
# A report for Ermha, Lifecentral and Suicide Safer Communities

**Dr Michelle Duffy**
(School of Environmental and Life Sciences, The University of Newcastle)

**Dr Monica Green**
(School of Education, Federation University Australia, Gippsland)

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## EXECUTIVE SUMMARY

Adolescents today face increasing mental health challenges, particularly in relation to suicide, self-harm, depression and anxiety, and alcohol/drug misuse. While there is a relatively large number of evidence based student mental health and well-being programs available for schools that are specifically designed to benefit students and the broader school community, research suggests that many of these programs are delivered in the 'margins' of school life, and tend to be sustained by a few dedicated staff. Despite the high levels of awareness around mental health issues for young people in school settings, research highlights the need for upskilling adults to be capable of identifying mental health problems early, and to have knowledge of effective prevention strategies and implementation (Graetz, 2016). Further to this are the increasing concerns for the health, well-being and resilience of those adults who as part of their professional employment, are expected to support young people with mental health issues.

Death from intentional suicide among young people in Australia accounts for 28.2% of all deaths in the 15-19-year-old age group (Australian Bureau of Statistics, 2016). This has occurred despite the existence of an improved national policy on suicide and increased government investment in suicide prevention over the same time period (Australian Government, 2007; Robinson, 2012). While knowledge of the risk and protective factors associated with youth suicide has become more nuanced, empirical evidence to support suicide prevention programs in schools is relatively lacking. Of even greater concern, little is known about what makes programs effective.

The focus of the Suicide Safer Schools Project is to support Secondary Schools to build their capacity to respond to people at risk of suicide and achieve accreditation as a 'Suicide Safer School Community' through the development and implementation of a comprehensive suicide prevention framework. This Project operates from capacity building and sustainability principles; working with the school and their broader communities to establish a network of trained responders for acute risk of suicide through the learning of intervention skills, a policy framework for the establishment of 'safety contacts' and systems within the school and a network of connected local community and health services.

This Report draws on the analysis of material arising out of a small-scale qualitative study that examined the effectiveness of training school staff through the Suicide Safer Schools program. The aim of this component of the Project was to create a narrative evidence base of the effectiveness of the Suicide Safer Schools training for staff in three Victorian secondary schools. School staff within the three highlighted case studies were trained in either safeTALK or suicideTALK, 2-3hour training as to building awareness around suicide, and ASIST (Applied Suicide Intervention Skills Training), an intensive 2-day course that provided accredited suicide awareness and first responder intervention training. The key research focus was to determine how effective the implementation of the Suicide Safer Schools training had been for staff in secondary school settings. To address this over-arching question, semi-structured small focus group interviews with teaching and non-teaching staff at three schools located in the Melbourne's south-eastern peri-urban areas were conducted. This small-scale study considered in (a) what ways has the Suicide Safer Schools training program equipped staff to deal with mental health issues in secondary schools, (b) what impact has the implementation of the Suicide Safer Schools training program had in secondary schools, and (c) what were teachers' experiences of being trained in the Suicide Safer Schools training program.

## The key findings of this study

- Suicide intervention training has the capacity to challenge the 'taboo' nature of suicide, including its complexities, associated myths and assumptions.
- Staff training (ASIST and safeTALK) training provides an important "permission giving" space whereby staff could share personal and professional experiences of suicide, which were validated and respected by peers.
- Training provided an important opportunity to practice using appropriate suicide language and to roleplay suicide intervention.
- Brokering the complexities of suicide allowed staff to identify the need for their school to embark on widening and advancing suicide as a critical and cultural dimension of school life (e.g. that it be given greater attention in the wider curriculum).

- The ASIST training was identified as a robust way of equipping staff to confidently identify and deal with suicidal behaviour.
- The safeTALK/suicideTALK training was identified as effective in raising suicide awareness, but less effective in equipping staff to identify and deal with suicidal behaviour in confident ways.

## Recommendations

**Recommendation 1**
Whole school approaches to suicide intervention for leadership, teaching and non-teaching staff that will increase capacity to identity mental health problems early, and implement effective suicide prevention strategies, knowledge and skills across the wider school/college community.

**Recommendation 2**
Schools to establish school systems, protocols, a safety contact check list, a register of trained staff, and chains of command action plans that support immediate response to suicidal behaviour during school and non-school hours (e.g. week-ends/holiday periods).

**Recommendation 3**
School leaders to establish formal and informal means of communicating with staff about student records/history in relation to suicide.

**Recommendation 4**
Schools to establish effective strategies that engage families/parents/guardian about mental health and suicidal behaviour.

**Recommendation 5**
Schools to prioritise training for all staff that focuses on strategies to support staff in their collective and individual endeavours to maintain personal mental health (e.g. mental health first aid), gate keeper training and mental literacy.

**Recommendation 6**
Increased and transparent whole school messages that reinforce the idea (a) suicide intervention is the role of all school staff members regardless of their professional position and responsibility, and (b) suicide intervention is relevant and applicable to all members of the school community.

## AUTHORSHIP AND ACKNOWLEDGEMENTS

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## 1 INTRODUCTION

Suicide is now the leading cause of death for young people 15-24 years (Australian Bureau of Statistics, 2012). Beyond Blue states that 26.4% of Australians aged 16 to 24 currently have experienced a mental health disorder in the last 12 months and half of all lifetime cases of mental health disorders start by age 14 years and three fourths by age 24 years. Suicide has immense effects on the families, friends, and communities of people who die by suicide, causing long lasting grief and guilt. Arguably, these effects are even greater when the person who died by suicide is young. It is estimated that suicide costs the Australian economy $17 billion per year (The Estimation of the Economic Cost of Suicide to Australia, 2009). Researchers and policymakers recognise that suicide is preventable, yet suicide rates are increasing.

Adolescents today face increasing mental health challenges, particularly in relation to suicide, self-harm, depression and anxiety, and alcohol/drug misuse (Beinecke, 2016). This reality has a direct bearing on schools, which are identified as significant sites for reaching large numbers of young people (including the key adults critical to their development) about mental health. These circumstances trigger broader consideration about 'the appropriate role and function of schools with respect to mental health and well-being' (Graetz, 2016: 5). While there is a relatively large number of evidence based student mental health and well-being programs available for schools that are specifically designed to benefit students and the broader school community, research suggests that many of these programs are delivered in the 'margins' of school life, and tend to be sustained by a few dedicated staff (Alderman & Taylor, 2000). The general view is that many schools are challenged to effectively plan, instigate and sustain student mental health and well-being programs into normal school practice. Despite the high levels of awareness around mental health issues for young people in school settings, research highlights the need for upskilling adults to be capable of identifying mental health problems early, and to have knowledge of effective prevention strategies and implementation (Graetz, 2016). Further to this are the increasing concerns for the health, well-being and resilience of those adults who as part of their professional employment, are expected to support young people with mental health issues. In light of this, their own self-awareness, social awareness and self-management emerge as critical

considerations (Beltman, 2015). How teachers and other teaching staff are supported and prepared for the challenges of dealing with mental health must be addressed. In this light, professional development opportunities and training programs are critical for supporting teachers to maintain their own, as well as their students' well-being and resilience (Fleming et al, 2013).

At a time when greater implementation of mental health programs into and across mainstream school practice is required, whole school mental health training approaches and programs are identified as a vital solution (Graetz, 2016). In recognising this, the Suicide Safer Schools training program is designed to assist schools in mental health awareness and practice by increasing staff professional mental health learning through whole school approaches. The evaluation of the program will shed new light on the impact of training secondary school professionals in secondary schools who are committed to addressing current mental health issues for young people across the wider school community.

## Overview of Suicide Safer Schools Project

The focus of the Suicide Safer Schools Project is to support Secondary Schools to build their capacity to respond to people at risk of suicide and achieve accreditation as a 'Suicide Safer School Community' through the development and implementation of a comprehensive suicide prevention framework, for first response and streamlined referral pathways where underlying or additional needs are identified.

For a school to achieve accreditation as a 'Suicide Safer School Community' the Project needs to first engage with the participating school in a process of assessment to understand their current strengths and areas for development. Following assessment, the project then works with the school to address any gaps in their suicide prevention competence and so meet the requirements of accreditation. This process occurs under the areas of:

- **Understanding current situation:** The Needs Analyses provide information on the connectedness and cohesiveness within the school; a snapshot of the current suicide risk of the school community; insights as to the current concerns of individuals within the school community and are an imperative component which

are designed to inform the recommendations for accreditation as a Suicide Safer School Community.

- **Building competence:** Evidence-based training delivery (for students, teachers, interested parents) in suicide awareness and first response intervention
- **Building systemic capacity for immediate response:** Establish safety contacts within the schools as a system for immediate response and intervention
- **Building systemic capacity to address underlying needs:** Work with the school and local services to establish streamlined referral pathways for addressing underlying and unmet needs (including ensuring external services are adequately trained)
- **Building systems for sustainability:** Work with the school to establish a policy framework for maintaining their suicide response capacity

The Project operates from capacity building and sustainability principles; working with the school and their broader communities to establish a network of trained responders for acute risk of suicide through the learning of intervention skills, a policy framework for the establishment of 'safety contacts' and systems within the school and a network of connected local community and health services.

## Evaluation of the Suicide Safer Schools training (*safeTALK and ASIST)

This Report draws on the analysis of material arising out of a small-scale qualitative study that examined the effectiveness of training school staff through the Suicide Safer Schools program. The aim of this component of the Project was to create a narrative evidence base of the effectiveness of the Suicide Safer Schools training for staff in three Victorian secondary schools. The key research focus was to determine how effective the implementation of the Suicide Safer Schools training had been for staff in secondary school settings. To address this over-arching question, semi-structured small focus group interviews with teaching and non-teaching staff at schools were conducted in order to consider in what ways has the Suicide Safer Schools training program equipped staff to deal with mental health issues in secondary schools, what impact has the implementation

(* The safeTALK program was replaced with a similar suicide prevention training program called suicideTALK in Case studies #1 and #2, conducted over 45-120 minute sessions).

of the Suicide Safer Schools training program had in secondary schools, and what were teachers' experiences of being trained in the Suicide Safer Schools training program. The Report sets out the findings from this evaluation.

## 2 AIMS OF EVALUATION

The main aim of this small-scale qualitative project was to determine how effective the implementation of the Suicide Safer Schools Project was for teaching and non-teaching staff in secondary school settings. In addressing this, the evaluation sought to address the following questions:

- In what ways has the Suicide Safer Schools training program equipped staff to deal with mental health issues in secondary schools?
- What impact has the implementation of the Suicide Safer Schools training program had in secondary schools?
- What is the experience of staff in the Suicide Safer Schools training program?
- What are the strengths and limitations of the Suicide Safer Schools training program?
- How might the training program be improved?
- What are the motivations behind schools undertaking professional training/learning in the area of mental health?

## 3 SUICIDE PREVENTION IN AUSTRALIAN SCHOOLS: LITERATURE REVIEW

Death from intentional suicide among young people in Australia increased by 32% from 2006 to 2015 and accounts for 28.2% of all deaths in the 15-19-year-old age group (Australian Bureau of Statistics, 2016). This has occurred despite the existence of an improved national policy on suicide and increased government investment in suicide prevention over the same time period (Australian Government, 2007; Robinson, 2012). While knowledge of the risk and protective factors associated with youth suicide has become more nuanced, empirical evidence to support suicide prevention programs in schools is relatively lacking. Of even greater concern, little is known about what makes programs effective. After a brief overview of recent developments in the literature on suicide, this review will turn to the nature and extent of suicide prevention efforts with the purpose of determining which approaches hold the most promise. The paper concludes with a series of recommendations for future research and program development in this area.

### 3.1 Recent developments in suicide research

Most people who think about suicide do not go on to make suicide attempts and predictors of suicide in the extant research are, in fact, predictors of suicidal ideation rather than actual suicide attempts. Some of the better-understood risk factors such as the presence of psychiatric symptoms, while differentiating those who think about suicide from those who do not, are very poor at distinguishing between suicidal ideators and attempters (see Acosta et al., 2012). Differentiating suicide attempters from suicidal ideators is a critical frontier for suicidology research (Klonsky & May, 2014). To this end, recent research suggests that suicide capability, reduced pain sensitivity, fearlessness, and a history of self-injury are better predictors of actual suicide attempts (Smith, Cukrowicz, Poindexter, Hobson & Cohen, 2010; Taliaferro & Myehenkamp, 2014). There is also emerging evidence that alcohol use is elevated in young people who attempt suicide (Taliaferro & Myehenkamp, 2014).

