

# YOUNG PEOPLE AT RISK OF SUICIDE:

## A GUIDE FOR SCHOOLS



### Acknowledgments

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This Guide is published by the Ministry of Education and the National Advisory Committee on Health and Disability (National Health Committee) as advice on best practice for the prevention, recognition and management of young people at risk of suicide within schools. Material in these guidelines may be copied providing the source is acknowledged.

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# CONTENTS

The purpose of the Guide	3
Using the Guide	4
Information about suicide of young people	5
Figure 1: Hospitalisation and deaths due to suicide for 1994/95	5
Relating the figures to your school	6
Risk factors for suicide attempts	6
Responsibility of principals and boards of trustees	7
Prevention of suicide by young people	9
Implementation of health education and maintaining a healthy environment	9
Preparation for the management of the consequences of suicide within a school	9
Recognition of young people at risk	10
Figure 2: An overview of the processes of recognition, intervention, assessment and management of young people at risk of suicide	10
Intervention and assessment by the counsellor	12
Table 1: Assessment of young people at risk of suicide (opposite page 12)	12
Assessment of young people identified as at risk of suicide	13
Evaluation of personal difficulties	14
Positive resources	14
Previous suicide attempts	15
Suicide plan	15
Assessment of depression	16
Management of young people at risk of suicide	17
Table 2: Management of young people at risk of suicide (opposite page 17)	17
Immediate intervention	18
Development of a therapeutic relationship - working together	18
Consultation	19
Confidentiality	19
Liaison with the family/whanau/caregivers	20
Cultural considerations	20
Referral to a healthcare professional or agency	21
Follow up	22
Review of the programme and staff competence	23
Training of staff to recognise at risk young people	23
The management of the consequences of a suicide or serious suicide attempt within a school	24
Traumatic incident response plan	24
Traumatic incident response checklist	26
Contact numbers of resource professionals and groups	27
Appendix	33

## THE PURPOSE OF THE GUIDE

This consultation guide has been developed for New Zealand schools jointly by the Ministry of Education and the National Health Committee in consultation with education and health professionals and agencies.

It is based on the conclusions and recommendations contained in a report commissioned by the Ministry of Education and the National Health Committee called **The prevention, recognition and management of young people at risk of suicide**. A copy of the source report has been sent to each school and can be obtained from Learning Media Ltd or the National Health Committee.

This guide outlines the responsibilities of the various parties within a school and sets out what is regarded to be “best practice” in usual circumstances. It is recognised that not all schools and communities may be in a position to implement these guidelines in full at present but they provide a guide to the services and practices that should be developed.

Any effective response to the current high levels of suicide by youth will involve a wide range of health professionals as well as the young person's family and community. While this guide focuses on what is the best practice for a school, it should not be taken to mean that schools are the only agency or part of the community with responsibility for addressing this problem. The factors which contribute to a young person seriously contemplating suicide are mostly located in the young person's life outside of the school.

School-based suicide prevention and management programmes have been shown to be effective in recognising and providing assistance for young people who are at risk of suicidal behaviours. The main thrust of these programmes should be on identifying those who are at risk and then seeking appropriate support, care and management for them.

The focus of this guide is on identifying young people who are in a state of “emotional distress” and are at risk of harming themselves by attempting suicide or similar actions. This guide suggests a range of actions from monitoring the young person within the school environment to immediate referral to a specialist mental health service; the appropriate action being determined by the severity of the distress and risk of suicide.

This guide is just one part of creating a positive, safe environment in schools. It is important that in using this guide, counsellors have regard for the more detailed advice in the source report: **The prevention, recognition and management of young people at risk of suicide**. It is recommended that when implementing the advice for the first time, or when in any doubt, the report should be consulted.

Counsellors and staff involved in implementation will also need to have regard for other health resources such as the health curriculum, specific mental health resources and relevant treatment guidelines (eg the National Health Committee's *Guidelines for the treatment and management of depression*).

## USING THE GUIDE

This guide aims to increase the awareness of boards of trustees, principals, teachers and other adults in schools, including administrators, psychologists, counsellors, nurses, social workers and other allied staff, about young people who experience emotional distress and who may then be at risk of suicidal behaviour such as seriously contemplating, planning or attempting suicide.

### **Use of this guide should:**

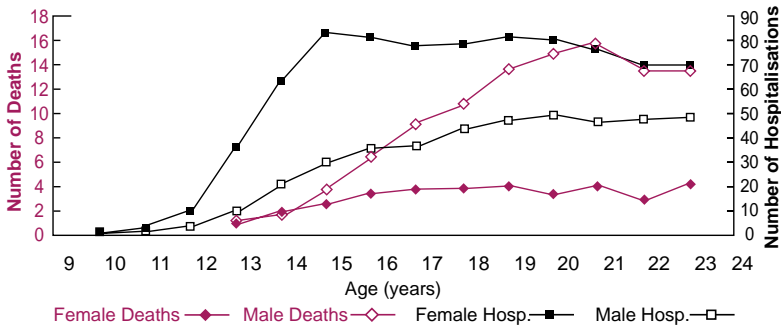
- increase awareness of emotional distress and risk of suicide among members of the school community
- improve the ability of all staff to identify distressed students and refer them to a counsellor
- develop mechanisms for referral of at risk young people to local health services and how to establish ongoing liaison with these services (eg. develop a list of local services and contact people and numbers - see page 26)
- develop a trauma management plan which will minimise the impact and consequences of any serious suicide attempt or death on students and staff
- increase the skill of counsellors in assessing the risk of suicide and developing and implementing appropriate management plans.

## INFORMATION ABOUT SUICIDE OF YOUNG PEOPLE

New Zealand has the highest rate of reported youth suicide among industrialised (OECD) countries. While completed suicide rates are higher in the 20-24 age group than among 15-19 year olds, the rate of attempted suicide is higher for those in the adolescent age range of 13-19 years. Those over 20 years are, therefore, at higher risk of death from self-harm and those under 20 years have a higher risk of injury and hospitalisation following incidents of self-harm.

While a sizeable proportion of young people may contemplate suicide, only about 5% of young people attempt suicide. Most attempts are relatively minor, neither requiring hospital treatment nor resulting in death. About 40 to 45 young people aged 10-19 years will die as a result of suicide each year. Approximately 600 to 700 young people aged 10-19 will be admitted to hospital following a suicide attempt each year. A larger number will be treated at Accident and Emergency or local Health Centres and not be hospitalised. Most of those admitted to hospital will be female, whereas most of those dying by suicide will be male. Historically, rates of suicide have been lower among Maori than non-Maori. However, rates of suicide and suicide attempts in young Maori appear to have increased in recent years, and currently rates of suicide in Maori and non-Maori are similar.

