IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 001525

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Simon McGregor
Deceased:	AHT
Date of birth:	2 March 1996
Date of death:	17 March 2020
Cause of death:	1(a) INJURIES SUSTAINED IN A FALL FROM A 15TH FLOOR APARTMENT
Place of death:	[redacted]La Trobe Street, Melbourne, Victoria, 3000
Keywords:	Suicide, fall, international university student

INTRODUCTION

1. On 17 March 2020, AHT was 24 years old when he died from injuries sustained in a fall from the fifteenth floor of the apartment building where he resided. At the time of his death, AHT lived at [redacted] La Trobe Street, Melbourne, with two housemates.

2. AHT was born in China. In 2016, he moved to Melbourne to commence studying a Bachelor of Applied Science (Construction Management) at the Royal Melbourne Institute of Technology (**RMIT**) after being granted a TU-573 Student Visa.[1] He completed this degree in the first semester of 2019, it appears after failing and repeating some subjects,[2] and then commenced the RMIT Master of Project Management in the second semester. AHT passed three of the four Master's subjects he took in 2019, and was enrolled to continue his studies in 2020.[3] He attended the first class of the new year on 10 March 2022. The fatal incident occurred on the second day he was scheduled to attend class.[4]

3. People who knew AHT stated that he was socially isolated in Melbourne. JPC studied with AHT in China before they both moved to Melbourne. He stated that AHT was quite social in China and regularly played soccer, but had become withdrawn and stopped playing soccer in Melbourne, instead taking up online gaming.[5] YWQ, who shared an apartment with AHT between 2016 and 2018, stated that AHT was shy, did not have many friends, and would rarely leave his apartment other than to attend university.[6] DGS, one of AHT's housemates at the time of his death, stated that in the year he resided with AHT, he never saw AHT socialise with others and that he 'seemed to sleep all day and rarely leave his room only coming out at night'.[7]

4. The only proximal stressor identified was a relationship breakdown between AHT and his girlfriend, who he had met in an online game approximately six months before his death. After learning of AHT's passing, JPC spoke with AHT's girlfriend, who was clearly upset and stated that she had wanted to end the relationship, but AHT had said 'if he broke up with her, he

1 Department of Home Affairs records.

2 AHT's friend YWQ stated that AHT "failed part of the course and had to repeat it" (Coronial Brief, p.18).

3 Coronial Brief, statement of Chris Hewison, p.57.

4 Coronial Brief, statement of Chris Hewison, p.57.

5 Coronial Brief, statement of JPC, p.23.

6 Coronial Brief, statement of YWQ, p.18.

7 Coronial Brief, statement of DGS, p.15.

might die'. JPC later learned from AHT's parents that while back in China and on holiday in Europe, AHT had also been 'constantly arguing' with his girlfriend on the phone.[8]

5. JPC was not aware that AHT had any previous mental health issues, but reflected that in China, 'mental health and depression are very taboo subjects and not discussed openly'.[9]

6. Health insurance records indicate that AHT made no claims during his time in Australia.[10]

THE CORONIAL INVESTIGATION

7. AHT's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

8. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

9. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

10. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of AHT's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

11. This finding draws on the totality of the coronial investigation into the death of AHT including evidence contained in the coronial brief. Whilst I have reviewed all the material,

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8 Coronial Brief, statement of JPC, p.24.

9 Ibid., p.24.

10 Coronial brief, email from Kathy Matthews, Allianz Health, dated 15 September 2020, p.55.

I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[11]

12. In considering the issues associated with this finding, I have been mindful of AHT's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

13. After completing the first semester of his Master's course in late 2019, AHT visited family in China over the university holiday period, arriving back in Melbourne on 7 March 2020 to continue his studies.[12]

14. On the weekend of 14-15 March 2020, AHT was not present at his apartment, which was somewhat unusual for him.[13]

15. On 15 March 2020, JPC met up with AHT, at which time he 'seemed okay', 'happy' and 'back to his old self'.[14] DGS also noticed nothing out of the ordinary when he spoke briefly to AHT before heading to work on the afternoon of 17 March 2020.[15]

16. At approximately 4:48 pm on 17 March 2020, police received reports of a person having fallen from a height at 68 La Trobe Street, Melbourne, and hitting the awning at that address. Attending police observed a male, later identified as AHT , lying on top of the awning next to a large indentation.[16] He appeared to take one breath, before ceasing.[17] He was motionless and unresponsive, with significant injuries and bleeding.[18]

17. Emergency services were unable to gain immediate access to AHT's body due to the damage to the underside of the awning and its flimsy construction. The structure was deemed at risk

[11] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.
[12] Coronial Brief, statement of JPC, p.23; statement of DGS, p.15.
[13] Coronial Brief, statement of DGS, p.15.
[14] Coronial Brief, statement of JPC, p.24.
[15] Coronial Brief, statement of DGS, p.16.
[16] Coronial Brief, statement of First Constable Isaac Collier, p.47.
[17] Ibid..
[18] Coronial Brief, statement of Senior Constable Andrew Mutimer, p.32

of further collapse and police evacuated the immediate area.[19] Metropolitan Fire Brigade members attended a short time later and were able to use their heights access equipment to gain access to AHT's body approximately an hour later, at which time they confirmed that he was sadly deceased.[20]

18. Police searched AHT's body and discovered his Myki Card, Commonwealth Bank of Australia card and RMIT student ID, which enabled his identification.[21] Police attended AHT's apartment and found no signs of a struggle or suspicious circumstances.[22]

Identity of the deceased

19. On 20 March 2020, AHT , born 2 March 1996, was visually identified by his friend JPC.

20. Identity is not in dispute and requires no further investigation.

Medical cause of death

21. Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine conducted an external examination on 18 March 2020 and provided a written report of her findings dated 23 March 2020.

