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School Based Responses to Non-Suicidal Self Injury and Suicide: Literature Considerations When Framing a Policy Response

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Introduction

Deliberate Non-Suicidal Self Injury (NSSI) and suicide present distinct but related concerns for schools. An Australian study of over 6,300 families containing children/ adolescents aged 4 to 17 years found that one in 10 young people had engaged with NSSI – with three quarters of this cohort having harmed themselves in the previous twelve months (Lawrence et al., 2015). The same study found that within the 12 to 17-year-old age group, one in 13 individuals had considered suicide in the previous 12 months, with one in 40 having made attempts (Lawrence et al., 2015). This article seeks to articulate key themes from literature that demand consideration by schools seeking to construct their own framework or pastoral response, balancing the prioritisation of student safety whilst also attending to the realities of staff competencies. Given the age group presented in the Lawrence et al., (2015) study, it should not be surprising that adolescents in the school context may disclosure the presence of intrusive thoughts pertaining to at-risk behaviours. Consequently, schools are well placed to deliver prevention services and simultaneously, need to be prepared to respond to situations of NSSI and suicide attempts. Drawing on the expertise of staff from an Edmund Rice Education Australia (EREA) school located in Brisbane, this paper draws links to existing policy determinants of pastoral care from within this Catholic school, whilst considering the issue of risk-to-self with relevant themes organized according to the three action areas outlined by the Queensland Suicide Action Prevention Plan (Queensland Mental Health Commission, 2015) namely: prevention; intervention; and postvention.

Contextualising NSSI and Suicide

Edmund Rice Education Australia (EREA), takes the name of the founder of the Christian Brothers and since 2007 has assumed the function of governing body overseeing schools formerly run by the Brothers. As a school in the Edmund Rice tradition, the mission of St James College is one of reflecting the Touchstones of Inclusive Community, Liberating Education, Justice and Solidarity and Gospel Spirituality. Specifically, St James College proactively seeks to "integrate faith, life and culture in an environment of tolerance, pride and respect for individual worth" (St James College, 2019). Furthermore, there is an emphasis placed upon "the happiness of the individual" – a construct that is tied to self-discipline, personal responsibility and ultimately, individual achievement (St James College, 2019). With statistics suggesting that one in 10 children/adolescents aged 4 to 17 years had engaged with NSSI and one in 13 individuals in the 12 to 17-year old age group having considered suicide in the past 12 months (Lawrence et al., 2015), the issue of 'happiness' merges with one of safety. On the subject of assisted suicide, Pope Francis suggested the need for a compassionate response to these issues "so that the sacred value of the life of the patient does not disappear or become obscured, but instead shines with greater splendour precisely in suffering and helplessness" (Catholic News Agency, 2016). This document seeks to outline the relevant literature such that school-based practitioners feel supported in their duty to deliver a compassionate and informed response to behaviours that represent a risk to the wellbeing of the student.

Though sharing some common risk factors (Hawton, Saunders & O'Connor, 2012) NSSI and suicide represent distinct behaviours. Literature also refers to NSSI as self-harm, deliberate self-injury, deliberate self-poisoning, attempted suicide, and parasuicide (Hawton et al., 2002; The Royal Australian and New Zealand College of

Psychiatrists, 2016). Complexities pertaining to defining NSSI have been articulated elsewhere, though critical and common features include a deliberateness in intent, accompanied by an awareness that the behaviour is harmful (Carter et al., 2016). Self-cutting and overdose have been identified as some of the most common methods of NSSI (De Leo & Heller, 2004; Guerreiro et al., 2017). However, self-poisoning represents the most common presentation in hospital emergency departments for adults (Carter et al, 2016) and is the most common method of self-injury amongst adolescents (Mitchell et al., 2018). It is acknowledged that NSSI behaviour can be linked to an increased risk of suicidal ideation (Headspace, 2009). 'Attempted suicide' describes instances in which an individual harms themselves "…with the intent to die but not resulting in death" which is distinguished from 'suicide' or, "…a deliberate act to end one's life resulting in death" (Government of Western Australia, 2017, p. 3).

Typically, the onset of NSSI behaviour is between ages 12/13 and 14/15 years (Heath et al., 2010; Jacobson & Gould, 2007 cited in Jarvi et al., 2013; Storey et al., 2005). An Australian study found that between 1 July 2001 and 30 June 2012, there were 18,223 hospitalisations pertaining to NSSI, with a treatment cost of $64 million (Mitchell et al., 2018). Whilst many adolescents will cease self-harming at some point in time, for some children, NSSI behaviours "become more hazardous with time" (Storey et al., 2005, p. 74).

