Department of Education
GOVERNMENT OF WESTERN AUSTRALIA

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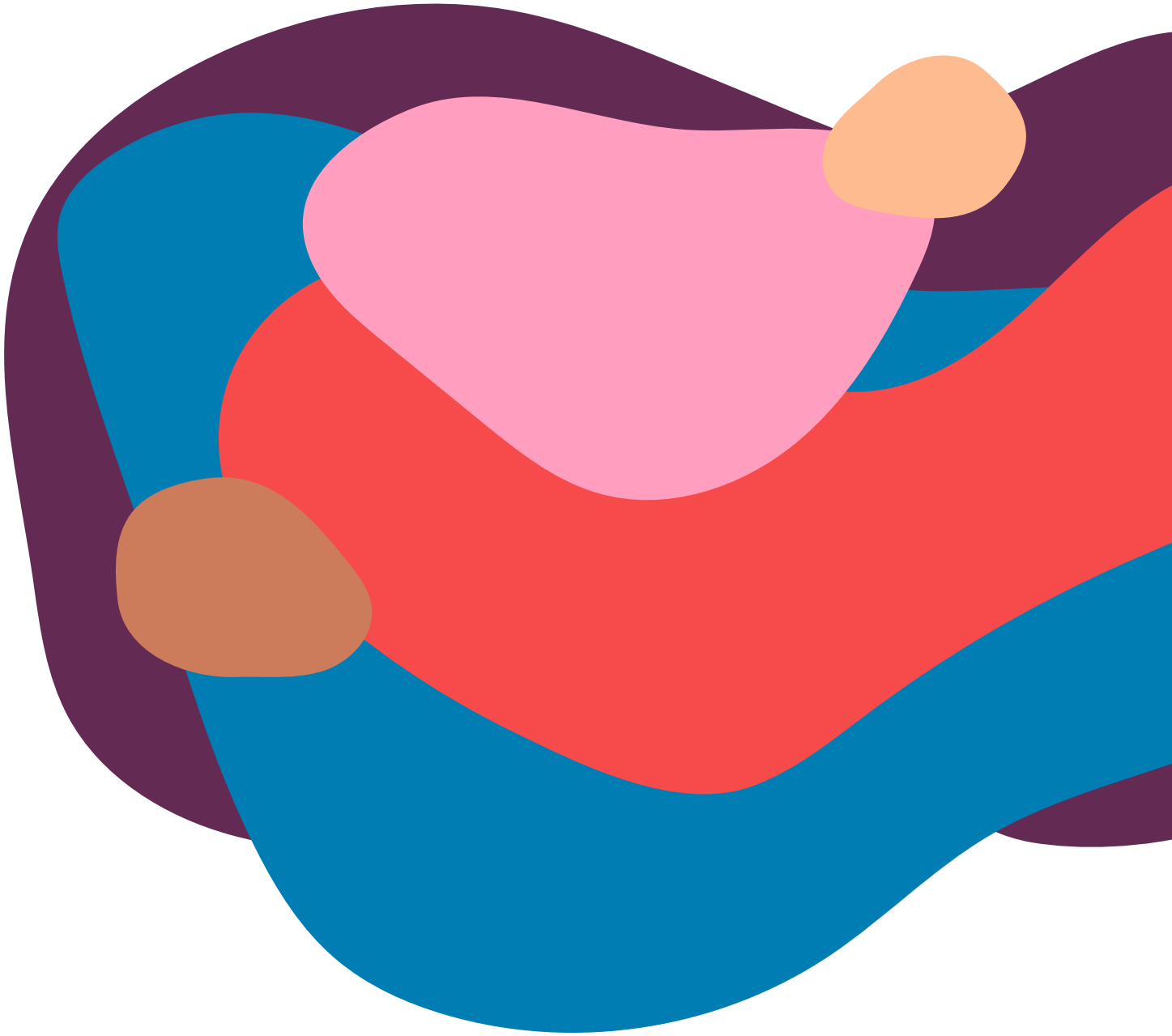
Association of Independent Schools of Western Australia

CATHOLIC EDUCATION
WESTERN AUSTRALIA

School response and planning guidelines for students with suicidal behaviour and non-suicidal self-injury



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School response to suicidal behaviour and non-suicidal self-injury

"Every life lost to suicide is one too many; we must all work together to prevent these tragic events."

Suicide Prevention 2020: Together we can save lives
Mental Health Commission, Western Australia

Glossary

The following terms are defined in the context of schools:

- **Suicidal ideation** refers to an individual's thoughts about ending their life.
- **Suicidal behaviour** includes suicidal ideation, communications, attempts and suicide.
- **Communications** refer to direct or indirect expressions of suicidal ideation, through verbalisation, behaviour or planning actions.
- **Imminent risk** suggests a crisis or urgency which requires constant supervision and immediate action.
- An **attempt** refers to an individual deliberately harming themselves with the intent to die but not resulting in death.
- **Suicide** is a deliberate act to end one's life resulting in death.
- **Further suicidal behaviour (previously referred to as contagion)** is when one suicide can increase the risk of further suicides or suicidal behaviour in the community. A cluster refers to a number of suicides occurring within geographic or psychosocial proximity.
- **Non-suicidal self-injury (NSSI)** is a deliberate act to harm oneself without the intent to die, usually to reduce uncomfortable or distressing emotions and often repetitive in nature. NSSI can be referred to as self-harm (the term deliberate self-harm is also used by health care professionals).
- A **Safety Plan** is a tool developed collaboratively between the student and their health practitioner, with an aim to maintain safety and support recovery. The strategies and supports outlined in the plan are matched to the needs of the student.
- A **Risk Management Plan** (RMP) is an organisational plan developed by the school which identifies foreseeable circumstances where a student may be at risk of harm and outlines strategies to manage this risk.
- A **Risk Management Memo** is used in less complex cases to inform school staff of concerns regarding a student's mental health and wellbeing and provide strategies to support student safety at school.
- **Postvention** refers to steps taken after a death by suicide and forms part of an overall response to suicide, comprising of prevention, intervention and postvention measures[1].
- **Cultural safety** is an environment that is safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning, living and working together with dignity and truly listening[2]. Clients are the only people who can determine what is culturally safe for them[3].

Of the people who think about suicide, a proportion will go on to attempt suicide; a much smaller number will take their own life.

1 Andriessen K. (2009). Can Postvention be prevention? *Crisis*, 30, 43-7.

2 Williams, R. (2008). Cultural safety: What does it mean for our work practice? *Australian and New Zealand Journal of Public Health, vol. 23*, no. 2, pp.213-214.

3 Vadiveloo, D. and Edwardson, R. (22 July 2020). Cultural safety in education is the key to reaching all our students. *ABC Education* [online]. Available at: https://education.abc.net.au/newsandarticles/blog/-/b/3613644/cultural-safety-in-education-is-the-key-to-reaching-all-our-students

1.1 Introduction

The School Response and Planning Guidelines for Students with Suicidal Behaviour and Non-Suicidal Self-Injury (NSSI) support school staff to identify and effectively respond to suicidal behaviour and/or NSSI in students.

It should be used in conjunction with existing school-based policies and in consultation with professionals who have specialist knowledge in the area of mental health.

These guidelines complement but do not replace skills and knowledge gained through attending training such as Youth Mental Health First Aid and Gatekeeper Suicide Prevention.

Maximising the social and emotional outcomes for students by providing engaging, safe and supportive learning environments is a priority for all school staff.

Many children and young people will navigate their school years with few concerns regarding their own mental health and wellbeing. However, some children and young people will have experiences that may affect their functioning including serious emotional or psychological distress and exposure to trauma and cumulative harm. Without support, these factors can lead to an increase in the risk of mental health problems and, in some cases, suicidal behaviour or NSSI.

Encouraging understanding of mental health issues amongst students and staff, promoting help seeking options with caring adults and working in collaboration with external services, families and communities, supports student care and protection whilst at school.

1.2 Mental health promotion

The World Health Organisation defines mental health as 'a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community.'[4]

School leaders can adopt a whole-school approach to promoting mental health and wellbeing to raise awareness of the importance of good mental health, promote positive relationships, reduce stigma, develop helpful coping strategies and instill values such as care for self and others.

Whole-school approaches may involve:

- Implementing overarching frameworks that promote mental health and wellbeing.
- Promoting programs to reduce the stigma of poor mental health, or encouraging help seeking such as Youth Mental Health First Aid for staff and Teen Mental Health First Aid for students.
- Implementing social and emotional programs such as Friendly Schools Plus, Promoting Alternative Thinking Strategies (PATHS), Aussie Optimism, or MindUP.

Resources available to guide schools include the Student Wellbeing Hub, the Australian Student Wellbeing Framework and Be You.

1.3 Indicators of concern

Most people considering suicide indicate that they are not coping, however in some circumstances there are few or no observable signs. Ignoring any signs or interpreting signs as attention seeking behaviour becomes a barrier for students expressing their needs to someone who can help.

As students spend a significant amount of time at school, school staff play an important role in identifying indicators of concern and supporting students who may be at risk of suicidal behaviour or NSSI.

While indicators of concern do not always mean a student may be at risk of suicidal behaviour or NSSI, they could be indicative of other wellbeing concerns requiring the implementation of support or intervention.

Some examples of common indicators of concern are:

- changes in activity and mood
- poor emotional regulation
- withdrawal from usual or previously enjoyed activities and daily interactions
- decrease in academic performance
- difficulty concentrating or making decisions
- communications of thoughts about death or suicide
- negative view of self or world
- significant tiredness or loss of energy
- grief and loss responses
- peer conflict or withdrawal
- persistent or sudden absence from school
- sudden weight loss or gain
- change in appearance (no care or sudden care for clothes, hair, makeup etc.)
- unexplained injuries such as cuts, burns, bruises
- wearing long sleeves or covering up (not due to religious or cultural reasons)
- changes in eating or sleeping
- trauma responses
- risk-taking behaviours
- alcohol and/or other drug use
- any other sudden, unexpected or concerning changes.

4 World Health Organization (2018). Mental health: strengthening our response (fact sheet - Updated March 2018). Retrieved from World Health Organization website: http://www.who.int/en/news-room/fact-sheets/detail/mental-health-strengthening-our-response

1.3.1 Non-suicidal self-injury (NSSI)

NSSI is often referred to as self-harm (the term deliberate self-harm is often used by health care professionals).