22. The post-mortem examination revealed widespread abrasions and bruising.

23. The post-mortem computed tomography (**CT**) scan showed a mandibular fracture, left humerus complete fracture, multiple pelvic fractures and bilateral haemopneumothoraces.

24. Toxicological analysis of post-mortem blood samples did not identify the presence of any alcohol or any commons drugs or poisons.

25. Dr Francis provided an opinion that the medical cause of death was 1(a) injuries sustained in a fall from a 15th floor apartment.

26. I accept Dr Francis's opinion.

[19] Coronial Brief, statement of First Constable Isaac Collier, p.48.
[20] Coronial Brief, statement of Detective Senior Constable Leigh Nicholds, p.38-39.
[21] Coronial Brief, statement of Detective Senior Constable Leigh Nicholds, p.38.
[22] Coronial Brief, statement of Detective Senior Constable Leigh Nicholds, p.40.

CPU REVIEW AND FURTHER INVESTIGATIONS – INTERNATIONAL STUDENT SUICIDES

27. I directed that the Coroners Prevention Unit (**CPU**)[23] conduct a review of the circumstances of AHT's death with a view to identifying recurring themes and circumstances that might in turn point to opportunities to support international students better and thus reduce the risk of further suicides - which have a devastating impact on the student's family, friends, and the wider university community - in future.

28. The investigation into AHT's death was conducted in parallel with my investigations into four other suicides of international students which occurred during 2020. The five deaths related to students born in five different countries who attended four different universities across Victoria, who were studying diverse subjects (at both undergraduate and postgraduate level), and who had diverse living arrangements (including on-campus accommodation, share houses with other international students, and residing with family members).

29. To assist in this investigation, I requested information and policies from RMIT about how they support the wellbeing and health (including mental health) of international students. I was greatly aided by the response I received from RMIT Critical Incident Response Team Lead Chris Hewison, who provided a detailed statement about AHT's academic progress and his engagement with student services including health and wellbeing services. Mr Hewison provided copies of relevant policies, procedures and protocols spanning student mental health and wellbeing, suicide prevention, and critical incident management, amongst other areas. I am grateful to RMIT and Mr Hewison for their efforts in this regard.

30. Upon review of AHT's case, the CPU found that a striking feature was how little engagement AHT had with RMIT in a health and wellbeing context. Mr Hewison confirmed that AHT had not accessed RMIT's mental health support services at any time, nor had he engaged in Special Consideration or Academic Progress processes; and there were no identified suicide risk factors. His only interactions with student services were related to administrative tasks such as enrolment, replacing a student card, and similar. On the evidence before me, AHT also did

[23] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

not engage with health services external to the university, nor did he appear to disclose any mental health issues, stressors or suicidality to anybody other than possibly his girlfriend.

31. AHT's lack of engagement with RMIT health and wellbeing services was echoed across the other four suicides I investigated. In each case the student had not contacted or been linked with relevant university services and was not engaged with any other health services in the community for mental health treatment and support.

32. In highlighting this lack of engagement, I make clear that I make no criticism of RMIT. As mentioned above, RMIT provided a range of information to me about supports for students in general and international students in particular; I was impressed by the thoroughness of this material and I have no evidentiary basis for any concern with service design and delivery. Instead, through considering the material gathered across my five investigations, I have come to the conclusion that universities may be facing a different challenge: how to encourage international students to engage with and seek help from existing university services in the first place when they experience mental health crises and/or suicidality. Given that none of the five international students engaged with health services in the wider community or (to the best of my knowledge) disclosed suicidality to family or friends or clinicians, the challenge is even broader than this: how to encourage international students to seek help at all.

33. I am not the first Victorian coroner to identify this challenge. Coroner Audrey Jamieson of this Court previously investigated the suicides of Zhikai Liu and Nguyen Le, two international students who had not sought any health or wellbeing support either from the universities where they attended, or from health services in the broader community.[24] Coroner Jamieson was also supported in her investigations by the CPU, whose case investigators undertook an analysis of Victorian suicides among adult students during the period 2009-2015, comparing between international students and Australia-born students. The CPU reported a number of differences, the most pertinent of which (for present purposes) were as follows:

> *The data shows a far lower prevalence of diagnosed mental illness among international student suicides (14.8%) than Australian-born student suicides (66.7%), and a corresponding higher proportion of deceased with suspected mental illness (33.3% versus 17.9%) or with no evidence of mental ill health (51.9% versus 15.5%).*

[24] Jamieson A, *Finding into death of Zhikai Liu without inquest*, Coroners Court of Victoria, reference COR 2016 001035, delivered 10 January 2019; Jamieson A, *Finding into death of Nguyen Pham Dinh Le without inquest*, Coroners Court of Victoria, reference COR 2018 00622, delivered 13 January 2021.

