

Suicidal students' use of and attitudes to primary care support services

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Aim: The aims of this study were to improve responses to students in distress and who are feeling suicidal, to help practitioners to increase their responsiveness to those at high risk of suicide and to develop effective responses to those affected by their deaths. The study sought to build a detailed picture of students' patterns of service use. **Background:** National suicide prevention strategies emphasise that suicide prevention requires the collaboration of a wide range of organisations. Among these, primary care services play a key role in relation to suicide prevention for young people in crisis. **Methods:** This study, undertaken between 2004 and 2007, focused on 20 case studies of student suicide that took place in the United Kingdom between May 2000 and June 2005. It adopted a psychological autopsy approach to learn from a wide range of informants, including parents, friends, university staff and the records of coroners or procurator fiscals. Twenty families gave permission for their son's or daughter's death to be included in the study and agreed to participate in the study. Informants were interviewed in person and the data were analysed thematically. Analysis of the case study data suggested that in a number of cases students had failed to engage with services sufficiently early or in sufficient depth. Primary care practitioners need to be proactive in communicating concerns about vulnerable students to student support services. At local levels, collaboration between student support and National Health Service practitioners varied considerably and channels of communication need to be developed.

Key words: higher education; primary care; students; suicide

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Introduction

In England, the National Suicide Prevention Strategy (Department of Health, 2002) emphasises that suicide prevention requires the collaboration of a wide range of organisations. Among these, primary care-based National Health Service (NHS) services play a key role in suicide prevention for young people in crisis. This study draws on data from the Responses and Prevention in Student Suicide (RaPSS) study, a national

study of 20 cases of student suicide occurring between 2000 and 2005 in higher education institutions (HEIs) across the United Kingdom (Stanley *et al.*, 2009). A multi-perspective methodology allowed the accounts of parents, friends and university staff to be brought together to develop a picture of students' patterns of service use while they were at the university. Some students had made little or no use of health or counselling services, others had limited contact with primary care and/or mental health services and/or student support services, whereas others had received intensive or timely support. In all cases, these students took their own lives; the intention therefore is not to compare or evaluate

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different forms of service provision but rather to use research participants' detailed accounts to elucidate students' attitudes towards and experiences of primary care support services. Studying this group of students has the potential to illuminate understanding of how practitioners can increase their responsiveness to those at high risk of suicide.

The higher education (HE) context

The HE sector in the United Kingdom has grown rapidly over the last decade; both the numbers of HEIs have increased and the size of individual institutions has grown, with 47 of the 169 HEIs now having more than 20 000 students (Universities UK (UUK), 2008). The UK government's widening participation policy (Dearing, 1997) has succeeded in encouraging over 40% of 18–20-year-olds into higher education. Although the numbers of mature students have increased, the 18–21 age group dominates, with 78% of full-time undergraduates being aged under 21 years in 2004–05 (HESA, 2006).

The student population is also increasingly diverse in terms of ethnicity, nationality and disability. International students (non-UK) number 541 470 of the whole student population in the United Kingdom standing at 2 362 815 (UUK, 2008) and the numbers of black and minority ethnic UK students have increased, especially among those studying part-time (HESA, 2006), although participation is spread unevenly across black and minority ethnic communities (Fitz *et al.*, 2005). Students who have disclosed a disability now represent 6% of the total population (HESA, 2007), although the stigma attached to mental health difficulties, the category most relevant to suicide prevention, means that they are less likely to be captured by these figures.

An increased proportion of the student population now attends their local university and lives at home rather than in student accommodation (MORI and HEPI, 2005). Students from working class or minority ethnic backgrounds where finances are limited and where community and family ties are particularly valued are more likely to live at home (Pugsley, 2004; Fitz *et al.*, 2005). These students may be registered with local primary health services and may continue to use them in preference to student health or counselling

services. The same applies to part-time students who now form the majority of postgraduate and just under half of the undergraduate student populations (UUK, 2008).

The consequences of the rapid growth of the sector on student well-being have been acknowledged and concerns about the quality of student experience and retention have resulted in new resources for student support services (UUK and Standing Committee of Principals (SCOP), 2002). These have included some initiatives focused on suicide prevention in the student population (see Kracen 2002; Yeoman, 2005). However, those working within student services (Rana *et al.*, 1999; Grant, 2006) argue that the development of student support services has not kept pace with the growth in need due to increased numbers.