Using data from the 2010 Minnesota Student Survey, Taliaferro and Muehlenkamp (2014) identified risk and protective factors that differentiated young people who never thought about suicide from those who have thought about suicide and those who had attempted suicide. The sample comprised over 70,000 students from Year 9 and Year

12. They considered a vast array of risk factors including bullying (victim or perpetrator), family substance use, being witness to family violence, physical or sexual abuse, being a victim of dating violence, mental health or physical problems, cigarette smoking, marijuana use or alcohol use, binge drinking, and the misuse of prescription or illegal drugs. Additional variables included whether the young person had run away from home, skipped school, self-injured, perpetrated violence, had been a victim of school violence, perceived that they were overweight or had maladaptive dieting behaviour, had same-sex sexual experience, or experience a range of psychiatric symptoms including depression, hopelessness, stress/anxiety or distractibility/impulsivity. The protective factors were parental connectedness, connectedness to other adults, teacher caring, caring friends, whether they liked school, had an average level of academic achievement, felt that their school was safe, felt that their neighbourhood was safe, and whether they participated in team sports.

Results from Taliaferro and Muehlenkamp's (2014) study revealed that the most important risk factor that differentiated suicidal ideators from attempters was a history of self-injury. Other risk factors that differentiated the two were dating violence victimization and cigarette smoking for males and same-sex sexual experience for females. Running away from home also increased the risk of suicide attempt for both sexes. Furthermore, while parent connectedness and academic achievement differentiated all three groups in the study, neighbourhood safety lessened the risk of transition from suicidal ideation to attempt in their linear modelling. The authors conclude that interventions among suicidal youth need to reduce significant risk factors and enhance protective factors in order to determine what effect this has in terms of suicide prevention.

Smith et al. (2010) tested the hypothesis that in order to make a serious or lethal suicide attempt, a person must experience sufficient reductions in fear and pain sensitivity as to overcome biological instincts towards self-preservation. They did so using two measures – a self-report assessment of 'fearlessness' and a laboratory test of aversion – with a small sample of college students who had either never thought about suicide, thought about suicide, or attempted suicide. Participants completed a clinical interview, the Beck Depression Inventory, the Beck Anxiety Inventory, the Beck Hopelessness Scale, and the Beck Scale for Suicide Ideation. Fearless and pain insensitivity was assessed using the

Acquired Capability for Suicide Scale, and the Painful and Provocative Events Scale, Impulsive Behaviors Scale, and the Life Experiences Survey. For the aversion test, participants viewed positive, negative, neutral and suicide-related images whilst wearing headphones and receiving a burst of white noise. Their eye-blink reflexes during the task were recorded using electromyography. The results from Smith et al.'s (2010) study revealed that those who had previously attempted suicide rated more highly on fearlessness and pain insensitivity than the other two groups. Painful and provocative life events, in particularly, were more common among suicide attempters. However, the hypothesis that suicide attempters would display less aversion to suicide-related images compared to neutral or negative images was not supported. This finding was consistent across all three groups. This suggests, as the authors argue, that it is the perception of fearlessness and insensitivity to pain that is related to the actual capability for suicide.

Using a longitudinal research design, McManama O'Brien et al. (2014) examined the interaction between depression severity and alcohol use in a cohort of 143 adolescents aged 12 to 15 years, given the known interaction between alcohol and depression severity in adulthood. Frequency of alcohol use was assessed using measures based on the Youth Risk Behaviour Surveillance System, and depression severity was assessed using the Child Depression Inventory. The suicide item from the Child Depression Inventory was used to measure thoughts about suicide (i.e., suicidal ideation), and hospital records were used to identify adolescents who had attempted suicide. An additional assessment of lifetime suicide attempts was also made by asking hospitalised adolescents about their histories. Statistically, McManama O'Brien et al. (2014) predicted the odds of suicidal ideation and recent suicide attempts on the basis of depression severity and alcohol use. Their first finding was that frequency of alcohol use was higher among suicidal adolescents compared to the general population, with approximately 33% of young people reporting the regular consumption of alcohol prior to hospital admission. Similarly, frequency of alcohol use significantly differentiated between adolescents who thought about suicide and those who had attempted suicide. However, frequency of alcohol use did not differentiate between adolescents who had never thought about suicide from those with suicidal ideation, but severity of depressed mood did. This

indicates that in the presence of suicidal ideation, alcohol use increases the risk of a suicide attempt.

In summary, recent research on suicide prevention has begun to focus on those risk and protective factors that distinguish between those who think about suicide and those who attempt suicide. While this does not mean that young people with suicidal thoughts do not require professional help, it does mean that if interventions are to actually prevent suicide then they need to better targeted. The next stage for empirical research is to conduct longitudinal studies aimed at determining the causal pathways from risk to behaviour in suicide attempters. The challenge for suicide prevention programs is to target those same risk factors and determine whether this leads to improved outcomes.

### 3.2 The evidence for school-based suicide prevention

In Australia, the most sustained efforts to systematically research the evidence for effective interventions in this area has been carried out by Jo Robinson and colleagues from the Centre of Youth Mental Health at the University of Melbourne (Milner, Carter, Pirkis, Robinson & Spittal, 2015; Huisman, Pirkis, & Robinson, 2010; Robinson, Hetrick, & Martin, 2011; Robinson et al., 2008; Robinson et al., 2011; Robinson et al., 2012; Robinson, 2014; Robinson et al., 2016a; Robinson, 2016b). Initially, Robinson et al. embarked on a review of suicide prevention research in Australia in order to identify any gaps. They found that the majority of research on suicide prevention was in the area of epidemiology rather than intervention studies. They then randomly selected 200 stakeholders from various groups (i.e., researchers, psychiatrists, general practitioners, NGOs, and government agencies) to nominate areas of high priority. The stakeholders rated intervention studies as the highest and epidemiological studies that identify risk and protective factors as the second highest priority. Stakeholders also expressed a desire to see more targetted interventions, that select students out, rather than universal approaches that include all students in a year level. As a follow up to this study, Robinson et al. (2013) conducted a systematic review of school-based interventions aimed at either preventing, treating or responding to suicidal behaviour in young people. They found that the most promising interventions for schools were ‘gatekeeper training’ and screening programs.

Gatekeeper training is designed to increase the likelihood of identifying young people at high risk of suicide and ensuring that they receive timely mental health treatment (Lamis et al., 2016). They typically involve the training of school personnel, but some programs also train student peers as 'gatekeepers'. Gatekeeper programs aim to increase general knowledge of youth suicide, knowledge of risk and protective factors, and reduce the stigma of suicide. Another aspect of gatekeeper training is improving the confidence and self-efficacy of staff to engage in positive suicide prevention practices (Robinson et al., 2013). Outcomes of evaluation studies suggest that gatekeeper programs are successful in changing attitudes towards suicide, increasing knowledge about suicidal behaviour, increasing confidence in dealing with suicide-related behaviours, and promoting positive change in prevention practices. As Robinson et al. (2013) noted, however, very few of these changes were maintained at 3-, 6- or 9-month follow up and were more likely to be maintained by student peers and counselling staff than by teachers and principals. This suggests that the effectiveness of gatekeeper training may only be short-term or that booster-training sessions are required to maintain its benefits over time.

Screening programs are aimed at identifying young people at risk of suicide but who have not sought professional help or been referred for help. Screening programs often employ a self-report questionnaire as the first stage with a structured clinical interview at the second stage. Evidence suggests that self-report measures are much better at picking up those at risk compared to school staff who tended towards 'false positives' (Robinson et al., 2013). More importantly, screening measures successfully identify young people at risk of suicide who have not previously sought help. Furthermore, studies indicate that screening students for suicide risk does not cause undue distress, in that it does not cause an increase in negative mood and is reported to be acceptable amongst students (Gould, et al., 2005; Robinson et al., 2011).

Studies at an international level also support the ability of school-based interventions to reduce suicidal ideation and the number of suicide attempts (Calear, et al., 2016; Wasserman et al., 2015). In response to a need for more randomised controlled trials in this area, Wasserman et al. (2015) conducted a multi-site, school-based intervention with 11,110 adolescents, aged 15 years, across 10 European countries. Students were first screened via self-report questionnaire and any who had exhibited suicidal behaviour at

baseline were excluded from the analysis. Students who reported suicidal behaviour at 3- or 12- month follow up were investigated, assessed and referred to professional help. The study compared three interventions with a control group – a manualised gatekeeper program, a universal program aimed at all students in the year level (a brief, 5 hour intervention across 4 weeks), and a targeted program with selected students screened by health professionals. Results revealed that the universal program significantly prevented new cases of suicide attempts and severe suicidal ideation (i.e., including planning) by 50% when compared to controls. The gatekeeper program and the screening program did not have a significant effect in this study.

Calear et al. (2016) conducted a review of international studies which compared the same gatekeeper program with a universal program and a program for parents across three settings – school, community, and clinical. Programs contained a number of psychosocial strategies including cognitive behaviour therapy, problem solving, motivational interviewing, psychoeducation, and psychosocial interventions designed to enhance social support. Multiple comparisons were conducted according to intervention setting, intervention content, intervention approach, and delivery format. They found no specific effects for any of these variables, with all appearing to be equally effective. Surprisingly, however, they found that programs carried out with individuals alone only had effects on suicidal ideation whereas group and family programs only had effects on suicide attempts. They conclude that further research is needed to understand the mechanisms behind this finding.

An area of research currently gaining momentum is the potential of internet-based interventions and other forms of brief intervention (Milner, et al., 2015; Robinson et al., 2015; Robinson et al., 2016b). Milner et al. (2015) examined the use of letters, ‘green cards’, telephone calls and postcards in reducing self-harm suicide attempts and suicide using a strict, meta-analytic protocol. Although their analyses did reveal lower odds of self-harm or suicide attempt when comparing intervention with control, these comparisons were not statistically significant. The authors attribute the lack of significant findings to the inclusion of a small number of studies with low statistical power. For these reasons, comparisons were not made between types of brief intervention. They conclude

that the evidence-base for the use of brief interventions is poor, and there is no basis on which to recommend their widespread implementation.

Robinson et al. (2016b) conducted a review of studies examining the utility of social media sites for suicide prevention. Of the thirty studies identified, each considered one of four questions: (1) what format do social media sites use; (2) what potential does social media have in terms of its ability to reach people at risk; (3) how do people use social media sites for suicide prevention; and (4) what are the experiences of people who use these social media sites? For the most part, programs tended to use social media platforms to direct people to a static website. Social media platforms had the capacity to reach over 18,000 people. In terms of how people use social media sites, studies suggested that communication by moderators and users tended to be empathic, caring, and compassionate. Moderators also use employment, interpretation and cognitive change strategies (i.e., strategies that focus on problematic thinking). Perhaps for these reasons, people who use social media sites, whether they are at risk individuals or those bereaved by suicide, find them to be supportive. Some of the issues with the use of social media sites include the emotional burden on volunteers that moderate sites, the potential for 'copycat' or viral transmission of negative thoughts and images. A number of studies have found that at a cultural level, increases in suicide-related posts on social networking sites are significantly associated with higher rates of suicide (e.g., Jashinsky et al., 2013; Won, et al., 2013).

Finally, a relatively neglected issue in youth suicide prevention to date is the need for cultural sensitivity. The most notable groups in need of attention are non-Western populations, Indigenous populations, and rural youth (Clifford, Doran, & Tsey, 2013; Hirsch, 2006; Kong & Kim, 2016; Robinson, G. et al., 2016). In terms of Australian Indigenous populations, Clifford et al. (2013) note that the Indigenous peoples of Australia, Canada, United States and New Zealand all experience higher rates of suicide than the general population. They reviewed studies that targetted these populations. Nine evaluations were identified, but only three measured changes in rates of suicide. The authors note, however, that each of these studies was seriously flawed in their methodology, including weak study designs, reliance on self-report, and poor follow-up rates. Encouragingly, all three reported significant improvements. The interventions

combined gatekeeper training with community prevention and school-based education. However, the authors concluded that relatively high number of descriptive and non-experimental designs in this area is a weakness (i.e., lack of a control group against which to measure change), and that without strong, rigorous experimental designs the likelihood of ineffective interventions is increased.

Considering the literature on rural suicide, Hirsch (2006) noted that in Australia, Canada, the US, Asia, the United Kingdom, Eastern Europe, Bangladesh, and South Africa rural rates of suicide are significantly higher than urban. In putting forward some potential explanations for such a widespread phenomenon, Hirsch (2006) suggested that rural life and culture presented unique challenges to agricultural communities. In particular, he argued that the requirements of a rural existence to 'soldier on' create an environment where suicidal thoughts and behaviours may be neglected. Economic and sociopolitical distress tends to be higher in rural areas, services are less available, and there is greater access to lethal means of suicide compared to urban areas. Researchers have noted elsewhere that rural adolescents with mental health problems face additional barriers to helpseeking due to the social geographies of rural communities (see Boyd et al. 2005; Boyd & Parr, 2008; Boyd et al., 2011). This points to the need to acknowledge the unique characteristics of rural life in the design of suicide prevention programs in this group.

