UWE Bristol Suicide Prevention and Response Strategy

Developed in partnership with University of the West of England (UWE Bristol), University of Bristol and NHS partners.

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Acronyms

HEI – Higher Education Institutions

LGBTQ+ - Lesbian, gay, bi, trans, queer and other identities

SPRG – Suicide Prevention and Review Group

UUK – Universities UK

VC – Vice Chancellor

Statement of Purpose

Suicide is the leading cause of death in adolescents and young people in the UK [1]. Student suicides, as well as being devastating for friends and family, may also have profound impacts on the wider community of students and staff. In recent years, Bristol has experienced clustering of student suicide deaths making our response to this issue all the more important. We recognise that universities play a key role in helping to prevent suicides and that this requires a whole university approach and the need to work in close partnership with students, parents, local government and the NHS.

We are committed to ensuring that students and staff at our universities are as suicide-safe as possible and our strategy has been informed the 2018 UUK guidance "Suicide-Safer Universities" [2]. This starts with a strategic, whole university approach to wellbeing and mental health, which means that all students and staff understand its importance and the role it plays as the foundation for learning and academic achievement.

We are committed to mental health permeating every aspect of the university culture and experience and it being part of the language of education.

Context

Office for National Statistics (ONS) data indicate that there were 95 suicide deaths among higher education students in England & Wales in the 2016 / 2017 academic year, an incidence of 4.7 deaths per 100,000 students [3]. Suicide rates were twice as high among male than female students, somewhat higher in undergraduates than post-graduates, but there was no evidence of an increased risk in people from ethnic minority populations.

UK research [5] [6] [7] and our experiences in Bristol indicate that student-specific factors that may increase the risk of suicide include disruption to studies, poor course attendance, financial pressures, alcohol and substance misuse and stresses related to periods of transition. Some of these factors may reflect the academic and social demands of university life, including difficulties accessing support. They may also reflect the impact of pre-existing mental health problems, often undiagnosed or undisclosed, on course performance and social integration. It is important to recognise the complexity and individualistic nature of deaths by suicide.

Today's generation of young people, particularly young women, are more likely to experience mental illness than previous generations with 4% of males and 15% of females aged 16-24 years experiencing symptoms of severe depression or anxiety in the previous week [8]. Around three-quarters of adults with a mental illness first experience symptoms before the age of 25, with the peak age of onset for most conditions falling between the age of 18 and 25 [9]. Suicidal thoughts, suicide attempts and self-harm are all very real issues for young people. 40% of women aged 16-24 years reported having had suicidal thoughts and one in four have self-harmed at some point in their lives. There has been sustained increases in the prevalence of suicidal thoughts and self-harm across both sexes since 2000. In keeping with this there have been sharp increases in demand on support services in

Bristol and at most other HEIs [10]. In 2017 Universities UK (UUK) identified mental health and wellbeing in higher education as a "strategic priority" [11].

Furthermore, young people appear to be particularly vulnerable to suicide contagion i.e. where exposure to a death by suicide, often through media reporting, may trigger suicidal thoughts and behaviours in others, particularly those who are already vulnerable. Whilst suicide clusters arising from contagion are very rare they may account for up to 1-2% of suicide deaths [12] [13] in young people and have been reported in universities, secondary schools and other institutional settings.

Box 1: Important definitions:

Suicide – Deliberate act of taking of one's life.

Suicide attempt – A suicide attempt is a deliberate action undertaken with at least some wish to die as a result of the act. Although, the degree of suicidal 'intent' varies and may not be related to the lethality of the attempt.

Suicidal feelings - Suicidal feelings can range from being preoccupied by abstract thoughts about ending one's own life, or feeling that people would be better off without you, to thinking about methods of suicide, or making clear plans to take your own life.

Suicidal behaviour – A range of behaviours related to suicide and self-harm in vulnerable individuals, including suicidal thinking, deliberate recklessness and risk-taking, self-harming not aimed at causing death and suicide attempts. Around 20% of young people have self-harmed (non-suicidal) by the age of 20, far fewer (around 2-3%) make suicide attempts.

Non-suicidal self-harm – An action that is deliberate but does not include an intention to die and often does not result in hospital care. It can be used for one or more reasons that relate to reducing distress and tension, inflicting self-punishment and/or signalling personal distress to important others. Non-suicidal self-harm is a signal of underlying mental health difficulties; people who self-harm may also make suicide attempts and be at risk of suicide.

