A whole campus approach to suicide prevention and intervention

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Keeping you safe

- Discussing suicide can evoke painful memories for those who have lost someone close to them through suicide, or if you have experienced suicidal ideation or attempts
- If you get distressed by the content of this presentation, or discussions that take place within it, please do take some time out from the session
- Speak to me afterwards if you want to refocus your thoughts
- Additionally, the Samaritans are available 24/7 on the following free phone number **116 123**

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- Created in 2007 through merger of several colleges of higher and further education (although only providing HE courses now)
- Approximately 10,000 students and 1000 staff
- Allied healthcare, teacher training, arts, sports science, and STEM subject
- 5 campuses (2 x Carlisle, 1 x Lancaster, 1 x Ambleside, 1 x London)
- 1.3FTE Psychological Therapists
- 0.6FTE trainee counsellors and psychotherapists

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Question

- What approaches to behaviour management do you have on your campus?

Behavioral Intervention Team

- Are a 2nd generation campus based team that have evolved from the "Student of Concern" meeting model
- BITs are formal membership based team, that meet regularly, and have standardised operating protocols
- They are pro-active not reactive
- Have a single point of access for staff, students, and community to raise concerns
- Often have a designated caseworker assigned to the team
- Regardless of acronym, the philosophy that underpins the team is to empower early intervention within a culture of caring and reporting on campus

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U missing is intentional

NaBITA – The National Behavioral Intervention Team Association

- NaBITA brings together professionals from multiple disciplines who are engaged in the essential function of behavioral intervention in schools, on college campuses, and in corporations and organizations for mutual support and shared learning.
- Whether it is to combat bullying, prevent violence, support individuals with disabilities, empower the success of those suffering from mental health challenges, or assist those who are in crisis, their members are joined in common purpose and exploration of best practices.
- NaBITA is an independent, not-for-profit association incorporated. It has more than 2800 active members from colleges, universities, schools and workplaces across North America.