- Injuries from NSSI can vary from very mild to severe.[5]
- It is difficult to determine whether an individual's behaviour is a result of suicidal ideation or NSSI without thorough assessment. To add to the complexity, NSSI and suicidal thoughts and behaviours can occur at the same time.

Reasons people give for why they self-injure include:

- Intensely personal or internal psychological reasons are most often given when people are asked why they self-injure.
- Other less frequently reported reasons for self-injury include interpersonal or social motivation, for example letting others know how they feel or coercing others to behave as desired.
- Direct peer-to-peer modelling of self-injurious behaviour, an atmosphere of encouragement and competition has also been identified as reasons for self-injury.[6]

1.4 Suicide risk assessment

Any suspicion or evidence of suicidal behaviour or NSSI needs to be taken seriously. Responding, asking questions and gathering further information helps to clarify the concerns and identify the actions needed to improve the safety and wellbeing of a student.

When there is concern a student may be at risk of suicidal behaviour or NSSI, a risk assessment by a staff member with appropriate training (Gatekeeper Suicide Prevention or equivalent) or by an external provider needs to be immediately considered.

A **suicide risk assessment** requires the exploration of thoughts, feelings and actions of an individual, in a safe and culturally responsive way, to gain an understanding of their current situation, ascertain suicide risk at the present time, identify actions to maintain safety and to plan ongoing support needs.

As the risk of suicide is dynamic and can change rapidly, risks cannot be eliminated, only minimised. Risk assessments are limited to a 'snapshot' of presenting issues which are sensitive to triggers in the environment as well as current individual presentation.[7]

Consultation with a Gatekeeper (or equivalent) trained person is an important part of any risk assessment (see Appendix 2 – Emergency and consultation contacts for school staff use).

Information gathered in a suicide risk assessment assists to determine actions to support the young person immediately as well as in the longer term and provides information to inform a school's Risk Management Plan.

Underlying the risk assessment framework is the crucial assumption that suicide is preventable. It may not be possible to prevent every suicide, however, assessing risk, sharing information, coordinating actions and planning enhances positive outcomes.

1.5 Guidelines for staff

1.5.1 Establishing roles and responsibilities

Coordinated school responses include:

- clarifying the roles and responsibilities of all staff in identifying and responding to suicidal behaviour and NSSI;
- preparing in advance and clearly establishing processes including responsibility for case coordination; and
- providing school-wide staff education about mental health and wellbeing, suicidal behaviour and NSSI.[8]

The term '**nominated staff member**' is used in this guideline to refer to the school-based staff member/s who need to be informed when there is a concern. The nominated staff member is routinely on the school site and will vary from school to school and may include, for example, the principal, deputy principal, student services or other support staff, class teacher or a combination of these.

Research indicates that NSSI is a significant issue, with 17.2% of adolescents reporting that they have engaged in NSSI at some point.[9]

5 Swannell, S., Martin, G., Page, A., Hasking, P., & St John, N. (2014). Prevalence of Non-Suicidal Self-Injury in nonclinical samples: Systematic review, meta-analysis and meta-regression. *Suicide and Life-Threatening Behavior*, 44(3). DOI: 10.1111/sltb.12070

6 Walsh, B. W. (2012). *Treating self-injury: A practical guide (2nd ed.)*. The Guilford Press.

7 Mental Health Division (2008). *Clinical Risk Assessment and Management (CRAM) in West Australian Mental Health Services: Policy and Standards*. Government of Western Australia Department of Health, Mental Health Division.

8 Hasking, P., Heath, N. (2016). Position paper for guiding response to non-suicidal self-injury in schools. School Psychology International 37(6). DOI: 10.1177/0143034316678656

9 Swannell, S., Martin, G., Page, A., Hasking, P., & St John, N. (2014). Prevalence of Non-Suicidal Self-Injury in nonclinical samples: Systematic review, meta-analysis and meta-regression. *Suicide and Life-Threatening Behavior*, 44(3). DOI: 10.1111/sltb.12070

1.5.2 Sharing information

Respecting student confidentiality is an important professional consideration in the care of a young person. Gaining consent to exchange information allows school staff, parents, students and external providers to collaborate for the purpose of making decisions and developing plans with a shared understanding of who has access to this information. An example form for schools to use when seeking consent to exchange information with external providers is available (Appendix 1 – Consent for schools to exchange information with external providers).

There are times when informed consent is not able to be obtained or is withheld. In general, there is sufficient reason to share information without consent when maintaining confidentiality puts the wellbeing of a young person at further risk and disclosure minimises the threat of harm. Both the Children and Community Services Act[10] and Mental Health Act[11] allow for information to be exchanged for the purpose of establishing and maintaining the safety of a young person.

In these specific cases, the information shared is directly related to planning for safety and is connected to continuous communication. The decision to share information is recorded.[12] If there is disagreement about information sharing despite goodwill further advice should be sought through the principal (or nominee) and/or other appropriate channels within your organisation (see Appendix 2 – Emergency and consultation contacts for school staff use).

1.5.3 Training

Training is recommended for key staff across all school settings. This may be particularly relevant in roles and responsibilities such as those undertaken as part of student services teams.

Enhancing knowledge and skills that match an individual staff member's roles and responsibilities in following up or responding to disclosures could include training in:

- cultural competency to build culturally responsive and culturally safe practices;
- trauma informed practices;
- mental health awareness (e.g. Youth Mental Health First Aid); and
- suicide risk assessment and prevention (e.g. Gatekeeper Suicide Prevention).

In determining training needs at a whole-school and individual staff level, principals are encouraged to consider:

- staff understanding of mental health;
- preparedness to respond to disclosures of suicidal behaviour and NSSI, including availability of staff trained in risk assessment; and
- preparedness to respond to a student sudden death or suspected suicide.

1.5.4 Promote self-care

It is important for staff to be aware of their own professional and personal needs and to seek support as required. Staff can seek professional collegiate support within their own networks and organisation, or personal support through their employer's current employee assistance program or an external support agency.

Wellbeing resources available online include:

- Be You: Staff wellbeing
- Black Dog Institute: Wellbeing
- Work and mental health - Beyond Blue

1.5.5 Responding to disclosures (All Staff)

A **direct disclosure** is when a student informs a school staff member of any thoughts, feelings or actions related to suicidal behaviour or NSSI. This may include a verbal disclosure, observations of a concern (e.g. self-injury or other behaviour) or communication through a task such as an essay or a piece of artwork.

An **indirect disclosure** is when a school staff member is informed by a third person including information from another student, school or community member.

If a student discloses suicidal behaviour or NSSI, calm, caring and non-judgmental responses are most effective. The staff member should listen and reassure the student that talking about their feelings is positive and helpful. Avoid expressing overly emotional responses such as pity, anger and disgust or taking punitive action. It is critical that the student is linked to appropriate support and safety is maintained.

It is helpful to develop an awareness in students early on that there are limits to the confidentiality of information relating to suicidal behaviour and NSSI and that there is a duty of care to pass on these concerns to people in a position to help (nominated staff member; support staff; parent/carer), while at the same time providing reassurance that this will be done in a collaborative and supportive way.

A quick reference guide for staff to use following a disclosure is available at Appendix 3 – School response to student suicidal behaviour and non-suicidal self-injury quick reference.

10 Government of Western Australia (2004). Children and Community Services Act 2004. Western Australian State Law Publications.

11 Government of Western Australia (2014). Mental Health Act 2014. Western Australian State Law Publications.

12 Ombudsman South Australia (2014). Information sharing guidelines for promoting safety and wellbeing. State of South Australia.

Example supportive response following a disclosure: Actions will depend on staff member's role and responsibilities.

- Use protective interrupting techniques if disclosure occurs in front of peers.
- Find an appropriate place to discuss the concern.
- Listen, gather information and summarise what the student has disclosed or share the information you have received.
  "I appreciate it is difficult to let me know these thoughts and feelings. So, what you're telling me is... Have I got that right?"
  or
  "I have heard that you said 'I wish I wasn't here' to your teacher, what did you mean by that?"
- Discuss your next actions with the student remembering the limits to your confidentiality.
  "It is important that we discuss this with someone who can help get you the right support."
- Link the student to appropriate support.
  "There are a few people we can go to. Who would you rather?" "Let's go together now."
- Identify others who may be impacted and ascertain support requirements.
- Follow up with the student to reinforce belonging and connection.
  "I just wanted to check in and see how you are going."

Staff cannot keep disclosures of suicidal behaviour or NSSI confidential.

1.5.6 Direct disclosures

Student directly discloses suicidal behaviour or NSSI to staff member.

When the disclosure occurs verbally the staff member listens and responds to the student in a calm, caring and non-judgmental way. If the student discloses during a lesson/in front of peers, the teacher is advised to protectively interrupt and follow-up with the student individually. This should happen without delay and may include directing them gently away from peers, following up at an appropriate gap in teaching or at the end of the current lesson. The staff member reminds the student that in order to best support them the concerns have to be shared with appropriate school staff.

When a student does not disclose verbally but information indicates there is concern about suicidal behaviour or NSSI (e.g. observable self-injury, communication via school work) the staff member takes actions such as discussing the concern with the student if appropriate, and informing appropriate school staff.

If the disclosure or concern indicates that the student is at **imminent risk**, the staff member keeps the student safe and informs the principal (or nominee) **immediately**. The staff member does not leave the student unsupervised. The principal (or nominee) contacts the parent/carer and if necessary, follows incident management procedures.

Where there is an existing plan in place (such as a Risk Management Plan), follow the actions outlined. If the plan does not address current student need, seek support from the principal (or nominee). See Appendix 4 – Risk Management Plan example template or Appendix 5 – Risk Management Memo example template.

In all other cases, the staff member supports student safety by:

- arranging for the student to receive first aid if injured;
- linking the student to the nominated staff member – judge whether to take the student immediately or following current class/activity. This needs to occur as soon as practical following the disclosure;
- providing information to nominated staff member to assist in identifying and supporting peers and staff who may have been impacted by the disclosure; and
- document actions in line with school and system requirements.

1.5.7 Indirect disclosures

Staff member is informed of concern regarding student suicidal behaviour or NSSI by a third party (may be information from another student, school or community member).

The staff member advises that the information will be shared with appropriate school staff so the student is supported and reassures them that they have taken the right action.

The staff member ascertains the impact on the individual who made the indirect disclosure, links with appropriate support and provides them with contact information, including emergency response numbers (see Appendix 6 – Emergency, consultation and support contacts for sharing with parent/carer/student), if necessary.

