

## University of Bristol Suicide Prevention and Response Plan

Summary			
<p>This document has been produced with the aim of helping to prevent student suicides at the University of Bristol. It was developed in collaboration with local Public Health colleagues and the University of the West of England. For the University of Bristol this work was overseen by the Suicide Prevention and Response Group. The final section of the Plan highlights areas for action based on best available evidence and expert opinion. Details of how these actions will be achieved will be detailed in a University of Bristol suicide prevention and response action plan, which will be an internal document.</p>			
Scope			
<p>This is a whole-institution document and is relevant for all staff and students.</p>			
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# **University of Bristol Suicide Prevention and Response Plan**

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## Acronyms

HEI – Higher Education Institutions

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

SPRG – Suicide Prevention and Response 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, the University 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 plan 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. This plan is part of the University's Mental Health and Wellbeing Strategy, which is informed by UUK as best-practice for the HE sector and with reference to the JED Foundation's comprehensive approach.

**We are committed to mental health permeating every aspect of the University culture and experience and it being part of the language of education. This plan is a key part of our commitment and it is the University's aim that all staff and students are aware of the plan within the context of the wider Mental Health and Wellbeing Strategy, its key themes and the actions.**

## 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. Here in Bristol, as the result of a recent cluster, numbers of deaths have been higher than expected based on national incidence figures. Recent student mental health survey data indicate approximately 2% of students have attempted suicide in the last 12 months and a quarter reported experiencing suicidal thoughts in the previous fortnight, although the low response rate (25%) means these figures may be over- or under-estimated [4].

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. Other factors that may increase risk amongst students may be a sense of failure, for example those students who have come through clearing; suffered a loss; underlying specific learning difficulty, disability or medical issue. 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 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
- Previous brain injury e.g. concussion

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

## **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, to look out for them, to understand what to do next and how to access support. Limiting access to means of suicide can act as an effective intervention.

### **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; they do change their minds and may want to be saved. 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.

### **Our institution 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

### **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 will be detailed in a University of Bristol suicide prevention and response action plan.

### 1. Leadership and Communication

Overall strategic direction is provided by the Vice Chancellor (VC) and the Executive team, who have positioned wellbeing and mental health as a strategic priority. Culture change and effective communication will be key. Oversight and strategic planning will be provided by the University Suicide Prevention and Response Group (see Appendix 1 for Terms of Reference and group membership).

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

## 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 Health and Wellbeing Strategy outlines how the institution will build an environment where students and staff can thrive and where mental health and wellbeing are supported in all aspects of university life. Specifically, this includes the development of the new Student Wellbeing Service and the Residential Life Service with the core remit of student support and community building; introduction of the Bristol Futures courses designed to help students improve their personal resilience and to develop skills to deal with the increasing complexity of our world; a greater focus on student wellbeing during student and staff induction; and training for all staff in contact with students, which will cover wellbeing, mental health and suicide awareness.*

**Action:** *Development of a Substance Misuse policy and plan that seek to increase awareness and education amongst students and staff; promote a harm reduction approach and improve access to support a healthy environment.*

**Action:** *To respond to the negative impact of bullying, harassment and hate crime on wellbeing and mental health, the University will continue to develop approaches that support an inclusive campus and effectively challenge divisive and discriminatory behaviours.*

**Action:** *Provide students access to wellbeing education and information by working with internal and external providers to offer a variety of formats including self-help resources, one-off events, ongoing skills-based workshops and other proactive activities.*

### **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:** *Ensure appropriate policies and procedures are in place across the University to ensure the safekeeping of potentially dangerous chemicals.*

**ACTION:** *Ensure estates reviews potential high-risk locations (e.g. the tops of high rise residential accommodation and University buildings) and ensures these are secure and takes note of the impact of automatic doors that prevent return of access.*

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

**ACTION:** *Work with the local authority to identify actions that can be taken to reduce access to local high-risk locations, including the Clifton Suspension Bridge.*

### **4. 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 encourage disclosure and maintain records of relevant information prior to arrival and throughout a students' time at university and how to use this*

information to identify individuals at heightened risk and respond in an appropriate and timely way. This will include information regarding mental illness, university or course transfers, suspensions and withdrawals, lecture attendance, substance misuse to inform appropriate referral and support plans from Student Services and external providers.

**ACTION:** The University will review procedures for obtaining emergency contact details for all students and early conversations about the need and benefits of information sharing within the University and with external partners such as guardians and health professionals.

**ACTION:** The [Information Sharing and Suicide Prevention: Consensus Statement](#), which outlines legal duties of confidentiality and is designed to promote greater sharing of information within the context of the law, should be adopted by the University and widely disseminated across relevant University staff with links to relevant local policies.