Suicide prevention in primary care

The frequency of consultations with general practitioners (GPs) increases before suicide (Michel *et al.*, 1997), although those making such visits, particularly men, often fail to disclose their suicidal intentions (Michel, 2000). Appleby *et al.*'s (1996) study of 61 young suicides found that the number of GP contacts increased in the months before death and a pattern of increased visits in the week before the death was particularly evident among females. Although psychological reasons motivated most appointments, a high risk of suicide was not identified in any of the final consultations. However, Owens *et al.*'s (2004) study of 100 cases of completed suicide in the west of England found that 44% of those judged retrospectively to have a mental illness had not consulted their GP in the month before their deaths. Among those who did consult their GP, three-quarters were identified as having a mental health problem and were offered treatment; however, this intervention was not successful in preventing suicide.

Depression in young people is known to be under-recognised in primary care (Kramer *et al.*, 1997). Jacobson (2002) highlighted the paradox that, although young adults' negative attitudes towards older health professionals mean that they require more time from the GP in which to develop a confiding relationship, they receive less time than other patients (Gledhill *et al.*, 2003).

If GPs perceive that young patients have psychological problems they do not always explore these and follow-up or a management plan is set up for only a minority (Iliffe *et al.*, 2009).

GP education is seen as a means of improving the effectiveness of primary health care's performance in suicide prevention and Rutz *et al.*'s (1989) Gotland study showed a reduction in general suicide rates following the delivery of a suicide prevention training programme to GPs. However, the numbers involved in this study were small. Stanley *et al.* (2008) reported considerable variation in the extent to which GPs were prepared to devote time and resources to working with young people whom they identified as at risk of suicide and they advocate the use of case studies for GP training in this field. A similar approach is adopted in a toolkit on young people's mental health aimed at primary care practitioners (Charlie Waller Memorial Trust, 2009).

Young people's use of services

As a group, young people are generally likely to make low use of health and other support services (Viner and Barker, 2005). Their limited experience of accessing professional services on their own account may make them more likely to turn to informal rather than formal sources of help (Jones *et al.*, 1997; Richardson *et al.*, 2000) and those with mental health needs are less likely to consult their GP than other groups (Vassilas and Morgan, 1993; Bebbington *et al.*, 2000). Biddle *et al.*'s (2004) survey of 1300 young adults in the Bristol area found that the majority of those who were assessed as having a probable mental disorder had not sought any form of help. Young women identified as having a probable mental disorder were more likely than young men to access support when distressed and help from family or friends was the type of support most frequently utilised. Young women were considerably more likely to use family and friends for support than young men, but only slightly more likely to see a GP or counsellor. An evaluation of pilot projects aimed at reducing suicidality found that young men saw GPs as lacking in empathy and likely to restrict their response to prescribing medication (Oliver and Storey, 2006).

In the HE context, similar patterns were identified in Grant's (2002) study of a sample of the

student population at the University of Leicester. Friends and family were the most frequently used source of support cited by 65% of respondents; the student health centre was identified as a potential source of help by 40%, while only 7% cited the student counselling centre as a source of support. As with Biddle *et al.*'s (2004) study, those with the most severe problems were most likely to utilise help and women were more likely to use GP and counselling services than men. An Australian study (Eisenberg *et al.*, 2007), focusing on students with mental health problems, found a range of factors associated with failure to receive services including lack of felt need, being unaware of services (although these were freely available in the HE setting), scepticism about the effectiveness of intervention, low socioeconomic background and ethnicity. Detailed accounts from those participating in the study reported here provided an opportunity to explore some of these themes in more depth.

Method

This research, undertaken between 2004 and 2007, focused on 20 case studies of student suicide that took place in the United Kingdom between May 2000 and June 2005. The case studies were identified through contacts with HEIs and coroners or procurators fiscals. For cases identified through HEIs, contact was made in the first instance with the head of counselling or student services who approached the student's family for permission to include the case in the study; coroners or procurators fiscals were asked to contact families in the same way. In total, 48 letters were sent to families from someone who would have been known to them. Twenty families gave permission for their son's or daughter's death to be included in the study and agreed to participate in the study. This level of response may be attributed in part to letters sent some years after the death failing to reach families, but some families clearly chose not to participate.