If disclosure indicates that the identified student is at **imminent** risk, the staff member informs the principal (or nominee) **immediately** so that steps can be taken to locate and keep the student safe. Once located, the student is not left unsupervised. The principal (or nominee) contacts the parent/carer and if necessary, follows incident management procedures.

Where there is an existing plan in place, follow the actions outlined. This is commonly referred to as a Risk Management Plan (see Appendix 4 – Risk Management Plan example template or Appendix 5 – Risk Management Memo example template).

In all other cases, the staff member supports student safety by:

- checking the student is at school and in class by following normal school processes; and
- informing the nominated staff member of the indirect disclosure as soon as practical.

Document actions in line with school and system requirements.

1.5.8 Process for nominated staff members following a disclosure

Following a disclosure, the nominated staff member may take or delegate the following actions as soon as practical:

- Follow the RMP if there is one in place.
- Gather further information from the student and/or others as necessary.
- Discuss and prepare the student for actions that are likely to form part of the response, such as support, referral options and involvement of parent/carer.
- Provide the student with emergency response numbers (see Appendix 6 – Emergency, consultation and support contacts for sharing with parent/carer/student).
- Consult with appropriate staff such as an onsite colleague or a contact on the consultation list (see Appendix 2 – Emergency and consultation contacts for school staff use).
- Arrange ongoing monitoring of the student while they are at school.
- Contact the parent/carer to tell them about the concern.
  - Identify the appropriate parent/carer contact, checking for family information such as court orders.
  - Contact the student's emergency contacts if parent/carer cannot be reached.
  - Emphasise the need for parent/carer to be supportive in their response to their child's disclosure.
  - Gain consent from parent/carer for a suicide risk assessment to be undertaken by appropriately trained staff if one has not already taken place. Note: where there is a direct disclosure to a staff member trained in suicide risk assessment, the staff member may have completed the assessment prior to contacting the parent/carer, if appropriate.
  - Recommend external suicide risk assessment in cases where a staff member is not available to undertake one or the parent/carer declines one at school.
  - Provide the parent/carer with emergency response numbers (see Appendix 6 – Emergency, consultation and support contacts for sharing with parent/carer/student).
- If it is not possible to contact a suitable adult, consult further with appropriate staff such as an onsite colleague (including principal or nominee) or a contact on the consultation list to ascertain next steps (see Appendix 2 – Emergency and consultation contacts for school staff use).
- Depending on the urgency of the situation and nature of the disclosure, the following actions may also be considered:
  - Consult with or refer to the Department of Communities (Communities) where there are child protection concerns;
  - in the metro area, consult with the Child and Adolescent Mental Health Services Emergency Telehealth Service;
  - in rural, regional and remote areas, consult with the local WACHS CAMHS or hospital emergency department;
  - conduct a home visit;
  - contact emergency services; and/or
  - contact WA Police.

Document actions in line with school and system requirements.

1.5.9 Where there is concern about contacting home

- Consult with appropriate staff such as an onsite colleague (including principal or nominee) or a contact on the consultation list to ascertain next steps (see Appendix 2 – Emergency and consultation contacts for school staff use).
- Consult with and/or refer to Communities if there is reason to believe that notifying the parent/carer will put the student at greater risk due to child protection concerns.
- Take actions based on any additional information received through consultation.

Document actions in line with school and system requirements.

1.6 Completing a suicide risk assessment at school

In cases where a suicide risk assessment is completed at school, the student is linked with an appropriately trained staff member (Gatekeeper Suicide Prevention or equivalent). The staff member conducting the suicide risk assessment makes sure the student is aware that where information is shared, it is for the purpose of keeping them safe and engaging them with appropriate supports.

The staff member conducting the suicide risk assessment provides the student with support information, including emergency response numbers (see Appendix 6 – Emergency, consultation and support contacts for sharing with parent/carer/student) and explores with the student suitable adults who can support them at school, in the community and at home. Providing basic support information and emergency response numbers can be seen as part of safety planning for a student.

A Safety Plan involves the young person – ideally with support from a health professional or their local supports – identifying coping and help-seeking strategies that are tailored for their needs, situation and personal relationships.

Be You: Suicide Safety Planning for Young People

Following the suicide risk assessment, the parent/carer is notified of supporting actions and recommendations before the student leaves school. This may include one or more of the following:

- ongoing monitoring of the student
- strategies to increase safety
- providing emergency response numbers
- linking the student with appropriate services through referral
- gaining consent to exchange information regarding the incident or disclosure with involved external agencies and private service providers, as appropriate (See Appendix 1 – Consent for schools to exchange information with external providers)
- recommending the student is taken to a hospital emergency department for further assessment.
  - If the student is being taken for further assessment by ambulance or parent/carer (e.g. to hospital), gain consent to provide relevant information to the external agency, unless it is an emergency.
  - Information regarding the urgency of the student's presentation should be provided to the agency by whatever means possible.
  - schools are discouraged from transporting a student to an emergency setting, however if this is the only option they should collaborate with parent/carer and school leadership and ensure the student is accompanied by more than one staff member.

1.7 Limited parent/carer support

If the student has limited parent/carer support, reiterate concerns to the parent/carer and emphasise the need for collaboration, ongoing monitoring of the student at home and provide emergency contacts in case of a change in the presentation of their child (see Appendix 6 – Emergency, consultation and support contacts for sharing with parent/carer/student).

In consultation with the principal (or nominee), the following actions may also be considered:

- Consult with appropriate staff such as an onsite colleague or a contact on the consultation list to ascertain next steps (see Appendix 2 – Emergency and consultation contacts for school staff use).
- Contact the parent/carer directly (preferably by phone), with follow up through email, or a formal letter to confirm the school's concerns, discussion and recommendations.
- If Communities is currently involved, consult with or refer to the case worker.
- Consult with or refer to Communities through Central Intake Team (1800 273 889) during business hours or Crisis Care (1800 199 008) out of hours where there are child protection concerns, including when a parent/carer's response may put the student at further risk of harm.

1.8 Actions for consideration in all cases where risk is identified

- Keep the principal (or nominee) updated on actions and outcome.
- Follow-up with and offer support to any students and staff impacted by the disclosure or incident.
- Consider potential social media activity and plan or respond as needed.
- Obtain consent to inform any external service providers of the incident or disclosure, as appropriate.
- Confirm with the parent/carer if any recommended actions have occurred, such as an external suicide risk assessment.
- Develop or review an individually tailored RMP and confidential memo or other planning for support, to enhance student safety at school.
- Communicate planning to appropriate staff (including teachers of the student) so they can manage the safety of the student when at school.
- Where necessary, organise a return to school meeting with relevant school staff, the parent/carer, external agencies and the student, as needed.
- Document and securely store information.
- Non-Government Schools consider whether a Reportable Incident needs to be lodged.
- Public schools consider whether an Online Incident Notification (OIN) needs to be lodged. Refer to Ikon for information.
- Consider self-care and determine whether an opportunity to debrief with a colleague or access to professional support is needed.

1.9 Additional considerations for schools

Consider the individual differences, needs and environment when responding to and planning for cases of suicidal behaviour and NSSI.

1.9.1 Aboriginal and Torres Strait Islander students

The term 'Aboriginal' respectfully refers to Aboriginal and Torres Strait Islander people.

Suicide is the leading cause of death in young Aboriginal people. Aboriginal people aged 15-19 years are 4 times more likely to die by suicide than non-Aboriginal young people.[13]

The *Commitment to Aboriginal Youth Wellbeing* released in March 2020 is the Government of Western Australia's response to the State Coroner's *Inquest into the deaths of thirteen children and young persons in the Kimberley* and *Learnings from the Message Stick: The report of the Inquiry into Aboriginal youth suicide in remote areas*. The following statements are attributed to the Premier of Western Australia.

"To significantly reduce Aboriginal youth suicide, we must commit to making clinical and community services more accessible and effective, and at the same time address a broader range of factors. Our goal must be to build young Aboriginal People up to be strong in culture, resilient in mind and body, and confident of a future in which they are valued, supported and have the capacity to thrive."

Commitment to Aboriginal Youth Wellbeing, March 2020, Department of the Premier and Cabinet Western Australia

Staff responsible for following up or responding to disclosures made by Aboriginal young people would benefit from formal training in suicide risk assessment and prevention, cultural competency training delivered by local Aboriginal people and professional learning to embed culturally responsive practices. They would also benefit from the advice and guidance of Aboriginal mental health practitioners, particularly when culture-bound syndromes may be indicated.

Cultural safety and cultural responsiveness is the ability to understand, interact and communicate effectively and sensitively with people from a cultural background that is different to one's own, and demonstrating this ability with proficiency. It is characterised by respect for culture, ongoing self-reflection, expansion of knowledge and commitment to improving practices and relationships.

Culturally safe and responsive staff establish and maintain mutually respectful and trusting relationships with Aboriginal students, their parents and families. They support Aboriginal students to feel a sense of belonging and connection and create culturally safe environments, including undertaking a process of informed cultural consent when appropriate.

Public schools have access to the Aboriginal Cultural Standards Framework[14] to guide the incorporation of culturally responsive and safe practices into their everyday work.

It is helpful to understand that the high rate of Aboriginal youth suicide is attributed to complex and interrelated factors including historical and political factors and the impact of these on traditional cultures and languages, economic and educational disadvantage, social determinants including racism, disproportionate exposure to grief and loss, as well as the impact of intergenerational trauma. These factors result in Aboriginal people having consistently higher levels of psychological distress than other Australians.[15]

For Aboriginal children and young people, culture plays a key role in their development, identity and sense of belonging, and is a pre-determinant and a contributing factor for their health, wellbeing and resilience. Providing opportunities for Aboriginal children and young people to strengthen their cultural and linguistic identities and providing culturally safe environments are protective factors against suicidal behaviour and NSSI.[16] It is important that cultural identity is explored in a safe way when undertaking a suicide risk assessment.

For some Aboriginal students, Standard Australian English is an additional language/dialect. Consider the need to seek the support of an Aboriginal person, and/or significant adult familiar with the student's language and cultural background, as part of the communication, engagement and referral process.

13 Dudgeon, P., et al. (2016). *Solutions that work: What the evidence and the people tell us. Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report*. University of Western Australia, Perth.