Globally, suicide has been suggested to be "…the second or the third leading cause of death in adolescents in the West and an important cause of death in developing countries" (Ougrin et al., 2015, p. 97; see also Hawton, Saunders & O'Connor, 2012; Surgenor et al., 2016). It is suggested that in Queensland alone there are over 600 deaths by suicide per annum (Queensland Mental Health Commission,

2015, p. 4). In terms of Queenslanders under the age of 18 years, there were an estimated 23 deaths by suicide in the 2013-2014 period (Queensland Mental Health Commission, 2015, p. 20). To separate the figures pertaining to adolescent and adult suicide rates ignores the reality that adolescents in schools are not separate entities from the adults that inhabit our communities – they were themselves educated in our schools and are often attachment figures for current adolescents/students.

NSSI and suicidal behaviours -including thoughts of same - do not in themselves constitute a mental illness. However, they do appear as features of some conditions. Indeed, NSSI holds "clinical significance and presence across multiple disorders" (Klonsky, 2009, p. 260) - for example as a diagnostic criterion for Personality Disorder (American Psychiatric Association, 2013; Gratz et al., 2012). It has also been suggested that the presence of psychotic experiences may serve as a predictor of NSSI and suicidal attempts (Martin et al., 2015). Elevated risk of suicide has been reported across mental illnesses inclusive of eating disorders (anorexia nervosa, bulimia nervosa), mood disorders (depressive disorder, obsessive compulsive disorder and anxiety disorders), and trauma (American Psychiatric Association, 2013).

Catholic school responses to Non-Suicidal Self Injury and Suicide are informed by State Legislature and involve an interplay with a range of interrelated policies. The Queensland Catholic Education Commission (QCEC) has issued a policy on Inclusive Practices in Queensland Schools. This document suggests that "Queensland Catholic schools have a strong commitment to social inclusion and student wellbeing, catering for students with a diverse range of personal characteristics and experiences" (Queensland Catholic Education Commission, 2014). In terms of legislation, the dual emphasis on inclusivity and wellbeing -as outlined by

QCEC- is met by attending to the Child Protection Act 1999 and Mental Health Act 2016. In terms of student wellbeing, the Child Protection Act 1999 mandates notification to Child Safety if a parent is likely unable or unwilling to protect a child from the risk of harm, inclusive of an inability or unwillingness to engage with mental health supports when appropriate. Adhering to the principle of a 'least restrictive approach' to treatment, as outlined in the Mental Health Act 2016, the suggestion is that schools action the ideal of inclusivity when they support a timely return of any student to school following a period of absence arising from mental illness or treatment need.

An Informed Practice Approach

Literature suggests that young people routinely avoid seeking help from professionals when it comes to matters of NSSI (Hawton, Saunders & O'Connor, 2012; Wasserman et al., 2012) and that this behaviour may in fact remain hidden until into adulthood (Storey et al., 2005). However, it has also been suggested that young people are unlikely to deny existing suicidal thoughts if asked directly (Headspace, 2009). In instances in which a young person does elect to tell someone of this behaviour, this is usually a friend or family member (De Leo & Heller, 2004). In the event that parents are informed, parents are most likely to seek the assistance of a GP or emergency department (Royal Australian and New Zealand College of Psychiatrists, 2004), though in some instances parents were found not to immediately engage any service (Storey et al., 2005). In a review of trends relating to NSSI amongst Australian children under the age of 16 years, Mitchell et al. (2018) reviewed hospital admissions between 1 July 2001 and 30 July 2012 and proposed "…a need to increase awareness among parents, health professionals and those who work with

children, such as teachers, to address potential risk factors associated with self-harm". (p. 5).

The authors practice experience suggests that within school disclosures are not uncommon, especially when considering direct disclosures to staff are augmented by following up upon any reported suspicions held by one student with respect to a friend/peer student. The suggestion that the school should serve as a key context for detection and provision of support has been made (Calear et al., 2016; Doyle, Treacy & Sheridan, 2015). Specifically, it has been suggested that schools need to develop a protocol document around the management of self-harm behaviours (Toste & Heath, 2010). Schools are increasingly seen as responsible for actions and learnings that were traditionally seen as the role of families. Schools have long been the vessel through which students learn about sex education and identity, relationship formation, bullying, cybersafety and mental and emotional health, amongst other topics above and beyond what is stipulated in the curriculum. Whilst not necessarily a teaching and learning topic, the need for schools to respond to the increasing instances of suicide and non-suicidal self-injury is borne out in the increasing number of young people engaging in these behaviours. Additionally, in an increasingly litigious society, schools need to develop responses that will minimise risk in terms of insurance and areas of potential litigation when inaction could be seen as negligence (Hopkins, 2004). A number of studies suggest that training of school staff in youth suicide prevention, reaction to incidences and postvention strategies is necessary in order to deal with this burgeoning issue. For example, mental health first aid training represents an option for consideration (Mental Health First Aid Australia, 2019). Suggestions as to what should be included in this protocol have been outlined in detail (Hasking et al., 2018) and are discussed under the headings of Prevention,

Intervention and Postvention.