**Figure 1: Youth suicide hospitalisation and deaths 1995/96 moving average**



(Source: New Zealand Health Information Services. Hospitalisation refers to when a young person is admitted and does not include treatment at Accident and Emergency.)

## **Relating the figures to your school**

On average, a secondary school of 1,000 pupils could expect:

- up to a quarter of all young people to experience suicidal thoughts on which they do not act at some time in each year
- up to 20 young people to attempt suicide with most not resulting in any physical injury each year
- one serious suicide attempt resulting in an admission to hospital each year
- one death by suicide every 12.5 years.

A serious suicide attempt, or death, will also affect the emotional well-being and educational achievements of a significant number of young people within the school.

## **Risk factors for suicide attempts**

Research has consistently identified four factors that distinguish young people who make suicide attempts from other young people. These are:

- those making suicide attempts tend to come from socially and educationally disadvantaged backgrounds
- those who make suicide attempts often come from disturbed or unhappy family and childhood backgrounds
- almost all of those making suicide attempts will display some recognisable mental health or adjustment difficulty prior to the suicide attempt
- immediately prior to the suicide attempt, the young person will face some severe stress or life crisis that will often, but not invariably, revolve around the breakdown of an emotional or supportive relationship.

Research has consistently suggested that approximately 90% of young people dying by suicide or making suicide attempts will have had a recognisable mental health disorder at the time. The three mental health disorders most commonly associated with suicidal behaviours are:

- depressive disorders - present in almost three quarters of those making suicide attempts
- alcohol, cannabis and other drug abuse - present in over one third of those making suicide attempts
- significant behavioural problems (such as conduct disorders and antisocial behaviours) - present in one third of young people making suicide attempts.

In many cases those making suicide attempts will have more than one of these disorders and the typical profile of the young person most at risk is:

- he/she lives or has lived in a family environment that is subject to multiple stresses, including abuse and other difficulties
- he/she has, at a relatively early age, developed adjustment problems that span and include depression, alcohol and other drug use disorders and behavioural difficulties

- at the time of the suicide attempt, the young person is likely to have been exposed to a significant stress (most commonly involving the breakdown of a supportive emotional relationship or problems with the law).

In many young people, the attempted suicide (regardless of whether the suicide is completed) represents the end point of an unhappy life in which elements of family adversity, adjustment difficulties and personal stress all contributed.

**The single most important factor in the prevention of suicide is to address the causes of mental health and personal adjustment problems in young people. Prevention efforts in schools should occur within the context of:**

- health education programmes (including the current health and physical education curriculum<sup>1</sup> and healthy schools material) and cultural development processes (eg bilingual units and whanau facilities) that promote a safe and healthy environment, increase self esteem and address adolescent difficulties in general
- efforts to address and manage the difficulties faced by young people from adverse childhood backgrounds who have multiple problems of personal adjustment stress
- improving recognition of mental health problems (including disorders such as depression, alcohol and drug abuse and conduct disorders) in young people.

## RESPONSIBILITY OF PRINCIPALS AND BOARDS OF TRUSTEES

School administrators are required to provide the best possible learning environment for their students. This includes catering for those young people whose emotional distress may lead to less than expected educational achievement. This will vary from mild distress, which may occur for a short period of time in a significant number of young people, to distress which may lead to the young person seriously contemplating, planning or attempting suicide.

Principals are required under Section 77 of the Education Act 1989 to take all reasonable steps (as part of the school's day to day administration) to ensure that:

- students receive good guidance and counselling
- parents are told of matters that are preventing or slowing the student's progress or harming the student's relationship with teachers and other students.

<sup>1</sup> *Health and Physical Education Curriculum Draft 1998*

Boards of trustees are charged with the complete discretion to control the management of the school (Section 75 of the Education Act 1989). They are required to:

- ensure that the school is emotionally and physically safe for students (NAG)<sup>1</sup>
- have a goal of achieving successful learning outcomes for students by identifying barriers to achievement and ensuring appropriate supports are put in place (NEG)<sup>2</sup>
- increase participation and success by Maori through the advancement of Maori education consistent with the principles of the Treaty of Waitangi (NEG)<sup>2</sup>
- foster the personal, social and intellectual development of students
- comply with the statutory requirements of the Health and Safety in Employment Act 1992, to ensure a safe and healthy workplace for both staff and students (Section 16).

**It is recommended that boards of trustees develop the following processes:**

- **Prevention** - implement health education programmes which promote a safe and healthy environment including teaching the current health and physical education curriculum. Develop policies and procedures for the management of any traumatic event such as the death of a student or a member of staff, so that distress to others is minimised
- **Recognition** - acknowledge in written policy that, as far as they are trained and able, it is the responsibility of all staff to endeavour to identify young people experiencing mental health and personal adjustment problems and especially those who may be at risk of seriously contemplating, planning or attempting suicide
- **Intervention** - ensure that any student who is identified as being at risk is referred to the designated staff member (ie counsellor), is assessed, assistance and support are provided or a referral made to an appropriate service
- **Management** - develop a management plan for young people at risk of suicide which details the immediate actions necessary to promote their safety, including consultation with other professionals and family members, monitoring and/or referral to appropriate services and follow up
- **Review** - the ongoing review of the policies, procedures and competence of staff to identify and appropriately refer students who are at risk of attempting suicide.

1 Ministry of Education National Administration Guidelines.

2 Ministry of Education National Education Goals.

## PREVENTION OF SUICIDE BY YOUNG PEOPLE

### **Implementation of health education and maintaining a healthy environment**

The single most important factor in the prevention of suicide in the school environment is to address the causes of mental health and personal adjustment problems in young people.

Prevention efforts in schools should occur within the context of health education programmes (including the current health and physical education curriculum and healthy schools material), and other policies and practices within the school which promote the well being of students.

A safe and healthy school environment should be promoted with programmes designed to strengthen and maximise student participation and feelings of self worth and to promote social equity.

It is recommended that programmes aimed at increasing the awareness of young people about issues of youth suicide are NOT undertaken. While programmes to assist school staff and associated staff to better recognise and manage mental health problems (which may result in an increased risk of suicide) among young people appear justified, extending the provision of suicide awareness programmes to students may have unintended negative effects with vulnerable students.

