Preventing Suicide in Higher Education Institutions: Opportunities and Obstacles to Successful Suicide Prevention

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National Context: Youth is peak age of onset for most MH Difficulties

Students are a high risk group for Mental Health difficulties based on AGE
+ other vulnerability factors/stressors
(transition, exam and study demands, external factors eg parental divorce)

Victoria (Aus) Burden of Disease Study: Incident Years Lived with Disability rates per 1000 population by mental disorder
Youth and Student Mental Health Problems, Self Harm and Suicide: A Rising Tide?

• 15 – 24yrs is the peak period for the onset of mental disorders (75%); 1 in 4 young people will experience a mental disorder in any 12 month period.

Consistent rise in incidence of MH problems in students in recent years

• Self harm has peak incidence in young people (females are high risk group with highest rates (APMS 2014) and is a significant, persistent risk factor for future suicide, 50-100x lifetime risk

• Suicide most common cause of death for young people in the UK

• No. of suicides is low in CYP but rises in late teens: 30% females; 70% males (National Confidential Inquiry into Suicide 2016)

Official suicide statistics under-report suicide in the student population, however they still show an increase in student suicide from 97 in 2007 to 163 in 2015 (ONS 2015)
Suicide by Young People in England National Confidential Inquiry into Suicide (May 2016)

Suicide antecedents: 22% bullying, 13% bereaved by suicide, 15% abuse/neglect
  • 53% in education at time of death
  • 15% experiencing academic pressures
  • 27% exams or exam results at time of death

Suicide related internet use: 12% searched for info on suicide method, 9% posted suicidal thoughts, 6% online bullying

Over a third had sought medical help for a physical health condition
54% previous self harm,
27% expressed thoughts of suicide in past week

41% contact with Mental Health services, 43% no known contact with any services
Zero Suicide (ZS)
(Hogan and Goldstein Grumet 2016)

An aspirational goal, mindset, a specific set of suicide prevention (SP) practices:

**Core Values**—belief/commitment that suicide can be eliminated in a population under care…by improving service access and continuous quality improvement.

*Q Do HEIs share these core values?*

**Systems Management**—taking systematic steps with bold but achievable goals to eliminate suicide attempts and deaths among members.

*Q Is suicide prevention a key strategic goal for HEIs?*

**Evidence-based clinical care practice including** engagement and education of patients, families and health care professionals.

*Q Are HEIs following evidence based SP practice?*

HEI’s are ‘Communities of Practice’ with some unique features where ZS could potentially be successfully adapted/applied
Adapting Zero Suicide approach to a HEI setting

• Requires adaptation of the model to be 'fit for purpose' in an educational setting where health care delivery is not its primary function.

• Requires a 'hearts and minds' shift in HEI from anxieties about reputation, recruitment, 'duty of care' and corporate responsibility to an overt focus on 'student suicide' prevention.

How many more publicly profiled student suicides are required for HE institutions to prioritise student suicide prevention as a core responsibility/role for HE?
What might ZS look like within a HEI setting?
(Adapted from Zero Suicide Key Elements identified by Hogan and Goldstein Grumet 2016):

Leadership:
Commitment to and a culture emphasizing suicide prevention as a critical student safety issue, goal setting and action planning using evidence-based approaches to suicide prevention, support for staff who may be in a role supporting students who are self harming/suicidal.

Training
A competent, confident, caring trained workforce with training and intervention skills appropriate to staff roles. Staff who interact with students are aware of signs of suicidality and know the steps they should take.
What might ZS look like within a HEI setting?
(Adapted from Zero Suicide Key Elements identified by Hogan and Goldstein Grumet 2016):

**Suicide Risk Identification**
identifying potential suicide risk among students with speedy referral for assessment by a skilled clinician to evaluate risk/immediate danger and agree a safety/support plan.

**Suicide Care Protocol/Policy**
Structured protocol to guide care for students who are actively suicidal including engagement, regular contact, safety planning, access to specialist treatment and crisis support, steps to reduce access to lethal means.