Most important of all of the reasons for schools to engage with literature pertaining to NSSI and suicide strategy is to minimise the impact of the actions on the individual young person and the community as a whole. Integral to the care of all students in an EREA school is the Charter that provides the blueprint for engagement with all members of the community. The formation of the Charter arose from the handover of the Christian Brothers' Schools to the new auspice of EREA. EREA, as a Prime Juridical Person within the Catholic Church, is charged with the responsibility of governance of the schools and ensures that the Charism of Edmund Rice lives on. The Charter has four Touchstones around which the Charism is enlivened. The school-based response to NSSI and suicide is informed by the Touchstones in that it reflects the reality that schools are well placed to offer a critical - even life affirming – service that ensures each young person's distress is met with a pragmatic service that includes immediate responses, liaison with home and referral to ongoing supports. The Charter is expressed via these Touchstones in the following ways:

- "Liberating Education: We open our hearts and minds, through quality teaching and learning experiences, so that through critical reflection and engagement each person is hope-filled and free to build a better world for all" (Edmund Rice Education Australia, 2018). The importance of hope within the church is reflected in its description as being a theological virtue (Libreria Editrice Vaticana, 1993). This focus on hopefulness is significant when contrasted with the hopelessness that accompanies suicide. In practice it is the promotion of containment of powerful emotions and minimisation of contagion that is significant if the education of all students is free to continue

with minimal disruption. Significantly, for the students involved, immediate care is provided via the appropriate youth mental health agencies.

- "Gospel Spirituality: We invite all people into the story of Jesus and strive to make his message of compassion, justice and peace a living reality within our community" (Edmund Rice Education Australia, 2018). By intervening on behalf of students who are troubled by mental and emotional issues such that they contemplate suicide or self-harm, the school actively strategises to support the student to find peace in themselves. In particular, to equip students with less destructive responses to distress through skill sets taught in personal development. The compassionate approach provided by the policy lives up to this Touchstone's expectation of being the Christ in students' lives.
- "Inclusive Community. Our community is accepting and welcoming, fostering right relationships and committed to the common good" (Edmund Rice Education Australia, 2018). It is hoped that a rigorous and informed approach will ensure that students affected by NSSI or suicide will remain within the school community. Engagement with literature and best practice enables schools to welcome all students into their midst in a constructive way that provides safety, considered and reasoned response to issues that provide a tremendous challenge to the community.
- "Justice and Solidarity: We are committed to justice and peace for all, grounded in a spirituality of action and reflection that calls us to stand in solidarity with those who are marginalized and the Earth itself" (Edmund Rice Education Australia, 2018). A comprehensive approach to NSSI and suicide seeks to reduce the impact upon the student who is experiencing distress. This in turn, allows students and their families who are marginalised by this issue

to be fully and proactively supported by the school community. For example, to be cognizant of minimising the stigma attached to mental illness and adapting the learning space thus ensuring the possibility of inclusion and success for all.

The application of these Touchstones to the three action areas outlined by the Queensland Suicide Action Prevention Plan (Queensland Mental Health Commission, 2015) are outlined below.

Prevention.

Promoting the Touchstone described as 'Liberating Education', the practitioner is reminded of the value in opening our "hearts and minds" such that each person is "hope-filled" (Edmund Rice Education Australia, 2018). It is this emphasis upon hope that underscores the importance of prevention – with prevention representing one of three responses to concerns pertaining to the prevalence of NSSI and Suicidal Ideation within the adolescent population. In particular, prevention is addressed through a pastoral program that seeks to augment the traditional focus on the mind and engage with the student as a whole – inclusive of each student's context, strengths/limitations, needs/resources. As such, any policy pertaining to risk-to-self behaviours must sit within a suite of resources aimed at supporting the wellbeing of the student.

Understanding risk factors.

NSSI behaviour is believed to be more common in females (Doyle, Treacy & Sheridan, 2015; Guerreiro et al., 2017) though current Australian guidelines suggest that whilst females are more likely to present to hospital with this behaviour, NSSI

rates in the community are roughly equal between genders (Carter et al., 2016). Other risk factors include: exposure to NSSI behaviours; bullying; mental illness and psychological distress; substance misuse and addictions; reduced family support; living in out-of-home care; and concerns regarding sexual orientation (Andrews et al., 2014; De Leo & Heller, 2004; Doyle, Treacy & Sheridan, 2015; Guerreiro et al., 2017; Mitchell et al., 2015; O'Connor et al., 2009; O'Connor et al., 2014; Storey et al., 2005; The Trevor Project, 2017; Yao et al., 2014).

