John Calvin School Albany
A School with the Bible

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H006	Mental Health, Suicide and Non-Suicidal Self-Injury Policy
Purpose	This policy supports responses in relation to students with mental health concerns.
Authority	WA Mental Health Act 1996
Policy	JCSA is committed to the success of all students, including those with mental health concerns. Regarding students with a mental health disorder, the school will, within reasonable limits, do what is in its power to: • Implement early intervention measures and treatments for students where there is reasonable suspicion that a student has a mental health difficulty • Acknowledge but not stigmatise mental health conditions • Make suicide prevention a priority • Aid and encourage students to seek professional advice, help or treatment when this is needed, working closely with parents in cases of mental health crises or other developments with sensitivity to whether the 'home' may be integral to the exacerbation of the health concern • Provide appropriate levels of support
Delegation	The Principal
Related Policies	Child Protection (CP001) Harmful Substance (H003) Records Management (G006) Health Records Management (H004) Privacy (G001)
Date approved	May 2009; May 2012, September 2019
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Keywords	Mental health; depression; suicide; non-suicidal self-harm; psychosis;
Authorised by: **Chairman**	
Date	

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H006 Mental Health, Suicide and Non-Suicidal Self-Injury Procedure

A 'mental health disorder' is a diagnosable illness which causes major changes in a person's thinking, emotional state and behaviour, and disrupts the person's ability to work or study and carry on their usual personal relationships. Because of the fall into sin and the subsequent brokenness of life, illness, mental health disorders, suicide and non-suicidal self-injury (NSSI) are issues that we, too, are confronted with at the Albany John Calvin School.

JCSA can expect a range of mental health disorders among students such as:

- Depression
- Anxiety
- Psychosis
- Substance Use Disorders
- Eating Disorders
- Suicidal Behaviour and Non-Suicidal Self-Injury

Such students are to be provided for within regular classes as much as is reasonably possible.

Student safety and well-being is the school's first priority when confronted with mental disorders.

Unless mental difficulties are somehow caused, or suspected to be caused by situations in the family home, the school will consult and cooperate with parents wherever possible.

For reasons best known to them, students with mental disorders may confide in or seek help from staff who are not always in a position to extend such help.

Nevertheless, as much as is reasonably possible, the member of staff so chosen will apply the basics of **Mental Health First Aid**. Similar to physical first aid using the 'DR ABC' approach, mental help can be extended using the Mental Health First Aid Action Plan, A.L.G.E.E:

1. **A**ssess the risk of suicide or harm
2. **L**isten non-judgementally
3. **G**ive reassurance and information
4. **E**ncourage the person to get appropriate professional help
5. **E**ncourage self-help strategies

This procedure has been broken down into the following sections:

1. Helping a student through a mental health crisis.
2. Depression.
3. Anxiety Disorders.
4. Psychosis.
5. Eating Disorders.
6. Suicidal Behaviour and Non-Suicidal Self-Injury
7. If your friend threatens to commit suicide.
8. Mental Health Individual Case Management.

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1. Helping a student through a mental health crisis

A mental health crisis may occur when a student feels suicidal, has an anxiety attack, is in an acute stress reaction, or is out of touch with reality in a distressing psychotic state.

Some general strategies staff can use to help are:

- Ask if the student knows who you are, otherwise introduce yourself, and explain why you are present.
- Remain courteous and non-threatening, but be honest and direct.
- Listen to him or her in a non-judgmental way.
- Avoid confrontation at all costs - be prepared to "agree to differ" with the student's perspective.
- If needed, call the local Mental Health Crisis Team (1800 676 822) for their help or advice.
- If someone is at risk of being hurt, call 000 for emergency services.
- Stay calm and positive.
- In case of a panic attack, assure the student you will stay with them and keep them safe until the attack stops.
- Accept the student's reality. Clarify and address what he or she regards to be major issues (not what you, the helper, regard as major concerns).
- Do not attempt to manhandle the student, except to prevent serious assault or suicide attempts.
- Be alert to the effects of alcohol, inhalants or marijuana (they can bring on psychosis and reduce initiative & motivation).
- Encourage / assist the student to receive professional help and help from parents where appropriate.
- If you conclude that a student (or a member of staff) may be suicidal, try to find out if he or she has:
    - A current suicide plan;
    - The means and opportunity to commit suicide; and
    - Made a previous attempt to commit suicide.

  To find this out you will need to encourage the student to talk about how they are feeling.

If you conclude the student is at risk of hurting himself or herself check this out by some direct questions such as:

- Are you thinking of killing yourself?
- Do you have a specific suicide plan?
- Have you ever tried to kill yourself before?
- How long do you think you can keep yourself from acting out your suicidal thoughts?
- What help could make it easier for you to deal with the pain you are in now?

NB: *Contrary to common belief, this type of questioning does **not** encourage a person to pursue suicidal behaviour. Instead, it signals to them that you care, that you are genuinely concerned for their wellbeing and that you want to help.*

Take serious any communication of distress. If you believe the person is at risk of harming him or herself, seek professional help immediately.

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How to help a suicidal person

1. Do not put yourself in danger, e.g. do not try to physically restrain a young adult.
2. Ensure the person is not left alone – stay with him or her if you consider the risk of suicide is high or try to arrange that someone is with them while they go through the immediate crisis.
3. Seek immediate help:
    - Phone the mental health crisis number, 1800 676 822, or
    - Phone Emergency, 000, or
    - Take the person to a hospital emergency department, or
    - Take the person to a General Practitioner (GP)
4. If the person has been consuming alcohol or drugs, try to stop them from consuming any more.
5. Try to ensure the person does not have ready access to means to take their life, e.g. pills, a rope or a gun.
6. Encourage the person to talk. Listen without judgement. Be polite and respectful. Don't deny the person's feelings. Don't try to give advice.
    - Don't try and frighten a student out of suicide by stating that hell inevitably awaits them if they kill themselves (Reformed theologians such as W Pouwelse1 argue otherwise).
    - Don't give unhelpful advice such as 'pull yourself together' or 'cheer up'.
    - Avoid confrontation unless necessary to prevent harmful or dangerous acts.