U missing is intentional

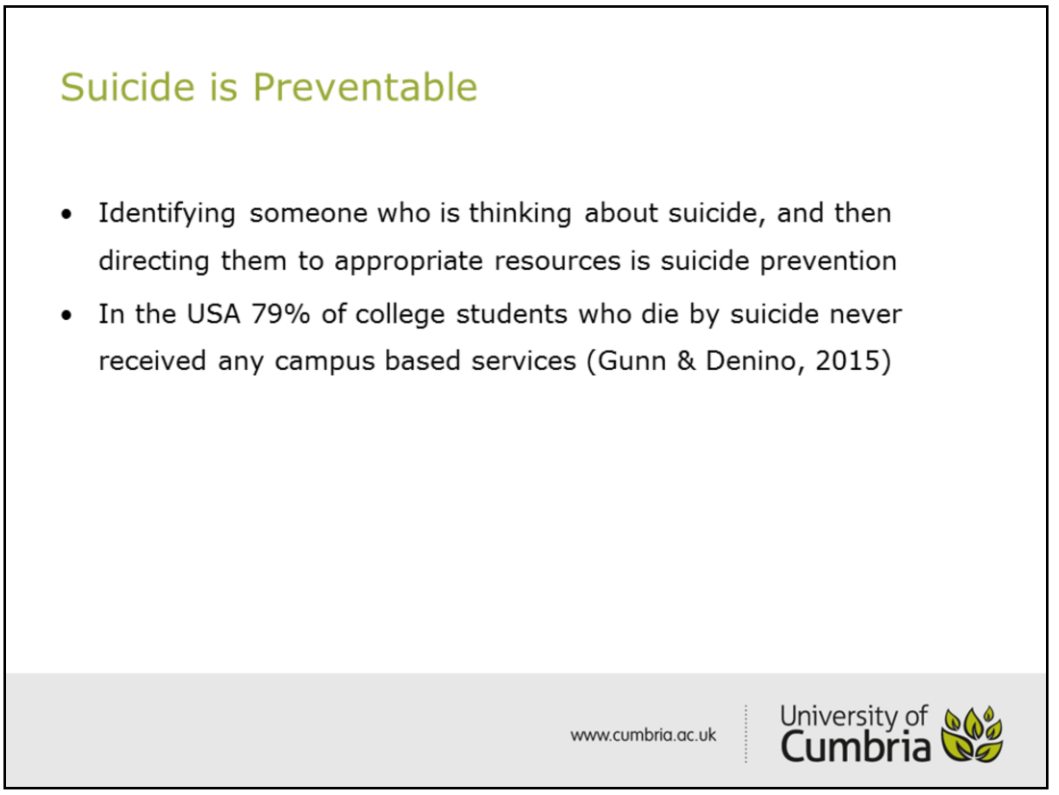
Suicide - Prevalence

- The World Health Organisation (WHO, 2016) state that globally, a suicide takes place every 40 seconds. It is the 15th most common cause of death worldwide
- Surveys carried out in the USA, state that 16.5% of students have thought about ending their own life (Drum *et al*, 2009).
- In the USA, suicide is the 2nd leading cause of death for students (after accidents). Suicide kills more students than all other medical illnesses combined (National Data on Campus Suicide, 2015)
- Two thirds of students struggling with symptoms of depression do not seek support (Center for Collegiate Mental Health, 2015)

Suicide - Prevalence

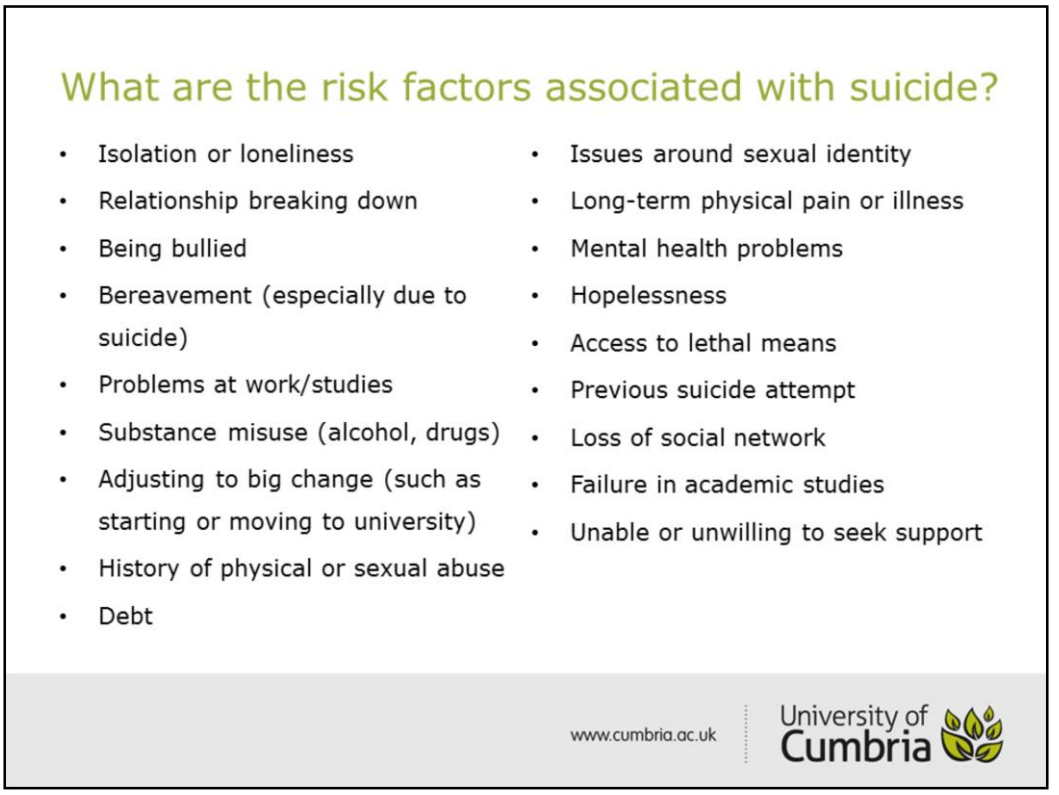
- In one NUS study (Kerr, 2013) stated that 13% of students surveyed had suicidal thoughts during their studies, this figure increased to 33%* in 2015 (Gil, 2015)
- Around 18% of students who refer to the University of Cumbria's Psychological Wellbeing Service indicate they have suicidal thoughts
- In 2012, 112 UK students took their own life. In 2014 (the most recent statistics) the number of UK students who took their own life rose to 130 – the figure is likely to be higher (ONS, 2016).