A Norwegian study found that two thirds of adolescents who had engaged in repeated NSSI, also reported suicidal intent (Larsson & Sund, 2010). Hawton, Saunders and O'Connor (2012) outlined a range of sociodemographic, educational, psychiatric and psychological factors that represent risk pertaining to suicide. Specific to the school context, bullying exists as a correlation and "possibly an independent cause" of suicide (Cooper, Clements & Holt, 2012, p. 280). The link between bullying and suicide is well documented (Bhatta, Shakya & Jefferis, 2014; Hawton, Saunders & O'Connor, 2012) with suicidal ideation and attempts having been linked to verbal, social and cyberbullying (Williams et al., 2017). Alarmingly, a recent study of Queensland teachers provided anecdotal support for the idea that bullying was not being adequately addressed (Ross et al., 2017, p. 527). Other known risks specific to the educational environment include: identifying as LGBTQ (The Trevor Project, 2017, p. 4); and being subject to violence and threatening behaviours at school (Nickerson & Slater, 2009). In many instances warning signs pertaining to suicidal ideation are evident through "…personal situations, thoughts, images, thinking styles, moods, or behaviors" (Stanley & Brown, 2012, p. 258).

Conversely, a range of protective factors such as engagement in mental health care; positive connections with friends, family, community and social institutions; and

problem-solving skills likely reduces risk (MindMatters, 2018; The Trevor Project, 2017). Furthermore, school connectedness -achieved through perceived safety, established relationships, and a sense of belonging- each represent additional protective factors (Whitaker et al., 2016). The point has been made that student engagement with school and increasing academic achievement are goals common to the educational context as well as suicide prevention programs (Wynam et al., 2010). Indeed, low connectedness to school and dropping out of school have been linked to increased risk of suicide attempts (Tang et al., 2013).

Gatekeeper training.

Professional help seeking is uncommon both before (9%) and after (12%) episodes of NSSI behaviour (Doyle, Treacy & Sheridan, 2015). It is recognised that teachers "remain at the forefront for initial identification" and that school mental health professionals are "central to assessment and intervention" (Heath et al., 2011, p. 36). Gatekeeper training refers to a program of skills training that upskill "natural helpers (i.e., teachers, school personnel, etc.) to recognize signs and symptoms in students and how to react effectively" (Surgenor et al., 2016, p. 413). This training seeks to increase staff knowledge and confidence in dealing with risk factors (Reis & Cornell, 2008). A knowledge base pertaining to risk factors is significant when considering that the attitude of a school professional towards self-injury not only impacts upon the quality of the staff member's response but also upon the likely level of comfort experienced by the adolescent when asking for help (Heath et al., 2011, p. 40). Indeed, gatekeeper training and screening programs have been identified as the most effective means to supporting young people within the school context (Robinson et al., 2013). Conversely, the effectiveness of school-based suicide prevention

programs have been questioned on the basis that "most of the studies … exhibited a number of methodological problems, making definitive conclusions about the efficacy of these programs difficult" (Miller, Eckert, & Mazza, 2009, p. 183).

In order for staff to perform a gate keeper function, there must be adequate awareness of "risk factors, warning signs, protective factors, response procedures, referrals, postvention, and resources regarding youth suicide prevention" (The Trevor Project, 2017, p. 4). Specific attention should be drawn to the matter of how to construct communication when discussing the subject of suicide, such that stigmatizing language is replaced with appropriate terminology (Suicide Prevention Australia, 2014). Applied to the student population, *Sources of Strength* represents a peer leaders training program that seeks to engage with suicide prevention by increasing "…a set of protective factors including their norms pertaining to help-seeking, connectedness with adults, and school engagement". (Wynam et al., 2010, p. 1658) which may prevent suicide clusters (Cox et al., 2016).

Screening and assessment.

The screening of the wider, or even entire, student population for risk factors, with a view to engaging identified students with mental health services has been discussed (Husky et al., 2011; Scott et al., 2009; Surgenor et al., 2016). In particular, screening may ultimately have outcomes that foster the ideal of hopefulness through greater engagement with counselling (Mashego & Madu, 2009) and a reduction in the risk of suicide clusters (Cox et al., 2016). In terms of practicality it is proposed that screening might involve:

> "… occasionally (e.g. once a year) administering a screening test (or a questionnaire) for suicidal behaviour to the students and thereafter discussing

> the results and the implications with the participants. Those who need counselling or therapy should be referred to the appropriate professionals for help" (Mashego & Madu, 2009, p. 476).