> *These differences were reflected in the CPU analysis of most recent health service contacts for reasons relating to mental health […]. Among the international student suicide cohort, 22.2% attended a health service for mental health related issues within six weeks of death. In contrast, 57.1 % of the Australian-born student suicide cohort had attended a health service for reasons relating to mental health within six weeks of death.*
>
> *The CPU further reviewed the available Coronial material and noted that among international students who did not have a formal diagnosis of mental ill health, there was often evidence that friends and/or family members were concerned about the student's behaviour and deteriorating mental state in the period leading up to suicide. This suggests that the lower incidence of diagnosed mental illness in the international student cohort may be due to lack of engagement with the Australian health system (a diagnosis must be given by a health practitioner) rather than reflecting a lower incidence of mental illness as such.* [25]

34. Considering this analysis in the light of Zhikai Liu's death, Coroner Jamieson commented:

> *While I am unable to conclude that Zhikai Liu would still be alive if he had engaged with a health service to treat his deteriorating mental state, at the very least this would have created prevention opportunities that did not otherwise exist. Further to this point, the extant literature on international student mental health suggests that there is an underlying systemic issue with engaging international students in mental health treatment in Australia. Published studies have repeatedly found that international students in Australia experience a range of stressors impacting on their mental health, and they are less likely than domestic students to seek assistance for mental health issues because of cultural and financial and linguistic and other hurdles.*
>
> *I acknowledge that greater international student engagement with mental health services is a goal far easier articulated than achieved. Researchers have long identified cultural, linguistic, financial and other barriers to such engagement, and I do not have the evidence before me to make any specific recommendations about how to overcome these barriers.*[26]

35. These comments resonate strongly with my own experience investigating the deaths of the five international students including AHT during 2020. In reflecting on the circumstances of the five deaths, I have not developed any clear insights into how help-seeking among

[25] Jamieson A, *Finding into death of Zhikai Liu without inquest*, Coroners Court of Victoria, reference COR 2016 001035, delivered 10 January 2019, p16.

[26] Jamieson A, *Finding into death of Zhikai Liu without inquest*, Coroners Court of Victoria, reference COR 2016 001035, delivered 10 January 2019, p6.

international students might be promoted, and I suspect a coronial investigation may not be the most suitable mechanism to explore this.

36. At the early stage of my investigation into these five suicides, when I was still gathering evidence and considering how to approach the issues, I commissioned Orygen[27] to prepare resources including a list of questions to ask universities about their health and wellbeing services, and an evidence-based Quality Evaluation Framework to assist me in understanding what types of policies and programs should be in place across universities to support international students. My initial intention was to use the Framework to assess the design and delivery of university services that the international students came into contact with prior to their deaths, so I could identify potential gaps to be addressed. As the investigations unfolded and the lack of engagement between the students and their respective universities' services became clearer, I came to realise that this type of assessment would not generate the insights I was seeking. However, I believe the Quality Evaluation Framework may still have utility for international student prevention.

37. Orygen developed the Quality Evaluation Framework after a comprehensive review of research on university student and international student health and wellbeing, as well as suicide prevention and mental health promotion in tertiary education settings. The Quality Evaluation Framework identifies ten areas (five university-wide, five specific to international students) where universities are recommended to review their policies, guidelines and practices. The areas include mental health, suicide prevention and postvention, staff training in mental health and suicide awareness, initial orientation for international students, ongoing support for international students, and access to mental health services. In each area, the Quality Evaluation Framework describes minimum expectations that should be met, as well as best practice to aim towards.

38. I found the Quality Evaluation Framework to be an extremely helpful tool orienting me to elements and features I should be looking for when I reviewed the material that the universities provided to assist my investigations. I consider, therefore, that universities might also find the Quality Evaluation Framework to be a useful tool for developing and reviewing how they support the health and wellbeing of international students.

[27] Orygen is a not-for-profit mental health service and research institute dedicated to youth mental health.

39. I am grateful to Orygen and the CPU for their exceptional assistance in these investigations and the valuable insights they have contributed.

FINDINGS AND CONCLUSION

40. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was AHT , born 02 March 1996;

    b) the death occurred on 17 March 2020 at [redacted] La Trobe Street, Melbourne, Victoria, 3000, from INJURIES SUSTAINED IN A FALL FROM A 15TH FLOOR APARTMENT; and

    c) the death occurred in the circumstances described above.

41. Having considered all of the circumstances, I am satisfied that AHT intentionally took his own life.

RECOMMENDATIONS

42. Delivering her finding in the death of Nguyen Dinh Pham Le on 13 January 2021, Coroner Jamieson made the following recommendation:

> *(i) With the aim of promoting public health and safety and preventing like deaths, I recommend that the Victorian Department of Health and Human Services takes on the role of leading and coordinating efforts to support mental health and wellbeing of international students studying in Victoria, and to ensure international students can access mental health treatment.*

43. Professor Euan Wallace, the Secretary for the Department of Health, indicated in his response dated 6 April 2021 that the Department would convene a taskforce to discuss the findings and consider the key themes raised by Coroner Jamieson's investigation. Professor Wallace further noted that the Department was establishing a new Suicide Prevention and Response Office, and that international students would fall within the scope of the Office's remit.

44. In this context, I intend to provide a copy of the Orygen Quality Evaluation Framework to the Suicide Prevention and Response Office at the Victorian Department of Health.

Pursuant to section 72(2) of the Act, I make the following recommendations:

> (i) I recommend that the Suicide Prevention and Response Office review the Orygen Quality Evaluation Framework (attached as **Appendix A**) in the context of this finding and its other work relating to international students, and consider whether a resource

such as the Quality Evaluation Framework would assist universities to assess and review how they support international student health and wellbeing.

(ii) I recommend that the Victorian Department of Health consider developing and maintaining a resource of this type to assist Victorian universities in implementing and reviewing their programs targeted at international student wellbeing. The resource could be regularly revised in collaboration with the universities to share new research, program design and ideas for monitoring international student wellbeing and encouraging help-seeking among those who may be experiencing mental health crises or suicidality.

