisfaction Evaluation 2015
>
> **'Our presenter was extremely knowledgeable and experienced and adapted the training session to our school context, acknowledging past history, present context and future challenges.'**
>
> – Qualitative comment, hSS Awareness and Satisfaction Evaluation 2015

This level of service customisation can only occur in an environment where vulnerable young people are supported to identify themselves as members of these population groups and to discuss their needs in a culturally safe way. As many young people choose not to identify themselves as members of these population groups, removing barriers to their engagement remains a key concern for hSS.

8. School staff wellbeing and support

Rationale

Effective postvention practice should respond to the wellbeing of school staff after a suicide. Staff may also experience their own feelings of guilt and grief after a suicide, and it is important that they remain mindful of their own wellbeing and receive appropriate support. From working with schools and leadership teams, and from feedback hSS has received at national roundtables, hSS is aware of the considerable emotional challenges that staff can experience following a student suicide. The stress associated with such challenges is often not linked to dealing with the immediate event, and can manifest months and even years following a death. The Principal and immediate school leadership group in particular are often heavily impacted by having to lead an entire school community through the challenging and complex circumstances of a student suicide. hSS has observed that principals often experience a heightened sense of isolation and distress as a result of their position as school leader. But despite their high work demands and levels of stress, many do not seek support. This negatively impacts on a principal's longer-term mental health and wellbeing and may affect their ability to lead their school through recovery.

[19] For further information on gatekeeper training, refer to Component 6: Early identification and management of vulnerable students.

When school staff are supported in their grief, they are better able to attend to their own wellbeing needs and the wellbeing needs of students. This helps students to feel well supported and cared for, thereby reducing the time taken for the school to return to routine functioning.

Process

hSS helps schools to monitor and respond to the wellbeing of school staff by:

- advising school leaders of the need for some staff to take time off or be excused from performing some tasks that may be required of them if they do not feel able (e.g., informing students of a suicide, staffing the student support room)
- advising the school to arrange for several substitute teachers and social workers/counsellors to be on hand to provide rotating coverage in case staff need to take time out from their duties or want to attend the funeral. Schools may be advised to appoint an experienced school leader on an interim basis, to relieve school leaders from administrative responsibilities and allow them to devote their attention to specific postvention tasks
- encouraging staff to put their own wellbeing first and to ask for respite, support or a change in role if needed
- offering tailored support and wellbeing advice to staff through the provision of information sessions and fact sheets
- ensuring schools provide staff with regular opportunities to meet and debrief
- ensuring schools provide staff with information about relevant employee assistance programs
- ensuring schools remind staff of the importance of self-care and stress management strategies
- advocating for counselling or support options to be available to staff
- assisting with the referral of individual school staff to local health services, where a need has been identified by hSS clinical staff.

The component in practice

To provide an opportunity for staff employed in the Queensland state school system to practise self-care, hSS presented a webinar on OneChannel, a state-wide professional development webinar program run by the Department of Education and Training. Feedback about the webinar was consistently positive and participants reported that the session was useful in improving resilience, stress management and help seeking.

Following a pilot in 2016, the Principal Coaching and Support Service (PCSS) was developed by **headspace** in partnership with the Queensland Department of Education and Training to support Queensland state school principals and heads of campus (HOC) who have experienced a school-based trauma or critical incident. The high work demands and levels of stress reported by school leaders to hSS, particularly after experiencing a school-based trauma or critical incident such as suicide, prompted the development of the Principal Coaching and Support Service (PCSS) in 2017. While this service was subsequently developed as a separate state-funded project as a partnership between **headspace** and the Queensland Department of Education and Training, it demonstrates how national funding can seed important services at a state level. This was particularly important given that national evidence suggests that leaders often do not seek support for managing such stress (82). With potential application in other states, the service aims to support leaders' mental health and wellbeing both during an incident and in the longer term. A school leader can access face-to-face or telephone professional/personal coaching sessions that may include referral to appropriate support services, such as employee assistance programs. Supporting resources and seminars for leaders have also been developed.

To enhance and strengthen the resilience and capacity of school staff responding to a suicide contagion in the Victorian regions of Casey and Cardinia in 2012, hSS also advocated for the Department of Education and Training Victoria to provide supervision to wellbeing staff. For further information, see Appendix A.

At a national level, hSS has developed a range of resources for schools to raise awareness of how school staff may be impacted by a suicide and strategies to respond to students and practise self-care. (For a summary of hSS resources, see Appendix D.)

Qualitative feedback from school staff that have been supported by hSS following a suicide has highlighted the importance of this service in the recovery phase.

> **'The headspace staff were responsive to our unique needs. Our two suicides were caused by relationship breakdowns and seemed to be a spur of the moment decision. The two young fellas who took their life gave minimal signs that they were thinking suicide. headspace helped us to deal with this – many of us felt we should have taken more notice. headspace staff worked with us postvention and let us know that what we had done was okay and that we're not super people. They helped us be kind to ourselves at a very difficult time. This was extremely important.'**
>
> – Qualitative comment, hSS Awareness and Satisfaction Evaluation 2015

As these examples illustrate, responsiveness to the wellbeing needs of school staff is a vital component of an effective and holistic postvention service.

9. Long-term recovery support

Rationale

To minimise the burden of a suicide, the suicide response should provide long-term recovery support to the school community for at least 12 months after the suicide. Recovery activities should:

- promote connectedness and post-traumatic growth
- be aligned with whole school wellbeing frameworks and schoolwide practices
- be identified collaboratively with the school's Emergency Response Team
- include a review of postvention planning activities, to shape future Suicide Postvention Plans.

A comprehensive recovery strategy – which takes into account the longer-term priorities of a school community – restores and improves the longer-term wellbeing of the school community (62) and returns the school to a state of health and wellbeing promotion and suicide prevention.

Recovery is the process of a gradual restoration of a 'satisfying, hopeful and meaningful way of life' (83) or in the case of a school community, a return to the school's typical routine. The process of recovery begins immediately following the suicide and continues until the completion of any anniversaries, birthdays and significant events, often up to a period of 18 months.

2

Process

At a school level, hSS supports the school recovery process for at least 12 months and often more after a death by suicide. This extended period of support is important to assist the school to plan for peak risk periods. During this period, support may include:

- delivering professional learning and development, including *Skills-based Training on Risk Management* (i.e., *STORM*) to school staff, to enhance the school's ability to identify and respond to students at risk of suicide. For further information, see Component 6: Early identification and management of vulnerable students (Gatekeeper training)
- assisting the school to plan for peak risk periods (e.g., anniversaries, birthdays and graduations) and new student intakes
- assisting schools to continue to monitor and support vulnerable students
- providing guidance on the review and development of relevant school policies and protocols
- providing education and training to the school community (including school staff and parents) about mental health and wellbeing topics (such as self-care and managing stress)
- encouraging schools to facilitate general mental health awareness programs for students covering topics such as the symptoms, risk factors and sources of help for common mental health problems; how to support a peer; stress reduction; coping techniques and positive mental health
- maintaining linkages (e.g., referral pathways) with local mental health services to provide long-term care for students
- assisting with ongoing reviews for several months after the death to evaluate the school's response, reassess school needs and highlight any crisis response policies and/or guidelines that should be developed and/or reviewed to ensure continuous program improvement
- advising the school to audit current curriculum for any social and emotional health and wellbeing content and enhance this where necessary
- encouraging the school to consult with students, staff and parents (e.g., through focus groups and/or surveys) to generate ideas for improving the health and wellbeing of the school community and work with student leadership groups, student councils, parents and staff to implement these.

At regular intervals during this recovery period, hSS review the need for ongoing assistance. Schools may request more support or decline further assistance at any stage during this time. At the completion of this episode of care, hSS reviews the assessment and delivery of services to the school and provides the school with a letter summarising the services provided and any final recommendations for the school to consider. Schools are also invited to contact hSS whenever the need arises.

For two case studies describing the hSS recovery process, see Appendix E.

The component in practice

In a remote school in the Kimberley region of Western Australia that had experienced a student suicide, hSS recovery activities involved consistent, ongoing and face-to-face relational support and the development of strong collaborations with the school community over a three-year period. As the school did not have strong relational links with the community at the time of the suicide, hSS assisted the school to meet with Elders, community members and local services to understand the community's needs and current interventions and supports, including wraparound supports needed for Indigenous students at the school. hSS also helped the school to review and update their Suicide Postvention Plan. In addition to this

face-to-face support, hSS provided ongoing telephone and email support at pivotal response times – for example, in preparation for holiday periods and other times when grief reactions were likely to resurface. hSS also supported the school to link students to local services and provide support information for Indigenous parents. The hSS commitment to timely communication and collaboration with a local education sector representative, the local shire and relevant health services and agencies was particularly important given the remote context of the school: in remote towns in Western Australia, Perth-based agencies and services are often referred to as 'seagulls' by locals because they fly in and out on charter flights when there is a crisis without necessarily understanding the nuances of the community or building relationships with them.

At an independent school in New South Wales that had experienced a number of suicides in the school community, ongoing concerns were raised about the level of distress and suicidality amongst the students and the wellbeing of staff. Concerns were also raised about the fact that a significant number of year 10 students would be transitioning to another school at the completion of the school year. In this instance, recovery activities included planning for a separate service for year 10 students to mark the end of the school year and facilitating linkages with their next school to ensure handover conversations occurred and support plans could be put in place for students if required. hSS also participated in a curriculum review that resulted in revisions to assigned English and Drama texts.

In addition, to assist staff and parents to identify and manage vulnerable students, hSS delivered *STORM* training (*Skills-based Training on Risk Management*)[20] and conducted several parent information sessions. These activities resulted in increased student awareness and capacity to seek help and support through the school community, local services and online services. *STORM* training evaluations indicated increased staff confidence and competence in responding to and supporting students who were indicating risk of suicide. Staff also reported improved wellbeing as a result of their increased knowledge of plans and processes to support them and the school community. In particular, the Principal and key leadership staff reported feeling well supported and guided by hSS and indicated that they were more inclined to contact hSS for secondary consultation because of the in-person support hSS provided.

Similarly, parents reported increased confidence, knowledge and support around how to seek help and respond to their children's concerns. They also reported feeling reassured about the support the school was providing and felt more inclined to engage with local service providers.

A school in Tasmania that had experienced a cluster of suicides in the previous year engaged with hSS to train staff in how to identify and support vulnerable students. This involved:

- training all staff in the My FRIENDS Youth Program, a social and emotional resilience training program for adolescents aged 12 to 15 years
- training every grade coordinator and the leadership team in *STORM*. For further information on *STORM*, refer to Component 6: Early identification and management of vulnerable students.

The school also conducted a postvention planning session and revised their Suicide Postvention Plan for new leadership staff. In addition to empowering school staff to enhance student resilience, these recovery activities helped to foster a whole school approach to mental health, which included a common language around social and emotional wellbeing among the school community.

The respectful and collaborative nature of hSS engagement with schools in the recovery phase has also been noted by school staff.

> **'headspace School Support was informative about longer-term follow up after suicide. It was very much appreciated that headspace School Support did not "take over" but were supportive, informative and asked how they could support the school further.'**
>
> – Qualitative comment, hSS Awareness and Satisfaction Evaluation 2015

Recovery activities that empower schools to meet their long-term needs in a collaborative and holistic manner are paramount to a school's ability to minimise the burden of a suicide and return to typical routines.

[20] *STORM* is a program for school-based leaders covering suicide risk assessment, safety planning and postvention. For further information on *STORM*, refer to Component 6: Early identification and management of vulnerable students.

10. Data collection, evaluation and dissemination

Rationale

To ensure that suicide postvention in schools is evidence-based and responsive to current stakeholder needs it is essential that individual and service-level data about suicide and suicide responses is collated, investigated and shared with all agents involved in the development or delivery of suicide postvention services.

As a world-first service, hSS must rely heavily on this data to inform its daily operations. Importantly, high quality data collection, evaluation and dissemination enables hSS to:

- facilitate communication and continuity of care across hSS national and state teams, **headspace** centres and other agencies
- provide evidence of the standard and quality of care and collaboration provided to schools, local community agencies, other government and non-government agencies, young people and their families
- fulfil the contractual requirements of hSS
- meet relevant professional, medico-legal and statutory requirements
- provide information for audits, performance management, quality management, education, research and evaluation, and clinical and resource management
- detect patterns and trends in student suicides that are not captured elsewhere to quickly identify potential areas of contagion.