14 Department of Education Western Australia (2015). Aboriginal Cultural Standards Framework. Retrieved from http://www.det.wa.edu.au/policies/detcms/policyplanning-and-accountability/policies-framework/strategic-documents/aboriginal-cultural-standards-framework-.en?cat-id=3457058

15 Dudgeon, P., et al. (2016). *Solutions that work: What the evidence and the people tell us. Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report*. University of Western Australia, Perth.

16 Commissioner for Children and Young People Western Australia (2015). *"Listen to us": Using the views of WA Aboriginal and Torres Strait Islander children and young people to improve policy and service delivery*. Retrieved from: https://www.ccyp.wa.gov.au/our-work/resources/aboriginal-and-torres-strait-islander/

The Aboriginal and Torres Strait Islander Suicide Prevention and Evaluation Project (ATSISPEP) Program Evaluation Framework[17] provides a framework for choosing appropriate programs and strategies in the prevention of suicide and postvention following a death by suicide. This framework recognises the important role of cultural healing in the prevention of suicide and postvention responses.

Respecting the diversity of Aboriginal people includes understanding and being responsive to local cultural protocols and kinship structures, culturally sanctioned behaviours and social explanations of mental illness and wellbeing, culturally sanctioned self-harming behaviours, and cultural resources to promote healing and resolution of cultural issues.[18]

Seeking the expertise of local Aboriginal community representatives who have an understanding of specific contexts and situations is crucial to ensuring practices and approaches are culturally responsive.

1.9.2 Culturally and Linguistically Diverse students

Understand the importance of using culturally responsive practices when engaging with culturally and linguistically diverse students and their parents, families and communities in the management of student suicidal behaviour and NSSI.

Consider the need to seek the support of an appropriate and suitably experienced person who is connected with the student's language and cultural background as part of the communication, engagement and referral process.

Consider using the translating and interpreting service where the student and/or family has a language background other than English.

Consider cultural competency training such as the online *Diverse WA Cultural Competency Training* (accessible to public schools) to help staff work effectively with students.

1.9.3 Lesbian Gay Bisexual Trans Intersex Queer/ Questioning Asexual and other sexualities and gender identities (LGBTIQA+)

LGBTIQA+ is used in this guideline to encompass all people whose sexual orientation, gender identity or sex differ from heterosexual or male/female sex and gender norms, regardless of the identity labels people use. Sometimes the terms same sex attracted or gender diverse are used to describe feelings, experiences and behaviours rather than fixed identities. Whatever term is used, it is important to note that this might change over time.

Students identifying as LGBTIQA+ can experience increased vulnerability to poor mental health outcomes due to exposure to peer rejection, bullying, lack of family support, physical and verbal abuse, school issues and homelessness.[19]

LGBTIQA+ young people are five times more likely to attempt suicide and twice as likely to engage in self-injury than their peers. People who identify as transgender are 11 times more likely to attempt suicide than the general population.[20]

LGBTIQA+ people are also disproportionately affected by suicide deaths, attempts and ideation of friends, family and the wider community.[21]

Homophobic or transphobic verbal and physical abuse of same sex attracted, gender diverse and gender questioning young people occurred at school in 80% of the instances reported in a study by La Trobe University. There is a strong relationship between abuse and the incidence of self-harm with twice the number of LGBTIQA+ young people who suffered verbal abuse and four and a half times the number of LGBTIQA+ young people who experienced physical abuse having attempted suicide compared to those who did not experience either verbal or physical abuse.[22]

Consider whole-school practices that promote safe, inclusive and supportive learning environments which value diversity.

Consult with colleagues and other professionals who have experience in supporting LGBTIQA+ students.

Consider additional planning to support the identified needs of LGBTIQA+ students. This may be represented in an individualised documented plan for a student.

Telethon Kids Institute has published Suicide prevention guidelines for LGBTQA+ young people, which provides further guidance and considerations.

17 Dudgeon, P., et al. (2016). *Solutions that work: What the evidence and the people tell us. Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report*. University of Western Australia, Perth.

18 Leckning, B., Ringbauer, A., Robinson, G., Carey, T.A., Hirvonen, T., Armstrong, G. (2019) *Guidelines for best practice psychosocial assessment of Aboriginal and Torres Strait Islander people presenting to hospital with self-harm and suicidal thoughts*. Menzies School of Health Research: Darwin

19 Rosenstreich, G. (2013). *LGBTI People Mental Health and Suicide*. Revised 2nd Edition. National LGBTI Health Alliance. Sydney.

20 National LGBTI Health Alliance February 2020 Snapshot of Mental Health and Suicide Prevention Statistics for LGBTI People retrieved from https://d3n8a8pro7vhmx.cloudfront.net/lgbtihealth/pages/240/attachments/original/1595492235/2020-Snapshot_mental_health_%281%29.pdf?1595492235

21 Rosenstreich, G. (2013). *LGBTI People Mental Health and Suicide*. Revised 2nd Edition. National LGBTI Health Alliance. Sydney.

22 Hillier, L., Jones, T., Monagle, M., Overton, N., Gahan, L., Blackman, J. & Mitchell, A. (2010). *Writing themselves in 3: the third national study on the sexual health and wellbeing of same sex attracted and gender questioning young people*. Australian Research Centre in Sex, Health and Society, La Trobe University.

1.9.4 Students exposed to cumulative harm

Understand that harm and trauma, especially during early childhood, increases risk of adverse mental health issues, suicidal ideation and behaviours, and NSSI in later development.

Understand that those children who have been exposed to trauma during childhood may require special consideration in risk management planning as they may exhibit maladaptive coping strategies including but not limited to suicidal behaviour and NSSI.

Identify, through trauma informed practice, the difference in response to triggers or stressors in the environment and the time it takes to regulate emotions for young people exposed to trauma and take this into account when establishing a Risk Management Plan.

1.9.5 Students in care of Department of Communities

When a student is in the care of the Department of Communities, the CEO of Communities is their legal guardian.

Inform the student's Communities case worker or team leader and foster carer when there is a concern for a student regarding suicidal behaviour and/or NSSI and collaborate with Communities and foster carers in the development of a Risk Management Plan.

All Aboriginal children in care have a cultural plan and access to an Aboriginal Practice Leader via their district case worker who is available for consultations.

1.9.6 Students with a disability

Understand that young people with a disability are more likely to have mental health problems compared to those without a disability.[23]

Seek consultation, where possible, with a professional who has specialist knowledge of the specific disability before intervention.

Consider the functional needs of the student when discussing a disclosure and/or when providing support.

Consider the barriers to communication a student experiences and provide assistance to fully understand the extent of their distress, where needed.

Attend to spoken and unspoken information communicated by the young person in order to fully understand the extent of their distress.

Utilise information from the parent/carer and/or other relevant adults such as the teacher in addition to information from the student when deciding on supporting actions.

Utilise parent/carer, staff and other involved adults to implement actions to reduce distress and increase safety for a student.

1.9.7 Social transmission of NSSI

Social transmission of NSSI may be identified when multiple instances of self-injury are experienced among peers within a school over a short period of time.[24]

Intervention strategies for schools can include the following:[25]

- Reducing detailed communication about NSSI.
- Encourage help seeking behaviours among those feeling distress.
- Encourage parents to provide a calm, supportive environment for their child.
- Encourage peers to inform a trusted adult if they are concerned for the wellbeing of a friend or peer.
- Developing practical and caring ways of responding to wounds (such as first aid procedures) and scarring (such as recognising that choosing not to conceal scars may be a part of recovery).
- Referring students to individual therapies to develop an understanding of their own NSSI and useful alternatives.

23 Dix, K., Shearer, J., Slee, P. & Butcher, C. (2010). *KidsMatter for students with a disability: evaluation report*. Ministerial Advisory Committee: Students with Disabilities, The Centre for Analysis of Educational Futures, Flinders University.

24 Hasking, P., Heath, N. (2016). Position paper for guiding response to non-suicidal self-injury in schools. *School Psychology International 37(6)*. DOI: 10.1177/0143034316678656

25 Hasking (2016).

1.9.8 Primary schools

Suicidal behaviour and NSSI can occur in primary school-aged children. Data from a Kids Helpline report in 2018 found 10 percent of calls from 5 to 12 year olds were suicide related.[26]

Consider the developmental capacity of the student when discussing a disclosure and undertaking suicide risk assessment. This should include sensitively ascertaining the student's concept of death.[27] It is important to understand that a lack of awareness regarding the permanency of death is not necessarily a protective factor.

Gather information from the parent/carer and others such as the teacher, in addition to information from the student, when deciding on supporting actions.

Understand that increasing the awareness of supportive adults about suicide risk identified in children promotes opportunities for their needs to be heard and taken seriously.[28]

All expressions of suicidality require an action. Where a child has used suicidal language but questioning, investigation and consideration of the context reveals no suicidal intent, suitable actions such as informing parent/carer, encouraging alternative problem solving and communication strategies might apply.

1.9.9 Students 18 years and over

Identify services to support students over 18 years old (e.g. adult mental health services).

Identify and maintain multiple current emergency contact details which may not be the student's parent/carer.

Understand that regardless of age, duty of care continues for students over 18 years.

Understand that in the over 18 years age group, interventions may involve negotiation and involvement of people other than the parent/carer.

1.9.10 Disclosures outside school hours

Consider how to provide general information on emergency supports to students and families out of hours. This might be via email, messaging systems or school website/social media that students or families may access outside of regular school hours such as during holiday periods.

If a disclosure of suicidal behaviour or NSSI is made or discovered outside of school hours such as during an after school activity or marking school work/ assessments, best attempts to contact the parent/carer is recommended. If a student discloses via email or any other electronic means, encourage them to seek help and provide them with emergency contact and support information (Appendix 6 – Emergency, consultation and support contacts for sharing with parent/carer/student).

On making contact with a parent/carer, inform them of the disclosure and provide emergency and support information. If contact cannot be made, the police can be contacted to conduct a welfare check.

Inform the principal as soon as possible and document any actions taken.

Follow-up with the family and student should occur regarding support and student safety at school.

1.9.11 Rural and remote schools

Identify emergency response numbers and after-hours mental health services in the local area including those run out of community clinics.

Identify and utilise external agency partnerships to develop coordinated actions in regions where mental health services are unavailable or unreachable.

Recognise the multiple relationships existing between families, students and staff in rural and remote towns and their impact on the provision of mental health intervention and referral options.

Plan and seek professional peer support when navigating competing responsibilities and blurred boundaries.[29]

26 Yourtown (2019). *Kids Helpline Insights 2018: National Statistical Overview*. Brisbane.

27 Mishara, B. L. (2003). How the media influences children's conceptions of suicide. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 24(3)*, 128–130.