Examples of large-scale screening tools are the *Connected Community Wellness Screen* program (Hilt al., 2018), the *Suicidal Ideation Questionnaire* (SIQ) and the *Reynolds Adolescent Depression Scale—2nd Edition* (RADS-2). The recommendation being that "a school with limited resources desiring to provide suicide screenings for their students in a cost-effective manner could rely on administration of just the SIQ". (Gutierrez & Osman, 2009, p. 215). Alternatively, the *Signs of Suicide* program combines psychoeducation and screening (https://mentalhealthscreening.org/programs/sos-signs-of-suicide/prevention). This program provides an educational component –a video and discussion guide– that targets increasing knowledge regarding symptoms of depression, stressing awareness regarding greater adaptive responses and offering a screening tool in the form of the *Columbia Depression Scale* (Aseltine & DeMartino, 2007).

Given that NSSI and suicide are not mutually exclusive behaviours, the case has been made to screen for both (Heath et al., 2011). It is suggested that 29% of children and adolescents who attempt suicide will disclose suicidal intent in a time frame that enables intervention (Sheftall et al., 2016). The flipside being that it is not uncommon for suicide to be void of any warning or help seeking behaviour in the lead up (Lewiecki & Miller, 2012). Examples of assessment tools include: *Columbia Suicide Scale* (Posner et al., 2017) and *Suicidal Self-Injury Assessment Tool* (Whitlock & Purington, 2013). In addition, a range of measures have been outlined in Sansone and Sansone (2010) with more generalised adolescent risk behaviour discussed by Lescano et al. (2007). Regardless of the tool, it is understood that asking

about NSSI and suicide is not only not harmful but is likely beneficial (Gould et al., 2005, p. 1641). However, it is also acknowledged that in terms of application, the implementation of a screening tool is accompanied by significant considerations surrounding the need for a high degree of confidence in the tool used, awareness of appropriate responses to any identified concerns and resources to enact these responses.

Intervention.

Aligning with the Touchstone described as "Gospel Spirituality", the attention of the practitioner is focused upon the significance of imparting a "message of compassion, justice and peace" (Edmund Rice Education Australia, 2018). The ideal of 'peace' being one that has anecdotally been described as being absent when suffering in the form of NSSI or suicidal ideation are present. Catholic schools are tasked with recognising "the uniqueness and the diversity of students as children of God" (Queensland Catholic Education Commission, 2014). Arguably this is principle is reflected in a range of policies common to Brisbane Catholic Education Council (BCEC) and Edmund Rice Education Australia (EREA) on the subjects of: student behaviour support; employee and volunteer codes of conduct; anti-bullying practices; student protection procedures; consideration of Aboriginal and Torres Strait Islander needs (Brisbane Catholic Education, 2019; St James College, 2019). Returning to Pope Francis' emphasis upon a compassionate response, it is suggested that a compassionate response is put into practice through a range of measures that exceed a policy pertaining on the specific subject of NSSI and suicide, to include measures such as: enrolments of students who might have found other school contexts to be unsustainable or inaccessible; rigorous professional development on the subject of

children at risk of harm; differentiated resources that recognise mental illness as a unique need such that social and emotional needs are considered within the learning support context; clear procedures – such as a Restorative Justice Process – for responding to bullying; access to a Personal Development curriculum that supports the growth of the whole self; informed Careers Counselling that promotes pathway planning that recognizes individual strengths and interests; engagement with community through pastoral processes such as formation of the student body into smaller 'communities' in which the student is not only known but feels seen; offering supportive engagement with families inclusive of therapeutic interventions such that staff and parents/carers form an effective working alliance.

It has been suggested that diverse interventions are required as no one intervention has been identified as being uniquely significant (Calear et al., 2016). As part of an emphasis upon mental health promotion, the Australia wide *MindMatters* program includes an evidence-based flow chart describing the application of interventions (MindMatters, 2018b; Ross et al., 2017) which may be applied by schools seeking to formulate the nature and delivery of responses to incidents of self-harm and suicidal ideation

Support and referral.

School-based mental health professionals should be "trained in the interconnectivity among school law, school system functioning, learning, mental health, and family systems" (The Trevor Project, 2017, p. 3). Within the school the role of the counsellor includes "… hearing adolescent's stories, validating their experiences, and providing a safe refuge" (Kress, Gibson & Reynolds, 2004, p. 200). The importance of addressing interpersonal problem-solving skills (Sheftall et al.,

2016) is reflected in an understanding that the meaning around NSSI can include: relief; punishment; to show desperation; to die; to frighten others; alleviate negative affect; influence others (Guerreiro et al., 2017; Klonsky, 2009). A suicide prevention approach would involve the student shifting the meaning of the symptom away from sadness to understanding that mental illness may be a factor (Cusimano & Sameem, 2011), thereby establishing NSSI as a response in the absence of a "more adaptive coping strategy" (Tanner, Hasking & Martin, 2015, p. 976). The role of the school nurse (Cooper et al., 2012; Waternabe et al., 2012; Williams et al., 2017) and outreach mental health services (Doyle, Treacy & Sheridan, 2015) have also been discussed and thus highlight the various professional services that may be engaged as part of a wrap-around service- services that have significant financial implications for schools and thus require consideration at a leadership level.