The study used an adapted version of the psychological autopsy approach (Beskow *et al.*, 1990). Rather than focusing on a single informant (usually a parent of the person who has died) and on the individual's mental health, a range of sources were utilised to build a picture that took

account of the individual's social context as well as psychological factors. For each of the case studies, semi-structured interviews were undertaken with the student's parents (sometimes individually but mostly together) and, where possible, the student's friends and a member of HE staff who had known the student (either academic or student support staff). Copies of Coroners' and Procurators Fiscal records were also accessed. Two to six data sources were collated for each case study and a total of 73 data sources were collected for all 20 case studies. Some additional interviews were undertaken: four interviews were undertaken with friends of a student whose death was not included as a case study (since they were not contacted through parents); these participants contacted the researchers via a bereavement organisation. Ten positive practice interviews aimed at identifying good practice in this field were also completed with student support staff from HEIs across the United Kingdom.

All interviews were recorded and transcribed with the participants' permission. Data were analysed thematically across the case studies using an approach that both utilised key themes from the literature and distinguished themes generated by the data (Silverman, 1993; Coffey and Atkinson, 1996). NVivo software was used to assist the process of sorting and storing data. Case studies were also analysed using a key events approach that allowed for patterns and divergences to be identified across cases. The nature of the study demanded careful attention and sensitivity to ethical issues and, in accordance with good practice in suicide research (Hawton *et al.*, 2003), interviewees were offered a bereavement pack designed for suicide survivors (Hill *et al.*, 1997) and were telephoned shortly after the interview to check out their responses to the interview. Participants and the HEIs have been anonymised in this study; the research received ethical approval from the NHS Multi-Region Research Ethics Committee.

Findings

The case study group

In all, 18 of the 20 students studied were young men and in this respect, the sample conformed to

the pattern of young suicides found in wider community studies (CSIP and NIMHE, 2006). Most of the students who died were in their early twenties, one was under 20 years and four were aged between 25 and 35 years. All 20 students were white and from the United Kingdom; attempts to include the deaths of international students in the study were unsuccessful since the HEIs concerned judged that communication difficulties and the sensitivities surrounding these suicides made contact with the families inappropriate. All the case study students were attending HEIs away from home and most were living in privately rented accommodation. They were studying a wide range of subjects; one was a postgraduate student.

Two-thirds of the students had a diagnosed mental health problem. Four of this group had a diagnosis predating higher education, three disclosed their problems at admission, although one student's request that this information should not be shared meant that most of the staff who knew her and the majority of her friends were unaware of her mental health history until she became seriously depressed. In a further nine cases, students were given a diagnosis of depression by their GP while at university. An additional student was identified as suffering from depression by a university counsellor. Most of the students of this group with a diagnosed mental health problem had received a diagnosis in the year before their death suggesting that the onset of severe and identifiable mental health need was relatively recent. However, it is important to acknowledge that six of the students who died had no identified mental health problem.

The recent histories of the students who died exhibited a range of difficulties including relationship problems, heavy use of alcohol and drugs, financial problems and, in two cases, concerns about sexual identity. In four cases, there was evidence that the student's death was influenced or itself had influenced another young person's suicide. The timing of the deaths also appeared relevant; with the majority falling into transition periods at the beginning and end of the academic year (see Stanley *et al.*, 2009). Disrupted academic progress was a feature of the histories of half the cases studied; these disruptions included missing key examinations at school, changes of both programmes and institutions, periods of suspended

study and 'giving up on studying'. Fear of failure was a key theme that appeared to characterise the state of mind of a number of students in the periods preceding their deaths (Bell *et al.*, in press).

Disclosure of distress

Although most of the students who died had given some indication of their suicidal intentions, from the interviews it appeared that three students had made no disclosure of their distress to either informal sources of support or to professionals, or they had made only very limited disclosures which did not convey the level of risk. On occasion, informants reported that students flatly denied suicidal feelings when questioned. One parent described attending a consultation with a psychiatrist with their son who answered 'No' when asked directly whether he was suicidal. Parents can experience difficulty in distinguishing symptoms of mental disorder from 'difficult' adolescent behaviour (Stanley, 2005) and one parent described how she had been misled by her son's behaviour:

He didn't give the appearance of being depressed at all that last time he came home, rather the reverse...he got quite cocky and began to talk about dropping out. We tried to get him to face up to reality but with little success. Afterwards, I really did wonder if this was the onset of some more serious mental illness....

(Parent)

Although seven students were found to have previously attempted suicide, it was only in retrospect that the seriousness of these incidents became evident. At the time, the risks appear to have been minimised, either because the student did not attend accident and emergency services or because information about the attempt was not widely shared. In one case, a student had attended accident and emergency services twice without receiving any further support. Lilley *et al.*'s (2008) large-scale study in the United Kingdom found that, while two-thirds of those seen in hospital emergency departments following an incident of self-harm were offered a psychosocial assessment, less than half of those who self-injured by cutting were offered this follow-up. Health professionals in the United Kingdom

have been criticised for negative attitudes towards both self-harm and suicide attempts in young people (Wilson, 2003; Mental Health Foundation (MHF), 2006).