The need for comprehensive data collection, research and dissemination is well recognised at a national level also. The Australian Institute of Family Studies, in its evaluation of the first National Youth Suicide Prevention Strategy in 2000, made the following recommendation:

> **'More attention needs to be directed to enhancing the accessibility and effective use of practice-based evidence. Documentation and dissemination of information is not enough. Many agencies lack the tools that are required to tap into existing stores of knowledge and to ensure that their own experiences are subject to critical reflection and are fully used. All organisations should have structures and processes in place which facilitate ongoing learning as a basis for ongoing action.' (84)**

The fulfilment of this recommendation still remains a challenge.

Process

hSS routinely facilitates data collection, research and dissemination at a local, state/territory and national level.

Local

hSS provides guidance to schools about developing and maintaining adequate documentation of each step of the suicide management process for approximately 12 months. This includes documentation of:

- all decisions and actions of the Emergency Response Team
- vulnerable students and any referrals for extra support
- the content of all Emergency Response Team, staff and parent meetings
- all communication with external agencies (e.g., police, coroner and mental health services).

State/Territory

hSS has established avenues for the exchange of coronial information between **headspace** centres and a state-based coronial court to identify suicide prevention opportunities in the state. This was achieved via a data linkage study that retrospectively matched the suicides that hSS had assisted with since its inception with all school-aged suicides during that period. The aim of this study was to identify the proportion of all student suicides that hSS provided assistance with in the state and how this has changed over time.

National

hSS maintains a database of hSS contacts and service activity that is cross-referenced by state/territory and national hSS teams and discussed on a weekly basis. This database is used to record information about each hSS service user, their unique circumstances and needs, and the services they receive. Information about each suicide[21], including the student's year level (Figure 6) and month of the year (Figure 7), is also recorded.

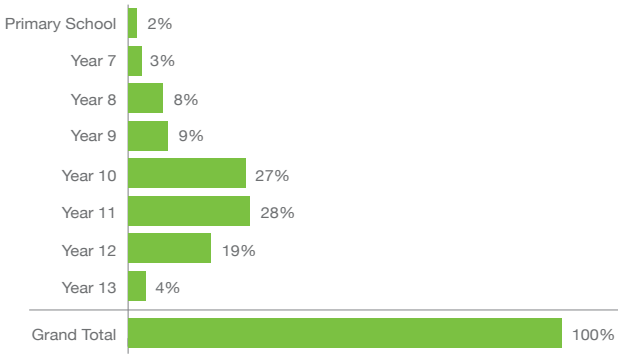


Figure 6. Graph showing suicides by student year level

[21] hSS suicide data differs from suicide data collected by the Australian Bureau of Statistics for two reasons: 1) hSS collects information about student deaths that have not necessarily been confirmed as suicides by a coroner and 2) hSS only collects information about a student suicide with the consent of the student's next of kin.

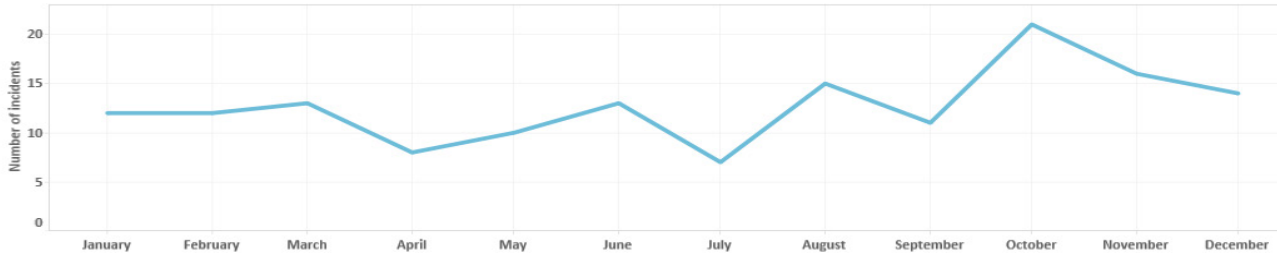


Figure 7. Graph showing breakdown of suicides by month

All hSS Consultants regularly update this database and entries are routinely audited by the hSS National Clinical Advisors[22]. Online reports generated from this database are used by hSS management to evaluate the service and provide service funders and stakeholders with high-level information about service activity. When recording each occasion of service or support, hSS staff are expected to adhere to national hSS documentation rules and guidelines, which clearly stipulate what types of information should be recorded, when this information should be recorded and how it should be presented in the hSS database. This ensures consistent recordkeeping and accurate reporting across hSS.

hSS also curates a growing body of evidence in the form of lived-experience case studies, an expert consensus (Delphi) study (62) and feedback from national evaluations and surveys – i.e., the *hSS Evaluation 2014* and the *hSS Awareness and Satisfaction Evaluation 2015* – to continually inform the development of the service. For further information on the research and evaluation activities undertaken by hSS, see Background, Building the evidence base for suicide postvention in schools.

The component in practice

Clear documentation of clinical practice at a school level has enabled schools to:

- undertake critical incident review following a suicide
- provide details of its postvention actions to authorised agencies, if required.

It also allows hSS staff to demonstrate their professional obligations, accountability and legal requirements related to their contact and interventions with schools and their communities.

At a national level, the hSS database of suicide and service activity has allowed for improved service delivery data collation and analysis across the program, which has in turn enhanced clinical governance. It has also facilitated an ongoing clinical focus on reporting in schools with emergent contagion patterns – and with targeted needs and planning requirements – to ensure timely support and follow up for these high-risk schools. By detecting previously uncaptured data patterns and trends emerging from exposure to a suicide, the database has also been instrumental in anticipating future service delivery. The national nature of this dataset also ensures that exposure to suicide across state and territory borders is identified and addressed.

As limited evidence for models of suicide prevention, early intervention and postvention work in schools existed at the time of the inception of hSS, findings from national surveys, evaluations and studies have been instrumental in the development of a best practice model for suicide postvention in secondary schools. This evidence is continually translated into new and improved services and resources, in line with hSS national quality assurance processes. For example, in 2013 hSS funded an independent expert consensus (Delphi) study to refine the hSS best practice guidelines for responding to suicide in school communities (64). The results of this study affirmed existing hSS practice and resources for working with schools and generated actions that would potentially reduce further exposure and contagion of young people (62).

As these outcomes illustrate, high quality data collection, evaluation and dissemination is a necessary precursor both to the identification of effective postvention practice and continuous service improvement. And as the reliability of hSS data is dependent upon the level of trust that hSS service users and partners place in hSS, building and maintaining relationships with these stakeholders is an essential precursor to high quality data collection.

[22] Further information about the workforce structure of hSS is provided in Appendix F.

Data linkage study with coronial court

Recognising the synergies between the information generated by hSS and the coronial courts, hSS initiated a pilot project with a state coronial court in 2015 to enhance their collective understanding of suicide among 13–25 year olds[23].

The project aimed to equip hSS to better respond to vulnerable young people, and provide the court with contextual information about the prior involvement of **headspace** in communities where deaths in this age bracket had occurred, from 1 July 2015 until the project's conclusion on 1 September 2016.

Through secure data sharing between hSS and the coronial court, the project:

- identified contact with **headspace** and other health services by each individual in the cohort of deaths
- provided **headspace** with a summary analysis of whether hSS had any contact with these young people and identified the schools that had the lowest rate of reporting deaths to **headspace**
- determined inconsistencies in the proportion of deaths that were reported to **headspace** in comparison to the deaths that were not reported to **headspace**.

From the studies conducted, a series of reports on the suicidality of this age group were compiled. These reports examined the nature, characteristics and service contact of young people aged 13-25 years who died during the study period and had contact with a **headspace** centre. As well as highlighting the current level of effectiveness of **headspace** programs in engaging with young people who are most vulnerable to suicide, these reports identified future directions for outreach to young people who are most vulnerable to suicide.

This collaboration between hSS and a coronial court has allowed both organisations to gain a better understanding of suicide amongst 13–25 year olds in one Australian state. Findings from these studies have influenced improvements to both the coronial court's data collection and hSS services. These will also facilitate the identification of, and detailed information about, suicide clusters, which is an issue of particular concern for schools. At the time of publication, ongoing projects are being explored with coronial courts in other states and territories.

[23] This coronial court has a legislative mandate to investigate all unnatural and unexpected deaths and has an explicit role in public health and safety. Accordingly, information generated for these investigations comprises the most comprehensive and reliable data source available on suicide in the state.

Section 3: The way forward

hSS has developed a strong body of practice and evidence for effective postvention in schools communities, built on strong relationships with schools and other key stakeholders. This work has highlighted the value of a national approach to effective postvention. This section will outline key recommendations for continuing to develop and deliver this standard of postvention support in Australian schools.

The holistic and robust delivery of suicide postvention in Australian schools will require the embedding in a national postvention service of the 10 core components, as described in this report. At the time of publishing this report, this has been widely acknowledged and postvention services building on the work of hSS are presently being incorporated in the national integrated Mental Health in Education (MHE) program, which spans all education settings in Australia.

Moving into the future, hSS recommends 5 concurrent areas of activity. These areas of activity capture what is already being achieved, and what still remains to be achieved, at a federal, state/territory/regional and local community/school level. Importantly, within the scope of these recommendations is the extension of support to primary and tertiary education settings, where a growing need for postvention support has been identified.

The 5 areas of activity recommended by hSS are summarised below.

1 Clear organisational systems and structures, working seamlessly together at a national, state/territory/regional and local community/school level to coordinate a national suicide postvention strategy.

Key features of this work include the establishment of a cross-sectoral body to advocate for postvention within the context of larger mental health reform, and the extension of national postvention services – which are fully integrated with state and territory services and school mental health services and programs – across the education spectrum.

2 Ongoing development and customisation of standards, guidelines and tools to facilitate best practice across the health, education and media sectors.

This relates to the adaptation and extension of postvention standards, guidelines and tools for a range of audiences – including schools and other educational settings, service providers and communities – and the establishment of protocols between the national postvention service and key stakeholders (e.g., police, hospitals, schools and education sectors) to ensure postvention practice is aligned with existing evidence-based policies, programs and services.

3 Centralised and standardised collection of suicide data that is routinely shared with, and monitored by, relevant stakeholders, according to agreed protocols.

This involves the accurate logging of all suicide deaths and attempts on a centralised data platform, to continuously improve guidelines and practice.

4 Enhanced communication and workforce capacity building across the education and health sectors.

This includes the establishment of a centralised communications platform for schools and services to build the capacity of workforces to understand postvention and further development of postvention training for schools, services and the community. The implementation of nationally consistent language regarding suicide, self harm, mental health and postvention is a key feature of this work.

5 A robust youth suicide and postvention research and evaluation program to strengthen the postvention evidence base and facilitate the continuous improvement of postvention service delivery.

This involves the establishment of a national postvention research agenda and the ongoing evaluation of existing prevention, interventions and postvention programs and services.

To articulate the interplay between these different areas, and respond to new learnings and developments in postvention practice over time, hSS has mapped each of these recommended areas of activity – and the individual recommendations associated with each of these areas of activity – into a flexible and multi-levelled plan of action in Appendix H.

Conclusion

Since its inception in 2011, hSS has amassed vast experience and knowledge in the field of postvention. The incorporation of this work into the national integrated Mental Health in Education (MHE) program 2017–2019 recognises the indispensable role that hSS has established in this landscape. It is imperative that the postvention service model that hSS has refined over the past six years remains a central and distinct element of this integrated mental health strategy. Effective postvention has the capacity to be effective *prevention* in schools because it specifically targets school communities that have already been exposed to a suicide. As highlighted in Section 1 of this report, international research indicates that young people who are exposed to suicide can be susceptible to suicide contagion (10, 12, 13, 18).

For postvention to efficiently return impacted schools to a state of health and wellbeing promotion and suicide prevention, it is vital that all postvention efforts are guided by the 10 core components of effective postvention practice established by hSS (outlined in Section 2 of this report). This will ensure that postvention remains a highly specialised and customisable service that sits within a whole school, whole community and whole sector approach to mental health. Such an approach recognises that a school's transition from postvention to prevention is complex and unique to the circumstances and needs of the particular school community. By immediately delivering personalised clinical and educational support to schools, an effective response caters to the range of emotional and operational impacts that are triggered by a suicide. An effective multidisciplinary service relies on, and is strengthened by, the continued efforts of postvention service providers to nurture cross-sectoral partnerships between the education and health sectors at a federal, state/territory and local level, and to build strong relationships between schools, the community and local service providers. Not only does this approach increase trust in the postvention service, it also ensures schools are well placed to receive coordinated and comprehensive support with minimal service duplication. All of these service components are further enhanced by high quality data collection, evaluation and dissemination, to ensure that services remain evidence-based and responsive to current stakeholder needs and trends in student suicide.

headspace commends the Australian Government's investment in postvention in Australian education settings as part of an integrated approach to the mental health and wellbeing of all young Australians. **headspace** is committed to continue to work with others in the field to contribute to the continuous improvement of postvention services at all levels of Australian education.