Literature also highlights the need to refer students to services located outside of the school (Heath et al., 2010; Szumilas & Kutcher, 2011). The rationale being that the primary role of the school-based professional is to focus on assessment of risk, facilitate referral and provide student support (Toste & Heath, 2010) whereas therapeutic intervention "should be delivered in a clinical setting" (Robinson et al., 2013, p. 178). For example, the *Connected Community Wellness Screen* facilitates case management such that the school-based professional seeks to liaise with external providers and secure an appointment for identified students within two days, though obstacles to treatment engagement are acknowledged (Hilt et al., 2018). The need to engage with medical professionals is also paramount in instances of higher risk and increased harm. Though medication has been described as "fobbing off" (Storey et al., 2005, p. 73), a medical model of intervention – inclusive of assessment and admission -- may be warranted (Carter et al., 2016). In terms of therapy, one review found that

programs delivered via a one-to-one approach successfully reduced suicidal ideation (the thought process) amongst at risk individuals, whereas group and family programs impacted suicidal attempts (the behaviour), with programs that included individual and group delivery impacting both ideation and attempts (Calear et al., 2016). Ultimately the task facing the school is to is to facilitate the ideal of greater collaboration with external mental health services (Doyle, Treacy & Sheridan, 2015, p. 492) especially in light of the suggestion that young people are most at risk of a suicidal attempt in the two weeks post hospitalisation (Singer, 2017) which also represents the period in which the student is likely to be returning to school

Safety plans.

For some students NSSI and suicidal thoughts represent repeated intrusions into their cognitions. In instances of increased risk, a professional may work with the student to develop a safety plan. Safety plans are designed to lower the imminent risk of suicide by detailing the following:

> "(a) recognizing warning signs of an impending suicidal crisis; (b) employing internal coping strategies; (c) utilizing social contacts as a means of distraction from suicidal thoughts; (d) contacting family members or friends who may help to resolve the crisis; (e) contacting mental health professionals or agencies; and (f) reducing the potential use of lethal means" (Stanley & Brown, 2012, p. 258).

The difference between a safety plan versus a contract to keep oneself safe, being that a safety plan provides detailed information as to how to respond if suicidal (Stanley & Brown, 2012). For some students, the unpredictable timing of intrusive thought patterns and the immediacy of the required response detailed within the safety plan,

will entail that more than one school-based professional be informed and able to engage with the safety plan. Yet simultaneously there is likely a need to create a therapeutic or pastoral response in which the ideas of predictability and containment are modelled to the student through scheduled appointments with a regular and consistent practitioner. These appointments should continue well past the reduction of intrusive thoughts such that the student learns to trust that there are alternative ways to engage with staff around matters of mental and emotional wellbeing.

Psychoeducation.

In order to address the risk factors associated with NSSI and suicidal thoughts/behaviours, schools have been encouraged to focus on targeting the following themes: interpersonal and family concerns; mental health inclusive of emotional literacy; problem solving skills; sexual orientation concerns; social media/bullying; stigma reduction; substance use; violence (Andrews et al., 2014; O'Connor et al., 2009; Pena et al., 2012; Ross et al., 2017; Wong et al., 2013). An example of a school-based, manualised approach is contained within the *Youth Aware of Mental Health Program* (YAM) (Wasserman et al., 2015). The YAM has shown significant efficacy when compared with no intervention and is delivered via means of:

> "3 hours of role-play sessions with interactive workshops combined with a 32-page booklet that pupils could take home, six educational posters displayed in each participating classroom and two 1-hour interactive lectures about mental health at the beginning and end of the intervention" (Wasserman et al., 2015, p. 1538).

This program seeks to develop skills and knowledge pertaining to mental health

specifically around the following subject areas: awareness about mental health; self-help advice; stress and crisis; depression and suicidal thoughts; helping a troubled friend and getting advice (UT Southwestern, 2018).

Postvention

Aligning with the Touchstone that describes Inclusive Community, and the practice of being accepting and welcoming, is the need for a comprehensive postvention response that not only supports but embraces students and families after an episode of NSSI or suicide.

Toolkits and resources.

The goals of postvention can be summed up as the need to reduce future risk and current distress (Cimini & Rivero, 2013; Fineran, 2012). Responses should promote safety, calmness, connectedness and hope (Wie, Szumilar & Kutcher, 2010), incorporate self-care for staff members (Fineran, 2012) and abstain from judgement (McKinnon & Chonody, 2014).

