A close-up photograph of a vibrant blue starfish resting on a collection of smooth, grey, rounded rocks. The starfish is the central focus, with its five arms spread out. The background is softly blurred, showing more rocks and a hint of a bright, overcast sky. The overall color palette is cool, dominated by blues and greys.

Updated evidence and guidance supporting suicide prevention activity in New Zealand Schools 2003 - 2012

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Updated evidence and guidance supporting suicide prevention activity in New Zealand Schools 2003 - 2012

Commissioned by the Ministry of Health, and undertaken by Professor Sunny Collings, Social Psychiatry & Population Mental Health Research Unit, University of Otago Wellington, and Te Pou o Te Whakaaro Nui (Te Pou).

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Foreword

This document updates the two existing New Zealand evidence reviews about suicide prevention activities in secondary schools. It supports *Preventing and responding to suicide – Resource kit for schools* (Ministry of Education 2013) which provides practical guidance for staff in New Zealand schools.

Previous evidence reviews include *The prevention, recognition and management of young people at risk of suicide: development of guidelines for schools* (Beautrais et al, 1997) and a review of the evidence on school-based suicide prevention programmes *Evidence for student-focused school-based suicide prevention programmes: criteria for external providers* (Bennett et al, 2003) which was the basis for *Youth Suicide Prevention in Schools: a practical guide* (Ministry of Youth Affairs, 2003).

The material is not presented as a systematic review, as is common for health interventions, for three reasons. First, high-quality evidence on programmes that work is very scant (Berman, 2009); secondly, the effectiveness of complex interventions is highly dependent on the context within which they are applied, so even an intervention that has been shown to be effective is not automatically transferable to a new setting; and finally, consultation with end-users of these documents indicated that the part of the guide they would value most (i.e. guidance on how to manage the suicide of a student, on an hour-by-hour and day-by-day basis) could only ever be based on a combination of evidence, knowledge of the context, an understanding of social systems, and considered judgment.

In addition to the above, post-incident review is recommended as a critical aspect of ensuring the best possible responses to these relatively rare but devastating events in school communities.

This review focuses on evidence and other material directly related to suicide prevention and postvention rather than including comprehensive information on programmes that aim mainly to mitigate risk factors for suicide such as substance misuse. It supports the more general guidance for schools on the management of emergencies and traumatic incidents (Ministry of Education, 2010a; Ministry of Education, 2010b).

Acknowledgements

While new evidence has come to light since earlier evidence reviews, much of the content of the existing documents is still relevant. In general, the new evidence has refined knowledge rather than changed the direction for best practice. This document relies heavily on previous work and the authors of the precursor documents, which are listed below, are acknowledged.

The prevention, recognition and management of young people at risk of suicide: development of guidelines for schools (1997). Beautrais A, Coggan C, Fergusson D and Rivers L. Wellington: Ministry of Education and National Health Committee. ISBN 0-478-10462-6

Evidence for student-focused school-based suicide prevention programmes: criteria for external providers (2003). Bennett S, Coggan C and Brewin M. Auckland: Injury Prevention Research Centre, School of Population Health, University of Auckland. ISSN 1174-5371

Young people at risk of suicide: a guide for schools (1998). Beautrais A, Coggan C, Fergusson D and Rivers L. Wellington: Ministry of Education and National Health Committee. ISBN 0-477-05074-3

Youth Suicide Prevention in Schools: a practical guide (2003). Wellington: Ministry of Youth Affairs. ISBN 0-478-25014-2

Acknowledgement is also due to the staff in schools and from Boards of Trustees who provided information used in the preparation of this report and from colleagues who peer reviewed the document and the accompanying school guidelines *Preventing and responding to suicide* (Ministry of Education 2013).

Contents

- Foreword.....3
- Acknowledgements4
- Executive Summary7
- 1. Background.....10
 - Suicide and adolescents in New Zealand10
 - The role of schools.....11
- 2. Suicide amongst young people: what do we know?17
 - Suicidal behaviours amongst young people.....17
- 3. First do no harm: safety in school suicide prevention23
 - Approaches to classroom-based suicide prevention23
 - Programme considerations26
- 4. School-based suicide prevention programmes30
 - Typology of school-based suicide prevention programmes.....30
 - Universal curriculum-based suicide prevention programmes.....30
 - Screening, selective and indicated programmes32
 - Whole school approaches.....38
 - External providers of school suicide prevention programmes44
- 5. Recognition, assessment and management of at-risk students.....46
 - Recognition of young people at risk of suicide.....46
 - Checklist of risk factors.....50
 - Assessment by the counsellor50
 - Symptoms of suicide risk.....52
 - Management of young people at risk of suicide.....62
 - Relationships with and referral to health and other services.....68
- 6. Responding to suicide: Postvention in New Zealand Schools.....74
 - Schools’ responsibilities.....74
 - Postvention planning76
 - Long-term support82
- References84
- Appendix One: Article selection.....102

Appendix Two: Criteria for assessment of suicide prevention programmes and assessment of selected programmes against criteria.....	103
Safety for Participants.....	103
Programme considerations.....	104
Providers.....	105
Programmes that have been assessed in New Zealand.....	105
Programme summaries.....	107
Appendix Three: Structured assessments.....	111
Example of a structured assessment.....	111
Appendix Four: Psychosocial assessments of young people.....	113
HEEADSS Psychosocial assessment in adolescents.....	113

Executive Summary

This document supports *Preventing and responding to suicide – Resource kit for schools* (Ministry of Education 2013) which provides practical guidance for staff in New Zealand schools.

New Zealand has seen significant reductions in serious suicidal behaviours among young people since the peak in youth suicide rates in 1995. Over this time there has been a reduction of 38.3 per cent for suicide and 37.1 per cent for hospitalizations from intentional self-harm amongst young people aged 15-24 years (Ministry of Health 2012). However, there are good reasons to prioritise activities and maintain programmes that will contribute to reductions in suicide and intentional self-harm rates.

Suicidal thinking and suicidal behaviours including self-harm remain a significant issue among young people. In a 2007 New Zealand sample of secondary school students (Adolescent Health Research Group 2008), 19 per cent of young women and nine per cent of young men reported thinking seriously about suicide in the previous year. Suicidal behaviours among adolescents have a major impact on families/whanau and communities.

School-based programmes are now accepted as an effective way to recognise and support youth at risk of suicide, although the focus and balance of programmes has shifted as new evidence about benefits and harms has become known.

This evidence review suggests there are a number of key aspects to successful suicide prevention, recognition and management of risk, and postvention in schools. They include:

- The emerging model of suicide prevention in schools is a hybrid of clinical and public health frameworks. **This is known as the ‘whole school’ model. This model recognizes that suicide prevention needs to be a part of comprehensive health education activities such as those provided for in the New Zealand Health and Physical Education Curriculum.** Suicide prevention also requires expert knowledge and skill in programme design and delivery.
- Schools should ensure that any programme delivered by an external provider uses trained professionals (usually health professionals, sometimes education specialists) to administer programmes. People without recognized specialist expertise should not implement or deliver school-based suicide prevention programmes with young people.
- Suicide prevention programmes must firstly, have a robust theoretical model underpinning their content, design and delivery; secondly, be informed by an expert understanding of the contributing roles of various risk and protective factors for suicidal behaviours among young people; thirdly, have established robust links with mental health and social services agencies outside the school; and fourthly, have been subject to rigorous publicly available evaluation.
- New Zealand schools are expected to provide a safe physical and emotional environment in classrooms and the wider school. Programme planners and implementers must be aware that, like most health interventions, suicide prevention efforts may have unforeseen negative consequences, and evaluations should be designed to detect these.
- For schools to contribute safely to suicide prevention, it is essential that referral pathways are effective. Poor communication with mental health agencies reduces the potential effectiveness of programmes that seek to identify and refer young people at risk of suicide for mental health care. The development and enhancement of whole school approaches should include

careful attention to the development and maintenance of strong relationships with named staff in local services outside the school, such as Child and Family Mental Health Services.

- Evaluation provides an important safety framework for schools and potential participants. Because the research evidence is scant, and there are risks associated with school-based suicide prevention activities, it is imperative that prior to its widespread implementation in New Zealand schools, any new programme must have been comprehensively evaluated, and evaluation findings must be available for consideration by schools. The programme must also be accompanied by a clear and logical ongoing evaluation framework, which includes appropriate outcome measures.
- It is recommended that schools develop, adopt and regularly review a clear and documented process to detect young people who are emotionally distressed and consequently may be at risk of suicidal behaviour. The four key risk factor domains are: mental illness or major adjustment problems, multi-problem family contexts, socioeconomic disadvantage, and significant recent stressors.
- The evidence suggests that all teachers, and to a lesser extent other school staff, should receive initial training and then ongoing awareness training of common signs which might give rise to concern about a young person and consideration of a referral to a counsellor.
- Regular staff training should include information on the symptoms of psychosocial distress, depression and risk of suicide, so staff can develop the confidence and competence to refer and support distressed young people.
- Such training should be linked to the regular review and update of policy and processes relating to **the school's approach to suicide prevention. The utility of any guideline or policy is entirely dependent on staff being familiar with it and competent and confident in their roles in relation to it.**

The evidence also suggests that certain interventions are not recommended. These include:

- the use of screening instruments for the identification of young people at risk of suicide except as part of comprehensive whole-school approaches which are being subjected to external evaluation. However, educators and other school staff can play an important role in recognising the warning signs of suicidal behaviour. By improving staff ability to identify at-risk students, schools will be in a better position to refer young people at risk of self-harm to appropriate support or treatment services.
- the use of peer support programmes as part of the whole-school approach to suicide prevention. To date there is an insufficient body of evidence supporting the efficacy or safety of peer support programmes in suicide prevention.

Postvention

Any school may have a student who seriously attempts or completes suicide. When this happens, there may be consequences for other students. Close friends will experience some grief reaction, others may experience guilt. For some it may bring back memories and reactions to other loss experiences. For a small number, especially those who are already experiencing difficulties, it may raise the awareness of suicide as an option for them. The nature of the impact on the school is influenced by how a school responds. Some level of traumatic incident response, based on sound and safe suicide postvention

principles, needs to occur in the schools since ‘doing nothing’ is considered to be potentially harmful. Those affected who receive a more proactive response are more likely to seek or use support.

Postvention is a term used to describe a planned response to a suicide or suicide attempt, in order to minimize the risk of further attempts. The aim of the postvention response is to assist the school community to return to a normal routine as soon as possible. Most students will be able to engage quickly back into their schedules and daily routine without significant emotional disturbance. The evidence suggests:

- As suicide is a rare event in schools, it is recommended that a specific section on suicide is **included in the school’s Traumatic Incident Response Policy (TIRP) as opposed to developing a stand-alone suicide postvention plan.** When applied to traumatic incidences related to a death by suicide, these plans may also be referred to as postvention plans.¹
- The management of traumatic incidents requires high levels of teamwork. Traumatic incident response plans provide the basis for teamwork following a suicide or attempted suicide. Communication technology, such as texting and social networking pages, can mean that students are aware of the death very soon after the event, sometimes before the school is notified.
- Students who are vulnerable should be identified. All staff should be reminded about the referral procedures for at-risk students. Students who have a history of emotional distress and risk of suicide should be identified and should have at least one screening interview with a competent staff member. As necessary, they should be referred for further assistance. There should also be the opportunity for other individuals to self-identify, or be identified by teachers or other students as having difficulties following the suicide, and to receive appropriate assistance.
- Those students who had been identified as at-risk should be regularly monitored over the next 6 – 8 weeks and then their risk status reviewed. Monitoring of at-risk students may need to be ongoing, especially those who had been identified as at-risk before the death. Some students, especially close friends, will take longer to recover and extra on-going support may be required. While their grief needs to be acknowledged and support offered, it is important that their grieving is not disruptive of **the school’s return to the normal schedule.**
- There is some debate about how much information should be shared and whether the death should be named as a suicide. New Zealand schools need to be cognisant of the legal stipulations of the Coroners Act 2006 which states that a death can only be legally classified as suicide by a **coroner’s finding.** **Ministry of Education guidelines on managing traumatic incidents recommend** that all suspected suicides be referred to as sudden deaths. Before notification of any persons, the school leadership team should check that they have all the information that is available and that the information they have is factual and accurate.
- It is important that staff are supported not only to undertake the support role to students but to address their own response to the death and be given the opportunity to access support people to

¹ The Ministry of Education has produced guidelines for schools and early childhood education centres on managing traumatic incidents *Managing Emergencies and Traumatic Incidents – The Guide*. This is the main reference document schools should refer to in developing their TIRP, found at <http://www.minedu.govt.nz/theMinistry/EmergencyManagement/Preparedness/EmergenciesTraumaticIncidents/TheGuide.aspx>.

discuss their own feelings about the suicide. Staff should meet regularly during the first few days following the suicide. A parent information evening on loss and grief, understanding of depression and how to support distressed young people could also be organised during the first week after the death.

Finally, because suicide in any single school is likely to be a rare event, it is critical that the introduction of a new policy or guideline is not seen as a one-off event but as the establishment of an ongoing process of working towards suicide prevention in the school.

1. Background

Suicide and adolescents in New Zealand

Suicidal thinking and suicidal behaviours including self-harm are a significant issue among young people (Hawton & Fortune, 2008). More than a quarter of adolescents report considering suicide at some stage, and across 128 international studies, a mean of almost 10 per cent reported a previous suicide attempt (Evans et al, 2005). In a 2007 New Zealand sample of secondary school students, 19 per cent of young women and nine per cent of young men reported thinking seriously about suicide in the previous year (Adolescent Health Research Group, 2008). Suicidal behaviours among adolescents have a major impact on families/whanau and communities (Beautrais et al., 1996; Bennett, Coggan, Hooper et al., 2002; Coggan et al., 1995; Langley et al., 2000; Lawson-Te Aho, 1998).

New Zealand has seen significant reductions in serious suicidal behaviours among young people since the peak in youth suicide rates in 1995 (by 38.3 per cent for suicide and 37.1 per cent for hospitalizations from intentional self-harm). However, these remain important public health and social problems in New Zealand and world-wide. When ranked alongside other OECD countries, New Zealand has the fourth highest suicide rate for males aged 15-24 years and the second highest suicide rate for females aged 15-24 years (Ministry of Health 2012).

In 2010, young people aged 15-19 years had the highest rate of any age group for intentional self-harm hospitalizations of two days or longer, at 130.9 per 100,000 (Ministry of Health, 2012, p. 44). That rates are higher than for older age groups is of concern because a history of intentional self-harm is a risk factor for future self-harm and eventual suicide (Hawton et al, 2003). Young women are hospitalised for intentional self-harm at a higher rate than young men (191.8 compared to 73.2 per 100,000 for 15-19 year olds in 2010).

There is no guarantee that youth suicide rates will continue to fall, and in fact they have increased slightly since 2007 (Ministry of Health 2012, p. 11). Current suicide prevention efforts must be maintained and strengthened.

Among Maori, all-age suicide rates are significantly higher than for non-Maori (16.0 compared to 10.4 per 100,000 in 2010), and while non-Maori rates appear to be reducing over time, this pattern is not so apparent for Maori suicide rates. In 2010 there were 25 suicides amongst Maori youth aged 15-19 years, out of a total of 53 (Ministry of Health 2012, p. 17). The self-harm hospitalization rate for Maori youth was 155.7 in 2010, compared with 123.2 amongst non-Maori (Ministry of Health 2012, p. 54).

In 2010 there were five deaths amongst Pacific young people aged 15-19 years, and four amongst Asian young people in the same age group (Ministry of Health 2012, p. 17). Intentional self-harm admissions

numbers are also relatively small for these groups, with 28 young Pacific people aged 15-19 years admitted for self-harm in 2010, and 15 young Asian people (Ministry of Health 2012, p. 49).

Adolescence is a life-stage that is associated with highly specific health, psychological and social needs. Because health and social behaviours that persist into adulthood are laid down during these years, any investment in promoting good mental health is paid back over a long period (Viner & Barker, 2005). In adolescence the common risk, predisposing and protective factors for problems such as smoking, alcohol use and psychological distress follow mainly from the developmental processes associated with this life phase (Shrier et al, 1997), which explains the clustering of the risk factors for suicide with those for other adolescent health and social problems. There is general agreement that health and risk behaviours in adolescence must be addressed within a framework giving weight to cognitive, emotional and social development as well as the environments where young people spend their time (Maes & Lievens, 2003; Bennett & Coggan, 1999; Onoda, 1995).

The role of schools

The factors that contribute to the likelihood of a young person considering suicide lie mainly outside the school setting; however schools are the social institution with access to the greatest number of young people over extended periods of time (King, 2001; Coggan et al, 2003). They are therefore an ideal setting in which to base activities to promote health and social wellbeing, including physical and mental health, suicide prevention and attitudes and behaviours related to health and social and individual responsibility (WHO, 1995). Because school is such a major context for young people, it also has the potential to moderate risk behaviours and to identify and secure help for at-risk individuals (Kalafat, 2003).

It has been suggested that schools should be involved in the primary prevention of suicide for five main reasons:

1. to develop productive and mature citizens, including developing psychological health
2. to resolve problems that interfere with education
3. to utilize resources that the school has for resolving problems, such as school counsellors
4. to teach health education, and
5. to **acknowledge the school's duty of care (Smith, 1991).**

These are consistent with the philosophy that school programmes should address adolescent health concerns more broadly, as many programmes focusing on issues such as alcohol and drug misuse, bullying prevention, and awareness of and help-seeking for mental health issues are in fact addressing risk factors for suicidal behaviours.

School-based programmes are now accepted as the best way to recognise and support youth at risk of suicide (Beautrais et al, 1997), although the focus and balance of programmes have shifted over the past two decades as new evidence about benefits and harms has come to light. For example, recent evidence suggests that some school-based programmes may be strengthened by including attention to the **young person's relationships with parents and family** (Kaminiski, 2010). There is also acknowledgment that much yet needs to be done to develop and evaluate interventions that are safe and effective, given the opportunities and potential provided in school settings to impact on the mental health of young people through, for example, mental health literacy programmes (Kutcher 2012).

New Zealand schools, through governance by Boards of Trustees and management by principals, are expected to provide a safe physical and emotional environment in classrooms and the wider school to provide the best possible learning context (Ministry of Education, 1999). Beautrais (1997) suggested that providing effective suicide prevention and postvention was part of this expectation. In their 1997 background report to the guidelines for schools, Beautrais et al (1997) recommended the following processes be developed by each school:

Prevention: implement health programmes which promote a safe and healthy environment, including teaching the current health curriculum. Develop policies and procedures for the management of any traumatic incident such as the death of a student or a member of staff, so that distress to others is minimized.

Recognition: acknowledge in written policy that it is the responsibility of all staff to be able to identify young people experiencing emotional distress, and especially those who may be at risk of seriously contemplating, planning or attempting suicide.

Intervention: ensure that any student who is identified as being at-risk is referred to the designated staff member, is assessed, and the appropriate level of assistance and support is provided or a referral made to an appropriate service.

Management: develop an individual management plan for young people at risk of suicide which details immediate interventions to ensure their safety, consultation with other professionals and family/whanau members, monitoring and/or referral to appropriate services and follow up.

Evaluation: ongoing evaluation of the policies, procedures and competence of staff to identify and appropriately refer students who may be at risk of attempting suicide. This includes the school having sufficient staff who are competent² to assess and counsel students and resourced to provide the services outlined in *Preventing and responding to suicide* (Ministry of Education 2013).

These are major responsibilities, and it is critical that schools are supported in this by the availability of accessible and appropriate materials so they can make pragmatic and evidence-led decisions about what to offer regarding suicide prevention, and how to do so. In 1997 the Education Review Office noted that societal problems (including suicidal behaviours) are barriers to the progress of children and young people attending school (Education Review Office, 1997). The New Zealand Youth Suicide Prevention Strategy was released in 1998 (Ministry of Youth Affairs, Ministry of Health, & Te Puni Kokiri, 1998), providing a framework for developing youth suicide prevention activities.

Best practice guidelines for schools about the prevention, recognition and management of young people at risk of suicide were also published in 1998 (Beautrais et al., 1998). These outlined a clinical approach to identifying and managing students in emotional distress, with a focus on risk assessment. Although concerns were documented about some programmes, there was no structured process for schools to assess their safety and effectiveness.

In 1999, the *Health and Physical Education in the New Zealand Curriculum* policy was implemented by schools in order to better address the physical and emotional health issues confronting children and adolescents. Following this, schools and Boards of Trustees were targeted by a number of providers of

² 'Competent' means staff who are appropriately qualified, receiving clinical supervision and a member of a professional association with a suitable code of ethics and disciplinary processes.

suicide prevention programmes tailored for the school environment. However there were significant concerns about the potential unintended consequences of some activities and in 2002, the Ministries of Education, Youth Affairs and Health provided policy advice to schools regarding externally-provided suicide prevention programmes. The provision of *Evidence for student focused school-based suicide prevention programmes: criteria for external providers* (Bennet et al, 2003) gave schools a structured way of assessing what was on offer.

The current Ministry of Education guideline (2013) promotes the development of a whole-school approach to promoting student wellbeing, and advises against the introduction of externally-provided programmes that focus on suicide.

The Ministry is trialling the My FRIENDS Youth programme in some New Zealand Schools during 2013. This is a resilience-building programme which has been successfully introduced and evaluated in Australian schools and elsewhere. Once the New Zealand trial has been evaluated, it is planned to make the programme more widely available.

For the information of schools that wish to consider external programmes, this report updates the evidence on the effectiveness of student-focused school-based suicide prevention programmes and activities since the late 1980s. It builds on the existing reviews and is based on the literature published in English.

Most of the research has been done in the USA, although there is some work from the UK and Australia. Since the 2003 review there has also been a small amount of relevant work from New Zealand. As in the Bennett et al 2003 review, this review has focused on studies which: evaluated an intervention; were conducted on school-aged young people; provided information in suicide-related outcomes and/or cost; described a prospective study; and had a control group (this included before/after studies).

School guidance counsellors

School counsellors have been identified as a potential key contributor to suicide prevention activities in schools (Fortune & Clarkson, 2006). However, they are a heterogeneous group in terms of professional backgrounds, training and experience, and specific skills relevant to suicide prevention. They are employed under a range of titles, including 'school guidance counsellor'/'guidance counsellor' (70 per cent), 'counsellor' (15 per cent), and a range of other titles such as 'student advisor', teacher in charge of 'pastoral care', and 'pastoral care assistant' (Post-primary Teachers' Association, 2004). The range of titles reflects the complex development of the profession in New Zealand over many decades, and the diversity of day-to-day tasks associated with the role. Guidance in NZ schools was originally more associated with vocational advice, disciplinary control and more general educational and life-skills mentoring than with the expectation of providing specific mental health care. The impact of *Tomorrow's Schools* in 1989 shifted substantial financial and administrative responsibilities for managing schools to elected boards of trustees. Schools became responsible for the allocation of funds for the employment of guidance staff, with no centralised system of appointment or support for the guidance network. Over time these changes have resulted in role changes, so the guidance service meets the needs of specific schools. Some schools no longer employ guidance staff, and conditions vary between schools employing guidance staff (Bulkeley, 2010).

Currently guidance counsellors are registered as teachers, which limits some flexibility in the ability of schools to employ mental health professionals or trained counsellors who are unable to register as teachers.

Guidance counsellors report supporting more students with psychosocial disorders (including substance misuse). The most common problems presenting to guidance counsellors are: family/whanau problems, career decisions, educational problems, disruptive behaviour and conflict with peers (Manthei, 1999). Severe problems are reported as depression, family/whanau problems, suicide attempts, sexual abuse and substance misuse, with over half of counsellors rating depression as the most serious problem presenting to them (Ramage et al, 2005).

Clearly many of the problems described may require a clinical response as part of overall psychosocial management. However, the knowledge and skills of school guidance counsellors vary in their support to students experiencing mental health difficulties (Bulkeley, 2010). Furthermore, in addition to providing direct care to students, there is some expectation that guidance counsellors will provide some leadership in the areas linked to ensuring the school is a safe environment for students and staff (Crowe, 2006), including responses to suicide prevention and postvention.

This state of affairs presents a challenge to the provision of a coherent approach to suicide prevention in schools, particularly if the leadership is seen to be vested in the counsellors and/or the counselling service is the usual route to clinical or social care. For school suicide prevention activities to be effective, it is critical that school guidance counsellors have access to the training and professional development that will ensure they have the knowledge and skills needed to assess, manage and refer the moderate- and high-risk presentations. It is also important that they have sufficient time to effectively manage high case-loads, and clinical supervision.

School guidance counsellors must be able to refer young people outside the school when necessary and have a relationship of trust with the services they refer to. Referrals are generally made in consultation with parents, most commonly to Child and Adolescent Mental Health Services (CAMHS) or the GP.

Among some counsellors there is a perception that CAMHS will only accept referrals when there is imminent risk to a young person, that waiting times are long and that it is difficult to get referrals accepted. However, increasingly CAMHS teams have routine liaison with school counsellors, and an identified person for them to contact. Some use joint assessments, which provide an excellent opportunity to share knowledge and skills (Bulkeley, 2010). Nevertheless, CAMHS services are under strain themselves (Fortune and Clarkson, 2006), and it is important that school guidance counsellors have sufficient knowledge and skills to be able to 'hold' clinical situations when necessary.