Finally, if the incident was traumatic for you, or you feel anxious or distressed, discuss these issues with a colleague or with a mental health professional.

Helpful resources

www.headroom.net.au (for professionals, service providers, parents and students 12-18.)

www.youthinmind.net/Aus (for parents, teachers and young people).

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2. Depression

Mental Health First Aid

1. **A**ssess the risk of suicide or harm.
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5. **E**ncourage self-help strategies.

Depression has no single cause and often involves the interaction of biological, psychological and social factors. People may become depressed when something very distressing has happened to them and they cannot do anything to control the situation. It can affect a young person's behaviour in a number of ways:

- Becoming socially withdrawn;
- Seriously falling behind in performance and school work;
- Engaging in risk-taking, involving e.g. motor vehicles or sexual activities;
- Drug and alcohol misuse;
- Using a physical health problem to get attention or help.

General Symptoms of Depression

If a person is clinically depressed, they would have five or more of the following symptoms for at least two weeks:

- An unusually sad or irritable mood that does not go away.
- Loss of enjoyment and interest in activities that used to be enjoyable.
- Lack of energy and tiredness.
- Feeling worthless, or guilty, when not at fault.
- Thinking about death a lot, or wishing to be dead.
- Difficulties in concentrating or decision making.
- Moving more slowly or, sometimes, becoming agitated and unable to settle.
- Having sleeping difficulties or, sometimes, sleeping too much.
- Loss of interest in food or, sometimes, eating too much.

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Helping a depressed person

When faced with a depressed student, help him or her to feel hope and optimism and to realise that:

- They have a real medical condition.
- Depression is a common illness.
- Depression is not a weakness, laziness or character defect.
- God's promises to them are sure.
- If they agree, you will pray with and for them.
- Even when they don't know how to pray, the Holy Spirit will pray for them.
- Effective treatment is available for depression from GPs or counsellors.
- Depression takes a while to develop and sometimes a while to restore.

Helpful resources

www.moodgym.anu.edu.au and www.reachout.com.au (both based of cognitive behaviour therapy)

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3. Anxiety Disorders

Mental Health First Aid

1. **A**ssess the risk of suicide or harm.
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4. **E**ncourage the person to get appropriate professional help.
5. **E**ncourage self-help strategies.

Everybody experiences anxiety at some time. It can be quite useful to avoid dangerous situations or to solve problems. An anxiety disorder differs from normal anxiety in the following ways:

- It is more severe
- It is long-lasting
- It interferes with a person's work or relationships

There are many types of anxiety disorders, such as phobic disorder, generalised anxiety disorder, separation anxiety disorder, panic disorder, post-traumatic stress disorder, and obsessive-compulsive disorder.

General Symptoms of Anxiety Physical:

- Cardiovascular: palpitations, chest pain, rapid heartbeat, flushing.
- Respiratory: hyperventilation, shortness of breath.
- Neurological: dizziness, headache, sweating, tingling and numbness.
- Gastrointestinal: choking, dry mouth, nausea, vomiting, diarrhoea.
- Musculoskeletal: muscle aches, pains (especially neck, shoulders, back), restlessness, shaking.

Psychological:

- Unrealistic and / or excessive fear and worry (about past or future events).
- Mind racing or going blank.
- Decreased concentration and memory.
- Indecisiveness.
- Irritability, impatience, anger.
- Confusion.
- Restlessness or feeling 'on edge' or nervous.
- Tiredness, sleep disturbance, vivid dreams.

Behavioural:

- Avoidance of situations.
- Obsessive or compulsive behaviour.
- Distress in social situations.
- Phobic behaviour.

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Helping a person having a panic attack

1. If you are not sure whether a student is having a panic attack, asthma attack or heart attack, or whether he or she is in distress, call an ambulance.
2. If you are sure that a student is having a panic attack, move him or her to a quiet, safe place if possible.
3. Whatever the type of attack, first aid for a conscious person is to keep them as calm as possible with slow, deep breathing.
4. Help to calm the person by encouraging slow, deep breathing in unison with your own. Using the second hand of a watch, encourage a person to breathe in for 3 seconds, hold for 3 seconds and breathe out for 3 seconds.
5. Be a good listener, without judging.
6. Explain to the person that they are having a panic attack and not something life-threatening.
7. Explain that the attack will soon stop and they will recover fully.
8. Assure the person that someone will stay with them and keep them safe until the attack stops.