In terms of the pragmatics of a response, the American-based, The Trevor Project (2017) breaks the postvention responses into: verify the death; assess the situation; share information; avoid suicide contagion; initiate support services; develop memorial plans. Within Australia significant support is available to schools through the Headspace initiative entitled *Suicide Postvention Toolkit: A Guide for Schools* (Headspace, 2012; Rickwood et al., 2017). This document scaffolds how a school may respond to suicide –inclusive of attempted or suspected suicide- in the immediate instance, first 24 hours, first week, first month and beyond, inclusive of sample documents to guide staff meetings, student and family communication

(Headspace, 2012). Many of the key components within the Headspace document reflect the 20 common themes found to sum up the 548 actions endorsed within literature for inclusion in postvention guidelines –for example, developing an Emergency Response (ER) plan, informing staff of the suicide, dealing with the media (Cox et al., 2016)[1]. Similarly, the toolkits entitled *Suicide Postvention Guidelines* (Department of Education and Child Development, 2016) and *After a suicide: A toolkit for schools* (Suicide Prevention Resource Center, 2011) detail pragmatic responses. Specific considerations for Indigenous communities demand consideration (Isaacs & Sutton, 2016).

Managing contagion.

Exposure to NSSI amongst family and friends increases the risk of the same behaviour manifesting in any one individual (De Leo & Heller, 2004; Hawton et al., 2002; O'Connor et al., 2009). Specifically, it has been suggested that the risk of NSSI rises 3.5% if an adolescent is close to someone engaged in this behaviour (Doyle, Treacy & Sheridan, 2015). Although there is limited evidence to support effective responses to suicide clusters, commonly cited approaches include:

> "…developing a community response plan; educational/psychological debriefings; providing both individual and group counselling to affected peers; screening high-risk individuals; responsible media reporting of suicide clusters; and promotion of health recovery within the community to prevent

[1]A summary of postvention actions include the following: "1. Developing an ER Plan; 2. Forming an ER Team; 3. Activating the ER Team; 4. Managing a suspected suicide that occurs on school grounds; 5. Liaising with the deceased student's family; 6. Informing staff of the suicide; 7. Informing students of the suicide; 8. Informing parents of the suicide; 9. Informing the wider community of the suicide; 10. Identifying and supporting high-risk students; 11. Ongoing support of students; 12. Ongoing support of staff; 13. Delaying with the media; 14. Internet and social media; 15. The deceased student's belongings; 16. Funeral and memorial; 17. Continued monitoring of students and staff; 18. Documentation; 19. Critical Incident Review and annual review of the ER Plan; 20. Future prevention". (Cox et al., 2016)

further suicides" (Cox et al., 2016, p. 212).

Schools may respond to the risk of a repeat incident by targeting: detection (Talbot & Bartlett; 2012) including monitoring for possible triggers (Toste & Heath, 2010); psychoeducation (Jarvi et al., 2013) including an understanding of NSSI as a maladaptive coping behaviour (Toste & Heath, 2010); as well as the provision of onsite counselling; and monitoring of media coverage (Suicide Prevention Resource Center, 2011).

Complex Presentations

Finally, the Touchstone that is described as being Justice and Solidarity "calls us to stand in solidarity with those who are marginalised" (Edmund Rice Education Australia, 2018). The following represents some examples of possible complexities which demand further reflection in terms of the nuances of clinical practice within the school environment. Arguably, the increase in diversity of student populations within many Catholic schools requires any policy document be cognisant of this diversity. This paper was written by authors employed within an inner city, Catholic, mixed gender high school attending to the needs of students with divergent needs. Mention has been given to the prevalence of students from the LGBTIQ community and the stressors that exist when a young person is in the process of developing their sexual identity. Additionally, students from culturally diverse backgrounds also have inherent behaviours that may preclude them for seeking help. Language barriers when dealing with parents and carers of students from different ethnicities provide a challenge for schools when dealing with the highly nuanced issue of suicide and self-harm. More challenging than that is the shame that some cultures preserve for this sort of behaviour and the resultant difficulties that can ensue from this. These can include

denial that the student has an issue, failure to cooperate or to act in getting the student help, and the basic communication pathways being opened. Whilst there many reasons for these behaviours playing out, the prevalent need to act in a timely fashion makes these a significant challenge. The skill level of parents and carers can also be a significant factor in intervening successfully on behalf of the student. Adults whose education is minimal can, at times, be reticent to engage with public services, or struggle to understand the extent of their child's issues on both intellectual and emotional levels.

Culturally and linguistically diverse students.