Programmes on suicide awareness directed at young people are often designed both to encourage young people to recognise suicidal behaviours in their peers, and to lower the threshold for discussion of suicide in the belief that this will encourage young people to discuss their suicide ideation (ideas and plans).

Reservations have arisen about the efficacy of such programmes and of greater concern are suggestions that programmes directed at students may encourage, rather than prevent, suicidal behaviour. The concept of suicide may become normalised in the youth population and seen as a socially acceptable option for young people under stress. Rather the focus should be on recognition and appropriate response to mental health problems experienced by young people such as depression, abuse of substance, etc, within the context of the health curriculum.

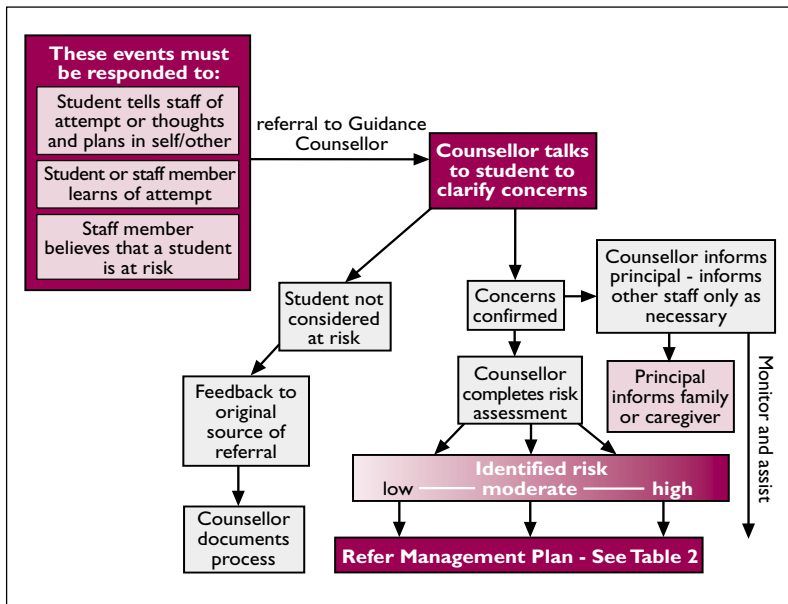
### **Preparation for the management of the consequences of suicide within a school**

All schools are likely at some stage to have a student seriously attempt suicide. In this event there is almost certain to be consequences for other students. Almost all the close friends will experience some grief reaction, others will experience guilt. For some it may bring back memories and reactions to other loss experiences and for a small number, especially those who may already be experiencing difficulties, it may raise the awareness of suicide as an option. For these reasons, it is important that schools have a traumatic incident response plan, developed in advance, which provides appropriate processes for students and staff to grieve, and minimises any harmful outcomes of the traumatic event. Such a plan will contribute to the emotional safety of students.

The details of what should be in a traumatic incident response plan and the processes for its development can be found in the report: **The prevention, recognition and management of young people at risk of suicide**. A checklist is on page 26.

## RECOGNITION OF YOUNG PEOPLE AT RISK

**Figure 2: An overview of the processes of recognition, intervention, assessment and management of young people at risk of suicide**



Common signs of distress which school staff will notice and which should be checked by a counsellor are:

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

- **ideas and themes of depression, death and suicide** - reading selections, written essays, conversation, and artwork contain themes of depression, death and suicide. Statements or suggestions that he/she would not be missed if they were gone. Appears to collect and discuss information on suicide methods. Begins giving away prized possessions (possibly with some elevation in mood) and has demonstrated previous direct or indirect suicide threats or attempts
- **change in mood** - withdrawal, sudden tearfulness, and remarks which indicate profound unhappiness, despair, hopelessness, helplessness. Anger at self, increased irritability, moodiness and aggressiveness. Lack of interest in surroundings and activities and marked emotional instability. New involvement in high risk activities
- **grief about a significant loss** - stress due to the recent disintegration of their family or has had a recent death or suicide in the family or has lost a friend through death or suicide or a break up with a boyfriend or girlfriend
- **withdrawal from relationships** - change in relationships with friends and classmates. Loses interest in extracurricular activities and may drop out of sports and other clubs. Begins to spend long periods of time alone
- **physical symptoms with emotional cause** - eating disturbances or chronic physical complaints, such as headaches, stomach aches, fatigue, body aches, scratching or marking of the body, or other self-destructive acts. Reduced personal hygiene and self care
- **high risk behaviours** - increased use of alcohol and drugs to the point of intoxication. Engages in other risky behaviours (eg dangerous driving, playing with guns).

The significance of the risk factors above may be accentuated in young people who lack parental warmth; for example, their parents appear uninvolved, unsupportive, and demonstrate denial of the student's problems. They appear angry, threatened and defensive or there is evidence of a long history of home problems, such as physical and/or sexual abuse.

Once a staff member has identified a student who is considered to have a number of these symptoms, who is likely to be distressed and where the staff member judges there to be some risk (no matter how small) that they may harm themselves, then the staff member must make a referral to the counsellor or other designated person. The staff member should decide to refer a young person based on the overall severity of the symptoms and their intuition, rather than the number of symptoms. The staff member should continue to support the young person, especially while the referral to the counsellor is being arranged. Consideration should be given to arranging for an appropriate support person (ie family/whanau, responsible friend) for the young person, during this process.

## BEHAVIOURS WHICH MAY INDICATE DISTRESS AND STUDENTS AT RISK (The decision to refer a young person is based on the overall severity of the symptoms and intuition about the degree of risk rather than the number of symptoms)

unexpected reduction of academic performance	<input type="checkbox"/>
ideas and themes of depression, death and suicide	<input type="checkbox"/>
change in mood	<input type="checkbox"/>
grief about a significant loss	<input type="checkbox"/>
withdrawal from relationships	<input type="checkbox"/>
physical symptoms with emotional cause	<input type="checkbox"/>
high risk behaviours	<input type="checkbox"/>

## INTERVENTION AND ASSESSMENT BY THE COUNSELLOR

It is advisable that all schools should have access to qualified, competent and externally supervised counsellors who assume the responsibility for the assessment and management of all at risk young people in the school. Schools should develop clear procedures (based on this guide) and a climate which encourages young people to discuss their personal concerns with teachers and feel comfortable about talking to the counsellor. This includes:

- clear lines of communication and processes for staff to refer young people
- a climate and system whereby young people can easily access the counsellor either for themselves or for others they are concerned about. This may include peer support and peer referral systems outlined in the report: **The prevention, recognition and management of young people at risk of suicide.**

Once a young person has been referred, the counsellor will assess the risk of suicide as soon as is practicable.