Beliefs and understanding about suicide

The reasons for suicide are often complex and individual. However, we know that financial difficulties, social pressures, life transitions and academic challenges can all have a significant impact on the mental health of young people. Research indicates that a range of factors may be associated with an increased risk of suicide [14] [15] [7], these include:

- A history of previous suicide attempts or self-harm
- Suffering with a mental health disorder
- Alcohol and / or drug abuse
- Being male
- Relationship and / or family breakdown
- Identifying as LGBTQ+ or being unsure about sexual orientation and gender identity
- Being bereaved or affected by suicide in others
- Debt or financial worries
- Experiencing bullying including cyberbullying
- Perfectionism and the negative impacts of social media
- Suffering from a chronic physical health condition

We also know that central to an effective response is an understanding of the facts about suicide and addressing common myths (see Box 2).

UWE Bristol recognises that:

- Suicidal thoughts are common and should always be taken seriously
- Suicide is a difficult thing to talk about and we are therefore committed to training staff in identifying and responding to suicide risk
- Lack of understanding and stigma around suicide and mental illness can be a barrier to seeking and offering help and we are therefore committed to tackling this through training and educating our students and staff
- The effect of a student suicide can be far reaching with a significant impact on family and friends; students both on and off campus; and teaching and support staff across the university
- Suicide prevention is everybody's business and we are committed to a whole university approach that facilitates wide engagement and involvement of students, parents and staff

Box 2: Myths and facts about suicide [34] [35]

Myth 1: Talking about suicide can create or worsen risk
Suicide can be a taboo topic in society. Often, people feeling suicidal don't want to worry or burden anyone with how they feel and so they don't discuss it. By asking directly about suicide you give them permission to tell you how they feel. People who have felt suicidal will often say what a huge relief it is to be able to talk about what they are experiencing. Once someone starts talking they've got a better chance of discovering other options to suicide.

Myth 2: People who talk about suicide aren't serious and won't go through with it.
People who kill themselves have often told someone that they do not feel life is worth living or that they have no future. Some may have actually said they want to die. While it's possible that someone might talk about suicide as a way of getting the attention they need, it's vitally important to take anybody who talks about feeling suicidal seriously.

Myth 3: Most suicides happen suddenly without warning
The majority of suicides have been preceded by warning signs, whether verbal or behavioural. Evidence shows that young people often tell their peers of their thoughts and plans. Of course, there are some suicides that occur without warning. But it is important to understand what the warning signs are and look out for them.

Myth 4: Someone who is suicidal is determined to die
The majority of people who feel suicidal do not actually want to die; they do not want to live the life they have. Often, feeling actively suicidal is temporary, even if someone has been feeling low, anxious or struggling to cope for a long period of time. This is why getting the right kind of support at the right time is so important.

Myth 5: You have to be mentally ill to think about suicide
Most people have thought of suicide from time to time and not all people who die by suicide have mental health problems at the time of death. However, many people who kill themselves do suffer with their mental health, typically to a serious degree. Sometimes it's known about before the person's death and sometimes not. Approximately two thirds of people who die by suicide have not been in contact with mental health services.

Evidence base for suicide prevention strategies

There is a growing evidence base to support Local Government in the development of suicide prevention strategies [16]. The evidence base for strategies in higher education is more limited, however much can be learnt from other settings when developing a university focused strategy. A Cochrane review published in 2014 found insufficient evidence to support widespread implementation of any programs or policies for primary suicide prevention in university settings [17]. The strongest available evidence for population-based suicide prevention in general supports:

a) Training people who are likely to be in contact with suicidal individuals (so-called 'gate-keepers' e.g. lecturers, tutors, student administrators, security staff, accommodation staff, cleaners) in recognising and responding to risk, may improve short-term knowledge and confidence about being able to talk to someone who is suicidal and prevent suicide. In some studies gate-keeper training has been associated with short-term declines in youth suicide in general population settings [17] [18]. There are emerging university-specific training packages being developed in the UK [19].

b) Restricting access to lethal means has reduced overall rates of suicide [20] [21]