There is, of course, a degree of overlap between rural, remote, and Indigenous communities. Robinson, G. et al. (2016) tie the higher rates of suicide among Indigenous Australians to their geographical remoteness. Rates of youth suicide among the remote communities in the Northern Territory, in particular, are alarmingly high and account for 55% of all suicides in the Territory (Robinson, G. et al., 2012). To address this, Robinson, G. et al (2016) developed a pilot life skills program in collaboration with the Maningrida community to whom 90% of Indigenous people in the region belong. Together they developed a curriculum that was specifically tailored to the risk factors that young people in their community faced including alcohol use and emotional literacy. While introducing the curriculum, the researchers conducted a 'process assessment' by videotaping the lessons and discovered that sporadic class attendance was a factor affecting the delivery of the program. It also became apparent that low literacy levels limited the ability of students to work with text-based scenarios. Language use needed to be carefully

‘scaffolded’ in this context through the use of kinaesthetic games and visual tasks. They also concluded that teachers did not necessarily understand the challenges that students faced at home or in the wider community, which may affect the ability for the lessons to resonate with students. Despite the limitations of the pilot implementation, however, a close attention to process enabled the researchers to further refine and extend their program.

### 3.3 Suggestions for future research in school-based suicide prevention

The most recent research in suicide prevention focuses on differentiating those who think about suicide from those who go on to attempt suicide. This distinction is vital for several reasons. First, it acknowledges that thinking about suicide does not necessarily result in suicide and that talking about self-injury with young people is an important task for suicide prevention. Second, it strengthens the case for improved screening of the factors that predict actual suicide attempts – e.g., history of self-harm, alcohol use, and painful life events. Third, it highlights the need for sensitive programs that can respond appropriately to students whose *behaviour* might lead to suicide. And fourth, it points to the importance of strengthening neighbourhood and community-level supports.

One of the obvious features of the research to date is the lack of understanding of the mechanisms of change when it comes to the effectiveness of any one program. Randomised controlled trials are able to identify *which* interventions work when compared to other interventions or a control group but not *how* they work. While it is important to explore with staff and students how they feel about a program, it is also important to understand how new learning evolves, how it is communicated, and how it diffuses over time. This can be achieved by taking a social learning approach (see Robinson G. et al, 2017) or by performing a situational analysis that lays out the major human, nonhuman, discursive, and material elements of prevention programs as they unfold in the school context and then analysing the relations among them (see Clark, 2005). The need for rigorous, controlled trials in this area needs to be balanced with more in-depth studies that focus on the *processes* involved in suicide prevention.

Another problem within this field of research is an apparent ‘piecemeal’ approach to intervention that separates gatekeepers, students, and parents into ‘target’ populations with very little regard to how these interventions might complement one another.

Interventions that have adopted an adhoc approach tend not to maintain their benefits over time. Similarly, the use of manualised programs might be ideal for later meta-analysis, but this potentially neglects the specific needs of individual schools and communities whose young people face context-specific challenges such as Indigenous and rural communities. In the arena of mental health promotion, whole school approaches that are adaptable to the individual needs of schools and their students have achieved some success (Nielsen, Meilstrup, Kubstrup Nelausen, Koushede, & Holstein, 2015; Wearne, 2000). Developing methods for better integrating multiple interventions within the whole school environment may be the next step in improving the outcomes of suicide prevention efforts in schools.

Over the next decade, the field will continue to call for the funding of large-scale, randomised controlled trials to improve the strength of the evidence base for youth suicide prevention. Given the extent of the problem and the lack of clear, consistent findings then this call is justified. However, in a field that is currently dominated by the statistical evaluation of outcomes, there appears to be little understanding of what makes some programs work and not others. Mixed-methods approaches to program evaluation that provide an in-depth analysis of processes and needs would provide these insights. In addition, interventions that adopt a flexible, whole of school approach need to be developed and evaluated using methods that are capable of revealing their mechanisms of change.

# 4 STUDY LOCATION

## 4.1 Melbourne's south-eastern growth corridor

The geographical location of the three schools that participated in this pilot study lie within Melbourne's south-eastern growth corridor, a region undergoing significant and rapid change and recognised as one of Victoria's most socially and environmentally diverse, and economically significant locations (South East Melbourne Group of Councils 2015). The City of Casey is the third fastest-growing municipality in Victoria, with a population of approximately 288,000 (City of Casey website). In the 10 years between 2001 and 2011, Casey's population grew by an average of 43.9% or 7,300 people per year, and is projected to have a population of 514,021 by 2041 (City of Casey, population forecast). Currently 7,300 people move into Casey every week (City of Casey website). Cardinia Shire, which neighbours the City of Casey, currently has a population of 95,992, and this is projected to rise to 175,562 by 2036 (Cardinia Shire Council, population forecast). Cardinia has a hardship index rating of 7 compared to 3.4 for Melbourne, and its residents experience the highest financial stress of interface and growth Councils (Cardinia Shire Council website).

A key concern of local government and human service providers is that the rapid urbanisation occurring in the City of Casey and Cardinia Council Shire, as well as increased ethnic and cultural diversity, has not been adequately addressed by increased services and infrastructure (City of Casey home page; Cardinia Council Shire home page). Key characteristics of this rapid growth include a large population under the age of 50 years, and high numbers of families with young children to young adults.

Of relevance to this Report, between 2011-2013 a cluster of suicides occurred in the Casey and Cardinia LGAs; in 2011, six people under 24 years of age suicided in Casey and four in Cardinia, while in the period 2012-2013, fourteen young people suicided (Smith, R., 2015). In 2010, one young person in each of these LGAs had suicided. Their deaths caused significant anxiety and stress across the entire community as well as schools and local services (Connolly, 2016). Psychiatrist Michael Gordon (Monash Health) stated at the time that, although Council responded quickly, 'by the time you actually know there's a problem, in fact it's probably too late' (quoted in Smith, R. 2015 online). In 2011, the Federal Government funded *headspace*, the National Youth Mental

Health Foundation, to develop and deliver a specialist suicide post-vention program, *headspace* School Support, which was targeted at secondary schools across Australia. Evaluation of the *headspace* project recommended that significant gains were realised for schools in the Casey-Cardinia region but cautioned,

> *sustaining these achievements is paramount to ensuring youth suicides in the region continue to be contained and that the community can focus its energies and resources on building resilience and capacity within the schools and among parent groups and community agencies* (Connolly 2016: 27).

| | City of Casey | Cardinia Shire Council |
|---|---|---|
| **Population** | 299, 301 | 95,128 |
| **Median age** | 34 | 24 |
| **Number of families** | 79,494 | 25,127 |
| **Country of birth % (top responses; comparison with state responses in brackets)** | | |
| | Australia 56.2 (64.9) | Australia 74.8 (64.9) |
| | India 6.0 (2.9) | England 4.4 (2.9) |
| | Sri Lanka 3.8 (0.9) | India 1.8 (2.9) |
| | Afghanistan 2.9 (0.3) | New Zealand 1.7 (1.6) |
| | England 2.8 (2.9) | Sri Lanka 0.9 (0.9) |
| | New Zealand 2.4 (1.6) | Netherlands 0.7 (0.3) |
| **Religious affiliation % (top responses; comparison with state responses in brackets)** | | |
| **No religion, so stated** | 24.3 (31.7) | 36.2 (31.7) |
| **Catholic** | 23.9 (23.2) | 21.7 (23.2) |
| **Not stated** | 8.0 (9.4) | 12.4 (9.4) |
| **Anglican** | 7.9 (9.0) | 8.8 (9.0) |
| **Islam** | 7.4 (3.3) | 3.4 (3.3) |
| **Average number of people per household** | 3.1 | 2.8 |
| **Median weekly household income** | $1554 | $1497 |
| **Median monthly mortgage repayment** | $1733 | $1733 |
| **Median weekly rent** | $340 | $320 |

***Table 1:*** *Demographic data for the City of Casey and Cardinia Shire Council, adapted from 2016 ABS QuickStats (www.abs.gov.au/websitedbs/D3310114.nsf/Home/2016%20QuickStats)*

## 4.2 Study location: Three Victorian case studies

### 4.2.1 Case Study #1

The first case study involved an independent Victorian school situated in the south-eastern corridor of Greater Dandenong and Casey areas, which is one of the state's fastest growing local government areas. Established in 1970, the school has grown from small beginnings into a multi-site school, with a community made up of diverse cultural and economic backgrounds. Across its three campuses – Senior School (Years 9-12), Middle School (Years 6-8) and Junior School (ELC – Year 5) – the school has an enrolment of approximately 830 students and 120+ staff including administration. Being a Christian Parent-Controlled School, the school is governed by parents and friends who are members of the Association for Christian Education. Maranatha Christian School has grown into a three-campus school with junior schools (early learning – Year 5) at two sites, which feed into the main (Years 6-12) campus.

| ASIST Training | SuicideTALK Training | Focus Group Participation | Staff Survey Completion | School population | No. Campus | Staff |
|---|---|---|---|---|---|---|
| 23 | 101 | 12 | 91 | 830+ | 3 | 120+ |

***Table 2:*** *Case study #1 demographic and training overview*

### 4.2.2 Case study #2

The second case study comprised an independent school also in the south-eastern corridor of Greater Dandenong and Casey areas. At 2017 the school had enrolments of approximately 2950 students and over 300 staff (teaching and support staff) across three different campuses – a Year 10-12 campus, and two Year 7-9 campuses. For the past 8-10 years the school has developed a team of psychologists who support the health and well-being of the school community. While suicide has not been a readily reported concern, the school is increasingly experiencing a number of students who have reported suicidal behaviours. More recently, the school community experienced an incident of suicide, which had a profound effect on the school community. The school has a strong counseling team who have been identified as responsible for supervising and addressing

issues of mental health within the school. With a changing cultural demographic, the school has identified the need to increase communication with families about the significance of suicide, including the school's systems and protocols for managing suicidal behavior and suicide events.

| ASIST Training | SuicideTALK Training | Focus Group Participation | Staff Survey completion | School population | No. Campus | Staff |
|---|---|---|---|---|---|---|
| 14 | 30 | 12 | 73 | 2950+ | 3 | 300+ |

***Table 3**: Case study #2 demographic and training overview*

### 4.2.3 Case study #3

The third case study involved a Community College that operates from three campuses - one in peri-urban Melbourne, and two in regional Victorian townships, in other locations as required, and in workplaces through traineeships and workplace based training, south-east of Melbourne. The College has an enrolment of 120 students and 18 teaching staff, and an additional 60 administrative staff, is a not for profit Registered Training Organisation (RTO) and a Registered Independent Senior Secondary School offering community based adult and vocational education and training via accredited courses from Certificate 1 through to Diploma across a wide range of curriculum areas. The College operates from a strong foundation of business and community partnerships, which support the building of skills across its respective communities. As with the other two case studies, the College community is committed to supporting its professional and administration staff in matters pertaining to suicide. These levels of support are particularly significant given the majority of students come from low socioeconomic backgrounds that include intergenerational poverty and long-term unemployment. The majority of students attend the college as a consequence of transferring from mainstream schools; many experience mental health issues and some have difficulties around socialising. Although there is a strong emphasis on learning, the development of academic skills is secondary to advancing social and personal skills such as confidence, self-esteem and communication.

| ASIST Training | SafeTALK Training | Focus Group Participation | Staff Survey Completion | School population | No. Campus | Staff/ Lecturers |
|---|---|---|---|---|---|---|
| 9 | 20 | 12 | 33 | 120 | 3 | 80+ |

***Table 4:*** *Case study #3 demographic and training overview*

## 5 METHODOLOGY AND METHODS

### 5.1 Methodology

This evaluation employed qualitative research methodology and involved semi-structured small focus group interviews with teaching and non-teaching staff at schools that had participated in the Suicide Safe Schools training program. In addition to this qualitative data, the survey results of staff and student participants, as well as the recommendations provided by the trainers to each of the three schools, were made available. This data was used to inform the findings of the focus group interview material.

### 5.2 Human Ethics approval

Approval to conduct this research was provided by the Federation University Human Research Ethics Committee in November 2016 (project number A16-159). This Human Ethics Committee reviews all research involving humans at Federation University to ensure that it is compliant with the *2007 National Statement on Ethical Conduct in Human Research* (National Health and Medical Research Council, 2015).

### 5.3 Focus groups with secondary school staff

In consultation with representatives of the consortium[1] delivering the Suicide Safer Schools training, it was agreed that a total of nine targeted focus group discussions would be scheduled for the three participating secondary schools. It was anticipated that three focus group discussions would be held at each of the three schools, with up to 15

[1] This comprised ERMHA Ltd, Life! Central Services Incorporated, Suicide Safer Communities Inc. and Black Ink Holdings Pty Ltd.

individuals in each of these focus groups; thus, a total of 135 individuals were expected to participate.

Focus group discussions were scheduled to follow the delivery of the Suicide Safer Schools training of both the students at each of the three schools, and after the trainers had analysed their findings and prepared and delivered a set of recommendations to the schools. Three different levels of training were offered to school staff:

1. ASIST: a 2-day program designed to increase suicide intervention skills and build community networks;
2. safeTALK: a 3.5-hour program designed to increase the number of people in the community who are alert to and able to provide initial help to those with thoughts of suicide.
3. suicideTALK: 45-120mins program designed to increase the number of people in the community who are alert to and able to provide initial help to those with thoughts of suicide.