Helping a person who has experienced a traumatic event

1. The most important thing is to give information about the situation and to offer practical help for the necessities of life such as food, accommodation and contact with family.
2. Let the student tell their own story if they wish, but do not push them if they don't want to. People who experience a traumatic event have their own pace for dealing with trauma. It is important to let them set the pace. Urging someone to discuss the trauma may actually re-traumatise him or her.
3. Be a patient and sympathetic listener, before giving any advice. Make personal contact and listen non-judgementally before making any recommendation for help.
4. Validate a student's reaction as being a normal response to abnormal events. Explain that stress reactions are normal for days or even weeks after a trauma and that people usually have a normal recovery of their emotions. These stress reactions include shock, fear, grief, emotional numbing, indecisiveness, worry, unwanted memories, fatigue, difficulty sleeping, being easily startled, distrust and irritability.
5. Encourage the student to reach out to other people who can provide support and to share feelings about what is happening. Encourage traumatised students to talk with family and friends, following their own instinct on how much they say and with whom they talk. Don't tell the student to stop reliving the event and to simply forget the trauma and get on with life.
6. Advise the student not to use alcohol, drugs or medication to cope. Instead advise them to use simple breathing and relaxation techniques.
7. If the stress reaction persists, encourage the student to seek professional help.
8. If the student continues to experience stress reactions or severe distress that interferes with normal functioning after a month following the trauma, encourage him or her to seek professional help.

Helpful resources:

www.nimh.nih.gov/healthinformation/anxietymenu.cfm (good information)

www.crufad.com (includes self-help section and downloadable fact sheets)

www.med.monash.edu.au/mentalhealth/paniconline (to be used in collaboration with the treating GP)

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4. Psychosis

Mental Health First Aid

1. **A**ssess the risk of suicide or harm.
2. **L**isten non-judgementally.
3. **G**ive reassurance and information.
4. **E**ncourage the person to get appropriate professional help.
5. **E**ncourage self-help strategies.

Psychosis is a general term describing a mental health problem in which a person has lost some contact with reality. Psychosis severely disrupts a person's life and amounts to severe disturbances in thinking, emotion and behaviour. Relationships, work, study and self-care are difficult to initiate and maintain.

The main psychotic illnesses are schizophrenia, bipolar disorder (this used to be known as manic-depressive disorder), psychotic depression, schizoaffective disorder and drug induced psychosis.

These illnesses are relatively rare among school-aged individuals.

Common symptoms when a psychotic disorder is developing:

NB: People in the early stages of psychosis often go undiagnosed for a year or more before receiving treatment. This is mainly because psychosis often begins in late adolescence or early adulthood and the early symptoms involve behaviours and emotions which are common in this age group. Many young people will have some of these symptoms without developing psychosis.

Changes in emotion and motivation:

- Depression.
- Anxiety.
- Irritability.
- Suspiciousness.
- Blunted, flat or inappropriate emotion.
- Changes in appetite.
- Reduced energy and motivation.

Changes in thinking and perception:

- Difficulties with concentration or attention.
- Sense of alteration of self, others or the outside world.
- Odd ideas.
- Unusual perception experiences (e.g. reduction or greater intensity of smell sound or colour).

Changes in behaviour:

- Sleep disturbance.
- Social isolation or withdrawal.
- Reduced ability to study, work or carry out social roles.

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Cannabis and Psychosis

FRSA Procedures Cannabis (marijuana, hashish, pot, grass or weed) is Australia's most widely used illicit drug. Most people using it occasionally don't experience any obvious harmful effects.

Regular use may produce short-term effects including paranoia, confusion, increased anxiety and even hallucinations, which can last up to several hours.

Longer-term risks may include asthma and bronchitis, cancer of the mouth, throat and lungs, poor concentration and memory, learning difficulties and occasionally psychosis.

What to do if a person appears threatening:

Call the police (**131 444**) Tell them that a person has a mental illness and needs medical help. Ask them to send a plain-clothes officer if available to reduce any threat.

You could also call the mental health crisis team (**1800 676 822**), but in many regions they require accompanying police presence if there is threatened violence.

- Do not put yourself in danger, e.g. do not try to restrain a violent person.
- Do not block the person's escape, but position yourself for easy exit.
- Take a neutral and safe position in the room;
- Try to create a calm, non-threatening atmosphere.
- Talk slowly, quietly, firmly and simply.
- Reduce distractions, e.g. don't have music, videos etc.
- Don't get close to the person.
- Avoid direct and continuous eye contact.
- If possible, sit down and invite the person to sit down.
- If possible, offer a cup of coffee or tea.
- Do not try to reason with acute psychosis.
- Do not express irritation of anger.
- Do not threaten, shout or criticise.
- Express empathy for the person's emotional distress, but don't overdo this.
- Comply with reasonable requests.

Helpful resources:

www.eppic.org.au (good, downloadable info on psychosis)

www.sane.org (SANE Australia has useful info on symptoms, treatment, medication etc)

www.blackdoginstitute.org.au (includes assessment tool and education program)

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5. Eating Disorders

Mental Health First Aid

1. **A**ssess the risk of suicide or harm.
2. **L**isten non-judgementally.
3. **G**ive reassurance and information.
4. **E**ncourage the person to get appropriate professional help.
5. **E**ncourage self-help strategies.

Eating disorders amount to a disturbance of eating habits and weight-control behaviour which results in impairment to physical health or that which affect the person' s psychological and social functioning. Eating disorders occur in people who over-evaluate their body shape and weight. Whereas most young people evaluate themselves by achievements in various areas, such as social relationships, school, work or sporting ability, those with eating disorders see their self-worth largely in terms of their body shape and weight and their ability to control these.

Some young people with eating disorders lose weight, sometimes to the point of starvation. Although a young person may be seriously underweight, they see this as a success rather than as a problem and have limited motivation to change. This is the pattern in the disorder of **anorexia nervosa**. Others attempt to lose weight, but these attempts are undermined by periods of uncontrolled overeating so that normal weight is maintained. This is the pattern of **bulimia nervosa**. Most young people with disturbance of eating habits or weight control behaviour do not fit the typical pattern of either anorexia or bulimia and are said to have **atypical eating disorders**.