Appendices

Appendix A: Suicide contagion experience – the Casey Cardinia Project

Rationale

Between March 2011 and December 2012 a significant number of suicides occurred in the Casey Cardinia region in south-east Victoria. The deaths, many of which affected school-aged young people, caused high levels of anxiety across the entire community and led to schools and local services being overwhelmed.

In response to the deaths and heightened anxiety in the region, in March 2013 the Victorian Government funded a dedicated **headspace** team to deliver a specialist suicide postvention project in the region with a focus on schools and their communities (the Casey Cardinia Project). Building on existing structures and services in the region, the Casey Cardinia Project aimed to enhance the strength, resilience and capacity of the local community, reduce suicide risk among high school students and to promote recovery across the region. hSS supported the project team as this promised a more systematic approach to postvention and prevention.

Process

The Casey Cardinia Project adopted a community development framework, which focused on developing skills within the community. In this way, **headspace** aimed to make the processes, relationships and support networks formed during the project more sustainable.

The project was implemented in three stages between March 2013 and August 2015 by a project team funded to sit alongside hSS who provided gatekeeper training[24] for school wellbeing staff, tools for identifying vulnerable students and specifically targeted interventions for those at risk in conjunction with clinical backup. This approach was based on international best practice and evidence indicating that a coordinated multi-level approach combining high quality school staff gatekeeper training with early detection and intervention programs is the most effective method for suicide postvention (29).

An in-depth evaluation was also completed and a number of conclusions were drawn about the overall impact of the project.

Stages of project delivery

Stage 1, between March 2013 and 31 December 2013, included:

- stakeholder engagement
- building a service system to support referrals, by coordinating and liaising between schools, local mental health services and community services in the region
- needs assessments of six prioritised schools and postvention plans
- delivery of 12 parent and 12 school staff workshops across the region
- suicide risk management training
- secondary consultations with wellbeing staff members to discuss students who were identified as directly and/or indirectly impacted by youth suicide and/or who were demonstrating suicidal behaviours identified by risk assessments.

Stage 2, between January 2014 and 31 December 2014, included:

- ongoing stakeholder management
- needs assessments of a further six prioritised schools
- facilitating and/or delivering a further 18 parent workshops and 18 training sessions for school communities.

Stage 3, between January 2015 and 31 August 2015 included:

- capacity-building activities
- delivering My FRIENDS Youth and *Adult Resilience for Life* facilitator training to school and community staff
- encouraging the delivery of the My FRIENDS resilience workshops to school students, staff and parents throughout the region.

[24] For further information on gatekeeper training, see Section 2, Component 6: Early identification and management of vulnerable students.

Outcomes

The Casey Cardinia Project made significant gains for the schools in the Casey Cardinia region and the community at large. In particular, awareness of youth suicide and the community's needs was significantly raised among relevant government departments, local politicians, service providers, community leaders and schools. School wellbeing staff reported a greater awareness of suicide risk, knowledge of a shared language for discussing levels of risk and safety plans, and an increase in their capacity to correctly identify vulnerable young people and to have them assessed and referred to specialist support as quickly and effectively as possible. Tertiary services staff reported that the increase in education and training in schools had led to their services undertaking more accurate risk assessments and more appropriate referrals. These factors combined have led to an overall increase in the efficiency and availability of immediate assessments for young people at risk throughout the region.

The direct access school wellbeing staff had to **headspace** project workers was emphasised as a project standout. Relationships between stakeholders and **headspace** project workers were paramount to the positive outcomes of the project. The information exchanged through these partnerships enhanced collaboration and coordination throughout the region and created a sense of shared responsibility for the wellbeing of every child. The networks that emerged, out of both the crisis and the project, have contributed to increasing the safety of young people throughout the region; responsibility for their wellbeing has become a matter of the entire region rather than the sole responsibility of individual schools. A cultural shift within the schools was also observed, in terms of the value they attributed to student wellbeing and the health of their staff members. Finally, the project produced a practical set of risk management tools for use by education and health services in the Casey Cardinia region to assist with the management, assessment and referral of vulnerable young people.

These outcomes demonstrate the value of hSS leveraging its national funding to support and inform dedicated state teams to establish targeted interventions that can continue to be funded at the state level. Maintaining the sustainability of these achievements is essential to ensuring youth suicides in the region continue to be contained and that the community can focus its energies and resources on building resilience and capacity within the schools and among parent groups and community agencies.

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Appendix B: Development of the hSS service

Stage 1: Scoping the hSS service (July 2011 – December 2011)

To guide the development of the hSS world-first service model, a thorough preliminary scoping exercise was commissioned in 2011. As little evidence existed about the efficacy of suicide postvention activities in schools in 2011 (29), this exercise was vital to ensure that the proposed hSS service offering stemmed from a solid evidence base, implemented best practice and worked within existing services, rather than duplicating programs already in existence.

The hSS scoping stage consisted of the following research activities:

A. Evidence review

hSS undertook a systematic review of the empirical literature pertaining to suicide postvention, prevention and early intervention in school settings to identify the interventions supported by the best available evidence. Included in this review were school-based programs targeting suicide, attempted suicide, suicidal ideation and self harm where intent is not specified. The review identified 43 studies that reported on the effectiveness of school-based interventions for suicide-related behaviour. The review classified the retrieved studies into four categories informed by a framework previously applied to the development of mental health interventions (85) and later applied to suicide prevention (86). The four categories were:

1. **universal interventions** that targeted whole student populations with the aim of increasing knowledge and awareness of suicide and how to seek appropriate help for feelings related to suicide, either in oneself or in a friend or a peer, of which there were 15
2. **selective interventions** that focused on either training school wellbeing staff to better identify and support students at risk of suicide, i.e., gatekeeper training, of which there were 12, or screening studies that sought to specifically identify young people at risk, of which there were 11
3. **targeted interventions** that provided treatment to students already demonstrating suicide-related behaviours, of which there were three
4. **postvention programs** in a school setting, of which there were two.

The findings have been published in the form of an academic paper (29) and in an evidence summary produced by hSS (87). They are briefly summarised below.

1. Universal interventions

Overall, the review found that while the universal education programs targeting students did appear to increase knowledge and awareness of suicide and various help-seeking options, concerns have been expressed about their safety (88). Therefore, the study concluded that while they may be intuitively appealing they require further testing before their broad implementation.

2. Selective interventions

With regard to the selective interventions, i.e., gatekeeper training programs for school wellbeing staff and screening programs designed to identify vulnerable students, these did show some potential. Indeed, for the most part, the screening programs appeared to identify the correct students and did not show any unintended effects. Moreover, the training programs led to improved reports of knowledge, perceived skill and confidence on the part of school staff when working with vulnerable students.

Questions have been raised with regard to the acceptability and feasibility of implementing widespread screening programs in school settings (89), which has led to limited uptake of such programs outside of the United States. But gatekeeper training is a widely accepted suicide prevention approach, including in schools. It has been a focus of the national approach to suicide prevention in Australia for some time (50) and was one of the key recommendations to arise from *Before it's too late: Report on early intervention responses aimed at preventing youth suicide* (53).

3. Targeted interventions

The studies focusing on indicated and postvention interventions were fewer in number. Three indicated intervention studies were identified (90-92), each of which employed a randomised controlled design to test a specific form of treatment or therapy on students at risk of suicide, and all three reported reduced risk of suicide over time in both the treatment and control groups.

4. Postvention programs

Two postvention studies were identified and the findings from these were less conclusive (39) (93). The first study investigated the effectiveness of one component of a pilot postvention project program conducted in two Australian schools following student suicide and reported no differences in student wellbeing following postvention. The second was conducted in the United States and investigated the effects of postvention programs in response to suicide clusters in three schools over four years. Although postvention practices differed across the schools, there were no significant differences in either of the key outcomes of interest (i.e., rates of post-traumatic stress disorder or high-intensity grief scores).

Conclusion

Overall, the review highlighted the limited evidence regarding suicide postvention in secondary schools — resulting largely from methodological concerns including a lack of controlled studies and an inability to accurately measure suicide-related outcomes. In particular, little evidence could be established to support the types of targeted intervention that would be appropriate for delivery in a school setting. In the absence of appropriate school-based interventions, it was advised that individual and specific targeted interventions be delivered in a clinical setting.

In spite of these limitations, hSS uncovered reasonable evidence to support the implementation of specific suicide prevention gatekeeper training to school staff and the use of routine mental health screening or check ups for high school students (29).

B. Stakeholder consultation

hSS undertook two overlapping phases of stakeholder consultation to inform the development and implementation of its service model. The aim of this process was to ensure the new model was most effective in addressing the needs of schools and working within existing services and supports, rather than duplicating existing programs.

Phase one consultations

Phase one identified the needs of secondary schools after a suicide and highlighted relevant policies and current programs. This was achieved through the completion of 92 one-on-one interviews with representatives from state and territory departments of health and education, independent and Catholic school personnel, mental health service providers, **headspace** centres and representatives from non-government organisations with an expertise in the area of suicide or representing a particular vulnerable group.

The consultations focused on gaining an understanding of secondary school mental health services across Australia and the needs of secondary schools after a suicide. Grey literature was gathered regarding current policies and practices relating to suicide prevention and postvention to ensure hSS worked within existing policy frameworks and did not duplicate what was already in place.

Overall, those interviewed in phase one consultations indicated that there was a genuine need to provide additional and specialised support to schools affected by suicide. A number of themes were identified with regard to the nature of this support, which broadly fit within two response timeframes: initial support (i.e., the days and weeks after a suicide) and longer-term support.

In the initial response to a suicide, stakeholders identified the following as key areas of need: coordination and planning, including guidance in managing and delivering communication; up-to-date resources; assistance developing linkages internally within schools as well as between schools and outside services; and guidance on speaking to the media. In the longer term, stakeholders described the need for help developing policy or response plans, and the need for school staff, parents and the wider community to have the knowledge, skills and confidence to respond to a suicide. Additional services designed to facilitate the early identification of young people with mental health issues were also identified as a longer-term need.

The following population groups were also identified as groups that may require extra support or specialised resources when affected by suicide:

- Aboriginal and Torres Strait Islander young peoples
- young people from rural and/or remote communities
- refugees
- lesbian, gay, bisexual, transgender and intersex (LGBTI) young people.

Overall, findings from phase one consultations illustrated the need for a flexible approach that could adapt to the diverse context of Australian secondary schools. Phase one also highlighted the need for ongoing monitoring and evaluation of service delivery.

The findings from phase one, along with the results from the evidence review and grey literature analysis, informed the development of the draft hSS Service Model. The draft model included two response timeframes – initial support and longer-term support. Initial support options included website resources – such as fact sheets, a postvention toolkit and links to other resources and organisations, and face-to-face support from hSS staff. If required, the face-to-face support could include response coordination, expert advice and facilitation of linkages in the local community. Longer-term support included a range of website resources, education and training, expert advice and guidance to improve internal and external linkages.

This preliminary model was based on a state and territory team approach, supported by a central management and coordination team. A national coordination team was to be based centrally at the **headspace** National Office in Melbourne, Victoria. At the state and territory level, the service was to be structured into six local support teams that would work with school communities across all states and territories. Teams would be located within **headspace** centres to facilitate local referral and enable ready access to broader clinical support for both schools and the local support team workers. The service would also develop relationships with other mental health services to ensure young people could access pathways to care in the event that a **headspace** centre was not accessible.

Phase two consultations

Phase two was designed to receive in-depth feedback on the content, structure and usefulness of this draft service model. It was also intended to seek in-depth feedback on service implementation strategies for the range of diverse contexts within the Australian Catholic, independent and government secondary school sectors. To facilitate this, 15 focus groups were held in metropolitan and rural locations across Australia. All states and territories were visited except for the Australian Capital Territory. Of the 381 stakeholders from various state, territory and national bodies who were invited to participate in the focus groups, 159 attended.

In the majority of focus groups conducted, the proposed hSS service design was overwhelmingly supported and endorsed, in particular for its flexibility and capacity to be adapted to local contexts. Stakeholders also reported that the model would meet current needs of schools requiring support after a suicide.