**Referral Pathways to Enable Timely Access to Evidence-Based Treatment**
Appropriate referral via primary care or direct to crisis support services to facilitate timely access to evidence based treatment and crisis support.
What might ZS look like within a HEI setting?
(Adapted from Zero Suicide Key Elements identified by Hogan and Goldstein Grumet 2016):

**Enable Successful Care Transitions**
Provision of support to enable successful care transitions between the University and health care providers including follow-up support.

**Performance And Quality Improvement Processes**
Student death by suicide routinely recorded and monitored. Student safety reviews provide a 'no blame' review opportunity to enable organizational learning and quality improvement.

**Research and Evaluation**
Developing an understanding of student suicide, adaptation of a Zero Suicide approach in HEIs, robust evaluation of HEI suicide prevention programmes.
What is the potential contribution of HEIs to a wider suicide prevention agenda?

Huge youth mental health literacy/emotional resilience opportunity where 50% of young people currently attend HEIs in the UK

Embedding knowledge and skills in the curriculum to future proof the next workforce generation and support longer term suicide prevention across the lifespan

Research evidence and knowledge contribution through systematic review and robust evaluation of suicide prevention interventions, including Zero Suicide
Suicide prevention planning: Why are partnerships with HEI important?

Access to a large cohort of young people at a key life stage

Collaborative working opportunities across health and education sector interface for young people facing health issues while in education

Education, training, resource development, consultation, involvement opportunities: HEIs are in most major cities, many will have a community outreach agenda

Evidence appraisal and evaluation
What is happening about student suicide in HEI?

• Limited epidemiological evidence or incidence data on student suicide in UK
• Few research studies with a specific focus on student suicide or its antecedents
• Many mental health and wellbeing initiatives in Universities supported by national NGOs (eg Nightline, Student Minds, Students Against Depression, Charlie Waller Memorial Trust, Samaritans, MWBHE, UUK)
• Interventions with high risk student groups such as medical/veterinary students (eg. BMA students)
• Few examples of whole university suicide prevention initiatives: Universities of Worcester, Wolverhampton, York, Bristol, Canterbury.
• Call to action: UUK and MWBHE (2017) ‘Step Change’ targeting HEI Vice Chancellors
University of Worcester ‘Suicide Safer’ Project Project

Working in partnership with stakeholders to develop, implement and evaluate a mental wellbeing and suicide prevention model targeting students/young people to provide a:

• ‘Suicide safer’ University and contribute to a:
  • ‘Suicide safer’ City
  • ‘Suicide safer’ County
Leadership, Context and Scope

- **Dedicated project leadership** supported by a project group (University and partner agencies (PHe, WCC, Health and NGOs) chaired by Pro-VC Students
- **Expertise/experience within the University** and local community
- **University: low suicide incidence but consistent with explicit organisational values** and aligned with other University health/wellbeing and disability/inclusion initiatives
- **Existing work around protecting mental health and well being** and targeted support to high risk groups
- **Community outreach opportunity** to work with local partners to:
  - Raise awareness and take small actions
  - Share and develop existing good practice initiatives
  - Develop collaborative working to impact positively on young people in relation to self harm and suicide.
Three Project Strands

**Strand 1:** **Awareness Raising and Education** of students, staff (embedding MH knowledge and skills into the curriculum) and local partner organisations in relation to understanding, empathy, knowledge and skills contributing to a ‘suicide safer’ HEI environment.

**Strand 2:** **Support for students (and parents) and staff** to maintain wellbeing, information about and availability of early support services, risk identification and support to reduce risk, crisis support services, support for those affected by suicide and suicide survivors.