Safety planning is an important part of planning for less harmful responses when intrusive thoughts are suggestive of a suicidal response. Safety plans prompt the client to "…work through steps until you feel safe" (Beyond Blue, 2018). According to Andrews et al. (2014), students born outside Australia and especially those from culturally and linguistically diverse backgrounds, were identified as being at greater risk of self-injury. Students from culturally and linguistically diverse backgrounds originating from countries featuring overt violence may well answer questions pertaining to 'safety' in a manner that provides an inaccurate understanding of their current level of risk to self. These students have placed a high priority upon leaving their lives behind, in order to access the relative safety that defines the existence of inhabitants of a Western, developed country featuring clearly defined rule of law. The concept that they could be 'unsafe' in this country can be experienced as perplexing when current context is compared with the physical threats that represented immediate and significant risk in their country of origin. Put differently, 'safety' is a relative term. Further complicating matters is the nuance that accompanies the term

'safety' within populations for whom a knowledge of English is only emerging and very much grounded in literal applications. In such instances it is proposed that 'safety plans' be relabelled to read 'self-care plans'. This change in emphasis reduces the previously described ambiguity pertaining to the term 'safety'. Furthermore, it establishes an emphasis upon self-efficacy in terms of capacity to influence own choices around behavioural responses to intrusive thoughts. Finally, this terminology establishes a basis for a conversation suggestive that self-care exists along a continuum and is not limited to instances when tempted to engage behaviours arising from NSSI or suicidal thoughts and that there is value in attending emotional regulation prior to escalation to more critical concerns.

Non-English speaking parents.

In the ordinary course of practice, school staff will seek to notify parents of all instances of NSSI and suicidal ideation and/or behaviours. Such action represents a clear exception to client confidentiality and as such, clients are always informed at the outset of therapy that risks to self or others will not be privileged in the same manner as other content. However, parents of students from culturally and linguistically diverse backgrounds will not infrequently have minimal if any knowledge of the English language. In instances where parents or carers have an absence of English language skills, the need to proceed in an alternative manner is clear. However, in instances in which parents/ cares have some, albeit minimal language skills, there must be an attempt to engage the parent in a modified – often shorter and simpler-conversations, with efforts to ensure comprehension of uncommon words and especially medical terminology pertaining to risk, self-harm and suicide. Regardless of parental language capacity, the principle remains that the school does not seek to

engage in sustained management of a concern for which the solution will require extensive parent/ carer engagement and for which the expertise is likely to be found in a healthcare context. Alternative pragmatic responses to this scenario might include:

- Use of a professional interpreter where finances, time frames and access to someone not known to the student/family allow,
- Engaging a sibling, over the age of 18 years, to translate the concern to a parent preferably whilst in the company of the counsellor,
- Writing a therapeutic letter that the student may translate to their parent, again in the company of the counsellor,
- Requesting that an alternative service already known to the family but typically engaged around other areas of need -perhaps specific to matters of refugee support or housing - to act in the specific capacity as a conduit of information,
- Informing the parent that the student is to be taken to the hospital whilst engaging with translation services at a tertiary institution.

Challenges to engagement

It bears mentioning that proposed obstacles to accessing school-based support have included perceived stigma and confidentiality (Hawton, Saunders & O'Connor, 2012; Heath et al., 2010). In addition, staff capacity may be a limiting factors in that less than one-third of teachers feel they possess adequate knowledge on the subject of NSSI (Heath et al., 2011), a position confirmed in a recent study of Queensland teachers (Ross et al., 2017) and in a study of school-based nurses (Olympia, Wan & Avner, 2005). Amongst school students seeking school-based support, it has been reported that younger students and those presenting with a greater range of self-

injurious behaviours or levels of psychological distress, were more willing (Heath et al., 2010).

Conclusion

Schools are called to provide a policy response to risks associated with NSSI and suicide amongst adolescent student populations. Key strategies to be considered were grouped under headings that align with the three action areas outlined by the Queensland Suicide Action Prevention Plan, namely: prevention, intervention and postvention. As a whole these three action areas inform a pastoral response to student's experiencing extreme distress and/or mental illness, manifesting in a risk to self. In terms of formulating a structured framework that responds to these complex student vulnerabilities, the following demand consideration: prevention - understanding risk factors, gatekeeper training, screening and assessment; intervention – support and referral, safety plans and psychoeducation; postvention – toolkits/resources, managing contagion. Examples of some possible complexities demanding of increased reflection were detailed and related to culturally and linguistically diverse students and non-English speaking parents. The importance of the school's responsibility with regard to providing such a service to its community was also discussed and concluded that schools are well placed to provide such front line care for their students. This is brought sharply into focus given the increased number of children of school age presenting with NSSI and suicidal ideation, and the responsibility of the school to provide a structured framework, incorporating specific procedures that attend to the needs of the student population in a manner consistent with the Touchstones that underpin an EREA education.

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