Evidence-led guidance

In this review, the term *evidence-led* activities is used, rather than *evidence-based* ones, for three reasons. First, the problem of heterogeneity of studies remains as described by Bennett et al and confirmed in a further recent review (Miller et al, 2009). When design, target groups, outcome measures and interventions are all highly varied across studies, review techniques such as statistical meta-analysis have limited utility (Foxcroft et al, 2003). Furthermore, these strategies do not provide the contextual information that is critical in making a choice about approaches to take.

Secondly, the tiered ranking approach commonly taken in guidelines for clinical practice in health would have been of very limited use as there are insufficient robust trials to make meaningful distinctions between many levels of evidence.

Finally, the feedback from the potential users of the guidance was that they wanted a succinct summary of practical information with clear action steps designed for specific school staff roles, rather than a lot of

‘academic’ material. It was concluded that if the guideline itself was too large and the content was weighted towards research material then these would be barriers to its use.

Contemporary suicide prevention in New Zealand

Internationally, suicide prevention strategies usually comprise a series of multi-sectoral activities in which actions range from broad social goals such as reducing social inequalities to individual-level clinical interventions. All have a part to play in reducing the risk of a person dying by suicide. Since the last guideline for schools was written, suicide prevention in New Zealand has changed considerably.

The *Like Minds, Like Mine* anti-discrimination campaign³ has now been running for 13 years and is a core public health activity funded by the government. The goal of the *National Depression Initiative (NDI)*⁴ is to reduce the impact of depression on New Zealanders, and its activities have wide reach. They include: supporting individuals and family/whanau to notice early signs and seek help (for example via the television advertisement campaign featuring John Kirwan); improved clinician responses (for example via the guidelines on recognition and management of common mental disorders in primary care); and web-based self-help resources such as *the Lowdown*⁵ for people aged under 25 and *the Journal*⁶ for others. The NDI online programmes include free back-up support through texting, email and telephone counselling.

New Zealand’s suicide prevention strategy (Ministry of Health, 2007), covers all ages and has broad coverage from mental health promotion through improving treatment for mental illnesses to fostering research. In other sectors, there are major policies and programmes such as: Violence within Families (Ministry of Social Development); Sexual Violence (Ministry of Justice); Strengthening Parenting (Family Start/Early Start, Ministries of Social Development and Education); and Towards Wellbeing (support for young people in care and protection, CYFS). The Prime Minister’s Youth Mental Health Programme (2012) will provide for additional funds and initiatives aiming to improve the mental health of young people. These are all highly relevant to suicide prevention in the short- and long-term. Media guidelines for reporting of suicide (Ministry of Health, 1999) have been redeveloped and there is more research on suicide prevention in the New Zealand setting than ever before.

The Law Commission’s review *Alcohol in our Lives: Curbing the Harm* (2010) opened up possibilities for reducing the impact of alcohol on suicide rates, especially for young people.

Scope of this review

Given the broad range of suicide prevention strategies, it is unrealistic to expect coverage of them all in a single report (Guo & Harstall, 2002).

As with previous reviews, the focus is the role of schools in prevention (including recognition and early management of students at risk) and postvention, rather than specific treatment/management of the problems that may be precursors to suicide, and programmes for educating teachers and parents have not been included. Gatekeeper training is included as one component of the whole-school approach. The parameters for the literature search are in Appendix 1.

³ <http://www.likeminds.org.nz/page/5-Home>

⁴ <http://www.moh.govt.nz/moh.nsf/indexmh/national-depression-initiative>

⁵ <http://www.thelowdown.co.nz/>

⁶ <http://www.depression.org.nz>

Although there is some evidence to support a number of approaches, the nature of suicide as it occurs at the individual level means that it will probably never be possible to have a completely reliable way to identify and manage young people at risk of suicide.

At the coalface, suicide prevention is an uncertain activity. Taking reasonable steps to identify and support vulnerable students will sadly not always be enough to prevent suicide.

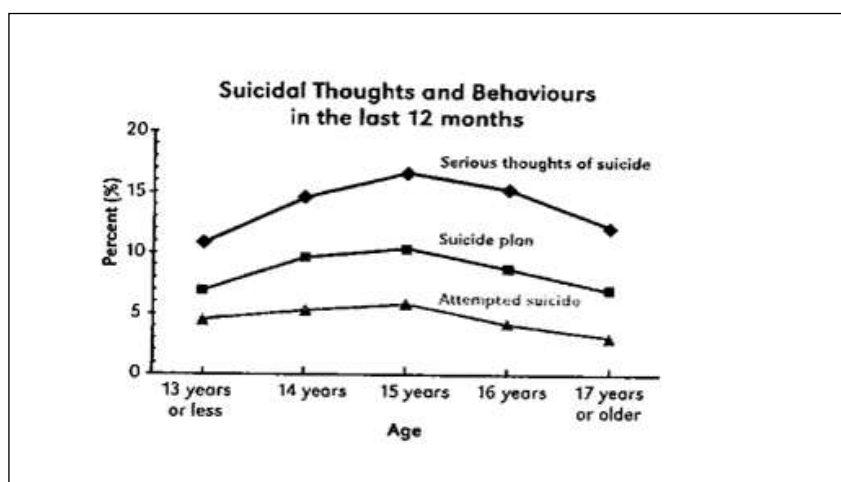
2. Suicide amongst young people: what do we know?

All suicidal behaviours lie on a spectrum ranging from occasional suicidal thoughts to death from suicide. Actual suicide is the least common phenomenon on this spectrum, but naturally this is the focus of attention and concern especially among the public. We are fortunate in New Zealand to have robust recent research evidence about suicidal behaviours among young people.

Suicidal behaviours amongst young people

The Youth 07 survey of 9107 secondary school students aged 18 or younger showed 10 per cent of female students and seven per cent of male students reporting significant symptoms of depression (Adolescent Health Research Group, 2008). Twenty-five per cent of females and 16 per cent of males had intentionally harmed themselves in the previous 12 months, although only three per cent of these incidents required treatment by a health professional. Nineteen per cent of females and nine per cent of males reported thinking seriously about suicide in the previous 12 months, with seven per cent and three per cent respectively making a suicide attempt in that time. Figure 1 shows the percentages reporting the spectrum of suicidal behaviours by year of age.

Figure 1. Percentage of young people experiencing suicidal thoughts and behaviours in previous 12 months^{7*}



Symptoms of depression, suicidal thoughts and suicide attempts were all less common in the 2007 survey than the previous 2000 survey. They suggest that, by the age of 18 years, about one young person in 20 will have made a suicide attempt. Many of these attempts either lead to no injury or very minor physical injury (Horwood and Fergusson, 1997). In 2007, 111 10-14-year-olds and 404 15-19-year-olds were admitted to hospital for at least two days because of

⁷Reproduced from Adolescent Health Research Group, (2008). *Youth'07: The Health and Wellbeing of Secondary School Students in New Zealand. Initial Findings*. Auckland: The University of Auckland.

intentional self-harm, and two and 42 young people in these age groups respectively died by suicide (Ministry of Health, 2009).

These figures suggest that many secondary schools are likely to have students who will think about suicide or who engage in intentional self-harm. However, in any year, relatively fewer schools will have pupils who are admitted to hospital because of medically serious suicide attempts, or who will die by suicide (Beautrais et al, 1997).

The figures suggest that on average, a school can expect one death by suicide every 10-12 years. Of course, some schools will experience more than this due to the high loading of risk factors in their school community, and some schools will have no suicides.

Suicide attempts and suicides may cluster, so the occurrence of one suicide attempt in a school may be followed by others within the same school, locality and/or social network (Gould et al, 1990; Hazell, 1993). A serious suicide attempt or death will affect the emotional well-being and educational achievements of a significant number of young people within the school. Such events are also likely to increase the risk of other young people within the school considering suicide (Beautrais et al, 1997).

Suicide may have become a theme in the discourse of young people about themselves, and among some groups of young people, self-harm such as superficial cutting is relatively common and openly discussed (Collings & Beautrais, 2005). Young people in New Zealand consider suicide among their peers to be more common than it is, with two-thirds of people in a sample of 25 year-olds believing that more than half of all suicides occurred among young people (Beautrais et al 2004), and only five per cent considering depression as relevant among causal factors (Heled & Read, 2005). It is speculated that ready access to means of unmonitored quick mass communication and information sources may amplify the effects and reach of some of the less healthy aspects of some youth cultures. However recent New Zealand research indicates that high-risk young people tend to use texting and social networking as a means of personal support, rather than to engage in risk behaviours (Collings 2011).

The prominence of the discourse about ‘youth suicide’ in New Zealand culture may influence the suicide risk behaviours of some vulnerable young people, and may lead to some entering a high-risk group if they have other risk factors and also come to view suicide as either a normal response to highly stressful circumstances or as an ‘option’ for problem solving (Collings & Beautrais, 2005).

Methods and locations of suicide and suicide attempt

Methods of suicide and suicide attempt vary by gender, by community and by cultural significance and appear to depend, in part, on availability and familiarity with or preference for particular methods (Boor, 1981; Clark and Lester, 1989; Farmer and Rohde, 1980; Marzuk et al, 1992; Berman et al, 2006). In the 15-24 year age group, approximately 72 per cent of deaths from suicide occur at home, with a further 21 per cent occurring in public places. Very few occur on the premises of institutions such as schools (Taylor and Collings, 2010).

Causes of suicidal behaviour in young people

The risk of young people attempting suicide or dying by suicide relates to a balance between four key risk domains and a number of protective factors (Catalano, 2002). Those with many risk factors and few protective factors are at greater risk than those with the opposite

combination. However most young people who experience what would appear to be high-risk contexts do not die by suicide, and those with outwardly straightforward lives are not at zero risk.

Risk factor domains and ‘warning signs’

It is useful to distinguish between risk factors, which are derived from observational studies of suicide and self-harm, and what can be called ‘warning signs’, which are indicators of possible imminent suicide attempt, and are derived from clinical experience (Rudd et al, 2006). The four key risk factor domains are: mental illness or major adjustment problems, multi-problem family contexts, socioeconomic disadvantage, and significant recent stressors.

1. Mental health problems

Most young people who make suicide attempts have significant and recognisable mental health or adjustment problems. Psychopathology is the most reliable risk factor. The most common problems are depression, substance misuse (including alcohol, cannabis and other drug use or dependency) and criminal offending or antisocial behaviour. Approximately 90 per cent of young people who attempt suicide exhibit these disorders prior to a serious attempt and/or suicide (Beautrais, 1996; Brent et al, 1993a; Marttunen et al, 1991; Runeson, 1989; Shaffer et al, 1996).

Often mental health problems in those who attempt suicide will be associated with specific features such as low self-esteem, high levels of neuroticism, impulsivity, a pervasive sense of hopelessness (Beautrais, 1996; Brent et al, 1994; Marttunen et al, 1991; Runeson, 1989) and antisocial behaviours leading to problems with the law.

Relatively few young people who attempt or die by suicide will have more severe forms of mental disorder such as schizophrenia. Nonetheless, among the small minority with a severe mental disorder, the risk of suicide and suicide attempt is very high (Caldwell and Gottesman, 1992; Roy, 1992).

2. Family difficulties

Secondly, young people who make suicide attempts are also more likely to have experienced dysfunctional family/whanau environments, including childhood sexual and physical abuse, marital disharmony, parental mental health problems and related problems, and poor parental care. The young person is more likely to have been in some form of institutional or foster care during childhood and/or adolescence (Beautrais, 1996; Fergusson and Lynskey, 1995b; Garland and Zigler, 1993).

3. Social disadvantage

Those who engage in serious suicidal behaviours are more likely to come from socially disadvantaged backgrounds characterised by low socio-economic status, limited educational achievement, and material and economic disadvantage (Beautrais, 1996; Beautrais et al, 1996; Fergusson and Lynskey, 1995b). There is evidence that in New Zealand, suicide became more concentrated among these social groups during the 1990s (Collings et al, 2005). The concentration of suicidal behaviours and suicide among these disadvantaged groups means young people in these groups are more likely to be exposed to the behaviours and events, which also increases their risk.

4. Personal stress factors

Finally, specific stress and adversity often immediately precedes the suicide attempt. The major sources of stress which may contribute to suicidal behaviour are: first, the breakdown of interpersonal relationships, including romantic or supportive attachments; and secondly, significant problems with the law and/or with police (Beautrais, 1996; Brent et al, 1993b; Hawton et al, 1982).

Of these, the breakdown of relationships is by far the most common, immediate reason for the suicide attempt. In over 60 per cent of suicide attempts among young people there is some identifiable life experience or stress that precipitated the suicidal behaviour (Beautrais, 1996; Heikkinen et al, 1994).

The effect of these risk factors is cumulative, and suicidal behaviours across the spectrum are uncommon (although not absent) in young people without some combination of family/whanau and social disadvantage, psychiatric disorder and related problems (Beautrais et al, 1997).

Warning signs

Warning signs are time-limited and more dynamic in comparison to risk factors, and may signal 'near-term' risk i.e. hours or days. They may also have more potential for modification than some long-standing or historical risk factors.

A useful way of thinking about the relationship between the two is to consider that risk factors increase the long-term likelihood that a suicidal crisis will arise in an individual, while warning signs indicate that the crisis is happening (Rudd et al, 2006).

They include overt threats to kill oneself; seeking access to the means; writing and talking about death, dying or suicide; hopelessness; rage, anger or seeking revenge; reckless behaviour without apparent concern for consequences; feeling trapped; increasing drug or alcohol use; withdrawal from family/whanau or society; agitation, anxiety, sleeplessness or oversleeping; dramatic mood changes; and seeing no reason for living (Rudd et al 2006). It has been suggested that what underlies these warning signs is a deep psychological pain associated with feeling expendable or ineffective, and disconnected or isolated from others (Schneidman, 1996; Joiner, 2005). Clinicians also sometimes observe a period of apparently elevated mood following a prolonged period of despair, perhaps indicating the young person has decided to kill themselves as a solution to their problems.

Protective factors

There is some evidence that risk factors can be balanced by protective factors, in two ways (Fleming et al., 2007). Firstly, positive family/whanau and school environments are associated with lower rates of depression and other risk factors for suicide among young people (Resnick et al., 1997; Cichetti et al., 1998; Denny et al., 2004).

Secondly, results from a 2000 study of 9699 New Zealand secondary students show that students who report having caring parents and other family/whanau members, fair teachers and feeling safe at school, have lower rates of suicide attempts even after accounting for symptoms of depression and anxiety, alcohol abuse, family/whanau violence, sexual orientation and exposure to suicide attempts by others. This suggests that supportive social contexts may reduce the

likelihood that a young person will attempt suicide as a response to low mood or stressors (Fleming et al, 2007).

Culture, ethnicity and suicidal behaviours

The relationship between ethnicity and suicidal behaviours in New Zealand is complex. Historically, suicide rates were lower among Maori than non-Maori, but by the mid-1990s, rates were similar (Ferguson et al, 2005).

Maori youth suicide rates have been consistently higher than those for non-Maori youth for 14 years, and are not declining at the same rate as non-Maori rates (Ministry of Health, 2009). In 2010, Maori youth suicide rates were 35.3 per cent compared with 13.4 per cent for non-Maori (Ministry of Health 2012).

Because of the small numbers of young Pacific and Asian people dying by suicide (five and four respectively aged 15-19 years during 2010), rates have not been established.

Hospitalisations involving intentional self-harm amongst Maori have remained relatively stable since 1996, with 108 young people aged 15-19 years hospitalised in 2010, compared with 28 Pacific and 15 Asian from a total of 422 young people (Ministry of Health 2012).

Suicide clusters among young people

Suicide clusters or contagion are a major concern, and one of the purposes of postvention activities is to minimise their likelihood (Johansson, 2006). A recent New Zealand study identified 15 suicide clusters during the period 1990 – 2007, which accounted for 1.3 per cent of all suicides during the 18-year period. The median age of the 122 decedents was 34 years, which does not support the common assumption that suicide clusters are exclusively a feature of suicidal behaviour amongst young people (Larkin, 2011).

This review found few other recent studies, other than those based on case reports, of suicide clusters among young people, although it appears to be more common in 15-24 year-olds than other age groups (Gould, 1990). Suicide clusters, although relatively rare, have been found to account for up to 13 per cent of teen suicides (Gould, 1990; Gould, 1990a; Pelkonen, 2003).

There appear to be two main types of suicide clusters – mass clusters and point clusters (Joiner, 1999). Mass clusters are associated with media exposure, and are most likely to be clusters in time but not necessarily geographical location. Point clusters are those that are a series of suicides in the same geographical location. Within this latter group there are clusters thought to be associated with socio-economic deprivation (Exeter and Boyle, 2007), and smaller scale point clusters that may occur in schools or other institutions. Larkin and Beautrais (2012) found that decedents within individual clusters had lived close to each other, and the data suggested that information about suicide occurred at an urban level.

Suicide contagion by imitation is the commonly suggested mechanism for point clusters, and is supported by evidence of clustering of self-harm (Gould, 1994) although in itself this is not a strong explanation as it begs the question of why some people imitate suicidal behaviours but most do not (Joiner, 1999). Joiner has suggested that people who may be at increased risk of suicide, because of adversity, personality qualities, or other risk factors, form relationships with others at increased risk. This means that people who, given stressful circumstances are more

likely to become suicidal, are already clustered prior to a suicide. They may then be vulnerable to suicide if there is a combination of severe negative events and low social support (Joiner, 2003).

Joiner's theory supports the idea that any severe stress may activate the suicide risk of potential cluster members. In the school setting, this means being mindful of all potentially vulnerable students, and that a school suicide may not be the only relevant stressor.

Conclusion

Continuing concerns about New Zealand's high rate of youth suicide are well-founded because of the disparities by ethnic group and economic deprivation, and the greater burden of lost years of life when a young person dies. It is important to reduce the waste of life, loss of potential and personal, family/whanau, school and community tragedy caused by youth suicide. Yet it is also important that the issues relating to youth suicide are kept in perspective. Suicide among school-aged people is relatively rare, so misleading claims about both the frequency and origin of suicidal behaviour in young people are to be avoided (Beautrais, 1997) lest they contribute to community beliefs about young people which may foster the normalization of suicidal behaviours among them.

3. First do no harm: safety in school suicide prevention

The introduction of suicide prevention programmes into school settings has been a contentious issue in the past. Nationally and internationally, the desire of health professionals and the concerned community to reduce the burden of suicidal behaviours among young people competes with a desire to reduce any risks associated with suicide prevention activities.

In 1996, Hazell and King suggested that, in the future, Australian schools may face legal challenges over their community responsibility not only to intervene, but also to make sure that such interventions are appropriate and safe. A similar argument may be made with reference to contemporary New Zealand schools. **The two clear imperatives have not changed:** “to be sure that the initiatives we put in place to prevent suicide will really make a **difference**”, and “to be absolutely sure that our initiatives do not have the opposite effect and place people at more risk of suicide and self-harm” (Beautrais, 1998, p.2).

Since the evidence published by Bennett et al (2003) there has been a small amount of additional literature discussing the safety of school-based programmes, and the following section summarises these and the earlier work.

Approaches to classroom-based suicide prevention

Findings from evaluations of early classroom-based suicide prevention programmes gave some cause for concern (Gould et al, 2005), and there is some evidence that students who are at risk of mental health problems are less likely to attend such programmes (Berman, 2006). In addition, while suicide education programmes have potential to modify attitudes to suicidal behaviours (Miller, 2009), they have specific limitations (Ayyash-Abdo, 2002) in two areas.

Firstly, while such programmes may be effective in increasing awareness or transmitting knowledge, education alone is not sufficient to modify behaviours (Garland and Zigler 1993; Berman et al, 2006).

Secondly, several studies have shown that some classroom-based suicide prevention programmes (i.e. those based mainly on a strong educational component such as lectures in suicide statistics and warning signs, or audiovisual presentations of vignettes of at-risk young people) may increase the risk of suicidal behaviours among vulnerable young people (Beautrais et al., 1997, Bennet et al., 2003). There is a strong suggestion that students already at high risk (such as those who already feel suicidal) may react more negatively than non-suicidal peers to prevention programmes consisting mainly of classroom-based delivery that focuses on suicide. Such negative effects are serious and must not be overlooked, especially as they may be more potent among young males, who are already more likely to die by suicide than their female counterparts (Mazza, 1997; Berman, 2006) with a ratio of almost 3:1 in New Zealand (Ministry of Health, 2009).

Shaffer and colleagues (1990; 1991) found that exposure to such programmes may increase the risk of some students attempting to kill themselves. Students who reported initial undesirable attitudes did not change as a result of participating in the programme, and suicidal young people reported that they would not recommend the programme to other students.

Although this study has been criticized, (Leenaars and Wencksten, 1999), the results are convergent with two additional studies of specific suicide programmes (Kalafat and Elias., 1994, Overholser et al., 1989), reported below. Together they raise the possibility that a narrow focus on suicide in such programmes may not be beneficial or neutral in effect on all students.

In a study by Overholser et al. (1989), one programme had positive effects for females in reducing levels of hopelessness, evaluative and experiential attitudes and reliance on maladaptive strategies, but the opposite was true for males. The investigators argued that the approach to classroom-based programmes needed to be substantially reviewed if they were to be of benefit to young men, who represent the greater risk group for suicide.

The potential risk of some brief classroom-based programmes may be associated with two aspects of programme content. The first is a focus on stress as a precursor to suicide. Unless skillfully conveyed alongside a significant amount of other content including on mental health, this could readily be interpreted by students to mean that stress is a cause of suicide, and that suicide is not particularly associated with mental health problems. In other words, the programmes may create a normalizing effect.

The second concern about content relates to delivery. Many programmes use some form of a 'trigger', such as a video or vignette to introduce students to the topic (Hazell & King, 1996). These educational videos tend to choose attractive actors, and to dramatise the action which may glamorise or inadvertently trivialise the precipitants to suicide. By sharing many of the characteristics of news and fictional broadcasts of suicide, such videos may encourage imitation (Gould, Wallenstein, & Davidon, 1989; Velting & Gould, 1997).

A third, more general limitation with all classroom-based programmes is that the research has neither assessed effects on suicidal behaviours at the more severe end of the spectrum, nor investigated long-term outcomes (Miller, 2009).

The research evidence supports the view that classroom-based programmes focusing on suicide awareness and/or indirect case-finding by educational means are either ineffective (Berman, 1995; Vieland, 1991; Shaffer, 1999) or detrimental to some students. A more recent systematic review of such programmes found evidence that some could improve knowledge, attitudes and help-seeking behavior, but there was no evidence that they reduced suicide rates (Cusimano, 2011).

Both the earlier New Zealand-based evidence reviews by Beautrais (1997) and Bennet (2003) concluded that there was no evidence to support the provision of classroom-based suicide prevention programmes. Both suggested that instead, general mental health issues be incorporated into school health curricula.

Programmes focusing on identifying students at high risk

The goal of some programmes is to identify students at high risk and support their early access to assistance. Most students who have an outwardly observable constellation of risk factors, or report having them, will not be at high risk of suicide, and a few who have apparently unproblematic lives will be at high risk. Although screening high school students for psychological distress has not been found to cause significant undue stress for young people (Robinson, 2011), any process identifying at-risk students is compromised to some extent by the occurrence of false positives and false negatives.

False positives mean the incorrect identification of young people who are not at high risk of suicide for inclusion in additional support activities. False negatives occur when there is a failure to identify young people at risk of suicide or serious mental health issues. If the school is solely reliant on the use of a suicide prevention programme based on identifying those at high risk, these young people may not receive the support they require.

In the past, the stigma associated with mental illness has influenced the acceptability of some school-based suicide prevention programmes. Following an early review of school-based suicide prevention programmes, Garland and colleagues (1989) reported that several programme directors considered that linking suicidal behaviours to psychopathology would discourage young people from disclosing their **own, or a peer's, suicidal intentions**. However, at least one study has specifically addressed the issue of whether there are potential benefits to teaching students that suicide is strongly associated with mental illness. These included a positive influence on attitudes towards self-disclosure of suicidal thinking and help-seeking from peers and professionals (Ciffone, 1993).

Stigma also affects the ability of young people to acknowledge mental health problems and to seek help. Education about mental health and mental illness can improve attitudes, making a real difference in encouraging young people to seek help and stay well (Bennett et al, 2002; Rowling et al, 2002). Further support for addressing stigma associated with mental health issues may be found in programmes such as Mentally Healthy Schools (Ministry of Health, 2003) and public health initiatives such as the 'Like Minds, Like Mine' anti-discrimination campaign.

In order not to undermine positive effects, it is vital that school suicide prevention programmes recognize and appropriately address any stigma associated with the identification of individual students and directing them to special support activities. In New Zealand, there is evidence that stigma about mental illness is decreasing (Brown 2011), and therefore ought to be less of a barrier than previously. However school personnel must be appropriately skilled and resourced to address issues associated with stigmatization should they arise.

Programmes using peer support

Peer support has been a major component of some whole-school approaches to mental health promotion related to suicide prevention in the past. However, important safety issues have been identified with suicide prevention peer support programmes which target potential helpers, rather than those who are at risk of suicidal behaviours (Hazell et al, 1996).

Such programmes were based on the evidence that adolescents are more likely to discuss suicide problems and concerns with peers rather than adults. However, the responsibility adolescents were made to feel for their peers in such programmes was a major concern. Many of these programmes reinforced the peer focus, but did nothing to increase the likelihood that friends would facilitate bringing suicidal peers forward for assessment (Hazell et al, 1996).

Those who felt they were responsible for taking care of their peers were found to take an unreasonable degree of responsibility and/or inadvertently worsen situations that call for professional help. Young people who volunteer for such programmes may themselves be vulnerable.