The NUS studies have to be taken with a pinch of salt as the questions are quite vague, and it's very easy to "self-diagnose"

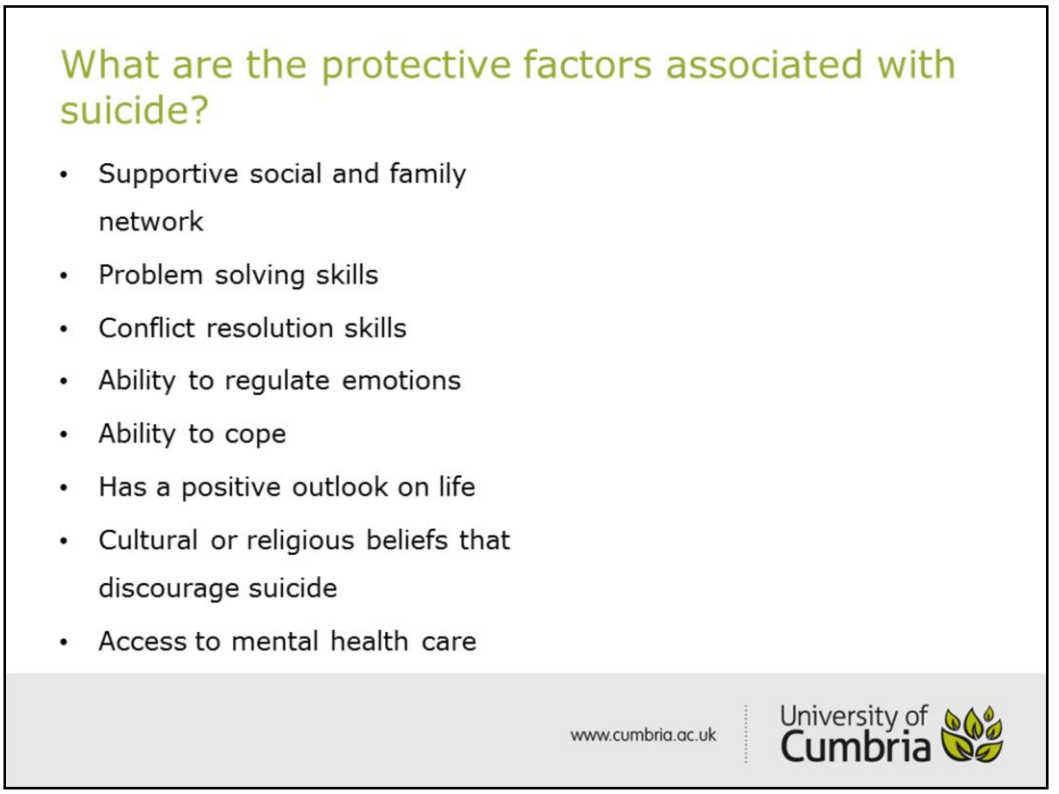


If the USA is anything to go by – we need more than just campus counsellors to be identifying and supporting distressed students!

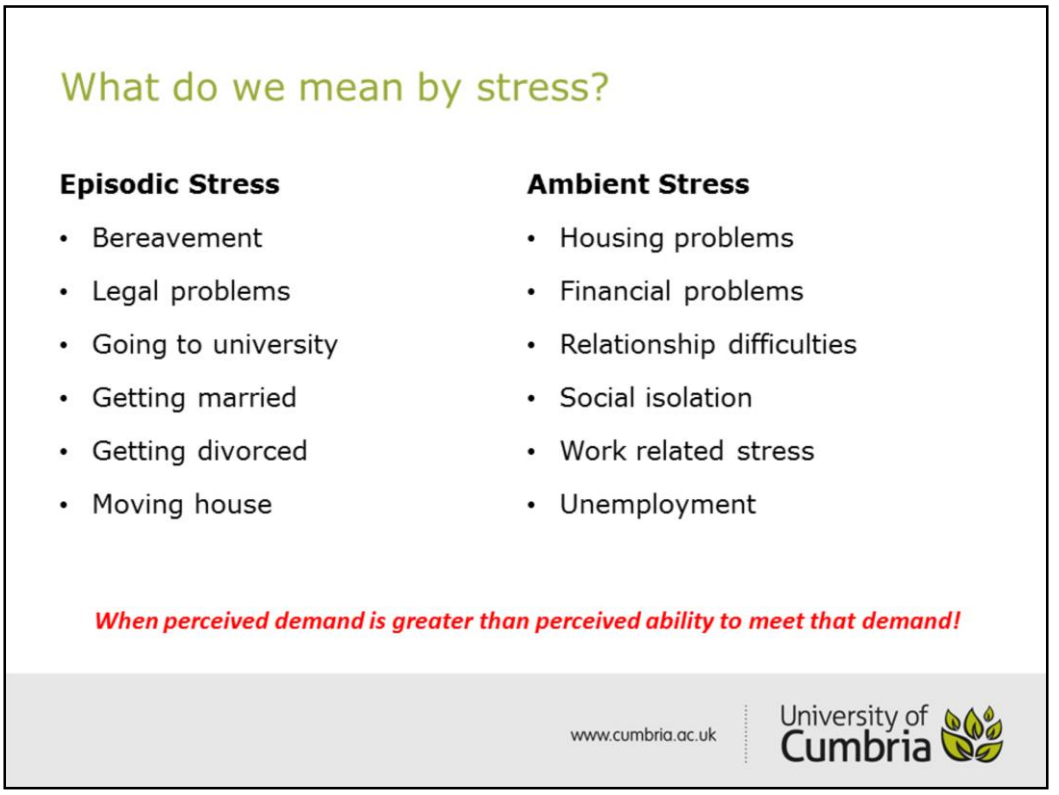
"I jumped off the Golden Gate Bridge"