Case study #1 invited the wellbeing staff to attend the ASIST training: the remainder of staff participated voluntarily. All staff were required to attend suicideTALK.
Case study #2 allowed staff the choice to participate in the ASIST training which was held in out of school hours. suicideTALK training was conducted during school hours.
Case study #3 invited fulltime staff to attend the ASIST training, and lecturers were invited to attend safeTALK.

Focus group interviews were conducted at each of the school sites in a location, and on dates, determined by the school. Semi-structured interview questions were posed so as to elicit the experiences of staff in training, their views on the training program's strengths and limitations, and their perceived impact of this training in school communities.

A total of five focus group interviews were held, which involved a total of 35 teaching and non-teaching staff. Two focus group interviews were conducted at case study school #1, and one focus group interview at case study schools #2 and #3. Focus group interviews were approximately 40 – 60 minutes in length, depending on when each school was able

to schedule staff availability. These were usually held over the lunch period of after school teaching hours, which meant in either case staff were participating during their non-working hours.

While the number of overall participants was disappointingly low, the focus group interview material does provide rich data with which to build evidence for the impact of the Suicide Safer Schools training on equipping staff in order to deal with mental health issues in secondary schools.

### 5.4 Surveys conducted with school staff post suicide training

In addition to the focus group data, all staff participating in either of the two training programs were asked to complete a paper-based survey distributed to staff via the school administration. While general questions in the survey initially included information about their specific position in the school, the nature and scope of communication from the school's leadership team to staff and the broader school community, specific questions/statements in relation to suicide followed, and included by way of example:

- If a COLLEAGUE'S words and/or behaviors suggest the possibility of suicide, I would ask directly about suicide
- If a FAMILY MEMBER'S words and/or behaviours suggest the possibility of suicide, I would ask directly about suicide.

The next set of questions asked about the process staff would take if/when concerned about a person's mental health, including their willingness to respond if concerned about the mental health of a COLLEAGUE, whether the levels of support available to them if they needed to respond to a colleague were adequate in the workplace, levels of confidence about recognising suicidal risk factors, and knowledge about school policies and procedures that guide staff in relation to a student who is at risk of suicide.

Subsequent questions included:

- Have you known someone who has deliberately injured themselves?
- Have you known someone who died by suicide (including response?
- Have you ever had thoughts of suicide?
- If you were to have thoughts of suicide, or were not feeling mentally well, what steps would you take to address your concerns?

- How connected do you feel you are with your colleagues/students you teach?
- Engaging in activities for enjoyment is important for well-being. Please list your most frequent extra-curricular activities (e.g. sports activities, socialising)
- If you could change one thing about your school what would it be?

## 6 LIMITATIONS OF THE STUDY

The evaluation of the suicide training undertaken across three case studies as represented in this report has generated significant findings in relation to how suicide is understood and managed in secondary school settings. As a pilot project exclusively involving three schools, the information presented reflects the perspectives of staff participants.

Prior to undertaking the focus group interviews, the study design required that each school involved in this evaluation:

- Had staff and students undertake training;
- Had student and staff completed an accompanying survey delivered by the trainers;
- Was provided with survey data and a set of recommendations.

The roll out of the Suicide Safer Schools training required a considerable amount of time and coordination. However, we note, scheduling events within schools is challenging given the constraints of curriculum, timetabling and school administration. Other challenges include organisational complexities such as communication and coordination, particularly in multi-campus schools where the numbers of staff are in the 100's.

For the upper year levels selected to participate in the Suicide Safer Schools training, changes to schedules can be particularly stressful, and this stress is also borne by school staff. In addition, changes within a school can prolong or hinder the implementation of new initiatives, as happened in the case of one of the case study sites in this project. Finally, there are some restrictions on staff participation in activities not specifically related to individual organisational roles. While the Suicide Safer Schools training could be identified as part of professional development, in one of the case studies, participants were required to undertake training during personal time, and in another, some staff were

precluded from training because of school restrictions on the number of staff permitted to be away from the school campus. This is not to say that the schools were unsupportive of the training, rather that there does need to be careful consideration as to how this training might be incorporated into an already detailed, full and complex school timetable.

A further limitation of the evaluation is concerned with focus group participation. Despite earlier expectations of higher participation levels (initially 400+, which was then reduced to an expected 120+), a total of 35 professional and administrative staff across the three study sites attended.

All of these factors impacted both on the time frames for the evaluation of the training program and post-training participation.

Finally, we acknowledge the simultaneous training (2-3 hours) that was also conducted in each of the case study schools with secondary students after the completion of staff training. Due to the focus of this report, we do not provide any student perspectives of the suicide training they received.

## 7 ANALYTIC APPROACH

Thematic analysis of the interview material was undertaken by the academics in the evaluation team, which involved identifying important ideas, concepts and terms; generating a set of codes that respond to the evaluation's research questions (as outlined on p. 10 of this Report); and developing a detailed analysis of each them; all of which then informed the findings and discussion of this report. This analytic approach is important to this evaluation given the difficult subject matter of the training, as a thematic analysis retains the experiences and stories of participants, and does so in the context of their everyday lives (Vaismoradi et al., 2013). The thematic analysis of the interview material was also informed by the theoretical and empirical studies provided in the literature review, thus the analysis is framed by current thinking about what may or may not be effective in suicide awareness training.

Access was provided to some of the survey data conducted post-training at each of the three schools. While the evaluation for this Report was focused on qualitative data, the survey data sets did provide some insight into the broader context of staff who participated in the focus group discussions.

# 8 ANALYSIS OF CASE STUDY DATA

## 8.1 Case Study #1

### *8.1.1 Staff responses to suicide intervention training*

Participants in the two focus groups held very positive views on the level of training that had been provided, and staff specifically made mention of the support and knowledge provided by the trainers. Non-teaching staff completed the 3 hour safeTALK training, while teaching staff were able to elect to undertake the 2-day ASIST training.

Those who completed safeTALK wanted to have the opportunity to learn more. As one staff member explained,

> *it starts you thinking but [safeTALK] doesn't take you anywhere after that…there definitely needs to be a follow-up*,

while another noted that,

> *it makes you aware of what's going on and how to approach things but not how to take that next step*.

When asked specifically about this, staff who had safeTALK training felt less prepared to deal with suicide than those who had the ASIST training. However, it was agreed that the safeTALK training was beneficial in raising awareness about suicide.

For staff who completed the ASIST training, they felt they now knew what questions to ask, and how to ensure the individual concerned felt safe and was appropriately supported. Some staff disclosed that they had previously experienced such situations with family members or colleagues but had felt inadequate and unable to offer the right kind of assistance; however, the training made them feel confident in knowing the right way to help. Evidence of the success of this training occurred on the day this focus group discussion was held, with staff successfully assisting a student at one of the senior campuses;

> *I got a call this afternoon…to say that they had an incident this afternoon and they felt that as a result of the training, they'd been able to handle that really well…they'd put in support in place, they've contacted the student psychologist, they'd made arrangements to see them tomorrow, they made arrangements for safe care for the student tonight and all of that was the result of the program*

Three significant points came out of this focus group discussion:

1. Staff acknowledged that talking with someone about suicide does not lead to suicide:

   *I think there have been a couple of significant myths that were debunked, so a lot and they weren't thinking about it before? So just that real, it's fundamental belief shifting that you're not going to make worse by asking.*

2. After the training staff were more conscious of changes in the behaviour of students or staff and would now be more likely to approach these individuals and talk:

   *I found myself post-training being more alert to how my students are actually behaving or being a little more conscious and questioning how they're going for the day.*

3. The training has facilitated more open discussion about suicide:

   *I think there was almost disbelief that suicide is as common as it really is or as prevalent as it is … and that stats were showed to us, so just an awareness among the adult community who don't really bother about [is important].*

Although at the time of the focus group discussions only senior team leaders had seen the school survey results, those few who had been privy to this data were surprised at the level of students and staff who had thoughts of suicide, were connected to individuals (students, colleagues, friends or family) who had thoughts of suicide or who knew of people who had who had lost their life to suicide. This in turn led to reflection on the situations students are living with, including a high level of negative behaviour:

> *I was really, not shocked in a sense, but really saddened by the fact that there were students … I just thought, sometimes our students are sitting in our classrooms and they've got all this happening in their heads and I'm trying to teach them maths, if that makes sense.*
>
> *I don't have the results in front of me but I remember thinking it was about one third of the students had, had significant thoughts of suicide or had been touched by a suicide in the friends and family… the other surprising thing was the high rate of self-harm that was picked up in the survey.*

A number of staff commented that the ASIST training was confronting, especially in terms of feeling able to openly discuss suicide and thoughts of suicide, as well as engaging in role play exploring this topic. Nonetheless, staff did acknowledge the importance of this in this training;

> *I think that while it's confronting, it's also incredibly empowering. And so we have been raised in a society where suicide is almost a taboo subject … a day into the course staff were talking around it … it took quite a while to use the word*

*"suicide", now once they learnt to use the word then they're empowered and they feel that yes, they can go straight to the topic and there are questions they can ask because now they're confident that they know in what direction to move.*

*I think maybe the thought of, the topic 'suicide' seems so extreme, whereas I feel since the course it's – not, don't want to say suicide has been normalised, but those, the fact that people could land up thinking about it at some stage in their life, that's become a lot more understandable and normalised, it's not seen as a shocker.*

*When you're role-playing someone who's suicidal can be quite confronting and role-playing being the person who's trying to keep them safe is confronting as well… it was challenging but worth it… it took a long time to get to the point where we could, even in a role play, ask the questions the way they needed to be asked.*

What is clear from these two focus group discussions held at this school is that staff feel they have differing levels of capacity to deal with suicide because of the different training received. Nonetheless, some staff feel that the school now has a strong core of staff who have completed the ASIST training, which will have positive outcomes for the school as a whole. As one staff member said, '*you're looking at 25% of staff who've done the top level training…it impacts culture.'*

### *8.1.2 Challenges of implementing/undertaking suicide intervention training*

For this case study school, the training was offered during the school holidays and during term time, and most staff who completed the training attended during the school holiday period. This meant that for most staff the training was undertaken during their own time. A smaller number of staff were able to complete the training during term time. However, this had two impacts on the school:

1. Scheduling training during the teaching semester had cost implications because if a staff member is away from the campus the school is required to hire a Casual Relief Teacher (CRT), and no more than four staff members may be off campus at one time.
2. In addition, for those undertaking the ASIST training, two consecutive days of training are mandatory. Staff felt training during term time was potentially more disruptive for senior students and staff under pressure to complete the year's curriculum.

Participation in the training was voluntary, and while there was some difference of opinion about this, on the whole most agreed that training should remain voluntary.

While not a challenge in the sense of practical implementation of the programs, some staff talked about the emotional impact of dealing with students considering suicide and having some sense of what is provided for students after the initial intervention. This was particularly of concern when a student does suicide:

> *That's the other aspect of the training. that you need to be prepared that there will be kids that you, no matter what you do, you're not going to save them. And having to live with the fact that you tried and failed is incredibly difficult because you keep thinking, I could have done more, I could have done more.*
>
> *[Suicide] that's a pretty intense moment for you to deal with but part of that training, there's, there's no part of that training that then deals with the, the one that's coming to that confrontation of their own emotions.*

Staff were also concerned about what support is available outside the school once the initial in-school support had been handed over to external organisations:

> *And that's where those supports need to be in place … that was perhaps as aspect of the training that could have been explored a little bit further.*
>
> *I think we need to understand what the system is too, to know what we're sending people to or how they can help and if there's anything we can send them further … the reality is that there are so few support placements available that as often as not they'll tell them what they want to hear and off they go.*

While this level of professional support is outside the responsibility of the school, staff agreed it was important to have some understanding as to how the well-being of staff and students in such circumstances is continued.

### *8.1.3 Communication about suicide intervention training within the school*

This was discussed in three ways:

1. Staff noticing discussion about suicide within the student cohort;
2. Staff talking about suicide with peers;
3. Communication from school leaders to staff as to who has completed the training, particularly ASIST, and thus be in a position to provide assistance if able to.

On the whole staff had not noticed conversations relevant to the training amongst students, however, they observed that this did not mean such discussions were not happening. As one staff member explained:

> *I can't say that I've heard any conversations in that regard since doing the training really this year, I haven't heard a lot, but that doesn't mean they're not having those conversations. It might just mean we're not privy to them. We did get some good feedback from the students about their confidence in their ability to, to help people that were in that frame of mind.*

However, school team leaders who had seen the survey results made note that students would not approach a staff member as a first course of action if seeking help;

> *It was very interesting to see that most kids would never see the school counsellor. So they want to talk to other, for the younger students their parents, and their friends and then as a senior school it was more friends and then parents.*

This point is taken up below in regard to setting up appropriate policies and the inclusion of parents in suicide intervention training.