Support from friends

In common with other young people (Smalley *et al.*, 2004; Office of the Deputy Prime Minister, 2005), many of the students in the case studies appeared to have utilised friends as their main form of support. In eight of the case studies, friends and housemates had been involved in providing support over a period of days or weeks for distressed young people who were receiving either no formal support or whose support was confined to a prescription for anti-depressants:

.... they were very good friends they took a great deal of care of him, they were very concerned for his wellbeing and, to some extent, opted to change their own path through what they were doing, in order to help him out.

(Tutor)

However, students sometimes were described as struggling to find effective ways of supporting their distressed friends:

.... a few days before he had told them that he had attempted suicide with this noose and they didn't know what to do about it. Because they're 19 and they didn't know what to do. So they took him out to the pub to cheer him up.

(Parent)

In a small number of cases, students ended up providing 24-hour support for students in crisis. It was notable that for these students contacting the HEI's student support services did not appear to be an option. This seemed to be either because the possibility did not occur to them or because the stigma attached to counselling services rendered them unacceptable in friends' eyes. Nor were there opportunities for them to liaise with formal services, such as the police, who in one case picked up and cautioned a student shortly before his death. In another case, a student's housemate, who was aware of his suicidal thoughts, persuaded him to attend the GP's surgery and accompanied him there, but was dissuaded

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by the suicidal student from entering the surgery and speaking to the GP with him:

I wanted to go in with him to explain to the GP how he had been, but he wouldn't let me so I waited outside....I asked him if he had mentioned to the GP the suicidal thoughts that he had been having, but from his response I don't think he had.

(Student's friend)

In these cases, the identity of students' friends as young people, together with anxieties about breaking confidences, may have made it difficult for them to assert themselves in the context of professional intervention.

Support from family

Parents still played a key role in the lives of most of the students who died and three were staying with their parents at the time of death, suggesting that they had returned home for parental support at a time of crisis. However, a need to assert independence from parents and concerns about revealing the full extent of problems meant that some parents had a very restricted picture of their son's or daughter's state of mind until after their death.

Professional codes of confidentiality can be experienced as excluding or undermining parents of young people (Stanley, 2005). A small number of parents felt that an emphasis on confidentiality by health practitioners acted to undermine their capacity to care for their son or daughter. These parents considered that health professionals could have shared more information with them:

... he could have said to [my son] 'do you mind if I speak to your parents?'... the GP should say, well when it's a matter of life and death....then confidentiality has absolutely no role to play in that argument.

(Parent)

Assurances of confidentiality have been identified as key in encouraging young people to engage with health services (Finlay, 1998; Stanley *et al.*, 2008). However, both professional guidance (Department of Health, 2005) and research with GPs (Stanley *et al.*, 2008) offer illustrations of ways in which young people's agreement to share information with parents can be elicited.

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Use of primary care

All 11 students who were diagnosed with depression by their GP were prescribed antidepressants, which a number of students were reportedly unwilling to take. Two students were known not to have taken the medication; among those who did so initially, and often reluctantly, compliance was not always consistent, especially when medication was experienced as ineffective or stigmatising:

.... when he got offered antidepressants at the doctor's with his mum, he didn't want them because he said it was recorded on your record.

(Student's friend)

Five of the students diagnosed with depression by their GP received no psychological or NHS counselling (though one had been referred but did not attend), this was despite the fact that three of them had been diagnosed between 6–12 months before their death:

No counselling, offered. No, it was just drugs. Well it was almost as if, you know, here's a 'script [prescription], we've solved your problem, get on with it. When really he needed a sit down and talk about his problems, he needed counselling more than anything else.

(Parent)

In some cases, students visited their GP shortly before their death, but the extent of their suicidal intent was not apparent. In one case, parents considered that the GP who saw the student immediately before his death should have probed more deeply for suicidal thoughts rather than advising him to return to university to make use of its counselling services:

.... his doctor said, 'I can't do anything for you here it'll be six weeks before I can get you counselling.' He said, 'if you go back to university you know you'll get counselling straight away'.

(Parent)

Here, the student appeared to be forced to choose between using speedily accessible university services or benefiting from the support available in the parental home.