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

## Intervention

### 5. Promoting cultural change and encouraging help-seeking behaviour

Reducing stigma and discrimination through education and awareness (see Prevention, section 2) is part of the solution to promoting cultural change and 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 health and wellbeing 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. Careful consideration will need to be given to what type of services are available, ensuring these are culturally appropriate, easy to navigate and readily accessible, how they are advertised and promoted and how to capture the student voice in terms of need. This will include development of a directory of local services to be widely disseminated across students and staff.

**ACTION:** Provide opportunities for students to gain wellbeing and mental health awareness and training to create a culture of acceptance and inclusivity; improve their own life-skills and help seeking behaviours; to better understand how to support a friend or colleague and improve their future employability.

### 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. There are a number of organisations providing suicide awareness and prevention training. Applied Suicide Intervention Skills Training (ASIST) which aims to equip people with an ability to recognise when someone may have thoughts of suicide and work with them to create an immediate safety plan would be recommended for Group 1. Group 2 will ideally have undertaken suicide awareness training e.g. safeTALK, which aims to equip people with a willingness and ability to spot the signs that someone is struggling and signpost them to appropriate resources or ASIST trained personnel for further support. All staff, regardless of role, will undertake annual on-line refresher training to improve awareness.*

## **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:** *Mapping of current local services will be undertaken and used to inform the potential redesign and implementation of shared care pathways for students in distress. This will require multiagency involvement from internal and external stakeholders. A clear care pathway map will be published, visible and accessible throughout the University.*

## **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:** *Review the University [student death protocol](#) which 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.

**ACTION:** *The university will develop an approach for engaging with parents/carers of students, who take their own life. This will ensure that they feel respected, supported and involved from the point of death. They will also be offered the opportunity to help the University learn lessons from the loss of a loved one. Develop a consistent approach by identifying training for senior staff to engage with the bereaved.*

**ACTION:** *Appropriate support will be identified and offered to staff who have been involved with a student who has died by suicide and to those involved in the SPRG / IRT on a long-term basis.*

**ACTION:** *[PHE guidance](#) on how to identify and prioritise vulnerable people following a suicide should be adopted so that appropriate support can be provided to those who need it.*

**ACTION:** *A list of additional resources e.g. Help is at Hand, The Support after Suicide Website and other sources of support e.g. Samaritans Step by Step service, for both students and staff following a suicide will be developed.*

## **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. Head of Media 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:** *Communication 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 suicide cluster [36]**

A series of three or 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:** *The University SPRG will develop and maintain strong links with the Bristol suicide prevention group (led by Bristol City Council public health) to ensure the development of a shared community action plan for responding to possible suicide clusters.*

**ACTION:** *The University SPRG will be responsible for ongoing surveillance in order to help identify possible clusters early.*

**ACTION:** *In the event of an emerging cluster the University SPRG will establish an Incident Response Team (IRT) in collaboration with Bristol City Council public health. The IRT 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 due to their proximity to the deceased as defined by PHE guidance.*

## **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. This requires the implementation of a robust monitoring and review system. It is unlikely to be possible to capture all suicide attempts as some will occur without anyone being aware. Therefore for the purposes of monitoring we would attempt to capture serious attempts defined as those with high severity resulting in admission to hospital intensive care units or those using a high lethality method such as hanging or jumping.

**ACTION:** *The University SPRG will carry out a serious incident review for every suicide and serious attempt that takes place. A serious attempt in this context is defined as one that leads to an individual being admitted to intensive care or the individual has used a high mortality method. This will involve developing a monitoring system to capture essential information about a suicide or serious suicide attempt and demographic, personal, academic or other pertinent information. This will be informed by findings from the suicide audit which will be repeated at regular intervals and used to develop recommendations to reduce future risk.*

**ACTION:** *Collate and interpret data from our own and other institutions in order to build a profile of vulnerability within HE students with a view to helping us establish mechanisms for identification, targeting support and developing appropriate support resources.*