I convey my sincere condolences to AHT's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

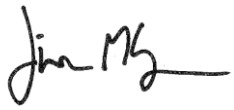
I direct that a copy of this finding be provided to the following:

AHT's parents, Senior Next of Kin

Chris Hewison, RMIT, Critical Incident Response Team Lead

First Constable Isaac Collier, Coroner's Investigator

Signature:



Coroner Simon McGregor

Date : 02 October 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an

investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.

Appendix A

RESPONSE TO THE VICTORIAN CORONER'S OFFICE

INTERNATIONAL STUDENT SUICIDE PREVENTION

OVERVIEW OF SUGGESTED AREAS FOR REVIEW

UNIVERSITY WIDE

1. Mental health policy - Does the institution have a written policy addressing how mental health issues are managed?
2. Suicide prevention policy & postvention guidelines - Does the institution have policies or guidelines for suicide prevention and postvention?
3. Suicide prevention programs - Does the institution have any suicide prevention programs?
4. Staff training related to mental health and/or suicide - Does the university provide mental health or suicide awareness training to staff?
5. Clear and accessible pathway to mental health services for all students - Does the university provide mental health services that can be accessed easily and in a timely manner by all students who need support? Are university staff provided with information on community mental health services, including referral pathways, for students experiencing mental ill-health?

INTERNATIONAL STUDENT SPECIFIC

1. Orientation program for international students - Does the university provide an orientation program to support students upon arrival to Australia?
2. Ongoing support - Does the university provide ongoing support services to international students that address the stressors that may increase risk of suicide?
    a. Key risk factors (e.g. acculturation/academic stress/discrimination etc)
    b. Mental health specifically
3. Risk screening and monitoring - Does the university have risk screening or monitoring processes in place?
4. Staff training policies relevant to international student mental health - Does the university provide staff training that addresses international student mental health?
5. Affordable Mental health service access - Does the university provide free mental health service access or financial aid to international students to access mental health services? Are these services culturally accessible (i.e. are staff trained in cultural awareness and/or are interpreting/liaison supports provided)?

UNIVERSITY WIDE POLICIES AND PROGRAMS

There are a variety of institution wide policies and programs that are relevant to suicide prevention that can be implemented by universities. Although these approaches may not directly address international students, they are often foundational to high quality mental health promotion and the provision of services accessible to all students, including international students.

MENTAL HEALTH POLICY – DOES THE INSTITUTION HAVE A WRITTEN POLICY ADDRESSING HOW MENTAL HEALTH ISSUES ARE MANAGED?

Rationale: Existing evidence shows that demand for university mental health services exceeds capacity, student mental health issues are increasingly complex, and that service delivery is variable across institutions (1). A mental health policy can be used to address such issues (2).

Best practice recommendations: Current best practice recommendations for a mental health policy are 1) that it address mental health promotion, mental illness prevention and the provision of mental health services; 2) implementation should be driven by senior management with input from students, staff across the institution, student associations, and representatives from external services; and 3) that it include a strategy for communicating the policy to staff and students. (2)

SUICIDE SPECIFIC POLICIES – DOES THE INSTITUTION HAVE POLICIES OR GUIDELINES FOR SUICIDE PREVENTION AND POSTVENTION?

Rationale: Policies and guidelines for suicide prevention and postvention are important tools that may reduce the risk of suicide occurring (3, 4). Prevention policies can shape institutional approaches and responses to suicide risk monitoring, prevention efforts, and support services. Postvention guidelines can cover similar elements, but also address the necessary steps after a suicide occurs to minimise distress (4). Postvention guidelines show promise for preventing suicide clusters where a number of individuals take their life after an initial suicide within their community (4, 5). The university should have suicide prevention and postvention policies and/or guidelines available to staff and students within the larger mental health policy or as a set of specific resources. Alternatively, the university may endorse appropriate guidelines provided by other relevant groups such as Universities Australia (6).

Best practice: Regardless of whether the guidelines are developed internally or by an external body, the university should have a clear documented communication strategy in place so that relevant staff and/or students are aware of the policy or guidelines and associated requirements (2, 6). For example, if using the Universities Australia Postvention guidelines, all staff should be made aware of Part A (e.g., the all staff section), while those responsible for responding to a suicide should be made aware of Part B (e.g., the suicide response team section) of the guidelines. If the institution has developed their own policies or guidelines, the document should ideally outline the development process. Key reported procedures in existing guidelines include how existing evidence, best practice approaches, and expert and lived experience consultation was used to inform guideline development (4).

SUICIDE PREVENTION PROGRAMS – DOES THE INSTITUTION HAVE ANY SUICIDE PREVENTION PROGRAMS?

Rationale: A small but growing body of evidence shows that universities can be an effective context for the implementation of suicide prevention interventions that can reduce suicidal ideation and risk of suicide (7).

Best practice: A common framework in suicide prevention classifies interventions as universal, selective or indicated on the basis of target groups (8, 9). Universal interventions target whole populations regardless of risk through increasing access to services, promoting student mental health, limiting means access for suicide, or promoting appropriate reporting through media (10). For example, mental health campaigns for all staff or students fall into this category. Selected interventions target subgroups who may be vulnerable to suicide due to specific or elevated risk factors such as LGBTQ+ individuals (11) and international students (12). For instance, gatekeeper programs are used to train those in contact with vulnerable populations (e.g., staff, student peers,

community leaders etc) to provide them with the skills necessary to assist at risk individuals and refer them to relevant support services. Gatekeeper training is currently the most widely used and researched suicide prevention strategy implemented within universities (7). Indicated interventions target those already displaying suicidal or self-harm behaviour through linking individuals into relevant support services such as mental health providers. For example, students identified as experiencing suicidal ideation can receive a clinical intervention such as cognitive behavioural therapy (3). This framework may be helpful when reviewing policies and programs at the university by allowing for a clear assessment of each of the different approaches:

Assessing Universal approaches) does the university have any universal suicide prevention programs or policies? (E.g., Mental health promotion campaigns, suicide awareness programs, limitations of means access policy etc.)