These programmes were also underpinned by an implicit assumption that the peer networks of adolescents at risk for suicide are as extensive and behave in the same way as the peer networks

of non-suicidal young people. There is emerging evidence that for adolescents, despite the importance of peer relationships, peer connectedness has much less positive impact on suicidality than connectedness with family. There is also indicative evidence that strong peer connectedness may be associated with greater suicidality in some circumstances, although this requires further investigation (Kaminski et al, 2010).

The evidence suggests that suicide prevention programmes using peer support as a major vehicle for identifying young people at risk should not be used.

Programme considerations

In providing any school-based suicide prevention programme, schools must provide a safe physical and emotional environment in classrooms and the wider school. Programmes should be underpinned by a robust theoretical model, informed by an expert understanding of the contributing roles of various risk and protective factors, have established links with mental health and social services resources and be subject to rigorous publicly available evaluation. Furthermore, programme planners and implementers must be aware that suicide prevention efforts may have unforeseen negative consequences, and evaluations should be designed to detect these.

Within these constraints, developing and delivering school-based suicide prevention programmes also requires experience, creativity, and the ability to adapt to shifting social and political forces (Breton et al., 2002). This is because the evidence base is still developing, and there is no universal theory of suicide that encompasses its multidimensional nature (Beautrais, 2000; Bennett, Coggan, Adams, 2002, 2003; Gould & Kramer, 2001) to guide programme planning and development (Breton et al., 2002). Consequently, it is in the best interests of programme designers to clearly define the underlying theory of suicide for new programmes (Breton et al., 2002).

Theoretical models of school suicide prevention programmes

Until recently, school suicide prevention programmes were understood from two broad theoretical bases, firstly the mental health (psychopathology) model, and secondly the stress model. Almost without exception, the early suicide prevention programmes subscribed to a stress model theoretical orientation (Garland et al, 1989) which represented suicide as a response to a significant or extreme amount of stress. This was the antithesis of the **accumulating published research demonstrating that young people's suicidal behaviour is strongly associated with mental illness or psychopathology** (Beautrais, 2000; Gould et al., 2003).

Portraying suicide as an outcome of stress has the potential to increase the likelihood of suicidal behaviours, because suicide could be viewed as a desirable response to stressful conditions (Shaffer et al, 1998). It also had the potential to 'normalise' suicidal behaviours by suggesting that, given sufficiently stressful circumstances, everyone may be vulnerable to suicide (Ciffone, 1993; Shaffer et al., 1988). In contrast to this, emphasising the connections between mental illness and suicide may make suicidal behaviours less appealing as a means of coping with stress, and prompt young people to seek professional help (Shaffer et al, 1988).

The emerging model of suicide prevention in schools is a hybrid of the clinical and public health frameworks, as adopted by the Ministry of Education in its current guidelines (2013). The complexity of suicide prevention requires a more nuanced consideration grounded in a multi-

layered comprehensive approach. This is a 'whole school' model, the general philosophy of which is evident in national suicide prevention strategies, which recognize that no one or even several approaches can reduce suicide rates: a comprehensive range of strategies is needed.

Key elements in the emerging model include:

- recognizing that suicide prevention is complex and, having inherent risks, requires expert knowledge and skill in programme design and delivery
- a multi-layered approach that, like other prevention programmes (e.g. for substance abuse), addresses multiple risk factors at several levels of influence (e.g. policies on alcohol availability as well as efforts to change public and parental attitudes to alcohol misuse)
- a focus on the link with mental health problems
- a focus on ongoing skills and competency development in young people, rather than expecting didactic time-limited sessions to have any lasting effect
- an approach that is sensitive to specific contexts of schools while maintaining a sound base in theory and robust empirical evidence
- flexibility to incorporate new knowledge
- recognition that capacity building in schools themselves (e.g. school counsellors, principals) is critical
- recognition that prevention efforts should not raise expectations and demand for services that do not exist or do not have the capacity to respond.

Many of the suicide prevention programmes discussed in this review of evidence are delivered by external providers. Schools in New Zealand are advised by the Ministry of Education to adopt a whole school approach, and ensure that any programme delivered by an external provider uses trained professionals (usually health professionals, sometimes education specialists) to administer programmes. People without recognized specialist expertise should not implement or deliver school-based suicide prevention programmes with young people.

Links with community mental health and social services

A core component of suicide prevention is the identification, referral and treatment of young people at risk of suicidal behaviours. However, links between school-based suicide prevention programmes and existing community mental health resources are frequently inadequate, both overseas and in New Zealand (O'Carroll 1994; Fortune & Clarkson, 2006; Bulkeley, 2009). Inadequate communication with mental health agencies clearly reduces the potential effectiveness of programmes that seek to identify and refer suicidal young people for mental health care. For schools to contribute to the prevention of suicide, it is essential that referral pathways are effective.

Research and evaluation

From a scientific perspective, the effectiveness of school-based suicide prevention programmes has not been demonstrated although many aspects are looking very promising. There are two main problems with the research to date. The first is simply the small number of studies (Gould

et al., 2003); a recent review of programmes identified only 13 that used an experimental or quasi-experimental design (Miller et al, 2009). Of these, two demonstrated robust effects.

The second problem is that most studies have major methodological shortcomings in terms of experimental design, programme integrity (Miller et al, 2009), and attention to process evaluation which is now regarded as an essential component of trials of complex interventions. Process evaluation findings are especially relevant when attempting to transfer programmes from the original experimental setting to other settings.

Most studies use limited outcomes for which associations with adolescent suicide are not clearly established, such as attitudes towards help-seeking, or improved knowledge of mental illness and suicide.

Although limitations often occur for pragmatic reasons, large studies with longer periods of follow-up and more relevant outcome measures such as self-harm and suicide are sorely needed (see for example Vieland et al, 1991). The choice of outcome measures should be related to the programme objective(s), and measures with demonstrated validity and reliability for the population being studied should be used wherever possible.

In response to the deficits in the design and methods of project evaluations conducted under the Australian National Youth Suicide Prevention Strategy (Mitchell, 2000), a number of recommendations were made to enhance the rigor of youth suicide prevention programme evaluation. These were that research/evaluation projects should have: 1) an appropriate research/evaluation framework; 2) clear definitions of goals and objectives; 3) an appropriate design; 4) appropriate methods; 5) comprehensive reporting of interventions, methods and results; 6) literature review; 7) realistic timelines; 8) evaluation built into the programme design; 9) appropriate tools and instruments utilized; 10) sufficient resources and dedicated staff; 11) appropriately managed evaluation resources; and 12) utilized an evaluation team approach (Mitchell, 2000).

Meeting these standards would mean future studies would make a more meaningful contribution to our understanding of school-based suicide prevention.

Because the research evidence is scant, and there are risks associated with school suicide prevention activities, any programme introduced must be rigorously evaluated and monitored, the cost of which needs to be built into their funding.

Appendix Two outlines criteria against which programmes delivered by external providers can be assessed before adoption by schools, with some examples. The USA Substance Abuse and Mental Health Service Administration (SAMHSA) programme effectiveness registry also lists several programmes and reports their effectiveness and the rigor of the evaluations:

<http://www.nrepp.samhsa.gov/find.asp>.

Conclusion

All suicide prevention programmes in school settings are accompanied by some safety concerns and considerations. In particular, programmes need to have a sound theoretical orientation which encourages, rather than prevents young people from seeking assistance when it is required. Safe and effective programmes must use proven implementation and instructional strategies delivered by trained professionals. Consideration must also be given to enhancing the safety of young people who are identified as vulnerable and who could potentially participate in

school-based suicide prevention programmes. Brief didactic suicide prevention programmes with no connection to services should be avoided. Strong links with community mental health services and other key agencies are essential.

There is support for programmes that are carefully designed, evidence-led, and couched in a broader context of teaching positive mental health and wellbeing skills and establishing appropriate follow-through and linked services. All programmes should be appropriate for the diverse cultural backgrounds of potential participants.

Evaluation provides an important safety framework for schools and potential participants. The unforeseen negative consequences of suicide prevention efforts can be catastrophic, and evaluation measures should be designed to detect and prevent such consequences.

4. School-based suicide prevention programmes

Typology of school-based suicide prevention programmes

In their 2003 review of school-based programmes, Bennett et al classified⁸ school-based suicide prevention programmes as follows:

1. Universal classroom-based suicide prevention programmes;
2. Screening, selective⁹ and indicated programmes targeting specific groups or individuals; and
3. Whole-school approaches to positive mental health promotion, including youth suicide prevention.

In their original review, Bennett et al noted several approaches to classification and terminology. However, with the emergence of the whole school model, a hybrid of public health and clinical approaches which recognizes that any single programme will have multiple elements, none of **these classifications are quite adequate. Bennett et al's classification is a better reflection of the kind of programme approaches that are now evident.**

Universal curriculum-based suicide prevention programmes

Universal curriculum-based prevention or education programmes are among the most common suicide prevention programmes offered to young people (Ayyash-Abdo, 2002; Guo & Harstall, 2002). They are based on the assumption that educating young people, and sometimes gatekeepers, about suicide, will change attitudes and encourage help-seeking. Some of these educational interventions have consisted of a single lecture on the warning signs of suicide (O'Carroll, Potter, & Mercy, 1994), although research suggests that such programmes should be run over longer periods and have a broader focus on mental health and include material on self-harm as well as suicide (Berman et al, 2006; Kalafat, 2003)

The goals of curriculum-based programmes include: increasing **students'** awareness of suicidal behaviours; helping students identify warning signs of suicide; providing students with information about mental health resources and how to access them; teaching appropriate responses to those who may disclose suicidality, and encouraging suicidal young people to disclose their feelings and intentions to access appropriate help (Garland et al., 1989; Kalafat & Elias, 1994; Mazza, 1997; Shaffer, Garland, Gould, Fisher, & Trautman, 1990; Shaffer, Garland, Vieland, Underwood, & Busner, 1991). A small set of programmes also focused on improving **students'** coping strategies (Shaffer et al., 1988).

Over 30 reports in English of separate universal classroom-based interventions were identified (some interventions were reported in more than one paper). Most reports were from the USA and many were simply descriptive. In a recent review, Miller et al identified eight of these

⁸ This New Zealand-specific classification, which reflects the implementation site and administrative approach of programmes, has been retained in the current document, with additional commentary.

⁹ Selective programmes have been added to this category.

studies as meeting their review criterion of being experimental or quasi-experimental in design (Miller et al 2009). Most of these studies were insufficiently described to be certain that they met rigorous standards, even within the limits of their design. Most were also poor quality from a methodological perspective, essentially meaning that outcomes could not be reliably assessed.

An exception was LaFramboise and Howard-Pitney (1995) who reported a study of a school-based suicide prevention programme with the Zuni Native American people. This study is significant because it is relatively robust, having well-described components, good programme fidelity, and using multiple sources for outcome measurement, and was devised specifically for Native American youth, a known high-risk group. The design was pseudo-experimental, with four classes non-randomly allocated to intervention and control status. The curriculum was implemented by trained teachers in the language-arts class, and emphasized a life skills development approach while also including some specific information on suicide risk and intervention. The programme took place over three sessions per week for 30 weeks. Despite small numbers, there were significant reductions in rates of self-reported hopelessness in the intervention group and non-blind observer ratings of suicide intervention and problem-solving skills.

Curriculum-based education programmes are based on the belief that most suicidal youth come to the attention of their peers rather than adults, and peers may play an important suicide prevention role if they take responsible action on behalf of their troubled friends (Kalafat & Elias, 1994; Guo and Harstall 2002). Consequently, the goal of most curriculum-based programmes is to increase the likelihood that students who come into contact with potentially suicidal peers can more readily identify them, know how to obtain adult help for them and will be consistently inclined to take this action (Kalafat & Elias, 1994). However, evidence suggests that some adolescents do not respond to potentially or overtly suicidal peers in an empathic or helpful way, and that only one out of four teens is likely to tell an adult about a potentially suicidal friend (Kalafat & Elias, 1992; Spirito et al., 1988).

In addition, many classroom-based programmes have been criticized for de-emphasising the connection between suicide and mental illness, thus misrepresenting the facts (Burns & Patton, 2000; Garland & Zigler, 1993).

Also, programmes that portray suicide as a response to common stressors, perhaps in an attempt to destigmatise suicide, may be at risk of normalizing suicidal behaviours and reducing potentially protective taboos (Burns & Patton, 2000). The positive impact on knowledge, which is demonstrated by some programmes, is relatively unimportant without concomitant changes in attitudes and actual suicidal behaviours (Burns & Patton, 2000; Ploeg et al., 1996).

Overall, the evidence suggests that general mental health issues should be incorporated into school curricula, rather than teaching classroom-based programmes which focus specifically on suicide prevention (Beautrais, 1998). Although not the focus of this review, there is stronger support for education programmes about youth suicide prevention for teachers, allied school professionals and parents (Beautrais, 1998).

Of the eight experimental studies they reviewed, Miller et al (2009) considered only Klingman and Hochdorf (1993) and LaFromboise and Howard-Pitney (1995) to be robust enough to provide 'promising to strong evidence'.

We are more cautious: overall we consider the evidence in support of universal classroom-based suicide prevention programmes is very weak, because even the most robust studies are sufficiently flawed (e.g. using non-random allocation) as to introduce doubt about whether reported differences are due to the intervention.

In 1996, Ploeg et al reported their view that there was insufficient evidence to support the adoption of classroom-based suicide prevention programmes. Interventions in which suicide education is incorporated within a life skills approach show more consistent evidence of having a positive effect, but the effectiveness of the suicide-specific element is uncertain (Commonwealth Department of Health and Aged Care, Health Services Division, 1999).

It is notable that our review did not identify any new studies of this kind since that time. We concluded that there is insufficient evidence to support future development of universal classroom-based interventions.

Screening, selective and indicated programmes

A classroom-based programme may not meet the needs of high-risk or vulnerable young people in a school setting. Recently, selective and indicated programmes (which require case-finding by a range of approaches including gatekeeper referrals and screening of individuals) have been receiving increasing attention as a prevention strategy (Gould et al., 2003; Scott et al 2009), especially in the USA since the passing of an Act of Parliament providing for widespread suicide screening programmes in 2004 (Pena & Caine, 2006). There are few studies evaluating selective and indicated interventions and few on screening.

Screening

In order to provide selective and indicated interventions, students who may benefit must be reliably identified. This requires a screening process of some sort. Screening processes used in practice range from professional judgements made by observations by teachers who are concerned about a student, to detailed testing of all students in a school using well-designed and thoroughly tested screening tools. In between these, there is the possibility of only formally screening students about whom general concerns have been raised.

Most of the work on screening in schools comes from the USA, where its use was not widespread prior to 2000 (Hayden and Lauer; 2000), but is gaining momentum, with at least two organizations dedicated to promoting screening and disseminating resources (Pena & Caine, 2006). Screening has intuitive appeal, and is essential to the more targeted interventions.

The potential of screening programmes has been widely discussed in the literature, as it is a potentially efficient way to focus prevention resources on those in greatest need (Gould, 2005; Eggert, et al, 1995; Kachur et al, 1995; Cantor, 1994; Yufit, 1989; Shaffer, et al., 1988; Eddy, Wolpert and Rosenberg, 1989). However, screening has both benefits and costs that must be weighed up before embarking on programmes.

Screening tools must have been demonstrated to perform well in identifying as many people as possible who have the problem of interest, while not taking in large numbers of people who turn out on further investigation not to have the problem of interest.

It is a public health intervention that is appropriate only in certain conditions, and all screening programmes must follow case-finding of those at potentially increased risk with more intensive assessment and access to treatment as required (Shaffer and Pfeffer, 2001).

Criteria that must be considered when deciding whether to set up screening programmes include:

- the condition should be suitable i.e. it should be an important problem with an identifiable latent period, marker or risk factor
- there is a suitable test, which is acceptable to the population, simple, safe, validated and precise, and which has a known distribution in the population
- there should be a policy on investigation of people who screen positive
- there should be an effective treatment that is known to have better outcomes than no treatment or later treatment
- good management of the condition should be widely and routinely available prior to starting the screening programme
- the benefits of the screening programme should outweigh the harms (National Advisory Committee on Health and Disability [National Health Committee] 2003).

Harms include opportunity costs associated with ineffective screening programmes.

In a systematic review, the National Institute for Health and Clinical Excellence found no randomized controlled trials investigating whether routine screening improved problem identification or mental health outcomes for young people (National Institute for Health and Clinical Excellence, 2005). Cuijpers et al (2006) systematically reviewed three trials of screening followed by treatment for depression and calculated that 30 adolescents would need to be screened to produce one successfully treated case of depression. On this basis the number needed to screen to prevent a suicide would be much greater.

Arguments in favour of screening school students for mental disorder and/or suicide risk include: that it is cost-effective (Shaffer and Craft; 1999) (although note that this has not been tested empirically); that screening for depression and targeting interventions for treating this would have a higher yield (Andrews, Szabo, & Burns, 2002) and would have a flow-on effect in reducing suicide rates; that suicidal adolescents have identifiable risk factors (Gould, 2003); these risk factors include treatable mental disorders (Shaffer et al, 1996); and that at-risk and suicidal adolescents are under-detected (Kashani et al, 1989; Shaffer & Craft, 1990; Shaffer et al, 1999).

Apart from consideration of whether screening would meet the required criteria from a public health perspective, there are other issues to be thought through. One issue relates to the unstable nature of many aspects of suicidality.

While many of the risk factors related to social exposures such as ongoing family conflict or a history of abuse are fixed, risk factors or warning signs associated with emotional state and thinking can be highly changeable even over short periods. Students at apparently low risk today may be high risk a month later.

Another issue is that screening is a much more visible and direct activity than a classroom prevention presentation (Hayden & Lauer, 2000).

There have been concerns that screening, like some other interventions, may be harmful either by stigmatizing students who need further assistance, or, for a small group of vulnerable students, by triggering suicidal behaviours (Gould, 2005).

A further concern is that opposition from students, teachers, parents or administrators can terminate or undermine a screening programme at any stage. It is important that screening strategies are a good fit with the values of the school and local community (Pena & Caine, 2006).

In a 'real world' feasibility study of screening using the Suicide Risk Screen (Thompson & Eggert, 1999), Hallfors et al noted that feasibility problems were mostly associated with school readiness, including the capacity of staff to deal with the increased workload, the willingness of staff to engage in additional training, and procedural issues, such as clerical staff not notifying parents as they did not want to worry them. In the USA, school principals have, in the past, preferred curriculum-based programmes and staff training to screening (Miller et al 1999; Scherff et al 2005).

In poorer schools with less access to resources, principals may be concerned about revealing a high degree of need that cannot be met, and parents may fear that there will be government agency interventions or interference with their children or family/whanau (Brown & Grumet, 2009).

It would seem likely that such concerns would apply to most secondary schools in New Zealand, both from a school resource perspective, and the availability of viable external referral pathways to services with extra capacity (Bulkeley, 2009). Finally, participation rates in school suicide screening programmes are low at around 60 per cent, (Gould, 2005; Shaffer et al, 2004).

The matter of possible harmful effects on suicidal behaviours from school screening programmes has now been rigorously evaluated in one study (Gould, 2005).

In a randomized experimental design with 2,342 adolescents aged 13-19 in school settings, Gould and colleagues investigated whether asking about suicidal behaviours led to distress or increased suicidal behaviours in the following three days.

Possible harms measured by well-validated scientifically robust instruments, were impact on distress, impact on suicidal ideation, and differential impact on high-risk students (those with high depression scores, substance use problems or previous suicide attempts). There was no evidence of any harmful effects from the screening, including for high-risk students. This finding has been supported in a more recent study of screening high school students for psychological distress which found that the screening process did not cause significant undue stress for young people (Robinson, 2011).

A number of screening programmes have been designed to identify youth at high risk of suicide (for example O'Carroll, et al, 1992; Kalafat and Underwood, 1989; Bradley and Rotheram-Borus, 1990; Ramsay, et al., 1994; Columbia University, 2010; Screening for Mental Health Inc, 2010). The programmes typically administer an initial screening test to a large number of students, with follow-up screening of students who are identified as potentially at risk. Some instruments are subject to copyright, and/or require extensive training of those who administer them. Both these factors would be significant barriers to their adoption in the school setting in New Zealand.

Examples of suicide screening instruments designed for schools

There are few instruments with established reliability and clinical validity against ‘gold standard’ measures (Pena & Caine, 2006) such as the Suicidal Behaviour Interview (Reynolds, 1990). In the original guideline document, Beautrais (1997) noted that it was not possible to present a scientifically robust instrument suitable for use in schools. There have been some developments since then, and we present four examples of screening instruments that have established reliability and clinical validity.

The Suicidal Ideation Questionnaire (SIQ) and its adaptation, the SIQ-JR (for children in grades 7, 8, and 9) were first reported in the early-mid 1990’s (Reynolds, 1991; Keane et al 1996). The SIQ is a 30 item self-report questionnaire, has sensitivity of 80-100 per cent and specificity of 49-70 per cent, depending on the cut-off used, and a positive predictive value of 25¹⁰ (Reynolds, 1991; Pena & Caine, 2006).

The Suicide Risk Screen has 20 self-report items and is reliable with good concurrent and predictive validity, and sensitivities ranging from 87-100 per cent and specificity from 54-60 per cent, with a positive predictive value of 63-69 (Eggert et al, 1994; Thompson & Eggert, 1999; Thompson et al, 2000; Pena & Caine, 2006).

Two more widely known instruments are the Columbia Suicide Screen (Shaffer et al, 2004), and the SOS screen (Aseltine, 2004). Both of these have been incorporated into full suicide prevention programmes.

The Columbia Suicide Screen is a brief screening measure with good sensitivity and moderate specificity, (Shaffer et al, 2004). To avoid a focus on suicide, the suicide-specific items are distributed among 32 questions about general health issues. It has sensitivities of 75-88 per cent and specificities of 76-83 per cent (Shaffer & Craft, 1999; Shaffer et al, 2004). The Columbia Suicide Screen has been shown to identify the one-third of students with mental health problems who are not already known to school staff (Scott et al 2009). It is used as part of the Columbia Teenscreen Programme. The screen has now been used in multiple settings across the USA, including more recently, schools with poorer ethnic minority students (for example, Brown & Grumet, 2009).

The Signs of Suicide programme (described more fully below) includes a brief suicide screen, the Columbia Depression Scale. The tool itself is used as a self-education tool, whereby students evaluate their own risk and are told to seek help immediately if their score is over a certain threshold (Pena & Caine, 2006). The psychometric and screening properties of the Columbia Depression Scale in relation to use as a suicide screen have not been reported.

Selected and indicated intervention programmes

What happens to a student who screens ‘positive’ on a suicide screening instrument is arguably more important than the screen itself. This is why there has been a recent move to incorporate screening into broader programmes. Commonly these broader programmes involve a number of components, including educative and selective indicated interventions. For the purposes of

¹⁰ The proportion of screened people who screen positive and have the condition of interest, however that is defined. This is dependent on the population base rate of the condition being screened for, the ‘gold standard’ comparator, and the cut-off score used. For a detailed discussion of these issues in relation to suicide screening, see Pena & Caine, 2006.

school suicide prevention, the distinction between selective and indicated interventions is of limited use, so they have been grouped. Only three programmes were identified in this category for which there was sufficient information to judge aspects of their quality and effectiveness.

The Columbia University TeenScreen programme is increasingly well-known. It uses the Columbia Suicide Screen (Shaffer et al, 2004), described above, or more recently, the Columbia Health Screen, which is broader in focus (National Registry of Evidence-based Programs and Practices, 2010), as part of the 10 minute computerized TeenScreen National Mental Health Checkup, to identify students (or young people in any other setting) who may be at elevated risk of suicide, and directs these students to a further in-depth assessment by clinically licensed professionals.

Students who do not require further help following the clinical assessment are given an individualised debriefing that includes an anti-stigma element. Students who are determined to need further support are assigned a case manager following notification of the parents, and parents take responsibility for treatment choices. The case manager arranges the appropriate intervention. The programmes are set up with community buy-in and the access route is via parents, schools, health centres or other institutions. TeenScreen is now operating in over 400 sites in most states in the USA, and in Columbia, Korea, Panama, and Taiwan (National Registry of Evidence-based Programs and Practices, 2010), although it has attracted some controversy in relation to parental consent and appropriateness of diagnosis (Lenzer, 2005).

One-third of the students identified by the screen are not identified by other means such as teachers (Scott et al, 2009). It has been shown in a two-year follow-up study to enhance the likelihood that young people who need help will engage in treatment (Gould et al, 2009), although its effectiveness in preventing suicide specifically is untested. The research and support materials around the Columbia TeenScreen programme are regarded as moderately robust (National Registry of Evidence-based Programs and Practices, 2010).

Signs of Suicide (SOS) includes a universal classroom-based element and brief screening as described above (Aseltine & DeMartino 2004; Aseltine, James et al 2007). To date, this is the only universal classroom-based programme shown in a randomized controlled evaluation to reduce suicidal behaviours. It has been classified with screening/selective/indicated interventions because it screens, then includes follow-up for students who may be at risk. It was also reported as improving student knowledge and attitudes about depression and suicide. SOS is a 2-day programme combining curriculum content communicating the link between suicidal behaviours and mental disorder, especially depression; a powerful message of the non-normative nature of suicidal behaviours as a response to stress; and brief screening for depression and other risk factors for suicidal behaviours.