In all, 6 of the 14 students who were diagnosed with mental health problems used NHS mental health services; this included two students who were referred for alcohol addiction, two students with bipolar disorders and two diagnosed with depression. Five of these six students were referred to community mental health services by their GP (one student cancelled the appointment). In one case, the student's family ensured that she had contact with mental health services from the start of her university career and another student was referred directly to mental health services by the HEI.

For some of this group, engagement with mental health services was problematic; one student made extensive use of mental health services over the year before his death, but failed to make contact with local services when he returned home in the vacation. Another student did not attend his appointment because of concern over the stigma associated with a psychiatric diagnosis.

Liaison and co-ordination between services

Lack of communication and co-ordination between the different services and professionals involved in providing support was a key theme in the accounts of professional support offered before a student's death. This problem is identified by the UK national suicide prevention strategy documents (Department of Health, 2002; CSIP and NIMHE, 2006).

Some parents who were caring for their son or daughter while they were living at home described a lack of continuity of personnel within local health services that made communication difficult:

He went to see the GP, I think he put him on an antidepressant And he said, 'unfortunately I can't see you again because I'm going on a secondment for several weeks, but I'll hand you over to one of the partners, and they will deal with you', so he saw another partner, who said that there would be a CPN [Community Psychiatric Nurse] arranged A CPN came.... The next week another CPN came, we're now in the third week of since he'd come back from university.... and he came into the kitchen and said, 'they keep asking me all the same things, these people', he said 'I've told them all this...'

(Parent)

Parents also criticised the lack of effective joint working between HEI staff and primary health services:

Now at the inquest it came out, that he'd seen a counsellor and it also came out that he'd been to his GP saying that he felt suicidal, that he was depressed that was when he was prescribed the antidepressant but from what I gather, there was no contact between the GP and the counsellor at the university, or the GP and anyone else for that matter ...

(Parent)

However, in one case, HEI staff acted immediately to secure mental health service intervention for a student in crisis:

The college set it up yes, absolutely, because I rang them before she was coming back and told them in great detail what had happened before and I said, 'I'm very worried about her', and so they... she went back on the Sunday and was at a psychiatrist on the Monday, they'd already booked an appointment.

(Parent)

In another case, a psychiatrist who saw a student who admitted to thoughts of overdosing made an urgent referral to the HE counselling service and he was seen the following day.

The distance between a student's family GP and HEI services appeared to function as a major barrier to communication. This student's parents found their local doctor unhelpful about where their son might receive further support:

When we saw a doctor, he told the doctor he'd been cutting himself and we said, 'so what happens now?' [The doctor asked] 'Have you a counsellor at university?'but we worried about where do you go from therewhat's the progression after?

(Parent)

Parents also described breakdowns in communication and co-ordination between primary health care and community mental health services:

They [the community mental health team] didn't tell the GP that he had turned down this first meeting. The other problem was

them ringing up and saying, ‘can I speak to him?’ three days after he’d taken his life. They should be switched on enough to know what’s going on in their own area ...they should have a proper system where....the information is available.

(Parent)

Students’ attitudes towards support services

A lack of communication and co-ordination between services was often combined with reluctance to access and use services on the part of students. The shame associated with seeking help and the stigma attached to mental health problems through contact with mental health services were frequently cited as disincentives to using services:

Friend 1: ...everything else that we suggested, really sort of positive things like you know can we get you to go the GP, do you fancy speaking to some sort of counsellor, the [professional organization] offer a counselling service, that sort of thing, he didn’t want, he didn’t want any of those sorts of things.

Friend 2: There, yeah, he was quite het up on the stigma associated with mental illness. ...he would find it very difficult to go to those type of people and say, ‘look, I’m not really the person you see, I’m this, you know, drop-out who wants to end my life’

(Student’s friends)

The stigma associated with disclosure of mental health problems may be perceived as a particular barrier to career progression by students on professional programmes such as nursing or social work (Stanley *et al.*, in press, 2011), but an awareness of stigma was not confined to professional students in this study and has been reported by other studies with the student population (Tinklin *et al.*, 2005; Quinn *et al.*, 2009).

As noted above, a perceived stigma was also attached to the use of anti-depressants. The concern that they would not make an immediate difference meant that they were frequently not taken. Anti-depressants were also unpopular with some students who favoured natural, non-medical approaches to health:

... he held the medical profession generally in sort of fairly low regard. He didn’t really

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trust or believe in conventional medicine, I think he was so much more interested in sort of alternative medicine and holistic medicine, so pills and potions...doctors just left him cold really...he was very sceptical.