28 O'Grady, L. (2019). Suicide and Young Children. *InPsych: The Bulletin of the Australian Psychological Society Limited. 41 (3).*

29 Psychologists living in small, remote, or rural communities affected by disaster (2016) Australian Psychological Society

1.9.12 Excursions and camps

Recognise the importance of participation in co-curricular activities for young people with mental health issues including suicidal behaviour and NSSI.

Develop a plan for managing disclosures of suicidal behaviour and/or NSSI when off-site, which includes consideration of access to means and adequacy of supervision.

Include strategies from an existing RMP for use in the management of an individual student during offsite events.

Collaborate with parent/carer, student and any external agency or service provider to gather up to date information, including stressors and indicators of concern to develop an appropriate response strategy.

Gain knowledge of the excursion site to assist with the development of context specific strategies, such as environmental considerations and access to external services/hospital.

1.9.13 TAFE and workplace learning students

It is important that students with mental health issues including suicidal behaviour and NSSI participate in offsite education opportunities.

Students may require adjustment to or development of a RMP which extends beyond the school setting.

Share information to enhance the safety of the student with the external education provider.

Have clear, pre-organised contact pathways for the external education provider to contact parents/carers or mental health providers for planning and in the case of an incident or disclosure.

1.9.14 Students in residential settings

Establish enrolment processes that include transition planning and support for students identified to be at risk.

Use the guidelines to develop a plan for managing disclosures of suicidal behaviour and/or NSSI that address issues that may arise outside school hours.

Identify emergency response numbers and after-hours mental health services in the local area.

Establish clear communication processes between the residential setting, school and the student's family and identify potential supporting actions in the case of a student mental health crisis.

Improve staff capacity to respond to concerns through:

- increasing staff understanding of mental health, how to identify risk and referral pathways; and
- provision of training in suicide prevention (such as Gatekeeper Suicide Prevention Workshops) for staff who may have contact with at risk youth.

Educate students on mental health and wellbeing strategies, including how to get help.

Consider the impact of the residential setting on mental health and wellbeing including:

- distance from family, peers and community;
- adaptation to a new living environment, peers and staff; and
- changed responsibilities and expectations which come with boarding.

1.9.15 Students studying in an online environment

Vulnerable students studying in an online environment require a preparedness amongst staff to respond to distress, suicidal behaviour and NSSI.

In the online environment, some components of the students' current plans will apply and some may need to be adapted to those times where there is scheduled contact such as check in phone calls, online participation or email exchanges.

Contingency plans for disclosures or appearance of distress via email, phone or face to face, can include providing reassurance, encouraging help seeking and providing emergency contact and support information.

Adaptation of reasonable safety planning can be undertaken with a young person, taking into account what is known of their home environment, supervision arrangements and presenting issues with scope for additional involvement of parent/carer.

Contact parent/carer and pass on information received and provide them with emergency and support information (see Appendix 6 – Emergency, consultation and support contacts for sharing with parent/carer/student).

If the parent/carer is unable to be contacted and the situation requires urgent action, contact WA Police or Communities through Central Intake Team (1800 273 889) during business hours or Crisis Care (1800 199 008) out of hours.

1.9.16 Disclosure by a staff member

A disclosure by a staff member can be prepared for by providing clarity for staff in the area of confidentiality and the limits to confidentiality, maintaining current emergency contacts, and providing contact information for appropriate support services including employee assistance providers.

If a disclosure by a staff member is received:

- Facilitate communication with their emergency contact, another identified significant person or a clinician to assist in accessing support and to enable safety.
- Identify and provide contact information for appropriate support services including Employee Assistance Provider details.
- Liaise with school administration teams and/or region/organisational services if concerned about employee capacity to perform work duties or functions.
- Contact emergency services or arrange a police welfare check if necessary.

1.9.17 Disclosure by a parent/carer or community member

Disclosures by a parent/carer or community member require action:

- Identify and provide contact information for appropriate support services, including emergency numbers.
- Encourage communication with a significant person, relative or clinician to assist with accessing support and to enable safety.
- If necessary, contact emergency services or arrange a police welfare check.

1.10 Reference to suicide and NSSI in schools and classrooms

The topic of suicide is best addressed in the context of whole-school mental health and wellbeing education. Programs that aim to improve general mental health and wellbeing at the individual and organisational level, promote help seeking behaviour and reduce stigma associated with all mental health issues are useful in addressing the issue of suicide and suicidal behaviour in schools.

Programs specifically addressing suicide or 'stand-alone' programs are considered less effective than programs which recognise and work within a mental health promotion framework at a system and school level.

Whilst it is important to inform and educate audiences through guiding safe and effective conversations about suicide,[30] we are not always aware of individuals affected by suicide and those for whom focused attention to the issue of suicide could be distressing.

Conversations and presentations specifically regarding suicide in any public forum, including schools and school groups, require careful preparation and monitoring of impact on young people with underlying and unidentified vulnerabilities.

All presentations to student groups in schools require careful consideration within the usual context of whole-school curriculum planning. Safety planning in advance of these presentations can also be undertaken to improve preparedness to respond to disclosures of suicidal behaviour or NSSI.

When considering any program for students, including on the topic of suicide, it is useful to consider the evidence supporting the program and whether the program does achieve its purported outcomes.

It may not always be appropriate for presentations or programs with a specific focus on suicide to occur in schools, particularly when there are contextual factors such as a recent suspected suicide, recent exposure to suicide attempts or NSSI.

Understand that conversations may naturally arise in the context of the broader curriculum, including classroom discussions, novels, films and mental health and wellbeing programs.[31] When this occurs:

- avoid normalising or glamorising suicide by describing it as an understandable solution to a significant life event or by describing it as heroic or altruistic behaviour;
- avoid increasing knowledge about methods of suicide and their lethality; and
- emphasise the availability of help and encourage people to seek help, highlight the impact of the loss on people left behind and discuss that suicide is the result of multiple stressors and risk factors.

1.11 Screening students for suicidal risk and NSSI

The recommended approach for identifying vulnerable individuals is through individual psychosocial assessment,[32] such as the Gatekeeper suicide risk assessment framework or similar, which can be conducted by trained school staff. To complement this approach, information and support in accessing school based and community services can also be provided to encourage help seeking and facilitate access to services for students who may not be otherwise identified.

The use of screening tools and measures is sometimes considered by schools as a means of identifying young people at risk of suicide who have not sought help or are not already receiving services. However, both individual assessment and screening tools can only provide a snapshot of an individual's wellbeing. Suicide risk is not static, it can change over time and is sensitive to dynamic factors such as stressors and precipitating events.

Problems arising from screening tools and measures include falsely identifying that a student is at risk when they might not be and conversely not identifying a student who does need help.[33] These measures also do not account for the fact that unforeseeable events can dramatically change an individual's risk in a short period of time. Disclosures of suicidal behaviour or NSSI gained through the completion of screening tools and measures need to be investigated and addressed.

Consult with an appropriate mental health professional if considering the use of these tools or measures.

30 Conversations Matter (2017). Core principles for guiding community conversations. Retrieved from http://www.conversationsmatter.com.au/professional-resource/core-principles

31 Conversations Matter (2017). Group discussions about suicide prevention. Retrieved from http://www.conversationsmatter.com.au/resources-community/group-discussions-about-suicide-prevention

32 headspace. *Suicide intervention in schools – an evidence summary*. Retrieved from https://headspace.org.au/assets/School-Support/Suicide-intervention-in-schools.pdf

33 Robinson, J., Bailey, E., Browne, V., Cox, G., & Hooper, C. (2016). *Raising the bar for youth suicide prevention*. Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne.

Section 2

School risk management plan guidelines: student suicidal behaviour and non-suicidal self-injury

A school risk management plan (RMP) identifies circumstances where a student may be at risk of harm and strategies to manage this risk.

2.1 Risk management planning

A school risk management plan (RMP) is an organisation plan which identifies foreseeable circumstances where a student may be at risk of suicidal behaviour and/or NSSI and outlines strategies to manage this risk in the school setting (see relevant sections of 1.9 for excursions, workplace learning etc.) Following the strategies in a plan supports a coordinated approach to improving safety and promoting recovery.

Risk management plans may be referred to by other names to suit a school context e.g. support plan or wellbeing plan, however the purpose of the plan remains the same and is tailored to the individual student and circumstances.

In developing a RMP, consider the following:

- Develop a plan as soon as practical once the need has been identified. Interim strategies for monitoring student safety can be implemented while a more comprehensive RMP is developed.
- Communicate the RMP and any actions that need to be taken, to the family, school staff and external agencies.
- Parent/carer consent is recommended before implementing a RMP. Where a student is in care of the Department of Communities both guardian and carer consent should be sought.
- In cases where parent/carer consent is not provided or is difficult to obtain, a RMP can be implemented in order to improve student safety and wellbeing.
- In cases where parent/guardian consent is not provided or difficult to obtain school staff should consult further with relevant personnel. In public schools this may include the School Psychologist, Lead School Psychologist and regional office staff.
- RMPs are focused on recovery and supportive in nature.
- Tailor the RMP to the student's needs, information available and complexity of the individual circumstances. Generic RMPs or lists will not reflect individual circumstances.
- In less complex cases, staff can be informed of concerns and strategies using a risk management memo (see template for example) or other appropriate communication.
- Collaborate with all relevant parties where possible including parent/carer, school staff, residential staff, external agencies and service providers and the student.
- Discuss with the student how they can access support during the school day.
- Consider the risks associated with the use of an exit card (or similar) such as the maintenance of supervision.
- Staff members identified in the RMP should be routinely accessible on the school site.
- Store the RMP in a confidential place.
- Review the RMP regularly to take into account fluctuations of risk, including after a significant incident that may influence risk.
- The RMP may be phased out in stages when a student's recovery suggests less monitoring and additional strategies are required.
- Cease the RMP when all relevant parties agree that monitoring and additional strategies are no longer required, as the student is able to be supported through usual school processes.

2.2 Risk management plan sample strategies

The below are a guide only to the areas that may need to be covered by a RMP. The context and the associated strategies should reflect the individual needs of the student and the information available through a suicide risk assessment or other sources.

Attendance/absences
- Parent/carer notifies school staff before the school day starts if the student will not be attending that day.
- Identify absence/presence at beginning of class.
- Notify administration or student services if the student is absent but meant to be at school so steps can be taken to locate student.