After an initial assessment has been completed, and the counsellor considers that the young person is at risk of suicide, it must be considered whether or not the principal should be informed. From this point the principal, in liaison with the counsellor, must consider if, when, and to what degree, any other staff should be informed. They will also decide if, when and how the parents are to be informed. The primary goal is the safety of the young person.

Counsellors or designated staff, will then have the primary responsibility to arrange appropriate assistance for the young person while he or she is within the care of the school.

Risk of suicide will be classified as low, moderate or high (see Table 1: Assessment of young people at risk of suicide). A different management plan for each level will be formulated based on Table 2: Management of young people at risk of suicide (facing page 17) of this guide.

## **Assessment of young people identified as at risk of suicide**

This section focuses on the skills that are required to assess young people who are identified as being at risk and the management that is then required to ensure that they get access to the necessary assistance.

**This assessment is only to be carried out by the counsellor or another designated and competent staff member.**

In the absence of a counsellor, another staff member or professional from outside the school with sufficient qualifications, experience and current competencies, may be designated to make an assessment, providing their work is professionally supervised.

The outcome of decisions that counsellors make in such an assessment could, if wrong, result in a young person making a suicide attempt. Therefore, for the protection of both the young person and the counsellor, it is important that the principles of best practice outlined in this guide and in other related mental health guidelines are complied with, and that the work of counsellors is professionally supervised.

It should be noted that there are occasions when even the most experienced professionals fail to recognise a young person at risk of suicide.

It is important that all young people who are referred to the counsellor with significant personal problems are assessed for risk of suicide regardless of whether the original referral identified this as an issue. Most young people who are identified as having mental health or personal adjustment problems will not be preoccupied with thoughts of suicide - most suicidal ideas will be fleeting, will occur from time to time and in most cases are not likely to be actioned. However, for a small number, the risk of suicide is significant and must be addressed. It is recommended that staff take a conservative approach and any suspected risk of suicide is assessed and managed to keep the young person safe, before other assistance, such as counselling, is provided.

If in doubt, a written referral should be made to a competent service or health professional and adequate documentation kept.

The initial assessment should be appropriate to the level of any risk of suicide expressed by the young person. If there is only a suggestion of thoughts about suicide then the assessment should start with this and proceed if, and as, the young person provides evidence that they are thinking of suicide as one "solution" to their distress. Young people may not communicate their thoughts about suicide directly, even if specifically asked. However, they are likely to make indirect references, especially in their school work, to relatives, friends or within a general conversation with a counsellor.

It must also be recognised that suicidal ideation in particular, and mental state in general, can fluctuate considerably over relatively short periods of time. It is therefore necessary to determine the need for reassessment over the next few hours, days and weeks. However, the degree of risk of suicide and therefore the actual wish to die may fluctuate and consequently needs to be closely monitored.

Suicide risk assessment is based on the counsellor's identification of risk factors and on subjective intuition. The counsellor needs to attend to her/his intuition as well as objective responses when determining if, and the degree to which, a person is at risk of suicide. It is usually most appropriate to inquire about current suicidal ideas in the context of a series of questions, rather than abruptly and directly asking about suicide.

It is common for young people with a depressive disorder to have thoughts about suicide. Many young people will be relieved to be asked about their suicidal thoughts. Asking them about what they are thinking and careful and sensitive questioning will not cause them to become more suicidal. Care should also be taken to focus on the positive reasons why the young person should not carry through with a suicide plan. In this way the immediate intervention begins within the assessment process and this can lead to a strong positive relationship developing between the young person and the counsellor.

During the assessment the counsellor should attempt to obtain information about each of the following areas as outlined in Table 1: Assessment of young people at risk of suicide.

## Evaluation of personal difficulties

- **stress** - any significant life crisis that is likely to encourage or precipitate suicidal ideas and plans and behaviour. Common sources of stress are the breakdown of a close relationship, problems with the law, death of a friend and academic difficulties
- **depression** - or other mental health problems
- **lack of coping abilities** - the individual's ability to cope and address their problems. A young person who is considering suicide may have ambivalent feelings about actually dying. They often have a core commitment to life that can be the basis for forming a therapeutic relationship. Conversely, in some cases, ideas and planning about suicide are part of a pattern of high risk behaviours (eg alcohol and drug abuse, dangerous driving, potential for accidents etc).

## Positive resources

- **family and friends** - the availability of positive social support from the family and friends
- **communication** - the ability of the young person to express their suicidal thoughts and any expressed intentions such as 'punishing others'

- **lifestyle** - the stability of the young person's lifestyle and relationships.

## Previous suicide attempts

- **previous suicide attempts** - a history of previous events by the person is the most accurate predictor of a future suicide. Suicide or suicide attempts amongst family and/or friends should also be considered a risk factor.

## Suicide plan

- **suicide plan** - the extent to which the young person has formulated and reports having made a clear plan of the way they intend to take their lives. For instance, does the plan include how the suicide will be attempted, the availability and lethality of the method and the proposed timing (including the likelihood of being discovered and stopped).

Having collected the information compare the person's situation with the three profiles in Table 1 to determine the **best fit** of low, moderate or high risk. Pay particular attention to the viability of the plan, the lethality of the method, any instability and your intuition. If in doubt, be conservative and rate the risk higher. The severity of the risk of suicide will not necessarily depend on the number of symptoms, but their overall severity and likelihood.

It should be noted that there have been suggestions that sexual orientation may be a risk factor for youth suicide. These suggestions are, at present, based on anecdotal evidence. Conclusive research evidence linking sexual orientation to suicide risk is not available. However school counsellors should be aware of the possibility that young people who are lonely and isolated may have issues about their sexuality that should be investigated and appropriate support given.

There are additional indicators which may accompany a Maori person at risk of suicide. The indication of these will require careful and respectful probing by those observing, as well as an empathetic relationship with the person concerned.

Additional indicators for Maori students may include:

- suggestions of breaches of cultural protocols
- preoccupation with a close relative who has recently died
- irritability and/or uncharacteristic aggression
- issues of injustice (especially cultural), experienced by the person or their whanau, which have resulted in:
  - intense internalised shame or guilt (Pūihi)
  - intense externalised shame or guilt (sometimes referred to as Whakamā, though this does not have a negative connotation)
- unresolved grief or loss of a significant person or their own status
- somatic complaints with no apparent physiological cause.