Participants agreed that hSS should have a holistic community approach – engaging families, local services, community members and neighbouring schools. Additionally, partnerships were regarded as an important aspect of hSS.
A number of education departments, health departments and local service providers expressed the need to

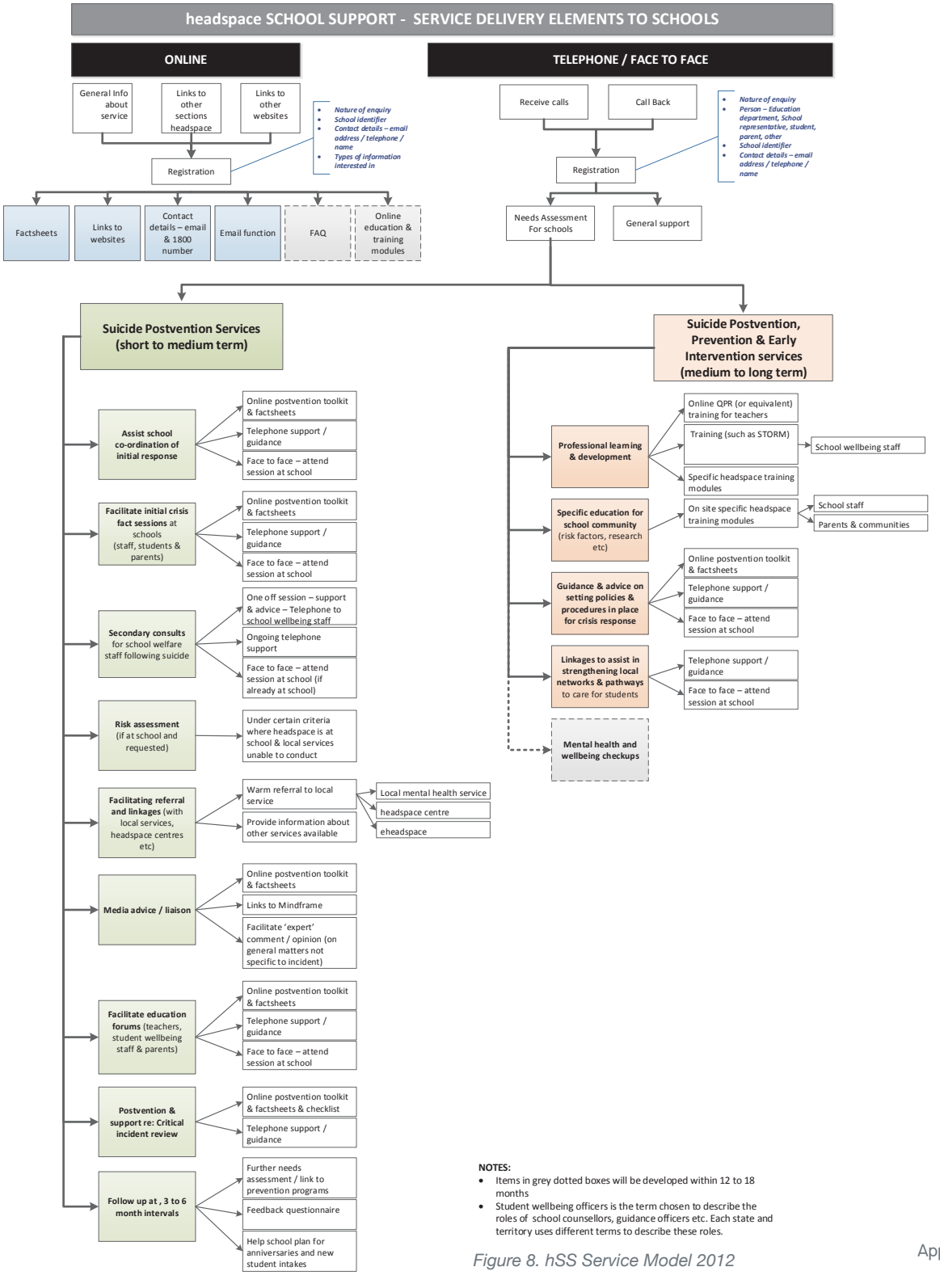
collaborate to most effectively gain access to local resources and current services.

There was strong support in all focus groups for the inclusion of a training component within the service. This was seen as having great potential benefit for schools across Australia. Teachers were considered as the preferred target group, and stakeholders suggested that a combination of online and face-to-face training would be most appropriate.

In all focus groups, participants discussed or made recommendations about the 'resource' component of hSS. There was vast support for up-to-date resources and information specifically tailored to schools and located centrally on the **headspace** website. Aboriginal and Torres Strait Islander young peoples and geographically isolated young people were consistently highlighted as vulnerable groups with an urgent need for appropriate and specialised resources. Further, the notion of expert advice on suicide prevention and postvention, and guidance for adapting resources or updating response plans, was highly regarded.

Stakeholders reiterated the importance of a strong monitoring and evaluation framework but acknowledged the challenge of evaluating a flexible service that varies across regions, states and territories.

Feedback from phase two was instrumental in the refinement of the initial hSS Service Model (displayed in Figure 8). The model was updated in 2017; it is described in Section 1, What does hSS offer to schools?



NOTES:

- Items in grey dotted boxes will be developed within 12 to 18 months
- Student wellbeing officers is the term chosen to describe the roles of school counsellors, guidance officers etc. Each state and territory uses different terms to describe these roles.

Figure 8. hSS Service Model 2012

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Stage 2: Soft launch of hSS (January 2012)

In January 2012, hSS commenced service delivery, assisting schools to respond to the suicide death of a student. hSS operated solely from **headspace** National Office in Melbourne, with national support being provided via the hSS website, email and dedicated telephone line. Suicide-specific resources developed by hSS were available on the website from this time. Clinical staff began being employed in each state and territory from July 2012, and this facilitated face-to-face service delivery across the country in addition to the existing telephone and email support. During this phase the hSS Work Plan had a strong focus on service promotion, networking and education and training, rather than the delivery of clinical services.

During the early stages of service delivery (June 2012), a letter of support for hSS signed by then Minister for School Education, the Honourable Peter Garrett, and then Minister for Mental Health and Ageing, the Honourable Mark Butler, was sent to Australian secondary schools. Similar letters were also sent to the ministers for school education in each state and territory. The purpose of these letters was to generate awareness of, and foster willingness to utilise, hSS among secondary schools.

Shortly after commencing service delivery in 2012, hSS recognised that postvention planning (often called 'disaster planning' or 'preparedness') was an essential and interdependent component of effective response and recovery work, and adapted its service model accordingly.

Further to this hSS developed the following best practice components for postvention in schools:

1. school suicide postvention response planning
2. professional learning
3. parent and carer engagement
4. partnerships with local services and agencies
5. partnerships with other schools
6. evidence-based practice
7. intervention strategies for at-risk young people
8. ongoing recovery
9. whole school approach to mental health.

Note: The 10 core components of effective postvention practice outlined in Section 2 of this report have now replaced the hSS Best Practice Model from 2012.

Stage 3: Formal launch of hSS (October 2013)

hSS was formally launched by then Minister for Mental Health and Ageing, the Honourable Mark Butler, on 25 October 2013. At this point, clinical staff were employed by hSS in most states and territories. The service model and skillset of staff continued to be adjusted and developed between late 2012 and early 2013 to further enhance the effectiveness and efficiency of the service.

One key development was the establishment of formal relationships with education departments and other school governing bodies, including Catholic education offices and independent school organisations, in each state and territory. The reason for this development was that schools would be more willing to utilise hSS if it was formally endorsed and promoted by their relevant governing body. These relationships were formalised with letters of intent from March 2013 onwards.

Another key service development was the addition of the 'preparing' arm of the service to increase the extent to which schools were prepared for, and had a response plan in place in the event of, a student suicide. The 'preparing' arm was also designed to facilitate the establishment of strong working relationships between hSS and secondary schools prior to a suicide occurring. The logic behind this approach was that schools that had been in contact with hSS prior to a suicide occurring would be more likely to approach or accept support from hSS than schools that had not previously been in contact with hSS.

A third key development at this time was the employment of staff with specialist education and training skills to develop and help deliver hSS education and training to secondary schools. This was known as the 'capacity' arm of the service. While hSS clinicians had initially undertaken this work, it became apparent that staff with specialist education and training skills were required to ensure the quality of education and training activities, and so that clinicians could spend their time on clinical response work.

Figure 9 displays the hSS Service Model from 2013 to 2016. It comprises a preparing component, a clinical component that assists schools to respond to and manage a suicide (responding), an education and training component (capacity), a wide range of written resources (resourcing) and an evaluation component (evaluating).

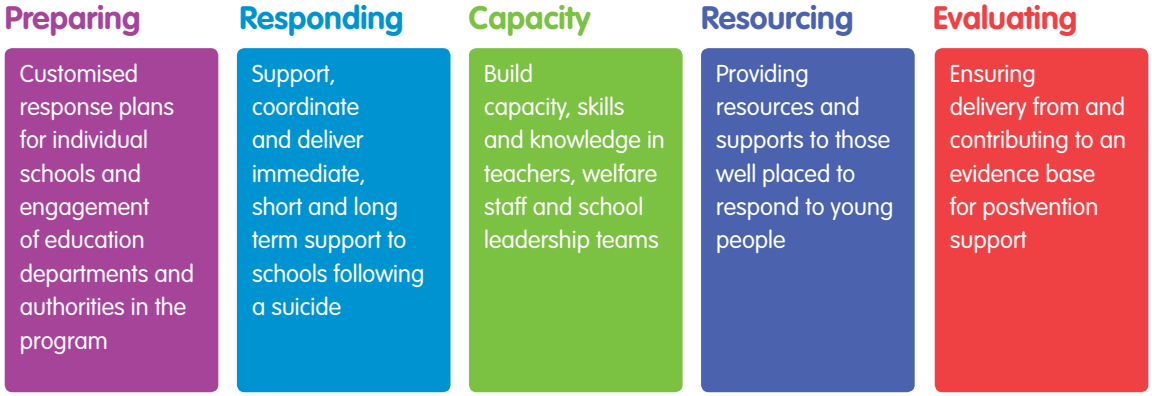

Figure 9. hSS Service Model 2013 to 2016

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The hSS service has continued to develop over the last six years through research, evaluation and reflective practice. For further information on the research and evaluation activities undertaken by hSS, see Background, Building the evidence base for suicide postvention in schools.

Appendix C: hSS Evaluation 2014

Rationale

To assess the implementation of the newly established hSS service – including early impacts and outcomes of the service, and areas for improvement – the **headspace** Research and Quality Improvement team undertook an evaluation of hSS in 2014.

Process

The evaluation involved:

- analysis of service activity data
- a national survey of the need for and awareness of hSS among school wellbeing staff
- a satisfaction survey for school staff who have accessed hSS services to collect data on the perceived increased skill and confidence level as a result of the service
- case studies from schools accessing hSS following a suicide
- interviews with hSS staff and management.

The evaluation employed a mixed methods approach combining quantitative and qualitative elements. This approach was chosen to ensure the reliability and richness of data, and the validity of findings and recommendations.

Outcomes

Overall, the evaluation confirmed that the initiation of hSS had been welcomed and valued by schools; hSS provided critical assistance to schools responding to a suicide, and could help schools to be better prepared and equipped for a suicide.

Some key findings from the evaluation are as follows.

- Almost half of school wellbeing staff surveyed across the country indicated that they had heard of hSS, and more than half of these respondents reported that they had used and/or had a good understanding of the service.
- Of school representatives surveyed about their experiences with the hSS service:
    - almost all reported that the service was helpful, they would recommend it to other staff/schools, and they would use hSS in the unfortunate event that their school experienced a suicide
    - the majority reported that they thought hSS had improved their knowledge about suicide generally, services that assist in dealing with suicide, and how to respond to and manage a suicide
    - the majority reported that as a result of using the service they felt better equipped to deal with student distress and future suicides, and to support and respond to young people at risk of suicide.
- An evaluation of the impact of *Skills-based Training on Risk Management (STORM)*[25] delivered by hSS suggests that the training can increase the confidence and skills of school staff in working with students at risk of suicide and related behaviour, and the confidence and skills of school staff in working with students with mental health issues.
- Schools that accessed assistance from hSS following a suicide reported that the service made them feel supported and helped them manage their response.
- Schools that accessed assistance from hSS following a suicide – who had also had experience responding to a suicide in the past – reported that they thought hSS can help schools provide a more coordinated response and help schools feel more supported than would otherwise be the case.
- The majority of hSS staff indicated that working for hSS was rewarding but that there are not enough staff in each state/territory.
- The reports of the hSS leadership team suggest that the service has developed strong, strategic working relationships in the education and health sectors, and had an impact at a policy level.

The evaluation suggested that there were aspects of the service that may require further consideration and/or amendment. These recommendations include, but are not limited to:

- ensure the timely development of resources specifically for schools affected by the suicide of an Aboriginal and/or Torres Strait Islander young person
- continue to monitor the extent to which the location of hSS clients is in line with the location of all schools (at a state/territory and metropolitan/rural level) and further target areas that are currently under-represented
- further develop the extent to which hSS equips schools to recognise the signs and symptoms of someone at risk of suicide and to respond appropriately
- continue to investigate the impact of hSS on the policy and strategic directions of state, territory and national bodies.