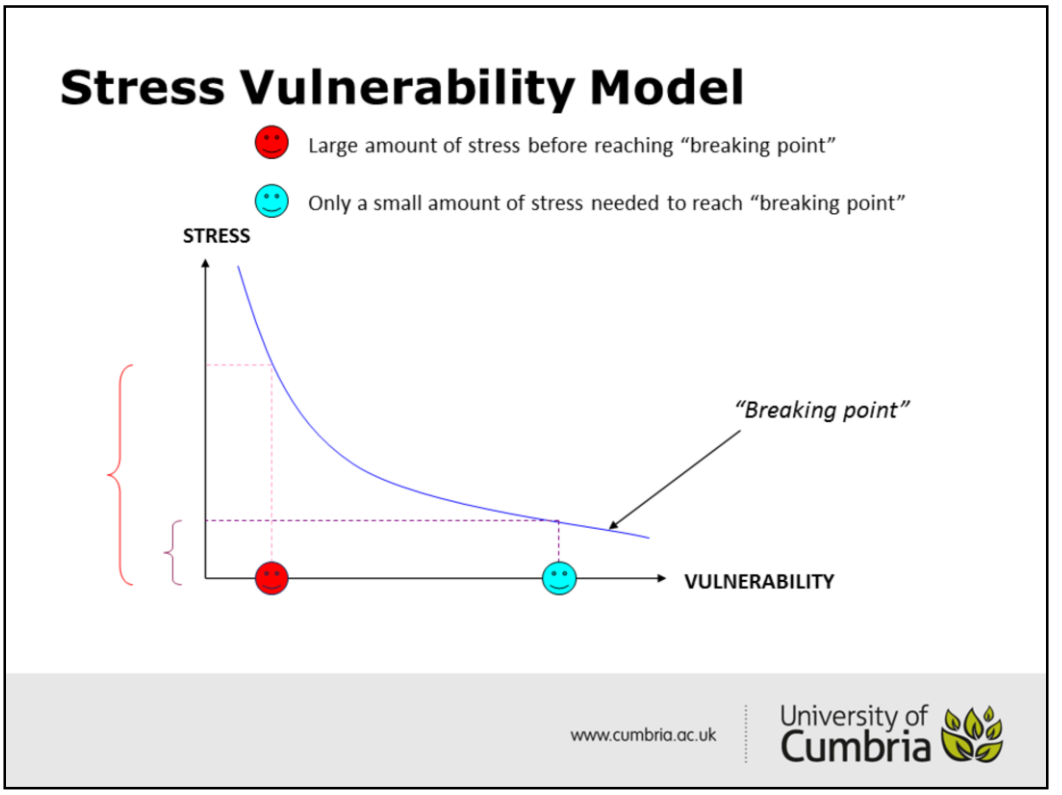
But only looking at risk factors can be dangerous. Too easy to assume and can easily become a tick-box exercise



The next slide has a video clip that is a very moving piece by a survivor of a suicide attempt, Kevin Hines, who is now a leading advocate for better mental health support in the USA



Episodic stress relates to discreet short term or one off stresses. Ambient are ongoing stresses.