The core purpose is to teach secondary students to respond to signs of suicide risk in themselves or others as a medical emergency. Telling a responsible adult is a key part of this response. In the trial, the primary outcome measure was self-reported suicide attempt at three months post-intervention, with the intervention group 40 per cent less likely to report a suicide attempt than the control group. The short follow-up means there is no evidence about the longevity of the effects. The trial was moderately robust: important limitations included use of outcome measures without documented validity and reliability, lack of pre-trial data on the outcome measures, and a failure to account for possible effects of clustering by school in the analysis.

This programme has been used in over 3,000 schools in the USA and is listed on the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Effective Programs (Substance Abuse and Mental Health Services Administration, 2010).

Eggert and colleagues (1995) compared the effects of suicide prevention programmes with differing frequencies and duration, and reported that a single counselling session produced similar effects to one-semester or two-semester programmes.

This team (Randell et al, 2001; Eggert et al, 2002) went on to test a four-hour intervention called Counsellors Care (Assess, Respond, Empower) (C-CARE) comprising a computer-assisted suicide risk assessment (Measurement of Adolescent Potential for Suicide, MAPS) followed by a counselling intervention focusing on providing support and reinforcing positive coping and help-seeking behaviours, and an intervention comprising the C-CARE counselling component and a further 12 sessions, small-group skills training and social support intervention, called Coping and Support Training (CAST). Both were successful at reducing suicidal behaviours including suicidal ideation, depressed affect, anger control problems and family distress, and improved protective factors such as self-efficacy, self-esteem and perceived family support. These are relatively robust studies, with appropriate comparison conditions, good intervention fidelity and well-described programme components.

The studies have been assessed as robust despite being limited by small size and attrition rates greater than 10 per cent (Miller et al, 2009; National Registry of Evidence-based Programs and Practices, 2010).

Bridge et al developed a resource for use in high-risk secondary schools in Northern Australia, called 'Toughin' it Out' (TIO) (Bridge, Hanssens & Santhanam, 2007). Their approach assumed that the mainly Aboriginal students in these high-risk schools were already exposed to suicidal behaviours and actual suicides in their communities.

The aim is to counterbalance these exposures with appropriate and accessible material communicating that suicidal thoughts can be managed, that suicide is not a normal response to crises, that crises will pass but death from suicide is final, and that suicide is unnecessary and preventable, with a terrible impact on others. Although not formally evaluated, the authors noted that there appears **not to have been any increase in 'copy-cat' or other suicides among** young people exposed to the resource.

No robustly evaluated suicide-specific programmes were identified in Australia or New Zealand, although there are several general mental health programmes including, for example, the Adolescents Coping with Emotions (ACE) programme (Sheffield et al, 2006), the Resourceful Adolescent Programme (RAP) (Shochet & Ham, 2004), which has been adapted for New Zealand (Kiwi-RAP) and the TRAVELLERS programme (Dickinson et al, 2003). Kiwi-RAP has been subject to an RCT (Merry et al, 2004). This randomly allocated attention controlled trial of 392 students from two schools showed a small positive effect on depression scores over an 18-month follow-up. The authors recommended further study of the delivery of such programmes by teachers.

In a systematic review of Australian school-based prevention and early intervention programmes for anxiety and depression, Neil and Christensen identified 17 universal programmes of which 10 had been subject to RCT and seven to controlled trial without randomization (Neil & Christensen, 2007). The main focus of programmes was the

development of problem-solving and social skills, assertiveness, relaxation, managing role transitions, perspective-taking and conflict resolution.

The two interventions most strongly supported by evidence were the FRIENDS and the RAP programmes. FRIENDS focuses on problem-solving and positive relationships and is delivered alongside the usual curriculum by teachers following a one-day training workshop. It has been used in several countries and in one trial had positive effects on anxiety up to 24 months post-intervention. RAP (Resourceful Adolescent Program) is also implemented as part of routine classroom activity and focuses on self-esteem, negative cognitive styles, problem-solving and social support.

Although it did reduce depression scores, random allocation was used in only one of the four Australian trials reviewed. However, Merry et al reported in a Cochrane review of 21 methodologically robust psychological and/or educational interventions for the prevention of depression in children and adolescents, that purely educational interventions were ineffective, as were universal psychological interventions (Merry et al 2004).

Whole school approaches

‘Whole school’ is a term that refers to “mobilizing the whole school as an organization, using a complex, multi-component approach, involving a wide range of people, agencies, methods, and levels of intervention.” The most effective programmes “are supported by a school culture, environment and ethos which supports mental health by being, for example, warm, caring, respectful, ordered, inclusive, participative, creative and positive¹¹.”

The move towards whole school approaches to mental health promotion as a contribution to suicide prevention was based partly on a lack of evidence of effectiveness of universal classroom-based programmes and limited evidence on indicative programmes (Beautrais, 1998; Kalafat, 2003).

This approach is an alternative to explicit school-based suicide prevention programmes. Whole school approaches usually include a universal component which may or may not include elements focusing on suicide, and also aim to promote protective factors, that is, personal and environmental characteristics that moderate the occurrence of problem behaviours even in students who may have a variety of risk factors (Kalafat, 2003), as well as to reduce risk factors. They may also include screening and selective/indicated components. The WHO has endorsed school-based universal mental health promotion as a component of effective suicide prevention for young people (World Health Organisation, 1999).

While a number of whole school approaches have been developed, most have not been subject to rigorous evaluation. In this review only those that have been rigorously evaluated have been described.

Theoretical support for programmes that promote generic protective factors as a means of moderating suicidal behaviours among young people is provided by promising evidence from programmes addressing other problem behaviours.

Such programmes are likely to include components designed to:

¹¹ Excerpt from European Commission DataPrev website, www.dataprevproject.net/Educational_Settings

- increase awareness of mental health issues among students;
- destigmatise mental illness;
- encourage students to recognise mental health problems in themselves and their friends, and to facilitate processes for appropriate help-seeking for themselves and peers; and
- teach self-awareness, coping skills, social skills and problem-solving skills (Beautrais 1998).

There is some longitudinal evidence that whole school approaches to mental health programmes to promote such protective factors can moderate the appearance of a number of risk factors, such as substance abuse, delinquency, and violent behaviours (Elias, Gara, Schuyler, Branden-Muller, & Sayette, 1991; Hawkins, Catalano, Kosterman, Abbott, & Hill, 1991; LaFromboise & Howard-Pitney, 1995; Lonczak, Abbott, Hawkins, Kosterman, & Catalano, 2002). Additionally, there is some evidence for an association between protective factors such as connection with school and pro-social norms and reduced suicidal thoughts and plans (Bennett, Coggan, & Dickinson, 2002; McBride et al., 1995).

Furthermore, because of the co-morbidity of and shared risk factors between suicide and other problem behaviours such as substance abuse and problem solving deficits, programmes that promote protective factors may also moderate suicidal behaviours (Gould & Kramer, 2001).

Whole school models that promote protective factors as well as reduce risk factors are clearly **congruent with schools' socialization** and protective missions and represent an efficient use of school resources. However such interventions alone may not be sufficient to address the mediators of suicidal behaviours (Kalafat, 2003).

While non-specific activities may have many demonstrable positive outcomes, showing an association with reduction in suicides is difficult.

Examples of researched whole school approaches

The universal classroom-based programme developed by Ciffone (1993) and described earlier, has evolved to include some aspects of a whole-school approach, although its focus remains explicitly on suicide (Ciffone et al, 2007). It includes written materials for all staff of the school, the orientation for new students with the social worker, an easy straightforward process for students to access the social worker throughout the academic year, compulsory structured classroom discussions on mental health, mental illness and suicide, follow-up screening and intervention for at-risk students, and a postvention process to be used, should there be a suicide at the school. The emotional tone of the classroom-based work is minimized through the use of a quiz style process, where information about suicide is conveyed as 'facts', i.e. **there can be a right and wrong answer** to the quiz questions.

The positive results from the initial study were replicated: course participants developed more desirable attitudes to suicide and help-seeking behaviours.

However, from a programme evaluation point of view there were similar limitations to the report of the first study, i.e. the intervention components were poorly described, outcomes were not standardized measures but simple self-report on a small number of questions, the outcomes were not proximal to the true outcome of interest (i.e. suicidal behaviours) and there was no information about fidelity of implementation.

The Miami-Dade County suicide prevention programme (Zenere & Lazarus, 2009) is a whole school programme that has been running for eighteen years. It is to date the only evaluation examining the true outcomes of interest, suicide and attempted suicide, in a before-after design.

The programme consists of:

- a series of classroom-based lessons on life-skills development, aimed at building protective characteristics among students;
- a study unit on warning signs of suicide in self and others;
- **a student unit and campus posters on being a ‘good samaritan’ and seeking help for peers they recognize as at-risk;**
- annual training for all staff focusing on recognizing warning signs and risk factors, with an emphasis on the association between mental illness and suicide;
- specific training for school psychologists and social workers on suicide risk assessment, the process for contacting parents, referral to other agencies, and postvention;
- **a process for teachers to regularly review all students’ academic and social progress to identify those who may be at risk, with students referred to the counsellor for further assessment;**
- maintenance of strong connections for smooth referral to local agencies and services outside the school;
- a clear documented process to manage imminent risk, including advice on close supervision of the student;
- a clear process for re-integrating the student back into school following any absence for treatment.

Clearly, this is a comprehensive suicide-focused programme, containing all the elements of a strong school-wide intervention (King, 2001; Kalafat, 2003; Mazza & Reynolds, 2008). Data on student suicides in the county since 1980 have been collected, and pre-intervention and post-intervention periods compared for suicide rates.

Prior to the intervention, the mean annual rate was 5.5/100,000 whereas after the intervention began, it was 1.4/100,000 over the eighteen-year period, with a steady decline throughout. This difference was statistically significant.

Suicide attempts also declined over the eighteen years of the intervention, although this data is less reliable and will represent an undercount due to under-reporting. Because this is not an experimental design, the results can only be regarded as highly promising.

The intervention with the Zumi Native American people (LaFramboise and Howard-Pitney 1995) described earlier demonstrated that the link between non-specific mental health promotion and mental health literacy related to depression and suicide may be more than theoretical. More recently, in a detailed account of the development and implementation of the intervention, the lead investigator has argued that one of the keys to success is the adoption of a skills enhancement approach to modify the risk factors for suicide (LaFromboise & Hayes, 2008). Her view is that although this strategy is used widely in other adolescent prevention programmes, it has been under-used in school suicide prevention programmes. It is noteworthy

that each component of the skills-based programme was carefully selected on the basis of peer-reviewed evidence of effectiveness, prior to consultation with the Zumi people regarding adaptation to ensure relevance and face validity with them.

The Gatehouse Project (Patton et al., 2000) is an example of a well evaluated whole-school approach to mental health promotion. The conceptual framework of the Gatehouse Project emphasizes healthy attachments with peers and teachers via the promotion of a sense of security and trust, communication, and a sense of positive self-regard based on participation in many aspects of school life. The project incorporates the following components: 1) a profile of school social climate; 2) the identification of priorities for change; 3) the development of interventions which focus on the promotion of positive social climate within the school; and 4) curriculum-based health education.

As endorsed by Eggart et al (1995), the Gatehouse Project promotes linkage between the school and the broader community with an emphasis on the needs of young people at high risk of school drop-out.

While there were encouraging differences between intervention and control groups for health risk behaviours such as alcohol and tobacco use, there were no differences in depressive symptoms and social relationships (Bond et al 2004).

The Australian Beyondblue schools intervention programme was delivered and evaluated between 2003 and 2005, but was not reported in time for the Neil and Christensen review. The intervention consisted of a community forum, a classroom curriculum, a programme to improve the quality of support in the school and a programme to improve the service pathways for adolescents who need additional help or educational support. There was no difference in depressive symptoms between the intervention and control groups over the three years of the programme.

MindMatters also provides a framework for mental health promotion in Australian secondary schools (Wyn, Cahill, Holdsworth, Rowling, & Carson, 2000). It has been running Australia-wide since a successful pilot in 1997-98 (Ainly, Withers, Underwood & Frigo, 2006). Programme objectives are to facilitate exemplary practice in the promotion of whole-school approaches to mental health promotion; develop a mental health education resources curriculum as well as professional development programmes which are appropriate to a wide range of schools, students and learning areas; trial guidelines on mental health and suicide prevention; and encourage the development of partnerships between schools, parents and community support agencies to promote the wellbeing of young people (Wyn et al., 2000). Evaluation findings indicated that only four of the 24 schools who participated in the MindMatters pilot project reported any uptake of the curriculum component on the issue of suicide (MindMatters Evaluation Consortium, 2000). After a decade of experience in evaluating MindMatters, Rowling (2009) identified two key educational areas, leadership and professional learning, that are requirements of successful mental health promotion in schools.

Overall, both teacher and student response to this unit ranged from neutral to positive for each of the four schools. While the majority of participating pilot schools recognised the importance of including a unit of work on suicide in any project addressing mental health, schools were generally reluctant to take any action in this area.

One of the issues of concern for schools was how best to address the issue of suicide with students. Schools with established religious education programmes considered that they were already addressing the issue of suicide through this structure. Overall, most schools requested further direction and professional staff development before considering further, or any, implementation of this work.

In New Zealand, the Mentally Healthy Schools (MHS) initiative was designed to operate in conjunction with the New Zealand Health and Physical Education curriculum, and utilize a whole-school approach to promote positive mental health, thereby encouraging policies and practices to support good mental health within the school environment (Bennett, Coggan, & Dickinson, 2002).

A process evaluation indicated that the strengths of the MHS initiative included: the clarity of essential and desirable criteria to guide schools in their participation in the initiative; the interrelationships between the initiative, the Mental Health Matters curriculum resource and the National Health and Physical Education curriculum; activities that enabled schools to focus on the mental health needs of their staff and students; activities that encouraged and facilitated empowerment; and support for activities that enabled the review of school policies that impacted on the mental health and wellbeing of students and staff (Bennett, Coggan, & Dickinson, 2002).

Impact evaluation findings demonstrated that participation in the MHS initiative enabled schools to undertake changes to school policies and practices. For example, school policies including suicide postvention, violence, and harassment policies and procedures were developed and reviewed (Bennett, Coggan, & Dickinson, 2002). However, follow-up findings from a student survey indicated that there was a negligible ‘trickle-down’ effect of initiative activities in a way which supported the mental health status and wellbeing of students.

Importance of the integrity of whole school programmes

Whole school approaches to suicide prevention appear promising. However, it is important that all elements are delivered and so the integrity of the programme is maintained. If elements are ‘picked off to be delivered outside an overall comprehensive strategy, schools risk defaulting to unplanned, unsupported combinations of classroom-based and screening/selective/indicated interventions that have not been researched.

An important component of a whole school approach is gatekeeper training, which aims to prevent suicidal behaviours by improving the knowledge and awareness of teachers and other adults about issues of youth suicide (Gould et al., 2003). The purpose of gatekeeper training is to develop the knowledge, attitudes and skills to identify students at risk, determine the levels of risk, and make referrals where necessary (Garland & Zigler, 1993; Kalafat & Elias, 1995).

Research examining the effectiveness of gatekeeper training is encouraging. Significant improvements in school personnel’s knowledge, attitudes, intervention skills, preparation for coping with a crisis and general satisfaction with training have been reported (Garland & Zigler, 1993; Gould et al., 2003; Shaffer et al., 1988). Gatekeeper training programmes are acceptable to indigenous communities as a means of preventing youth suicide (Capp et al., 2001).

Gatekeeper training has the best chance of success if the ‘gatekeepers’ can be certain that the processes for referral are robust and reliable. However, engaging teachers as gatekeepers can be

challenging, as staff can be highly ambivalent about being involved with at-risk students (Hamrick et al, 2004; Scouller & Smith, 2002).

The identification and referral of vulnerable young people to appropriate support is therefore also critical (Kalafat, 2003). As stated earlier, the guidance network concept (including extensions into the community) is a unique and powerful feature of New Zealand secondary schools. In terms of prevention, recognition of risk and response, it is as significant, if not, arguably, more significant, than curriculum and structured programmes are likely to be.

Although guidance in schools literature, in the New Zealand context in particular, is relatively limited, it is essential to take this dynamic in schools into account.

These review findings suggest that screening instruments for the identification of young people at risk of suicide should not be used in New Zealand schools except as part of comprehensive whole-school approaches which are being subjected to external evaluation. Rather, it is suggested that all teachers, and to a lesser extent other school staff, receive initial training and then ongoing awareness training of common signs which should give rise to concern about a young person and consideration of a referral to a counsellor. The development and enhancement of whole school approaches should include careful attention to the development and maintenance of strong relationships with named staff in local services outside the school, such as Child and Family Mental Health Services.

Peer support

The rationale supporting peer support programmes is congruent with that of suicide awareness programmes: suicidal young people are potentially more likely to confide in a friend than an adult (Kalafat & Elias, 1994). Peer support programmes have a range of roles for peers, ranging from listening and reporting warning signs of suicidal behaviours to counseling responsibility (Gould et al., 2003). While peer support programmes address a range of serious mental health issues, it has been reported that one-quarter involve some suicide prevention role (Lewis & Lewis, 1996).

To date there is an insufficient body of evidence supporting the efficacy or safety of peer support programmes in suicide prevention, despite their widespread use (Gould et al., 2003; Lewis & Lewis, 1996). Therefore the use of peer support programmes as part of the whole-school approach to suicide prevention is not endorsed.

Evaluations of peer support programmes are limited and are often confined to student satisfaction measures (Lewis & Lewis, 1996; Morey et al., 1993). It is particularly concerning that the potential negative side effects of peer support programmes are rarely examined (Gould et al., 2003). In particular, peer-group interventions which aim to harness the power of peer influence to support young people's commitment to pro-social behaviours, are increasingly associated with concern. Dishion and colleagues report that high-risk youth may be particularly vulnerable to the iatrogenic effects of peer-group interventions (Dishion et al., 1999). Findings of particular concern are those which suggest that the unplanned, incidental interactions among high-risk young people may be more powerful in shaping future behaviours than those interactions engineered by an intervention (for example, group exercises or social skills role plays) (Dishion et al., 2001). Therefore caution is required in relation to the safety and efficacy of peer support programmes, as emerging evidence suggests that they may increase the vulnerability of troubled young people.

Reflections on the state of the evidence

An overall appraisal of the evidence is based on the quality of existing studies, and the contextual and methodological challenges that restrict the use of very robust designs. For example, studies may be forced into weak randomisation processes, blinding of outcome observers may be impossible, and control groups may be contaminated (Burns & Patton, 2000). Furthermore, for a statistically rare outcome such as suicide, it is hugely challenging to resource the studies required to establish whether certain exposures (suicide prevention programmes) are protective, as very large numbers and long follow-up periods are required (Brown et al, 2007). **For example, it has been estimated that “to prove that an intervention results in a 15% reduction in the national (Australian) suicide rate, a study sample of almost 13 million people would be required” (Zoellner, 2009).** As these prevention activities are not single clinical interventions undertaken with individuals, as with a traditional RCT, evaluation of the implementation and suitability for dissemination is also critical, and this is commonly neglected in research reports.

Interestingly, in the case of interventions for adolescent antisocial behaviour, an individual-level risk factor for adolescent suicide, these aspects are relatively better described than for interventions for affective disorders and non-fatal suicidal behaviours (Burns & Patton). Finally, there has been a tendency for people to develop their own programmes rather than to further test existing ones that have shown promise.

Effectively this means that it is necessary to move beyond the traditional trial paradigm (Goldney, 1998), and many studies described in this paper have done this, for example, by studying high-risk populations that have higher suicide rates than the general population, or by using surrogate outcomes as study endpoints, which is the case in all the studies reported here. One of the weaknesses of the research to date, however, relates to this use of surrogate outcomes. If suicidal behaviours are understood as being on a continuum, it can be seen that many of these studies use outcomes that are distant from the real outcome of interest, such as attitudes to suicidal behaviours or to help-seeking. Studies using markers of clinical state are closer to the real outcome, and those using actual self-harm are closer still. Although it is possible to show an effect on the surrogate outcome, there may be a more muted effect on the real outcome i.e. suicide rates. Interventions very distal from the outcome of interest are those most likely to be applied to large numbers of people, including those at lower risk, and because of this it is critical that potential harmful effects are proactively monitored. Other approaches could be taken to augment our knowledge, such as using wait-list trial designs or pooling participants from multiple trials in long-term follow up studies (Brown et al, 2007).

Unfortunately, in New Zealand at present, as has been the case in Australia in the past (Burns & Patton), there is limited capacity to provide information and practical support to agencies wanting to adapt and rigorously test promising interventions.

External providers of school suicide prevention programmes¹²

There are a number of externally-provided broader-based programmes provided to New Zealand schools, which could be considered suicide prevention activities, including (for

¹² From Bennett et al, 2003

example) peer support programmes, anti-stigma programmes, bullying prevention, parenting programmes and drug and alcohol programmes.

However, some programmes which focus on reducing suicidal behaviour among young people may have unintended negative consequences. Consequently, it is imperative to err on the side of caution when considering the suitability of externally provided student-focused school-based suicide prevention programmes. The consequences of not doing so are potentially life-threatening for vulnerable young people. *At a minimum, school-based suicide prevention programmes must do no harm.* This principle is congruent with the need, as stated by the National Administrative Guidelines 5(i), for school Boards of Trustees to provide a safe emotional environment.

Any evidence that potential harm may result from a particular programme, including those above, is powerful evidence that such programmes should not be implemented in school settings. Criteria have been developed against which schools can assess providers of suicide prevention programmes which are being proposed for school settings and involve students. These criteria are listed in Appendix Two. However it is strongly suggested that no suicide awareness/suicide education programmes be delivered in school settings to students until there is sufficient evidence to demonstrate their effectiveness and safety.

5. Recognition, assessment and management of at-risk students¹³

As indicated previously, schools need to develop and maintain clear protocols, a climate that ensures that young people will feel comfortable discussing their personal concerns with teachers and counsellors, and a quality improvement approach that involves regular review and update of policies and procedures. This ideally requires:

- clear, up-to-date information available to all staff
- clear lines of communication and processes for staff to refer young people
- a supportive climate and systems whereby young people can easily access the counsellor either on their own or on behalf of others they are concerned about
- annual review of procedures and documentation, and annual staff training refreshers
- external independent evaluation of suicide prevention programmes, especially if they are not based on the most robust existing evidence
- strong links with relevant services external to the school.

Recognition of young people at risk of suicide

Schools have an important role in the recognition of young people at risk of suicide and in subsequent intervention and management. Educators and other school staff can learn to recognise the warning signs of suicidal behaviour. By improving staff ability to identify at-risk students, schools will be able to refer young people at risk of self-harm to appropriate support or treatment services. Adolescent suicidal behaviour requires immediate preventive efforts.

The success of school suicide prevention efforts will depend on three elements being present.

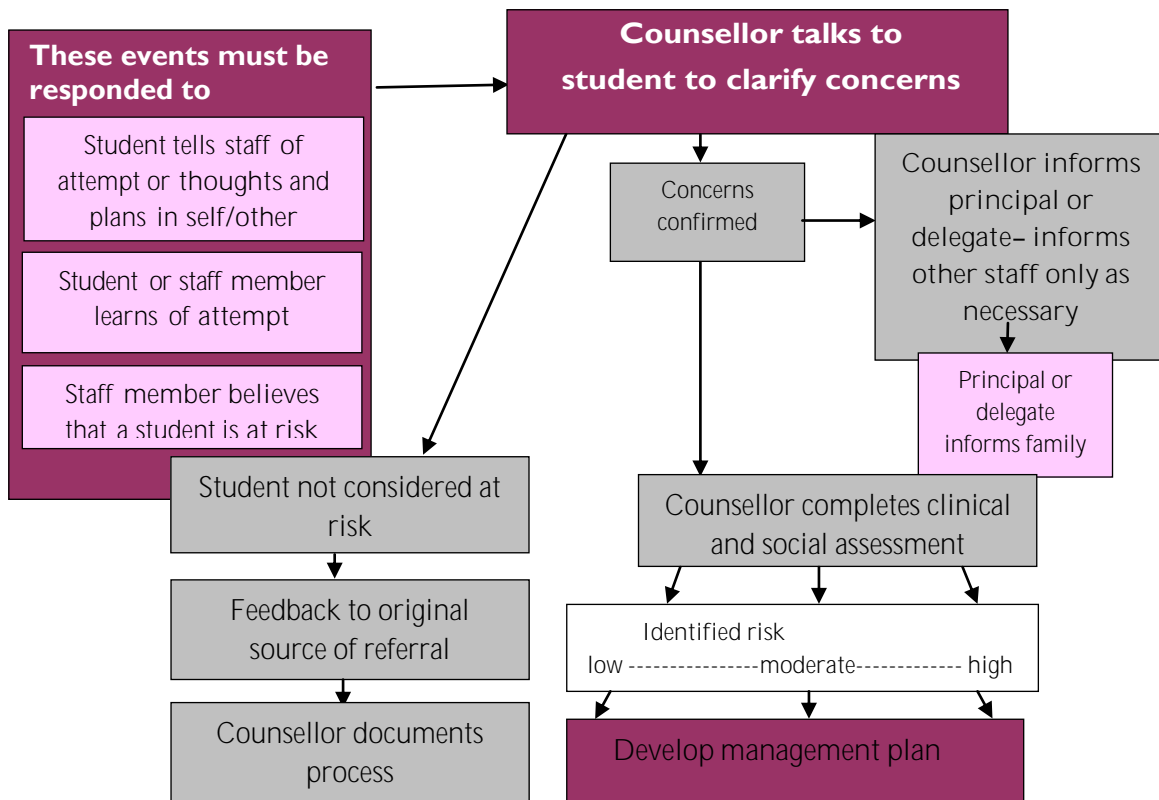
1. Firstly, there must be a clear process for all staff to follow.
2. Secondly, staff must know what this is, understand their role in it and have the required competencies. For this to be achieved and maintained, there needs to be regular training and review.
3. Finally, staff must work together and at times with external agencies to ensure that barriers to young people receiving timely support and treatment are minimized. This requires supportive and collegial relationships between the professionals, where the needs of the young person are seen as paramount.