Early symptoms of

Anorexia Physical signs:

- Loss of period (or not starting to menstruate in young girls).
- Weight loss without any other illness that would account for it.

Psychological signs:

- Obsessive concern about body weight, shape and dieting.
- Unrealistic belief of being fat.
- Extreme fear of gaining weight or of eating.

Behavioural signs:

- Cutting out foods that were once enjoyed.
- Excessive exercising.
- Inducing vomiting or using laxatives to become thin. It may be difficult to tell whether a student is inducing vomiting. Regularly leaving the table during or directly after meal times may be a sign.
- Avoiding meal times with others because of concern about food.
- Excessive analysing of food labels, or counting kilojoules from food and exercise.

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Questions for detecting eating disorders

These questions give some idea of the behaviour teachers should watch for:

- Do you make yourself sick (induce vomiting) because you feel uncomfortably full?
- Do you worry that you have lost control over how much you eat?
- Have you recently lost more than 6 kg in a three-month period?
- Do you think you are too fat, even though others say you are too thin?
- Would you say that food dominates your life?

Two or more 'Yes' answers indicate a likely eating disorder.

What causes eating disorders?

As for other mental disorders, there is no single cause. A range of biological, psychological and social factors contribute. The following factors all increase a student's risk of developing an eating disorder:

Mental health disorders in family members:

- Family members with an eating disorder.
- Family members with other mental disorders, e.g. depression or alcohol misuse.

Life experiences:

- Conflict in the home.
- Parents have little contact with their children.
- Parents have high expectation of their children.
- Sexual abuse (reported as frequent motivation for eating disorder).
- Family dieting.
- Critical comments from others about eating, weight or body shape.
- Pressure to be slim because of sport or gymnastics.

Personal characteristics:

- Low self-esteem.
- Perfectionism.
- Anxiety.
- Obesity (increased risk of bulimia).
- Early start of periods (increased risk of bulimia).

Useful resources:

www.anzaed.org.au (useful links to Australian websites)

www.something-fishy.org (useful info on eating disorders and misconceptions)

www.eatingdisordersonline.com (mainly factual website)

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6. Suicidal Behaviour and Non-Suicidal Self-Injury

Mental Health First Aid

1. **A**ssess the risk of suicide or harm.
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3. **G**ive reassurance and information.
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5. **E**ncourage self-help strategies.

What is Non-Suicidal Self-Injury?

NSSI is considered to be a deliberate acts to harm oneself without the intent to die and is aimed at reducing uncomfortable or distressing emotions. The behavior is often repetitive in nature. NSSI is often referred to as self-injury. Common methods of NSSI can include, for example:

- Cutting, scratching, scraping or picking skin
- Swallowing inedible objects
- Taking an overdose of prescription or non-prescription drugs
- Swallowing hazardous materials or substances
- Burning or scalding
- Hair-pulling
- Banging or hitting the head or other parts of the body
- Scouring or scrubbing the body excessively
- Eating disorders

What is Suicidal Behaviour?

Suicidal behaviour includes suicidal ideation, suicide attempts and suicide

- Suicidal ideation refers to an individual's thoughts about ending their life
- An attempt refers to an individual harming themselves with the intent to die but not resulting in death
- Suicide is the deliberate act to end one's life resulting in death. This is usually termed "death by suicide" or "suicided"

Indicators

Some examples of common indicators of concern are:

- Changes in activity or mood
- Poor emotional regulation
- History of trauma
- Decrease in academic performance
- Difficulty concentrating and/or making decisions
- Disclosure of persistent thoughts about death and/or suicide
- Negative view of self and/or world
- Significant tiredness and/or loss of energy

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- Significant loss and grief issues
- Alcohol and/or drug use
- Peer conflict or withdrawal
- Risk-taking behaviours
- Persistent or sudden absence from school
- Sudden weight loss or gain
- Change in appearance (no care for clothes, hair, make-up etc)
- Unexplained injuries such as cuts, burns, bruises
- Wearing long sleeves or covering up
- Changes in eating and/or sleeping

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

Risk factors

The following risk factors, particularly in combination, may make a young person particularly vulnerable to self-harm:

- Individual Factors:
    - Depression / anxiety
    - Poor communication skills
    - Low self-esteem
    - Poor problem-solving skills
    - Hopelessness
    - Impulsivity
    - Drug or alcohol abuse
- Family Factors
    - Unreasonable expectations
    - Neglect or physical, sexual or emotional abuse
    - Poor parental relationships and arguments
    - Depression, self-harm or suicide in the family
- Social Factors
    - Difficulty in making relationships / loneliness
    - Being bullied or rejected by peers

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Warning signs

School staff may become aware of warning signs which indicate a student is experiencing difficulties that may lead to thoughts of self-injury or suicide. These warning signs should always be taken seriously and staff observing any of these warning signs should seek further advice from management to safeguard the student.

Be aware, however, that people who self-injure often go to great lengths to hide the evidence- making it hard for staff to recognise any signs. Students who do this attempt to avoid exposing their injuries or scars, typically by making excuses to avoid playing sports or engaging in other activities they typically enjoy. Other signs a student could be self-harming include becoming withdrawn or depressed or sudden mood changes. If a student has recently experienced a significant event (such as a break-up or family issue) they are more vulnerable to self-harm and staff should monitor them more closely than usual. Although self-harming and suicidal behaviors can coincide, they are not necessarily linked.