(Student’s friend)

Talking therapies were clearly more acceptable to some students but others showed a similar resistance to engagement with counselling services:

...he was very sceptical about counselling and therapists and he was just trying to outwit them rather than actually accepting that they might be able to help him. So I think that the sessions he had were just a bit of a disaster because of that reason...

(Student’s friend)

Analysis of the case study data suggested that in a number of cases students had failed to engage with services sufficiently early or in sufficient depth. The data convey a range of reasons for this lack of engagement including students’ perceptions of services as stigmatised or ineffective; the difficulties experienced by friends and family members in accessing appropriate support for individuals whom they thought to be at risk and a lack of co-ordination between services.

The positive practice interviews with staff in HE support services identified a number of strategies that HEIs have adopted in attempts to minimise the stigma attached to seeking professional support. Peer support was seen as a means of harnessing students’ natural inclination to look to their friends as a first line of support and as offering a less stigmatised form of help. The HE staff interviewed also emphasised the value of establishing good communication with primary care or mental health professionals, but this was more likely to be conceptualised as a relationship with an individual or particular GP practice than as a wider organisational link.

Discussion

The findings presented here are drawn from completed suicides that occurred before 2006 and recent developments in practice may not therefore have been captured. However, qualitative suicide research requires a period of time to have

elapsed between the deaths studied and fieldwork to allow participants to describe distressing events 'from a distance'. This study is also limited in that the case studies may be unrepresentative and participants may not have disclosed matters that they considered might cause distress. The research team sought to minimise these risks by seeking a wide range of informants and offering reassurance to gatekeepers and participants that the study was attempting to learn lessons rather than to apportion blame. Engagement with the primary care practitioners working with the students who died was not possible within the confines of this study. This might mean that important sources of information have been missed and this could provide the focus for further studies.

Key messages for primary care services include the need for collaboration between GPs caring for students in the family home and those treating them at university. Students' ambivalence about the use of anti-depressants and their preference for other forms of intervention also need to be directly addressed in GP consultations. This study also found that communication between student support and local NHS services varied considerably among HEIs. Accounts in the literature (Waller *et al.*, 2005) indicate that close relationships are often fostered by particular clinicians who have an interest in student health. HE staff interviewed emphasised that local mental health services were often under-resourced and did not regard students as a priority group. There is little evidence available to indicate implementation of the Royal College of Psychiatrists' (2003) recommendation that NHS Mental Health Trusts should appoint a designated member of staff to take responsibility for liaison with HEIs in areas with substantial student populations.

However, some of the impetus for the development of such relationships needs to come from within the HE sector and not just health practitioners. HEIs are increasingly emphasising their role in their local communities (Watson, 2007); community engagement needs to extend beyond the economic role of the HEI to include dialogue with local primary and secondary health care services concerning students' access to mental health resources, contributions to local public health strategies and increased co-ordination between HEIs and local health commissioners.

Primary care practitioners also need to be proactive in communicating concerns about

vulnerable students to student support services. This will generally require the patient's agreement, which may be forthcoming if liaison with the HEI is conceptualised as a means of reducing academic demands on students. HEIs can be complex organisations to communicate with but a number of HEIs have appointed mental health advisers or co-ordinators who assume responsibility for co-ordinating the service response to students with identified mental health needs. Such individuals offer a valuable contact point for primary care staff. They can assist those delivering primary care to develop a clear picture of the health and counselling services offered by HEIs and they offer a channel for communicating with HEI staff about students at risk.

Conclusion

In its focus on completed suicides, this study inevitably highlights the failures rather than the achievements of HE and primary care services in preventing suicide. However, the findings deliver some important messages concerning both the co-ordination of services and students' willingness to use relevant services at times of crisis. If primary care services are to substantially increase their accessibility for students in crisis, students themselves will need to be consulted about what would reduce perceptions of stigma and ensure that services are experienced as available and user-friendly. Approaching such consultation as a joint task might lay the ground for increased communication and collaboration between HE and primary care services.

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References

- Appleby, L., Amos, T., Doyle, U., Tomenson, B. and Woodman, M. 1996: General practitioners and young suicides: a preventive role for primary care. *The British Journal of Psychiatry* 168, 330–33.