**Strand 3:** **Research** local audit and data collection, evaluation of project elements and a contribution to the understanding of student suicide and suicide prevention in HE through a programme of research.
Phased implementation Programme

**Phase 1: Building a ‘Suicide Safer’ University:**
- Mental health awareness events
- Peer support initiatives
- Mental health ‘Inspire and Share’ events for academic staff
- Information and skills training, resources and support for students/parents/staff

**Phase 2: Contributing to a ‘Suicide Safer’ City:**
- Support to local partners through sharing information, resources, training, consultation, events participation
- Schools and CAMHS mental health awareness training outreach
- Public Lectures

**Phase 3: Contributing to a ‘Suicide Safer’ County:**
- Suicide audit group
- Research evidence, training, information, resources
- Contributions to local suicide prevention action planning
- Public awareness through media releases, radio interviews, public lectures, campaigns
- Skilling graduate professional health/education/social care workforce
Smith J (2016) Student Mental Health: A new model for Universities
Guardian Higher Education Network (March 2016)
NUS Disabled Students (2016) Mental Health and Suicide Prevention
Guide: An in-depth guide for students' unions and student activists
March 2016 (pg 75)
Smith (2016) Making Hay While the Sun Shines: Promoting Wellbeing
and Emotional Resilience with Hay Festival Goers', 'What Works Centre
for wellbeing' Gov UK website
Public Health England (2016) Local suicide prevention planning A
practice resource November 2016 (pg 22)
UPP and student Minds (2017) Student Living: collaborating to
support mental health in university accommodation. April 2017 (pg
18-19)
Institute for Public Policy Research (2017) Not By Degrees: Improving
student mental health in the UK's universities September 2017 (pg
51, 52 and 59)
Hunt J (2017) Steep Rise in Student Suicides Must Be Tackled Times
Higher Education September 20th 2017

For further information about the UOW Suicide Safer Project email:
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Take home messages...

• Students are a high risk group in most major cities who should be equipped to promote personal/peer mental health and wellbeing, identify mental health problems/self harm early and how to/where to seek help

• Embedding Mental Health Training in the HEI Curriculum offers a ‘critical period’ opportunity for early intervention/prevention across the lifespan and future proofing the next adult workforce

• HEI to be included as a partner to jointly plan and commission ‘fit for purpose’ service access and provision for students who may be temporary residents/in transition.

• HEIs need to be vigilant to ensure timely, effective early detection/intervention for emerging mental health problems and self harm/suicide risk in student/staff community

• HEIs should be active partners contributing to a Countywide HWB Strategy and SP planning and delivery.

Encourage and support a ‘Zero Suicide’ Mindset In HEIs to reduce student suicide
County Context for Suicide Prevention

- Dr Frances Howie,
- Director of Public Health,
- Worcestershire County Council
Focus on the system wide enablers for strong local initiatives such as this excellent University programme:

- Two key policies: the Health and Well-being Strategy; and the Sustainability and Transformation Plan (STP)
- Building a community of interest around mental health and well-being
- Sharing an ambition on prevention
- Together, building a social movement.
Health and Well-being Strategy

• The County Council has a statutory duty to produce a Health and Well-being Strategy, setting priorities for local, system wide, work to improve health and well-being and narrow health inequalities;

• We consulted widely on the method for selecting priorities, and on the priorities themselves. We used on-line surveys, local workshops, and focus groups;

• Our priorities were selected because they are:
  • linked to a high and avoidable burden of disease;
  • have a clear evidence base about what needs to be different to bring about improvement;
  • and because better partnership working was required to bring about change;

• **Improving mental health and well-being was identified as one of 3 priorities for the County**
Health and Well-being Strategy: prevention:

• The Strategy also committed to making sure that there was a focus on prevention in all the work which came from the priority area.
• We described what we meant by prevention:
  • Creating a health promoting environment, making sure that the places where people live and work drive healthy choices;
  • Encouraging and enabling people to take responsibility for themselves, their families, and their communities;
  • Providing clear information and advice across the age-range;
  • Commissioning prevention services based on evidence of effectiveness and within the funding available;
  • Gate-keeping services so they are targeted at those who need them most.
• The HEI initiative delivers against all these types of prevention.
Health and Well-being Strategy, from policy to action

- An action group was formed around each of the Health and Well-being priorities, to draw up an action plan, and work out how we could work better together, with a shared understanding of what to do, and some strong commitment to delivery