Possible warning signs include:

- Changes in eating / sleeping habits (e.g. student may appear overly tired if not sleeping well)
- Increased isolation from friends or family, becoming socially withdrawn
- Changes in activity and mood e.g. more aggressive or introverted than usual
- Lowering of academic achievement
- Talking or joking about self-harm or suicide
- Abusing drugs or alcohol
- Expressing feelings of failure, uselessness or loss of hope

Staff roles

<u>The school response to student suicidal behaviour and/or NSSI is outlined in the flowchart in Appendix 6.</u>

Students may choose to confide in staff member if they are concerned about their own welfare, or that of a peer. Staff may experience a range of feelings in response to this; for example, anger, sadness, shock, disbelief, guilt, helplessness, disgust and rejection. However, in order to offer the best possible help to students it is important to try and maintain a supportive, sympathetic and open attitude – a student who has chosen to discuss their concerns with a member of staff is showing a considerable amount of courage and trust.

Ask simple questions in order to help determine whether the student has purposefully hurt themselves. If they have, or even if you are not sure, it is important to notify management.

Example of a teacher's response following a disclosure:

- *Secure an appropriate place to discuss concern.*
- *Summarise the information the student has disclosed - "I appreciate it is difficult to let me know these thoughts and feelings. So what you're telling me is…. Have I got that right?"*
- *Link the student to appropriate support - "We need to support you and understand better what's going on, so I'm going to discuss this more with (appropriate staff member)."*
- *Negotiate with the student remembering that staff are not able to maintain absolute confidentiality with a student who has disclosed suicidal behaviour or NSSI. Explain it is important that the concern is reported and followed up by an appropriate staff member - "There are a few people we can go to….who would you rather?" "How does that sound?"*
- *Document the disclosure using the student's own words where possible.*

If the disclosure indicates that the student is at imminent risk, the staff member keeps the student safe and informs management immediately. The staff member does not leave the student unsupervised. Management

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contacts the parent/guardian and if necessary contacts emergency services (000) and follows emergency management procedures.

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

- *accessing emergency assistance or taking the student to receive first aid if injured*
- *linking the student to management – judge whether to take the student immediately or following current class/activity. This needs to occur as soon as practical following the disclosure.*

Any suspicion or evidence of suicidal behavior or NSSI should be taken seriously and followed up appropriately. This may include a trained professional completing a risk assessment. A risk assessment requires the assessor to question and explore the thoughts, feelings and actions of an individual to gain an understanding of their current situation, ascertain suicide risk, and to determine ongoing support needs.

A student's suicidal behavior or NSSI may come to the attention of school staff through either direct or indirect means.

A **direct disclosure** is when a student informs a staff member of any feelings, thoughts or actions associated with suicidal behaviour or NSSI. This may include verbal disclosure or disclosure through a curriculum task such as an English essay or a piece of artwork where there has been an expression of suicidal behaviour or NSSI.

An **indirect disclosure** is when information or concerns for a student are brought to the attention of a staff member by a third person; such as another student or community member.

Students need to be made aware that it may not be possible for staff to offer complete confidentiality. **If you consider a student is at serious risk of harming themselves then confidentiality cannot be kept**. It is important not to make promises of confidentiality that cannot be kept even if a student puts pressure on you to do so.

Any member of staff who is aware of a student engaging in or suspected to be at risk of engaging in self-harm should consult management for safeguarding the student.

Following the report, management will decide on the appropriate course of action (see flowchart). This may include:

- Contacting parents/guardians
- Arranging professional assistance e.g. GP, social services, CAMHS, School Psychologist
- Immediately removing the student from lessons if their remaining in class is likely to cause further distress to themselves or their peers
- In the case of an acutely distressed student, the immediate safety of the student is paramount and an adult should remain with the student at all times
- If a student has self-harmed in school a first aider should be called for immediate help

Risk Management Plan (RMP)

Details of any meetings with a student, their parent/s or their peers regarding suicidal behaviour and/or NSSI should be recorded in writing using the "Risk Management Plan template" (Appendix 1). The staff member completing the risk assessment are to discuss the limits of confidentiality before the assessment. The student (and parent/guardian) is to be provided with emergency and support contact details (see Appendix 2: "Emergency and consultation contacts"). Contact staff should also be informed of the Risk Management Plan (see Appendix 3: "Risk Management Memo template).

For further details on developing a Risk Management Plan refer to Appendix 4, "Developing a Risk Management Plan".

For an example of a RMP refer to Appendix 5, "Risk Management Plan example".

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The staff member who conducted the risk assessment is to notify the parent/guardian of concerns and recommendations including:

- ongoing monitoring of the student
- providing emergency response numbers
- linking the student with appropriate services through referral
- consulting with *Urgent mental health telephone support for children and families* on 1800 048 636
- recommending the student is taken to a hospital emergency department for assessment.

If the student is being taken for further assessment (e.g. to hospital) the staff member who conducted the risk assessment is to contact the agency and provide relevant information. The staff member is also to document relevant information and provide this to the agency in writing, fax or email. Where possible, the staff member should obtain consent from the parent/guardian before this occurs.

Checklist

After a disclosure Management are to ensure that the following actions have been taken (where needed)

- Follow-up with and offer support to any students and staff impacted by disclosure/ incident.
- Make staff aware of the potential impact of social media use and monitor this where possible.
- Where the student is already a client of an external service provider, inform them of the incident/disclosure. Where possible, obtain consent from the parent/guardian if this has not occurred already.
- Liaise with parent/guardian and check that agreed actions such as an external risk assessment or referral has occurred, where appropriate.
- Develop a risk management plan (RMP) in consultation with relevant staff (school staff, family, student, external agency) or review an existing RMP; and inform or update relevant teachers so they can manage the safety of the student when they return to class.
- Distribute the RMP to contact staff.
- Where necessary, organise a return to school meeting and include relevant school staff, parent/guardian, external support agencies and student (as appropriate).
- Review the RMP on an ongoing basis and when there is any significant incident or perceived change in risk that may impact on management of risk at the school level.
- Confirm that the school's actions are documented.
- Consider self-care and determine whether an opportunity to debrief with a colleague or access to professional support is needed.