It is recommended that schools develop, adopt and regularly review a clear and documented process to detect young people who are emotionally distressed and consequently may be at risk of suicidal behaviour.

The figure below outlines such a process.

¹³ Updated from Beautrais, Coggan, Fergusson & Rivers. 1997. Prevention, recognition and management of young people at risk of suicide: development of guidelines for schools-Chapters 4, 5 and 6.

Figure 1: An overview of the processes of recognition, intervention, assessment and management of young people at risk of suicide



The importance of regular training and review

The responsibility for detecting young people who are experiencing emotional distress and are possibly at risk of suicide lies with ALL school staff and is an important part of ensuring that all young people achieve their potential within the school programme. Ideally, all staff should receive regular training (with in-school refresher training at least every year) to increase staff members’

- knowledge of the symptoms of psychosocial distress, depression and risk of suicide
- confidence and competence to refer and support distressed young people
- comfort with working with these situations.

The utility of any guideline or policy is entirely dependent on staff being familiar with it and competent and confident in their roles in relation to it. Because suicide in any single school is likely to be a rare event, it is critical that the introduction of a new policy or guideline is not seen as a one-off event but as the establishment of an ongoing process of working towards suicide prevention in the school.

Staff identification of at-risk students

There are several ways in which teaching or other staff may hear of suicidal behaviour or become aware of young people who are emotionally distressed and could be at risk of suicide. The staff member may become aware of changes in the young person which are not characteristic of them or which show an interest in issues of death, suicide or similar. Other

students may learn of a fellow student's intentions to harm him/herself, report this to a teacher or other staff member, specifically or in a more general and guarded manner. Finally, the young person may share his/her thoughts about suicide with the staff member, directly or obliquely.

It is important that all concerns are responded to. Once a staff member becomes aware of a concern, he/she *must* refer to the counsellor or other designated person, *no matter how uncertain they are of the seriousness of the risk*. Counsellors may well be familiar with the young person or can check with another staff member (such as a form teacher or Dean) to verify the concern and learn more about its context. The concerned staff member should continue to support the young person especially while the referral to the counsellor is being arranged.

Once a young person has been referred, the counsellor will assess them as soon as is practicable. The early part of the assessment will be a process of exploration directed at engaging, supporting and showing acceptance towards the student. Building rapport and encouraging the student to discuss problems and express feelings are also a part of this phase (Ramsay et al, 1994). Next, a process of gaining understanding of the student and their situation involves general and specific inquiry and evaluation of the information offered. By evaluating the **student's** mental state, resources and strengths and the nature of the crisis, the level of risk can be determined.

The counsellor will clinically assess the student to clarify concerns, gain an understanding of the context, and assess the risk of the young person harming themselves or attempting suicide. As part of the assessment, it is recommended that the counsellor uses a simple suicide risk checklist (see page 50). The advantage of using a checklist is that it ensures that no domain of potential concern is overlooked, and the different contributors to risk are documented.

If the counsellor considers the young person to be at risk of suicide, the primary goal is to maintain his or her safety. The next step is to decide whether the principal or other designated staff member should be informed. From there, the principal, in liaison with the counsellor, must decide if, when and to what extent, any other staff should be informed.

The same decision must be considered for the parents or guardians. The person who originated the referral should also be informed of the outcome of the assessment, given feedback on their initial observations and encouraged to support the young person.

The evidence for and against the use of whole-school screening programmes in New Zealand schools was discussed in Section 5. The best practice for the current New Zealand school setting is to use warning signs in combination with educated subjective **judgement** (O'Carroll, et al, 1992; Rivers, 1995, Suicide Prevention Australia: Train the Trainers Manual, 1995; Silbert and Barry 1993; Ministry of Education, 1993). Currently identified risk factors/warning signs can provide early indications of troubled adolescents whom counsellors and other school staff can monitor. Informed school personnel can combine such information with other data to identify possible suicidal adolescents for further assessment by trained mental health professionals. These other data include warning signs that an adolescent is troubled, such as significant changes in relation to the four dimensions of happiness, progress, behaviour and friendships (Rivers, 1995). An alternative is to assess students across the four indicator areas of school behaviour, personal behaviour, parent/family/whanau indicators and interpersonal/peer indicators (Silbert and Berry, 1993).

It is possible to support this with processes that make use of routinely collected information to systematically create a profile of students who may be at increased risk. For example, a crisis intervention programme in Dade County, Florida, used computer software to compile easily available school performance data in order to identify students who may need special attention. Every nine weeks a “**Student Intervention Profile**” was created, consisting of seven elements based on grades, attendance, tardiness, and classroom behaviour.

When a student profile changed in three or more areas, a message was generated that the student may need help, and a counsellor would have a private meeting with the individual (O’Carroll, et al, 1992). The benefit of a process such as this is that it can monitor the changing potential risk profile.

Specific precipitating events have long been known to commonly occur prior to a suicide attempt or completion (Beautrais, 1996; Shaffer, et al, 1988). Examples include a break up with a girlfriend or boyfriend, problems with the police or a humiliating event. This knowledge underpins the importance of ensuring that all adult school personnel (administration and teaching) enhance their ability to identify and respond to imminent suicidal behaviour among potentially at-risk adolescents.

The *New Zealand Guidelines for Identification of Common Mental Disorders and Management of Depression in Primary Care* (New Zealand Guidelines Group, 2008) recommend that routine screening of young people in schools is not undertaken at present, but noted that the evidence suggests it is worth investing in further research. This review recommends that screening instruments for the identification of young people at risk of suicide should NOT be used in New Zealand schools except as part of comprehensive whole-school approaches which are being subjected to external evaluation.

However, if staff are equipped with appropriate knowledge and skills, the staff culture is one of vigilance, and this is reinforced with regular training, a number of potentially at-risk students could be identified. Regular teacher training in simple suicide prevention awareness has the potential to increase the likelihood that teachers will respond proactively to concerns they may have about students (Davidson and Range 1999; King et al 1999). Furthermore, it is possible for schools to institutionalize suicide prevention activities and maintain them over a number of years if a number of steps are taken, such as designating a named person as responsible for programme implementation (and resourcing this), ensuring ongoing consultation and support **opportunities for staff involved in ‘championing’ the programme, and creating policies and structures that support its maintenance** (Kalafat and Ryerson, 1999).

The checklist below is an update of that devised by Beautrais et al for the 1997 School Guidelines. It aims to be a pragmatic and acceptable approach that can be used by teachers, although it is recommended that counsellors use more structured clinical assessments.

Note that the significance of these risk factors may be accentuated in young people who lack parental warmth; if, for example their parents appear uninvolved, unsupportive and demonstrate denial of the student’s problems. They may appear angry, threatened and defensive or there is evidence of a long history of home problems, such as physical and/or sexual abuse (Beautrais et al, 1997). It is recommended that staff use the following checklist of risk factors to identify **clinically significant changes in students’ thinking, emotions, behaviour and circumstances.**

Checklist of risk factors

Persistent change in mood - *withdrawal, tearfulness, and remarks which indicate profound unhappiness, or helplessness. Anger at self, increased irritability, moodiness and aggressiveness. Lack of interest in surroundings and activities and marked emotional instability.*

Profound hopelessness - *a sense that the young person sees no future for themselves, there is no plan of activities or goals (even short term) or expectation of a future to look forward to.*

Physical symptoms with emotional cause - *eating disturbances or chronic physical complaints such as headaches, stomach aches, fatigue, body aches, scratching or marking of the body, or other self-destructive acts. Reduced personal hygiene and self-care.*

Ideas and themes of depression, death and suicide - *reading selections, written essays, conversation, and artwork contain themes of depression, death and suicide. Statements or suggestions that he/she would not be missed if they were gone. Appears to collect and discuss information on suicide methods. Begins giving away prized possessions (possibly with some elevation in mood) and has demonstrated previous direct or indirect suicide threats or attempts.*

Unexpected reduction of academic performance - *unusual failure to complete assignments, apathetic in class, has recently received a much lower than expected grade, extremely disappointed at being rejected for a course or demonstrates abrupt changes in attendance, such as increased absences, tardiness, or truancy.*

Withdrawal from relationships - *change in relationships with friends and classmates. Loses interest in extracurricular activities and may drop out of sports and clubs. Begins to spend long periods of time alone.*

Grief about a significant loss - *stress due to the recent disintegration of their family/whanau or has had a recent death or suicide in the family/whanau or has recently lost a friend through death or suicide or a break-up with boyfriend or girlfriend.*

High-risk behaviours - *increased use of alcohol and drugs to the point of intoxication; other risky behaviours (e.g. dangerous driving, playing with guns).*

Once a member of the school staff has identified a student whom they consider to have a number of these issues, especially if they are distressed and there is some risk (no matter how small) that they may harm themselves, then the staff member must make a referral to the counsellor or other designated person for further assessment. The staff member should continue to support the young person especially while the referral is being arranged.

Assessment by the counsellor

Ideally, all schools should have access to qualified, competent and externally supervised counsellors who assume responsibility for the assessment and management of all at-risk young

people in the school. The counsellor will assess the risk of self-harm or suicide and inform the principal as appropriate (the amount of information will depend on the degree of risk).

When any young person is identified as being at risk of suicide, the first concern must be for their immediate safety. If they are at very high risk they should be in a safe environment where they are closely and continually supervised by responsible adults over the next few hours, until specialist assessment is undertaken and a management plan devised. During this period it is important to remove lethal weapons, pills and poisons from the young person's environment and to prevent ready access to these. The development/maintenance of a good relationship between the counsellor or other supervising adults and the young person is also important for safety in the short term. **The key people in the young person's social network are also important** – they should be encouraged to be supportive while continuing with their usual activities.

In-depth assessment of the degree of risk of suicide by a counsellor or other specialist should begin as soon as is practical. The counsellor or other specialist should assess in detail the domains outlined above, and also pay particular attention to the extent and history of other psychological symptoms, family/whanau history, and the social and support context (e.g. availability of caring relationships, services that are involved) of the young person both within and outside the school.

In some situations where risk is low, there may be advantages in the counsellor taking more time to complete a thorough assessment of the young person to determine their underlying mood state, which may differ from the level of distress at the time of presentation. However this decision is best made by a person with sufficient knowledge and skills to do the in-depth assessment, should this be required. For example, a teacher may have initial concerns about a **student's risk, but after discussion with the counsellor it is determined that it is acceptable to wait a few days until a full appointment slot is available in the counsellor's schedule.**

However, if there is serious suicidal intent or risk is considered high for other reasons (for instance intent is low to moderate but the person is psychotic or there is severe self-neglect), the young person should be immediately (i.e. with a response expected on the same day) referred to secondary care mental health services (New Zealand Guidelines Group, 2008).

Suicide risk assessment for young people can be challenging even for experts. This is because young people may not communicate their thoughts about suicide directly, even if asked (Fawcett et al, 1990), and because most people with suicidal thoughts and even plans are ambivalent about dying. Furthermore, although the contextual factors that contribute to risk may be relatively stable, the thoughts, emotions and impulses about suicide as a response to problems typically fluctuates markedly, and this can occur over short periods of time, especially in young people.

These issues mean that while it is important to ask young people directly about their suicidal thinking, it is also important to speak with relatives and other appropriate people. This is because young people commonly make indirect references to their suicidality, especially to relatives and friends. In one report, 68-86 per cent made such references (Jamison, 1986). While it is desirable to obtain the permission of the young person, if they are over 16 years old, if there is a serious and imminent threat to the life or health of the individual, this is not essential (refer to Rule 11(2d) Health Information Privacy Code 1994).

The fluctuating nature of suicidality means that close monitoring of risk is required, especially when it has been high. Even a brief period of serious suicidal intent indicates a need for immediate referral to secondary mental health services (National Institute for Health and Clinical Excellence, 2005).

Asking young people about thoughts of suicide does not precipitate suicide attempts (Gould et al, 2005). The ambivalence about dying means that many people who are thinking about suicide are relieved to be invited to talk about it. However, it is usually most appropriate to enquire about current suicidal ideas in a series of questions that arise naturally from a more general assessment interview, rather than abruptly and directly asking about suicide. This approach means that rapport and the beginnings of a therapeutic alliance can be established. As mentioned earlier, this in itself can contribute to risk reduction and is important for effective **management planning. The person's ambivalence about dying provides an opportunity to use the underlying core commitment to life as the basis for building a therapeutic relationship.**

Counsellors and other clinical experts have the option of using structured assessment scales along with general clinical assessment to determine suicide risk. It is common practice to embed a brief structured scale into a more extensive assessment. Using a risk assessment scale on its own is not appropriate in a clinical situation where there is a need to establish a relationship of trust and a therapeutic alliance. Such use of a scale would also not provide sufficient information for the development of a management plan. The use of structured scales remains a supplement to clinical judgement (Cantor, 1992; Goldney, 1992).

Suicide risk assessment is based on the identification of risk and protective factors and on considered judgement about warning signs and clinical status. The counsellor needs to combine her/his **'gut feeling'** with more externally verifiable factors in determining if a young person is at minimal, moderate or high risk of self-harm. The risk assessment of young people should be based on multiple sources of information, preferably including the family/whanau and teachers.

Symptoms of suicide risk

Systematic consideration of the following factors, adapted from Edwards and Pfaff (1997), will help counsellors determine a young person's current level of risk:

Hopelessness.

This is the single most powerful predictor of suicidal behaviour. Individuals can endure a great deal of discomfort if they believe their circumstances will improve. However, if this hope diminishes, so may commitment to life. A pessimistic outlook is a key risk factor for suicide in psychologically distressed young people (Beck et al, 1985; Beautrais et al, 1996; Edwards and Pfaff, 1997).

Suicide plan and access to means.

The more detailed and feasible the plan, the ready availability of the means, the more lethal the method, and the less likelihood of discovery, the greater is the risk. Young people who die by suicide usually use highly lethal methods (Coggan et al, 1995) but detailed planning is unusual in this age group, so absence of a plan does not mean risk is low.

Thoughts, beliefs and feelings.

Suicidal thoughts and plans can range from non-specific, fleeting thoughts of death, through well-organised plans to end one's life, to psychotic command hallucinations to kill oneself. The counsellor must consider both the frequency and intensity of these thoughts (Edwards and Pfaff, 1997). When a young person expresses disappointment at having survived a previous suicide attempt, does not think there have been any positive changes in their life since the previous attempt, and believes the method used was potentially highly lethal, the current level of risk is increased.

People suffering from depression experience changes in their thoughts and feelings, including difficulties in making decisions, and feelings of guilt, dejection, sadness, worthlessness and hopelessness. They may also worry and be concerned about imminent danger or difficulty and be in a prolonged state of uneasiness. Suicidal thinking is often associated with mental disorders such as depression. In young people, changes in thinking and feelings may be unstable, so a brief period of improvement on a background of being troubled does not necessarily mean all is well. Furthermore, persistent irritability and frustration are important indicators of depression in young people, for both boys and girls (Crowe et al, 2006; Michaud et al, 2005).

Physical symptoms.

Young people with severe depression may also experience changes to their appetite, and energy and loss of interest in activities they formerly enjoyed.

Disturbance of sleep and loss of concentration can also occur and are more commonly experienced by boys (Crowe et al, 2006). They may experience bodily complaints such as frequent headaches, muscle tension, abdominal pain or restlessness.

Previous attempts or threats of suicide.

The most accurate predictor of a future suicide is a prior attempt. The view that self-harm and suicide attempts can be considered as 'gestures' that are manipulative or attention-seeking is outdated. Up to 75 per cent of completed youth suicides are preceded by previous attempts. Where an earlier attempt was in the previous 12 months, risk is increased. Prior use of methods other than drug ingestion or superficial cutting also increases risk (Brent et al, 1993; Salkovskis et al, 1990).

Stressors and social context.

In addition to being strongly associated with mental health problems, suicidal behaviours among young people are commonly associated with social or educational disadvantage or unhappy family/whanau backgrounds and/or a recent stressful life event such as relationship breakup, problem with the police, or family/whanau crisis or bereavement (Beautrais, 2000). Young people who attempt or complete suicide are more likely to have weak social networks, with significantly fewer close friends in the year preceding death. The presence of a strong social support system can act as a protective factor after negative life events by helping a young person feel needed and understood.

Young people struggling with issues about sexual identity may also be at greater risk (Fergusson et al, 1999; McDaniel et al, 2001), as are those who have experienced a suicide in the family/whanau or social network.

Substance misuse.

Up to 70 per cent of adolescent suicides occur in the context of alcohol or drug use. Therefore the young person's history of alcohol and drug use should be part of every suicide risk assessment. Substance use disrupts relationships, increases social isolation, and leads to increasingly impulsive behaviour. Young people with a history of substance misuse and impulsive behaviour should be considered at higher risk.

Use of checklists as part of clinical assessment

It is not possible to precisely quantify risk of suicide in an individual. This is quite a different exercise to identifying potentially high-risk people in a population. When dealing with an individual, brief screening tools cannot substitute for in-depth assessment. Indeed, even a full risk assessment does not substitute for a thorough clinical and social assessment. To arrive at an assessment of risk, it is crucial that an expert who is experienced in communicating with and treating young people with mental health problems considers all the domains listed above.

These domains **must be considered alongside a full appreciation of the young person's mental state, personal story and circumstances** (Goldney and Spence, 1987). Checklists can be useful to ensure that all the relevant domains are considered, and potential risk is evaluated in a systematic way, but they are only a supplement to thorough assessment. There are several checklists in use (see Appendix 4). Note that there are a very few psychometrically robust methods for assessing suicide risk in individuals, such as the Beck Suicide Inventory, but these are generally restricted to use only by certain groups of health professionals, as they require specific scoring strategies and interpretation.

Note that in a clinical interview it is important to follow the flow of information provided by the young person, while also guiding towards and probing for details needed to make a clinical **judgement about risk. There is no single 'right' question, or time in an interview, to elicit any particular piece of information.** The point of a checklist is to ensure that the completed interview covers all domains.

It is important to maintain a calm, validating but neutral stance during a suicide risk assessment. Also note that a skilled risk assessment interview may have relatively few questions focusing on suicide.

Below is a series of example questions and prompts, grouped by domain of interest, elaborated from Beautrais et al, 1997. They could be modified to suit the situation and incorporated into a clinical interview and or/used to gather information for completion of a checklist. Note that these questions are based on clinical expertise and the evidence about risk factors for suicide. This is not a psychometrically tested checklist and it is not a suicide risk screen for populations.

Table 1: Suicide Risk Assessment Questions

WHAT TO ASSESS/CONSIDER	SUGGESTED QUESTIONS
<p>Suicidal thinking</p> <p><i>Consider persistence and intrusiveness of thoughts, ability to distract and think of alternatives</i></p> <p><i>Use direct questions as young person may be reluctant to volunteer information</i></p> <p><i>Direct questioning will not increase the risk</i></p>	<ul style="list-style-type: none"> • Sometimes when people are feeling really stressed and overwhelmed by things, they think that life isn't worth living anymore, or that there is no way to improve things. Have you had thoughts that life isn't worth going on with? Tell me more about these. (Prompt for frequency, duration, recency, triggers) • How easy is it for you to stop thinking about suicide/is it hard to get these thoughts out of your head? (Prompt for self-management of thoughts) • Have you thought about harming yourself? Tell me about that. (Prompt for method, likely setting, duration, recency, triggers) <i>AND</i> is it hard to get these thoughts out of your head? (Prompt for self-management of thoughts) • Have you thought about killing yourself/taking your own life/suicide? (Prompt for recency, duration, triggers, self-management of thoughts) <i>AND</i> is it hard to get these thoughts out of your head? (Prompt for self-management of thoughts).
<p>Suicide plan</p> <p><i>Consider lethality, reversibility, preparation, likelihood of early discovery</i></p> <p><i>Use direct questions as young person may be reluctant to volunteer information</i></p> <p><i>Direct questioning will not increase the risk</i></p>	<ul style="list-style-type: none"> • Have you thought about how you would act on these thoughts/ what would you do to take your own life/do you have a plan? • Tell me about the plan (Prompt for specific method, location, setting, proximity of others and timing; preparation such as purchase of tablets, acquisition of rope, finding key to gun/ammunition cabinet or arrangements for required sequence of events) • How long have you had the plan for? • Have you practiced/rehearsed any parts of the plan?
<p>Intent</p> <p><i>Note if goal to die associated with feelings of guilt or worthlessness, desire to be with someone who has died or to punish/hurt somebody (e.g. 'they'll be sorry')</i></p>	<ul style="list-style-type: none"> • How badly do you want to die? (It can be useful to ask the client to self-rate likelihood of carrying out the plan on a self-assessment ruler)* • Do you think you would actually carry out your plan? (The ruler can be used for this also) • What are your thoughts about staying alive? (Prompt for good reasons for living) • Is there anything that would change your mind? • Is there anyone or anything that would stop you? Tell me more about that • Have you given away any special things or arranged for this to happen? What arrangements have you made? • What do you think the effect on your family/whanau and friends would be if you killed yourself?

<p>Hopelessness</p> <p><i>Very important indicator of risk</i></p>	<ul style="list-style-type: none"> • Do you think things might get better? • What do you see ahead of you in your life? • Once these problems are sorted out, do you think you'll be happier than you are now? • When you think about the future, do you see things being better than they are now? • Have you thought of asking for help? (If not, prompt for why)
<p>Previous attempts</p> <p><i>Note recency of last attempt or self-harm, potential seriousness, reversibility, likelihood of early discovery, extent of planning, nature of triggers, intoxication</i></p>	<ul style="list-style-type: none"> • Have you harmed/hurt yourself in the past? • Tell me more about that. (Prompt for when, details of method) • Have you tried to take your own life before? (Prompt for when, details of method) • Did you plan ahead for it (Prompt for details of location, setting, proximity of others, timing, preparation) • What was going on for you at that time? (Prompt for triggers, context) • Were you drunk or had you taken some other drug at the time of the attempt? • What things were helping keep you safe/stopping you from killing yourself at that time? • Did doing this change the way you felt about living and dying, at the time? Tell me more about that. • What sort of preparations did you make to carry out this plan? • Why did you want to take your own life in the past? • Do you have a detailed plan?
<p>Other behaviours</p>	<ul style="list-style-type: none"> • Tell me about your drinking (i.e. alcohol) (Probe for specific amounts, drinking pattern, context, use to manage feelings/stress) • Tell me about your use of any other drugs (Probe for specific amounts, drinking pattern, context, use to manage feelings/stress) • Do you do things that are risky, like deliberately drive too fast, not use a seatbelt, get into fights, have unsafe sex, other things that could harm you if they went wrong?
<p>Stressors/context</p> <p><i>Empathically acknowledge importance</i></p> <p><i>Note protective factors</i></p>	<ul style="list-style-type: none"> • Who is living at home with you at the moment? (Probe for trusting/difficult relationships, absent family members) • Tell me about your friends. • Is there anyone special in your life at the moment? Tell me about him/her. • Tell me about what has been happening in your life recently? • What's it been like at home/school/in your social life recently? (Prompt for issues: at home – relationships, communication, conflict, a new person in household/family; at school – marks, peer group; violence, bullying; on line relationships, chat rooms, texting, other relationships outside home and school) • What has made you feel so awful? • Tell me about the pressures on you at the moment? • What was the 'last straw' for you? Tell me more about that. • Why do you want to take your own life?

<p>Self-management strategies</p> <p><i>Note extent of ability and willingness to communicate directly about mood, suicidal thoughts and impulses, and to describe inner and social world</i></p> <p><i>Note strengths</i></p>	<ul style="list-style-type: none"> • Tell me about yourself/ how would you describe yourself to someone else/what are you like as a person? • What do you think might help change how you are feeling and thinking? (Probe for actions the client could take) • People have lots of different ways to cope with stress and worry. What have you done in the past to help yourself cope with problems/stresses? (Probe for strategies other than substance use, self-harm/suicide) • In the past, what has stopped you from acting on your suicidal thoughts? • In the past, have you used any strategies to distract yourself from the thoughts about death/self-harm/suicide? Prompt for elaboration • At other times when you have felt this bad/this close to harming/killing yourself, what has stopped you? Why is that? • Have you told anyone else about your thoughts and feelings about hurting yourself/suicide? (Who was that? Why that person? What made that possible/not possible?) • How does talking about this with me make you feel?
<p>External support sources</p> <p><i>Note if family/whanau hostile/exhausted/unavailable</i></p> <p><i>Note positive resources</i></p>	<ul style="list-style-type: none"> • What would make it easier to cope with your problems at the moment? (Probe for reasons) • Who are the most important people in your life at the moment? • Is there anyone who really understands and cares about you and what is happening for you just now? • Who would you like to have with you now? • What would she/he think about you feeling this bad at the moment? • What do you think he/she would do if they knew? • How much can/does this person help you? • Would you be willing to let them help you now? • Who would you like to save you?