When a young person is assessed by a counsellor as being at risk, the counsellor

should only pass on as much detail as is necessary to ensure appropriate action is taken and the young person is kept safe. Once the severity of the risk has been determined and it is moderate or high, then the counsellor should consider informing the principal of the significance of the risk, the proposed management plan and discuss the question of informing parents and relevant staff.

It would be advisable for the principal and counsellor to negotiate an agreement for their own school, specifying in what situations the principal will be informed of a young person at risk of suicide. Consideration should be given to the need of the principal to be forewarned of any potential tragedy, the ethical practice expected of the counsellor and the potential effect on vulnerable students in the future. Any agreement should consider matters such as :

- the severity of the risk
- new or unusual cases
- the implications for young people already the focus of attention for other matters.

Where the possibility of suicide is a particular concern, it is important to speak with the family at the earliest opportunity. While it is desirable to obtain the permission of the young person, if there is a serious and imminent threat to the life or health of the individual this is not essential (refer to Rule 11(2d) Health Information Privacy Code 1994, NZAC Code of Ethics). However, the development and maintenance of a good relationship between the young person, the counsellor, their family, and their social network, will be an important factor contributing to safety in the short term. In cases of high risk of suicide, it will be necessary to supervise the young person and arrange a clear transfer of responsibility to another professional or the family until a referral to a mental health service is arranged. Explicit instructions should be given to those providing the supervision about how to make an environment safe (ie removal of the means of suicide) and how to provide supportive supervision. Advice may be sought from a Duly Authorised Officer (DAO) of the local mental health service. The DAO is most often a nurse authorised to commit a person to compulsory assessment and treatment, if necessary against their will. Counsellors should identify how they can access this 24hr a day service.

It is best to adopt a conservative approach which treats the young person as being at risk until it is clear that the risk no longer exists. If a student continues to be even at low risk after six to eight weeks, the young person should be referred to a specialist mental health service and treated as if the risk was moderate to high.

## **Assessment of depression**

If during the assessment of suicide it is suspected that the young person is depressed then there is value in the counsellor completing an assessment of depression. The process for such an assessment is outlined in *Guidelines for the*

*treatment and management of depression by primary health professionals* (National Health Committee, 1996).

Staff should be cautious about applying such diagnostic systems to young people from non-European cultures and are advised to consult the Guidelines for depression (1996) for a Maori and Pacific Islands perspective of depression, or consult the local mental health service's cultural advisory staff.

### **The threat of suicidal behaviour should be regarded seriously and investigated**

- any student for whom concerns about suicide risk exist should be assessed to determine the degree of risk of suicide
- if doubts exist about the appropriate course of action, then advice/consultation with mental health professionals should be sought promptly
- in most cases prompt and continued liaison with families of at risk students should be instituted
- any student who is considered to be at risk of suicide should be treated as being at risk until it is clear that risk no longer exists.

## **MANAGEMENT OF YOUNG PEOPLE AT RISK OF SUICIDE**

This section outlines the role of counsellors in the management of young people at risk of suicide. Other school staff should not provide these services, except in an emergency.

This guide recommends that schools implement an appropriate management plan to respond to students assessed as being at low, moderate or high risk of suicide. Once the degree of suicide risk has been established, a management plan should be developed which is appropriate for the current level of risk. The level of risk can change and this should be regularly monitored and the management modified accordingly.

Four actions are identified as part of this management plan: **immediate intervention**, **consultation**, **referral** and **follow up**. Each is discussed in the following section of this guide.

The management of a young person at risk of suicidal behaviour will depend on the extent of the perceived risk. The level of intervention increases with the assessed risk of suicide. In summary, students with a low risk should be monitored and supported within the school's resources for a maximum of six weeks. If the low risk status persists longer than six weeks then it should be regarded as moderate and a specialist opinion sought. Students with a moderate risk should be managed together with specialist services and those with a high risk should be directed immediately to specialist services (with the school in a supportive role).

## Immediate intervention

When there is a significant risk of suicide, referral to a specialist service for assessment and treatment should be done immediately (see page 27 for a template of services which schools might use to make referrals or obtain support). Advice on whether and how best to make a referral may be sought from a Duly Authorised Officer (DAO) of the local mental health service. At the same time, it is important to take measures to remove lethal means (including firearms, pills, ropes and poisons) from the young person's possession, their environment (families will need to know), and to prevent further ready access to these.

In an emergency, information should be sought if it is "necessary to save the person's life, to prevent serious damage to the health of the person or to prevent the person from causing serious injury to himself or herself or others" [Section 62, Mental Health (Compulsory Assessment and Treatment) Amendment Act, 1992]. This may be the case where information is sought on the medication that a person has used to overdose or about possible access to firearms, etc.

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

If the young person has been, or is presently, subject to abuse (physical, sexual or emotional) then it may be necessary to exclude the parties that are perpetrating the abuse, including unsupportive family members and make a referral to the Children, Young Persons and their Families Service or the Police for these matters to be investigated. There is an agreed protocol for the reporting and management of child abuse and neglect between the Children, Young Persons and their Families Service and Education and this should be followed. Referrals to, and responses from the Children, Young Persons and their Families Service should be documented.

## Development of a therapeutic relationship - working together

The development of a good relationship between key staff members, any health professional involved and both the young person and their social network will be an important factor contributing to safety and a positive outcome. The relationship with the young person should be developed during the assessment phase as information is sought about the nature and severity of their thoughts and plans about suicide. During this stage, school staff and/or any health professional should

take time to explain the nature of the support that will be provided and other relevant information, such as the side-effects of any proposed medication. An explanation of the length of time that the supports will be in place, emphasising both the expected outcome and the need to persist, may also help.

## Consultation

### Confidentiality

Confidentiality is an important issue when working with young people. Many young people will ask for others to promise secrecy before they make a disclosure. **This should be avoided and every effort made to encourage them to share their concerns and plans without any promise of confidentiality.** If a young person is at risk of suicide, the counsellor and/or principal must do everything in their power to ensure the student's safety. If the risk to the young person's life is high, immediate action is required and this may mean informing parents or significant others even if the student does not agree.

Possible conflicts about confidentiality issues need to be resolved early in the assessment and the limits of confidentiality established in each situation.

The issue of whether any, some, or all, teaching staff are to be advised must be resolved for each individual case according to the level of risk. Teachers involved with the young person may need to consider how best to assist them within the classroom. As agents of the school, teachers have an implied duty of care and need to be informed if they are to carry this out. Also, teachers as part of the school have a duty to inform the principal of any matters that are of concern and may contribute to the collective duty of the school towards the young person. The focus is therefore on what information is shared and how this is done - in the best interests of the young person.