## References

- [1] Office for National Statistics, "Deaths registered in England and Wales (series DR): 2016," 2017.
- [2] UUK & Papyrus, "Suicide-Safer Universities," Sept 2018. [Online]. Available: <https://www.universitiesuk.ac.uk/policy-and-analysis/reports/Documents/2018/guidance-for-sector-practitioners-on-preventing-student-suicides.PDF>. [Accessed Sept 2018].
- [3] Office for National Statistics, "Estimating suicide among higher education students, England and Wales: Experimental Statistics," 2018.
- [4] University of Bristol, *Bristol Student Mental Health and Wellbeing Survey 2018: preliminary analysis*, Bristol: unpublished, 2018.
- [5] K. Hawton, H. Bergen, S. Mahadevan, D. Casey and S. Simkin, "Suicide and deliberate self-harm in Oxford University students over a 30 year-period," *Soc Psych Psych Epidemiol*, vol. 47, pp. 43-51, 2012.
- [6] N. Stanley, "Trapped in transition: findings from a UK study of student suicide," vol. 37, no. 4, pp. 419-433, 2009.
- [7] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH), "Suicide by children and young people.," University of Manchester, Manchester, 2017.
- [8] S. McManus, P. Bebbington, R. Jenks and T. Brugha, "Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey," NHS Digital, Leeds, 2014.
- [9] R. Kessler and P. Wang, "The descriptive epidemiology of commonly occurring mental disorders in the United States.," *Annu Rev Public Health*, vol. 29, pp. 115-29, 2008.
- [10] C. Thorley, "Not by degrees: Improving student mental health in the UK's universities," IPPR, 2017.
- [11] West, S (Chair UUK Mental Health in Higher Education Working group), "#stepgcahngc: Mental health in higher education," 2017.
- [12] M. Gould, S. Wallenstein and M. Kleinman, "Time-space clustering of teenage suicide," *Am J Epidemiol*, vol. 131, pp. 71-8, 1990.
- [13] P. Jones, D. P. S. Gunnell, J. Scourfield, K. Lloyd, P. Huxley, A. John, B. Kamran, C. Wells and M. Dennis, "Identifying probable suicide clusters in Wales using national mortality data," *PLoS ONE*, vol. 8, no. 8, 2013.
- [14] Department of Health, "Preventing suicide in England: A cross-government outcomes strategy to save lives," London, 2012.
- [15] G. Turecki and D. Brent, "Suicide and suicidal behaviour," *Lancet*, vol. 387, p. 1227-39, 2016.
- [16] Public Health England, "Suicide prevention: resources and guidance," 9 Jan 2017. [Online]. Available: <https://www.gov.uk/government/collections/suicide-prevention-resources-and-guidance>.
- [17] C. Harrod, C. Goss, L. Stallones and C. DiGuseppi, "Interventions for primary prevention of suicide in university and other post-secondary educational settings.," *Cochrane Database of Systematic Reviews*, 2014.

- [18] L. Garraza, S. Boyce, C. Walrath, D. Goldston and R. McKeon, "An Economic Evaluation of the Garrett Lee Smith Memorial Suicide Prevention Program," *Suicide and Life Threat Behav*, vol. 48, no. 1, 2018.
- [19] L. Gask, N. Coupe, D. McElvenny and G. Green, "Pilot study evaluation of suicide prevention gatekeeper training utilising STORM in a British university setting," *British Journal of Guidance & Counselling*, vol. 45, no. 5, pp. 595-605, 2017.
- [20] G. Zalsman, K. Hawton, D. Wasserman, K. van Heeringen, E. Arensman, M. Sarchiapone, V. Carli, C. Höschl, R. Barzilay and J. Balazs, "Suicide prevention strategies revisited: 10-year systematic review," *Lancet Psychiatry*, 2016.
- [21] M. Sarchiapone, L. Mandelli, M. Iosue, C. Andrisano and A. Roy, "Controlling Access to Suicide Means.," *Int J Environ Res Public Health*, vol. 8, no. 12, p. 4550–4562, 2011.
- [22] Samaritans, "Media guidelines for the reporting of suicide," Samaritans, 2018. [Online]. Available: <https://www.samaritans.org/media-centre/media-guidelines-reporting-suicide>. [Accessed Aug 2018].
- [23] Y. Chen, P. Yip, C. Chan, K. Fu, S. Chang, W. Lee and D. Gunnell, "The impact of a celebrity's suicide on the introduction and establishment of a new method of suicide in South Korea.," *Arch Suicide Res*, vol. 18, no. 2, pp. 221-6, 2014.
- [24] D. Wasserman, C. Hoven, C. Wasserman, M. Wall, R. Eisenberg, G. Hadiaczky and I. Kelleher, "School-based suicide prevention programmes: the SEYLE cluster-randomised, controlled trial.," *Lancet*, vol. 385, no. 9977, pp. 1536-44, 2015.
- [25] M. Cusimano and M. Sameem, "The effectiveness of middle and high school-based suicide prevention programmes for adolescents: a systematic review," *Inj Prevention*, vol. 17, no. 1, pp. 43-49, 2011.
- [26] Y. Razvodovsky, "Beverage-specific alcohol sale and suicide in Russia.," *Crisis*, vol. 30, no. 4, pp. 186-91, 2009.
- [27] JED Foundation, "JED's Comprehensive Approach," 2017. [Online]. Available: <https://www.jedcampus.org/our-approach/>. [Accessed June 2018].
- [28] Mental Health Foundation, [Online]. Available: <https://www.mentalhealth.org.uk/a-to-z/s/suicide>.
- [29] C. Walrath, L. Garraza, H. Reid, D. Goldston and R. McKeon, "mpact of the Garrett Lee Smith youth suicide prevention program on suicide mortality.," *Am J Public Health*, vol. 105, no. 5, pp. 986-93, May 2015.
- [30] C. Crane, K. Hawton, S. Simkin and P. Coulter, "Suicide and the Media: Pitfalls and Prevention Report on a Meeting Organized by the Reuters Foundation Program at Green College and University of Oxford Centre for Suicide Research at Green College," *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, vol. 26, no. 1, pp. 42-47, 2005.
- [31] M. Gould, M. Kleinman, A. F. J. Lake and J. Midle, "Newspaper coverage of suicide and initiation of suicide clusters in teenagers in the USA, 1988–96: a retrospective, population-based, case-control study," *Lancet Psychiatry*, 2014.
- [32] Centers for Disease Control and Prevention (CDC), "Connectedness as a strategic direction for the prevention of suicidal behavior," 2011.