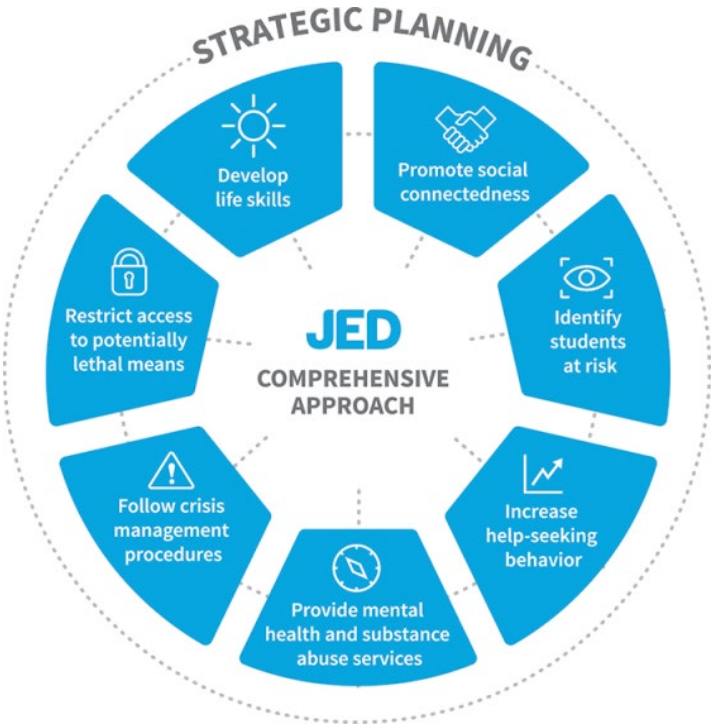
c) Inappropriate media reporting and portrayal of suicides can influence suicidal behaviour leading to increases in the overall number of suicides and increases in the use of particular methods [22] [23].

d) Secondary school-based suicide prevention programmes have been shown to improve knowledge, attitudes and help-seeking behaviours among adolescents [24] [25].

e) Interventions aimed at reducing alcohol consumption in the overall population have been shown to reduce suicide rates [26]

The Jed Foundation, a not-for-profit organisation in the US, has led the way in developing a strategic public health approach to student suicide prevention. They designed an evidence-based 'comprehensive approach' to student suicide prevention on US university campuses [27]. The framework recognises that a comprehensive effort needs to address three parts; prevention, intervention and postvention (actions taken following a suicide with the aim of providing support to those bereaved and to reduce the risk of contagion). It also emphasises that planning and learning around one component will impact the planning and ultimately the effectiveness of the other two components. The framework is set out in the diagram below:

Fig 1: JED's Comprehensive Approach to Mental Health Promotion and Suicide-Prevention for Colleges and Universities [27]



Areas for action

The following section highlights areas for action based on best available evidence and expert opinion and identifies specific actions the university will need to take to implement a comprehensive suicide prevention and response plan. We list these under the headings prevention, intervention and postvention. Details of how these actions will be achieved can be viewed in the UWE Bristol suicide prevention and response action plan.

1. Strategic Planning

Overall strategic direction is provided by the Vice Chancellor (VC) and the University Directorate, who have positioned wellbeing and mental health as a strategic priority via the Mental Wealth First Strategy. Oversight and strategic planning will be provided by the university Suicide Prevention and Response Group, reporting into the University Mental Wealth Coordinating Group

ACTION: *The University's Suicide Prevention and Review Group (SPRG) will oversee delivery of the suicide prevention, intervention and response strategy, building in mechanisms for ongoing review and updates, reporting to the University Safeguarding Steering Group.*

Prevention

2. Creating an environment that promotes wellbeing, good mental health and social connectedness and supports the development of life skills and emotional resilience

Many common mental health problems (e.g. depression, anxiety, substance misuse) begin in adolescence / young adulthood. Attending university represents a major transitional point in many young adults' lives; many students face additional financial, academic and social pressures. It is therefore appropriate that universities create an environment that is supportive of good mental health and emotional wellbeing and goes beyond the development of academic skills to include broader life skills. Social support and connectedness are key protective factors against suicide and can help to buffer the effects of risk factors in people's lives. Improving understanding and tackling stigma surrounding mental health, including suicide and suicidal feelings, and the appropriate use of language is a vital part of this and will encourage help-seeking. There is recognition that suicide more generally needs to become part of an open conversation in our universities in a way that is supportive and helps to reduce stigma.