Learning environment
- Student moves to a prearranged, supervised area if they are distressed and unable to stay in class.
- Teacher locates the student if they do not return in a reasonable time after a toilet break.
- Teacher notifies the nominated staff member if they cannot find the student.
- Teacher encourages the student to engage in classroom tasks and where necessary adjust academic and homework requirements in consultation with parent/carer.

Break times
- Student encouraged to remain with friends/peers during breaks.
- Student to access support from a staff member available in a set location if they need support.

Peers
- Encourage the student to seek help from staff if they need support rather than sharing confidential or distressing information with peers.
- Parent/carer, teachers to notify a nominated staff member if they become aware of any issues with peers.

Suicidal behaviour and NSSI
- School staff to inform nominated staff member immediately if there are concerns indicating suicidal behaviour or NSSI.
- Undertake suicide risk assessment by an appropriately trained staff member, where needed.
- Parent/carer to collect the student from school and seek further assistance as needed.
- Check in with the student on return to school following an incident/disclosure of suicidal behaviour or NSSI.

Communication
- Ongoing communication between family, school and external agencies and service providers regarding any issues related to student safety and wellbeing at school.
- Parent/carer to inform nominated staff member or school nurse of any changes to medication as needed.

Other strategies and information relevant to maintaining student safety in the school environment can also be considered.

2.3 Risk management templates

The following templates are available:
- Appendix 4 – Risk Management Plan example template
- Appendix 5 – Risk Management Memo example template

Section 3

Postvention

3.1 Postvention

Postvention refers to the steps taken after a death by suicide and forms part of an overall response to suicide, comprising prevention, intervention and postvention measures.[34] In the context of schools, this may refer to the actions taken following the suspected suicide of a student, staff member or member of the school community which impacts the school.

The aim of postvention is to provide long term, multi-faceted support to those affected by suicide. It forms part of a whole-school approach and focuses on mental health and wellbeing, whilst addressing trauma, facilitating healing and restoring the function of the school.

School staff should act in accordance with previously developed incident management and/or postvention plans that facilitate preparedness and allows the assessment of risks and the implementation of measures to eliminate or reduce the incidence and severity of critical incidents.

All school staff should be aware of their roles and responsibilities in a critical incident, including the need for notifying school leadership if they become aware of a suspected suicide in the school community.

School staff can consult with their support networks, including interagency colleagues, to manage the impact of a suspected suicide. In public schools, this can include School Psychologists, Lead School Psychologists and Coordinators of Regional Operations at regional education offices.

See Appendix 7 – Postvention operational checklist for immediate response.

3.1.1 Establish facts

Information of a suspected student suicide may come from a variety of sources.

Once information has been received about a suspected suicide it is vital to verify information before any communication is made with the school community. While the process of verification may take time, it is important that information is obtained from at least two reliable sources.

These may include:

- WA police
- the parents and/or family of the young person
- an external agency or service (e.g. CAMHS)
- Department of Education Service Response Branch.

The Department of Education Service Response Branch coordinates the communication process through which key agencies, services, regions and schools are notified of a suspected suicide to enable the best possible coordination of services.

3.1.2 Language and communications

All postvention communications with the school community should be made carefully in consultation with the family and the school system or sector.

Public school staff are advised to consult with the Department of Education's media unit prior to distribution of any communications. This includes information communicated through the school's social media. In addition, School Psychologists, Lead School Psychologists and regional office are available for consultation.

In deciding on terminology to be used when referring to the death of a student, the wishes of the family and the context of the school needs to be considered. Appropriate terms may include 'suspected suicide' or 'believed to be suicide', 'sudden death' or 'unexpected death'.

Further suicidal behaviour is when one suicide can lead to further suicides or suicidal behaviour in the community. The risk of this occurring can be minimised by reporting information accurately and respectfully without glorifying suicide or discussing details such as the location and method.

Refer to Mindframe[35] or Be You Suicide Response[36] resources for more information on speaking or writing about suicide.

On receiving information regarding a suspected suicide, it is important that school administrators, regional or central offices are alerted to enable timely support for schools and students.

34 Andriessen, K. (2009). Can Postvention be prevention? *Crisis*, 30, 43-7.

35 Mindframe National Media Initiative (2017). *Talking to the media about suicide*. Retrieved from https://www.mindframe-media.info/for-mental-health-and-suicide-prevention

36 BeYou (2018). Suicide response resources: Complete toolkit. Retrieved from https://beyou.edu.au/-/media/pdfs/suicide-prevention-and-response/suicide_response_toolkit_complete_version_pdf_20mb.pdf?la=en&hash=C4173CE603C5B1A6C2D79C4CD3697CAFAF4BA097

3.1.3 School-based responses

Effective school-based responses are tailored to the specific situation and context. They can include:[37]

- providing appropriate information to the school community
- providing information in small groups where individual support needs can be identified and provided
- providing appropriate avenues for help seeking and support
- providing resources for those impacted
- facilitating natural coping behaviour
- returning the school to a normal academic routine when ready
- identifying the ongoing needs of the school community

When planning responses:

- respect family needs and privacy
- consult with the family regarding references to the death when providing information to students, parents, and wider community
- confirm automated messages, such as those facilitating absentee information, reporting or interaction with School Standards and Curriculum Authority are disabled
- provide tailored information to vulnerable students and their families when referring to the support available at school and in the wider community
- consider potential impact and needs of students not attending or disengaged from school
- consider potential impact on students and staff that have recently left the school, are absent or on leave
- liaise with and use agency and interagency supports
- conduct staff meetings or briefings
- consider and be responsive to cultural protocols
- identify and use monitored support rooms with staff available to provide one on one support or redirection back to classes
- arrange an operational debrief at an appropriate time in the future.

3.1.4 Common responses following a traumatic event or suicide

Anyone with current risk factors such as pre-existing mental health issues or poor coping mechanisms may be especially vulnerable following a suicide.

Student reactions can include:

- distress or confusion over how they should be feeling or what they should be saying
- relating to the perceived pain of the deceased
- wanting to talk or find out more about the death
- being reminded of previous losses or experiences
- repetitive dreams about the event
- guilt (from not having prevented the death or helping the student)
- depression and preoccupation with blaming others (e.g. other students, parents or teachers)
- fear that their friends may do the same
- increased susceptibility to media portrayal of violence, tragedy etc.
- spreading rumours and speculating on details.

Parents/Carers reactions can include:

- wanting to learn more about the death
- comparing the death to their child's circumstances
- wanting to know about warning signs and indicators so they can protect their own child
- disinterest due to a genuine indifference or desire to deny that such events occur
- anger or unwillingness to acknowledge their child's emotional reaction
- criticism toward the school for acknowledging the death or their management of the incident
- blaming others to explain why the event occurred.

Staff reactions can include:

- wanting to talk or find out more about the death
- uncertainty or confusion about how to support other students
- anger at the student for taking their life
- guilt from not preventing the death or helping the student
- being reminded of previous losses or experiences
- inability to understand the behaviour
- fear of further suicides.

3.1.5 Vulnerable groups and individuals

Though it can be difficult to determine which students will be impacted emotionally in response to a traumatic event, it is important to identify, monitor and follow-up students who may be at risk following a traumatic event.[38]

The following factors are important to consider in identifying those students who are *most likely* to present with symptoms of trauma.

Given the subsequent shock and grief experienced, anyone affected may have difficulty accessing their usual coping strategies.

37 Erbacher, T.A., Singer ,J.B. & Poland, S. (2015). *Suicide in Schools: A Practitioner's Guide to Multi-level Prevention, Assessment, Intervention and Postvention*. School-Based Practice in Action Series. Routledge NY.

38 Erbacher, T.A., Singer ,J.B. & Poland, S. (2015). *Suicide in Schools: A Practitioner's Guide to Multi-level Prevention, Assessment, Intervention and Postvention*. School-Based Practice in Action Series. Routledge NY.

Students with one or more of these features are at particularly increased risk:[39]

- Students who witnessed the event, discovered the deceased or thought their own life was at risk.
- Close friends, neighbours, and family members who knew the deceased well or were in contact shortly before the event.
- Students with poor coping or problem-solving skills, lack of social support, history of mental illness, suicidal ideation, trauma or loss.

This also applies to school staff and members of the school community.

3.1.6 Funerals and Memorial services

School involvement in funerals and memorial services will vary according to the wishes of the family, cultural and religious observances, as well as the context of the school community. Key considerations include:

- Communication with the school community regarding funeral arrangements should occur in liaison with the family of the deceased student.
- Should schools choose to hold a service for a student or staff member who has died by suspected suicide, parents should be informed, this should be voluntary for students and ideally occur outside of normal scheduled classroom time e.g. lunch, after school.
- Schools with churches, chapels or other places of worship located on school premises should be mindful of the potential impact of students being exposed to services for individuals who have died by suicide.
- Students that wish to attend any public funeral or memorial service should do so in consultation with and supported by their family.
- For Aboriginal students and staff, it is recommended that advice be sought from Aboriginal families and community organisations about cultural healing processes and facilitating opportunities for that to occur if desired.

See Be You: Suicide Prevention and Response

3.1.7 Permanent memorials

With regards to permanent memorials on school sites, it is recommended that schools have a consistent policy for all deaths.

Students may feel that a permanent memorial on a school site is an appropriate and respectful way to honour a student who has died by suicide. However, permanent memorials erected on a school site such as plaques, perpetual scholarships or events, statues, trees and gardens[40] can also be constant and unnecessary reminders of loss for existing and new school community members. *Living memorials* such as donations to charitable organisations or research foundations can be encouraged in their place.

3.1.8 Social media

One of the ways schools can support their students following a suspected suicide is to be aware of the potential impact of social media. Use of technology means that information can be distributed quickly and to a wide audience at all hours of the day. Social media travels across geographical, cultural, social and economic boundaries and can cause disturbance in the school community even with strategies in place.

As far as practical, schools can monitor social media posts and use their own sites to encourage help seeking, promote social support networks, and provide proactive ways to share accurate information and promote mental health and wellbeing.

Monitor social media activity

- Where possible, link with and work alongside friends and family to facilitate respectful and positive help-seeking and access to support services.
- Identify the administrator of any online memorial page and encourage respectful use, monitoring, help-seeking and general mental health and wellbeing promotion.
- Identify potential concerns including inaccuracies and rumours, disrespectful comments, posts indicating that other students may be at risk and information about student-organised gatherings.