Staff agreed that having a cohort of staff within the school who have completed the training and are now open to discussions around suicide but also conversations about mental well-being is valuable:

> *it's always a hard subject to bring up so if there is a group of people that have done the course then it's a lot easier to talk to other people knowing that they are understanding a bit more.*

However, staff suggested it would be useful to know who had completed the ASIST training not just in terms of peer support but also in case needed urgently in the course of the school day. As two participants explained this is important for non-teaching staff as well as teacher:

> *I don't know if the teachers have a list, but even at reception if there's a list of, in circumstance A, call these numbers, in circumstance B call these numbers. So you don't have to say 'Oh, now which ones should we be calling?' Having a very short index, if they're talking like this, then this aid group or this … or whatever, this is the lot to call, there's, because there's so many different people to have to try to call in those circumstances.*

> *We've really got to have an understanding of the [school] system, not just teachers knowing but if I'm dealing with, in the First Aid side of things, because I can't run around for a teacher, 'quick, who do I call?'*

This point is taken up in the following section.

### *8.1.4 New policies/action response as a consequence of suicide intervention training*

Not all staff had yet seen the student survey results, however the School Principal and School Leadership Team acknowledged that school policy and strategies needed to be determined. Part of the work the senior team will engage in will involve developing a resource pack, and to put policy and strategies in place for semester 2 this year. As one staff member noted,

> *I think our school has always been a place where our students have known that they can talk to us and that, but it just would seem that because of different things in their head… there were different reasons why they wouldn't say or why they wouldn't…they could know we care deeply for them but then it's like, 'Oh but if I said that to Mrs X she's just going to see me in a different light.' So there was a few fears that students had.*

Staff also indicated that it would be necessary to maintain practice of the learnings from the training program, and that all staff have this as part of yearly Professional Development, for, as on staff member said,

> *I think staff would benefit greatly from having that training in terms of looking out for people that re doing it tough, being prepared to ask those hard questions and then offer support.*

There was some discussion about continuing the training for the student chort as well.

As noted in the previous section, professional staff suggested a protocol alerting staff as to who needs to be called in these situations was required, similar to what was already in place for health emergencies.

### *8.1.5 Parental inclusion/information evenings regarding suicide intervention training*

Staff were keen to have parents and grandparents involved in the broader training of suicide awareness but are aware of the costs involved. They were aware that in some instances it is the student who is dealing with family members who are expressing suicidal thoughts, so the challenge is not simply school based but also family and community based;

> *We're dealing with young people who are dealing with threatening – parents who are threatening suicide, who are really holding their children to ransom. They are*

> *traumatised by that and it's not just once or twice, but it's coming and coming. And helping them deal with that is a really big thing … it's dealing with people … mostly who are suffering depression and not just the kids themselves but it's all those people around them and understanding how to help them.*

One outcome noted by staff that was increased empathy for individuals and families that were facing difficulties and then finding ways to offer assistance, a response that came directly out of the suicide awareness training and a now greater capacity to ask the "right" questions:

> *In my experience I think there was one … person [who] was able… had asked the questions thing and then we were able to support that person in their life, in a sense as Christians, as, as brothers and sisters, they were actually able to put things together… I was talking to her afterwards and I was saying, "Our biggest issue as human beings I think is to actually ask for help." So 'I'm not coping,' 'I'm a single mum, say, and I'm not coping with the yard, or the house, and the thing we tend to not say, I'm really struggling, the grass hasn't been cut, or whatever. She was able, through their conversation, to actually ask for help and the help was given and it was a really beautiful community thing.*

For this school, therefore, the program resonated with the values of the school and community, and staff wanted to have the opportunity to build community capacity and support.

### *8.1.6 Staff survey results*

Approximately two-thirds of those who completed the survey indicated that they have had training in how to recognise the risk of suicide. Yet, in dealing with suicide behaviour, slightly more than half of respondents felt confident recognising suicidal risk factors, while just under half did not feel confident.

A significant number of staff know of someone who deliberately harmed themselves, including a significant number who knew of students who harmed themselves. Approximately one-third indicated that they did not know of anyone who self-harmed. Over 90% have not deliberately harmed themselves.

Just under half of the respondents did not know of anyone who had died by suicide. For those who indicated that they did know of someone, most were acquaintances or family members. While almost 60% indicated they have never had thoughts of suicide, just under one-third have had thoughts of suicide at some point in their lives. A very small

number had had these thoughts in the last year, and one had had such thoughts in the week prior to the survey.

Just over half of the respondents have not been a support person for someone at risk of suicide and around one-third have had this experience; however, approximately 10% of respondents were unsure if they have played such a role. In terms of knowing what to do, the majority were unsure of the process but 'worked through it', while almost 60% knew how to respond, although just under 10% indicated they would have liked a clearer process.

In responding to an individual who may display behaviour that suggested the possibility of suicide, the majority of staff indicated that they would try some avenue of support for that person. However, the first line of intervention did vary depending on the relationship the staff member had:

- If a COLLEAGUE'S words or behaviour suggested the possibility of suicide, the majority of staff 'somewhat agreed' with asking directly about suicide. Most indicated in their response it was 'extremely likely' that they would refer to school policy and follow as directed, or to report their concerns to a superior. Most indicated they were unlikely to leave the individual to solve the issue on his/her own.

- In the case of similar observations of a STUDENT, staff indicated they would take their concerns to their supervisor or to the well-being team; and are extremely unlikely to leave the student to deal with the issue alone. Two thirds of staff indicated they would ask the student directly about suicide (approximately just over one-third strongly agreeing with this, and one-third agreeing with this to some extent). A small proportion indicated they strongly disagreed with asking a student directly about suicide.

- In instances of a student stating that s/he was thinking about suicide, approximately two-thirds of respondents indicated willingness to do a suicide intervention, with a slightly higher number strongly agreeing with this statement. A small number would not do a suicide intervention, and just under one-third were unsure.

- In the case of a FAMILY MEMBER OR FRIEND displaying this behaviour, over 90% stated they would ask directly if that person was contemplating suicide, with two-thirds strongly agreeing with this approach.

Two-thirds of staff indicated that the school has policies and procedures to guide responses to a student who is at risk of suicide, approximately one-third were unsure, and one person indicated policies and procedures did not exist. Almost 90% indicated it was important for his/her role that there are school processes and procedures with regards to responding to suicide.

Overall, the majority of staff felt extremely or somewhat connected to their colleagues, and similar results were found when asked how connected would staff like to be, thus demonstrating a positive sense of cohesion within the staff cohort.

The majority of staff felt somewhat connected to the person or people they directly report to, with slightly less feeling strongly connected. Approximately 10% felt somewhat or extremely disconnected. The majority of staff would like to feel strongly connected to the person or people they respond to, with slightly less indicating they would like to feel somewhat connected.

### *8.1.7 Summary*

Overall, staff indicated that the training was beneficial in that it provided clear guidelines for awareness off suicide behaviours and an appropriate procedure for assisting the person displaying such behaviour. However, staff feel they have differing levels of capacity to deal with suicide because of the different training received, ie some undertook the safeTALK training while others completed ASIST. A significant outcome of offering the ASIST program to teaching staff only is that non-teaching staff feel they have little to contribute to school well-being. For example, one non-teaching staff member did not see the relevance of the training in her role because she was '*not dealing with the students or anything as such*.' Yet non-teaching staff have a significant role in that they work with and across staff and student cohorts, and often have a very good sense of everyday behaviour and possible changes to that behaviour. While there are challenges in scheduling suicide awareness and intervention training, staff stated that this training should continue and be part of professional development training. There was also discussion as to how parents and family members could be included in the training, and therefore in keeping with the philosophy of the school as integral to the broader Christian community.

## 8.2 Case Study #2

### *8.2.1 Staff responses to suicide intervention training*

Participants in the second case study focus group also showed very positive views on the level of training that had been provided. As with case study #1, staff who had completed the safeTALK training indicated a need for more extensive training and felt less equipped to deal with suicide compared to their ASIST-trained colleagues. Furthermore, staff were looking to bring the concept of suicide more broadly into curriculum and to the attention of the wider community.

1. The training has facilitated more open discussion about suicide
2. The training has contributed to building a new school culture around suicide and suicide intervention

School staff indicated that prior to the training, the school community had not engaged in extensive conversations or training pertaining to suicide. Staff generally agreed that suicide was a topic most staff and students were uncomfortable with, and suggested that students were possibly more exposed to suicide due to their age, and to social media given its capacity to readily disseminate information.

Despite the initial fears expressed by staff about engaging in suicide conversation and training, staff (both teaching and support) described the impact of the ASIST 2-day training for teachers, non-teaching staff and students alike, as substantial and impactful. As a consequence of the ASIST training, teachers in particular, expressed a newfound confidence and preparedness to support students by using explicit suicide language, and asking strategic questions to determine the possibility or likelihood of suicide risk with their students. Accordingly, the training enabled staff to move from feeling confronted by the topic of suicide towards feeling more able and confident to speak about it, including the capacity to use appropriate suicide language, e.g. *“Learning to actually say it [the word suicide] out loud”,* and to engage with the reality that suicide was a very real issue for the broader school community, particularly its young people. This matter was at the forefront of the conversation which was particularly pertinent to this school community given the recent loss of one of its students to suicide. By way of example, one staff person commented:

> *I think we've been given more confidence to ask the questions of the students especially when it comes to our roles in the head of house first before it goes to the counselling team where we can alert them to that.*
>
> *So, I've developed some confidence to now know what questions to ask and then what responses are going to cause more concern for us.*

This included greater staff preparedness to respond to student concerns about suicide, for example when students came to them with concerns about either feeling suicidal, or through observations they had with peers who they deemed 'at risk':

> *I had a student come to me in Year 10 yesterday. My friend has said these things, shown me these things, doing these things, I can't help him but I know you can and I'm telling you.*

Staff referred to the training as 'empowering', suggesting that it should be built into the school's broader professional development calendar as a way of ensuring all staff were equipped with suicide awareness and the capacity to deal with suicidal behaviour across the school community.

> *…the conversations I'm hearing [with students] are showing how empowering this training's been for the staff and I think that the thing that's jumping out at me is gosh of course it should be mandatory for all teachers who are working with young people that they should do some sort of suicide awareness… the staff are feeling empowered…*
>
> *I'm really impressed that teachers are being empowered in this really sensitive topic.*

Although the school's counselling team historically dealt with such matters, a number of staff suggested the need for all staff to be better prepared to support students and colleagues around suicide matters during school hours, as well as in the holiday periods. Similarly, the focus group highlighted the need for suicide to be an 'embedded' component of school culture:

> *…if we build a culture within the College that this [training] happens every year and we have a culture of an openness to the dialogue around suicide then I believe that will be just about who we are.*

These cultural dimensions included equipping staff to deal with any student who may approach them at any given time:

*Without judgement [we can say] have you spoken to your head of house, have you spoken to your parent, [did you know] there's a counselling service here…not try and take it on and solve it yourself but we know we can ask them [counsellors] and they'll tell us where to really get help.*

Being trained in suicide intervention was identified by one staff person as the equivalent of any other first aid training: "mental health is no different to a broken arm or a visible injury". The 2-day ASIST training was highlighted as beneficial for having the opportunity to develop strategies for dealing with suicide, including using everyday mental health language exploring content knowledge at a deep level, and moving beyond feeling uncomfortable is asking questions about suicide tendencies. This included the art of learning to actually say the word 'suicide' as part of an everyday conversation. For example, staff indicated that by acting out/role playing as part of the course, although uncomfortable, they were able to deal with real life suicide situations.

***8.2.2 Challenges of implementing/undertaking suicide intervention training***

Several challenges were identified in relation to how best to implement the inaugural roll out of the suicide training. The multiple timetabling challenges faced by schools was noted by several staff:

1. Time and timetable constraints
2. Scheduling professional development training during non-teaching periods

The first challenge was concerned with time constraints, namely finding space within a very busy and complex school curriculum described by one teacher as a *"competitive space"*. Staff highlighted limitations as to how much could realistically be *"squeezed"* in to one day. Other challenges identified were in relation to the cost of training staff across all three campuses, which the school identified as over $10,000.

Some teaching staff resented the lack of lead in notice from leadership staff about the suicide training, which had been scheduled during the school holiday period (teachers' personal time). Although not definitive, some staff indicated that had there been greater notice and communication about the training, they may have been more available to participate. The low levels of staff participation in the training may have been attributed to its timing.

> *As someone though who's at the younger end of the teachers, I don't have a small family I'm away every school holidays and I know I speak for a lot of my colleagues who were in the same boat as me. We wanted to do the 2-day training but we had already got our holidays booked. So, I'm sure that did influence it [the low numbers of participation].*

It was also noted by staff that any expectations of staff undertaking professional development during end of term holidays was unreasonable, given the need to replenish their personal well-being from demanding weeks of work.