ACTION: *The University Mental Wealth First Strategy formalises our commitment to make the health and wellbeing of our community a strategic priority. This means that it will inform all of our strategies and operations. It will play a key part in shaping the University's future as we look to define our path to 2030 for our students, staff and partners. Based on the Universities UK Step Change Framework and an audit of our existing provision, the University has published its Mental Wealth First Strategy, and has established an institutional Action, Governance and Coordinating Group. The Action Plan shows how the University will emphasise and develop health and wellbeing across all activity areas, including, for example, curriculum design and campus activities and facilities such as Centre for Sports, the Student Centre and the 24/7 Student Advice Service.*

3. Reducing access to means

Reducing access to high-lethality means of suicide is regarded as one of the most effective suicide prevention strategies [20]. In the university setting, key issues are access to laboratories and chemicals and local high-risk locations for jumping both within the university estate e.g. Halls of Residence and close to the university campus e.g. Clifton suspension bridge. A more generalised concern is cognitive access i.e. increased awareness of particular methods of suicide following reporting of a method after a death either in national and local news or through social media networks and the potential for further imitative deaths or suicide attempts [28] [29]. This will be covered in greater detail in Section 9 Managing Press and Social Media.

ACTION: *Review facilities and accommodation on campus to provide "pause points" that interrupt suicidal intention / action*

ACTION: *Review methods of suicide used amongst university students (through suicide audit and ongoing monitoring) to identify and address any specific concerns*

ACTION: *Promote safe prescribing policy with General Practitioners*

ACTION: *Adopt a multi layered harm reduction approach to address issues related to student use of alcohol and drugs, including how this may interrelate with mental health*

4. Considering how to gather and use information about students in order to respond to individual needs

Universities have a duty to take reasonable care for the wellbeing and health and safety of their students. This can be a challenge for universities where crucial information about individuals is either unknown or undisclosed. Concerns over confidentiality and information sharing also raise significant challenges for universities to address individuals' needs in an appropriate and timely way. An evolving area of interest is the use of IT systems to collect data and triangulate information to help identify students in difficulty and those who might therefore benefit from early support.

ACTION: *The University will invest in market leading learner analytics software as a means to measure engagement with specific academic activities, such as lecture attendance, engagement with the virtual learning environment and coursework submission data to enable us to offer earlier interventions to those who may be at risk*

ACTION: *The University will continue to develop the Students of Concern Information Sharing process to ensure we are able to communicate risk and organise support.*

ACTION: *The University Student Wellbeing Training will re-inforce good practice of our staff in terms of recognising and responding to concerns and referring vulnerable people to specialist support when appropriate.*

ACTION: *Review key administrative and academic processes that may increase stress for students e.g. withdrawal, plagiarism, to identify opportunities to flag concerns over student wellbeing and to ensure the communications throughout the processes are reviewed for content and tone and involve face to face meetings wherever appropriate.*

Intervention

5. Promoting and encouraging help-seeking behaviour

Reducing stigma through education and awareness (see Prevention, section 2) is part of the solution to encouraging help-seeking behaviour. But universities need to go further ensuring the provision of a diverse, accessible and comprehensive range of supportive services.

ACTION: *The Mental Wealth First strategy outlines the range of student support services available and set outs future plans to improve access, build capacity and promote better integration of services across the University, for example via our plans for "Connected Delivery". In addition, the range and scope of our wellbeing provision will be extended via our commitment to provide, for example, the Out of Office Hours Student Adviser Service and the on-line BACP accredited counselling. Careful consideration will need to be given to ensure all our services are culturally appropriate and easy to navigate.*

6. Identifying and responding to a student in distress

It is paramount that the university community as a whole understand how to identify and support someone who may be at risk through appropriate training and awareness raising. It is helpful to divide the community into different categories depending on what role they can be expected to play in suicide prevention with each category benefiting from different levels of training. These include:
Group 1 - people with an explicit responsibility for the mental and emotional wellbeing of students e.g. student services staff, medical staff and senior tutors
Group 2 – People who are an integral part of the community and can therefore be expected to notice, be supportive towards and refer appropriately distressed individuals and those experiencing suicidal thoughts e.g. students, lecturers and other teaching staff, security and accommodation staff, student administrators, estates staff, security staff, cleaning staff and catering staff