Respond to concerning content

- Work with students and parents/carers to promote the respectful use of social media, and the importance of reporting concerning messages that may indicate or create risk. Refer to existing eSafety messages used by the school.
- Raise awareness and provide suitable avenues for responding to or reporting trolling or other offensive content.

Distribute help-seeking information

- Share information about support services offered at school, in the community and online.
- Share material promoting positive mental health and wellbeing and suicide prevention (e.g. ReachOut.com, e-headspace, Beyondblue, Kids Helpline and Lifeline).
- Encourage students, parents/carers to share help-seeking advice, access to professional help and suicide prevention information on their social media pages.
- Seek advice appropriate to the school if contact is made by journalists for comments or confirmation of details about a suspected student suicide. Public schools should contact the Department of Education's Communications branch.
- For Aboriginal children and young people, seek advice from local Elders, families and community organisations about culturally responsive approaches to supporting students, staff and families.

39 Erbacher, T.A et al (2015)

40 Erbacher, T.A et al (2015)

3.2 Postvention resources and services

3.2.1 External resources for schools

Be You Suicide Prevention and Response
Resources for supporting schools in suicide prevention, including a toolkit for suicide response.

Conversations matter
Community and professional resources for having safe and supportive discussions about suicide.

Mindframe National Media Initiative
Information on safely communicating about suicide and mental health.

3.2.2 Resources for online safety

Chatsafe Resources
Guidelines for supporting young people to safely communicate about suicide online, including memorials, language, sharing lived experience and responding to others.

Office of the eSafety Commissioner
Resources for eSafety, including reporting of cyberbullying, image-based abuse and offensive and illegal content.

Social media advice – for families
A combined headspace and Facebook resource for navigating Facebook following the loss of a young person, including memorialization, removing an account and reporting inappropriate posts.

3.2.3 Services

Be You Suicide response support for secondary schools
Assists school staff to prepare for, respond to and recover from a suicide impacted death.
Phone: (national) 1800 688 248

Pastoral Critical Incident Response (PCIR)
YouthCARE PCIR chaplains provide emergency support during critical incidents such as bushfires, sudden death, suicide and serious assault.
Phone: 0407 413 855

Anglicare's Active Response Bereavement Outreach (ARBOR)
Outreach Support service for adults recently bereaved by suicide, including grief counselling, peer support and support groups. ARBOR can also offer the services of an Aboriginal counsellor.
Phone: 1300 11 44 46

Anglicare's Children & Young People Responsive Suicide Support (CYPRESS)
Support service for metropolitan students aged between 6 and 18 bereaved by suicide. Support is provided through outreach, counselling, peer support and support groups.
Phone: 1300 11 44 46

Coroner's counselling service
Counselling and support, including understanding the coronial process.

National Indigenous Suicide Postvention Service

13YARN - Call 13 92 76 | 24 /7 Crisis support for Aboriginal and Torres Strait Islanders
Free and confidential service available 24/7 to talk with an Aboriginal or Torres Strait Islander Crisis Supporter.

Youth Focus
Free, face-to-face and web-based professional counselling service for young people aged 12 to 25 who may be experiencing suicidal thoughts, depression, anxiety and self-harm.

Section 4

Young people with significant risk of suicidal behaviour – linking schools with acute services

A school risk management plan (RMP) identifies circumstances where a student may be at risk of harm and strategies to manage this risk.

4.1 Information for schools

Young people experiencing significant suicidal behaviour typically have complex needs requiring coordinated support.

A young person may be at heightened risk of suicidal behaviour while they transition from emergency or inpatient settings to supports and services in the community. Returning to home and school from an acute setting is an important step in recovery from a mental health crisis. The systemic cooperation required for this transition needs to be responsive and flexible.[41] [42] As always, cultural considerations are important.

Responding to frequent suicidal behaviour or NSSI is demanding for schools and families. Utilising a case management approach which gives consent to ongoing collaboration with the parent/carer and any external agencies, including private service providers such as psychologists, enables routine intervention and the opportunity to escalate intervention when needed. (See example form for schools Appendix 1 – Consent for schools to exchange information with external providers).

Case coordination of services aims to achieve seamless service delivery through collaboration between school staff, family and agency staff. This wrap-around approach promotes engagement of students with mental health support needs. It is important for schools and external agencies to identify key contacts for communication at the time of re-entry to school from acute settings and for ongoing planning and review.

Other considerations include:

- Establishing information channels which can alert the parent/carer and any external agencies and service providers to changes in presentation and significant incidents that impact risk management.
- Regularly reviewing individual risk factors, in light of predisposing factors including mental illness, developmental history, family history of suicide etc.
- Sharing student centered plans and organisational plans including risk management plans to coordinate actions with external agencies and external service providers.
- Recognition that different mental health disorders may require highly individualised responses and support strategies.
- The heightened vulnerability of students with chronic suicidal behaviour or NSSI in the event of a traumatic incident, such as an attempted suicide or death by suspected suicide in the family, at the school or in the broader community.
- The ongoing impact on staff, family and peers and the potential need for them to access ongoing support.

The following sections outline some of the key acute services available to schools, children and young people and their families through the Child and Adolescent Health Services. The Department of Health is guided by the Clinical Care of People who may be Suicidal. The focus is on safety and recovery and is informed by Principles and Best Practice for the Clinical Care of People who may be Suicidal.

41 Ombudsman WA (2014). *Investigation into ways that State government departments and authorities can prevent or reduce suicide by young people*. Ombudsman Western Australia.

42 Professor Bryant Stokes, AM. (2012). *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*. Government of Western Australia Department of Health, Mental Health Commission.

4.1.1 CAMHS Crisis Connect

This service provides phone and online videocall support for children and young people in the Perth metropolitan area up to their 18th birthday who are experiencing a mental health crisis as well as support and advice to families and carers.

The CAMHS Crisis Connect is a free service, available in the Perth metropolitan area, 24 hours a day, seven days a week. The service is operated by a mental health clinical nurse specialist and consultant child and adolescent psychiatrist.

Phone: 1800 048 636
CAMHS Crisis Connect

Young people in the Perth metro area aged 18 years and over, please call the Mental Health Emergency Response Line (MHERL).

Phone: 1300 555 788

4.1.2 WA Country Health Service (WACHS) Mental Health Emergency Telehealth Service (MH ETS)

In rural, regional and remote areas of Western Australia, the WACHS MH ETS is available to all age groups through referrals managed by doctors and nurses located at Emergency Departments across country WA. Out of hours mental health support in rural, regional and remote areas is available through Rurallink from 4.30 pm to 8.30 am Monday to Friday and 24 hours a day on weekends and public holidays.

Phone: 1800 552 002
Rurallink
WACHS Mental Health Emergency Telehealth Service

4.1.3 Acute Mental Health Inpatient Unit – Perth Children's Hospital

This service provides statewide support for children and young people under the age of 16 with acute mental health concerns. Referral to the unit is through the local community mental health service or hospital emergency department.

Mental Health Inpatient Unit (Ward 5A) - Information for schools

4.1.4 Mental Health Youth Unit – Fiona Stanley Hospital

This service provides statewide support for young people aged 16 to 24 years of age with acute mental health concerns. Referral to the unit is made through the local community health service or hospital emergency department.

Mental Health Youth Unit

4.1.5 East Metropolitan Youth Unit

This service provides support for young people aged 16 to 24 years of age with complex and acute mental health concerns.

East Metropolitan Youth Unit (EMyU)

4.1.6 Joondalup Mental Health Unit

This service provides support for young people aged 16 to 24 years of age with acute mental health concerns. Referral can be through emergency department, or directly through SPs, community mental health teams or mental health professionals.

Mental Health Services (Joondalup Health Campus)

4.1.7 School of Special Education Needs: Medical and Mental Health

School of Special Education Needs: Medical and Mental Health (SSEN:MMH) provides educational support for all students whose medical or mental health prevents them from engaging in their enrolled school programs.

The service is available to students from government and non-government schools. Referrals are received through the Department of Health with parental consent, to provide ongoing learning support and facilitate links between key contacts upon return to school.

SSEN:MMH

Appendices

Editable templates are available for all education sectors. Please contact your sector's psychology service for further information.

Appendix 1 – Consent for schools to exchange information with external providers

Student Name:		School:	
Parent/Guardian:		DOB:	
Address:		Year:	
Phone:		Case Manager:	

Schools safeguard the confidentiality of information obtained to make appropriate educational adjustments to support students' needs whilst at school. They also respect the privacy of information held or obtained by others.

For this reason, consent is sought to release or obtain information about students from agencies, GPs, Psychologists or other services involved in caring for your child. This information will be used by school staff to make appropriate educational and well-being adjustments to support your child's needs while at school. Any information collected may be accessed by relevant school staff and the involved external care providers named below.

The information collected will not be given to any other person or agency unless you have given permission or school staff are authorised or required by law to do so. The information on this form will be stored securely. If you wish to access or correct any of the personal information on this form or discuss how the information has been used, please contact the school in the first instance.

If you have a concern or complaint about the way this personal information has been collected, used, stored or disclosed, please also contact the school in the first instance. The consent provided in this form can be withdrawn at any time.