### *8.2.3 Communication about suicide intervention training within the school*

Communication about suicide intervention training within the school was discussed in two ways:

1. Broader staff communication
2. Communication from school leaders to staff as to who has completed the various levels of training

Staff highlighted the need for greater communication with the school's leadership team, suggesting that information did not necessarily filter down effectively to the teaching staff. This was evident by one comment from a teacher who asked: *"When was the 2-day training?"*, and may have had a bearing on the eventual low take up of training within the school. The focus group discussion brought to light a number of logistical matters pertaining to the suicide intervention training. Teaching staff in particular identified the need for improved communication across the school about the names of staff that had undertaken the training, as well as the specific level of training.

Staff expressed a desire to know who else had undertaken the training. Given the school's expansive operations which meant training was undertaken across three campuses, staff illustrated the benefits of knowing which other staff had done the training. as way of seeking a level of emotional support from others should they require it. One staff member suggested greater opportunities to talk to other people who had also participated.

> *… it's almost a wasted opportunity to not be able to talk to those people and to not – I don't know if you did it and you'd feel comfortable talking about the training but that's always something that I'm keen to do is if someone goes to something it's good to know who it is so you can pick their brain*.

Furthermore, staff suggested they would like further information and communication about the context and content of student training that had been undertaken within the school. This included understanding which year levels underwent the training and a specially designated time for staff to debrief their own training.

In addition to these comments, one senior leadership representative indicated the school may not necessarily pursue 2-day suicide intervention training. The rationale for this was threefold: (a) the level of counsellors and counselling support/skill already available in the school, (b) the demands of other first aid and other training being placed on staff, and (c) teachers were identified as being able to undertake the training more speedily, and potential trainers.

> *I wouldn't be thinking 2 days [of training] for us. Not when we've got such a strong counselling team. I don't see that as a need except for the collegial support… The 1½ hour training I could see, we could have done that in 50 minutes.*
>
> *But when you talk about child safety, anaphylaxis and then you throw in the suicide conversation that's a really hard morning for staff.*

### *8.2.4 New policies/action response as a consequence of suicide intervention training*

1. The need for developing and disseminating suicide policies
2. Calls for action response plans that are well known to all staff

Many staff – teaching and non-teaching, indicated the need for greater education about its school policies and processes in relation to suicide. Given the school's expansive population, staff suggested the importance ensuring all staff, regardless of their campus, were equipped with the knowledge of "a chain of command", protocols and actions that were well understood by all staff. This included protocols for holiday periods, which was identified as a vulnerable time for young people who do not necessarily have the accustomed levels of support available during school hours/periods, as identified:

> *The high number of student suicides are in fact in the holiday's when they don't feel supported and they don't have access to their normal people around them like teachers or heads of houses, all that sort of thing, support. So that for us was really an important move.*

Leadership staff indicated that the school psychologists should take the lead around any suicide scenario. It was agreed that such protocols should be developed for in and out of school settings, that is, during and beyond school time, and would involve specific resources/contact people that would be utilised/contacted where appropriate.

#### *8.2.5 Parental inclusion/information evenings regarding suicide intervention training*

1. Bringing the wider school community into suicide communication
2. New innovations for parent/guardian training

The notion of parental/guardian suicide awareness was acknowledged as a critical dimension of educating the broader school community. Staff suggested that educational evenings could be one possibility of advancing suicide awareness, particularly in relation to preparing parents to engage with their sons/daughters about suicide, and to support them to identify it or speak up about if they had concerns about their friends. While the difficulty of attracting parents to various information nights was noted, it was also suggested the school might attempt to hold more information evenings that included a small amount of training with authentic scenarios parents could relate to, such as things a parent might notice in their child, possible language and phrases they might use etc.

> *I think parent awareness or guardian awareness could be something to do, information of what we're encouraging your child to identify or speak up about if they see their friend to help look after each other, and these are the things that you might notice in your child as well that maybe you be able to need to ask.*
>
> *I think once we build a strong culture within the school and having those conversations I think we might find ways to engage the parents in that conversation and it could be a drip feed of information through our parent portal of the importance.*
>
> *I mean one technique could be to have it at, try having the information, that sort of training with parents and students and see how it works. And if they get told this is what to look for, this is what to ask, give them a scenario, here is what your child is presenting as.*

Some generational challenges around attracting staff to information evenings were also identified.

> *I was thinking it might be something that changes as the time goes on because this stigma around not talking about mental health seems to be generational as*

*well. So, I know that my parents' generation they would never feel comfortable talking about mental health whereas my generation we've been lucky enough to grow up in a time where everybody talks about it.*

Another suggestion was to establish short online modules and electronic surveys as a more flexible option given general low parental attendance at evening school meetings. While staff identified the stigma of suicide as an ongoing issue for some parents, staff identified the need to address the increasing cultural demographics of the school, e.g. to be more communicative with the increasing numbers of families with diverse sub-continent and ethnic backgrounds who may not necessarily be accustomed to dealing with suicide matters, and unaware of support mechanisms within the school community.

### *8.2.6 Staff survey results*

Staff survey results suggest that communication between the school and its families as mostly 'good'. In relation to how connected staff felt to other staff, more than 50% felt relatively well connected, however far less than this number of staff felt connected to the school's leadership group. At least two thirds of the staff surveyed indicated they would be prepared to ask a colleague directly about suicide if they needed to, and at least three quarters of staff suggested they would be able to do the same with family members. In terms of the general set of questions about processes undertaken about colleagues' mental health, the majority of responses indicated the likelihood of notifying another colleague or reporting the matter to a superior, and less towards the likelihood of dealing directly with the person concerned.

Overall, the majority of staff indicated they felt either 'extremely' connected or 'somewhat' connected to their students. While many staff suggested the level of support available to them – e.g. mental health days, mentoring, employee assistance program etc. was adequate, a significant proportion were either unsure or not satisfied with the level of support around personal mental health. Less than half staff surveyed indicated they would be prepared to undertake a suicide intervention, and similar numbers were unsure. A very small proportion said they would not.

Most staff agreed that the workplace was a likely place in which conversations about suicide would take place, and would similarly attempt to ask directly about suicide. In terms of responding to a student if they were concerned about their mental health, most

suggested they would take some form of action (e.g. directly with student, contact parents, or discuss with a co-worker. Only half of the staff surveyed had experienced training on how to assess suicide, but more than half felt confident to recognise suicidal risk factors.

In answer to the question: *If you could change one thing about your school what would it be* – a number of considerations were mentioned, including: more staff support, more accessible procedures, more openness towards diversity, culture, disability, anxiety; improved staff relations and communication/consultation between leading staff and other staff, including timely notification of events and other information; better orientation for new staff; improved policies, and sharing information about policies; address sexual discrimination with dress code; open up greater conversations with students about sex, drugs, sexuality etc. The overwhelming majority of staff acknowledged they knew someone who had died by suicide.

#### *8.2.7 Summary*

What is evident from the focus group discussion is that staff feel they have differing levels of capacity to deal with suicide because of the different training received. Despite this differentiation, there was general belief that overall the staff training has ignited important conversations within the school and amongst the staff about suicide intervention, and introduced the need for suicide intervention to be an increased aspect of school culture.

## 8.3 Case Study #3

### *8.3.1 Staff responses to suicide intervention training*

Four significant points emerged from the focus group discussion at this school in relation to the suicide training received:

1. Historical and contemporary associations with suicide
2. The training has facilitated more open discussion (personal and professional) about suicide
3. The need to take the training out into the broader community context
4. Observation of students post training

The focus group discussion at this school commenced with the following comment by one of the leading teachers who suggested: *"suicide is something that we deal with on a regular basis with the school students".* This statement was supported by other staff who described a number of instances of students either contemplating suicide, or threatening suicide, and on one occasion, of talking a student down from attempting suicide. Staff described these events as *"stressful and confronting",* and explained they involved having to engage youth workers and counsellors to assist, as well as providing follow up de-briefs post the event.

There was general agreement amongst staff about the stigma associated with suicide, a notion highlighted by one of the teachers who indicated an increasing capacity of staff to engage with suicide intervention as a consequence of the ASIST training:

> *Previously the S word was something that was rarely very used and now staff and it took them, most of 2 days to get used to that, they're far more comfortable in saying to students, "Are you thinking about suicide? Have you made any plans?"*

Although it took a while for participants in the 2-day ASIST program to use the word "suicide" as part of their training, they felt "confident" to use suicide language by the end of the training, which included being familiar with the direction of putting safety plans into place.

> *I think the difference post-training has been staff are more, far more open in terms of having the conversation with kids and doing it in a very forthright manner.*

In terms of the 'confronting' nature of the ASIST training as described by the staff, participants spoke highly of the training presenter, who they suggested, maintained good

communication and a high level of sensitivity with participants about the potential need to leave the room during the training. Staff appreciated that this same level of support was also offered to their students. The need for extensive levels of support about the topic of suicide across the college more broadly was identified by another participant who suggested that many school members of the college (staff and students alike) had experienced suicide either in losing a family member, or through experiencing the threat of suicide. In re-counting these stories, the emotional toll of managing such scenarios was evident.

As part of maintaining positive relationships with students, staff in this case study are accustomed to offering pastoral support to students, particularly around health and well-being. Indeed, many describe this role as one of their key teaching responsibilities. Describing many of their students as coming from welfare backgrounds, staff highlighted the day-to-day likelihood of being sought out by students about personal and social matters, which often included issues such as suicide, depression and anxiety, as well as managing family relationships. While staff expected to be available to students for such discussions, they also identified the topic of suicide as an urgent matter that required greater attention and discussion within the college.

Although the ASIST training was described by some as *"very confronting", "intense"* and *"challenging"*, staff believed they were more open to having conversation with their students about suicide (who they suggested were more inclined to speak about suicide than older generations) as a consequence of the training. Referring to the 2-day ASIST training as *"a real eye-opener",* a teaching staff member indicated a new preparedness to ask direct questions to students about suicide. Another staff member responsible for teaching adults in their class (who would eventually teach young people) identified the need for their students to have the opportunity to do the training as part of their study.

> *I think there's, there was almost disbelief that suicide is as common as it really is or as prevalent as it is. And I think that they could also do with some, a little more reading, a little more understanding on that and training as well because it's, it's incredible to know how, how often it happens.*

Having done the training, she was able to take back some information and share it with her adult students, who she cited as knowing *"very little about the high incidence of suicide".*

Generally speaking, staff expressed they felt more confident to deal with a suicide situation if it arose, and a clear take home message from the training was *"to keep people safe".* Having been exposed to students that had either self-harmed or suffered depression, some staff described the ASIST training as adequately skilling them with how best to speak to students, and to take action to support them. This included a request from one staff person for further training in being able to understand and identify depression.

The ASIST training equipped staff *"with tools"* that allowed them to speak with students, and to put in place the *"necessary strategies".* One staff member referred to an incident at one of the campuses about a student 'at risk', explaining that as a result of the ASIST training they were able to use appropriate questions and language with the student: they knew to contact the student psychologist and made immediate arrangements for safe care for the student and other follow up matters.

> *I got a call this afternoon from X to say that they had an incident this afternoon and they felt that as a result of the training, they'd been able to handle that really well and very comfortably from their point of view. They'd put in supports in place, they've contacted the student psychologist, they'd made arrangements to see them tomorrow, they made arrangements for safe care for the student tonight and all of that really was a result of the, the program that they took with them.*

Branching out from these considerations, other staff indicated the need to extend the reach of the training into both the school and the wider community, each facing considerable challenges around mental health and associated social issues.

> *The training would be beneficial to all adults in the community it, it equipped us with tools to, to talk about it and to, to intervene to, to put in place strategies to keep people safe. So, I would, I'd recommend to anyone that they do it.*
>
> *So, we come across people who are not suicidal not in just schools but out in the wider community as well and in our family situations.*
>
> *Well we've had a staff member here at one stage … he came and spoke to me … I was so concerned about this person I actually went further, because*

*they, they were showing all those signs. So, we've had it actually in staff, but that person's no longer here*.

*At the moment, we're dealing with young people who are dealing with threatening, parents who are threatening suicide, who are really holding their children to ransom, they are traumatized by that and it's not just once or twice, but it's coming and coming. And helping them to deal with that is a really big thing. So, we've got across the board, parents, grandparents, one grandparent who's very traumatised at the moment by family situations and it's dealing with people again mostly who are suffering depression and not just the kids. themselves but it's all those people around them and understanding how to help them, it's big.*

Finally, this last aspect of the focus group conversation refers to staff observations of students post their participation in their 2-hour training, as described by one of the teaching staff:

*I think the, the training for the students normalised the fact that everyone goes through a period in their life when things get really bad and you cannot see a way out and so suicide becomes an option. They went through statistics on, on how everyone worries about things but at the end of the day a very small proportion of those worries actually create major dramas. I think just the fact that it's not abnormal you're not mentally deranged because you have suicidal thoughts, was really important to them And then the fact that there are people who are there to support you, and they talked about Lifeline and Beyond Blue and stuff like that. I don't think the kids are particularly shocked by discussions around suicide but given that it was aimed at empowering them to support their peers it took the pressure away from them and it was more what can I do to help other people and I thought that was really, really good. And to be honest after the, whatever it was 2 hours that we had them in here, most of them had stayed with the program really well.*

*Mine went really well with it and they talked about it a lot for the rest of the day but there's been a lot of discussion at the moment in our class about the Netflix* movie "13 Reasons" [which has a confronting teenage suicide scene].