- Bebbington, P.E., Meltzer, H. and Brugha, T.S.** 2000: Unequal access and unmet need: neurotic disorders and the use of primary care services. *Psychological Medicine* 30, 1359–67.
- Bell, J., Stanley, N., Mallon, S., and Manthorpe, J.** In press: the role of perfectionism in student suicide. Three case studies from the UK. Omega.
- Beskow, J., Runeson, B. and Asgard, U.** 1990: Psychological autopsies: methods and ethics. *Suicide and Life Threatening Behavior* 20, 307–23.
- Biddle, L., Gunnell, D., Sharp, D. and Donovan, J.L.** 2004: Factors influencing help-seeking in mentally distressed young adults: a cross-sectional survey. *British Journal of General Practice* 54, 248–53.
- Charlie Waller Memorial Trust.** 2009: *Young people with mental health problems: a toolkit for school nurses, primary care and community professionals*. London: Primary Care Partners and Mental Health Foundation.
- Coffey, A. and Atkinson, P.** 1996: *Making sense of qualitative data*. London: Sage Publications.
- CSIP and NIMHE.** 2006: *National suicide prevention strategy for England: annual report on progress 2005*. Leeds: Department of Health.
- Dearing, R.** 1997: *Higher education in the learning society: report of the national inquiry into higher education*. London: HMSO.
- Department of Health.** 2002: *National strategy for suicide prevention in England*. London: Department of Health.
- Department of Health.** 2005: *You're welcome quality criteria: making health services young people friendly*. London: Department of Health.
- Eisenberg, D., Golberstein, E. and Gollust, S.E.** 2007: Help-seeking and access to mental health care in a university student population. *Medical Care* 45, 594–601.
- Finlay, F.** 1998: Providing healthcare information suitable for adolescents. *Health Visitor* 71, 16–18.
- Fitz, J., Taylor, C., Pugsley, L., Madden, L., Stephens, N., Lewis, J. and Smith, M.** 2005: *Attitudes towards participation in higher education in Wales*. Cardiff: University of Cardiff.
- Gledhill, J., Kramer, T., Iliffe, S. and Garralda, E.** 2003: Training general practitioners in the identification and management of adolescent depression within the consultation: a feasibility study. *Journal of Adolescence* 26, 245–50.
- Grant, A.** 2002: Identifying students' concerns: taking a whole institutional approach. In N. Stanley and J. Manthorpe, editors, *Students' mental health needs: problems and responses*. London: Jessica Kingsley, 83–105.
- Grant, A.** 2006: Personal tutoring: a system in crisis? In L. Thomas and P. Hixenbaugh, editors, *Personal tutoring in higher education*. Stoke on Trent: Trentham Books.
- Hawton, K., Houston, K., Malmberg, A. and Simkin, S.** 2003: Psychological autopsy interview in suicide research: reactions of informants. *Archives of Suicide Research* 7, 73–82.
- HESA.** 2006: Students and qualifiers data tables. Retrieved 5 February 2010 from <http://www.hesa.ac.uk>
- HESA.** 2007: Students and qualifiers data tables. Retrieved 5 February 2010 from <http://www.hesa.ac.uk>
- Hill, K., Hawton, K., Malmberg, A. and Simkin, S.** 1997: *Bereavement information pack for those bereaved by suicide or other sudden death*. London: Royal College of Psychiatrists.
- Iliffe, S., Williams, G., Fernandez, V., Vila, M., Kramer, T., Gledhill, J. and Miller, L.** 2009: Treading a fine line: diagnosing depression or medicalising moodiness in young people? *British Journal of General Practice* 59, 156–57.
- Jacobson, L.** 2002: Identifying students' mental health problems in primary health care settings. In N. Stanley and J. Manthorpe, editors, *Students' mental health needs: problems and responses*. London: Jessica Kingsley.
- Jones, R., Finlay, F., Simpson, N. and Kreitman, T.** 1997: How can adolescents' health needs and concerns best be met? *British Journal of General Practice* 47, 631–34.
- Kracen, A.** 2002: *Suicide awareness training with staff in an Irish university setting*. Dublin: Trinity College.
- Kramer, T., Murray, E., Iliffe, S. and Waterman, S.** 1997: Which adolescents attend the GP? *British Journal of General Practice* 47, 327.
- Lilley, R., Owens, D., Horrocks, J., House, A., Noble, R., Bergen, H., Hawton, K., Casey, D., Simkin, S., Murphy, E., Cooper, J. and Kapur, N.** 2008: Hospital care and repetition following self-harm: multi-centre comparison of self-poisoning and self-injury. *The British Journal of Psychiatry* 192, 440–45.
- Mental Health Foundation (MHF).** 2006: *Truth hurts: report of the national inquiry into self-harm among young people*. London: MHF.
- Michel, K.** 2000: Suicide prevention and primary care. In K. Hawton and K. van Heeringen, editors, *Suicide and attempted suicide*. Chichester: Wiley.
- Michel, K., Runeson, B., Valach, L. and Wasserman, D.** 1997: Contacts of suicide attempters with GPs prior to the event: a comparison between Stockholm and Bern. *Acta Psychiatrica Scandinavica* 95, 94–99.
- MORI and HEPI.** 2005: *The student experience report 2005*. Bristol: UNITE.
- Office of the Deputy Prime Minister.** 2005: *Transitions: young adults with complex needs, a social exclusion unit final report*. Wetherby: ODPM Publications.
- Oliver, C. and Storey, P.** 2006: *Evaluation of mental health promotion pilots to reduce suicide amongst young men: final report*. London: Thomas Coram Research Unit, University of London.
- Owens, C., Lloyd, K.R. and Campbell, J.** 2004: Access to health care prior to suicide: findings from a psychological autopsy study. *British Journal of General Practice* 54, 279–81.
- Pugsley, L.** 2004: *The university challenge: higher education markets and social stratification*. Aldershot: Ashgate.
- Quinn, T., Wilson, A., MacIntyre, G. and Tinklin, T.** 2009: 'People look at you differently': students' experience of