The evaluation indicated that hSS was a key part of the overall **headspace** platform; **headspace** centre managers reported that they used the service and found it useful to be able to refer to and draw on the service. Additionally, young people reported that they were becoming aware of and linked in with other **headspace** services (namely **headspace** centres and **eheadspace**) via hSS. This suggested that hSS was well placed to seamlessly facilitate young people accessing mental health support.

[25] For further information on *STORM*, refer to Section 2, Component 6: Early identification and management of vulnerable students.

A snapshot of the evaluation findings can be seen in Figure 10.

Figure 10. ***hSS Evaluation 2014*** *findings*

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Appendix D: hSS resources

hSS has a range of practical resources to assist schools to implement these core components in their own school community. They are regularly updated to reflect new research in the area of suicide postvention in schools. All of these resources can be accessed via the **headspace** website at headspace.org.au/schools/. hSS also distribute hard copies of these resources, as appropriate.

Suicide Postvention Toolkit – A Guide for Secondary Schools

hSS has developed a practical guide that details the steps to be taken following a suicide in the school community. It is divided into five sections, which focus on what to do immediately after the suicide, in the first 24 hours, in the first week, in the first month and longer term.

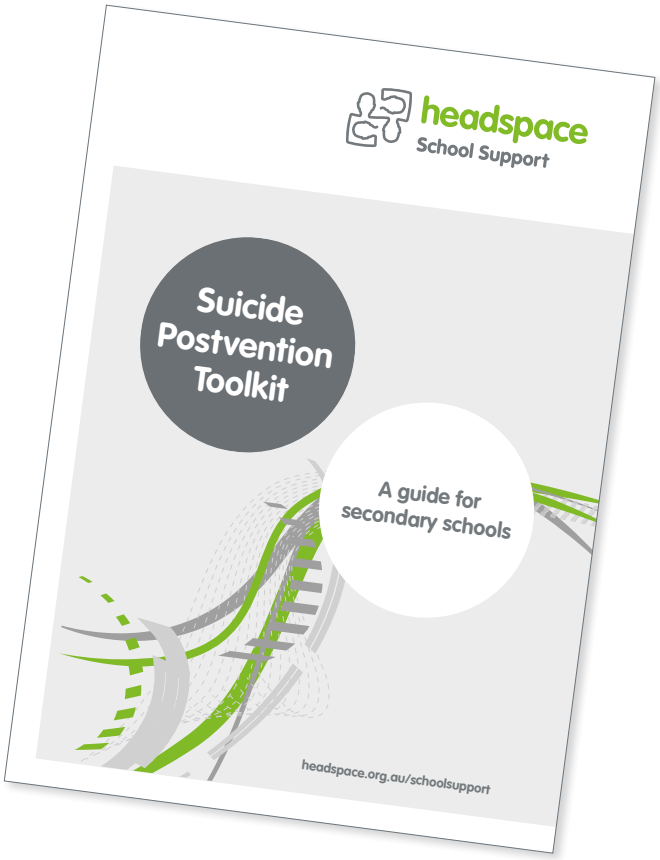
The *Suicide Postvention Toolkit – A Guide for Secondary Schools* (65) provides schools with step-by-step guidelines on how to respond to a suicide within the school community. The toolkit addresses both the short and longer-term response, and contains sample documents including scripts for teachers, a letter for parents and links to relevant fact sheets.

Fact sheets

hSS develops and maintains a wide array of fact sheets to assist schools, parents and communities in four key areas:

1. suicide and self harm
2. working with young people
3. following a suicide
4. Aboriginal and Torres Strait Islander young peoples.

Many of these resources are available in languages other than English, including Vietnamese, Chinese, Italian, Greek and Arabic.



Appendix E: Response and recovery case studies

Case study one: Response assistance following the suicide of a student from a large regional school

> **'It was certainly well worth having [hSS staff] here…It was great to have that support and that ongoing follow-up support and what seemed to be genuine concern not just for how the school was responding but for us as the people at the front putting that response in place.'**
> – Vice Principal

Based on interviews with: Three representatives from the school's response team (Vice Principal, Wellbeing Advisor and Head of Student Wellbeing) and the hSS Coordinator who assisted the school.

Background: A student who had recently started attending the school died by suicide. The school notified their education department who recommended that they contact hSS. While the school leadership team had not had prior contact with hSS, a wellbeing staff member from the school had met with a local hSS staff member to do some suicide 'preparing' work. hSS staff (a Coordinator and an education/training staff member) were at the school within a couple of hours of being notified of the suicide.

Immediate and short-term assistance from hSS

- Before hSS staff arrived at the school, the school's response team had begun working through hSS 'preparing' resources and templates to inform their first steps.
- Once they arrived, hSS staff:
    1. Met with the school's response team to get a good understanding of the situation and ensure the school had a good plan in place.
    2. Helped inform the information sent to parents about the suicide.
    3. Helped allocate tasks to members of the school response team.
    4. Provided a sense of containment and support.
    5. Helped ensure wellbeing and leadership staff were working in separate spaces so that they could get on with their respective tasks.
    6. Provided assistance to the school the student had previously attended.
    7. Spoke at a session for school staff at the end of the first day to answer questions and settle anxieties etc.
    8. Informed relevant local services about the suicide to ensure they were primed to provide assistance if required.

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Longer-term assistance from hSS

- Made contact with the school a number of times over the following weeks and months.
- Helped to inform the content of an information session for students about looking out for one another.
- The hSS Coordinator indicated that she thought further ongoing work would be beneficial particularly given that the school had experienced an influx of people presenting to their wellbeing centre:

> **'For me it's clear that there's the initial response but there's also the longer-term recovery. We're really at the beginning of a longer-term recovery process, which I'm still involved in, which is another part of the story.'**
> – hSS Coordinator

- While the school indicated that they found it helpful that the assistance from hSS was not confined to the short term, they indicated that they did not think they needed ongoing assistance. They acknowledged that their situation may be unusual in that respect, given the student had not been at their school very long.

Perspective of hSS

- Developing a working relationship with the school was initially challenging. When the hSS Coordinator first met with the school's response team to ascertain the situation and formulate a plan, some members of the response team instead wanted to get on and do things rather than 'sit around'. The Coordinator picked up on this and modified their approach accordingly but maintained the importance of responding in a calm and considered way and ensuring that everyone knew what their role was. The hSS Coordinator highlighted the importance of the service being flexible in order to meet the schools' different needs.
- The hSS Coordinator highlighted that they thought providing the school with a sense of containment and support was a really important part of their work with the school.

Perspective of school representatives

- Although the school representatives appeared to find things challenging at first, it was clear that they greatly appreciated the assistance they received from hSS. They reported that a key benefit was knowing that their decisions were informed by evidence and by experts in the suicide sector:

> **'I agree with you about being able to go home and sleep ok that night, getting that reassurance from people representing an organisation that, you know, this is their specialty area.'**
> – Wellbeing Advisor

- The school representatives highlighted the importance and value of schools being prepared for a suicide and recommended the hSS 'preparing' arm in this regard:

> **'I suppose our advice to other schools would be you hope you don't have to go through a situation like this but as a school you have a responsibility to make sure that you do have a plan in place and doing something like the suicide "preparing" session is useful.'**
> – Vice Principal

- The school representatives highlighted that the assistance they received with the information session for students was excellent.

Case study two: Response assistance provided to a combined primary secondary school with complexities including student notification of death via social media

> **'What was really helpful was that it [the response] was immediate and that the team travelled to us so they could be here on our first day that we were managing the situation…What they offered us was pretty amazing and made a huge difference.'**
> – Principal

Based on interviews with: Three representatives from the school's response team (Principal, Head of Senior School, School Pastor) and the hSS Coordinator who assisted the school.

Background: A student died by suicide after school hours and the community (including the school leadership team and students) initially started finding out via social media content posted by the student prior to their death. The school's local **headspace** centre put the school in touch with hSS. hSS staff (a Coordinator and clinician) were at the school within two hours of being notified.

Immediate and short-term assistance from hSS

- Helped to inform the information sent to parents about the suicide.
- Provided guidance around whether or not to discuss the suicide with junior school students.
- Provided guidance around commemorating the student and the school's presence at the funeral.
- Guided support of students affected by the death.
- Helped inform decisions about whether or not the suicide should be discussed in the context of religion (it was a religious school).
- Helped develop a plan for the school for the first 24, 48 and 72 hours.
- Answered questions in a staff briefing at the end of the first day, and contributed to a subsequent leadership meeting.
- Provided advice and practical assistance with managing social media content posted by the student prior to death.
- Located an employee assistance program that school staff could access for support anonymously.

Longer-term assistance from hSS

- Made contact with the school a number of times to ascertain how the school community was coping and highlighted the importance of ongoing monitoring in the longer term. The school representatives reported that they thought this was valuable and indicated that without the 'tactful' prompting of hSS they may not otherwise have realised the importance of ongoing work:

> **'You're coached by [hSS] to think what might you do in the future…It wasn't like they were just going to come in as an emergency team and then it's all over.'**
> – Principal

- The school subsequently contacted hSS for advice around dealing with some other issues including a parent of a student who died by suicide and a student who was threatening suicide.

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Perspective of hSS

- From the outset the hSS Coordinator set up a working relationship with the Principal whereby they would share their knowledge of the evidence base but they did not tell the Principal what they thought the school should do. That is, the Coordinator left it to the Principal to make decisions based on the evidence they presented them with. The logic behind this was that while they, as an hSS Coordinator, were an expert with regard to the evidence base, the Principal was the expert in terms of what was best for their school.
- hSS provided the school with language to use and evidence to refer to when communicating with the school community about decisions made and actions taken following the suicide.
- hSS staff deliberately modelled a calm and considered approach and the importance of taking care of themselves despite there being a lot to do (i.e., taking some time out to have lunch etc.).

Perspective of school representatives

- The school appreciated the physical presence of hSS staff and the fact that they arrived at the school so quickly.
- The Principal appreciated that hSS did not try to tell her what to do. hSS instead listened to what the school had planned and provided evidence-based feedback and suggestions:

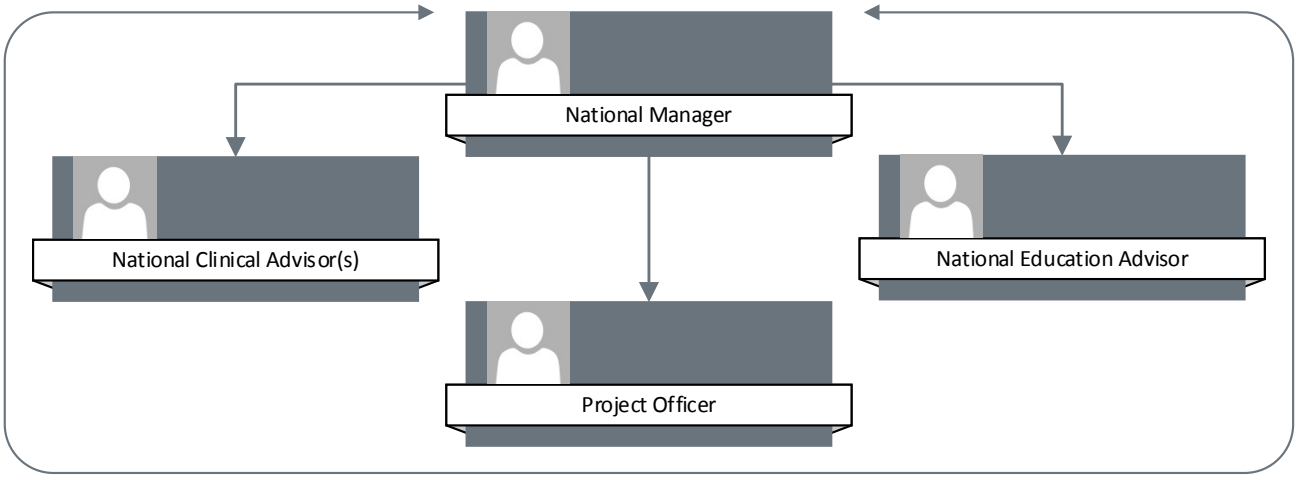
> **'They were very interested to know what we were planning to do and then they added to that, rather than coming with a plan of their own which they dictated…The model of equipping the staff really worked well for us.'**
>
> – Principal

- Being able to inform staff, students and other members of the school community that the school's response was evidence-based and informed by experts in the suicide sector was very helpful and relieved anxieties about and increased confidence in decisions made.