ACTION: *A suicide prevention-training schedule and register will document who should receive what training, through what method and how often. This will be monitored by SPRG, reporting to the University Safeguarding Steering Group.*

ACTION: *We will review Wellbeing Service internal risk assessment protocols and DNA processes to enhance the means through which we identify vulnerable students.*

7. Developing and implementing a care pathway for a student in distress

A clear and simple care pathway is essential in the management of support for a student in distress. Development and implementation of care pathways requires multiagency collaboration involving student services, GPs, secondary care, NHS mental health providers, local authority and third sector organisations.

ACTION: *Foundation and development of Bristol HE & NHS Liaison forum to improve strategic working relationships between NHS Mental Health teams and University support services (UoB & UWE) and to look at improving referral pathways and outcomes for students.*

ACTION*: Enhance the connectivity of UWE Bristol's internal support services via the Connectivity Project.*

Postvention

The term postvention is used to refer to actions taken following a suicide with the aim of providing support to those bereaved, to reduce the risk of contagion and ensure lessons are learnt to reduce future risk.

8. Responding to a suicide in the university setting

A suicide death in the university community can have wide reaching effects. Furthermore, in some circumstances, through the process of social contagion the death of one student by suicide may trigger suicidal thoughts and behaviours in others, particularly those who are already vulnerable (see section 9 below). It is therefore essential that the response to a student death is managed in a planned way in order to minimise further harm.

ACTION: *The University student death protocol outlines actions that should be taken immediately and in the longer term and sets out clear roles and responsibilities including initial reporting arrangements, immediate actions to consider, notification of staff, students and external partners e.g. local authority, family liaison, managing press enquiries and how to appropriately remember a student. The student death protocol outlines how the University will ensure that relevant information is shared and that those directly impacted by a death are supported and their voice heard.*

9. Managing press and social media

The media often report suicide deaths, and the deaths of young people may be considered particularly newsworthy. There is a strong body of research highlighting the negative impacts of irresponsible media reporting, including the risk of contagion or imitative behaviour. Furthermore, press intrusion may exacerbate the grief of families and communities at a very difficult time in their lives and therefore needs to be managed appropriately through communication with the media and support and forewarning to families.

ACTION: *A lead person will be identified i.e. the Director of Corporate Communications, through which all communication with the local and national press should be managed and should follow best practice guidelines i.e. Samaritans Media Guidelines for the Reporting of Suicide*

ACTION: *Develop and maintain close links with local authority public health to provide support and direction when dealing with concerns relating to local media and press.*

ACTION: *Strategic Communications Team leads will monitor the reporting of a student suicide on widely used social media platforms and risk assess if a response is required.*

10. Identifying and responding to suicide clusters

Suicide clusters can be difficult to identify and define (see box 3). Their impact can be widespread, and an effective response therefore requires good preparation and multiagency collaboration. The PHE Identifying and responding to suicide clusters and contagion: a practice resource provides clear guidance on the steps that need to be taken to prepare for a suicide cluster. This emphasises the link that needs to be made with the local multiagency suicide prevention group led by local authority public health. It provides guidance on how to identify a potential cluster early on and suggests responses to reduce the risk of contagion.

Box 3: Definitions of a suicide cluster [36]
A series of three of more closely grouped deaths…which are linked by space or social relationships. In the absence of transparent social connectedness, evidence of space and time linkages are required to define a cluster. In the presence of a strong demonstrated social connection, only temporal significance is required.

ACTION: *In the event of an emerging cluster the University SPRG will establish an Incident Response Team in collaboration with Bristol City Council public health. The Incident Response Team will meet regularly to monitor the situation and respond appropriately in terms of media liaison, internal and external communications, provision of support to those affected and identification and support for those considered vulnerable.*

11. Learning from deaths and serious suicide attempts

An essential aspect of suicide prevention is to learn from any deaths and serious suicide attempts. Through learning we can understand if there is anything that could be done differently or indeed where good practice has been demonstrated.

ACTION: *The University SPRG will carry out a serious incident review for every death by suicide. This will capture essential information which will be added to the ongoing audit of student deaths by suicide in order to identify any wider themes and used to develop recommendations to reduce future risk.*

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