Helpful resources:

www.selfharm.org.uk	(a UK information site for young people)
www.focusas.com	(a North American site for parents)
www.nshn.co.uk	(a UK site for people who support those who self-harm)

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7. If your friend threatens to commit suicide…

If your friend tells you he *(this counts for girls just as much, but for ease of writing the male gender is used)* is feeling suicidal or that he wants to end his life, take it seriously. Hearing this might make you feel overwhelmed or worried, especially if your friend is very upset or angry.

Suggestions for helping your friend

There are things you can do to support and help your friend if he threatens to take his own life.

- **Don't keep it a secret**

  Secrets can be dangerous if your friend is going to get hurt or die. It is important to tell someone, a teacher, minister, elder or doctor who can help you and keep your friend safe. Although your friend's parents have the first right to know, it is often wise to let a teacher or church office bearer to tell them.

- **Encourage your friend to seek help**

  It is very important that your friend seeks help from a minister, elder, doctor or some other trusted adult. It might seem difficult, but these people have much more insight and training to help your friend to deal with his difficulties and to keep him safe.

- **If your friend refuses to see someone**

  Keep encouraging him. If you feel able, and your friend will let you, simply sit down and pray with him. Putting his needs before the Lord may have a calming effect and it may help your friend to realise that He knows, and cares.
  On the other hand, you might offer to go with your friend when he speaks to someone about how he is feeling.

- **Offer your support**

  It can be scary to realise you need help. Let your friend know that you care and spend time with him. Just knowing that somebody cares can be reassuring as he may feelvery alone and think no one cares.

- **Remain positive**

  If he does talk to you about how he is feeling, don't try and answer all his problems; acknowledge that he is feeling down and that things might seem hard, but try to remain positive and encouraging.

- **Talking**

  Timing can be an important part of talking to someone about sensitive stuff. If possible, and if he is not at immediate risk of harming himself, try to choose a time when you're both relaxed.
  Avoid talking to him during an argument or if he is really upset. If you talk to him during an aggressive or defensive moment, you may end up getting a bad reaction and distance him.
  If you're not sure about what to say, you might try saying 'I'm worried about you', 'You mentioned the other day that you felt like ending your life, do you still feel that way?'

- **Ask them to postpone the decision/look for alternatives**

  While your friend may feel like acting now, he can try to postpone that decision. He can keep a list of other things to distract himself. This might include watching a DVD, playing a game, ringing a friend, playing some sport or doing some exercise, reading a book or listening to music. He can put this into action when the feeling starts to surface.
  Many people report that by postponing a decision to die they found that life did change. They got the support they needed and could move on to a better, happier frame of mind.

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- **Thoughts don't need to lead to action**

  Remind your friend that thoughts about taking life are just thoughts. They do not mean he has to act on them, no matter how overwhelming they are or how often he has them. They also don't mean that he will always have those thoughts.

- **Get informed**

  It might help if you have some general knowledge about suicide and depression. By becoming informed you may be able to better understand what your friend is going through and what might help.

- **Looking after yourself**

  When you are worried about a friend you might feel stressed or overwhelmed and forget to look after yourself. It is important that you take care of how you are feeling. Speak to someone you trust, such as a parent, family member, friend, teacher or office bearer.

- **Have time away from your friend**

  This can be important and allow you to relax. Make sure you spend some time doing what you enjoy. You may want to play sport, hang out with other friends, listen to music, or go for a walk.

- **Finally**

  It is important to remember that even though you can offer support, you are **not** responsible for the actions or behaviour of your friend. If he is not willing to help himself, it is not your fault.

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8. Mental Health Individual Case Management

Case Management Plans are to be established when a student requires support or guidance to meet his or her needs in dealing with mental health issues.

The Principal or teaching staff are required to contact a student's parents and engage in a consultation process when mental health issues are encountered. Parents must be involved in the process of case management planning.

Case Management Plans must be drawn-up and agreed on clarifying issues that are being addressed and the strategies to be used. Desired outcomes and the effectiveness of these strategies are to be noted.

Staff must take every opportunity to encourage parent participation by genuinely seeking information and assistance in response to a student's mental health issues.

Case Management Plans for students with mental health issues help to clarify the level and range of desired teaching and learning adjustments, they will vary greatly but most will include:

- The appointment of a Case Manager (the Principal or a senior teacher).
- Comprehensive medical and related details including names and emergency numbers of parents and health professionals.
- Agreed areas of responsibility of:
    - the student;
    - individual members of staff;
    - parents;
    - health professionals;
    - minister / consistory;
- Involvement of School Psychologists (possibly to provide training).
- Ongoing specific interventions suggested by mental health professionals.
- Provisions for a (highly) structured learning environment.
- Specifics regarding contact with mental health professionals.
- Agreed risk management strategies.
- Agreement details regarding feedback to parents.