As the parent/guardian of the above student I/we give the following consent for:

School staff member:	
School staff member:	

☐	to provide information to (please tick)	☐	to receive information from (please tick)

Agency/GP/Psychologist/ Service:	
Name:	
Address:	

☐	to provide information to (please tick)	☐	to receive information from (please tick)

Agency/GP/Psychologist/ Service:	
Name:	
Address:	

Parent/guardian signature:	
Date:	

Appendix 2 – Emergency and consultation contacts for school staff use

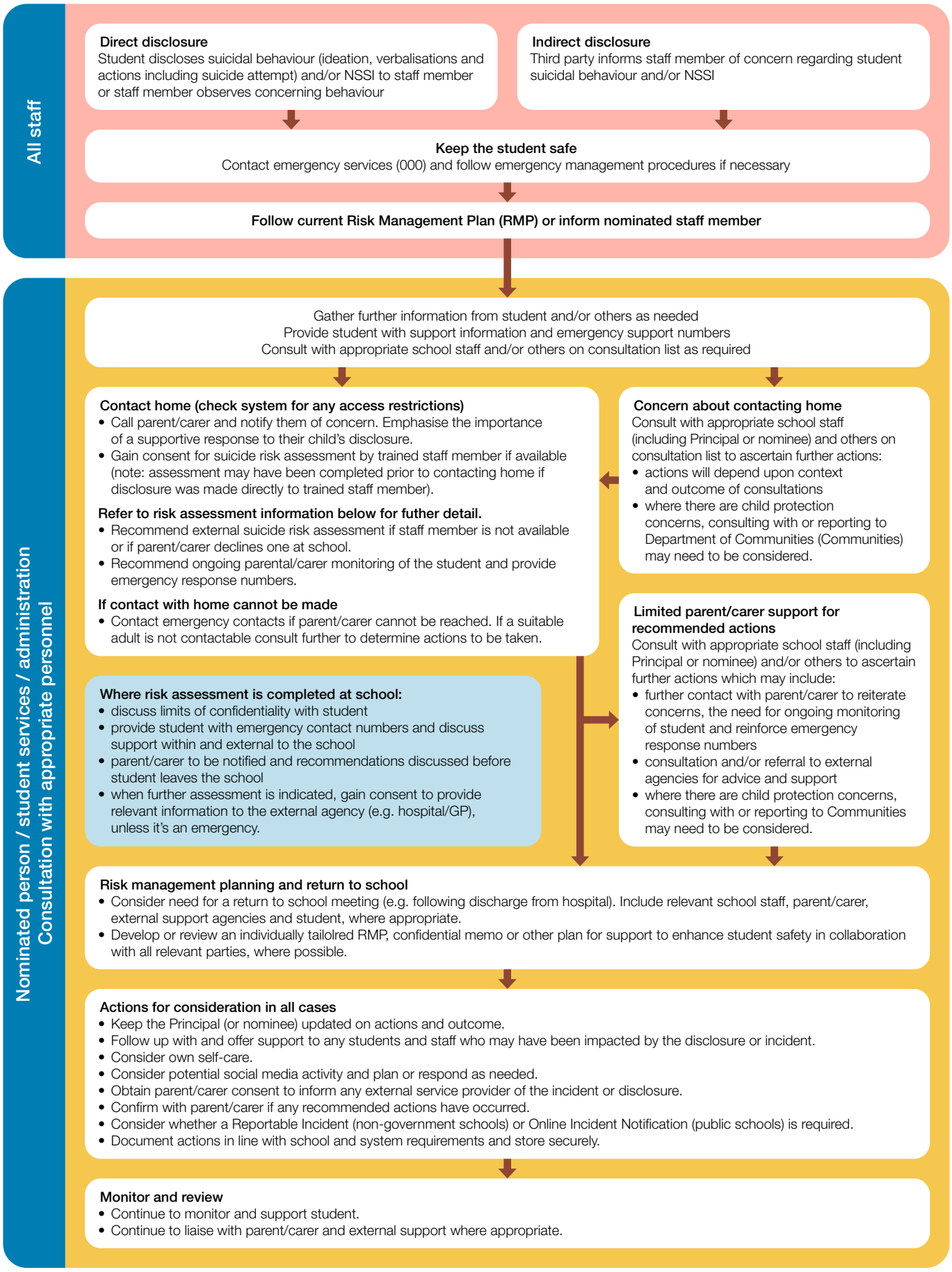
	Contact numbers
School contacts	
School contact	
Nominated staff member/s	
AISWA schools	
Coordinators AISWA School Psychology Service	0417 148 397
School psychologist	
Employee assistance program	
CEWA schools	
Chief Psychologist, Psychology, Safety and Wellbeing	6228 6675 0477 900 475
School psychologist	
Employee assistance program	1300 687 327
Public school contacts	
School psychologist	
Lead School Psychologist	
School psychologist consultant - suicide prevention	9402 6433 0477 757 125
Regional education office	
Pastoral Critical Incident Response (PCIR) - YouthCARE	0407 413 855
Service Response - Child Protection enquiries	9402 6124
Media advice and support	9264 5821
Employee assistance program (PeopleSense)	1300 307 912
Manager assistance program (PeopleSense)	1300 307 912
Local contacts	
Department of Communities local office	
Child and Adolescent Mental Health Service	
Medical Service	
Hospital	
Interpreter Service	
Emergency and agency contacts	
CAMHS Crisis Connect (Metropolitan children and young people – 24 hours, 7 days)	1800 048 636
Department of Communities Central Intake Team (Metropolitan area)	1800 273 889
Mental Health Emergency Response Line (MHERL Metropolitan)	1300 555 788
Mental Health Emergency Response Line (MHERL Peel)	1800 676 822
Rural Link (All ages regional, rural and remote areas)	1800 552 002
Police (non life-threatening assistance)	131 444
Poisons Information Service	13 11 26
Alcohol and Drug Information Service	9442 5000 1800 198 024 (Country)
Sexual Assault Resource Centre	6458 1828 1800 199 888

Telephone 000 for emergencies

Under 16 years old, present to Perth Children's Hospital emergency department, 24 hours.
Over 16 years old, present to any local hospital emergency department, 24 hours.
People of any age in country areas, attend local hospital emergency department, 24 hours.

Appendix 3 – School response to student suicidal behaviour and non-suicidal self-injury quick reference

This flowchart is a quick reference guide to be used in conjunction with Section One and Section Two of the Guidelines. Access Appendix 3 and 6 for consultation contacts for school staff and parent/carer and student support.



Appendix 4 – Risk Management Plan example template

Confidential					
School name:					
Student details					
Name:		Year:		DOB:	
Principal:		Teacher/Year Coordinator:			
Parent/Carer:		Phone:			
Parent/Carer:		Phone:			
Date of implementation:		Review date:			
Nominated staff member/s					
Title:		Contact:			
Title:		Contact:			
Student support staff					
Title:		Contact:			
Title:		Contact:			
External contacts					
Emergency: 000	Consultation Number (e.g. CAMHS ETS; Rurallink)		External agency: #		
Context /Environment	School-based strategies to manage risk at school		Home-based strategies to reduce risk at school		
Signatures – record of endorsement					
Parent/Carer:		Student, where appropriate:			
Administration:		Student Services:			
Teacher/s:		Other Staff:			
Date:					
Note: In cases where parent/carer consent is not provided or is difficult to obtain, a RMP can be implemented in order to improve student safety and wellbeing. This should be documented in school records.					

Appendix 5 – Risk Management Memo example template

Modify to match the information available

[Insert recipient name]

[Insert Student name, Year group] - Confidential risk management memo

Recently there have been some concerns raised about **[student name]** wellbeing.

To support **[student name]** safety at school, please monitor them in class and notify **[staff member name and contact number]** of any concerns or changes in their behaviour or mood as soon as possible.

Strategies to support safety include: **[insert strategies as appropriate]**

- If **[student name]** is expected in class but not present, please inform **[staff member name]** at the beginning of class.
- **[further strategies as appropriate].**

While **[student name]** is aware that additional strategies are in place for them, please maintain confidentiality and do not discuss this with them.

If you have any questions or would like to discuss this further, please contact **[staff member]**.

Thank you for your support.

[nominated staff member]

[job title]

Appendix 6 – Emergency, consultation and support contacts for sharing with parent/carer/student

	Contact
13YARN Crisis support line for mob who are feeling overwhelmed or having difficulty coping (24 hours, 7 days)	13 92 76
CAMHS Crisis Connect (children and young people 24/7)	1800 048 636
Department of Communities Crisis Care Service (24/7)	1800 199 008
e-headspace (12-25 years 9:00 am to 1:00 am AEDST, 7 days)	1800 650 890
Health Direct (24/7)	1800 022 222
Kids Helpline (5–25 year olds, 24/7)	1800 551 800
Lifeline (All ages 24/7)	13 11 14
Mental Health Emergency Response Line	1300 555 788 (Metro) 1800 676 822 (Peel)
Poisons Information Centre (24/7)	13 11 26
Rural Link (All ages regional, rural and remote areas)	1800 552 002
Suicide Callback Service (All ages affected by suicide 24/7)	1300 659 467
QLife (3 pm to midnight)	1800 184 527
Local hospital	
Local CAMHS or WACHS CAMHS	
Telephone 000 for emergencies	

Additional Resources

- Beyond Blue
- Black Dog Institute
- Everymind
- headspace
- ReachOut
- Sane
- Transforming Families
- RightByYou
- Perth Aboriginal services – mental health services (healthywa.wa.gov.au)
- Ngala Parenting Line – Metro: (08) 9368 9368 • Country: 1800 111 546
- Thirrili National Indigenous Postvention Support – 1800 805 801

Under 16 years old, present to Perth Children's Hospital emergency department, 24 hours.
16 years old and over, present to any local hospital emergency department, 24 hours.
People of any age in country areas, attend local hospital emergency department, 24 hours.

Appendix 7 – Postvention operational checklist for immediate response

Establish facts:

- ☐ Establish communication with the family and obtain permission to inform and disclose information. Sensitively discuss preferences for language used such as suspected suicide or sudden death.
- ☐ Confirm information from at least two reliable sources (e.g. family, WA Police, external agency, Department of Education, Office of the Chief Psychologist).

Activate:

- ☐ Convene school critical incident/crisis management team.
- ☐ Refer to and follow Incident Management /Crisis Management plans already in place.

Communicate:

- ☐ Inform relevant system personnel:
  - Public schools inform their Regional Education Office and submit an online incident notification.
  - CEWA schools inform Team Leader, Psychology, Safety and Wellbeing.
  - AISWA schools may wish to advise AISWA Executive and seek support from AISWA School Psychology Service.
- ☐ Develop communications (e.g. scripts/letters) and inform staff, students and families. Include relevant facts, common responses to a traumatic event such as death, and help seeking information within and external to the school. Ensure communications do not describe the method or location of the suicide.
- ☐ Seek advice through relevant system personnel prior to distributing communications to school community.
  - Public schools liaise with the Media and Communications Branch, Regional Education Office and School Psychology Service.
  - CEWA Schools with the CEWA Psychology Team and Communications and Marketing Team.
  - AISWA schools liaise with AISWA Executive and School Psychology Service, as relevant.

Support:

- ☐ Identify and support close contacts, vulnerable students and staff.
- ☐ Identify and arrange internal and external support for students and staff, as required.
- ☐ Monitor own self-care needs.

Confirm:

- ☐ Confirm automated messages, such as those facilitating absentee information, reporting or interaction with the School Curriculum and Standards Authority are disabled.
- ☐ School communications and postvention actions are documented in line with school and system requirements.
- ☐ Schedule time to reconvene school critical incident/crisis management team.