*Self-assessment ruler - copy the following onto a piece of paper, and ask the client to put a mark representing where they are currently on the continuum:

Strongly want to live _____ Strongly want to die

Acute or imminent risk and chronic risk

Some young people are impulsive, have difficulty managing their emotional arousal and negative mood states and have few skills for managing the interpersonal difficulties that can result. Suicidal behaviours may become part of their coping repertoire leading to the development of a chronic pattern of suicide and self-harm risk and behaviours (Collings et al, 2003). In addition, young people with this profile may be more likely to develop disorders such as depression and substance misuse, which in turn increase suicide risk. In the school setting it is unwise to differentiate between acute or imminent and chronic suicide risk, unless there has been a recent full assessment by the local Child and Family Mental Health Service, or Youth Early Intervention Service, and the school counsellor is an active participant in a management plan that explicitly includes strategies directed at reducing the chronic risk element. This means

that in the school setting and, without explicit planning to the contrary, any degree of suicide risk should be assumed to be acute or imminent.

Confidentiality

The requirements for confidentiality vary with the age of the student. For students of any age, making promises about maintaining confidentiality is not good practice, as the counsellor may be obliged to break confidentiality if imminent or severe risk becomes apparent.

In the Privacy Act (1993) and the Health Information Privacy Code (1994), people's rights and limits to confidentiality are set out (see <http://www.privacy.org.nz/the-privacy-act-and-codes/>). If a young person aged 16 or over asks about this during the assessment, a response such as:

"I will keep what you say confidential to the school counselling service unless I think you are at serious risk of harm to yourself or other people. If that is the case then I will take steps to protect your safety or that of others. As far as I can, I will discuss this with you before I do anything," will cover the practitioner, should disclosure be necessary to maintain safety.

For students aged 15 or younger, health practitioners are required to exercise discretion, taking into account the developmental age of the student, about disclosing information to parents and guardians. Again, however, the need to maintain safety will over-ride the need to maintain confidentiality.

It is generally in a young person's best interests that appropriate members of the family/whanau are engaged in the management process, so even at the assessment stage it is wise to signal that you would like, if possible, to be able to include them later on.

Suicide risk assessment involves gaining information about a number of domains of interest (both risk factors and warning signs) and then weighing them up in what is essentially a subjective process based on clinical knowledge, skill and experience. Risk can also fluctuate to an important degree, commonly because of fluctuations in warning signs, and in young people such fluctuations can be relatively rapid (e.g. within hours).

For an individual there is no simple linear relationship between the presence of any number of group-level risk factors known to be associated with suicide, and any eventual suicide. The idea of warning signs can help explain this. While risk factors can be considered to be more fixed or historical, warning signs are indicators that a suicidal crisis may be in train, and there may be imminent risk. The presence of a risk factor with strong association with suicide increases the likelihood that a person will at some time experience a suicidal crisis i.e. a constellation of warning signs (Rudd et al, 2006). For instance, even in the apparent absence of other risk factors, if a depressed young person is planning to hang him/herself, then this alone constitutes a serious risk.

Suicide risk moves along a continuum, from almost no risk to very high imminent risk. Risk must be considered as a dynamic phenomenon. The various risk factor domains need to be considered as also lying on continua of low/medium/high, and the appraisal of these, combined with clinical judgement about warning signs, can then be used to designate overall suicide risk, similarly, as low/medium/high. The various risk elements (i.e. risk factors and warning signs) for suicide have been classified into one of three broad categories in Table 2: Assessment of young people at risk of suicide (next page). It is recommended that counsellors use the table to assess the risk of suicide in young people who are referred to them.

Table 2: Assessment of young people at risk of suicide

During the interview with the young person, investigate each of the areas in the column on the left and categorise the response as low, moderate or high risk. In investigating any suicide plan it is important to use direct questions as the young person is likely to be reluctant to volunteer the information. Direct questioning will not aggravate the risk of suicide but failure to fully investigate, evaluate the risk and respond appropriately may result in a suicide that could have been avoided. Finally, on the basis of the young person's responses, determine which of the three risk levels, low, moderate or high, best describe the situation and proceed with the management plan for that level of risk.

AREAS TO CONSIDER	LOW RISK	MODERATE RISK	HIGH RISK
1: Suicidal thinking			
Thoughts	<ul style="list-style-type: none"> Occasional suicidal thoughts 	<ul style="list-style-type: none"> More than one suicidal thought per day 	<ul style="list-style-type: none"> Frequent or persistent suicidal thoughts Suicidal thoughts associated with psychotic symptoms
Intent			<ul style="list-style-type: none"> No reasons for living Nothing would change their mind or stop them Wish to die or not be here very strong
Plan Details Availability of means Time Lethality of method Chance of intervention	<ul style="list-style-type: none"> Vague Not available, will have to get the means No specific time or in the future Pills, slash wrists Others are present most of the time, or highly likely to discover/interrupt 	<ul style="list-style-type: none"> Some specifics Available, has close by Within a few hours Drugs & alcohol, car wreck Others available if called upon 	<ul style="list-style-type: none"> Well thought out; knows when, where, how Has the means in hand Immediately Gun, hanging, jumping, carbon monoxide No one nearby; isolated
Mood state	<ul style="list-style-type: none"> Mildly depressed; feels slightly down 	<ul style="list-style-type: none"> Moderately depressed; some moodiness, sadness, irritability, loneliness and decrease in energy 	<ul style="list-style-type: none"> Overwhelmed with hopelessness, sadness or anger Feelings of worthlessness; self-neglect Extreme mood changes
Hopelessness	<ul style="list-style-type: none"> Has some plan for future 		<ul style="list-style-type: none"> Future bleak and empty

AREAS TO CONSIDER	LOW RISK	MODERATE RISK	HIGH RISK
	<ul style="list-style-type: none"> • Thinks things might possibly get better 		<ul style="list-style-type: none"> • Has conviction that things can never improve
Communication	<ul style="list-style-type: none"> • Direct expression of thoughts and feelings 	<ul style="list-style-type: none"> • Interpersonalised/oblique suicide goal (“They’ll be sorry”, “I’ll show them”, “I don’t deserve to live” or “I want to be with someone who has died”) 	<ul style="list-style-type: none"> • Very indirect or non-verbal expression of internalised suicide goal (guilt, worthlessness)
2: Risk behaviours			
Previous suicide attempt/self-harm	<ul style="list-style-type: none"> • None or one of low lethality 	<ul style="list-style-type: none"> • Multiple of low lethality or one of medium lethality; history of repeated threats 	<ul style="list-style-type: none"> • One of high lethality or multiple of moderate lethality • Several attempts over past weeks, of any lethality
Other risky behaviours	<ul style="list-style-type: none"> • Does not or very rarely engages in risky behaviours 	<ul style="list-style-type: none"> • Occasional risky behaviours in context of occasional substance use 	<ul style="list-style-type: none"> • Multiple or frequent risky behaviours in context of substance use • Very high risk behaviours such as driving at excessive speed without a seatbelt with blasé attitude about potential consequences
3: Stressors/context	<ul style="list-style-type: none"> • No significant stressors 	<ul style="list-style-type: none"> • Moderate reaction to loss/ social context changes • Bereavement in wide social/school circle 	<ul style="list-style-type: none"> • Severe reaction to loss or social context change • Many recent social/personal crises • Bereavement in closer social/school circle, especially if sudden

AREAS TO CONSIDER	LOW RISK	MODERATE RISK	HIGH RISK
4: Self-management	<ul style="list-style-type: none"> • Maintaining daily/social activities with little change in level of functioning • Communicating openly about issues being faced and working through them • Can marshal several problem-solving strategies • Willing to seek and accept help/support • Stable relationships, personality and school performance 	<ul style="list-style-type: none"> • Some activities disrupted, disturbance in sleep, eating, school work • Communicates from time to time, or partial communication • One or two approaches to solving problems, some difficulty carrying them through • Ambivalent about receiving help • Recent increase in behaviours asserting independence by breaking rules or family/social norms • Substance abuse 	<ul style="list-style-type: none"> • Significant disturbances in daily functioning • No communication about problems • Unable to effectively approach solving due to severe narrowing of repertoire or inability to carry them through • Significant self-neglect • Repeated difficulty with peers, family and teachers • Extreme or escalating behaviours breaking rules or family/social norms
5: Positive resources	<ul style="list-style-type: none"> • Significant others concerned and willing to help • Other help available, in particular a concerned and trusted adult 	<ul style="list-style-type: none"> • Family/whanau and friends available but unwilling to help consistently 	<ul style="list-style-type: none"> • Family/whanau and friends not available or hostile, exhausted, injurious

Management of young people at risk of suicide

If there are any concerns about suicide risk for a particular individual, the student should be assessed to determine the extent of suicide risk. The most accurate predictor of a future suicide is a prior attempt. Given that intent can be difficult to assess, any suicidal behaviours (i.e. any self-harm) should be considered as if they are attempts, unless after expert assessment and in the context of a management plan they are considered differently. Whenever a student has been assessed as being at-risk, they should be treated as being at-risk until further in-depth assessment has shown that the risk is diminished.

Family/whanau liaison is a critical aspect of management planning and should be instituted early and continued until risk is assessed as being low. The one caveat to this is in instances where a family/whanau member may be a contributor to the risk (e.g. in cases of abuse), in which case after careful consideration it may be appropriate to notify CYPFS or the police.

Principles of management planning

Once the young person has been fully assessed and the nature of the risk has been gauged, a clear management plan, that attends to the problems faced by the young person and is appropriate for the degree of assessed risk, should be put in place. The management plan outlines suggested actions and timelines for intervention, consultation, referral and follow-up. It articulates where responsibility lies for various tasks. The management plan should include planned monitoring and re-assessment, and therefore is time-limited with the expectation of review, should there be a change in risk, clinical picture or circumstances. The process of developing and reviewing a management plan can contribute to risk reduction because it brings together the different actors in the system around the young person at risk (Collings et al, 2009). If doubts exist about the appropriate course of action to take for any student deemed to be at risk of suicide, then advice should be sought promptly from mental health professionals.

It is important that the management plan is developed with the young person and preferably their family/whanau, to ensure the best outcome. The development of a positive therapeutic relationship during the assessment phase will support working together on the management plan. The counsellor should take time to explain the support that will be provided and other relevant information. An explanation of the length of time that the supports will be in place, emphasising both the expected outcome and the need to persist, may also help.

‘Contracts’ between counsellors and young people at risk of self-harm or suicide are not considered good practice. While the young person may feel able to undertake not to harm themselves at a future time while in the counsellor’s office, the fluctuating nature of suicidality may render such an undertaking meaningless even within a few hours. A young person may also feel under pressure to agree to such a ‘contract’. If the young person does harm themselves following such an agreement this can undermine the therapeutic relationship as the young person feels they have failed the counsellor, and/or the counsellor feels let down.

Making promises about maintaining confidentiality is also not good practice, as the counsellor may be obliged to break confidentiality if imminent or severe risk becomes apparent. While it is desirable to obtain the permission of the person to talk to family/whanau, if there is a serious and imminent threat to the life or health of the individual this is not essential [refer to Rule

11(2d) Health Information Privacy Code 1994]. However, the development of a good relationship between the young person, the counsellor, their family/whanau and their social network, will be an important factor contributing to safety in the short term.

In all cases where significant concern exists about suicide risk, the school should refer the student to available mental health services and/or consult with these services about the most appropriate response. In cases of high risk, it will be necessary to supervise the young person at all times and arrange a clear transfer of responsibility to another professional or the family/whanau until a referral to a mental health service is arranged. Explicit instructions should be given to those providing the supervision about how to make an environment safe (i.e. remove the means of suicide) and how to provide supportive supervision.

In creating a management plan, ten core principles should be adhered to:

- Any threat of suicidal behaviour should be regarded seriously and investigated further
- The development of a strong therapeutic relationship with the young person is critical
- **Confidentiality has limits when the young person's safety is at risk**
- The psycho-social developmental age of the young person should be considered when developing the plan with the young person
- Family/whanau/significant others should be involved early and in an ongoing way, while being mindful that in some cases these people can be contributors to risk
- The cultural context is an important consideration in management planning
- 'No self-harm' or 'no suicide' contracts are not considered good practice
- In cases of high risk, the young person should be supervised at all times
- A management plan needs to be responsive to change and should therefore be subject to regular review
- A management plan must focus on domains other than (but inclusive of) suicide risk

Clinical management

Creating the management plan is the first part of intervening to reduce the student's risk and improve their general situation. In the school setting, the management plan will have two components: the clinical management which is the responsibility of the counsellor to initiate; **and the school process management, which is the responsibility of the principal or principal's delegate.** It is important that school personnel distinguish between these aspects of suicide intervention, because they entail different practical and conceptual levels of involvement with suicidal students. Whatever the intervention, schools can expect to have a part in the treatment or management plan while the young person continues to be a pupil at the school.

For clinical management, once the assessment is as complete as possible for the urgency of the situation, what has been described as an action phase begins (Ramsay et al, 1994). Depending on the level of risk, the counsellor is either non-directive, co-operative or directive in approach. The aim is to implement a plan that will create a sense of direction, instill hope and prevent suicide.

The joint development and execution of a management plan for suicidal adolescents is supported by four steps (Johnson and Mail, 1987):

1. Explore the dimensions of the problem, gathering information of immediate relevance;
2. Explore options for action and short-term solutions, noting that if risk is high the immediate options may be limited;
3. Assist the student to take concrete action toward crisis resolution or problem solving. This may involve making a referral to another agency, and
4. Follow up to ensure the immediate intervention fits into a longer-term framework for treatment and change (if referral is made); or continue working with the young person as primary clinician if a referral is not made or if awaiting pick-up of an urgent or routine referral.

Note that steps two and three are congruent with the general cognitive problem-solving approach currently seen as relevant to brief interventions for mental health problems and which look promising for deliberate self-harm (Townsend et al, 1991; Portskey and van Heeringen, 2007; Grover et al, 2009).

Counsellors generally work with suicide-risk students in two ways. The first is associated with crises and is where the focus is on evaluating the risk of suicidal behaviour, determining what actions are needed and implementing the immediate actions required to save the person's life. The counsellor provides help in a manner that develops the young person's **confidence** in the relationship and increases the likelihood that they will seek help.

The second way counsellors are usually involved is as a provider of counselling as a clinical intervention. This refers to the helping process, and strategies and skills applied by a trained person to assist another person who is experiencing problems.

It is sometimes during such counselling that a potential suicide may first be detected. In this case, the counselling should first focus on suicide intervention before proceeding with other issues. Counselling can also occur following a suicide intervention, once the immediate suicide risk has reduced. It can often take the form of providing support and monitoring the situation of a potentially suicidal or previously suicidal student. Counselling can require one or several sessions.

Psychotherapeutic interventions are generally beyond the scope of school counselling services. The counsellor is likely to be the key or sole clinician only in cases where risk is low to moderate. In all cases of high risk it is preferable that the young person is being managed by the mental health service, with the counsellor as part of the team for monitoring and support.

This is because where there is high risk, the underlying problem must be addressed as well as immediate safety. In cases of moderate risk where it is not possible to have a young person seen by the mental health service, the counsellor should liaise with the GP. If a student continues to be at even low risk after six to eight weeks they should be referred to a specialist mental health service and treated as if the risk was moderate to high.

Management of acute or chronic suicide risk can be demanding for clinicians and requires skillful tolerance of the chronic risk, alongside active management of the periods of acute moderate to high risk (Batcheler et al, 2008). It is preferable for this management not to be shouldered by a single isolated clinician.

When there is high risk

When there is a high or imminent risk of suicide, the counsellor should refer immediately to a specialist service for assessment and treatment, with the expectation of a response on the same day (New Zealand Guidelines Group, 2009). The young person should remain under supervision. It is important to remove lethal means (including firearms, pills, ropes and poisons) from the young person's possession, their environment (including the home) and to prevent ready access to these.

If there is concern that the young person will not accept treatment, the advice of the Mental Health Emergency Team should be sought, as they have authority to arrange for a compulsory assessment under the Mental Health (Compulsory Assessment and Treatment) Act.

When there is abuse

The young person should always be informed of the steps which need to be taken for their safety. A decision to contact their family/whanau should also take into account the likely impact on the person's current and future relationship. When a person is unwilling for the counsellor to contact his/her relatives, it may be appropriate in the short term for another member of staff to be available to the family/whanau to assist with issues of concern to them, while preserving confidentiality about information relating to the young person.

If the young person has been, or is currently, subject to abuse (physical, sexual or emotional) then it may be necessary to exclude the parties that are perpetrating the abuse or make a referral to the Children, Young Persons and their Families Service or the Police for these matters to be investigated. If the young person is 16 years or less, any action which contemplates not contacting the family/whanau, must involve the Children, Young Persons and their Families Service. Table 3: *Process and clinical management of young people at risk of suicide* outlines some strategies for managing low, moderate and high risk students in the school setting.

Table 3: Process and clinical management of young people at risk of suicide

ACTION	LOW RISK	MODERATE RISK	HIGH RISK
Immediate intervention	<ul style="list-style-type: none"> • Consult with the principal who then informs the appropriate staff • Establish an appropriate regime to monitor the young person's suicide risk • Check on family/whanau and other support available and, as appropriate, involve them 	<ul style="list-style-type: none"> • Take a team approach to ensure the safety of the student while at school • Principal to inform the parents/whanau/caregivers as appropriate and discuss strategies appropriate to the level of risk • Establish appropriate regime to monitor the person's suicide risk • Arrange for the young person to get access to the appropriate level of counselling/treatment 	<ul style="list-style-type: none"> • Consult with the principal who will then inform the appropriate staff to minimise any immediate risk • Principal to inform the parents/whanau/caregivers of the risk and proposed management as appropriate • Counsellor to ensure the young person's immediate safety, arrange for any hand over of responsibility (including informing parents of safety precautions) to parents or a health professional
Consultation	<ul style="list-style-type: none"> • Consult with the principal and then, as appropriate, staff and parents/guardians • Counsellor to consult with supervisor as necessary • Check if other services are involved and co-ordinate: clarify who is leading clinical management planning 	<ul style="list-style-type: none"> • Counsellor to consult with health professionals (GP, SES, mental health services) to discuss actions required • For new cases, referral for assessment by GP or mental health services desirable • Counsellor to consult with supervisor as necessary • Check if other services are involved and co-ordinate: clarify who is 	<ul style="list-style-type: none"> • Continue contact with the young person and their family/whanau/whanau/caregivers to ensure the required level of service is being provided and to facilitate a smooth return to normal involvement in the school • Consult with health professionals involved to ensure they know of the current level of risk, any behaviours evidenced in the school, and that the appropriate services are being accessed • Counsellor to consult with supervisor as necessary

ACTION	LOW RISK	MODERATE RISK	HIGH RISK
		leading management planning	
Referral/clinical management	<ul style="list-style-type: none"> • Provide information to the young person (and the family/whanau) on resources available to assist them. • Provide ongoing clinical management as part of school counselling service 	<ul style="list-style-type: none"> • Referral to mental health services desirable for new cases • If referral will not be picked up, actively manage with self-management strategies as appropriate, and weekly monitoring 	<ul style="list-style-type: none"> • Counsellor to make a referral to an appropriate health professional (GP, SES, mental health services) for further assessment and primary management • Ensure communication about primary management to school counsellor so clear role can be established
Follow up	<ul style="list-style-type: none"> • Regular review of the young person to identify any changes in risk • If there has been no improvement in 4-6 weeks then treat as if the risk were moderate and seek additional assistance. 	<ul style="list-style-type: none"> • Check outcome of any referral with the health professional and family/whanau • Monitor risk and behaviours within the school environment and take action as appropriate • Ensure all staff involved with the young person report all incidents which cause concern (risk factors: unexpected reduction in academic performance, ideas and themes of depression, death, suicide, changes in mood, grief, withdrawal, physical symptoms, high risk behaviours). 	<ul style="list-style-type: none"> • Check outcome of any referral with the health professional and family/whanau • Ensure all staff involved with the young person report all incidents which cause concern (risk factors: unexpected reduction in academic performance, ideas and themes of depression, death, suicide, changes in mood, withdrawal, physical symptoms, high risk behaviours) • Liaise with family/whanau to ensure they have support and that the young person's environment is safe (i.e. removal of means of suicide and close monitoring and support) • Prior to the student returning to school, establish the necessary monitoring and support systems.

Management of a young person with suicidal risk in the community

Most young people at some risk of suicide are managed in their usual living situation, so it is vital to ensure that adequate resources are available. While it is not expected that school staff will be responsible for implementing the following procedures, this section is included to highlight what schools can expect from other services and any resulting issues for schools. In any management of a young person at risk of suicide in the community, the following matters should be considered:

- Information on the current mental state of the person, medication, precipitants of the suicide act and the degree of further risk of suicide. The person's GP should have details of treatment
- The need for 24-hour supervision and support of the young person
- The level of supervision which the person requires
- Ongoing access to professional assessment of the person by a multi-disciplinary team, with specific appointments for review. Specialist mental health follow-up for patients indicating chronic suicidality should be a priority
- The ability to respond to changes in the state of the person. The caregivers and others directly involved should be aware that the Mental Health Act can be used and that the police may be called in emergencies
- The safety of the person's physical environment
- The availability of others living in the home to offer support, given that they may also be under considerable stress.
- When the young person is in their usual living situation, the following factors may also need to be considered with regard to their safety. These will need to be discussed with the primary caregivers:
 - The ability to access appropriate support, including the ability to respond to emergencies
 - The potentially distressing and unsettling effect on other family/whanau members
 - The difficulty of removing potentially harmful objects/substances (e.g. poisons, ropes, firearms, vehicles) from the environment.

Relationships with and referral to health and other services

Referrals to health services can be a fraught area, with referrers often feeling their concerns about clients are not dealt with in a timely way, or that they do not get the response they hoped for, and those receiving the referral feeling the referral contains insufficient information.

It has been suggested that a focus on risk assessment has meant that CAMHS in New Zealand have come to be seen as suicide prevention or suicide risk assessment services (Fortune and Clarkson, 2006). However this is not their main role, and from the CAMHS perspective it is problematic. They can be overwhelmed by referrals for risk assessment and risk management, to

the point where the main focus of their work, which is to provide treatment options for young people and families/whanau, is eroded (Fortune and Clarkson, 2006).

The problem can be moderated if school counsellors and the local CAMHS invest in building a relationship of collegiality and trust. This would require recognition that the roles of school counsellors and CAMHS staff are distinct, although there is some overlap of clinical expertise depending on the background of the counsellor. Regular (although not necessarily frequent) face-to-face meetings would help build relationships, and familiarity may make phone consultations for brief advice both more likely to happen and more productive.

There may be some benefits to joint consultation where the counsellor sits in on an assessment with CAMHS staff, as this does not interrupt the therapeutic relationship with the young person, and it provides the opportunity for skill sharing and development of a joint management plan. Once relationships are built between counsellors and their local CAMHS, opportunities for supervision and support may arise (Fortune and Clarkson, 2006). This would enhance the capacity of school counsellors to more comfortably contain their support of some troubled young people within the school setting.

Counsellors can also refer young people to primary health care services such as a GP (or the **young person's existing GP**) and youth **'one stop shop' health services**. GPs are able to provide treatment for common mental health problems, refer to mental health care services, and can provide support in low- to medium-level risk assessment and management. Because of the fee for service arrangements by which New Zealand GPs are paid, cost may be a barrier for a young person to access a GP, and there may be less likelihood of a joint assessment.

If the counsellor suspects a young person may be developing a psychotic illness, the local Youth Early Intervention Service or CAMHS are the appropriate first options for consultation.

Local areas will also have culture-specific services (often NGOs or DHB services) which can provide additional support to young people. However, in some cultural groups use of these can be challenging because of the need to maintain confidentiality. There are also support groups (such as Rainbow Youth) for young people with sexual identity issues.

It is important that the counsellor identifies the professionals, agencies and groups in their community and forms partnerships with them before their services are required. A list of local GPs and other relevant services, including alcohol and drug services, will be helpful.

The list should include after-hours service details such as Psychiatric Emergency teams, as these services sometimes take over from routine services at 4.30pm or even 4pm.

How to make a referral

Some agencies have a form to be completed that enables them to process referrals efficiently because all the required information is provided. Use these forms, because ultimately it will save time.

Always indicate the needs of the person and their suspected problem areas, your expectations of the referral and your expectation for ongoing responsibilities for management and crisis management, as part of the referral. Again, this saves time because if referrals do not include all the necessary information and therefore cannot be allocated in a meeting, they may be held over for one or more weeks. It is very helpful for the receiving clinicians/intake worker if you include details from your own assessment, rather than simply stating, for example, that the person is

‘very depressed’. Remember that the point of the referral is to secure appropriate support for the young person to improve their situation.

If the referral is taken up, ask for a progress report, and if necessary phone the service to talk to the clinician seeing the young person. While it is always good when feedback comes unprompted, this often does not happen so do not hesitate to seek it. This sharing of information should be done with the young person’s consent but also in accordance with accepted principles of confidentiality. Where issues of safety are relevant, client consent is desirable but not mandatory.

Follow-up

If, after 6-8 weeks, there is not a clinically significant improvement, a reappraisal of the treatment or management approach is necessary.

The school counsellor should approach the clinician who is seeing the young person and family/whanau and discuss this possibility. If there is no improvement after three months and it is thought that the young person may have a diagnosable mental illness, reassessment is a priority and a referral elsewhere (e.g. from GP to CAMHS or Early Intervention Service) may be appropriate.