Staff indicated they believed students had a more flexible and accepting approach of dealing with suicide. This was largely because of the nature of student-teacher relationships, but also because of the culture of the college, and young people's current circumstances:

*We've been delivering that message and I think that's a really strong part of what we do here, that the school is based on welfare and well-being, academic comes*

*secondary to that. So, building up the confidence and they will sit down and, and dump issues on you and I think that's amazing because it's not as if it's a long-term relationship often but they build up a, a confidence in the staff.*

*I think the actual conversations about suicide and things like that are not as taboo amongst our young people as they are amongst people of our age.*

### *8.3.2 Challenges of implementing/undertaking suicide intervention training*

1. Challenging nature of training
2. The role and impact of social media in relation to suicide
3. Providing professional support mechanisms for staff

Although staff participants in the safeTALK training described it as "beneficial", and "setting us to a certain level", many suggested the allocation of time (3 hours) was insufficient in providing them with absolute confidence to manage a suicide scenario.

*There should be a, a bit more training in how to deal with it [suicide]. It was definitely, it did help a bit but it could be expanded more. I did find it a benefit.*

Many staff highlighted the challenging nature of the ASIST training, especially in terms of feeling able to openly discuss suicide and thoughts of suicide, as well as engaging in role playing.

*I found having to do the role plays quite confronting. When you're role playing someone who's suicidal can be quite confronting and role playing being the person who's trying to keep them safe, is confronting as well. So that was, that was challenging but worth it, it took us a long time like X said to, to, to get to the point where we could, even in a role play ask the questions the way they needed to be asked.*

*The role playing was awful, it really was, I just could not get from where I had to go to where I should be, it was horrible, I, the woman who was with me, the other teacher she was just making me think of a student that I'd had.*

Staff appreciated not being forced into undertaking this aspect of the training.

Another matter raised by staff was concerns with how best to support students who might be dealing with suicide on social media (outside the context of the college). They suggested that not being privy to the nature of "outside" conversations made it difficult to support students, and were not clear on how the school would be involved in this particular context. Staff suggested they needed to be prepared to provide a level of care for the possibility or potential of suicide amongst students outside of college time.

Given the likelihood of trauma at this particular school, including the nature of trauma more broadly across students' family lives and the wider community in which the school is situated, staff highlighted the need for greater psychological support on a day-to-day basis. Some staff highlighted the stressful nature of their work such as informally counselling students, managing confronting family circumstances and situations, and in extreme instances, watching students being taken away in an ambulance and not knowing the specific destination of where the student was being taken. The majority of staff agreed for regular opportunities to debrief with peers and other professionals, which included ongoing professional support on a day to day basis.

In addition to these requests, staff identified the confronting reality of not being able to necessarily "save" a suicidal student:

> *So, I think that's, that's the other aspect of the training that you need to be prepared that there will be kids that you, no matter what you do you, you're not going to save them. And having to live with the fact that you tried and failed is incredibly difficult because you keep thinking, I could have done more, I could have done more. And so you're, you're walking away with this guilt thing.*

Building on these considerations, staff made the observation about the need for the ASIST training to include follow up information about students that may have been removed from the school by medical people:

> *I think another part that maybe is not explained in the training is what the system does with the, with the people, the hospital and, and all that stuff.*

### *8.3.3 Staff well-being and greater support*

Given the nature of trauma occurring more broadly across students' family lives and the socio-cultural context of the college, staff highlighted the need for greater psychological support on a day-to-day basis. Some staff highlighted the stressful nature of their work such as informally counselling students, managing confronting family circumstances and situations, and in extreme instances of watching students being taken away in an ambulance and not knowing where they were going. Many suggested they managed challenging scenarios by debriefing with other peers, while others expressed the need for greater and ongoing professional support.

Although some staff appeared familiar with protocols around suicide, the majority of staff indicated they were unclear, and expressed a need for greater dissemination of

information - a formal chain of command within the College - as a way of understanding which processes to follow should they be required. Administration staff initially felt they were isolated from these processes, some believing that their role was 'less important' than the role of professional staff, and that they would not necessarily be involved in suicide intervention. However, staff agreed that all College staff, regardless of position, rank and responsibilities should be equipped to apply an action response if they were to hear or see something in relation to abnormal behavior.

### *8.3.4 Staff survey results*

In relation to the support mechanisms available to staff, the majority of staff at this particular school identified a range of known options available to them in the workplace, ranging from mental health days, employment assistance program, mentoring and internal support from colleagues. With regards to whether or not staff would ask directly about suicide if friends or family member's words and/or behaviours suggested the possibility of them contemplating suicide, three quarters of the staff strongly agreed they would. The remaining staff indicated 'somewhat agreed' in their response. In relation to doing similar with colleagues, more than half indicated they would approach their peer directly, while the remainder suggested 'somewhat' agreed. In terms of the general set of questions about processes undertaken about colleagues' mental health, the majority of responses indicated the likelihood of notifying another colleague or reporting the matter to a superior, as well as dealing directly with the person concerned. Half of the participants indicated they would refer to school policy and follow necessary directions if they were concerned about a colleagues' well-being, and a quarter suggesting this same action to be 'unlikely'.

Half the respondents suggested they were highly connected to the students, while the other half indicated 'somewhat connected'. Regarding the likelihood of undertaking a suicide intervention, two thirds suggested they would, while the remainder suggested they were unsure – no participants suggested 'no'. The majority of staff indicated they would be likely to approach a student if they thought they were contemplating suicide – only one respondent indicated they wouldn't.

### *8.3.5 Summary*

The focus group discussion highlighted the prevalence of mental health issues and suicide related incidents as an everyday element of the school's culture. The impact of this reality suggests that staff can become acutely involved in the personal lives of their students. As with the other case study sites, there was general belief that overall the staff training has ignited important conversations within the school and amongst the staff about suicide intervention, and introduced the need for suicide intervention to be an increased aspect of school culture.

## 9 DISCUSSION

As outlined in the literature review provided in this Report, there has been a significant increase of death from intentional suicide among young people in Australia. Yet, research to date has focused on epidemiological studies rather than the efficacy of intervention, hence little is known about what makes programs effective. However, there are some factors acknowledged associated with youth suicide. In their study on important risk factors that differentiate suicide ideators from those who attempt suicide, Taliaferro and Muehlenkamp (2014) argue that what is required are interventions that reduce significant risk factors and enhance protective factors. What is known is that protective factors include parental connectedness, connectedness to other adults, teacher caring, that students felt that their school was safe and that they felt their neighbourhood was safe. Robinson et al. (2011, 2012, 2013) found that the most promising interventions for schools were programs that focused on 'gatekeeper training' and screening programs.

The findings of this Report contribute to research that seeks to provide evidence for effective intervention in youth suicide, through a specific focus on the of training school teaching and non-teaching staff. In broad terms, this pilot study examined the perception of preparedness of staff of three schools following training in either safeTALK or ASIST; the strengths and limitations of these training programs; and how the training program may be improved.

While staff at each of the three case study schools found aspects of the training program challenging due to the subject matter, all staff who participated in the focus group discussions who had completed the ASIST training, acknowledged that they now felt

empowered; discussion about suicide was more open within the school communities, staff felt confident in asking direct questions of those seemingly at risk, and there were, on the whole, clear directives as to how to support and assist those at risk. In comparison, staff who had completed the safeTALK training felt less confident in dealing with suicide behaviour. This is a significant issue to think carefully about, as the majority of those who completed the safeTALK training were non-teaching staff, and while not interacting with students in a classroom setting, nevertheless may often have particular insight into student (and staff) behaviour in a broader setting. Along with student awareness and training, a whole-of-school approach through gatekeeper training increases the likelihood of identifying those at risk and ensuring they receive appropriate and timely treatment (Larris et al, 2016).

On the whole, staff felt that there needed to be clearer school procedures and policies in place with regards to supporting students at risk, as well as support for staff dealing with at risk students. Focus group participants at all three schools suggested that there needs to be a register of trained staff made available to the broader school community in case of emergency. In addition, senior leadership teams need to have in place clear communication channels and appropriate procedures for dealing with students at risk. Staff also indicated that the risk of suicide is not simply a school issue, but one that is embedded within family and community relations and networks. Therefore, there needs to be clear communication both on the topic of suicide, and a means to increase awareness of suicide behaviour, outside of school. The need for a whole-of-community framework is supported by recent research (although further research is required to differentiate between the effects on suicide ideation and suicide attempts; Calear et al, 2016).

In addition, many participants explained that knowledge about who is trained would be an important source of peer support for those who have had to assist students at risk of suicide. The need for staff support was particularly raised in case study #3, where, given the personal contexts of many students, staff were more likely to be approached for advice about difficult personal issues. Even so, the training at all three schools revealed to staff that many students were coping with challenging personal issues and home situations.

In the course of these discussions, reference was made by staff to the geographical location of these schools' campuses within Melbourne's rapidly growing south-eastern growth corridor, and the pressures placed on individuals and families because of a lack of appropriate infrastructure and services. In addition, staff made mention of drug and alcohol abuse within the broader community and its impact on students and families. As noted in this Report's literature review, research focused on youth suicide prevention has neglected somewhat the need for cultural sensitivity, although there is a significant body of research on rural suicide (Hirsch, 2006; Boyd et al., 2005; Boyd & Parr, 2008; Boyd et al., 2011). Given the particular range of issues present in urban growth areas, a whole of school and whole of community approach would offer ways to assist youth face context-specific challenges, and supports the views offered by staff that parents, family members and members of the broader community have access to suicide awareness and intervention training. One suggestion for accomplishing this was through the use of online modules, which was seen as potentially useful given the general low attendance of parents at school information sessions.

Staff agreed that suicide awareness and intervention training would be best included as part of professional development, and that refresher training be offered annually. Yet, staff also acknowledged the difficulty of incorporating this training into an already tightly scheduled curriculum, and specifically as to how the release of staff to undertake the 2-day ASIST training would impact on senior students. Senior staff also noted the financial costs of replacing teachers while undertaking training, as well as school restrictions as to how many staff may be away from the school campus on any given day. However, schools need to consider how the skills and capacities of trained staff will be maintained, for, as Robinson et al (2013) found, the effectiveness of gatekeeper training decreases over time.

## 9.1 SUMMARY OF KEY THEMES IDENTIFIED IN SCHOOL CASE STUDIES

### 9.1.1 Suicide intervention training

- Suicide intervention training has the capacity to challenge the 'taboo' nature of suicide, including its complexities, associated myths and assumptions.
- Staff training (ASIST and safeTALK) training provides an important "permission giving" space whereby staff could share personal and professional experiences of suicide, which were validated and respected by peers.
- Acknowledgement of trainers who were perceived as considerate to the needs of participants, and provided sound levels of emotional support.
- Training provided an important opportunity to practice using appropriate suicide language and to roleplay suicide intervention.
- Brokering the complexities of suicide allowed staff to identify the need for their school to embark on widening and advancing suicide as a critical and cultural dimension of school life (e.g. that it be given greater attention in the wider curriculum).
- The ASIST training was identified as a robust way of equipping staff to confidently identify and deal with suicidal behaviour.
- The safeTALK training was identified as effective in raising suicide awareness, but less effective in equipping staff to identify and deal with suicidal behaviour in confident ways.

### 9.1.2 Suicide education and general communication within schools and the wider school community

- Schools are complex places, and face multiple challenges around timetabling.
- Staff across the three schools suggested improved communication about suicide within the school. and with the wider school community.
- Staff across the three schools identified the need for greater communication about the topic of suicide within the school.
- Staff across the three schools identified the need for greater communication about the topic of suicide with the wider school community. This would involve seeking new forms/ways of educating and involving families about suicide, and seeking

opportunities for extending future training across a greater representation of the wider school community.

- Staff recognised the need for greater development and communication about suicide chains of command within respective schools. This included in and out of school hours.
- Staff requested improved relationships and communication between leadership and teaching staff in general, but also in relation to knowing about upcoming training such as the suicide training.

# 10 RECOMMENDATIONS

## 10.1 Recommendation 1

Whole school approaches to suicide intervention for leadership, teaching and non-teaching staff that will increase capacity to identity mental health problems early, and implement effective suicide prevention strategies, knowledge and skills across the wider school/college community.

## 10.2 Recommendation 2

Schools to establish school systems, protocols, a safety contact check list, a register of trained staff, and chains of command action plans that support immediate response to suicidal behaviour during school and non-school hours (e.g. week-ends/holiday periods).