- [33] L. Garraza, C. Walrath, D. Goldston, H. Reid and R. McKeon, "Effect of the Garrett Lee Smith Memorial Suicide Prevention Program on Suicide Attempts Among Youths," *JAMA Psychiatry*, vol. 72, no. 11, pp. 1143-1149, 2015.
- [34] Samaritans, "Myths about suicide," 2018. [Online]. Available: <https://www.samaritans.org/how-we-can-help-you/what-speak-us-about/signs-you-may-be-struggling-cope/myths-about-suicide>. [Accessed July 2018].
- [35] World Health Organization, "Preventing suicide: a global imperative - Myths," [Online]. Available: [http://www.who.int/mental\\_health/suicide-prevention/myths.pdf](http://www.who.int/mental_health/suicide-prevention/myths.pdf). [Accessed July 2018].

## **Appendix 1: UoB Suicide Prevention and Response Group – Terms of Reference (June 2018)**

### **Purpose**

- **Suicide prevention:** to provide overarching guidance on the Institutional approach to student and staff suicide prevention. This will include development and implementation of a suicide prevention plan and oversight of any internal reviews.
- **Immediate suicide response:** to enable the immediate mobilisation of a senior internal team who can work closely with external partners to provide overarching guidance and management of the urgent response required in the event of an unexpected death. This will include advice on urgent policy change relating to vulnerable student or staff complex cases and oversight of the immediate and reactive work carried out by relevant divisions, including HR, Student Services and Communications.

### **Responsibilities**

In the event of an unexpected student or staff death, the Suicide Prevention and Response team will oversee all immediate and urgent key activities related to the Institutional response. Key responsibilities for both immediate response and prevention will include:

1. Oversight of the individual engagement and support to family and close friends.
2. Oversight and coordination of the engagement and support to staff and students, including the provision of additional mental health and wellbeing services.
3. Engagement with key external stakeholders in relation to suicide prevention. This includes, but is not limited to, stakeholders such as The Samaritans, Independent Press Standards Organisation, Avon Coroners Courts, Bristol City Council (BCC) and The Clifton Suspension Bridge Trustees.
4. Oversight of institutional media and external relations engagement in line with Public Health England guidance.
5. Development and implementation of a suicide prevention plan in line with the Institutional mental health framework and our external partners from BCC and The University of West England.
6. Review of the effectiveness of internal policies and processes with remit to make recommendations to Mental Health and Wellbeing Taskforce in the event of an unexpected death.
7. Learning from serious suicide attempts, where reported to the University, with the purpose of informing the Institutional suicide prevention approach

### **Accountability and Reporting**

The Suicide Prevention and Response Team reports to the Mental Health and Wellbeing Taskforce and through it to the University Management Team and the Expert Advisory Group.

### **Meetings**

The meetings will be chaired by the Deputy Registrar and will be held approximately monthly. The chair may nominate the HR Director to act as chair in the event of an

unexpected staff death. In exceptional circumstances, an unexpected death or cluster of deaths, the team will meet daily or as required in relation to individual circumstances.

### **Membership**

Deputy Registrar (Chair); Chief Executive of the Student Union; Director of External Relations; Director of Student Services; Head of Media; Assistant Director of Communications and Marketing Services; Head of Student Wellbeing; Professor of Epidemiology; HR Director; Head of Student Residential Life; Interim Director of City Wellbeing, Bristol City Council.