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A 'typical' case management plan will consist of:

1. A description of activities, times and individuals which have shown to increase the risk of harm or disruption, complete with strategies for avoidance or management.
2. Adjustment of curriculum, including lesson and outcomes modifications.
3. Clear statements indicating when:
    a. professional help is to be sought;
    b. parents are to collect their son/daughter for respite;
    c. a student is to be (temporary) excluded from school.
4. Strategies to promote inclusion in regular classes.
5. Support between students, i.e. in-class or in-school buddies.
6. Information or instructions to other students explaining appropriate responses to e.g. anxiety attacks.
7. Agreed strategies for the management of e.g. anxiety, such as withdrawal to a safe place and breathing exercises.
8. Strategies for the management of self-harm, i.e. appropriate medical responses and a return to class as soon as possible.
9. Period-by-period monitoring of attendance and participation.
10. Face-to-face meetings with teachers in order to work together on strategies.
11. Daily teachers' feedback to the Case Manager, decreasing to weekly.
12. Structured communication with parents at a designated time.
13. Fortnightly review meetings.

If Educational Assistants (EA) are to be used, the following needs to be clearly stated to them:

1. Supervision and intervention strategies for times when the teacher leaves the class, and for times when the student leaves the class to go to a safe place.
2. Instructions for monitoring the student during class time.
3. Specifics to monitor and record the student from afar during recess and lunch.
4. Specifics for daily recording of behaviour as per plan.
5. Agreed strategies following self-harm as per risk management plan.
6. The EA's role in debriefing following self-harm incidents and general reviews.

For expert medical and educational advice, contact the school psychologist or doctor.

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A School with the Bible

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Appendix 1 | Risk Management Plan Template

Risk Management Plan template

Confidential

School name:

Student details	
Student name:	**Year:**
DOB:	**Principal:**
Parent/Guardian: Ph:	**Teacher/Year Coordinator:**
Parent/Guardian: Ph:	**Deputy Principal:**
Date of implementation:	**Review date:**
Nominated staff member/s	
Title (Mr, Mrs, Miss, Ms):	**Contact:**
Title:	**Contact:**
Supporting staff	
Title:	**Contact:**
Title:	**Contact:**

Situation/Environment	**School-based strategies to reduce risk at school**	**Home-based strategies to reduce risk at school**

SIGNATURES: Record of endorsement

_____ (Parent/Guardian)
_____ (SSO)
_____ (Teacher)
_____ (Management)
_____ (Other)
_____ (SSO)

_____ (Student, where appropriate)
_____ (Student Services)
_____ (Teacher)
_____ (Management)
_____ (Other)
_____ (Student Services)

Date: _____

Note circumstances where endorsement received via telephone or signature not obtained:

_____
_____

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Appendix 2 | Emergency and Consultation Contacts

Emergency and consultation contacts	Contact numbers
Urgent mental health telephone support for children and families (Under 18 years - 24 hours - 7 days)	1800 048 636
Crisis Care (24 hours)	9223 1111
Family Help Line	9223 1100
CAMHS	9892 2440
Albany Hospital	9892 2222
Kids Help Line	1800 551 800
Lifeline	13 11 14
Rural Link	1800 552 002
Headspace Albany	9842 9871
CPFS	9841 0777
AISWA Psychologist (Dana)	9842 2100 0427 431 977
Websites	
www.headspace.org.au	
www.reachout.com.au	
www.sane.org	
www.beyondblue.org.au	

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Appendix 3 | Risk Management Memo Template

Confidential Risk Management Memo

Date

RE: Student name

Year group

Dear Staff

Recently there have been some significant concerns raised about X's health and wellbeing. X will be accessing support for this (and a Risk Management Plan is being developed – if applicable).

To ensure X remains safe at school, please monitor him/her in class and let me know of any concerns or changes in his/her behaviour or mood as soon as possible.

If X is not in class and is not marked absent, please inform Administration immediately.

While X is aware that his/her teachers are being informed, please maintain confidentiality and do not discuss this with him/her.

If you have any questions or would like to discuss this further, please contact me.

Thank you for your support.

Kind regards

Nominated staff member

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Appendix 4 | Developing a Risk Management Plan

Following a student disclosure of suicidal behaviour or non-suicidal self-injury (NSSI) it is critical for school staff to implement strategies to monitor and manage potential risk while the student is at school.

A school Risk Management Plan (RMP) identifies foreseeable circumstances where a student may be at risk of harm and outlines strategies to reduce this risk. Following the strategies in a plan based on information gathered as part of a comprehensive risk assessment, is a strong step in assisting to improve safety and promote recovery.

In developing a RMP, consider the following guidelines:

1. In all circumstances **student safety and wellbeing is the priority**, with a plan developed as soon as is practical. An interim plan can be implemented while a more comprehensive RMP is developed. Staff can be informed of important actions using a risk management memo if required.
2. **Parental consent** is recommended before implementing a RMP. However, maintaining the safety of the student is the priority.
3. The plan is to be **individualised**, as required, and will be more or less detailed depending on the student's circumstances.
4. Some circumstances may require a **complex plan**, for instance when multiple agencies are involved, an ongoing history, or where there is imminent risk. In other situations, a less detailed plan will be more appropriate.
5. The plan is developed in **collaboration** with all relevant parties where possible (eg parent/ guardian, relevant school staff, residential staff, relevant interagency staff and the student if appropriate).
6. **Relevant teachers are informed of student risk** and suggested strategies through the RMP.
7. All strategies to access appropriate support during the school day to be discussed with the student. The **use of an exit card (or similar)** is to be considered with caution and only following assessment of associated risks such as maintaining supervision.
8. The **nominated staff member** should be the most available and appropriate staff member for a student. It is often not suitable to identify school staff members who are not routinely on site.
9. The **RMP or memo is distributed** to relevant school staff, parent/guardian and any interagency staff working with the student.
10. **The plan is kept in a secure and confidential place.**
11. The plan is **reviewed regularly** and when there is any **significant incident** that may impact on the management of risk at the school level.
12. The plan **ceases** when all relevant parties agree that it is no longer required.