Assessing Selective approaches) Does the university have policies or programs to support at risk groups? (E.g., Gatekeeper training, specific support services for at risk groups etc.)

Assessing Indicated approaches) Does the university have processes in place to identify those at risk and/or provide support pathways for individuals who indicate suicide risk or self-harm behaviours? (E.g., Decreased class attendance monitoring, graduate supervisor training to identify suicide risk, etc.)

STAFF TRAINING RELATED TO MENTAL HEALTH AND/OR SUICIDE – DOES THE UNIVERSITY PROVIDE MENTAL HEALTH OR SUICIDE AWARENESS TRAINING TO STAFF?

Rationale: University staff regularly come into contact with students facing mental ill-health and are well placed to identify potential suicide risk in this group (13). However, staff often lack the skills and confidence to discuss mental health issues or suicide with students (13). Programs such as gatekeeper training or other mental health training can be used to improve staff confidence and skills relevant to supporting student mental health and suicide risk (7, 14, 15).

Best practice: It is important to consider the different staff groups who receive training and their specific needs. For example, academic staff may require training that clarifies their responsibilities related to student mental health, in combination with general capacity building related to identifying and referring on suicide (13). In contrast, staff employed in by the university counselling service may need more targeted training such as methods of safety planning that can be used with at risk individuals (15). Identifying the specific staff training and development pathways for different staff groups may facilitate a clearer picture of any existing gaps in the available training across the organisation.

CLEAR AND ACCESSIBLE PATHWAY TO MENTAL HEALTH SERVICES FOR ALL STUDENTS – DOES THE UNIVERSITY PROVIDE MENTAL HEALTH SERVICES THAT CAN BE ACCESSED EASILY AND IN A TIMELY MANNER BY STUDENTS?

Rationale: Accessible mental health services play a vital role in supporting student mental health by providing therapeutic care and referrals to other relevant health services (14). Existing evidence shows therapeutic care is an effective method for reducing suicidal ideation and suicide attempts (16). However, university mental health services tend to face greater demand than they can effectively manage, which may lead to long wait times for access or service rationing (14, 17).

Best practice: Current Best Practice Guidelines for the Provision of Counselling Services in the Post-Secondary Education Sectors of Australia and New Zealand recommend a student to staff ratio of 1

counsellor per 1000 students. Although current evidence suggests this is rarely the case across the sector with recent reported ratios of 1 staff member to anywhere between 3000-12000 students (17).

INTERNATIONAL STUDENT SPECIFIC POLICIES AND PROGRAMS

International students face a unique set of stressors (e.g., financial, language, cultural, discrimination, etc.) (18-20) that can negatively impact mental health (20), increase suicidal ideation (12, 21, 22), and even lead to death by suicide (23, 24). Complicating matters, international students can face specific barriers such as lower mental health literacy and help-seeking intentions that can reduce engagement with support services, especially for suicidal ideation (25, 26). This combination of factors may increase the risk of death by suicide for those who could otherwise receive help (24). Prevention strategies and programs need to account for the unique stressors and barriers to reduce suicide risk in this group (12, 26). Only a small amount of research has directly addressed suicide prevention in international students (7). However, a variety of research, interventions and best practice recommendations have been developed that aim to support international students adapt and manage stressors associated with living and studying in another country (12, 19, 27-32). These strategies can be used to address the stressors and barriers that may increase the risk of suicide. Additionally, research addressing suicide prevention in other migrant communities has identified key areas that should be of focus including acculturation issues, stigma related to help-seeking, and the need for creating supportive communities (33). The combination of this research is used to guide the following suggestions.

ORIENTATION PROGRAM FOR INTERNATIONAL STUDENTS – DOES THE UNIVERSITY PROVIDE PRE-DEPARTURE TRAINING OR AN ORIENTATION PROGRAM TO SUPPORT STUDENTS UPON ARRIVAL TO AUSTRALIA?

Rationale: Orientation programs are important tools that can be used to help students understand the local culture, address early acculturation issues, and promote mental health services, while reducing stigma related to service access (34, 35). Pre-departure training on the host country culture and university systems can also be beneficial for addressing initial adjustment challenges (36). Such programs can decrease stress associated with adapting to a new country, increase awareness and engagement with health services, and help students form connections with their peers (32).

Best practice: Pre-departure programs should prepare students for life in Australia and the challenges that they may face while in country (37). Orientation programs should seek to address any potential misunderstandings (e.g., when to seek support, fear of repercussions, available services, etc.) and stigma related to mental health service access, as students can be reticent to access services due to mental health stigma and visa concerns (28, 37).

ONGOING SUPPORT – DOES THE UNIVERSITY PROVIDE ONGOING SUPPORT SERVICES ADAPTED TO INTERNATIONAL STUDENTS THAT ADDRESS THE STRESSORS THAT MAY INCREASE RISK OF SUICIDE?