The legislation related to seeking information about the person, as opposed to giving out information about the person, is not straightforward. The principles of confidentiality and respect for the person's wishes and rights must be adhered to. However, there will be situations where a comprehensive assessment cannot be completed without additional information from the family. This is so particularly when a young person is new to the school, is being assessed for the first time or is reluctant to provide information. In these cases decisions must be made with the primary interest being the young person's safety.

## **Liaison with the family/whanau/caregivers**

Since many suicide attempts will occur outside the family situation, it is important that the young person's family is alerted to their young person's situation and involved at an early stage in the management plan. Ideally, the young person's consent for family involvement should be sought and obtained. However, in cases where the young person is at high risk of suicide but refuses family involvement, it may be necessary for the school to consider overriding the young person's preferences to ensure adequate protection and safety. This decision will involve a careful weighing of issues of individual rights and privacy with considerations of the immediate risk and safety.

The ideal situation is one in which the school, the family and the available mental health resources work co-operatively to develop a plan which minimises risk to the young person. The extent to which such a partnership is possible will depend, in part, on the school's ability to develop strategic linkages with the mental health services, and with parents.

In preparing a management plan it is important that the school maintains close liaison with the family and advises them of the steps being taken to ensure the young person's safety.

Family and whanau can, and often want to provide important input into such assessments. Where the person gives their permission for such contact, this assistance should be actively sought. In a small number of cases, this may not be appropriate if the family is a contributing factor to the young person's risk of suicide. Difficulties can arise if the young person refuses permission for the counsellor to speak to their relatives, particularly when the person is under 17 years of age. In such cases the Children, Young Persons and their Families Service should be notified. Steps taken by the school should be documented and the outcomes recorded.

## **Cultural considerations**

Managing suicidal behaviour in young people whose cultures are different from one's own is a considerable challenge. Of critical importance in cross-cultural suicide prevention and interventions is the value of using a person of the same culture as the student as part of the assessment process. It is also important for counsellors to develop effective liaison relationships with individuals and agencies in the ethnic communities they serve.

The counsellor may need to contact the young person's family, appropriate community resources, church, or alternative health providers to gain an understanding of the young person's difficulties. Again, issues of confidentiality and the rights of the individual need to be carefully considered. There may be conflict between the presumed right of the family to know about their distressed member (to contribute to decision making and to be involved in treatment) and the wishes of the young person, particularly among second generation Pacific Island people.

In the case of young Maori, cultural experts such as kaumatua, whanau support workers and Maori mental health workers can be valuable in advising on these matters and resolving any conflict. This is especially so if they are already part of the school community. In New Zealand there are Treaty of Waitangi responsibilities which support the provision of culturally appropriate treatment options for Maori.

Appreciation and consideration of sociocultural factors are important for all people in improving treatment outcomes and the health of the community. The more the counsellor is able to appreciate the cultural perception of the individual to whom they are offering assistance, the better the therapeutic relationship will be.

**This guide recommends that where there is a significant difference between the cultural views held by the young person and the counsellor, the counsellor should endeavour to liaise with or make a referral to a culturally appropriate service or specialist.** This is clearly the case where the person's primary culture and language (eg Maori) is not that of the counsellor, but could also include situations where spiritual values differ significantly. The offer to arrange and be supportive of a culturally appropriate referral should come from the counsellor.

Appreciation of how the young person views himself or herself is critical for any successful treatment. When working with a young person of the counsellor's own ethnic group, it is important not to assume that they subscribe to the same cultural or world views.

It is often helpful to seek guidance about issues and beliefs from the family, religious organisations and community leaders when dealing with a culture and/or religion that the counsellor is not familiar with. It may also be appropriate to seek the services of a local health service cultural adviser or religious leader if the young person values their involvement and trusts the particular person.

If there is a specialist health service for the young person's cultural group, the counsellor, with the young person's consent, should offer to involve this service in the support process. Having made a referral, the counsellor should continue to be available to support the person. Most people are likely to be referred back to the counsellor for ongoing counselling and monitoring. Wherever possible, joint responsibility for treatment, preferably with a written understanding on roles and responsibilities, should be arranged.

## **Referral to a healthcare professional or agency**

When making a referral to a healthcare professional or agency, the following principles may be useful:

- the referral should be made to healthcare professionals who are experienced and trained to work with young people at risk of suicide and/or with depressive disorders, such as clinical psychologists, psychiatrists, qualified psychotherapists and counsellors. **It is strongly recommended that referrals are only**

**made to professionals who are members of a recognised professional organisation which has documented ethical guidelines, professional conduct procedures and requirements for supervision**

- in making a referral it is important to consider the ethnic and cultural background of the professional and other factors influencing the effectiveness of treatments that they use
- it is helpful when making a referral to indicate the needs of the young person and their suspected problem areas, the expectations of the referral and the ongoing roles and responsibilities for support (especially crisis management)
- any intervention (eg counselling) should generally be time-limited, focused on the young person's current problems and aimed, firstly, at symptom resolution and secondly at the prevention of future risk of suicide
- to ensure that adequate feedback is received from the healthcare worker, the school should specify that it wants a report on progress by a specified date. This sharing of information should be done with the person's consent but also in accordance with accepted principles of confidentiality
- there is a need to monitor the outcome whenever treatment is initiated. This is especially important if counselling is used as the only treatment and the person fails to show any improvement in four to six weeks. In such situations, the school should consult the professional, consider a re-assessment and review the management plan.

It is not always easy to access prompt and appropriate care from support agencies, particularly in rural areas. It is important that schools document their attempts to seek help from support agencies and health professionals. Efforts to obtain help should continue, despite frustration. Failure to get an adequate response should be addressed in writing to the agency concerned and as necessary, to the bodies to which they are responsible.

## Follow up

Identifying that a young person is at risk of suicide and providing an appropriate intervention and management plan are likely to be the first steps in the assistance provided by the school.

Underlying causes for the distress need to be addressed to reduce the likelihood of recurrence. In some young people, the risk of suicide will periodically return and ongoing monitoring will be needed. This is especially likely at times which are stressful for the young person. Such cases will be part of the usual workload of counsellors and the professionals who assist them.