> **'It was really empowering for us to be able to say, "Research has shown that this is the best way to manage this" or "This is the best way to go about this" or "This is the next step we need to take" so [School Support's] advice to us I suppose removed the intensity of making decisions.'**
>
> – Head of Senior School

Appendix F: hSS workforce structure

headspace National Office team



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hSS state teams

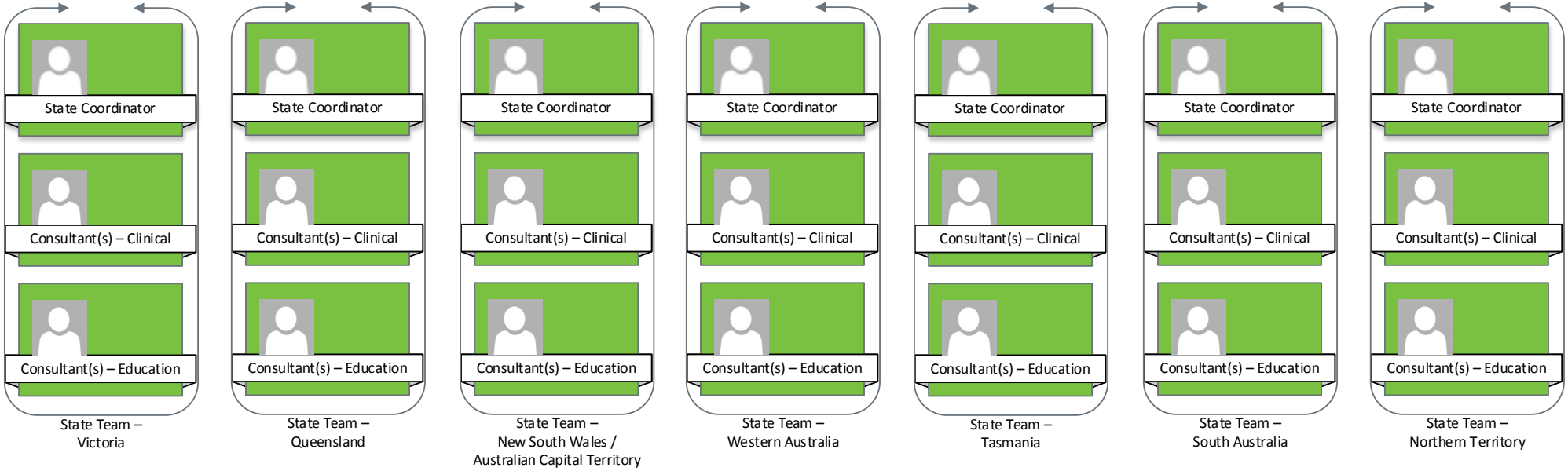

Figure 11. hSS workforce structure

*The roles outlined in this figure may at times be supplemented by specialist project staff and/or interns.

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Appendix G: A whole school approach to mental health

The concept of a whole school approach to health was first publicised in the Ottawa Charter for Health Promotion 1986 (34), which drew attention to the effect of the environment on health and health promotion and the importance of developing personal skills. In 1997, the Australian Health Promoting Schools Association was commissioned by the (then) Australian Department of Health and Family Services to develop a national framework for health promoting schools that was consistent with the Ottawa Charter.

A health promoting school is one in which the whole school community is involved in the creation of a healthy setting for living, learning and working (94). Schools achieve this by mobilising teachers, non-teaching staff, students, parents and community members to lead and coordinate health promotion actions and activities within the capacity of the school's resources (94). The support of an overarching government and/or local education authority policy, especially one established through a formal partnership between the health and education departments, has been identified as a key determinant in the success of a health promoting school (94).

The Health Promoting Schools Framework was first introduced into Victorian schools in 1997, in a collaborative project involving Deakin University and the (then) Department of Education, Employment and Training. The framework used in the pilot project involves 3 overlapping components, as shown in Figure 12, specifically:

- curriculum teaching and learning
- school organisation, ethos and environment
- community links and partnerships.

Following the early success of this pilot, the Parliament of Victoria Education and Training Committee recommended in 2010 that the (then) Victorian Department of Education and Early Childhood Development strengthen the development and implementation of the health promoting schools approach in the state (94).

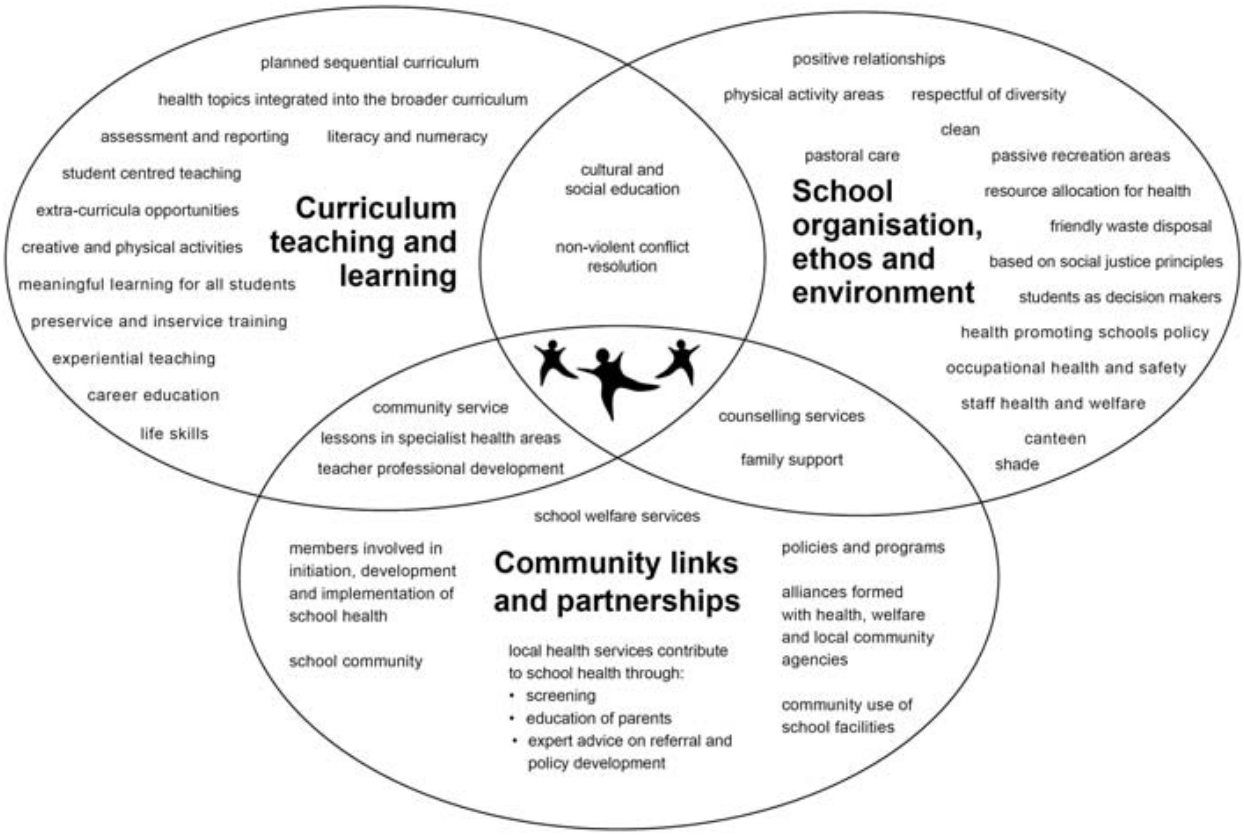

Figure 12. Health Promoting Schools Framework (95)

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Appendix H: Recommendations for an integrated national suicide postvention strategy

hSS recommends that 5 concurrent areas of activity are required to deliver an integrated systems-based national suicide postvention strategy in schools. It builds on evidence discussed in the report and on the 10 core components of effective postvention practice developed by hSS and outlined in Section 2 of the report.

The 5 recommended areas of activity are:

1. Clear organisational systems and structures, working seamlessly together at a national, state/territory/regional and local community/school level to coordinate a national suicide postvention strategy.
2. Ongoing development and customisation of standards, guidelines and tools to facilitate best practice across the health, education and media sectors.
3. Centralised and standardised collection of suicide data that is routinely shared with, and monitored by, relevant stakeholders, according to agreed protocols.
4. Enhanced communication and workforce capacity building across the education and health sectors.
5. A robust youth suicide and postvention research and evaluation program to strengthen the postvention evidence base and facilitate the continuous improvement of postvention service delivery.

The actions and strategies necessary to operationalise each of these recommendations are mapped in the table overleaf at national, state/territory/regional and local community/school levels (top row of the table). Where appropriate, arrows (→) are used to indicate where recommended activities/strategies span multiple levels.

Rather than being viewed as a static set of recommendations, hSS intends for this map to be understood as a flexible and evolving plan of action that is capable of incorporating new learnings and developments in effective postvention practice over time. The matrix structure enables the interplay between different areas and levels, and the dynamic and non-linear nature of the recommendations, to be understood. It should be noted that in this map, much of the work recommended to be undertaken by a national postvention service has been undertaken by hSS since 2012, with funding provided by the Australian Government Department of Health.

The recommended activities/strategies are shaded according to current provision or level of priority for immediate action, as shown below:

Urgent/immediate priority

Longer-term priority

Already in place (undertaken by hSS)

Already in place (undertaken by external agency)

Abbreviations

ABS	Australian Bureau of Statistics
CALD	Culturally and Linguistically Diverse
ERT	Emergency Response Team
LGBTI	lesbian, gay, bisexual, transgender and intersex
LOTE	languages other than English
LSP	local service provider
MH	mental health
NCIS	National Coronial Information Service
NPS	national postvention service
PHN	Primary Health Network

1. Organisational systems and structures

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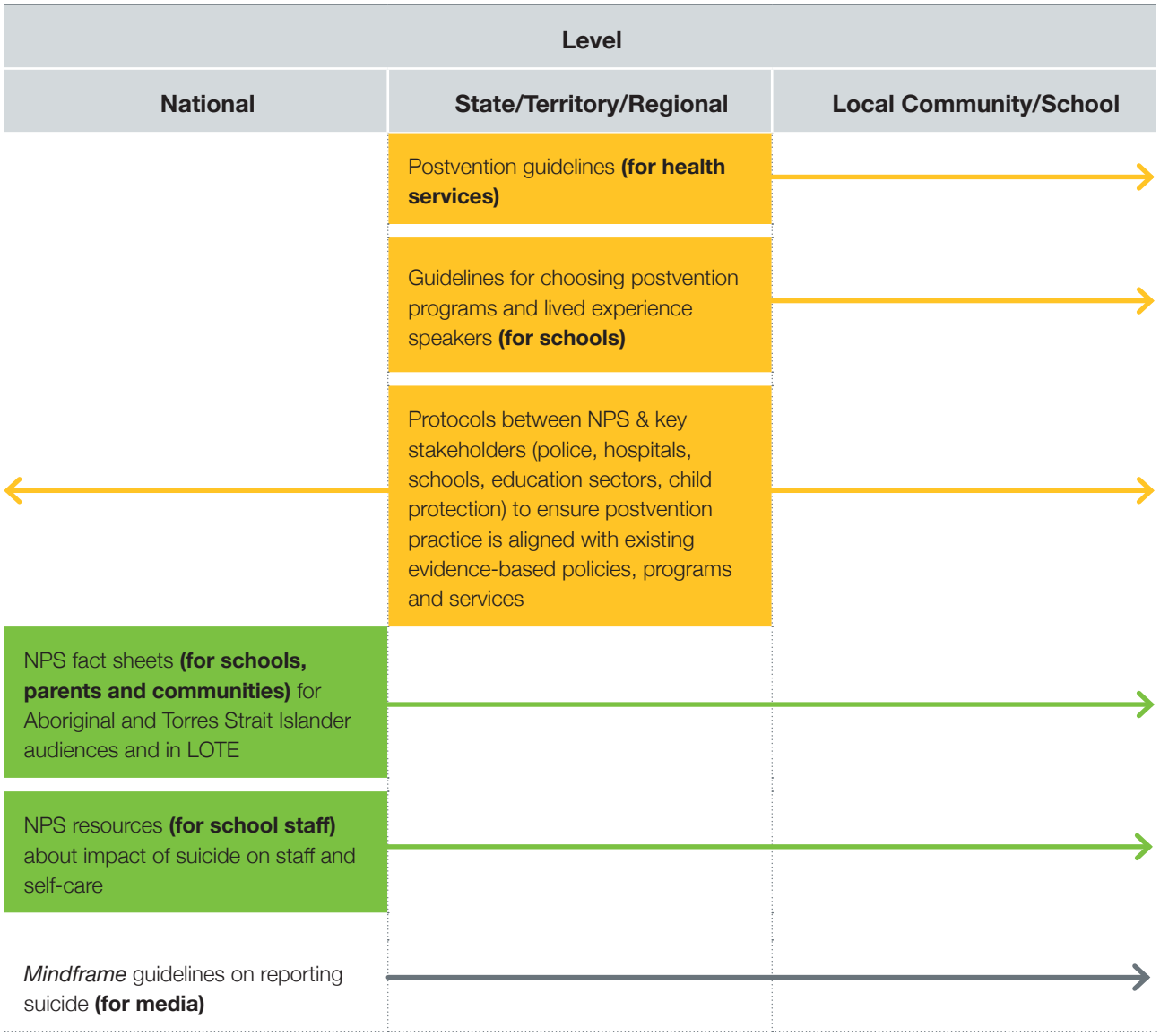
2. Standards, guidelines and tools