We all exist somewhere along the vulnerability axis (Vulnerability tends to be either genetic or acquired – such as brain injury or early life experiences, environment)

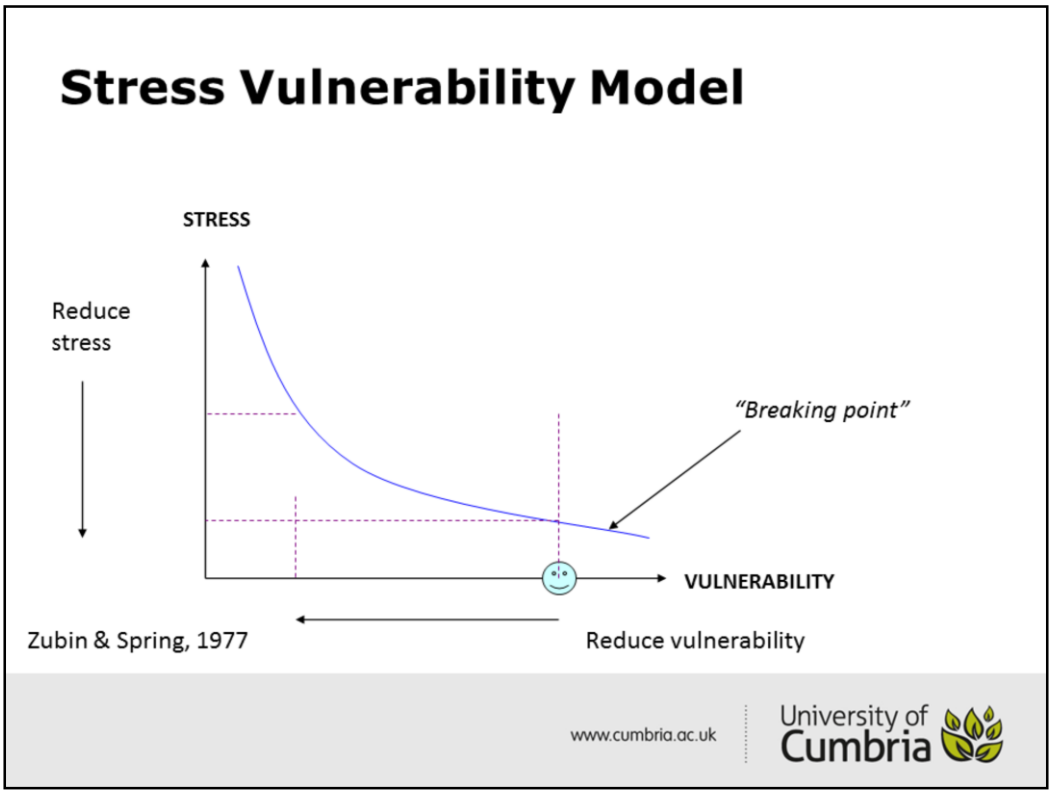
Explain what each line represents

Imagine two people with different vulnerabilities

Red face – low vulnerability, can tolerate a lot of stress

Blue face – high vulnerability , can't tolerate a lot of stress before breaking point

Most of us given enough stress would have feelings of hopelessness which can lead to suicidal ideation



What can we do to help person with high vulnerability?

Taking meds can reduce or buffer against vulnerability

Taking street drugs can increase it

We can try and reduce the person's environmental stress in areas of relationships, accommodation, extending deadlines, DSA application, finances for example

Aim to try and keep the person maintained away from Breaking point. This model offers hope and suggests ways that the individual can help himself to reduce stress

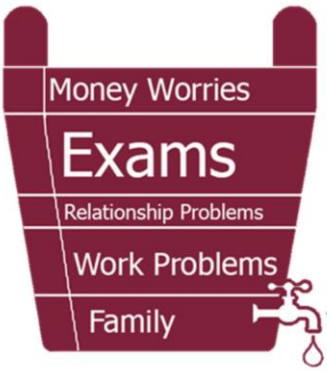
Can try to prevent relapse and keep people well as well as trying to make the psychotic experience less stressful and traumatic

Things don't have to be understood completely within the medical model for example a client when stressed may be more vulnerable to spiritual intrusion in his life and his mind being altered