In every case it is important to assist the young person to reintegrate into the school. This can involve arranging for "catch-up" material and helping teachers to relate appropriately to the young person. As far as possible, all staff should be encouraged to support the young person in as normal a manner as possible - such as including them in activities, appropriate greetings within the school environment and occasional inquiries about "how are things going?"

## REVIEW OF THE PROGRAMME AND STAFF COMPETENCE

A critical aspect in the implementation and a significant influence on the value of any programme outlined in this guide will be the ongoing review of the policies and procedures and levels of staff knowledge/competence. Therefore, it is sensible to build review into the programme from the beginning.

Review of the policies and procedures included in this guide should be part of the normal governance of the school. However, the success of any programme like this is dependent on the knowledge and skill of staff in recognising and referring to the counsellor young people who seem to be distressed and may be at risk of suicide. For this reason, it is essential that there be regular in-school training and awareness raising, conducted by the counsellor or, if available, a local health professional.

### Training of staff to recognise at risk young people

The extent to which staff are able to identify at risk young people will depend on training, maintaining a “high index of suspicion” and a climate where mental health problems are considered important in the life of a young person.

Schools provide a valuable window of observation where young people at risk can be identified. School staff should be encouraged to share this responsibility by taking part in regular and ongoing training which includes:

- increasing knowledge of the symptoms of distress and risk of suicide
- increasing staff members’ confidence and competence to refer and support distressed young people
- increasing staff members’ willingness and competence to work in these situations.

# THE MANAGEMENT OF THE CONSEQUENCES OF A SUICIDE OR SERIOUS SUICIDE ATTEMPT WITHIN A SCHOOL

## Traumatic incident response plan

In the event of a serious attempt or death by suicide it is important that the effects are well managed in order to limit the consequences for other students. In general, this is the same for any similar trauma, but in cases of suicide, there is also a risk of other students being more likely to consider suicide as a possible “solution” to their distress. This contagion effect is well documented in New Zealand and a serious threat in any school where there has been a well publicised suicide.

The United States Center for Disease Control (CDC) has developed a set of principles which have been shown to be important in limiting any contagion following a serious suicide attempt or death by suicide:

- 1 Each school should develop its own response plan before a traumatic incident occurs - there will be no time to develop a plan when an incident occurs.
- 2 The response plan should involve all staff and make provision for inclusion of students, parents and support agencies from outside the school, as appropriate. The plan should not depend upon any single person but be able to be implemented by the staff available at the time. It should also avoid placing any particular staff member in “the hot seat”, but rather promote the coordinated responsibility of a team of people who can support each other.
- 3 The relevant community resources/agencies should be identified. The support they can provide, contact protocols and any limitations on their involvement should be discussed with each of them. Contact persons and phone numbers (preferably including after hours contact) should be listed in the plan.
- 4 The conditions under which the response plan should be implemented should be clearly understood by key staff.
- 5 The implementation of the plan should allow key staff to be contacted and prepared before they have to respond to other staff, students and the community.
- 6 The plan should ensure the response should be conducted in a manner which avoids glorifying the suicide victim(s) and minimises sensationalism. The reporting of the suicide should be as accurate as possible and announced in a manner that provides maximum support for the students, family and other members of the affected community and minimises the likelihood of hysteria.

- 7 Students who have a history of emotional distress and risk of suicide should be identified and should have at least one screening interview with a competent staff member. If necessary, they should be referred to the counsellor for further assistance. There should also be the opportunity for other individuals to self-identify, or be identified by teachers, as having difficulties following the suicide and to receive appropriate assistance in the normal way, with a minimum of fuss.
- 8 A timely flow of accurate, appropriate information should be provided to the media. Schools should ensure that there is a single media liaison person who would coordinate information from the school and other sectors and provide frequent, timely information and present a complete and honest picture of the pertinent events. Issues of privacy and confidentiality and the wishes of the family should be considered. It is acceptable to choose to make “no comment”.
- 9 Elements in the school environment that might increase the likelihood of further suicides or suicide attempts should be identified and changed. This should include, as far as possible, access to methods that may have been used in the recent suicide (ie access to poisons, high buildings, etc) and also other potential risk factors.
- 10 Long-term issues suggested by the nature of the suicide should be addressed. If there are aspects of the student’s environment/culture or barriers to accessing the required services (eg counselling, medical help, etc) these should be addressed as part of an ongoing prevention policy.

(adapted from CDC recommendations for a community plan for prevention and containment of suicide clusters, US Government Printing Office, 1988)

The most effective way of implementing the CDC recommendations is for each school to develop a traumatic incident response plan. The aim of the plan should be to manage the consequences of any traumatic event such as a serious attempt at, or completed, suicide. This will help members of the school community cope with what has happened and reduce the chance of other trauma such as further suicide attempts. As such, it will also reduce the negative consequences for students and staff.

The management of traumatic incidents requires a high level of team work, trust and professionalism among the key team members. For this reason, the key staff involved in the management of an incident should have a clear understanding of the various roles and delegations. This can be achieved by each team member being aware of the plan and holding meetings before the event to discuss roles and responsibilities.

It is often appropriate for schools to call on outside assistance following a traumatic event. This assistance should complement and, where appropriate, guide the actions of the school and support the staff and students. The responsibility for the implementation of a traumatic incident response plan remains with the school staff.

The following checklist outlines the key steps to take in the development and the first stages of the implementation of a response plan for traumatic incidents. This is not a plan in itself but a checklist of the steps necessary to develop and maintain a plan and the first actions in any implementation of it.

### Traumatic incident response checklist

Response plan developed and approved	date approved ...../...../20...
Key members of the response team meet to discuss roles.	...../...../20...
Plan to be reviewed annually: next review due	...../...../20...
All staff reminded of the plan at the beginning of the year	...../...../20...
Staff responsible for media contact are trained. (Course completed)	...../...../20...

Implementation	(date)...../...../20...
Principal and senior staff notified	time: <input type="checkbox"/>
Staff in the management team all notified	time: <input type="checkbox"/>
Management team meets	time: <input type="checkbox"/>
Media spokesperson confirmed	time: <input type="checkbox"/>
Ensure counsellors have sufficient resources and backup	time: <input type="checkbox"/>
Community resource professionals identified	time: <input type="checkbox"/>
A resource room established	time: <input type="checkbox"/>
All staff informed including : <ul style="list-style-type: none"> <li>• details of the death or injury and what, and how, students are to be told</li> <li>• staff are to identify close friends of the victim</li> <li>• staff responsibility for identifying and referring any young people unduly affected by the event or who are thought to be at risk</li> <li>• provisions available for student and staff support - including the location and hours of the resource rooms</li> </ul>	time: <input type="checkbox"/>
Arrangements made for informing close friends and then the rest of the school	time: <input type="checkbox"/>

## Review

Once the event has been managed, debrief key staff	...../...../20...
Review the plan and arrange for the necessary approval for the revised plan	...../...../20...
Review staff within the management team	...../...../20...
Identify staff training needs and arrange training if necessary	...../...../20...
Report to staff about the outcome and advise any improvements to the plan	...../...../20...
Revised plan approved by board of trustees	...../...../20...