Rationale: Students can face a variety of stressors throughout their time studying in Australia (28, 38). Common stressors for international students include academic stress, financial hardship, experiences of discrimination, language issues, and feelings of loneliness (19, 20, 39). Such stressors can lead to poor mental health (39) and have been identified as risk and contributing factors to suicide deaths of international students (23, 24, 40). Universities can provide ongoing support services that can help students manage such stressors (34). For example, buddy programs are widely used to help international students build connections with local students (34). Similarly, academic support services can help students manage stress associated with academic work or language issues (34). Universities

are also well placed to monitor academic related stress. For example, an emerging field of research has demonstrated that digital technologies can be used to identify students who are potentially at risk of academic failure and notify relevant staff (41). Students who are at risk of failure can then be referred to appropriate academic support services.

Best practice: Culturally competent health services may improve outcomes for migrants accessing services (42). Current evidence indicates that providing written materials or services in the native language of migrants can improve outcomes (42). Additionally, training in symptom recognition for common mental health diagnoses may increase engagement with services, as evidence suggests that international students may not recognise they have a problem until they reach a crisis point (37). Employment of dedicated international student support staff, and especially those who speak the native languages of common international groups, may facilitate the most culturally appropriate support services (34).

RISK SCREENING AND MONITORING – DOES THE UNIVERSITY HAVE SUICIDE RISK SCREENING OR MONITORING PROCESSES IN PLACE?

Rationale: Risk screening tools are important for identifying potential suicide risk that may otherwise be missed. This may be especially important for international students because evidence suggests that they are less likely to engage with services before a suicide attempt (43). A number of tools can be used by universities to identify potential risk and opportunities engage students with relevant support services. These include the reporting of mental health issues on intake, monitoring of class attendance, and ongoing check-in surveys (32).

Best practice: A comprehensive approach that involves both initial and ongoing screening for mental health issues and the regular monitoring of other relevant predictors such as class attendance will have the greatest potential to identify suicide risk.

STAFF TRAINING POLICIES RELEVANT TO INTERNATIONAL STUDENT MENTAL HEALTH CONCERNS – DOES THE UNIVERSITY PROVIDE STAFF TRAINING THAT ADDRESSES INTERNATIONAL STUDENT MENTAL HEALTH?

Rationale: Training that provides staff with an understanding of specific stressors and risk factors for international student mental health may help staff better support international student needs (32, 34). Similar to the general staff training, clarifying staff roles related to international student mental health should be part of the training (32, 34).

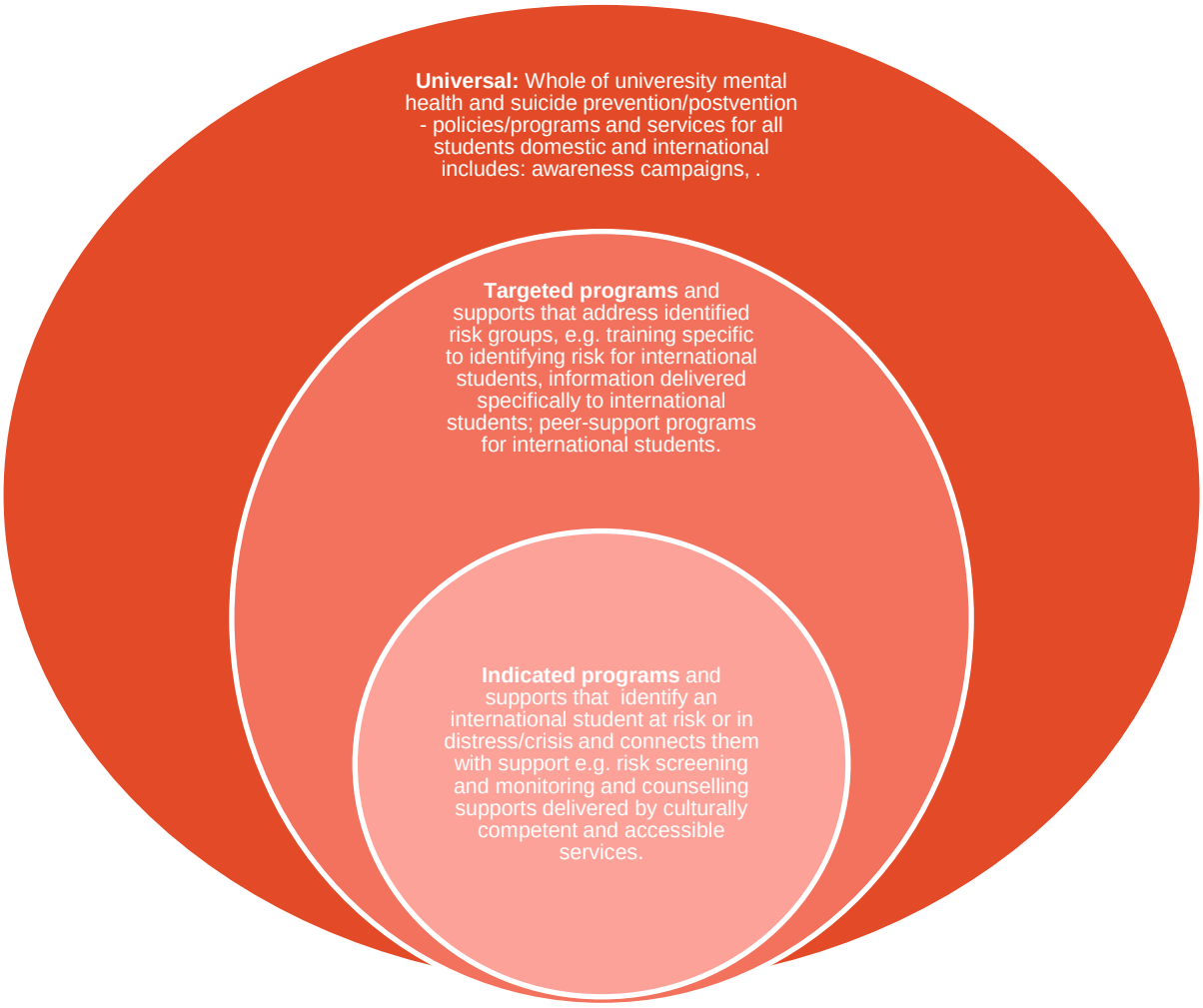
Best practice: Training should seek to provide staff with the capacity to deliver culturally appropriate responses to international students (34). Ideally, training should be developed through co-design processes with international students (34).