In preparing and carrying out a management plan it is important that the school maintains close liaison with family/whanau and advises them of the steps being taken to ensure the young person’s safety. Failure to communicate clearly with families may lead to misunderstandings, accusations and, in cases where the young person may proceed to attempt suicide, considerable difficulties for the school and everyone involved. The ideal situation is one in which the school, the family/whanau and the available mental health resources work co-operatively to devise a plan which treats/manages the young person’s **problems and** minimizes their risk. The extent to which such a partnership is possible will depend, in part, on the school’s ability to develop and maintain strategic linkages with mental health services and with parents.

Maori students

Cultural identity is considered a critical element of health and well-being, especially for the mental health of indigenous people, and this is recognized internationally (Hirini and Collings, 2005). Maori are a diverse social and cultural group, and suicide may be viewed differently from iwi to iwi (Ihimaera and MacDonald, 2009). This observation is consistent with what is known about some other societies with an underlying tribal structure (Novins et al, 1999). Maoricultural heritage is important in shaping ideas, attitudes and reactions, particularly during times of illness (Durie, 1977), just as it is for non-Maori. For example, explanations of illness based on a possible breach of tapu have meaning for many Maori and therefore have implications for counsellors in the recognition and management of Maori students with mental health problems (Durie, 1994).

Note however, that

A Maori identity, even when vigorously defended, cannot be presumed to mean a conventional Maori lifestyle. Nor should it be forgotten that, for many Maori, cultural identity is a sophistication; it is more than enough simply to get through each day” (Durie, 1994, p. 214).

For Maori students, the early involvement of whanau is critical. It is important that school counsellors have ongoing relationships with local Maori mental health providers. Early consultation with such services may be useful as they may have different intake criteria to mainstream services. In schools with a high proportion of Maori students, there may be a designated person whose role is to support Maori students. Such a person is an important contact for the counsellor to identify and engage appropriate external supports for the student. It may be appropriate for this person to be involved with the management plan (but not treatment delivery unless they are clinically qualified). It is regarded as good practice to have the question about a possible choice between Maori and mainstream services asked by the Maori service provider, not the mainstream provider.

Most guidance counsellors will have had the opportunity to attend training to equip themselves with the skills to appropriately assess Maori students. This will have included some relatively simple things, the observance of which can make a huge difference to a Maori student and whanau experience of a service. Examples include:

- It is not appropriate to immediately ask patients to reveal their name (or personal information) without any preliminary remarks about where you are from to establish rapport and connection.
- Direct eye contact is not appropriate especially when discussing sensitive issues. Such eye to eye contact with an older person may be considered a sign of haughtiness or disrespect.
- A family/whanau member who answers questions on behalf of a person is not necessarily being dominant; often it will be both appropriate and helpful to all parties. Younger people may feel embarrassed or intimidated.
- Make an effort to pronounce personal and place names correctly.

If you are uncertain about what is appropriate, a good rule of thumb is to ask. For instance, you could ask if the senior member of the whanau would like to begin/end the session with a karakia or whakatauki. Showing that you are accepting and respectful will make a difference to the development of rapport and a therapeutic alliance and sets a stronger foundation for a management plan.

In addition to symptoms of emotional distress, there are other indicators which may accompany a Maori person at risk of suicide. The identification of these will require careful and respectful probing by the health professional. These include: suggestion of breaches of cultural protocols, preoccupation with a close relative who has recently died, unresolved grief or loss (of a significant person or their own status), and issues of injustice (especially cultural), experienced by the person or their whanau.

If there are indications of any of these signs, especially any involving tapu and death, serious consideration should be given to involving Maori mental health services. Roles and responsibility for aspects of the treatment and care of the person will need to be carefully and respectfully negotiated between the parties involved, including the young person and their family/whanau.

If the treatment of the person is to take place jointly with a Maori health service, then there should be clear definition of the respective roles and responsibilities, ongoing sharing of information from both specialists and attention given to clarifying terms and concepts from the

different perspectives. This is likely to work best when there is an existing relationship between the healthcare provider and Maori services, preferably established before any particular patients are referred for assessment or joint treatment.

Other cross-cultural considerations

Managing suicidal behaviour in young people whose cultures are different from one's own can be a considerable challenge.

It is important for counsellors to develop effective liaison relationships with individuals and agencies in the ethnic communities they serve. It can be useful to have a person of the same culture as the student as part of the assessment process but it is often not possible.

The presentation, course and outcome of periods of emotional distress varies from person to person. A number of factors influence this, including cultural factors (Kirmayer, Young and Robbins, 1994). Even within an ethnic, cultural or religious group there may be wide diversity in views about the origins and best management of mental health problems and suicidal behaviours. This means that although it is important to have some knowledge of the beliefs and possible concerns of people from the cultural backgrounds most served by your school, this is never a substitute for asking the young person for their perspective. Bear in mind though, that it **might be difficult for the young person to clearly articulate ('translate') ideas, feelings, social rules or beliefs that are culturally determined.**

Empathy and a respectful enquiring stance are the keys to a successful cross-cultural assessment and treatment. Appreciation of how the person views him/herself is critical for any successful outcome. When working with a young person of the counsellor's own ethnic group, it is important not to assume that they subscribe to the same cultural or world views. Ask how the young person views their current problems and any suicidal intent and what help they consider to be appropriate. The presence of a family/whanau member or support person may be useful in enabling the young person to speak about these issues, although this is not always the case, for instance, where there are suicidal feelings but suicide is proscribed by strongly held religious beliefs. In such a situation, it is often helpful to seek guidance about issues and beliefs from religious organizations, community leaders or a local cultural adviser when dealing with an unfamiliar culture and/or religion. Caution must be taken to maintain confidentiality when seeking input from such sources.

If there is a specialist health service for the young person's cultural group, the counsellor should offer to involve this service in the support process.

Having made a referral, the counsellor should continue to be available to and supportive of the young person. Due to the scarcity of specialist cultural treatment services, most people are likely to be referred back to the counsellor or the school for ongoing management and monitoring. Wherever possible, joint responsibility for treatment, preferably with written agreement on roles and responsibilities, should be arranged.

Issues for Pacific peoples

The term 'Pacific peoples' refers to people living in New Zealand who define themselves as being of Pacific Islands ethnicity (for example Samoan, Tongan, Cook Island Maori, Fijian, Niuean or Tuvaluan). This group comprises more than 15 different ethnic communities, each with its own distinctive culture, language, and histories of settlement and colonization. Almost 50 per cent of

Pacific Island people in New Zealand are Samoan. Around 50 per cent of Pacific Island people here are aged under 20 years. Sixty seven per cent of New Zealand Pacific Island people live in greater Auckland, and 13 per cent live in the Wellington region (Statistics New Zealand, 2010). The majority of Pacific peoples living in New Zealand now were born here. There is a growing proportion of Pacific peoples with multiple ethnicities who identify as belonging to more than one ethnic group.

Pacific peoples are not a homogeneous group. There are differences in the social structures, worldviews, cultures and languages of peoples from the different Pacific nations. Within these ethnic and cultural variations there are also differences in how Pacific models of wellbeing and concepts of disability are viewed and understood.

Although there is an awareness that the mental health needs of Pacific people are not well met by mainstream services, full Pacific mental health services are only offered in the main centres. Counsellors should be aware of the linguistic and cultural diversity of people of Pacific Island backgrounds, and the fact that most Pacific Island students will have been born in New Zealand whereas their parents may not have been. It may be necessary to consult with people with specialised knowledge about the various Pacific Islands nations' views of mental health.

When there is a recognised risk of suicide (e.g. for depression) for a person from the Pacific Islands, a number of factors need to be taken into account when selecting the appropriate treatment and provider. Whenever possible, the person should be offered the option of an appropriate Pacific Islands healthcare worker(s), and if one is not available, guidance from a Pacific Islands service or recognised local and community organisation is recommended. Alternative healing such as traditional healers (Fofu, Taulasea) may be offered, particularly if requested by the young person. In cases of clear mental illness, this should be in addition to conventional treatments.

6. Responding to suicide: Postvention in New Zealand Schools

Any school could at some stage have at least one student seriously attempt or complete suicide. When this happens there will almost certainly be consequences for other students. Close friends will experience some grief reaction. Others will experience guilt. For some it may bring back memories and reactions to other loss experiences. For a small number, especially those who are already experiencing difficulties, it may raise an awareness of suicide as an option for them.

There will always be young people who are vulnerable to the effects of a crisis within the school. There may be occasions where the death of a student or staff member, particularly if it is by suicide, will have a profound and long-term effect on a number of students.

The degree to which the death impacts on the school is influenced by how a school chooses to respond. Generally it is agreed that some level of traumatic incident response, based on sound **and safe suicide postvention principles, needs to occur in the schools since ‘doing nothing’** may be potentially more harmful than doing too much (Poland, 1989; Dunne-Maxim, Godin, Lamb, Sutton & al, 1992). A comparison between proactive and passive postvention responses showed that those affected who received a more proactive response were more likely to seek support and attend groups (Cerel and Campbell, 2008).

Schools’ responsibilities

The Ministry of Education National Administration Guidelines (NAG) requires schools to provide emotionally and physically safe environments for students. Traumatic incident response planning contributes to the emotional safety of students. Schools without such plans expose themselves to increased organisational risk.

Specifically, the risks include harm to individual students through the increased possibility for cluster suicide, ongoing acrimony and division with parents if cluster suicides should occur and the possibility of litigation for not having met the National Administration Guidelines.

Traumatic Incident Response Plan

The Ministry of Education recommends that all schools have a traumatic incident response plan (TIRP), which provides appropriate processes for students and staff and minimises any harmful outcomes of a traumatic event. Traumatic incident response plans and associated policies must be developed before such events occur so that planned responses can be implemented. These plans are sometimes referred to as **‘postvention’** plans when the traumatic incident is a suicide.

As suicide is a rare event in schools, it is recommended that a specific section on suicide is **included in the school’s TIRP as opposed to developing a stand-alone suicide postvention plan**. The Ministry of Education has produced guidelines for schools and early childhood education centres on managing traumatic incidents *Managing Traumatic Incidents – a handbook for ECE services and schools*¹⁴ and is the main reference document schools should refer to in developing their TIRP. Schools can get support by calling 0800 TI TEAM (0800 84 8326).

¹⁴ Managing traumatic Incidents – A Handbook for ECE services and schools: Ministry of Education 2009

A prepared traumatic incident response plan will:

- prepare staff for the impact of suicidal behaviour such that they are confident about being able to offer an appropriate response
- facilitate a quick, co-ordinated and direct response in the event of an incident
- allocate specific roles to staff which they can familiarise themselves with before the event
- develop appropriate links with community resources before they are required and assist in their quick and smooth implementation when needed
- allow for the needs of all members of the school community (including students, administrators, teachers, parents) to be carefully considered and the appropriate actions planned.

Schools' readiness

The management of traumatic incidents requires high levels of teamwork. Students can be aware of the death very soon after the event, sometimes before the school is notified because of texting and social networking. Intervention must begin immediately the school becomes aware of the traumatic incident and a core group of staff must be involved in the response plan (Adler & Jellinek, 1990; Dunne-Maxim et al, 1992, Hazell, 1993b; Komar, 1994; Poland 1989, Range, 1993; Taylor & Silva, 1990). The core staff making up the TIRP team must be ready to implement the plan as soon as possible. This requires them to be fully briefed and knowledgeable regarding their roles and feel competent and comfortable in the tasks they undertake. Development of a TIRP should include an audit of skills within the school and training provided to those on the TIRP team (Streufert, 2004).

In the urgency of the incident, there can be confusion among staff about how best to proceed. **There may be diverging opinions about the school's role in responding to an incident.** The attitudes of staff, and the way the school as a whole responds to the incident can be critical in determining **students' responses**. A TIRP provides the framework for the school to collectively work from, **and sets the school's expectations of all staff involvement in the response.** The ethos and organisation of the school is also important. For example, effective traumatic incident management requires high levels of delegation and trust. If these are not present within the school culture prior to the traumatic incident, they are unlikely to develop during the management of it. Traumatic incident planning helps the leadership team to identify and anticipate any potential problems (Atkinson, 2002) including potential philosophical and organizational issues that may impede the smooth implementation of a response.

Suicide contagion

With a death by suicide, the school not only has to respond to the grief within the community but must also be alert to the possibility of suicide contagion. Exposure to suicide or suicide attempts increases the risk of suicidal behaviour in other young people (Burns & Patton, 2000). Students who are already vulnerable to suicide may be particularly vulnerable at this time, whether or not they were closely associated with person who died (Taylor et al, 2000).

Suicide contagion refers to the occurrence of subsequent suicides that are triggered by an earlier suicide death. While completed suicides is the usual measure of a contagion effect, suicide

attempts should also be considered as part of the effect. Suicide contagion has a significant impact on the school and wider community.

The subsequent suicides may involve people who were direct acquaintances but can also include others who knew the person indirectly, by word of mouth or media reports. A common characteristic among the deaths is that there is a prior history of personal problems, personal difficulties and/or mental disorders that render them vulnerable to suicidal behaviour.

In some cases, you may have students ‘copying’ the means of suicide (Insel & Gould, 2008), which is the reason that discussion on the means of suicide is not encouraged. School management needs to ensure that any postvention response activities do not, intentionally or unintentionally, glorify or sensationalise the death as this can lead to fascination with suicide by vulnerable others. Care also needs to be taken to not create panic or undue concern with staff, pupils, or their families as well as to give consideration to the religious and cultural background of the one who has died and the school population.

Postvention planning

Taylor (2007) suggests that the purpose of a postvention response is three-fold.

1. the facilitation of an appropriate and safe response to the death;
2. the minimising of the risk of suicide contagion in the school community; and
3. the promotion of a healthy recovery in the long term for those affected.

Postvention delivered in a school setting can also alleviate guilt amongst survivors and minimize the scapegoating of parents’, teachers’ and peers’ behaviour (Shaffer et al, 1988; Norton, 1994; Range, 1993, Goldney & Berman, 1996). Poland (1989) suggests that the primary task of postvention is grief resolution while Carter and Brooks (1990) suggest that postvention efforts should have a ‘clinical’ focus to avoid them being counter-productive by promoting pseudo mourning and attempt to “protect survivors from painful emotions that they must process in order to truly survive” (p. 388). Taylor (2007) suggests that postvention activities do not seek to explain away the suicide but to provide terms of reference to understand it and the uncertainty it brings. While postvention activities should help to facilitate the expression of feelings about the suicide, care should be taken that any activities do not inadvertently glorify or romanticise the means of death nor make the dead person a hero.

It needs to be noted that most of the literature on postvention is descriptive of what has worked in schools and there have been few robust studies undertaken to measure efficacy of recommended activities. Much of the writing on postvention in schools dates from the 1990s (Adler & Jellinek, 1990; Dunne-Maxim et al, 1992, Hazell, 1993; Komar, 1994; Norton, 1994; Poland 1989; Range, 1993; Taylor & Silva, 1990; King 1999) but is still relevant.

While there is little evidence to advise on ‘best practice’ for all aspects of postvention procedures (e.g. funeral attendance, media relationships, memorials, etc), there is a general agreement in the literature that postvention in a school is critical for both suicide prevention and clinical reasons. **“The basis for the belief that postvention may be required and useful is that it is presumed that suicides have an impact similar to that which produces post-traumatic stress disorders”** (Goldney & Berman. 1996, p. 9).

Much of the postvention literature focuses on the bereavement needs of those affected by the death, especially those who were close to the deceased: family/whanau members, partners and close friends. While bereavement support is part of a postvention plan, Taylor (2007) suggests that such support is only one of the goals of a postvention response and that sometimes there can be a tension between bereavement support goals and postvention goals. Taylor provides working definitions of postvention and bereavement support to highlight the similarities and differences.

Postvention is described as a population/group-based process to:

- facilitate individual and collective support to those affected by the suicide
- proactively identify those who may be at risk of suicide or self-harm as a result of the suicide
- implement monitoring, support and follow up procedures for those at risk or who have been adversely affected by the death
- maximise resilience and minimise risk within the school community
- establish structures and procedures to appropriately and safely respond to the aftermath of the suicide, and
- plan community-based responses if required.

Development of a postvention plan¹⁵

1. Each school should develop its own Traumatic Incident Response Plan (TIRP). It is recommended that postvention response is part of this plan. It is necessary to develop the plan before any event since the initial steps in a plan will need to be carried out immediately. There will be no time to develop a plan when an incident occurs.
2. The response plan should involve all sectors of the school and specify the co-ordination mechanisms. To be effective, the postvention plan should include all staff and make provision to include students, parents and support agencies from outside the school. The development of the plan should involve consultation with and, as appropriate, participation by each group. The plan should not depend on any single person but be able to be implemented by the staff available at the time. It should also avoid placing any **particular staff member in 'the hot seat', but rather promote the co-ordinated responsibility of a team of people who can support each other.**
3. The relevant community resources should be identified and the plan should be discussed with each of the community resources or agencies. The support they can provide, contact protocols and any limitations on their involvement should be discussed with each. The name and phone number of a contact person (including after-hours contact details) for each should be listed in the plan.
4. The conditions under which the response plan should be implemented must be clearly specified and understood by key staff. This allows for an appropriate response.

¹⁵ Developed from King A (1999) High school suicide postvention: recommendations for an effective programme. *American Journal of Health Studies*, 15(4) 217-222.

5. The implementation of the plan should allow key staff to be contacted and prepared before they have to respond to other staff, students and the community. The principal and other senior staff need to be informed as soon as possible or practical.

Information Dissemination

In the event of a suicide, the death needs to be acknowledged in the school as soon as possible. All students, staff and parents of the school should be notified of the event and provided with accurate information (Adler & Jellinek, 1990; Dunne-Maxim et al, 1992, Hazell, 1993b; Norton, 1994; Poland 1989; Taylor & Silva, 1990).

There are varying opinions about how much information should be shared and whether the death should be named as a suicide. It should not be assumed that the death is a suicide. This must be dealt with cautiously and the full range of possibilities kept open until the cause is clear. However, even among those who support the early naming of the death as suicide (Poland, 1989), there is agreement that no details on the method used should be provided. In New Zealand, schools need to be cognisant of the legal stipulations of the Coroners Act 2006 which **states that a death can only be legally classified as suicide by a coroner's finding.** Ministry of Education guidelines on managing traumatic incidents (2009) recommend that all suspected suicides be referred to as sudden deaths.

At times, the school may face a tension between the wishes of a family who may not want to believe or acknowledge that the death was the result of suicide and public knowledge or a perception among the friends of the dead person that the death was by suicide. While the wishes of the family need to be sensitively taken into account, the school has a broader duty of care responsibility towards its students and should implement the TIRP as a suicide postvention response.

Before notification of any persons, the school leadership team should check that they have all the information that is available and that the information they have is factual and accurate. Ongoing liaison with the family as well as police is advised. (Taylor & Silva, 1990, Department of Communities, 2008)

Notification of Staff

All school staff (executive, teaching, library, caretakers, grounds and others) should be notified as soon as possible after the death. Early notification will assist in preparing the staff to deal with **students' concerns or to identify students who require assistance. This is important in retaining students' and parents' confidence both in staff themselves and that the 'crisis' is being managed.**

Notification will also ensure that all staff have the opportunity to contribute what they know about the death as well as making all staff aware of the need to report episodes of unusual behaviour to the TIRP team.

When school management is notified of the death outside school hours, even in a weekend or during a term break, staff should be notified through such methods as a telephone chain and a meeting of staff should be organised prior to the start of the next school day (Poland, 1989; Taylor & Silva, 1990; Dunne-Maxim et al., 1992).

A staff meeting should be called as soon as is practical. The first full staff meeting may cover the following issues:

- Content of the written statement to be used by staff to tell students what has happened
- Support services available for staff and students including the use of a Support Room if this is provided
- What communication processes will be used to keep staff and students updated
- Referral process for at risk students
- A brief summary of how students may react (tears, anger, expressions of frustration, anger, blaming of others and other emotions that may not often be seen by teachers) and suggestions on how to respond to them.

Notification of Students

The literature recommends that students be notified of the death as soon as is reasonably possible (King, 1999). This notification is best done via small classroom announcement rather than large school assemblies (Poland, 1989; Taylor & Silva, 1990; Dunne-Maxim et al., 1992). Most literature does not take into account the efficiency and speed of modern communication technologies including texting and social networking internet sites such as Facebook.

It is likely that many students will be aware of the death before the official announcement and in some cases even before the school is officially notified of the death.

Even if this is the case, the classroom-based notifications should still occur as the purpose of such meetings is not just to inform students of the death but also to provide accurate information on the death to minimise inaccurate gossip or glorification of the death; information on the support that is available; and to provide an opportunity for students to discuss the death and to express their feelings and concerns (Adler & Jellinek, 1990; Garfinkel, 1989; Klingman, 1989; Poland 1989; Taylor & Silva, 1990; Taylor et al, 2000).

Notification of students is best communicated by a prepared statement provided by the TIRP team. The statement provides consistency of information for staff and students. The statement should, as far as possible, avoid distressing details. It should not contain details of the method of suicide. It should contain the most accurate information available at the time that it is written. If further information becomes available then this should be conveyed to students in consistent prepared updates.

Notification of Parents

Parents should be sent on the first school day a fact-based notice with information similar to that provided to students but also with information about grief in young people, possible warning signs that a child or young person is experiencing emotional or psychological distress, and support services that are available (Adler & Jellinek, 1990; Poland 1989; Taylor & Silva, 1990; Taylor et al, 2000). A parent information evening on loss and grief, understanding of depression and how to support distressed young people could also be organised during the first week after the death (Taylor & Silva 1990). Parents and caregivers should be seen as the primary sources of support to the young person. While the school has a role to play during school hours, it is important that parents provide warm and empathic concern and talk to their young people in supportive and caring ways. Where this cannot happen – for example, boarding schools or when parents or caregivers are unable to be supportive – staff should ensure the young person has other opportunities, if necessary within the school, to express their feelings and concerns.

Ensure that the parents and caregivers of all the young people who are particularly at risk are told that concerns are held by the school about their safety. If parents are not told, they will feel the emotional state of their young person was hidden from them. If that young person later dies by suicide, there is potential for blame, anger, guilt, and recrimination. Encourage these parents and caregivers to keep their young people safe by knowing where they are, who they are with and what they are doing.

Some parents and caregivers may have difficulty accepting that their young person is at risk. **Highlight the importance of monitoring the young person's emotional state** over the coming days and provide suggestions of agencies where the parents and caregivers can get help for themselves and their children especially in evenings and weekends. Offer to meet with the parents to develop a joint support plan for the young person.

Support for School Staff

Staff are often expected to be sources of support for the students so it is important that they are supported not only to undertake the support role to students (Poland 1989; Taylor & Silva, 1990) but to address their own response to the death and be given the opportunity to access support people to discuss their own feelings about the suicide (Dunne-Maxim et al 1992; Taylor & Silva 1990). Staff should meet regularly during the first few days following the suicide. These meetings are to talk about student reactions and to provide support for each other. Where there are too many staff for a full meeting to be effective, staff should meet briefly to share information and then divide into smaller groups such as subject areas. Some staff may need to attend to students while the meetings are being held. These staff can be brought up to date at a later time. If the student who died was taught by a number of different staff, it may be appropriate for this group to meet together.

It may be appropriate for schools to call on outside assistance following the death of a student through suicide. This assistance should complement and, where appropriate, guide the actions of the school. For example, counsellors from other schools may come in to assist; however the responsibility for the implementation of the traumatic incident response plan and postvention programme must remain with the school.

Senior staff and deans should be vigilant for distress among individual members of staff, especially those who may have had traumatic or recent deaths within their own families. Some staff may feel that the suicide was their fault. No staff member should feel compelled to undertake a support role with which they are not comfortable.

Identification of those at risk

Students who are vulnerable should be identified. All staff should be reminded about the referral procedures for at-risk students (See Section 5 of this document). A register of those who are at risk should be established and staff asked to identify any students they have particular concerns about. Taylor (2007) provides a process to map those who may be vulnerable in a community and who might require additional support or monitoring. This process could be adapted for a school community. Mapping can help to identify those outside the school community who will be affected and identify which organisations are involved and who is supporting who, as well as identify the gaps in service provision. Mapping is most useful when it is undertaken with community agencies as part of a wider community postvention response.

Students who have a history of emotional distress and risk of suicide should be identified and should have at least one screening interview with a competent staff member. As necessary, they should be referred for further assistance. There should also be the opportunity for other individuals to self-identify, or be identified by teachers or other students as having difficulties following the suicide, and to receive appropriate assistance.

Close friends of the student who died should be identified and monitored. These young people should be assessed for suicide risk and, where appropriate, involved in follow-up. There will be others at risk, who have not been identified (Parrish & Tunkle, 2005). These may include friends and others in the same social network as the deceased, those who have made prior suicide attempts, those who are depressed or have low self-esteem, those whose life experiences or circumstances are similar to those of the person who died, those with family members who have died through suicide, homicide or accident, and those with a history of impulsive or violent behaviours.

Support of Students

A central question for the survivors of a traumatic incident is 'why did it happen?' Regardless of any suicide notes or any other avenues for explanation, it is often difficult to find satisfactory explanations for the suicide. This is partly why suicide has such an impact and why recovery is sometimes difficult. Emotional distress will be heightened and for some this may be the first experience of the traumatic death of someone they know.

In an attempt to answer the question of why, some may engage in fault finding, looking for someone to blame. Students should be encouraged not to look for blame and the focus of the support should be on addressing the shared sorrow, bewilderment and the uncertainty around the death (Parrish & Tunle, 2005).