- We already had a lot of great small scale work and we were able to draw on this and create stronger partnerships – our community of interest, building up a social movement around mental health

- We included health and social care professionals, recovery workers, VCS workers, professional networks, people with lived experience, education sector partners

- We drew up our over-arching plan:
**Vision:** Worcestershire residents are healthier, live longer and have a better quality of life especially those communities and groups with the poorest health outcomes

**We will focus on:** building resilience and improving lifestyles to improve mental well-being and reduce the risk of dementia, particularly within;

**To do this we will:** work in partnership to develop local solutions, using national frameworks and best practice which encourages and empowers people of all ages to;
Second policy driver: STP: a new commitment to prevention

- The NHS required every area to produce an STP by 2017. These plans had to set out how the local area was going to: improve health and well-being outcomes; improve the quality of services; and narrow the ‘financial affordability gap’, making the NHS sustainable in the longer term.
- Extensive consultation took place about our STP, with thousands of our residents taking part in online surveys, paper surveys, public meetings, and focus groups.
- One of the strongest themes from our public engagement exercise was about prevention. People wanted the NHS to shift its attention upstream, and renew its efforts to prevent problems from happening, and to act swiftly to contain problems when they did happen.
STP: shaping prevention

- The STP identified four key prevention initiatives, to be embedded right across the system, including within the mental health programme:
  - social prescribing (making sure we do not medicalise problems unnecessarily),
  - digital inclusion (making sure everyone can access on-line services, recognising some will need assistance);
  - front-line staff training (Making Every Contact Count in motivating people to live healthily);
  - behaviour change programmes (specific, effective, help targetted at those who need it most.)
So...

- The Health and Well-being Strategy and the STP gave a very strong context for:
- Prioritising mental health and well-being
- Prioritising prevention, with one element of that being to build health promoting settings.
- These two policy drivers take us straight to our local work on suicide prevention: with a system wide approach making sure that problems are prevented if possible and, if they do emerge, they are found early and the right level of help is accessed fast.
Suicides in Worcestershire: Public health approach.

• The stories from some survivors have had high media interest: a mother who lost her promising young son and who spoke publicly about the role she saw cyber bullying as having played in his life; a widow whose husband fell from a footbridge where others had fallen too
• But these were not the only stories and not the whole picture
• We wanted to get a shared understanding across the County on what the key facts are about suicide locally, and how we can best tackle it
So...what did the numbers tell us?

• Suicide numbers are the same or below the national average. About one person a week takes their own life in Worcestershire.
• Every week, every year, for the last 10 years.
• Leaving incalculable numbers of others who are deeply affected by the death for the rest of their lives.
The picture in Worcestershire is similar to the national picture. Over a 10 year period:

- Men were 3 times more likely than women to take their own lives
- Redditch Borough Council residents consistently have a higher suicide rate than England (although this is not always statistically significant.)
- Residents aged 25-44 have the highest suicide mortality rate.
- People in least affluent areas of Worcestershire are twice as likely to die by suicide than those living in the most affluent areas.
- Highest numbers of deaths over the period occurred in the skilled trades occupation, although in latter years both the process, plant and machine operatives group and the elementary occupations group have shown considerable increases.
- A notable number of suicides occur in the two prisons in Worcestershire
- The most common method is hanging which accounts for half of the suicides.
Improving mental health and well-being and preventing suicide

• We put on workshops; held meetings with key professionals; met and spoke with some bereaved families; and we developed our County suicide prevention plan
• We built on and further developed a community of interest, taking part in a social movement
• We see suicide as an avoidable health outcome to be approached in the same way as any other cause of early death – identify the risks and reduce them
• And we have come to see zero suicide as the only acceptable target or ambition.
Take home messages on contextual enablers to the HEI initiative:

• We created a system wide focus on mental health and on prevention, articulated through local policy;
• We built a community of interest around mental health and well-being and suicide prevention, involving partners and voices from across NHS, Councils, University, VCS, and lived experience;
• We are keeping up the momentum of building a social movement, which aims to recognise and meet the challenges of a zero suicide ambition.