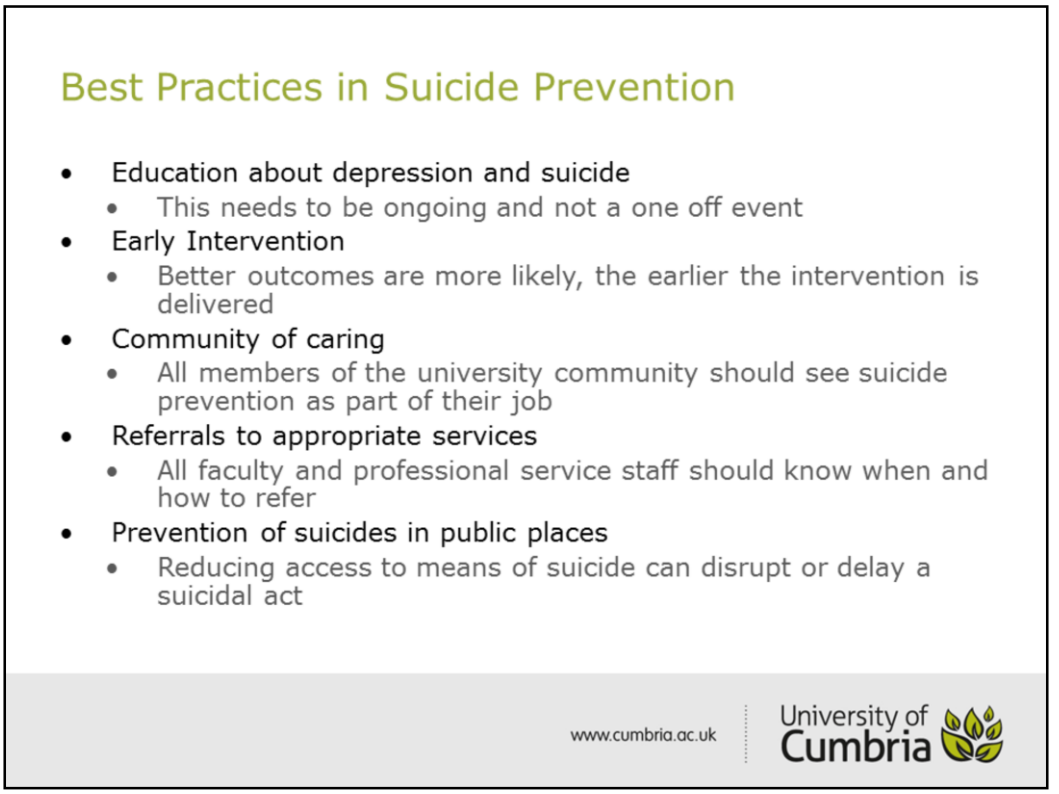
Models of early adversity leading to "final straw" event

(NCISH, 2016)

The stress bucket – Brabban & Turkington, 2002



We all need a tap to release the pressure



Evidence suggests that whilst it might be “interesting” to have a speaker come on to campus to talk about suicide, it doesn’t have a lasting affect.

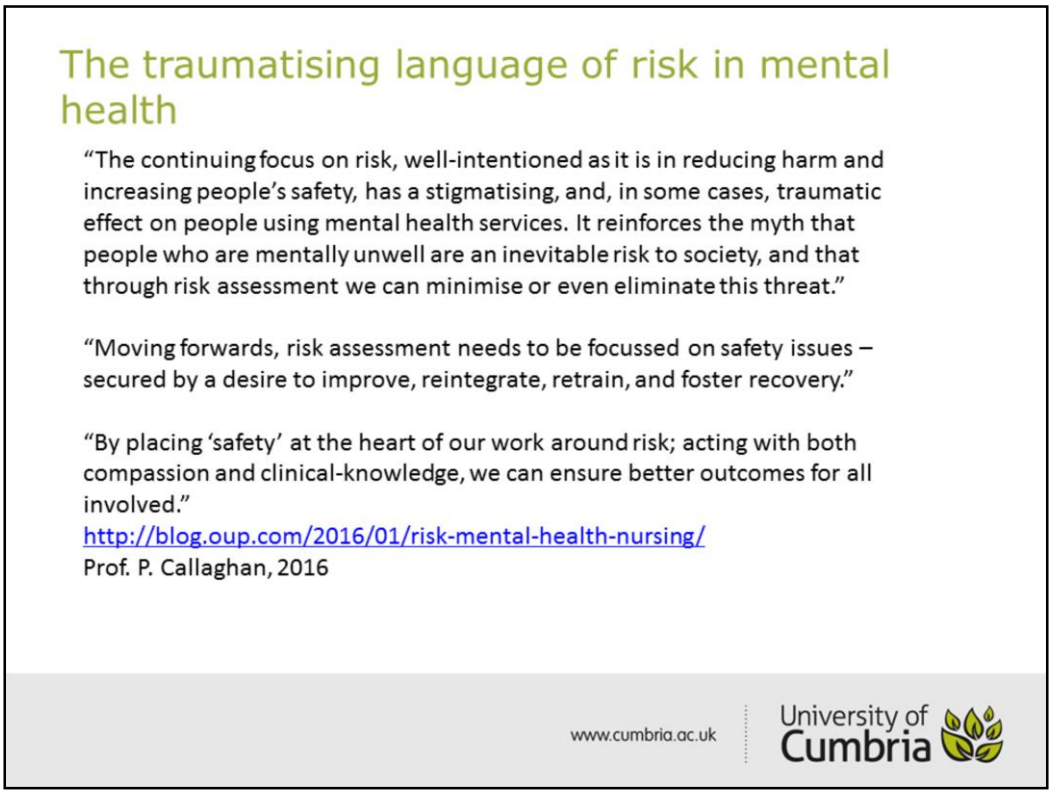
The earlier an intervention is put in place, the better and more positive the outcome. Hence why teaching all staff on campus about the how to screen for suicidal ideation in students works!