During the first few days, the following key messages should be reinforced by all staff:

- Suicide is not a good solution to what are generally temporary problems. The task is to assist young people to see other solutions.
- Death is permanent. The permanence of death may seem obvious but the focus of a young person at risk of suicide may be on an image of other people's sorrow, guilt, regret, and pain. This is a powerful image for them and the reality that death is permanent may be lost. This is a particularly important issue for young people at risk of suicide. They are least likely to grasp or attend to the concept that death is permanent.
- Foster an environment of looking out for each other at this time. Encourage students to notify staff if they are concerned about the welfare of any student. Emphasise that getting help for a friend is not a breach of loyalty.
- **Remind students that people grieve differently and that 'not crying' does not equate to not caring.**

During these discussions, staff must watch carefully for those students whose reactions to the suicide seem inappropriate. Inappropriate reactions might be that the death was heroic or that suicide was a good choice. A desire to die in order to be with the victim is also an inappropriate reaction. If students show these reactions, then bring the discussion to an end and consider including these students in suicide risk assessment processes.

Absent students

Students who are already aware of the death may not attend school. It is important that the whereabouts of these students is known and also whether adult supervision is being provided. If students are not under adult supervision, it is recommended that parents are notified and that students are encouraged to attend school and participate in the support being offered.

As a part of their grieving, some students may gather at the place where the death occurred and **may even erect a memorial or 'shrine' in memory of the person.** These gatherings can be intense and very emotional for those attending especially for already vulnerable students. It is preferable that these gatherings are monitored by adults and staff should liaise with parents about such gatherings. It is desirable that attendance at such gatherings is time limited and students are encouraged not to linger.

It is important that students are reminded that they may not leave the school during school hours without permission and that if they leave school, they must provide information on where they will be. Absences should be closely monitored, with class rolls taken at each class and any absences notified to the appropriate staff.

Support room

Where possible, support for students should be managed within the classroom setting. Students are best supported by the adults they know and trust, their teachers and parents. However some students may require additional support, or their distress may become too disruptive for the classroom (Poland 1989, Dunne-Maxim et al 1992; Taylor & Silva 1990). In these situations, it may be useful for the school in the first days to have a designated adult-supervised room where these students can go for support.

The purpose of a support room is to provide a comfortable and safe space for those who are distressed to have time out. It is important that the school has some criteria about who uses the room and when, as it can be difficult to manage the emotions and responses of young people together. Clearly stated rules are needed about the length of time students can stay in the room.

The support room should be accessible during class time for students who become distressed and may require extra support. The room should be staffed by school staff and preferably at least one helping professional. Some light nutritious food can be made available and also art supplies so students can write or draw as a way of processing their emotions. After the first day, the need for the support room should be assessed on a daily basis.

Absences from classes – and the time the student arrives and leaves the support room – should be documented and checked against the attendance rolls.

Long-term support

The aim of the postvention response is to assist the school community to return to a normal routine as quickly as possible. Most students will be able to engage quickly back into their schedules and daily routine without significant emotional disturbance.

Those students who had been identified at-risk should be regularly monitored over the next 6- 8 weeks and then their risk status reviewed. Monitoring of at-risk students may need to be ongoing, especially those who had been identified as at-risk before the death.

Some students, especially close friends, will take longer and extra ongoing support may be required. While their grief needs to be acknowledged and support offered, it is important that

their grieving is not disruptive of the school's return to the normal schedule. In providing longer-term support, counsellors must be careful that the extra support does not inadvertently create opportunities for secondary gain by the students (Davidson 1989). Secondary gain occurs when the student, due to their distress, receives special consideration which, rather than being therapeutic, actually discourages the young person from moving on. Callahan's case study (1996) showed that a group of at-risk young people who had too readily available access to the sympathetic counsellor, usually during class time and thus avoiding academic work, ultimately had more difficulties.

Where students do not appear to be moving on in their grief or have become 'stuck' then they should be assessed for possible depression and referred to more specialist grief counselling. At regular intervals (about 3-4 months apart) it is useful for the counsellor to check in with close friends and identified at-risk students about how they are going. Issues to check out are:

- Degree to which they have been able to re-engage with regular routines of daily living
- Connection with friends and family
- Emotional responses to thoughts about the dead person
- Helpfulness of coping strategies they are using (positive and negative)
- Any disturbance in sleeping patterns
- Changes in alcohol and drug use – increase in consumption or episodes of binge drinking
- Any thoughts or desires to be re-united with the dead person.

The finality of the death may not be fully realised until several months after the death, resulting in a secondary grief response. This response is usually very individualised and private. Signs it may be occurring include:

- Lack of concentration or disinterest in school or social activities
- Withdrawing from friends or families
- High levels of agitation or anxiety
- Easily distressed about or have a **strong emotional response to their or other people's** difficult situations, especially an experience of loss
- Pre-occupied with thoughts about the dead person.

Subsequent notable events such as the birthday of the dead person, the coronial inquest hearing and the anniversaries of the death can be emotive times (Dunne-Maxim 1992, Taylor & Silva 1990). Close friends or those severely affected at the time of the death should be monitored around these times and the significance of the event acknowledged. Marking of these events should be low-key and focused on either individual or small group responses. Emphasis should be on celebrating the memories of the dead person, acknowledging the impact the loss has had on their lives and affirming that they have come through this difficult experience.

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Appendix One: Article selection

We searched from 1996 onwards in the following databases:

Medline, Pubmed, Psycinfo, CINAHL, Google Scholar, INNZ (Index New Zealand), Cochrane Library, ERIC and Scopus.

We augmented these with the following databases: CYPFS, Ministry of Education, Ministry of Health, Maori Affairs, and the University Libraries of Auckland, Canterbury, Massey, Otago, Victoria and Waikato.

We aimed to retrieve articles in English from the following searches (terms in brackets are the associated truncated search terms):

- suicide prevention AND school
- suicide postvention AND school

We searched these as terms in titles, abstracts and keyword lists.

The initial searches for *suicide prevention AND school* and *postvention and school* yielded 167 and 29 unique articles in English.

We followed this with further searches using formulations and truncations of these search terms: crisis management; crisis intervention; curriculum-based suicide prevention; gatekeeper programmes; gatekeeper; prevention; screening; intervention; postvention; prevention; youth suicide; teenage suicide; education; secondary schools; students and suicide.

Although we did not exclude material from other countries, we focused on Australia, Canada, New Zealand, England, Ireland, Scotland, and the USA.

In addition we hand-searched the reference lists of reviews and other key papers.

We used Google to search for grey literature focusing on known organizations and agencies with a focus on suicide prevention and searched for material on suicide prevention in schools.

In addition, we sourced other relevant materials such as the New Zealand guidelines on identification of common mental disorders and management of depression in primary care (NZGG 2008), and the guidelines on assessment and management of people at risk of suicide, and similar documents from NICE in the UK. We also referred to a range of textbooks.

Material was included if it was directly relevant to suicide prevention and postvention in New Zealand schools. Where the same research material was duplicated in more than one published paper, we have cited the main publication.

Appendix Two: Criteria for assessment of suicide prevention programmes and assessment of selected programmes against criteria

It is recommended that programmes that decrease known suicide risk factors or which increase protective factors, but which are not specifically identified or labelled as ‘suicide prevention programmes’ should be assessed by schools against the following criteria.

The criteria are organised to address safety issues for students, programme considerations and provider considerations and are prioritised into two groups: essential criteria and desirable criteria. In order to ‘pass’ the criteria, programme providers must be able to demonstrate to schools that they are able to provide a positive ‘yes’ response to each essential criterion. The best-case scenario, or gold standard, is that in addition to passing all the essential criteria, the programmes are also able to provide a positive response to each of the desirable criteria. Each of the essential criteria is as important as the others. Similarly, each of the desirable criteria is equally important.

Safety for Participants

Essential criteria:

- Programme does not directly or indirectly raise awareness of suicide. Externally-provided programmes which simply raise awareness of suicide are dangerous and should not be implemented in school settings.
- Programme does not encourage young people to take a high degree of responsibility for the wellbeing of their peers.
- Programme providers have good established and ongoing relationships with key people in the school and in the community, including school counselling services, youth mental health and crisis education services.
- Programmes which focus on help-seeking should not focus solely on suicidal behaviours, but should rather focus on help-seeking for a range of health, educational and other social concerns.
- Young people in distress should be supported by professionally trained adults. Externally-provided programmes should ensure that they facilitate access to appropriate sources of support for young people.
- Programme providers must be able to demonstrate comprehensive and appropriate links to community mental health services which are known to, and supported by, the school guidance counsellor.

Desirable criteria:

- Programme content is appropriate for the age, gender, and cultural background of the students at the school.

- Parents, caregivers and whanau are informed that the programme is being provided. Multiple strategies should be used to ensure that every avenue is used to inform parents, caregivers and whanau of the participation of young people in externally-provided programmes. Ideally, written informed consent should be received from the young person, and their parents, caregivers and whanau prior to participation in any externally-provided programme.
- Programme addresses issues of stigma associated with the identification of potentially high-risk participants.
- Programme providers must demonstrate to schools a clear understanding of the role of the external provider in the event of a suicide attempt, death or suicide cluster occurring within schools.
- Programme providers must be able to demonstrate that the goals and principles of their programme are consistent with the school's policies and practices.

In the event of a suicide attempt, death or suicide cluster, external providers of the suicide prevention programmes should review their operations in consultation with senior school management, the Ministry of Education guidelines for schools relating to young people at risk of suicide, and their school crisis plan. The Ministry of Education Traumatic Incidence Team provides postvention support to schools (0800 84 8326).

Programme considerations

Essential criteria:

- Programme providers must demonstrate how the programme principles and content are congruent with the *Health and Physical Education in New Zealand curriculum* and existing school policies and practices relating to student safety.
- Programme providers must demonstrate that the programme has an appropriate and explicit theoretical or research base.
- Programme outcomes must be rigorously evaluated, preferably by an independent provider.
- The benefits of the programme should be substantiated by ongoing evaluation.

Programme providers must be able to demonstrate the theoretical and research base which informed the programme development, and which informs programme implementation. Programme providers must be able to demonstrate that a review of the literature has been undertaken and that there has been significant and systematic expert input into the development of the programme.

Prior to its widespread implementation in New Zealand schools, the programme must have been comprehensively evaluated, and evaluation findings must be available for consideration by schools. The programme must also be accompanied by a clear and logical ongoing evaluation framework, which includes appropriate outcome measures.

Desirable criteria:

- Programme providers must demonstrate how the programme principles and content are congruent with the purposes and principles of the NZ Suicide Prevention Strategy (MoH 2006).
- Programme providers must identify any ethical implications for the school in implementing or administering the programme.
- Programme providers must demonstrate how the programme assists schools with implementing a whole-school approach to mental health promotion.
- All costs to the school, including time commitments of students and school staff, must be clearly documented at the beginning of the programme. Transparency of roles, responsibility, costs and financial contributions is vital.

Providers

Essential criteria:

- Programme providers must be able to demonstrate to schools that they have a good understanding of the New Zealand Health and Physical Activity curriculum and how their programme is aligned with it.
- Programme providers must be able to demonstrate appropriate formal qualifications which are suitable for the roles required in the programme to be provided.

Desirable criteria:

- Providers must provide to schools comprehensive information about their organization, programme content and programme procedures.
- Providers should be able to provide supportive documentation detailing their experience of working in schools in New Zealand.
- Providers should be able to demonstrate to schools that the programme is sustainable in the long term, including the likelihood that the school will be able to ultimately incorporate the programme within school systems.
- Providers must be able to provide comprehensive literature about their proposed programme, including its history, goals and principles, and information suitable for school community members (for example, parents).
- Providers must also be able to demonstrate a history of positively and appropriately working with schools in New Zealand, including letters of support.

Programmes that have been assessed in New Zealand

The following section is reproduced from *Evidence for student-focused school-based suicide prevention programmes: criteria for external providers*; Bennett et al, 2003. Some of the programmes may no longer be available to schools.

Introduction

At the beginning of 2003, the Ministries of Youth Affairs, Health and Education agreed to jointly fund an independent report to review the evidence for the effectiveness of externally-provided student-focused suicide prevention programmes in schools and to develop a set of

criteria which schools could use to evaluate external providers of such programmes. The Ministries of Youth Affairs, Health and Education also requested that an assessment of up to six school-based suicide prevention/mental health promotion programmes be undertaken.

Following several discussions with representatives from the Ministries and key school personnel, it was determined that the following suicide prevention/mental health promotion programmes be approached, for the following reasons:

Project K – an example of a community development model, with considerable reach into school communities, and high public profile;

Yellow Ribbon – an example of a universal programme, with extensive reach into school communities, and high public profile, which was being implemented in a number of other countries;

Project Hope – an example of a universal programme, with a specific focus on suicide prevention;

TRAVELLERS – an example of a pilot early intervention indicated programme with the potential for further reach into school communities; and

RAP-Kiwi – an example of a pilot universal programme with the potential for further reach into school communities, which was being implemented in a number of other countries.

The following analysis is based on information and programme materials available as at February/March 2003, and provides a ‘snapshot’ of the programmes at this particular point in time. It should be noted that the programmes considered here may have changed since this time. Additionally, the information provided here should not be considered a substitute for a formal independent evaluation of these programmes.

Methodology

A case study approach was adopted for this analysis. For each case, selected information was sought via: 1) a review of relevant programme materials; 2) if available, a review of the relevant internet site; and 3) key informant interviews. Background materials were provided by: Project K, Yellow Ribbon, Project Hope, TRAVELLERS and RAP-Kiwi. Internet sites were reviewed for Project K, Yellow Ribbon and Project Hope. Background materials and information obtained via the Internet were used to provide factual information for the conduct of this assessment. Key informant interviews were undertaken with representatives of Project K, Yellow Ribbon, Project Hope, TRAVELLERS, and RAP-Kiwi programmes; school personnel and relevant community representatives.

In the following section, a summary of the programmes is provided, followed by an assessment of the programmes against the criteria. Assessment was informed by a critical analysis of issues which emerged from the review of the evidence detailed in this report, programme documentation and stakeholder comments. The responses to the criteria are as follows:

‘yes’ or ‘positive’ response = √

‘no’ or ‘negative’ response = X

‘further evidence required’ response = ?

Programme summaries

Project K

Information from the Project K website states that the Project K Trust is dedicated to building self-esteem and giving life direction to 13-15 year olds to encourage them to maximise their potential (www.projectk.org.nz). The Trust's programmes adopt a holistic approach to personal development and empowerment (www.projectk.org.nz/HTMLS/HowProjectKworks.htm). The traditional Project K programmes are offered to selected Year 10 students. Student selection occurs following an individual screening test. After cross-referencing the survey results with teachers, some students are invited to participate, with their **parents'/caregivers' permission**. The Project K programme consists of three stages. Part one, the Wilderness Adventure, commences with a 10-day camp, followed by a 10-day wilderness experience. During this experience, participants are encouraged to focus on goal-setting, team work, perseverance, self-reliance and self-knowledge. In the second part of the programme, the Community Challenge, participants are encouraged to develop closer links with their local communities to further develop their experiences from the Wilderness Adventure. The final part of the programme involves developing personal goals to be achieved during the following 12 months. Participants are matched with a community mentor, and each group meets fortnightly.

Yellow Ribbon

The Yellow Ribbon 'It's OK to ask for **help**' programme is informed by a peer support model and is "a pro-active, preventative, outreach programme which has the aim of strengthening young people by arming them with a communication tool, which encourages youth to talk about the difficulties they may be facing and to seek positive **solutions**" (www.yellowribbon.org.nz). In 2002 the 'It's OK to ask for **help**' programme had been implemented in 140 schools within New Zealand.

Programme documentation relating to the Yellow Ribbon 'It's OK to ask for **help**' programme indicates that the programme aims to "create an environment that encourages and empowers young people to ask for help in a time of need and to educate the community so that they are able to respond correctly to the needs of young **people**" (Yellow Ribbon Overview, p.5).

Senior student volunteers are trained as Yellow Ribbon ambassadors. The programme is centred around the Yellow Ribbon 'It's OK to ask for **help**' card, which young people are encouraged to present to someone they trust. The card signals that the young person has an issue of importance that they wish to discuss. The programme model indicates that the Yellow Ribbon 'It's OK to ask for **help**' programme is "run by youth for **youth**" (Yellow Ribbon Overview, p.5). Consequently, Yellow Ribbon ambassadors, in conjunction with the guidance counsellor, are responsible for driving the programme and activities undertaken under the Yellow Ribbon 'It's OK to ask for **help**' banner.

Project Hope

Project Hope was founded in 1996. It is a non-profit, non-religious organization dedicated to reducing the suicide rate in New Zealand. The principles of Project Hope have been disseminated widely, including through various books and publicity campaigns within 138 secondary, area and intermediate schools and a number of university campuses.

Programme representatives consider that the Project Hope programme is a “system of self-education based on feeding many good thoughts into our subconscious so that we **don’t** have any time **for bad.**” The messages are relayed through the website, (www.project-hope.co.nz) which enables links to both a youth support website and a local adult education site. This is called the Buddyriccardo Internet Education and Support service, which is a 24-hour service, supported by the “Write to Come Right” programme. Young people write down their problems and receive a response from Project Hope.

Programme representatives distribute documentation and resources to schools. This usually includes the basic Life Skills video/workbooks and leaflet packs. During 2002, 130,000 copies of this material were distributed to schools within New Zealand.

TRAVELLERS

The TRAVELLERS pilot programme is an indicated early intervention programme which aims to foster the healthy development of young people by: 1) exploring their change, loss and transition experiences; 2) developing ways to navigate their movement through change, loss and transition in safe and adaptive ways; 3) supporting young people in exploring links between how they think and feel about change, loss and transition situations and how their thoughts and feelings influence how they cope, respond and make meaning; and 4) enhancing supportive environments for young people experiencing change, loss and transitions, and thereby improving their learning outcomes (Dickinson et al, 2003). Programme representatives state that the programme is offered to selected year 9 students. During 2001, the TRAVELLERS programme was pilot tested in two schools, with a further implementation trial in 10 schools during 2002/03. Potential programme participants are screened using four self-report measures. The TRAVELLERS programme consists of eight sessions of 60-90 minutes, held in school time. Sessions are facilitated by specifically trained school counsellors, health educators and guidance personnel.

RAP Kiwi

The ‘RAP (Resourceful Adolescent Programme) Kiwi’ programme is a universal programme that aims to prevent depression among young people. The programme is informed by Resourceful Adolescent Programmes developed in Australia, and is based on cognitive behavioural principles. During 2000, the RAP-Kiwi programme was trialled in two schools over an 11-week period with Year 9 and Year 10 students. The programme aims to provide young people with resources to maintain self-esteem when faced with a variety of stressors. Health teachers facilitated the programme, during class time.

CRITERIA ASSESSMENT:	Project K	Yellow Ribbon	Project Hope	Travellers	RAP-Kiwi
SAFETY FOR PARTICIPANTS: Essential criteria					
Programme does not directly or indirectly raise awareness around suicide.	√	X	X	√	√
Programme does not encourage young people to take a high degree of responsibility for the wellbeing of their peers.	√	X	√	√	√
Programme providers have good established and ongoing relationships with key people in the school and in the community, including school counselling services, youth mental health and crisis education services.	√	?	X	√	√
SAFETY FOR PARTICIPANTS: Desirable criteria					
Programme content is appropriate for the age, gender, and cultural background of the students at the school.	√	√	X	√	√
Rents, caregivers and whanau are informed that the programme is being provided.	√	√	X	√	√
Programme must address issues of stigma associated with the identification of potentially high-risk participants.	?	√	√	?	?
Programme providers must demonstrate to schools a clear understanding of the role of the external provider in the event of a suicide attempt, death or suicide cluster occurring within schools.	?	?	?	√	√
PROGRAMME CONSIDERATIONS: Essential criteria					
Programme providers must demonstrate how the programme principles and content is congruent with the <i>Health and Physical Education in the New Zealand curriculum</i> .	√	√	X	√	√
Programme providers must demonstrate that the programme has an appropriate and explicit theoretical or research base.	√	X	X	√	√
Programme and programme outcomes must be rigorously evaluated, preferably by an independent provider.	√	X	X	√	√
The benefits of the programme should be substantiated by ongoing evaluation.	√	X	X	√	√

CRITERIA ASSESSMENT:	Project K	Yellow Ribbon	Project Hope	Travellers	RAP-Kiwi
PROGRAMME CONSIDERATIONS: Desirable criteria					
Programme providers must demonstrate how the programme principles and content are congruent with the aims and broad principles of the NZYSPS.	√	√	X	√	√
Programme providers must demonstrate that there are minimal financial, time and opportunity costs or ethical implications for the school in implementing or administering the programme.	?	?	?	?	√
Programme providers must demonstrate how the programme assists schools with implementing a whole-school approach to mental health promotion.	√	√	X	√	√
PROVIDERS: Essential criteria					
Programme providers must be able to document and demonstrate to schools that they have sufficient educational training and qualifications to demonstrate an understanding of the New Zealand curriculum.	√	?	X	√	√
PROVIDERS: Desirable criteria					
Programme providers must provide to schools comprehensive information about their organization, programme content and programme procedures.	√	√	√	√	√
Providers should be able to provide supportive documentation, detailing their experience of working in schools in New Zealand.	√	√	?	√	√
Programme providers should be able to demonstrate to schools that the programme is sustainable in the long term, including the likelihood that the school will be able to ultimately incorporate the programme within school systems.	?	√	?	?	?

Appendix Three: Structured assessments

Structured assessments should be used to augment the usual in-depth clinical assessment, because clinicians may neglect key information, and in particular fail to record it, even in relation to a serious issue such as self-harm or suicidality (Burn et al, 1990). Most structured assessments are essentially a list of questions which investigate the areas of the young person's life most likely to be related to their desire to die by suicide. Structured assessments provide a framework which ensures that all areas of the person's life are assessed. They vary in length and content, ranging from a simple list of questions to schedules which attempt to rate the severity of each warning sign or risk factor. Structured assessments of any kind do not substitute for a good clinical interview conducted once rapport is established, and they should not be used as the sole means of gaining information from a person in distress. Appropriate use of structured assessments assumes a high degree of skill on the part of the counsellor to know which risk factors, warning signs and combinations of these, constitute a low, moderate or high risk.

An example of a structured assessment for suicidality follows. No single instrument exists as a gold standard for suicide risk assessment. Bear in mind also that it would be best to put these questions in your own words (while maintaining the specificity) so they flow naturally in your communication.

Example of a structured assessment

(Adapted from: RAPID assessment of patients in distress. In *Centre for Mental Health. Mental Health for emergency departments: a reference guide*. NSW Department of Health; 2001.)

Suicide assessment

Have you had thoughts that life isn't worth living? Yes No

Have you thought of harming yourself? Yes No

Are you thinking of suicide? Yes No

Have you tried to harm yourself in the past? Yes No

If yes, how many times?

When was the most recent time?

In last day in last week last month longer ago (specify)

How often are you having these thoughts?

Have you thought about how you would act on these (is there a plan)?

(Does this plan seem feasible? Are the methods available? Is it likely to be lethal?)

Have you thought about when you might act on this plan?

Are there any things/reasons that stop you from acting on these thoughts?

Do you know anyone who has recently tried to harm themselves?

If any answer is 'yes' prompt with:

'Tell me more about that' as discussion will help to convey the extent of risk.

If a suicide attempt has been made

What did you hope would happen as a result of your attempt?

(Did they want to die, or end their pain?)

Do you still have access to the method used?

Did you use alcohol or drugs before the attempt?

What did you use?

Do you have easy access to a weapon?

Commentary

Consider whether the person is safe to be alone

Risk factors include:

- definite plan
- hopelessness
- severe depression
- psychotic symptoms
- recent discharge from a psychiatric unit
- use of alcohol, street drugs, particularly recent escalation
- recent suicide attempt
- homelessness
- medical illness
- history of childhood abuse
- recent suicide attempt by a whānau/family member or a friend.

Appendix Four: Psychosocial assessments of young people

HEEADSS Psychosocial assessment in adolescents

The HEADSS acronym(i) updated in 2004(ii) to HEEADSSS or HE₂ADS₃ is a well-known prompt to structure a psychosocial assessment in adolescents. It has the advantage of progressing from routine questions to more probing ones, giving the practitioner a chance to establish rapport before approaching the most difficult areas. However, the order of the interview depends on the dictates of common sense and clinical instinct and the young person's presenting complaint should be addressed as a priority.

Home: relationships, communication, anyone new?

Education/Employment: ask for actual marks, hours, responsibilities

Eating: body image, weight changes, dieting, exercise

Activities: with peers, with family

Drugs: tobacco, alcohol, other drugs – use by friends, family, self

Sexuality: sexual identity, relationships, coercion, contraception, pregnancy, sexually transmitted infections (STIs)

Suicide and depression: sadness, boredom, sleep patterns, anhedonia

Safety: injury, seatbelt use, violence, rape, bullying, weapons

Issues of ethnic identity may also be critical domains, particularly among adolescents/rangatahi from minority cultures.* iii

Sources:

i Goldenring JM, et al. *Contemp Pediatr*. 1988;5(75).

ii Goldenring JM, et al. *Contemp Pediatr*. 2004;21(64):1–20.

iii Ministry of Social Development. *Cultural identity: the social report*. Wellington: Ministry of Social Development; 2007.

iv Ministry of Health. *Family violence intervention guidelines: child and partner abuse*. Wellington: Ministry of Health; 2002.

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