## CONTACT NUMBERS OF RESOURCE PROFESSIONALS AND GROUPS:

### Specialist Education Services:

Contact person: \_\_\_\_\_ Phone: \_\_\_\_\_

Other(s) \_\_\_\_\_

\_\_\_\_\_

After hours: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

email: \_\_\_\_\_ Fax: \_\_\_\_\_

### Local Medical Centre(s)

Contact person: \_\_\_\_\_ Phone: \_\_\_\_\_

Other(s) \_\_\_\_\_

\_\_\_\_\_

After hours: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

email: \_\_\_\_\_ Fax: \_\_\_\_\_

## MENTAL HEALTH SERVICES:

### Acute Assessment Team:

Contact person(s):  
Duly Authorised Officers: \_\_\_\_\_ Phone: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

After Hours: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

email: \_\_\_\_\_ Fax: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Youth Mental Health Services:

Contact person(s): \_\_\_\_\_ Phone: \_\_\_\_\_  
\_\_\_\_\_

After hours: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

email: \_\_\_\_\_ Fax: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### CYP& F Service (DSW):

Contact person(s): \_\_\_\_\_ Phone: \_\_\_\_\_  
\_\_\_\_\_

After hours: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

email: \_\_\_\_\_ Fax: \_\_\_\_\_  
\_\_\_\_\_

## Community Support Agencies and Resource People:

### Cultural Advisers and support people:

#### Maori

Contact person(s):

Phone

After hours:

Address:

email:

Fax:

Contact person(s):

Phone

After hours:

Address:

email:

Fax:

Contact person(s):

Phone

After hours:

Address:

email:

Fax:

#### Other

Contact person(s):

Phone

After hours:

Address:

email:

Fax:

Contact person(s): \_\_\_\_\_

Phone \_\_\_\_\_ After hours: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

email: \_\_\_\_\_ Fax \_\_\_\_\_

**Public Health resource people (eg Nurse):**

Contact person(s): \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_ After hours: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

email: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact person(s): \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_ After hours: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

email: \_\_\_\_\_ Fax: \_\_\_\_\_

\_\_\_\_\_

**Child and Family Services:**

Contact person(s): \_\_\_\_\_

\_\_\_\_\_

After hours: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

email: \_\_\_\_\_ Fax: \_\_\_\_\_

\_\_\_\_\_

Contact person(s): \_\_\_\_\_

Phone \_\_\_\_\_ After hours: \_\_\_\_\_

Address: \_\_\_\_\_

email: \_\_\_\_\_ Fax: \_\_\_\_\_

**Special interest groups:**

Contact person(s): \_\_\_\_\_

After hours: \_\_\_\_\_

Address: \_\_\_\_\_

email: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact person(s): \_\_\_\_\_

Phone \_\_\_\_\_ After hours: \_\_\_\_\_

Address: \_\_\_\_\_

email: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact person(s): \_\_\_\_\_

After hours: \_\_\_\_\_

Address: \_\_\_\_\_

email: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact person(s): \_\_\_\_\_

Phone \_\_\_\_\_ After hours: \_\_\_\_\_

Address: \_\_\_\_\_

email: \_\_\_\_\_ Fax: \_\_\_\_\_

**Other resource people/groups:**

Service: \_\_\_\_\_

Contact person(s): \_\_\_\_\_

Phone: \_\_\_\_\_ After hours: \_\_\_\_\_

Address: \_\_\_\_\_

email: \_\_\_\_\_ Fax: \_\_\_\_\_

Service: \_\_\_\_\_

Contact person(s): \_\_\_\_\_

Phone: \_\_\_\_\_ After hours: \_\_\_\_\_

Address: \_\_\_\_\_

email: \_\_\_\_\_ Fax: \_\_\_\_\_

Service: \_\_\_\_\_

Contact person(s): \_\_\_\_\_

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email: \_\_\_\_\_ Fax: \_\_\_\_\_

Service: \_\_\_\_\_

Contact person(s): \_\_\_\_\_

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Address: \_\_\_\_\_

email: \_\_\_\_\_ Fax: \_\_\_\_\_

Service: \_\_\_\_\_

Contact person(s): \_\_\_\_\_

Phone: \_\_\_\_\_ After hours: \_\_\_\_\_

Address: \_\_\_\_\_

email: \_\_\_\_\_ Fax: \_\_\_\_\_

\_\_\_\_\_

In December, 1996 the Ministry of Education convened a meeting of health and education professionals to discuss the development of guidelines on youth mental health and suicide.

In March, 1997 the Ministry of Education commissioned four authors with expertise in the area of youth suicide to provide advice and comment on how young people at risk of suicide might be better detected within a secondary school setting. The authors (in alphabetical order) were: Dr Annette Beautrais, Dr Carolyn Coggan, Associate Professor David Fergusson and Mr Lewis Rivers.

Specifically, the authors were asked to report on the following issues:

- the spectrum of suicidal behaviour in young people and the causes
- the development of school based policies and strategies to manage and prevent suicidal behaviour in the school context
- recommendations for responses to suicidal behaviour in school students
- advice and recommendation to manage the aftermath of suicide, suicide attempts and suicidal behaviour in school students

The early drafts of the report were considered by two groups of education and health professionals from the perspective of policy developments and implementation.

A Guide for Schools was written and derived from the full report. This guide, in draft form, was sent to all secondary schools and a selected group of primary and intermediate schools and other learning institutions seeking suggestions to improve it. In addition, a series of twenty six consultation meetings were held in fourteen locations around the country, giving opportunity to members of Board of Trustees, principals and guidance counsellors to make comment. 276 written submissions were received from individuals and organisations either directly from the meetings or sent subsequently to the Ministry of Education.

Following an analysis of the submissions and consultation process the authors Dr Annette Beautrais, Dr Carolyn Coggan, Associate David Fergusson and Mr Lewis Rivers agreed to a number of alterations to the text.

## NOTES