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Appendix 5 | Risk Management Plan Example

Risk Management Plan Example

Confidential

School name:	
Student details	
Student name:	**Year:**
DOB:	**Principal:**
Parent/Guardian: Ph:	**Teacher/Year Coordinator:**
Parent/Guardian: Ph:	**Deputy Principal:**
Date of implementation:	**Review date:**
Nominated staff member/s	
Title (Mr, Mrs, Miss, Ms):	**Contact:**
Title:	**Contact:**
Supporting staff	
Title:	**Contact:**
Title:	**Contact:**
Support contacts	
Emergency: 000	Urgent mental health telephone support for children and families (Urgent MHTS):1800 048 636
External agency:	

Situation/Environment	School-based strategies to reduce risk at school	Home-based strategies to reduce risk at school
Absences Student does not arrive at class although is expected to be at school.	Roll marked at beginning of each class. 1. If student is absent from class but supposed to be at school, teacher notifies administration/student services who informs nominated staff member. 2. Nominated staff member (or nominee) immediately takes steps to ascertain student's whereabouts (e.g. checks bathrooms). 3. If student is unable to be located, nominated staff member contact parent/guardian.	Parent/guardian notifies school (phone number) **before school starts** if child will not be attending that day. Parent/guardian considers risk associated with travel to and from school and considers alternatives if required.

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Situation/Environment	School-based strategies to reduce risk at school	Home-based strategies to reduce risk at school
Class Student does not feel able to remain in class (feels distressed or has unsafe thoughts).	Encourage student to use strategies on their safety plan (if available) and/or other self-regulation strategies (e.g. relaxation/breathing techniques). If student is distressed and unable to stay in class, student moves to a prearranged area with accompaniment and suitable supervision. Use relevant strategies such as: • Encouraging student to use strategies on safety plan and/or other self-regulation strategies; and return to class when ready. • Link in with appropriate support staff. • Contacting parent/guardian if student is unable to stay at school. If student leaves class for a drink or the toilet, teachers to follow-up if student is not back in reasonable time (eg 5 minutes). Check to see if student is okay. Notify nominated staff member if not located. Staff to report concerns about student's mood to nominated staff member immediately and they will follow up with student and determine required actions. School to maintain records of classes missed.	If necessary, parent/ guardian to collect child from school and seek further assistance where required (e.g. Urgent MHTS, hospital, doctor). If there is an existing Safety Plan, consent from parent/ guardian and child to share strategies with relevant school staff requested.
Academic Student does not focus in class/does not do homework.	Treat the student as normally as possible as part of the class group, encourage them to do the work but do not hassle as it is to be expected that they may have other things on their mind and have difficulty concentrating. As long as student is not distracting other students. Allow student some space to recover emotionally before focusing on academics. Adjust academic and homework requirements as needed.	If necessary, parent/ guardian to collect child from school and seek further assistance where required (eg Urgent MHTS hospital, doctor). Academic adjustments to be made in consultation with parent/guardian.
Break times Student is distressed or feels unsafe at recess and lunch times	Student to remain with friends. If unable to or having unsafe thoughts, student to access support at administration/student support as agreed. Support staff or nominated staff member to assist student to establish where they feel most comfortable (not on own, link in with peers).	If necessary, parent/ guardian to collect child from school and seek further assistance where required (eg Urgent MHTS, hospital, doctor).
Peers Information shared with peers is unhelpful.	Discuss with student the adult supports available to assist when feeling distressed or having unsafe thoughts. Discuss with student the risk of sharing confidential information with peers School staff to monitor and report any unhelpful gossip or rumours to nominated staff member. Support peers to use protective interrupting and redirect support seeking to appropriate adults.	Parent/guardian to notify nominated staff member if they become aware of any issues with peers.

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NSSI and/or suicidal behaviour (add or delete as required)		
Student is at risk of harm.	School staff to monitor and inform nominated staff member immediately if there are concerns. Nominated staff member to use relevant strategies such as: • Respectfully enquiring whether self-injury has occurred or if student plans to self-injure. • Assessing risk where needed. • If self-injury has occurred assist the student to apply appropriate first aid. If necessary, seek medical assistance. • Encouraging student to use strategies on safety plan and/or other self-regulation strategies. • Contacting parent/guardian to inform them of concerns where needed.	Parent/guardian to monitor and notify nominated staff member of any concerns. If necessary, parent/ guardian to collect student from school and seek further assistance where required (eg Urgent MHTS, hospital, doctor).
Ongoing communication		
School + Home + External agency.	Ongoing communication between home, school and external agency regarding any issue relevant to assisting student to stay safely at school. Copy of this risk management plan provided to student's teachers, relevant school staff, parent/ guardian and external agency. External agency contacts: #	Parent/guardian to inform nominated staff member of any concerns that may impact on school. Parent/guardian to inform nominated staff member or school nurse if child starts medication that may increase risk at school. Parent to update external agencies of progress/ concerns as required.
Other		
(eg student is in highly distressed state)	School-based strategies	Home-based strategies

SIGNATURES: Record of endorsement

_____ (Parent/Guardian)

_____ (SSO)

_____ (Teacher)

_____ (Management)

_____ (Other)

_____ (SSO)

_____ (Student, where appropriate)

_____ (Student Services)

_____ (Teacher)

_____ (Management)

_____ (Other)

_____ (Student Services)

Date: _____

Note circumstances where endorsement received via telephone or signature not obtained:

_____

_____

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Appendix 6 JCSA Response to Student Suicidal Behaviour and/or NSSI