AFFORDABLE MENTAL HEALTH SERVICE ACCESS – DOES THE UNIVERSITY PROVIDE FREE MENTAL HEALTH SERVICE ACCESS OR FINANCIAL AID TO INTERNATIONAL STUDENTS TO ACCESS MENTAL HEALTH SERVICES?

Rationale: International students are often under financial strain, which can reduce willingness to access fee paying mental health services (44). Providing free services or financial aid to international students for mental health services may reduce this barrier to access (44).

Best practice: Current best practice recommendations suggest that promotion of available mental health services for international students should occur on a regular basis, as this group report poor levels of awareness of available services (35). Ideally, students should also have a single point of contact that can help them navigate the available options and find the appropriate service to make sure they don't slip through the cracks (37). *Unfortunately, most university health services only provide short term support, and are ill-equipped to manage more complex cases (37). This means that students may need to seek help external to the university. However, few free or cheap external services provide long term support to international students, and this may increase the risk of suicide in this cohort due to the financial barriers.*

LEVELS OF ACTION/RESPONSE USING A SUICIDE PREVENTION FRAMEWORK



AREA FOR REVIEW	MINIMUM EXPECTATION	TOWARD BEST PRACTICE	SUPPLEMENTARY QUESTIONS
UNIVERSITY WIDE			
Mental health policy - Does the institution have a written policy addressing how mental health issues are managed?	Policy describes aims, objectives, rationale and high level activities to respond to mental health issues and support wellbeing. The policy spans mental health promotion, prevention, early identification of risk and responses for mental ill-health.	Policy PLUS implementation and action plan to accompany policy with timeframes, deliverables and responsibilities described. Endorsed/approved and supported by university leadership including VC.	How is the policy communicated and promoted to all members of the university community including staff, students, services? Are there dedicated resources allocated to delivering the policy? Has the policy/will the policy be evaluated? How often is the policy reviewed? What type of stakeholders (internal/external) are involved in the review process?
Suicide prevention policy & postvention guidelines - Does the institution have policies or guidelines for suicide prevention and postvention?	Suicide Prevention Policy/Guidelines describes aims, objectives, rationale and high level activities to respond to: • preventing suicide and suicide related behaviours (including addressing risk factors) • responding to suicide related behaviours (including ideation and attempts) • postvention responses to a completed suicide.	Policy PLUS implementation and action plan to accompany policy with timeframes, deliverables and responsibilities described. Endorsed/approved and supported by university leadership including VC.	How is the policy communicated and promoted to all members of the university community including staff, students, services? Are there dedicated resources allocated to delivering the policy? Has the policy/will the policy be evaluated? How often is the policy reviewed? What type of stakeholders (internal/external) are involved in the review process?
Suicide prevention programs - Does the institution have any suicide prevention programs?	Mental health promotion, campaigns and suicide awareness programs to assist students and staff to: • look after their mental health and wellbeing	Provides activities and programs across all of the following: • **Universal approaches** for entire university community (mental health promotion, limitations of means etc).	How are these programs communicated and promoted to all members of the university community (for universal approaches) and to specific cohorts

AREA FOR REVIEW	MINIMUM EXPECTATION	TOWARD BEST PRACTICE	SUPPLEMENTARY QUESTIONS
	• understand the signs if they/or someone else is at risk • know about university and community based services/supports that are available.	• **Selective approaches** targeted at risk groups of students, e.g. specific services for students with mental health conditions. • **Indicated approaches** which actively identify individual staff/students who might be at risk either through drop in performance, drop in attendance, suicide related behaviours.	(targeted) or individual students and staff (indicated)? How are the programs delivered chosen? Are they evidence-based? How are they resourced and who is responsible for their delivery? How often are the programs run? Have the programs been evaluated? Are student focused programs co-produced and/or delivered by students.
Staff training related to mental health and/or suicide - Does the university provide mental health or suicide awareness training to staff?	Support services staff receive appropriate and ongoing professional development and training in relation to mental health conditions and suicide risk. Training is made available to all staff who are interested at no cost on: • Communicating with students about mental health issues or suicide risk. • Responding to disclosure. • Designing curriculum to mitigate against unnecessary stress. • Making adjustments for a student with a mental illness. • Responding to a mental health crisis.	All staff **and students** are provided mental health literacy or suicide awareness training as a core learning module. Training is tailored to specific groups, e.g. academic staff, different to student support staff. Specific training is provided to support staff on working with diverse student population groups, including CALD, Aboriginal and Torres Strait Islander students, LGBTIQA+ and students with disabilities.	How is the training resourced and who is responsible for their delivery? Is the training available to all staff (and students) or only available to identified staff or only available if the faculty/staff member agrees to pay cost? How often is the training delivered during an academic year? Has the training been evaluated? Is the training delivered or co-delivered by trainers with lived experience of mental ill-health? Is the training flexible and/or adaptable to suit a range of learning styles and audiences?
Clear and accessible pathway to mental health services for all students - Does the university provide mental health services that can be accessed easily and in a timely manner by students?	Students are supported to navigate mental health services: • Services and supports (both on and off campus) are promoted to students. • On campus services and supports are free and accessible	• A coordinated approach to providing support both on and off campus which can assist with navigating services in order to meet students' needs. • Services and supports respond to complexities among **specific**	How are services promoted to students and are they promoted more at certain times of the year, if so, when year? How does the university monitor service use and evaluate service provision and outcomes?