The problem however is the referral pathways. Just as cancer treatment is often discussed as a “postcode lottery” so too is mental health support. It varies massively.

Reducing access to means has been proven time and time again in helping to reduce the number of suicides. Some campuses in the USA now do regular audits looking at how to reduce access to means e.g. safety windows in all tall buildings. Removal of ligature points. Free hotlines to the USA equivalents to Nightline/Samaritans

Suicide Screening, Risk Assessment & Management

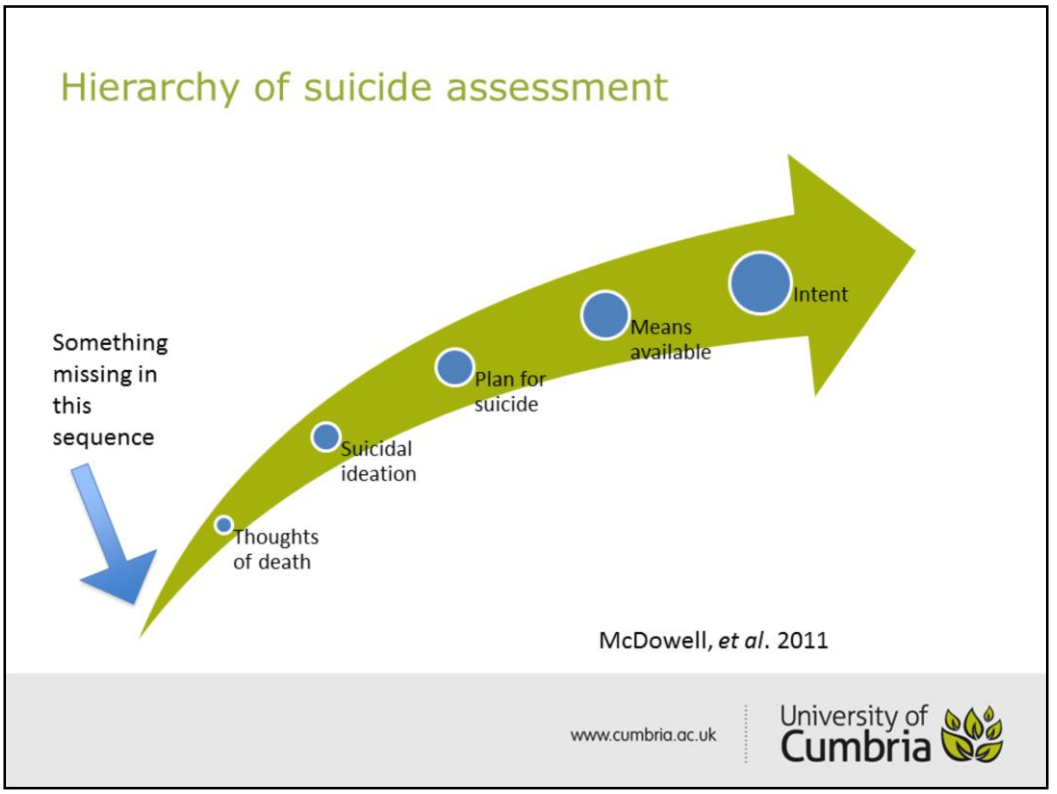
- Suicide Screening is not a full risk assessment
- Risk Assessment is more detailed and good practise dictates that it should be undertaken by a mental health clinician in collaboration with the service user
- Both of the above require a Structured Clinical Approach if following best practise
- Risk management refers to the intervention required to keep a person safe and functioning, helping them to move on from the crisis they find themselves in



Be wary of terminology. Try to think about safety and recovery.