- mental health support within Higher Education. *British Journal of Guidance & Counselling* 37, 405–18.
- Rana, R., Smith, E. and Walkling, J.** 1999: *Degrees of disturbance: the new agenda, A report from the heads of university counselling services, march 1999*. Rugby: British Association of Counselling.
- Richardson, G., Parry-Landon, N., Jacobson, L. and Donovan, C.** 2000: *Bridging the gap: how do teenagers and health care providers view each other?* London: NHS Executive.
- Royal College of Psychiatrists.** 2003: *The mental health of students in higher education*. London: Royal College of Psychiatrists.
- Rutz, W., von Knorring, L. and Walinder, J.** 1989: Frequency of suicide on Gotland after systematic postgraduate education of general practitioners. *Acta Psychiatrica Scandinavica* 80, 151–54.
- Silverman, D.** 1993: *Interpreting qualitative data: methods for analysing talk, text and interaction*. London: Sage Publications.
- Smalley, N., Scourfield, J., Greenland, K. and Prior, L.** 2004: Services for suicidal young people: qualitative research on lay and professional perspectives. *Youth and Policy* 83, 1–18.
- Stanley, N.** 2005: Parents' perspectives on young suicide. *Children and Society* 19, 304–15.
- Stanley, N., Manthorpe, J. and Gillespie, L.** 2008: Family physicians' interventions with young people in distress and their parents – managing confidentiality and levels of engagement. *Academic Psychiatry* 32, 92–97.
- Stanley, N., Mallon, S., Bell, J. and Manthorpe, J.** 2009: Trapped in transition: findings from a UK study of student suicide. *British Journal of Guidance and Counselling* 37, 419–32.
- Stanley, N., Ridley, J., Harris, J., and Manthorpe, J.** 2011, In press: Disclosing disability in the context of professional regulation: a qualitative UK study. *Disability and Society* 26.
- Tinklin, T., Riddell, S. and Wilson, A.** 2005: Support for students with mental health difficulties in higher education: the students' perspective. *British Journal of Guidance & Counselling* 33, 495–512.
- Universities UK (UUK).** 2008: Higher education in facts and figures. London: UUK. Retrieved 5 February 2010 from <http://www.universitiesuk.ac.uk/Publications/Documents/Stats2008.pdf>
- Universities UK (UUK) and Standing Committee of Principals (SCOP).** 2002: *Student services: effective approaches to retaining students in higher education*. London: UUK.
- Vassilas, C. and Morgan, H.** 1993: General practitioners' contact with victims of suicide. *British Medical Journal* 307, 1359–67.
- Viner, R.M. and Barker, M.** 2005: Young people's health: the need for action. *British Medical Journal* 330, 901–903.
- Waller, R., Mahmood, T., Gandhi, R., Delves, S., Humphrys, N. and Smith, D.** 2005: Student mental health: how can psychiatrists better support the work of university medical centres and university counselling services? *British Journal of Guidance and Counselling* 33, 117–28.
- Watson, D.** 2007: *Managing civic and community engagement*. Maidenhead: Open University Press.
- Wilson, H.W.** 2003: Staff knowledge and attitudes towards deliberate self-harm in adolescents. *Journal of Adolescence* 26, 623.
- Yeoman, F.** 2005: Degrees of stress. *Times OnLine*. Retrieved 23 April 2005 from <http://www.timesonline.co.uk/article/0,,17329-1579791,00.html>