## 10.3 Recommendation 3

School leaders to establish formal and informal means of communicating with staff about student records/history in relation to suicide.

## 10.4 Recommendation 4

Schools to establish effective strategies that engage families/parents/guardian about mental health issues and suicidal behaviour.

## 10.5 Recommendation 5

Schools to prioritise training for all staff that focuses on strategies to support staff in their collective and individual endeavours to maintain personal mental health (e.g. mental health first aid), gate keeper training and mental literacy.

## 10.6 Recommendation 6

Increased and transparent whole school messages that reinforce the idea (a) suicide intervention is the role of all school staff members regardless of their professional position and responsibility, and (b) suicide intervention is relevant and applicable to all members of the school community.

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**APPENDICES**

## Appendix 1: Ethics approval

| | |
|---|---|
| Principal Researcher: | Dr Michelle Duffy |
| Other/Student Researcher/s: | Dr Monica Green |
| School/Section: | Faculty of Education and Arts |
| Project Number: | A16-159 |
| Project Title: | Evaluation of pilot study: Suicide Safer Schools. |
| For the period: | 06/12/2016 to 31/12/2017 |

*Quote the Project No: A16-159 in all correspondence regarding this application.*

**Please note**: Ethics Approval is contingent upon the submission of Annual Progress reports and a Final report upon completion of the project. It is the responsibility of researchers to make a note of the following dates and submit these reports in a timely manner, as reminders may not be sent out. Failure to submit reports will result in your ethics approval lapsing

**REPORTS TO HREC:**

Annual reports for this project must be submitted to the Ethics Officer on:**6 December 2017**

A Final report for this project must be submitted to the Ethics Officer on: **31 January 2018**

These report forms can be found at:

http://federation.edu.au/research-and-innovation/research-support/ethics/human-ethics/human-ethics3

Fiona Koop
**Ethics Officer**
**6 December 2016**
**Please see attached 'Conditions of Approval'.**

## CONDITIONS OF APPROVAL

1. The project must be conducted in accordance with the approved application, including any conditions and amendments that have been approved. You must comply with all of the conditions imposed by the HREC, and any subsequent conditions that the HREC may require.

2. You must report immediately anything which might affect ethical acceptance of your project, including:

- Adverse effects on participants;
- Significant unforeseen events;
- Other matters that might affect continued ethical acceptability of the project.

3. Where approval has been given subject to the submission of copies of documents such as letters of support or approvals from third parties, these must be provided to the Ethics Office before the research may commence at each relevant location.

4. Proposed changes or amendments to the research must be applied for, using a '**Request for Amendments**' form, and approved by the HREC before these may be implemented.

5. If an extension is required beyond the approved end date of the project, a '**Request for Extension**' should be submitted, allowing sufficient time for its consideration by the committee. Extensions cannot be granted retrospectively.

6. If changes are to be made to the project's personnel, a '**Changes to Personnel**' form should be submitted for approval.

7. An '**Annual Report**' must be provided by the due date specified each year for the project to have continuing approval.

8. A '**Final Report**' must be provided at the conclusion of the project.

9. If, for any reason, the project does not proceed or is discontinued, you must advise the committee in writing, using a '**Final Report**' form.

10. You must advise the HREC immediately, in writing, if any complaint is made about the conduct of the project.

11. You must notify the Ethics Office of any changes in contact details including address, phone number and email address.

12. The HREC may conduct random audits and / or require additional reports concerning the research project.

## Appendix 2: Plain languageinformation statement

| | |
|---|---|
| PROJECT TITLE: | 'Evaluation of pilot study: Suicide Safer Schools' |
| PRINCIPAL RESEARCHER: | Dr Michelle Duffy |
| OTHER RESEARCHER: | Dr Monica Green |

This information sheet is for you to keep. Our names are Dr Michelle Duffy and Dr Monica Green and we work in the Faculty of Education and Arts at Federation University, Australia. (Please see the end of this Information Sheet for contact details.)

**Why did you choose me to be part of this research?**

We are inviting you to be part of this research because you undertook training in the Safer Suicide Schools program at your school as either a teacher or as another member of school staff.

The aim of the research

**The aim of this research is to create an evidence base of the effectiveness of the Suicide Safer Schools training for staff in secondary schools.**

What does the research involve? **The study involves participation in an audio-recorded semi-structured focus group interview at a mutually agreed location convenient to your school (at one of the school's campus). If you choose to participate in this research you will be part of a small focus group (no more than 10 people) who will be invited to respond to the questions below, as asked by one of the researchers.**

Has there been an increase in suicide awareness in students and/or staff post the implementation of the Suicide project?

Have you noticed a change/increase in self-reporting?

Has there been an increase in students reporting others?

Have you noticed an increase in open discussion in your school about suicide, suicide thought and self-harm?

Have you noticed an increase in awareness of self-care and protective factors in students and/or staff?

Have you noticed/recorded an increase in help-seeking behavior?

In what ways could staff preparation for the Project be improved in the school context?

Having viewed the survey results collected at your school, what is your response about the portrayed levels of suicide thought and behaviour?

**Possible benefits**

The research may help in developing strategies for determining:

Possible impact on school communities who have been professionally trained to deal with adolescent mental health.

How mental health can be dealt with as part of a whole school approach.

**How much time will the research take?**

The interview will take around 30-45 minutes.

**Can I withdraw from the research?**

Being in this study is voluntary and you are under no obligation to consent to participate. If you do participate, you may choose to withdraw from the research at any time, by informing the researchers. Any unprocessed data related to you will be withdrawn. During the interview, you may decline to answer any particular question, or ask for the interview to stop. We do not anticipate any risks to you in participating, but we recognise that talking about matters pertaining to mental health might be upsetting for some people. If you became upset during the interview, we would take a short break or stop the interview. Help is also available through Lifeline (13 11 14) or Beyond Blue (1300 22 4643).

**Confidentiality**

**Individuals will be given pseudonyms in any publication arising out of this project. However, given the small population size of the two schools involved in this research, it cannot be guaranteed that participants will not be identifiable. We will make every effort to protect your identity and preserve confidentiality.**

Storage of data

**Storage of the data collected will adhere to the University regulations and kept on University premises in a locked cupboard/filing cabinet for 5 years. Electronic data will be kept for 5**

**years in password-protected storage. At the end of this time, all research data will be destroyed. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.**

Results

**If you would like to be informed of the overall research findings, please contact Dr Michelle Duffy (see email address below)**

| |
|---|
| If you have any questions, or you would like further information regarding the project titled<br><br>'Evaluation of pilot study: Suicide Safer Schools', please contact the Principal Researcher, Dr Michelle Duffy in the Faculty of Education and Arts: **PH:** 5122 6559 **EMAIL: michelle.duffy@federation.edu.au** |
| Should you (i.e. the participant) have any concerns about the ethical conduct of this research project, please contact the Federation University Ethics Officer, Research Services, Federation University Australia, PO Box 663, Mt Helen VIC 3353. Telephone: (03) 5327 9765, Email: research.ethics@federation.edu.au<br><br>CRICOS Provider Number 00103D |

## Appendix 3: Letter to participants

29 March 2017

Dear teachers and non-teachers,

As part of our research project: **'Evaluation of pilot study: Suicide Safer Schools',** Dr Michelle Duffy and Dr Monica Green are hoping to speak with you about your involvement in the Suicide Safe Schools training program in your school that was conducted by ERMHA. As part of this process, we would like to interview you to determine your perspective on the training, including your insights into the impact of the program.

Please consider the attached Plain Language Information Statement that explains the nature of the research, and your involvement in it.

We look forward to working with you.

Monica M. Green Michelle Duffy

Kind regards

Monica Green and Michelle Duffy

**Dr Monica Green**
Senior Lecturer | School of Education | Faculty of Education & Arts
T: +61 3 5122 6364 | F: +61 3 5122 6361 | M: 0407 547445
E: monica.green@federation.edu.au

**Dr Michelle Duffy**
Senior Lecturer in Sociology | School of Arts, Humanities & Social Sciences | Faculty of Education & Arts
E: Michelle.Duffy@federation.edu.au T: 03 51226559

## Appendix 4: Letter to Principal

[Date/address]

Dear [School principal's name],

As part of an evaluation research project: **'Evaluation of pilot study: Suicide Safer Schools',** Dr Michelle Duffy and Dr Monica Green are hoping to speak with staff who were involved in the Suicide Safe Schools training program in your school conducted by ERMHA. As part of this process, we would like to interview school staff to determine their perspective, and impact of the program. The conversation would be recorded and staff would have to provide consent to that.

If you agree to the above research, we would appreciate a letter of confirmation (on school letterhead) agreeing to staff availability.

Many thanks for your involvement in the research, and we look forward to hearing from you.

Monica M. Green Michelle Duffy

Kind regards

Monica Green and Michelle Duffy

**Dr Monica Green**
Senior Lecturer | School of Education | Faculty of Education & Arts
T: +61 3 5122 6364 | F: +61 3 5122 6361 | M: 0407 547445
E: monica.green@federation.edu.au

Dr Michelle Duffy
Senior Lecturer in Sociology | School of Arts, Humanities & Social Sciences | Faculty of Education & Arts
E: Michelle.Duffy@federation.edu.au T: 03 51226559

Federation University Australia
PO Box 3191 Gippsland VIC 3841

## Appendix 5: Participant consent form

| | |
|---|---|
| PROJECT TITLE: | 'Evaluation of pilot study: Suicide Safer Schools' |
| RESEARCHERS: | Dr Michelle Duffy and Dr Monica Green |

**Consent – Please complete the following information:**

I, . . . . . of . . . . . .

. . . . . .

. . . . .

hereby consent to participate as a subject in the above research study.

The research program in which I am being asked to participate has been explained fully to me, verbally and in writing, and any matters on which I have sought information have been answered to my satisfaction. I understand I am agreeing to participate in an audio-recorded interview that could last up to an hour.

I understand that: all information I provide will be treated with the strictest confidence and data will be stored separately from any listing that includes my name and address. I understand that the small number of participants might have implications for privacy and anonymity.

- Aggregated results will be used for research purposes and may be reported in scientific and academic journals

- ***I am free to withdraw my consent at any time during the study in which event my participation in the research study will immediately cease and any information obtained from it will not be used.***
- ***once information has been aggregated it is unable to be identified, and from this point it is not possible to withdraw consent to participate***

**SIGNATURE** **DATE**

## Appendix 6: Interview questions

| | |
|---|---|
| PROJECT TITLE: | 'Evaluation of pilot study: Suicide Safer Schools' |
| PRINCIPALRESEARCHER: | Dr Michelle Duffy |
| OTHER RESEARCHER: | Dr Monica Green |

Interview questions:

- Has there been an increase in suicide awareness in students and/or staff post the implementation of the Suicide project?
- Have you noticed a change/increase in self-reporting?
- Has there been an increase in students reporting others?
- Have you noticed an increase in open discussion in your school about suicide, suicide thought and self-harm?
- Have you noticed an increase in awareness of self-care and protective factors in students and/or staff?
- Have you noticed/recorded an increase in help-seeking behavior?
- In what ways could staff preparation for the Project be improved in the school context?
- Having viewed the survey results collected at your school, what is your response about the portrayed levels of suicide thought and behaviour?
- Did the survey results meet with expectations regarding the level of suicide thought and behaviour among students?
- In what way might the Survey content be improved?
- Are there any areas that you think are important to wellbeing that were not sufficiently covered?

## Appendix 7: Interview schedule

| | |
|---|---|
| PROJECT TITLE: | 'Evaluation of pilot study: Suicide Safer Schools' |
| PRINCIPAL RESEARCHER: | Dr Michelle Duffy |
| OTHER RESEARCHER: | Dr Monica Green |

Schools will take responsibility for arranging focus group interviews. The number of focus groups required at each school is a minimum of one. Depending on staff availability and consent, there may be multiple focus groups at each of the respective schools. We cannot provide exact numbers until the schools confirm these arrangements.

**School 1:**

**Focus group interviews to be conducted in Term 2 (early May, 2017)** Invitation to be sent out to teaching and professional staff in January 2017 by principal. Groups of no more than 10 will be arranged by the school, according to the type of training program participants enrolled in (for example, from either the two-hour safeTALK training program OR the 2 day ASIST program.

**School 2:**

**Focus group interviews to be conducted in Term 1 (Mid March, 2017)** Invitation to be sent out to teaching and professional staff in January 2017 by principal. Groups of no more than 10 will be arranged by the school, according to the type of training program participants enrolled in (for example, from either the two-hour safeTALK training program OR the 2 day ASIST program.

**School 3:**

**Focus group interviews to be conducted in Term 3 (Late June, 2017)** Invitation to be sent out to teaching and professional staff in January 2017 by principal. Groups of no more than 10 will be arranged by the school, according to the type of training program participants enrolled in (for example, from either the two-hour safeTALK training program OR the 2 day ASIST program.