Level		
National	**State/Territory/Regional**	**Local Community/School**
NPS postvention standards and guidelines **(for secondary schools)** customised to each state/territory, including: • mandatory annual postvention planning • documentation of suicide management process • return to school plans to guide re-entry process after an event • management of complex needs cases, including students with disabilities		
• uniform risk assessment tool • guidelines for MH literacy, prevention, intervention and postvention, linked to teacher professional standards		
NPS postvention standards and guidelines **(for primary schools)** to be developed for each state/territory		
Guidelines on rights and responsibilities **(of service providers and consumers e.g., education departments/ schools)** including guidelines related to privacy, confidentiality, ethical practice etc.		
Guidelines on language to use when discussing suicide, self harm, MH and postvention **(for services, schools, parents and communities)**		
Guidelines **to support schools and researchers** to engage young people & families & friends with lived experience of suicide		
National considerations for risk assessment **(for service providers)**		
Program manual **(for NPS)**		


Level
National
State/Territory/Regional
Local Community/School
Postvention guidelines (for health services)
Guidelines for choosing postvention programs and lived experience speakers (for schools)
Protocols between NPS & key stakeholders (police, hospitals, schools, education sectors, child protection) to ensure postvention practice is aligned with existing evidence-based policies, programs and services
NPS fact sheets (for schools, parents and communities) for Aboriginal and Torres Strait Islander audiences and in LOTE
NPS resources (for school staff) about impact of suicide on staff and self-care
Mindframe guidelines on reporting suicide (for media)

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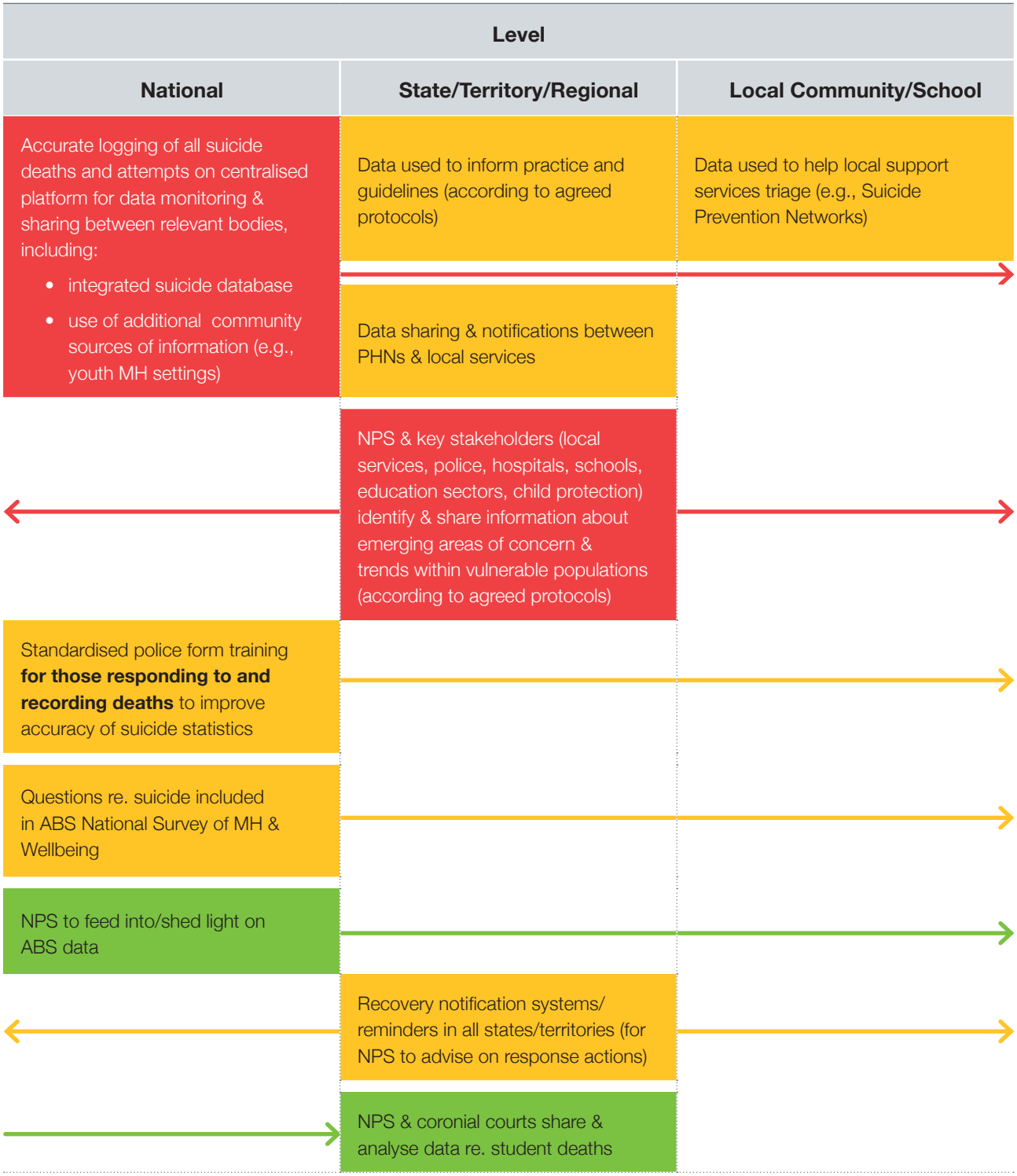
3. Suicide data monitoring and sharing



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4. Communication and workforce capacity building

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Level		
National	**State/Territory/Regional**	**Local Community/School**
National awareness raising/ campaigns to destigmatise help-seeking (e.g., Facebook) to target youth suicide and respond to identified risks (e.g., risky material in media)		
Cultural competency training **for all NPS staff**		
	Ongoing training/conferences/ seminars **(for services)** about: • standards & protocols • national resources & tools • response, recovery, postvention planning • postvention programs & services • postvention research	
		NPS training/education sessions **(for schools, parents, community)** about: • response, recovery, postvention planning • postvention programs & services • local pathways of care • grief responses • risk factors/warning signs • positive coping strategies
		NPS information/training **within schools (e.g., leadership, teachers, wellbeing staff) and between schools & LSPs** about: • communication pathways (between schools & LSPs) • resources that could be shared (between schools) • collaboration opportunities (e.g., joint training sessions)
		NPS training/education sessions **(for communities, schools & services)** customised for rural and remote communities
		Training/education sessions **(for schools and parents) about MH issues**

5. Research and evaluation

Level		
National	**State/Territory/Regional**	**Local Community/School**
National research agenda to: • coordinate contributions to evidence base • address methodological/ethical challenges for postvention research • better understand youth suicide/ exposure/risk factors/ resilience • engage young people in research & evaluation • enhance NCIS • test more accessible alternatives to interventions (e.g., online alternatives) • investigate appropriate postvention approaches and resources in primary schools	Research across education sectors & systems re. implementation of postvention plans, actions, protocols	Postvention plans in schools to be audited
Ongoing evaluation of: • efficacy of existing prevention, intervention & postvention programs & services (inc. sharing current evaluations) • resources • training • cross-sectoral body		
Support for qualitative research exploring lived postvention experiences of students, school staff and families		
Guidelines/tools updated every 2–3 years (or more frequently if new evidence becomes available that significantly changes the content of existing guidelines/tools) to reflect emerging learning and strategic direction		
NPS database of service users and services to facilitate service evaluation →		
	NPS to work with coroners, bereavement services and emergency services in each jurisdiction to cross check statistics and identify patterns of suicidal behaviour and effective strategies for responding when a suicide occurs	

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References

Note: All websites listed below were accessible at the time of publishing this report.

1. *Mindframe National Media Initiative*. Suicide and mental illness in the media: a *Mindframe* resource for the mental health and suicide prevention sectors. 2014.
2. Cerel J, McIntosh JL, Neimeyer RA, Maple M, Marshall D. The continuum of "survivorship": definitional issues in the aftermath of suicide. Suicide Life Threat Behav. 2014;44(6):591-600.
3. MacNeil WK, Topping KJ. Crisis management in schools: evidence-based postvention. Journal of Educational Enquiry. 2007;7(2):1-20.
4. Andriessen K. Can postvention be prevention? Crisis. 2009;30(1):43-7.
5. Gaffney M, Hannigan B. Suicide bereavement and coping: a descriptive and interpretative analysis of the coping process. Procedia Soc Behav Sci. 2010;5:526-35.
6. Andriessen K, Draper B, Dudley M, Mitchell PB. Pre- and postloss features of adolescent suicide bereavement: a systematic review. Death Studies. 2016;40(4):229-46.
7. Cerel J, Maple M, Aldrich R, van de Venne J. Exposure to suicide and identification as survivor: results from a random-digit dial survey. Crisis. 2013;34(6):413-9.
8. O'Carroll PW, Potter KB. Suicide contagion and the reporting of suicide: recommendations from a national workshop. Morbidity and Mortality Weekly Report: Recommendations and Reports. 1994;43:9-18.
9. Sher L. Educating health care professionals about suicide prevention. Aust N Z J Psychiatry. 2012;46(5):481-2.
10. Swanson SA, Colman I. Association between exposure to suicide and suicidality outcomes in youth. CMAJ. 2013;185(10):870-7.
11. Ho T, Leung PW, Hung S, Lee C, Tang C. The mental health of the peers of suicide completers and attempters. Journal of Child Psychology and Psychiatry. 2000;41:301-8.
12. Cox GR, Robinson J, Williamson M, Lockley A, Cheung YT, Pirkis J. Suicide clusters in young people: evidence for the effectiveness of postvention strategies. Crisis. 2012;33(4):208-14.
13. Hacker K, Collins J, Gross-Young L, Almeida S, Burke N. Coping with youth suicide and overdose: one community's efforts to investigate, intervene, and prevent suicide contagion. Crisis. 2008;29:86-95.
14. Davidson LE, Rosenberg ML, Mercy JA, Franklin J, Simmons JT. An epidemiologic study of risk factors in two teenage suicide clusters. JAMA. 1989;262(19):2687-92.
15. Hazell P. Adolescent suicide clusters: evidence, mechanisms and prevention. Aust N Z J Psychiatry. 1993;27(4): 653-65.
16. Hanssens L. The search to identify contagion operating within suicide clusters in Indigenous communities, Northern Territory, Australia. Aborig Isl Health Work J. 2007;31(5):27-33.
17. Wilkie C, Macdonald S, Hildahl K. Community case study: suicide cluster in a small Manitoba community. Can J Psychiatry. 1998;43(8):823-8.
18. Robinson J, Too LS, Pirkis J, Spittal MJ. Spatial suicide clusters in Australia between 2010 and 2012: a comparison of cluster and non-cluster among young people and adults. BMC Psychiatry. 2016;16(1):417.
19. Gould MS, Wallenstein S, Davidson L. Suicide clusters: a critical review. Suicide Life Threat Behav. 1989;19(1):17-29.
20. Australian Bureau of Statistics (ABS). Causes of death, Australia, 2015 (Cat. No. 3303.0). Canberra, ACT: ABS; 2016.
21. Lawrence D, Johnson S, Hafekost J. The Mental Health of Children and Adolescents: report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Canberra, ACT: Department of Health 2015.
22. Cerel J, Jordan JR, Duberstein PR. The impact of suicide on the family. Crisis. 2008;29:38-44.
23. Beautrais AL. Suicide postvention: support for families, whanau and significant others after a suicide. A literature review and synthesis of evidence. Wellington, New Zealand: Ministry of Youth Development; 2004.
24. Clark SE, Goldney RD. The impact of suicide on relatives and friends. The international handbook of suicide and attempted suicide. West Sussex, England: Wiley; 2000. p. 467-84.

25. Jordan JR. Is suicide bereavement different? A reassessment of the literature. Suicide Life Threat Behav. 2001;31: 91-102.

26. Provini C, Everett JR, Pfeffer CR. Adults mourning suicide: self-reported concerns about bereavement, needs for assistance, and help-seeking behaviour. Death Studies. 2000;24(1):1-19.