AREA FOR REVIEW	MINIMUM EXPECTATION	TOWARD BEST PRACTICE	SUPPLEMENTARY QUESTIONS
	both face to face and digital services. • Targeted strategies and outreach programs that support **early detection** and intervention for students experiencing mental health issues. • Clear processes and procedures for supporting a student in significant distress or crisis.	**cohorts** of students at increased risk of mental ill-health. • Clear relationships/agreements are in place with community based mental health services. • Services and supports are co-designed with lived experience.	What is the counsellor to student ratio in the university student support services? What are the average wait times for student services provided directly by the university during the academic year?
INTERNATIONAL STUDENT SPECIFIC			
Orientation program for international students - Does the university provide an orientation program to support students upon arrival to Australia?	International students are required to participate in an information session specifically on mental health and wellbeing during orientation with specific focus on: • Destigmatising mental health issues and addressing reluctance in help-seeking behaviours. • Information on what to do if you or someone you know is struggling. • Service access and contact information. • Information on privacy and confidentiality of sharing personal/health information with education providers.	Mental health and wellbeing information provided to students (as per minimum expectation) is also: • Co-designed with other international students. • Available in languages other than English. • Followed up and re-provided at other times across the course of their studies. • Clear guidelines on how mental health disclosure is managed by universities and health providers in Australia.	At what point in the pre-departure/orientation process does the university provide international students with mental health related information? In what format is that information provided? Are all students provided this information?
Ongoing support - Does the university provide ongoing support services to international students that address the stressors that may increase risk of suicide?	Provision of support and services to international students which respond to stressors they may experience, including (but not limited to): • financial stress, • discrimination,	Culturally competent services which includes cultural competency training and access to tools for student services and support staff. Engagement of specific international student support/wellbeing staff.	Which area of the university is responsible for developing and delivering supports that respond to international student stressors and/or needs? Does the university maintain a working list of interpreters; ethnic community organisations and religious

AREA FOR REVIEW	MINIMUM EXPECTATION	TOWARD BEST PRACTICE	SUPPLEMENTARY QUESTIONS
• **Key risk factors (e.g. acculturation/academic stress/discrimination etc)** • **Mental health specifically**	• academic and • cultural stress. Provision of peer supports and networking/social connection programs for international students (with each other and with domestic student and other community members)	Translators/translation of information into languages other than English are made available for international students. Relationships with professionals and organisations that can assist with complexities that are arising because of the diversity of linguistic, cultural or ethnic background of International students.	organisations/services to support culturally appropriate responses?
Risk screening and monitoring - Does the university have risk screening or monitoring processes in place?	Standard process for university to provide opportunity to disclose any existing mental health issue(s) on Enrolment Forms. Should be clear that this information will only be used to connect students with appropriate support services if need identified and no other purpose. Standard process for staff who have identified a drop in academic performance or class attendance/engagement to connect to student services for follow up. Simple reporting processes outside of staff including housemates, other students and friends. There should be clear and simple ways for these people to advise responsible staff of their concern.	A comprehensive approach that involves both initial and ongoing screening for mental health issues (including an online check-in survey) and the regular monitoring of other relevant predictors such as class attendance. Where education is delivered online, teaching and/or student support staff proactive check-in with students periodically during the semester.	How are these processes monitored and reviewed? How are these processes communicated to staff and students? Are online systems/data on academic performance and attendance linked with student services/supports to identify and respond to emerging issues? How are staff supported to manage disclosures of mental ill-health? Do they have adequate time and resourcing to identify and respond to risk?
Staff training policies relevant to international student mental health - Does the university provide staff training that addresses international student mental health?	All staff provided information, resources and training (if resourced to deliver and attend) which focuses on the specific stressors for international students, stigma relating to mental health issues and communication strategies to discuss these issues with international students.	Training on culturally appropriate responses to international students related to suicide prevention, mental health and wellbeing. Ideally, training should be developed through co-design processes with international students.	Which area of the university is responsible for developing, contracting and/or delivering this training? How is the training promoted? How often is the training provided and at what time of the year? Is the training evaluated?

AREA FOR REVIEW	MINIMUM EXPECTATION	TOWARD BEST PRACTICE	SUPPLEMENTARY QUESTIONS
Affordable Mental health service access - Does the university provide free mental health service access or financial aid to international students to access mental health services?	Promotion and provision of financial counselling and support services for international students on a regular basis. Promotion and provision of free university support services which deliver mental health supports. Promotion of Overseas Student Health Cover (OSHC) entitlements and information on how to pay for and access treatment.	Dedicated international student wellbeing/support service or dedicated staff within student services that provides a single point of contact who can then assist with service navigation, referrals and advice on health cover service eligibility and costs. Information and promotion of free or low-cost culturally sensitive counselling and support services available in the community.	How are these services promoted to international students? Is financial aid available to address financial barriers to accessing mental health care? Are students services staff trained in cultural awareness and/or are interpreting/liaison supports provided?

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