International Association for Suicide Prevention

- First contact
  - Not everyone has to take on the responsibility of treating those with suicidal thoughts and actions, but at the very least those who are in the situation where such persons may present should have the basic skills to make a general assessment of suicidal persons. The initial contact is particularly important, as often a suicidal person has recently perceived rejection, so building up some rapport and the use of empathy is key.
- Degree of suicidal intent
  - Suicidal intent can be determined on the basis of the degree of planning, knowledge of lethality, the degree of isolation etc., especially by asking open ended questions which can illicit some ambivalent feelings
- Initial management
  - The most important initial decision is based on one's assessment of the safety of the suicidal person. It may be that the opportunity to discuss thoughts and feelings is sufficient for the person. Or it may be signposting to specialist services that are required



Practical Suicide-Risk Management for the Busy Primary Care Physician. Anna K. McDowell, MD; Timothy W. Lineberry, MD; and J. Michael Bostwick, MD 2011

We want to help guide people away from intent, and ultimately away from death, back down to the pre-contemplative stage

First Aid and Mental First Aid

- St John's or Red Cross typically 3 days for "First Aid at Work" certification
- Red Cross Emergency First Aid is 1 full day and covers CPR
- Mental Health First Aid is typically 2 days long, and around £300 per delegate
- Cumbria's Suicide Prevention and Intervention training – 2.5 hours and Psychological Wellbeing Team members time.

Columbia Suicide Severity Rating Scale (CSSRS)

Who uses it?

- US Military
- Some US law enforcement departments
- Some US fire departments
- US schools, colleges and universities
- First Aiders
- Homeless shelters

Posner, K. *et al*

- University of Cumbria

Columbia Suicide Severity Rating Scale (CSSRS)

- Developed by leading experts on suicide attempters
- Evidence based
- Short administration time
- Can be administered by non-mental health clinicians
- Used internationally across research, clinical and institutional settings
- More accurate than relying on PHQ-9 Q9
- It's a checklist, not a tickbox exercise

Posner, K. *et al*

CSSRS Screener Items

1. Wish to be Dead
   - **Have you wished you were dead or wished you could go to sleep and not wake up?**
2. Non-specific Active Suicidal Thoughts
   - **Have you actually had any thoughts of killing yourself?**
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act
   - **Have you been thinking about how you might do this?**

CSSRS Screener Items

3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act
   - **Have you been thinking about how you might do this?**
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan
   - **Have you had these thoughts and had some intention of acting on them?**

CSSRS Screener Items

5. Active Suicidal Ideation with Specific Plan and Intent
    - **Have you started to work out or worked out the details of how to kill yourself?**
    - **Do you intend to carry out this plan?**
6. Suicide Behaviour
    - **Have you ever done anything, started to do anything, or prepared anything to end your life?**
    - (If "YES") **How long ago did you do any of these?**

CSSRS Screener Training Video

What to say or do

- **What one thing would need to change for you to stop feeling suicidal?** Jobes, 2006
- Allow the student to express negative thoughts and feelings – sharing this can help towards reducing self-destructive thoughts and feelings
- Follow up with the student, as this will indicate you care
- Do believe what they are telling you – even if they seem jokey!
- Take your time, listen, be calm – avoid trying to find a quick solution
- Stigma is real and dangerous – try to de-stigmatise suicide and mental health, and counselling
- Offer practical support – extending deadline
- Remember your professional boundaries

Lessons from the University of Cumbria

- Have aims and objectives clearly defined early on – but don't be afraid to change them
- Work with colleagues in the community – get involved in the local suicide prevention task force, collaborate with SU, local/campus GP services, local mental health teams within the NHS, voluntary sector etc.
- Have regular anti-stigma campaigns and health promotion campaigns – not just one off speakers or not to rely on World Mental Health Day as your only campaign message
- Have out of hours support posters in key places e.g. multi-storey car parks, high rise accommodation blocks, etc.
- Don't just rely on campus counselling or campus mental health services as being the only point of contact for distressed students
- Develop a suicide prevention and intervention strategy as part of a wider wellbeing strategy
- Provide regular training to non-clinical and clinical staff on campus

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Last points!

- Just want to thank you all for attending
- It's not an easy subject to listen to and discuss, but by considering and then implementing a campus approach to suicide prevention and intervention might save a student's life!
- Please remember the support available to you – it can be emotionally draining discussing suicide, and you need to look after Number 1!

The beginning

helping one person might not change
the whole world,

but it could change the world for
one person.

chibird

References and further reading

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- Van Brunt, B. (2014) The Book of BIT 2nd Edition. Borrego Publishing
- For more information about the C-SSRS http://www.cssrs.columbia.edu/about_cssrs.html
- Zero Suicide international initiative http://zerosuicide.sprc.org