27. Hawton K, Rodham K, Evans E, Weatherall R. Deliberate self harm in adolescents: self report survey in schools in England. Br Med J. 2002;325:1207-11.

28. De Leo D, Heller TS. Who are the kids who self-harm? An Australian self-report school survey. Medical Journal of Australia. 2004;181(3):140-4.

29. Robinson J, Cox G, Malone A, Williamson M, Baldwin G, Fletcher K, et al. A systematic review of school-based interventions aimed at preventing, treating, and responding to suicide-related behavior in young people. Crisis. 2013;34(3):164-82.

30. Robinson J, Hetrick S, Martin C. Preventing suicide in young people: systematic review. Aust N Z J Psychiatry. 2011;45(1):3-26.

31. Robinson J, Pirkis J. Research priorities in suicide prevention: an examination of Australian-based research 2007–2011. Australian Health Review. 2014;38(1):18-24.

32. Hazell P. Postvention after teenage suicide: an Australian experience. Journal of Adolescence. 1991;14(4):335-42.

33. Robinson J, Pirkis J, O'Connor RC. Suicide clusters. The international handbook of suicide prevention: Wiley; 2016. p. 758-74.

34. World Health Organisation. The Ottawa Charter for Health Promotion. Geneva, Switzerland; 1986.

35. Rickwood D, Telford N, Kennedy V, Bailey E, Robinson J. The need for and acceptance of a suicide postvention support service for Australian secondary schools. Journal of Psychologists and Counsellors in Schools. (in press).

36. Australian Bureau of Statistics (ABS). Causes of death, Australia, 2008 (Cat. No. 3303.0). Canberra, ACT: ABS; 2010.

37. Cantor CH, Neulinger K, De Leo D. Australian suicide trends 1996-1997: youth and beyond? . Medical Journal of Australia. 1999;173(3):137-41.

38. Bartik W, Maple M, Edwards H, Kiernan M. The psychological impact of losing a friend to suicide. Australas Psychiatry. 2013;21(6):545-9.

39. Hazell P, Lewin T. An evaluation of postvention following adolescent suicide. Suicide Life Threat Behav. 1993;23(2): 101-9.

40. Poijula S, Dyregrov A, Wahlberg K, Jokelainen J. Reactions to adolescent suicide and crisis intervention in three secondary schools. Int J Emerg Ment Health. 2001;3(2):97-106.

41. Haw C, Hawton K, Niedzwiedz C, Platt S. Suicide clusters: a review of risk factors and mechanisms. Suicide Life Threat Behav. 2013;43(1):97-108.

42. Robinson J, Yuen HP, Martin C, Hughes A, Baksheev GN, Dodd S, et al. Does screening high school students for psychological distress, deliberate self-harm, or suicidal ideation cause distress - and is it acceptable? Crisis. 2011;32(5):254-63.

43. Rickwood DJ, Mazzer KR, Telford NR. Social influences on seeking help from mental health services, in-person and online, during adolescence and young adulthood. BMC Psychiatry. 2015;15:40.

44. Andriessen K, Draper B, Dudley M, Mitchell PB. Bereavement after suicide. Crisis. 2015;36:299-303.

45. MindMatters, beyondblue. Component 1, Module 1.3: what is mental health?: Australian Government; n.d. [Available from: https://www.mindmatters.edu.au/docs/default-source/learning-module-documents/mm_module1_3-moduleoverview]

46. Christianson CL, Everall RD. Constructing bridges of support: school counsellors' experiences of student suicide. Canadian Journal of Counselling. 2008;42(3):209-21.

47. Wyman PA, Brown CH, Inman J, Cross W, Schmeelk-Cone K, Guo J, et al. Randomized trial of a gatekeeper program for suicide prevention: 1-year impact on secondary school staff. J Consult Clin Psychol. 2008;76(1):104-15.

48. Mitchell P. Valuing young lives: evaluation of the National Youth Suicide Prevention Strategy. Melbourne, VIC: Australian Government; 2000.

49. Australian Government. LIFE: research and evidence in suicide prevention. Canberra, ACT; 2007.

50. Australian Government. Living Is for Everyone (LIFE): a framework for prevention of suicide in Australia. Canberra, ACT; 2007.

51. Australian Government. The hidden toll: Suicide in Australia. Canberra, ACT: Community Affairs References Committee; 2010.

52. Australian Government. Commonwealth response to The hidden toll: Suicide in Australia report of the Senate Community Affairs Reference Committee. Canberra, ACT; 2010.

53. Australian Government. Before it's too late: report on early intervention programs aimed at preventing youth suicide. Canberra, ACT: House of Representatives, Standing Committee on Health and Ageing; 2011.

54. Australian Government. Australian Government response to Before it's too late: report on the inquiry into early intervention programs aimed at reducing youth suicide. Canberra, ACT: House of Representatives Standing Committee on Health and Ageing; 2013.

55. Australian Government. National Aboriginal and Torres Strait Islander Suicide Prevention Strategy. Canberra, ACT; 2013.

56. National Mental Health Commission (NMHC). National Review of Mental Health Programmes and Services. Sydney, NSW: National Mental Health Commission; 2015.

57. Australian Government. National Suicide Prevention Strategy. Canberra, ACT; 2015.

58. Australian Government. Fourth National Mental Health Plan: an agenda for collaborative government action in mental health 2009-2014. Canberra, ACT; 2009.

59. Tasmanian Government. Youth Suicide Prevention Plan for Tasmania 2016-2020. Hobart, TAS: Department of Health and Human Services; 2016.

60. Tasmanian Government. Respectful Schools Respectful Behaviour. Hobart, TAS: Department of Education; 2016.

61. Cosgrave EM, Robinson J, Godfrey KA, Yuen HP, Killackey EJ, Baker KD, et al. Outcome of suicidal ideation and behaviour in a young, help-seeking population over a 2-year period. Crisis. 2007;28(1):4-10.

62. **headspace** School Support. Responding to suicide in secondary schools: a Delphi study. Melbourne, VIC: **headspace** National Youth Mental Health Foundation; 2015.

63. Good Grief. Seasons for healing. Sydney, NSW; 2017 [Available from: https://www.goodgrief.org.au/seasons-healing].

64. Cox GR, Bailey E, Jorm AF, Reavley NJ, Templer K, Parker A, et al. Development of suicide postvention guidelines for secondary schools: a Delphi study. BMC Public Health. 2016;16:180.

65. **headspace** School Support. Suicide Postvention Toolkit – a guide for secondary schools. Melbourne, VIC; 2012.

66. Maple M, Cerel J, Sanford R, Pearce T, Jordan J. Is exposure to suicide beyond kin associated with risk for suicidal behavior? A systematic review of the evidence. Suicide Life Threat Behav.47(4):461-74.

67. Victorian Government. Victorian Suicide Prevention Framework 2016-2025. Melbourne, VIC: Department of Health and Human Services; 2016.

68. Garraza L, Walrath C, Goldston DB, Reid H, McKeon R. Effect of the Garrett Lee Smith Memorial Suicide Prevention Program on suicide attempts among youths. JAMA Psychiatry. 2015;72(11):1143-9.

69. Cross W, Matthieu MM, Lezine D, Knox KL. Does a brief suicide prevention gatekeeper training program enhance observed skills? Crisis. 2010;31(3):149-59.

70. Robinson J, Green G, Spittal MJ, Templer K, Bailey E. Impact and acceptability of delivering Skills-based Training on Risk Management (STORM) in Australian secondary schools. Health Behavior and Policy Review. 2016;3(3):259-68.

71. Lipson SK. A comprehensive review of mental health gatekeeper-trainings for adolescents and young adults. Int J Adolesc Med Health. 2014;26(3):309-20.

72. Robinson J, Gook S, Yuen HP, McGorry PD, Yung AR. Managing deliberate self-harm in young people: an evaluation of a training program developed for school welfare staff using a longitudinal research design. BMC Psychiatry. 2008;8(1):75.

73. Kataoka S, Stein BD, Nadeem E, Wong M. Who gets care? Mental health service use following a school-based suicide prevention program. J Am Acad Child Adolesc Psychiatry. 2007;46(10):1341-8.

74. Gask L, Dixon C, Morris R, Appleby L, Green G. Evaluating STORM skills training for managing people at risk of suicide. Journal of Advanced Nursing. 2006;54(6):739-50.

75. **headspace** National Youth Mental Foundation (**headspace**), Department of Education and Early Childhood Development (DEECD). SAFEMinds: Schools and Families Enhancing Minds, NIP it in the bud! toolkit. Melbourne, VIC: **headspace** & DEECD; 2014.

76. **headspace** National Youth Mental Foundation (**headspace**), Department of Education and Early Childhood Development (DEECD). SAFEMinds: Train the Trainer Program, Final Project Evaluation Report, August 2016. Melbourne, VIC; 2016.

77. Australian Government. Young Australians: their health and wellbeing. Canberra, ACT: Australian Institute of Health and Welfare; 2011.

78. Robinson J, McCutcheon L, Browne V, Witt K. Looking the other way: young people and self-harm. Melbourne, VIC: Orygen, The National Centre of Excellence in Youth Mental Health; 2016.

79. Robinson J, Bailey E, Browne V, Cox G, Hooper C. Raising the bar for youth suicide prevention. Melbourne, VIC: Orygen, The National Centre of Excellence in Youth Mental Health; 2016.

80. Hunter Institute of Mental Health, Transcultural Mental Health Centre. Supporting CALD communities to talk about suicide. Newcastle, NSW; 2015 [Available from: http://www.conversationsmatter.com.au/professional-resource/resources-for-cald-communities].

81. Leonard W, Pitts M, Mitchell A, Lyons A, Smith A, Patel S, et al. Private lives 2: the second national survey of the health and wellbeing of gay, lesbian, bisexual and transgender (GLBT) Australians. Melbourne, VIC: The Australian Research Centre in Sex, Health and Society, La Trobe University; 2012.

82. Institute for Positive Psychology and Education. The Australian principal occupational health, safety and wellbeing survey: 2016 data. Fitzroy, VIC; 2017.

83. Victorian Government. Guidelines to assist in responding to attempted suicide or suicide by a student. Melbourne, VIC: Student Wellbeing and Engagement Division; 2013.

84. Mitchell P. Valuing young lives: the National Youth Suicide Prevention Strategy and its evaluation. Family Matters. 2000;57.

85. Mrazek PJ, Haggerty RJ. Reducing risks for mental disorders: frontiers for preventive intervention research. Washington, D. C.,: National Academy Press; 1994.

86. Silverman MM, Maris RW. The prevention of suicidal behaviours: an overview. Suicide Life Threat Behav. 1995;25(1):10-21.

87. **headspace**. Suicide intervention in schools: an evidence summary. Melbourne, VIC: **headspace** National Youth Mental Health Foundation; 2012.

88. Shaffer D, M. S, Wilcox H, Maslow C, Hicks R, Lucas CP, et al. The Columbia SuicideScreen: validity and reliability of a screen for youth suicide and depression. J Am Acad Child Adolesc Psychiatry. 2004;43(1):71-9.

89. Hallfors D, Brodish P, Khatapoush S, Sanchez V, Cho H, Steckler A. Feasibility of screening adolescents for suicide risk in 'real-world' high school settings. American Journal of Public Health. 2006;96(2):282-7.

90. Eggert LL, Thompson EA, Herting JR, Nicholas LJ. Reducing suicide potential among high-risk youth: tests of a school-based intervention program. Suicide Life Threat Behav. 1995;25(2):276-96.

91. Eggert LL, Thompson EA, Randel BP, Pike KC. Preliminary effects of brief school-based prevention approaches for reducing youth suicide-risk behaviours, depression, and drug involvement. Journal of Child and Adolescent Psychiatric Nursing. 2002;15:48-64.

92. Tang T, Jou S, Ko C, Huang S, Yen C. Randomized study of school-based intensive interpersonal psychotherapy for depressed adolescents with suicidal risk and parasuicide behaviours. Psychiatry Clin Neurosci. 2009;63:463-70.

93. Poijula S, Wahlberg KE, Dyregrov A. Adolescent suicide and suicide contagion in three secondary schools. Int J Emerg Ment Health. 2001;3:163-8.

94. Parliament of Victoria Education and Training Committee. Final report: inquiry into the potential for developing opportunities for schools to become a focus for promoting healthy community living. East Melbourne, VIC; 2010.

95. Deakin University, Department of Education Employment and Training Victoria (DEET). Health Promoting Schools in action: a guide for schools Melbourne, VIC: Deakin University, DEET and VicHealth; 2000.

96. Victorian Department of Education. Framework for student support services in Victorian government schools: professional development support materials. Melbourne: Department of Education (VIC); 1998.

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